



## **SC HIV PREVENTION PLAN 2010-2014**

October 5, 2009

STD/HIV DIVISION  
SC DEPARTMENT OF HEALTH &  
ENVIRONMENTAL CONTROL

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Planning for prevention of Human Immunodeficiency Virus (HIV) has been an integral part of programs at the SC Department of Health and Environmental Control (DHEC) STD/HIV Division for more than 24 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. A new model for integrated community planning that includes both HIV prevention and care was implemented at DHEC in January 2005 after a yearlong community participatory planning process with stakeholders. The mission of the **SC HIV Planning Council (HPC)** is to develop a comprehensive, statewide HIV Prevention and Care Plan for a responsive, effective, and efficient continuum of services for persons living with HIV/AIDS and those at risk for HIV infection. Establishing linkages between clinical care settings and community-based prevention providers is essential to creating a comprehensive prevention-care service environment.

This comprehensive five-year 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 identify appropriate interventions. DHEC and the HPC 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 HPC 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 collaborative efforts with our state, agency, and community partners, we can make a difference in the future of this epidemic in South Carolina.

Troy A. Bowers  
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Susan L. Fulmer  
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September 10, 2009

## Updates of the SC HIV Prevention Plan

The 2010-2014 SC HIV Prevention Plan is a living and evolving document, with continual review and updating as is necessary. Chapter 1, the Epidemiologic Profile for HIV/AIDS in South Carolina, is updated annually. With major changes in 2012 in the CDC guidance for HIV Planning, the updating of several chapters is necessary. Chapters 2 and 9 (Community Services Assessment and Recommendations and Goals for Prevention Services, respectively) were revised and submitted with the Interim Progress Report in September 2012. The Engagement Plan has been completed. Additional revisions are underway and will be submitted in December 2012 and as otherwise needed.

Troy A. Bowers  
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## ACKNOWLEDGEMENTS

*We gratefully acknowledge the following members of the South Carolina HIV Planning Council during 2008-2009 that contributed their time, expertise and advice to make this plan possible.*

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*We gratefully acknowledge the following members of the South Carolina HIV Planning Council during 2012 that contributed their time, expertise and advice to make the updates of this plan possible.*

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## EXECUTIVE SUMMARY

The **2010-2014 Comprehensive HIV Prevention Plan** is the culmination of work completed between 2008 and mid-year 2009, with Epidemiologic Profile updates in 2010-2012 by the South Carolina HIV Planning Council (HPC) in collaboration with the South Carolina Department of Health and Environmental Control (DHEC) STD/HIV Division. The original 2010-2014 Comprehensive Plan, submitted in 2009 to the Centers for Disease Control and Prevention (CDC), was completed in compliance with the 2002-2008 HIV Prevention Community Planning Guidance put forth by the CDC. The 2012 updates are completed in compliance with the CDC's new guidance for HIV planning, release in 2012. While the 2010-2014 Comprehensive Plan cannot fully address or prioritize all HIV prevention needs in South Carolina, the HPC, in collaboration with DHEC, combined science, data and the wisdom of affected communities to identify effective strategies for the populations most in need of prevention services with the goal of reducing the greatest number of new infections.

The **2010-2014 Comprehensive HIV Prevention Plan** includes the following 10 sections:

- ◆ Epidemiologic Profile for HIV/AIDS in South Carolina;
- ◆ Community Services Assessment;
- ◆ Prioritization of Target Populations;
- ◆ Recommended HIV Prevention Interventions;
- ◆ Coordination and Linkages (with affiliated programs/agencies/services in South Carolina);
- ◆ Surveillance and Data Collection Initiatives (completed or underway between 2005 and mid-year 2009);
- ◆ Technical Assistance Needs and Priorities;
- ◆ Evaluation and Monitoring;
- ◆ Recommendations and Goals for Prevention Services; and
- ◆ Appendices to the Plan.

The **2010-2014 Comprehensive HIV Prevention Plan** originally replaced the 2005-2008 Plan released in 2004 (with update for 2009), with some distinct differences in the document:

- ◆ The Community Services Assessment includes a description of needs assessment activities, identification of populations at risk and unmet needs, identification of additional needs, a resource inventory with checklist, and an analysis of gaps;
- ◆ A new model was developed to prioritize populations, which utilized both quantitative and qualitative data;
- ◆ Interventions selected for priority populations now include the Diffusion of Effective Behavioral Interventions (DEBIs), stressing the importance of utilizing evidence-based interventions that have shown to be effective in reducing HIV risk factors; and
- ◆ The prioritization of HIV prevention interventions was no longer required by the CDC's 2002-2008 HIV Prevention Community Planning Guidance.

The 2012 updates to the **2010-2014 Comprehensive HIV Prevention Plan** include a revised Community Services Assessment (Chapter 2) as well as revised Recommendations and Goals (Chapter 9). Other updates (resource checklists and gap analysis and the prioritization of target populations, and the attachments thereto) will be completed by December 2012. The updated Surveillance and Data Collection Initiatives will be completed by early 2013.

# An Epidemiologic Profile of HIV and AIDS in South Carolina 2015



Division of Surveillance and Technical Support  
Bureau of Disease Control  
South Carolina Department of Health and  
Environmental Control

## Executive Summary

In June 1981, the CDC published a report which documented five cases of *Pneumocystis carinii* pneumonia in otherwise healthy young men in Los Angeles, California; these would be considered the first cases of AIDS identified in the United States. That report would prompt AIDS case reports from other areas of the U.S. such as New York, San Francisco, and in 1982, South Carolina.

Since 1986, more than 27,671 people have been diagnosed with HIV infection (including AIDS) in South Carolina through December 2014. During 1985-1990 an average of 860 cases were diagnosed each year. In the subsequent three years (1991-1993), newly diagnosed HIV/AIDS cases averaged 1,306. 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 average number of newly diagnosed cases has been about 759 per year. According to the CDC however, many more people are infected but have not been tested.

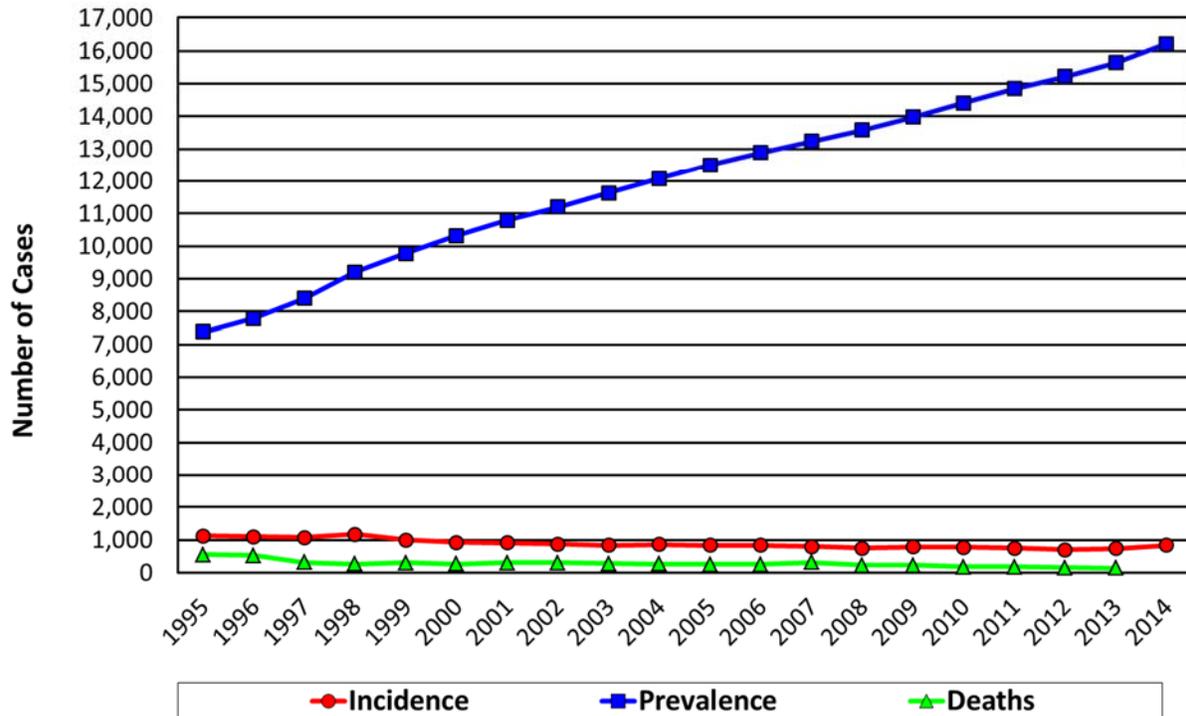
Some of the changes over time in numbers of new cases are largely the result of reporting patterns or targeted testing initiatives. The initial steep rise in the epidemic reflects the early years when less was known about the transmission of HIV and effective medical treatments did not exist. As a result, 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.

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 145 AIDS related deaths in 2013, a 45 percent decrease from the 266 deaths in 2004. 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 people estimated to be living with HIV/AIDS) is continuously increasing. The number of people living with HIV/AIDS (PLWHA) at the end of each year has increased 30 percent from 2005 to 2014. 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.

## Epidemiologic Profile

Figure 1.01 shows total incidence (the number of new cases within a specified time period), deaths, and prevalence of HIV/AIDS cases in South Carolina since 1994.

**Figure 1.01: South Carolina HIV/AIDS incidence, prevalence, and deaths**



Note: number of cases diagnosed in S.C. only; excludes out of state cases returning to S.C.

The epidemic in South Carolina is predominantly 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.

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## Overview of Epidemiologic Profile

The purpose of this Epidemiologic Profile is to provide information to the S.C. HIV Planning Council (HPC) on the number and characteristics of people becoming HIV infected. The HPC has a primary responsibility to review the Epidemiologic Profile and ensure that HIV prevention services and resources are directed by DHEC to the populations and geographic areas with the greatest disease burden.

This Epidemiologic Profile 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:

**What are the socio-demographic characteristics of the population?**

**What is the impact of HIV/AIDS on the population?**

**Who is at risk for becoming infected with HIV?**

**What is the geographic distribution of HIV infection? \***

**What are the patterns of service utilization of people living with HIV/AIDS?**

**What are the characteristics of people who know they are HIV-positive but who are not in HIV primary care?**

These questions will be explored through analyses of currently living with HIV/AIDS (prevalence) and newly diagnosed (incidence) 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.

## 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.

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

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

**Health Professional Shortage Area (HPSA)** – A Department of Health and Human Services (HHS) designation system to identify areas facing a critical shortage of primary medical, dental, or mental health care professionals.

**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 occurs in a population over a period of time. It is also a measure of risk of getting the disease.

**Natural Breaks (Jenks)** – Is a data classification method designed to determine the best arrangement of values into different classes. This is done by seeking to minimize each class's average deviation from the class mean, while maximizing each class's deviation from the means of the other groups.

**Other Risks** – In relation to Risk Exposures, the term “Other” or “Other Risks” is used to describe a group of risks which include such categories as: hemophilia, blood transfusion, and perinatally acquired infection.

**PLWHA** – People Living With HIV/AIDS.

**Prevalence** – The number or proportion of people 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 people 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 behaviors. 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 people with STD or HIV who seek treatment, or data on estimated condom use among women cannot 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 work-group to complete the South Carolina Epidemiologic Profile of HIV/AIDS.

### **Selected Data Source Description and Limitations:**

#### **DHEC, Enhanced HIV/AIDS Reporting Surveillance System (eHARS)**

All health care providers, hospitals, and laboratories in South Carolina are required to report people 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. DHEC's surveillance system, eHARS, serves various functions: 1) monitoring the incidence and demographic profile of HIV/AIDS; 2) describing the modes of transmission among people with HIV/AIDS; 3) guiding the development and implementation of public health intervention and prevention programs; and 4) assisting 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 people. It includes people 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 people. AIDS surveillance data do not represent people 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 not all HIV-infected people in the population have been 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 (people 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 people seeking or receiving HIV testing early in their infection stages, provide an opportunity to compare people 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 37 percent of adult/adolescent HIV infection/AIDS cases reported in 2014 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 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, people 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”.

### **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 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 people with these infections have no symptoms or do not recognize symptoms. Most studies of STDs are conducted in health-care settings specifically for people who do recognize symptoms; therefore, these studies usually overestimate the proportion of infected people who are symptomatic. Studies of STD screening in non-health-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) suggests that most people 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, where screening of asymptomatic people 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 likelihood 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.

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

Counseling and testing data, while highly informative about people 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 people 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 includes 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.

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. People who received multiple tests during the report period are only counted once. It includes people tested in family clinics, maternity clinics, TB, STD clinics and people voluntarily requesting services or referred through partner counseling services. Approximately one third of the total of newly diagnosed and reported people with HIV infection each year is from DHEC counseling and testing sites. People 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: men who have sex with men (MSM), injection drug use (IDU), or heterosexual contact with a person at risk for or infected with HIV. 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.

The CDC's hierarchy of risk includes a category for the combined risks of MSM and IDU; in previous HIV/AIDS Epidemiologic Profiles, the combined risks of MSM and IDU have been grouped and reported within the single category of 'Injection Drug Use'. This report leaves the combined risks of MSM and IDU as a stand-alone category. 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.

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.

### **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 Health Resources and Services Administration (HRSA).

### **South Carolina Community Assessment Network (SCAN)**

Its purpose is to provide basic reference data for a variety of users. The primary use of SCAN is 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.

SCAN is also used to enumerate and characterize birth attributes.

### **U.S. Department of Health and Human Services (DHHS): National Survey on Drug Use and Health (NSDUH)**

The National Survey on Drug Use and Health is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. The Substance Abuse and Mental Health Services Administration (SAMHSA), which funds NSDUH, is an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services (DHHS). Supervision of the project comes from SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ).

Through a competitive bidding process, SAMHSA selected Research Triangle Institute (RTI) to conduct the NSDUH through 2014. RTI has successfully conducted the survey since 1988. RTI's role in this long-term national effort includes study design, sample selection, data collection, data processing, analysis, and reporting.

Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. To assess and monitor the nature of drug and alcohol use and the consequences of abuse, NSDUH strives to:

- provide accurate data on the level and patterns of alcohol, tobacco and illegal substance use and abuse;
- track trends in the use of alcohol, tobacco, and various types of drugs;
- assess the consequences of substance use and abuse; and
- identify those groups at high risk for substance use and abuse.

## Epidemiologic Profile

A scientific random sample of households is selected across the United States, and a professional RTI interviewer makes a personal visit to each selected household. After answering a few general questions during the in-person visit by the interviewer, one or two residents of the household may be asked to participate in the survey by completing an interview. Since the survey is based on a random sample, each selected person represents more than 4,500 United States residents.

Participants complete the interview in the privacy of their own home. A professional RTI interviewer personally visits each selected person to administer the interview using a laptop computer. Individuals answer most of the interview questions in private and enter their responses directly into the computer so even the interviewer does not know the answer entered. For some items, the interviewer reads the question aloud and enters the participant's response into the computer.

Each interview data file – identified only by a code number – is electronically transmitted to RTI on the same day the interview is conducted. Combined with all other participants' answers, the data are then coded, totaled, and turned into statistics for analysis. As a quality control measure, participants may receive a telephone call or letter from RTI to verify the interviewer completed the interview with them in a professional manner.

### **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 system consists of national, state, and local school-based surveys. In South Carolina, the YRBS consists of questionnaires administered to middle school (6th-8th grade) and high school (9th-12th grade) students in the public school system. A two-stage sampling process is used to provide a state-wide sample at each level. In the first stage, regular public schools with any of the target grades are sampled with probability proportional to the school enrollment. In the second stage, intact classes are sampled randomly and all students in these classes are eligible to participate. The overall response rate is calculated as the percentage of sampled schools that participate multiplied by the percentage of sampled students that complete useable surveys. If this overall response rate is 60% or greater, the resulting data are weighted to be representative of the state as a whole.

There are 367 private K-12 schools in South Carolina; however, none of them are included in the survey. Also, while schools are randomly selected for participation some may choose not to participate. The survey includes questions about injury and violence, tobacco use, alcohol and other drug use, sexual risk behaviors, physical activity, and nutrition behaviors (the specific questions can vary from year to year).

This survey is conducted by S.C. Healthy Schools at the Department of Education, and relies heavily on surveillance methods and self-reports; so it depends on how well respondents understand the questions and how well they can accurately and honestly answer the question. However, the questionnaire has demonstrated good test-retest validity and the data are edited, checked and weighted. These data are representative of only public middle school students (grades 6-8) or public high school students (grades 9-12) in South Carolina.

## 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 people 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 30,061 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. Manufacturing is the state's leading industry, followed by tourism and forestry.

### Populations

Based on Census Bureau data, the total number of South Carolinians is 4,832,482 (2014 estimate). Of this total, 64 percent were Caucasian, 27 percent were African-American, 0.4 percent were Native American/Alaskan, 1.5 percent were Asian/Pacific Islander and 5.4 percent were of Hispanic origin. Fifty-one percent are female and 49 percent are male. 67 percent of the population distribution in South Carolina is defined as metropolitan; 33 percent is non-metropolitan. (Figure 1.02).

**Figure 1.02: Selected demographic information  
South Carolina and United States**

	South Carolina	United States
Population (2014 est.)	4,832,482	318,857,056
Proportion of Persons Living in Non-Metropolitan Areas, 2013	33%	14%
Median Age, 2014	38.8	37.7
Racial/Ethnic Distribution of Pop. (2014 est.)		
White	64%	62%
Black	27%	12%
Hispanic	5%	17%
Educational Attainment 2013		
High school grad. or higher	85%	86%
Bachelor's degree or higher	25%	29%
Unemployment Rate, 2014	6.4	6.2
Median Household Income, 2013	\$44,779	\$53,046

Sources: U.S. Census Bureau.

**Education & Earnings**

Educational attainment is strongly correlated with poverty, and South Carolina continues to rank low in percent of people over 25 years of age who have bachelor’s degrees or higher (40th of fifty states and District of Columbia). Just over fifteen percent (15.1 percent) of the population has less than a high school education. By race, 11 percent of the white population, and 21 percent of the African American population, over the age of 25 in South Carolina have an educational attainment of less than a high school diploma.

In comparison, African-Americans and people of Hispanic origin have lower per capita incomes, averaging 38 percent below the state’s mean income, while Asian and whites earned 10 percent above the state’s mean income. (Figure 1.3)

**Figure 1.03: S.C. Per Capita Income by Race and Ethnicity**

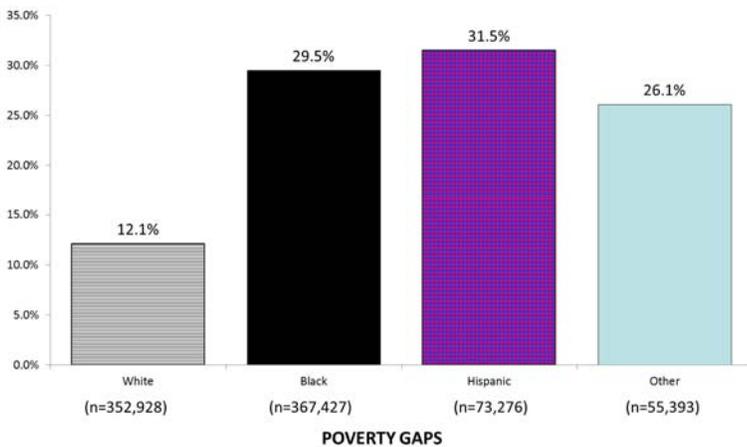
Per Capita (mean) Income (2013 Inflation-Adjusted Dollars)	Estimate	Relative to African-Americans
African-American	\$ 15,627	1.0
American Indian/Alaska Native	\$ 17,962	1.1
Asian	\$ 23,768	1.5
Hispanic or Latino origin (of any race)	\$ 13,572	0.9
Native Hawaiian/Other Pacific Islander	\$ 18,083	1.2
White (non-Hispanic)	\$ 28,295	1.8
<b>South Carolina Overall :</b>	<b>\$ 23,687</b>	<b>1.5</b>

Data Sources: U.S. Census Bureau

**Poverty Level**

Despite the economic strides made in recent years, South Carolina remains among states with the highest percentage of people who live below the poverty level (10th of fifty states, District of Columbia, and Puerto Rico). According to US Census Bureau data, in South Carolina approximately 18.1 percent of individuals and 13.7 percent of families live below the poverty level.

**Figure 1.04: Percent of each racial/ethnic pop. living below federal poverty level: S.C. 2013**



Data Source: U.S. Census Bureau, American Community Survey.

An estimated 30 percent of African-American South Carolinians were below the poverty level in 2013, compared to 32 percent of people of Hispanic descent, 12 percent among whites and 26 percent of people categorized as ‘Other’, which includes Asian, Pacific Islanders and Native Americans (Figure 1.04).

### Insurance/Access to Primary Care

Almost sixteen percent (15.8 percent) of South Carolinians do not have health insurance coverage and 35 percent have some type of public health insurance. In South Carolina, all or part of forty-five (out of forty-six) counties are designated as Health Professional Shortage Areas (HPSA). An estimated 1,253,951 South Carolinians live in HPSAs; or approximately 27.1 percent of the South Carolina's population, compared to 17.7 percent of the total U.S. population (Figure 1.05).

**Figure 1.05: Selected access indicators, S.C. and U.S.**

	South Carolina	United States
<b>Total Population Uninsured, 2013</b>	<b>15.8%</b>	<b>14.5%</b>
<b>Individuals Below 200% Poverty Level, 2013</b>	<b>40.1%</b>	<b>34.8%</b>
<b>Population living in a Primary Care Health Professional Shortage Area, 2012</b>	<b>27.1%</b>	<b>17.7%</b>
<b>Population with public health insurance coverage, 2013</b>	<b>34.5%</b>	<b>31.6%</b>

Data Source: U.S. Census Bureau, American Community Survey.

### Employment

South Carolina's unemployment rate at mid-year 2014 was 6.4 percent, slightly higher than the US rate of 6.2 percent. The median household income in South Carolina was \$44,779 (\$8,000 below the US median income of \$53,046).

### Housing

According to the US Census, 68 percent of the state's homes were owned. The S.C. Council on Homelessness estimates there were 5,040 homeless adults and children in 2014.

### 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.

## 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. Current surveillance activities provide 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 2013, according to the CDC HIV/AIDS Surveillance Report, South Carolina ranked 13th among states, the District of Columbia, and U.S. dependent areas with an AIDS case rate of 10.5 per 100,000 population (*the first time S.C. has not been in the top 10 states*). The epidemic is continuing to grow with an average of 70 cases of HIV infection reported each month during 2014. As of December 31, 2014, among South Carolina residents 16,222 people have been reported living with HIV infection (including AIDS). The incidence rate in South Carolina for 2014 is 17.4 per 100,000 population.

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

### Gender

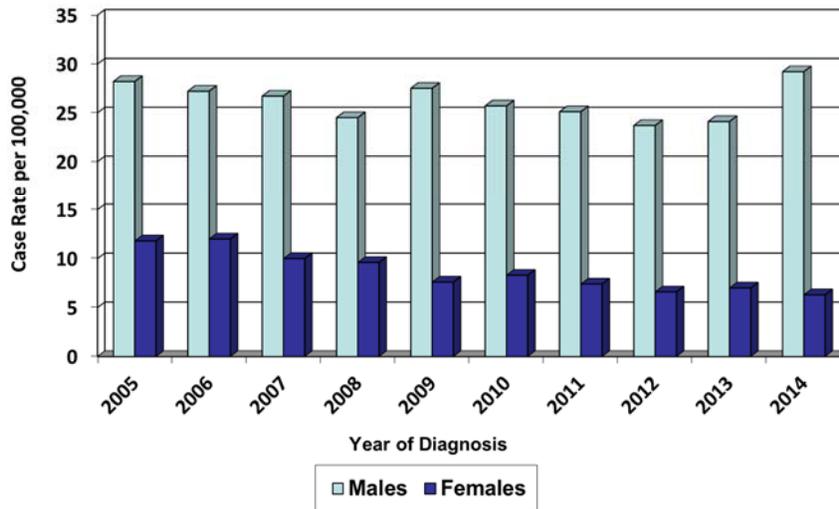
Figure 2.01 shows the impact of HIV on the men and women in South Carolina. Men unequivocally are disproportionately affected by HIV/AIDS. Men make up 49 percent of South Carolina's total population, but comprise 71 percent of PLWHA (prevalence). HIV/AIDS diagnosed cases during the two-year period 2013-2014 gives an estimate of more recent infections or potentially emerging populations.

**Figure 2.01: Disproportionate S.C. HIV impact by sex**

SEX	S.C. Total Population, 2014 est.		Total Estimated Living With HIV/AIDS, 2014		Total HIV/AIDS Diagnosis, 2013-2014	
	No.	%	No.	%	No.	%
Male	2,349,394	49%	11,482	71%	1,243	79%
Female	2,483,088	51%	4,740	29%	328	21%
Total	4,832,482		16,222		1,571	

Figure 2.02 shows the rate per 100,000 population for males and females diagnosed with HIV/AIDS from 2005 to 2014. The graph shows how the case rate fluctuates from year-to-year for both men and women. The rate for females has a downward trend, and the rate for 2014 was 10 percent lower than the rate in 2013. For males, the rate has more pronounced fluctuations; with the rate for 2014 being 21 percent higher than the rate in 2013.

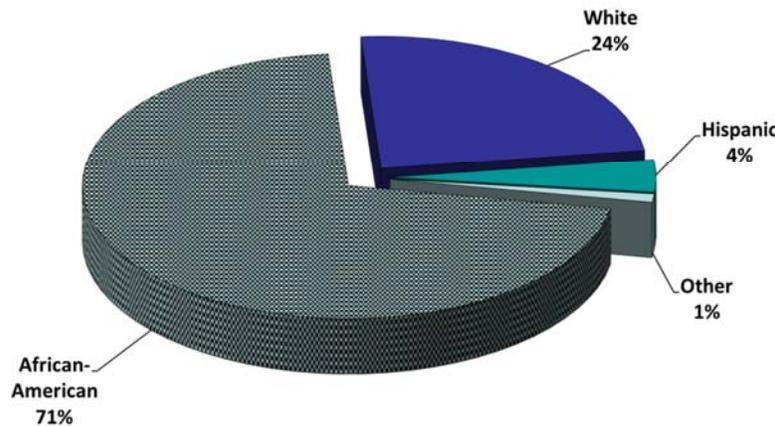
**Figure 2.02: S.C. HIV/AIDS case rate per 100,000 for males and females, 2005-2014**



**Race/Ethnicity**

African-Americans are disproportionately impacted by HIV/AIDS in South Carolina. African-Americans comprise 28 percent of the state’s total population, yet 71 percent of the total people living with HIV are African-American. Four percent of total cases are Hispanics, who comprise five percent of the state’s population (Figure 2.03).

**Figure 2.03: Proportion of persons living with HIV/AIDS by race/ethnicity, 2014**



## Epidemiologic Profile

African-American men, who comprise only 13 percent of the state’s population, make up the largest proportion of both PLWHA in 2014 and new diagnosis in 2013/2014 (48 percent and 54 percent respectively).

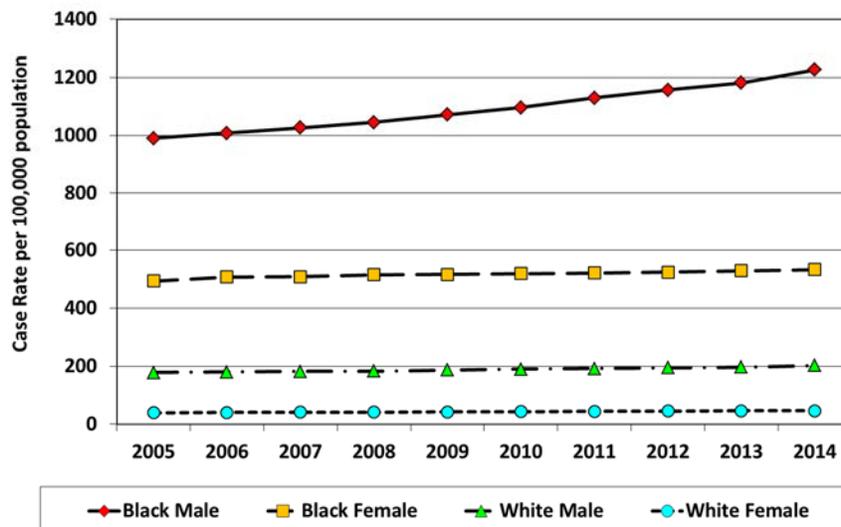
African-American women, who similarly comprise 15 percent of the population, make up 24 percent of PLWHA in 2014 and 16 percent of new diagnosis in 2013/2014. Whites, who comprise the largest proportion of the population in South Carolina (32 percent males; 33 percent females), make up 24 percent of PLWHA in 2014 (19 percent males; five percent females) and 23 percent of new diagnosis in 2013/2014 (19 percent males; four percent females), (Figure 2.04).

**Figure 2.04: Disproportionate HIV impact by race/ethnicity/gender, S.C.**

Race/Ethnicity & Gender	SC Total Population		Total Persons Living With HIV/AIDS, 2014		Total HIV/AIDS Diagnosis, 2013-2014	
	No.	%	No.	%	No.	%
Black Males	632,321	13%	7,760	48%	847	54%
Black Females	716,223	15%	3,815	24%	247	16%
White Males	1,528,126	32%	3,103	19%	297	19%
White Females	1,594,167	33%	742	5%	59	4%
Hispanic Males	141,679	3%	459	3%	60	4%
Hispanic Females	120,073	2%	122	1%	13	1%

Each year the number of all people 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 2.05 shows, the rate per 100,000 population in 2014 is six times higher for black males than for white males, and eleven times higher for black females compared to white females.

**Figure 2.05: S.C. HIV/AIDS prevalence rates by race/gender, 2005-2014**

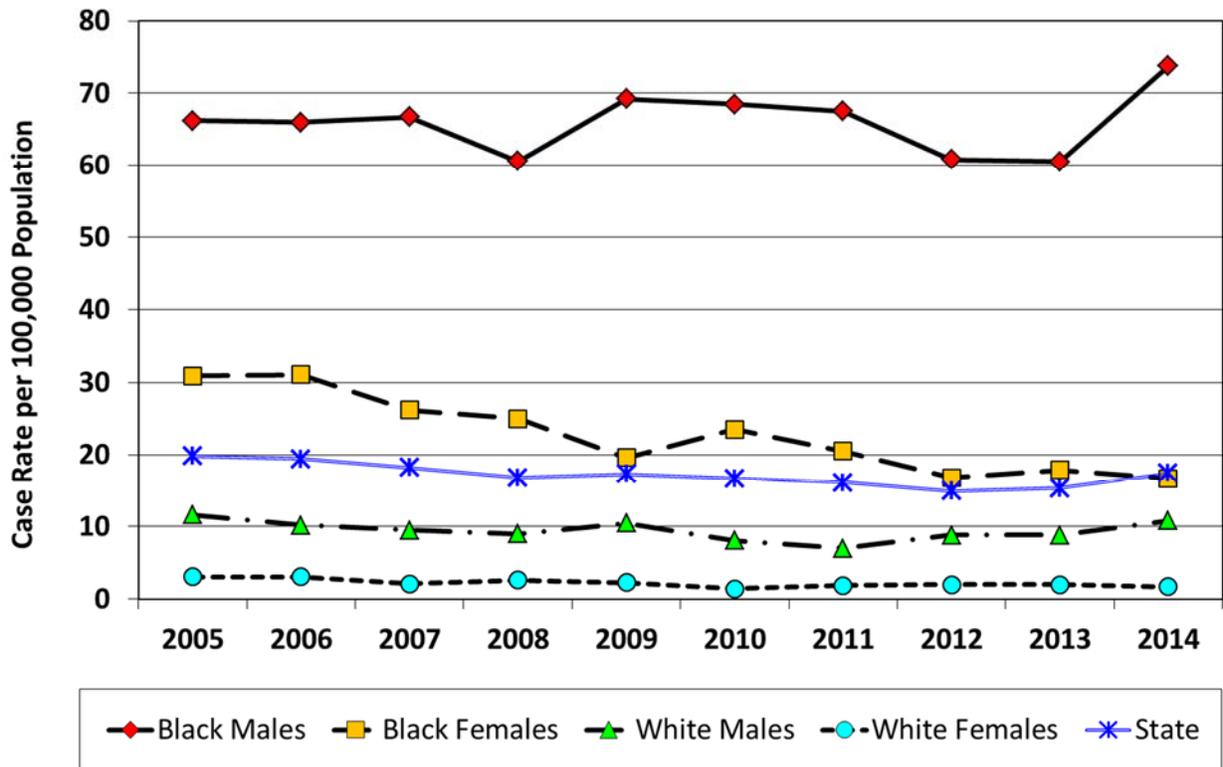


In South Carolina, the trend in the number and rate of people newly diagnosed with HIV/AIDS each year has been declining; with a 12 percent decrease in the rate per 100,000 population between 2005 (19.8) and 2014 (17.4). However, during this ten year time period, there have been high and low fluctuations from one year to the next; the 2014 rate is 14 percent higher than the rate in 2013 (15.3). There are also important differences in the rates among race/gender populations (Figure 2.06).

Women have seen the sharpest decline in rate of newly diagnosed HIV/AIDS. The rate for African-American women has decreased 46 percent between 2005 (30.9) and 2014 (16.7) and the rate for white women has decreased 45 percent over the same time period (3.1 to 1.7). Even in 2014 when the state rate increased from 2013, the rate for women decreased; seven percent for African-American women (17.9 to 16.7) and 15 percent for white women (2.0 to 1.7).

Men have not seen the same decline in the rate of newly diagnosed HIV/AIDS as women have; the rate in 2014 for African-American males (73.8) is 11 percent higher than the rate in 2005 (66.2), while the rate for white males decreased seven percent over the same time period (11.6 to 10.8). From 2013 to 2014, the rate of newly diagnosed HIV/AIDS increased for both African-American males (60.5 to 73.8) and white males (8.8 to 10.8), a 22 percent and 23 percent increase (respectively).

**Figure 2.06: S.C. HIV/AIDS case rates by race/gender and year of diagnosis, 2005-2014**



**Age**

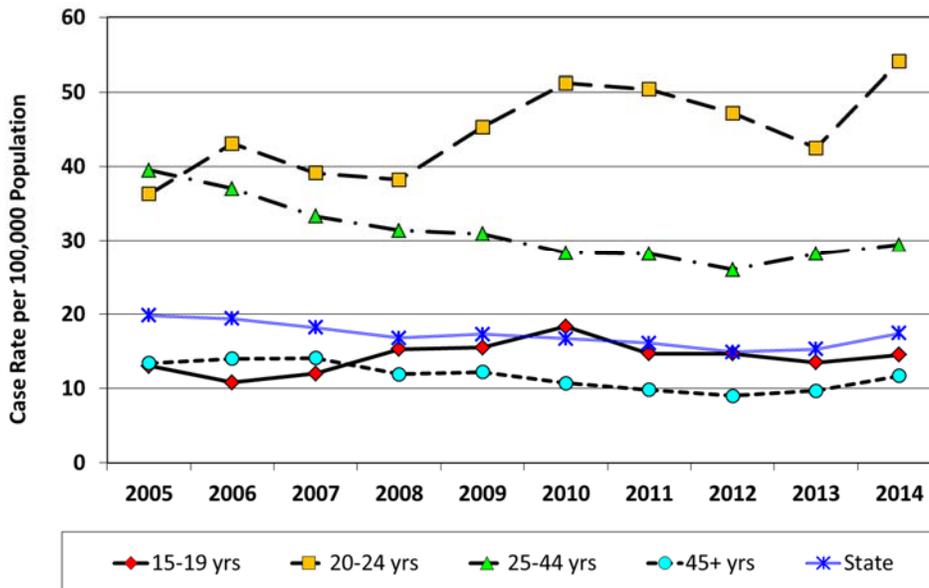
People between the ages of 20 and 44 are disproportionately impacted. They make up 32 percent of the total population yet they represent about 42 percent of PLWHA and 67 percent of newly diagnosed cases (Figure 2.07).

**Figure 2.07: Disproportionate S.C. HIV impact by age**

Age Range	SC Population		Total Persons Living with HIV/AIDS, 2014		Total HIV/ AIDS Diagnosis, 2013-2014	
	No.	%	No.	%	No.	%
<15 Years	903,343	19%	46	0.3%	10	0.6%
15-19 Years	310,676	6%	81	0.5%	87	6%
20-24 Years	352,705	7%	749	5%	342	22%
25-44 Years	1,223,680	25%	5,971	37%	701	45%
45+ Years	2,042,078	42%	9,375	58%	431	27%

Figure 2.08 shows HIV/AIDS case rates by year of diagnosis for selected age groups. Between 2005 and 2014, people 15-24 had the largest increase in the rate of newly diagnosed HIV/AIDS. The rate for people 20-24 years of age increased 49 percent from 2005 (36.3) to 2014 (54.1) and the rate for people 15-19 increased 12 percent over the same time period (13.0 to 14.5). While people age 25-44, and 45 and over, saw a decrease in the rate of newly diagnosed HIV/AIDS over the same ten year time period. The rate in 2014 for people age 25-44 (29.4) is 27 percent lower than the rate in 2005 (39.5), and the rate for people age 45 and over decreased 13 percent from 2005 to 2014 (13.4 to 11.7). From 2013 to 2014, the rate of newly diagnosed HIV/AIDS increased for all age groups. For people age 15-19, there was a seven percent increase (13.5 to 14.5), people age 20-24 had the highest increase of 27 percent (42.5 to 54.1), people age 25-44 had the smallest increase at four percent (28.2 to 29.4), and people age 45 and over had the second highest increase of 21 percent (9.7 to 11.7).

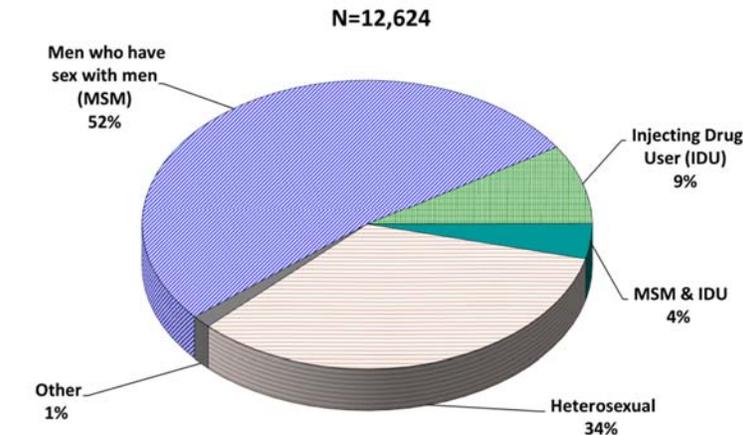
**Figure 2.08: S.C. HIV/AIDS Incidence case rate by year of diagnosis and age, 2005-2014**



**Risk Exposure**

Of the cases with an identified risk factor, men who have sex with men was the highest reported risk factor in 2014 for PLWHA (52 percent). Heterosexual contact accounted for 34 percent of reported risk factors. Nine percent reported a risk of injecting drug use (IDU). Four percent reported the combined risks of MSM and IDU (Figure 2.09).

**Figure 2.09: Proportion of persons living with HIV/AIDS by risk exposure, 2014**

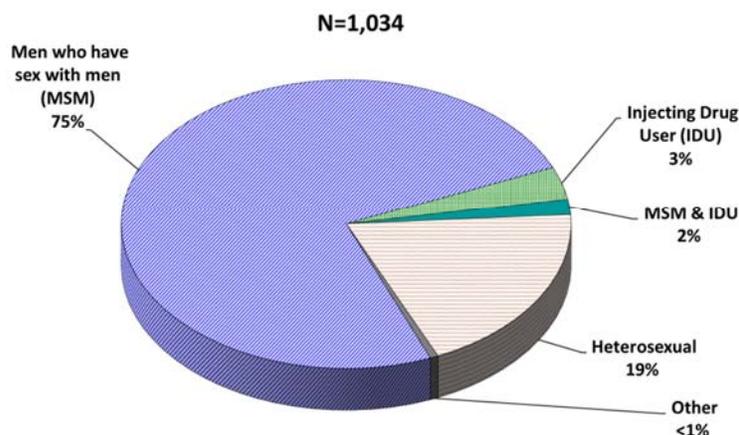


Note: Total excludes cases with no risk identified.

