

PARTNERSHIP FOR COMPREHENSIVE HIV/AIDS PLANNING

OF

VOLUSIA AND FLAGLER COUNTIES



**COMPREHENSIVE
HIV PREVENTION PLAN**

FOR

2006 - 2009

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A HISTORICAL PERSPECTIVE...

In 1981, New York and California notified the Centers for Disease Control and Prevention about two individuals who would later be confirmed as having the first documented cases of AIDS in the United States. Later that same year, a case reported from the state's Department of Health marked the beginning of the AIDS epidemic in Florida...

By 1985, there were more than 1,100 known cases in Florida, prompting the state Health Department to establish a distinct AIDS Program Office that would later become known as the *Bureau of HIV/AIDS*. The Bureau has continued operations since that time, specializing in the planning and provision of up-to-date, high-quality, and cost effective services to prevent and treat the spread of HIV disease throughout all 67 counties in Florida.

By 1993, HIV and AIDS had become a heavily publicized, national epidemic. The Centers for Disease Control and Prevention (CDC) responded by working closely with other governmental and non-governmental partners to develop a model for states and local areas to plan effective and appropriate prevention strategies to meet the needs of the highest-risk populations in their jurisdictions. From those efforts, the agency created a guidance document to serve as an initial blueprint for the implementation of *HIV Prevention Community Planning*. In December of the same year, states were mandated to begin a community planning process during 1994 in order to qualify for continued Federal funding in 1995 and beyond.

Community Planning in Florida

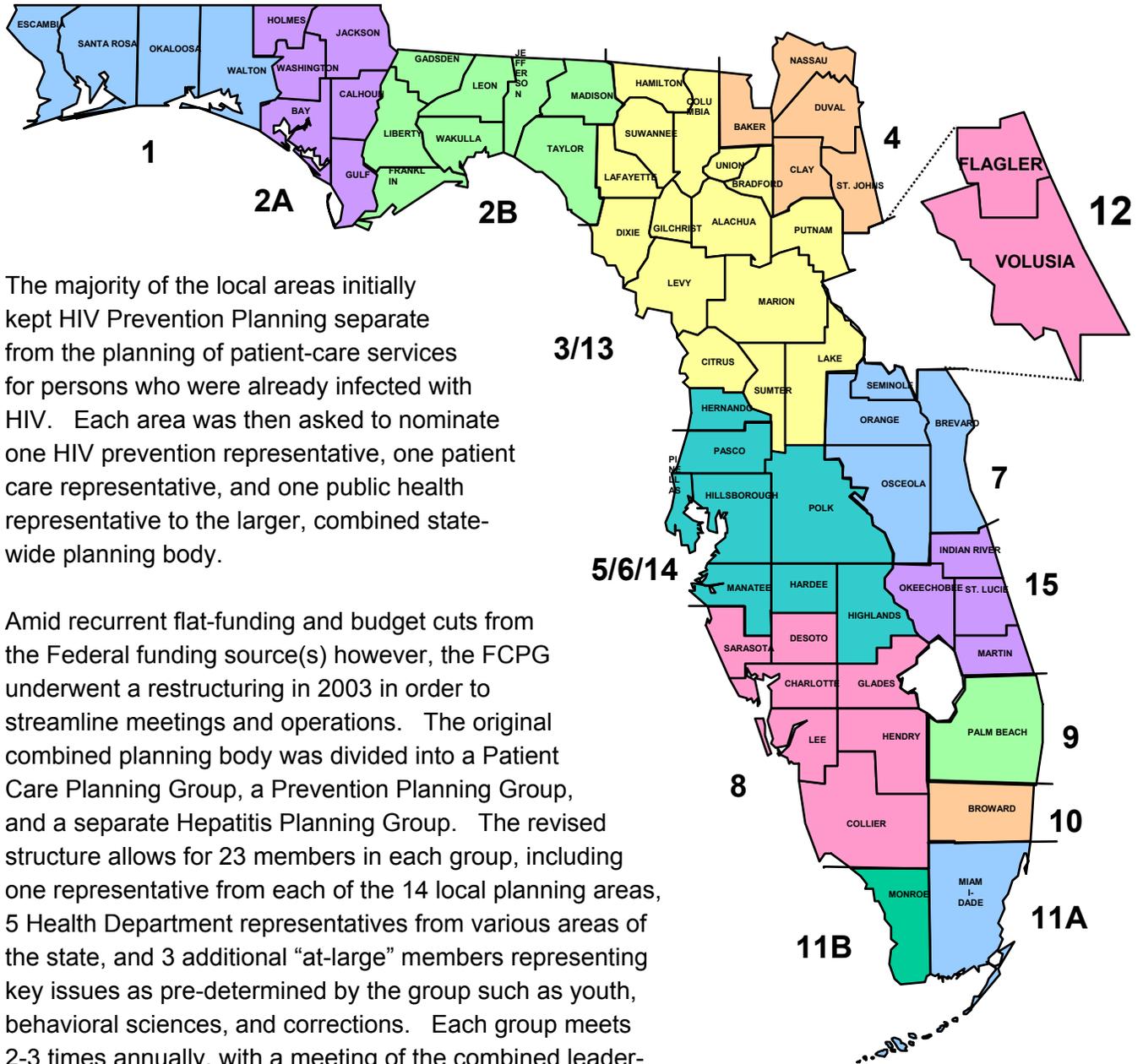
As the third most affected state in the Nation, Florida had already taken a lead role in fighting the epidemic as the first state to implement voluntary, confidential HIV counseling and testing at all county health departments in 1987, by passing the *Omnibus AIDS Act* in 1988, and by implementing the Project AIDS Care (PAC) waiver program within the state's Medicaid system in 1989. By the time the federal *Ryan White Comprehensive AIDS Resources Emergency (CARE) Act* was authorized in 1990, there were more than 13,775 known cases in Florida. The state's first Ryan White Title II Consortia was formally organized in 1991.

The *Florida HIV/AIDS Community Planning Group (FCPG)* was chartered in 1993 in response to the CDC's Guidance and mandate; and was organized to plan both HIV Prevention as well as HIV/AIDS Patient Care services for the state. There were more than 43,500 AIDS cases in Florida in 1994 when the state's first Comprehensive HIV Prevention Plan was completed.

Immediately recognizing significant differences among the populations and behaviors in different regions of the state, the Bureau of HIV/AIDS also called for the formation of seventeen individual local planning partnerships. The districts were drawn as single or multiple-county regions in which there were somewhat similar geographic, demographic, and socio-economic conditions; and which represented both urban and rural communities.

Soon after, two of the large, multiple-county partnerships opted to divide into separate smaller planning areas due to the unique needs and conditions of different communities within their jurisdiction(s). Meanwhile, several other adjoining partnerships simultaneously discovered that combining their resources to form a single collaborative Community Planning Partnership proved to be more effective for their efforts. After the reconfigurations, there remained a total of 14 local planning partnerships operating in the state of Florida.

Volusia and Flagler Counties comprise Area 12 for HIV/AIDS community planning in Florida.



The majority of the local areas initially kept HIV Prevention Planning separate from the planning of patient-care services for persons who were already infected with HIV. Each area was then asked to nominate one HIV prevention representative, one patient care representative, and one public health representative to the larger, combined state-wide planning body.

Amid recurrent flat-funding and budget cuts from the Federal funding source(s) however, the FCPG underwent a restructuring in 2003 in order to streamline meetings and operations. The original combined planning body was divided into a Patient Care Planning Group, a Prevention Planning Group, and a separate Hepatitis Planning Group. The revised structure allows for 23 members in each group, including one representative from each of the 14 local planning areas, 5 Health Department representatives from various areas of the state, and 3 additional “at-large” members representing key issues as pre-determined by the group such as youth, behavioral sciences, and corrections. Each group meets 2-3 times annually, with a meeting of the combined leadership occurring at least once annually.

Community Planning in Volusia and Flagler Counties

In Volusia and Flagler Counties, the *Prevention and Education Planning Partnership* (PEPP) was formed in 1994 to plan and coordinate HIV Prevention services for the region. There was also a separate planning group, the *Volusia/Flagler AIDS Consortium* (VFAC) that had formed to plan Ryan White Title II Patient Care services for those persons who were already living with the disease. With many of the volunteer members participating in both groups, the two bodies were formally merged in April of 2001 in an effort to streamline meetings as well as provide more integrated, comprehensive planning for all of the HIV-related needs in the two-county Area. The newly combined planning group, the **Partnership for Comprehensive HIV/AIDS Planning**, or “PCHAP,” was one of only two comprehensive local planning bodies in the state.

PCHAP was structured to include of a minimum of 15 *voting members*, as well as an unlimited number of additional non-voting *community members*, that represent various government and non-government programs, community-based organizations, and affected communities. The planning body’s mission is to create a comprehensive plan for the coordination and delivery of HIV/AIDS services within the district.

The prevention-related activities of PCHAP are directed by the latest version of the CDC’s *HIV Prevention Community Planning Guidance*, as well as decisions from the statewide planning body. The CDC guidance includes a strong emphasis that community planning be an open and participatory process; and that planning partnerships strive to achieve the tenets of *parity, inclusion, and representation* (often referred to as *PIR*) among their memberships.

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

Additionally, patient-care planning activities are guided by the United States Health Resources and Services Administration (HRSA) and the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The CARE Act includes a recommendation that state and regional Title II Consortia (PCHAP is the Title II Consortia for Volusia/Flagler) include persons who are living with HIV or AIDS as at least 25% of their voting membership.

PCHAP members may represent other planning efforts and partnerships within the two-county jurisdiction, allowing for even greater networking among other systems of care.

An important goal of Community Planning and PCHAP is to utilize available networks and resources prior to implementing new programs so that existing services are not duplicated.

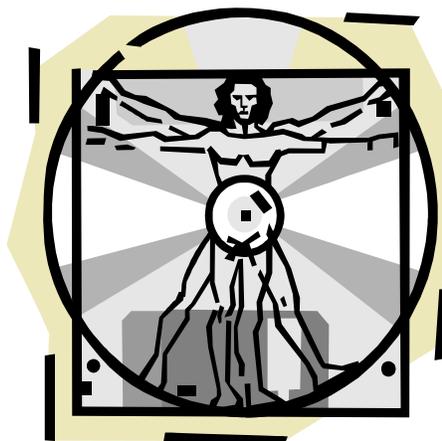
Networking in and utilizing alternate systems of care will continue to become even more critical to the partnership in the current environment of funding stagnancy and reductions. In August, 2005, the Florida Bureau of HIV/AIDS announced that it could no longer support the individual local planning partnerships statewide. Although the majority of local Areas, including Area 12, have voiced a commitment to retaining their current efforts, the future of local HIV Prevention Community Planning in Florida remains uncertain at this time.

