

**SC HIV PREVENTION PLAN  
2005-2008**

**October 4, 2004**

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# FORWARD

Planning for prevention of Human Immunodeficiency Virus (HIV) has been an integral part of programs at the South Carolina Department of Health and Environmental Control (DHEC) STD/HIV Division for more than 19 years. Since the first reported cases of HIV/AIDS in 1985, DHEC has been involved in conducting activities to address the prevention needs of those most at risk of infection.

Starting in January 1994, DHEC organized a statewide HIV prevention community planning group (CPG). In a shared effort with DHEC, the CPG developed a statewide plan to improve prevention efforts by strengthening the scientific basis, community relevance, and population or risk based focus of prevention interventions. During 2004, DHEC and the CPG have been involved in developing a new plan. This new comprehensive SC HIV Prevention Plan is the result of the efforts of many dedicated individuals who have worked to assess HIV prevention needs and to prioritize populations and interventions.

DHEC and the CPG have been fortunate to participate in a process that involves so many individuals concerned about the health and well being of South Carolina's citizens. It is the hope of DHEC and the CPG that local prevention providers and others will find this a useful and relevant document for planning local activities and efforts. We also believe that through the ongoing efforts to work together and collaborate that we can make a difference in the future of this epidemic. We believe that by TEAMwork, Together Everyone will Achieve the Mission of eliminating HIV.

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## KEY TO ABBREVIATIONS AND ACRONYMS

<b>AA</b>	African Americans
<b>AAMSM</b>	African American Men who have Sex with Men
<b>AED</b>	Academy for Educational Development
<b>AHED</b>	AIDS Health Educator (SC DHEC)
<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ASO</b>	AIDS Service Organization
<b>ATOD</b>	Alcohol, Tobacco, and Other Drugs
<b>BRFSS</b>	Behavioral Risk Factor Surveillance System
<b>CBCT</b>	Community Based Counseling and Testing
<b>CTS</b>	Counseling and Testing Services
<b>CBO</b>	Community Based Organization
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CLI</b>	Community-Level Intervention
<b>CPG</b>	SC HIV Prevention Community Planning Group
<b>DAODAS</b>	Department of Alcohol and Other Drug Abuse Services
<b>DEF</b>	Data Entry Form
<b>DHEC</b>	Department of Health and Environmental Control
<b>DIS</b>	Disease Intervention Specialist (SC DHEC)
<b>DOC</b>	Department of Corrections
<b>EPI</b>	Epidemiologic
<b>GHS</b>	Greenville Hospital System
<b>GLI</b>	Group-level Interventions
<b>GMOC</b>	Gay Men of Color
<b>HARSS</b>	HIV/AIDS Reporting Surveillance System
<b>HBCU</b>	Historically Black Colleges and Universities
<b>HC/PI</b>	Health Communications and Public Information
<b>HE/RR</b>	Health Education/Risk Reduction
<b>HIV</b>	Human Immunodeficiency Virus
<b>IDU</b>	Injecting Drug User
<b>ILI</b>	Individual-level Intervention
<b>IPF</b>	Implementation Planning Form
<b>LIP</b>	Local Implementation Plan
<b>MCBO</b>	Minority Community Based Organization
<b>MIS</b>	Management Information Systems
<b>MUSC</b>	Medical University of South Carolina
<b>MSM</b>	Men who have Sex with Men
<b>MSM/IDU</b>	Men who have Sex with Men/Injecting Drug User

<b>MSW</b>	Men who have Sex with Women
<b>NIR</b>	No Identified Risk
<b>OUT</b>	Outreach
<b>PCM</b>	Prevention Case Management
<b>PCRS</b>	Partner Counseling and Referral Services
<b>PEMS</b>	Program Evaluation Monitoring System
<b>PSA</b>	Public Service Announcement
<b>SCDC</b>	South Carolina Department of Corrections
<b>SCSU</b>	South Carolina State University
<b>SDE</b>	State Department of Education
<b>STD</b>	Sexually Transmitted Disease (synonymous with STI)
<b>STI</b>	Sexually Transmitted Infection (synonymous with STD)
<b>TA</b>	Technical Assistance
<b>USC</b>	University of South Carolina
<b>WAR</b>	Women at Risk
<b>WSM</b>	Women who have Sex with Men
<b>YAR</b>	Youth at Risk
<b>YRBS</b>	Youth Risk Behavior Survey

## EXECUTIVE SUMMARY

The HIV/AIDS epidemic continues to impose a significant presence on citizens and on the health care system in South Carolina. In the southeastern states, HIV/AIDS has followed the patterns of other sexually transmitted infections (STIs). Sexually transmitted infections, including HIV, account for over 90% of all reported infectious diseases in the state. South Carolina ranked seventh highest in the country in 2002 for annual AIDS case rates, tenth for infectious syphilis, third for gonorrhea, and eighth for chlamydia. Over \$70 million was spent in 2003 in South Carolina for HIV related medical care.

African Americans bear a disproportionate burden of the HIV and infectious syphilis epidemics in South Carolina. African Americans make up more than 70% of persons living with HIV and 85% of persons with syphilis. Such disparities are due, at least in part, to the fact that African Americans are likely to seek care in public clinics that report STD more completely than do private providers; however, reporting bias does not fully explain differences in infection rates among African Americans, particularly with HIV/AIDS.

While being African American is not in itself a risk factor for HIV and STDs, there is a positive correlation between being African American and primary health status influencing factors such as poverty, access to quality health care, health care seeking behavior, illicit drug use, and living in communities with high prevalence of sexually transmitted diseases.

Public health and community efforts have made progress in changing the course of HIV and STD epidemics, resulting in declines in the number of deaths due to HIV and decreases in the number of perinatal HIV infections. Infectious syphilis cases have continued to decline over the past eight years. Routine screening for chlamydia and gonorrhea in young sexually active women is resulting in small declines in prevalence of these diseases, and may be contributing to recent declines in hospital and emergency room visits for pelvic inflammatory disease.

Fewer HIV deaths, along with stable rates of new infection, means there are more people living with HIV who are in need of both care and prevention services. South Carolina has experienced an increase of 72% in persons living with HIV/AIDS from 1995 to 2003. More dramatically, there has been an increase of 97% in the number of women living with HIV during this time. As of December 31, 2003, there were an estimated 13,221 persons living with HIV/AIDS in the state.

Even though the overall number and rate of newly diagnosed persons with HIV/AIDS each year appears to be generally stable, it is unacceptably high. Each year an average of 880 persons are newly diagnosed with this disease. However, this number represents only those persons who have been tested. Many persons with high-risk behaviors have not yet chosen to be tested, and many persons at highest risk are not yet reached by our prevention efforts and do not seek diagnosis and treatment.

Prevention needs are essential, as persons living with HIV/AIDS are engaging in sexual and/or substance use risk behaviors. Interviews from July 2002 through March 2004 with recently

diagnosed persons with HIV indicate that one third reported substance use during the past five years, 30% reported being potential alcoholic, and 40% used illicit drugs. Nine percent reported that they had ever injected drugs and 16% had used crack. More men than women reported each substance use-related risk.

Sexual risks reported by HIV infected persons interviewed indicate that 36% of men paid someone for sex; 15% of women received either money or drugs for sex. Thirty-eight percent of men and 23% of women reported having at least one sexually transmitted disease during the past ten years.

Needs assessment with prevention providers and persons with HIV or at risk for HIV have identified priority interventions that will reduce new infections. These include needs for information for high-risk groups who do not access community/agency services (unemployed, out of school); additional programs targeting men who have sex with men; targeted peer education programs for youth and young adults; improved access to drug treatment and prevention counseling for alcohol/other drug using persons; increased numbers of trained staff that can conduct effective interventions particularly for men who have sex with men and for persons living with HIV disease.

Effective interventions to prevent HIV must be increased, integrated with STD prevention efforts, and involve leaders and members of African American communities. Additionally, care and prevention efforts must be integrated, so that the risk of transferring HIV to others from those already infected is reduced and the number of persons living with HIV who are in a system of care is increased.

Finally, for each of its priority populations, the statewide HIV Prevention Community Planning Group identified needs for more behavioral risk data, social network information and needs assessment information involving members of priority populations that will result in better decisions for planning, designing interventions, and targeting resources.

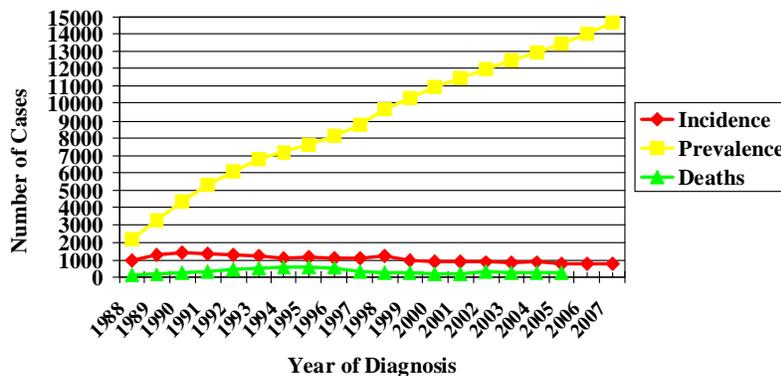
No single agency or community organization can reduce the racial and ethnic disparities in HIV infection among African Americans without the active involvement of more African American leaders and institutions. Addressing and overcoming barriers will take time, and will require effective and proven strategies along with sustained community mobilization in which community based organizations across South Carolina collaborate to address HIV/AIDS prevention priorities comprehensively and completely.

## Executive Summary

Since 1986, more than 22,400 persons have been diagnosed with HIV infection (including AIDS) in South Carolina through December 2007. During 1985 – 1990, an average of 848 cases were diagnosed each year. In the subsequent three years (1991 – 1993), newly diagnosed HIV/AIDS cases averaged 1,310. The increase during this period was in part due to the artificial rise in AIDS cases as a result of the change in case definition in 1993. For the past five years, the annual number of new cases has been about 805. Many more persons are infected but have not been tested.

Some of the changes over time in numbers of new cases are largely the result of reporting patterns or targeted testing initiatives. The initial steep rise in the epidemic reflects the early years when less was known about the transmission of HIV and effective medical treatments did not exist. As a result, infection rates increased and more HIV-infected individuals went on to develop AIDS. Most experts believe that when more was learned about HIV and the behaviors involved in its spread, effective prevention strategies reduced the overall number of new infections, and medical treatment, for some individuals, postponed the onset of AIDS. In more recent years, however, there is concern nationally that the epidemic may grow particularly among young men who have sex with men.

**Figure 1. South Carolina HIV/AIDS Incidence, Prevalence and Deaths**



Number of Cases Diagnosed in SC only; excludes out of state cases returning to SC.

Since 1994, new anti-retroviral drugs and strengthened care services have contributed to a decline in overall AIDS deaths. This decline is illustrated by the 249 deaths in 2005, a 58% drop from the 590 deaths in 1994. It is important to note that despite the decline in deaths due to AIDS and the apparent stabilization of the number of new HIV/AIDS cases diagnosed annually, the prevalence of HIV infection (the number of persons estimated to be

living with HIV/AIDS) is significantly increasing. The number of persons living with HIV/AIDS at the end of each year has increased 67% from 1997 to 2007. It is also important to note that there are differences among certain populations in the number and rate of new and prevalent infections, as this profile will indicate. Figure 1 shows total incidence (the number of new cases within a specified time period), deaths and prevalence of HIV/AIDS cases in South Carolina since 1988.

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The epidemic in South Carolina is primarily driven by sexual exposure, primarily among men who have sex with men and heterosexuals at risk. Injecting drug use appears to be diminishing as a risk for HIV.

African-Americans are disproportionately affected by HIV/AIDS and are over-represented among all risk populations.

### **Overview of Chapter**

The purpose of this Epidemiologic Profile is to provide information to the SC HIV Prevention Community Planning Group (CPG) on the number and characteristics of persons becoming HIV infected in order to target and prioritize HIV prevention activities.

This chapter of the SC HIV Prevention Plan includes a list of definitions and describes the data sources used, the limitations of each data type, and presents the data in order to answer the following questions:

- 1. What are the socio-demographic characteristics of the population?**
- 2. What is the impact of HIV/AIDS on the population?**
- 3. Who is at risk for becoming infected with HIV?**
- 4. What is the geographic distribution of HIV infection? \***
- 5. What are the patterns of service utilization of people living with HIV/AIDS?**
- 6. What are the characteristics of persons who know they are HIV-positive but who are not in HIV primary care?**

These questions will be explored through analyses of cumulative living (prevalent) and newly diagnosed (incident) HIV/AIDS cases; a description of seroprevalence data from HIV counseling and testing sites and other studies; a summary of other risk behavior profiles and community-based HIV risk assessment information; and a discussion of related sociodemographic, health and risk behavior indicators.

*\*Note: geographic distribution will be discussed within questions 2 and 3 for each population/risk described.*

### **Definitions**

**AIDS** - Acquired Immunodeficiency Syndrome, the end stage of HIV infection characterized by life-threatening or severely disabling disease.

**HIV** - Human Immunodeficiency Virus, the cause of HIV infection.

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**HIV/AIDS** - Includes those persons with HIV infection, as well as those who have progressed to AIDS. Unless noted, most HIV data in this profile includes persons diagnosed with AIDS.

**HIV Only**- Includes only persons with HIV infection who did not develop AIDS within 365 days of report of positive HIV test.

**Incidence**- The number of new HIV/AIDS cases newly diagnosed and reported each year. Incidence cases may be combined in two or three year periods.

**Incidence Rate** - Number of new cases occurring during a period of time, divided by the annual average population, multiplied by 100,000. It is a measure of the frequency with which an event (e.g. new HIV/AIDS cases) occurs in a population over a period of time. It is also a measure of risk of getting the disease.

**Prevalence**- The number or proportion of persons estimated to be living with HIV/AIDS at the end of a particular period of time (e.g. year).

**Prevalence Rate** - Total number of living HIV/AIDS cases (both old and new cases) during the year of report, divided by the annual average population multiplied by 100,000. It is the proportion of persons in a population who have a particular disease or attribute at a specified point in time (or specified period of time).

### Rates are used to:

- measure the frequency of disease (in this case, HIV/AIDS) or other outcomes of interest,
- describe the distribution of disease occurrence in human populations,
- allow comparison of the risk of disease or burden of disease across populations,
- characterize the risk of disease for a population, and
- identify determinants of disease.

### They may also be used to help:

- prioritize prevention programs among competing causes,
- identify target groups for intervention,
- acquire funding for resources, and
- compare events across geopolitical boundaries.

### TYPES AND QUALITY OF DATA

Because no one epidemiologic data set will provide a complete picture of HIV/AIDS in the community, or the state for that matter, we have assembled data from several categories and sources. Data from a variety of categories provide a more accurate picture of past, present and future HIV/AIDS infection trends. Keeping in mind that not all data are equal, data sources must be considered in the context of their objectives, strengths and limitations; who the target populations are; how the data were collected; and the validity of the data.

As described above, several data sets are used to illustrate the South Carolina populations diagnosed with HIV/AIDS and to characterize the nature of risk-taking. All of these data sets share limitations or have similar types of bias introduced, in that most are reported by third parties, largely providers, who must seek information from the affected individual as to illness, transmission mode, and demographic characteristics. These reports are limited both by the willingness of providers to ask about these factors and that of clients to report on personal behaviors. These data are also limited in their ability to broadly characterize populations. For instance, STD (sexually transmitted disease) or HIV/AIDS case report data can only characterize persons with STD or HIV who seek treatment, or data on estimated condom use among women can not characterize all women but only those who agree to participate in selected behavioral surveys. Individuals who seek treatment for STD (and who are offered HIV testing) may be very different from those individuals who do not. However, each of the data sets referred to in this profile provide information to describe the relative risk and impact of this disease on the people of South Carolina.

The following summarizes data sources, and limitations, used by the data working group to complete the South Carolina Epidemiologic Profile of HIV/AIDS.

#### **Selected Data Source**

##### **Description and Limitations:**

##### ***Department of Alcohol and Other Drug Abuse Services (DAODAS) SC Treatment Needs Assessment: Household Telephone Survey Data***

The purpose of the survey was to collect data on the prevalence of use of alcohol, marijuana, hallucinogens, cocaine, and heroin; to identify treatment needs related to use of these substances; and to determine the background characteristics associated with different patterns of use. The state was stratified into four regions and within each stratum a random sample of telephone numbers were selected using random digit dialing (RDD). The questionnaire was based largely on the National Technical Center's Telephone Substance Dependence Needs Assessment Questionnaire, which is "designed to be the centerpiece of a needs assessment of treatment services that state or territories may conduct as part of their substance abuse planning activities. Trained staff conducted interviews. A total of 10,324 interviews were completed as part of the study by residents 18 years of age and older.

Advantages to conducting a telephone survey compared to face-to-face interviews are as follows:  
1) it costs three times less; 2) able to collect data from a significantly large number of

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individuals, resulting in smaller standard errors for the overall estimates of use of various substances and a larger number of individuals with rare characteristics.

Limitations include: population coverage—collecting data by telephone limits the potential respondents to those living in households and excludes individuals, such as the homeless, those in correctional facilities, and those in treatment facilities who may be more likely to experience problems with alcohol and other drugs. Moreover, according to 2000 census data, 4.2% of households in South Carolina do not have telephones and, consequently, had no chance of being included in the study. Secondly, underreporting—in general, respondents’ concerns over confidentiality produce underestimates of reports of sensitive behaviors such as those considered in this study. Despite these limitations, telephone surveys can provide comparatively reliable estimates of substance use and characteristics associated with such use and they have been regarded as an effective means for collecting such data from the general population.

### *HIV Counseling and Testing Program Data from SC-DHEC Clinics*

Counseling and testing data, while highly informative about persons who seek counseling and testing, does not tell us anything about people who do not seek testing or choose not to test. All states provide HIV counseling and testing services and maintain data to quantify HIV counseling and testing services delivered in publicly-funded sites and to determine the characteristics of persons receiving those services. These data are used by prevention programs to plan and target services for high-risk individuals. The type of data collected in South Carolina include the counseling and testing site type, number of clients tested and number positive for each risk group, number tested, number positive by type of test site, and number tested and number positive by race/ethnicity gender, and age group. Clients receive confidential counseling and testing in each of the 46 county health department clinics.

Note: in 2001 counseling and testing was also provided by community organizations but data from these sites were not available for this report.

The counseling and testing data system is standardized and has been in place for several years. Data in this Epi-Profile reflect number of individual clients tested during a specific period of time. Persons who received multiple tests during the report period are only counted once. It includes persons tested in family clinics, maternity clinics, TB, STD clinics and persons voluntarily requesting services or referred through partner counseling services. Approximately one third of the total of newly diagnosed and reported persons with HIV infection each year are from SC-DHEC counseling and testing sites. Persons tested in other settings, such as physician offices, hospitals, state facilities, etc. are not included in the DHEC counseling and testing database.

To determine a client’s level of risk, each person is assigned a risk status (e.g. injecting drug use, male to male sex, heterosexual with known risk). Since most clients acknowledge multiple risks, risk status is determined by using the CDC’s hierarchy of risk. This process assigns the client’s “highest” risk. The highest possible risk in the hierarchy is sex with a person with HIV/AIDS, while the least significant risk is “no acknowledged risk”. A person is only represented in their highest risk category regardless of how many risks the client acknowledges. This CDC risk hierarchy can limit interpretability of data; it also does not reflect associated risks such as other non-injecting substance use, i.e. crack-cocaine.

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Counseling and testing data in South Carolina and nationally is distinct from blinded, HIV seroprevalence surveys which generate an estimate of HIV seroprevalence that is unbiased by client self-selection. The DHEC counseling and testing system only includes clients who seek out counseling and testing services or agree to be tested after consultation with a counselor at a clinic site. However, for those clinic sites in which clients can obtain services other than counseling and testing for HIV, and in which all or nearly all clients actually receive HIV testing, (for example, maternity and STD clinics), data for those sites approximates the reliability of the blinded surveys. For example, the annual percentage of HIV positive tests is consistently 0.1% in DHEC maternity clinics where an estimated 80-90% of clients receive HIV testing. This rate is very similar to the blinded childbearing women seroprevalence survey rate of 0.19%, which tests a representative sample of all live births in the state.

### ***SC-DHEC, HIV/AIDS Reporting Surveillance System (HARSS)***

All health care providers, hospitals, and laboratories in South Carolina are required to report persons diagnosed with confirmed HIV infection and/or AIDS. Each year approximately one-third of new cases are reported from county health departments, one-third from hospitals, one-fifth from physicians, and the remainder from state/federal facilities (including prisons) and laboratories. HARS monitors the incidence and demographic profile of HIV/AIDS; describes the modes of HIV transmission among persons with HIV/AIDS; guides the development and implementation of public health intervention and prevention programs; and assists in evaluating the efficacy of public health interventions. It is the principal source of knowledge regarding trends in the number and characteristics of HIV-infected persons. It includes persons in all age, gender, race/ethnic, and mode-of-HIV-exposure groups; and it provides a historical perspective in trends dating to the earliest recognition of the AIDS epidemic.

This profile primarily presents data on the total infection/disease spectrum: HIV infection including AIDS (not AIDS alone). Because of the long and variable period from HIV infection to the development of AIDS, trends in AIDS cases data do not represent recent HIV infections or all HIV-infected persons. AIDS surveillance data do not represent persons whose HIV infection is not recognized or diagnosed. AIDS cases have declined nationwide; however, because AIDS surveillance trends are affected by the incidence of HIV infection, as well as the effect of treatment on the progression of HIV disease, future AIDS trends cannot be predicted.

Because trends in new diagnoses of HIV infection are affected when in the course of disease a person seeks or is offered HIV testing, such trends do not reflect the total incidence of HIV infection in the population. In addition, because all HIV-infected persons in the population might not have had the infection diagnosed, these data do not represent total HIV prevalence in the population. Interpretation of these data is complicated by several factors, ranging from a person having both HIV then AIDS diagnoses in the same year, varying time between reporting HIV and AIDS cases, and numerous reasons why the number of new HIV diagnoses changed (increased, decreased, or stable).

Some data is provided on HIV infection-only (persons reported with HIV infection who do not have an AIDS diagnosis within 365 days of being diagnosed with HIV). This data, while highly dependent on persons seeking or receiving HIV testing early in their infection stages, provide an

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opportunity to compare persons presumably infected more recently with those infected as long as ten or so years ago (AIDS diagnosis).

Risk categories are assigned similar to the methods described above in HIV Counseling and Testing. There are some slight differences in the type of categories between HIV/AIDS surveillance reports and HIV Counseling and Testing reports. In South Carolina, about 33% of adult/adolescent HIV infection/AIDS cases reported in 1998 did not have risk categories reported. These cases are defined as “No Identified Risk”- NIR). The proportion of NIR cases has been increasing nationally as well. The primary reason for incomplete risk information (NIRs) is that reports from laboratories do not include risk, and an increasing proportion of cases result from heterosexual transmission but are not able to be defined in CDC’s definition of heterosexual transmission. For example, persons who report having multiple heterosexual partners or who have sex for money/drugs but the status of their partners is not known, are not classified as “heterosexual”, they are “No Identified Risk”. South Carolina has received funding from CDC to conduct a special project to collect and define indicators of behavioral risk, particularly to define high risk heterosexual behaviors. Indicators include multiple heterosexual and same sex partners, drug use, evidence of blood transfusion or hepatitis, history of sexually transmitted disease, or exchange of money or drugs for sex. This project will provide more useful risk information for prevention planning in the future.

### ***SC-DHEC, Sexually Transmitted Diseases Management Information System (STD\*MIS)***

Health care providers and laboratories are required by law to report certain sexually transmitted diseases (including syphilis, chlamydia, gonorrhea, chancroid, hepatitis) to SC-DHEC. A sexually transmitted disease, other than HIV infection, represents a visible and immediate health problem that stems from unprotected intercourse with an infected partner. Research from several studies strongly indicates that STDs increase the possibility of acquiring and transmitting HIV infection. The emerging problem of heterosexual HIV transmission in the South closely parallels that of syphilis and gonorrhea. Gonorrhea, syphilis, and chlamydia incidence and prevalence data are used by programs to: 1) monitor local, and state trends; 2) identify high-risk groups and geographic areas in which unsafe sexual behaviors occur, 3) guide the development and implementation of public health intervention and prevention programs; and 4) assist in evaluating the efficacy of public health interventions.

Considering the short incubation periods for these infections, gonorrhea, syphilis, and chlamydia incidence represent recent consequences of unsafe sexual behavior and point to populations who are potentially at very high risk for acquiring and transmitting HIV infection. Unfortunately, an often unrecognized aspect of STDs, including bacterial STDs, is how frequently persons with these infections have no symptoms or do not recognize symptoms. Most studies of STDs are conducted in health-care settings specifically for persons who do recognize symptoms; therefore, these studies usually overestimate the proportion of infected persons who are symptomatic. Studies of STD screening in nonhealth-care settings (e.g., jails, workplaces, and communities) or health-care settings where STD treatment is not the primary function (e.g., family-planning clinics) suggest that most persons with gonorrhea or chlamydia are asymptomatic.

Limitations: STD data lack much information that would help to better understand HIV risk, such as mode of transmission. Also, bias is introduced for some diseases, such as chlamydia,

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where screening of asymptomatic persons is done much more frequently in women than in men. For example, all women <25 years attending family planning and STD clinics in county health departments are routinely screened for chlamydia and gonorrhea. Also, there may be bias in that the majority of reports are from public clinics; the personal nature of STD's may affect providers' willingness to report. This may account, in part, for the disparity of some STDs to occur at much higher rates among African-Americans who are more likely to seek care in public clinics, where there is more complete reporting.

### ***South Carolina Statistical Abstract, 2006***

An annual publication of the South Carolina State Budget and Control Board, Office of Research and Statistics. This state document provides a comprehensive, single-source reference of demographic and economical data pertinent to South Carolina. Statistics providing information on factors impacting the state's social and economical development are compiled from in-house data bases as well as a variety of federal, state, local, and private sources. In order to complete the epidemiologic profile, sociodemographic data from sections State and County Rankings, Education, Employment, Housing, Income, and Population were used. The abstract depends heavily on the US Bureau of the Census data from 2000. As a result of this, data may not represent the current situation in South Carolina.

### ***South Carolina Vital and Morbidity Statistics, 2006***

Its purpose is to provide basic reference data for a variety of users. The primary uses of the report were to enumerate and characterize mortality attributed to HIV infection. The data were also used to compare trends in HIV infection mortality with other leading causes of death and to characterize the impact of HIV infection on mortality. Data on causes of death are based on information recorded by hospitals, physicians, coroners, midwives and funeral directors. Recorded information may be inaccurate or incomplete due to underreporting of certain causes of deaths, the number of HIV-related deaths and the conditions may be underestimated. Vital statistics data are not as timely as AIDS case reports due in part to processing time.

### ***Youth Risk Behavior Surveillance System (YRBSS)***

The Youth Risk Behavior Survey (YRBS) was developed cooperatively by the Centers for Disease Control and Prevention (CDC), several federal agencies and state departments of education to measure the extent to which adolescents engage in health risk and health enhancing behaviors. The survey is a 99-item questionnaire administered to 6<sup>th</sup>-12<sup>th</sup> graders in the public school system. Samples are randomly selected based on school size (small, medium and large). Of the 99 items, 11 are on tobacco use, 5 on alcohol use, 4 on marijuana use, 9 on cocaine use, 8 on sexual behaviors for pregnancy, HIV/AIDS and other STD risk, 2 on HIV/AIDS Education, 1 on HIV/AIDS testing and 2 on HIV/AIDS risk perceptions. There are 367 private K-12 schools in South Carolina (SC Statistical Abstract, 2003). However, none of them are included in the survey. Also, while schools are randomly selected for participation some may choose not to participate.

This survey relies heavily on surveillance methods and self-reports; so it really depends on how well respondents understand the question and how well they can accurately and honestly answer the question. However, the data are edited, checked and weighted. These data are representative of only public high school students in grades 6-12 in South Carolina.

### ***Ryan White Program Data Report***

The Ryan White HIV/AIDS Program Data Report (RDR) is an annual report that captures information regarding the services provided by all Ryan White funded entities. The RDR is divided into sections including: service provider information; client information; service information; HIV counseling and testing; and medical information. Providers report on all clients who received services eligible for Ryan White Parts A, B, C or D funding regardless of the actual funding source used to pay for those services. The South Carolina Ryan White Part B contractors complete the RDR forms and submit them to DHEC. DHEC assembles all of the reports and submits the data to HRSA.

### **Question #1: What are the sociodemographic characteristics of the population?**

The HIV epidemic in the United States, and in South Carolina, is a composite of multiple, unevenly distributed epidemics in different regions and among different populations. These populations may comprise persons who practice similar high-risk behavior, such as injecting drugs or having unprotected sex with an infected person. Although race and ethnicity are not risk factors for HIV transmission, they are markers for complex underlying social, economic, and cultural factors that affect personal behavior and health. Low socioeconomic status is associated with increased disease morbidity and premature mortality. Unemployment status is correlated to limited access to health care services, resulting in increased risk for disease. This section provides background information on South Carolina's populations and contextual information, i.e. education, poverty level, housing, etc, for assessing potential HIV impact. The social, economic, and cultural context of HIV infection must be considered when funding, designing, implementing and evaluating HIV prevention programs for diverse populations.

### **The State**

South Carolina lies on the southeastern seaboard of the United States. Shaped like an inverted triangle, the state is bounded on the north by North Carolina, on the southeast by the Atlantic Ocean, and on the southwest by Georgia. It ranks 40th among the 50 states in size and has a geographic area of 30,111 square miles. South Carolina has a diverse geography that stretches from the Blue Ridge Mountains in the northwest corner to the beaches along the Atlantic coast in the southeast. There are 46 counties and they are divided into 8 public health regions. Columbia, located in the center of the state, is the capital and the largest city. There are 3 metropolitan areas with a population of 500,000 or more: Columbia, Charleston and Greenville areas. The state is crisscrossed by interstate highways that link it with every part of the country, including I-95 extending north-south across the center of the state from New York to Florida and I-26 from Asheville, North Carolina to Charleston, South Carolina, and I-20 that extends east-west across the state from Florence, South Carolina to Atlanta, Georgia. Manufacturing is the state's leading industry, followed by tourism and forestry.

**Populations**

Based on projected population estimates, in 2007, the total number of South Carolinians was 4,299,600. Of this total, 65% were Caucasian, 29% were African-American, 0.3% was Native American/Alaskan, 1.1% was Asian and Pacific Islander, and 4% were of Hispanic origin. Fifty-one percent were female and forty-nine percent were male. Sixty-five percent of the population distribution in South Carolina is defined as metropolitan, 35% is non-metropolitan. The proportion of persons who completed a bachelor’s degree or higher is 23%, lower than the U.S. proportion of 28%. (Figure 2)

**Figure 2: Selected Demographic Information South Carolina and United States**

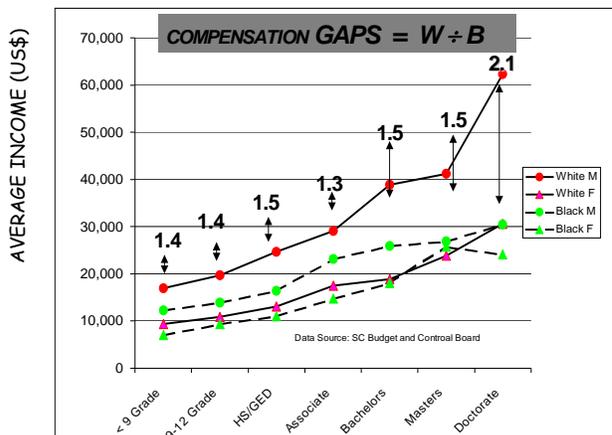
	South Carolina	United States
Population (2007 estimates)	4,299,600	298,215,360
Proportion of Persons Living in Non-Metropolitan Areas	35%	16%
Median Age	37.1	36.4
Racial/Ethnic Distribution of Pop.		
% White	65	66
% Black	29	12
% Hispanic	4	15
% Other	3	7
Educational Attainment		
% High school grad. or higher	81	84
% Bachelor’s degree or higher	23	27
Unemployment Rate, November 2007	5.8%	4.7%
Median Household Income, 2007	\$42,561	\$49,901

Sources: U.S. Census Bureau, Kaiser Family Foundation

**Education & Earnings**

Despite the economic strides it has made in recent years, South Carolina remains among the states with the highest percentage of persons who live below the poverty level (11th of fifty states and District of Columbia). Educational attainment is strongly correlated with poverty, and South Carolina continues to rank low in percent of persons over 25 years of age who have bachelors’ degrees or higher (36th of fifty states and District of Columbia). Nearly twenty percent (19.2%) of the population has less than a high school education.

**Figure 3: Income by Educational Attainment by Race & Gender: SC, 1990**



Educational attainment and earnings are directly related. The more education a South Carolinian has, the more money he/she is likely to earn. However, if we compare across gender and racial lines, there are inconsistencies.

White males clearly attain the highest incomes. The income gap between whites and blacks is higher for each education level, but particularly increases for persons with bachelors degrees or more. Income for whites is 1.5 times greater than blacks for persons with bachelors and masters degrees, and is 2.1 times greater than blacks for persons with doctorates. (Figure 3)

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**Figure 4: SC Per Capita Income in 1999  
by Race and Hispanic Origin**

	<b>INCOME GAPS</b>	<b>Rel to Blacks</b>
• For Whites	\$22,095	1.9
• Native Hawaiian/ Other Pacific Islander	\$21,638	1.8
• For Asian	\$20,541	1.7
• For American Indian/ Alaskan Native	\$15,325	1.3
• Of Hispanic Origin	\$12,143	1.0
• For Other Races	\$10,473	0.9
• For Blacks	\$11,776	1.0
• OVERALL	\$18,795	1.6

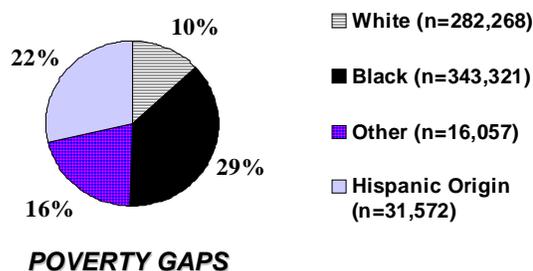
In comparison, Blacks, people of Hispanic origin, and other races earned the least per capita income, averaging 39% below the state's average. Whites earned 18% above the state's average per capita income. (Figure 4)

Data Source: SC-Budget & Control Board, Office of Research & Statistics

### Poverty Level

Based on 2006 Census data, approximately 15.7% of South Carolinians lived below the poverty level (ranking 12th in the US); and 11.9% of South Carolinian families lived below the poverty level.

**Figure 5: Percent of Each Racial/Ethnic Pop Living Below Federal Poverty Level; SC, 2006**



Twenty-nine percent of Black South Carolinians were below poverty in 2006, compared to 22% of persons of Hispanic descent, 10% among Whites and close to 16% of persons categorized as other, which includes Asian, Pacific Islanders, and Native Americans. (Figure 5)

Data Source: 2006 American Community Survey

### Insurance/Access to Primary Care

Sixteen percent (16%) of South Carolinians do not have health insurance coverage. A significantly higher proportion of persons in the state do not have access to a primary care provider (35.8%) compared to the total U.S. population (17.1%) (Figure 6). Over 95% of counties are designated all or part medically underserved areas and all or part health profession shortage areas (1999).

**Figure 6: Selected Access Indicators, SC and US**

	South Carolina	United States
Total Pop. Uninsured, 2006-2007	16.2%	15.3%
Below 200% Poverty Level, 2006	39.5%	34.6%
Counties Designated All/Part Medically Underserved Areas, 1999	95.7%	80.5%
Without Access to Primary Care Provider, 1996	35.8%	17.1%
Women Receiving 1 <sup>st</sup> Trimester Prenatal Care, 2003	83.6%	89%

Source: U.S. Dept. of Health and Human Services, HRSA, Kaiser Family Foundation

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### **Employment**

South Carolina's average unemployment rate for 2007 was 6.9%, higher than the US rate of 6.3%. The median household income in 2007 was \$42,561 vs. the US median income of \$49,901.

### **Housing**

According to the US Census, in 2007, 70% of the state's homes were owned. The SC Council on Homelessness estimates 6,759 persons are homeless in South Carolina.

### **Summary**

South Carolina, as many southern states, ranks high for poverty, low educational attainment, and uninsured population compared to other US states. These factors can affect one's ability to access prevention and health care services and adhere to regimens for treatment and care of diseases that may lead to more severe consequences.

### **Question #2: What is the impact of HIV/AIDS on the population?**

In the United States, HIV/AIDS remains a significant cause of illness, disability, and death, despite declines in new AIDS cases and deaths from 1995 to 2007. Current surveillance provides population-based HIV/AIDS data for tracking trends in the epidemic, targeting and allocating resources for prevention and treatment services, and planning and conducting program evaluation activities.

In South Carolina, AIDS cases have been reported since 1981, and confirmed cases of HIV infection have been reportable since February 1986. During the calendar year of 2006, according to the CDC HIV/AIDS Surveillance Report, South Carolina ranked 9th among states and the District of Columbia with an AIDS case rate of 16.3 per 100,000 population. During this same time period, South Carolina also ranked seventh among states and the District of Columbia with an AIDS case rate of 12.5 per 100,000 for female adolescent/adult AIDS cases. The epidemic is continuing to grow with an average of 65 cases of HIV infection reported each month during the past year. As of December 31, 2007, there were 22,489 persons cumulatively reported with HIV, and of them, 17,394 have been diagnosed with AIDS.

South Carolina has experienced a 67% increase of all persons living with HIV/AIDS from 1997 to 2007. More dramatic, there has been an increase of 81% in the number of women living at the end of 2007 compared with the number living in 1997.

This section summarizes the overall toll of the epidemic in South Carolina based on total reported HIV/AIDS cases and deaths.

**Figure 7: Disproportionate HIV Impact by Gender, South Carolina**

SEX	No. (%) SC Total Population*	No. (%) of Total Estimated Living With HIV/AIDS, 2007	No. (%) of Total HIV-Only Diagnosis, 2006-2007
Male	1,948,929 (49%)	10,144 (69%)	675 (69%)
Female	2,063,083 (51%)	4,552 (31%)	299 (31%)
Total	4,012,012	14,696 (100%)	978 (100%)

\*Source: 2000 US Census Data; SCDHEC HARS

Figure 8 shows the rate per 100,000 population for males and females diagnosed with HIV/AIDS each year. During 1997 – 2007 the case rate for females appears to be slightly decreasing. For males, the rate had declined prior to 1998, when the rate increased due to screening in the state correctional facilities. With the exception of 1998, the ratio of men to women has averaged about 2 to 1 during the past three years, where previously it was more than 3 to 1.

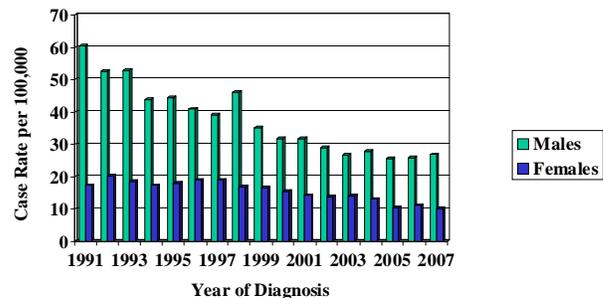
**Race/Ethnicity**

African-Americans are disproportionately impacted by HIV/AIDS in South Carolina. They comprise 30% of the state’s total population, yet 73% of the total persons living with HIV are African-American. Two percent (2%) of total cases are Hispanic, who comprise the same proportion of the state’s population (Figure 9).

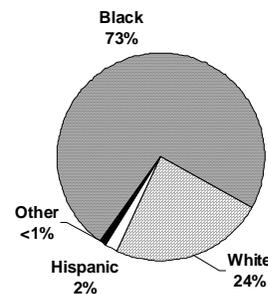
**Gender**

Figure 7 shows the impact of HIV on the men and women in South Carolina. Men unequivocally are disproportionately affected by HIV/AIDS. They make up 49% of South Carolina’s total population, but comprise 69% of persons living with HIV (prevalence). HIV-only diagnosed cases during the two-year period 2006-2007 gives an estimate of more recent infections or potentially emerging populations.

**Figure 8 : HIV/AIDS Case Rate per 100,000 for Males and Females, 1991 - 2007**



**Figure 9: Proportion of Persons Living with HIV/AIDS by Race/Ethnicity, 2007**



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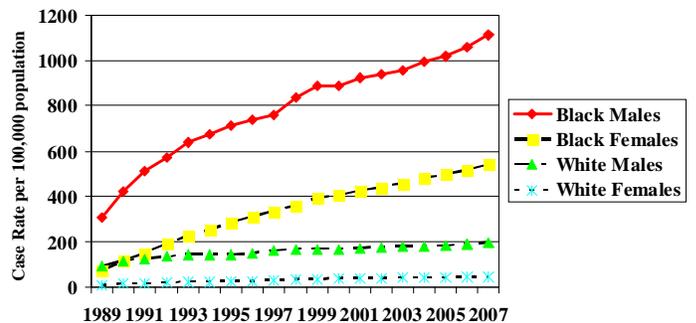
African-American men comprise 15% of the state’s population, yet 47% of the total prevalent HIV/AIDS cases in 2007. African-American women, similarly, comprise 17% of the population, yet 26% of prevalent cases. More recent infections (HIV-Only Diagnosis) during 2006 - 2007 reflect a slight increase among African-American men and a slight decrease among African-American women relative to the proportion of persons living with HIV in 2007 (Figure 10).

Figure 10: Disproportionate HIV Impact by Race/Ethnicity/Gender, SC

Gender & Race/Ethnicity	No. (%) SC Total Pop.	No. (%) of Total Persons Living With HIV/AIDS, 2007	No. (%) of Total HIV Only Diagnosis, 2006-2007
Black Males	593,707 (15%)	6963 (47%)	486 (50%)
Black Females	668,799 (17%)	3777 (26%)	235 (24%)
White Males	1,355,222 (34%)	2856 (19%)	166 (17%)
White Females	1,394,284 (35%)	669 (5%)	50 (5%)
Hispanic Males	23,978 (0.6%)	282 (2%)	17 (2%)
Hisp. Females	22,296 (0.6%)	79 (.5%)	14 (1%)

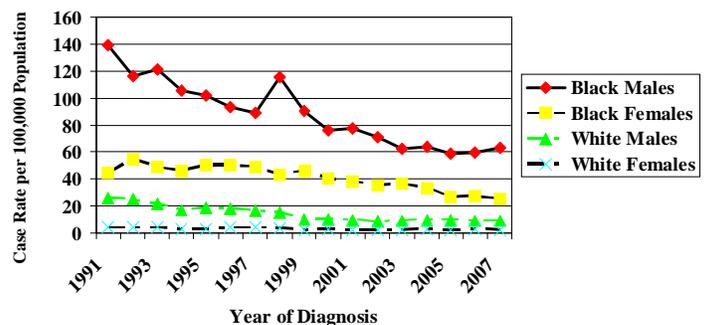
Each year the number of all persons living with HIV/AIDS continues to grow. Case rates per 100,000 by race and gender show the disparate burden of HIV among African-Americans. As Figure 11 shows, the rate per 100,000 population in 2007 is six times higher for black males than for white males, and twelve times higher for black females compared to white females. An increase in the case rate for black men in 1998 reflected a large number of new cases reported as a result of a Department of Corrections screening.