Other risks include blood transfusions, hemophilia, and perinatal transmission; all of which account for a very small proportion of PLWHA. Of the total estimated number of PLWHA in 2013, 22 percent had no risk identified.

Figure 2.10 shows reported risk for people newly diagnosed with HIV/AIDS during 2013-2014. The proportion of new cases with a reported risk of MSM was 75 percent and with a reported risk of heterosexual contact was 19 percent; IDUs made up three percent and the combined risk of MSM and IDU two percent. Twenty-two percent of new cases had no risk identified. Over time, the proportion of cases with no risk identified in a given year decreases as risks are determined through follow-up surveillance activities.

**Figure 2.10: Proportion of HIV/AIDS cases diagnosed 2013-2014 by risk exposure**



Note: Total excludes cases with no risk identified.

The race/gender profile of newly diagnosed cases in 2013-2014 with no risk reported is relatively close to the total proportion of HIV/AIDS cases by race/gender (Figure 2.11).

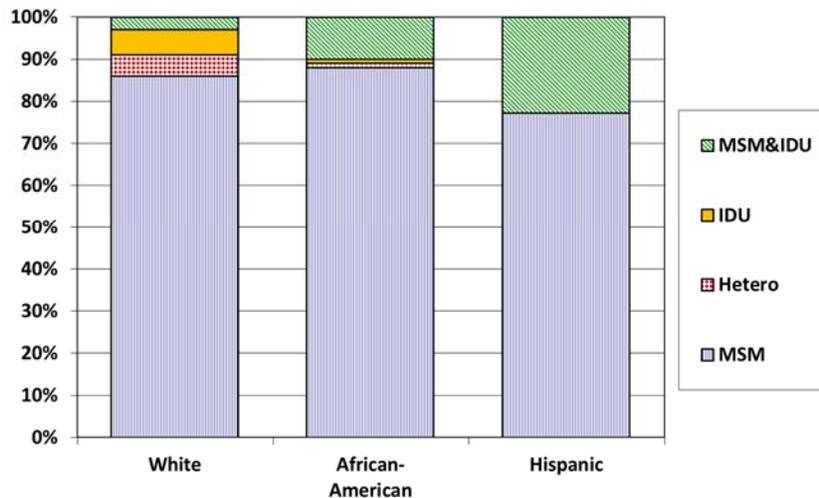
**Figure 2.11: New S.C. HIV/AIDS cases (2013-2014)  
Race/Ethnicity and Gender: Proportion of No Risk Identified  
Compared to Proportion of Reported Cases**

Race/Gender (Adult/Adolescent Cases)	New HIV/AIDS Cases 2013-2014	
	% with No Risk Identified (N=511)	% Cases Reported (N=1,523)
Black Male	48%	56%
Black Female	29%	16%
White Male	13%	20%
White Female	5%	4%
Hispanic Male	4%	4%
Hispanic Female	1%	1%

*Note: Primary reasons for risk exposure information not reported were explained in the South Carolina HIV/AIDS Surveillance System section of the introduction.*

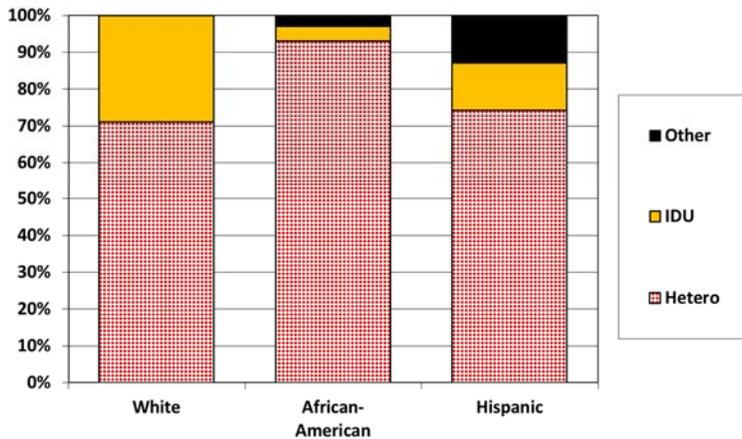
Of reported risks for newly diagnosed case in 2013-2014, among African-American men, most cases were attributed to MSM contact (88 percent) and heterosexual risk (10 percent). For white men, most cases were attributed to MSM contact (86 percent), the combined risk of MSM and IDU (six percent), IDU only (five percent), and heterosexual risk (three percent). Of Hispanic men with reported risk factors, most cases were attributed to MSM contact (78 percent) and heterosexual risk (23 percent), (Figure 2.12). Twenty-eight percent of men diagnosed in 2013-2014 had no indicated risk.

**Figure 2.12: Proportion of Male HIV/AIDS cases by exposure category, diagnosed 2013-2014**



Excludes persons with no risk reported. The exposure category "Other" = <1% for each race/ethnicity.

**Figure 2.13: Proportion of Female HIV/AIDS cases by exposure category, diagnosed 2013-2014**

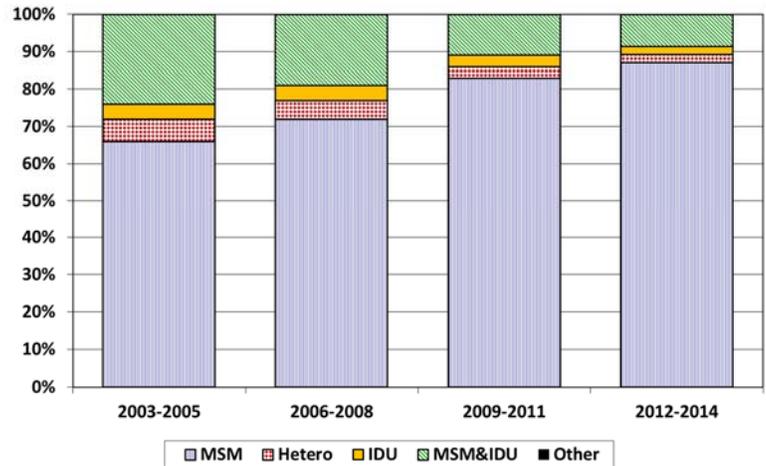


Excludes persons with no risk reported.

Among women diagnosed during 2013-2014 Heterosexual contact is the most often reported risk (87 percent). Ninety-three percent of African-American women reported Heterosexual contact as their risk, while 75 percent of Hispanic women and 71 percent of white women reported a risk of Heterosexual contact. White women report Injecting Drug Use more often (29 percent) than Hispanic women (13 percent) or African-American women (four percent), (Figure 2.13). Fifty-seven percent of women diagnosed in 2013-2014 had no indicated risk.

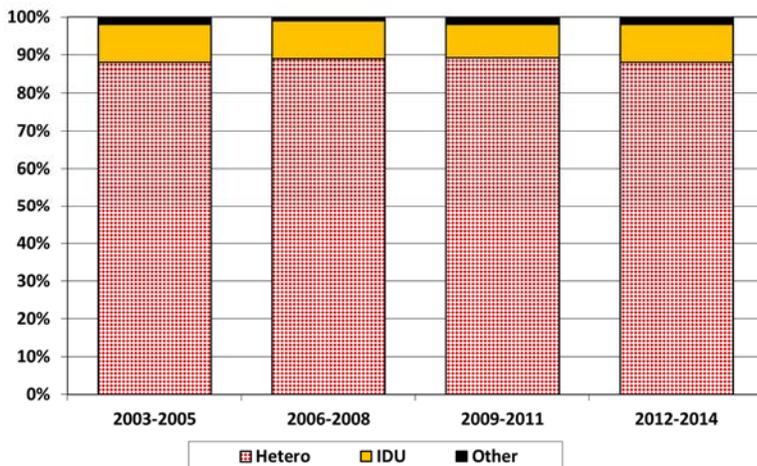
Figures 2.14 and 2.15 show the proportion of total HIV/AIDS cases diagnosed during four periods from 2003 to 2014 by sex and risk exposure category for males and females in South Carolina. The reported risk of Injecting Drug User continues to decrease for men; two percent of reported risks for 2012-2014, down 20 percent from 2009-2011.

**Figure 2.14: Proportional distribution of male HIV/AIDS cases by exposure category, diagnosed 2003-2014**



Excludes persons with no risk reported.

**Figure 2.15: Proportional distribution of female HIV/AIDS cases by exposure category, diagnosed 2003-2014**



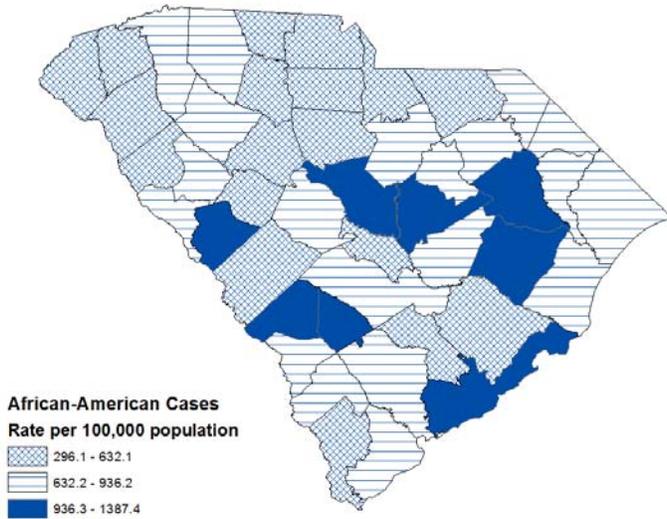
Excludes persons with no risk reported.

Women, however, saw an 18 percent increase in the reported risk of Injecting Drug User (10 percent of reported risks for 2012-2014). The proportion of heterosexual risk decreased two percent for men and one percent for women during the same time periods.

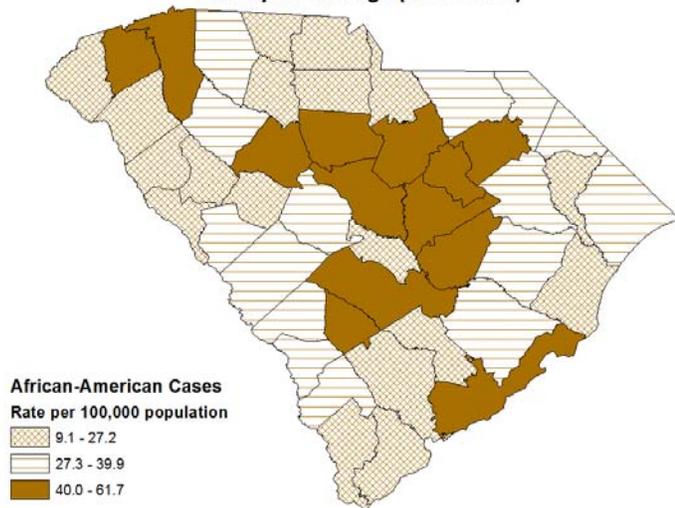
**Residence**

People living with HIV/AIDS are widespread throughout the state. Figure 2.16 shows the 2014 prevalence rate and Figure 2.17 shows the three year average (2012-2014) incidence rate for African-Americans. Twenty-eight percent of South Carolina counties have a prevalence rate greater than the state prevalence rate for African-Americans (858.3 per 100,000 population). Thirty percent of South Carolina counties have a three year average (2012-2014) incidence rate for African-American greater than the state three year average incidence rate for African-Americans (39.7 per 100,000 population)

**Figure 2.16: S.C. HIV/AIDS prevalence rates 2014**



**Figure 2.17: S.C. HIV/AIDS incidence rate:  
Three year average (2012-2014)**



While the HIV/AIDS rate for whites in South Carolina is significantly lower than for African-Americans, the distribution throughout the state is not dissimilar. Figure 2.18 shows the 2014 prevalence rate and Figure 2.19 shows the three year average (2012-2014) incidence rate for whites. Twenty-six percent of South Carolina counties have a prevalence rate greater than the state prevalence rate for whites (123.2 per 100,000 population). Thirty-five percent of South Carolina counties have a three year average (2012-2014) incidence rate for whites greater than the state three year average incidence rate (5.6 per 100,000 population).

Figure 2.18: S.C. HIV/AIDS prevalence rates 2014

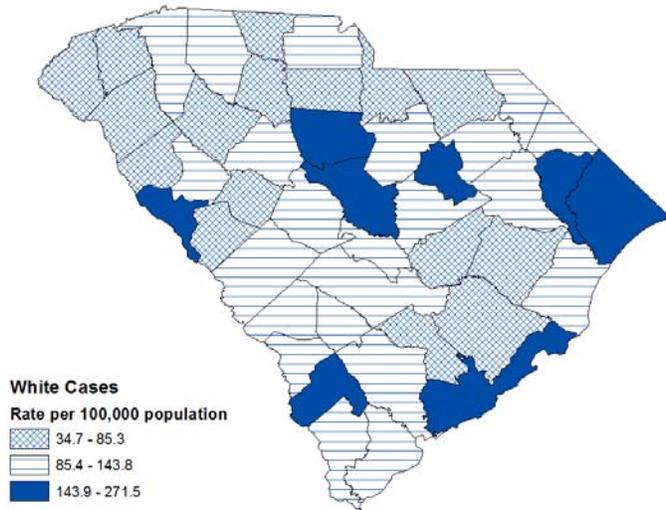
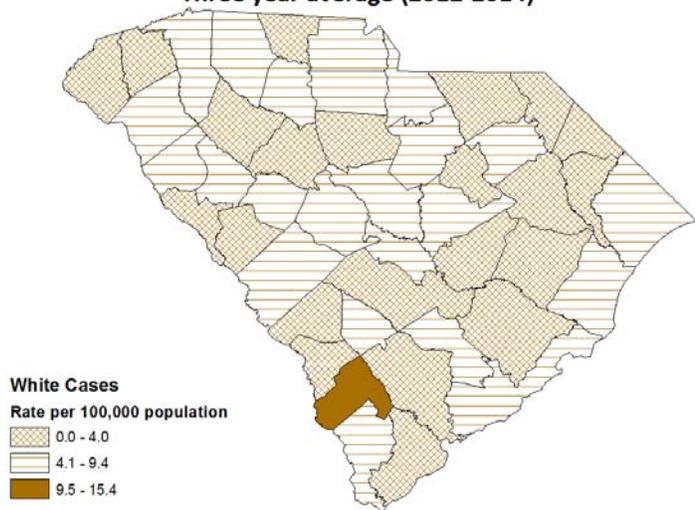


Figure 2.19: S.C. HIV/AIDS incidence rate: Three year average (2012-2014)



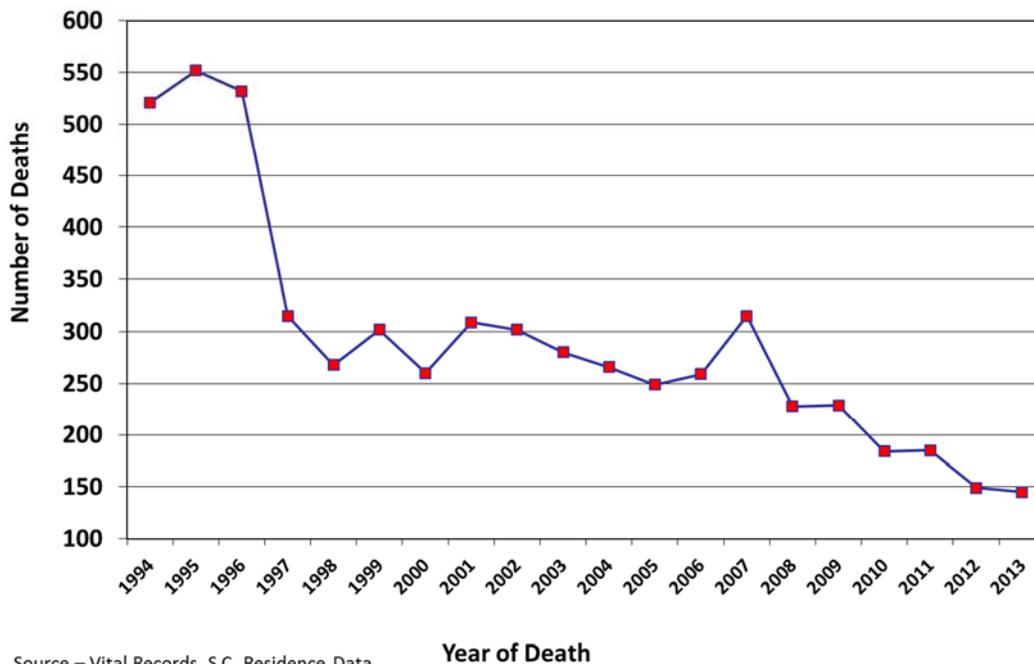
**Mortality**

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

Large declines in AIDS 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 antiretrovirals, 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 2.20 shows the largest decline in deaths in South Carolina was in 1997, with AIDS related deaths dropping to 317 from 532 the previous year. Since 1997, the number of AIDS deaths per year has continued to decline; however, as seen in the graph, there are fluctuations in the number of AIDS deaths from year to year. 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 2.20: Deaths Due to AIDS (HIV) in South Carolina, 1994-2013**



## Epidemiologic Profile

In addition to representing 48 percent of PLWHA, African-American males accounted for the majority of people who died from AIDS (60 percent) in 2013. African-American females accounted for 20 percent of AIDS related deaths followed by white males (18 percent). By age group, the majority of deaths occurred among people age 45 and older (64 percent) (Figure 2.21).

**Figure 2.21: Characteristics of persons who died of AIDS, 2013**

	Number	Percent
<b>Race/Sex</b>		
Black Male	85	60%
Black Female	29	20%
White Male	26	18%
White Female	2	1%
<b>Age Group</b>		
<15	1	1%
15-24	3	2%
25-44	48	33%
45+	93	64%

Source – Vital Records, S.C. Residence Data.

Public Health Region 3 and Region 4 are the areas with the highest number of deaths from AIDS in South Carolina in 2013 (Figure 2.22). These areas are also among those that have the highest prevalence of HIV/AIDS in the state.

**Figure 2.22: Number of persons who died of AIDS by health region, 2013**

Health Region	No.	%
Region 1	8	6%
Region 2	17	12%
Region 3	32	22%
Region 4	20	14%
Region 5	19	13%
Region 6	18	12%
Region 7	22	15%
Region 8	9	6%
<b>TOTAL</b>	<b>145</b>	<b>100%</b>

Source – Vital Records, S.C. Residence Data.

*Note: Vital Records 2013 data reported using eight regions.*

## Who is at risk for becoming infected with HIV?

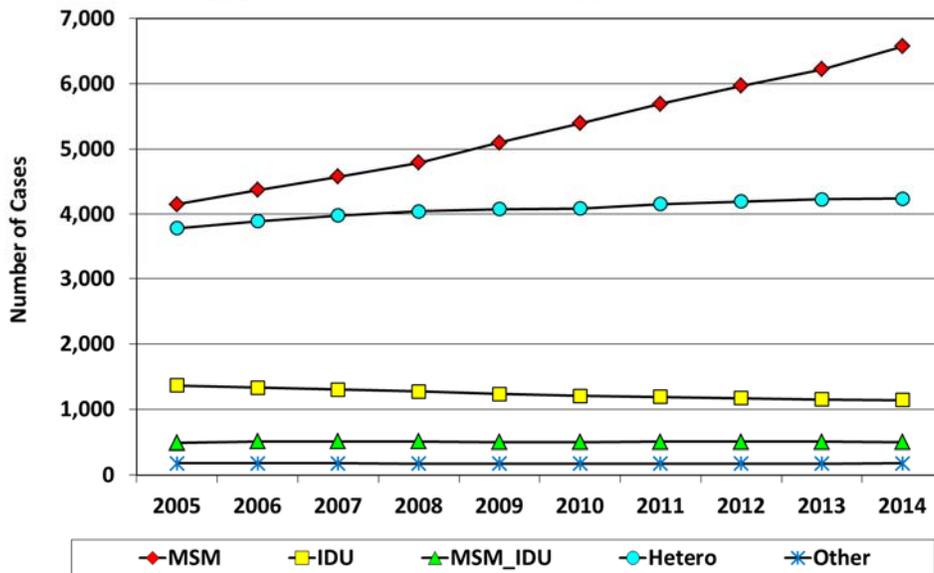
HIV can be transmitted via blood coming in contact with an infected person’s blood, breast milk, or sexual fluids. The people most likely to become infected with HIV are those who engage in high-risk behaviors which place them at greater than normal risk. Transmission happens most often during sexual or drug-using activity, and the frequency of the high-risk behavior combined with 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 people who become newly infected with HIV and people 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 People at Highest Risk

Analysis of characteristics of people with HIV/AIDS helps identify people 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 3.01 shows the number of people in South Carolina living with HIV/AIDS at the end of each year by reported risk. MSM comprise the greatest number of people living with HIV, followed by heterosexuals. IDU, MSM and IDU, and other risks comprise fewer numbers.

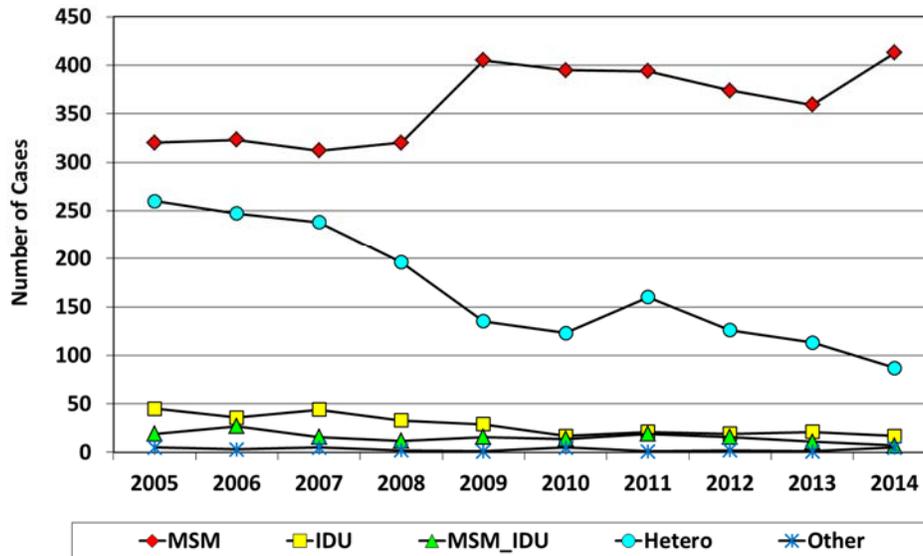
**Figure 3.01: Number of people living with HIV/AIDS by year and reported risk, 2005-2014**



Excludes persons with no risk reported.

Prior to 2005, heterosexual contact was the most often reported risk; however, beginning in 2005, more people are reporting their risk as men who have sex with men (Figure 3.02). While not validated, many local experts believe 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, and the combined risks of MSM and IDU reported each year has declined over the past decade.

**Figure 3.02: Number of new HIV/AIDS cases by year of diagnosis and reported risk, 2005-2014**



Excludes persons with no risk reported.

Based on data in this profile, the following primary populations have been identified as being at the highest risk of HIV/AIDS: men who have sex with men (MSM), high-risk heterosexuals, injecting drug users (IDUs), and men who have sex with men and injecting drug use. Women will be described in the heterosexual and injecting drug user section, and teenagers/young adults will be described within each population category.

**Men who have Sex with Men**

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

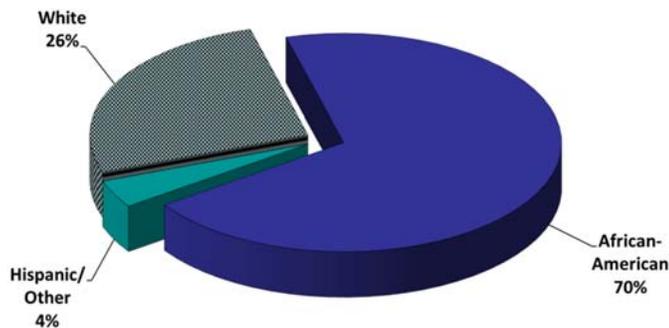
According to the U.S. Census Bureau, there are an estimated 1,543,523 males in South Carolina between the ages of 15-64, which is the age range when people are most sexually active. Review of literature and other state profiles, indicates that the estimated percentage of men who have sex with men (MSM) ranges from 2.1 percent to 10.1 percent, with the average at 2.7 percent. This would mean the number of MSM in South Carolina could be estimated to 41,675; although the estimated range is much broader.

**Characteristics of men who have sex with men**

Of PLWHA in South Carolina with a reported risk, the largest proportion is men who have sex with men (52 percent). MSM also accounted for the highest proportion (75 percent) of recently diagnosed adult/adolescent cases in 2013-2014.

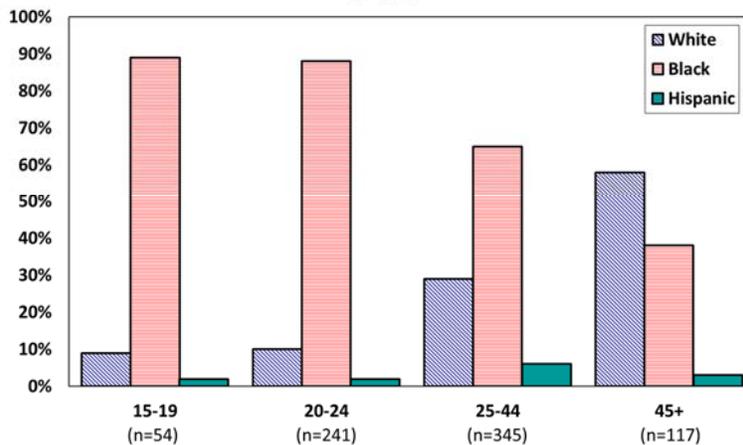
As Figure 3.03 demonstrates, the majority of MSM cases diagnosed during 2013-2014 were African-American (70 percent). White men accounted for 26 percent of the new cases and four percent were Hispanic or other races.

**Figure 3.03: Proportion of men diagnosed with HIV/AIDS in 2013-2014 who reported a risk of MSM by race/ethnicity (N=757)**



The majority of MSM diagnosed during 2013-2014, were 25-44 years of age (46 percent); 32 percent were 20-24 years old and 15 percent were 45+ years. For men recently diagnosed, African-Americans accounted for the highest proportion for each age group except those 45 and older, where whites accounted the highest proportion (58 percent) (Figure 3.04).

**Figure 3.04: Percent of MSM HIV/AIDS cases diagnosed 2013-2014 by age group & race/ethnicity (N=772)**

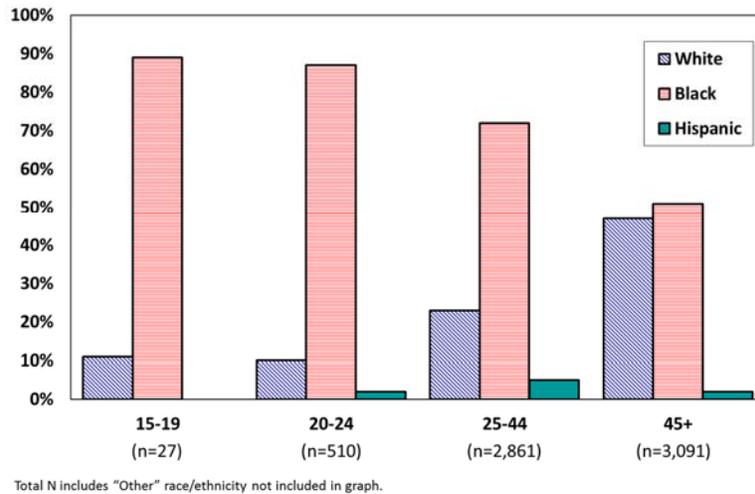


Total N includes "Other" race/ethnicity not included in graph.

## Epidemiologic Profile

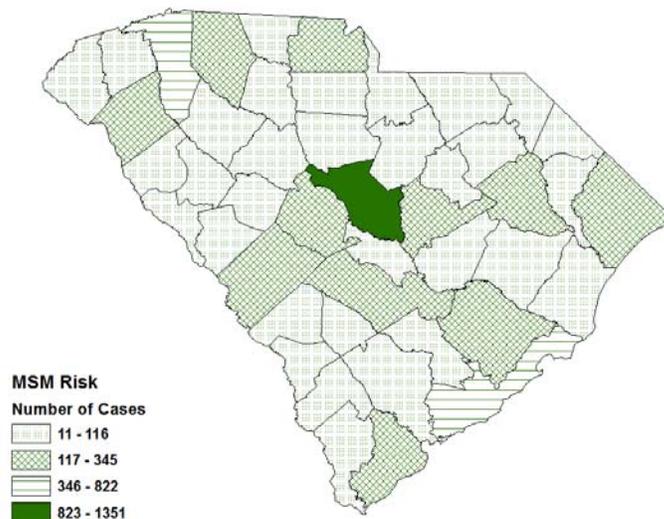
Of men who have sex with men living with HIV/AIDS in 2014, 63 percent were African-American, 34 percent were white and three percent were Hispanic men. As Figure 3.05 shows, for MSM age 15 to 44, African-Americans comprise the greatest proportion. However, among those 45 years and older, the proportion is almost equal for both white (47 percent) and African-American (51 percent) men.

**Figure 3.05: Percent of MSM living with HIV/AIDS by age/race, 2014 (N=6,570)**



Richland County has the greatest number of MSM living with HIV/AIDS in 2014 (1,351), with Greenville (822) and Charleston (605) having the next highest numbers. Most South Carolina counties had fewer than 117 MSM living with HIV/AIDS (Figure 3.06).

**Figure 3.06: S.C. HIV/AIDS 2014 prevalence**



### Summary

Among men who have sex with men, African-American men account for over half the proportion of both living with HIV/AIDS (63 percent) and newly diagnosed HIV/AIDS cases (70 percent). And of men who have sex with men under the age of forty-five, African-American men comprised 74 percent of cases living with HIV/AIDS and 75 percent of newly diagnosed HIV/AIDS.

## High Risk Heterosexuals

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

It is difficult to make an assessment of the number of people 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 people with HIV/AIDS and the population of those with a non-HIV STD, most experts acknowledge that a diagnosis of an STD would suggest the individual is engaging in unsafe sexual practices. During 2014, 27,120 cases of chlamydia, 7,944 cases of gonorrhea and 249 cases of infectious syphilis were reported in South Carolina. More data on STDs, as well as other behavioral indicators such as teenage pregnancy and condom use, is described later.

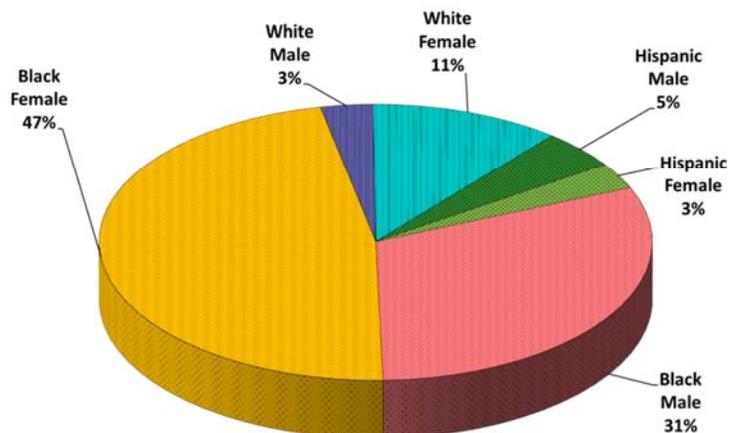
In order for a case of HIV or AIDS to be considered as heterosexual transmission, it must be reported that the individual had heterosexual contact with a person who has documented HIV infection or AIDS, or had heterosexual contact with a person who is in a high risk group for HIV (MSM or IDU).

### Characteristics of high risk heterosexuals

People with documented high-risk heterosexual contact comprise 34 percent of the total adult/adolescent PLWHA at the end of 2014 and 19 percent of people more recently diagnosed during 2013-2014 (excluding people with no risk identified for both new and prevalent cases). Of PLWHA in 2014 who reported a risk of heterosexual contact, almost half were African-American women (47 percent), 31 percent were African-American men, 11 percent were white women, and three percent were white men. The number of heterosexual cases diagnosed has decreased 29 percent from 2010 to 2014.

Figure 3.07 shows that African-American men and women comprise a disproportionate 78 percent of recently diagnosed heterosexual HIV/AIDS cases. African-American women account for 47 percent of recent cases and white women account for 11 percent. Thirty-one percent are African-American men while white men account for only three percent of recent cases with a reported risk of heterosexual contact.

**Figure 3.07: Proportion of heterosexual HIV/AIDS cases by race/ethnicity, diagnosed 2013-2014 (N=197)**



## Epidemiologic Profile

**Figure 3.08: S.C. HIV/AIDS cases attributed to heterosexual transmission, by sex and year of diagnosis**

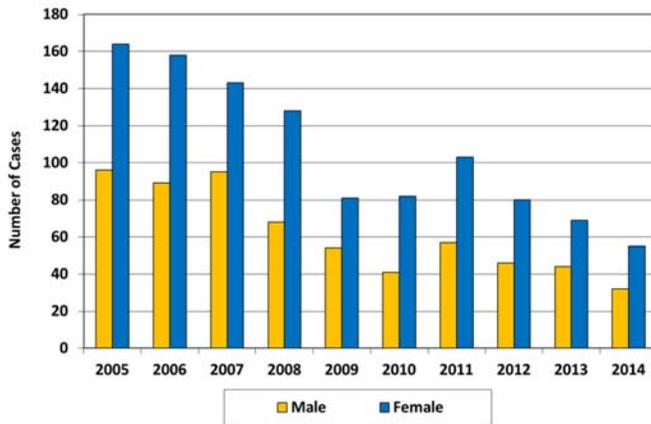
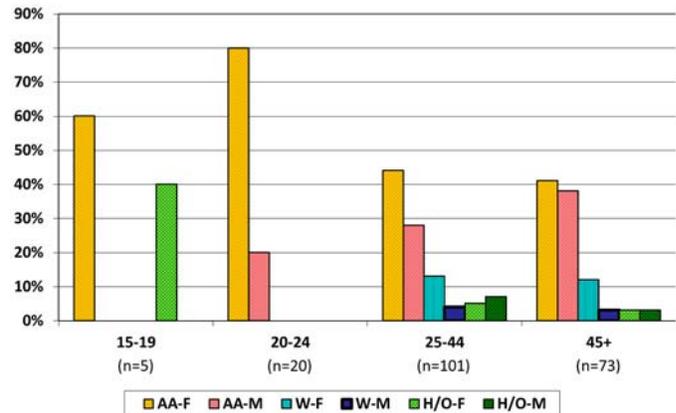


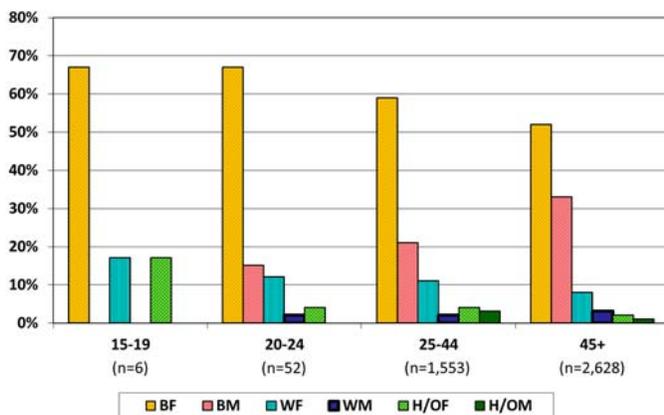
Figure 3.08 shows the number of heterosexually acquired HIV cases in men and women in South Carolina from 2005 to 2014. During most of this period, the proportion of female cases averaged 72 percent higher than males. The number of men and women reporting heterosexual risk has steadily decreased over the past several years. 2011 saw a slight increase; however, the numbers have continued to decline since.

The majority of high risk heterosexuals diagnosed in 2013-2014 were 25-44 years of age (51 percent); 37 percent were 45 years and older and 13 percent under 25 years. African-American women and men comprised the greatest proportion of cases in each age group (Figure 3.09). Among young women less than 45 years of age, newly diagnosed with HIV/AIDS, eight out of every ten are African-American.

**Figure 3.09: Percent heterosexual S.C. HIV/AIDS cases diagnosed 2013-2014 by age/race/sex (N=199)**



**Figure 3.10: Percent of heterosexuals living with HIV/AIDS by age group and race/ethnicity/gender, 2014 (N=4,239)**



Eight of every ten women under age 25 living with HIV/AIDS are African-American. Within the 25 to 44 age group, African-American women comprise the largest proportion (59 percent). Of PLWHA in 2014 who reported a risk of heterosexual contact, 62 percent were age 45 and over; African-American women comprised the greatest proportion (52 percent), followed by African-American men (33 percent) (Figure 3.10). White men and women account for 12 percent of PLWHA who reported a risk of heterosexual contact across all age groups.

**Figure 3.11: S.C. HIV/AIDS 2014 prevalence**

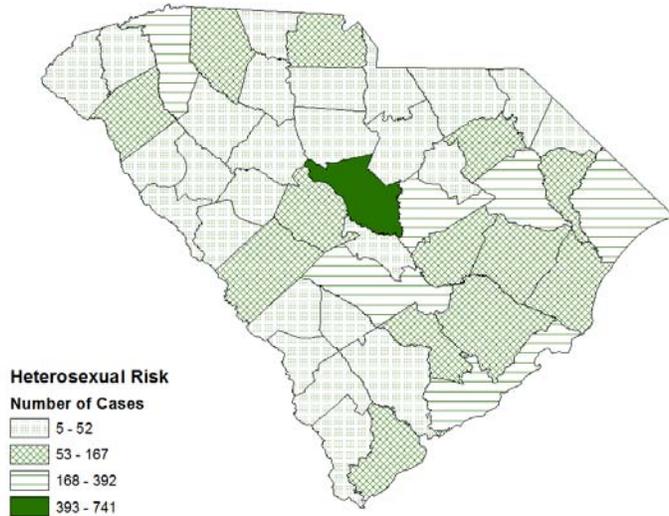
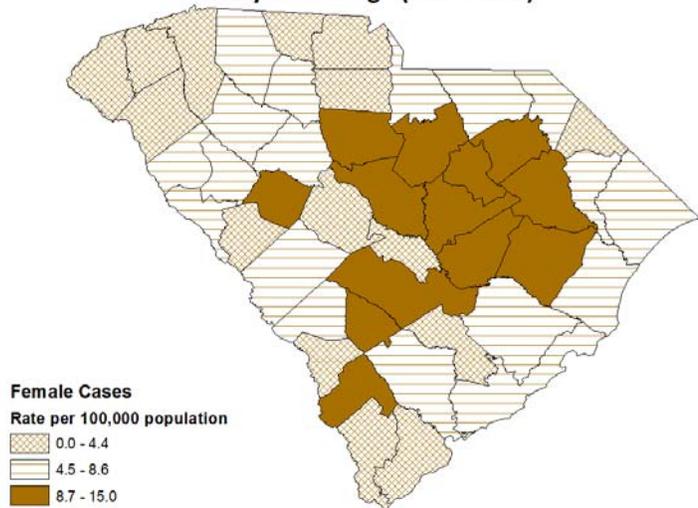


Figure 3.11 shows the counties with the highest prevalence of PLWHA due to heterosexual transmission. Richland county has the highest number of reported cases (741), followed closely by Charleston, Florence, Greenville, Horry, Sumter, and Orangeburg. Eighty-five percent of South Carolina counties each have less than 168 reported cases.