ANATOMY OF THE PLAN

Purpose

The CDC designates the primary task of every Community Planning Group (CPG) as “the development of a comprehensive HIV prevention plan that includes prioritized target populations and a set of prevention activities/interventions for each target population.” Each grantee or jurisdiction is required to produce at least one comprehensive plan every five years in order to receive funding from the agency.

The State of Florida functions on a three-year planning cycle that is observed throughout all areas of the state. The 2001-2003 comprehensive plan was the first three-year plan produced in Area 12; followed by the 2004-2006 plan. The trends, goals, and strategies in those previous plans have served as a foundation and starting point in the development of the current plan. This 2007-2009 Comprehensive HIV/AIDS Prevention Plan is intended to serve as a blueprint and a guide to decision makers, planners, service providers, and the community as a whole in the development and delivery of HIV prevention services throughout the two-county Area over the next three years.



Layout and Use

In July of 2003, the original CDC guidance document was revised to incorporate the latest strategies and guidelines outlined in the agency's then fledgling initiative known as *Advancing HIV Prevention: New Strategies for a Changing Epidemic*. The newly updated *2003-2008 HIV Prevention Community Planning Guidance* document was implemented in Florida during 2004, and the 2004-2006 plans were updated to reflect the new guidelines. This new plan was designed to include all of the critical components described in the most current version of the CDC guidance, and they are listed on the following page.

Epidemiologic Profile: a description of the current state of the HIV/AIDS epidemic within the region, including which communities and population groups are most heavily impacted by the disease.

Community Services Assessment: a description of the documented prevention needs among populations that are known to be at high-risk for HIV infection, the services and other resources that are available to meet those needs, and the shortages or "gaps" in existing services.

Prioritized Target Populations: a ranked listing of population sub-groups that are known to be at highest risk of HIV infection as shown by the Epidemiologic Profile and the Community Services Assessment. Populations are typically characterized by gender, race/ethnicity, and the behaviors that place them at risk for HIV infection.

Appropriate Science-Based Prevention Activities and Interventions: a ranked list of HIV prevention activities and interventions that were chosen by the community based on documented effectiveness, cultural appropriateness, and the regional capacity to perform them.

Technical Assistance Needs: a ranked listing of training, development, and capacity building needs as reported by local providers and affected communities. These topics will serve as a basis for the planning of educational and training programs for Area providers.

THE TOLL OF HIV AND AIDS...

Analysis of HIV and AIDS case data can provide a quantitative basis to document trends among populations and to help determine which groups are most severely affected by the disease. The HIV/AIDS data presented in this plan was supplied by the Florida Department of Health, Bureau of HIV/AIDS, Surveillance Section. As with any data, there are specific strengths and limitations for each type of information shown. For this reason, it is important to note that the case data is not all-inclusive and represents only a minimal estimate of actual cases. Special considerations are presented with each set of data; and a summary of limitations is provided at the end of this section.

The HIV and AIDS case data are reported in three general categories:

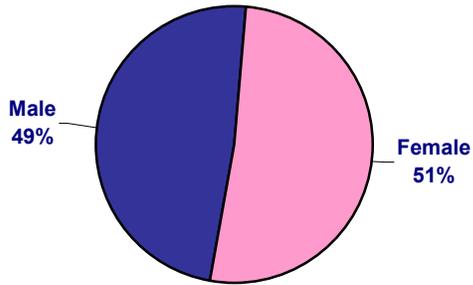
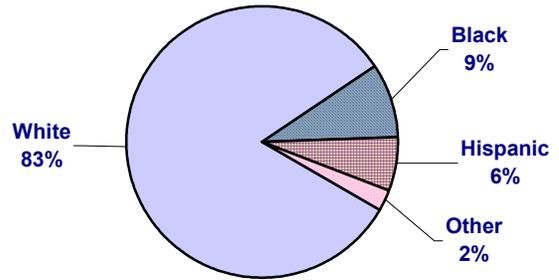
1. The *incidence* of newly reported cases during the specified calendar year,
2. The *prevalence* of cases that were reported when diagnosed and were presumed to be living at the time of report, and
3. The *cumulative* totals of all reported cases through 12/31/04, regardless of whether they were still living or deceased at the time of report.

Within the data, there is a significant proportion of cases that have been reported without information on how the virus was acquired; and these are reported separately under the category of "No Identified Risk" (NIR). While the actual "raw" data will remain unaltered, the Florida Department of Health initiated a reclassification effort in 2003 to research and distribute these cases proportionately back into the established leading exposure categories for the purposes of more effective tracking and planning. For those cases that remain as NIR, there is no reason to suspect that HIV is being transmitted in some unusual way, but rather that there are insufficient staff resources to devote to the reclassification process.

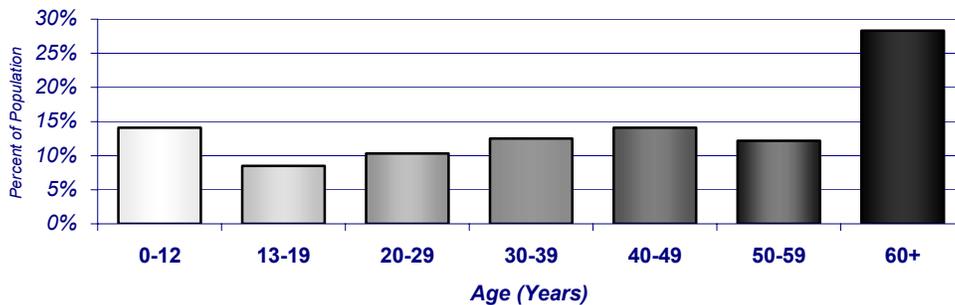
General Population

Volusia and Flagler Counties comprise approximately 1,588 square miles of Northeast Florida, extending more than 70 miles along the coastline of the Atlantic Ocean and inland to the St. Johns River. The region was home to approximately 493,175 individuals in the year 2000 according to the U.S. Census; and the most recent population estimate for 2005 was 569,776, indicating a 15.5% increase in permanent residents over five years. The region's growth is strongly fueled by Flagler County, which is listed as the fastest growing County in the United States by the Census Bureau, experiencing a 53.3% increase in residents within the five year period from 2000-2005 (compared to 10.5% in Volusia County and 11.3% in all of Florida).

Overall, approximately 84% of area residents in 2000 were White (non-Hispanic), an additional 9% were Black/African-American, and 7% were of Hispanic/Latino origin. There were slightly more females than males. The diagrams on the following page illustrate the population by composition of male and female, as well as by race/ethnicity, as reported in the 2000 Census.

Figure 1: Total Population, Area 12 by Gender, 2000**Figure 2: Total Population, Area 12 by Race/Ethnicity, 2000**

Nearly one-third (31%) of all residents were adults within the prime child-bearing ages of 20-44 years; and older adults between the ages of 45 and 64 years made up an additional 25%. Senior citizens age 65 and older, and youth aged 19 and below comprised nearly half of all area residents, with each group representing approximately 23% of the total population.

Figure 3: Total Population, Area 12 by Age, 2000

As a whole, the region has been fairly successful in educating youth and adolescents through high-school; although a lower percentage continue into college. Florida's average percentage of persons over the age of 25 years who have not completed high school or an equivalent certification is 20.1%. For Volusia County, the figure is 18.0% while in Flagler it drops to 14.2%. The proportion of persons completing a college degree program, however, is lower than the rest of the state. In Volusia, only 11.6% of residents have completed a college degree program; while the rate increases slightly in Flagler County to 13.4%. Both figures fail to meet the state average of 14.3% of residents who are college graduates.

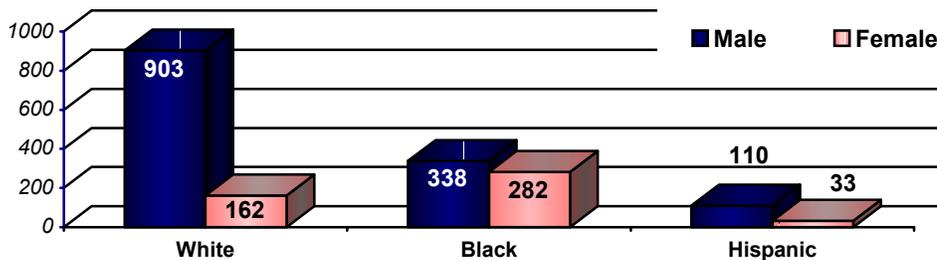
As a result of the lower education levels, local residents generally rely upon traditionally lower-wage occupations; with service industry and retail sales positions accounting for nearly two-thirds (64%) of the employed adult population across both counties in 2000. More than one in every four working adults in the region worked in retail trade, entertainment, recreational, or food service jobs. There are significant differences however, in employment and income levels between the two counties. Volusia County reported that approximately 3.5% of the work force was unemployed in 2004, while Flagler boasted a 2.0% unemployment rating. The median household income in Flagler was 3.6% higher than the average for Florida; while in Volusia however, the average household brought in at least 9.3% less than the rest of the State.

Total HIV and AIDS Cases

Cumulative HIV and AIDS data refers to the total of all cases that have been reported for the Area, and does not take into account whether the cases are living or deceased at the time of measurement. Studying total case data can assist researchers in measuring and comparing the overall impact of HIV disease on various population groups.

As of April 24, 2006, there had been a total of 544 cases of HIV (not AIDS) and 1,456 AIDS cases recorded from Volusia/Flagler. Male cases out-number female cases at a ratio of 2.76 to 1. The disease has had a profound affect on persons of color within the Area; with at least one out of every three cases occurring in Black/African-Americans, despite the fact that black persons make-up less than one out of every 10 people in the region. Among only the females, nearly 2 out of every 3 cases has occurred in black women. The figure below, however, illustrates that while black persons do comprise just over a third (34.3%) of known cases; white men still account for nearly one half (49.1%) of all cases within the region.