Figure 11: HIV/AIDS Prevalence Rates by Race/Gender, SC



While the overall number and rate of newly diagnosed persons with HIV/AIDS each year is stable, there are differences among race/gender populations. (Figure 12) The case rate per 100,000 population among white men in South Carolina has on average remained relatively stable during the past five years (2003-2007). Recently, the rate for African-American women in S.C. decreased 30% from 2003 to 2007. As stated previously, the case rate among African-American males increased in 1998-1999 due to correctional facility screening; however, overall the rate have remained stable during the past five years.

Figure 12: HIV/AIDS Case Rates by Race/Gender and Year of Diagnosis, SC



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### Age

When looking at age groups, persons between the ages of 20 and 44 are disproportionately impacted. They make up 37% of the total population yet they represent about 52% of prevalent and 69% of HIV-only diagnosed cases. (Figure 13)

**Figure 13: Disproportionate HIV Impact by Age, SC**

Age Range	No. (%) SC Population	No. (%) of Total Persons Living with HIV/AIDS, 2007	No. (%) of Total HIV-Only Diagnosis, 2006-2007
< 13 Years	724,209 (18%)	52 (<1%)	7 (<1%)
13 – 19 Years	411,579 (10%)	127 (<1%)	54 (6%)
20 – 44 Years	1,467,669 (37%)	7,610 (52%)	677 (69%)
45+ Years	1,408,565 (35%)	6,907 (47%)	240 (25%)

**Figure 14: S.C. HIV/AIDS Case Rate per 100,000 by Age by Year of Diagnosis, 1991-2007**

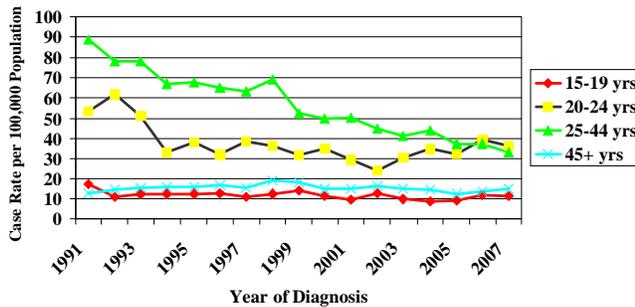
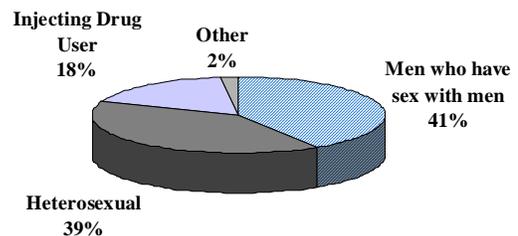


Figure 14 shows the HIV/AIDS case rates per 100,000 population by year of diagnosis for selected adult/adolescent age groups for the past seventeen years. The rates are highest for persons 20-24 years of age, followed by those 25-44 years.

### Risk Exposure

Men who have sex with men (MSM) comprise the greatest proportion of persons living with HIV/AIDS at the end of 2007 with known risk factors (41%), followed closely by heterosexuals (39%). Eighteen percent (18%) are injecting drug users (Figure 15). Other risks include blood transfusions, hemophilia, and perinatal transmission. Of the total estimated number of persons living with HIV/AIDS in 2007, 24% had no risk identified (not reflected in Figure 15).

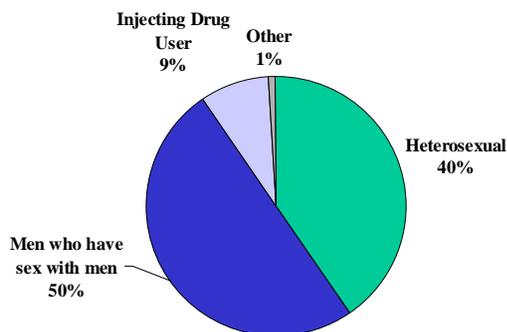
**Figure 15: Proportion of Persons Living with HIV/AIDS by Risk Exposure, 2007**  
N=11,123



Note: Total Excludes Cases with No Risk Identified

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**Figure 16: Proportion of HIV/AIDS Cases by Risk Exposure, 2006-2007**  
N= 1,066



Note: Total Excludes Cases with No Risk Identified

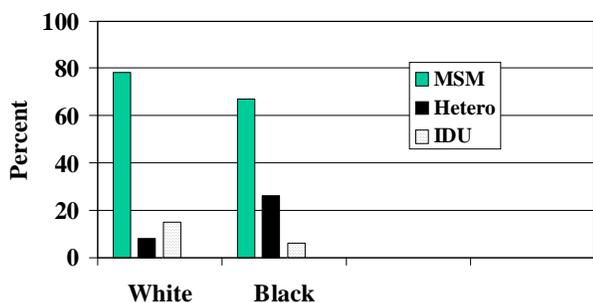
Note: The primary reasons for risk exposure information not reported were explained in the Introduction, South Carolina HIV/AIDS Surveillance System section. Over time, the proportion of cases with no risk identified in a given year decreases when risks are determined through follow-up surveillance activities. For example, during 2000 there were 312 cases originally reported with no risk; as of December 2001, risks were determined for 249 of the 312 cases. The race/gender profile of 2007 cases originally reported with no risks is relatively close to the total proportion of HIV/AIDS cases by race/gender (Figure 17).

Figure 16 shows a slight shift in risk exposure categories among persons diagnosed with HIV/AIDS during 2006–2007 with known risk exposures compared to the prevalent cases in Figure 15. The proportion of cases due to heterosexual transmission was 40%, men who have sex with men accounted for 50% and IDUs made up 9%. Thirty-two percent (32%) of these cases had no risk identified (not reflected in figure 16).

**Figure 17: Comparison of No Risk Identified Cases with Total S.C. HIV/AIDS Reported Cases, 2007**

Race/Gender (Adult/Adolescent Cases)	% Total Cases with No Risk Identified, 2007 N=256	% Total HIV/AIDS Cases Reported, 2007 N=780
Black Male	52%	50%
Black Female	25%	22%
White Male	11%	17%
White Female	5%	4%
Other	8%	6%

**Figure 18: Proportion of White and Black Male HIV/AIDS Cases By Exposure Category, Diagnosed 2006-2007**



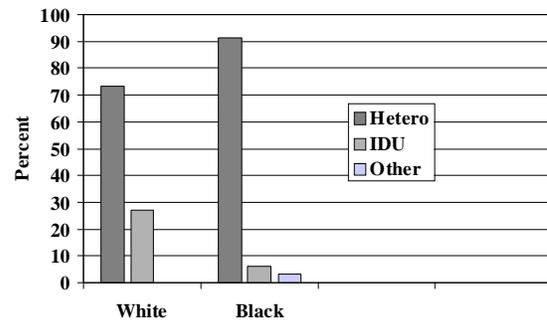
Total Males, All Ages; Excludes Persons with No Risk Reported; N=729

During 2006 – 2007, 70% of males diagnosed with HIV/AIDS were African-American. Among African-American males with reported risk factors, most cases were attributed to male to male sexual contact (67%) and heterosexual contact (26%). Injecting drug use is more commonly reported among white males (15%) than among black males (6%). Among white men, 78% were men who have sex with men. Only 8% reported heterosexual risk (Figure 18).

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Among women diagnosed during 2006 – 2007, 79% of cases were among African-American women. Heterosexual contact was the most common reported risk for all women (89%). Injecting drug use is more commonly reported among white women (27%) than among black women (6%). (Figure 19)

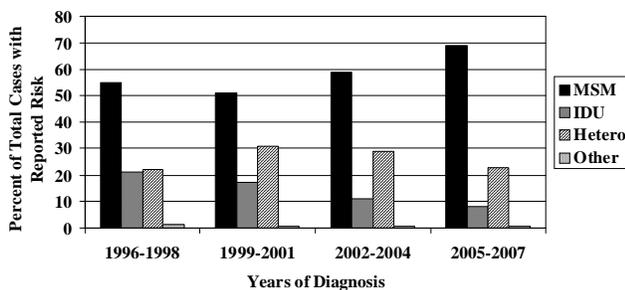
**Figure 19: Proportion of White and Black Female HIV/AIDS Cases By Exposure Category, Diagnosed 2006-2007**



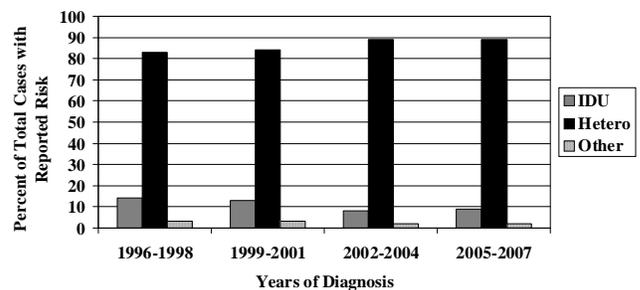
Total Females, All Ages; Excludes Persons with No Risk Reported; N=283

Figures 20 and 21 show the proportion of total HIV/AIDS cases diagnosed during four periods from 1996 – 2007 by sex and risk exposure category for males and females in South Carolina. Both men and women experienced decreases over time in the proportion of total cases with risk reported among injecting drug users. During 1996 – 1998 to 2005 – 2007, there was a 62% decrease in the proportion among injecting drug use among men and a 36% decrease among women. The proportion of heterosexual risk increased 5% for men and increased 7% for women during the same time periods.

**Figure 20: Proportional Distribution of Male HIV/AIDS Cases, by Exposure Category, Diagnosed 1996-2007**



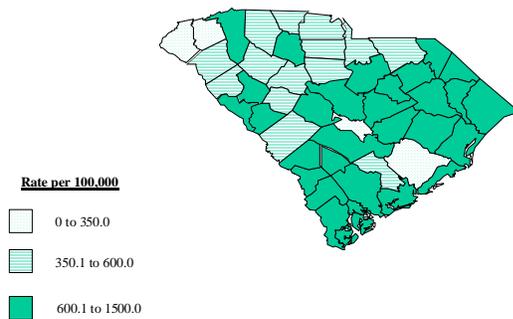
**Figure 21: Proportional Distribution of Female HIV/AIDS Cases, by Exposure Category, Diagnosed 1996-2007**



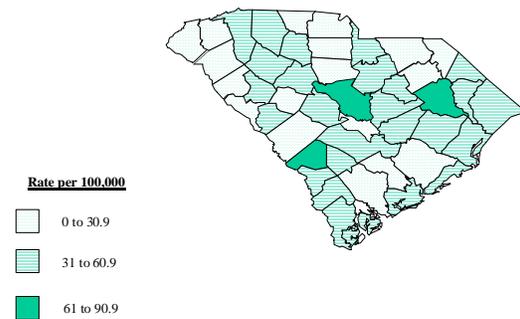
**Residence**

Persons living with HIV/AIDS are widespread throughout the state. Over 60% of counties have prevalence rates >600 per 100,000 for African-Americans, as reflected in Figure 22. Annual case rates in counties of more recently diagnosed African-American persons during 2005 – 2007 reflect essentially the same counties as highest prevalence rates. Richland County has the highest annual case rate (Figure 23).

**Figure 22: SC HIV Prevalence Rates (per 100,000 population) Cases Currently Living, 2007 African-American**

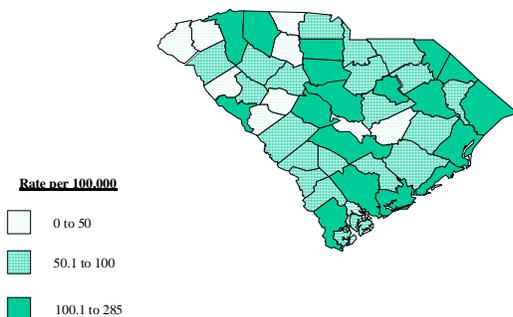


**Figure 23: SC HIV/AIDS Incidence Rates (per 100,000 population) 2005-2007 Average of Cases African-American**

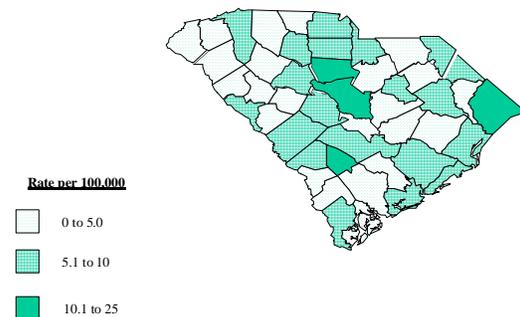


Counties with highest prevalence rates among white persons include more urban areas of Greenville, Spartanburg, Richland and Lexington (Columbia), Charleston, Horry (Myrtle Beach), as well as Orangeburg, Florence, Marlboro, Fairfield, McCormick, Colleton, Jasper, Dillon and Lee (Figure 24). Figure 25 shows counties with highest rates of more recently diagnosed white persons are Richland, Charleston, Horry, Orangeburg, Fairfield, Lee, and Bamberg.

**Figure 24: SC HIV Prevalence Rates (per 100,000 population) Cases Currently Living, 2007 Whites**



**Figure 25: SC HIV/AIDS Incidence Rates (per 100,000 population) 2005-2007 Average of Cases Whites**

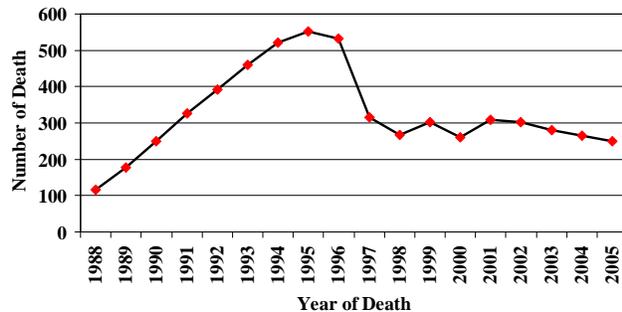


**Mortality**

With the advent of combination therapies and the use of prophylaxis, persons infected with HIV are living longer, delaying the progression of AIDS, which is the advanced stage of the disease. These medications have also led to the decrease in HIV-related deaths.

Large declines in HIV mortality nationally essentially occurred during 1996 – 1997. Officials at the Centers for Disease Control and Prevention (CDC) cautiously attributed the sudden drops in deaths to new anti-retrovirals, protease inhibitors, combination therapies, and increased prophylaxis for opportunistic illnesses. However, the initially reported gains were tempered by reports of demographic differentials that suggested only certain groups were benefiting from these new therapies

**Figure 26: Deaths Among Persons with AIDS in South Carolina, 1988-2005**



Source – SCDHEC, Vital Records, SC Residence Data

Figure 26 shows largest declines in deaths in South Carolina were in 1997, dropping to 317 from 532 the previous year. In recent years, death among persons with AIDS has remained fairly stable, which may indicate diminishing efficacy of therapies among some patients. Reasons for this may include delay in diagnosis of HIV infection until severe symptoms arise, difficulty in adherence to prescribed medical treatments, and development of viral resistance to therapy.

**Figure 27: Characteristics of Persons who died of AIDS, 2005**

	No.	%
<b>Race/Sex</b>		
Black Male	128	51
Black Female	65	26
White Male	45	18
White Female	11	4
<b>Age Group</b>		
<15	---	0
15-24	5	2
25-44	124	50
45+	120	48

Although black males represent 47% of persons living with HIV/AIDS, in 2005, they accounted for the majority of persons dying from AIDS (51%). African-American females accounted for 26% of AIDS related deaths followed by white males (18%). By age group, the majority of deaths occurred among persons 25-44 years (50%). (Figure 27)

**Figure 28: Number of Persons who died of AIDS by Health Region, 2005**

Health Region	No.	%
Region 1	18	7
Region 2	41	16
Region 3	55	22
Region 4	49	20
Region 5	18	7
Region 6	16	6
Region 7	35	14
Region 8	17	7
TOTAL	249	100

Region 3 and Region 4 represent the highest number of deaths from AIDS in South Carolina in 2005 (Figure 28). These areas are also among those that have the highest prevalence of AIDS in the state.

### Question #3: Who is at risk for becoming infected with HIV?

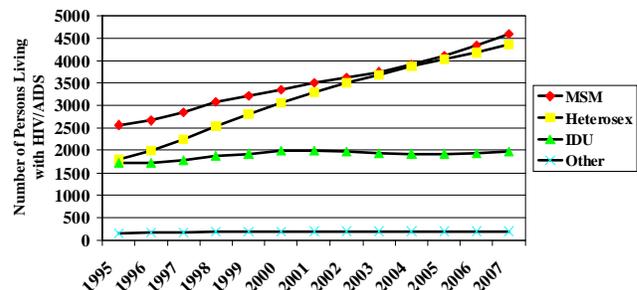
The persons most likely to become infected with HIV are those who engage in high-risk behaviors with persons in communities with a high number/rate of persons living with HIV infection, i.e. prevalence. As mentioned previously, growing numbers of people with HIV in South Carolina are living more healthy lives, including sexual activity. The frequency of high-risk behavior combined with the HIV prevalence in sexual or drug using-networks determines a person’s risk for becoming infected. In order to accurately target STD/HIV prevention and treatment activities, it is important for community planning groups (and program providers) to have information on the number and characteristics of persons who become newly infected with HIV and persons whose behaviors or other exposures put them at various levels of risk for STD and HIV infection. This section summarizes HIV infection among population groups at high risk for HIV infection, sexually transmitted disease data, and behavioral data.

#### Characteristics of HIV/AIDS in Persons at Highest Risk

Analysis of characteristics of persons with HIV/AIDS helps identify persons at greatest risk for becoming infected. Risk for infection can be determined by assessing the frequency of high-risk behavior (e.g., unprotected sex, needle-sharing) in combination with the estimated prevalence of HIV/AIDS and incidence of HIV/AIDS.

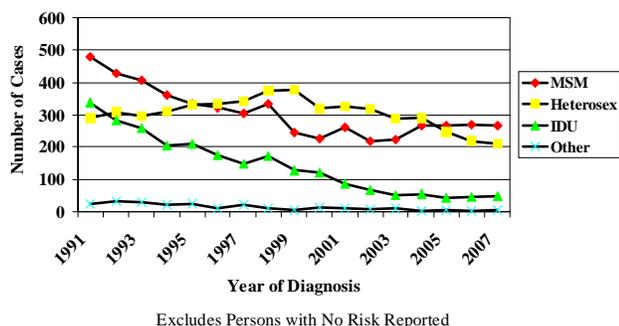
Figure 29 shows the number of persons in South Carolina living with HIV/AIDS at the end of each year by reported risk. Men who have sex men (MSM) comprise the greatest number of living persons, followed closely by heterosexuals. Injecting drug users (IDUs) and other risks (e.g. hemophilia, blood transfusion, perinatally acquired infection) comprise fewer numbers.

**Figure 29: Number of Persons Presumed Living with HIV/AIDS at End of Year by Risk, 1995-2007**



Number Excludes Persons with No Risk Reported; MSM/IDU included in IDU category

**Figure 30: Number of HIV/AIDS Cases by Year of Diagnosis and Risk, 1991 -2007**



While men who have sex with men comprise the greater proportion of persons living with HIV, newly diagnosed HIV/AIDS cases each year indicate that beginning in 1997, more persons report heterosexual risk than male to male sex, except in 2004 and 2005 where the number reporting heterosexual risk and male to male sex were almost equal and in 2006, the number reporting male to male sex slightly exceed heterosexual risk. While not validated, many local experts believe that the number of heterosexuals among African-American men may be artificially high due to

fears of discrimination; therefore, men do not reveal male to male sex as a risk behavior. The number of injecting drug users reported each year has remained stable over the past five years (Figure 30).

Based on data in this profile, the following primary populations have been identified as being the highest risk of HIV/AIDS: men who have sex with men (MSM), high-risk heterosexuals, and injecting drug users (IDUs). Women will be described in the heterosexual and injecting drug user section, and teenagers/young adults will be described within each population category. Since African-Americans are disproportionately impacted across each risk category, this impact will be described for each risk population rather than as a separate population. Infants and children and prison populations will be described separately.

### Men Who Have Sex With Men

#### Estimates of Men Who Have Sex with Men Behavior in South Carolina

According to the U.S. Census Bureau, there are approximately 1,436,281 males in South Carolina between the ages of 15-64, which is the age range when persons are most sexually active. Review of literature and other state profiles, indicates that the estimated percentage of men who have sex with men (MSM) ranges from 2.1% to 10.1%, with the average at 2.7%. This would mean that the number of MSM in South Carolina could be estimated to be 38,780, although the estimated range is much broader.

#### Characteristics

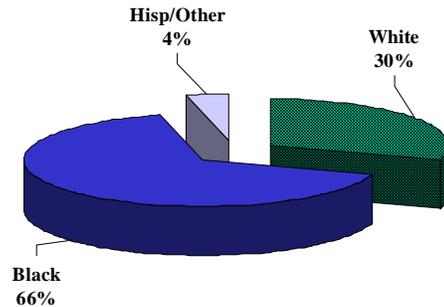
*Note: for purposes of this analysis, cases that are both men who have sex with men (MSM) and injecting drug users (IDU) are included in the injecting drug user category.*

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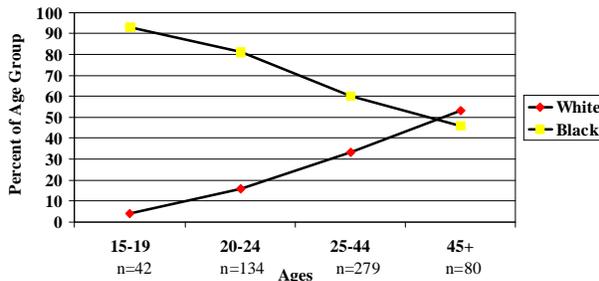
The largest proportion of persons living with HIV/AIDS in South Carolina at the end of 2007 was men who have sex with men (41% of total prevalent adult/adolescent cases with identifiable risk). MSM account for a slightly higher proportion (50%) of the more recently diagnosed adult/adolescent cases during 2006-2007. The number of MSM cases diagnosed each year increased 16% from 2003 to 2007.

As Figure 31 demonstrates, the majority of MSM cases diagnosed during 2006 - 2007 were African-Americans (66%). White men accounted for 30% of the new cases and 4% were Hispanic or other races.

**Figure 31: Proportion of Men with HIV/AIDS Who Have Sex With Men by Race/Ethnicity, Diagnosed 2006-2007**  
N=536



**Figure 32 : Percent MSM HIV/AIDS Cases Diagnosed 2006-2007 by Age Group & Race**  
N=536

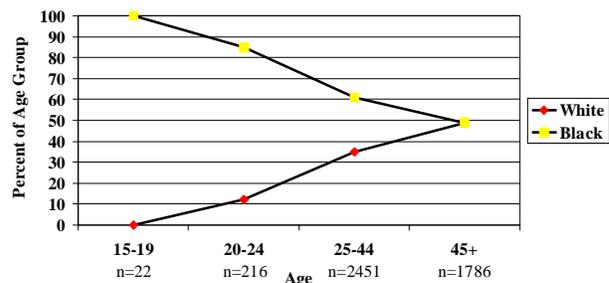


Total N includes 24 Other Men Not Included in Graph Due to Small Numbers

Of the men who have sex with men presumed living with HIV in 2007, 69% were African-American, 28% were white and 3% were Hispanic/other men. As Figure 33 shows, for each younger age category less than 45 years, African-Americans comprise the greatest proportion of living MSM. However, among those 45 years and older, the proportion is equal for white and African-American men (50%).

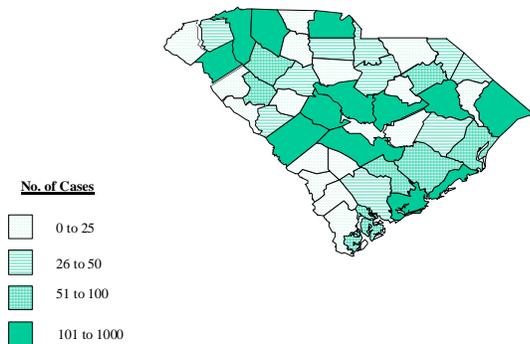
The majority of men who have sex with men diagnosed during 2006 – 2007 were 25 – 44 years of age (52%); 25% were 20 – 24 years old and 15% were 45+ years. For men more recently diagnosed, African-Americans accounted for the highest proportion for each age group except for those 45 and older (Figure 32).

**Figure 33: Percent of MSM Living with HIV/AIDS by Age Group & Race, 2007**  
N=4,587



Total N includes 112 Other Men Not Included in Graph Due to Small Numbers

**Figure 34: SC HIV Prevalence by Exposure Category, 2007 Reported Cases, by County MSM**



The more urban counties of Greenville/Spartanburg, Anderson, York, Richland, Lexington, Charleston, Sumter, Horry, Florence and Orangeburg have the greatest number of men who have sex with men living with HIV/AIDS in 2007 (Figure 34).

Due to small numbers for many counties, portraying the three-year annual case numbers of men who have sex with men by county is not useful.

### Conclusions

These data indicate that prevention efforts targeted to men who have sex with men need to be tailored to both African-American and white men. African-American men account for almost half the proportion of both living cases (47%) and newly diagnosed HIV/AIDS cases (50%). Increased efforts in particular are needed to reach younger African-American MSM <25 years of age; for white men, targeted efforts are needed for those >25 years. Interventions also need to be particularly available for persons living in the more urban areas of the state.

### High Risk Heterosexuals

#### Estimates of High-Risk Heterosexual Behavior in South Carolina

It is difficult to make an assessment of the number of persons in South Carolina who engage in heterosexual contact that puts them at high risk for becoming infected with HIV. While there are some differences in the population of persons with HIV/AIDS than for those with a sexually transmitted disease, most experts acknowledge that a diagnosis of an STD would suggest that the individual is engaging in unsafe sexual practices. During 2007, 26,117 cases of chlamydia, 9,932 cases of gonorrhea and 95 cases of infectious syphilis were reported in South Carolina. Women with an STD, in particular, indicate high-risk heterosexual activity. Among the 2007 cases of chlamydia, 20,542 were among women, and 5,453 women were reported with gonorrhea. More data on STDs, as well as other behavioral indicators such as teenage pregnancy and condom use is described later.

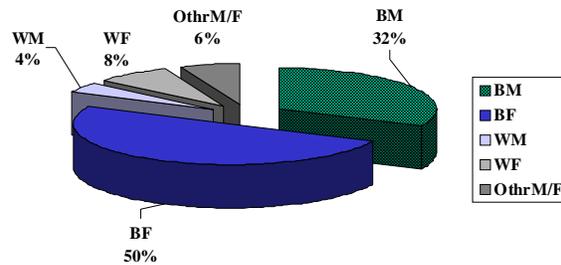
In order for a case of HIV or AIDS to be considered as heterosexual transmission, it must be documented that the individual had heterosexual contact with a person who has documented HIV infection or AIDS, or had heterosexual contact with a person who is in a high risk group for HIV (MSM or injecting drug user).

**Characteristics of High Risk Heterosexuals**

Persons with documented high-risk heterosexual contact comprise 30% of the total adult/adolescent persons living with HIV/AIDS at the end of 2007 and 27% of persons more recently diagnosed during 2006-2007 (excluding persons with no risk identified for both new and prevalent cases). The number of heterosexual cases diagnosed each year decreased 34% from 2000 to 2007 (see Figure 30).

Figure 35 shows that over half (58%) of recently diagnosed heterosexual HIV/AIDS cases are women. African-American women account for 50% of recent cases and white women account for 8%. Thirty-two percent (32%) are African-American men. White men account for only 4% of recent cases.

**Figure 35: Proportion of Heterosexual HIV/AIDS Cases by Race/Sex, Diagnosed 2006-2007**  
N=429



**Figure 36: Number of HIV/AIDS Cases Attributed to Heterosexual Transmission, By Sex and Year of Diagnosis**

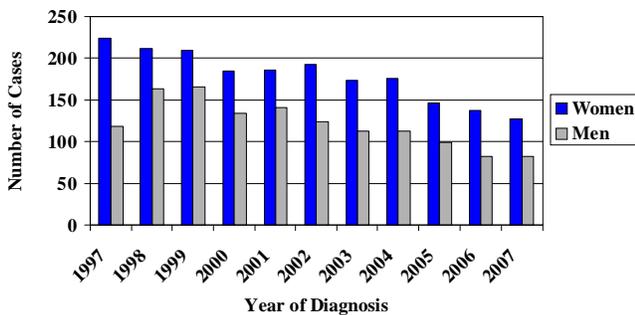
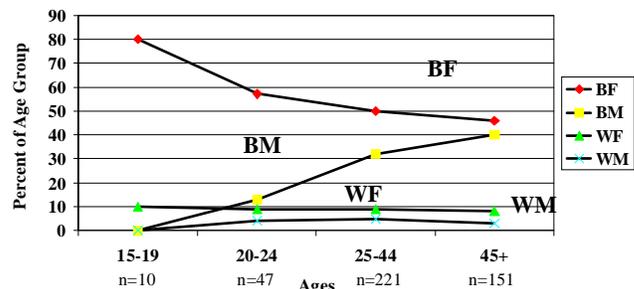


Figure 36 shows the number of heterosexually acquired HIV in women and men in South Carolina from 1997 to 2007. During most of this period, the proportion of female cases outnumbered the male cases by an average of 40%. The number of women reporting heterosexual risk has gradually decreased by 26% in the past five years from 2003 to 2007. Likewise, the number of men reporting heterosexual HIV risk has gradually decreased by 27% in the same time period.

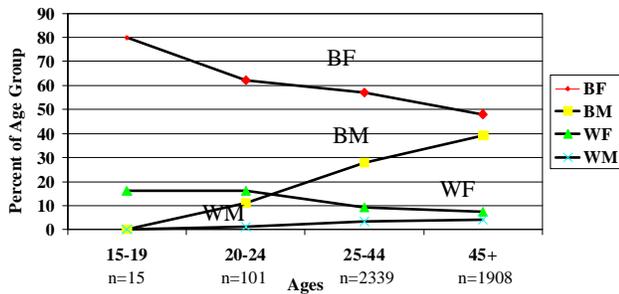
The majority of high risk heterosexuals recently diagnosed were 25 – 44 years of age (52%); 35% were 45 years and older, and 13% under 25 years. With the exception of the 15-19 year old group, African-American women and men comprised the greatest proportion of cases in each age group (Figure 37). Among young women less than 45 years of age, over 8 out of every 10 of the total cases are African-American women. White women and men account for an average of 15% or less of young and older ages.

**Figure 37: Percent Heterosexual HIV/AIDS Cases Diagnosed 2006-2007 By Age Group and Race/Sex**  
N=429



Total N includes 25 Other Race Not Included in Graph Due to Small Numbers

**Figure 38: Percent of Heterosexuals Living with HIV/AIDS by Age Group and Race/Sex, 2007**  
**N=4,363**



Total N includes 116 Other Race Not Included in Graph Due to Small Numbers

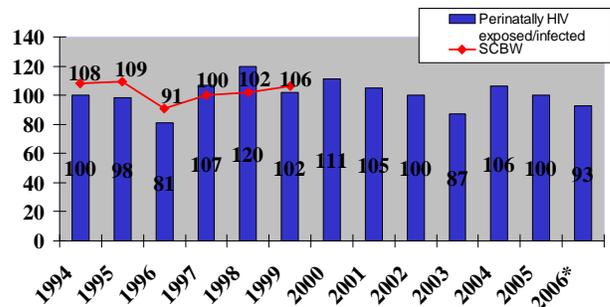
Of the high risk heterosexual persons presumed living with HIV/AIDS in 2007, over half were African-American women (53%), 32% were African-American men; 8% were white women. As Figure 38 shows, over 8 of every 10 young women under age 25 living with HIV/AIDS were African-American; over one half of persons 25 – 44 are African-American women. Similarly, the proportion of persons living with HIV across all age groups is greatest for African-American women followed closely by African-American men. As with more recently diagnosed persons, white women and men account for an average of 12% of persons living with HIV across all age groups.

**Estimates of prevalence of HIV among High Risk Heterosexual Women**

Estimates of HIV prevalence among women were obtained during 1990 – 1997 through a population-based seroprevalence survey of women who deliver live births at hospitals throughout the state. Recently estimates are obtained by the pediatric surveillance system using reports of HIV infected women delivering live births. While this prevalence is limited to child-age bearing women who have delivered a child, it provides the best overall estimate available for HIV infection among women 15 – 44 years of age.

Figure 39 shows that the number of HIV infection cases among all women delivering live births has been stable during the past seven years, averaging nearly 100 per year. The rate, though, is nearly 9 times higher among African-American women compared to white women.

**Figure 39 : Perinatally HIV Exposed Births by Year of Birth Compared to SC Survey of Child Bearing Women**

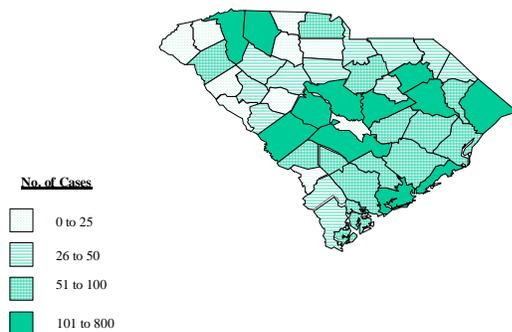


Source: provisional SC STD/HIV Surveillance Program Data

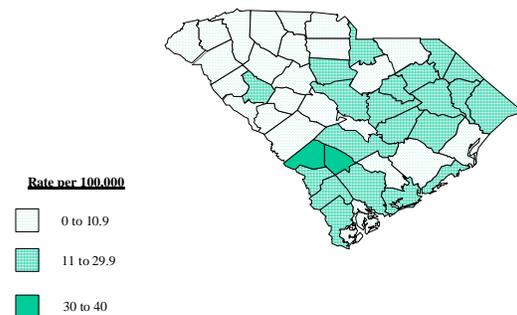
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Figure 40 shows the counties with highest prevalence of persons living with HIV/AIDS due to heterosexual transmission. These are the more urban counties of Florence, Greenville/Spartanburg, Richland, Lexington, Sumter, Orangeburg, Horry and Charleston, as well as Darlington and Aiken counties. Figure 41 shows the case rate for 2005-2007 among women, an indicator for more recent heterosexual risk. Richland, Sumter, Orangeburg, as well as rural Marlboro, Marion, Bamberg, Barnwell and Allendale counties had the highest case rates in the state.

**Figure 40: SC HIV Prevalence by Exposure Category, 2007 Reported Cases, by County Heterosexual Contact**



**Figure 41: SC HIV Incidence Rates (per 100,000 population) 2005-2007 Average of Cases Females**



### Conclusions

These data indicate that prevention efforts targeted to high risk heterosexuals need to be tailored to African-Americans, particularly young women under age 25, who account for over six of every ten persons of both living cases and more recently diagnosed cases in this age group. Efforts also need to target African-American men and women 25 – 44 years, who account for over eight out of every ten persons living and more recently diagnosed cases (all ages). Prevention efforts targeting African-American men and women should also be tailored to reach those 45 years and older.

### Injecting Drug Users

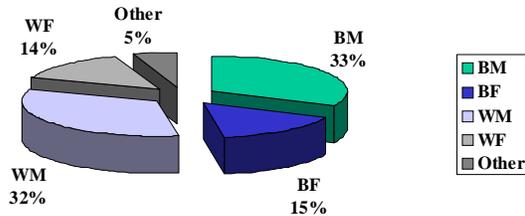
#### Estimates of Injecting Drug Use Behavior in South Carolina

According to 1999-2000 estimates of heroine use provided by the SC Department of Alcohol and Other Drug Abuse Services (DAODAS), there are 8,000 persons in South Carolina who are injecting drug users in need of treatment services.

**Characteristics of Injecting Drug Users**

*Note: persons who are categorized as both men who have sex with men and injecting drug users are included in this population description.*

**Figure 42: Proportion of Injecting Drug Users Diagnosed with HIV/AIDS 2006-2007 by Race/Sex N=93**

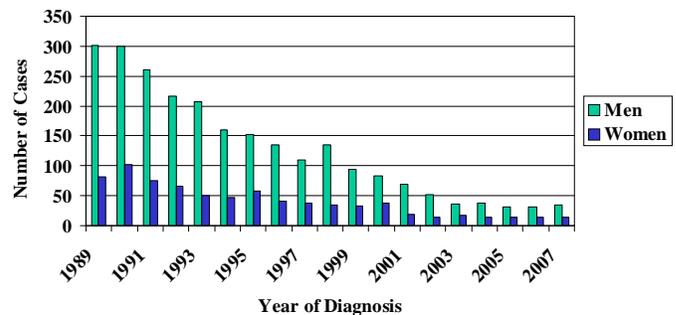


Men are overwhelmingly impacted by HIV transmitted by injecting drug use, averaging 3 cases to every one case reported among women each year. Men show a decrease in number of diagnosed IDU cases since 1998. For most of this same period, the number of diagnosed IDU cases among women was fairly stable. The increase in 1998 cases for men is likely due to targeted screening in corrections facilities, identifying more new cases that year. (Figure 43)

Injecting drug users (IDUs) account for 18% of the persons presumed living with HIV/AIDS in 2007 and 9% of persons more recently diagnosed with HIV/AIDS during 2006-2007. The number of IDU cases diagnosed each year decreased 45% from 2001 to 2007 (See Figure 30).

Figure 42 shows that 33% of recently diagnosed injecting drug use cases are African-American men; white men account for 32% of recent diagnoses. African-American women account for 15% of cases, and the least proportion is among white women (14%).

**Figure 43: Number of HIV/AIDS Cases Due to Injecting Drug Use by Sex and Year of Diagnosis, 1989-2007**



**Figure 44: Percent of Injecting Drug Users Diagnosed with HIV/AIDS 2006-2007 by Age Group N=93**

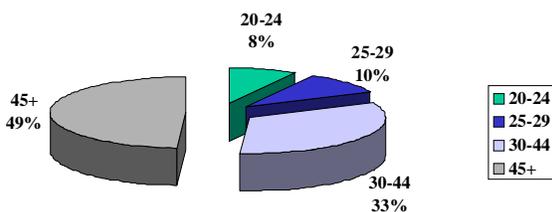
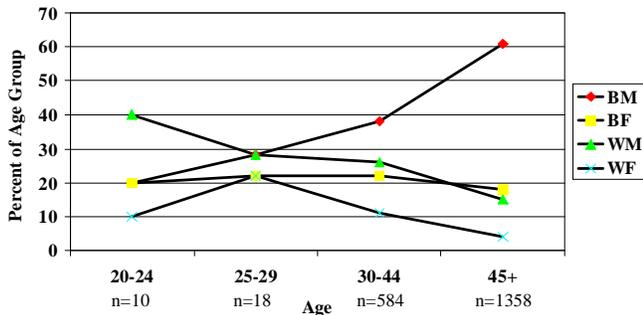


Figure 44 shows that 49% of recently diagnosed IDU cases are 45 years and older; 43% are 25 – 44 years of age. Only 8% of persons diagnosed during 2006-2007 were under 25 years.

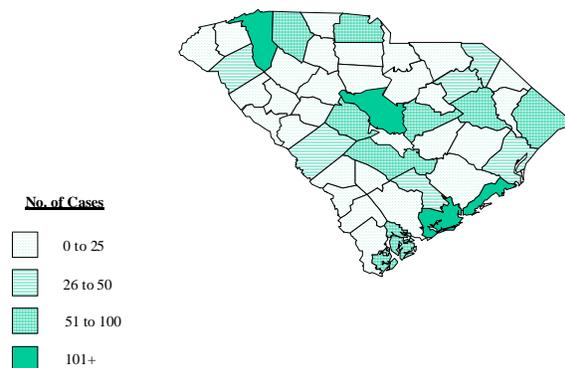
**Figure 45: Percent of IDU Persons Presumed Living with HIV/AIDS by Race/Sex and Age Group, 2007**  
N=1,970



Similarly, persons living with HIV/AIDS due to injecting drug use are largely 25 years of age and older (99%). African-Americans account for the greatest proportion of cases in each age group, with African-American men accounting for over 61% of those older than 25 years. (Figure 45)

Figure 46 indicates the counties with the highest number of persons living with HIV with injecting drug use risk (Richland, Greenville, and Charleston). As with other risks, the more urban counties have the greatest numbers.

**Figure 46: HIV Prevalence by Exposure Category, 2007 Reported Cases, by County IDU**



**Conclusions**

Prevention efforts targeting injecting drug users need to be tailored to men, primarily African-American men who comprise a majority of recently diagnosed cases, followed by white men. Efforts should target persons older than 25 years and those who are predominately in more urban counties including Lexington, York, Florence, Spartanburg, Horry, Orangeburg and Sumter.

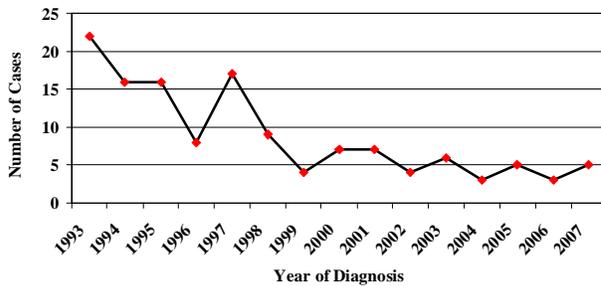
**Other Populations**

Other populations at varying risk for HIV are described below and include infants and children, persons with sexually transmitted diseases, and pregnant teen-age women.

**Infants and Children: (Children under 13 years of age)**

The majority of infants and children are infected with HIV through exposure to their mother during pregnancy. Through December 2007, there were 105 HIV infection cases diagnosed among children less than 13 years of age, of which 52 had AIDS. This represents less than 1.0 percent of the total reported AIDS and HIV infection cases. The majority of the children with HIV are black.

**Figure 47: Number of Children <13 Years Old Diagnosed with HIV/AIDS in South Carolina, 1993-2007**



Source: SCDHEC, HARS

There has been significant progress during the past five years in reducing the number of infants with perinatal acquired HIV infection. Figure 47 shows the decline in the number of infants diagnosed from 16 cases in 1997 to 5 cases in 2007.

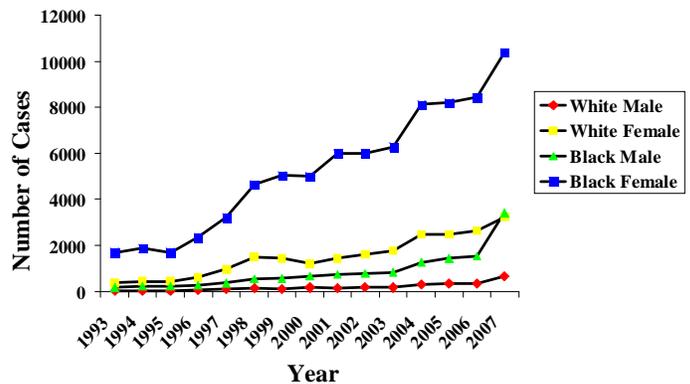
**Persons with Sexually Transmitted Diseases (STDs)**

STDs are primary risk factors for HIV infection and a marker of high risk, unprotected sexual behavior. Many STDs cause lesions or other skin conditions that facilitate HIV infection. Trends in STD infection among different populations (e.g. adolescents, women, men who have sex with men) may reflect changing patterns in HIV infection that have not yet become evident in the HIV/AIDS caseload of a particular area.