Figure 3.12 shows the case rate for 2012-2014 among women, an indicator for more recent heterosexual risk. Lee and Orangeburg counties have the highest case rates in the state (15.0 and 14.6 per 100,000 population respectively). Seventy-two percent of counties have case rates below 8.6 (the state rate is 6.6).

**Figure 3.12: S.C. HIV/AIDS incidence rate: Three year average (2012-2014)**



**Summary**

Among heterosexually exposed cases, African-American women account for almost half of newly diagnosed HIV/AIDS cases (47 percent) and African-American men account for 30 percent. Among people living with HIV/AIDS with a reported risk of heterosexual contact, African-American women account for 55 percent and African-American men account for 29 percent. African-American men and women 25-44 years of age account for eight out of every ten PLWHA and seven out of every ten people diagnosed in 2013-2014.

## Injecting Drug Users

### Characteristics of Injecting Drug Users (IDU)

Injecting drug users' account for nine percent of people living with HIV/AIDS in 2014 and four percent of people recently diagnosed with HIV/AIDS during 2013-2014.

The number of new HIV/AIDS diagnosis with a reported risk of injecting drug use has averaged about 16 per year over the last ten years. Historically, men have accounted for the largest proportion of those reporting injecting-drug-use as their risk; however, between 2011 and 2013, women outnumbered men. With 2014 data men once again accounted for the largest proportion of IDU: 88 percent (Figure 3.13).

**Figure 3.13: Number of HIV/AIDS cases due to injecting drug use by sex and year of diagnosis, 2005-2014**

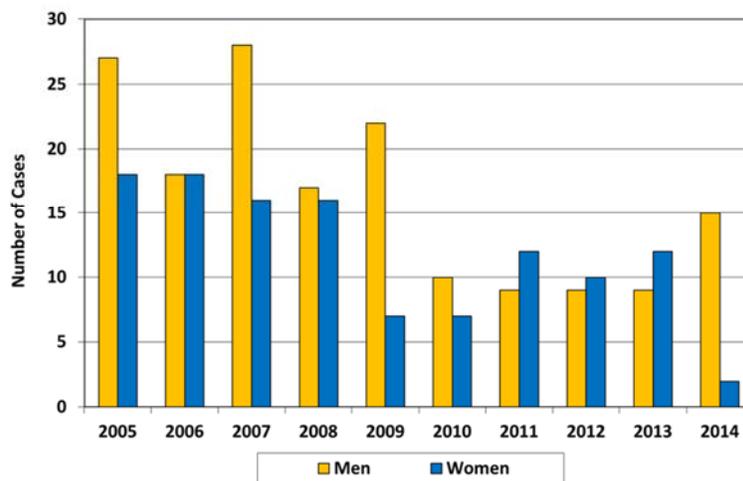


Figure 3.14 shows the race and gender proportions of recently diagnosed (2013-2014) IDU cases. Whites comprise the largest proportion 61 percent and African-Americans 39 percent. White males are the highest proportion (34 percent), while white women and African-Americans males account for 27 percent each; African-American women accounted for 12 percent.

**Figure 3.14: Proportion of injecting drug users diagnosed with HIV/AIDS 2013-2014 by race/sex**

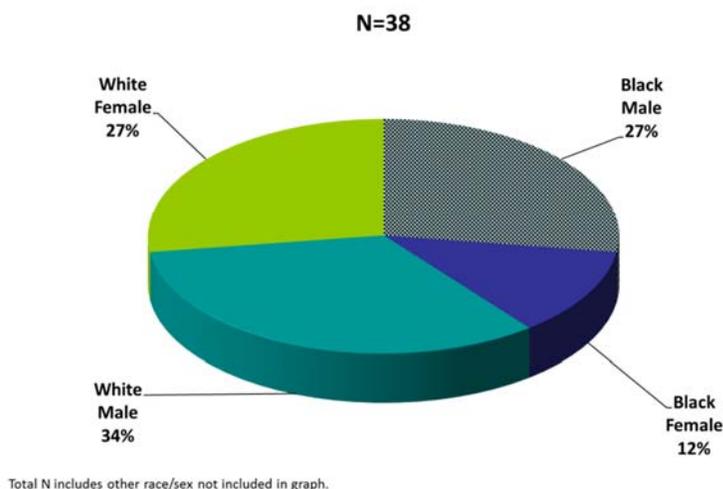
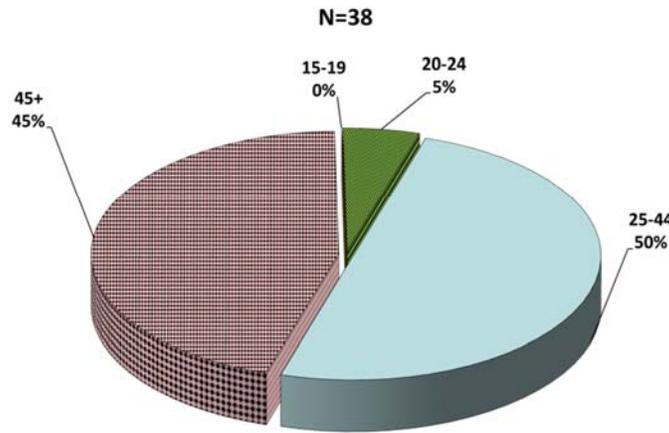


Figure 3.15 shows that 50 percent of IDU cases diagnosed in 2013-2014 are age 25-44 and 45 percent are age 45 and over.

**Figure 3.15: Percent of injecting drug users diagnosed with HIV/AIDS 2013-2014 by age group**



Of PLWHA with IDU as identified risk factor, most (84 percent) are 45 years of age and older. African-Americans account for the greatest proportion of cases over the age of 45, with African-American women accounting for 52 percent and African-American men accounting for 26 percent. Within the 25-44 age group, African-American women account for the greatest proportion (26 percent) and African-American men the next highest proportion (25 percent), followed by white women at 24 percent. (Figure 3.16).

**Figure 3.16: Percent of IDU persons living with HIV/AIDS by race/sex and age group, 2014 (N=1,139)**

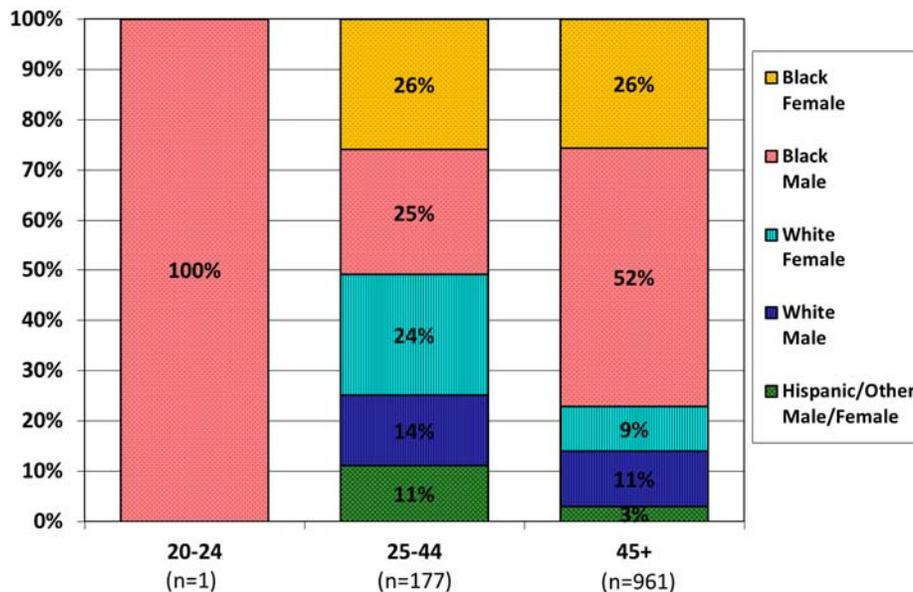
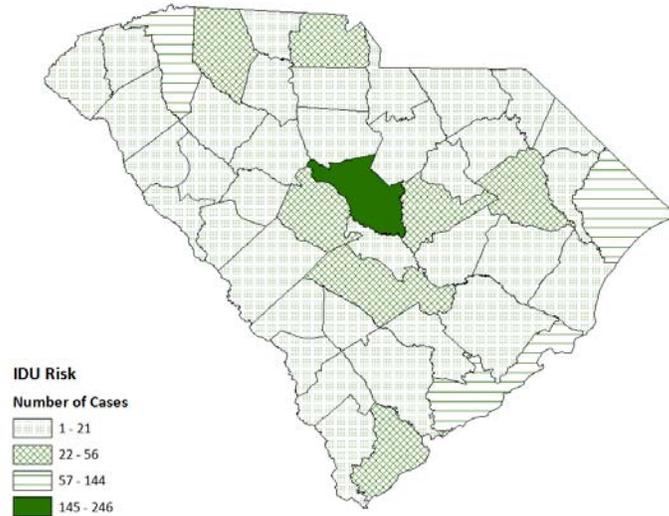


Figure 3.17 shows Richland County has the highest number of PLWHA with IDU as identified risk factor. As with other risks, the more urban counties have the greatest numbers.

**Figure 3.17: S.C. HIV/AIDS 2014 prevalence**



### **Other Populations at Risk**

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

### **People 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**

Figure 3.18 shows the increase in chlamydia over the last decade; some of this increase may be attributed to initiating routine screening for all young women attending family planning and STD clinics in health departments statewide. In 2014, there were 27,120 cases of chlamydia diagnosed in South Carolina. Among those cases with a reported race, 52 percent were African-American women and 20 percent were white women. African-American men comprised 21 percent of chlamydia cases, and white men accounted for six percent. Thirty-four percent of chlamydia cases have ‘Unknown’ race; this is attributed to the fact that these conditions are primarily reported by labs, which frequently do not collect a race.

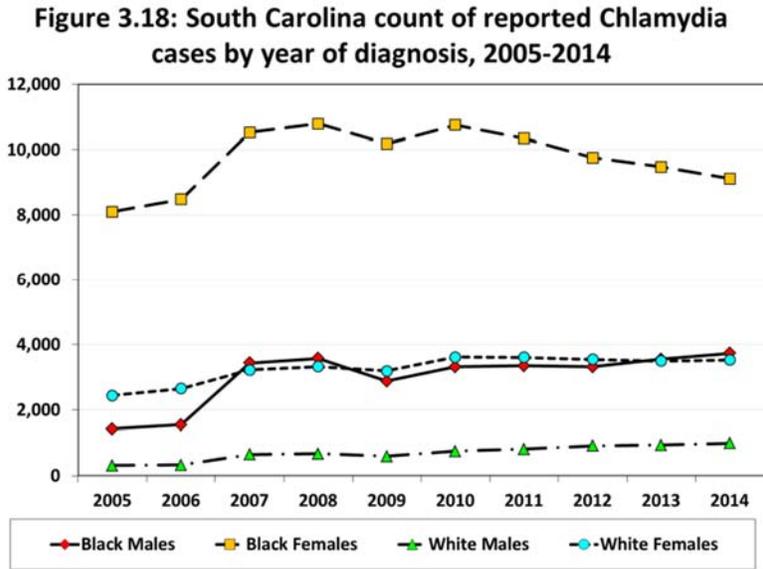
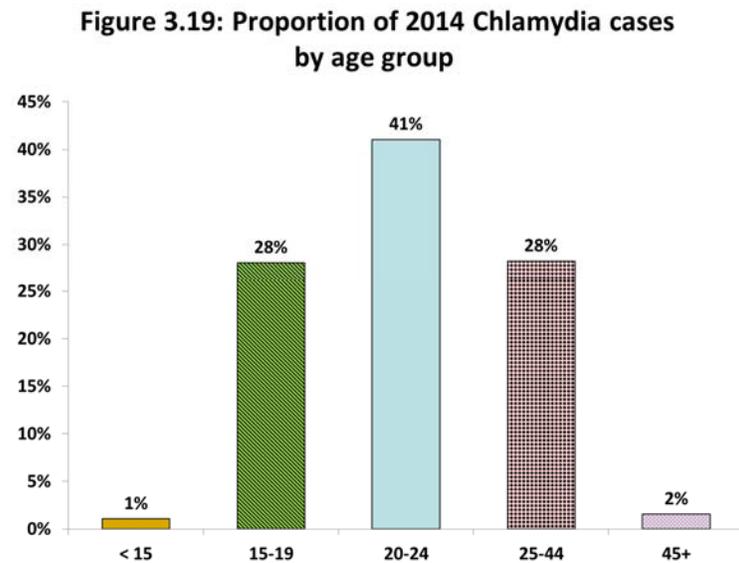


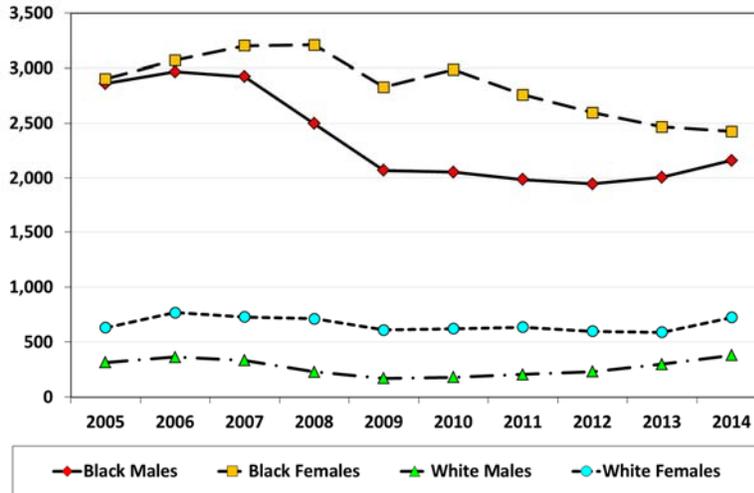
Figure 3.19 shows that in 2014, young adults 20-24 make up the highest proportion of chlamydia cases (41 percent) in the state. In 2014, Persons age 19 and under, and 25 to 44, each accounted for 28 percent of chlamydia cases.



**Gonorrhea**

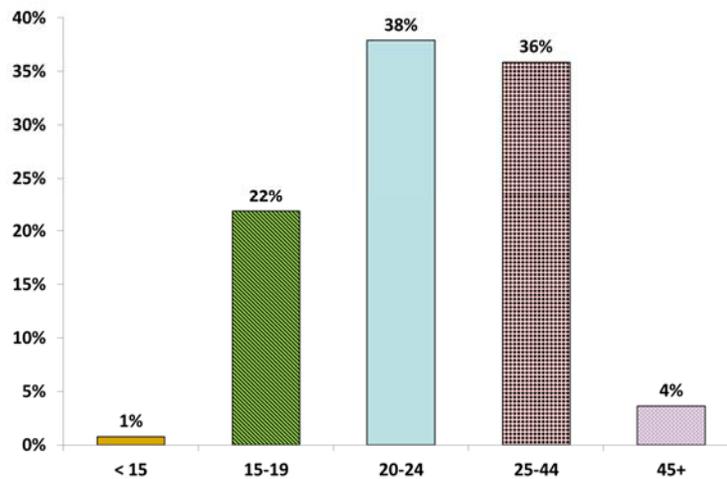
In 2014, 7,944 gonorrhea cases were diagnosed. Of cases with a reported race, African-American men and women account for 81 percent of reported cases; African-American women 43 percent and African-American men 38 percent. As with chlamydia, twenty-seven percent of reported gonorrhea cases have an 'Unknown' race. Figure 3.20 shows trends among reported race/gender by year.

**Figure 3.20: South Carolina count of reported gonorrhea cases by year of diagnosis, 2005-2014**



Gonorrhea cases most affect young adults under the age of 25 (60 percent of total). Thirty-eight percent of cases in 2014 were to people age 20-24, with people age 19 and under comprising 22 percent. People 25-44 comprised 36 percent of reported cases (Figure 3.21).

**Figure 3.21: Proportion of 2014 Gonorrhea cases by age group**



### Infectious Syphilis

In 2014, 249 cases of infectious syphilis were diagnosed; this is down from the 272 cases reported in 2013 (an eight percent decrease). The number of infectious syphilis cases in 2014 is a 58 percent increase from the number of cases reported in 2010 (158), and a 204 percent increase from 2005 (82).

**Figure 3.22: South Carolina count of reported Infectious Syphilis cases by year of diagnosis, 2005-2014**

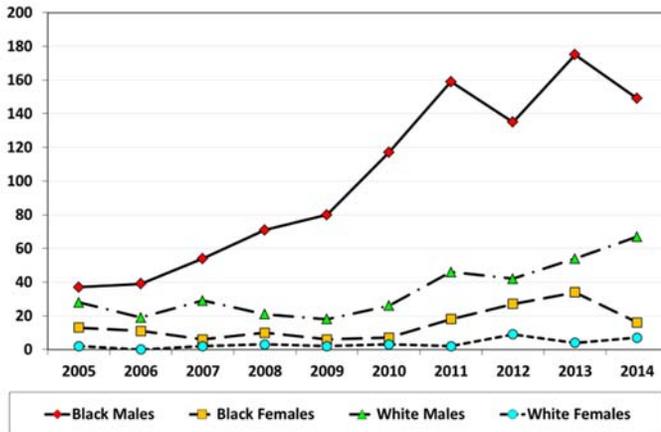
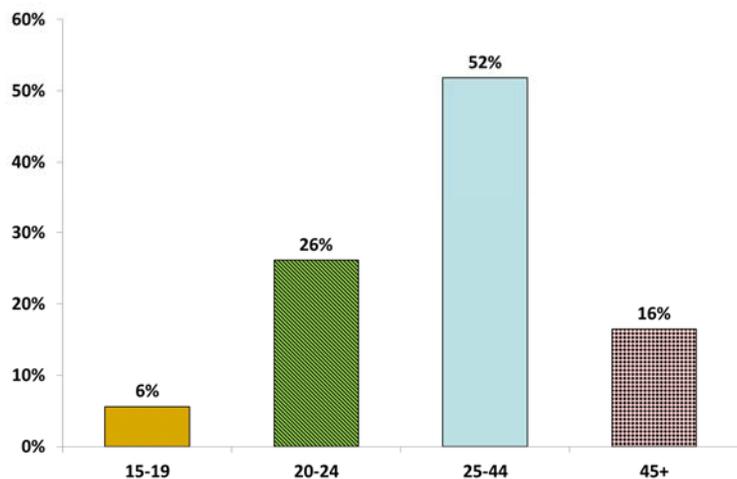


Figure 3.22 shows the number of cases in 2014 increased among white men (24 percent increase) and white women (75 percent increase) over the numbers in 2013. The number of cases decreased 15 percent for African-American men and 53 percent for African-American women over the same time period. Men continue to represent the majority of cases (91 percent); African-American men specifically, are most impacted, accounting for 60 percent of total cases, and white men accounting for 27 percent. Women account for nine percent of the total infectious syphilis cases; African-American women comprised 70 percent of women diagnosed. In 2014, less than one percent (0.4%) of infectious syphilis cases has 'unknown' or 'other' for race.

Figure 3.23 shows the proportion of 2014 infectious syphilis cases by age group. People age 25-44 comprise the largest proportion (52 percent) while people 20-24 comprised 26 percent. However, unlike chlamydia and gonorrhea where people over 45 comprise a small proportion of cases (two percent and four percent respectively), persons over 40 comprise 16 percent of infectious syphilis cases diagnosed in 2014.

**Figure 3.23: Proportion of 2014 Infectious Syphilis cases by age group**

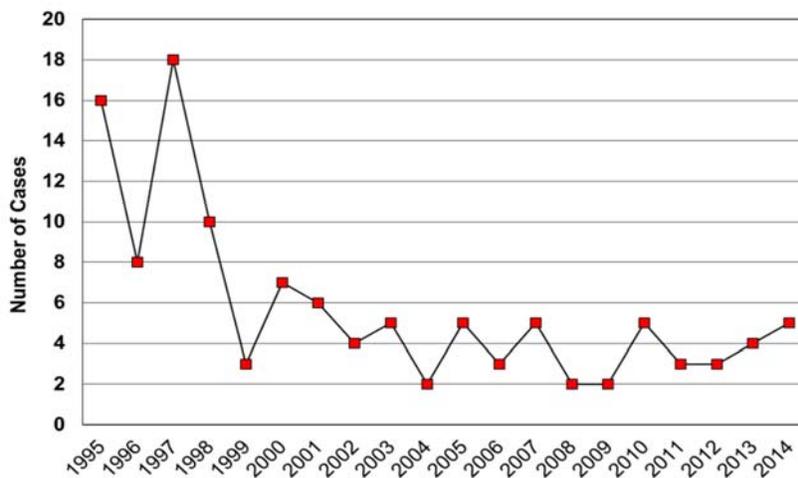


**Infants and Children: (Children under 13 years of age)**

Cumulatively, through December 2014, there have been 237 HIV infection cases diagnosed among children less than 13 years of age; this represents one percent of the total reported AIDS and HIV infection cases.

Most infants and children infected with HIV acquired it perinatally from their mother. There has been significant progress during the past twenty years in reducing the number of infants with perinatal acquired HIV infection (see Perinatally HIV exposed births below). When reporting small numbers of cases, trend graphs, such as the one in Figure 3.24, tend to display a lot of fluctuation over the given time period. The highest number of cases reported was 21 in 1993 (not on graph); the lowest number is 2 cases. There were five cases in 2014.

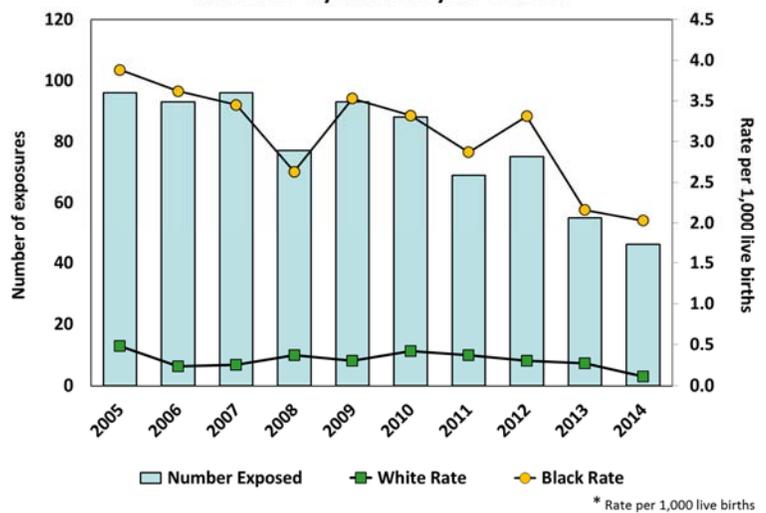
**Figure 3.24: Number of children <13 years old diagnosed with HIV/AIDS in South Carolina, 1995-2014**



**Perinatally HIV exposed births**

The number of perinatally HIV exposed births averages around 79 per year, while perinatally acquired HIV cases average one per year. This translates into 1.5 percent of perinatally HIV exposed births testing positive for HIV. Figure 3.25 shows number of perinatally HIV exposed births (values on left) and the rate by race of mother (values on right). In 2014, the exposure rate for African-American women is 19 times higher compared to white women.

**Figure 3.25: Perinatally HIV exposed births by year of birth and rate\* by race and year of birth**



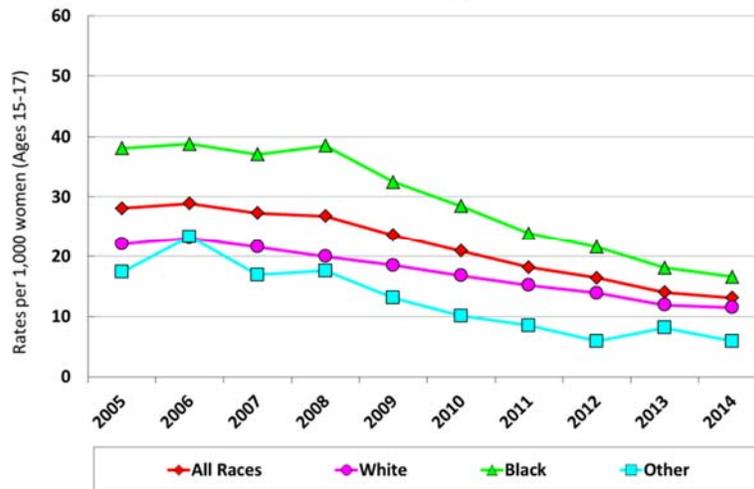
### Teenage Pregnancy

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, the rate has decreased from 1.7 in 2005 to 0.6 per 1,000 live births in 2014.

Teenage live births among 15-17 year old South Carolinians have decreased from a rate of 28.1 per 1,000 live births in 2005 to 13.1 in 2014; a 53.4 percent decline (Figure 3.26). This success is also seen when viewing teen birth rates by racial/ethnic subgroups. The rate for white 15-17 year old teens was 22.1 in 2005 and 11.5 in 2014, representing a 48 percent decline. The rate for African-American 15-17 year old teens declined 56 percent from 38.1 per 1,000 live births in 2005 to 16.6 in 2014.

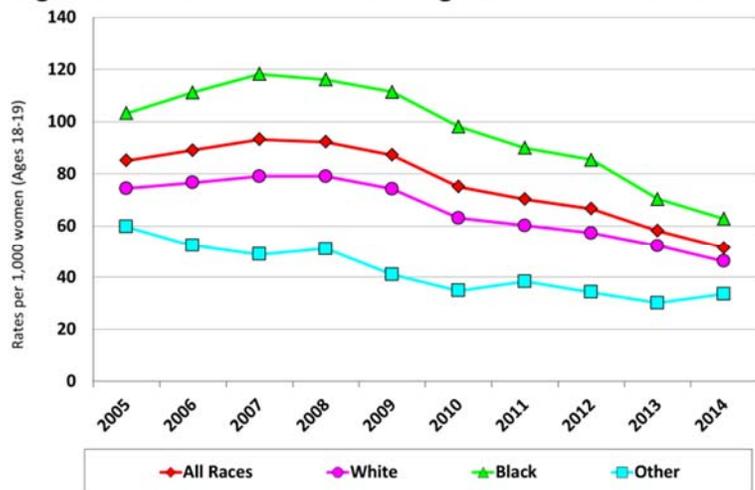
**Figure 3.26: South Carolina teens age 15 - 17 live birth rate**



Source – SCDHEC, Vital Records, SC Residence Data

Figure 3.27 shows the teen birth rates (per 1,000 live births) for 18 and 19 year olds. As with the previous age groups, African-American teenage girls continue to have higher live birth rate than other races. All races have seen an overall decrease in the live birth rates from 2010 (75.1 per 1,000 live births) to 2014 (51.5 per 1,000 live births).

**Figure 3.27: South Carolina teens age 18 – 19 live birth rates**



Source – SCDHEC, Vital Records, SC Residence Data

### **People 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 people tested voluntarily in local health departments. This data reflects number of individuals tested, not the number of tests. In 2014, African-Americans comprised 67 percent of the total people tested, and 76 percent of the total positive. Men accounted for 31 percent of people tested and 84 percent of total positive. People 20-39 years of age represented the highest proportion tested (77 percent) and the highest proportion total positive people (71 percent). People over the age of 40 comprised 14 percent of the total people tested, and 26 percent of the total positive.

Public Health Regions (PHR) that accounted for the greatest proportion of people tested who were positive include those with the same urban counties of highest prevalence:

Lowcountry PHR (includes Charleston County) – 28 percent of total positives;

Midlands PHR (includes Richland County) - 27 percent of total positives tested;

Pee Dee PHR (includes Sumter and Florence counties) – 11 percent of total positives;

Upstate PHR (includes Greenville and Spartanburg Counties) – 29 percent of total positives;

### **Other Behavioral/Risk Data**

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

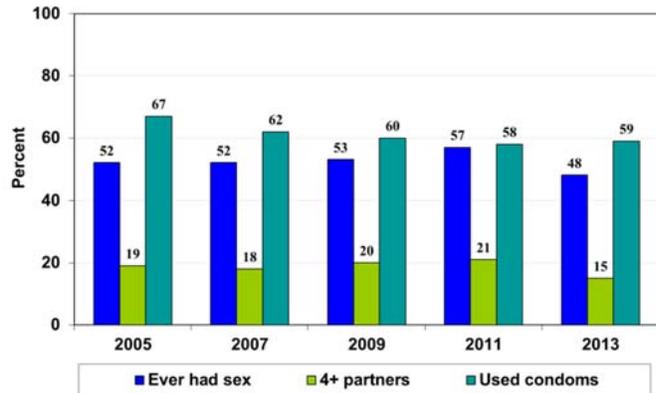
Behavior Risk Factor Surveillance System is the world's largest random telephone survey of non-institutionalized population aged 18 or older that is used to track health risks in the United States. In 1981, the Centers for Disease Control and Prevention (CDC), in collaboration with selected states, initiated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

The HIV/AIDS questions for the 2010 survey focused on respondents HIV/AIDS testing history. Results show that when asked about ever being tested for HIV themselves, only 40.8 percent of respondents indicated ever being tested. African-Americans were more likely (59.9%) to have been tested than Caucasians (33.7%). Hispanics are less likely to have been tested, with only 25.1% reporting having ever been tested. Men are only slightly less likely to have been tested than women (39.5% versus 42.0%). Of those reporting having ever been tested, 14.9% reported being tested in 2010 and 59.5% reported being tested between 2005 and 2009.

### Youth Risk Behavior Survey (YRBS)

The YRBS has been conducted in SC high schools every other year since 1991 and in middle schools since 2005. The survey is part of a national effort to monitor priority health risk behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults in the United States. Figure 3.28 shows the proportion of high school students who have been sexually active, report having had four or more lifetime partners, and report using a condom at last sexual intercourse (had intercourse in past 3 months). Number of partners and condom use are important because of the increased risk of exposure to HIV.

**Figure 3.28: Proportion of high school students indicating sexual risks, 2005-2013**



Source – SC Dept. of Education & CDC

### Substance Use

Drug use is known to be a major factor in the spread of HIV infection. The Centers for Disease Control (CDC) specifically includes Injection Drug Use (IDU) as a transmission category for the classification of cases that summarizes a person's possible HIV risk factor. IDU is considered a high risk because shared equipment (primarily used needles, but also other equipment) can carry HIV, which is drawn up into a syringe and then injected along with the drug by the next user of the syringe. Sharing equipment for using drugs can also be a means for transmitting hepatitis B, hepatitis C, and other serious diseases.

Additionally, non-injecting drug use, including methamphetamine or alcohol, is linked with unsafe sexual activity, which increases the risk of becoming infected with HIV or another sexually transmitted disease. Often, substance users have multiple sexual partners and do not protect themselves during sexual activity. Also, substance users may have an increased risk of carrying sexually transmitted diseases; this can increase the risk of becoming infected with HIV, or of transmitting HIV infection.

According to the Office of National Drug Control Policy, from the 2009-2010 National Survey on Drug Use and Health, 8.88 percent of South Carolina residents reported using illicit drugs in the past month. The national average was 8.82 percent. Additionally, 3.9 percent of South Carolina residents reported using an illicit drug other than marijuana in the past month (the national average was 3.6 percent). According to data from the El Paso Intelligence Center's National Seizure System (EPIC-NSS), the number of meth lab seizure incidents in South Carolina increased 158%, from 130 incidents in 2008 to 335 incidents in 2011. (Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.)

## What are the patterns of service utilization of HIV-infected people?

### Ryan White Part B

In 1990, Congress enacted the Ryan White CARE Act to provide funding for states, territories and Eligible Metropolitan Areas to offer medical care and support services for people living with HIV disease who lack health insurance and financial resources for their care. Congress reauthorized the Ryan 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 and finally in 2009 with the Ryan White HIV/AIDS Treatment Extension Act.

Ryan White 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 4.01: Characteristics of Ryan White Part B clients compared to S.C. persons living with HIV/AIDS in 2014**

	Ryan White Part B Clients, N=8,749	Persons Living with HIV/AIDS, N=16,222
<b>Race/Ethnicity</b>		
White, not-Hispanic	23%	24%
Black, not-Hispanic	73%	71%
Hispanic	3%	4%
Other	1%	1%
<b>Sex</b>		
Male	67%	71%
Female	33%	29%
Transgender	<1%	---
<b>Age Group</b>		
< 24	6%	5%
25-44	38%	37%
45+	56%	58%

During 2014, 8,749 clients received services through the Ryan White Part B funds. Figure 4.01 presents the distribution of Part B clients by race/ethnicity, sex and age as well as for PLWHA in South Carolina through December 2013. 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) Medical Case Management.

Figure 4.02 shows a breakdown of Ryan White Part B clients who received six of the core services through funding and the average number of visits per clients. Among the 8,749 clients who received services, the majority of clients obtained medical case management services (n=7,615) followed by medical care (n=6,132), Medication Assistance (n=4,502 utilization of HIV related medications is described in the ADAP section), mental health services (n=1,094), dental care (n=908) and substance abuse services (n=464).

**Figure 4.02: South Carolina Ryan White Part B Service Utilization by Service Type, 2014**

	No. of clients receiving service	No. of visits per category	Avg. no. of visits per client
Medical Care	6,132	22,889	4
Medication Assistance (ADAP)	4,502	See SC ADAP Data	See SC ADAP Data
Oral/Dental Care	908	1,839	2
Mental Health	1,094	2,757	3
Substance Abuse	464	1,178	3
Medical Case Management	7,615	80,555	11

Of those services utilized most by clients (visits/clients), medical case management services were among the highest (11 visits per clients), followed by medical care (4 visits per client), substance abuse (3 visits per client), mental health services (3 visits per client), and dental care services (2 visits per client).

Additional services obtained by clients in 2014 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 (S.C. ADAP) operates under the Ryan White HIV/AIDS Treatment Modernization Act to provide access to medications that treat HIV disease and to prevent the serious deterioration of health arising from HIV disease in eligible individuals. The S.C. ADAP provides medication assistance via the following service tiers: 1) Direct Dispensing to provide medications via mail-order through a contracted pharmacy; 2) Insurance Assistance to reimburse costs for private insurance premiums, copayments, and deductibles; and 3) Medicare Assistance to provide support for Medicare Part D copayment and deductible costs. S.C. ADAP enrollment and services are centrally managed by the S.C. Department of Health and Environmental Control.

Currently there are 90 drugs on the approved S.C. ADAP formulary. The S.C. ADAP has an advisory body of infectious disease (ID) physicians and program staff that meet regularly to review the S.C. ADAP formulary and make recommendations for program improvements. In the past, once an antiretroviral medication received FDA approval, it was automatically added to the S.C. ADAP formulary. With the new development of extremely expensive therapies, such drugs are added as appropriate, after a thorough medical and fiscal review and in compliance with ADAP performance measures. Fuzeon, Selzentry, and pegylated interferon currently require prior authorization for approval. As of April 1, 2014, prior authorization is not required for abacavir-containing medications or ribavirin. There are no restrictions or caps on the number of antiretroviral medications per client.

Eligibility for S.C. ADAP includes verified HIV-positive status, South Carolina residency, and income criteria per ADAP service tier. The financial requirement is measured according to the Federal Poverty Guidelines. Eligibility for the ADAP direct dispensing service tier is 300 percent of the Federal Poverty Level (FPL). Eligibility for the ADAP insurance assistance service tier is 550 percent of FPL. Eligibility for the Medicare Assistance service tier is 550 percent of FPL and applies for individuals who do not qualify for the Medicare Part D Full Low-income Subsidy (FLIS). Expenditures are carefully monitored and projections are reviewed monthly.

Figure 4.03 lists the characteristics of clients enrolled in ADAP during 2014. Clients served through ADAP have a similar distribution to that of PLWHA in South Carolina. The majority of the clients are non-Hispanic African-American (70 percent), male (72 percent) and in the 45+ year age group (52 percent).

**Figure 4.03: Characteristics of ADAP clients compared to S.C. persons living with HIV/AIDS in 2014**

	ADAP Clients, N=5,554	Persons Living with HIV/AIDS, N=16,222
<b>Race/Ethnicity</b>		
White, not-Hispanic	24%	24%
Black, not-Hispanic	70%	71%
Hispanic	5%	4%
Other	1%	1%
<b>Sex</b>		
Male	72%	71%
Female	27%	29%
Transgender	1%	N/A
<b>Age Group</b>		
< 24	5%	5%
25-44	43%	37%
45+	52%	58%

## Epidemiologic Profile

Figure 4.04 shows a similar list of characteristics by Service Type. Men comprise the largest proportion across all three service types (72 to 77 percent). ADAP’s Direct Dispensing served the largest number of clients and has a similar distribution to that of PLWHA in South Carolina. African-American’s also comprise the largest proportion within the Insurance Program and Medicare Part D Assistance.

**Figure 4.04: 2014 ADAP Patient Profile Compared to Persons Living with HIV/AIDS**

	S.C. HIV/AIDS Prevalence N=16,222	Direct Dispensing N=4,132	Insurance Program N=1,848	Medicare Part D Assistance N=320
<b>Race/Ethnicity</b>				
White, not-Hispanic	24%	21%	30%	44%
Black, not-Hispanic	71%	72%	66%	55%
Hispanic	4%	5%	3%	1%
<b>Sex</b>				
Male	71%	72%	72%	77%
Female	29%	27%	28%	23%

Figure 4.05 shows a breakdown of SC ADAP clients who received each of three types of services that support access to medications and the average number of services per client. The majority of SC ADAP enrollees received prescriptions, via mail order for uninsured clients and at retail pharmacies with insurance copayment/deductible assistance from SC ADAP (n=5,257). The SC ADAP paid health insurance premiums for enrollees with access to private insurance (n=1,020) and supported out-of-pocket costs for enrollees with Medicare Part D coverage (n=326).

**Figure 4.05: South Carolina ADAP Service Type, 2014**

	Number of clients receiving service	Number of visits per category	Average number of Services per client
Prescription Refills: (Direct Dispensing & Insurance Copayments/Deductibles)	5,257	100,770	19
Premiums: Health Insurance Premiums (including Pre-existing Condition Plans)	1,020	4,549	4
Medicare Copayments/Deductibles*	326	8,546	26

\*Insurance Copayments and Deductibles are associated with specific prescriptions and are reported as Refills/Medications.

### In Care vs. Not In Care

This section looks at the number and characteristics of people who know they are HIV positive but who are not receiving HIV primary medical care.

eHARS data was used to determine the in-care/not-in-care status of PLWHA in South Carolina. The selection criteria included all people diagnosed through December 31, 2014, who were alive as of December 31, 2014, and have South Carolina as their current residence. Cases meeting these criteria were linked to laboratory tests (CD4 and viral load tests have been reportable since January 1, 2004) from January 1, 2014 through December 31, 2014. A person was considered “in care” if they had at least one CD4 or viral load test in 2014 and that test was at least thirty days after the initial date of diagnosis; people with no CD4 or viral load test in this time period were considered “not in care”.

**Figure 5.01: People living with HIV/AIDS (2014) proportion estimated in care vs. not in care (N=18,253)**

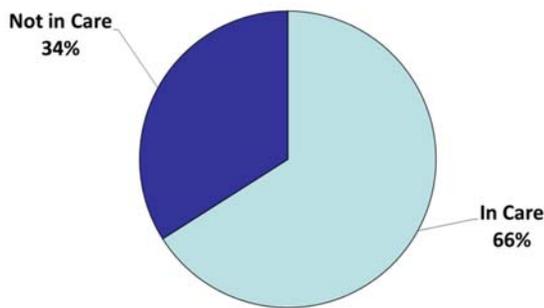
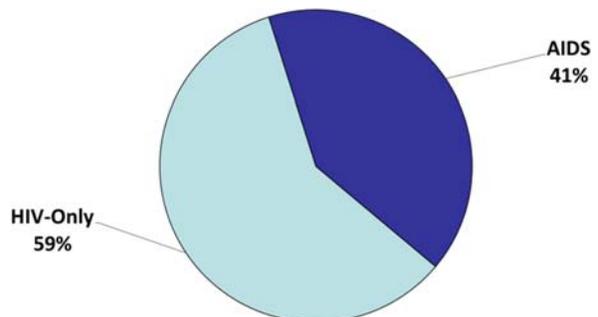


Figure 5.01 shows that of the 18,253 PLWHA as of December 2014, 34 percent (6,292) did not receive a CD4 or viral load test report within the specified time period, and therefore are reported as not in care. Sixty-six percent are defined as in care.