Figure 4: Cumulative HIV and AIDS, Area 12 by Gender and Race, (through 2/28/05)



The virus has been most commonly transferred through white Men who have Sex with Men (MSM), who account for 35.5% of all cases in Area 12. The second most affected group overall has been black women, who comprise more than 15% of all cases. White, Injection Drug Users (IDU, both male and female) have been the third most impacted population in the region, representing a combined total of 12% of cases. Men in this category however, out-number women by 3 to 1. Hispanic men and women represent a relatively small portion of cumulative cases, 7.8%, but comprise a larger proportion of newer and living cases – indicating a more recent emergence of HIV transmissions within this community.

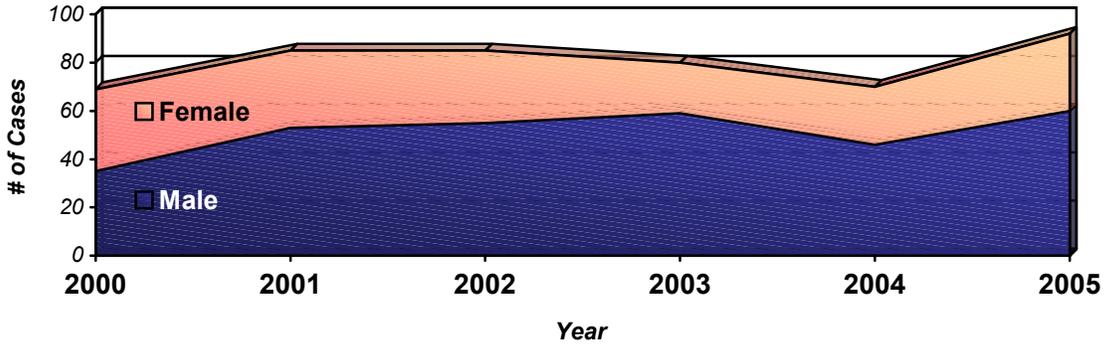
HIV Incidence

HIV incidence refers to cases that were newly diagnosed during a specific period of time; and can help researchers discover in which population groups new infections are most commonly occurring. As of April 2004, HIV Incidence data from the Florida Department of Health reflects all newly diagnosed cases, regardless of their AIDS status. In other words, persons who have already reached an AIDS status when they are first diagnosed with HIV are counted as both a new HIV case as well as a new AIDS case; thus these categories are no longer “mutually exclusive” and cannot be added together to get a total number of new cases.

Case reports released on April 24, 2006 indicate that there were at least 92 cases of HIV known to have been newly diagnosed within the region during 2005. Of those, two-thirds were male.

There were nearly equal numbers of white and black cases reported during the year; and Hispanics made up the remaining 12% of new cases. The figure below illustrates that there has not been a decline in the occurrence of new HIV diagnoses during the past 5 years in Volusia and Flagler Counties; and in fact, indicates a slight overall increase in the rate of new infections during that time.

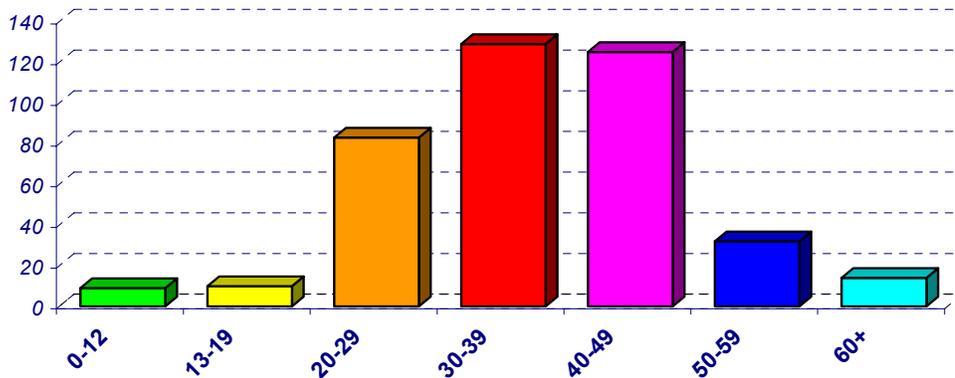
Figure 5: Total HIV Incidence for Area 12, Years 2000-2005



Further identifying trends in HIV incidence among specific populations over time can help illustrate changing infection rates in various groups, and ultimately assists planners in projecting future prevention needs. The Florida Department of Health provided each partnership Area with complete 5-year data reports that include all reported HIV and AIDS cases from 2000-2005.

There were a total of 402 new cases of HIV diagnosed during the 5-year period. The ratio of male to female cases overall was approximately 2 to 1. Similar to the 2005 case reports, there were nearly equal percentages of white and black cases (approx 43% each), with Hispanics representing an additional 12.2%. The vast majority of new cases has occurred among young to middle-aged adults. The age groups of newly reported cases is shown in the figure below.

Figure 6: New HIV Cases, Area 12, 2000-2005



Men were most commonly infected through sexual contact with other men, accounting for nearly 60% of male cases during the five-year period. Men infected through heterosexual contact made up an additional 16% of cases, followed by Injection Drug Use (IDU) for at least 13% of male cases. There were also at least 14% of male cases for whom a risk category has not yet been identified. The most common mode of exposure for women was heterosexual contact, accounting for at least 73% of new cases since 2000. There were an additional 16% of cases for whom no risk category has been identified, and approximately 7% who were indicated as IDU's when tested.

Figure 8: Male HIV Cases, 2000-2005

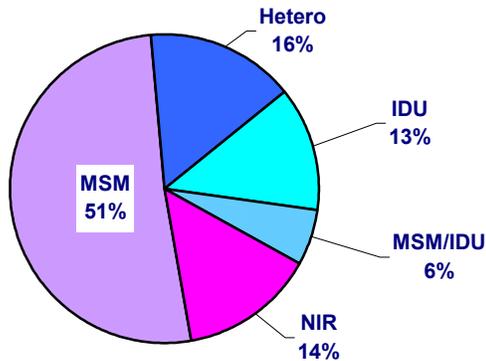
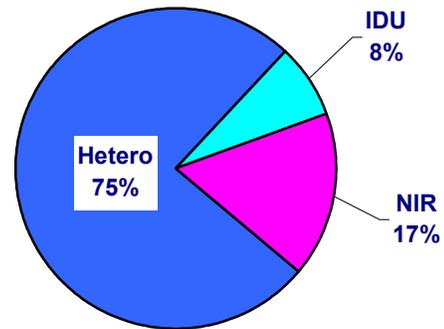
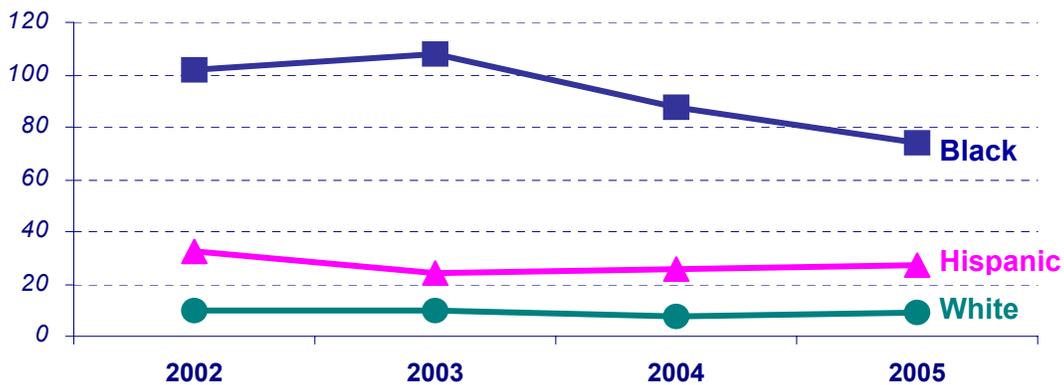


Figure 9: Female HIV Cases, 2000-2005



Case rates reflect the approximate number of cases per every 1,000 individuals within a specific population group, and allow for direct comparisons between different groups. For example: If 1,000 white individuals and 1,000 black individuals were randomly selected from Area 12 in 2005, reported case rates indicate that only 8 of the white persons would be likely to have HIV, while at least 73 black persons would be expected to have the virus. Case rates illustrate disproportionate impact within populations (when a population represents a higher percentage of infected cases than the percentage of their overall presence within the population). The following diagram shows the change in calculated case rates among the three primary race and ethnicity categories from 2002 through 2005.

Figure 7: HIV Case Rates, Area 12, 2002-2005



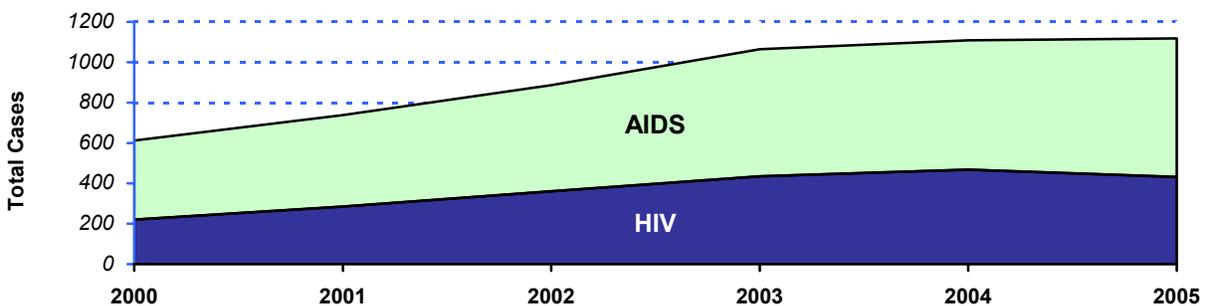
As shown on the previous page, although there has been a reduction in the rate of HIV among African-Americans over the previous two years, infection rates among this group were still more than seven times the rate in whites in 2005. Of the 175 new cases diagnosed among blacks during 2000-2005, approximately 55% were male and 45% were female. New infections among whites, on the other hand, were 75% male and 25% female. Additionally, Hispanic individuals remain approximately three times as likely as whites of becoming infected with HIV; with men outnumbering women by nearly three to one in this category as well.