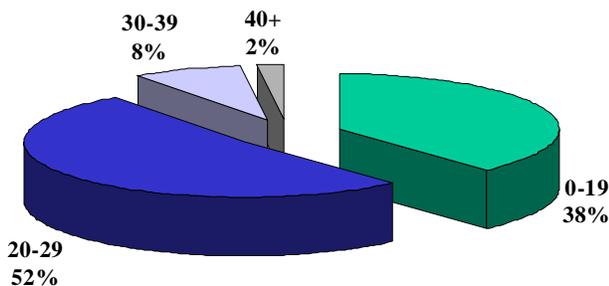
**Chlamydia**

In 2007, there were 26,117 cases of chlamydia diagnosed in South Carolina. Figure 48 shows the increase of chlamydia as a result of initiating routine screening for all young women attending family planning and STD clinics in health departments statewide. Among those cases with reported race/gender, 57% were African-American women; 18% were white women in 2007. Hispanic men and women accounted for 1% of cases in 2007.

**Figure 48: South Carolina Reported Chlamydia Cases by Year of Diagnosis, 1993 - 2007**



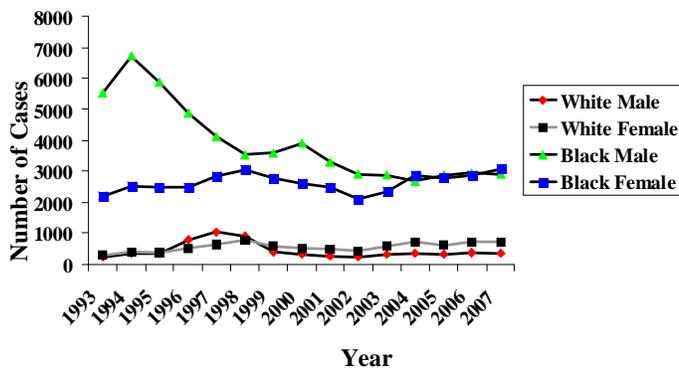
**Figure 49: Proportion of 2007 Reported Chlamydia Cases by Year of Diagnosis by Age Group**



Excludes persons with no reported age

Figure 49 shows that in 2007 young adults 20-29 have the highest proportion of chlamydia (52%) in the state. Counties with highest chlamydia rates per 100,000 population in 2007 were Bamberg (1,460.6), Allendale (1,358.4) and Richland (1,196.9).

**Figure 50: South Carolina Reported Gonorrhea Cases by Year of Diagnosis, 1993 - 2007**

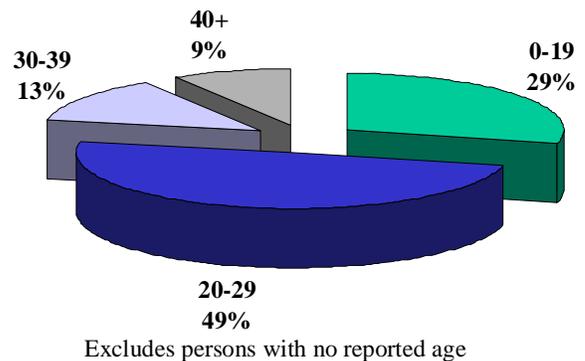


As with chlamydia, gonorrhea cases most affect young adults 20-29 years of age (49% of total) (Figure 51). Counties with highest rates per 100,000 of gonorrhea in 2007 were Lee (481.5); Orangeburg (405.1); and Richland (385.7).

**Gonorrhea**

In 2007, 9,932 gonorrhea cases were diagnosed. African-American men and women account for 85% of reported cases with known race/gender in 2007. Figure 50 shows trends among race/gender by year.

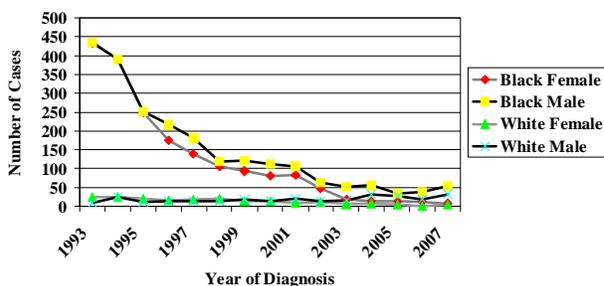
**Figure 51 : Proportion of 2007 Reported Gonorrhea Cases by Year of Diagnosis by Age Group**



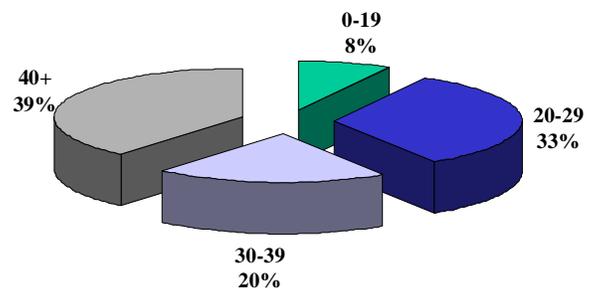
**Infectious Syphilis**

In 2007, 95 cases of infectious syphilis were diagnosed. As Figure 52 shows, significant decreases have occurred during the past ten years for all infectious syphilis cases. As with other STDs, African-Americans are most impacted, accounting for 75% of total cases. Unlike other STDs, syphilis most impacts older adults, 30 years and older (59% of total) (Figure 53). Counties with highest infectious syphilis rates per 100,000 population in 2007 were Lee (9.7), Allendale (9.3), Richland (9.2), and Calhoun (6.7).

**Figure 52: South Carolina Reported Infectious Syphilis Cases by Year of Diagnosis, 1993-2007**



**Figure 53: Proportion of 2007 Reported Infectious Syphilis Cases by Year of Diagnosis by Age Group**



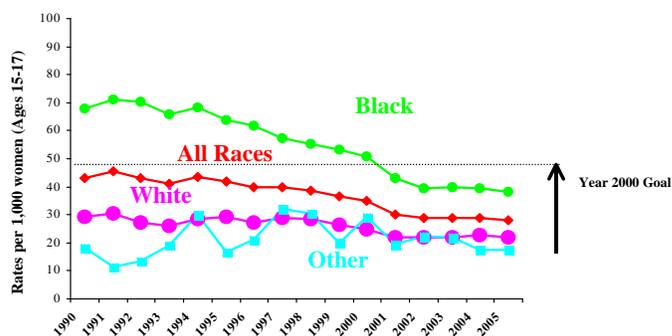
### Teenage Pregnancy

Pregnancy, birth and abortion rates, like STD rates, are indications of the extent of unprotected sexual activity in a population.

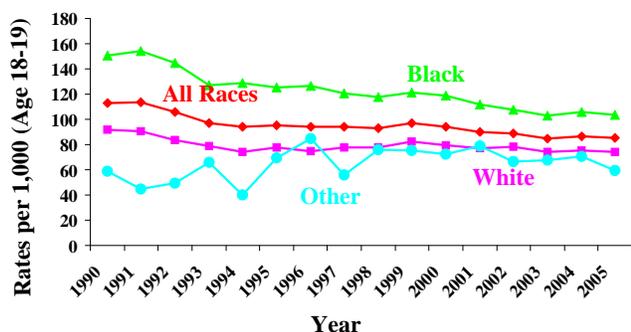
African-American girls between the ages of 10 and 14 have continued to have higher rates of live births than their white counterparts. However, their rates have decreased from 4.2 in 1988 to 1.8 per 1,000 in 2006, respectively.

Teenage pregnancies among 15-17 year old South Carolinians have decreased from a rate of 43.2 per 1,000 live births in 1990 to 28.1 in 2005; a 35% decline (Figure 54). This success is also seen when viewing teen pregnancy by racial/ethnic subgroups. The rate for White 15-17 year old teens was 29.1 in 1990 and 22.1 in 2005, representing a 24% decline. The rate for African-American 15-17 year old teens declined 44% in the same time period from 1990 to 2005. The rate for Others is the only exception to a consistent declining trend where the rate was 21.2 in 1996 and climbed to 30.4 in 1998 and down again to 17.4 in 2005, representing a 18% decrease in the rate over the 1996 to 2005 period. This fluctuation may be due to small numbers and the trend for this subgroup requires further observation.

**Figure 54: South Carolina Teenage Live Births Rates, Ages 15 - 17**



**Figure 55: South Carolina Teenage Live Births Rates Ages 18-19**



Source – SCDHEC, Vital Records, SC Residence Data

Figure 55 shows the teen pregnancy rates for 18 and 19 year olds. As with the other two age groups, African-American and other teenage girls continue to have higher live birth rates over the 15-year period than all races. But also as seen in the other age groups their rates have decreased from 150.6 to 103.3, 1990 and 2005, respectively.

### Persons Receiving HIV Counseling and Testing At County Health Departments

Data from local HIV counseling and testing sites (county health departments) generally reflect similar trends as HIV/AIDS surveillance data in terms of who is most likely to be HIV infected, risk category, and county of residence. As stated in the Introduction, the data reflects only those persons tested voluntarily in local health departments. HIV infected persons diagnosed through counseling and testing sites account for about one-third of the newly diagnosed persons in South Carolina annually. This data reflects number of individuals tested, not the number of tests. In

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2007, African-Americans comprised 64% of the total persons tested, but 77% of the total positive. Men accounted for 38% of persons tested but 70% of total positive. Persons 20-49 years of age had the highest positivity rate and comprised 82% of the total positive persons.

Public Health regions that accounted for the greatest proportion of persons tested who were positive include those with the same urban counties of highest prevalence: Region 3, (includes Richland County)- 28.1% of total positives tested; Region 2, (includes Greenville/Spartanburg County) – 16.2% of total positives; Region 5, (includes Orangeburg County) – 10.8% of total positives; Region 4 (includes Sumter and Florence counties) – 14.3% of total positives; Region 6 (includes Horry County) – 9.1% of total positives; Region 1 (includes Anderson County) – 5.1% of total positives; Region 7, (includes Charleston County)- 9.1% of total positives; and Region 8 (includes Beaufort County) – 4.2% of total positives.

### Other Behavioral/Risk Data

#### Behavioral Risk Factor Surveillance System (BRFSS)

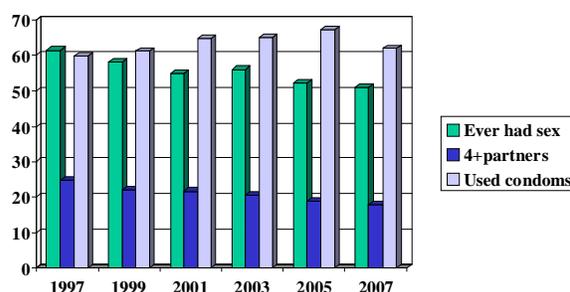
Behavior Risk Factor Surveillance System is the world's largest random telephone survey of non-institutionalized population aged 18 or older that is used to track health risks in the United States. In 1981, the Centers for Disease Control and Prevention (CDC), in collaboration with selected states, initiated a telephone based behavioral risk factor surveillance system to monitor health risk behaviors. South Carolina began administering BRFSS since 1984. Several core questions address knowledge, attitudes, beliefs, and behaviors regarding sexually transmitted diseases, particularly AIDS.

Results of the 2004 survey suggest most respondents have a fair knowledge of transmission and treatments of HIV/AIDS. Fifty-two percent of respondents said they believed treatments are available to HIV+ women to reduce the chance of transmission to the baby, and 89% believed medical treatments are available to help HIV+ persons live longer. When asked about ever being tested for HIV themselves, only 47% of respondents indicated ever being tested with 67% of those having been tested in the past 4 years. Most respondents who had been tested revealed the main reason for the test was part of a routine check-up or required (51.4%), pregnancy (13.9%), or reasons of personal interest (19.6%). When asked if in the past 12 months if a doctor, nurse, or health professional discussed condom use for preventing STDs, a majority (85.1%) said this had not occurred.

#### Youth Risk Behavior Survey

The Youth Risk Behavior Survey is administered to students in public high school in South Carolina. Figure 56 shows that over time there have been slight decreases in the proportion of students who have been sexually active, had four or more lifetime partners, and increases in those reporting condom use at last sexual intercourse.

Figure 56: Proportion of YRBS Students Indicating Sexual Risks, 1997 - 2007



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### **Substance Use**

A 1999-2000 household telephone survey of 10,324 adults  $\geq 18$  yrs was conducted by the SC Department of Alcohol and Other Drug Use Services (DAODAS) to assess substance use practices. Results indicated that 37% of persons used alcohol during past 30 days, 3% used marijuana, and less than 0.5% used cocaine and hallucinogens during past month. General patterns of substance use by persons in the state indicate that more men than women use drugs/alcohol; higher use levels are generally among younger respondents (18 – 44 years of age).

### **Summary/Recommendations**

A review of this epidemiological profile indicates the following primary target populations and recommendations for prevention efforts:

#### **Men Who Have Sex With Men**

These data indicate that prevention efforts targeted to men who have sex with men need to be tailored to both African-American and white men. African-American men account for over half of both living cases (58%) and newly diagnosed HIV/AIDS cases (66%) who report MSM risk. Increased efforts in particular are needed to reach younger African-American MSM <25 years of age; for white men, targeted efforts are needed for those >25 years. Interventions also need to be particularly available for persons living in the more urban areas of the state.

#### **Heterosexuals**

These data indicate that prevention efforts targeted to high risk heterosexuals need to be tailored to African-American women, particularly young women under age 25, who account for nearly half of both living heterosexual cases and more recently diagnosed persons in this age group. Efforts also need to target African-American men and women 25 – 44 years, who account for over three-fourths of living and more recently diagnosed cases (all ages). Prevention efforts targeting African-American men and women should also be tailored to reach those 45 years and older.

#### **Injecting Drug Users**

Prevention efforts targeting injecting drug users need to be tailored to men, primarily African-American men who comprise just under half (48%) of recently diagnosed IDU cases, followed by white men. Efforts should target persons older than 25 years and those who are predominately in more urban counties including Richland, Greenville and Charleston as well as Lexington, York, Florence, Horry, Orangeburg and Sumter.

### **Question #4: What are the patterns of service utilization of HIV-infected persons?**

In 1990, Congress enacted the Ryan White CARE Act to provide funding for states, territories and EMAs to offer medical care and support services for persons living with HIV disease who lack health insurance and financial resources for their care. Congress reauthorized the Ryan

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White CARE Act in 1996 and 2000 to support Titles I through IV, Special Projects of National Significance (SPNS), the HIV/AIDS Education Training Centers and the Dental Reimbursement Program, all of which are part of the CARE Act. The legislation was reauthorized again in 2006 when it became the Ryan White HIV/AIDS Treatment Modernization Act. With that reauthorization Titles I-IV were changed to Parts A-D.

Part B funding is used to assist States and Territories in developing and/or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals and families living with HIV.

**Figure 57: Demographic Characteristics of CARE Act Part B Clients Compared with Characteristics of Persons Living with HIV/AIDS, South Carolina, 2007**

	CARE Act Clients, N=8,760, %	Persons Living with HIV/AIDS, N=14,696, %
<b>Race/Ethnicity</b>		
White, not-Hispanic	22%	24%
Black, not-Hispanic	72%	73%
Hispanic	3%	2%
Other	2%	<1%
<b>Sex</b>		
Male	61%	69%
Female	39%	31%
Transgender	<1%	---
<b>Age Group</b>		
<13	1%	1%
13-24	6%	4%
25-44	50%	49%
45+	43%	47%

During 2007, 8,760 clients received services through the Ryan White Part B funds. Figure 57 presents the distribution of Part B clients by race/ethnicity, sex and age as well as for those persons living with HIV/AIDS in South Carolina through December 2007. Clients served through Part B are representative of the population affected with HIV/AIDS in all categories.

HRSA has directed that States should allocate funds for essential core services: 1) Primary Medical Care consistent with Public Health Service (PHS) Treatment Guidelines; 2) HIV Related Medications; 3) Mental Health Treatment; 4) Substance Abuse Treatment; 5) Oral Health; and 6) Case Management.

**Figure 58: South Carolina Ryan White Part B Service Utilization by Service Type, 2007**

Figure 58 shows a break down of Ryan White Part B clients who received five of the core services through funding and the average number of visits per clients. Utilization of HIV related medications is described in the ADAP section. Among the 8,760 clients who received services, the majority of clients obtained medical case management services (n=6,776) followed by medical care (n=6,470), dental care (n=1035), mental health services (n=660), and substance abuse services (n=547).

	No. of clients receiving service	Avg. no. of visits per client
Medical Care	6,470	4.8
Medication (ADAP)	2,887	N/A
Oral/Dental Care	1035	2.2
Mental Health	660	2.5
Substance Abuse	547	2.0
Case Management	6,776	6.5

Of those services utilized more by clients (visits/clients), case management services were among the highest (6.5 visits per clients), followed by medical care (4.8 visits per client), mental health services (2.5 visits per client), dental care services (2.2 visits per client) and clients receiving substance abuse care averaged about 2.0 visits in 2007.

Additional services obtained by clients in 2007 included treatment adherence, counseling, food bank/home delivered meals, health education/risk reduction, referral for health care and supportive services, psychological support services, housing assistance and transportation services.

### **AIDS Drug Assistance Program (ADAP)**

The South Carolina AIDS Drug Assistance program (SC ADAP) was established under the Ryan White CARE Act to provide drugs to treat HIV disease and/or to prevent the serious deterioration of health arising from HIV disease in eligible individuals, including measures for the prevention and treatment of opportunistic infections and document the progress made in making the drugs available. The SC ADAP is operated through a centralized pharmacy and an insurance assistance program located at the Department of Health and Environmental Control. Currently 67 drugs are on the approved formulary. During calendar year 2006, ADAP served 2,887 clients. The SC ADAP has an advisory body of infectious disease (ID) physicians and program staff that meets annually to review the SC ADAP formulary and make recommendations for program improvements.

In the past, once an antiretroviral medication received FDA approval, it was automatically added to the SC ADAP formulary. With the new development of extremely expensive therapies, such drugs are added as appropriate after consultation with the SC ADAP Medical Advisory Committee. Fuzeon, pegylated interferon and ribavirin currently require prior reauthorization for approval. No restrictions or caps on the number of other Antiretroviral medications per client exist.

Eligibility in ADAP includes verified HIV positive status, South Carolina residency, and limited income. The financial requirement is measured according to the Federal Poverty Guidelines. Eligibility remains at 300% of the Federal Poverty Guidelines, and the sliding fee scale includes up to 550% of poverty level. Expenditures are carefully monitored and projections are reviewed monthly.

Figure 59 lists the characteristics of clients enrolled in the ADAP program during 2006. Clients served through ADAP have a similar distribution to that of persons living with HIV/AIDS in South Carolina. The majority of the clients are non-Hispanic African-Americans/Black (69%), male (71%), and in the 25-44 year age group.

**Figure 59: 2006 ADAP Patient Profile Compared to Persons Living with HIV/AIDS**

Profile	SC HIV/AIDS Prevalence, 12/31/07: 14,696 Persons	Central Pharmacy Total Served: 2,224	Insurance Program Total Served: 663
Male	69%	71%	69%
Female	31%	29%	30%
African American	73%	69%	69%
White	24%	25%	26%
Hispanic/Latino	2%	4%	4%

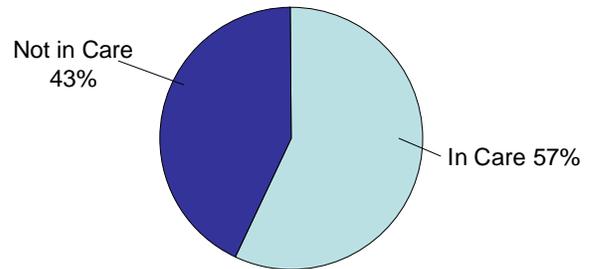
**Question#5: What are the number and characteristics of persons who know they are HIV+ but who are not receiving HIV primary medical care?**

To analyze the number of persons living with HIV/AIDS in South Carolina not “in care,” HARS (HIV/AIDS Reporting System) data was used to review all persons diagnosed through December 2007. HARS in South Carolina is a laboratory based reporting system with all CD4 and viral load tests being reportable as of January 1, 2004. Persons who were deceased as of December 31, 2007 were excluded from the analysis. Only current SC residents were included. A person was reported as being “in care” if they had at least one CD4 or viral load test report from January 1, 2007 through December 31, 2007. Persons with no CD4 or viral report in this time frame were defined as “not in care”.

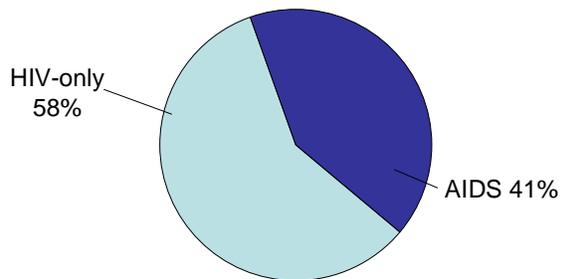
South Carolina conducted the Interstate Duplication Evaluation Project (IDEP) in 2002 assuring that HARS eliminated duplicate cases across states.

**Figure 60: SC HIV/AIDS Cases Estimated Not in Care vs. In Care Diagnosed through 2007 (N=15,465)**

Figure 60 shows that of the 15,465 patients diagnosed through December 2007, 43% (6,656) patients did not receive a CD4 or viral load test report within the specified time period, therefore are reported as “not in care”. Fifty-seven percent are defined as “in care”.



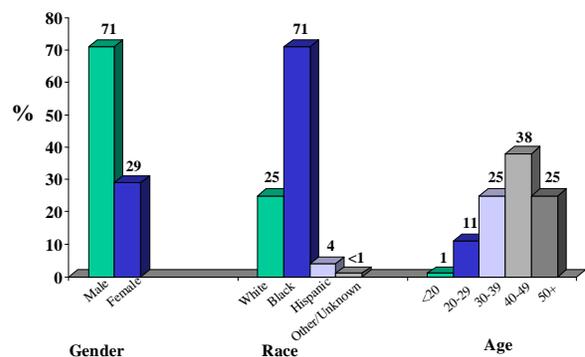
**Figure 61: SC HIV/AIDS Cases Estimated NOT In Care Diagnosed through 2007, HIV-only vs. AIDS (N=6,656)**



Of the 6,656 clients not in care, 58% are living with HIV-only and 41% are living with AIDS (Figure 61).

Figure 62 demonstrates a comparison of persons not in care by select demographics. By gender, the percent of men not in care (71%) is more than double of the percentage of women not in care (29%). Seventy one percent of those not in care are African-Americans. In addition, a comparison by age groups shows that most persons living with HIV/AIDS and not receiving care are between the ages of 30-49 (63%), followed by those who are 50+ (25%) and 20-29 (11%).

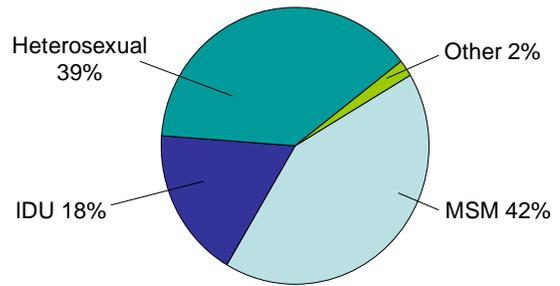
**Figure 62: SC HIV/AIDS Cases Diagnosed through 2007, Comparison within Select Demographics Estimated Percentage Not In Care**



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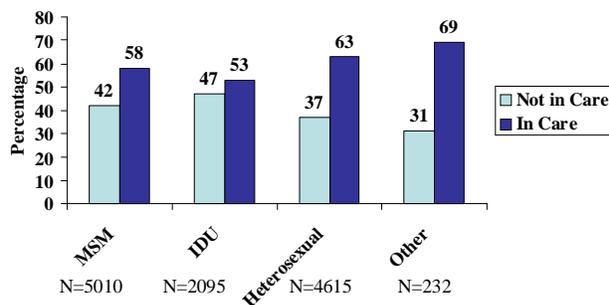
An analysis by mode of exposure of persons living with HIV/AIDS indicates most persons not in care are MSM (42%) and heterosexuals (39%) followed by IDUs (18%) (Figure 63).

**Figure 63: SC HIV/AIDS Cases Estimated NOT in Care Diagnosed through 2007 by Mode of Exposure\***



\*excludes cases with no risk identified, N = 3,513

**Figure 64: SC HIV/AIDS Cases Diagnosed through 2007, Comparison within Mode of Exposure In Care vs. Not in Care\***

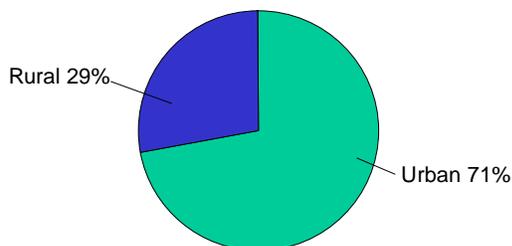


\*excludes cases with no risk identified, N = 3,513

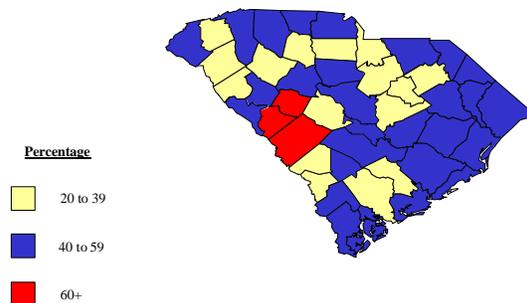
Figure 64 goes further to compare those in care versus those not in care within each risk category. Among all MSMs living with HIV/AIDS, more persons are in care (58%) than not in care (42%). Focusing on those persons whose mode of exposure was injecting drug use, the number of those in care (53%) is greater than the number out of care (47%). Likewise, among heterosexuals with HIV/AIDS, 63% are in care compared to 37% not in care.

The location of a person’s residence may have an impact of whether or not they are in care. There are more persons not in care from urban areas (71%) versus rural areas (29%). (Figures 65 and 66).

**Figure 65: SC HIV/AIDS Cases Estimated NOT in Care Diagnosed through 2007, by Location (N=6,656)**



**Figure 66: SC HIV/AIDS Cases NOT in Care Diagnosed through 2007, by County**



## CHAPTER 2: COMMUNITY SERVICES ASSESSMENT

This Chapter describes the Community Services Assessment conducted including identifying the prevention needs of populations at risk for HIV infection, the prevention interventions/activities implemented to address these needs regardless of funding source, and service gaps.

### Key Steps to Conducting A Community Services Assessment

A community services assessment is an essential component of the HIV prevention community planning process. Indicated in HIV Prevention Community Planning Guidance a community services assessment is comprised of three steps:

- 1) *Needs assessment* — A process for obtaining and analyzing information to determine the current status and service needs of a defined population or geographic area.
- 2) *Resource inventory* — Current HIV prevention and related resources and activities in the project area, regardless of the funding source. A comprehensive resource inventory includes information regarding HIV prevention activities within the project area and other education and prevention activities that are likely to contribute to HIV risk reduction.
- 3) *Gap analysis* — a description of the unmet HIV prevention needs within the high-risk populations defined in the epidemiologic profile. The unmet needs are identified by a comparison of the needs assessment and resource inventory.

The goal of the community services assessment is to investigate both the met and unmet needs of each population selected and identify barriers to reaching them and engaging them in prevention activities. A met need is a required service that is currently being addressed through existing HIV prevention resources that are available to, appropriate for, and accessible to that population as determined through the resource inventory. An unmet need is a required service that is not currently being addressed through existing HIV prevention services and activities, either because no services are currently available or because available services are either inappropriate for, or inaccessible to, the target populations.

Additionally, the assessment of prevention needs furnishes information about the extent to which specific target populations are aware of HIV transmission methods and high-risk behaviors, are engaging in specific high-risk behavior, have been reached by HIV prevention activities, and are likely to participate in HIV prevention activities. The assessment also identifies barriers that make it difficult to reach specific target populations and involve them in HIV prevention initiatives and suggests strategies that may be effective in overcoming these barriers.

The following sections describe how each of the three key community services assessment steps were conducted during 2003 and 2004.

### 1. Needs Assessment of Priority Populations

A Needs Assessment Workgroup was established to provide leadership in completing a review of needs assessment process and make recommendations for future directions. The first step involved reviewing the updated Epi Profile in 2003 and comparing that with the 2000 priority populations. Based on review of the Epi Profile data, the Needs Assessment Workgroup summarized the data and made recommendations to the CPG to modify the list of priority populations. The CPG approved these recommended changes at their meeting in June 2003. See Chapter 4 for a more detailed explanation and description of the populations.

2004 - 2008 Priority Populations
HIV Positive Persons
African American MSM
African American Women who have sex with men (AAWSM)
African American Men who have sex with women (AAMSW)
White MSM
Injecting Drug Users
Hispanic/Latino Men and Women

Using these populations as a starting point, the Workgroup determined that the first step in collecting needs assessment information on these priority populations was to first determine what had already been done to date in the state. The Needs Assessment activities conducted in 2001 for the 2002 – 2004 HIV Prevention Plan are summarized in the Table below for Phase I.

PHASES	ANTICIPATED TIMEFRAME	TASKS TO BE COMPLETED
Phase I	2001	Phase I of the needs assessment consisted of collecting information regarding the priority populations through secondary data sources; conducting focus groups with two prevention provider groups, and surveying providers to determine the extent to which prevention services were available, accessible and appropriate for the priority populations.
Phase II	2002	Phase II of the needs assessment will focus on obtaining information from the priority target populations through focus groups, surveys, town meetings, interviews, etc.
Phase III	2003	Phase III of the needs assessment will include round table discussions with representatives of the target populations to share results of Phase II assessment and obtain feedback on the meaning of the results, verification and to learn recommendations for prevention strategies.

Since 2001, Phase II activities were initiated by the CPG as well as many other community needs assessments by local prevention contractors and organizations. For example, in 2003 and 2004 two cities, Columbia and Charleston, conducted RARE (Rapid Assessment, Research and Evaluation) projects funded through the U.S. Department of Health and Human Services. Results of the RARE assessments were shared with members of the CPG. In addition, the CDC’s *Advancing HIV Prevention Initiative* directed health departments and community planning groups to prioritize HIV infected persons as the number one priority population.

As a result of these new assessments and revisions to priority populations, prior to continuing with Phase III roundtable activities, the Needs Assessment committee wanted to update the secondary research conducted in 2001. During January to June 2004, the University of South Carolina’s Institute for Families in Society was contracted to collect and summarize the various needs assessment information from the HIV prevention contractors and providers in the state, to

summarize their findings by priority population, and to make recommendations on future steps for needs assessment activities in South Carolina.

The Institute for Families in Society reviewed the data and presented a summary of their findings at the June 2004 meeting of the CPG. A final written report was provided in August 2004. At the June 2004 meeting Dr. Muriel Harris, the Principal Investigator, indicated that there were strong limitations to what could be gleaned from the various needs assessments because they utilized different methodologies, often combined priority populations into mixed groups to complete the needs assessment, and asked different questions precluding comparisons. The following summary points and recommendations were made to the CPG:

- A total of 78 documents were received, reviewed and analyzed for needs information. Only 62 contained information related to needs and 33 had information related to services. Three had both.
- Seventy-seven were specific to South Carolina, 71 were HIV/AIDS specific studies or publications, 55 were specific to South Carolina CPG-specified priority populations.
- Twenty-two documents did not have any data, results or findings.
- The most frequently occurring method of obtaining needs assessment information was focus group discussion (n=22), followed by surveys (n=17), program reports (n=15) and face-to-face interviews (n=12).
- Most of the documents (12) contained information on HIV positive persons, the number one priority population. Other priority populations were represented by far fewer studies (1-4), with Injecting Drug Users (IDUs) and Hispanics being the least represented.
- While there were some unique needs identified for each priority population (see attached power point slides from presentation to CPG), overall there were five major themes in the assessment of needs among all the priority populations:
  - Increase knowledge and skills in HIV prevention,
  - Provide opportunities for behavior modification for both sexual and drug taking risks associated with the spread of HIV/AIDS.
  - Provide improved health care and social services,
  - Ensure the integration of HIV/AIDS care and drug treatment services, and
  - Address issues of stigma and discrimination.
- Final recommendations from the researcher were:
  - Consolidate needs assessment activities at the state level to ensure consistency in methods used and questions asked.
  - Adopt and implement a standardized approach to the collection of data for needs assessment.
  - Conduct a search to identify existing reliable and valid tools for conducting needs assessment among the priority populations.
  - Develop a multi-year plan for conducting needs assessment activities.

Use of Data:

The CPG considered this needs assessment information along with reports from the RARE assessments and local providers, such as the CDC-Direct Funded Project ‘Between Brothers’, to update the descriptions of barriers, risks, and prevention needs for the priority population profiles in Chapter 4 Priority Populations and Interventions. Several data were consistent with other data

sources (project reports/grant narratives, focus groups, epi profile) thus it validated existing perceptions. For example, several data sources across populations indicate that substance use is a behavior associated with HIV risk through sexual activity; therefore, substance users are listed as a subpopulation in the priority population profiles for all populations as well as the need for stronger linkages to substance use services.

The primary use of this Needs Assessment report is being used by the committee to plan future activities for the 2005 – 2008 period, particularly completing round-table discussions with priority populations and linking activities with assessments being conducted by care providers.

## **2. Resource Inventory**

This comprehensive resource inventory includes information regarding HIV prevention activities in South Carolina and other education and prevention activities that are likely to contribute to HIV risk reduction. The resource inventory information described in this Chapter helps to describe the ‘met’ prevention needs by geographic area in the state.

In 2004, a listing of the primary HIV prevention activities was compiled into a table format that summarizes:

- Name of provider and contact information
- Geographic areas served (by public health district boundaries as of June 2004)
- Estimated DHEC, CDC or other funding levels, if known
- Targeted populations
- Types of programs offered

The information was compiled through reviewing the 2001 Provider Survey responses from 105 agencies with updates from DHEC STD/HIV Division contact lists. Local providers and CPG members reviewed the list for completeness in September 2004. The Table is on pages 14- 26 of this Chapter.

In addition to the data in the Table listing primary prevention providers/services in the state, DHEC staff prepared GIS maps depicting the primary HIV prevention providers to visually summarize met and unmet needs by geographic area. This allowed CPG members to compare to maps showing HIV incidence and prevalence by district to determine if the number of providers by location are reflective of the epidemic. The maps are found on pages 8-10. The GIS maps were prepared based on the recommendation from the 2002 – 2004 planning period to enhance the gap analysis and priority setting process.

The primary funding for direct HIV prevention services in South Carolina is the Centers for Disease Control (CDC) HIV prevention cooperative agreement to SC DHEC and the CDC direct-funded community organization funds to PALSS, S.C. HIV/AIDS Council, and Hope Health. These CDC funds account for over \$5.7 million in 2004/2005. Additionally, DHEC receives some state funds for HIV/STD prevention (approximately \$4 million annually). Additional funds for HIV counseling and testing services are provided in the HRSA Title III grants and the SAMAHA Alcohol and Drug Abuse Block Grant – HIV Early Intervention requirement.

### Limitations

The information in the Resource Inventory Table on target populations, interventions, and funding is specific for the DHEC funded providers and CDC Direct-Funded providers. However, for other providers, it was not always possible to obtain information describing populations served according to the CPG's priority population definitions. Therefore, the summary analysis often limits population types to race/gender categories and may not reflect risk characteristics. In addition, the types of interventions for these other providers could not always be specifically defined. For these providers, funding amounts were also not always available particularly for the particular prevention intervention listed. For example, the total amount of HRSA Ryan White Title III funds an organization receives may be known, but not the amount allocated for counseling and testing services. DHEC funds allocated includes state and federal funds for STD activities and it is not possible to distinguish precisely the amount specific to HIV prevention as DHEC considers STD control to be HIV prevention and staff are integrated at the state and local health department level. Data on the programs and target populations reached is based on 2003 contractor and program reports and may not be indicative of future services but it serves as a guide for who is providing what services for what populations.

While these data attempt to portray the *availability* of prevention services in South Carolina, the data do not relay other key components of unmet need such as *acceptability* and *accessibility* of services. For example, services may exist in a county for counseling and testing but may not be offered during times of day or days of the week that are convenient for people who work and can't take time off. Or, the physical environment of an agency offering services and staffing skills and make-up may not be user-friendly or culturally acceptable to the target populations. For example, a community delivered HIV counseling and testing event at a college campus may not reach those at greatest risk (such as African American MSM) because that population will not likely participate in a testing event where other students/faculty are present, regardless of how 'confidential' the staff attempt to make the environment. Also, while some services may be available in each county, the data do not specifically reflect staff burdens compared to HIV incidence and prevalence, particularly important for staff-intensive interventions such as PCRS, PCM, etc.

Finally, it is there may be other providers delivering services not reflected in the Resource Inventory. The original 2001 provider survey had a low response rate (16% of 600 surveys mailed). In 2004, staff focused the inventory to those organizations and activities most involved with HIV prevention or sexual/drug risk reduction. There may be other organizations such as clinical trials or other research projects at medical schools or universities not reflected. Special grants from foundations that are time-limited are included, such as SCHAC's Ford Foundation – anti stigma grant and Hope Health's Pzifer grant. However, both these grants are time limited (1 – 2 yrs) so for decision-making around HIV prevention funds for the next 3 years, the CPG acknowledged these important contributions but did not weigh them for future longer-term program needs.

### Summary Analysis

The CPG used the information from the Resource Inventory table and DHEC's local health department and HIV prevention contractors to determine the estimated representation of HIV

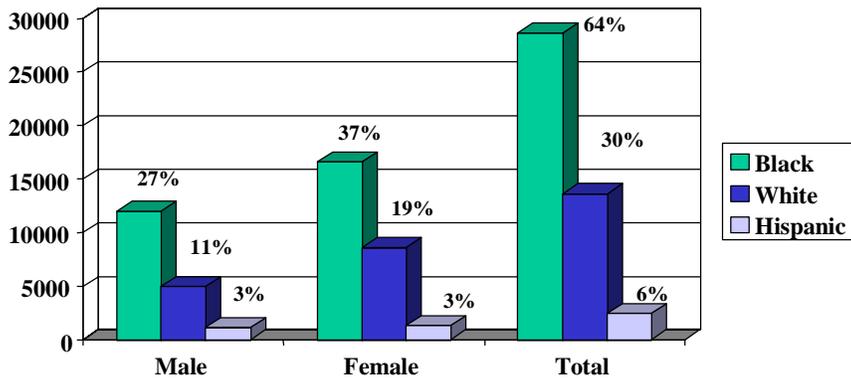
prevention efforts during 2003/2004 and the funding available for primary interventions in the state and by geographic region.

a. *Populations Served*

Figures 1 – 4 below portray the populations reached for DHEC HIV counseling and testing sites, community counseling and testing providers, PCRS services, and Health Education/Risk Reduction providers. These data come from DHEC program and contractor reports. Consistently across all prevention services, the majority of populations reached are African Americans (average percent is 69%).

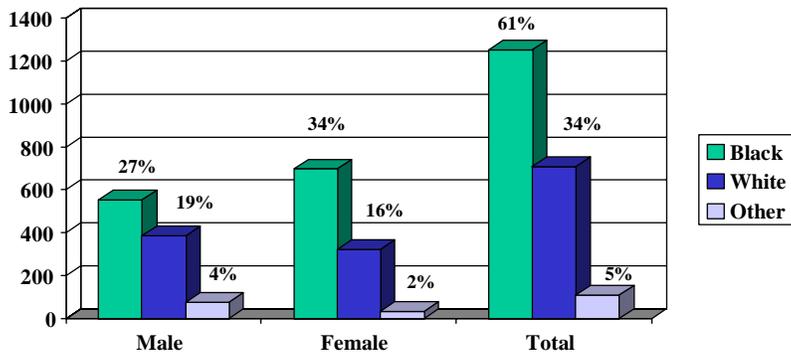
Counseling and testing services by local health department and community organizations contracted by DHEC (Figures 1 & 2) serve primarily African American women (about 33% of total persons served), followed by African American men (27% of total).

**Figure 1. Number and percent of persons receiving HIV counseling and testing services in local health departments Y2003, by Race/Gender**



Race percents for males and females are based on total number of persons receiving services (N = 44,723). Data excludes persons with other/unknown race.

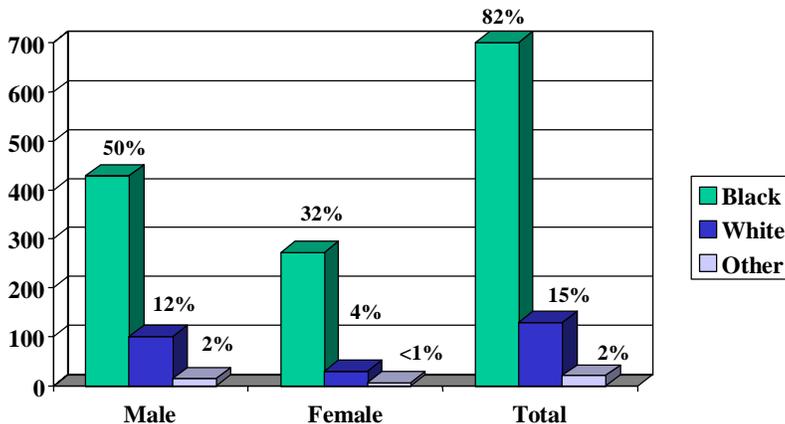
**Figure 2. Number and percent of persons receiving HIV counseling and testing services by DHEC-supported community organizations**



Race percents for males and females are based on total number of persons receiving services (N =2,066 ). Data excludes persons with unknown race.

PCRS services (Figure 3) represent the number of HIV infected persons interviewed for partner follow up (contacts reached are not reflected in this data). These data essentially equal the portion of newly diagnosed and reported persons, with 82% of total persons interviewed being African Americans; 50% were men, 32% were women.

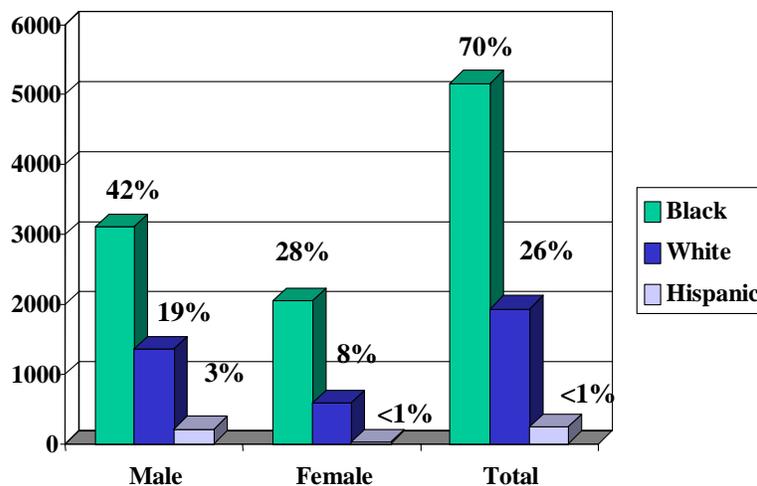
**Figure 3. Number and percent of HIV infected persons receiving partner counseling services in CY2003, by Race/Gender**



Race percents for males and females are based on total number of persons receiving services (N =849). Data excludes persons with race unknown.