Of the 6,292 PLWHA not in care, 59 percent have a diagnosis of HIV-only and 41 percent have been diagnosed with AIDS (Figure 5.02).

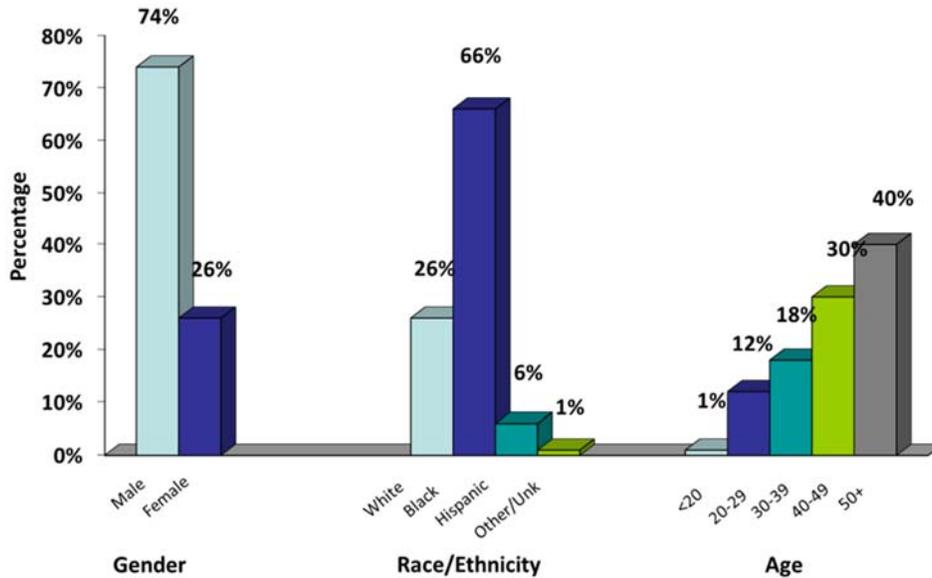
**Figure 5.02: People living with HIV/AIDS (2014) estimated not in care: HIV-only vs. AIDS (N=6,292)**



## Epidemiologic Profile

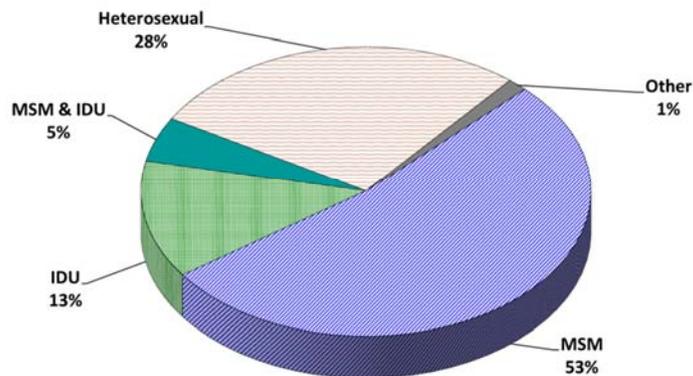
A comparison of PLWHA who are not in care by gender shows men account for the largest proportion (74 percent); when compared by race/ ethnicity, the majority (66 percent) are African-American; when compared by age groups, seventy percent are over the age of 40 (40-49 thirty percent and 50+ forty percent). (Figure 5.03)

**Figure 5.03: People living with HIV/AIDS (2014) estimated not in care: Comparison within select demographics of individuals**



An analysis by mode of exposure of PLWHA indicates most people not in care are MSM (53 percent) and heterosexuals (28 percent) followed by IDUs (13 percent) (Figure 5.04).

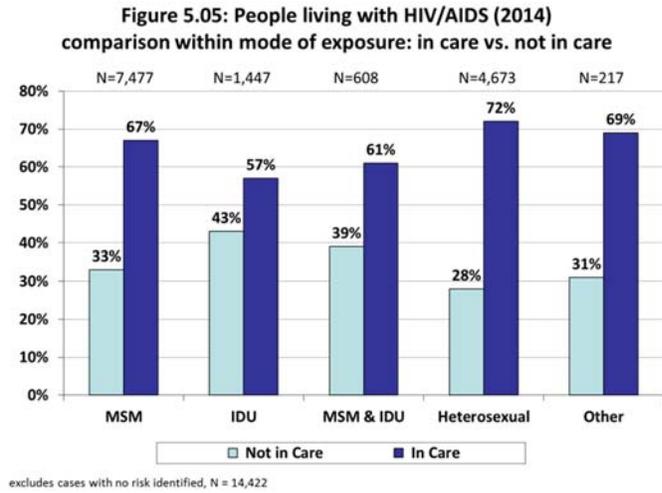
**Figure 5.04: People living with HIV/AIDS (2014) estimated not in care by reported risk**



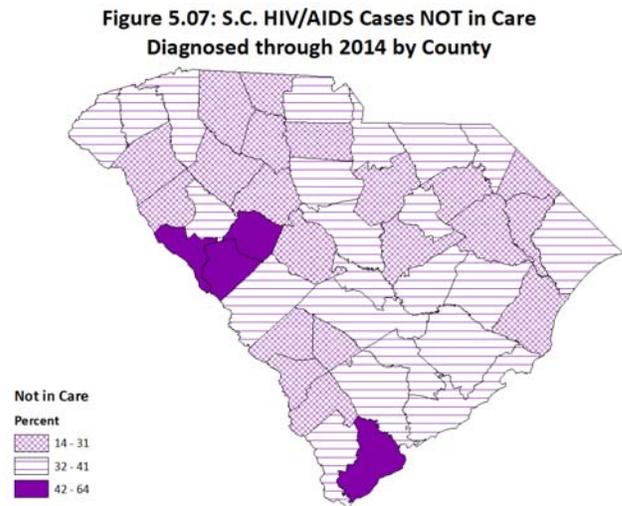
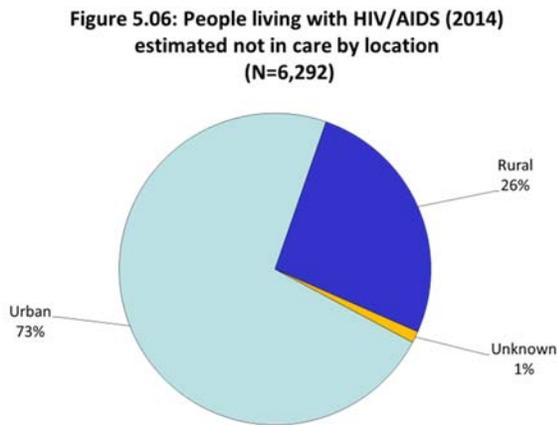
Excludes cases with no risk identified. N = 4,683

## Epidemiologic Profile

Figure 5.05 goes further to compare those in-care versus those not-in-care within each risk category. Among all MSM living with HIV/AIDS, more are in care (67 percent) than not in care. For people whose mode of exposure was injecting drug use (IDU), the proportion of those in care (57 percent) is similar to those in care whose mode of exposure was the combined risk of MSM and IDU (61 percent). Among heterosexuals with HIV/AIDS, 72 percent are in care.



The location of a person's residence may have an impact of whether or not they are in care. Of people not in care, more people are in urban areas (73 percent) versus rural areas (26 percent) (Figures 5.6 and 5.07).



*Note: Border counties, such as Aiken and Edgefield (the two solid fill counties), may have artificially high percentages of not in care due to S.C. residents receiving care in other states, where test results are not provided to S.C. (Note: In 2014, S.C. entered into a data sharing agreement with Georgia to receive test results for S.C. residents.)*



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## CHAPTER 2: COMMUNITY SERVICES ASSESSMENT

A community services assessment is an essential component of the HIV prevention community planning process. A community services assessment is comprised of three steps:

- 1) *Needs assessment* — The process of 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 examine both the met and unmet needs of each priority 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.

### **Priority Populations**

After detailed review of the Epi Profile, the Prevention Committee put forward recommendations at the June 16, 2009 meeting of the SC HIV Planning Council for seven priority populations for the five-year HIV Prevention Plan (2010-2014). Only a slight modification was made from the previous Prevention Plan (2004-2009). The recommendations were ratified by the full Council. The seven priority populations, in rank order, were:

- 1) Persons living with HIV/AIDS
- 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) Hispanics/Latinos.

With the new HIV Prevention Planning Guidance, released in 2012, it is noted that the priority populations do not need to be prioritized in rank order. **Accordingly, the Priority Populations are now listed and not rank-ordered, to include: Persons living with HIV/AIDS, African American Men who have Sex with Men (Ages 15-44), African American Women who have Sex with Men (Ages 15-44), African American Men who have Sex with Women (Ages 15-44), White Men who have Sex with Men (Ages 15-44), Injection Drug Users (Ages 20-44), and Hispanics/Latinos.** Surveillance data for 2012 will be reviewed to determine if any changes need to be made to the priority populations for 2013, including the target ages for each population.

The populations are more fully discussed in Chapter 3: Priority Populations.

## **1. Needs Assessments of Priority Populations**

On a yearly basis, the Prevention Committee reviews the literature and explores any new information on effective behavioral interventions and recommends to the full HIV Planning Council any necessary changes to the priority interventions table in Chapter 3. Since the last HIV Prevention Plan was submitted in 2004 for 2005-2008 (the first years of the SC HIV Planning Council, the integrated planning body for both HIV prevention and care) and the update for 2010-2014, a number of needs assessment activities have been completed or are underway.

In 2005, focus groups were conducted across the state with HIV positive consumers, both in care and out of care. In 2007, a town hall forum with facilitated discussion was held one evening for African American MSM in conjunction with the state HIV/STD Conference and, from January 2008-April 2009, focus groups with this population were also held. In 2008, a town hall forum was similarly held at the HIV/STD Conference with People Living with HIV/AIDS. Also in 2008, a survey was conducted with consumers of Ryan White Part B programs. In 2009, additional focus groups and/or key informant interviews were completed with White MSM and Hispanic/Latino MSM as part of the data collection efforts for the development of the state's MSM Strategic Plan. A survey of Transgender persons was also conducted in 2009 to gather information from this population, which had not been specifically addressed in previous data collection initiatives. These efforts were fully described in the plan originally submitted for 2010-2014, submitted in late 2009, but are included herein as the updated plan for 2010-2014.

### **2005 Focus Groups with Persons Living with HIV/AIDS**

The purpose of this assessment was to identify the prevention and care needs of persons living with HIV/AIDS, to identify what influences HIV positive people to seek and/or continue HIV/AIDS medical care, and the perceived quality of HIV prevention and care services in South Carolina. The project was designed and executed in collaboration with the SC HIV Planning Council, the SC Ryan White Care Consortia, the National Alliance of State and Territorial AIDS Directors (NASTAD), DHEC's STD/HIV Division, and researchers from the Arnold School of Public Health at the University of South Carolina. Discussion guides addressed the following four areas as they impact (or affect) people living with AIDS: service utilization, barriers to care

and unmet needs, prevention services and testing, and consumer involvement. Twenty (20) focus groups were held, with a total of 113 participants across 12 sites. The final report of these findings may be found on the HPC website at

[http://www.schpc.org/images/Final\\_Report\\_Focus\\_Groups\\_with\\_Consumers\\_3.6.pdf](http://www.schpc.org/images/Final_Report_Focus_Groups_with_Consumers_3.6.pdf).

### **2007 Town Hall Meeting with African American MSM**

A Town Hall Meeting for African American Men who have Sex with Men was held on October 17, 2007, sponsored by the SC HIV Planning Council and the AAMSM Workgroup. The survey instrument was a one-page, 10-item, self-administered questionnaire developed by the AAMSM Workgroup. It included questions about demographics, HIV status and testing history, sexual identity, recognition of the “Many Men, Many Voices” HIV prevention intervention, and awareness of/participation in community HIV/AIDS services. There were also two qualitative questions about the services needed for AAMSM in respondents’ respective communities, and AAMSM issues in their communities. The survey was administered at the AAMSM Workgroup’s Information and Awareness Forum at the 2007 South Carolina STD/HIV Conference. Thirty-seven AAMSM responded to the survey. After respondents completed the survey, they participated in a moderated discussion, lasting approximately 45 minutes, in which they were asked additional questions about the perception of HIV in AAMSM communities, HIV/AIDS service delivery, barriers to AAMSM participation in HIV/AIDS programs, and strategies for overcoming those barriers. The Report from the 2007 Town Hall Meeting with AAMSM is available on the HPC website at

[http://www.schpc.org/images/Final\\_Report\\_from\\_AAMSM\\_Workgroup\\_Forum\\_held\\_on\\_October\\_17,\\_2007\\_-\\_final\\_report\\_1-31-08.pdf](http://www.schpc.org/images/Final_Report_from_AAMSM_Workgroup_Forum_held_on_October_17,_2007_-_final_report_1-31-08.pdf).

### **2008 Consumer Town Hall Forum for People Living with HIV/AIDS**

In 2008, the SC HIV Planning Council (HPC), with guidance from its Consumer Advisory Committee and Needs Assessment Committee, elected to pursue the development and implementation of a Consumer Town Hall Forum to access direct input from persons living with HIV/AIDS across South Carolina. Working with the SC HIV/STD Conference Executive and Planning Committees, the HPC made plans to hold the Forum at the conference hotel and conference center one evening during the conference. The Conference’s Scholarship Committee worked closely with the HPC to enhance and support registration and lodging scholarship opportunities for consumers. Utilizing the Conference’s scholarship application process and with additional support from an anonymous donor, forty-five (45) registration scholarships were awarded, with twenty-five (25) of those recipients (who lived more than 50 miles outside of Columbia) also receiving lodging for the two nights of the conference. Additionally, HIV positive consumers not attending the conference were invited through area AIDS Service Organizations (ASOs) and encouraged to attend and participate. A total of sixty-two (62) consumers attended the event, which was held on October 15, 2008. Input from the Consumer Town Hall Forum was utilized both in the development of the Ryan White Statewide Coordinated Statement of Need (SCSN) and Comprehensive Plan, as well as the HIV Prevention Plan for 2010-2014. The final report from the Consumer Town Hall Forum is available on the HPC website at

[http://www.schpc.org/images/Consumer\\_Town\\_Hall\\_Forum\\_Summary\\_Report\\_Final\\_12-08.pdf](http://www.schpc.org/images/Consumer_Town_Hall_Forum_Summary_Report_Final_12-08.pdf)

### **January 2008 - April 2009 Focus Groups with African American MSM**

Based on the results of an African-American Men who have Sex with Men (AAMSM) Town Hall Forum held at the 2007 South Carolina STD/HIV Conference, a plan was developed to hold a series of focus groups throughout the state. These focus groups and the data analysis were made possible through a collaborative effort between the AAMSM Workgroup, the South Carolina HIV/AIDS Council, Lowcountry AIDS Services, AID Upstate, HopeHealth, and the South Carolina HIV Planning Council. The focus groups were designed to expand upon the findings of the Town Hall Forum, eliciting participants' responses to questions about general AAMSM health issues, HIV risk factors, awareness of and participation in HIV prevention programs, barriers to mobile HIV testing, and strategies for overcoming those barriers.

Initially, six focus groups were held in the first quarter of 2008 at community-based organizations who had received funding to implement the "Many Men, Many Voices" curriculum: the South Carolina HIV/AIDS Council in Columbia; Lowcountry AIDS Services in Charleston; and AID Upstate in Greenville. Additional groups of mixed ages were held at the three initial focus group sites, for a total of twelve focus groups. A total of 88 AAMSM took part in the twelve focus groups. Forty participants were between the ages of 18 and 25, and 48 participants were age 26 or older. There were some participants who came to groups that did not match their age group, due to scheduling conflicts with their age-appropriate group or being recruited to participate in the wrong group. Because their experiences and input were still considered valuable, they were not turned away in those situations. **The final report from the January 2008 - April 2009 Focus Groups with African American MSM may be found on the HPC website at**

**[http://www.schpc.org/images/2009\\_08\\_AAMSM\\_Focus\\_Group\\_Report.pdf](http://www.schpc.org/images/2009_08_AAMSM_Focus_Group_Report.pdf).**

### **2008-2009 Hispanic/Latino Community Needs Assessment Activities**

On June 4, 2008, a Statewide Hispanic/Latino HIV/AIDS Strategy Roundtable Summit was held in Columbia. One of a series of summits held in the Southeast, the event provided information that was used to develop a set of recommendations identifying needs of the Hispanic/Latino community. Co-sponsored by the Latino Commission on AIDS, the Deep South Project, Palmetto AIDS Life Support Services (PALSS), Catawba Care Coalition, the SC Hispanic/Latino Health Coalition, and the SC DHEC STD/HIV Division, the meeting included introductory remarks, presentation of Hispanic/Latino epidemiologic data, a panel discussion, and smaller workgroup discussions. Recommendations from the event fell into six broad categories: Data and Research, Outreach and Recruitment, Culturally and Linguistically Appropriate Services, Networking, Intervention, and Policy. These recommendations were accepted by the HPC at its August 19, 2008 meeting:

#### **Cultural and Linguistic Competency Recommendations:**

- Help agencies recruit and retain bilingual staff.
- Find out where to get Spanish-language materials.
- Increase consumers' understanding of how U.S. medical system works.
- Get all dialects available on the language line (e.g. Mixteco).
- Produce culturally and educationally appropriate materials (no higher than 4<sup>th</sup>-grade literacy level).
- Encourage services to expand hours to accommodate Latino clients.

#### Data/Research Recommendations:

- Compile data on what happens when clients come to facilities, i.e. DHEC, RW clinics? What is the reality of service provision?

#### Intervention Recommendations:

- Learn about the interventions already developed for this population.

#### Outreach recommendations:

- Forge links with Spanish-language media in the area.
- Identify key people in the community as potential intermediaries (e.g. business owners, trailer parks, apartment complexes).
- Identify and map community resources.
- Build trust in available services.
- Publicize policy that RW is available to undocumented; create a resource directory?

#### Networking recommendations:

- Create a subcommittee within the state Planning Council.
- Use the PC outreach and training group to build capacity throughout the state.
- Liaison with other communicable diseases' staff.

#### Policy recommendations:

- Collect data disaggregated by ethnicity (not just white, black, other).
- Increase Latino representation on Planning Council.
- Open Planning Council to ER representatives.
- Formulate recommendations to DHEC on how to improve access.
- Encourage students in the health professions to learn Spanish.

A formal report of the data, beyond these recommendations, is not available. As a direct result of the recommendations from the Roundtable Summit Recommendations, the HPC Hispanic/Latino Workgroup was created.

#### **October 2008 – February 2009 Survey of People Living with HIV/AIDS**

The South Carolina Department of Health and Environmental Control (DHEC) contracted with Public Consulting Group (PCG), Inc. to conduct a Needs Assessment of People Living with HIV/AIDS (PLWHA) in order to identify the HIV care and treatment needs of the clients in care throughout the eleven (11) Ryan White Part B HIV/AIDS Service Providers in South Carolina.

PCG conducted surveys on site at all eleven providers in South Carolina which include: ACCESS Network, Inc.; AID Upstate; CARETEAM; Catawba Care Coalition, Inc.; Hope Health Edisto; Hope Health Lower Savannah; Hope Health Pee Dee; Medical University of South Carolina; USC Department of Medicine; Upper Savannah Care Services; and Piedmont Care, Inc. throughout the months of October through December, 2008 and follow up surveys in January and February, 2009. The 11 service providers provide medical care and supportive services to people living with HIV/AIDS, with a focus on the following core services: outpatient/ambulatory medical care, ADAP (local), oral health care, health Insurance premium and cost sharing assistance, home health care, home and community-based health services, hospice services, mental health services, medical nutritional therapy, medical case management, and outpatient substance abuse services.

Additionally, limited support services including case management (nonmedical), emergency financial assistance, food bank/home delivered meals, health education/risk reduction, housing services, legal services, linguistics services, medical transportation services, outreach services, psychosocial support services, referral for health care/supportive services, and treatment adherence counseling are offered to patients in order to allow patients access to care and retention in care. All of the 46 counties in South Carolina are served by one of the 11 service providers depending on geographic proximity to the service provider. ADAP services are available through a direct dispensing model for all eligible patients and insurance assistance for persons with low income HIV/AIDS population throughout the state of South Carolina. PCG’s objective was to identify gaps, barriers, and needs in the Ryan White Services that the eleven providers offer to HIV/AIDS clients. The survey was administered to clients who currently receive care or had received care at that specific provider within the past two years. DHEC and PCG determined the number of samples needed for the surveys for each provider.

PCG’s final report of the Ryan White Part B Consumer Surveys is data in table format. A summary analysis of the findings, done for the purpose of reporting for this Plan, indicated that 560 randomly selected clients, served by a Ryan White Part B service provider in the past two years, were surveyed. The purpose of the survey was to gain insight into the client’s knowledge of available services and whether clients are accessing needed services. This assessment also identified service gaps and those service needs not being met for the clients.

Testing and Linkage

Thirty-four percent of clients found out they were positive by requesting a test. The majority of clients were diagnosed through passive methods: 48% found out when receiving care for something else, 4% found out when donating blood, and 5% found out in prison. 84% report being referred to HIV medical care when they became aware of their HIV status. 70% report going to medical care immediately, 17% went within one year, and 13% waited 1 year or more.

Medical Care

Ninety-eight percent of survey respondents were HIV positive clients receiving medical care. 2% were HIV positive and not receiving care. 91% claimed to not often miss their medical appointments. Of those 9% missing medical appointments, transportation was the most commonly sighted reason. Other reasons included: worried someone will find out status, no way to pay for it, work schedule, and forgetting. 94.4% of respondents with AIDS reported that they take their medications daily, on a regular schedule as prescribed. If clients were to miss doses the top reasons include: forgetting, side effects, difficult schedule, and not wanting to take the medications. 76.9% reported having received HIV/AIDS education and/or counseling.

Satisfaction with Medical Services

Table 1.

	<b>Satisfaction</b>	<b>Dissatisfaction</b>
Contacting Medical Doctor	74% very satisfied	2% very dissatisfied
Doctor’s Medical Advice	95% satisfied	5% dissatisfied
Nurse’s Medical Advice	87% satisfied	13% dissatisfied
CM Medical Advice	84% satisfied	16% dissatisfied

### Knowledge and Use of Available Services

The most commonly reported accessed services were: Medical Care (85% accessed), Medical Case Management (66%), AIDS Drug Assistance (60%), Oral Health Care (48%), Health Education/Risk Reduction (46%), and Medical Transportation (30%). These most commonly used services were also those that most clients knew were available to them. Clients were most aware of available Medical Care (95% known), AIDS Drug Assistance (90%), Psychosocial Support (88%), Medical Case Management (87%), Medical Transportation (86%) and Health Education/Risk Reduction (85%).

The most unknown services to clients were: Health Insurance Assistance (59% unknown), Housing Services (55%), and Legal Services (46%). All three of these rated high on Table 1, which shows the gap analysis of need for services with the usage of services.

Table 2. Comparing need with usage

	% of those needing a service that did not get it in the past 12 months
Hospice Services – Core	94%
Legal Services – Support	94%
Housing Services – Support	93%
Linguistic Services – Support	86%
Health Insurance Assistance – Core	72%
Home Health Care – Core	67%
Emergency Financial Assistance – Support	65%
Substance Abuse Services – Core	61%
Psychosocial Support – Support	45%
Food Bank – Support	43%
Treatment Adherence – Support	40%
Transportation – Support	39%
Oral Health Care – Core	38%
Mental Health – Core	36%
Medical Nutrition Therapy – Core	35%
Medical Case Management – Core	19%
AIDS Drug Assistance – Core	13%
Health Ed./Risk Reduction – Support	10%
Medical Care – Core	3%

As noted in Table 2, there were varied gaps between the need and usage of every eligible Ryan White service. Noticeably, providers were meeting the needs best with Medical Care, Health Education/Risk Reduction, AIDS Drug Assistance, and Medical Case Management. These programs have been the HRSA-mandated focus of the RW Part B program.

There probably was misunderstanding on the part of the clients about some definitions for the less known and less used services. Obvious examples included Hospice Services and Linguistic Services. It is doubtful that Hospice Services were medically indicated for the 103 clients in this sample population that claimed Hospice as a need. Ninety-nine percent of survey respondents indicated that English was the language they were most comfortable speaking yet there is a large gap in meeting the need for Linguistic Services.

Housing Services, Legal Services, Health Insurance Assistance and Emergency Financial Assistance represented the greatest client needs not being met by Ryan White service providers.

Clients claimed ease with obtaining most services that they have tried to access. Oral Health Care, Emergency Financial Assistance, and Medical Transportation were identified as the most difficult to obtain. The reasons stated for these being difficult were service delivery and no access/availability.

#### Other Services of Importance Identified by Clients

Besides, HIV Medical Care, other services identified as important to the clients in order of most responses: financial assistance (32), housing (22), dental services (22), other health care needs (20), support groups (16), insurance, including Medicaid and Medicare (14), and education (6).

#### Suggested Changes from Clients

The most commonly stated suggestion for change was for more community awareness, education and testing (25). Other common suggestions were: support groups (16), dental services (15), transportation services (15), and confidentiality (8).

There were also multiple suggestions related to providers (21): these ranged from having more doctors, more clinic hours, better communication with providers, provider choice, less wait time, seeing the same doctor for all health issues, seeing the same doctor each time, and ensuring doctors are knowledgeable HIV specialists.

In conclusion, the majority of clients were satisfied with and thankful for the services they received from the Ryan White Part B providers. Most were self-reported as consistent with their medical care and adherent to their prescribed medication regimen.

#### Knowledge of Services and Ease of Use

The self-reported adherence to medical treatment was consistent with the findings on client's use of services. Client's needs were most met for: Medical Care, AIDS Drug Assistance, Health Education/Risk Reduction, and Medical Case Management. Clients had greatest knowledge of these services and indicated ease with obtaining them. Knowledge of these services and ease of obtaining services appeared to be contributing factors to reducing unmet need of services and, in this case, adherence to medical treatment.

The less commonly known services seemed to correlate with those services that were less often used and were some of the clients' greatest gaps in service needs. Knowledge of service and ease of access were two variables to consider when reducing service gaps. Client eligibility for specific services, resource limitations, and HRSA priorities may also be factors in these service gaps.

One recommendation suggested by several survey respondents for increasing knowledge of services was to create a service listing by provider. This may increase user knowledge and increase requests for services. The eligibility for services, resources limitations, and HRSA's priorities and resource limitation should also be included.

#### Recommended Priority Services

As noted in Table 2, all eligible Ryan White services had an identified unmet need. Based on the commonality and consistency of needs identified throughout the survey, needs identified in the gap analysis, and needs stated directly by the client, the following list of services was identified as priorities for reducing the unmet need. HRSA's priorities were also taken into consideration in the development of this list.

- (1) Medical Transportation – Medical Transportation was the only service that was stated by clients to directly interfere with adherence to medical care. Medical Care is one of HRSA's priority services. Transportation was stated as a need by many clients and was considered a difficult service to obtain.
- (2) Oral Health – Oral Health Care is a HRSA priority service. It was consistently mentioned by clients as a need and was difficult to obtain. Although Oral Health Care is relatively well-used service, it can be assumed that the client's dental issues were more involved than the dental services offered.
- (3) Housing Services and Emergency Financial Assistance – With 78% of clients living below 200% of the FPL and 68% of clients not working, housing and emergency financial assistance were widely stated throughout the questionnaire as important needs. Housing was relatively unknown service and was one of the greatest demonstrated gaps. EFA was indicated difficult to obtain.
- (4) Psychosocial Support – Although the gap in Psychosocial Support was not as large as other services, these appeared to be of much value to the clients. Clients clearly indicated a need for support groups and commented on the need for confidentiality and community education. Confidentiality was also a factor in medical care treatment adherence. An assumption could be made that the need for support groups comes from feeling of discrimination and stigma from the community.
- (5) Health Insurance Assistance – Health Insurance Assistance is a HRSA priority service and cost saving to the Ryan White program. Although many clients will not qualify, clients and service providers would benefit if all eligible clients were enrolled.

**PCG's report on the Ryan White Part B Consumer Surveys is data in a table format and, thus, a final written report is not available other than the information provided in the above text.**

### **2009 Transgender Survey**

In 2006, during a review of SC Ryan White Care programs data by the HIV Planning Council's Needs Assessment Committee, it was noted that eight transgender (TG) persons were receiving Ryan White care and support services in the AID Upstate service area. The entire remainder of the state did not reflect serving as many (8) transgender people. Concerned that this was a data anomaly and not truly reflective of the number of TG persons served in the state, the Committee informally began inquiring as to if and how service providers noted TG clients in their consumer population. As a result of anecdotal reports, the Committee elected to seek a trainer for and begin development of a Transgender 101 course. Upon recommendations of community contacts, a male-to-female transgender person from the upstate was contacted and a successful and informative one-day training was held in late 2006. Following completion of that course, a Capacity Building Assistance request was filed in early 2007 with the CDC for a workshop to be provided by The Transitions Project (UCSF) on HIV Prevention with Transgender Persons. Following that successful skills-building training, the Committee recognized that SC had no needs assessment data on the TG population, and efforts were begun to develop and implement a comprehensive survey of transgender persons. Over the course of 2008, an 18-page survey was developed and pilot tested. In April of 2009, the survey was distributed through social networks of TG persons and via HIV prevention and care contractors. As of July 31, 2009, a total of 17 completed surveys were received. Due to the small number of respondents from the convenience sample, the data were reported to the HPC but no final written was prepared.

### **2010 Survey of African American Women who have Sex with Men (AAWSM)**

In 2010, the HPC documented and reported on the HIV-related knowledge, attitudes, behaviors and beliefs of AAWSM, one of South Carolina's priority populations. This survey was administered to women who: 1) are African American, 2) identify as female, 3) are 18 years or older and 4) live or attend school in South Carolina. Between the months of August and December, 324 surveys were administered to groups of no less than four African American women over the age of 18 that attended and participated in community presentations and other targeted outreach of the STD/HIV Division's prevention contractors and community partners. That report, finalized in March 2011, is available on the HPC website at [http://www.schpc.org/images/Final\\_AAWSM\\_Survey\\_Report\\_3-28-11.pdf](http://www.schpc.org/images/Final_AAWSM_Survey_Report_3-28-11.pdf).

### **2011 Survey of African American Men who have Sex with Women (AAMSW)**

In 2011, the HPC documented and reported on the HIV-related knowledge, attitudes, behaviors and beliefs of AAMSW, another of South Carolina's priority populations. This survey was administered to men who: 1) are African American, 2) identify as male, 3) are 18 years or older and 4) live or attend school in South Carolina. By design, sexual orientation was not an eligibility determinant. This allowed for a more accurate assessment of all men who may have had sex with women during the last five years, regardless of their self-identified sexual orientation. The survey was designed to be a convenience sample of clients participating in various agency- or clinic-sponsored services or events. A total of 416 surveys were returned. The final report on the survey was presented at the December 13, 2011 meeting of the HPC and is available on the HPC website at [http://www.schpc.org/images/AAMSW\\_survey\\_report\\_-\\_Dec\\_2011-FINAL.pdf](http://www.schpc.org/images/AAMSW_survey_report_-_Dec_2011-FINAL.pdf).

## 2012 Survey of Hispanic/Latino Men and Women

For 2012, the Needs Assessment Committee is working with the Hispanic/Latino Workgroup to assess the HIV-related knowledge, attitudes, behaviors and beliefs of Hispanic/Latino men and women in the eight health department regions across South Carolina. Fourteen implementations of the survey will be conducted, with two in each of six public health regions with higher numbers of Hispanics/Latinos and one each in the other two regions. Agencies and organizations that serve Hispanics/Latinos in these areas were contacted to assist with recruitment of participants and/or to host the surveys. To raise community awareness and dispute common myths, an HIV 101 workshop will be offered immediately after each administration of the survey. When the assessment, data analysis, and final report are completed, the report will be presented at the December HPC meeting and published on the HPC website.

## Other data collection efforts in South Carolina are more fully discussed in Chapter 6: Surveillance and Data Collection Initiatives

### 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.

South Carolina’s public health system is divided into eight regions representing anywhere from four to ten county health departments. The state office, the STD/HIV Division, is located in the Bureau of Disease Control along with the TB Control Division, Division of Acute Disease Epidemiology, Division of STD/HIV Surveillance, and Immunization Division, all within the Health Services Deputy area of the SC Department of Health and Environmental Control. The STD/HIV Division and Division of STD/HIV Surveillance are physically located on the same floor, enhancing opportunities for data sharing and reporting. The STD/HIV Division also includes and houses Ryan White program staff, increasing communication for linkage to care and joint planning and training efforts.

## DHEC Regions



All public health regions offer STD and HIV prevention services including STD screening and treatment, HIV counseling and testing, partner services (formerly know as partner notification and partner counseling and referral services or PCRS), and HIV prevention comprehensive risk counseling and services. Central office staff provides quality assurance, contracts management, training and capacity building, public information/health communication, evaluation, and planning. In 2009, a Resource Inventory of HIV prevention activities was compiled into two sets of tables. The first set of tables, a checklist of services provided by county, provides an at-a-glance look at a spectrum of prevention services. The second set of tables includes prevention contractors and health department providers, the interventions provided, and target populations served.

The format of the Resource Checklist was presented to the HPC during the April 2009 meeting for review and to offer any additions or changes. From that meeting, the checklist was updated and by-county information collected and entered. Services provided in each county were contrasted with services available to county residents but provided outside the county. The revised Resource Checklist for the 2010-2014 Plan was presented and approved at the August 2009 HPC meeting. **The Resource Checklist is currently being updated for 2012 and will be presented at the December HPC meeting.**

## CHAPTER 3: PRIORITIZATION OF TARGET POPULATIONS

### Population Priority Setting Process

#### Priority Populations for 2005-2009

Population priority setting was accomplished by considering CDC's mandated population of persons living with HIV/AIDS (PLWHA); 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.

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

- 1) Persons living with HIV/AIDS
- 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) Hispanics/Latinos.

For a detailed description of the priority setting process and the literature reviews for identifying recommended types of interventions for each priority population, please review the archived 2005 – 2009 S.C. HIV Prevention Plan, Chapter 4, at the DHEC web site: [http://www.scdhec.gov/health/disease/stdhiv/sc\\_hiv\\_prevention\\_plan.htm](http://www.scdhec.gov/health/disease/stdhiv/sc_hiv_prevention_plan.htm).

#### Priority Populations for 2010-2014

In February 2009, DHEC staff distributed and reviewed the *South Carolina's Epidemiologic Profile* (with data through 2007) with the HPC. The Prevention Committee reviewed the Epi Profile and other supplemental data, re-examined the priority populations for 2004-9, and then presented their recommendations for the 2010 priority order of populations at the June 2009 HPC meeting. The recommendations ratified by the HPC were to reaffirm the seven priority populations as previously ranked and noted above.

\*NOTE: HIV epi risk data presented in the following sections for each population has been calculated from those persons reporting an HIV risk.

**POPULATION #1  
PERSONS LIVING WITH HIV/AIDS**

Size of Population: 14,696

As of December 31, 2007, there were 14,696 persons reported to be living with HIV, including AIDS, in South Carolina. The growing number of persons living with HIV/AIDS (PLWHA) challenges both prevention and care service systems. Prevention needs are essential to address the sexual and substance use risk behaviors among some PLWHA. The need is increasing for continual supportive services at the individual, group and community levels to assist PLWHA in their personal health care and behavior change. Adherence to drug regimens reduces the viral load of the person living with HIV/AIDS, thus reducing the likelihood of HIV transmission if risk behaviors are engaged in. As people live longer and longer with HIV/AIDS, the need will certainly increase for prevention programs to adapt to meet the needs of the aging population who may otherwise “burnout” on previous or current prevention interventions.

**Subpopulations of Concern:**

- AAMSM and WMSM
- AAMSW and AAWSM
- IDU

**Needs Assessment Findings:**

- High incidence of unprotected sex
- High incidence of STD/history of STDs
- 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
- Unmet necessary needs (shelter, food, etc.)
- Low sensitivity, empathy and confidentiality by health care providers

## **POPULATION #2**

### **AFRICAN AMERICAN MEN WHO HAVE SEX WITH MEN, AGES 15 - 44**

Estimated Size: Minimum of 24,515 men

African American men who have sex with men (AAMSM) comprise 24% of the reported PLWHA in South Carolina. Among those recently diagnosed with HIV/AIDS in South Carolina, AAMSM comprise 33% of the cases. There are significant prevention challenges related to AAMSM in South Carolina, similar to other southeastern states. Few programs are targeted toward this population. Access to the population is difficult due to secrecy of the activity, denial of AAMSM engaging in same sex activities and the double stigmas of racism and homophobia. Many 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 too little 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 PLWHA
- Youth and young adults (<25)
- Incarcerated
- Substance users
- HIV infected
- Bisexual
- Transgenders
- Sex workers
- MSM who do not identify as MSM

#### **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 unprotected sex
- High incidence of closeted (down-low) sexual behaviors
- 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
- Prevalence of societal discrimination & stigma related to race, sexual orientation & economic status
- High incidence of STD/history of STDs

**POPULATION #3**  
**AFRICAN AMERICAN WOMEN WHO HAVE SEX WITH MEN, AGES 15 - 44**

Estimated Size: 284,437 women

African American women who have sex with men comprise 21% of the PLWHA in South Carolina. Among recently reported cases during 2006-2007, African American heterosexual women accounted for 20% of the total cases. This trend is similar across southern states where joblessness, substance abuse, teenage pregnancy, STDs 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 PLWHA
- Youth and young adults (<25)
- Incarcerated
- Substance users
- HIV infected
- Sex workers
- Pregnant women

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

**POPULATION: #4**  
**AFRICAN AMERICAN MEN WHO HAVE SEX WITH WOMEN, AGES 15 - 44**

Estimated Size: 262,924 men

African American men who have sex with women comprise approximately 13% of PLWHA and of the more recently diagnosed cases in South Carolina. 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 PLWHA
- Men older than 25 years
- Incarcerated
- Substance users
- HIV infected

**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
- 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

## **POPULATION #5**

### **WHITE MEN WHO HAVE SEX WITH MEN, AGES 15 - 44**

Estimated Size: Minimum of 16,698 men

White men who have sex with men (WMSM) comprise approximately 16% of PLWHA and 15% of the more recently diagnosed cases in South Carolina. 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 reported PLWHA 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 PLWHA
- Youth and young adults (<25)
- Substance users
- HIV infected
- Sex workers
- Older adults (>44)
- Internet “cruisers”

#### **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
- 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

## **POPULATION #6 INJECTION DRUG USERS, AGES 20 - 44**

Estimated Size: 8,000 (All races/genders)

Injecting drug users (IDUs) comprise approximately 18% of PLWHA and 9% of the more recently diagnosed cases in South Carolina. There is an apparent decline in the number of new HIV infections reported among both men and women due to injecting drug use (IDU). Among the newly diagnosed cases of HIV/AIDS with injecting drug use as a risk factor, 32% are African American men compared to 22% who are white men. African American women account for 21% of recent cases due to injecting drug use; white women account for 20%. The majority (92%) of recently diagnosed IDU cases are among persons 25 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 PLWHA
- 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

## **POPULATION #7 HISPANIC OR LATINO/A**

### **Estimated Size: 168,920**

Two percent of the total persons living with HIV infection are Hispanics, who comprise about 3.8% of the state's population (2007 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. 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 underserved 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.