HIV and AIDS Prevalence

HIV and AIDS Prevalence case data refers to all reported cases that are presumed to be living (i.e.: have not been reported as deceased) at the time of measurement. (*HIV prevalence* includes only those who have been reported as HIV positive, but have not yet converted to an AIDS diagnosis.) Surveillance of actual living cases within an area has become more important for HIV Prevention planning since the release of the CDC's new prevention strategies in 2004. The *Advancing HIV Prevention* initiative emphasizes the need for specialized intervention programs to work with those persons who are already HIV-positive in order to help them prevent the transmission of the virus to others.

Volusia County currently ranks ninth among Florida's sixty-seven counties for the number of living AIDS cases, and is ranked twelfth in the state for the number of HIV cases. The most current prevalence data available from March 20, 2005 shows that there were 431 men and women known to be living with HIV, as well as 687 individuals living with clinically diagnosed AIDS in Area 12 at that time. The figure below illustrates the steady increase of HIV/AIDS prevalence in the two-county region over the previous 6 years, during which time the number of known living cases nearly doubled.

Figure 10: HIV and AIDS Prevalence, Area 12, 2000-2005



Approximately two-thirds (67%) of the 1,118 persons living with HIV or AIDS in Area 12 are male. White men out-number blacks by more than 2 to 1 and account for 62% of male cases overall. The most common risk category among all men is MSM (54%), and more than three out of four (76%) of those cases are white.

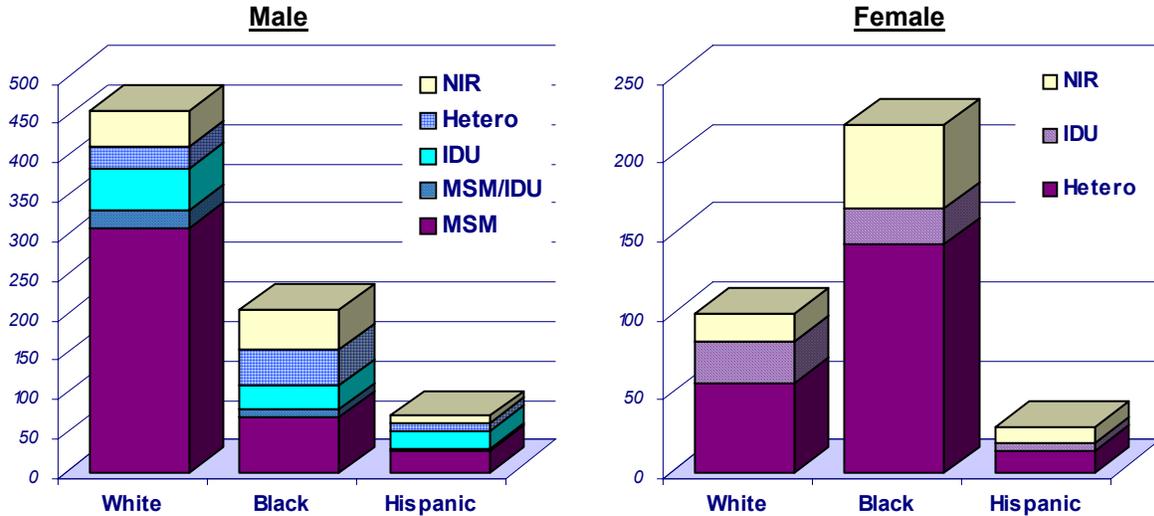
Among just the male AIDS cases, blacks account for 25%; and the most common risk reported for that group is MSM (35%), while only 17% reported contact through heterosexual relations. Among male HIV cases however, black men again account for a larger 35% overall; but there are nearly equal numbers of black MSM and heterosexuals recorded. Since HIV cases tend to reflect more recent infections, this data supports a shift in HIV transmissions from primarily affecting MSM when the virus first emerged in the United States to a rise in black heterosexual men during more recent years. An additional factor that may influence these figures is the unknown number of reportedly heterosexual men who are having sex with other men “on the down low,” or without disclosing this behavior to health professionals or female partners. An additional 10% of male cases are of Hispanic ethnicity; and the largest portion of those (36%) are heterosexual, followed closely by 29% who have reported using drugs intravenously. There are 102 males living with HIV or AIDS for whom no risk category has been identified.

The data also supports an increasing rate of HIV among women. Females make-up only 27% of AIDS cases overall, but account for more than 40% of living HIV cases. Female PLWHA are 62% black, 29% white, and 8% Hispanic. Among only female AIDS cases, the ratio of black women to white women is approximately 1.5 to 1. Among HIV cases however, the ratio increases to 3.2 black women for every 1 white woman. This again suggests a shift in which populations have been most affected by HIV during the later years of the epidemic.

The most commonly reported mode of exposure among females has been heterosexual contact, accounting for approximately 60% of living cases. Black females reported heterosexual risk at a rate of 64%; and they account for more than two thirds (67%) of all heterosexual females who are infected. Intravenous drug use has been reported for only about 10% of black female PLWHA. White women, on the other hand, have reported heterosexual contact at a lower rate of 52%; but have indicated IDU in 26% of cases, more than double the rate in blacks. Hispanic women represent approximately 8% of living HIV and AIDS cases, and there appears to be an increasing rate of transmission among heterosexuals from that population as well. There were nearly equal rates of heterosexual risk and IDU reported among female Hispanic AIDS cases; but heterosexuals out-number IDU's by 9 to 1 among the HIV cases.

The figures on the following page illustrate the composition of reported risk categories among each race/ethnicity, and between genders. It is important to remember that risk categories are reported at the time of diagnosis, and may not necessarily reflect current behavior patterns. It is also important to remember that living cases represent only those that have been tested and diagnosed, and do not include the unknown number of individuals who are HIV-positive but unaware of their status, those who have tested positive anonymously, or incarcerated persons.

Figures 11 and 12: Persons Living with HIV or AIDS in Area 12 as of 3/20/05



The persons who are living with HIV/AIDS in Area 12 are predominantly young to middle-aged adults (30-49 years). AIDS cases are most prevalent in persons over the age of 40, while HIV cases are fairly equally distributed among 20-49 year-olds. There are only 5 children under the age of 12 who have been reported and are known to be living within the Area; and 3 of those have received a clinical diagnosis of AIDS. The illustration below shows the prevalence of HIV and AIDS among the various age groups.

Figure 13: Living HIV and AIDS Cases in Area 12 by Age, as of 3/20/05



The vast majority (95%) of Area 12's PLWHA reside in Volusia County. More specifically, there are 5 cities within Volusia County that are home to nearly 90% of all persons known to be infected with HIV in both counties combined.

Table 1: Cities most affected by HIV/AIDS in Volusia/Flagler, as of 3/20/05

Daytona Beach	56.5%
Deltona	10.9%
DeLand	9.8%
Ormond Beach	6.6%
New Smyrna Beach	4.0%
Total Cases (5 cities)	87.8%

Daytona Beach

HIV/AIDS case data is tracked geographically using the zip code of residence at the time of diagnosis. As indicated on the previous page, more than one-half of all cases in Area 12 have reported one of the twelve zip codes that lie within the city limits of Daytona Beach. (Some zip codes within Daytona Beach extend into the surrounding suburbs of Holly Hill, South Daytona, and Daytona Beach Shores. These areas are included in the estimate because the data does not allow for differentiation.) Despite its high prevalence of PLWHA, Daytona Beach is home to only about 12% of the total population of the two-county Area; indicating a disproportionate level of HIV/AIDS concentration among city residents.

The metropolitan city covers approximately 60 square miles in east-central Volusia County; and is a popular vacation destination for travelers from all corners of the world who come to participate in race events at Daytona International Speedway, motorcycle events such as Bike Week and Biketoberfest, Spring Break, Black College Reunion, and others. The heavy flow of tourism supports a large segment of the local economy; with many residents relying on jobs created primarily to support those and other seasonal events. As a result, the median family income within the city is 26% lower than the county, and 32% below the State; with even greater disparities for minorities.

In the 2000 Census, residents of Daytona Beach were reported as 63% white, 33% black, and 3% Hispanic. The rate of persons living below the Federal Poverty Level (FPL) in the city is 23.6%, more than twice the county's average of 11.6%. In families where there is a female head of household, the city's poverty rate jumps to 37.4%. Approximately one-third of residents (31.5% in 2004) work in retail, accommodations, recreation, and food services; and at least 6% of the civilian workforce is unemployed. More than one of every five residents over the age of 25 does not have a high-school diploma or equivalent certification; and less than half have ever attended college courses. (Despite the fact that there are three major colleges/universities centrally located within the city.)

Postal Zip Code 32114

The single zip code of 32114 in Daytona Beach is particularly affected by HIV/AIDS in that it alone contains nearly a third (29%) of all known living cases in the two counties. As of 4/30/04, cases in this district were approximately 57% male and 43% female. Approximately half (49%) of the male cases are black/African American followed by 47% that are white; and 6% of cases reported Hispanic/Latino ethnicity. Among the females, the large majority (83%) are black, followed by 14% that are white, and 3% that reported as Hispanic. The vast majority of women in this district reported heterosexual contact as their most likely mode of exposure.

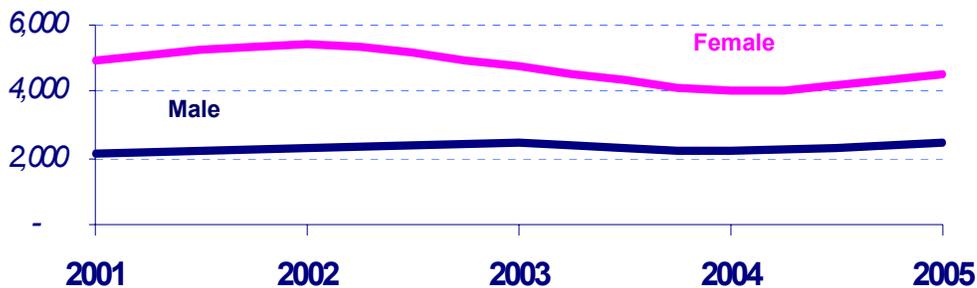
This zip code covers the majority of the central city and most disparaged neighborhoods, approximately 20 square miles. The zip code is home to nearly 35,000 people; with the black/African-American community representing more than 47% of the overall population. The proportion of residents within child-bearing (and prime sexual) years increases to 40%, which is nearly one-third greater than the overall county total. The rate of individuals living below the FPL is 2.58 times the overall county rate; and that figure increases to 2.95 times for the number of families living in poverty. The percentage of the workforce that is unemployed in this zone is also twice the rate for the county.