Health education/risk reduction providers (HE/RR) served mostly African American men (42%) and African American women (28%), reflecting the priority population rankings in the 2004 prevention plan. About 2% of the total persons receiving HE/RR services (excluding PCM), were HIV infected persons as only a small number of DHEC-funded providers (3) conducted interventions with HIV infected persons (the number one ranked priority population in 2004).

**Figure 4. Number and percent of persons receiving HE/RR\* programs by DHEC-funded providers in CY2003 by race/gender**



\*Includes ILI, GLI, and Outreach and includes 151 persons with HIV. Race percents for males and females are based on total number of persons receiving services(N =7,337). Data excludes persons with other/unknown race.

*b. Prevention Interventions Provided*

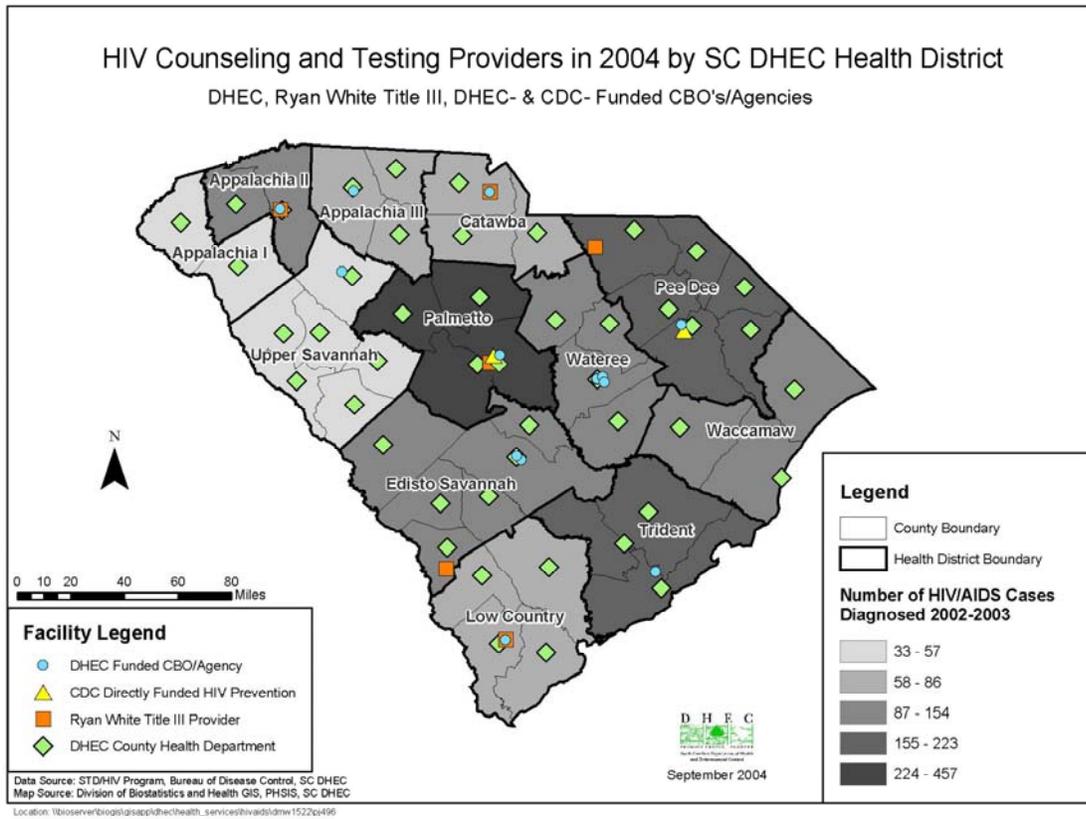
To summarize the types of interventions available across the state for all populations, the table below was prepared for the CPG indicating the number of agencies reporting providing the listed interventions. These data were compiled from the Resource Inventory Table.

**Number of Prevention Agencies/Organizations Providing Prevention Interventions**

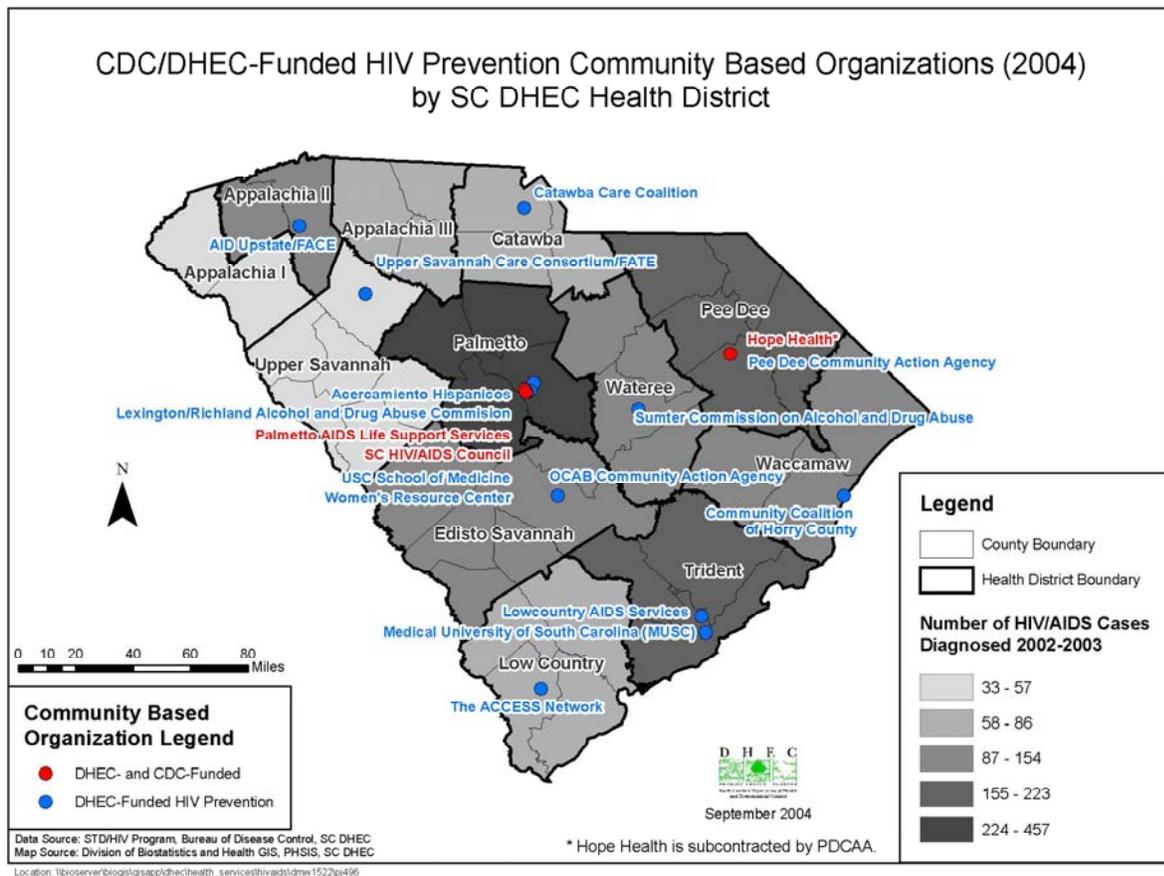
<b>Prevention Interventions Provided</b>	<b>Number of Agencies/Organizations</b>
HIV counseling and testing Clinic based & Community based	46 county health departments 5 RW Title III 5 Alcohol & Other Drug Abuse 13 CBOs SC State
Partner counseling and referral services	46 (county health depts.)
Health Communications/Public Information	20
Group level interventions	22
Individual interventions	14
Prevention Case Management	11
Outreach	12

In addition to this table, two GIS maps below provide visual information about geographic availability of interventions. Prevention services available in each county include clinic based HIV counseling and testing and partner notification services. Health Communications/Public Information activities are also widely conducted. There are fewer providers conducting GLI, ILI and PCM services.

Forty-six (46) county health departments, 5 RW Title III, 5 alcohol and drug abuse agencies, 13 CBOs, and SC State University provide HIV counseling and testing services. These sites either received 1) HIV prevention funding or 2) paid DHEC lab services for testing.



This map below shows DHEC and CDC HIV funded prevention providers. Of these, 13 organizations provide interventions specifically targeting African American MSM, and 5 target White MSM. The majority of providers target and reach African American men and women.



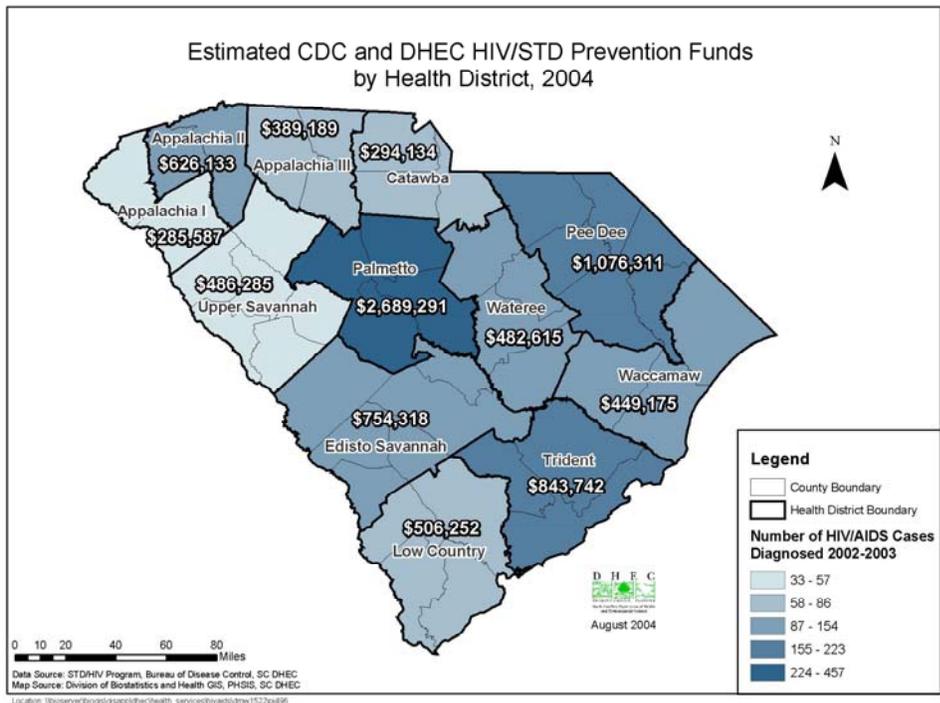
*c. Prevention Funding in South Carolina*

In order to assist the CPG in priority setting and assessing gaps in services, a following summary of HIV prevention specific **resources (funds)** in South Carolina was reviewed.

<b>DHEC FEDERAL HIV PREVENTION FUNDING FROM CDC</b>	
1. Counseling/Testing, PCRS	\$1,905,696
2. Health education/risk reduction	\$1,801,384
3. Public Information	\$109,956
4. Evaluation	\$183,193
5. Capacity Building	\$179,187
6. Community Planning	\$221,280
7. Other (includes agency fringe benefits, indirect, general overhead, office supplies, etc)	\$276,398
<b>SUBTOTAL</b>	<b>\$4,654,369</b>
<b>DHEC STATE GENERAL REVENUE STD/HIV FUNDS</b>	
1. County Health Departments (Nurses, DIS, Health Educators, in. Support Staff and operating to deliver HIV counseling and	\$2,845,111

testing, STD diagnosis and treatment, PCRS, Health Education )	
2. State Office (HIV/STD Lab test, STD treatments)	\$1,449,076
<b>SUBTOTAL</b>	<b>\$4,294,187</b>
<b>CDC DIRECT FUNDING TO CBOs</b>	
Directly Funded Prevention Projects (4)	\$1,402,763
<b>OTHER DHEC PREVENTION-RELATED FUNDING</b>	
1. DAODAS Contract for HIV Counseling and Testing, Hepatitis C Services	\$356,790
2. CDC Syphilis Elimination Funds	\$763,240
3. CDC Infertility Prevention	\$405,142
4. CDC STD Services	\$991,528
5. CDC HIV Surveillance	\$873,111
6. Office of Minority Health Demonstration Project	\$150,000
<b>SUBTOTAL</b>	<b>\$3,539,811</b>
<b>GRAND TOTAL</b>	<b>\$13,891,130</b>
<b>Note: funding amounts based on estimated CY2005 or FY2004/05 depending on type of fund</b>	

The GIS map below shows the total funds for HIV and STD prevention services from CDC and DHEC by health district and by 2002/2003 new HIV case diagnosis. This indicates that essentially the resources are allocated relatively consistent with the HIV epidemic. For example, Palmetto District has the greatest number of new HIV cases diagnosed and the greatest amount of HIV/STD prevention resources.



### 3. Gap Analysis

Based on a review of the community services assessment data (needs assessment and resource inventory) and the epidemiologic profile data, the CPG confirmed the populations at highest risk for HIV and the greatest need for services. The descriptions of Priority Populations in Chapter 4 summarize the specific barriers and needs for prevention services for each population.

*Summary: What are the Primary Met Comprehensive Prevention Needs in South Carolina?*

Based on the community services assessment, the following indicate ‘met’ prevention needs:

- Resources for HE/RR interventions reflect a greater amount of effort being targeted to the top priority populations (African American MSM and heterosexual men and African American women having sex with men).
- Interventions such as counseling, testing and referral; partner counseling and referral, and STD services are available in each county for all priority populations. It is acknowledged that these interventions are only partially “met” needs as they may not be consistently accessible; be delivered in convenient, community settings, or fully meet all the prevention needs of clients served.
- A significant amount of resources are allocated to reach HIV-infected persons through counseling and testing, partner notification and referrals to care. The wide network of existing HIV care providers in the state provide varying levels of HIV risk reduction counseling at least upon initial entry to care.

*Summary: What are the Primary Unmet Comprehensive Prevention Needs in South Carolina?*

More prevention programs are needed for ongoing services for HIV infected persons. Few providers are currently providing the recommended interventions of PCM, GLI or ILI. Enhanced case management activities are needed to improve the successful linkage of newly diagnosed persons to care services in a more timely manner (see description of Linkages in the Coordination and Linkages Chapter).

Both STD/HIV prevention and HIV care services target in particular African Americans, who are disproportionately impacted by these diseases. Many challenges exist, however, that must be addressed to eliminate this health disparity. The overall impact of poverty, substance use, and insurance status contributes both to placing African Americans at risk for acquiring STD’s and HIV and to creating challenges in providing prevention and care services. The impact is particularly significant in rural areas of the state where there are fewer prevention and care providers, longer distances to travel for services, and fears of stigma and discrimination.

Issues of confidentiality remain consistent barriers, especially for rural clients. Fear of alienation and rejection if someone in their small town finds out their HIV status are so great that many clients are reluctant to get tested, and if infected with HIV, are forced to live in denial. The fear of being found out prevents clients from seeking services, following up on symptoms, and from asking questions of health care providers. This fear also can be a barrier for drug adherence, challenging clients to prevent others from seeing the medicines in their home or work setting.

Primary barriers and unmet HIV needs that have been identified by both prevention and care providers include the following:

- Scarce human and financial resources challenge the delivery of HIV/STD services. Many STD clinics must turn clients away for same day treatment; HIV care providers do not have enough resources to meet client needs.
- Access to the targeted populations is challenged by distrust and wariness of data and medical/public health institutions.
- For African American men who have sex with men, there is a lack of defined, open “community” in which to direct outreach/education services; lack of family acknowledgement and support of sexuality issues reduces access to preventive health services.
- There is no singular HIV prevention program for African American MSM, multiple approaches are needed.
- Time constraints due to large client caseloads create inequities in availability (and quality) of clinic and risk reduction interventions.
- Barriers to being tested include the stigma of going to be tested, fear of clinic staff talking, fear of being seen at a clinic, and of simply not wanting to know if they have HIV disease.
- Lack of statewide opportunities for community delivered STD/HIV screening and outreach services for populations not being reached by “traditional” services.
- Need for easier access to drug treatment and prevention counseling for alcohol/other drug using persons.
- There is a lack of trained staff to provide range of effective interventions particularly to MSM and HIV infected persons.
- There is a lack of credible members of the affected community advocating for HIV prevention and ownership of HIV.
- There is a need to provide information to high risk groups who do not access community (agency) services (unemployed, out of school).
- Need for expanded, targeted peer education programs for youth and young adults, especially those who are gay, lesbian, bisexual, questioning and who are African American.
- Need for increased peer education and skill building for HIV positive persons.

Additionally, there is a need to better integrate and link care and prevention efforts to reduce the risk of transferring HIV to others from those already infected and to increase the number of HIV infected persons who are in a system of care.

Finally, for each of its priority populations, the statewide HIV Prevention Community Planning Group also identified a need for more behavioral risk data, social network information and needs assessment information involving members of the priority populations to better guide decisions for planning, designing interventions and targeting resources.

Key recommendations for addressing these unmet needs are:

- Reach uninfected people at risk at the community level.
- Involve African American community representatives in designing, planning and delivering local prevention initiatives.

- Reach infected people with HIV testing, treatment referrals, and on-going prevention services (including linking persons with substance abuse treatment programs, family planning, STD, mental health or job training, etc. services).
- Provide information to high-risk groups who do not access community/agency services (unemployed, out of school).
- Increase programs targeting men who have sex with men.
- Expand targeted peer education programs for youth and young adults.
- Improve access to drug treatment and prevention counseling for alcohol/other drug using persons.
- Increase number of trained staff to provide range of effective interventions particularly for men who have sex with men and HIV infected.
- Build capacity among community organizations, including the faith community recognizing differences in abilities to deliver services across communities
- Engage other key leaders to address underlying issues causing HIV stigma and health disparities for African Americans.

**HIV PREVENTION RESOURCE INVENTORY BY GEOGRAPHIC REGION AND  
PUBLIC HEALTH REGION/DISTRICT 2006 – Revised 11/29/05**

Name of Agency and Contact Information [Note: bold indicates DHEC funded HIV prevention contractor]	Type of Organization	Target Population	Types of Interventions (some services may not be offered in all locations)	CDC/DHEC STD/HIV Funding	% CDC HIV Only Funds	Direct CDC Funding To CBOs
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**REGION 1**

**APPALACHIA I HEALTH DISTRICT – ANDERSON, OCONEE COUNTIES**

Appalachia I Health District STD/HIV Services 220 McGee Road Anderson, SC 29625 (864) 260-5541	Public Health	HIV+ AAMSM AAMSW AAWSM WMSM IDU Hispanic	CTR PCRS PCM/ILI STD diagnosis and treatment	\$210,443	7%	None
<b>AID Upstate</b> PO Box 105 811 Pendleton Street 10 Medical Court, 29601 Greenville, SC 29602 (864) 232.2310	AIDS Service Organization (ASO)	HIV+ AAMSM AAMSW AAWSM WMSM IDU Hispanic	CTR/OUT ILI PCM VOICES Many Men Many Voices Healthy Relationships <a href="http://www.aidupstate.org/">http://www.aidupstate.org/</a> [note: total award from DHEC is \$221,000 to serve both App. I and II areas. AID Upstate serves Anderson, Greenville, Oconee, and Pickens]	\$221,000	100%	None
Adolescent Pregnancy Prevention Programs	Pregnancy Prevention	Youth	Funded by the South Carolina Department of Social Services (DSS in 35 of the 46 counties in South Carolina), these county-based programs work in their communities to reduce the incidence of teen pregnancy through programming that will delay the initiation of sex, reduce the frequency of sex, or increase the use of contraception by sexually active teens. <a href="http://www.teenpregnancysc.org/index.html">http://www.teenpregnancysc.org/index.html</a> Total = \$163,409 Anderson \$108, 418 Oconee \$54,991	None		None
Anderson/Oconee Behavioral Health Services 226 McGee Road Anderson, SC 29625-2104 Phone: (864) 260-4168 Fax: (803) 261- 7543	Alcohol and Other Drug Abuse Services (AOD)		CTR Early Intervention Services clients in AOD who may be at risk of HIV infection, Hepatitis C, TB, and other infectious diseases. Staff supported person to provide counseling and link to services.	None		None

**UPPER SAVANNAH HEALTH DISTRICT – ABBEVILLE, EDGEFIELD, GREENWOOD, LAURENS, MCCORMICK, SALUDA**

Upper Savannah Health District STD/HIV Services PO Box 3227 1736 S. Main Street Greenwood, SC 29646 (864) 942-3600	Public Health	HIV+ AAMSM AAMSW AAWSM WMSM IDU Hispanic	CTR PCRS PCM/ILI HE/RR PI STD diagnosis and treatment	\$388,083	52%	None
Upper Savannah Care Consortium P.O. Box 888 Laurens, SC 29360 (864) 984.1822 x103	ASO	AAMSM AAMSW AAWSM Hispanic	CTR/OUT	\$40,000	100%	None

**HIV PREVENTION RESOURCE INVENTORY BY GEOGRAPHIC REGION AND  
PUBLIC HEALTH REGION/DISTRICT 2006 – Revised 11/29/05**

Name of Agency and Contact Information [Note: bold indicates DHEC funded HIV prevention contractor]	Type of Organization	Target Population	Types of Interventions (some services may not be offered in all locations)	CDC/DHEC STD/HIV Funding	% CDC HIV Only Funds	Direct CDC Funding To CBOs
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Adolescent Pregnancy Prevention Program	Pregnancy Prevention	Youth	Funded by the South Carolina Department of Social Services <a href="http://www.teenpregnancysc.org/index.html">http://www.teenpregnancysc.org/index.html</a> Total = \$270,664 Abbeville \$37,959 Edgefield \$34,116 Greenwood \$69,324 Laurens \$64,626 McCormick \$34,126 Saluda \$30,513	None		None
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**REGION 2**

**APPALACHIA II HEALTH DISTRICT – GREENVILLE, PICKENS**

Appalachia II Health District STD/HIV Services PO Box 2507 200 University Ridge Greenville, SC 29602 (864) 282-4100	Public Health	HIV+ AAMSM AAMSW AAWSM WMSM IDU Hispanic	CTR PCRS PCM/ILI HE/RR PI STD diagnosis and treatment	\$480,264	36%	None
<b>AID Upstate</b> PO Box 105 811 Pendleton Street 10 Medical Court, 29601 Greenville, SC 29602 (864) 232.2310	ASO	HIV+ AAMSM AAMSW AAWSM WMSM IDU Hispanic	CTR/OUT ILI PCM VOICES Many Men Many Voices Healthy Relationships [Note: total award is for App. I & II districts]	\$221,000	100%	None
New Horizons Family Health Services 130 Mallard Street, PO Box 287 Greenville, SC 29602 (864) 751-3200 or 244-1534	RW Title III		CTR services Provides counseling and testing through HRSA Title IIIB grant	None		None
Adolescent Pregnancy Prevention Program	Pregnancy Prevention	Youth	Funded by the South Carolina Department of Social Services <a href="http://www.teenpregnancysc.org/index.html">http://www.teenpregnancysc.org/index.html</a> Total = \$252,991 Greenville \$181,015 Pickens \$71,976	None		None
Greenville County Commission on Alcohol and Drug Abuse 3336 Old Buncombe Road Greenville, SC 29617 Phone: (864) 467-3938 Fax: (864) 467-3779	AOD		Early Intervention Services clients in AOD who may be at risk of HIV infection, Hepatitis C, TB, and other infectious diseases. Staff supported person to provide counseling and link to services.	None		None

**HIV PREVENTION RESOURCE INVENTORY BY GEOGRAPHIC REGION AND  
PUBLIC HEALTH REGION/DISTRICT 2006 – Revised 11/29/05**

Name of Agency and Contact Information [Note: bold indicates DHEC funded HIV prevention contractor]	Type of Organization	Target Population	Types of Interventions (some services may not be offered in all locations)	CDC/DHEC STD/HIV Funding	% CDC HIV Only Funds	Direct CDC Funding To CBOs
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<b>APPALACHIA III HEALTH DISTRICT – CHEROKEE, SPARTANBURG, UNION</b>						
Appalachia III Health District STD/HIV Services PO Box 4217 151 E. Wood St. Spartanburg, SC 29305 (864) 596-3334	Public Health	HIV+ AAMSM AAMSW AAWSM WMSM IDU Hispanic	CTR PCRS PCM/ILI HE/RR STD diagnosis and treatment	\$297,013	25%	None
<b>Spartanburg Alcohol and Drug Abuse Commission (SADAC)</b> 187 W. Broad Street PO Box 1252 Spartanburg, SC 29304 (864) 585.8252 (864) 582.7588 x 336	AOD	AAMSM AAMSW AAWSM WMSM Hispanic	CTR/OUT SISTA Voices	\$70,000	100%	None
Adolescent Pregnancy Prevention Program	Pregnancy Prevention	Youth	Funded by the South Carolina Department of Social Services <a href="http://www.teenpregnancysc.org/index.html">http://www.teenpregnancysc.org/index.html</a> Total = \$260,060 Cherokee \$60,247 Spartanburg \$153,847 Union \$45,966	None		None
SADAC 187 W. Broad Street P. O. Box 1252 Spartanburg, SC 29304 Phone: (864) 582-7588, ext 342 Fax: (864) 582-8119	AOD		Early Intervention Services clients in AOD who may be at risk of HIV infection, Hepatitis C, TB, and other infectious diseases. Staff supported person to provide counseling and link to services.	None		None

<b>REGION 3</b>						
<b>CATAWBA HEALTH DISTRICT – CHESTER, LANCASTER, YORK</b>						
Catawba Health District STD/HIV Services PO Box 817 1833 Pageland Highway Lancaster, SC 29721 (803) 286-9948	Public Health	HIV+ AAMSM AAMSW AAWSM WMSM IDU Hispanic	CTR PCRS PCM/ILI HE/RR PI STD diagnosis and treatment	\$195,096	0%	None
<b>Catawba Care Coalition, Inc.</b> Catawba AIDS Prevention Network 1151 Camden Avenue Rock Hill, SC 29732 (803) 909.6363 ext. 234	ASO	HIV+ AAMSM AAWSM WMSM	CTR/OUT ILI SISTA	\$90,000	100%	None
Adolescent Pregnancy Prevention Program	Pregnancy Prevention	Youth	<a href="http://www.teenpregnancysc.org/index.html">http://www.teenpregnancysc.org/index.html</a> Total = \$200,289 Chester \$45,442 Lancaster \$58,609 York \$96,238	None		None

**HIV PREVENTION RESOURCE INVENTORY BY GEOGRAPHIC REGION AND  
PUBLIC HEALTH REGION/DISTRICT 2006 – Revised 11/29/05**

Name of Agency and Contact Information [Note: bold indicates DHEC funded HIV prevention contractor]	Type of Organization	Target Population	Types of Interventions (some services may not be offered in all locations)	CDC/DHEC STD/HIV Funding	% CDC HIV Only Funds	Direct CDC Funding To CBOs
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**PALMETTO HEALTH DISTRICT – FAIRFIELD, LEXINGTON, NEWBERRY, RICHLAND**

Palmetto Health District STD/HIV Services 2000 Hampton Street Columbia, SC 29204 (803) 576-2900	Public Health	HIV+ AAMSM AAMSW AAWSM WMSM IDU Hispanic	CTR PCRS HE/RR PI STD diagnosis and treatment	\$1,142,484	18%	None
<b>Palmetto AIDS Life Support Services (PALSS)</b> P.O. Box 11705 Columbia, SC 29211 (803) 779.7257	CBO	HIV+ men HIV+ women AA MSM AA MSW AA WSM	DHEC Funded: Partners in Prevention to male and female inmates SISTA CDC Directly Funded Activities: HE/RR (GLI-5B) to women in subsidized housing communities and domestic violence shelters (Women's Health Council Project) HC/PI to incarcerated men at Watkins Pre-Release. POL - To AA men and women at high risk who are negative or unaware of their HIV status. Healthy Relationships - HE/RR (GLI-5B) to HIV+ AA men and women enrolled in PCM. <a href="http://www.cdc.gov/od/oc/media/pressrel/r040521b.htm">http://www.cdc.gov/od/oc/media/pressrel/r040521b.htm</a> <a href="http://www.palss.org/">http://www.palss.org/</a>	\$125,000	100%	\$307,000
<b>Women's Resource Center</b> P.O. Box 5122 Columbia, SC 29250 (803) 771.0785	CBO	HIV+ women	Healthy Relationships	\$20,000	100%	None
<b>University of South Carolina</b> School of Medicine 2 Medical Park, Ste. 502 Columbia, SC 29203 (803) 540-1030	University/ Medical School	HIV+ women	PCM/ILI for HIV+ women who are pregnant (perinatal prevention funds)	\$83,492	100%	None
South Carolina HIV/AIDS Council SCHAC PO Box 2531 Columbia, SC 29202	CBO	AA MSM AA MSW AA WSM	<a href="http://www.cdc.gov/od/oc/media/pressrel/r040521b.htm">http://www.cdc.gov/od/oc/media/pressrel/r040521b.htm</a> SCAHC is a CDC-Direct funded CBO. They conduct Rapid CTR, GLI, ILI with VOICES and Between Brothers Program for YAAMSM that includes ILI, GLI, HCPI. They also received \$100,000 for anti-stigma project from Ford Foundation in 2003/2004. SCAHC receives \$189,577 from DHEC for Community-based Syphilis Elimination activities.	None		\$715,763
Richland Community Health Care Assn. 1520 Laurel Street Columbia, SC 29201 (803) 799-8407	RW Title III		CTR Provides counseling and testing through HRSA Title IIIB grant	None		None

**HIV PREVENTION RESOURCE INVENTORY BY GEOGRAPHIC REGION AND  
PUBLIC HEALTH REGION/DISTRICT 2006 – Revised 11/29/05**

Name of Agency and Contact Information [Note: bold indicates DHEC funded HIV prevention contractor]	Type of Organization	Target Population	Types of Interventions (some services may not be offered in all locations)	CDC/DHEC STD/HIV Funding	% CDC HIV Only Funds	Direct CDC Funding To CBOs
Adolescent Pregnancy Prevention Program	Pregnancy Prevention	Youth	Funded by the South Carolina Department of Social Services <a href="http://www.teenpregnancysc.org/index.html">http://www.teenpregnancysc.org/index.html</a> Total = \$357,279 Fairfield \$42,298 Lexington \$105,827 Newberry \$38,804 Richland \$170,350	None		None
<b>LRADAC: The Behavioral Health Center of the Midlands</b> 1325 Harden P. O. Box 50597 Columbia, SC 29502	AOD		VOICES Other funded services: Early Intervention Services clients in AOD who may be at risk of HIV infection, Hepatitis C,TB, and other infectious diseases. Staff supported person to provide counseling and link to services.	\$20,000	100%	None
<b>Acercamiento Hispano/Hispanic Outreach</b> PO Box 25277 Columbia, SC 29224-5277 (803) 714-0085	CBO	Hispanic	CTR/OUT Voices	\$40,000	100%	None
<b>REGION 4</b>						
<b>PEE DEE HEALTH DISTRICT – CHESTERFIELD, DARLINGTON, DILLON, FLORENCE, MARLBORO, MARION</b>						
Pee Dee Health District STD/HIV Services 145 E. Cheves Street Florence, SC 29506 (843) 661-4830	Public Health	HIV+ AAMSM AAMSW AAWSM WMSM IDU Hispanic	CTR PCRS PCM/ILI HE/RR PI STD diagnosis and treatment	\$575,451	24%	None
<b>Hope Health</b> PO Box 653 Florence, SC 29503 (803) 667-9414	ASO	AAMSM	DHEC Funded: CTR/OUT PCM/OUT (only the outreach component for PCM, (conducting PCM with other funds direct from CDC, see below) <a href="http://www.cdc.gov/od/oc/media/pressrel/r040521b.htm">http://www.cdc.gov/od/oc/media/pressrel/r040521b.htm</a> CTR GLI, ILI, PCM HopeHealth is a CDC Direct Funded CBO. They also received \$50,000 grant from Pfizer in 2003/2004 for community CTR.	\$50,000	100%	\$380,000
Care South 737 South Main Street Society Hill, SC 29593	RW Title III		CTR OUT			None
Circle Park Behavioral Health Services 601 Gregg Avenue P. O. Box 6196 Florence, SC 29502-4509 Phone: (843) 699-8087 Fax: (843) 678-9721	AOD		CTR Early Intervention Services clients in AOD who may be at risk of HIV infection, Hepatitis C,TB, and other infectious diseases. Staff supported person to provide counseling and link to services.	None		None

**HIV PREVENTION RESOURCE INVENTORY BY GEOGRAPHIC REGION AND  
PUBLIC HEALTH REGION/DISTRICT 2006 – Revised 11/29/05**

Name of Agency and Contact Information [Note: bold indicates DHEC funded HIV prevention contractor]	Type of Organization	Target Population	Types of Interventions (some services may not be offered in all locations)	CDC/DHEC STD/HIV Funding	% CDC HIV Only Funds	Direct CDC Funding To CBOs
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**WATEREE HEALTH DISTRICT – CLARENDON, KERSHAW, LEE, SUMTER**

Waterree Health District STD/HIV Services PO Box 1628 105 North Magnolia Street Sumter, SC 29150 (803) 773-5511	Public Health	All target populations in the Plan	CTR PCRS PCM/ILI HE/RR PI STD diagnosis and treatment	\$363,638	24%	None
<b>Sandhills Medical Foundation, Inc.</b> P.O. Box 249 Jefferson, SC 29718 (843) 658-3005			CTR/OUT	\$40,000	100%	None
Sumter Commission on Alcohol and Drug Abuse 115 North Harvin Street P. O. Box 39 Sumter, SC 29151-0039 Phone: (803) 775-5080 Fax: (803) 773-6232	AOD		CTR Early Intervention Services clients in AOD who may be at risk of HIV infection, Hepatitis C, TB, and other infectious diseases. Staff supported person to provide counseling and link to services.	None		
We Care Prevention 220 East Calhoun St. Sumter, SC 29150	CBO		CTR	None		None
Adolescent Pregnancy Prevention Program	Pregnancy Prevention	Youth	Funded by the South Carolina Department of Social Services <a href="http://www.teenpregnancysc.org/index.html">http://www.teenpregnancysc.org/index.html</a> Total = \$219,743 Clarendon \$42,529 Kershaw \$49,251 Lee \$39,971 Sumter \$87,992	None		None

**Region 5**

**EDISTO SAVANNAH (AIKEN, ALLENDALE, BAMBERG, BARNWELL, CALHOUN, ORANGEBURG)**

Edisto Savannah Health District STD/HIV Services PO Box 1126 1550 Carolina Avenue Orangeburg, SC 29116 (803) 533-7116	Public Health	HIV+ AAMSM AAMSW AAWSM WMSM IDU Hispanic	CTR PCRS PCM/ILI HE/RR PI STD diagnosis and treatment	\$681,328	34%	None
<b>OCAB Community Action Agency</b> PO Drawer 710 1822 Joe Jeffords Hwy Orangeburg, SC 29116-0710 (803) 536.1027	Community Action Agency	HIV+ AAMSM AAMSW AAWSM	CTR/OUT  OCAB serves Orangeburg, Calhoun, Allendale, and Bamberg counties.	\$40,000	100%	None

**HIV PREVENTION RESOURCE INVENTORY BY GEOGRAPHIC REGION AND  
PUBLIC HEALTH REGION/DISTRICT 2006 – Revised 11/29/05**

Name of Agency and Contact Information [Note: bold indicates DHEC funded HIV prevention contractor]	Type of Organization	Target Population	Types of Interventions (some services may not be offered in all locations)	CDC/DHEC STD/HIV Funding	% CDC HIV Only Funds	Direct CDC Funding To CBOs
SC State University Brooks Health Center 300 College St. N.E. Orangeburg, SC 29117	University		CTR	None		None
Adolescent Pregnancy Prevention Program	Pregnancy Prevention	Youth	Funded by the South Carolina Department of Social Services <a href="http://www.teenpregnancysc.org/index.html">http://www.teenpregnancysc.org/index.html</a> Total = \$326,966 Aiken \$94,704 Allendale \$43,133 Bamberg \$35,204 Barnwell \$41,392 Calhoun \$34,564 Orangeburg \$77,969	None		None
The Aiken Center 1105 Gregg Highway Aiken, SC 29802-0535 Phone: (803) 643-1900 Fax: (803) 643-2926	AOD		Early Intervention Services clients in AOD who may be at risk of HIV infection, Hepatitis C, TB, and other infectious diseases. Staff supported person to provide counseling and link to services.	None		None
Tri-County Commission on Alcohol and Drug Abuse 910 Cook Road P. O. Box 1166 Orangeburg, SC 29116 Phone: (803) 536-4900, Ext 132 Fax: (803) 531-8419	AOD		CTR Early Intervention Services clients in AOD who may be at risk of HIV infection, Hepatitis C, TB, and other infectious diseases. Staff supported person to provide counseling and link to services.	None		None
<b>REGION 6</b>						
<b>WACCAMAW HEALTH DISTRICT- GEORGETOWN, HORRY, WILLIAMSBURG</b>						
Waccamaw Health District STD/HIV Services 2830 Oak Street Conway, SC 29526 (843) 365-3126	Public Health	HIV+ AAMSM AAMSW AAWSM WMSM IDU Hispanic	CTR PCRS STD diagnosis and treatment	\$346,243	23%	None
<b>CARETEAM, Inc</b> 3926 Wesley Street, Suite 104 Myrtle Beach, SC 29579 Voice: 843.236.9000 Fax: 843.236.9117	ASO	HIV+ AAMSM AAMSW AAWSM WMSM IDU Hispanic	CTR/OUT PCM	\$80,000	100%	

**HIV PREVENTION RESOURCE INVENTORY BY GEOGRAPHIC REGION AND  
PUBLIC HEALTH REGION/DISTRICT 2006 – Revised 11/29/05**

Name of Agency and Contact Information [Note: bold indicates DHEC funded HIV prevention contractor]	Type of Organization	Target Population	Types of Interventions (some services may not be offered in all locations)	CDC/DHEC STD/HIV Funding	% CDC HIV Only Funds	Direct CDC Funding To CBOs
Adolescent Pregnancy Prevention Program	Pregnancy Prevention	Youth	Funded by the South Carolina Department of Social Services <a href="http://www.teenpregnancysc.org/index.html">http://www.teenpregnancysc.org/index.html</a> Total = \$202,131 Georgetown \$52,171 Horry \$102,577 Williamsburg \$47,383	None		None
Shoreline Behavioral 1004 Bell Street P. O. Box 136 Conway, SC 29526 (843) 365-8884	AOD		Early Intervention Services clients in AOD who may be at risk of HIV infection, Hepatitis C, TB, and other infectious diseases. Staff supported person to provide counseling and link to services.	None		None
<b>REGION 7</b>						
<b>TRIDENT HEALTH DISTRICT – BERKELEY, CHARLESTON, DORCHESTER</b>						
Trident Health District STD/HIV Services 4050 Bridge View Drive Suite 600 N. Charleston, SC 29405 (843) 746-3800	Public Health	HIV+ AAMSM AAMSW AAWSM WMSM IDU Hispanic	CTR PCRS PCM/ILI HE/RR PI STD diagnosis and treatment	\$664,953	43%	None
<b>Lowcountry AIDS Services</b> Trident HPC 1501 Manley Ave. Charleston, SC 29405 (843) 747.2273 x207	ASO	HIV+ AAMSM AAMSW AAWSM WMSM	CTR/OUT SISTA MPOWERment	\$130,000	100%	None
<b>Medical University of South Carolina</b> Charleston, SC 29401	University/ Medical School	HIV+ women	PCM for HIV+ women who are pregnant (perinatal prevention funds)	\$30,810	100%	
Adolescent Pregnancy Prevention Program	Pregnancy Prevention	Youth	Funded by the South Carolina Department of Social Services <a href="http://www.teenpregnancysc.org/index.html">http://www.teenpregnancysc.org/index.html</a> Total = \$292,521 Berkeley \$100,900 Charleston \$126,000 Dorchester \$65,621	None		None
Charleston Center 5 Charleston Center Drive Charleston, SC 29401 FAX: (843) 958-3401	AOD		CTR Early Intervention Services clients in AOD who may be at risk of HIV infection, Hepatitis C, TB, and other infectious diseases. Staff supported person to provide counseling and link to services.	None		None
<b>REGION 8</b>						
Low Country Health District STD/HIV Services 1407 King Street Beaufort, SC 29902 (843) 525-7603	Public Health	HIV+ AAMSM AAMSW AAWSM WMSM IDU Hispanic	CTR PCRS PCM/ILI STD diagnosis and treatment	\$317,731	43%	None

**HIV PREVENTION RESOURCE INVENTORY BY GEOGRAPHIC REGION AND  
PUBLIC HEALTH REGION/DISTRICT 2006 – Revised 11/29/05**

Name of Agency and Contact Information [Note: bold indicates DHEC funded HIV prevention contractor]	Type of Organization	Target Population	Types of Interventions (some services may not be offered in all locations)	CDC/DHEC STD/HIV Funding	% CDC HIV Only Funds	Direct CDC Funding To CBOs
<b>The ACCESS Network, Inc.</b> Low Country HPC & Prevention for Positives Project Rt. 1, Box 1006 Ridgeland, SC 29936 (803) 943.0554 (Hampton) (843) 379.5600 (Ridgeland)	ASO	HIV+ AAMSM AAMSW AAWSM Hispanic	CTR/OUT PCM	\$75,000	100%	None
<b>Low Country Health Care Systems</b> PO Box 990 Fairfax, SC 29827 (803) 632-2533	RW Title III	AAMSM AAMSW AAWSM WMSM IDU	CTR (serves Allendale as well) Provides counseling and testing through HRSA Title IIIB grant	\$40,000	100%	None
Adolescent Pregnancy Prevention Program	Pregnancy Prevention	Youth	Funded by the South Carolina Department of Social Services <a href="http://www.teenpregnancysc.org/index.html">http://www.teenpregnancysc.org/index.html</a> Total = \$200,033 Beaufort \$78,089 Colleton \$50,666 Hampton \$39,467 Jasper \$39,811	None		None
<b>STATEWIDE</b>						
South Carolina Department of Health and Environmental Control (DHEC) STD/HIV Division Box 101106 1751 Calhoun St. Columbia, SC 29201	Public Health, STD/HIV Prevention Programs	Priority Populations in the Comprehensive HIV Prevention Plan	Community Planning Community Contractor Funds (HE/RR, syphilis elimination) Lab Testing Contract (HIV/STD) STD Treatment Drugs Quality Assurance, and Fiscal & Programmatic Monitoring of Contractors and Public Health Staff delivering: CTR PCRS PCM/ILI HE/RR STD diagnosis and treatment Public Information, Federal Materials Review, and Education Prevention Materials Purchase Evaluation Training and Technical Assistance Capacity Building Grants Management Coordination and Linkages with HIV Surveillance and Care Services <a href="http://www.scdhec.gov/hs/diseasecont/stdwk/html/stdindex.htm">http://www.scdhec.gov/hs/diseasecont/stdwk/html/stdindex.htm</a>	\$4,476,262	44%	