### **Subpopulations of Concern:**

- HIV negative partners of PLWHA
- Farmworkers (Latino/a)
- Migrant farmworkers (Latino)
- Sex workers (Latina)

### **Needs Assessment:**

- Language and cultural barriers
- Low SES (education, income, employment)
- Transportation barriers
- Lack of health insurance
- Limited or no target-population specific programming and outreach

## **Populations of Special Interest**

In addition to the Priority Populations noted above, it is important to note several populations of special interest. The populations noted below do not have specific epidemiologic data to make them a priority population; however, there are factors that make them either populations for special consideration or emerging populations.

### **STD Clinic Patients**

Patients who present at the health department's STD clinics are coming due to onset or worsening of symptoms and/or fear of infection. These individuals have engaged in unprotected sex or have otherwise been exposed. Additionally, those diagnosed with an STD are at higher risk of becoming HIV infected. HIV testing and prevention efforts must be targeted to these clinic patients. Once STD symptoms subside, persons may not follow-up on return visits for treatment and follow-up or testing. Reaching these individuals as they present for services should be considered a top priority. This must also include persons who present at the clinic as a result of a disease investigation referral.

### **Partners of Persons Living with HIV/AIDS (PLWHA)**

Across studies of HIV-positive MSM, women, and IDUs, between 17% and 38% report unprotected vaginal or anal intercourse (many as recently as their last sexual encounter) with partners who are HIV negative or of unknown HIV status. High-risk sexual behavior among PLWHA is not limited to interactions with casual or anonymous partners. Multiple studies have found that safer sex precautions are less likely to be adopted in relationships characterized by affection and in ongoing sexual relationships than in casual or transient partnerships. This pattern has been found not only in the case of monogamous serodiscordant male couples, but also among affectionate relationships that are not mutually exclusive and in which partners do not know each other's serostatus.

In one analysis of couples in serodiscordant relationships, 31% reported unprotected anal sex with their primary partner at least once in the past 12 months. Several studies have suggested that PLWHA go through a period of sexual abstinence as they adjust to their infection status, but later resume their sexual activity. However, one study of newly infected persons found that 11% reported unprotected insertive anal sex and 26% reported unprotected receptive anal sex with unknown-serostatus or HIV-negative partners within a 6-month period after infection. This strongly suggests a need to address risk reduction concerns of newly diagnosed persons and their partners at the earliest possible times following knowledge of one's HIV positive status. Ongoing supportive counseling and education is needed for the partners of PLWHA in addition to the continual prevention activities directly with PLWHA themselves.

### **Partners of Persons from Priority Populations, Regardless of the Partner's Race, Ethnicity, or Age**

Persons who are having sex may choose to have sex with partners who are not of the same race, ethnicity or age as themselves. While there is little data to indicate what percentage of persons infected with HIV have had partners of a different race, ethnicity or age, anecdotal reports and disease investigation follow-up have shown that these sexual encounters are occurring. While

prevention efforts should be targeted to the populations with the highest incidence and prevalence of HIV infection, consideration must be given to any sexual partner at risk, regardless of race, ethnicity or age.

### **Persons who are Incarcerated**

While the S.C. Department of Corrections tests all persons as they enter the system, there are few and insufficient efforts to reach persons who are incarcerated in city or county jails. Some prevention contractors are working with their local jails for HIV testing and prevention messages. Other jails may have placed barriers to coordinated services and/or the access to incarcerated persons. Data is needed to demonstrate the percentages of those who are interfacing with detention facilities and have HIV or had an STD. With these data, opportunities may be pursued for additional funding to work collaboratively with the incarcerated population. Partners of persons with a history of incarceration should also be considered at increased risk for HIV/STDs.

### **Transgender**

Little data exists in South Carolina regarding the transgender population. If persons have had sexual reassignment surgery, they often “disappear” into the general population. Male-to-female transgender persons who have sex with men and do not realize the alignment of their sexual and physical identities are still considered Men who have Sex with Men. With the usually disenfranchised nature of this population and the high-risk sexual and drug behaviors that have been reported in other areas of the United States, transgender persons are considered a population of interest. Historically, HIV infection rates have been high among transgender persons in large metropolitan areas. The HPC Needs Assessment Committee recommended, designed, and has implemented an 18-page survey of transgender persons 18 years and older living or a student in South Carolina. Data from this survey, distributed through social networks and via prevention and care contractors, will help guide future training, cultural competence, and prevention strategies for providers serving this population.

### **Sex Workers**

Although little data exists in South Carolina on this population, sex workers should be a priority for prevention efforts due to the high-risk behaviors that have been anecdotally reported to prevention and care service providers. While outreach efforts sometimes reach these individuals, more sustained efforts need to take place to include consideration of this population’s complete sexual networks (i.e., significant others, johns, pimps, etc.). Special interventions should be considered for anyone with an arrest and conviction for solicitation or prostitution.

### **Victims of Sexual Assault**

Gender-based violence may increase a person’s risk for HIV infection through forced or coercive sex. Forced or violent intercourse can cause abrasions and cuts that can facilitate entry of HIV through vaginal and/or anal mucosa. Forced or coerced sex limits a person’s ability to successfully negotiate HIV prevention such as condom use. In addition, sexual violence may also expose a person to STD’s, which can increase the recruitment of receptor cells (CD4 cells) possibly increasing their risk for HIV acquisition in the future.

### **Other Drug Users**

While injection drug users are certainly at high risk for HIV infection, in S.C. their numbers are generally low. Other drugs, however, are a noted area of concern for service providers who recognize the need for alcohol/other drug intervention with their clients. Use of drugs such as crack cocaine, cocaine, methamphetamine, ecstasy, and other illegal and illicit drugs are major concerns in segments of their client populations. Noninjection drugs (such as "crack" cocaine) contribute to the spread of HIV and other STDs when users trade sex for drugs or money, or when they engage in risky sexual behaviors that they might not engage in when sober.

Comprehensive HIV prevention interventions for substance abusers must provide education on how to prevent transmission through sex. Studies have documented that drug users are at risk for HIV through both drug-related and sexual behaviors, which places their partners at risk as well. Comprehensive programs must provide the information, skills, and support necessary to reduce both risks. Many successful interventions aimed at reducing sexual risk behaviors among drug users have significantly increased the practice of safer sex (e.g., using condoms, avoiding unprotected sex) among participants.

Clearly, the need for substance abuse treatment vastly exceeds the state's capacity to provide it. Effective substance abuse treatment that helps people stop using drugs not only eliminates the risk of HIV transmission from sharing contaminated syringes but, for many, reduces the risk of engaging in risky behaviors that might result in sexual transmission. For individuals who continue to use alcohol/other drugs, harm reduction approaches will help reduce the risk of HIV and STD transmission. HIV prevention and treatment, substance abuse prevention, and sexually transmitted disease treatment and prevention services must be better integrated to take advantage of the multiple opportunities for intervention--first, to help the uninfected stay that way; second, to help infected people stay healthy; and third, to help infected individuals initiate and sustain behaviors that will keep themselves safe and prevent transmission to others.

### **Older Adults**

The number of persons aged 50 years and older living with HIV/AIDS has been increasing in recent years. This increase is partly due to highly active antiretroviral therapy (HAART), which has made it possible for many persons with HIV/AIDS to live longer, and partly due to newly diagnosed infections in persons over the age of 50. With post-menopausal women not having the need for birth control and with men bombarded with messages promoting medications for erectile dysfunction, the risk of exposure to HIV/STD increases for older adults. As the US population continues to age and is living healthier longer, it is important to be aware of specific challenges faced by older Americans and to ensure that they get information and services to help protect them from infection with HIV and other STDs.

### **Youth**

The SC Youth Risk Behavior Survey, administered to in-school youth, provides information on sexual activities occurring in this population. The proportion of sexually active teens that used condoms or birth control the last time they had sex decreased in 2007 (62%) from 2005 (67%). The rate of teens that had sex before they turned 13 increased slightly in 2007 for the first time since 1993. Teen births and HIV/STD rates among youth in SC are consistently among the highest in the nation. In addition, many young people use alcohol and other drugs and are more likely to engage in high-risk behaviors, such as unprotected sex, when they are under the

influence of drugs or alcohol. Abstinence from vaginal, anal, and oral intercourse is the only 100% effective way to prevent HIV, other STDs, and pregnancy. Youth may not choose to remain abstinent, so it is vitally important to provide all youth with Comprehensive Sexual Education (CSE). CSE is age-appropriate, abstinence-based, and provides young people with the knowledge and skills to avoid teen pregnancy and infection with HIV/STDs. HIV/STD prevention education should address the needs of youth who are not engaging in sexual intercourse as well as youth who are currently sexually active. It is important to ensure that all youth are provided with effective education to protect themselves and others from infection with HIV and STDs as well as teen pregnancy.

**Table 2A: HIV Prevention Priority Populations and Recommended Interventions<sup>1</sup> 2010 – 2016  
With Special Considerations<sup>2</sup> for South Carolina**

*Updated as of August 31, 2015 for alignment with the National HIV/AIDS Strategy and CDC’s High Impact HIV Prevention*

<b>Priority Populations (ranked)</b>	<b>Recommended Intervention or Public Health Strategy (not ranked), Including Interventions Proposed in August 2015 by the S.C. HIV Planning Council’s Prevention Committee for Inclusion in the CY 2017 – CY 2021 S.C. Integrated HIV Prevention and Care Plan (indicated as * and in bold type font below)</b>
<b>For All Priority Populations (#s 1 – 7, listed below)</b>	<ul style="list-style-type: none"> <li>▪ Prevention Counseling (using <i>Fundamentals of Prevention Counseling</i> model)</li> <li>▪ Outreach including Internet Outreach</li> <li>▪ Social Networking Strategies</li> <li>▪ Partner Services</li> <li>▪ Condom Distribution</li> <li>▪ Policies and Other Structural Interventions</li> <li>▪ Capacity Building</li> </ul>
1. Persons Living With HIV/AIDS (PLWHA)	<ul style="list-style-type: none"> <li>▪ <i>Anti-Retroviral Treatment and Access to Services (ARTAS)</i></li> <li>▪ <i>Comprehensive Risk Counseling and Services (CRCS)</i></li> <li>▪ Perinatal HIV Prevention Case Management Services (for pregnant women)</li> <li>▪ <i>Healthy Relationships</i></li> <li>▪ <i>Women Involved in Life Learning from Other Women (WILLOW)</i></li> <li>▪ Linkage to and Retention in Care and Treatment Services</li> <li>▪ <i>Project CONNECT (Client-Oriented New Patient Navigation to Encourage Connection to Treatment)*</i></li> <li>▪ <i>Strength Through Livin’ Empowered (STYLE)*</i></li> <li>▪ <i>Every Dose, Every Day*</i></li> <li>▪ <i>Partnership for Health*</i></li> <li>▪ <i>Project HEART (Helping Enhance Adherence to antiRetroviral Therapy)*</i></li> </ul>
<b>For All Priority Populations (#s 2 – 7, listed below)</b>	<ul style="list-style-type: none"> <li>▪ HIV Testing               <ul style="list-style-type: none"> <li>○ Routine, opt-out testing in health care settings</li> <li>○ Targeted HIV testing in non-healthcare settings</li> <li>○ Routine early HIV screening for all pregnant women</li> <li>○ Screening for other STDs, viral hepatitis and tuberculosis in conjunction with HIV testing</li> <li>○ <b>Couples HIV Testing and Counseling*</b></li> <li>○ <b>Personalized Cognitive Counseling (PCC)*</b></li> </ul> </li> </ul>
2. African American Men who Have Sex with Men (AAMSM)	<ul style="list-style-type: none"> <li>▪ <i>Many Men, Many Voices (3MV)</i></li> </ul>
3. African American Women who Have Sex with Men (AAWSM)	<ul style="list-style-type: none"> <li>▪ See previous “all priority populations” notes above.</li> </ul>
4. African American Men who Have Sex with Women (AAMSW)	<ul style="list-style-type: none"> <li>▪ See previous “all priority populations” notes above.</li> </ul>
5. White Men who Have Sex with Men (WMSM)	<ul style="list-style-type: none"> <li>▪ See previous “all priority populations” notes above.</li> </ul>
6. Injecting Drug Users (IDUs)	<ul style="list-style-type: none"> <li>▪ See previous “all priority populations” notes above.</li> </ul>
7. Hispanics/Latinos	<ul style="list-style-type: none"> <li>▪ See previous “all priority populations” notes above.</li> </ul>

<sup>1</sup>Interventions were recommended by the SC HIV Planning Council (HPC) through June 2012. After June, the SC DHEC STD/HIV Division revised the list of recommended interventions for alignment with CDC High Impact HIV Prevention.

<sup>2</sup>Special considerations are developed by the SC HPC’s Prevention Committee and approved by the entire HPC annually.

**Table 2B: Recommended Interventions’ Special Considerations for South Carolina**

*Updated as of April 2014 for alignment with the National HIV/AIDS Strategy and CDC’s High Impact HIV Prevention*

<b>Intervention/ Public Health Strategy</b>	<b>Special Considerations</b>
<i>Anti-Retroviral Treatment and Access to Services (ARTAS)</i>	<ul style="list-style-type: none"> <li>• Transportation is an issue in South Carolina. Many people live in rural areas with limited to no public transportation. Special consideration when implementing the ARTAS intervention is to provide transportation assistance (i.e. agency pick-up, bus token, taxi cab voucher).</li> <li>• Unreliable telephone service and contact information. Many clients utilize pre-paid cell phones with limited available minutes, which hinders’ the ability to communicate with providers, case managers, and intervention staff. Agencies should consider providing pre-paid calling cards or other incentives.</li> <li>• Lack of stable housing. Individuals are displaced for various reasons (i.e. incarceration, unemployment, and hospitalization). It is recommended that in conjunction with providing intervention services, staff utilize other social service avenues, such as HOPWA, drug and alcohol services and mental health services.</li> <li>• Marketing the ARTAS intervention. Use a multidisciplinary approach. Make sure other organizations are aware of who is providing the ARTAS intervention.</li> </ul>
<i>Healthy Relationships</i>	<ul style="list-style-type: none"> <li>• Transportation to and from the intervention: Many areas are very rural in our state. Many areas do not have public transportation or taxi cab service.</li> <li>• Providing the intervention in a retreat type setting or over the course of several days (i.e. weekend or Wednesday - Friday) seems to work better than over the course of five weeks. Consideration should be given to adapting the intervention to be implemented in a two- day session or a week-end retreat.</li> <li>• A person active in substance abuse or actively psychotic may not be appropriate for the intervention. A mental health assessment and/or a substance abuse assessment may need to be conducted prior to enrolling an individual in the intervention.</li> <li>• Many clients entering Healthy Relationship Intervention need to have a clear understanding of HIV and STD transmission. It is recommended that clients have this education or knowledge prior to enrolling. It is recommended that clients be assessed for education and knowledge and if needed, provided individualized education prior to enrolling.</li> </ul>
<i>Many Men, Many Voices (3MV)</i>	<ul style="list-style-type: none"> <li>• Continue the one-weekend or two-weekend retreat provision of the intervention, versus the seven-session (one session per week for seven weeks) method of intervention delivery.</li> <li>• Establish statewide support from trained 3MV facilitators to assist other areas due to high staff turnover and lack of experienced staff for this intervention.</li> <li>• Conduct recruitment for additional facilitators to implement more 3MV interventions, with encouragement to DHEC STD/HIV to seek special funds to provide support in this effort.</li> </ul>
<i>Women Involved in Life Learning from Other Women (WILLOW)</i>	<ul style="list-style-type: none"> <li>• Transportation to and from the intervention: Many areas are very rural in our state; consequently, many areas do not have public transportation or taxi cab services. It is recommended to have personal transportation available for participants not just bus tickets/tokens due to the lack of public transportation and/or program crossing multiple county lines.</li> <li>• Providing the intervention over the course of several days (i.e. in a retreat setting, Friday through Sunday or four Fridays in a row) works better than providing intervention during the week.</li> <li>• It is recommended that the WILLOW facilitators should have some alcohol/drug knowledge.</li> <li>• It is recommended that participants go through <i>Healthy Relationships</i> after completing WILLOW.</li> <li>• Specific considerations and/or adaptations are made for other populations participating in the WILLOW intervention (i.e. transgender individuals).</li> </ul>

**Table 2C: Other Implementation Considerations in South Carolina – August 2014**

- Transportation challenges for participants: Do they have reliable, consistent means to fully attend the intervention?
- Housing status of participants: Do participants have safe and stable housing situations?
- Staff training: Have the facilitators been trained in the intervention and in necessary supplemental education/skills?
- Funding and sustainability of interventions: Is there funding for ongoing implementation if a specific grant ends?
- Partnerships with other agencies: To maximize resources and fully serve clients, what partnerships are needed?
- Availability of specialty doctors: Local resources? To what extent could Telemedicine or other options be used?

## CHAPTER 5: COORDINATION AND LINKAGES

Collaboration and linkages between state and local agencies and organizations are essential to successfully plan, implement, and evaluate effective and comprehensive HIV prevention and care services. Coordination of resources (programmatic, skills, fiscal, and personnel) strengthens prevention and care efforts in local areas and across the state, especially in times of increasing demand and decreasing dollars. The governmental and non-governmental programs, agencies and organizations noted in this chapter work together to deliver comprehensive HIV prevention services and/or link to prevention activities that reduce the risk of transmission of HIV and delay onset of illness in persons with HIV.

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

- 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, but are not limited to:

- Standardized and consistent prevention and early intervention messages;
- Minimized duplication of effort;
- Maximized use of available 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; and
- Expanded communication and technical assistance opportunities through interaction with others who provide complementary skills, knowledge, or other resources.

Some providers experience or perceive disadvantages or threats related to participation, despite the benefits coordination offers. The strongest disincentives to coordination include, but are not limited to:

- 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.

SC DHEC and its partners work diligently to strengthen and increase linkages and coordination through their work to decrease gaps in and barriers to effective Program Coordination and Services Integration, as well as increase the benefits to participation. For a comprehensive chart of **Partnering Programs, Agencies, and Organizations**, please see **Appendix E**.

## **WITHIN SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL (SC DHEC)**

### The STD/HIV Division

**The SC DHEC STD/HIV Division** administers the CDC HIV and STD prevention programs, Ryan White Treatment Modernization Act Parts B (including ADAP) and D, and the statewide HOPWA program. This organizational structure ensures collaboration of state and local staff and coordination of planning and funding mechanisms.

Prevention programs are delivered primarily by eight health regions (covering 46 county health departments) and community organizations such as local alcohol and drug abuse commissions, AIDS service organizations, and minority community-based organizations. A complete listing of **Health Department-based HIV Prevention Program Models by Region** for CY 2009 is included as **Appendix F**. A complete listing of **Prevention Contractors** for CY 2009, the populations served and evidence-based interventions used, is included as **Appendix G**.

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;
- Consistent messages emphasizing the availability of a continuum of services from prevention to care;
- Partner services;
- Targeted health education/risk reduction interventions;
- Routine screening for HIV within funded hospital emergency departments;
- On-going training and capacity-building assistance; and
- On-going evaluation and quality management.

HIV and STD programs are fully integrated. HIV tests are routinely offered to patients being seen for STD screening/testing. A new “opt-out” policy for HIV testing was approved September 1, 2009, for all DHEC clinics. Educational messages, monitoring of data for trends, and staff training are conducted jointly. Mobile van screenings for HIV and STDs (syphilis, Chlamydia, and gonorrhea) were discontinued as of 12/31/08 due to the loss of Syphilis Elimination funding from CDC.

The toll-free S.C. AIDS/STD Hotline, operated by DHEC staff, facilitates linkages, including information about accessing counseling and testing services, and other prevention services, as well as Ryan White, HOPWA and other care services. To make referrals, the hotline staff uses the Statewide HIV/AIDS Resources and Information Network Guide (SHARING). Staff regularly review and update the listings.

The STD/HIV Division also maintains a website which is accessible to the public <<http://www.scdhec.gov/stdhiv>>. Information contained on the website includes:

- Surveillance report data for HIV/AIDS and other STDs;
- STD/HIV Prevention Information for Communities, including an overview of the SC HIV Planning Council, the SC Federal Materials Review Process, the Continuation Application, Partner 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 Statewide Coordinated Statement of Need and Comprehensive HIV/AIDS Care Plan;
- Public Information Programs; and
- Information for Health Care Providers, including information on Prenatal Screening; and Additional Resources and Links.

#### HIV Counseling, Testing, and Referral Services (CTRS)

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

- Partner services;
- AIDS hotline referrals;
- HIV prevention contractors and CBOs providing health education/risk reduction;
- Outreach strategies by community organizations, Ryan White Part C and D providers,
- Routine opt-out HIV screening in STD, TB, and Family Planning clinics;
- Routine HIV screening for pregnant women;
- Hospital Emergency Departments participating in the Expanded Testing initiative;
- HIV testing in several alcohol and drug abuse facilities;
- Physicians/primary care providers; and
- Public information/media awareness activities and events.

HIV counseling, testing and referral services are available in each county health department. Almost half (48%) of the annual number of newly reported persons with HIV in the state are diagnosed through the county health departments. More than 48,000 clients received CTRS during calendar year 2008 (includes those routinely screened during other STD, TB or family planning services).

DHEC HIV tests and number of new cases detected are leveling. Increased access to effective HIV treatments as well as intense prevention services delivered by community organizations, local health departments and HIV service providers have contributed to slowing the annual rate of new HIV cases. Expanding testing services in other clinical settings such as hospital emergency departments is recommended to diagnose more HIV infected persons earlier, allowing for improved health. A growing number of persons with HIV are living longer, requiring on-going care, treatment and prevention services. At the end of 2008, more than 14,000 persons were known to be living with HIV/AIDS in the state.

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 or Ryan White Parts B, C, and/or D 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 makes referrals for drug treatment services, counseling, support groups, AIDS service organization services, Medicaid, and other services as appropriate.

## Partner Services (PS)

**Partner services** utilizes public health resources to identify infected persons, notify their partners of their possible exposure, and provide infected persons and their partners a range of medical, prevention, and psychosocial services. These services can have positive results including 1) positive behavior changes and reduced infectiousness; 2) decreased STD/HIV transmission; and 3) reduced STD/HIV incidence and improved public health activities. PS activities are provided mainly by Disease Intervention Specialists (DIS) through local health departments and the activities encompass a broad array of services that are offered to persons with HIV infection, syphilis, gonorrhea and chlamydial infection and their partners, with HIV and syphilis infection being the established priority populations. It is a process in which infected persons are engaged to provide assurance of appropriate management as well as offer appropriate resources such as care, follow up therapy and/or counseling. Additionally, individuals are interviewed to elicit information about their partners and others who could benefit from risk reduction counseling, status identification or other intervention services. Each identified person is then confidentially notified of their possible exposure or potential risk. Additional critical components provided by DIS are the counseling and testing for those potentially exposed to infection as well as evaluation for other relevant STDs, including hepatitis screening and vaccination, treatment or linkage to medical care and/or other prevention services. Linkage or referral to other services (e.g., reproductive health services, prenatal care, substance abuse treatment, social support, housing assistance and mental health services) is also provided as needed.

During 2007, local health department staff provided partner counseling services to 710 (87% of 819) diagnosed and reported HIV-infected persons (both newly diagnosed and previous positive persons) who named 1215 sex/needle-sharing partners. Of the named partners, 984 (81.0%) were notified; of those notified 82 (6.7%) were newly diagnosed and 338 (27.8%) were found to be previously diagnosed, with both groups provided additional counseling and linkage opportunities to service.

## People of Color Initiative

With the STD/HIV Division's heightened commitment to working with African American communities and other organizations and agencies to address the disproportionate numbers of cases, a coordinator was named to heighten responsiveness to the needs of people of color who are most impacted with HIV/STD. The efforts of this heightened response collectively comprise the People of Color Initiative (POCI). The coordinator serves in a continuing role as liaison to the DHEC Office of Minority Health and also serves on NASTAD's African American Advisory Committee and is Chair of the Strategic Prioritization and Partnership Building subcommittee. The POCI also led the formation and continues the work of the state's African American Men who have Sex with Men Workgroup, an advisory committee begun in 2006. The POCI also provides consultation to the Minority AIDS Council, the Center of Excellence for HIV and Cancer Research (a project of USC and Claflin University), SC State University's Brooks Health Center staff, and other MCBOs.

## Adult Viral Hepatitis Prevention

The 2007 hiring of an Adult Viral Hepatitis Prevention Coordinator, partially funded by the Immunization Division, is increasing integration of Viral Hepatitis services. Activities have included the review and updates of DHEC policies/procedures on vaccines for PLWHA and high-risk HIV

negatives, the formation of a stakeholder group for development of the first SC Hepatitis Prevention Plan, and provision of Adult Hepatitis B vaccine to Ryan White Part B providers. Vaccine is also provided to the SC Department of Corrections, Part C, and other community health center providers. Targeted education is provided through a subcontract (using DAODAS funds) with the SC Hepatitis C Coalition.

#### Training and Capacity Building Assistance

Collaborative training and capacity building efforts are essential to maximize limited resources and address training needs of prevention providers, care and supportive services partners, and other minority- and community-based organizations. The STD/HIV Division sponsors and coordinates training on effective behavioral interventions, prevention counseling, population-specific prevention strategies, cultural competency, STD updates for clinicians and for non-clinicians, HIV 101 and 201, Red Cross HIV Starter Facts, HIV care and treatment, and capacity building topics. The Division conducts routine assessments on training needs and offers training workshops open to all prevention providers, minority CBOs, care providers, and community partners.

Key partners involved in planning and coordinating training include the CDC and its Capacity Building Assistance (CBA) providers, the SC AIDS Clinical Training Center (the state contractor of the Southeast AIDS Training and Education Center, funded via the Ryan White Treatment Modernization Act, Part F), DAODAS, the SC Association of Prevention Professionals and Advocates (SCAPPA), and others. National and regional CBA providers are invited to present training on diverse issues identified in training needs assessments. When possible, the Division hosts CDC-sponsored national or regional trainings to better enable the attendance and participation of health department staff, contractors, and community partners. The STD/HIV Division also works closely with planners of the state's annual HIV/STD Conference to ensure that up-to-date training opportunities are provided to state and regional health department staff, prevention and care contractors, CBOs, consumers, and other interested community partners and persons.

#### Other Health Department program areas

The **STD/HIV Surveillance Division** collects and analyzes data on HIV and STD morbidity and mortality and prepares surveillance reports. A complete description of STD/HIV Surveillance Division activities is listed in Chapter 6: Surveillance and Data-collection Activities.

The **Division of Acute Disease Epidemiology (DADE)** ensures Viral Hepatitis surveillance and manages electronic lab reporting. Staff from DADE also consults on special collaborative projects, such as the merger of Hepatitis C case data with HIV cases for first estimates of HIV-Hepatitis C co-infection.

The STD/HIV Division has a long-standing close collaborative relationship with **TB Control** for TB testing of and services to PLWHA. Through the provision of case management and Directly Observed therapy, Region TB staff ensures that TB treatment is maximized. Routine testing for HIV is provided for persons presenting with TB. Additionally, staff is cross-trained and epidemiologic data are closely monitored for trends.

The **Bureau of Public Health Laboratories** also has a long-standing relationship with the STD/HIV Division. The labs process and report confirmatory HIV, Viral Load, CD4, and STD test results.

The **Bureau of Maternal and Child Health's Division of Family Planning** also has a long-standing collaborative relationship with the STD/HIV Division. Cross-training is an important linkage between these programs. Additionally, federal Title X dollars fund four sites in the state for integrated HIV and Family Planning services. The **Perinatal Systems Division** coordinates with HIV perinatal prevention staff around educating Labor and Delivery Unit staff about the use of rapid HIV testing for women who present at Labor and Delivery with undocumented HIV status. Women who are HIV-infected are linked with care and support services for themselves and their infants.

**The Office of Minority Health's** (OMH) collaborative relationship with the STD/HIV Division has increased over the years as the HIV epidemic experienced significant growth in minority communities. OMH serves as principal advisor to the Agency as well as to other agencies and organizations on public health issues affecting minority populations (African Americans, Hispanic/ Latinos, American Indians and Asian/Pacific Islanders) in the state. OMH conducts training on cultural competence for health department staff and community partners upon request. Many efforts are targeted to African Americans as a priority population as they represent the largest minority group and carry a disproportionate burden of the health disparities.

The Office focuses its efforts on six priority health problems which account for the large and disproportionate number of preventable deaths and disabilities affecting minorities in the state, including HIV/AIDS. With South Carolina's increasing Hispanic/Latino population, the importance of OMH's Language Assistance Program for Limited English Proficiency (LEP) is significant. These vital services include:

- Telephone Interpreter Services: Interpretation services are provided using contracted vendors for Spanish and other languages;
- Translation Services: Through a joint partnership with DSS, DHEC utilizes HABLA (Hispanic Assistance and Bi-Lingual Access), housed at the University of South Carolina, to assist with translation of forms, educational materials and other documents and other contract services.
- Interpreter Qualification Program (IQP): This initiative is designed to ensure proficiency and accuracy when providing interpreter services to the agency's LEP customers through training, testing and qualification.

Although the funding from the Congressional Black Caucus has ended for the OMH AIDS Demonstration Project, OMH continues to support HIV/AIDS-related connections and communications with minority programs and consumers. Additionally, the OMH and the STD/HIV Division collaborate to sponsor events to promote HIV awareness in the African American community. The OMH continues its support of various initiatives within the STD/HIV Division. The coordinator of the Division's People of Color Initiatives serves as a direct liaison and meets periodically with the OMH.

The **Professional Offices of Nursing, Social Work, and Health Education** work with the STD/HIV Division's Central Office and Region staff to ensure discipline standards, guidelines, and services are consistent with national practice standards. Discipline-specific trainings are encouraged to enhance the skills of these direct service providers. STD/HIV Division consultants in these disciplines serve as the liaisons to the professional offices.

## PREVENTION PARTNERS

The primary mechanism for coordination of health education/risk reduction services has been through local HIV prevention contractors. DHEC provides funding to 12 HIV prevention contractors for implementation of proven effective evidence-based interventions. Each Prevention Contractor works collaboratively with various and diverse agencies and organizations, including but not limited to local alcohol and drug abuse authorities, health departments, county teen pregnancy prevention programs, housing communities, faith-based organizations and houses of worship, youth-serving organizations, jails and corrections facilities, minority-based organizations, and homeless and domestic violence shelters. Funded prevention contractors must demonstrate community partnerships and support as well as the ability to reach priority populations with priority interventions. [See **Appendix 5.3** for the complete listing of Prevention Contractors for CY 2009, the populations served and evidence-based interventions used.]

### SC HIV/AIDS Council

Project F.A.I.T.H. (Fostering AIDS Initiatives That Heal) is a statewide demonstration project of the South Carolina HIV/AIDS Council (SCHAC) designed to eliminate HIV/AIDS stigma and build the capacity of churches and other faith based entities who seek solutions related to the HIV/AIDS epidemic within their local communities. Funded with state dollars, Project F.A.I.T.H. will embark on its fourth year of funding during FY 2009-2010. SCHAC currently awards 39 faith-based organizations across the state (FY 2008-2009). HIV/AIDS stigma and educational prevention activities include the facilitation of: HIV/AIDS/STI health education/risk reduction education, skills development training, HIV testing, and behavioral risk interventions and other prevention events. Project F.A.I.T.H. funded organizations are from the following nineteen (19) counties: Aiken, Anderson, Bamberg, Beaufort, Charleston, Chesterfield, Florence, Horry, Georgetown, Greenville, Kershaw, Lancaster, Lexington, Marlboro, Marion, Orangeburg, Richland, Spartanburg, and Sumter. Project F.A.I.T.H. staff facilitate program development and capacity-building in two new innovations which include: Celebrate Recovery, a Christ-centered recovery intervention based on the 12 steps and has the capacity to address an individual's *'hurts, hang-ups, and habits'* (in Richland and Orangeburg counties), and the SATIR intervention, a therapeutic support group model used to increase coping skills among persons infected with HIV/AIDS, as well as family and other loved ones affected by this health concern (Orangeburg county).

### Nurturing the Tree of Life: HIV/AIDS Prevention Initiative at HBCUs

SCHAC's Nurturing the Tree of Live Initiative utilizes college students (NTTL Peer Health Advocates) to facilitate a four-module intervention originally created by the South Carolina HIV/AIDS Council in 1995 through funding from the Centers for Disease Control and in collaboration with the former Midlands HIV/AIDS Prevention Collaboration. The intervention curriculum is incorporated into freshman orientation and/or seminar programs. The HIV/AIDS prevention intervention consists of four modules which focus on (1) knowledge, (2) attitudes and beliefs, (3) relationships, and (4) risk reduction. The Nurturing the Tree of Life Initiative includes collaboration with SCHAC to assess health risk behaviors among college students. The provision of STI testing on each college campus twice a year is part of the intervention. STI screenings include: HIV, Gonorrhea, Chlamydia, Hepatitis C and Syphilis.

SCHAC is also a Ryan White Part B Medical Case Management provider, via subcontract with the USC School of Medicine's Midlands Care Consortium. Additionally, SCHAC is a CDC directly-funded community based organization for two projects which 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.

### **USC School of Medicine Perinatal HIV Prevention Project**

To achieve reductions in perinatal HIV infection, DHEC receives federal HIV perinatal prevention funds from CDC and Ryan White Part D funds from HRSA. These programs focus on ensuring that Public Health Service 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 HIV Prevention Perinatal Case Management Program (USC PCM). HIV-infected pregnant women in the Midlands are recruited from the Department of Obstetrics at USC for PCM services; these women may also be receiving HIV care from the Part B clinic at the Department of Medicine. Intensive case management services are provided to pregnant HIV-positive women, many of whom experience complex psychosocial HIV issues that increase the difficulty of adhering to recommended antepartum or postpartum therapy and/or care plans. The women are linked to Part B providers and may also be linked to Part D consumer advocates for peer education.

### **SC HIV Planning Council (HPC)**

In 2005, the STD/HIV Division integrated HIV prevention and care planning activities to increase Program Coordination and Services Integration (PCSI). Following a yearlong process (throughout 2004) with stakeholders from HIV prevention and care programs, a mission statement, bylaws, and policies and procedures were developed. With annual review and updates, these documents guide the efforts of the HPC. In December of 2007, the Bylaws and Policies and Procedures were amended to reflect a representative membership of thirty-one (31) voting members from CDC-funded prevention programs (both directly and indirectly funded), Ryan White Treatment Modernization Act-funded care and support services programs (Parts B, C, and D), collaborating state agencies, community-based organizations (CBOs), faith-based programs, and interested community members. Participation from consumers living with HIV/AIDS is ensured, with the bylaws mandating that six (6) of the 31 members be persons who are living with HIV. Additionally, a fifth meeting of the full HPC was added to the existing four.

Three of the HPC's committees (Prevention, Care and Support Services, and Needs Assessment) meet during a portion of the daylong HPC meeting as well as between meetings. The Consumer Advisory Committee meets on separate days prior to the HPC meetings, as its members are fully integrated into

the three working committees noted above. The Membership Committee meets as needed to review applications and recommend new members for the next term, plan and conduct membership orientations, fill vacancies, or deal with other membership issues that may arise.

Applications for membership in the HPC are sent out in the fall of each year as well as distributed at the annual SC HIV/STD Conference. The community planning principles of parity, inclusion, and representation guide the selection of HPC members. Persons selected serve a two-year term. The membership of the HPC reflects, as much as possible, the demographic characteristics of the HIV epidemic in South Carolina. The following criteria are utilized to assist in the selection of members:

- Infected or affected by HIV;
- Two years experience providing HIV prevention and/or care services;
- Expertise in the following HIV-related program service areas: HIV clinical care; case management; HIV counseling and testing services; partner services; comprehensive risk counseling and services; evidence-based health education/risk reduction programs; mental health counseling; substance use prevention and/or treatment; and housing;
- Representative of a geographical area of high incidence and prevalence; and/or
- Representative of priority populations: persons with HIV, African American Men who have Sex with Men (AAMSM); African American Women who have Sex with Men (AAWSM); African American Men who have Sex with Women (AAMSW), White Men who have Sex with Men (WMSM); Injection Drug Users (IDU); and Hispanics/Latino(a)s.

Within the two year period of 2007-2009, the HPC spearheaded the formation of several workgroups to further address specific population needs and provide recommendations to meet those needs. These workgroups include the African American MSM Workgroup, the Adolescent Sexual Health Workgroup, and the Hispanic/Latino Workgroup. Since 2008, the AAMSM Workgroup has been elevated to a program of the People of Color Initiatives.

### **Hepatitis C Coalition**

The Hepatitis C Coalition is a group of health care professionals and concerned citizens with various backgrounds working together to address the emerging problem of Hepatitis C in South Carolina. Its mission is to increase the level of awareness, education, treatment services, and prevention activities among target groups in South Carolina, including health care workers, health care providers, patients and the public. DAODAS provides funds to DHEC which contracts with the Coalition to: increase the awareness of Hepatitis C as a major public health issue to minimize its impact on South Carolina; focus on prevention programs; serve as a clearinghouse for information, educational resources and programs and patient referral systems for Hepatitis C; and establish and enhance collaboration among Coalition partners.

### **CDC Directly-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 and their projects are:

- South Carolina HIV/AIDS Council: HIV Counseling and Testing; *Community Promise* and *VOICES/VOCES* interventions for HIV positive persons and very high risk persons in the Columbia area;

- Palmetto AIDS Life Support Services: Comprehensive Risk Counseling Services for HIV positive African Americans; Healthy Relationships (for clients in their 8-county service area). The relationship between PALSS' prevention staff and the Richland County Health Department, Sandhills Medical Foundation in Sumter and Kershaw County, and Richland Community Health Care Association has ensured referrals to CRCS and the Healthy Relationships program. This is particularly beneficial for Sumter and Kershaw counties for individuals who lack support systems in rural areas.
- 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 African American women at very high risk for HIV infection; serving the six-county Pee Dee region, including Chesterfield, Darlington, Dillon, Florence, Marion, and Marlboro counties.

Palmetto AIDS Life Support Services (PALSS) also received funding from the U.S. Department of Health and Human Services (DHHS), via its Office of Minority Health, for provision of Columbia Community Promise. The Columbia Community PROMISE project has been mobilizing the African American community regarding HIV prevention since 2006. The Peer Advocates, 30 committed African American men, promote risk reduction strategies in their social networks and serve as gatekeepers in communities that often are unreachable by those who do not live in the community.

## **HIV CARE AND SUPPORT SERVICES PARTNERS**

The CDC's *Advancing HIV Prevention (AHP)* initiative focuses on the 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 this initiative centers on advances in HIV treatment which have significantly improved the lives of people living with HIV/AIDS and the approaches to responding to the epidemic. AHP emphasizes the importance of secondary prevention for the number one priority population for prevention services: persons living with HIV/AIDS, through the mechanisms of care, medical case management, health education and risk reduction, the availability of HIV medications, housing, and linkage to care for inmates, new positives, and persons out of care. Managing the disease helps both to delay the onset of AIDS as well as reduce the risk of HIV transmission to others by lowering viral loads and potentially decreasing the level of one's infectiousness.