HIV Counseling and Testing

Counseling and testing data is a crucial source of information about the nature and direction of the epidemic, and is used as an indicator to evaluate HIV prevention activities and policy making at the state and local level (*Florida HIV Counseling and Testing Annual Report, 2001*). The Florida Department of Health began collecting data from registered HIV test sites in 1985. Since that time, over 3 million anonymous and confidential tests have been conducted across the state. In 2005, there were over 1,100 public and private sites registered with the Health Department to provide HIV counseling and testing services in Florida. There are at least eleven registered testing sites in Volusia/Flagler Counties as of May 31, 2006.

The HIV counseling and testing data from the Department of Health includes all tests performed at the State Laboratories from county health departments and registered test sites. A total of 7,055 tests were performed in Area 12 during 2005, a 13.2% increase from 2004. The figure below shows trends in HIV testing by gender during the past five years.

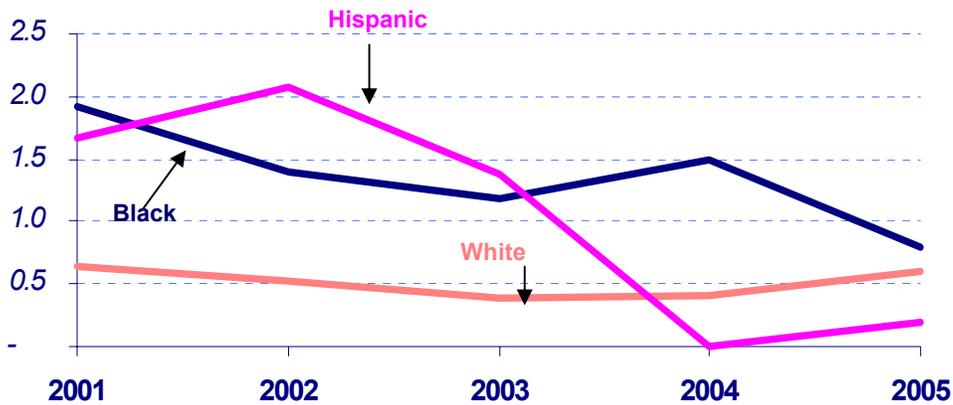
Figure 14: HIV Counseling and Testing by Gender, Area 12, 2001-2005



In addition to the number of tests performed, researchers also examine the percent of tests that yielded positive results. Positivity rates of tests performed is an indication of the effectiveness of targeted counseling and testing activities within the area. In Volusia/Flagler, although women account for the majority of persons being tested, positivity rates are consistently higher in men. In 2005, 64% (n= 4,538) of tests performed were on women, and of those there were 11 total positive tests for a rate of 0.20%. Of the 35% of tests (n= 2,497) performed on men however, there were 29 positive results, a rate of 1.20%.

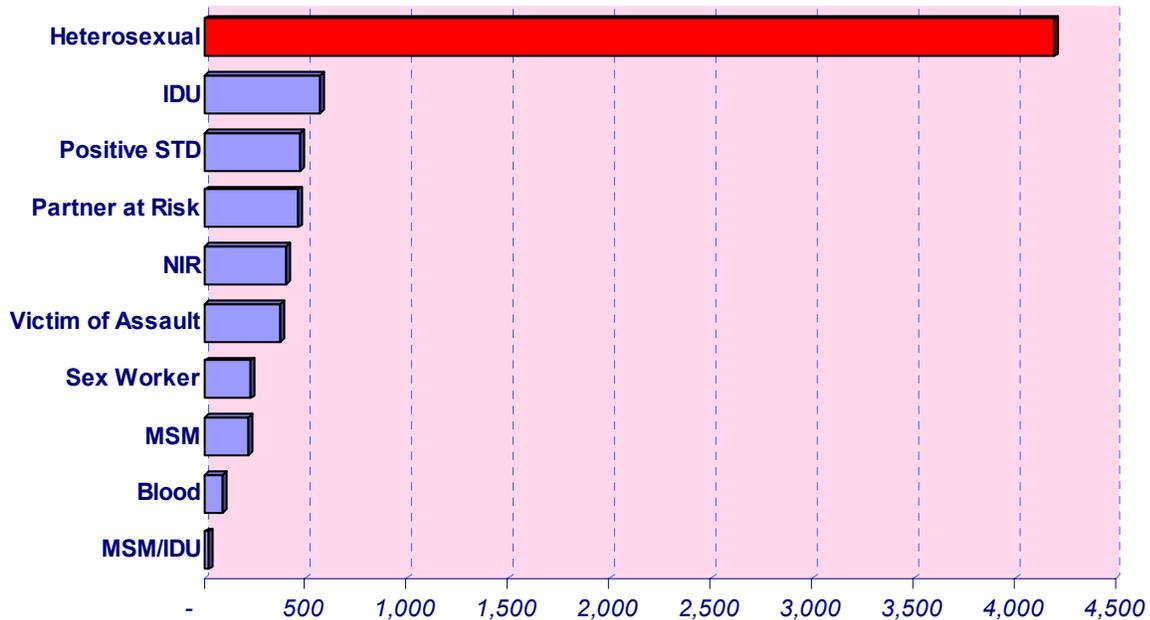
There have been fluctuations during recent years in the positivity rates of persons tested when examined by race and ethnicity. The figure on the following page shows that while the positivity rates among white persons tested has remained consistently low during the past five years; the rates among black and Hispanic persons have declined significantly. These figures indicate that although the overall number of tests performed increased during this time in every racial group; tests completed in more recent years appear to be less effectively targeted among the highest risk groups in each population.

Figure 15: HIV Testing Positivity Rates by Race/Ethnicity, Area 12, 2001-2005



Because individuals may engage in more than one risk behavior, each HIV test record is categorized according to the highest level of risk reported by the client. As shown below, heterosexual contact was the most predominant mode of exposure reported for all persons tested during 2005. Positivity rates were highest among MSM/IDU (11.5%) and MSM (4.5%). The percent of positive results among persons reporting only heterosexual risk was 0.3%.

Figure 16: Number of HIV Tests Performed During 2005 by Reported Risk Category



Limitations of HIV/AIDS Case Data

Type of Data	AIDS Case Data	HIV Case Data
Incidence <i>(New cases)</i>	<p>Includes all cases that received a clinical diagnosis of AIDS during the specified period; both those who were newly tested for HIV, and those who converted from an already reported HIV-positive status.</p> <p>Assists researchers in identifying trends in which populations are most severely impacted by the disease and which groups may be experiencing significant barriers that prevent them from accessing care.</p> <p>Also includes cases that are discovered through reviews of medical records and reported deaths and which may have been previously diagnosed but unreported.</p>	<p>Includes all newly-diagnosed and reported HIV-positive cases during the specified time period. (Beginning in January, 2002, all cases are counted, regardless of AIDS status at the time of diagnosis.)</p> <p>Tend to represent more recently acquired infections, and may more closely represent recent trends in disease transmission, although persons can be tested at any time during the disease, and there has historically been no mechanism to determine when the infection actually occurred.</p> <p>In 2004, the Florida Department of Health began implementing incidence surveillance through voluntary client participation using a method known as Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS). This testing is intended to help care providers and researchers pinpoint when HIV transmission occurred.</p>
Prevalence <i>(Living cases)</i>	<p>Includes all reported AIDS cases that are presumed to be living at the specified time.</p> <p>There are an unknown number of cases reported from within the jurisdiction who have since relocated to another district/state, and also an unknown number of cases who were diagnosed and reported in another area but have since relocated into Area 12. There are currently no mechanisms in place to track this inward and outward migration of individuals from one area to another.</p>	<p>Includes all reported HIV cases that are known to be living at the specified time, excluding those who have converted to an AIDS status since they were initially reported.</p> <p>There are an unknown number of cases reported from within the jurisdiction who have since relocated to another district/state, and also an unknown number of cases who were diagnosed and reported in another area but have since relocated into Area 12. There are currently no mechanisms in place to track this inward and outward migration of individuals from one area to another.</p>
Cumulative <i>(All cases, living and deceased)</i>	<p>Include all reported cases, regardless of whether the individuals are still living at the time of report.</p>	<p>Includes all reported cases since July 1997, excluding those who have since converted to an AIDS diagnosis, regardless of whether the individuals are still living at the time of report.</p>
All <i>(General limitations)</i>	<p>The Centers for Disease Control and Prevention (CDC) defines AIDS as documented HIV infection plus 1.) a medical diagnosis of an opportunistic illness, or 2.) a CD-4 T-cell count below 200 cells/mm.</p> <p>HIV/AIDS case data do not include cases from the Department of Corrections unless otherwise noted.</p> <p>There is an unknown number of individuals who are HIV positive or who have AIDS but who have not yet been tested or diagnosed.</p> <p>There is an unknown number of HIV and AIDS cases that have been diagnosed by private medical providers but not reported.</p>	<p>Data does not include HIV cases diagnosed prior to July 1, 1997 (when HIV reporting started in Florida).</p> <p>Case reports are limited to results that were reported from confidential testing, and <u>do not include individuals who tested anonymously.</u></p>

IDENTIFYING CAUSES AND SOLUTIONS

In order to better target increasingly limited resources, it is important to identify which population groups are at highest risk of acquiring HIV, which factors and behaviors most commonly place them at risk, what existing resources are directed toward each group, and where service gaps currently exist. The compilation of these elements can lead to an evidence-based selection and ranking of possible prevention activities and structured interventions that will have the greatest effect on the greatest number of people who are most at risk for HIV infection.

Priority Target Populations

The CDC requires each grantee and jurisdiction to identify a set of specific population groups that are known to be at highest risk of acquiring HIV; and to rank those groups by their degree of risk for HIV infection. Members of the *Florida HIV Prevention Planning Group* collaborated extensively during 2005 to develop a tool and methodology to achieve this task; and produced a template that has been distributed across the state. The use of the uniform prioritization tool will allow for more direct compilation and comparison between identified populations when each of the fourteen local prevention plans are compiled to yield a comprehensive plan for the state. The recommended process includes four distinct steps that factor actual case numbers, case rates (per 1,000 population), disparities in existing resources, and community input. The data for the first three steps was provided specifically for this task by the state's HIV/AIDS Surveillance Department, and is presented within each step as shown below. The fourth step was conducted with the full membership of PCHAP at the regularly scheduled planning body meeting in March, 2006; and the final ranking was presented to the full body and approved by the members in April of 2006.