**HIV PREVENTION RESOURCE INVENTORY BY GEOGRAPHIC REGION AND  
PUBLIC HEALTH REGION/DISTRICT 2006 – Revised 11/29/05**

Name of Agency and Contact Information [Note: bold indicates DHEC funded HIV prevention contractor]	Type of Organization	Target Population	Types of Interventions (some services may not be offered in all locations)	CDC/DHEC STD/HIV Funding	% CDC HIV Only Funds	Direct CDC Funding To CBOs
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**OTHER PREVENTION AND EDUCATION ORGANIZATION/AGENCIES THAT IMPACT HIV PREVENTION**

South Carolina Department of Health and Environmental Control (DHEC) Office of Minority Health Box 101106 1751 Calhoun St. Columbia, SC 29201	Public Health Minority Health & Health Disparities	African American Hispanic	The Minority HIV/AIDS Demonstration Project works to increase the capacity in minority community-based organizations to deliver HIV prevention by 1) creating linkages between community-based, minority serving organizations (CBMSOs) and others, 2) increasing their access to resources, and 3) increasing their knowledge and use of information. Project activities include: HBCU HIV/AIDS Summit, CBMSO Institute, Funding sustainability: Grant writing and Management, 501(c)3 strategies, HIV/AIDS/STD Updates, and the Black Church Week of Prayer for the Healing of AIDS. Project is supported by the US DHHS – Office of Minority Health	None		None
South Carolina Department of Corrections	State Corrections Agency	Young Adults and Adults HIV+ Heterosexual Men & Women	CTR (mandatory testing of all new inmates)	None		None
South Carolina Department of Education (SDE)	State Education Agency	In-School Youth	Comprehensive School Health Education (state law mandated in all 85 school districts 37.5 hours of health education is required for grades 6-8, this instruction must include HIV/STI prevention education, and 750 minutes of instruction on reproductive health and pregnancy prevention during grades 9-12 which includes information on barriers methods of birth control such as condoms). CDC funds for HIV & Healthy School Initiatives: <ul style="list-style-type: none"> <li>HIV Capacity Building for Teachers, CBOs, and other institutions that serve youth (CDC)</li> <li>Healthy Schools Coordinated School Health Capacity Building activities for teachers, districts and others (CDC)</li> <li>Youth Risk Behavior Survey (CDC)</li> </ul> <a href="http://www.myschools.com/offices/ace/healthyschools/">http://www.myschools.com/offices/ace/healthyschools/</a>	None	31%	\$625,000
Heritage Community Services 2810 Ashley Phosphate Suite B-10 Charleston, SC 29418 (843) 863-0508	Non-Profit CBO	School Age Youth	Abstinence Only Education, Title V, Section 510 Funding, \$811,757 in federal dollars with a state match of \$600,102 for a total of \$1,411,857.  Offices located in: Charleston, Pee Dee area, Greenville, Greenwood, N. Augusta, and Walterboro. Web: <a href="http://www.heritageservices.org/">http://www.heritageservices.org/</a>	None		None

**HIV PREVENTION RESOURCE INVENTORY BY GEOGRAPHIC REGION AND  
PUBLIC HEALTH REGION/DISTRICT 2006 – Revised 11/29/05**

Name of Agency and Contact Information [Note: bold indicates DHEC funded HIV prevention contractor]	Type of Organization	Target Population	Types of Interventions (some services may not be offered in all locations)	CDC/DHEC STD/HIV Funding	% CDC HIV Only Funds	Direct CDC Funding To CBOs
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South Carolina Department of Health and Environmental Control (DHEC) WCS-Family Planning Box 101106 1751 Calhoun St. Columbia, SC 29201	Public Health Women and Children's Services	Youth Young Women of Reproductive Age	Family Planning services are funded through Title X federal block grant dollars. These services are available in all 46 counties and 100 clinic sites and include counseling relative to risk-taking behaviors including risks for HIV/AIDS; screening and, if needed, treatment for sexually transmitted diseases; and providing information about all methods of birth control, including abstinence. <a href="http://www.scdhec.net/hs/mch/wcs/fp.htm">http://www.scdhec.net/hs/mch/wcs/fp.htm</a>	None		None
SC Campaign to Prevent Teen Pregnancy 1511 Gregg Street Columbia, SC 29201 803 771.7700	Non-Profit CBO	Youth	SC Campaign to Prevent Teen Pregnancy is the umbrella organization for assisting the Community Adolescent Pregnancy Prevention Initiatives (CAPP) in 35 of the 46 counties in South Carolina funded by the South Carolina Department of Social Services (DSS). These county-based programs work in their communities to reduce the incidence of teen pregnancy through programming that will delay the initiation of sex, reduce the frequency of sex, or increase the use of contraception by sexually active teens. <a href="http://www.teenpregnancysc.org/index.html">http://www.teenpregnancysc.org/index.html</a>  Communities Caring for Teens Project is a CDC funded project, 1 of 5 in the nation. Purpose: To build community and program leadership capacity that will support the implementation of evidence based teen pregnancy prevention programs that address the needs of the community, and to evaluate the effectiveness of these programs	None		None

**GUIDE TO ABBREVIATIONS:**

**Organization Types**

ASO AIDS SERVICE ORGANIZATION  
AOD ALCOHOL AND OTHER DRUG ABUSE AGENCY OR COMMISSION  
CBO COMMUNITY BASED ORGANIZATION

**Target Populations Types**

HIV+ HIV positive persons  
AAMSM African American Men Who Have Sex With Men  
AAMSW African American Men Who Have Sex With Women  
AAWSM African American Women Who Have Sex with Men  
WMSM White Men Who Have Sex With Men  
IDU Injecting Drug User  
Hispanic Hispanic person at risk

**Service/Intervention Types**

CTR Counseling, Testing and Referral  
HE/RR Health Education/Risk Reduction  
ILI Individual Level Intervention  
GLI Group Level Intervention  
PCRS Partner Counseling and Referral Services (Partner Notification)  
PCM Prevention Case Management  
Out Outreach

**Disease**

STD Sexually Transmitted Disease  
HIV Human Immuno-deficiency Virus

**Discipline**

DIS Disease Intervention Specialist  
HHED HIV Health Educator  
SW Social Worker

## CHAPTER 3: POTENTIAL STRATEGIES AND INTERVENTIONS

### Definition

*HIV Prevention Intervention: an activity designed to change or avert high-risk behavior that may result in HIV infection.*<sup>i</sup>

An intervention is a specific activity (or set of related activities) intended to bring about HIV risk reduction in a particular target population using a common method of delivering the prevention message. An intervention has distinct process and outcome objectives and a protocol outlining the steps for implementation.<sup>ii</sup> Successful interventions avert or reduce HIV related risk behaviors and do so at a minimal cost-benefit level of investment.<sup>iii</sup>

### Introduction

For almost twenty years in South Carolina, HIV health educators and other HIV prevention providers have used a variety of methods in attempting to control the HIV epidemic. Although local providers share a broad common goal, they have chosen many different routes to achieve it. They have taught people how to reduce their risks of infection and counseled high risk persons about the HIV antibody test and the importance of knowing their HIV status. HIV test providers have emphasized that those who know they are HIV positive can access early treatment and care as well as engage in behaviors that will prevent transmission of HIV to others. Providers have also advocated for more treatment facilities for injecting and other drug users and other structural and environmental changes that assist individuals in changing risky behaviors.

Health communication and public information initiatives have raised the awareness of policy makers and other community leaders through the mass media, supported abstinence programs among youth and others, helped promote condom use among sexually active adults, and involved community members in providing peer education.

In short, one could say that HIV education and prevention refers to those varied activities designed to encourage and enable people to take action to prevent the spread of HIV infection. The definition is deliberately broad while acknowledging the wide scope of activities involved in changing the behavior of those at risk and the integral relationships among prevention, education and associated social and political factors.

In 2003, CDC announced a new initiative, *Advancing HIV Prevention (AHP)*, as a framework for interventions and strategies at the federal, state and community levels. Among these strategies are putting a “number one” priority emphasis on prevention efforts with persons living with HIV, as well as a priority on increasing opportunities for HIV testing in physicians’ care settings and in community based sites. Additionally, *AHP* gives focused directions for prevention interventions with identified high-risk negative persons, including usage of CDC’s *Compendium of HIV Interventions with Evidence of Effectiveness*. Interventions listed in the *Compendium* are currently being disseminated nationwide through the *Diffusion of Effective Behavioral Interventions (DEBI)* project. This chapter presents choices of intervention strategies from *AHP*, the *Compendium*, and *DEBI* that will help local prevention providers realize their goals.

## Deciding Whom To Target

Issues to consider when determining who should receive HIV prevention interventions include:

- Priority consideration given to delivering services to persons living with HIV/AIDS (PLWHA), SC's and the nation's "number one" priority population.
- If not delivering services to PLWHA, then working with a population that corresponds to another priority population noted in this SC HIV Prevention Plan.
- Proportion of priority population in local area that engages in specific risk behaviors (especially if population is defined by race, ethnicity, or other non-risk related identifier).
- Culture and norms of the particular priority population in local area.
- Predominant language(s) of that population in local area.
- Education and literacy of the priority population in local area.
- Competing economic or social needs of the priority population.
- Predominant media channels used to reach this population in area.

A description of the priority population for a local area needs to include the risk factors and demographics of the population as well as the extent of the population that will be reached by the intervention (often referred to coverage). The basic demographics of age, race, ethnicity and sex can provide insight into developmental, cultural, and sex-specific issues. The description can also include other relevant details about the audience that inform the tailoring process for the intervention (such as languages and social or behavioral norms).

The specific audience to be served may also have economic or social needs that are different from the general audience described in the SC HIV Prevention Plan. For instance, the SC HIV Prevention Plan may list "injection drug users" as a high priority population, yet in a particular city, young methamphetamine users may be the majority of IDUs. Among these methamphetamine users, there may be low employment and high IDU-on-IDU crime. These unique issues should be taken into account in the intervention plan.

Another consideration is determining the relationship of how much of the priority population will be reached. For instance, a provider may believe that there are 300 injection drug users in her jurisdiction, but that she can only reasonably expect to reach 50 of them with prevention case management services during one fiscal year. Specification of the expected coverage provides a goal to which the provider and her funders can refer when determining if the intervention reached the intended number and types of individuals.

### Intervention Categories, Types, and Definitions

CDC’s Program Announcement 04064 for Community-Based Organizations (CBOs) and Program Announcement 04012 for health departments classify the broad categories of interventions. These broad intervention categories and the intervention types within each category are shown in Table 1. Table 2 provides a brief definition of each intervention type.

<b>Table 1: Intervention Category &amp; Specific Types of Interventions Within Each Category</b>	
<b>Intervention Category</b>	<b>Specific Intervention Types Within Each Category</b>
Health Education/Risk Reduction (HE/RR)	<ul style="list-style-type: none"> <li>• Individual-Level Intervention (ILI)</li> <li>• Group Level Intervention – Skills Building (GLI-SB)</li> <li>• Group Level Intervention – Support Group (GLI-SG)</li> <li>• Community-Level Intervention (CLI)</li> </ul>
Public Information, Including Health Communication/Public Information (HC/PI)	<ul style="list-style-type: none"> <li>• Mass Media, Including Websites</li> <li>• Hotlines</li> <li>• “One-shot” community presentations</li> </ul>
Counseling, Testing & Referral (CTR) And Partner Counseling & Referral Services (PCRS)	<ul style="list-style-type: none"> <li>• HIV Counseling, Testing &amp; Referral (CTR) including Community Based Counseling &amp; Testing (CBCT)</li> <li>• Partner Counseling &amp; Referral Services (PCRS)</li> </ul>
Other HIV Prevention	<ul style="list-style-type: none"> <li>• Outreach (OUT), particularly Targeted Outreach</li> <li>• Prevention Case Management (PCM)</li> <li>• Capacity Building (CB)</li> </ul>

<b>Table 2: Intervention Types and Definitions</b>
<p><b>Individual Level Intervention (ILI)</b> HE/RR intervention with a skills component provided to one person at a time.</p>
<p><b>Group Level Intervention – Skills Building (GLI-SB)</b> HE/RR intervention with a skills component provided to more than one person at a time.</p>
<p><b>Group Level Intervention – Support Group (GLI-SG)</b> HE/RR group intervention that reinforces health-enhancing behavior change through increased access to social networks that use peer modeling and peer support.</p>
<p><b>Community Level Intervention (CLI)</b> Activities that attempt to improve risk conditions, affect systems, and/or influence norms in a <i>specific community</i> of persons with identified shared risk behaviors for HIV infection --- and which may also be defined by race/ethnicity, gender or sexual orientation.</p>
<p><b>Health Communication/Public Information (HC/PI)</b> The delivery of planned HIV prevention messages through one or more channels (in person, through print materials, on the radio, via internet, etc.) to target audiences.</p>
<p><b>Counseling, Testing &amp; Referral (CTR), including Community Based Counseling &amp; Testing (CBCT)</b> HIV counseling and testing delivered in public health department sites and community-based (i.e., non public health department) settings in order to increase the numbers of persons who know their HIV status and, if positive, then can be linked into care and prevention services.</p>
<p><b>Partner Counseling &amp; Referral Services (PCRS)</b> A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.</p>
<p><b>Outreach (OUT)</b> Face to face interventions with high-risk individuals conducted in places where they congregate for the purpose of recruiting clients into CBCT, PCM, and other prevention or care services, as needed, as well as for the distribution of risk reduction supplies.</p>
<p><b>Prevention Case Management (PCM)</b> Client-centered, intensive, long-term, prevention-based, comprehensive counseling conducted with HIV positive persons or high risk negative persons for the purpose of preventing HIV transmission from self to others or personal avoidance of HIV infection or repeat infection.</p>
<p><b>Capacity Building (CB)</b> Capacity building is defined as strengthening the governmental and the nongovernmental public health infrastructure in support of HIV prevention, implementing systems to ensure the quality of services, and improving the ability to assess community needs and provide technical assistance in all aspects of program planning and operations.</p>

### Questions to Consider in Choosing Program Interventions

In light of the previously mentioned national initiative, *Advancing HIV Prevention (AHP)*, the following four major areas of emphasis need to be considered. Those are: 1) Incorporate HIV testing as a routine part of care in traditional medical settings; 2) Implement new models for diagnosing HIV infections outside medical settings; 3) Prevent new infections by working with people living with HIV/AIDS and their partners; and 4) Further decrease mother-to-child HIV transmission. Although the CPG and the CDC recognize the contribution of programs that have not yet received rigorous evaluation, the redoubling of prevention efforts has led to the need to place a premium on programs with evidence of effectiveness for reducing behaviors associated with HIV transmission. CDC's *Compendium of HIV Interventions with Evidence of Effectiveness* is a primary resource for proven, effective interventions. Additionally, interventions identified through the *Replicating Effective Programs* project and disseminated through the *Diffusion of Effective Behavioral Interventions (DEBI)* project represent the best currently available science related to HIV prevention.

In a review of these resources, program providers should consider the following before selecting an intervention:

- Who should I target?
  - Who is most in need?
  - Who is currently being served with what levels and types of programs and resources?
  - What are the gaps in intervention services?
- What are the intervention's resource requirements (ideal staffing patterns; materials needed)?
- What are my agency's resources (existing and feasibly acquired)?
- What is a particular intervention's complexity and implementation timeframe?
- What types of recruitment activities will be required to implement the intervention?
- What are the ideal physical settings and characteristics for implementing the intervention?
- What is a particular intervention's adaptability?
- What are the particular cultural, legal, ethical and political considerations in my agency and community as they relate to a particular intervention for a particular population?
- What are the necessary quality assurance measures that must be followed?
- How will I know if I am successful with a particular intervention?
  - What will be the required monitoring and evaluation data to be collected?
  - Does my agency have the capability to fully collect this data to determine the effectiveness of this intervention?

Upon completion of a program intervention plan analysis such as the one indicated above, the most appropriate strategies or interventions may be selected from among those indicated in the following table.

<b>Type of Intervention</b>	<b>Recommendations</b>
Individual Level Intervention (ILI)	<ul style="list-style-type: none"> <li>▪ Uses the HIV Prevention Counseling course as one framework/guidance. (All populations)</li> <li>▪ May also use <i>Project RESPECT</i> (All populations)</li> </ul>
Group Level Intervention-Skills Building (GLI-SB)	<ul style="list-style-type: none"> <li>▪ <i>SISTA Project</i> (AAWSM)</li> <li>▪ <i>Partners in Prevention</i> (AAMSM, AAWSM, WMSM)</li> <li>▪ <i>VOICES/VOCES</i> (AAWSM, AAMSW, Hispanics/Latinos [H/L])</li> <li>▪ <i>Many Men, Many Voices</i> (AAMSM)</li> <li>▪ <i>Healthy Relationships</i> (HIV+)</li> <li>▪ <i>Safety Counts</i> (IDUs)</li> <li>▪ American Red Cross <i>Talking Drums</i> (AAMSM, AAWSM, AAMSW, IDUs)</li> </ul>
Group Level Intervention-Support Group (GLI-SG)	<ul style="list-style-type: none"> <li>▪ Peer or professional led support groups with discussion topics inclusive of HIV prevention. (HIV+, Hispanics/Latinos)</li> </ul>
Community Level Intervention (CLI)	<ul style="list-style-type: none"> <li>▪ <i>Popular Opinion Leader</i> (All populations except HIV+)</li> <li>▪ <i>RAPP</i> (AAWSM)</li> <li>▪ <i>Mpowerment</i> (WMSM)</li> </ul>
Health Communication/Public Information (HC/PI)	<ul style="list-style-type: none"> <li>▪ SC DHEC AIDS/STD Hotline services, “One-shot” presentations and PSAs on radio, television</li> </ul>
Counseling, Testing & Referral (CTR) Services	<ul style="list-style-type: none"> <li>▪ Clinic-based testing offered in DHEC health departments’ clinics.</li> <li>▪ Clinic-based testing offered in routine health care settings including hospital emergency departments.</li> <li>▪ Testing provided through various methodologies, including rapid testing, that uses a DHEC-approved type of test.</li> <li>▪ Nonclinical (community-based) testing provided in venues that offer access to hard-to-reach, high risk populations when the setting is aligned with all CDC and DHEC policies, protocols and quality assurance standards.</li> <li>▪ Referrals must be offered to all clients receiving preliminary and confirmed HIV positive test results.</li> </ul>
Partner Services (PS)	<ul style="list-style-type: none"> <li>▪ Specific services provided by Disease Intervention Specialists (DIS) located in the 46 county health departments. (All populations)</li> </ul>
Outreach (OUT)	<ul style="list-style-type: none"> <li>▪ Portions of <i>Popular Opinion Leader</i> (All populations)</li> <li>▪ Uses the HIV Prevention Counseling course among the guidance for this intervention’s delivery (All populations)</li> <li>▪ May be delivered via the Internet in addition to face-to-face (for all populations) using <i>National Guidelines for Internet-based STD and HIV Prevention: Accessing the Power of the Internet for Public Health</i>, “Guidelines for Internet Outreach”. There should be flexibility in Internet outreach delivery to include length of the online sessions sometimes in excess of the standard of five to ten minutes per session.</li> </ul>
Comprehensive Risk Counseling & Services	<ul style="list-style-type: none"> <li>▪ Uses CDC’s CRCS Guidance for this intervention’s delivery. (All populations)</li> </ul>
Capacity Building (CB)	<ul style="list-style-type: none"> <li>▪ Trainings and technical assistance to deliver or enhance programs.</li> </ul>

*This page was last updated 12/31/08.*

## Measuring Success

Concrete information about progress is essential to ensure that high quality prevention services are delivered as intended, intended clients receive those services, training and supervision are provided in response to identified needs, and resources are expended judiciously. Collecting process data is often viewed as a time-consuming process. Although everyone is concerned about providing the best possible prevention services to the most people, many people are willing to continue providing services without proven value. Stakeholders and funding providers—from federal policymakers to community planning groups and members of the priority populations—are demanding empirical evidence of what is being done for people living with and at risk for HIV and how well those services work.

Various data collection systems are used in South Carolina. CTR data is obtained from the lab reports that accompanying the test. PCRS information is entered onto an *1129 Form* that is entered into a computer for data analysis. *Event Data Entry Forms (DEFs)* are temporarily used in late 2004 for reporting prevention activities classified as the following: HE/RR (ILIs, GLIs, CLIs); Outreach; HC/PI; and PCM. CBCT is reported on *DEFs*, in addition to the standard lab reports for the clinical portion of this prevention intervention. In early to mid 2005, CDC and DHEC will implement a new reporting process, *Program Evaluation Monitoring System (PEMS)*. These data collection and evaluation systems are described in more detail in Chapter 9. Additional information on the process monitoring of interventions can also be found at: <http://www.cdc.gov/hiv/aboutdhap/perb/guidance/chapter5.htm>

For information on *Advancing HIV Prevention (AHP)*, specific requirements for implementation and more detailed descriptions of the HIV prevention interventions and their effectiveness, the following links may be useful:

- CDC's *Advancing HIV Prevention* initiative at <http://www.cdc.gov/hiv/partners/ahp.htm>;
- *Characteristics of Reputationally Strong Programs* located at <http://www.cdc.gov/hiv/projects/rep/crsproj.htm>;
- *What Intervention Studies Say About Effectiveness* at: <http://www.healthstrategies.org/pubs/publications/InterventionEffectiveness.pdf>
- *Procedural Guidance for Selected Strategies and Interventions for Community Based Organizations Funded Under Program Announcement 04064* at: [http://www.cdc.gov/hiv/partners/pa04064\\_cbo.htm](http://www.cdc.gov/hiv/partners/pa04064_cbo.htm);
- *Advancing HIV Prevention: Interim Technical Guidance for Selected Interventions* at: <http://www.cdc.gov/hiv/partners/Interim-Guidance.htm>;
- *The Compendium of HIV Interventions with Evidence of Effectiveness* at: <http://www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm>;
- *Replicating Effective Programs Plus* at: <http://www.cdc.gov/hiv/projects/rep/default.htm>;
- *Diffusion of Effective Behavioral Interventions (DEBI) Project* at: <http://www.effectiveinterventions.org>

<sup>i</sup> Chapter 6, CDC Planning Handbook

<sup>ii</sup> Evaluation Guidance, vol.2, 3-1, <http://www.cdc.gov/hiv/aboutdhap/perb/hdg2/ch3res.pdf>

<sup>iii</sup> Appendix B, CDC Planning Handbook

## **CHAPTER 4: PRIORITY POPULATIONS AND INTERVENTIONS**

### **Population Priority Setting Process**

Population priority setting was accomplished by considering CDC's mandated population of HIV positive persons; size of at-risk populations; measurement of the percentage of HIV morbidity (i.e., HIV/AIDS incidence or prevalence); and prevalence of risky behaviors in the population.

DHEC staff distributed and reviewed the *South Carolina's Epidemiologic Profile* (March 21, 2003) with the CPG. The Needs Assessment Committee reviewed the Epi-Profile and other supplemental data, then presented their recommendations for changing the priority order of populations at the July 23, 2003 CPG meeting. The recommendations were ratified and the following seven (7) priority populations selected and defined by transmission risk, gender, age, race/ethnicity, and HIV status:

- 1) HIV Positive Persons
- 2) African American Men who have Sex with Men, Ages 15-44
- 3) African American Women who have Sex with Men, Ages 15-44
- 4) African American Men who have Sex with Women, Ages 15-44
- 5) White Men who have Sex with Men, Ages 15-44
- 6) Injection Drug Users, Ages 20-44
- 7) Hispanic/Latino.

### **Intervention Priority Setting Process**

Prior to 2003 the CPG only prioritized health education/risk reduction (HE/RR) interventions. In 2003, the CPG revisited priority interventions to determine if additional intervention types should be included for each population. Using the Behavioral and Social Science Volunteer Program, a local scientist was identified to assist the CPG's Behavioral and Social Science (BSS) Committee with the selection of interventions and strategies for each priority population.

DHEC staff reviewed the different HIV intervention types with the CPG using the *HIV Prevention Programs Health Education Risk Reduction Quality Assurance Guidelines* (March 2003). The BSS Committee also reviewed the following literature to help identify appropriate interventions.

- Addressing HIV/AIDS...Latino Perspectives & Policy Recommendations by National Alliance of State and Territorial AIDS Directors (NASTAD)
- Compendium of HIV Prevention Interventions with Evidence of Effectiveness from CDC's HIV/AIDS Prevention Research Synthesis Project
- Fact Sheets of Effective HIV Prevention Interventions compiled by Health Education Training Centers Alliance of Texas – San Antonio, University of Texas Southwestern Medical Center - Dallas, Texas Department of Health - Austin

**CHAPTER 4: PRIORITY POPULATIONS AND INTERVENTIONS**

- Incorporating HIV Prevention into the Medical Care of Persons Living with HIV  
HIV/AIDS: African American Perspectives and Recommendations for State and Local  
AIDS Directors and Health Departments by CDC
- Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States,  
2003 by CDC

Based on the literature review and DHEC staff presentation, the BSS Committee recommended the following intervention types to the CPG in July 2003. The CPG ratified the recommendations and the following interventions were selected for each priority population.

Below is a summary table.

<b>TARGET POPULATIONS BY RANK ORDER</b>	<b>INTERVENTIONS TYPES, NOT RANKED</b>
1. HIV Positive Persons	Individual Level Intervention Group Level Intervention – Support Group Outreach Prevention Case Management Counseling & Testing Partner Counseling and Referral Services
2. African American Men who have Sex with Men (AAMSM), Ages 15-44	Individual Level Intervention Group Level Intervention – Skills Building Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Capacity Building Community Level Intervention
3. African American Women who have Sex with Men (AAWSM), Ages 15-44	Individual Level Intervention Group Level Intervention – Skills Building Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Capacity Building Community Level Intervention
4. African American Men who have Sex with Women (AAMSW), Ages 15-44	Individual Level Intervention Group Level Intervention – Skills Building Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Capacity Building Community Level Intervention
5. White Men who have Sex with Men (WMSM), Ages 15-44	Group Level Intervention – Skills Building Prevention Case Management Counseling & Testing Partner Counseling and Referral Services

CHAPTER 4: PRIORITY POPULATIONS AND INTERVENTIONS

	Community Level Intervention
6. Injection Drug Users (IDU), Ages 20-44	Individual Level Intervention Group Level Intervention – Skills Building Outreach Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Community Level Intervention Other
7. Hispanic/Latino	Individual Level Intervention Group Level Intervention – Skills Building Group Level Intervention – Support Group Outreach Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Health Communication/Public Information Capacity Building

**Priority Population and Interventions For 2005-2008**

On the following pages are the detailed recommendation sheets presented to the CPG in July 2003 for ratification. These were reviewed again in August 2004 for inclusion in the revised plan for 2005-2008. Each description includes the estimated size of the population, sub-populations of interest, summary of needs from the needs assessment study (Chapter 2), primary risk behaviors to be targeted, intervention goals or outcomes, a table that summarizes the resource information reviewed and key findings from the literature, and a detailed bibliographic listing of the resources reviewed by the CPG Needs Assessment Workgroup and the Behavioral and Social Sciences Committees.

## POPULATION: #1 HIV POSITIVE PERSONS

### Size of Population: 19,462

As of December 31, 2003, there were 19,462 persons cumulatively reported with HIV, and of them, 13,213 have been diagnosed with AIDS. The growing number of persons living with HIV challenges both prevention and care service systems. Prevention needs are essential as sexual and substance use risk behaviors are occurring among persons living with HIV. Interviews with recently diagnosed persons with HIV indicate substance use during past 5 years or present was reported by one-third of persons with HIV interviewed: 30% reported potential alcoholic, 40% used illicit drugs during past five years. Nine percent reported ever injecting drugs and 16% had used. Sexual risks reported by persons interviewed indicate that one-fourth (28%) of men paid some one for sex; 9% of women received either money or drugs for sex. Thirty percent of men and 23% of women reported having at least one sexually transmitted disease (STD) during the past ten years.

### Sub-Populations of Interest:

AAMSM and WMSM  
AAMSW and AAWSM  
IDU

–Unmet necessary needs (shelter, food, etc.)  
–Low sensitivity, empathy and confidentiality by health care providers

### Needs Assessment Summary:

- High incidence of unprotected sex
- High incidence of STD/history of STD's
- Misinformation & lack of knowledge about HIV risky behaviors & transmission
- Multiple sexual partners
- Non-injection drug/substance use
- Lack of drug treatment programs and/or access to such
- High incidence of commercial sex work
- Low SES (education, income & employment)
- Inadequate support services for PLWH/A
- Frustration, hopelessness & resignation
- Mental health issues
- Limited access to & utilization of health & social services (health insurance, adherence & compliance, transportation, etc.).
- Social stigma, discrimination & phobias
- Little or no follow-up care or linkages to needed services
- Inadequate outreach services

### Risk Behavior: Unprotected Sex

**Intervention Goals:** 1) Implement new models for diagnosing HIV infections outside medical settings; 2) Prevent new infections by working with persons diagnosed with HIV and their partners.

### Intervention Goals/Outcomes:

1. Reduce Harm to Self
  - Prevent reinfection with another strain of HIV
  - Prevent the acquisition of other sexually transmitted infections (STIs)
2. Reduce Harm to Others
  - Reduce exposure of sexual or injection risk behavior that can transmit HIV, including drug resistant strains of HIV, to HIV-negative persons
  - Reduce sexual risk behavior that can transmit other STIs

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Note: For interventions specific to injection drug users see Intervention Recommendation Sheet for populations #6.

INTERVENTION TYPES	WHY?
<p>Note: Refer to “HIV Prevention Programs Quality Assurance Guidelines” for more detailed information on specific intervention types.</p>	
A. Individual Level Interventions (ILI)	A. ILI: (3, <b>4</b> , 5, 6, 7) <i>CDC recommended.</i>
B. Prevention Case Management (PCM)	B. PCM: Results of a CDC and HRSA-sponsored study indicate that HIV-infected persons who received ongoing HIV prevention case management adopted and sustained selected safer sexual practices during the six-month follow-up period. (1, 2, 3, <b>5</b> , 7, 8, 9) <i>CDC required.</i>
C. Outreach (OUT)	C. OUT: Organizations should approach and enlist HIV-infected clients to identify or recruit -- from their social, sexual, or drug-using networks --persons who may be likely to be infected with HIV but are not yet aware of their infection. (1, 3, 6, 7, <b>10</b> ) <i>CDC recommended.</i>
D. Group Level Intervention--Support Groups (GLI-SG)	D. GLI--SG: ( <b>3</b> , 6, 7, 9) <i>Among CDC-funded PHIPP demonstration interventions.</i>
E. Counseling and Testing (CT) – includes Community Based Counseling and Testing (CBC&T)	E. CT: Many persons who learn that they are HIV infected adopt behaviors that might reduce the risk for transmitting HIV. (1, <b>2</b> , 3, 4, 6, 7) <i>CDC required.</i>
F. Partner Counseling and Referral Services (PCRS)	<p>F. PCRS: 8% - 39% of partners tested in studies of partner counseling and referral services were found to have previously undiagnosed HIV infection. (1, 3, 4) <i>CDC required.</i></p> <p><i>Note: Numbers represent references in resource section below. <b>Bold typed</b> number above indicates primary reference or resource.</i></p>

**Resources:**

- Centers for Disease Control and Prevention. *MMWR*, 2003; vol. 52, no 15. “Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003.”

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2. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention. “SAFE, A Serostatus Approach to Fighting the HIV/AIDS Epidemic,” (The CDC Prevention for HIV-Infected Persons Project [PHIPP]), 2001.  
[www.cdc.gov/nchstp/od/program\\_brief\\_2001/AIDS%20Epidemic](http://www.cdc.gov/nchstp/od/program_brief_2001/AIDS%20Epidemic).
3. Centers for Disease Control and Prevention. “PHIPP Project Fact Sheets,” July 2002.
4. Centers for Disease Control and Prevention. *MMWR*, 2003, vol. 52, no. RR12. “Incorporating HIV Prevention into the Medical Care of Persons Living with HIV”.
5. National Academies Press, Institute of Medicine. *No Time to Lose: Getting More from HIV Prevention*. “Chapter 4: Using The Clinical Setting,” pp. 50 – 67, 2001.
6. University of California, San Francisco, AIDS Policy Research Center and Center for AIDS Prevention Studies, AIDS Research Institute. “Prevention with Positives Resources,” <http://ari.ucsf.edu/policy/pwp>.
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8. Centers for Disease Control and Prevention. *HIV Prevention Case Management Guidance*, September 1997.
9. University of California, San Francisco, AIDS Policy Research Center and Center for AIDS Prevention Studies, AIDS Research Institute. “Designing Primary Prevention for People Living with HIV,” Collins, C., et al, March 2000.
10. Centers for Disease Control and Prevention. “Solicitation for CDC Community Based Organization Demonstration Projects 2003-N-00895.”
11. [www.cdc.gov/hiv/partners/ahp.htm](http://www.cdc.gov/hiv/partners/ahp.htm)

**POPULATION: #2 AFRICAN AMERICAN MEN WHO HAVE SEX WITH MEN**

**Estimated Size: Minimum of 28,659 men, ages 15 - 44**

There are significant prevention challenges related to African American Men Who Have Sex With Men (AAMSM) in South Carolina, similar to other southeastern states. Few programs are targeted toward this population, and even fewer of the existing programs have demonstrated success in reaching them. Access to the population is difficult due to secrecy of the activity, denial of African American MSM engaging in same sex activities and the double stigmas of racism and homophobia. The majority of AAMSM often identify themselves as heterosexual. Thus, there is not a defined open “community” to focus needs assessments, target information or provide support. Further, the lack of family and religious institution support of sexuality issues reduces the population’s access to preventive health services. There is a lack of information on proven effective interventions for this population, particularly in rural areas. Culturally reflective staff, including peers, are often not available to deliver the interventions.

**Subpopulations Of Concern:**

- HIV Negative Partners of HIV Positive Persons
- Youth and young adults (<25)
- Incarcerated
- Substance users\*
- HIV infected\*
- Bisexual
- Transgenders
- Sex workers

**Needs Assessment Findings:**

- Unified gay community
- Financial and generation gap within community
- Apathy about HIV/AIDS
- Lack of accessible social, cultural & health information /resources
- Lack of alternative non-bar meeting/gathering places
- High incidence of drug use
- High incidence of commercial sex
- High incidence of unprotected sex
- High incidence of closeted (down-low) sexual behaviors
- Language and cultural barriers for subsets of the community

- High incidence of unknown HIV status, and unwillingness to be tested, and/or lack of awareness of benefits of testing/testing sites
- Misinformation & lack of knowledge about HIV risky behaviors and transmission
- Multiple sexual partners
- Non-injection drug use
- High rate of low SES
- Prevalence of societal discrimination & stigma related to race, sexual orientation & economic status
- High incidence of STD/history of STD’s

**Risk Behavior:** Unprotected Sex

**Intervention Goals/Outcomes:**

- 1) Abstain/postpone sexual intercourse, 2) Increase the correct and consistent use of condoms, 3) Reduce number of sexual partners, 4) Increase knowledge of their HIV status, 5) Reduce substance use/abuse in sexual situations

\* For interventions specific to HIV positive persons and injection drug users see Intervention Recommendation Sheets for populations #1 and #6.

<p><b>INTERVENTION TYPES</b></p> <p>Note: Refer to “<i>HIV Prevention Programs Quality Assurance Guidelines</i>” for more detailed information on specific intervention types.</p>	<p><b>WHY?</b></p>
<p>A. Individual Level Intervention (ILI)</p>	<p>A. ILI: One-to-one counseling, specially tailored to the particular behaviors practiced by each man, might be useful in preventing new HIV infections. This statement was taken from a document entitled “Explore Baseline Papers Summary”. (14, 15)</p>
<p>B. Group Level Interventions – Skills Building (GLI-SB)</p>	<p>B. GLI - SB: New research showed that group interventions were more effective than education for STD/HIV prevention. This statement was taken from Many Men, Many Voices brochure. (8, 10, 11, 12, 13)</p>
<p>C. Group Level Interventions – Support Group (SG)</p>	<p>C. GLI-SG: Awaiting documentation from Dr. J. White.</p>
<p>D. Counseling and Testing (CT) – includes Community Based Counseling and Testing (CBC&amp;T)</p>	<p>D. CT: Many persons who learn that they are HIV infected adopt behaviors that might reduce the risk for transmitting HIV. <b>(1, 2, 6) CDC required.</b></p>
<p>E. Capacity Building (CB)</p>	<p>E. CB: The Committee identified and focused on two areas of capacity building: (a) capacity building within health departments – to ensure effective service delivery to African American communities at highest risk, and (b) capacity building within CBOs – to ensure effective delivery of services to African American client populations (particularly transgenders, IDUs, women, MSM, young people as they are at highest risk). <b>(9)</b></p>
<p>F. Community Level Intervention (CLI)</p>	<p>F. CLI: CDC recognized as an effective intervention. <b>(7)</b></p> <p><i>Note: Numbers represent references in resource section below. <b>Bold typed</b> number above indicates primary reference or resource. .</i></p>

**Resources:**

1. Centers for Disease Control and Prevention. *MMWR*, 2003; vol. 52, no. 15. “Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003.”
2. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention. “SAFE, A Serostatus Approach to Fighting the HIV/AIDS Epidemic,” (The CDC Prevention for HIV-Infected Persons Project [PHIPP]), 2001. [www.cdc.gov/nchstp/od/program\\_brief\\_2001/AIDS%20Epidemic](http://www.cdc.gov/nchstp/od/program_brief_2001/AIDS%20Epidemic).
3. *American Journal of Public Health*, vol. 81 (2), pp. 168 – 171. “HIV Risk Behavior Reduction Following Intervention with Key Opinion Leaders of Population: An Experimental Analysis,” Kelly, JA, et al, 1991.
4. Centers for Disease Control and Prevention. *Evaluation Guidance Handbook: Strategies for Implementing the Evaluation Guidance for CDC-Funded HIV Prevention Programs*. “Chapter Nine: Guidance FAQs,” pp. 69 – 70, March 2002.
5. *American Journal of Public Health*, vol. 84, pp. 1938 – 1946. “Factors Mediating Changes in Sexual HIV Risk Behaviors Among Gay and Bisexual Male Adolescents,” Rotheram-Borus, M., et al, 1994.
6. Centers for Disease Control and Prevention. *No Turning Back: Addressing The HIV Crisis Among Men Who Have Sex With Men*, November 2001.
7. Centers for Disease Control and Prevention. “Compendium of HIV Prevention Interventions with Evidence of Effectiveness.” Atlanta, GA: US Department of Health and Human Service, CDC; 1999 (Revised 2001). Available at [www.cdc.gov/hiv/pubs/HIVcompendium/hivcompendium/pdf](http://www.cdc.gov/hiv/pubs/HIVcompendium/hivcompendium/pdf).
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9. National Alliance of State and Territorial AIDS Directors. “HIV/AIDS: African American Perspectives and Recommendations for State and Local AIDS Directors and Health Departments.” Washington, DC, NASTAD; 2003. Available at [www.nastad.org/documents/public/pub\\_prevention/2002219HVADSAfricanAmericanPerspectivesandRecommendations.pdf](http://www.nastad.org/documents/public/pub_prevention/2002219HVADSAfricanAmericanPerspectivesandRecommendations.pdf)
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13. Kelly, J.A. (1995). *Changing HIV Risk Behavior: Practical Strategies*. The Guilford Press, New York, New York. p. 1-59.
14. Beryl A. Koblin, Margaret A. Chesney, Marla J. Husnik, Sam Bozeman, Connie L. Celum, Susan Buchbinder, Kenneth Mayer, David McKirnan, Franklyn N. Judson, Yijian Huang, Thomas J. Coates, and the EXPLORE Study Team. “High-Risk Behaviors Among Men Who Have Sex With Men in 6 US Cities: Baseline Data From the EXPLORE Study.” *American Journal of Public Health* 2003 93 926-932. Available at [www.explorestudy.org](http://www.explorestudy.org)
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**POPULATION: #3 AFRICAN AMERICAN WOMEN WHO HAVE SEX WITH MEN**

**Estimated Size: 317,396 women, ages 15 - 44**

African American women comprise nearly one quarter of the persons living with HIV (25%) in South Carolina, the second highest proportion following African American men. Among recently reported cases during 2003, African American women accounted for 30% of the total reported cases, compared to 15% among white men and 4% white women. This trend is similar across southern states where joblessness, substance abuse, teenage pregnancy, STD’s inadequate schools, minimal access to health care and low incomes contribute to the increasing rates of HIV among this population. In addition, African American women are frequently unknowingly placed at risk by their male sexual partners who are more likely to be HIV infected through male to male sex and substance use. Women are often in power imbalanced relationships and perceive themselves as “victims” which creates significant challenges for prevention.

**Subpopulations of Concern:**

- HIV Negative Partners of HIV Positive Persons
- Youth and young adults (<25)
- Incarcerated
- Substance users\*
- HIV infected\*
- Sex workers
- Pregnant women

- Low SES (education, income and employment)
- Non-injection drug use
- Inadequate health, social and support services (transportation, health insurance, child care, etc.).

**Risk Behavior:** Unprotected Sex

**Intervention Goals/Outcomes:**

- 1) Abstain/postpone sexual intercourse, 2) Increase the correct and consistent use of condoms, 3) Reduce number of sexual partners, 4) Increase knowledge of their HIV status, 5) Reduce substance use/abuse in sexual situations

**Needs Assessment Findings:**

- High incidence of unprotected sex
- High incidence of STD/history of STD’s
- Misinformation & lack of knowledge about HIV risky behaviors and transmission
- Multiple sexual relationships
- High incidence of commercial sex work

\* For interventions specific to HIV positive persons and injection drug users see Intervention Recommendation Sheets for populations #1 and #6.

<p><b>INTERVENTION TYPES</b></p> <p>Note: Refer to “<i>HIV Prevention Programs Quality Assurance Guidelines</i>” for more detailed information on specific intervention types.</p>	<p><b>WHY?</b></p>
<p>A. Individual Level Interventions (ILI)</p>	<p>A. ILI: CDC recognized as an effective intervention. (2)</p>

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B. Group Level Interventions – Skills Building (GLI-SB)	B. GLI - SB: CDC recognized as an effective intervention. <b>(2)</b>
C. Counseling and Testing (CT) – includes Community Based Counseling and Testing (CBC&T)	C. CT: CDC required. <b>(3)</b>
D. Capacity Building (CB)	D. CB: The Committee identified and focused on two areas of capacity building: (a) capacity building within health departments – to ensure effective service delivery to African American communities at highest risk, and (b) capacity building within CBOs – to ensure effective delivery of services to African American client populations (particularly transgenders, IDUs, women, MSM, young people as they are at highest risk). <b>(1)</b>
E. Community Level Intervention (CLI)	E. CLI: CDC recognized as an effective intervention. <b>(2)</b>  <i>Note: Numbers represent references in resource section below. <b>Bold typed</b> number above indicates primary reference or resource.</i>

**Resources:**

1. National Alliance of State and Territorial AIDS Directors. “HIV/AIDS: African American Perspectives and Recommendations for State and Local AIDS Directors and Health Departments.” Washington, DC, NASTAD; 2003. Available at [www.nastad.org/documents/public/pub\\_prevention/2002219HVADSAfricanAmericanPerspectivesandRecommendations.pdf](http://www.nastad.org/documents/public/pub_prevention/2002219HVADSAfricanAmericanPerspectivesandRecommendations.pdf)
2. Centers for Disease Control and Prevention. “Compendium of HIV Prevention Interventions with Evidence of Effectiveness.” Atlanta, GA: US Department of Health and Human Service, CDC; 1999 (Revised 2001). Available at [www.cdc.gov/hiv/pubs/HIVcompendium/hivcompendium/pdf](http://www.cdc.gov/hiv/pubs/HIVcompendium/hivcompendium/pdf).
3. Centers for Disease Control and Prevention. *MMWR*, 2003; vol. 52, no. 15. “Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003.”