Many challenges exist for persons living with HIV, including but not limited to:

- Denial of one's HIV status;
- Stigma of HIV, particularly in rural areas;
- Awareness of and access to HIV and primary care;
- Factors related to continuation of and retention in care and support services;
- Adherence to medication and treatment regimens;
- Side effects of medications;
- Managing the high costs of care and medications;
- Diagnosis and management of co-morbidities;

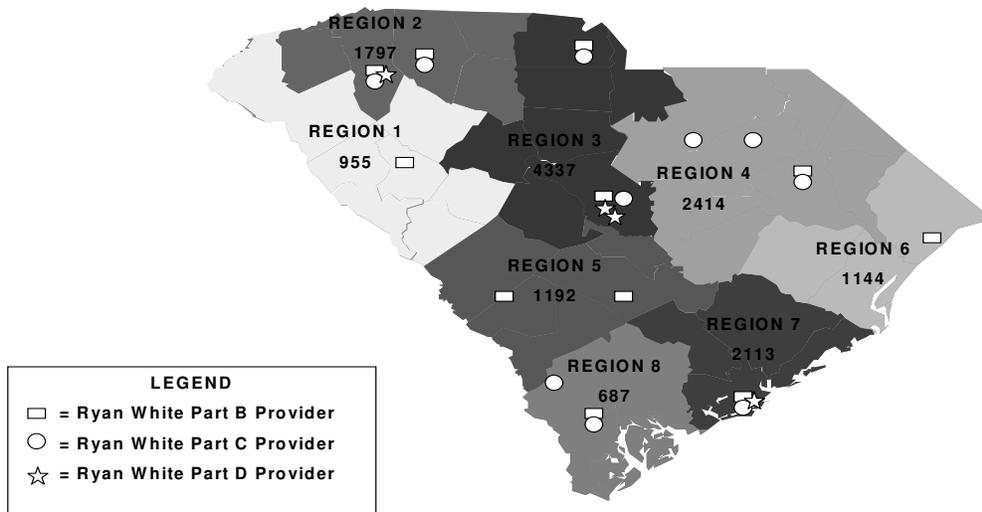
- Competing life events; and
- Depression and other psychosocial issues.

Ongoing medical management and 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. The state’s care system has expanded and evolved over the past two decades to meet the needs of the changing epidemic. Currently there are 18 Part B service providers, 10 Part C service providers, 6 Part D service providers and an ADAP with more than 60 drugs on the formulary. Total HRSA funding in the state for PLWHA is almost \$35 million.

DHEC contracts with HIV service providers in 11 regions of the state. The model of service delivery varies by region, depending upon the number and type of community partners within each region. In two regions of the state, the Ryan White Part B providers provide medical and support services through university based medical clinics and CBO partners. In other regions of the state, the Part B providers work in synchronicity with the Part C providers so that the part B provider is primarily tasked with providing supportive services while the Part C provider focuses on medical care, effectively sharing patients between the organizations. In two regions the Part B and the Part C provider are actually the same organization, thereby making available a virtual one-stop shop for PLWHA. There is at least one region of the state where the Ryan White Part B provider provides all of the supportive services and contracts for medical care with a network of physicians. The SC HIV Services Network Provider Chart is included as **Appendix H**.

The map below indicates the location of each Ryan White provider with an overlay of the number of PLWHA in each region of the state. It should be noted that HIV services have followed the HIV epidemic in South Carolina.

### Ryan White Care Providers in South Carolina and Number of People living with HIV/AIDS by Region, 2007



Specific local service provider services were identified for funding in FY 2009, based on the Needs Assessment efforts and the statewide Comprehensive Plan include (but are not limited to): Ambulatory/Outpatient Medical Care, Medications, Oral Health, Mental Health Services, Substance Abuse Services, Medical Case Management, Treatment Adherence/Compliance, Housing, Nutrition, Transportation, and Health Education/Risk Reduction. During 2008, service priorities were reviewed with each Ryan White Part B service provider to demonstrate that at a minimum of 75% of funds are being expended on core services.

The services provided in FY 2009 will address the needs of the emerging rural, impoverished, men who have sex with men (MSM) and Hispanic communities in South Carolina. Providing satellite services in the rural areas, including medical care, transportation, medical case management, outreach and education, mental health services and substance abuse services will empower these groups to enter and maintain care services.

The Ryan White Parts B, C and D service providers provide an array of services that will help clients establish and maintain medical care compliance. Treatment adherence counseling is an integral part of medical and supportive services and all Ryan White patients receive treatment adherence messages in the clinical and support services settings. Health Education/Risk Reduction services and Medical Transportation services also ensure that clients will remain engaged in HIV/AIDS primary medical care and adherence to HIV treatments.

Particular emphasis of all Ryan White Care providers is on increasing access to care and ensuring African Americans with HIV are linked to care services. Estimates of persons who are in care are based on several sources. Ryan White Part B service providers reported serving 7,929 persons during 2008. Clients served are essentially representative of the epidemic. In 2008, 74 percent of consortia clients were African American and 63% were male.

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.

#### Ryan White Part B Contractors

With the number one priority population for HIV prevention being persons living with HIV/AIDS, the importance of linkage to and retention in care and support services are significant. Eleven Ryan White Part B contractors serve residents living in all 46 counties in the state. Emphasis is placed primarily on the provision of core services. These 11 core services include outpatient/ambulatory medical care, medical case management services (including treatment adherence), AIDS pharmaceutical assistance (local), oral health, health insurance premium assistance, mental health treatment, substance abuse treatment, home health care, home- and community-based health services, hospice services, and medical nutrition therapy. Where funding is sufficient, support services may also be provided. These support services include non-medical case management, treatment adherence counseling, medical transportation services, child care services, emergency financial assistance, food bank/home-delivered

meals, health education/risk reduction, housing services, legal services, linguistic services, outreach services, permanency planning, psychosocial support services, rehabilitation services, and respite care,

Five Part B providers are provided with Adult Hepatitis B vaccines and it is hoped that all Part B providers will participate in the Adult Hepatitis B prevention initiative. The total funding for Ryan White Part B programs in South Carolina (including ADAP) for the 2009-2010 grant year is \$28,104,232.

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

South Carolina's ADAP is also funded with Part B funds. The statewide ADAP supplies medications to PLWHA who are income qualified and assists clients in paying health insurance premiums, co-pays and deductibles. The ADAP is managed through DHEC and provides medications and insurance assistance to those who are income qualified. Its formulary includes more than 60 medications and the program serves more than 3,000 clients annually. The ADAP's direct dispensing services were provided to 2,848 active clients in 2008. Sixty-nine percent (69%) of those clients were African American and 68% were male. The number of clients served by the ADAP 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.

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 2008, the Insurance Assistance Program served 717 individuals.

One of the cross-cutting issues identified by HIV care providers is that people living with HIV may not be adherent to their prescribed HAART medication regimen and/or with keeping appointments for medical care. This is rooted in many causes including, but not limited to, denial about one's HIV status, not "feeling sick," concerns about confidentiality, side effects of medications, lack of funds to pay for care and treatment, mental health or drug use issues, depression, and low self-esteem. Ryan White providers face ongoing challenges associated with HIV treatment costs and problems with client adherence to the HAART 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.

In June of 2006, the South Carolina ADAP was forced to implement a wait list due to the increased number of persons living with HIV/AIDS, increased drug costs, and decreased funding. Federal and state funding allocated for the Program were not enough to meet the demand. South Carolina received fewer state dollars per patient for ADAP and HIV Core Services in comparison with other Southern States. South Carolina averaged approximately \$39 per person in State ADAP funds, compared to \$680 and \$614 per person in Georgia and North Carolina, respectively.

As a result of the ADAP crisis, many South Carolina community partners sprang into action and spearheaded the formation of the South Carolina HIV/AIDS Care Crisis Task Force. The goal of the Task Force was to obtain adequate funding for ADAP and HIV/AIDS Core Services. The method was grassroots advocacy targeted at State representatives and local officials to influence change. The results were \$3 million recurring and \$1 million nonrecurring "one-time" funding.

#### Ryan White Part D Contractors

The South Carolina Ryan White Part D 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 is the grantee for these funds, which are provided through three contracted, regional medical care facilities located across the state: the Medical University of South Carolina (MUSC) in Charleston, the University of South Carolina School of Medicine (USC) in Columbia, and the Greenville Hospital System (GHS). Of the 1,119 HIV-infected and indeterminate clients served by Part D programs in 2008, 903 or 81% were African American and 65% were youth under 12 and young adults 13-24 years. The total funding for Ryan White Part D programs in South Carolina for the 2008-2009 (fiscal year begins August 1) grant year is \$579,487.

#### 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 participated 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. 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). Since 2005, a Women's Clinic at USC has been funded by Part D.

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 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. Fourteen 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. 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. HOPWA funds also support one Employment Assistance Program.

South Carolina has three long-term housing projects: one statewide tenant-based rental assistance project, one long term supportive housing facility and one transitional housing facility. This focus on long-term housing is a response to the changing HIV epidemic and assessment/prioritization of permanent housing 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.

#### Ryan White Part C Programs

The Ryan White Part C Early Intervention Services (EIS) program funds comprehensive primary health care in an outpatient setting for people living with HIV/AIDS. There are currently **10 Ryan White Part C service providers** in South Carolina with only one region (Upper Savannah) lacking access to a Part C provider. The Ryan White Part C providers have formed strong partnerships with Part B providers in several regions of the state. We continue to promote effective working relationships among all the Ryan White Parts in each region of the state. As a result of these strong partnerships we have been able to maximize resources and prevent the duplication of services.

#### Ryan White Part F Program: AIDS Education and Training Center

The **SC HIV/AIDS Clinical Training Center's** goal is to improve the quality of care and access to care of patients living with HIV/AIDS through the provision of high quality professional education and training to health care providers in South Carolina. This program accomplishes its goal through didactic presentations, case studies, skills building workshops, clinical consultation, clinical preceptorships, and technical assistance. Its target audience is physicians, advanced practice nurses, nurses, oral health professionals, physician assistants, pharmacists, and other healthcare professionals.

The Center is located at the University of South Carolina School of Medicine, Infectious Disease Division, in Columbia. It is a Local Performance Site for the Southeast AIDS Training and Education Center (SEATEC), a six state consortium that also includes Georgia, Alabama, Kentucky, Tennessee, and North Carolina. SEATEC is part of the network of regional AIDS Education Training Centers (AETC) funded through the HIV/AIDS Bureau of the U.S. Department of Health Resources and Services Administration (HRSA).

### Linkages between the Division's HIV Prevention and Care Programs

Linkages between HIV Prevention and Care programs are increased with integrated planning and training. Enhanced communication between all services and providers is considered essential for secondary prevention efforts, with linkage of newly identified positives to care and retention of existing clients in care as top priorities for Prevention with Positives. This emphasis is mirrored in the SC HIV Planning Council, which mandates the inclusion of a representative from each Ryan White-funded care program (Parts B, C, and D) and at least six consumers on the 31-member body. Consumers are also fully integrated into all committees of the HPC, not only providing valuable input for community planning through the Consumer Advisory Committee, but also for important documents such as the Ryan White Statewide Coordinated Statement of Need and Comprehensive Care Plan, and events such as a Consumer Town Hall Forum. Collaborative reviews of care data have resulted in innovative suggestions which have been implemented, including a statewide social network survey of transgender persons and their health needs, and the continued inclusion in 2008 of the specific categories of health education and risk reduction in the state's Provide Enterprise data system for Ryan White Part B service providers. Ryan White medical case management providers routinely include treatment adherence counseling and education as well as risk reduction messages to clients, improving secondary prevention efforts

### **GOVERNMENTAL PARTNERS**

#### SC Department of Alcohol and Other Drug Abuse 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. State and local agencies have received significant state budget reductions in the past three years that have resulted in an even more reduced number of staff, facilities, and services throughout the state.

The SC Department of Alcohol and Other Drug Abuse Services (DAODAS) contracts with DHEC for the provision of HIV Early Intervention Services that include needed resources to clients in the statewide alcohol and drug abuse (301) 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.

DAODAS funding comes from the Substance Abuse Prevention and Treatment block grant HIV Early Intervention set-aside. DAODAS also has funded designated local alcohol and drug abuse commissions that work directly with this high-risk population in need of alcohol and/or other drug services. SAMHSA-funded HIV Early Intervention Services provide risk reduction education and CTRS for admitted AOD targeted (injection drug-using) clients. The local county AOD authorities that are funded for these services, and the counties they serve, are: Anderson/Oconee Behavioral Health Services: Anderson and Oconee counties; The Phoenix Center: Greenville County; Spartanburg Alcohol and Drug Abuse Commission: Spartanburg County; The Lexington/Richland Alcohol and Drug Abuse Council, The Behavioral Health Center of the Midlands: Lexington and Richland counties; Keystone Substance Abuse Services: York County; Trinity Behavioral Health Services: Dillon, Marion, and Marlboro counties; Circle Park Behavioral Health Services: Florence County; Sumter County Commission on Alcohol and Drug Abuse: Sumter County; Aiken Center for Alcohol and Other Drug Services: Aiken County; The Dawn Center (Tri-County Commission on Alcohol and Drug Abuse): Bamberg, Calhoun, and Orangeburg counties; Shoreline Behavioral Health Services: Horry County; and The Charleston Center: Charleston County.

Additionally, a representative from DAODAS serves as a continuing voting member of the SC HIV Planning Council and also serves on the Corrections/AOD/HIV Workgroup and the SC HIV/STD Conference Planning Committee. Alternately, the STD/HIV Division's Planning Coordinator serves on the DAODAS Prevention Training Committee and on the Professional Development Committee of the SC Association of Prevention Professionals and Advocates (SCAPPA), the state's professional ATOD prevention association. Program collaboration and services integration, including cross-training for staff, receives important time and effort support from the administration of both agencies.

#### SC Department of Education (SCDE)

South Carolina's local school boards, with technical assistance from the SCDE, 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 SCDE Healthy Schools Program (HSP), which is a cooperative agreement with DHEC, supports these efforts by providing training, resources and technical assistance to the 86 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. Every district has a Comprehensive Health Education coordinator, which is the HIV Program Coordinator's contact person for providing HIV/STI professional development opportunities for schools and teachers in their district. Every district also has a 13-member health advisory committee, which has the responsibility of reviewing and approving all HIV/STI-related materials that will be used for instruction in that particular district.

HIV prevention education services, provided by the HSP, are directly funded by the CDC Division of Adolescent and School Health (DASH). DASH also separate funding to the Healthy Schools Program to conduct the Youth Risk Behavior Survey (YRBS). The YRBS is conducted bi-annually by SCDE or an identified sub-contractor. Results of the YRBS are presented at HIV Planning Council meetings and 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. For 2008, the HSP was funded at the following levels:

YRBS \$49,173

Coordinated School Health & Physical Activity Nutrition & Tobacco (CSHP & PANT) \$424,645  
HIV Prevention \$274,997

Additionally, the HIV Program Coordinator serves as a continuing voting member of the SC HIV Planning Council, representing the SCDE and the interests of school-aged youth. The Coordinator also serves as a member of the STD/HIV Division's Federal Materials Review Committee and on the Planning Committee of the SC HIV/STD Conference.

#### SC Department of Corrections (SCDC)

The SCDC currently tests all inmates upon entry into the system. All HIV-infected inmates are housed in two facilities in Richland County, one for men (Broad River Correctional) and one for women (Camille Griffith Graham Correctional). This enables the SCDC to better coordinate care and support services to infected inmates as well as reduce the spread of HIV within the prison population. These facilities provide 24-hour availability of medical services, HIV specialty care, and supportive services. All HIV-infected inmates receive Highly Active Anti-Retroviral Therapy (HAART) as standard of care. DHEC provides the SCDC with Adult Hepatitis B Vaccine. A representative from SCDC serves as a continuing voting member of the SC HIV Planning Council. The SC HIV/STD Conference also has representation on its planning committee from the SCDC.

The USC School of Medicine receives funding from the Part B Minority AIDS Initiative (MAI) for the Linkage for Ex-offenders project, which provides a Transitional Case Manager who facilitates entry into Ryan White care upon release from the SCDC. This linkage to care project provides a continuum of medical care and HAART to HIV positive inmates upon their release. State budget cuts, which resulted in the reduction in the provision of a 30-day supply of medications to five days, forced an emergency meeting of SCDC, SC DHEC, and USC SOM staff to problem-solve around the crisis. Interdisciplinary meetings on inmates are now held at least 30 days pre-release, which facilitates a smooth transition of services to inmates immediately upon release.

A Corrections/HIV/AOD workgroup, composed of representatives from DHEC, SCDC, DAODAS, and local service providers, began meeting in September 2008 to increase awareness of programs and services, enhance linkages and decrease barriers to collaboration, and to seek funding for special collaborative projects.

City and county detention centers are not under the jurisdiction of the SCDC. HIV/STD screening services are more limited for inmates in county/city jails. 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 testing is conducted in several county jails. Syphilis testing, previously provided in conjunction with syphilis elimination efforts, was discontinued due to the loss of those funds. Partner counseling and referral staff assist in providing test results counseling and referrals to care providers upon release.

### SC Budget and Control Board – Office of Research and Statistics (ORS)

The ORS is the gatekeeper for a wealth of data in South Carolina. These data include Medicaid data, including the amount of HIV Medicaid dollars spent by service category, age, and gender. Other social services, claims systems, all payer health care databases, behavioral health, health department, education, other state support agencies, and other data are potential linkage variables. The ORS works

with DHEC and other state agencies on collaborative data integration efforts. For example, ORS worked with the HIV/STD Medical Director and Division of STD/HIV Surveillance to determine where persons living with HIV had accessed health care services prior to their receiving an HIV test. The resulting data on *Missed Opportunities for Earlier Diagnosis of HIV Infection – South Carolina, 1997-2005* was published in the December 1, 2006 issue of the Morbidity and Mortality Weekly Report. Presently, the ORS is working with the State Alliance for Adolescent Sexual Health to formulate an Adolescent Sexual Health Data Cube to highlight the intersections between health, education, socioeconomic status, service utilization, providers, and other variables which may impact adolescent sexual health.

### University of South Carolina

#### USC School of Medicine

The SC Linkage Program for Inmates (SCLPI) is a SPNS project, funded by HRSA (Year 2 of a 4-year grant). Partners collaborating on the SCLPI are: Correct Care Solutions (contract care provider), ASG, Wright State University (for evaluation), DHEC's STD/HIV Division, SCHAC (testing), LRADAC (substance abuse counseling), and the Midlands Care Consortium (MCC) Clinic. The SCLPI serves inmates in the Alvin S. Glenn (ASG) Detention Center (which serves primarily Richland County). Approximately 20,000 inmates are processed through ASG annually. Daily, the number housed is approximately 1200, with approximately 35 living with HIV. About 10% of inmates are tested for HIV. Approximately 85% are Black, and 15% are White. Roughly 90% are male and 10% are female. Per the Syphilis Elimination Project, in 2007 less than 1% were HIV positive, noting 14 positives (8 known and 6 new cases).

Both male and female inmates are tested. Testing of males is conducted three times a week in the holding dorm (Tuesday, Wednesday and Thursday) in a multi-purpose room. Testing of females is conducted once a week in the medical bay. Inmates who test positive are involved in strengths-based case management, designed to be presented in seven sessions. HIV/AIDS Education and alcohol/other drug education are also provided. The SCLPI notes both systems barriers (including space, security, privacy, and staff refusal) and individual barriers (including inmate referral, fear, stigma, denial, lack of trust, embarrassment, and fatalism) to participation in the project. Additional challenges are noted upon an inmate's release: housing, substance abuse resources, mental health resources, financial resources, partner notification, transitioning from jail to the community, and medical and medication adherence. The SCLPI project coordinator serves on the SC HIV Planning Council, and is also a member of the Corrections/AOD/HIV Workgroup and the Planning Committee for the SC HIV/STD Conference.

## USC Arnold School of Public Health

Faculty, staff, and graduate students from the Arnold School of Public Health work on a variety of collaborative projects with the STD/HIV Division and its partners. From the planning, implementation, and analysis of focus groups, to personnel support for special events, to research and evaluation support for grants and special initiatives, this long-standing relationship benefits all involved.

## Center of Excellence in HIV and Cancer Research (USC and Claflin University)

The Center of Excellence in HIV and Cancer Research (formerly known as Project EXPORT) is a partnership between the USC's Institute for Partnerships to Eliminate Health Disparities and Claflin University and is designed to reduce health disparities in HIV/AIDS and HPV/cervical cancer, particularly among minorities in rural areas of South Carolina, specifically in Orangeburg County. Funded by the National Institutes of Health's (NIH) National Center on Minority Health and Health Disparities (NCMHD), the Center works with the community of Orangeburg to assist with research activities and design community-led programs which educate and promote awareness about HIV/AIDS and HPV/cervical cancer. COE partners include Victory Tabernacle Church, the Minority AIDS Council, the Arnold School of Public Health, and the USC School of Medicine.

Through its Research Education and Training Core, the Center is conducting two research studies: 1) the Carolina Women's Health Study (HPV risk in female students at USC and Claflin) and 2) Acupuncture and Oral Immune Function. The Center's Community Partnership and Outreach Core and the Community Advisory Group (CAG) continues to build and maintain partnerships with a variety of community organizations for purpose of engaging the Orangeburg County Community in a variety of community-led activities aimed at preventing and reducing HIV/AIDS and HPV/Cervical Cancer, which have included educational awareness and training conferences for community organizations, community leaders, public health professionals, students, and consumers. The CAG and its community partners include the Minority AIDS Council, Victory Tabernacle Church, the Orangeburg (County) Chapters of Alpha Phi Alpha Fraternity, Inc., Delta Sigma Theta Sorority, Inc., Zeta Phi Beta Sorority, Inc., A Family Affair, HopeHealth, OCAB Community Action Agency, SC Department of Health and Environmental Control (SCDHEC), and the South Carolina Cancer Alliance.

## **NON-GOVERNMENTAL ORGANIZATION PARTNERS**

Many Non-Governmental Organizations (NGOs), including AIDS service organizations (ASOs), Minority Community-based Organization (MCBOs), and Community-based Organizations (CBOs), also work collaboratively with the STD/HIV Division and its many partners. These include, but are not limited to: A Family Affair, the LEAD Center, the Wateree AIDS Task Force, CEASE, the SC Chapter of the Campaign to End AIDS (C2EA) and others. Additionally, collaborative efforts exist with local homeless and domestic violence shelters, teen pregnancy prevention programs, and other health initiatives. DHEC Regions and other prevention providers acknowledge the vital role of the church and other houses of worship in HIV prevention, and particularly as an important mechanism to reach African Americans. Prevention contractors, health department staff and other organizations work

collaboratively with churches and local community groups to coordinate and implement prevention activities including health and awareness fairs, observance of National Black Church Week of Prayer, National HIV Testing Day, and World AIDS Day.

Agencies such as the SC Primary Health Care Association and the SC Campaign to Prevent Teen Pregnancy provide staff for collaborative planning, programs, events and training. The SC HIV/AIDS Conference, a community-based conference since 1998, utilizes the commitment, expertise and participation of numerous agencies and organizations for its annual multi-day training for clinicians, social workers, health educators, alcohol and other drug prevention and treatment professionals, other service providers, consumers, and interested community members.

### State Alliance for Adolescent Sexual Health (SAASH)

In 2007, a five member multi-disciplinary team composed of representatives from SC DHEC's STD/HIV Division and Bureau of Maternal and Child Health, and the SC Department of Education attended a state team-building summit in California that was coordinated by national partners NASTAD, State and Territorial STD Directors, the Association of Maternal and Child Health Directors, and the Society of Public Health Education. The team returned to South Carolina and began work to convene an interagency and inter-organizational alliance to address issues affecting adolescent sexual health. The SC HIV Planning Council increased the initial support for the effort by forming an Adolescent Sexual Health Workgroup. In August of 2007, after receiving special grant support from the national partners, a Call to Action Meeting was held to convene the identified statewide partners. From that meeting, three workgroups have developed: the Data Integration Workgroup, the Resource Directory Workgroup, and the Call to Action Paper Workgroup. Work is underway in these workgroups to develop an adolescent sexual health data cube, catalog existing teen pregnancy and HIV/STD prevention initiatives across the state, and develop a Call to Action Paper addressing the needs for and gaps/barriers to improving adolescent sexual health in South Carolina.

### **CHALLENGES IN COORDINATING PREVENTION SERVICES**

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

- Lack of adequate federal and state funding to address stated prevention needs;
- 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 ongoing communication and partnerships;
- Lack of resources at the state and regional level to facilitate dedicated collaborative activities among prevention providers, especially with supportive services including but not limited to transportation, mental health, and alcohol and other drug treatment; and/or,
- 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 are slashed or, at best, remain level in the face of growing HIV prevalence, collaboration and coordination among existing and new prevention providers is critical in maximizing training efforts. When possible, the STD/HIV Division utilizes trained staff from prevention contractors to train others in interventions and on population-specific topics. 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 continue to offer or sponsor various training and capacity building activities for prevention providers to improve staff skills in delivering prevention programs, adapting or tailoring proven effective science-based HIV prevention interventions, providing culturally competent services, evaluating impact of services, administering/managing funds, and securing additional resources.

Many persons at greatest risk for HIV or who are HIV-infected have multiple health and social service needs. 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 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 housing, 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 she feels empowered to confront relationship issues.

Successfully linking a person from a prevention activity such as outreach to counseling and testing, to partner 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:

- Services not offered at times and/or on days that are convenient for clients;
- Appointment systems or procedures which may restrict prompt access to services;
- Service locations that are not handicap accessible or are difficult for clients to reach, particularly in more rural areas;
- Insufficient staff and resources to meet the increasing demand/need for services;
- Laws and policies regarding data-sharing which prohibit or limit sharing of data, which restricts referrals, treatment and service provision updates, thus limiting collaboration ;
- Political and/or public interaction which does not reflect understanding of HIV and other STDs and the science-based programs and approaches needed to address these epidemics;
- Lengthy approval processes for forms, contracts, and other procedural realities;
- Waiting lists for services or other resources; and/or
- Inability to meet all of a client's needs.

Provider-level barriers may include:

- Insufficient skills to effectively engage clients, inhibiting the accurate assessment of psychosocial and health needs;
- Client caseloads that are too large for service providers to manage effectively;
- Lack of knowledge of new or existing services and resources, preventing active referrals;
- The need to remain up-to-date on research and information related to HIV/AIDS, including updated care and treatment guidelines, interventions, and methodologies;
- Insufficient resources for meeting clients' needs;
- Lack of cultural competence skills, impairing effective communication with clients, their significant others and families; and/or
- Lack of foreign language skills to effectively communicate with non-English speakers.

Client-level barriers may include:

- Denial of one's HIV status;
- Other competing needs and issues, such as homelessness or dual diagnoses;
- Perceptions of wellness which delay or impede seeking HIV care and treatment;
- Lack of transportation to care and other services;
- Concerns of stigma or fear of confidentiality breaches preventing follow-through with making or keeping appointments;
- Lack of knowledge that services exist and/or how to successfully access them;
- Difficulty in navigating complex care or service systems, creating despondency or frustration with providers;
- Inability to qualify for needed services;
- Discomfort with discussions of risk behaviors and risk reduction methods; and
- Inability to adhere to recommended medication or treatment therapies.

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, a number of organizations 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.

Key recommendations for enhancing coordination and linkages in South Carolina are included in the highlighted box below.

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

Provide and support ongoing opportunities for state and local HIV prevention and care 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, DAODAS, SCDE, ASOs, CBOs, MCBOs, the SC Primary Health Care Association, the SC Campaign to Prevent Teen Pregnancy, and others partners.

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 prevention and 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 service needs of clients in order to make appropriate referrals.

Continue and enhance training and technical assistance to prevention and care staff on client-centered counseling skills and increasing the effectiveness of referrals.

Continue to obtain input and ideas from the Consumer Advisory Committee of the SC HIV Planning Council on best approaches to increase consumer awareness of prevention and care services and the skills necessary to access, navigate, and effectively utilize programs and services.

Coordination efforts should continue among prevention and care providers to identify and decrease barriers to service linkages. Efforts should also continue to integrate training and needs assessment activities 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.

## **CHAPTER 6: SURVEILLANCE AND DATA COLLECTION INITIATIVES**

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.

### **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. Health department staff conduct follow-up with persons diagnosed with syphilis and HIV infection in order to provide partner (notification) services, confidential counseling and testing 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 that 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 CD4 and viral load (VL) tests regardless of test results.

South Carolina also receives CDC funds for the Enhanced Perinatal Surveillance project that analyzes medical records 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, and to identify follow-up training, education, or protocol development to ensure no missed opportunities 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 6.1 below.

**Table 6.1 South Carolina HIV Reporting Performance Compared to CDC Minimum Standards, 2008 Preliminary Data**

<b>Performance Indicator</b>	<b>CDC Standard</b>	<b>South Carolina Performance</b>
<b>Completeness of Reporting</b>	≥85%	97.5%
<b>Timeliness of Reporting</b>	≥ 66% within 6 months of diagnosis	95%
<b>Accuracy of Reporting</b>	≤ 5% duplicate case counts	0.02%
<b>Identification of Transmission Risk Category</b>	85% of HIV cases	78%
	85% of AIDS cases	81%

Since 2005, South Carolina has received CDC funds for the HIV Incidence Surveillance project. This project measures the incidence of HIV infection in the United States; that is, the number of individuals newly infected with HIV per year. To determine incidence, new serologic (blood) testing methods were developed that distinguish between recent and log-standing HIV-1 infection. 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). Using both the STARHS test and information about a person's HIV testing history, CDC was able to calculate a new estimate of actual incidence among the U.S. population, as well as subgroups such as African American women or MSM.

In August 2008, CDC released an updated estimate of the number of new HIV infections per year, as 56,300 (using 2006 data; estimates for more recent years will be calculation using the new methods, as data become available). The new estimate is over 16,000 more infections per year than was previously estimated; however, this number does not represent an actual increase in the numbers of HIV infections, but reflects a more accurate way of measuring new infections. The South Carolina HIV/AIDS Surveillance Program also calculated a new estimate for the State, using these new methods; we estimate that in 2006, there were approximately 990 new HIV infections in South Carolina. This number is different than the number of new cases diagnosed in 2006. That year, there were less than 800 new HIV cases diagnosed; however, not all of these new diagnoses were newly infected. Information of this nature can help prevention programs target their prevention efforts more effectively, focusing on 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.

Since 2005, South Carolina has also participated in a 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. A

routine test is conducted to detect the presence of genetic mutations associated with HIV ARVDR. Clients receive the ARVDR results from their clinical caregiver, which are then used to determine appropriate antiretroviral treatments for the client.

From 2004 to 2009, South Carolina participated in the Medical Monitoring Project (MMP), an enhanced surveillance project consisting of patient interviews and medical record abstractions. The interviews gathered information about the experiences and needs of people receiving care for HIV, including behaviors, treatment and health status. This project was the first of its kind, and provided the opportunity to truly identify gaps in access to care, treatment, prevention efforts, and meeting the needs of people living with HIV/AIDS. The project was discontinued in South Carolina as of June 2009; when the MMP data are received from CDC, they will be shared with the HPC as well as Ryan White HIV care advisory groups and providers.

Surveillance staff analyzes HIV (and other STDs) surveillance data and disseminates findings to multiple prevention and care providers, media, community organizations, and others. Surveillance data are used extensively to develop the Epi Profile for HIV prevention community planning; data files are produced for local HIV prevention planning efforts; data by Ryan White service area are 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.

STD/HIV/AIDS surveillance reports are completed and posted on the South Carolina Department of Health and Environmental Control web site two times per year, located at: <http://www.scdhec.gov/health/disease/stds/index.htm>. This Web site includes data reports from the counseling and testing sites, and the Supplemental HIV/AIDS Surveillance (SHAS) Project conducted in South Carolina between 1991 and 2002. 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 to determine priority populations, identify unmet needs, describe risk behaviors and evaluate specific prevention efforts. These data are reflected throughout this prevention plan.

In addition, surveillance data are used to determine prevention and care funding allocations to public health regions, HIV prevention contractors and HIV services providers.

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 services (PS). Surveillance data are essential to initiate PS in South Carolina. All newly reported cases are provided to local disease intervention specialist (DIS) staff for follow-up partner services. Newly reported persons are contacted confidentially and referred for counseling and voluntary PS. 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, partner services are essential for them to learn of their risk, take 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. Almost 10.5 percent of partners tested in DHEC clinics were positive in CY2006, indicating the effectiveness of PS in targeting at-risk individuals. Referrals to medical care, support groups, substance use treatment, and community-based organizations are provided to clients at the time of PS.

Finally, perinatal surveillance data on HIV–exposed infants is used by local case managers to refer mothers/infants to the Ryan White Part D children’s care system and to monitor if subsequent testing has been done for final HIV status determination. About 25 percent of HIV exposed infants will become infected without proper treatment; with treatment the risk drops to 2 percent or less. Most infants’ true HIV status can be determined by 18 months of age.

## **CHAPTER 7: TECHNICAL ASSISTANCE NEEDS AND PRIORITIES**

Capacity building, training, and technical assistance are provided to health department staff, HIV prevention providers, care and support service providers, and other prevention partners to build their capacity to provide the full spectrum of HIV prevention services 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 trained participants at the conclusion of each training event conducted throughout the year to determine additional training/capacity building needs,
- 3) Surveys of training and capacity building needs at periodic interdisciplinary or discipline-specific meetings of health department staff and/or contractors,
- 4) Special request of health department and/or contractor staff;
- 5) Evaluation of HIV Planning Council meetings, including future training needs, and
- 6) Supervisory staff input based on site visits and reviews 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, but not limited to: in-person training workshops, broadcasts, site visits from DHEC central office staff, periodic meetings and in-service events, conferences, and in-state and/or on-site technical assistance from CDC's network of national Capacity Building Assistance (CBA) providers.

For HIV Planning Council members, presentations are offered at Council meetings on topics or issues of interest. In some cases, an identified training need cannot be met through a brief in-meeting presentation and members are referred to other Division courses to meet those needs. When referrals cannot be made to existing courses, every attempt is made to identify the appropriate course content and instructor(s) to provide the necessary content. At every HPC meeting, an updated training course calendar is provided with the latest training opportunities noted.

With most training courses, certain prerequisites must be met prior to participation in the course. Generally, all staff working in STD/HIV must complete three courses: SC STD/HIV Laws, HIV 101, and STDs 101. As new courses are available or requested, it is determined by the Division and CBA providers whether or not certain prerequisites must be met and what those are.

In addition to Division, region, and contractor staff, course offerings are open to other community partners on a space-available basis. Occasionally, courses may be limited to specific audiences as may be appropriate (Many Men, Many Voices; d-up: Defend Yourself!; SISTA; CLEAR; SIHLE). In some cases (i.e., Waived Rapid Testing), special permission or clearance must be received from the Central Office program coordinator prior to a registrant's acceptance for a course.

Courses are usually offered in Columbia for ease of access to participants from across the state; however, with increasing budgetary and travel constraints, attempts have been made to offer courses on a regional basis. In some cases when courses have been offered on a regional basis, these efforts have resulted in the course being cancelled due to insufficient registration. Additionally, when possible, the Division offers broadcasts and DVDs of training events to decrease barriers to access.

Cross-training is encouraged to better equip all staff to deal with the multi-dimensional aspects of HIV and STDs and co-morbidities such as alcohol/other drug use, addiction, and/or co-infections (i.e., TB, Hepatitis, etc.). Division training staff serves on training committees of other agencies and organizations to maximize the availability of and access to cross-training opportunities.

The STD/HIV Division frequently offers to host national or regional training events (especially Train-the-Trainer courses) in an attempt to meet the training needs of in-state staff while assisting in the coordination and implementation of these CDC- or other specially-sponsored events.

### **Assessment of Capacity Building and Technical Assistance Needs**

The STD/HIV Division conducts ongoing assessment of the needs of the prevention staff and contractors. This information is extrapolated both from meetings with the prevention staff, contractors, HPC members, and from data retrieved from training evaluations. In addition, prevention staff and contractors are encouraged to complete a TA form to request technical assistance.

Annually, the STD/HIV Division collaborates with CDC and AED to identify the needs of our prevention staff and contractors in the selection of Effective Behavioral Interventions (EBIs). The DEBI Training Needs Assessment for States and Jurisdictions Update Survey is completed to request training on interventions identified by both prevention and contractual staff. As a result of this process the STD/HIV Division has offered the following training opportunities to aid in identified capacity building for our grantees:

*Healthy Relationships*

*Many Men, Many Voices*

*Popular Opinion Leader (POL)*

*SISTA*

*VOICES/VOCES*

As a means of providing guidance to prevention staff and contractors in the selection and management of Effective Behavioral Interventions the following courses are offered:

*Selecting Effective Behavioral Interventions (EBIs)*

*Using Process Evaluation to Strengthen EBIs*

The STD/HIV Division offers training opportunities to assist CBOs in building capacity in CTRS by providing the following course offerings:

*Fundamentals of HIV Prevention Counseling*

*Addressing the Prevention Needs of Men Who Have Sex With Men*

*Addressing the Prevention Needs of Clients Who Test Positive*

*Fundamentals of Waived Rapid HIV Testing and Prevention Counseling*

Once identified, these requests are directed to the appropriate provider for assistance. Those needs that can be addressed by in-house staff are channeled to the appropriate provider. In instances where the aid of an outside provider is required, the necessary requests are made and the process is coordinated to finalize arrangements for the needed training and/or technical assistance.

### **Targeted Needs Assessment**

In the Spring of 2007, the STD/HIV Division conducted a targeted needs assessment to secure data from three populations: 1) HIV/STD prevention contractors, 2) DHEC regional staff, and 3) Central Office staff. This effort was designed to assess the populations' preparedness to provide services central to their professional disciplines and identify any needs for capacity building. Central to the survey was the need to determine what trainings were completed by each population, their existing training needs, preferred days for training, preferred medium of instructional delivery, and barriers to enrollment in and completion of training. The survey instrument included both open and closed-ended questions.

Responses from the three targeted populations were representative of 29 DHEC regional staff; 10 Central Office staff; and 13 staff from HIV/STD prevention contractors. A total of 52 responses were received.

The results of the survey determined the following:

- Each professional discipline should establish a learning plan inclusive of all required training for program staff. This would clarify what instruction is required and what instruction is viewed as electives.
- Instruction should include topics central to professional disciplines (i.e. DIS, Health Educators, Social Workers, etc.). It should be specific to core training requirements as well as requirements to ensure staff development, competence, and quality assurance (i.e., updates for clinical and non-clinical staff, services integration, etc.).
- Barriers to attending trainings included travel restrictions and budget restraints; conflict with other duties/ demands; and training scheduled at dates/time that are inconvenient.
- The preferred instructional delivery method is instructor-led in-person training, followed by televised broadcast, and online web-based.
- The preferred days for instruction are Tuesday-Thursday, with Fridays being preferred over Mondays as an alternate day of instruction.

Challenges and limitations identified as a result of this process included timely access to the training by participant, contractual delays, and the cost of training materials when not provided by the CBA provider. Participants experienced difficulties due to budgetary restraints and travel restrictions which hampered their ability to travel to centralized training sites. Results from

several surveys suggested the need for training to be offered in parts of the state other than Columbia. Additional comments suggested training needed to address the needs of multiple disciplines.

The Division makes a concerted effort to identify and provide training and training materials to all participants at no cost. The Division and/or CBA providers accomplish this through the purchase of materials. Some CBA providers, however, are unable to provide the necessary materials. In these instances, the Division provides agency and organizational participants with contact information for ordering the needed materials. When funding permits, the Division purchases the materials for participants or provides supplemental support materials.

The Division plans to continue building capacity in delivery of evidence-based interventions, CTRS and other prevention services. It is our goal to provide training in new EBIs as they become available. The identification and selection of other training priorities will depend on the identified needs of the state, Division and regional staff, and the contractors.

### **Collaborative Needs Assessment of DHEC Staff**

In the summer of 2008, a needs assessment survey was conducted collaboratively between the Southeast AIDS Training and Education Center (SEATEC) and DHEC. The purpose was to assess the training needs of DHEC personnel regarding the implementation of rapid HIV testing. With input from DHEC and the South Carolina HIV/AIDS Clinical Training Center, the needs assessment survey was modified from previous assessments conducted by SEATEC. The survey instrument was finalized in July 2008 and was completed by 181 DHEC personnel in eight regions across South Carolina in August 2008. Data entry and analysis was performed by SEATEC. The HIV Testing Needs Assessment Report, including descriptive results of the survey and a copy of the instrument, are included as **Appendix I**.