The list below shows, for the purpose of standardized inclusion in the statewide plan; the primary target populations .

- 1. Black MSM**
- 2. Hispanic MSM**
- 3. White MSM**
- 4. Black IDU**
- 5. Black Heterosexuals**
- 6. Hispanic IDU**
7. White IDU
8. Hispanic Heterosexuals
9. White Heterosexuals

The members of PCHAP, however, recognized that the CDC's suggested and "approved" interventions, as well as most major funding sources, do not define, differentiate, or target all populations in the same way. There are no specific interventions, for example, for black injecting drug users. Because interventions are typically based on risk behaviors, then adapted to cultural norms, the local partnership decided to group certain populations together by risk behavior to be included as larger priority target populations in the local comprehensive plan.

Volusia/Flagler HIV Prevention Priority Target Populations

The *Partnership for Comprehensive HIV/AIDS Planning* has approved the following priority target populations for 2006-2009 in Area 12. The sub-populations listed under each heading have been prioritized and included for instances when specialized interventions and/or funding may be available. (Note: Population 4, Injecting Drug Users, includes both males and females.)

1. Men who have Sex with Men (MSM)

Black
Hispanic
White

2. Black Heterosexuals

Female
Male

3. Hispanic Heterosexuals

Female
Male

4. Injecting Drug Users (IDU)

Black
Hispanic
White

5. White Heterosexuals

Female
Male

In addition to the populations acknowledged above, the local partnership has also identified a group of special populations that may experience unique barriers and difficulties in maintaining safe behaviors. The following groups were not prioritized by the partnership, but were recognized as priority sub-populations within each of the groups listed above. A brief justification and description of the groups are including in the following pages.

Persons Living with HIV/AIDS

Mentally Ill

Youth/Adolescents

Homeless

Geographically Isolated Communities

Substance Users/Abusers

Incarcerated and Re-entry

Elderly

Migratory workers



Persons Living with HIV/AIDS (PLWHA) – In accordance with Guidance issued by the Centers for Disease Control and Prevention (CDC) in 2004, persons who are already living with HIV or AIDS are designated as the highest-priority within each defined population group. The CDC recognizes that “each person living with HIV who adopts safer behavior can prevent many transmissions of HIV infection;” and encourages Health Departments and Community-Based Organizations to implement programs that address the specific needs of HIV-positive clients, as well as their sex and/or needle sharing partners, through education, risk reduction, and ensuring adequate healthcare.

Substance Using Populations – It is well known that the consumption of alcohol and/or illicit drugs impairs judgment and subsequently leads to “riskier” behaviors. Drug use and abuse has long been cited as a primary barrier to effective risk-reduction strategies among multiple populations within Volusia and Flagler Counties. Persons who regularly consume alcohol and/or use illicit drugs should be considered a high-priority within each defined population group. Prevention programs are encouraged to address the specific correlation between substance use and HIV transmission; and to provide linkages and referrals to substance abuse treatment for clients who demonstrate a need for those services.

Persons with Mental Health Disorders – Mental health disorders play a significant role in determining the choices and behaviors of the persons they inflict. Individuals who are struggling to maintain sound psychological health are often unable to initiate and/or maintain safe social and sexual practices. Additionally, it has been well documented that mental health and substance abuse disorders are closely correlated.

Incarcerated and Re-Entry Populations – PCHAP members recognize a strong correlation between crime-related activities and HIV risk behaviors; and available data supports higher rates of HIV infection among incarcerated individuals. Reports also indicate that a significant number of individuals may be infected with HIV while incarcerated, then return home to unaware sex and needle-sharing partners upon release. It is recommended that HIV Prevention programs be implemented to address this “revolving” inmate population, especially among African-American and Hispanic men.

Youth / Adolescents – The Volusia County School Board has historically prohibited HIV/AIDS and STD Prevention and Education programs that are not abstinence-focused. Abstinence-only education programs do not address the needs of teens who are already sexually active (an estimated 40+% of the adolescent population); and furthermore have not demonstrated proven effectiveness in delaying the first sexual encounter or reducing the frequency of sex in teens. It has been recommended that special programs be introduced outside of the schools in community-based settings to fill the large gaps overlooked by abstinence-based programs for school-aged youth and adolescents.

Elderly – Older adults sometimes find themselves unexpectedly “single” again after the dissolution of a long-term marriage or relationship, or the death of a spouse/partner. This population has special educational needs that focus on the dating/relationship behaviors that are common in their age group.

Homeless Persons – Volusia County has a large homeless and transient population when compared to other regions in Florida. Persons who are homeless tend to have higher than average rates of mental illness, substance abuse, bartering sex for money or drugs, and other high-risk factors and behaviors. They often face extraordinary barriers to accessing resources and reducing their risks of disease acquisition. It is suggested that special programs are needed to meet the multiple and complex needs of this population.

Migratory Workers – Agricultural workers in the western regions of Volusia and Flagler Counties are often transient and migratory due to seasonal cycles of available work around Florida as well as into neighboring states. These communities are often comprised of immigrant workers who speak little or no English; and are widely known to be “close-knit” communities in which it is difficult to gain entry and establish trust for providers

Also, a less typical group of migratory workers also infiltrates the Volusia/Flagler region at least 4-5 times per year. Hundreds and even thousands of outsiders enter the region during Race Weeks, Bike Week, and Spring Break events as vendors and support staff to the events. These persons bring along with them a variety of social and risk behaviors, then easily infiltrate into local communities to work and party alongside full-time residents. Additional educational and HIV awareness campaigns may be needed during larger events to remind residents and visitors alike of the dangers and risks associated with HIV transmission.

Geographically Isolated Communities – It is noted that resources for the prevention and treatment of HIV and AIDS are largely clustered in the central region of Volusia County, primarily within the city limits of Daytona Beach. Individuals who reside in more outlying regions of Volusia and Flagler Counties commonly report distance-related barriers to accessing both treatment and prevention services. It has been recommended that HIV Prevention programs reach-out to communities in the western and southern portions of Volusia County as well as into Flagler County. Alternate service sites are one possible solution, along with increased availability of transportation or alternative ways to participate in existing programs.

HIV Prevention Barriers

In terms of HIV prevention, *barriers* refer to the types of difficulties that individuals may face while attempting to access needed information, testing, or services. These obstacles may exist on multiple levels, and may be physical, behavioral, or perceived. They are often intangible, making them very difficult to identify and address for both the consumer and service provider(s). It is not uncommon for individuals or entire communities to face several issues simultaneously, creating very complex problems that require a comprehensive array of well-coordinated services to overcome. Individual barriers are generally classified into the following levels:

Internal Barriers are client-level obstacles which may or may not be within the individual's ability to control or influence. Physical internal barriers may include mental illness or other disability, lack of knowledge or awareness regarding HIV and available services, poor education, poverty, homelessness, language barriers, immobility (including lack of transportation), inability to leave work during times that services are available, lack of available child-care, and non-resident or immigrant status. There are additional behavioral patterns that make it more difficult for consumers to get needed help including substance use and abuse, relationships with abusive partners, fear, apathy, distrust, and cultural norms that contradict safe sexual practices and effective prevention strategies. There are also common myths and misperceptions that have been reported among different communities, and that prevent individuals from seeking needed information and/or care.

System Barriers are most commonly those that exist as a result of established policies and procedures created by different funding streams, service networks, and organizations. Comprehensive systems of care, by definition, include various types of services and programs – each of which likely have unique application, eligibility, and enrollment requirements. Local consumers often report being overwhelmed by having to travel to numerous locations and navigate through stacks of paperwork to access needed assistance. A shortage of quality services and providers create perceived system barriers among consumers. Service Gaps, as discussed in the next section of this plan, for example, may be perceived as system barriers if consumers feel that the services are not available for them due to discrimination, incompetency, or general lack of concern from providers.

Societal Barriers include community-level issues and concerns such as stigma toward HIV and associated risks, community-wide cultural practices, certain religious beliefs and practices, generalized apathy and lack of awareness, or communal distrust among large groups of people. A shortage of affordable housing throughout Volusia and Flagler Counties is viewed by many local consumers as a societal barrier to effective risk-reduction or overall good health.

Information about specific barriers for each priority population within the Area was gathered by the PCHAP Needs and Resources Committee through a series of consumer surveys and focus groups along with input from a mixture of health and social service providers. Not surprisingly, although many of the “root causes” were discovered to be problems found in every population, it was found that each community may be affected in a different way. These findings support the need for specialized, culturally appropriate services to address the distinct issues and needs of those communities that are most severely impacted by HIV and AIDS. The most frequently reported obstacles are described below, along with the unique ways they tend to impact the different target population groups.

Substance Use and Abuse has been identified as a primary concern among all of the identified target populations. The recreational and habitual use of alcohol and illicit drugs extends throughout every gender, race, ethnic background, age, and geographic location in the two-county jurisdiction. African-American men and women report an alarmingly high rate of individual crack-cocaine use, primarily within the city limits of Daytona Beach, and especially in zip code 32114. The illegal drug trade in this region is known to have a strong correlation with disease transmission, high crime rates, violence, prostitution, mental illness, poverty, and homelessness. Residents of low-income, predominantly white neighborhoods also report similar problems. The local male gay and bisexual community, however, reports higher rates of meth-amphetamine (aka: “crystal meth”), powder cocaine, and ecstasy use, primarily in social settings. In all of the circumstances, the drugs reportedly inhibit judgment and sound decision-making, resulting in a much greater occurrence of high-risk behaviors that may otherwise be avoided. Focus group participants who had previously been addicted to drugs or alcohol described a sense of the substance “taking over” their lives; leaving them to pursue whatever means necessary to get their next “fix.”