**POPULATION: #4 AFRICAN AMERICAN MEN WHO HAVE SEX WITH WOMEN**

**Estimated Size: 257,928 men, ages 15 -44**

African American men comprise approximately one-third of persons living with HIV due to heterosexual transmission (31%) and 35% of more recently diagnosed heterosexual cases. Many local HIV providers believe the proportion of African American men reporting heterosexual transmission is inflated due to stigma of male to male sex. However, it is recognized that many of these men have sex with women and as the number of African American women infected with HIV grows, the heterosexual risk to men will also grow. Additionally, many important programs developed by and for the African American community often focus more on women. African American men have fewer services provided specifically to meet their needs.

**Subpopulations of Concern:**

- HIV Negative Partners of HIV Positive Persons
- Men older than 25 years
- Incarcerated
- Substance users\*
- HIV infected\*

- High incidence of commercial sex work
- Low SES (education, income and employment)
- Inadequate health, social and support services (transportation, health insurance, child care, etc.).
- Apathy to HIV status

**Needs Assessment:**

- High incidence of unprotected sex
- High incidence of STD/history of STD’s
- Misinformation & lack of knowledge about HIV risky behaviors and transmission
- Multiple sexual partners
- Non-injection drug use

**Risk Behavior:** Unprotected Sex

**Intervention Goals/Outcomes:**

- 1) Abstain/postpone sexual intercourse, 2) Increase the correct and consistent use of condoms, 3) Reduce number of sexual partners, 4) Increase knowledge of their HIV status, 5) Reduce substance use/abuse in sexual situations

\* For interventions specific to HIV positive persons and injection drug users see Intervention Recommendation Sheets for populations #1 and #6.

INTERVENTION TYPES	WHY?
Note: Refer to “ <i>HIV Prevention Programs Quality Assurance Guidelines</i> ” for more detailed information on specific intervention types.	
A. Individual Level Interventions (ILI)	A. ILI: CDC recognized as an effective intervention. (2)
B. Group Level Interventions – Skills Building (GLI-SB)	B. GLI - SB: CDC recognized as an effective intervention. (2)

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C. Counseling and Testing (CT) – includes Community Based Counseling and Testing (CBC&T)	C. CT: CDC required. <b>(3)</b>
D. Capacity Building	D. CB: The Committee identified and focused on two areas of capacity building: (a) capacity building within health departments – to ensure effective service delivery to African American communities at highest risk, and (b) capacity building within CBOs – to ensure effective delivery of services to African American client populations (particularly transgenders, IDUs, women, MSM, young people as they are at highest risk). <b>(1)</b>
E. Community Level Intervention (CLI)	E. CLI: CDC recognized as an effective intervention. <b>(2)</b>  <i>Note: Numbers represent references in resource section below. <b>Bold typed</b> number above indicates primary reference or resource.</i>

**Resources:**

1. National Alliance of State and Territorial AIDS Directors. “HIV/AIDS: African American Perspectives and Recommendations for State and Local AIDS Directors and Health Departments.” Washington, DC, NASTAD; 2003. Available at [www.nastad.org/documents/public/pub\\_prevention/2002219HVADSAfricanAmericanPerspectivesandRecommendations.pdf](http://www.nastad.org/documents/public/pub_prevention/2002219HVADSAfricanAmericanPerspectivesandRecommendations.pdf)
2. Centers for Disease Control and Prevention. “Compendium of HIV Prevention Interventions with Evidence of Effectiveness.” Atlanta, GA: US Department of Health and Human Service, CDC; 1999 (Revised 2001). Available at [www.cdc.gov/hiv/pubs/HIVcompendium/hivcompendium/pdf](http://www.cdc.gov/hiv/pubs/HIVcompendium/hivcompendium/pdf).
3. Centers for Disease Control and Prevention. *MMWR*, 2003; vol. 52, no. 15. “Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003.”

**POPULATION: #5 WHITE MEN WHO HAVE SEX WITH MEN**

**Estimated Size: Minimum of 16,437 men, 15 – 44 years of age**

Men who have sex with men (MSM) continue to remain a significantly affected population with HIV, regardless of age, race/ethnicity and residence. The largest proportion of persons estimated to be living with HIV in the state are men who have sex with men. The level of new HIV cases appears to be declining among white MSM. However, further assessments need to occur to determine if testing patterns have changed (particularly among young men under 25 years) or if there are other factors to confirm if “incident” cases are truly declining. Most white MSM live in the more urban counties and may have more sense of community than exists with African American MSM, reducing some of the prevention barriers. Most white MSM infected with HIV are older than 25 years of age. Increases in very high risk behaviors among young MSM living in other areas of the country, however, is cause for concern among young MSM in South Carolina.

**Subpopulations of Concern:**

- HIV Negative Partners of HIV Positive Persons
- Youth and young adults (<25)
- Substance users\*
- HIV infected\*
- Sex workers
- Older adults (>44)
- Internet “cruisers”

- Language and cultural barriers for subsets of the community
- High incidence of STD/history of STD’s
- Misinformation & lack of knowledge about HIV risky behaviors and transmission
- Multiple sexual partners
- Non-injection drug use
- Misconceptions about HIV/AIDS antiretroviral drugs & therapy

**Needs Assessment:**

- Unified gay community
- Generation gap within community
- Apathy about HIV/AIDS
- Lack of alternative non-bar meeting/gathering places
- High incidence of drug use
- High incidence of commercial sex
- Prevalence of societal discrimination & stigma relating to race, sexual orientation & economic status
- High incidence of unprotected sex

**Risk Behavior:** Unprotected Sex

**Intervention Goals/Outcomes:**

- 1) Abstain/postpone sexual intercourse,
- 2) Increase the correct and consistent use of condoms,
- 3) Reduce number of sexual partners,
- 4) Increase knowledge of their HIV status,
- 5) Reduce substance use/abuse in sexual situations

\* For interventions specific to HIV positive persons and injection drug users see Intervention Recommendation Sheets for populations #1 and #6.

<p><b>INTERVENTION TYPES</b></p> <p>Note: Refer to “<i>HIV Prevention Programs Quality Assurance Guidelines</i>” for more detailed information on specific intervention types.</p>	<p><b>WHY?</b></p>
<p>G. Counseling and Testing (CT) – includes Community Based Counseling and Testing (CBC&amp;T)</p>	<p>A. CT: Many persons who learn that they are HIV infected adopt behaviors that might reduce the risk for transmitting HIV. (<b>1, 2, 8</b>) <i>CDC required.</i></p>
<p>H. Capacity Building (CB) &amp; Outreach (OUT)</p>	<p>B. CB/OUT: CDC recognized as an effective intervention. (3, 4, 5, 8, <b>9</b>). See *, **, *** in the Resources.</p>
<p>I. Group Level Interventions – Skills Building (GLI-SB)</p>	<p>C. GLI – SB: CDC recognized as an effective intervention (6, 7, 8, <b>9</b>). See** in the Resources.</p> <p><i>Note: Numbers represent references in resource section below. <b>Bold typed</b> number above indicates primary reference or resource.</i></p>

**Resources:**

- Centers for Disease Control and Prevention. *MMWR*, 2003; vol. 52, no. 15. “Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003.”
- Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention. “SAFE, A Serostatus Approach to Fighting the HIV/AIDS Epidemic,” (The CDC Prevention for HIV-Infected Persons Project [PHIPP]), 2001. Available at [www.cdc.gov/nchstp/od/program\\_brief\\_2001/AIDS%20Epidemic](http://www.cdc.gov/nchstp/od/program_brief_2001/AIDS%20Epidemic).
- American Journal of Public Health*, vol. 81 (2), pp. 168 – 171. “HIV Risk Behavior Reduction Following Intervention with Key Opinion Leaders of Population: An Experimental Analysis,” Kelly, JA, et al, 1991.
- American Journal of Public Health*, vol. 86 (8), pp. 1129 – 1136. “The Mpowerment Project: A Community-level HIV Prevention Intervention for Young Gay Men,” Kegeles, S.M., et al, 1996.
- Centers for Disease Control and Prevention. *Evaluation Guidance Handbook: Strategies for Implementing the Evaluation Guidance for CDC-Funded HIV Prevention Programs*. “Chapter Nine: Guidance FAQs,” pp. 69 – 70, March 2002.

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6. *AIDS*, vol. 3 (1), pp. 21 – 26. “AIDS Prevention in Homosexual and Bisexual Men: Results of a Randomized Trial Evaluating Two Risk Reduction Interventions,” Valdiserri, R.O., et al., 1989.
7. *Journal of Consulting and Clinical Psychology*, vol. 57 (1), pp. 60 – 67. “Behavioral Intervention to Reduce AIDS Risk Activities,” Kelly, JA, et al, 1989.
8. Centers for Disease Control and Prevention. *No Turning Back: Addressing The HIV Crisis Among Men Who Have Sex With Men*, November 2001.
9. Centers for Disease Control and Prevention. “Compendium of HIV Prevention Interventions with Evidence of Effectiveness.” Atlanta, GA: US Department of Health and Human Service, CDC; 1999 (Revised 2001). Available at [www.cdc.gov/hiv/pubs/HIVcompendium/hivcompendium/pdf](http://www.cdc.gov/hiv/pubs/HIVcompendium/hivcompendium/pdf).

## POPULATION: #6 INJECTION DRUG USERS

### Estimated Size: 8,000 (All races/sexes)

There is an apparent decline in the number of HIV infections reported among both men and women due to injecting drug use (IDU). Among the estimated number of persons living with HIV who are IDU's, the majority of African American men (56%) compared to 18% are white men. African American women account for 15% of recent cases due to injecting drug use; white women account for 9%. The majority (96%) of recently diagnosed IDU cases are among persons 25 – 45 and above. The urban areas have more persons living with HIV due to injecting use. Due to legal barriers, South Carolina does not have needle exchange programs, which limits effective prevention efforts for this population. Other barriers include South Carolina's legal policy of reporting pregnant substance users (including IDUs) for prosecution which may deter women from seeking early and regular prenatal care.

### Subpopulations of Concern:

- HIV Negative Partners of HIV Positive Persons
- Persons older than 25 years
- Incarcerated
- Substance users
- HIV infected\*
- Sex workers
- Homeless
- Pregnant women

### Needs Assessment:

- Co-existence of HIV infection and substance use
- Lack of availability and access to drug treatment
- Inadequate linkage and/or follow-up services
- Non-integration of physical and psychosocial needs of patients
- Non-integration of HIV/AIDS & drug treatment services/programs
- Non-expansive nature of drug treatment services
- Non-gender specific drug treatment programs

\* For interventions specific to HIV positive persons see Intervention Recommendation Sheet for populations #1.

**Risk Behavior:** 1) Unsafe needle sharing practices; and 2) Unprotected Sex

### Intervention Goals/Outcomes:

**Drug Behaviors** - 1) Abstain from using drugs; 2) Abstain from unsafe needle sharing practices; 3) Increase the correct and consistent cleaning of injection equipment; 4) Refer to a treatment facility; 5) Increase knowledge of their HIV status

**Sex Behaviors** -1) Abstain/postpone sexual intercourse, 2) Increase the correct and consistent use of condoms, 3) Reduce number of sexual partners, 4) Increase knowledge of their HIV status, 5) Reduce substance use/abuse in sexual situations

<p><b>INTERVENTION TYPES</b></p> <p>Note: Refer to “<i>HIV Prevention Programs Quality Assurance Guidelines</i>” for more detailed information on specific intervention types.</p>	<p><b>WHY?</b></p>
<p>A. Individual Level Interventions (ILI)</p>	<p>ILI: Prevention interventions must be personalized for each person at risk. Effective prevention requires more than simply passing out information and risk-reduction supplies. Persons at risk must be engaged in a personalized assessment of their own risk behaviors, assisted in identifying barriers to and resources available to help them change their behavior, and helped to formulate specific and achievable strategies to protect themselves and others. (1)</p>
<p>B. Group Level Interventions – Skills Building (GLI-SB)</p>	<p>GLI – SB: CDC recognized as an effective intervention. (3, 6, 7, 8, 9)</p>
<p>C. Outreach (OUT)</p>	<p>OUT: Outreach is viewed as an essential component of HIV prevention efforts targeting out-of-treatment drug users. Because drug use is a highly stigmatized illegal activity, drug users and their sexual partners may be difficult to access through traditional medical and social service agencies. Outreach conducted by individuals indigenous to the local community and familiar with drug use subcultures has been found to be highly effective in accessing out-of-treatment drug users and initiating behavior change. (1,2)</p>
<p>D. Counseling and Testing (CT) – includes Community Based Counseling and Testing (CBC&amp;T)</p>	<p>CT: CDC required. (4, 12)</p>
<p>E. Community Level Interventions (CLI)</p>	<p>CLI: CDC recognized as an effective intervention. (3, 5)</p>

<p>F. Other (Access to Sterile Syringes)</p>	<p>OTH: Clearly, the best solution for injecting drug users is to stop injecting and enter substance abuse treatment. However, many drug users either cannot get into substance abuse treatment programs or will not stop injecting drugs. Even those injectors who are in treatment may relapse to injecting drugs. Given these realities, several governmental bodies and institutions have recommended consistent, one-time-only use of sterile syringes as a central strategy in the effort to reduce the transmission of HIV and other blood-borne pathogens among those individuals who continue to inject drugs. (1, <b>10</b>)</p> <p><i>Note: Numbers represent references in resource section below. <b>Bold typed</b> number above indicates primary reference or resource.</i></p>
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**Resources:**

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11. Academy for Educational Development (AED). "HIV Prevention Among Drug Users: A Resource Book for Community Planners & Program Managers". Washington (DC): Academy for Educational Development; 1997. Funding provided under Centers for Disease Control and Prevention contract number 200-91-0906. Available at [www.cdc.gov/idu/idu.htm](http://www.cdc.gov/idu/idu.htm).
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**POPULATION: #7 LATINO/A OR HISPANIC**

**Estimated Size: 95,076**

Two percent of total persons living with HIV infection are Hispanics, who comprise about 2.4% of the state’s population (2003 estimates). While the general population has grown 15.1% in the period from 1990 to 2000, the Hispanic Population grew from 30,500 to 95,076 in the same period, a 211.71% growth. The US Census reports this number could double to 190,152 by 2010. The Counties with the highest Hispanic population growth are: Jasper 1,624.6%; Saluda: 1,529.1%; Newberry: 942%; and Hampton 670.4%. Most of this increase can be attributed to high levels of migration due to economic opportunities in agriculture, construction and food industries, as well as high Hispanic birth rates. This rapid growth has considerable implications for the health status of this medically under-served population. This growth has surpassed the ability of health care providers to provide adequate services to this group of people. Meeting the health care needs of Hispanics requires an understanding of their social, cultural, economic, and physical environments.

Hispanics in South Carolina face many barriers to health care and HIV education including language, lack of transportation, geographic inaccessibility, and financial constraints. Similarly, substance abuse, health risk behaviors (e.g. smoking, unhealthy dietary practices), and the occupational hazards of migrant work add to the risk of disability and chronic illness. At the same time, health care providers face certain barriers that make it difficult to offer adequate services to the Hispanic community such as shortages of bilingual and bicultural health care providers, and trained interpreters, at health care centers. As a result of these barriers, Hispanics are limited as to the quality and quantity of health care information they receive.

The enormous diversity within Latino communities, representing many different countries with diverse cultures and HIV risk factors makes dealing with HIV/AIDS especially complex and challenging. SC Hispanic Outreach –a non-profit organization- conducted an HIV/AIDS Awareness Survey among the Hispanic Community. A total of 450 individuals were interviewed for this needs assessment. These interviews were conducted in the counties of Richland, Lexington, Fairfield and Newberry in farms, migrant camps, apartment complexes, Mexican stores and other places where Hispanics were highly concentrated. Some of the findings of the HIV/AIDS Awareness Survey are presented here:

Percentages of Selected Demographic Characteristics from HIV/AIDS Awareness Survey (n=450)

Demographic	Percent	Demographic	Percent	Demographics	Demographic
<b>Sex</b>	Males 38%	<b>Origin</b>		<b>Education</b>	
	Females 62%	México	69%	(years)	10%
<b>Age</b>	13-19 11%	Guatemala	9%	1- 3	28%
	20-29 49%	Honduras	10%	4- 6	22%
	30-39 25%	Puerto Rico	6%	7- 9	31%
	40-49 9%	Colombia	2%	9- 12	8%
	50-59 5%	El Salvador	1%	College	1%
	60-69 1%	Others	4%	None	

Findings in Risk Detection:

48% of the participants use alcohol. The consumption of alcohol is seen as a contributing factor to HIV risk due to their living conditions. A great number of Hispanics are living away from their immediate families and generally share housing with other males. In these circumstances it is common for them to hire prostitutes who engage in sexual relations with all the residents of the house. Therefore, out of boredom and away from the social restraints of their culture and families, they drink excessively, which leads them to perform acts they typically wouldn't do. The alcohol is a generator of risky behaviors like unprotected sex, sexual promiscuity and drug use. 42% answered "No" to the use of condoms, and a disturbing 44% answered "No" or "I don't know" to the question "Do you protect yourself from HIV/AIDS?" 17% admitted to have two or more sexual partners. 10% of the total have used. 4% use cocaine and 2% admitted to injected drug use.

Findings HIV Awareness:

A disturbing 55% of the total answered "No" or "Just a little" to "are you informed about HIV?" This is a direct result of a lack of culturally appropriate outreach and information. Other agencies that have attempted to educate Hispanics did not take into account the cultural differences, the diversity within the Hispanic population, and the literature was not designed with Hispanics in mind, The consequences of such actions are that 21% consider themselves at risk of HIV and 31% are not sure if they are at risk.

An alarming 60% said they didn't know the difference between HIV and AIDS. We found that a generous percentage of the remaining 40% had misconceptions and erroneous knowledge about HIV.

The key to preventing this lack of knowledge is to educate the emerging population. While the numbers are growing fast, the numbers are still small enough that successful outreach is possible. Thus preventing an HIV explosion in the Hispanic population.

**Subpopulations:**

- HIV Negative Partners of HIV Positive Persons
- Farmworkers (Latino/a)
- Migrant Farmworkers (Latino)
- Sex Workers (Latina)

–Lack of health insurance

–Limited or no target-population specific programming and outreach

**Risk Behavior:** Unprotected Sex

**Needs Assessment:**

- Language and cultural barriers
- Low SES (education, income, employment)
- Transportation barriers

**Intervention Goals/Outcomes:**

- 1) Abstain/postpone sexual intercourse,
- 2) Increase the correct and consistent use of condoms,
- 3) Reduce number of sexual partners,
- 4) Increase knowledge of their HIV status,
- 5) Reduce substance use/abuse in sexual situations

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\* For interventions specific to HIV positive persons and injection drug users see Intervention Recommendation Sheets for populations #1 and #6.

INTERVENTION TYPES	WHY?
Note: Refer to “ <i>HIV Prevention Programs Quality Assurance Guidelines</i> ” for more detailed information on specific intervention types.	Note: Despite the fact that the AIDS epidemic has been devastating the Latino community for many years, there are still few proven strategies for HIV prevention. (10, <b>16</b> )
A. Individual Level Interventions (ILI)	ILI: CDC recognized as an effective intervention. ( <b>13</b> )
B. Group Level Interventions – Skills Building (GLI-SB)	GLI – SB: Interventions should naturally include the skills building that has proven helpful with other groups, but they must also address the difficult cultural issues facing Latinos. CDC recognized as an effective intervention. ( <b>11</b> )
C. Group Level Interventions - Support Group (GLI – SG)	GLI – SG: One intervention with gay and bisexual Latino men uses four structured small group discussions with ongoing support groups and asks group members to keep diaries of their sexual episodes. ( <b>16</b> )
D. Outreach (OUT)	OUT: Outreach and engagement of immigrant and migrant populations. (12, <b>15</b> )
E. Counseling and Testing (CT) – includes Community Based Counseling and Testing (CBC&T)	CT: CDC required. ( <b>14</b> )
F. Health Communication/Public Information (HC/PI)	HC/PI: Create public information and awareness campaigns that educate Latinos about their rights and entitlements as well as the availability and location of services locally. (8, 9, <b>10</b> )
G. Capacity Building (CB)	CB: Build and support local, community-based capacity. ( <b>10</b> )  <i>Note: Numbers represent references in resource section below. <b>Bold typed</b> number above indicates primary reference or resource.</i>

**Resources:**

**Group Level Interventions – Skills Building**

1. **Title:** *American Red Cross Hispanic HIV Education and Prevention Instructor Course*  
**Description:** This course trains instructors to facilitate pláticas (community HIV prevention and education sessions) using strategies such as role-plays, task groups, demonstrations and practice. Initially, pláticas may focus on sharing basic HIV/AIDS facts and personalizing these facts with the participants. Follow-up pláticas emphasize developing skills including practicing putting on and removing a latex condom, effective communication, negotiation, decision-making and community mobilization.  
**Contact:** James Harris, Jr., DHEC STD/HIV Division Training Coordinator, @ (803) 898-0480 or your local American Red Cross chapter
2. **Title:** *Ciruculos de Salud (Health Circles)*  
**Description:** This curriculum uses participatory health circles that provide participants with basic information on HIV transmission and prevention, and then involves the participants in active problem-solving discussions in response to a set of questions posed to the circle regarding risky situations and issues relevant to the lives of the participants.  
**Contact:** University of California - Berkeley  
  
Note:  
This curriculum is currently being pilot tested by the University of California - Berkeley and the manuscript is unpublished.
3. **Title:** *Hermanos de Luna y del Sol (Brothers of the Moon and Sun)*  
**Description:** This curriculum intervenes in a culturally appropriate manner and addresses: low self-esteem, perceptions of low sexual control, and fatalism regarding inevitability of HIV infection.  
**Contact:** Center for Community Research/SFSU, [rmdiaz@sfsu.edu](mailto:rmdiaz@sfsu.edu) or 415-552-1013
4. **Title:** *Nosotros Viviremos (We Will Live)*  
**Description:** A curriculum that addresses racism, poverty, sexism, homophobia and AIDS stigma with full awareness  
**Contact:** Manos a la Obra (Migrant Assistance Networks for Optimum Systems) or National Coalition of Advocates for Students (NCAS) [www.ncasboston.org](http://www.ncasboston.org) or (915) 833-8184
5. **Title:** *Nosotras Vivremos (We will Live) – for Women Farmworkers*  
**Description:** This curriculum focuses on: Basic HIV and female reproduction information, gender pride, negotiation skills, and communication skills. There are two versions for women: 1) Adolescent female farmworkers, and 2) Farmworking mothers.  
**Contact:** Manos a la Obra (Migrant Assistance Networks for Optimum Systems) or National Coalition of Advocates for Students (NCAS) [www.ncasboston.org](http://www.ncasboston.org) or (915) 833-8184
6. **Title:** *El Camino Hacia la Salud (The Way Towards Good Health)*

**Description:** This multiple sessions curriculum addresses HIV transmission, high-risk behaviors, self-esteem issues and conflict resolutions. Numerous exercises are used to practice, laugh, and learn.

**Contact:** NAF Multicultural Human Development @ (402) 434-2821

### **Outreach**

7. **Title:** *PROMISE (Peers Reaching Out and Modeling Intervention Strategies)*

**Description:** This peer-based intervention, where members of the target population provide most of the outreach. It consists of role-model stories, peer advocates and prevention materials.

**Contact:**

### **Health Communication/Public Information**

8. **Title:** *Fotonovelas (Comic book soap operas)/Radionovelas (Radio broadcasted soap operas)*

**Description:** Uses continuing scenarios of the same characters experiencing dilemmas associated with HIV transmission. Radio listeners are given program times and encouraged to tune-in.

**Contact:** Rural Women’s Health Project @ [rwHP@cafl.com](mailto:rwHP@cafl.com)

9. **Title:** *Teatro Campesino (Farm Worker Theater)*

**Description:** Contains politically charged, humorous, educational messages. The audience has been frequently invited into the skit to act-out their lived experiences.

**Contact:**

### **Other**

10. National Alliance of State and Territorial AIDS Directors. 2003. “Addressing HIV/AIDS: Latino Perspectives & Policy Recommendations”. Available at [www.nastad.org/documents/public/pub\\_prevention/2003723AddressingHVADS...LatinoPerspectivesandPolicyRecomme.pdf](http://www.nastad.org/documents/public/pub_prevention/2003723AddressingHVADS...LatinoPerspectivesandPolicyRecomme.pdf)
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## CHAPTER 5: COORDINATION AND LINKAGES

This chapter describes how various governmental and non-governmental agencies in South Carolina coordinate to deliver comprehensive HIV prevention services, and how prevention activities are linked to services that prevent or delay onset of illness in persons with HIV.

### 1. Coordination

#### *Why is Coordination Important?*

The purpose of coordination is to facilitate the accomplishment of state and local HIV prevention goals through enhanced communication and planning between public health agencies, other agencies, and individuals. Health districts and communities throughout the state organize and plan HIV prevention and care services based on their local resources (including skills, fiscal, and personnel) and culture. Such coordination maximizes use of local and state resources to strengthen prevention and care efforts in South Carolina.

Partnerships between programs facilitate coordination and relates to sharing information, materials, or client referrals. Coordination is an active process intended to enhance group efforts toward a common goal or purpose, and in doing so:

- blends, integrates, and maximizes resources;
- facilitates complementary and supplementary programs; and
- leads to a system in which the whole is greater than the sum of its parts.

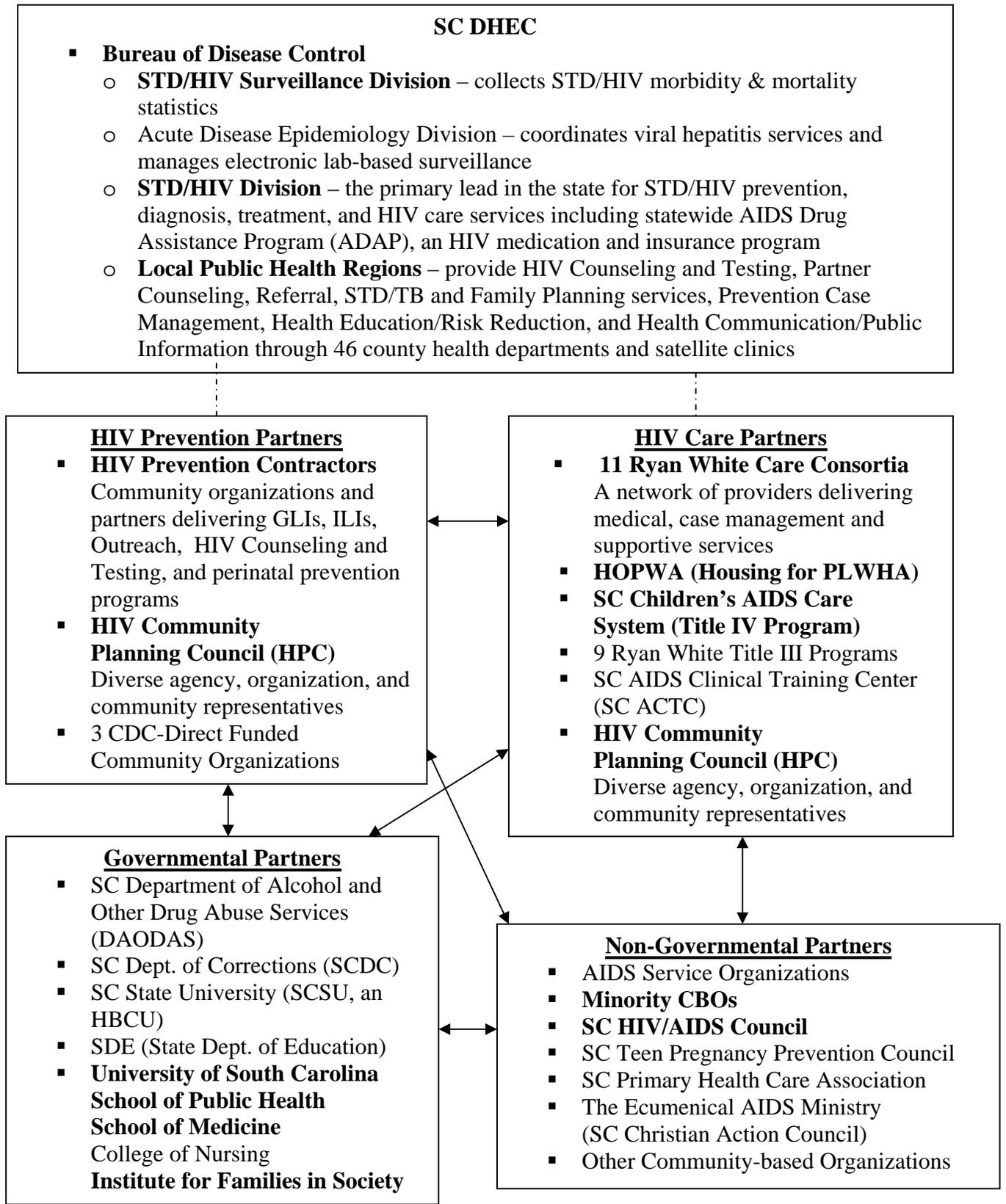
The benefits of coordination are compelling and beneficial to the public and include:

- standardized and consistent prevention and early intervention messages;
- reduced duplication of effort;
- maximized use of limited resources;
- increased access to funding opportunities and other resources;
- increased capacity and improved quality of services to individuals and communities because of shared knowledge and improved planning abilities; and
- expanded technical assistance opportunities for participating communities, agencies, and individuals through interaction with others who provide complementary skills, knowledge, or other resources.

Many providers experience or perceive disadvantages or threats related to participation, despite all the benefits coordination offers. The strongest disincentives to coordination include:

- increased competition for limited dollars or resources;
- concern by individuals or agencies that a coordinated process might result in their loss of control over programs or resources;
- a perceived change in equity or standing within the power structure; and
- time constraints of participants.

The schema below presents an overview of coordination and linkages. For abbreviations, please refer to the *Key* at the beginning of this plan.



NOTE: Bolded Partners/Organizations receive DHEC funds for HIV prevention and/or care services

*How is HIV prevention and care services planning coordinated in South Carolina?*

In 2004, a stakeholder group of representatives identified from the Ryan White CARE Act programs and the CPG was organized with the specific task of integrating planning for prevention and care services in South Carolina. The stakeholder group, composed of representatives from agencies/organizations providing prevention, care, or both prevention and care services, has developed bylaws and is presently working on a policies and procedures manual and membership application. The new integrated planning body, the SC HIV Planning Council (HPC), will officially begin its work in January 2005, with the primary goal of fully integrating planning for HIV prevention and care services in South Carolina. Twenty-five (25) voting members will serve on the Council, representing a balance of prevention and care providers, and will include a minimum of five consumers. Members of the HPC will be drawn from present representatives on the CPG and from among Ryan White care and support service providers, with representation also sought from Corrections, ATOD, and Mental Health programs.

The HPC will specifically incorporate the principles of Parity, Inclusion, and Representation in its membership, and will meet CDC and HRSA guidelines for planning bodies. The structure of the group includes five committees: (1) Prevention, (2) Care and Support Services, (3) Consumer Advisory, (4) Membership, and (5) Needs Assessment. Membership on the committees will be open to interested participants from across the state, with the exception of the Consumer Advisory Committee that is limited to and composed entirely of persons living with HIV.

The Council will have two co-chairs: the Planning Coordinator from DHEC and an elected community co-chair. The Planning Coordinator, hired in May 2004, was the Project Coordinator for the SC HIV Services Planning Project, the HRSA-funded multi-agency project (1990-91) to develop a comprehensive statewide plan (and a model regional plan) for services for persons living with HIV. The plan served as the foundation for the present networks of Ryan White CARE Act-funded care consortia and prevention collaborations in South Carolina.

*How are prevention services coordinated in South Carolina?*

**State Health Department**

The DHEC STD/HIV Division administers the CDC HIV prevention, STD prevention programs, Ryan White CARE Act Title II and Title IV, and HOPWA programs. This organizational structure ensures collaboration of state and local staff and coordination of planning and funding mechanisms. The STD/HIV Division maintains a strong collaboration with other Health Department programs, such as Maternal and Child Health programs, TB, Immunizations, and the public health laboratory. Staff from these programs coordinate cross-program training, clinical services, and quality assurance efforts.

DHEC has developed a comprehensive approach to STD/HIV prevention, which includes:

- active surveillance to track the STD/HIV epidemics;
- cost-effective routine screening and treatment of at-risk populations;
- mobile screening efforts to reach populations who are not accessing clinical services;

- partner notification and referral services;
- targeted health education/risk reduction interventions; and
- on-going training/quality assurance activities.

Prevention programs are delivered primarily by health districts/regions (covering 46 county health departments) and community organizations such as local alcohol and drug abuse commissions, community action councils, AIDS service organizations, and minority community based organizations.

Selected examples of coordination among governmental and non-governmental prevention providers for planning and delivery of services, capacity building, needs assessments, and training are highlighted below.

### **Local HIV Prevention Contractors**

The primary mechanism for coordination of health education/risk reduction services has been through local HIV prevention collaborations. DHEC provided funding to eleven HIV Prevention Collaborations covering all but two counties in the state (see Figure 1), in response to a need identified by the Statewide HIV Prevention Community Planning Group (CPG) to increase the capacity of local organizations to conduct HIV prevention activities.

Each Collaboration in the state involves partnerships with various and diverse agencies and organizations. Member organizations and community partners include local alcohol and drug abuse agencies, health departments, county teen pregnancy councils, housing communities, youth-serving organizations, corrections facilities, shelters, fraternal organizations, as well as representatives from minority organizations. These organizations include, but are not limited to: Sistercare, Columbia Housing Authority, Camille Griffin Graham Women's Correctional Institution, Broad River Correctional Facility, Lexington/Richland Alcohol and Drug Abuse Council, Lexington Department of Social Services, Morris Village In-Patient Programs, Killingsworth, Lexington County Jail, Women's Resource Center, 100 Black Men of Greater Columbia, Orangeburg Area Mental Health, Minority AIDS Council, Brooks Health Center at SC State University, Alpha Xi Chapter of Delta Sigma Theta Sorority, Inc., Tri-County Healthy People 2000, Alpha Omicron Zeta Chapter of Zeta Phi Beta Sorority, Inc., Lowcountry Healthy Start, OCAB Head Start, AFFIRM Youth, Stephen's House, Out of Bounds, New Attitude, Metropolitan Community Church, Greenville Detention Center, Greenville Free Medical Clinic, Anderson Free Medical Clinic, Piedmont Treatment Center, Greenville Alternative School, Young Men of Vision and Progress, and New Life Center.

The Collaborations 1) created an association of organizations that work together by developing a working structure (board, bylaws, etc.) to create a plan to meet the needs and fills the gaps in services, and 2) delivered services to populations at greatest risk based on the SC HIV Prevention Plan Epi Profile, local epidemiological data, and local needs assessment. The objectives and activities varied by area but were based on target populations, especially racial and ethnic minorities. In the past, each collaboration had a designated lead agency that DHEC contracted with, which managed the administration of activities for the group. Each lead agency

hired needed staff, supervised the planning, monitoring, and evaluation activities, and submitted quarterly reports.

SC DHEC devoted significant resources to strengthen these collaborations through capacity building, providing training and technical support, in an effort to institutionalize the collaborations in their local areas. Beginning January 2005, a new cycle of HIV prevention funding will go directly to agencies or organizations that plan and implement local activities based on the collaboration model of interconnectedness and resource-sharing, but greatly reducing the overhead costs involved with maintenance of the collaboration structure. Newly funded prevention contractors must demonstrate community partnerships and support as well as the ability to reach priority populations with priority interventions.

### **Perinatal Prevention Coordination**

To achieve reductions in perinatal HIV infection, DHEC receives federal HIV perinatal prevention funds from CDC and Ryan White Title IV funds from HRSA. These programs focus on ensuring that Public Health Services Guidelines for Preventing Perinatal HIV Transmission are practiced in South Carolina. These guidelines include routine HIV screening of pregnant women, rapid HIV testing during labor and delivery if indicated, access to antiretroviral treatment for HIV infected pregnant women and their children. DHEC's perinatal prevention activities focus on provider education and training, linking HIV exposed infants to care services, monitoring perinatal transmission rates, prevention case management for HIV infected pregnant women and education/outreach to high risk women. One example of coordination is the University of South Carolina Department of Medicine Perinatal HIV Prevention Case Management Program (USC PCM). HIV infected pregnant women in Columbia are recruited from the Department of Obstetrics at USC for PCM services; these women may also be receiving HIV care from the Title II clinic at the Department of Medicine. Intensive case management services are provided to pregnant HIV-positive women, many of who experience complex psychosocial HIV issues that increase the difficulty of adhering to recommended antepartum or postpartum therapy and/or care plans. Women may also be linked to Title IV consumer advocates for peer education. Following delivery, the women are linked to Title IV providers.

### **African American Communities Initiative (AACI)**

African American Communities Initiative (AACI), funded by Ryan White Title IV, includes targeted health education, case-finding through counseling and testing, and linkages of patients with consumer advocates. The primary goal of AACI is to increase case-finding strategies for African American youth and women to recruit and maintain those positive in HIV care and supportive services. AACI activities are also closely linked with the state's STD/HIV prevention and family planning services infrastructure to avoid duplication and ensure coordination and maximize resources.

Project staff network with key organizations serving African Americans at risk to provide on-going support for prevention education to enhance referral mechanisms to primary care services. Staff provides and/or coordinates with existing health education staff, STD/HIV prevention education and referral sessions that focus on HIV prevention and primary and specialty care

services. Project staff also coordinates with local HIV prevention providers conducting community-delivered HIV counseling and testing services targeting African American adolescents and young adults at risk in areas of highest morbidity such as Columbia, the Upstate and Charleston. Title IV health education staff collaborates with the HIV prevention partners to design health communication messages for radio stations that target priority population audiences. These health communication messages contain HIV/STD prevention messages as well as prenatal testing messages targeting young African American women who are pregnant or who are thinking about getting pregnant. These messages announce where counseling and testing events will be held across the state.

### **Syphilis Elimination Project**

In 1999, the Centers for Disease Control and Prevention launched a national plan to eliminate syphilis in the United States (US), awarding funding to states and cities with highest syphilis cases. DHEC has developed syphilis elimination activities including jail screening, outbreak response teams, enhanced community education and outreach. A major component of the syphilis elimination project is mobile screening. The mobile unit is a 'traveling clinic', offering free testing for syphilis, HIV, Chlamydia, and gonorrhea in counties with high syphilis rates. The mobile screening enables DHEC to target populations with appropriate resources, culturally competent staff, creativity, appropriate messages and strategies and strong community involvement to tackle the issue of syphilis. Over the past three years the mobile unit staff has strengthened current partnerships, opened opportunities for new partnerships, and made strides working with businesses, the historically black colleges, county detention centers and the Latino community. Outbreak response teams provide intensive outreach, syphilis and HIV screening and partner notification services. South Carolina's infectious syphilis cases continue to decline as a result of these strategies. In 2003, the number of cases dropped to 92 from 136 in 2002, and 380 in 1997.

### **DHEC Office of Minority Health and the AIDS Demonstration Project**

The DHEC Office of Minority Health, one of the STD/HIV Division's strongest partners, collaborates with community-based minority serving organizations to coordinate capacity building skills workshops, consultation and technical assistance. The HIV/AIDS Demonstration Project, funded with Congressional Black Caucus monies, strengthens the capacity of minority community based organizations (MCBOs) to provide HIV prevention services. The project, in its fourth year, has a project advisory committee that includes STD/HIV Division staff, representatives from primary care organizations, African American churches, African Americans living with HIV, DAODAS, faith communities/organizations, and others. The project coordinator is a visiting member of the HIV Prevention Community Planning Group. The MCBOs identified for capacity building are included in the STD/HIV Division's mailing lists to receive announcements for upcoming training events, funding opportunities, and other HIV-related news. Additionally, the Office of Minority Health and the STD/HIV Division collaborate to sponsor events to promote HIV awareness in the African American community.

Examples of collaborative events include the following:

- **The HBCU HIV/AIDS Summit** is a statewide collaborative effort coordinated by the SC DHEC-Office of Minority Health for the state's Historically Black Colleges and Universities (HBCUs). Other partners include the Ryan White Title IV African American Communities Initiative, DHEC District Health Education staff, faith communities, and HIV prevention contractors. The purpose of the Summit is to engage HBCUs in addressing HIV/AIDS on university/college campuses and the surrounding communities with an emphasis on implementing and institutionalizing HIV/AIDS prevention into HBCU curricula and activities. The Summit focuses on African-American students that attend HBCUs in South Carolina; however, other students that attend majority universities and colleges in the state are not excluded. It is planned to have this Demonstration Project used as a model for each of the HBCUs to use an implementation instrument for each of their campuses in order to develop and host HIV/AIDS Summits on their college/university campuses beginning in 2005.
- **The Minority Community Based Organizations (MCBO) Institute** was developed as a capacity-building effort of the SC DHEC Office of Minority Health, with a primary focus on education and training. The two-day Institute, targeting grassroot organizations that provide HIV/AIDS prevention services to African Americans, provides an opportunity to enhance and/or increase organizational and programmatic skills of the MCBO participants.
- **Cultural Competence in Serving Hispanic/Latinos.** This workshop included an introduction to the basic cultural competence principles, concept and skills to enhance efforts to effectively reach and service the Hispanic/Latino populations. The workshop explored Hispanic and Latino beliefs, values and customs, as well as existing cultural assumptions and their relevance to service providers. Discussions were held on current barriers to the delivery of services and ways to overcome those barriers, as well as a review of Hispanic/Latino population HIV/AIDS data in South Carolina
- **HIV/AIDS Grant Writing – A Beginners' Workshop** provided an overview of grant writing techniques commonly used by entities applying for funding from public (federal, state and local) and private/philanthropic organizations. The workshop reviewed the eight basic components of grants, with a focus on the type of information HIV/AIDS proposals should contain. There was also a session on where to search for grants; how to read and respond to a request for proposals, and the timeline/work plan needed for getting the proposal written and submitted. The main focus of the workshop was on public funds; however, differences between applying to public agencies, corporations, and foundations were discussed. This full-day, hands-on grant-writing workshop also included interactive components with group activities.
- **Building Healthier Communities Statewide Capacity Development Meetings,** a partnership with the federal Office of Minority Health Resource Center (OMHRC), utilized state offices of Minority Health, local CBOs, faith-based organizations, ASOs, health departments and community leaders, was formed to coordinate a series of national forums that highlighted the capacity development needs within these organizations. More specifically, these meetings aimed to clarify the needs of rural grassroots minority organizations in delivering HIV/AIDS services to the diverse rural and ethnic communities within their states. In 2004, the daylong meeting was held on Thursday,

May 20, at Brookland Baptist Church, a very large African American congregation in West Columbia. Follow up for this meeting includes capacity building trainings throughout the year to address the identified needs of the organizations and individuals who attended.