As a result of the survey, the SC HIV/AIDS Clinical Training Center worked with Division staff to identify and provide training to meet the identified needs of staff regarding implementing rapid HIV testing. Additionally, Division training staff has met with Central Office's CTRS staff, discipline-specific consultants, the STD/HIV Medical Director, and the HIV/AIDS Clinical Training Center staff to develop specific training plans for DHEC staff regarding implementation of rapid HIV testing.

### **Five-Year Recap of Training Activities**

This section is designed to provide a historical recap of the capacity building and professional development activities of the STD/HIV Division. Information reported is reflective of all training activities beginning with 2005 through the first six months of 2009.

For calendar year 2005, 50 training opportunities were provided to meet the needs identified by the HIV Planning Council, HIV prevention and care contractors, other community based organizations (CBOs), and DHEC regional staff. During the period of January 1, 2005 through December 31, 2005, the following training opportunities were provided:

- Fundamentals of HIV Prevention Counseling (3)
- The ABCs of Hepatitis and HIV (2)
- Addressing the Prevention Needs of Men Who Have Sex with Men (3)
- HIV, STDs, and SC Laws (3)
- American Red Cross African American HIV Education and Prevention Instructor Course (2),
- SISTA
- Healthy Relationships
- VOICES/VOCES
- Addressing the Prevention Needs of Youth
- Addressing the HIV Prevention Needs of Clients Who Test Positive (3)
- Helping Clients with HIV Status Disclosure (2)
- Prevention Case Management
- Update on Rapid Testing for HIV
- and other related courses.

These training opportunities represented collaborative efforts with independent consultants, 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.

For calendar year 2006, 49 training opportunities were provided to meet the needs identified by the HIV Planning Council, HIV prevention and care contractors, other community based organizations (CBOs), and DHEC Region Staff. During the period of January 1, 2006 through December 31, 2006, the following training opportunities were provided:

- Fundamentals of HIV Prevention Counseling (4)
- Addressing the Prevention Needs of Men Who Have Sex with Men (2)
- HIV, STDs, and SC Laws (4)
- American Red Cross African American HIV Education/Prevention Instructor Course (2)
- Healthy Relationships
- SISTA (2)
- VOICES/VOCES
- Addressing the Prevention Needs of Youth
- Addressing the HIV Prevention Needs of Clients Who Test Positive (2)
- Prevention Case Management
- Update on Rapid Test for HIV
- Overview of TB and the TB/HIV Connection
- Transgender 101
- and other related courses.

These training opportunities represent collaborative efforts with independent consultants, the Dallas HIV Prevention 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.

For calendar year 2007, 26 training opportunities were provided to meet the needs identified by the HIV Planning Council, HIV prevention and care contractors, other community based organizations (CBOs), and DHEC Region Staff. During the period of January 1, 2007 through December 31, 2007, the following training opportunities were provided:

- The ABCs of Hepatitis and HIV (2)
- Advanced HIV Prevention Counseling
- Fundamentals of HIV Prevention Counseling (2)
- Addressing the Prevention Needs of Men Who Have Sex with Men
- HIV, STDs, and SC Laws
- American Red Cross African American HIV Education and Prevention Instructor Course
- SISTA
- VOICES/VOCES
- Introduction to Human Sexuality
- Addressing the HIV Prevention Needs of Clients Who Test Positive (2)
- Addressing the HIV Prevention Needs of Hispanic and Latino Populations
- Cultural Competency
- Essentials of HIV/AIDS for AOD Professionals
- HIV 201: An Advanced Knowledge-Based Course
- Introduction to Human Sexuality
- Introduction to Behavior Change (2)
- HIV Prevention and the ‘Silent’ Population in the Hispanic/Latino Community
- Skills building for Culturally Competent Healthcare and HIV Prevention Efforts with Transgender Populations
- Understanding Sexual Addiction
- and other related courses.

These training opportunities represent collaborative efforts with independent consultants, the Dallas HIV Prevention Training Center, the UCSF Transitions Project, the Emory Regional Training Center, and the Southeast AIDS Training and Education Center (SEATEC).

For calendar year 2008, 33 training opportunities were provided to meet needs identified by the HIV Planning Council, HIV Prevention Contractors, other Community Based Organizations (CBOs), and DHEC District Staff. During the period of January 1, 2008 through December 31, 2008 the following training opportunities were provided:

- Advanced HIV Prevention Counseling and Risk Reduction (2)
- Fundamentals of HIV Prevention Counseling (3)
- Addressing the Prevention Needs of Men Who Have Sex with Men (2)
- HIV 101: A Basic Knowledge-Based Course (3)
- HIV 201: An Advanced Knowledge-Based Course (2)
- Introduction to Human Sexuality (2)
- STDs and SC Laws (3)
- HIV Stigma and Access to Care (2)
- VOICES/VOCES (2)
- Ethics, Boundaries, and Limitations (2)
- Addressing the HIV Prevention Needs of Clients Who Test Positive (2)

- Behavior Change in the Real World (2)
- Implementing the HIV-1 Rapid Antibody Test (2)
- Understanding Sexual Addiction (2)
- and other related courses.

These training opportunities represent collaborative efforts with independent consultants, the Dallas HIV Prevention Training Center, the Emory Regional Training Center, and the Southeast AIDS Training and Education Center (SEATEC).

In the first six months of 2009, 19 training opportunities were provided to meet the needs identified by the HIV Planning Council, HIV prevention and care contractors, other community based organizations (CBOs), and DHEC Region Staff. During the period of January 1, 2009 through June 30, 2009, the following training opportunities were provided:

- CLEAR
- Social Marketing
- HIV 101: A Basic Knowledge-Based Course (2)
- Group Facilitation Skills (2)
- SISTA
- SC HIV/STD Laws (2)
- d-Up!
- Healthy Relationships
- Popular Opinion Leader (POL)
- Introduction to Human Sexuality
- Fundamentals of HIV Prevention Counseling

Due to contractual difficulties in early 2009, some courses offered through the Division were postponed until the contractual matters could be resolved and appropriate trainers identified. As a result of the difficulties, some courses have had to be offered on a less-frequent basis; however, all necessary courses will be offered. Some of these courses are up for review or are in the process of being updated by the CDC (i.e., Prevention Needs of MSM; Fundamentals of HIV Prevention Counseling) and revised offerings will replace the planned courses as soon as possible.

Division-sponsored training opportunities represent collaborative efforts with independent consultants, the Academy for Educational Development, the CDC Capacity Building Branch, the Dallas HIV Prevention Training Center, and the Southeast AIDS Training and Education Center (SEATEC).

Additional courses are scheduled for the remainder of 2009. Other training needs have also been identified and will be scheduled and promoted when arrangements are finalized.

## CHAPTER 8: EVALUATION AND MONITORING

This chapter describes the evaluation plan for each type of required evaluation as described by the CDC's 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 late in 2009. This chapter also describes the evaluation plan for each type of required evaluation of care and support services, as proscribed by the Health Resources and Services Administration (HRSA; for Ryan White Parts B and D), Housing and Urban Development (HUD; for HOPWA), and the Minority AIDS Initiative.

### Prevention's 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: <ol style="list-style-type: none"><li>1) Collect evaluation surveys after each HPC meeting</li><li>2) Conduct exit interviews with departing HPC members</li><li>3) Conduct Community Planning Membership survey</li><li>4) Complete Membership Grid</li><li>5) Analyze survey data and report findings to HPC members</li></ol>
<b>Designing and Evaluating Intervention Plans</b>
Activities: <ol style="list-style-type: none"><li>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.</li><li>2) Contractors and Local Health Department (LHD) staff will submit the intervention forms for review.</li><li>3) Compile information on intervention forms to send to CDC with funding application</li><li>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.</li><li>5) Provide feedback, training, and assistance on an ongoing basis to improve quality of intervention plans.</li></ol>

<p><b>Monitoring and Evaluating Implementation of HIV Prevention Programs</b></p> <p>Activities:</p> <ol style="list-style-type: none"> <li>1) Continue to train and provide TA to DHEC regional 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 HPC for decision-making.</li> <li>7) Report evaluation data in progress reports.</li> </ol>
<p><b>Evaluating Linkages Between Comprehensive HIV Prevention Plan, CDC Funding Application, and Resource Allocation</b></p> <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 HPC 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) HPC makes recommendations for improvements/changes.</li> </ol>
<p><b>Monitoring Outcomes</b></p> <p>Activities:</p> <ol style="list-style-type: none"> <li>1) When applicable, collaborate with contractors and LHD staff to 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, HPC, CDC and others.</li> <li>7) Increase the capacity of contractors and LHD staff to plan and conduct outcome monitoring projects.</li> </ol>
<p><b>Generating and Monitoring Baseline and Target Measures for Indicators related to Community Planning, Evaluation and HE/RR Interventions</b></p> <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>

### 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 HPC membership (i.e. Evaluation question: Are members with less than 2 years of service less informed about the HPC process than members with 2 or more years?) and by other variables as requested by the HPC. Results from the CPM survey will be shared with HPC members annually to enhance the planning process.

Other evaluation activities will include the collection of evaluation forms after each HPC meeting and sharing the results with members at the next meeting. This allows for a timely response by the HPC Co-Chairs and/or by the HPC 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 a community representative. This process helps to inform the orientation process for new members and to clarify the role of HPC members based on their expertise and or representativeness.

(2). *Designing and Evaluating Intervention Plans.* DHEC requires staff in the local public health regions (health educators and social workers) and HIV Prevention contractors to submit annual intervention planning worksheets that reflect number of priority populations to be reached with priority interventions in a calendar year. Regional HIV epi-summaries are provided to assist in determining where the most recent HIV infections are diagnosed and which risk factors are associated with these infections for a specific geographic area.

Staff in the STD/HIV Division review 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. Intervention plans are entered into PEMS for all users by the state's PEMS implementation coordinator. Quarterly Narrative Reports (QNR) are tailored to reflect the finalized plan for each regional health educator and social worker and prevention contractors and are used to compare completed activities reported in this document to PEMS reports. Data from all plans are compiled and sorted by priority populations and intervention types. This information is shared with the HPC and is used as a basis for planning and allocation of resources by SCDHEC for the upcoming fiscal year.

(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. Below is a summary description of SC current data collection system by each program component.

- a) *Counseling, Testing and Referral Services (CTRS)* data for conventional HIV tests are collected by utilizing the S.C. DHEC Laboratory Request Form. Data on individuals tested in local health departments are keyed into a computer file at the Bureau of Laboratories (BOL) and confidentially stored. The DHEC BOL conducts all HIV testing for the STD/HIV program. In addition to conventional HIV testing services, all HIV prevention contractors and select local health departments utilize rapid test technology for the delivery of CTRS.

In May 2009, all health departments and prevention contractors were required to begin using the scannable CDC HIV Test Form to collect required CTRS data on persons testing, regardless of test technology. The Division is working to incorporate scanning

technology to ease the burden of data collection. The forms will be sent to the Division on a monthly basis for scanning. Once the data is scanned it will be encrypted and sent to CDC via the secure data network (SDN).

- b) *Partner Services (PS)* 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 electronic HIV/AIDS Reporting System (e-HARS) for data maintenance and reporting. It is anticipated that a newer version of STD\*MIS will include the required PS variables and that an import function in PEMS will allow the data to be transferred electronically.
- c) *Prevention for Positives* process data is collected through CTRS, PS, CRCS and through other health education/risk reduction interventions.
- d) *Health Education/Risk Reduction Services (ILI, CRCS, GLI, and Outreach)* are primarily provided by Health Educators and Social Workers in six of the eight public health regions and 12 HIV prevention contract agencies. Regional staff and contractors are required to enter completed HE/RR interventions into PEMS on a monthly basis. Data entered into PEMS includes demographic information including age, race, ethnicity, gender, and risk behavior on persons served, recruitment source of persons served, intervention activities completed, and when applicable, referral information. DHEC also requires regional staff and contractors to complete Quarterly Narrative Reports (QNR) that reflect activities completed through the end of the quarter. Data from QNR are compared to PEMS reports to assess completeness of interventions and progress towards reaching annual deliverables. Data results/analysis are provided to contractors and LHD quarterly to provide feedback and to CDC as required.
- e) *Health Communication/Public Information* data are collected in two ways. The DHEC AIDS/STD Hotline staff utilizes an *ACCESS database* to capture information from callers who speak to a staff person. After-hours calls are forwarded to CDC-INFO, a toll-free service providing information on a variety of health topics including HIV. 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, health department staff, etc.) Public information activities provided by contractors/regional staff are reported through PEMS.

(4). *Evaluating Linkages Between the Comprehensive HIV Prevention Plan and Application for Funding.* Until revised, DHEC 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 worksheet, PEMS reports, QNRs, and budgets from HIV prevention providers, information from the CTRS and PS data collection systems, and interviews with health department staff and providers. Results of this process are included in the CDC application and shared with HPC members during regularly scheduled meetings.

(5). *Outcome Monitoring and Outcome Evaluation.* In the previous plan, it was noted that DHEC would begin conducting outcome monitoring projects with local prevention contractors. However, due to staff shortages and other resource limitations, outcome monitoring and evaluation was put on hold. DHEC will be looking for guidance from CDC regarding expectations for outcome monitoring and evaluation when the need arises.

(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 current set of required Community Planning, Evaluation and HE/RR data elements for each performance indicator. CDC is reviewing a proposed set of revised Performance Indicators with the expectation that jurisdictions will begin measuring new indicators in 2010. New data collection sources will be identified once the final list of performance indicators is provided.

<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	CTRS and PS Data Systems, HE/RR planning worksheets, PEMS, QNR, and Program Budgets
E.4	CTRS and PS Data Systems, HE/RR planning worksheets, PEMS, QNR, and Program Budgets
<b>EVALUATION</b>	
<b>Indicator</b>	<b>Data Collection Source</b>
F.1	PEMS and QNR
<b>HEALTH EDUCATION/RISK REDUCTION</b>	
<b>Indicator</b>	<b>Data Collection Source</b>
H.1	PEMS and QNR
H.2	Intervention planning forms, PEMS, and QNR
H.3	PEMS and QNR
I.1	PEMS and QNR
I.2	PEMS and QNR

PEMS will be the primary data collection system to monitor these key performance indicators. However, reports compiled in PEMS do not provide all the information to complete data needed for reporting on performance indicators. Until PEMS reporting is fully functional, the Division will continue to use QNR to collect the required data elements.

## Summary of SC DHEC Ryan White Evaluation

Monitoring/ Evaluation Mission: To administer the HIV Care and Treatment services as authorized by the Ryan White HIV/AIDS Treatment Modernization Act (2006):

SC DHEC's role in Public Health administration is to ensure and demonstrate the SC HIV Care System's client-centered approach to effectively managing HIV AIDS as a *chronic* disease. Thus, DHEC applies Health Information Technology as a mechanism to ensure *all* of the following aspects of service: 1) access to and retention in quality care; 2) access and adherence to effective treatment 3) access to a variety of care providers in a coordinated network. Equally important, DHEC serves to ensure fiscal and scope of service accountability for service organizations, funded for Ryan White Part B, Part D and Housing Opportunities for People with AIDS (HOPWA) services.

The SC Ryan White and HOPWA Care Continuum is an ever-active matrix of service provision, data collection and funding sources. HIV service organizations provide service with funding from sources ranging from major HIV Federal Grants to local foundations, *all* with reporting requirements that change as frequently as quarterly. Support for HIV Care and Treatment Information Management often requires evaluation tools, database components and technical assistance strategies to be re-engineered for grantor requirements, while providers are actively *in-use* collecting and reporting data.

The range of client-centered services is documented thoroughly and reported in aggregate and/or client-level formats. For a description of Ryan White eligible services, review the following link; [www.scdhec.gov/rwhopwata](http://www.scdhec.gov/rwhopwata) , then click "Technical Assistance for Ryan White Part B Service Providers". (Please note: Core Medical Services are 75% of Ryan White funding priority and Supportive Services represent 25%.)

The SC DHEC HIV Care and Treatment information model is the only one of its kind in the country as of 2009, in its provision of real-time access to AIDS Drug Assistance Program (ADAP) information to prescribers and care providers. Client-centered data sharing and migration strategies streamline documentation, facilitate automation and reduce duplication of effort. DHEC applies Health Information Technology to not only collect and report data, but also to ensure quality and access to provider-relevant information.

Required data is entered, stored and transported securely. DHEC and participating providers ensure security via policies set forth in the "SC DHEC Ryan White/HOPWA Security Procedures Summary" (2007). The scope of security procedures encompasses Federal, State and Industry security standards, adhering to the strictest set of requirements.

SC DHEC collects data in a customized database, *Provide Enterprise*, as its primary data storage and reporting mechanism for South Carolina HIV care and treatment reporting needs, including the Ryan White Part B, HOPWA and SC ADAP. In addition, contracted service providers enter data in other Electronic Health Records, billing and accounting databases. Data from these sources are increasingly migrated into *Provide Enterprise* and converted to provider relevant information and tools.

The SC ADAP uses *Provide Enterprise* as its principal intake and data sharing evaluation software, to facilitate access to client-centered, real-time information. This includes access to client enrollment status, service utilization and critical client-centered alerts to care providers. In *Provide Enterprise*, service providers collect a standardized set of service indicators to ensure continuity and accuracy of reporting.

As the designee for a Statewide Quality Initiative, DHEC collects client-level data from all parts of Ryan White care, including Parts B, C, and D. Each participating agency receives data-related technical assistance and quality planning assistance to achieve measurable public health goals and improve health outcomes.

DHEC Ryan White/HOPWA Program administrators monitor fiscal and service activities of contracted organizations via the following: 1) at least 1 annual site visit, 2) special-purpose meetings, and 3) fiscal and program data reports, including client-level data. Program and evaluation staff attends and/or hosts meetings routinely to communicate funder information and receive provider feedback. Meetings include but are not limited to: Ryan White Part B Peer Review and Case Management Workgroup, All-Parts Meetings, SC HIV Planning Council, and SC HIV/AIDS Care Crisis Task Force.

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Review the charts of links for evaluation schedules and formats for HOPWA, Ryan White Parts B and D service providers.

**Evaluation, Monitoring and Reporting for HIV Care Programs in South Carolina**

<b>Funding Type</b>	<b>Funder</b>	<b>Funding Purpose</b>	<b>Requires Client Level Reporting?</b>
<i>Ryan White Part B</i>	HRSA*	Access to Medical Care, Medical Case Management	2009
<i>Ryan White Part B ADAP earmark</i>	HRSA	Access to Anti-retroviral Medications	2010
<i>Ryan White Part C</i>	HRSA	Access to Primary Care	2009

<i>Ryan White Part D</i>	HRSA	Women and Youth Access to Medical Care, Medical Case Management	2009
<i>Minority AIDS Initiative (MAI)</i>	HRSA	Minority Access to and Retention in SC ADAP and other Health Care Services	2009
<i>HOPWA</i>	HUD**	Coordinated Housing and other services to prevent homelessness	Aggregate Sponsor and Project Report
<p>* Health Resources and Services Administration                  ** Housing and Urban Development</p> <p><i>7/20/09</i></p>			

**Links and Resources**

Visit the site below to access the resources noted in the following table:

[http:// www.scdhec.gov/rwhopwata](http://www.scdhec.gov/rwhopwata)

<b>Resource Description</b>	<b>Location on Website</b>	<b>Location on Website</b>	<b>Location on Website</b>
Schedule of Deliverables	See Ryan White Part B TA* for Service Providers		
Report Formats	See Ryan White Part B TA for Service Providers	See HOPWA TA for Service Providers	See MAI TA for Service Providers
Reporting TA	See Provide Enterprise TA		
Service Glossary of Indicators in PE	See Provide Enterprise TA – “Statewide List of Services”		
SC QM	See “SC Quality Management”		

\*Technical Assistance

## CHAPTER 9: RECOMMENDATIONS AND GOALS FOR PREVENTION SERVICES

### Recommendations from the SC HIV Planning Council for High Impact HIV Prevention Services (by chapter)

1. Epidemiologic Profile
  - Continue surveillance efforts and monitoring 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.
2. Community Services Assessment:
  - Collect more behavioral risk data, social network information, and needs assessment information involving members of the priority populations to better guide decisions for planning, designing and/or implementing interventions and targeting resources.
  - Conduct needs assessment activities with African American men who identify as having sex with women (Completed December 2011; [http://www.schpc.org/images/AAMSW\\_survey\\_report\\_-\\_Dec\\_2011-FINAL.pdf](http://www.schpc.org/images/AAMSW_survey_report_-_Dec_2011-FINAL.pdf)).
  - Conduct needs assessment activities with African American women who identify as having sex with men. (Completed December 2010; [http://www.schpc.org/images/Final\\_AAWSM\\_Survey\\_Report\\_3-28-11.pdf](http://www.schpc.org/images/Final_AAWSM_Survey_Report_3-28-11.pdf)).
  - Conduct needs assessment activities with Hispanic/Latino men and women (Underway, 2012)
  - Conduct needs assessment activities with White men who identify as having sex with men (Planned for 2013)
  - Continue dialogue regarding assessing needs of injection drug users and/or other drug users who are at high risk for HIVinfection.
3. Priority Populations (listed but no longer ranked)  
Persons Living With HIV/AIDS (PLWHA);  
African American Men who have Sex with Men (AAMSM), Ages 15-44;  
African American Men Who Have Sex With Women (AAMSW), Ages 15-44;  
African American Women Who Have Sex With Men (AAWSM), Ages 15-44;  
White Men Who Have Sex With Men (WMSM), Ages 15-44;  
Injection Drug Users (IDUs), Ages 20-44: and  
Hispanics/Latinos
  - Increase outreach to priority populations to promote availability of counseling and testing and other prevention and care services.
  - Reach all people who are HIV-infected with HIV testing, referrals to care and support services, and ongoing secondary prevention services (including linking persons with programs for substance abuse treatment, family planning, STD, mental health, housing, etc.).
  - Provide HIV prevention and resource information to high-risk populations who may not normally access community/agency services (i.e., the homeless, IDUs, etc.).
  - Increase the number and availability of prevention programs targeting men who have sex with men.
  - Promote and increase culturally competent service provision to priority and emerging populations.

- Involve priority population representatives in planning, implementing and delivering local prevention initiatives.
4. Interventions:
- Increase HIV testing and STI screening in health department and community-based organization settings.
  - Increase immediate access to HIV testing across the state.
  - Increase opportunities for community-delivered HIV/STI screening and outreach services for populations not being reached by “traditional” services.
  - Reach uninfected people at risk at the community level and engage them in risk reduction activities.
  - Expand targeted peer education programs for youth and young adults.
5. Coordination and Linkages:
- Promote and increase efforts for Program Collaboration and Service Integration (PCSI) in HIV Prevention and Care Programs (including, but not limited to: STDs, TB, Hepatitis, Teen Pregnancy, Adolescent Health, Minority Health, Mental Health, Sexual Assault, and Substance Use).
  - Keep abreast of national and state policy development/change, especially related to the National HIV/AIDS Strategy, to advocate for people with or at risk for HIV/AIDS and the programs that serve them.
  - Increase awareness of HIV care as a prevention strategy.
  - Pursue opportunities for collaborative funding for high impact HIV prevention.
  - Increase community voices from emerging populations.
  - Implement better and earlier linkage to care for persons living with HIV and increase efforts to retain them in care.
  - Implement age-appropriate evidence-based Comprehensive Sex Education for all youth in kindergarten through grade 12 in all school districts in the state.
  - Increase linkages with youth-serving programs for the provision of sexual health education to protect youth from infection with HIV and STIs as well as teen pregnancy.
  - Improve access to drug treatment and prevention services for alcohol and other drug-using persons.
  - Engage key leaders to address underlying issues causing HIV stigma and health disparities for African Americans.
  - Increase cross-training opportunities between HIV/STI service providers and intimate partner violence/sexual assault service providers to include screening and referral services.
6. Surveillance and Data Collection:
- Continue monitoring of populations that are recently HIV-infected for trends, status of disease at diagnosis, and resistance, for more effective targeting of prevention efforts.
  - Utilize incidence data over time to evaluate the success or impact of prevention efforts in slowing HIV transmission among certain populations.
  - Increase identification of transmission risk factors for new cases of HIV infection.
7. Technical Assistance Needs and Priorities:
- Increase the number of trained staff to provide a range of effective interventions, particularly for men who have sex with men and for persons living with HIV/AIDS

- Educate legislators and policy makers about HIV/AIDS and the economic cost of inadequate programs and services.
- Build capacity among community organizations, including the faith community, to address community prevention needs while recognizing differences in abilities to deliver these services.
- Encourage and build capacity with health care providers to offer HIV testing as a routine part of medical care.
- Continue assessment of training and capacity-building needs for health department and community-based organization staff.
- Provide opportunities for training on new and revised evidence-based interventions.

#### 8. Evaluation

- Continue ongoing evaluation of prevention and care programs.
- Continue periodic monitoring to ensure quality assurance, fidelity, and effectiveness of programs and services.
- Develop quality assurance guidelines for new prevention interventions and strategies.

#### South Carolina's Goals:

1. To reduce the incidence of HIV and other STDs.
2. To increase the number of persons who know their HIV status by offering HIV testing in a variety of settings to persons at risk for HIV, and to the general population through the provision of HIV testing as a routine part of medical care.
3. To increase the number of persons infected with HIV who are successfully linked to and retained in care and support services, optimizing health outcomes.
4. To reduce HIV- and STD-related health disparities.
5. To promote and increase high impact prevention services that are holistic, evidence-based, comprehensive, and high quality to appropriate populations at every interaction with the health care system.

**KEY TO ABBREVIATIONS AND ACRONYMS**

<b>AA</b>	African American
<b>AAMSM</b>	African American Men who have Sex with Men
<b>AAMSW</b>	African American Men who have Sex with Women
<b>AAWSM</b>	African American Women 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>CBA</b>	Capacity Building Assistance
<b>CBCT</b>	Community Based Counseling and Testing
<b>CBO</b>	Community Based Organization
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CLI</b>	Community-Level Intervention
<b>CPG</b>	Community Planning Group
<b>CTRS</b>	Counseling, Testing, and Referral Services
<b>DAODAS</b>	SC Department of Alcohol and Other Drug Abuse Services
<b>DEF</b>	Data Entry Form
<b>DHEC</b>	SC Department of Health and Environmental Control
<b>DIS</b>	Disease Intervention Specialist (SC DHEC)
<b>EHARS</b>	Electronic HIV/AIDS Reporting System
<b>EPI</b>	Epidemiologic
<b>GHS</b>	Greenville Hospital System
<b>GLI</b>	Group-level Interventions
<b>GMOC</b>	Gay Men of Color
<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>HPC</b>	SC HIV Planning Council
<b>HRSA</b>	Health Resources and Services Administration
<b>IDU</b>	Injection Drug User
<b>ILI</b>	Individual-level Intervention
<b>IPF</b>	Implementation Planning Form
<b>LHD</b>	Local Health Department

<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/Injection Drug User
<b>MSW</b>	Men who have Sex with Women
<b>NGO</b>	Non-Governmental Organization
<b>NIR</b>	No Identified Risk
<b>OUT</b>	Outreach
<b>PCM</b>	Prevention Case Management
<b>PCSI</b>	Program Collaboration and Service Integration
<b>PEMS</b>	Program Evaluation Monitoring System
<b>PLWHA</b>	People Living with HIV/AIDS
<b>PS</b>	Partner Services
<b>PSA</b>	Public Service Announcement
<b>SCDC</b>	SC Department of Corrections
<b>SCDE</b>	SC Department of Education
<b>SCSU</b>	South Carolina State University
<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>WSM</b>	Women who have Sex with Men
<b>YRBS</b>	Youth Risk Behavior Survey

Appendix B

# **Qualitative Summary of Findings**

**From Focus Groups with Consumers  
Regarding HIV Care and Supportive Services in South Carolina**



**DECEMBER 4, 2005**

**RESUBMITTED**

**FEBRUARY 27, 2006**

**BY**

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## **Background**

South Carolina experienced a 131% increase in the number of persons living with HIV/AIDS from 1998 to 2002 and many of the newly infected were women. (*STD/HIV Program, 2005*) With the sharp increase in the number of new HIV/AIDS cases in the state, there has been a growing demand for health care, housing, support services, and prevention services for persons living with HIV/AIDS. As of December 31, 2002, there have been an estimated 12,553 cumulative cases of persons living with HIV/AIDS in the state. Approximately forty three percent (43%) of persons living with HIV are unemployed and earn less than \$10,000 annually (*STD/HIV Program, 2005*).

To specifically address the care and support service needs of HIV positive persons in South Carolina, eleven (11) Ryan White CARE Act Care Consortia service areas have been designated. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is federal legislation that addresses the unmet health needs of persons living with HIV/AIDS (PLWHA) by funding primary health care and support services that enhance access to and retention in care. South Carolina's eleven care consortia are as follows:

Table 1: HIV Care Consortia and Counties Served

<b>Ryan White Consortia</b>	<b>Counties served</b>	<b>Focus group conducted</b>
AID Upstate	Anderson, Oconee, Pickens and Greenville	Greenville
Catawba Care Coalition	Chester, York and Lancaster	Rock Hill
Low Country HIV Care Consortium	Beaufort, Jasper, Hampton and Colleton	Hampton
HopeHealth	Florence, Darlington, Marlboro, Marion, Dillon and Chesterfield	Florence
HopeHealth Lower Savannah	Aiken, Barnwell and Allendale	Aiken
Midlands Care Consortium	Lexington, Richland, Newberry, Fairfield, Clarendon Sumter, Lee and Kershaw	Columbia and Sumter
Piedmont Care	Spartanburg, Union and Cherokee	Spartanburg

<b>Ryan White Consortia</b>	<b>Counties served</b>	<b>Focus group conducted</b>
Tri County Interagency AIDS Coalition	Orangeburg, Bamberg and Calhoun	Orangeburg
Trident HIV Care Coalition	Charleston, Dorchester and Berkeley	Charleston
Upper Savannah Care Consortium	Laurens, Abbeville, Greenwood, Saluda, McCormick and Edgefield	Greenwood
Waccamaw HIV Care Consortium	Williamsburg, Horry and Georgetown	Myrtle Beach

These care consortia are responsible for providing services to HIV positive persons and their families who have no other ability to pay for services. Services include primary medical care, medications, case management, and support services. Funding is provided for medications via the AIDS Drug Assistance Program (ADAP) and for housing via Housing Opportunities for People with AIDS (HOPWA).

The purpose of this investigation was to identify the prevention and care needs of persons living with HIV/AIDS, to identify what influences HIV positive people to seek and/or continue HIV/AIDS medical care, and the perceived quality of HIV prevention and care services in South Carolina.

### **Project Design**

This project was designed and executed in collaboration with the SC HIV Planning Council, the SC Ryan White Care Consortia, the National Alliance of State and Territorial AIDS Directors (NASTAD), the SC Department of Health and Environmental Control's (DHEC) STD/HIV Division, and researchers from the Arnold School of Public Health at the University of South Carolina. Each of the eleven Care Consortia were asked to recruit participants from their service area, provide a neutral site to conduct the focus groups and provide a means and incentive for consumer participation. The original plan of the study was to conduct two focus

groups in each of the eleven Care Consortium areas: one designated for HIV positive individuals currently “in care” as defined by the Health Resources and Services Administration (HRSA; having had a CD4 count, viral load test, or HIV medication within the last year) and another for persons living with HIV/AIDS who were not currently “in care.” The Consumer Advisory Workgroup for the Care Consortia indicated that persons in care would be able to recruit those not in care to participate in the focus groups. Overall, this recruiting strategy did not prove to be effective. As a result, only one focus group was held solely with persons who were “not in care.” The remaining nineteen (19) focus groups were conducted with people who were “in care,” including some people who were uncertain about their being “in care.”

The discussion guide (see Appendix 1: Focus Group Discussion Guide - Persons in Care and Appendix 2: Focus Group Discussion Guide - Persons Not Presently In Care), participant survey form (see Appendix 3: Focus Group Participant Profile), and the informed consent form (see Appendix 4: Consent to Participate in Focus Group) were developed in a collaborative effort between DHEC, NASTAD, and researchers at the Arnold School of Public Health, specifically to meet the information needs of the SC Ryan White Care Consortia. Both discussion guides addressed the following four areas as they impact (or affect) people living with AIDS: service utilization, barriers to care and unmet needs, prevention services and testing, and consumer involvement.

In general, the format of focus groups allows the participants the freedom to discuss issues and concerns about a particular topic with complete anonymity and without the fear of negative repercussions. In this case, the participants were able to fully discuss their experiences utilizing HIV care services in South Carolina, where their needs were not being met, and suggestions for improving care and support services and HIV prevention in their service area. In

addition to the participants in the focus groups, there was a trained facilitator and a note-taker for each group. The focus group facilitators and note-takers were provided with an in-service training on August 9, 2005, by NASTAD staff. Each focus group was also recorded to document the focus group and to further aid the note-taker in transcribing his/her notes for data analysis.

### **Data Analysis**

The data analysis was comprised of two distinct sections: the quantitative (numerical) and qualitative (personal statements) sections. Quantitative data from the demographic information forms was entered into a database and analyzed utilizing SPSS to summarize the demographics of the participants. Qualitative focus group data was transcribed by the note-takers and forwarded to an independent data analyst. These data were then analyzed using NVivo 2.1, a software package for coding and analysis of textual data. Members of the research team developed a codebook, (see Appendix 5: NVivo 2.0 Node Listing for DHEC Focus Groups) derived from the questions and probes found in the discussion guides (see Appendix 1: Focus Group Discussion Guide - Persons in Care and Appendix 2: Focus Group Discussion Guide - Persons Not Presently In Care). Two members of the research team independently coded each transcript, identifying emergent and recurring themes. Emergent themes were identified from the data across all focus groups as well as from focus groups with just male participants or with just female participants. To be considered a theme, a topic had to occur across the majority of focus groups (or all female groups or all male groups) and had to be mentioned more than once in each focus group.

After all of the transcripts had been independently analyzed the researchers met and reviewed the analyzed documents to reach consensus. Having two researchers independently analyze the data ensures that each of the identified themes were correctly identified and coded

properly. The process of reaching consensus is a practice commonly done in qualitative data analysis to ensure that the data were analyzed to reduce bias. After consensus had been reached, the data were further analyzed to identify the new and recurring themes expressed during the focus groups. The quantitative and qualitative data were then assembled into a comprehensive report for the Ryan White Care Consortia and the SC HIV Planning Council.

### **Quantitative Summary**

Twenty focus groups were conducted with a total of 113 participants across 12 sites. The largest percentages of participants were from the Rock Hill (Catawba Care Coalition) and Spartanburg (Piedmont Care) areas with 10.6% each. The smallest percentage of participants was from Hampton (Low Country Care Consortium) with 4.4%. The majority of participants were African American (75.2%). Fifty-seven (57%) percent of the participants did not identify as belonging to any one ethnicity, but 40.7% reported they were not Hispanic. The focus group participants were almost evenly divided with males and females, with 49.6% being male and 48.7% being female. The average age of participants is 44 years old. The majority of the participants reported being heterosexual (60.2%), and 31% reported being homosexual.

Table 2: SC HIV Planning Council Focus Group Demographics

<b>Consortium</b>	<b>Number of Participants</b>	<b>Number of Focus Groups Per Site</b>	<b>Number of Males (%)</b>	<b>Number of Females (%)</b>	<b>Number of Transgender (%)</b>	<b>Number Gender not answered</b>
HopeHealth Lower Savannah	7	2	2 (29%)	4 (57%)	0	1(14%)
Midlands Care Consortium (Sumter)	11	2	3 (27%)	8 (73%)	0	0
HopeHealth AID Upstate	10	1	4 (40%)	6 (60%)	0	0
Upper Savannah Care Consortium	6	1	3 (50%)	3 (50%)	0	0
	9	2	7 (78%)	1 (11%)	1(11%)	0

<b>Consortium</b>	<b>Number of Participants</b>	<b>Number of Focus Groups Per Site</b>	<b>Number of Males (%)</b>	<b>Number of Females (%)</b>	<b>Number of Transgender (%)</b>	<b>Number Gender not answered</b>
Waccamaw HIV Care Consortium	10	2	7 (70%)	3 (30%)	0	0
Tri County Interagency AIDS Coalition	9	1	1 (11%)	8 (89%)	0	0
Catawba Care Coalition	12	2	9 (75%)	3 (25%)	0	0
Piedmont Care	12	2	10 (83%)	2 (17%)	0	0
Midlands Care Consortium (Columbia)	11	2	6 (55%)	5 (45%)	0	0
Low Country HIV Care Consortium	5	1	0 (0%)	5 (100%)	0	0
Trident HIV Care Coalition	11	2	4 (36%)	7 (64%)	0	0

### Socioeconomic Status

The majority of participants had some high school but didn't graduate (25.7%) or had some college but no degree (21.2%). Only 2.7% of participants reported education of 8<sup>th</sup> grade or less. A large percentage of participants were on disability (37.2%) or unemployed (25.7%) at the time of the focus groups. Almost 70% of participants reported an annual income level of \$19,999 or less (with the majority of those making less than \$5,000 per year). Most of the participants rent or own a house/apartment (63.7%), while 16.8% live with relatives or friends, or did not provide a response about their housing situation (15.9%; see Limitations page 10).

### HIV Care and Prevention Services

The vast majority of participants reported they were in care (96.5%) per the Health Resources and Services Administration (HRSA) definition of "in care." Seventy-five percent

(75.2%) of participants reported having received HIV medical care or a CD4 and/or viral load test in the past year (15.9% did not respond; see Limitations page 10). Approximately 63% reported having received HIV Prevention Services (educational sessions, counseling and testing, and/or contact with an outreach worker) in the past year, while 18.6% reported not receiving HIV Prevention Services (15.9% did not respond; see Limitations page 10).

### Gender

In total, 55 women participated in the focus groups. The majority of the female participants reside in Columbia (14.5%), Orangeburg (14.5%), and Charleston (12.7%). The female population was 89.1% African American, 10.9% Caucasian, and 1.8% Latina. Ninety-six percent (96.4%) of all female participants are in care. Sixty percent (60%) rent or own their home/apartment and 12.7% live with relatives or friends. Eighty-seven percent (87.3%) are heterosexual and 7.3% are homosexual. Education levels for females are as follows: 29.1% have some high school education and 20% have some college. Approximately 31% (30.9%) are unemployed and the same percentage (30.9%) is on disability, with approximately 30% working part time or full time. Thirty-six percent (36.4%) of female participants have a yearly income of less than \$5,000. Almost sixty-six percent (65.5%) have received HIV medical care, while 52.7% have received HIV prevention services.

### Limitations of the Qualitative Data:

For the Sumter and Orangeburg focus groups, the participants did not receive one of the necessary demographic data forms. Although the participants did complete the NASTAD demographic form, it did not contain all of the questions on the DHEC form; therefore, some responses were not collected for those participants.

## **Qualitative Summary**

### **Service Utilization**

Overall, there are no definitive statements that can be made about the HIV/AIDS medical care of persons living with HIV/AIDS in South Carolina. When asked, “*How do you feel about the HIV care services you have received?*” the amount, availability and quality of the care were specific to each service area. Some reported being quite satisfied with the services offered while others reported that there was a great deal lacking in their service area.

### **Case Managers**

The participants were further probed about their case manager. In the various consortia areas, the term “case manager” had a different and sometimes multiple meaning, according to how the Ryan White clinic was established in their specific area. Although many responded that they truly appreciate their case manager, there was frustration expressed about having multiple case managers and not knowing which one to access to solve their problems. Many participants reported that they would like to see a more centralized care system to reduce the amount of traveling and repetition required to attain health care and associated services (see Table 3: Service Utilization); however, many concerns were expressed about the stigma that would be associated with a centralized HIV service location.