Lack of knowledge and awareness about HIV and available services was also a common issue identified in each of the priority target populations in Volusia/Flagler. Uninfected individuals report being largely unaware of the magnitude of the disease within our local community, or that specific behaviors may place them at risk. Basically, local residents report that HIV and AIDS are simply “not on their minds.” Many cite as a primary cause the significant decline in the number and frequency of marketing campaigns and public service announcements informing people about how common the virus is and how they may be putting themselves at risk. A significant number of residents stated they do not know where or how to be tested for HIV. Others did not believe that HIV is a problem in today’s society because they had been told there is a cure, or that the disease is no longer as “bad” as when it first emerged. In addition, lower-income consumers have described a hierarchy of needs including housing, food, transportation, and other health concerns that tend to overshadow HIV prevention messages and make it difficult for them to exercise reduced risks. Persons from every population group reported that poor education regarding the disease throughout the general population is a root cause of stigma and mistreatment toward HIV-positive individuals.

Additionally, individuals report such internal barriers as **fear, apathy, and denial about HIV and its associated risks** as common reasons for not being tested for HIV, not improving behaviors, and not seeking care or treatment once diagnosed. Many survey respondents stated that they had not been tested for HIV, or initially delayed being tested, because they were afraid or did not want to know their status. Others described a feeling of inevitability that they would eventually be infected regardless of whether or not they modified behaviors, which resulted in a sense of hopelessness and eventual apathy regarding the disease and their odds of being infected. Still others, including some persons who know that they are HIV-positive, actively choose to ignore the fact that they are at-risk or already infected because of the stress and anxiety associated with having to accept those truths and initiating life changes.

An alarming new trend emerging within the region is an increasing number of reports from HIV-positive consumers that persons, particularly gay men, who are not yet infected, are **seeking to become infected with HIV**. To date there are no studies or reports available regarding the frequency or motivation for this behavior; although consumers who have been “approached” and asked to “share the gift” indicate that it occurs often, and may have to do with a desire to “belong” among social circles in which there are continually increasing rates of the disease. Additional statements argue that the advancement of antiretroviral medications and other treatments that reduce the physical and visible affects of the disease paint an illusion that persons with HIV can live for very long periods of time, but suffer very few symptoms, while still qualifying for disability benefits and other programs that offer free services and assistance. Some consumers speculate that persons may be seeking to become infected so that they can discontinue regular employment and join the growing number of individuals receive a wide variety of help with medical expenses, housing needs, and other services.

Persons seeking “the gift” have found an open forum on the world wide web, and have approached local consumers through **internet chat rooms** that are primarily visited by people who are living with HIV or AIDS. Several reports have emerged from around the state during recent years regarding the growing number of internet patrons who utilize these online venues to solicit **anonymous sexual encounters** with a large number of both HIV-positive and HIV-negative peers. Since actual names are not required in these forums, the use of “screen names” and nicknames makes it extremely difficult if not impossible to identify persons who are placing themselves at risk for the purpose of educating them or determining their current sero-status. With internet access becoming more readily available almost daily, a strategy will be needed within the next three years to contact, educate, and counsel internet chat room visitors, especially “gift seekers,” about the true nature and affects of HIV and AIDS.

HIV Prevention Resources

HIV Prevention Resources include all funds, programs, and activities that are employed to eliminate or reduce the transmission of HIV between individuals, reduce or eliminate risk-related behaviors among persons who are already living with HIV, and prevent the onset of illness and complications in persons who are HIV-positive. Prevention activities are generally classified into three tiers, as described below:

Primary Prevention programs are those that aim to prevent the spread of HIV to persons who have not yet been infected but are at risk of acquiring the disease.

Secondary Prevention programs work with persons who are already HIV-positive to assist them in adopting safer behaviors that will prevent the spread of the disease to others, and prevent themselves from being re-infected with other strains of the virus.

Tertiary Prevention refers to the provision of adequate primary medical care and other related healthcare and support services in order to prevent the onset of illness or opportunistic infection in persons who are living with HIV or AIDS.

Each year, the PCHAP Needs and Resources Committee develops and conducts a survey of all known HIV/AIDS service providers, as well as additional organizations and agencies that may provide services that are not specific to HIV but that may assist persons in reducing HIV-associated risks and maintaining good health. In June of 2005, surveys were mailed to at least sixty-eight local agencies and providers to gather information regarding any available resources, programs, and services that might benefit persons living with HIV or AIDS as well as individuals who may be at risk of acquiring HIV. A total of 23 agencies responded to the survey, and the findings are described in this section. Additional funding amounts and information have been provided by the Florida Bureau of HIV/AIDS.

Primary Prevention Programs

The Volusia County Health Department (VCHD) has two full-time employees (FTE's) allocated to provide HIV counseling and testing, health education, HIV/AIDS information and literature, condoms, risk-reduction counseling, partner counseling and referral, and to conduct community-wide events throughout Volusia County. There is one additional FTE dedicated to provide education, counseling, and testing within the Volusia County Branch Jail. The Flagler County Health Department (FCHD) also offers HIV information and literature, condoms, and health education to at-risk individuals in that county.

A large, locally-based Mental Health and Substance Abuse services provider was awarded funding from the United States Substance Abuse and Mental Health Services Association (SAMHSA) to conduct mobile HIV/AIDS outreach, education, counseling, and testing in the most affected neighborhoods of Volusia County. The agency's mobile van is scheduled to begin active services in August of 2006, under a three-year grant cycle.

There are currently no other State or Federally funded primary HIV prevention programs in the two-county region. A total of approximately \$256,000 has been allocated by the state HIV/AIDS office to conduct HIV prevention activities throughout the Area. The region has the absolute lowest level of state funding to community-based organizations when compared to all other regions of the state; and has virtually no direct CDC funded prevention programs. It should be recognized however, that there are at least three additional community-based agencies that have worked to continue previously implemented prevention activities including targeted outreach for minorities (especially within postal zip code 32114), targeted counseling and testing, health education and risk reduction counseling, advocacy, and referrals, despite the absence of external or supplemental funding to support and maintain these activities.

Secondary Prevention Programs

In concurrence with the CDC's Advancing HIV Prevention initiative, programs that address the prevention and risk-reduction needs of persons who are living with HIV or AIDS have been identified as a top priority in Area 12. "Prevention for Positives" programs aim to reduce and/or eliminate sexual and other behavioral risk factors among infected persons, and encourage better health and self-care for this population.

The AIDS Coalition of Volusia/Flagler, a community-based organization, was funded by the Florida Bureau of HIV/AIDS in 2005 to implement the group-level *Healthy Relationships* intervention for persons who are living with HIV and AIDS. The program focuses on disclosure behaviors and can be adapted to target a variety of population and cultural needs. This is the only state funded, community-based HIV Prevention program in the two-county region.

Primary medical providers within the region that receive funding under Ryan White Title II to provide patient care services are mandated to include HIV/AIDS education, risk reduction counseling, and appropriate support service referrals to persons who are living with HIV or AIDS during routine medical visits in order to help them improve behaviors, their own health, and prevent the transmission of the virus to others.

Tertiary Prevention Activities

The Volusia County Health Department is working to fully implement an "ARTAS" program designed to locate persons who are HIV-positive but who are not enrolled in care or receiving needed services from other sources. The program is intended to enhance and provide access to Early Intervention Services for persons newly diagnosed with HIV as well as those who have delayed entry into care for various reasons.

Additionally, the Ryan White Title II Patient Care Network within the region has several measures in place to help ensure that persons who are living with HIV/AIDS receive appropriate and adequate medical and support services in order to delay and/or prevent the onset of opportunistic infections or other illnesses. Core services within this network include primary medical care, pharmaceuticals, mental health and substance abuse treatment, oral healthcare, treatment adherence services, transportation, case management, and food supplements.

Agencies	Condoms	Information / Literature	HIV Counseling and Testing	Rapid HIV Testing	Linkage and Referrals	Partner Counseling and Referrals	HIV and Health Education	Risk Reduction Counseling	Prevention Case Management	Group Support	Internet Support	Community Events	Other
AIDS Coalition of Daytona Beach 240 Frederick Avenue, Suite E Daytona Beach, FL 32114 (386) 252-3032	X	X	X		X	X	X	X		X		X	
Digg's Miracle Care 875 Dr. Mary McLeod Bethune Blvd. Daytona Beach, FL 32114 (386) 323-9067	X	X	X		X	X	X	X		X		X	X
Flagler County Health Department 301 South Lemon Street Bunnell, FL 32110 (386) 437-7350	X	X	X				X						
Outreach Community Care Network 111 N. Frederick Avenue Daytona Beach, FL 32114 (386) 255-5569	X	X	X	X	X	X	X	X		X	X	X	
Responsible Choices Inc. 564 W. International Speedway Blvd Daytona Beach, FL 32114 (386) 248-2272	X	X	X					X					
Stewart Marchman Center 3875 Tiger Bay Road Daytona Beach, FL 32124 (386) 323-2074	X	X	X	X	X	X	X	X		X		X	X
Volusia County Division of Corrections 1354 Indian Lake Road Daytona Beach, FL 32124 (386) 254-4011		X	X	X	X		X						
Volusia County Health Department 1845 Holsonback Drive Daytona Beach, FL 32117 (386) 274-0663	X	X	X	X	X	X	X	X				X	X

HIV Prevention Service Gaps

While there are a variety of prevention services available in Volusia and Flagler Counties, there are often unique issues, barriers, and concerns of individual population groups that require specialized approaches and services that may not be available or readily accessible to them. *Service Gaps* refer to those “holes” in the existing service delivery system that are identified after reviewing all area needs, and all available resources. They refer to programs and activities that would help solve the documented *unmet needs* within the jurisdiction, but that do not exist or do not have enough capacity to provide all of the help that is needed.

Ambulatory and Residential Substance Abuse Treatment was the highest reported need, as well as the largest service gap identified within the region. While accurate data is not available regarding the prevalence and severity of illicit drug use among area residents, consumer reports describe this as a dire and severe problem affecting all populations in the two-counties. Residential treatment beds are often difficult to locate and access, even for trained and experienced case managers and social workers. Additionally, protective behaviors are inherent among substance abusers, and make it extremely difficult to identify the problem, gain client acknowledgement, and link clients to appropriate services. A phenomenon occurs each year in Area 12 during the annual patient care and prevention needs assessment process. Consumers are surveyed and asked to prioritize available health and support services in order of greatest need for themselves and the community at-large. At the same time, area providers are requested to complete the same exercise. Results over the past five years consistently show that local consumers consider substance abuse treatment to be one of the lowest priority needs in the region; while provider responses indicate this is one of the most predominant issues and needs throughout the jurisdiction. These findings indicate a significant level of denial among persons affected by this type of disorder; further reducing the effectiveness of HIV prevention messages and strategies within this population.