- **The 501(c)3 Workshop** acquainted participants with the application process, including prerequisites and requirements, for Recognition of Exemption under 501(c)3 of the Internal Revenue Code. This workshop gave participants “hands on” experience in completing the 501(c)3 application (IRS Form 1023) and other applicable forms and documents, as well as the specific steps required for recognition of exemption as an eleemosynary organization.

### **State Department of Education**

South Carolina’s local school boards, with technical assistances from the State Department of Education (SDE), are required to provide instruction in age-appropriate reproductive health and sexuality education to students during the middle and high school years under the Comprehensive Health Education Act (revised 1988).

The SDE Healthy Schools Program (HSP), which is a cooperative agreement with DHEC, supports these efforts by providing training, resources and technical assistance to the 85 school districts throughout the state. The HSP also employs an HIV Program Coordinator who works with local school districts to provide teacher training and to build upon and utilize linkages with community based organizations, DHEC, and other health agencies.

HIV prevention education services, provided by the HSP, are directly funded by the CDC Division of Adolescent and School Health (DASH). DASH also provides separate funding to the Healthy Schools Program to conduct the Youth Risk Behavior Survey (YRBS). The YRBS is conducted bi-annually by SDE or an identified sub-contractor. Results of the YRBS are widely shared with public health and HIV/STD prevention providers for planning and evaluation. Overall, CDC DASH funding provides for coordinated HIV/STI prevention education for school age youth in South Carolina.

### **SC Department of Alcohol and Other Drug Abuse Services**

The SC Department of Alcohol and Other Drug Abuse Services (DAODAS) contracts with DHEC for the provision of HIV Early Intervention Services and Resources to clients in the statewide alcohol and drug abuse system. Through establishment of this contract, the two agencies created an active referral system between county health departments and county alcohol and drug abuse agencies, training for public health staff on substance abuse risk assessment, and training for substance abuse staff on communicable disease issues. The contract is designed to provide HIV counseling and testing services statewide targeting substance users in health department, local alcohol and drug commissions, and community settings. The contract also includes funding to support Hepatitis C training and education through the SC Hepatitis C Coalition and testing for Hepatitis C in county health departments.. DHEC receives 34.4% of the 15% Substance Abuse Prevention and Treatment block grant HIV Early Intervention set-aside total from DAODAS for implementation of these services. DAODAS also has funded

treatment counselors across the state at several local alcohol and drug abuse commissions that work directly with this high-risk population in need of alcohol and/or other drug services.

### **SC HIV/AIDS Council**

SC DHEC coordinates several initiatives with the SC HIV/AIDS Council (SCHAC), a primary prevention and supportive services partner in South Carolina. The STD/HIV Division contracts with SCHAC to conduct community-based syphilis elimination initiatives in five (5) counties within the state. SCHAC works collaboratively with several DHEC-funded HIV prevention Collaborations to maximize resources by integrating HIV and syphilis community assessments, condom distribution, and local street outreach efforts into local HIV prevention efforts. SCHAC Syphilis Elimination staff assisted in creation of two 501(c)3 community-based coalitions and provides on-going technical assistance services upon request to ensure the facilitation of prevention activities within the two rural counties.

Efforts coordinated through local coalitions includes: a) dissemination of syphilis elimination resources, b) group level interventions (GLI), and c) syphilis screening coordinated by contractual Syphilis Elimination Outreach Coordinators within the five high prevalence counties. Coordination of activities (e.g., street outreach, GLI, and individual level interventions) are conducted in partnership with local health department staff (e.g., health educators, disease intervention specialists, etc.) to ensure implementation of HIV/STI interventions to high risk populations.

SCHAC is also a CDC directly funded community based organization for two projects. SCHAC is funded to provide community based HIV counseling and testing targeting African Americans at risk. They provide both in-house and mobile rapid HIV testing and prevention counseling to high and very high-risk clients. Partner counseling and referral services are coordinated with local and state health departments through a Memorandum of Agreement. SC DHEC staff assists by sharing resources and providing support to ensure quality assurance measures are linked with SC DHEC protocol. The second project, *Between Brothers*, targets young African American men who have sex with men through outreach, referrals to testing, and small group interventions.

### **CDC Direct-Funded Community Based Organizations (CBOs)**

In 2004 three CBOs in South Carolina were awarded direct HIV prevention grants from CDC for 2004 – 2009. The CBOs/projects are:

1. South Carolina HIV/AIDS Council: HIV Counseling and Testing; *Community Promise* and *Voices* interventions for HIV positive persons and very high-risk persons in the Columbia area
2. Palmetto AIDS Life Support Services: Prevention Case Management for HIV positive African Americans; *Healthy Relationships* (for clients enrolled in Prevention Case Management in their 8-county service area) and *Popular Opinion Leader* (for high-risk African Americans in the Columbia area) interventions
3. HopeHealth: HIV Counseling, Testing, and Referral for High Risk Individuals; Rapid Testing in Non-Clinical Settings for High Risk Individuals; Prevention Case

Management for Persons Living with HIV; Integration of Prevention Services into Medical Care for People Living with HIV; **SISTA** Project for seronegative women at very high risk for HIV infection; serving the six-county Pee Dee region, including Chesterfield, Darlington, Dillon, Florence, Marion, and Marlboro counties.

### **Training and Capacity Building**

Coordination for training and capacity building is essential to maximize limited resources and address training needs of prevention providers as well as in some cases, care and supportive services partners. The STD/HIV Division coordinates training on effective behavioral interventions, prevention counseling, STD clinical updates, Red Cross HIV Starter Facts, HIV care and treatment, and capacity building topics. Key partners involved in planning and coordinating training include the SC AIDS Clinical Training Center (University of South Carolina, Department of Medicine is the state contractor of the Southeast AIDS Training and Education Center - Ryan White CARE Act, Section F), DAODAS, and others. The Division conducts routine assessments on training needs and offers training workshops open to all prevention partners, minority CBOs, and care providers. National and regional technical assistance providers are invited to present training on diverse issues identified in training needs assessments.

### **Faith-based Initiatives**

Prevention providers acknowledge the importance of the church's role in HIV prevention, and particularly as a mechanism to reach African Americans. Prevention contractors, health department staff and other organizations work collaboratively with churches to coordinate and implement prevention activities.

The SC DHEC Office of Minority Health provides much support to faith-based organizations for HIV prevention and supportive services through mini-grants, sole source contracts, and identified special funding. These organizations plan, support, and implement HIV and complementary health-based programs for their members, often in rural and underserved areas of South Carolina.

The Ecumenical AIDS Ministry (TEAM) is a program of the SC Christian Action Council. This ministry builds church-based Care Teams that provide supportive services to persons living with HIV/AIDS. A second function of the Teams is to promote AIDS awareness and education among members of the congregation by establishing educational programs/libraries in churches, working with clergy and lay leaders, and talking about ministry during special events such as AIDS Sunday or World AIDS Day. Some churches also offer services of healing and support. The coordinator attends local collaboration and Ryan White care provider meetings, and assists in promoting the statewide HIV/STD conference and other training events among its members.

The SC HIV/AIDS Council is the creator and now financial conduit for the Interfaith AIDS Resource and Education Coalition (I-C.A.R.E.) that is funded through the SC Department of Alcohol and Other Drug Abuse Services. The mission of the I-Care Coalition includes the provision of HIV/AIDS/STI education, skills-building training, as well as enhancing access of

HIV/STI resources to faith-based denominations. I-CARE church members maintain a particular emphasis on engaging black churches in prevention activities due to the disproportionate number of African Americans directly impacted by HIV/AIDS in South Carolina. The organization's goal includes the intent to encourage HIV testing and prevention counseling as a behavioral action designed to slow down the spread of HIV/AIDS.

### **Challenges in Coordinating Prevention Services**

In South Carolina, the primary challenges in coordinating prevention services includes:

- Lack of communication among providers due to multiple tasks limiting time or opportunities to network or interact with other providers.
- Staff turnover, especially at the local service delivery level, impeding on-going communication and partnerships.
- Lack of resources at the state and regional level to facilitate dedicated collaborative activities among prevention providers, especially with mental health services.
- In some areas, increased competition for limited dollars or resources among multiple organizations creates reluctance to share information and coordinate services.

As state, local and federal resources decline or remain level in the face of growing HIV prevalence, collaboration and coordination among existing and new prevention providers will need a greater focus. DHEC and other key partners will continue to explore ways to facilitate communication among prevention providers, to create opportunities and incentives for maintaining current or forming new partnerships, to leverage resources (staff, funds, equipment, office locations, etc) among different community organizations and agencies. DHEC will also continue to offer or sponsor various training and capacity building activities for prevention providers to improve staff skills in delivering prevention programs, evaluating impact of services, administering/managing funds, and securing additional resources.

## **2. Linkages**

*Why is linkage between prevention and care/supportive services important?*

CDC's initiative, *Advancing HIV Prevention: New Strategies for a Changing Epidemic* (published in the April 18, 2003 issue of the Morbidity and Mortality Weekly Report), focuses on the increased need to reduce barriers to early diagnosis of HIV infection and increase access to quality medical care, treatment, and ongoing prevention services for those diagnosed with HIV. The basis for CDC's initiative centers on recent advances in HIV treatment have significantly impacted the lives of people living with HIV disease and the approaches to responding to the epidemic. HIV medications have delayed the onset of AIDS and offer hope of reducing transmission to others by lowering viral loads and potentially decreasing the level of one's infectiousness.

There are many challenges for persons living with HIV disease, including but not limited to:

- Adhering to sometimes difficult treatment regimens;
- Dealing with side effects of medications;
- Managing the high costs of care and medications;

- Dealing with other competing life events;
- Handling depression;
- Dealing with stigma, particularly in rural areas; and
- Recognizing denial in self and/or others.

Ongoing prevention support services must be available to help persons living with HIV disease to be successful with medication adherence to prevent or delay illness, and to help them adopt and maintain healthy behaviors including steps to prevent infecting others. Supportive services that link persons to stable, long-term housing, substance use treatment, or mental health counseling may also enable persons to reduce risk behaviors associated with HIV transmission.

Early identification of HIV status and linkage to HIV care and treatment services are essential for persons to benefit from these and other services. Data from several studies in other areas of the country indicate that 30-40% of persons with new HIV diagnoses are not linked to an HIV care provider within 12 months of their HIV diagnosis. A recently completed Antiretroviral Treatment Access Study (“ARTAS”) in four United States (US) cities indicates that providing case managers to help socioeconomically disadvantaged newly diagnosed persons into care significantly increases the percentage of persons who see an HIV care provider once within six months and twice within twelve months after their initial HIV diagnoses. After one year, 64% of case managed participants and 50% of non-case managed participants were linked to care. Such case management was also cost-effective (approximately \$1,000 per additional person successfully linked). The ARTAS model required only two to three face-to-face meetings on average with a case manager over a maximum of three months.

Many persons at greatest risk for HIV or who are HIV-infected have multiple health and social service needs. Many persons living with HIV may have other co-morbid diagnoses, such as substance use, hepatitis, mental illness, or tuberculosis. Needs assessments in South Carolina consistently indicate a high likelihood for depression among persons with HIV, particularly women in rural areas, creating a need for mental health and counseling services. A significant proportion of our target populations are likely to be uninsured or underinsured and have low incomes, creating needs for supportive services such as transportation, food, housing, and/or job assistance training.

Prevention and care providers must acknowledge that a holistic, culturally competent, client-centered approach is essential in order to increase effectiveness of both primary and secondary prevention. A recently discharged HIV-infected inmate is not likely to keep an initial appointment with the local HIV care provider when he/she has no job to obtain food, or reverts to substance use once back on the streets. Similarly, a woman in a dependent relationship with a partner prone to domestic violence is not likely to be successful in negotiating safer sex until relationship issues are confronted.

*What are the challenges for effective linkages?*

Successfully linking a person from a prevention activity such as outreach to counseling and testing, to partner counseling and referral services, to HIV patient care and to additional supportive services requires many elements. An effective, active referral system is a central component for effective linkages. It is important for providers to recognize that, even though essential services exist in our state, there are systems-level, provider-level and client-level barriers that may impede successful linkages.

Systems-level barriers may include:

- not offering services at times or days convenient for clients;
- locations that are difficult for clients to reach, particularly in more rural areas;
- lack of staff and resources to meet the demand/need for services, thus turning away clients;
- having waiting lists; and/or
- not being able to meet all a client's needs.

Provider-level barriers may include:

- lack of skills to engage clients, inhibiting the accurate assessment of psychosocial and health needs;
- lack of knowledge of available services and resources, preventing active referrals;
- lack of knowledge of updated care and treatment guidelines and methods;
- lack of cultural competence skills, impairing effective communication with clients and their families; and/or
- lack of foreign language skills to effectively communicate with non-English speakers.

Client-level barriers may include:

- lack of resources for transportation to care and other services;
- denial of one's illness;
- other competing needs and issues, such as homelessness or dual diagnoses;
- fear of stigma or lack of confidentiality, preventing them from making or keeping regular appointments;
- lack of knowledge that services exist or how to successfully access existing services; and/or
- difficulty in navigating complex care or service systems, creating despondency or frustration with providers.

To better identify and address these and other challenges, the state involves HIV-positive consumers in planning and delivery of services at the local and state level. The Ryan White Title IV Consumer Involvement project hires parent advocates at each regional care center to enhance cultural competence, increase consumer involvement in advocacy roles, planning and evaluation, and to provide a supportive role in maximizing medication adherence.

*What are the Key Linkages and Challenges in South Carolina?*

South Carolina has developed an extensive infrastructure of linkages between prevention and HIV care services. Many services in county health departments and community health centers are integrated, making it easier for persons to receive a range of prevention services such as HIV counseling and testing, STD diagnosis and treatment, TB screening, and reproductive health services. Additionally, many agencies in South Carolina are lead agencies for both HIV prevention and care services, allowing for a seamless transition for persons diagnosed with HIV. Integrated services can facilitate both effectiveness and efficiency of primary and secondary prevention efforts.

South Carolina has several strategies conducted and planned in response to CDC's "Advancing HIV Prevention: New Strategies for a Changing Epidemic" initiative. In July of 2003, the CPG prioritized persons living with HIV as the number one priority population in the state's Comprehensive HIV Prevention Plan. State health department staff has also been working with local health department staff and prevention contractors to begin to redirect services in 2004 to focus on persons living with HIV. To assist with this shifting of interventions and target populations, prevention staff teamed up with the Ryan White Care staff and hosted a joint meeting of local prevention and care providers in September of 2003 (including Titles II, IIIb, and IV) to discuss the new initiative and look at ways to enhance cooperative efforts. Staff presented a summary of the initiatives at the meeting and participants identified some initial ideas for integrating prevention into care services. Follow-up meetings are being held to facilitate communication and address specific prevention strategies for Title II providers. The meetings are also being used to plan specific approaches for screening and referral by hospital and other facilities in areas having an HIV prevalence rate of 1% or more.

Of the eleven Title II care consortia, seven agencies serve as the lead for both prevention and care services contracts with DHEC. In 2004, trainings and technical assistance meetings have been held to look at integrating interventions within the Ryan White-funded programs, such as prevention case management and individual level prevention activities focusing on reducing sexual or drug-use HIV transmission risk, and to closely link health department staff providing partner notification services in order to target persons most likely to be HIV-infected and refer them to care. Seven consortia included Health Education/Risk Reduction and/or prevention case management services as one of their 2004 plan objectives.

The SC Primary Health Care Association oversees 17 Federally Qualified Health Centers operating numerous satellite locations in medically underserved (and mostly rural) areas. The majority of these primary care clinics provide HIV testing services and nine sites also receive Ryan White Title IIIb funds for Early Intervention Services. Seven of these sites use Title IIIb funds to support HIV screening services to clients of their primary care facility. Additionally, the Medical College of Georgia, through its Title IIIb expansion grant, began offering services this year in Aiken. A contact list of all primary care sites is integrated with the STD/HIV Division's mailing list for training updates and meetings to allow for staff participation in relevant training.

Trainings have focused on integrating prevention for positive persons based on CDC curricula/training information. Although targeted to DHEC's prevention and Title II contractors, as well as Title IIIb and IV, staff from other organizations such as the primary care clinics and correctional facilities was allowed to participate.

To facilitate linkages, information about accessing counseling and testing services, other prevention services, Ryan White, HOPWA and other care services is available through the toll-free state AIDS Hotline operated by DHEC STD/HIV staff. For referrals, the hotline staff access an electronic database of all HIV-related services by county using the same software that local care consortia and HOPWA providers use (PROVIDE). Local case managers access the resource listings electronically. A committee periodically updates the listings. The database includes education/prevention, outreach, counseling and testing services, primary care, and support services. It describes statewide services available such as Ryan White CARE Act-funded programs, housing assistance, Department of Alcohol and Other Drug Abuse Services, Department of Mental Health, Community Long Term Care (Medicaid), church-based care teams, and others. Hotline and case management staff use the database to identify existing services and refer individuals to appropriate available services.

The STD/HIV Division also maintains a website which is accessible to the public <<http://www.scdhec.net/hs/diseasecont/stdwk/html/stdindex.htm>>. Information contained on the website includes:

- Surveillance report data for HIV/AIDS/STD;
- STD/HIV Prevention Information for Communities, including an overview of the CPG and the Community Planning Process, Collaborations, the SC Federal Materials Review Process, the Continuation Application, Partner Counseling and Referral Services, and Training;
- HIV Care and Support Information for Communities, including an overview of ADAP, and HOPWA;
- South Carolina Plans, including the SC HIV Prevention Plan and the SC Comprehensive HIV/AIDS Care Plan;
- Public Information Programs; and
- Information for Health Care Providers, including information on Prenatal Screening; and
- Additional Resources and Links.

Another resource tool is the Resource Directory developed by the Title IV African American Youth Initiative. The directory was developed in coordination with key youth-serving organizations in the Columbia area to enhance the referral system for adolescents from agencies where services are accessed. The directory provides a youth-friendly description of each service and is available for local agencies and service providers, and can be found on the Internet at <http://www.midlandsyouthdirectory.com>.

The following is a description of the key related services in South Carolina and how clients are linked to:

- HIV testing, counseling and referral services;
- Partner counseling and referral services (PCRS);

- HIV care and support services;
- Perinatal HIV prevention services
- Homelessness prevention services (Housing Opportunities for People with AIDS – HOPWA);
- Substance abuse treatment services;
- Mental health services; and
- Correctional systems.

### **HIV Counseling, Testing, and Referral Services**

The primary linkages to HIV counseling and testing services in South Carolina are made through:

- Partner counseling and referrals;
- AIDS hotline referrals;
- HIV prevention contractors and CBOs providing health education/risk reduction;
- Outreach strategies by community organizations, Ryan White Title III providers, the Ryan White Title IV African American Communities of Color Initiative, and DHEC mobile screening;
- Routine HIV screening in STD, TB, and Family Planning clinics;
- Routine HIV screening for pregnant women;
- HIV testing in several alcohol and drug abuse facilities;
- Public information/media awareness;
- Physicians/primary care providers; and
- Blood/plasma centers.

HIV counseling and testing services are available in each county health department. Approximately one-third (30%) of the annual number of newly reported persons with HIV in the state is diagnosed through the county health departments. More than 45,000 clients received counseling and testing services during calendar year 2003 (includes those routinely screened during other STD, TB or family planning services). Among the 640 clients whose tests were HIV positive, 380 (59%) were estimated to be newly diagnosed.

All newly diagnosed persons with HIV infection in counseling and testing sites are referred to existing care services. Depending on insurance status or personal situations, clients are referred either to private providers, Ryan White Care Consortia, Title III or Title IV providers. In order to facilitate referrals, county health department counseling and testing sites offer an initial CD4 and viral load test free to newly diagnosed persons with HIV. Screening for syphilis and tuberculosis is provided for all newly identified HIV-infected clients and referrals are made for treatment within the health department if necessary. Screening for Hepatitis C is also routinely provided. Staff also make referrals for drug treatment services, counseling, support groups, AIDS service organization services, Medicaid, and other services as appropriate.

An estimated 95% of all newly diagnosed persons at the health departments are provided their test results within 3 months and of these, all are provided an appointment to care. However, an estimated two-thirds (64%) of recently diagnosed persons served by local health department CTS

and partner notification services do not successfully become enrolled in care services within three months. Due to severe understaffing at most health departments, the existing referral system between the health department and the medical and supportive service providers does not allow for proper follow-up with newly diagnosed clients to document or verify if the appointment was kept. The agencies that receive the referrals are unable to make contact with the individual if they do not keep their appointments because they do not have the proper client authorizations to do so. Thus, the large number of newly diagnosed clients and the lack of referral coordination among the agencies both contribute to clients often not entering medical care in a timely manner.

To address the lack of capacity for health departments to follow – up on referrals to care, some health departments and Ryan White Care consortia have developed a mechanism for CTS staff to obtain consent for HIV care case managers staff to contact HIV positive persons who do not make their first care appointment.

In addition to county health department sites, HIV counseling and testing services are presently provided through 10 DHEC HIV prevention contractors; several alcohol and drug abuse treatment agencies; one CDC directly funded CBO in the Columbia area, and one CDC direct-funded CBO in Florence. These organizations all have either contracts or memoranda of agreement with DHEC and include referrals to primary care, partner counseling and referral services, and other services as appropriate. HIV counseling and testing services are also provided by primary care centers, and seven Ryan White Title IIIb projects for Early Intervention Services, which directly link HIV-infected persons to primary care.

Entry into HIV medical care is a complex issue for many individuals who are newly diagnosed. Barriers for many clients newly diagnosed actually completing referrals reported by counselors include denial of illness, not feeling “sick”, fear of confidentiality loss, other competing priorities. Often people have no outward symptoms of the disease and therefore do not feel an urgency to get into care. Many clients state they will not enter care until their CD4 count is below 500. Prevention staff around the state report it may take as long as six months and as many as 2-3 contacts before an individual will enter care. In addition to the individual psychological reasons that people do not enter care in a timely manner, there are barriers within the care system that prevent early entry into care. For example, case managers and health care providers are typically only available during normal business hours, which may be inconvenient for working people. Also, in rural parts of the state, transportation continues to be a barrier to care for clients/families that must travel long distances to regional clinics.

### **Partner Counseling and Referral Services (PCRS)**

Partner counseling and referral services provided by disease intervention specialists in local health departments are an effective intervention to link persons who have been exposed to HIV through sex or needle sharing exposure to HIV counseling and testing services. During 2003, local health department staff provided partner counseling services to 847 HIV-infected persons (both newly diagnosed and previous positive persons) who named 1720 sex/needle-sharing partners. Of the named partners with unknown or previous HIV negative test, 79% were tested after notification by PCRS staff. Among these partners who were tested, 11% were newly

diagnosed with a positive test; 31% of all named partners were HIV-infected (new and previous positives). PCRS staff also assists in referring both newly and previously HIV diagnosed persons to care services.

### **HIV Care and Support Services**

The primary linkages to HIV care and support services in South Carolina are made through:

- Provider referrals from HIV counseling and testing sites;
- Referrals from physicians, primary care clinics, hospitals, and other providers;
- Partner counseling and referral services;
- AIDS Hotline referrals;
- Direct referrals from Ryan White programs' case managers; and
- Direct referrals for HIV-infected inmates discharged from the SC Department of Corrections.

South Carolina has developed an HIV/AIDS services infrastructure which provides a continuum of primary care, supportive services and other related services for persons with HIV disease who are uninsured or underinsured. Primary care services are provided either directly or by referral through the 11 Ryan White Title II care consortia, nine Title IIIb HIV Early Intervention Services, and Title IV pediatric care providers. The main medical care providers include private physicians, Title II funded clinicians, and primary health care/community health center physicians. Access to therapies is provided through the Title II AIDS Drug Assistance Program (ADAP), Medicaid, and pharmaceutical company drug assistance programs. Supportive services that enable persons to access and remain in primary care are provided directly by case managers in each Ryan White care program. Case managers link clients to substance use treatment, housing services, mental health counseling, food resources, and other supportive services.

Particular emphasis of all Ryan White Care providers is on increasing access to care and ensuring African American persons with HIV are linked to care services. Estimates of persons who are in care are based on several sources. Ryan White Title II consortia reported serving 7,194 persons during 2003; the AIDS Drug Assistance Program (ADAP) had 2,452 active clients in 2003. Clients served are essentially representative of the epidemic. In 2003, 76% percent of consortia clients were African American and 64% were male; 70% of ADAP clients were African American and 70% were male. The Ryan White Title IV program is a statewide, collaborative network of providers and organizations serving HIV exposed/infected infants, children, youth, women and their affected families, including male caregivers. Of the 650 clients served by Title IV programs in 2003, 543 or 84% were African American and 65% were youth under 12 and young adults 13-24 years.

The SC ADAP currently does not have a waiting list, due to Supplemental Funding awarded to needy states since the 2000 reauthorization of the Ryan White CARE Act. The number of clients continues to increase at a steady pace. Expenditures are also increasing, due to a larger number of patients being served and the increasing cost of new medications.

Minority AIDS Initiative (MAI) funding has allowed increased services to address racial disparities and ensure African Americans are linked to ADAP services and medical care in four

high prevalence areas of the state. The focus of these programs is to encourage a smooth and timely transition into care after diagnosis, and also to bring persons who have been lost to care back into care.

ADAP continues to manage an Insurance Assistance Program. Besides covering copayments and deductibles, the Insurance Program also pays for premiums for patients meeting eligibility requirements, thus allowing individuals to maintain insurance coverage. This program has been highly cost effective and extremely beneficial to clients. During 2003, the Insurance Assistance Program served 389 individuals.

In a recent community services assessment survey conducted statewide with 54 medical providers, 38 (70%) were urban and 16 (30%) were rural HIV care providers. Unmet needs for rural providers include use of Internet resources and education to increase comfort with and knowledge of Highly Active Antiretroviral Therapy (HAART) guidelines. Unmet needs for all providers include education about providing counseling for established patients regarding HIV transmission risk reduction, substance abuse management, and HIV status disclosure.

One of the cross-cutting issues identified by HIV care providers is that many people with HIV are non-adherent in taking medications as prescribed and with keeping appointments for medical care. This is rooted in many causes, such as fears of government programs, fear of family members and others learning their HIV status, side-effects of medications, lack of funds to pay for medications, depression, and low self-esteem. Ryan White providers are facing ongoing challenges associated with HIV treatment costs and problems with adherence to the often complex drug regimens. The Ryan White Statewide Coordinated Statement of Need (SCSN) addressed the issue of HIV drug adherence as one of the priority goals for the state. Solutions include implementing education and counseling interventions for clients as well as training providers on adherence issues and how to assist clients with psychosocial and environmental support systems to facilitate adherence.

### **Perinatal HIV Prevention Services**

One of our greatest successes in HIV prevention is reducing mother to baby transmission. Routine screening of pregnant women and treatment for those infected continues to confine the proportion of infants born to HIV infected mothers who become infected to 2% each year from 14% in 1994. DHEC provides education and training opportunities to perinatal providers to ensure awareness of recommended screening and treatment guidelines. In 2004/2005, DHEC will participate in a CDC assessment of prenatal screening practices through medical chart review in eligible birthing hospitals to determine the proportion of pregnant women/infants receiving screening for HIV, syphilis, chlamydia, hepatitis B, Group B Streptococcus and rubella.

Services for infants born to HIV infected mothers are an essential component for perinatal HIV prevention. The South Carolina Ryan White Title IV program is a statewide, collaborative network of providers and organizations serving HIV exposed/infected infants, children, youth, women and their affected families, including male caregivers. DHEC's STD/HIV Division administers the program and oversees the performance of Title IV contractors and ten nurse case

managers in eight public health districts in the state. HIV specialty care is provided at three contracted, regional medical care facilities located across the state: Medical University of South Carolina (MUSC) in Charleston, University of South Carolina School of Medicine (USC) in Columbia, and the Greenville Hospital System (GHS). Each regional site has a case manager who works in conjunction with local public health nurse case managers (DHEC employees) to ensure that each family, including those living in very rural areas, receives appropriate follow-up, care coordination, and resource linkage based on medical and psychosocial needs. Expansion funding awarded in 2002 and 2003 established satellite specialty care clinics in rural areas challenged by the highest prevalence and incidence for HIV exposed/infected infants and distance to travel for specialty care: Florence (MUSC staffed), Sumter (USC staffed), and Spartanburg (GHS staffed).

In order to maintain these successes and to achieve elimination of perinatal HIV transmission in South Carolina, increased prevention strategies are needed that focus on women who receive inadequate or no prenatal care and on HIV-infected women with complex psychosocial issues who may not adhere to recommended antepartum or postpartum therapy and/or care plans. This will require increased provider training, increased coordination and linkages with existing systems of prenatal care providers and institutions, and specialized prevention case management services for HIV-infected pregnant women.

### **Preventing Homelessness: Housing Opportunities for People With AIDS (HOPWA)**

Many persons with HIV face increased risks of homelessness due to the impact of the disease on physical health and the high cost of care and treatment. The average cost of medications alone per year is approximately \$11,000. The Housing Opportunities for People With AIDS (HOPWA) grant from HUD provides funding to DHEC to help prevent homelessness. In addition, HUD directly funds the metropolitan statistical areas (MSAs) of Columbia, Charleston, Charlotte (includes York County), and Augusta (includes Aiken and Edgefield) to deliver HOPWA programs. Linkages to HOPWA services occur primarily through Ryan White case managers and local health department staff.

DHEC's HOPWA program continues to be a major portion of the delivery system of services to people and families living with HIV. Eleven contractors, experienced in providing a continuum of care for persons and families living with HIV/AIDS each year who are either homeless or at risk of becoming homeless, are recipients of HOPWA funds. Ten agencies provide short-term rent, mortgage and utility payments for persons with HIV/AIDS and their families. Project Care, a community residence in Greenville, continues to be funded through state HOPWA funding. Contractors also use HOPWA funds to provide case management and supportive services, and all are closely linked with Ryan White care providers. This assures a coordinated system of delivery to eligible persons and families with HIV/AIDS.

During FY 2004, DHEC's HOPWA funds for areas not covered by the direct-funded MSAs are expected to provide approximately 1500 eligible persons with Short Term Rent, Mortgage, and Utilities (STRMU) assistance and supportive services, and more than 300 eligible persons will receive supportive services not associated with housing assistance. It is estimated that 75

persons will receive tenant-based rental assistance. Identification of additional resources to use in leveraging HOPWA funding will be actively sought out.

Three long-term housing projects were funded in recent years: two tenant-based rental assistance projects, one in Fort Mill and the second in six rural counties surrounding Florence, and new construction of twelve units in Greenville. During FY 2003, an ongoing statewide tenant-based rental assistance program was developed. This focus on long-term housing is a response to the changing HIV epidemic and assessment/prioritization of permanent housing in South Carolina. In late 2004, an RFP will be issued for additional innovative long term housing to fill further housing needs of persons living with HIV in South Carolina.

Ongoing needs assessments with care and support service providers and with persons living with HIV indicate that, while there is variance around the state, there is a high demand for adequate, affordable housing. There are long waiting lists for subsidized housing, a lack of low-income, safe, and quality housing for low-income individuals, particularly single men with a history of substance abuse and incarceration. Specific types of housing needed include stable low-income housing, temporary shelters, advanced care facilities for those requiring medical assistance, and a hospice facility. None of the available shelters are prepared to provide quality assisted living for persons with HIV.

### **Substance Use Treatment and Mental Health Services**

Substance use treatment is primarily provided by the county alcohol and drug abuse facilities upon referral by counseling and testing staff and Ryan White care providers. Mental health services are provided through the local mental health centers and with a few consortia that have staff to provide psychosocial assessments and counseling. These two services remain two of the most often identified unmet needs, particularly in rural areas of the state. Access to substance use treatment or mental health services is often limited by a lack of treatment slots and inability to pay for services. State and local agencies have received significant state budget reductions in the past three years, resulting in reduced number of staff, facilities and services throughout the state.

### **Corrections Systems**

The state correctional facilities (SC Department of Corrections; SCDC) currently house all HIV-infected inmates in two facilities, one for men and one for women. This enables the SCDC to better coordinate care and support services to infected inmates. All new inmates receive mandatory HIV screening and if positive are placed in the designated facility. Recently, SCDC has an average of 500 men and 37 woman inmates who are HIV-infected. During the past four years, SCDC staff, state Ryan White Title II and Midlands Care Consortium staff have met to plan and develop a system of discharge to ensure inmates living with HIV are efficiently linked to the consortia and care services within thirty (30) days of release. This is to ensure a continuity of care and maintenance of therapies currently taken while in correctional facilities.

HIV/STD screening services are more limited for county/city jail inmates. This is primarily due to lack of financial and/or staff resources and, in some cases, a short incarceration time that

prohibits inmates who might be tested in a facility from getting results prior to discharge. HIV and syphilis testing is conducted in several county jails in conjunction with syphilis elimination efforts. Partner counseling and referral staff assist in providing test results counseling and referrals to care providers upon release.

Needs assessments have been conducted with both state- and county-released HIV-infected inmates to determine their most immediate health and social services needs. Results are shared with prevention and care providers to assist in development of improved discharge planning systems.

### **Key Recommendations for Enhancing Coordination and Linkages**

Provide and support ongoing opportunities for state and local HIV prevention providers to coordinate services through joint trainings, needs assessment activities, sponsorship of events, resource-sharing, development of evaluation plans, and continued collaboration.

Increase awareness of existing services and programs by other state and local agencies. Develop and enhance collaborative marketing strategies between such agencies and organizations as SC DHEC, the SC HIV/AIDS Council, AIDS service organizations, TEAM, the SC Primary Health Care Association, and others.

Recruit participation and/or membership from diverse agencies, non-governmental and community-based organizations, institutions, providers, and consumers for the SC HIV Planning Council, including mental health and substance use treatment services agencies.

Provide training and technical assistance to prevention and care providers to ensure they have culturally competent, client-centered skills to assess the range of health and social needs of clients in order to make appropriate referrals.

Continue to provide training and technical assistance to prevention and care staff on client-centered counseling skills and how to make active referrals.

Obtain input and ideas from the Consumer Advisory Committee of the SC HIV/AIDS Council on best approaches to increase awareness of target populations' knowledge of prevention and care services and the skills necessary to access and navigate the "system."

Coordination efforts should continue among prevention providers, as well as between prevention and care providers, to identify and resolve barriers to linkages to related services, integrating training and needs assessment efforts as appropriate to avoid duplication, and to maximize existing resources.

Providers should explore options to enhance linkages from prevention to care services by using peers or near-peers as "bridges" to services, incentives, and seamless systems of prevention and care.

## **CHAPTER6: GOALS**

### **1. Community Planning**

- Support broad-based community participation in HIV prevention planning.
- Identify priority HIV prevention needs (a set of priority target populations and interventions for each identified target population), with HIV-infected persons prioritized as the highest priority and uninfected, high-risk populations prioritized based on community needs.
- Ensure that HIV prevention resources target priorities set forth in the Comprehensive HIV Prevention Plan.

### **2. Counseling, Testing, Referral, and Partner Counseling and Referral Services**

- Provide individuals a convenient opportunity to learn their current HIV serostatus, and participate in counseling to help initiate and maintain behavior change to avoid infection, or if already infected, to prevent transmission to others.
- Implement and maintain a system to ensure clients who are HIV positive receive appropriate counseling and are entered and maintained in an appropriate system of care, including prevention services.

### **3. Partner Counseling and Referral Services (PCRS)**

- Provide confidential, voluntary, client-centered counseling and referral of sex and needle-sharing partners of HIV-infected persons.

### **4. Prevention for HIV Infected Persons**

- Increase opportunities for HIV infected persons and persons with negative or unknown serostratus at very high risk of infection to participate in programs designed to promote the adoption and maintenance of HIV risk-reduction behaviors.

### **5. Health Education/Risk Reduction (HE/RR)**

- Provide individual, group and community level HE/RR activities in accordance with prioritized target populations and interventions identified in the Comprehensive HIV Prevention Plan.
- Provide resources to minority and other community-based organizations to implement HE/RR activities.

### **6. Public Information**

- Provide a variety of public information activities to general audiences to dispel myths and address barriers to effective prevention programs, and to persons at increased risk for HIV and STDs to support efforts for personal risk reduction and assist in locating available prevention and care resources.

### **7. Perinatal Prevention**

- Provide prevention services to HIV infected women or high risk negative women who are likely to become pregnant to reduce the likelihood of transmission to their infant.

### **8. Quality Assurance**

- Develop and implement quality assurance procedures and training for staff providing prevention services including contracted organizations.
- Conduct periodic site visits and progress reviews to ensure the quality of HIV prevention programs.

### **9. Monitoring and Evaluation**

- Develop a comprehensive evaluation plan and conduct process and outcome evaluation according to guidelines and requirements established by CDC for HIV Prevention Programs.
- Conduct periodic site visits and progress reviews to monitor implementation of prevention programs.

### **9. Capacity-Building**

- Provide capacity-building assistance to HIV prevention service providers, and other prevention agencies/partners to:
  - (a) Strengthening organizational infrastructure, including financial management and compliance with grant regulations;
  - (b) Enhancing the design, implementation, and evaluation of HIV prevention interventions,
  - (c) Developing community infrastructure, and
  - (d) Strengthening HIV prevention community planning.
- Provide capacity-building assistance to staff of health department HIV prevention programs and staff, e.g., counseling and testing programs and PCRS.
- Provide capacity building assistance to CBOs to provide outreach testing, including the use of rapid tests.
- Increase the capacity of medical providers to provide routine HIV testing, including the use of rapid HIV tests.
- Provide capacity-building assistance to develop, pilot, and sustain prevention interventions for persons living with HIV/AIDS and other prioritized target populations.

### **10. Access to STD Diagnosis and Treatment:**

- Provide continued coordination and integration of HIV prevention and STD screening and treatment programs to reduce transmission of HIV and other STDs.

## **CHAPTER 7: SURVEILLANCE AND RESEARCH**

This Chapter summarizes on-going HIV surveillance and research activities and program evaluation efforts, how surveillance and research information are linked to the strategies in the plan, and recommendations for additional surveillance and research needed to enhance HIV prevention planning and evaluation in South Carolina.

### **1. Surveillance**

#### **Tracking the Epidemic**

The Introduction section of Chapter 1 “Epidemiologic Profile” contains a detailed description of HIV/AIDS surveillance systems in South Carolina. DHEC carefully monitors the status of HIV/AIDS and other sexually transmitted diseases enabling providers to implement strategies in communities around the state based on our best understanding of the epidemic.

In order to monitor the HIV epidemic in South Carolina, state law requires physicians, hospitals, laboratories, and other health facilities to report diagnosed HIV infection and AIDS cases to DHEC. The information obtained from health care providers includes risk factors, age, sex, race and geographic location. Follow-up with persons diagnosed with syphilis and HIV infection is conducted by health department staff to provide partner notification, confidential testing and counseling services, treatment, and referral to medical and support services. Surveillance data are also used to plan and design prevention and care programs to target persons most at risk for sexually transmitted diseases and HIV infection.

Active surveillance activities include routine visits with hospitals and infectious disease physicians to identify cases and complete CDC case report forms; comparisons with other data sources such as death certificates, TB registry, and the AIDS Drug Assistance Program.

Most reports of HIV infection and AIDS are initially laboratory based. All laboratories who conduct business in South Carolina are required to report to the health department all HIV infection or AIDS diagnosis when serum, urine, or oral fluid specimen is positive by screening test (EIA antibody), confirmatory test (Western blot) or an HIV detection test (PCR nucleic acid test, including viral load). In January 2004, laboratories were required to report all CD<sub>4</sub> and viral load (VL) tests regardless of test results.

South Carolina also receives CDC funds for the Enhanced Pediatric Surveillance project that analyzes medical record and other data to evaluate the effectiveness of perinatal HIV prevention efforts. Staff analyze the proportion of HIV infected pregnant women who have knowledge of their serostatus prior to delivery, proportion of HIV infected women prescribed antiretroviral therapy during pregnancy, labor and delivery and neonatal period, proportion of HIV infected women receiving cesarean sections, and selected birth outcomes. Each case of pediatric HIV infection due to perinatal transmission is analyzed to determine which prevention step was missed in order to identify follow-up training, education, or protocol development to ensure no missed opportunity for prevention.

Evaluation of key surveillance performance measures indicates South Carolina's surveillance system meets or exceeds CDC's performance criteria for 3 of 4 indicators: timeliness of reports, completeness of reports, and accuracy (duplication). See Table 9.1 below.

**Table 9.1 South Carolina HIV Reporting Performance Compared to CDC Minimum Standards**

<b>Performance Indicator</b>	<b>CDC Standard</b>	<b>South Carolina Performance</b>
<b>Completeness of Reporting</b>	≥85%	98%
<b>Timeliness of Reporting</b>	≥ 66% within 6 months of diagnosis	90%
<b>Accurateness of Reporting</b>	≤ 5% duplicate case counts & ≤5% incorrectly matched reports	0.06%
		1.4%
<b>Complete Behavioral Assessment</b>	85% of cases with behavioral risk	66 %

The CDC-funded Supplemental HIV/AIDS Surveillance (SHAS) project conducted 1991 – April 2004 obtained sociodemographic, health care, sex and substance use behaviors, and reproductive health information on newly diagnosed persons with HIV infection in five counties (urban and rural areas). Trained interviewers collected information using a standardized instrument. This project will be replaced by the Morbidity and Risk Behavior Surveillance Project in 2005, which is explained further in this Chapter.

Surveillance staff analyze and disseminate HIV (and other STD's) surveillance data to multiple prevention and care providers, media, community organizations, and others. Surveillance data is used extensively to develop the Epi Profile for HIV prevention community planning; data files are produced for local HIV prevention collaborations for local planning efforts; data by Ryan White service area is produced for care planning. Numerous custom reports are produced for legislators, local agencies, media, and others for grant writing, policy decisions, state health publications, progress reports and program planning and evaluation efforts.

Quarterly STD/HIV/AIDS surveillance reports are completed and posted on the South Carolina Department of Health and Environmental Control web site: <http://www.scdhec.net/HS/diseasecont/stdwk/html/surveillance.htm>. This web site includes data reports from the Counseling and Testing Sites, and the Supplemental HIV/AIDS Surveillance Project (SHAS). Reports are run for various demographic indicators (age, sex, race, and geographical areas) and behaviors (modes of transmission).

### **Linkage of Surveillance Data to HIV Prevention Programming**

As mentioned above, surveillance data were used extensively by the CPG to determine priority populations, unmet needs, describe risk behaviors, and evaluate specific prevention efforts. These data are reflected through out this prevention plan.

In addition, surveillance data are used to determine prevention and care funding allocations to local health districts, HIV prevention collaborations, and HIV care consortia.

One of the goals of a prevention system is to reach people who may have no knowledge of their risk of HIV infection. A key strategy to reach people is partner counseling and referral (PCRS). Surveillance data are essential to initiate partner counseling and referral services in South Carolina. All newly reported cases are provided to local disease intervention specialist staff for follow-up partner counseling services. Newly reported persons are contacted confidentially and referred for counseling and voluntary partner identification. Named or identified sex and needle-sharing partners are contacted and referred for HIV counseling and testing services.