The absence of an active, community-wide marketing campaign designed to educate the general population about the true prevalence, effects, and risks of HIV. It is believed that this type of program will serve to help reduce stigma and misunderstandings surrounding the disease, as well as raise awareness about the causes of transmission along with the needs of persons who are either at-risk or living with HIV - ultimately leading to more open discussions and willingness to explore preventative behaviors and alternatives. Many consumers still report, 2 decades into the epidemic, that family members have exiled them, refuse to eat from the same dishes or eating utensils, and will not use bathroom facilities that have been utilized by a person who is HIV-positive. Basic education and marketing is needed to open lines of communication to persons who have such negative misperceptions regarding the virus.

A related gap involves a **lack of participation from local Faith Leaders, Educators, and elected government officials**. A shortage of public attention toward HIV fuels increasing levels of apathy and ignorance about the disease throughout entire communities. Especially in minority communities, faith leaders are viewed as popular opinion setters, and could play a vital role in educating congregations about the risks and consequences of becoming infected.

There are only a total of three local churches that have actively participated in HIV Prevention Community Planning within the region, and approximately the same number have participated in HIV Prevention community events during the past three years. There has been no reported representation or interest from the local board(s) of education or government officials at any HIV-related community events in Volusia or Flagler Counties during the past two years.

Intensive risk-reduction counseling, education, and case management has been identified as a priority need among persons who are unable to adopt safer behaviors, and those who have difficulty maintaining them. As stated earlier, many local residents regularly experience a combination of many obstacles and barriers during their daily lives that prevent them from considering recommended risk-reduction strategies. Persons who cannot afford stable housing, for example, may turn to prostitution, drugs, or other undesirable activities in order to generate the money they need to survive and eat each day. It has been documented that HIV Prevention strategies are not a high priority among individuals who have more pressing needs.

Culturally appropriate group and individual-level education and counseling is a reported need among both African-American and Hispanic populations. The distinct cultural norms of these minority groups often contradict or inhibit safer sex and risk-reduction intentions, especially for the women in these populations. African-American women, for example, report that male sexual partners often do not “like” to use condoms and exercise a common level of dominance within the population that enables them to virtually “force” women to practice unsafe sex. Similar instances have been reported by Hispanic women as well; along with a reported stigma toward women in Hispanic communities who carry condoms or even openly discuss safer sexual practices. Many of these women report being made to feel “dirty” by family members, elders, and even peers on the basis that they were obviously planning to engage in pre or extramarital sex because they obtain or carry condoms. Strong religious and moral values among tight-knit Latino/a communities further enforce these types of negative attitudes and perceptions. Additionally, gay and bisexual men have acknowledged that there is a significant proportion of minority male populations that have sex with other men, but do not reveal this behavior to unsuspecting female sex partners. Severe stigma toward same-sex intercourse instills fear among many “closet” gay and bisexual men in minority communities, preventing them from accessing appropriate information and services.

Residents of the western and **outlying regions of Volusia/Flagler** report a lack of programs and services within geographically accessible range. To date, there are very few programs that are based or that have service sites near residents who live outside of the Daytona Beach metropolitan area in central Volusia County. Residents who do not have personal transportation face even greater challenges in relation to long travel distances to reach needed support and services. Consumers in Deland, Deltona, and DeBary report 2-3 hour one-way bus rides to the county health department for counseling and testing services. Several community-based agencies are actively working to expand services into these outlying areas.

HIV Prevention Interventions

The Centers for Disease Control and Prevention (CDC) has sponsored and conducted large volumes of research intended to measure the level of effectiveness of various behavioral interventions in influencing positive change among persons who either voluntarily or uncontrollably place themselves at risk of acquiring and/or transmitting the HIV virus. Through this process, the Federal agency has identified a set of HIV prevention activities and structured interventions that have been “proven effective” through sound scientific methodologies and practices. The CDC has developed and maintains two internet resource databases containing the detailed information, technical assistance, and materials needed to conduct these “proven” interventions, as available supplements to the guidelines and strategies outlined in the *Advancing HIV Prevention* initiative.

The agency has limited direct grant funding to programs that plan to implement one or more of the interventions contained within one of the two internet resource lists; and the Florida Department of Health opted to adopt the same requirements during the most recent funding award cycle in 2004. The complete list(s) of interventions and related materials can be accessed via the internet at the following locations:

Replicating Effective Programs (REP): <http://www.cdc.gov/hiv/projects/rep/default.htm>
REP helps make HIV prevention interventions that have been shown to work more accessible. They use everyday language, and are packaged to be “user-friendly” way.

Diffusion of Effective Behavioral Interventions (DEBI): <http://www.effectiveinterventions.org/>
DEBI provides training and technical assistance for health departments and CBO's that are implementing and performing evidence-based interventions.

Each of the CDC endorsed intervention packages targets a specific population group; and there are interventions available for a variety of populations and settings. Additionally, the federal authority allows agencies and networks to *adapt* and/or *tailor* the proposed curricula of the interventions to meet the special and unique needs of each community they intend to serve. There are, however, distinct **core elements** of each program that must remain in tact and without alteration in order to qualify for Federal or State funding. These elements are considered primary defining factors required for the intervention to be effective. There are also several **key characteristics** that are secondary defining characteristics of the original intervention, and the CDC recommends those be preserved as well; although does not specifically prohibit their enhancement or modification.

The CDC published a guidance document soon after the announcement of the AHP initiative in 2004 to assist health departments and community-based organizations (CBO's) in planning for, implementing, and providing the evidence-based interventions mentioned above. An updated and revised version of the document was released in April 2006, under the title of **Provisional Procedural Guidance for Community-Based Organizations**. The agency then also developed and published a streamlined “At-a-Glance” version of the guidance as a more user-friendly tool for “front line” CBO and Health Department staff.

The complete CDC Provisional Procedural Guidance documents can be accessed online at:
http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance.pdf

The abridged “At-a-Glance” version of the document can also be found online at:
http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/PGAtaglace.pdf

The documents contain information, technical assistance, and requirements of the following interventions, for the target populations shown. Information about adapting and tailoring the interventions to specific community needs is offered in the procedural guidance as well as on one or both of the REP and DEBI internet resources mentioned on the previous page.

TARGET POPULATION	RECOMMENDED INTERVENTIONS
Black MSM	Mpowerment
-----	Popular Opinion Leader
Hispanic MSM	Community Promise
-----	Healthy Relationships
White MSM	Many Men Many Voices
Black Heterosexuals	RAPP
-----	SISTA (<i>Women</i>)
-----	VOICES / VOCES
Hispanic Heterosexuals	Partnership for Health light Healthy Relationships
Black IDU	-----
-----	Community Promise
Hispanic IDU	-----
-----	Safety Counts
White IDU	
White Heterosexuals	RAPP
-----	VOICES/VOCES
-----	Partnership for Health light Healthy Relationships
<i>PLWHA</i>	Partnership for Health Healthy Relationships Integrating Prevention into Routine Medical Care Teens Linked to Care Holistic Harm Reduction Program
<i>Youth</i>	Community Promise Street Smart
<i>Incarcerated</i>	VOICES
<i>Homeless</i>	Street Smart

UPGRADING THE NETWORK

The Florida HIV Prevention Planning Group (PPG) has recommended that each local planning partnership identify and prioritize a set of **Technical Assistance** and **Capacity Building** needs within its existing HIV/AIDS Prevention service delivery network. The CDC provides the following definitions for technical assistance and capacity building:

Technical Assistance (TA): *the provision of expert programmatic, scientific, and technical support to organizations and communities in the design, implementation, and evaluation of HIV prevention interventions and programs.*

Capacity Building: *Activities that strengthen the core competencies of an organization (or network) and contribute to its ability to develop and implement an effective HIV prevention intervention; as well as sustain the infrastructure and resource base necessary to support and maintain the intervention.*

The CDC strongly values these functions, and such has created an entire branch dedicated to providing this type of assistance to a multitude of organizations. The agency's *Capacity Building Branch* (CBB) provides national leadership to ensure that the HIV prevention workforce has the knowledge, skills and technology to effectively and efficiently conduct HIV prevention across the country. The CBB is comprised of three distinct teams:

The Science Application Team strengthens and enhances the science-base and effectiveness of HIV prevention programs through the application of principles and methods of behavioral and social science and evaluation.

The Partnerships Team ensures effective implementation and coordination of Capacity Building projects to strengthen HIV prevention in communities of color.

The Training and Development Team develops, delivers, and coordinates curricula-based training activities to trainers and other providers to increase their skills relating to teaching and/or conducting HIV prevention programs.

The CBB partners with other federal agencies, national and regional non-governmental organizations, and other capacity building providers in the private and public sectors to provide Capacity Building Assistance (CBA) to HIV prevention planning groups, community-based organizations, health departments, and other HIV prevention stakeholders.

Additionally, the Florida Bureau of HIV/AIDS, Prevention Section, has developed the *Academy for Prevention Leadership* to assist leaders and prevention staff in increasing necessary skills to administer effective prevention interventions. The Academy is comprised of two separate centers, including a *Prevention Leadership Institute* and a *Capacity Building Enterprise Center*.

The Leadership Institute focuses educational programs around program proficiency, administrative infrastructure, and program design. The Capacity Building Center also addresses the same issues from an organizational perspective, but also includes specific trainings for organizational staff to implement the REP and/or DEBI interventions.

The statewide PPG provided a list of suggested technical assistance topics within a tool designed to identify the local partnerships' degree of need for each. The members of PCHAP discussed each suggested topic and deliberated to produce a final list of local needs in April of 2006. The subjects that were identified as "extremely or very" important to the partnership were:

- Client recruitment and retention**
(Including marketing and information distribution)
- Health education for HIV, STD's, HEP, and TB**
- Cultural Competency**
- Grant seeking and grant writing**
- Adapting and Tailoring REP/DEBI Interventions**

The members agreed that the partnership performs well in the areas of using epidemiological data and priority setting tools, conducting meetings using Robert's Rules, and developing a streamlined local prevention plan. Technical assistance and/or capacity building assistance is not considered a need to support these activities in Area 12 at this time.