Many persons contacted, particularly women, have no awareness of their past or current HIV risk or that of their partner. Because they do not perceive their risk, they are unlikely to actively seek information on HIV or get tested. For many persons, the partner counseling and referral process is essential for them to learn of their risk and steps to reduce it, and to learn their HIV status. Counseling and testing data indicate that partners of HIV infected persons consistently have the highest positivity rates (19.3% of partners tested in DHEC clinics were positive in CY 2003), indicating the effectiveness of PCRS in targeting at-risk individuals. Referrals to medical care, support groups, substance use treatment, prevention case management, community-based organizations are provided to clients at the time of PCRS.

Surveillance data, particularly HIV and syphilis are also used to identify counties and areas of highest rates that are used to identify locations for the mobile van screening services.

Finally, pediatric surveillance data on HIV-exposed infants is used by local case managers to refer mothers/infants to the Title IV children's care system, and to monitor if subsequent testing has been done for final HIV status determination. (About 25% of HIV exposed infants will become infected without proper treatment; with treatment the risk drops to 8% or less. Most infants' true HIV status can be determined by 18 months of age.)

### **New Surveillance Initiatives for 2005**

#### **HIV Incidence and Resistance Surveillance**

Incidence of HIV infection in the United States, that is, the number of individuals recently infected and diagnosed as having HIV, has not been measured. However, new serologic (blood) testing methods have been developed that distinguish between recent and log-standing HIV-1 infection, which would allow for the determination of national HIV incidence surveillance data. One of these tests is the Serologic Testing Algorithm for Recent HIV Seroconversion, or STARHS. STARHS is an experimental blood test that is part of an Investigational New Drug process overseen by the US Food and Drug Administration (FDA). South Carolina, in collaboration with CDC, is participating in incidence surveillance. Using both the STARHS test and information about a person's HIV testing history, CDC will develop estimates of actual incidence among populations, such as African American women or MSMs. For example, this information will help us try to tell if a person was infected with HIV recently or a long time ago.

Prevention programs can use this data to more effectively target efforts to populations that are recently infected. Incidence data can also be used over time to evaluate the success or impact of prevention efforts in slowing HIV transmission among certain populations.

The HIV incidence project will be introduced in the current South Carolina HIV/AIDS surveillance system in two phases: Phase I STARHS will initiate in January 2005 with persons newly diagnosed and tested through the DHEC Bureaus of Labs. Phase II will be offered by December 2005 to persons newly diagnosed and tested by non-DHEC providers/laboratories.

South Carolina will also be participating in a new surveillance effort by CDC to determine the prevalence of antiretroviral drug resistance (ARVDR) among newly diagnosed persons with HIV infection in public health settings or settings collaborating with public health departments. In 2005, a routine test will be conducted to detect the presence of genetic mutations associated with HIV ARVDR. Clients will designate a clinical caregiver to receive the ARVDRT result which will be used to determine appropriate antiretroviral treatments for the client.

### **Morbidity and Risk Surveillance Project**

South Carolina is one of 20 states selected by CDC to participate in a new surveillance project called Morbidity and Risk Behavior Surveillance starting late 2004 through May 2008. The purpose of the Morbidity and Risk Behavior surveillance project (MRBS) is to develop a supplemental HIV/AIDS surveillance system that will produce population-based estimates of characteristics of persons with HIV infection and the care they receive. This supplemental data will provide essential information needed by HIV care and prevention providers in South Carolina to understand the provision and impact of treatments for HIV, health care utilization, ongoing HIV risk behaviors, care seeking behaviors, quality of life for persons with HIV infection and acceptance of and adherence to prescribed antiretroviral therapy.

These data will also be very important to assist in evaluation of CDC's new prevention initiatives required by state health departments and Ryan White care providers to provide prevention services to persons living with HIV. Data will be obtained through medical record abstractions and patient interviews on a randomly selected national probability sample of approximately 400 persons annually. Both prevention and care providers will use patient interview information on risk behaviors and care-seeking behaviors to enhance current profiles or descriptions of our priority populations and incorporate in the SC HIV Prevention and Care Services Plan. Prevention staff will also incorporate project data in state/regional prevention program evaluation efforts.

### **Recharacterization of NIR's**

In the 2002 – 2004 SC HIV Prevention Plan, one of the surveillance needs described was to create a mechanism to better characterize heterosexual transmission cases and reduce the high number of cases with a “no identified risk” (NIR) category. In April 2004, DHEC surveillance staff began recording risk information beyond the CDC-defined risk categories. The list of risks documented are:

- Sexual intercourse with an infected person of the opposite sex
- Heterosexual prostitution (sex work or exchange of sex for money or drugs)
- Sexual contact with a prostitute of the opposite sex

- Multiple sex partners of the opposite sex (three or more partners after 1977 and before first HIV positive test)
- Sexually transmitted disease
- Crack/cocaine use
- Immigration from a country where heterosexual transmission of HIV predominates

This data will provide more insights on risks among persons with HIV determined as NIR by CDC; additionally, it will provide further risk information on the cases with a CDC-defined risk, such as a person with MSM risk and who also reports crack/cocaine use. All risk information collected is based on client-self report or provider information.

### **Additional Surveillance Needs**

The HIV community planning group, HIV prevention and care providers, and STD/HIV health department staff have identified the following priority supplemental surveillance needs in order to improve the prevention and care planning process, delivery of interventions, and evaluation of overall prevention and care efforts. The priority areas are:

- Behavioral Surveillance among HIV infected and Non-infected Populations
- Estimating HIV Incidence
- Clinical Outcomes

### **Behavioral Surveillance among HIV infected and Non-infected Populations**

A top priority need remains collecting behavioral data for HIV infected and non-infected priority populations. Behavioral information needed among HIV infected persons includes risk behaviors (sexual and drug-related); use of prevention services; access-to-care issues (medical care, sources of payment); types of partners; HIV testing history; identification of venues frequented and adherence to medications. South Carolina will rely largely on the three new surveillance activities described above to obtain this data (Morbidity and Risk Behavior Surveillance project, HIV incidence, and the recharacterization of NIR's).

Behavioral data needed for non-infected priority populations includes risk behaviors (sexual, drug related); use of prevention services; HIV testing history; types of partners; identification of venues frequented, and education to prevent HIV infection. South Carolina DHEC will rely on several data sources to obtain behavioral information for non-infected persons:

- Partner notification interview data among HIV partners and syphilis cases
- Behavioral assessment surveys conducted by organizations conducting community based HIV counseling and testing
- Revised CDC-defined risk data for HIV counseling and testing sites (this will include more information about substance use, types of partners, sexual risks, housing status, etc. than currently collected). This data will begin to be collected July 2005.

In addition, DHEC will use the CDC-sponsored behavioral surveys of youth and adult populations:

- Youth Risk Behavior Surveillance survey data among high-school age youth (includes information about condom use, sexual activity and substance use among sample of South Carolina students)

- Behavioral Risk Factor Surveillance survey data among randomized sample of South Carolina adults through telephone interviews (includes information about HIV testing behavior, knowledge of HIV prevention and treatment, and limited risk behavior data).

### **Estimating HIV Incidence**

Surveillance staff have identified a priority technical assistance need to facilitate HIV incidence estimation. This includes developing statistical models for estimation, introduction to STARHS test and methods for estimating incidence using HIV incidence surveillance data. South Carolina will obtain this technical assistance from CDC.

### **Clinical Outcomes**

Collection of clinical outcomes data for persons with HIV/AIDS is also an identified supplemental surveillance need. This data includes health care utilization (frequency, continuity of care); laboratory data (CD4, viral load tests); prevalence of antiretroviral resistance, immunization and prophylactic services; opportunistic infections; prescription and adherence to antiretroviral medications. Clinical outcomes data will be essential to better evaluate Ryan White care services, meet HRSA reporting requirements, estimate unmet care needs and identify care and treatment training/technical assistance needs. South Carolina will rely largely on the Morbidity and Risk Surveillance project and Resistance Surveillance initiative to obtain this data.

### **Emerging Populations**

In addition to the above priority supplemental surveillance data needs, there is a need to obtain more information about the prevalence of HIV infection and risk behaviors among Hispanic/Latino populations in South Carolina, which is identified as an emerging population. Periodic HIV testing among Latino populations in clinic and community settings will assist in obtaining more data.

## **2. Research**

### **Learning More About Our Populations and Program Effectiveness**

Research in this Plan is defined as activities to acquire information and knowledge to provide further insights and descriptions of systems, provider and population needs which is used to guide planning and programming for more effective HIV prevention services. Research is not defined here as scientific research to determine cause-effect relationships.

A review of the recently updated epi-profile indicates a continued apparent decline in new HIV cases among injecting drug users (70 cases were diagnosed in 2001 vs 41 in 2003). Also of note, is an apparent decline in the number and rate among African American men: the rate per 100,000 population in 2001 was 94.1 vs 72.4 in 2003. African American men had the greatest

decline in annual rate of new cases diagnosed. It is not known if this is truly declining prevalence/incidence or a reflection of a decline in testing among these populations. Particularly among African American men, prevention experts believe many are not accessing HIV testing services due to fears of stigma and discrimination. Prevention program efforts to more effectively reach these populations are needed along with strong program research and evaluation to determine the impact of programs to successfully reach these populations.

During the next three years, three broad areas for research are listed below with key questions. These questions reflect the needs identified by the CPG, DHEC and prevention providers as a result of completing priority setting and needs assessments for this Plan. It is expected that CDC/NIH demonstration project results, literature reviews, and enhanced surveillance efforts, needs assessments and evaluation efforts in South Carolina will focus on answering these questions.

**1. Intervention Effectiveness Research**

- What interventions are most effective in changing HIV risk behaviors for each of our priority populations?
- How does intervention effectiveness vary in terms of race/ethnicity, sexual orientation, age and other diversity?

**2. Research on the HIV Epidemic in South Carolina**

- What is the estimated incidence of HIV infection among our priority populations?
- What is the estimated prevalence of risk behaviors among our priority populations?
- Which identifiable subpopulations within MSM, at-risk heterosexual, and IDU populations are most at risk of becoming infected with HIV and should be targeted with prevention interventions?
- How is the overall rate of HIV infection changing? How does this vary by race/ethnicity, age, sex and county of residence?

**3. Research on HIV Prevention Programming in South Carolina**

- According to our priority populations, what are the best mechanisms to reach and attract them to our services?

- What are the social networks of our priority populations and in what locations do they interact?
- What are the locations of high –risk behavior and how would we conduct our services at or near these locations?
- According to our priority populations, what assets or strengths do they have to support prevention efforts in their communities?
- According to our priority populations, what life circumstances have led them to HIV infection?
- What proportion of our priority populations have been reached by specific interventions?
- What proportion of our priority populations have been referred and successfully linked to other primary and secondary prevention services?
- What are the technical assistance/training needs of our prevention providers?
- How effective is our comprehensive prevention system in impacting changes in knowledge, behaviors and HIV transmission?
- How would we develop an outcome monitoring system to evaluate the effectiveness of prevention interventions on our populations?

**Key Recommendations for Surveillance and Research:**

Improve the prevention and care planning process, delivery of interventions, and evaluation of overall prevention and care efforts through conducting supplemental surveillance efforts for :

- Behavioral Surveillance among HIV infected and Non-infected Populations
- Estimating HIV Incidence
- Clinical Outcomes

Ensure that the community planning needs assessment process and prevention interventions address the framework of research questions listed.

## **CHAPTER 8: TECHNICAL ASSISTANCE NEEDS ASSESSMENT AND PLAN**

Capacity building, training, and technical assistance are provided to health department staff, HIV prevention providers, and other prevention partners to build their capacity to provide HIV prevention services including outreach, testing, PCRS, and prevention for people living with HIV.

Capacity building and technical assistance needs are identified through a variety of strategies including the following:

- 1) periodic surveys of the providers delivering HIV prevention services,
- 2) evaluations of workshop participants at the conclusion of each training event conducted throughout the year to determine additional training/capacity building needs,
- 3) survey of training and capacity building needs at quarterly meetings of local public health district staff and the prevention contractors,
- 4) evaluation of monthly CPG meetings including future training needs, and
- 5) supervisory staff input based on site visits and review of quarterly narrative progress reports.

Based on the findings from these various assessment strategies capacity building and technical assistance are provided in a number of ways including monthly training workshops, site visits from state SC DHEC staff, periodic meetings, conferences, and on-site technical assistance from CDC's network of national CBA providers.

This chapter of the plan describes:

- 1) needs assessment data from a survey conducted in the Fall 2003,
- 2) needs identified by workshop participants for January – June 2004,
- 3) needs identified by CPG members in 2003 through 2004,
- 4) needs identified by minority CBOs in 2004, and
- 5) concludes with an overall summary of needs and recommendations for activities over the next four years.

### **Survey of Capacity Building Assistance/Technical Assistance Needs**

In October and November of 2003 the STD/HIV Division staff mailed a training needs assessment survey to HIV/AIDS staff in 13 Public Health Districts and to HIV prevention staff at 14 HIV prevention organizations funded by SC DHEC. DHEC personnel were given the option of completing the survey on-line through the agency's intranet or to complete a paper pencil version. Contractors were asked to make copies of the survey and have appropriate staff complete and return the survey to the agency. The Division received 43 surveys from 12 Health Districts (seven were completed on-line) and 17 surveys from nine of the 14 HIV prevention contractors for a total of 60 surveys. Using the organization as the unit of analysis the return rate for the health districts was 92 percent and the return rate for the HIV prevention contractors was 64 percent. The overall return rate was 78 percent.

The following tables provide information on the respondents (n=60).

<b>Professional Background</b>	<b>DHEC</b>	<b>HIV Prevention Contractors</b>
DIS	8	0
Nurse	15	0
Health Educator	9	12
Social Worker	9	1
Other	2	4

<b>Licenses and Certifications</b>	<b>DHEC</b>	<b>HIV Prevention Contractors</b>
CHES	3	1
LMSW	6	1
LISW	3	
RN	15	
CRNP	2	
<b>Number of Years in HIV/STD Field</b>	<b>DHEC</b>	<b>HIV Prevention Contractors</b>
< 1 year	3	0
1 – 3 years	6	7
> 3 – 5 years	5	0
> 5 years	28	10
No Answer	1	0

The survey included training topics by categories. Respondents were given the following response options to choose from; 1) Really needed, 2) Somewhat needed, 3) Not needed, 4) Don't know topic and 5) Not relevant to my job.

The first category of training topics was *STD/HIV Introductory Topics*. Topics were generated from the current list of trainings DHEC offers or coordinates through the Division's training coordinator. The following table includes the percentage of respondents, by professional background that indicated the topic was really needed or somewhat needed.

Basic STD facts	38	40	48	40	50
HIV/AIDS 101 (Starter Facts)	38	53	33	30	50
HIV and SC laws	63	73	86	60	100
<b>STD/HIV Introductory Topics</b>	<b>DIS (n=8)</b>	<b>Nurse (n=15)</b>	<b>Health Ed (n=21)</b>	<b>SW (n=10)</b>	<b>Other (n=6)</b>
Fundamentals of HIV prevention counseling	75	60	62	30	67
HIV Prevention counseling addressing youth issues	63	87	76	60	67
Addressing issues of HIV prevention for men who have sex with men	63	80	81	70	83

American Red Cross African American HIV Education & Prevention Instructor Course	25	47	57	50	67
American Red Cross Hispanic HIV Education & Prevention Instructor Course	38	67	76	40	50

The second training topic focused on the Implementation of HIV/AIDS Prevention Programs. Three specific categories were used to assess respondents training needs. The numbers represent the percentage of respondents that selected “Really needed” or “Somewhat needed” from the response options.

<b>HIV Education Skills</b>	<b>DIS (n=8)</b>	<b>Nurse (n=15)</b>	<b>Health Ed (n=21)</b>	<b>SW (n=10)</b>	<b>Other (n=6)</b>
Presentation/Facilitation Skills	75	73	62	80	100
Group Dynamics	25	80	71	80	100
Conflict resolution	75	93	67	80	100
Recruitment and retention of program participants	75	73	76	70	100

<b>Interventions for High Risk Negatives</b>	<b>DIS (n=8)</b>	<b>Nurse (n=15)</b>	<b>Health Ed (n=21)</b>	<b>SW (n=10)</b>	<b>Other (n=6)</b>
Individual-level Intervention	88	80	62	60	83
Prevention Case Management	88	47	48	50	83
SISTA (African American Women)	38	53	76	60	67
VOICES (African American & Hispanic heterosexual men & women)	50	60	76	70	83
Mpowerment (Men who have sex with Men)	50	60	71	70	83
Partners in Prevention (Male Version)	50	67	86	70	83
Partners in Prevention (Female Version)	50	67	81	70	67
Popular Opinion Leader (Men who have sex with men)	50	60	76	60	100
Community Promise (Non-gay identified men who have sex with men)	50	53	71	60	100

<b>Interventions for HIV Positives</b>	<b>DIS (n=8)</b>	<b>Nurse (n=15)</b>	<b>Health Ed (n=21)</b>	<b>SW (n=10)</b>	<b>Other (n=6)</b>
Individual-level Intervention	63	80	81	90	100
Prevention Case management	75	67	71	90	83
Group-level skills building interventions	50	60	71	80	100
Group-level support group interventions	50	60	76	90	100

The third training topic was *Evaluation of HIV/AIDS Prevention Programs*.

<b>Evaluation of HIV/AIDS Prevention Programs</b>	<b>DIS (n=8)</b>	<b>Nurse (n=15)</b>	<b>Health Ed (n=21)</b>	<b>SW (n=10)</b>	<b>Other (n=6)</b>
General descriptions of evaluation (how to/why to do it)	50	60	67	50	67
Developing program goals, objectives	38	73	62	60	100
Developing program logic models to determine what data/indicators to collect	75	73	62	40	83
Selecting/developing appropriate instruments	63	73	67	30	83
Conducting data collection	75	67	76	20	83
Conducting data analysis	63	80	81	20	83
Reporting evaluation findings	63	73	71	30	83
Making evaluation findings useful	63	73	76	50	83
Training program staff in evaluation skills	63	73	57	50	83

The final training topic was *HIV/AIDS Treatment and Management*.

<b>HIV/AIDS Treatment and Management</b>	<b>DIS (n=8)</b>	<b>Nurse (n=15)</b>	<b>Health Ed (n=21)</b>	<b>SW (n=10)</b>	<b>Other (n=6)</b>
Promoting treatment adherence in HIV care	75	87	62	80	83
Antiretroviral therapies	50	93	48	60	83
Treatment sequencing	38	87	33	30	50
Viral Load/CD4 measurements/resistance testing	88	80	38	40	67
Post exposure prophylaxis	63	80	38	20	50
HIV primary care/HIV treatment guidelines	88	87	38	60	100
Opportunistic Infections	88	87	57	90	100
Hepatitis (A, B, & C) & HIV	100	80	52	80	100
Other STDs & HIV	75	80	67	80	100

TB & HIV	100	80	62	70	100
Nutrition	63	87	67	80	67
Pain management & comfort issues/palliative care	50	60	33	60	50
Peripheral neuropathy	25	60	29	30	33
Perinatal transmission	63	80	52	50	83
Interview skills/taking a sexual history/risk assessment	88	87	76	60	100
How to do appropriate referrals/follow up with referrals	88	73	76	50	100
Dental/oral care	63	67	48	60	50

The following is a list of some of the priority training needs identified by professional background.

### **DIS**

Hepatitis (A, B, & C) & HIV  
 TB and HIV  
 Interview skills/taking a sexual history/risk assessment  
 How to do appropriate referrals/follow up with referrals

### **Health Education**

HIV and SC laws  
 Partners in Prevention Curriculum (male and female versions)  
 SISTA Curriculum  
 Conducting data analysis

### **Other professions**

HIV and SC laws  
 Group dynamics and conflict resolution skills  
 Group level skills building interventions for HIV positives  
 Hepatitis (A, B, & C) and HIV

### **Nursing**

Conflict resolution skills  
 Antiretroviral therapies  
 HIV prevention counseling addressing youth issues  
 Promoting treatment adherence in HIV care

### **Social Work**

Promoting treatment and adherence in HIV care  
 Group dynamic and conflict resolution skills  
 Opportunistic infections  
 Nutrition

### **The following topics received a 70 percent or higher rating by at least four of the professions.**

Presentation/facilitation skills  
 Group dynamics  
 Conflict resolution  
 Recruitment and retention of program participants  
 Individual level intervention for HIV positives  
 Prevention case management for HIV positives  
 Promoting treatment adherence in HIV care  
 Opportunistic infections  
 Hepatitis (A, B, & C) and HIV

**Other STDs and HIV**

**TB and HIV**

Interview skills/taking a sexual history/risk assessment

How to do appropriate referrals/follow up with referrals

Survey results have been shared with the HIV prevention contractors and health department professionals at quarterly meetings. Information from the survey was used to set priority training events for the next two years. The survey will be repeated in 2006.

**Summary of Training Needs Identified By Workshop Participants**

DHEC’s STD/HIV Division coordinates monthly training workshops. During the period of January 1, 2003 through December 31, 2003 forty-three (43) training events were provided reaching 1,181 participants.

The following training opportunities were provided: Fundamentals of HIV Prevention Counseling, Issues of Men Who Have Sex with Men, American Red Cross HIV/AIDS Starter Facts, American Red Cross African American and Hispanic HIV Education and Prevention Instructor Course interventions, SISTA Project Intervention training, HIV Prevention Counseling Addressing Issues of Youth, and Prevention Case Management training, Update on Rapid Test for HIV, Assessing Client Readiness.

These training opportunities represent collaborative efforts with the Dallas STD/HIV Behavioral Intervention Training Center, the Emory Regional Training Center, the Florida STD/HIV Training Unit of the Florida Health Department, Jackson State University’s Mississippi Urban Research Center, and the American Red Cross.

At the end of each training event, participants were asked about their on-going training and technical assistance needs. Below is a summary of needs identified in 2003:

<ul style="list-style-type: none"> <li>• Financial management and board training for community based organizations.</li> <li>• Counseling the HIV+ clients.</li> <li>• How to interpret HIV lab results.</li> <li>• Counseling skills for preemptive positives.</li> <li>• HIV 101</li> <li>• HIV 101 with a focus on African Americans and HIV.</li> <li>• Issues with MSM.</li> </ul>	<ul style="list-style-type: none"> <li>• MSM and Drugs</li> <li>• Ora-Quick certification process.</li> <li>• Prevention interventions with HIV+ women.</li> <li>• SISTA project</li> <li>• STDs</li> <li>• Contraceptives. lesbians.</li> </ul>
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**CPG Needs**

At the conclusion of each monthly meeting of the CPG, members are asked to evaluate the meeting and to respond to the question “What topics would you like to know more about or receive training in?” Below is a summary from Calendar Year 2003 and 2004:

<ul style="list-style-type: none"> <li>• Survey Composition – How to develop an effective evaluation tool</li> <li>• Effective interventions for priority populations in South Carolina</li> <li>• General overview of the Community Planning Process and an explanation of how the CPG fits in the overall state (S.C.) prevention scheme</li> <li>• How to Reach the Hispanic Community</li> <li>• Effective ways to educate your legislative delegation and local elected officials</li> <li>• How to conduct a local needs assessment</li> <li>• Outcome evaluation tools (software)/PEMS training</li> <li>• How to effectively get HIV positive consumers involved in the planning process</li> <li>• Overview of linkages between care &amp; prevention</li> </ul>	<ul style="list-style-type: none"> <li>• Overview of services available to HIV positive consumers around the state (S.C.)</li> <li>• How to market/implement Group Level Interventions (GLI) in rural communities</li> <li>• An overview of the Transgender population in S.C. and transgender mental health issues</li> <li>• How to integrate abstinence education into a comprehensive HIV education program</li> <li>• Advancing HIV Prevention Initiative and how it impacts S.C.</li> <li>• How to get young people involved in the planning process</li> <li>• National training opportunities on Interventions that the CDC says are proven and effective interventions</li> <li>• How to set up a support group in a setting that’s nontraditional (housing complexes)</li> </ul>
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Some of the training needs of the CPG are integrated within the monthly meetings, some needs are addressed by making them aware of the training calendar of scheduled workshops and events.

**HIV Prevention Contractors**

Staff for HIV prevention contractors attend quarterly meetings and also provide written quarterly narrative reports. Some of the CBA and TA needs identified during 2003 included:

<ul style="list-style-type: none"> <li>• Evaluation forms and processes</li> <li>• Effective behavioral interventions (compendium)</li> <li>• Fiscal accountability, budget development, and financial management.</li> </ul>	<ul style="list-style-type: none"> <li>• Designing outcome evaluation tools/questionnaires</li> <li>• Needs assessment</li> <li>• Organizational/Board development and planning.</li> </ul>
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**Local Health Department Staff**

Disease Intervention Specialist (DIS), nurses, social workers, and HIV/AIDS Health Educators (AHEDS) are located in 12 public health districts across the state, and provide counseling and testing, partner counseling and referral services, prevention case management, Health Education/Risk Reduction and Health Communication/Public Information programs. Local health department staff meet quarterly with the state department consultants and are asked to indicate any training or technical assistance needs they may have. Below is a summary of needs identified:

<ul style="list-style-type: none"> <li>• Comprehensive School Health Education requirements for HIV/STD education</li> <li>• Orasure testing</li> <li>• Developing local intervention plans</li> <li>• Update Federal Materials Review Process</li> <li>• Evaluation</li> <li>• Effective behavioral interventions (compendium)</li> <li>• Hispanic outreach and interventions</li> </ul>	<ul style="list-style-type: none"> <li>• Enhanced surveillance initiatives</li> <li>• Partnerships with CBO organizations</li> <li>• Syphilis elimination efforts</li> <li>• Updates on national events.</li> <li>• Updated statistics.</li> <li>• Changes in policies/procedures.</li> <li>• Quality assurance.</li> </ul>
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**Needs Identified By State Division Consultant Staff**

STD/HIV Division staff provide on-going site visits to assure the quality of programs, and to conduct monitoring and evaluation activities. As a result they are able to make observations about practice needs of staff. In addition, state staff also conducting monitoring and evaluation site visits to HIV prevention contractors. Again, they are able to make observations about practice needs. In addition, as new activities or requirements are mandated by CDC, Division staff must provide training and follow-up to assure these activities are being conducted. Often as a result, needs are identified. As a result of the Advancing New Initiatives for HIV Positives and the development of the Program Evaluation and Monitoring System (PEMS) Division staff have provided and will continue to provide training and technical assistance on the implementation of these two CDC initiatives.

**Office of Minority Health Survey of MCBOs**

The STD/HIV Division has worked collaboratively with SC DHEC’s Office of Minority Health (OMH) in conducting a demonstration project around providing technical assistance to Minority Community Based Organizations (MCBOs). OMH has developed a list MCBOs providing HIV prevention and has provided numerous workshops over the last three years to build their capacity including grant writing, obtaining 501(c) 3 status, how to obtain and use technology such as the use of computers and internet, understanding epidemiological data, meeting the needs of African American men, meeting the needs of other special populations. Based on a capacity building needs assessment conducted in May 2004 by staff of the national Office of Minority Health Resource Center, the following 10 categories are the top needs among the MCBOs:

<p>1) Organizational Development (35)</p> <ul style="list-style-type: none"> <li>a) How to manage money</li> <li>b) Vision/Mission</li> <li>c) Board Development/Staff Development</li> <li>d) Fiscal Development</li> <li>e) Accountability</li> <li>f) Bylaws</li> </ul> <p>2) Program Evaluation (31)</p> <ul style="list-style-type: none"> <li>a) Data collection instruments</li> <li>b) Outcome measures</li> </ul>	<p>5) Grant Writing/ Fund Development (24)</p> <ul style="list-style-type: none"> <li>a) How to write winning proposals</li> <li>b) Identifying unrestricted Funds</li> <li>c) Engaging Corporate America</li> </ul> <p>6) Prevention with Positives (21)</p> <ul style="list-style-type: none"> <li>a) Best practices</li> <li>b) Linking &amp; Collaborating</li> <li>c) Building capacity of medical providers</li> </ul> <p>7) Community Needs Assessment (19)</p>
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<ul style="list-style-type: none"> <li>c) Developing logic models</li> <li>d) Effective measurements/tools</li> </ul> <p>3) Social Marketing (29)</p> <ul style="list-style-type: none"> <li>a) Public relations</li> <li>b) Branding Strategies</li> </ul> <p>4) Community Mobilization (25)</p> <ul style="list-style-type: none"> <li>a) MSMs of color</li> <li>b) Community sex workers</li> <li>c) Military personnel</li> </ul>	<ul style="list-style-type: none"> <li>a) How to conduct a needs assessment</li> <li>b) Where to put time and money</li> <li>c) Long range planning</li> </ul> <p>8) Developing New Programs (17)</p> <ul style="list-style-type: none"> <li>a) Behavioral Science Theories</li> <li>b) Best Practices</li> </ul> <p>9) Developing Awareness Programs for Sub-Populations (16)</p> <ul style="list-style-type: none"> <li>a) Youth</li> <li>b) MSM</li> <li>c) Faith Based Organizations</li> </ul>
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**Summary Needs and Recommendations:**

Based on the TA assessments with CPG members, HIV Prevention Collaborations, local public health district staff, and other local HIV prevention providers there is an on-going need:

1. To provide training on effective HIV prevention interventions that are theory-based and shown to be effective.
2. To provide basic HIV information about HIV disease, how it is transmitted, and HIV epi-data.
3. To provide basic policy and programmatic updates (i.e.evaluation requirements and new initiatives) to contractors and local public health district staff.
4. To monitor and assure the quality of the delivery of HIV prevention interventions/programs.
5. To increase communication between various HIV prevention providers and providers of STD services and HIV care and treatment services.
6. To increase communication between the CPG, HIV prevention contractors, local health district staff, other local HIV prevention providers, and HIV care providers to provide additional input into the state HIV plan.

The CPG recommends that DHEC continue:

- Coordinate a schedule of monthly training workshops utilizing national CBA providers from CDC, as well as local TA providers.
- Conduct quarterly meetings of HIV prevention providers including contractors and local public health district staff.
- Conduct periodic integrated/joint meetings of HIV prevention contractors, health department staff, CPG members, and HIV care staff.
- Provide financial assistance for HIV prevention staff to attend the annual HIV/STD Conference, SC Community Planning Leadership Summit, and other conferences as needed or required.
- Conduct periodic site visits with HIV prevention contractors and health department staff to monitor and provide assistance with implementing and/or revising local intervention plans; conducting needs assessments; identifying additional resources, services, barriers and unmet needs among priority populations; making changes and improvements to financial

management systems; and prioritizing populations and interventions.

- Coordinate with the SCDHEC's Office of Minority Health to provide assistance to minority CBOs linked with the HIV prevention contractors through the *HIV/AIDS Demonstration Project to Provide Capacity Assistance*.
- Conduct on-going evaluation/assessments of of CPG members, health department staff, and other HIV prevention providers training and capacity building needs.
- Review quarterly reports and data available to identify needs and provide TA support.

## CHAPTER 9: EVALUATION PLAN

This chapter describes the evaluation plan for each type of required evaluation as described by the Evaluation Guidance (June 2001) and the reporting of core HIV prevention indicators as described in Program Announcement 04012. This plan will be revised as needed to meet CDC's new evaluation guidance which is expected to be released Summer/Fall of 2004.

### I. Evaluation Goals, Activities and Timelines

#### Evaluation Goals

1. To evaluate the HIV prevention community planning process.
2. To design and evaluate intervention plans.
3. To monitor and evaluate the implementation of HIV prevention programs.
4. To evaluate linkages with the comprehensive HIV prevention plan and the application for funding.
5. To monitor outcomes.
6. To generate and monitor baseline and target measures for indicators related to Community Planning, Evaluation and HE/RR interventions.

#### Activities for Meeting Evaluation Guidance Requirements

Below is a table listing each major evaluation goal with a description of activities to be completed yearly.

<b>Evaluating the HIV Prevention Community Planning Process</b>
Activities: 1) Collect evaluation surveys after each CPG meeting 2) Conduct exit interviews with departing CPG members 3) Conduct Community Planning Membership survey 4) Complete Membership Grid 5) Analyze survey data and report findings to CPG members
<b>Designing and Evaluating Intervention Plans</b>
Activities: 1) Provide training and technical assistance on the definitions for target populations, intervention types, and the intervention data collection forms to contractors and local health dept. staff. 2) Contractors and Local Health Department (LHD) staff will submit the intervention forms for review. 3) Compile information on intervention forms to send to CDC with funding application 4) Evaluate intervention plans for core set of data elements including approximate number and characteristics of people to be reached, categorized by type of intervention, sufficiency of evidence basis, and sufficiency of service plan for implementation. 5) Provide feedback, training, and assistance on an ongoing basis to improve quality of intervention plans.

<b>Monitoring and Evaluating Implementation of HIV Prevention Programs</b>
<p>Activities:</p> <ol style="list-style-type: none"> <li>1) With guidance from CDC PERB develop plan to train SCDHEC staff and contractors in PEMS.</li> <li>2) Collect process monitoring information from HIV prevention contractors and LHD staff. Data collected will comply with CDC’s new evaluation guidance.</li> <li>3) Compare process monitoring data collected to the intervention plans.</li> <li>4) Identify areas for improvement.</li> <li>5) Provide feedback and technical assistance to contractors and LHD staff on data collection issues.</li> <li>6) Provide information to the CPG for decision-making.</li> <li>7) Report evaluation data in progress reports.</li> </ol>
<b>Evaluating Linkages Between Comprehensive HIV Prevention Plan, CDC Funding Application, and Resource Allocation</b>
<p>Activities:</p> <ol style="list-style-type: none"> <li>1) Revise HIV Community Resource Assessment (CRA) process and tools.</li> <li>2) Conduct CRA survey based on CPG requirements and CDC guidelines.</li> <li>3) Provide summary process monitoring data on priority interventions with priority populations to compare linkages in the plan.</li> <li>4) CPG makes recommendations for improvements/changes.</li> </ol>
<b>Monitoring Outcomes</b>
<p>Activities:</p> <ol style="list-style-type: none"> <li>1) In collaboration with contractors and LHD staff determine behavioral and other outcome data to be collected.</li> <li>2) Finalize data collection instruments and process.</li> <li>3) Implement outcome monitoring process with providers.</li> <li>4) Conduct quarterly data analysis, provide feedback to providers.</li> <li>5) Analyze annual outcome monitoring data and write results.</li> <li>6) Disseminate data to providers, CPG, CDC and others.</li> <li>7) Increase the capacity of contractors and LHD staff to plan and conduct outcome monitoring projects.</li> </ol>
<b>Generating and Monitoring Baseline and Target Measures for Indicators related to Community Planning, Evaluation and HE/RR Interventions</b>
<p>Activities:</p> <ol style="list-style-type: none"> <li>1) Assess the quality of data collection systems used to calculate performance indicators.</li> <li>2) Monitor and reassess baseline and target measures as necessary.</li> </ol>

**II. Description of Evaluation Activities by Evaluation Goal**

(1). *HIV Prevention Community Planning Process.* Process data will be collected annually using the latest CDC Community Planning Membership (CPM) survey. The Membership Grid is completed using the data from the CPM survey. Data from the survey will identify possible gaps in membership representation based on the Epi Profile. Additionally, the 52 attributes will be analyzed individually and grouped by objective to determine percent agreement based on valid

responses. Each indicator must receive a rating of least 85 percent agreement in order for the attribute to be considered met. Survey data will also be analyzed by years of CPG membership (i.e. Evaluation question: Are members with less than 2 years of service less informed about the CPG process than members with 2 or more years?) and by other variables as requested by the CPG. Results from the CPM survey will be shared with CPG members annually to enhance the planning process.

Other evaluation activities will include the collection of evaluation forms after each CPG meeting and sharing the results with members at the next meeting. This allows for a timely response by the CPG Co-Chairs and or by the CPG Executive Committee to concerns or issues raised by members. Exit interviews with departing members will be conducted by the Chair of the Membership Committee and the community Co-Chair representative. This process helps to inform the orientation process for new members and to clarify the role of CPG members based on their expertise and or representativeness.

(2). *Designing and Evaluating Intervention Plans.* SCDHEC has required AIDS Health Educators (AHEDS) in the local health districts and HIV Prevention contractors to submit Local Implementation Plans (LIP) that reflect priorities in the State HIV Prevention Plan. In local health departments, staff is also required to use SCDHEC's Operational Plan as a basis for development of their LIP. As part of the LIP, Intervention Planning Forms (IPFs) are completed for each of the intervention types conducted during the year. The IPF requires the contractor to indicate who is being targeted (indicating risk behavior, race/ethnicity, age, and gender), type of intervention, scientific basis of the intervention, and a detailed description of the steps in carrying out the intervention. The IPF mirrors the process monitoring data that is submitted monthly to the program evaluation coordinator.

Staff in the STD/HIV Division review these plans and provide feedback regarding the number of persons to be reached in each priority population, the appropriateness of interventions with the priority populations and methods to evaluate the interventions. Data from the IPFs are sorted by priority populations and intervention types. This information is shared with the CPG and is used as a basis for planning and allocation of resources by SCDHEC for the upcoming fiscal year.

When PEMS is available prevention providers will be required to use the system to enter their annual intervention plans.

(3). *Monitoring and Evaluating the Implementation of HIV Prevention Programs.* All HIV prevention providers must conduct process monitoring. Several systems have been in place to monitor the implementation of programs in South Carolina. These systems will either be modified or replaced with PEMS to meet the new evaluation requirements. Below is a summary description of SC current data collection system by each program component.

a) *Counseling, Testing, and Referral Services (CTS)* demographic data are collected by utilizing the SCDHEC HIV Serology Request Form. Data on individuals tested in local health departments and by our community-based contractors are keyed into a computer file at the Bureau of Laboratories and confidentially stored. The SCDHEC Laboratory conducts all

HIV testing for the STD/HIV program. The STD/HIV program has developed an output report with the data required for the CDC counseling and testing reports.

The Division is planning to revise the data collection system for 2005 based on CDC's revised CTS data elements and deployment of PEMS. The CDC is working to incorporate scanning technology into PEMS to ease the burden of data collection. The Division anticipates training local health department staff and contractors in the new CTS form. The forms will be sent to the Division for scanning. Once the data is scanned it will be imported into PEMS for reporting and monitoring.

b) *Partner Counseling and Referral Services (PCRS)* information is collected utilizing the CDC Interview Record form. All forms are sent to the STD/HIV Division on a monthly basis and entered in STD MIS and the HIV/AIDS Reporting System (HARS) for data maintenance and reporting. It is anticipated that a newer version of the STD MIS system will include the required PCRS variables and that an import function in PEMS will allow the data to be transferred electronically.

c) *Prevention for Positives* process data will be collected through CTS, PCRS and through health education/risk reduction interventions.

d) *Health Education/Risk Reduction Services* (ILI, PCM, GLI, and Outreach) are primarily provided by AIDS Health Educators (AHEDS) and Social Workers in the 12 public health districts/local health departments (LHD), the 11 HIV Prevention Collaborations, 3 special projects, and 2 perinatal contractors. Currently, paper pencil data entry forms (DEFs) are used to collect the required age, race, gender, and risk behavior on persons served, intervention types and descriptions, and evaluation information. Health department staff and prevention providers submit completed DEFs monthly to the program evaluation coordinator. All DEFs are reviewed for completeness and consistency. Data from the DEFs are entered into Microsoft ACCESS and exported to Excel for analysis. Data results/analysis are provided to contractors and LHD quarterly to provide feedback, and to CDC as required. This system will continue to be used until PEMS becomes available. All staff involved with the collection of HIV prevention process data will be trained in PEMS.

e) *Health Communication/Public Information* data are collected in two ways. The SCDHEC AIDS/STD Hotline staff utilizes *EPI Info* to capture information from callers who speak to a staff person. After-hours calls are forwarded to the CDC National AIDS Hotline. An analysis is made of the data collected from calls answered by a staff person. Data collected include demographics, risk information if provided, type of information requested, and referral source to the hotline, (e.g. telephone directory listing, African American or Latino radio PSAs, etc.)

Public information activities provided by local collaborations/district staff are reported through the DEF reporting system described above.

(4). *Evaluating Linkages Between the Comprehensive HIV Prevention Plan and Application for Funding.* Until revised, SCDHEC will continue to use the process outlined in Chapter 5 of the Evaluation Guidance (Volume 2 Supplemental Handbook) for conducting this evaluation

activity. Data sources include the Comprehensive HIV Prevention Plan, Intervention Planning Forms and budgets from HIV prevention providers, information from the CTS and PCRS data collection systems, and interviews with health department staff and providers. Results of this process are included in the CDC application and shared with CPG members during regularly scheduled meetings.

(5). *Outcome Monitoring and Outcome Evaluation.* Based on the recommendations from an evaluation capacity building needs assessment completed in late 2003 and early 2004, SCDHEC is in the process of clarifying its expectations regarding outcome monitoring for local prevention contractors. Currently SCDHEC encourages all local prevention contractors to plan and conduct one outcome monitoring project as resources allow. To assist, SCDHEC provides sample data collection tools to measure pre/post impact and enters, stores and analyzes the data for the contractors. Feedback is provided to contractors through written reports and presentations.

An outcome monitoring technical assistance (TA) plan is being developed to build contractor’s capacity to evaluate their own prevention programs. Through a contract with the Center for Child and Family Studies at the University of South Carolina selected contractors are receiving individualized TA. This TA focuses on the following evaluation areas: 1) logic modeling to clearly define their program, 2) constructing outcomes and indicators, 3) reviewing standard evaluation designs, 4) basic survey methodology, 5) understanding and using basic statistics, 6) utilization of evaluation findings for program improvement, 7) generating useful reports for stakeholders, and 8) evaluation ethics. The ultimate goal of this TA is to embed HIV prevention evaluation into the contractor’s culture so that evaluation is routinely viewed as a viable means of enhancing learning and performance.

(6). *Generate and Monitor Baseline and Target Measures for Indicators Related to Community Planning, Evaluation and HE/RR interventions.* Working with the STD/HIV Division Director, the evaluation staff will monitor the data systems used to collect core HIV prevention indicators as outlined in Program Announcement 04012.

The following data sources will be used to collect the required Community Planning, Evaluation and HE/RR data elements for each indicator.

<b>COMMUNITY PLANNING</b>	
<b>Indicator</b>	<b>Data Collection Source</b>
E.1	Community Planning Membership Survey
E.2	Community Planning Membership Survey
E.3	CTS and PCRS Data Systems, HE/RR Intervention Planning Forms, and Program Budgets until PEMS is available
E.4	CTS and PCRS Data Systems, HE/RR Intervention Planning Forms, and Program Budgets until PEMS is available
<b>EVALUATION</b>	
<b>Indicator</b>	<b>Data Collection Source</b>
F.1	Data entry forms until PEMS is available

<b><i>HEALTH EDUCATION/RISK REDUCTION</i></b>	
<b><i>Indicator</i></b>	<b><i>Data Collection Source</i></b>
H.1	Data entry forms until PEMS is available
H.2	Intervention planning forms and data entry forms until PEMS is available
H.3	Data entry forms until PEMS is available
I.1	Data entry forms until PEMS is available
I.2	Data entry forms until PEMS is available

Once online, PEMS will be the primary data collection system to monitor these key performance indicators. Until then, the Division will continue to collect the required data elements through paper pencil surveys and forms.