### **Medical Care**

The respondents indicated that in some areas there are good, well-trained Infectious Diseases (ID) physicians but that, over all, medical treatment in South Carolina was lacking. Some areas have only one or no Infectious Disease doctor. As a result, people living with HIV/AIDS reported receiving services from other less-qualified providers. Participants also conveyed that many emergency room doctors and other care providers such as dentists and obstetrics and gynecology (Ob/Gyn) specialists were not well trained or not willing to treat

persons living with HIV/AIDS. The participants reported that medical care providers often treated them differently after their HIV status was divulged (see Table 3: Service Utilization).

Table 3: Service Utilization

Question	Positive Perspectives	Negative Perspectives
How do you feel about the HIV care services you have received?	<ul style="list-style-type: none"> <li>• <i>“They have been really good to me. I never have any problems. If I say I need something...they are like family.”</i></li> <li>• <i>“When I first started taking meds I missed doses. But they (health center) called to remind me and encouraged me to take them. They talked to me like I was a human being; lots of respect. They came with respect, so I responded with respect.”</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>“We’ve all had bad experiences with medical care.”</i></li> <li>• <i>“If you say you’re HIV positive, then you get bad care. If you don’t tell them that you’re HIV positive, then you get good care.”</i></li> </ul>
Probe: Case management	<ul style="list-style-type: none"> <li>• <i>“You (the patient) have to get to know them (the case manager). You have to open up to feel welcome.”</i></li> <li>• <i>“Have had no problems calling case manager if I need help.”</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>“Which one? There are so many (case managers) and they change like the wind.”</i></li> <li>• <i>“I feel like the case managers take on more then they are qualified for”</i></li> </ul>
Probe: Medical care	<ul style="list-style-type: none"> <li>• <i>The doctor and nurse were very considerate. Now they answer all my questions over the phone and call in ‘scripts’ for me.”</i></li> <li>• <i>“I was connected with the ID doctor in [Place].... The doctor is brilliant.”</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>“Some people in the hospital find out that you have HIV and they are nasty to you. Sometimes I feel like not telling them.”</i></li> <li>• <i>“I worked in the ER and avoided people with HIV and saw many doctors and nurses do it, too. The medical field still fears the disease.”</i></li> </ul>

Theme	Response
Lack of knowledgeable specialized medical professionals	<ul style="list-style-type: none"> <li>▪ <i>“My Ob/Gyn wouldn’t do a pap smear because he found out I was HIV positive.”</i></li> <li>▪ <i>“An Ear, Nose, and Throat (ENT) doctor... I have HIV related throat problems. They won’t treat you if you’re HIV positive.”</i></li> <li>▪ <i>“I got dental service once and the doctor changed all his mannerisms when he found out I was HIV positive.... I felt very ostracized.”</i></li> </ul>

Agency Perceptions

When asked “Have you ever felt particularly welcome, or motivated by an agency?” the participants conveyed that they rely heavily on their local HIV agencies for support and they have mostly positive perceptions of the services they receive. The participants did, however, show some concern over funding for their specific agencies, as well as discrepancies in treatment among clientele and a lack of proper training so that the agency staff could best serve them and their needs.

Table 4: Agency Perceptions

Question	Positive Perspectives	Negative Perspectives
Question: Have you ever felt particularly welcome, comfortable, or motivated by an agency?	<ul style="list-style-type: none"> <li>• <i>“There’s lots of support. They helped me go through the services, encouraged me to go back to school, gave me clothes, and help HIV positive individuals get benefits.”</i></li> <li>• <i>“I never had a bad experience. The volunteers at the clinic are like God-sent people.”</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>“Clinic not writing my reports correctly and intentionally keep you off of SSI and disability in South Carolina.”</i></li> <li>• <i>“The knowledge at the agency... it seems like they are lacking knowledge in certain areas.... Resources are available but they can’t get people to them.”</i></li> </ul>

Reasons to be in Care

During the focus groups the facilitator asked the participants “What motivated you to get HIV care?” Overwhelmingly, the participants indicated that they were in care in order to

prolong their lives. Several other reasons were noted as reasons to be in care, including family, overcoming life-threatening illness, and the influence of a medical provider (see Table 5: Reasons to be in Care).

Table 5: Reasons to be in Care

<b>Question</b>	<b>Response</b>
Question: What motivated you to get HIV care?	<ul style="list-style-type: none"> <li>• <i>“I just want to live.”</i></li> </ul>
Probe: Primary care provider	<ul style="list-style-type: none"> <li>• <i>“The doctor said I won’t live five years. So, I wanted to prove that he was a liar. So, I took my meds and wanted to live.”</i></li> <li>• <i>“I only started meds because I got sick and the doctor said I wouldn’t survive.”</i></li> </ul>
Probe: Family/Friends	<ul style="list-style-type: none"> <li>• <i>“When I found out, I wanted to give up. I let myself go down. My kids would say “Mama, what’s wrong...” You know you’ve got to be there for them.”</i></li> <li>• <i>“After talking to my pastor.... and my grandkids. I wanted to live to see them grow up.”</i></li> </ul>
Probe: Others	<ul style="list-style-type: none"> <li>• <i>“I went 5 years after being diagnosed. I was in denial... I got sick and felt I had to get help.”</i></li> </ul>

Barriers to care and unmet need

The second area explored during the focus group was barriers to care and unmet need. The greatest barriers to care among the participants in the focus groups were associated with transportation to care, the actual treatment they received while attempting to attain care, eligibility requirements, and the limiting rules and regulations around Medicare/Medicaid. The lack of public transportation in South Carolina also serves as a barrier to care. Many of the participants indicated that there was transportation offered, but often it proved to be inadequate to get them to their medical appointments in a timely manner. The participants also relayed that

they often felt mistreated by medical professionals and that not having private health insurance hinders the process for them to receive medical care in many health establishments.

The participants noted that the complex rules and regulations set forth by Medicare, Medicaid, and SC DHEC also proved to hinder care in South Carolina. Many reported that they were not able to receive adequate care for other conditions, even if the conditions were a result of having HIV.

Throughout the focus groups, it was evident that the climate surrounding HIV in South Carolina and the fear of not wanting to stigmatize their children served to be an additional barrier to receiving services. Also, because the majority of South Carolina is rural, the respondents indicated that they perceived that there is a lack of privacy that ultimately resulted in persons living with HIV/AIDS seeking care less often.

Many of the people who participated in the focus groups indicated that depression and the additional stresses and strains associated with being HIV positive often served as an additional barrier to seeking and actively receiving care (see Table 6: Barriers to Care and Unmet Need).

Table 6: Barriers to Care and Unmet Need

<b>Question:</b> What services or care have you wanted or needed and couldn't get?	
<b>Theme</b>	<b>Responses</b>
Probe: Housing	<ul style="list-style-type: none"> <li>▪ <i>"...housing, HIV (positive people) cannot be admitted to shelters"</i></li> <li>▪ <i>"They need housing for HIV positive people"</i></li> <li>▪ <i>"I couldn't get life insurance. The seller (of the life insurance) went and told my neighbor. I had to move."</i></li> </ul>
Probe: Insurance	<ul style="list-style-type: none"> <li>▪ <i>"If you don't have insurance you can't get treatment"</i></li> <li>▪ <i>"If you have to go to ER, you have to have trauma or problems with your heart. You have to have insurance."</i></li> </ul>
What were the problems in getting those required services?	

Theme	Responses
Not meeting eligibility requirements and cost	<ul style="list-style-type: none"> <li>▪ <i>“They won’t help with meds that aren’t directly related to HIV.”</i></li> <li>▪ <i>“The doctors do what I ask but are limited in what they’re allowed to do. I can’t get my heartburn ‘script’ covered. They’re covering things directly related to HIV but not the surrounding issues.”</i></li> </ul>
Stigma	<ul style="list-style-type: none"> <li>▪ <i>“I was not welcome at my job after I told them I had it (HIV).”</i></li> <li>▪ <i>“I deal with my children. I don’t want them to be chastised for me. It’s better if I don’t go to the clinic [because of the stigma effect on my children].”</i></li> </ul>
Privacy	<ul style="list-style-type: none"> <li>▪ <i>“The problem with this being a small town is that people talk about your business. People are afraid that their families will shun them so they’re afraid to speak out.”</i></li> </ul>
Mental Health	<ul style="list-style-type: none"> <li>▪ <i>“I wish I hadn’t been diagnosed. It changed my outlook on myself. It made me feel lesser.”</i></li> <li>▪ <i>“Some days you wake up and want to go on...some days you wake up and think “Lord no!”</i></li> </ul>

### HIV Prevention Services

The third area that was investigated during the focus groups was HIV prevention services and testing. The participants were asked, *“What prevention services do you have in your area that help people from getting HIV?”* The majority of the participants mentioned the agency that had recruited them to participate in the focus groups and the use of all types of media for HIV prevention. They also indicated that they had witnessed an increase in condom distribution in their communities but wondered if condoms were enough to address the risk among youth.

The participants were asked, *“What reasons have you heard for why people at risk for HIV have not had an HIV test?”* The reasons included fear of a positive HIV status, of stigma related to being HIV positive, and denial that they are at risk for contracting HIV.

Table 7: HIV Prevention Services

<b>Question:</b> What Prevention Services do you have in your area that help people from getting HIV?	
<b>Theme</b>	<b>Responses</b>
Probe: Media	<ul style="list-style-type: none"> <li>▪ <i>“I’ve seen some commercials. Hopefully this will open people’s eyes”</i></li> <li>▪ <i>“I’ve seen billboards and commercials and I’ve liked them.”</i></li> <li>▪ <i>“I see ads on the TV and hear them on the radio.”</i></li> </ul>
<b>Question:</b> What reasons have you heard for why people at risk for HIV have not had an HIV test?	
<b>Theme</b>	<b>Responses</b>
Theme: Fear	<ul style="list-style-type: none"> <li>▪ <i>“Scared to know. People say ‘knowing is beautiful’ but it is not. People are scared they might have it. ‘I’ve got a death sentence...’ People may know they have it but will not have the test.”</i></li> <li>▪ <i>“A lot don’t want to know their status. [They think] what you don’t know won’t hurt you.”</i></li> </ul>
<b>Question:</b> What reasons have you heard for why people at risk for HIV have not had an HIV test?	
<b>Theme</b>	<b>Responses</b>
Theme: Stigma	<ul style="list-style-type: none"> <li>▪ <i>“They’re afraid to find out. Afraid of the social stigma.”</i></li> <li>▪ <i>“There is a stigma to getting tested.”</i></li> <li>▪ <i>“...people are afraid to get tested because they are afraid they are going to be discriminated against”</i></li> </ul>
Theme: Denial of risk	<ul style="list-style-type: none"> <li>▪ <i>“They feel that it can’t happen to them.”</i></li> <li>▪ <i>“I might live longer if I don’t know it. They might not be able to handle it.”</i></li> </ul>

The participants were then asked, “What can care or service providers do to help people with HIV tell their sex partners about their HIV status?” The responses were not conclusive.

Many indicated that it was a personal matter that should not include professional health care providers, whereas others suggested educated personnel would help in the discussion process.

Table 8: Disclosure of HIV Status to Sex Partner

Question: What can care or service providers do to help people with HIV tell their sex partners about their HIV status?	
<b>Theme</b>	<b>Response</b>
Personal event	<ul style="list-style-type: none"> <li>• <i>“...there is support for help in telling your partner. But I don’t think that’s for the healthcare provider. That’s personal.”</i></li> </ul>
Case worker assistance	<ul style="list-style-type: none"> <li>▪ <i>“Case workers could come with you.”</i></li> </ul>
Better education	<ul style="list-style-type: none"> <li>• <i>“Give them lots of information, a real understanding. Give them literature.”</i></li> </ul>

### Consumer Involvement

The final area of discussion solicited suggestions about improving HIV care and/or prevention services. They were asked, *“What would be the single most important change you would suggest to improve services to people living with HIV?”* The respondents from every area had a plethora of ideas and suggestions focusing on HIV education, advocacy and policy change. The respondents felt as though the greatest need for prevention was among youth. They wanted to see more education in the schools and with parents. There was also recognition that the fundamentals of HIV prevention need to start at the individual level. Many of the participants also indicated that there needed to be a change in the HIV testing policy as well as advocacy for sexual minorities in South Carolina.

Table 9: Consumer Involvement

Question: What would be the single most important change you would suggest to improve services to people living with HIV?	
<b>Theme:</b>	<b>Responses</b>
Education	<ul style="list-style-type: none"> <li>▪ <i>“Educate: school, community, children, and parents. Let them know HIV/AIDS is here and it is real.”</i></li> <li>▪ <i>“These kids think they are invincible. They are having sex early. I don’t understand if a person doesn’t want their kids to learn.”</i></li> </ul>
Individual responsibility	<ul style="list-style-type: none"> <li>▪ <i>“We do need more people out there spreading the word.”</i></li> <li>▪ <i>“But each individual has to take responsibility. It has to be an individual responsibility to take care of yourself. It is preventable to a certain extent.”</i></li> </ul>
Advocacy and policy change	<ul style="list-style-type: none"> <li>▪ <i>“Things are not going to change until you have mandatory testing”</i></li> <li>▪ <i>“You’d have to be able to fight homophobic politics.”</i></li> <li>▪ <i>“Ads for HIV/AIDS is very limited in this county. It’s very homophobic...more emphasis should be promoted that the disease is prevalent throughout the community.”</i></li> </ul>

## Conclusion

At the conclusion of the focus groups the participants were asked “*Is there anything else you would like us to know?*” The overall sentiment expressed by the participants was that people living with HIV/AIDS are resilient and have faith that they can live long productive lives.

- *“I have HIV, but HIV doesn’t have me.”*
- *“I strongly believe they will find a cure and I will get it.”*

Many consumers that are in care have been able to move beyond how and when they contracted the virus to focus on living.

- ***“When I found out I thought I had danced with the devil and now I’m caught.”***
- ***“I don’t think this is going to kill me as long as I take the meds.”***
- ***“It’s just about living today.”***

There are many people in South Carolina who are HIV positive and actively seeking prevention and care services. They are aware of the shortcomings of the systems in place and, when given a voice, many are willing to become advocates for change. Over the past twenty years, the face of HIV has changed drastically and SC DHEC’s STD/HIV Division and Ryan White Care programs are facing the challenge head on. HIV prevention and care services must be available for all regardless of payer source. South Carolina is a poor state and, thus, the needs of persons with HIV/AIDS burden an already overwhelmed medical system for persons with limited means.

## **References**

*STD/HIV Program.* (2005). Retrieved October 21, 2005, from

<http://www.scdhec.net/health/disease/stdhiv/index.htm>

**Note: For a copy of any appendix to this document, please contact  
the SC DHEC STD/HIV Division office at 803-898-0749.**

Appendix 1: Focus Group Participant Profile

Appendix 2: Consent to Participate in Focus Group

Appendix 3: Focus Group Discussion Guide - Persons in Care

Appendix 4: Focus Group Discussion Guide - Persons Not Presently In Care

Appendix 5: NVivo 2.0 Node Listing for DHEC Focus Groups



South Carolina HIV Planning Council  
African American Men who have Sex  
with Men (AAMSM) Workgroup

Results from the  
Information and Awareness Forum  
Held October 17, 2007

Prepared by  
Stacy W. Smallwood, MPH

Release Date: February 7, 2008



**Greetings From The  
African American MSM Workgroup  
Chairperson**

The African American MSM (AAMSM) Workgroup was formed in September 2006 as an Ad Hoc Group of the South Carolina HIV Planning Council. The group was formed to provide recommendations on strategies and approaches to address barriers to HIV Testing and participation in HIV Prevention Education and activities among AAMSM.

The formation of this group was critical, as these are critical times for AAMSM in South Carolina. This population continues to be Priority Population #2, when HIV is 100% preventable. It is the belief of the workgroup that we must review the existing conditions of prevention efforts targeted toward this population, improve in areas where improvement is necessary, and create new prevention approaches in order to reach and engage AAMSM.

The information shared within was gathered during the African American MSM Forum and clearly shows “Why We Can’t Wait.” We must do more to address the HIV Prevention needs of this population. I encourage you to join us in this effort as we seek to improve the health status of African American MSM in South Carolina by decreasing the spread of HIV/AIDS.

Sincerely,

*Matt Jenkins*

Matt Jenkins, Chairperson  
S.C. African American MSM Workgroup

## Results from the AAMSM Information and Awareness Forum Held October 17, 2007

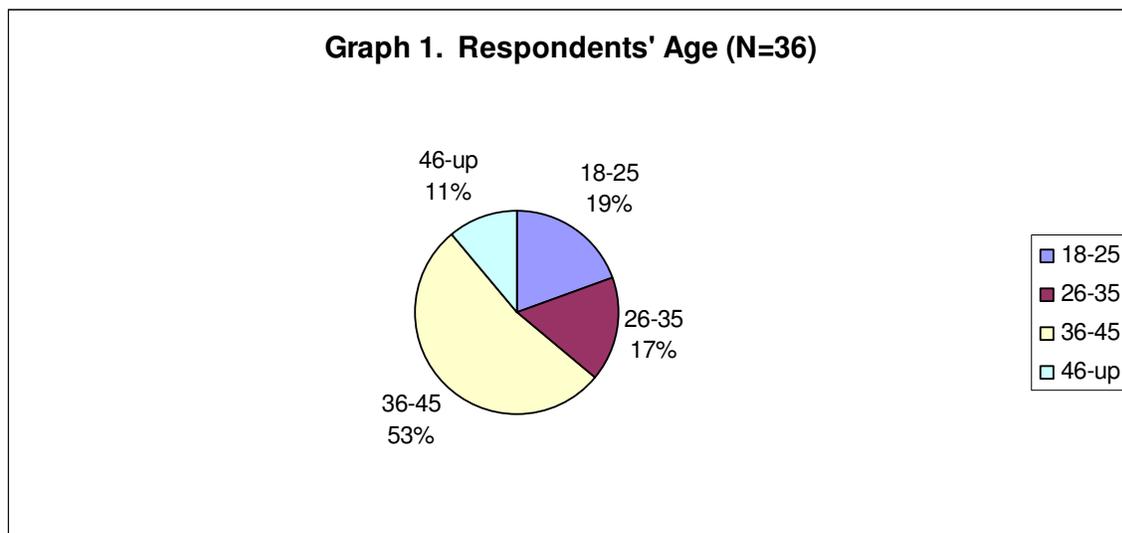
### *Methods*

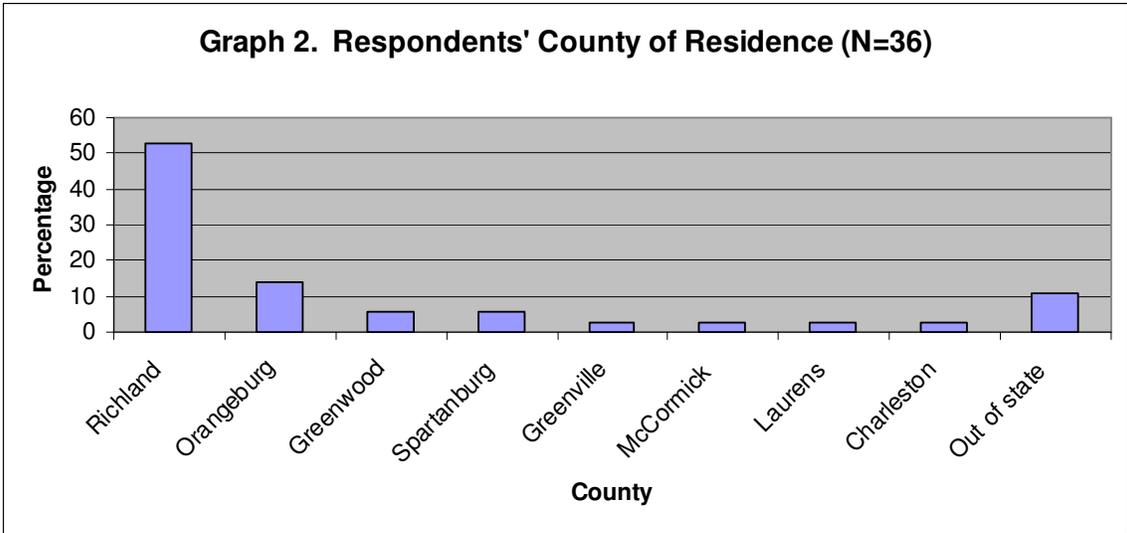
The survey instrument was a one-page, 10-item, self-administered questionnaire developed by the SC HIV Planning Council's African American Men who have Sex with Men (AAMSM) Workgroup. It included questions about demographics, HIV status and testing history, sexual identity, recognition of the "Many Men, Many Voices" HIV prevention intervention, and awareness of/participation in community HIV/AIDS services. There were also two qualitative questions about the services needed for AAMSM in respondents' respective communities, and AAMSM issues in their communities.

The survey was administered on October 17, 2007 at the AAMSM Workgroup's Information and Awareness Forum at the 2007 South Carolina HIV/STD Conference. Thirty-seven African American MSM responded to the survey. After respondents completed the survey, they participated in a moderated discussion in which they were asked additional questions about the perception of HIV in AAMSM communities, HIV/AIDS service delivery, barriers to AAMSM participation in HIV/AIDS programs, and strategies for overcoming those barriers. The discussion lasted approximately 45 minutes.

### *Results*

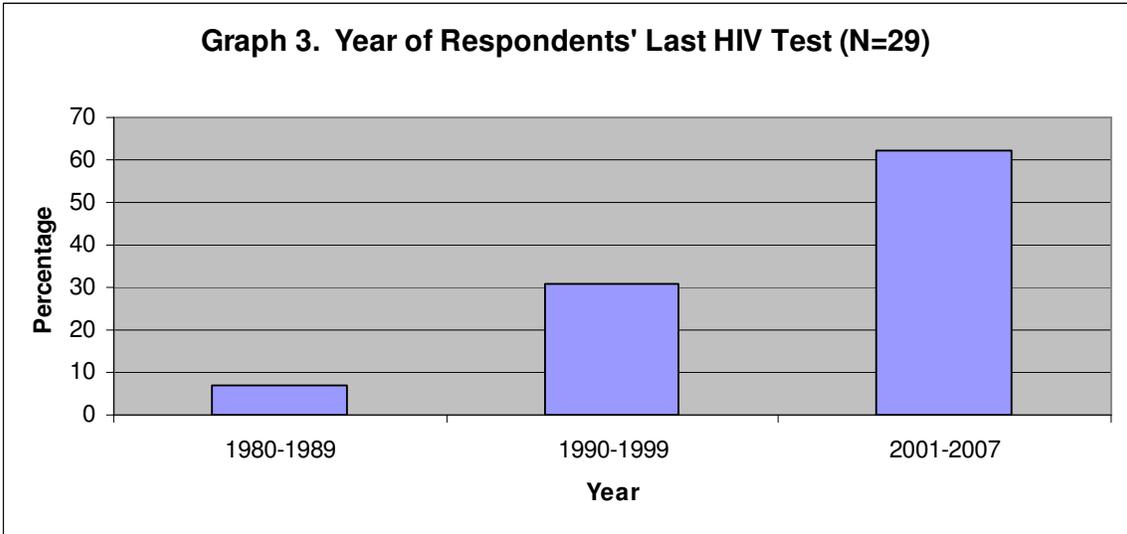
The mean age of respondents was 37.2, with a standard deviation of 9.69. Respondents' ages ranged from 18 to 57, with most respondents between the ages of 36-45. Graph 1 shows the age distribution of respondents, and Graph 2 shows the respondents' county of residence. The majority of respondents (53%) listed Richland County as their county of residence, followed by Orangeburg County. Eleven percent (11%) of respondents were from outside the state.



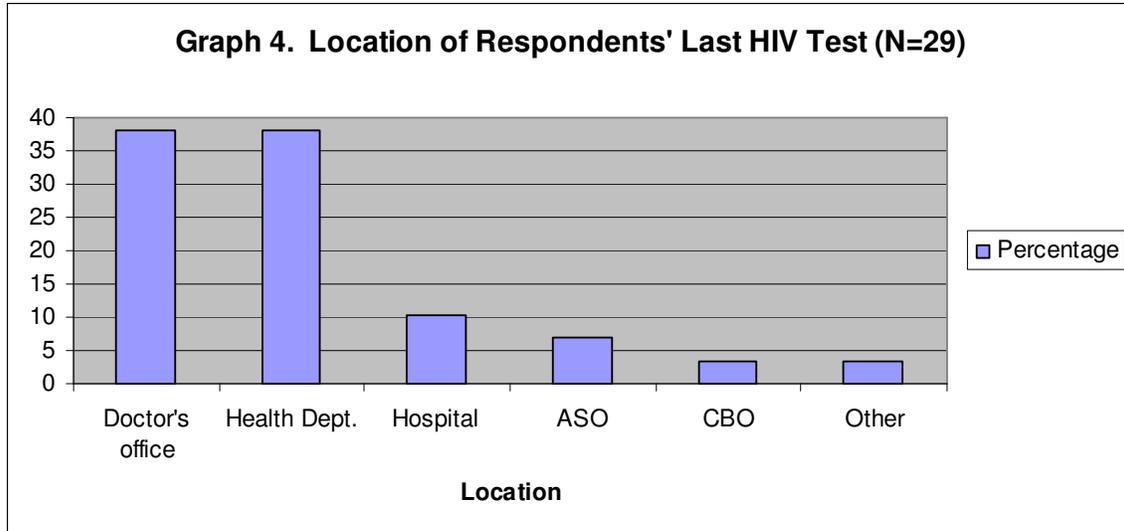


*HIV Testing*

One hundred percent (100%) of respondents reported having been tested for HIV. Graph 3 illustrates the year of respondents' most recent HIV test. When asked about the date of their most recent test, 24.3% had been tested in 2007, and 48.6% had been tested since 2001. Just over 24% reported their last test being in the 1990s, and 5.4% reported being tested last in the 1980s. 21.6% did not respond to this question.

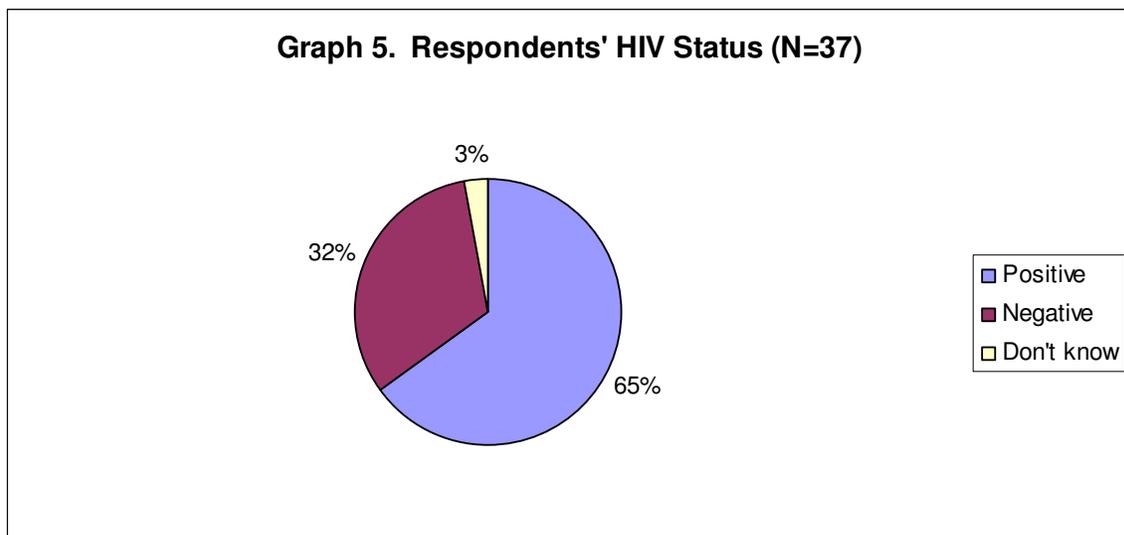


Graph 4 shows the location of respondents' most recent HIV test. Most respondents reported getting their last HIV test in a doctor's office or at the health department (37.9% each), followed by hospitals (10.3%), AIDS service organizations (6.9%), and community-based organizations (3.5%).



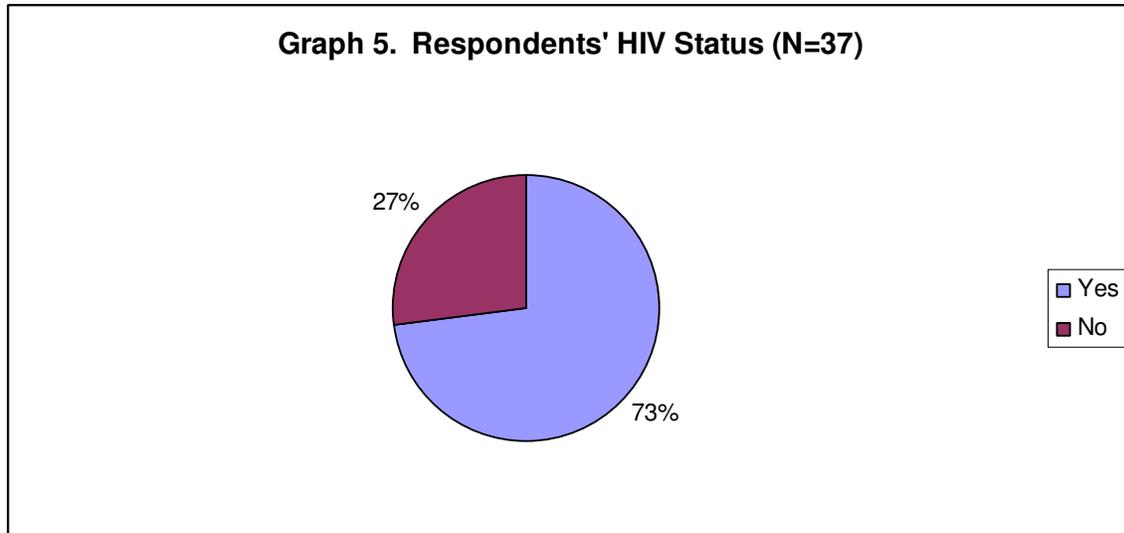
Respondents were asked to report their HIV status. Graph 5 shows the respondents' reported HIV status. Sixty-five percent (65%) of respondents reported being HIV-positive, while 32% reported testing negative, and 3% did not know their status. Of those who were HIV-negative, two-thirds reported being tested in the year 2007.

Of those who reported being HIV-positive, four percent reported not receiving care and treatment. Seventy-one percent of those who reported being HIV-positive also reported that they were receiving care and treatment.



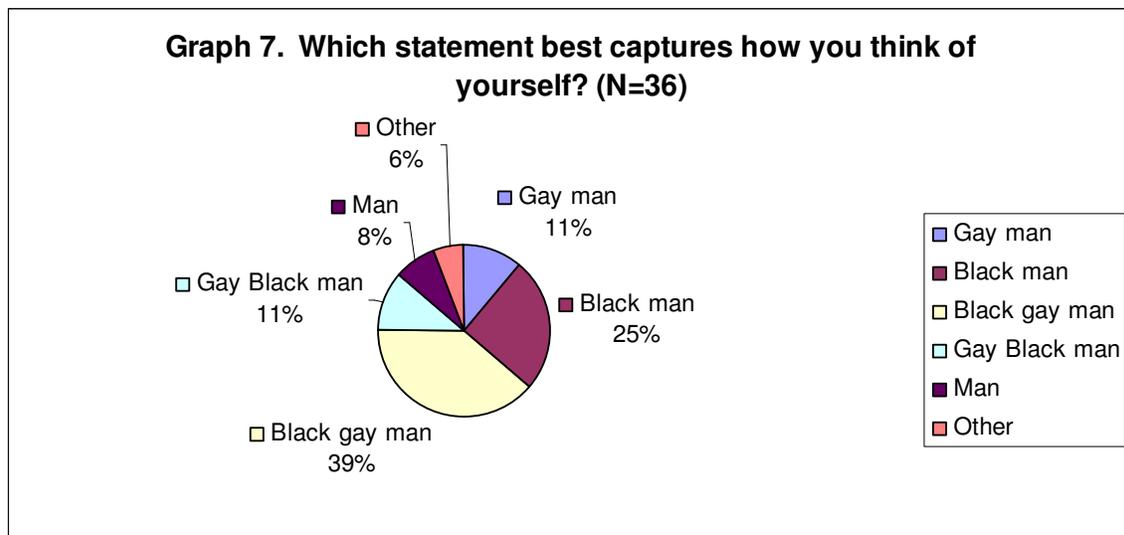
*Program Recognition*

Graph 6 describes respondents' familiarity with the "Many Men, Many Voices" intervention. When asked about the "Many Men, Many Voices" intervention, 73% of respondents reported that they had heard of the program, while 27% reported that they had not. Seventy percent of those who had not heard of the intervention live in Richland County.



*Sexual Identity*

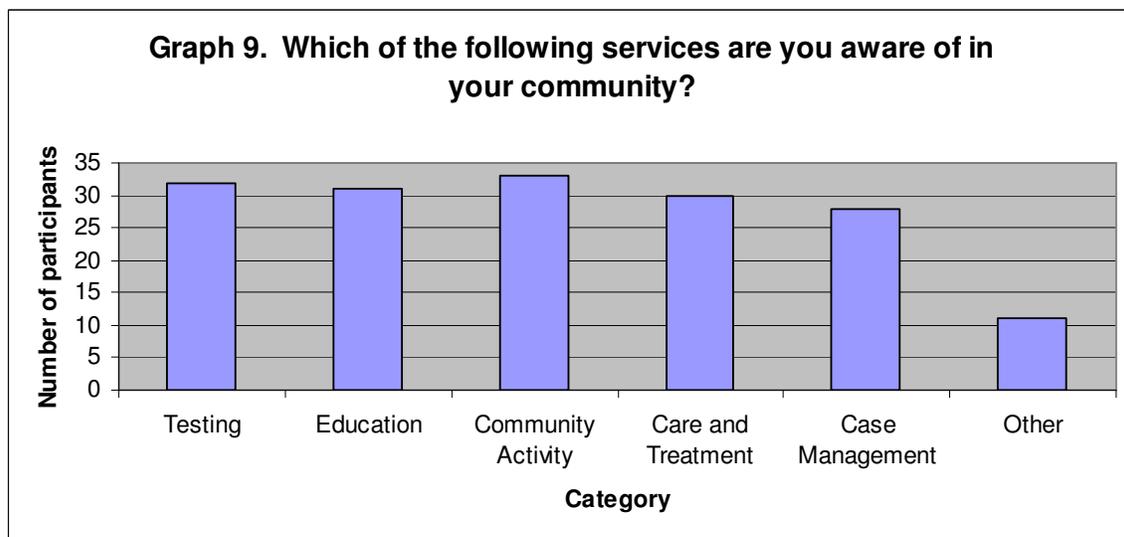
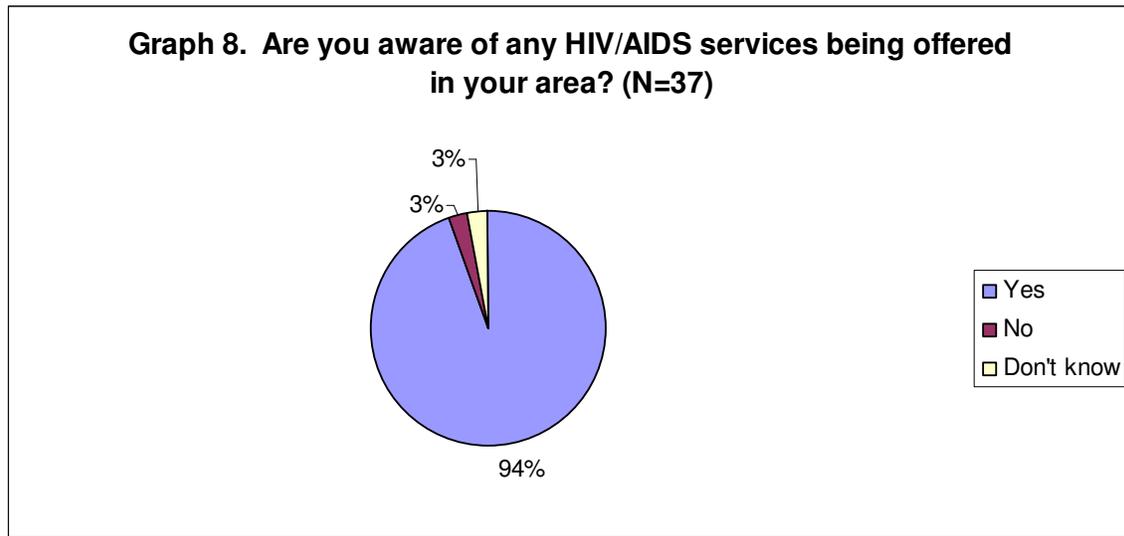
Respondents were asked to choose the statement that best described how they thought of themselves. Their responses are shown in Graph 7. More than a third (38.9%) chose the statement, “I am a Black gay man,” and 25% chose the statement, “I am a Black man.” The statements “I am a gay man” and “I am a gay Black man” were each chosen by 11.1% of respondents. Those who chose “other” identified themselves as “A man part Black and gay,” and “Same gender loving.”



*HIV/AIDS Services*

Graph 8 shows respondents’ awareness of HIV/AIDS services in their communities. The majority of participants reported being aware of HIV/AIDS services being offered in their area (94.6%). Graph 9 shows the services with which respondents were familiar. The services they were most aware of were: Community HIV/AIDS Activities (e.g. World AIDS Day), HIV Testing, and HIV/AIDS Education. The services they were least aware of were: Care and Treatment, and Case Management. Other services identified included

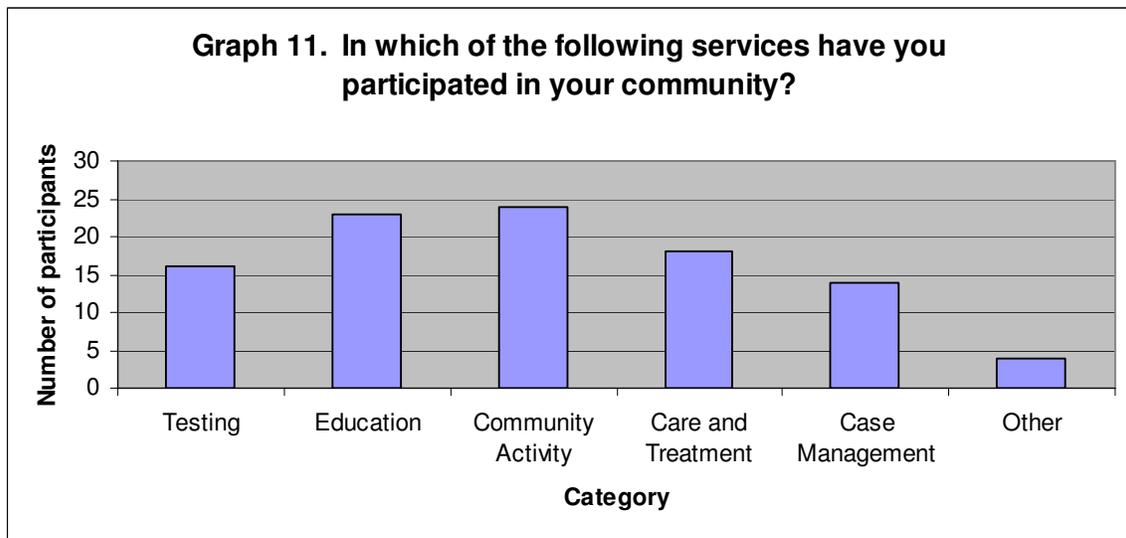
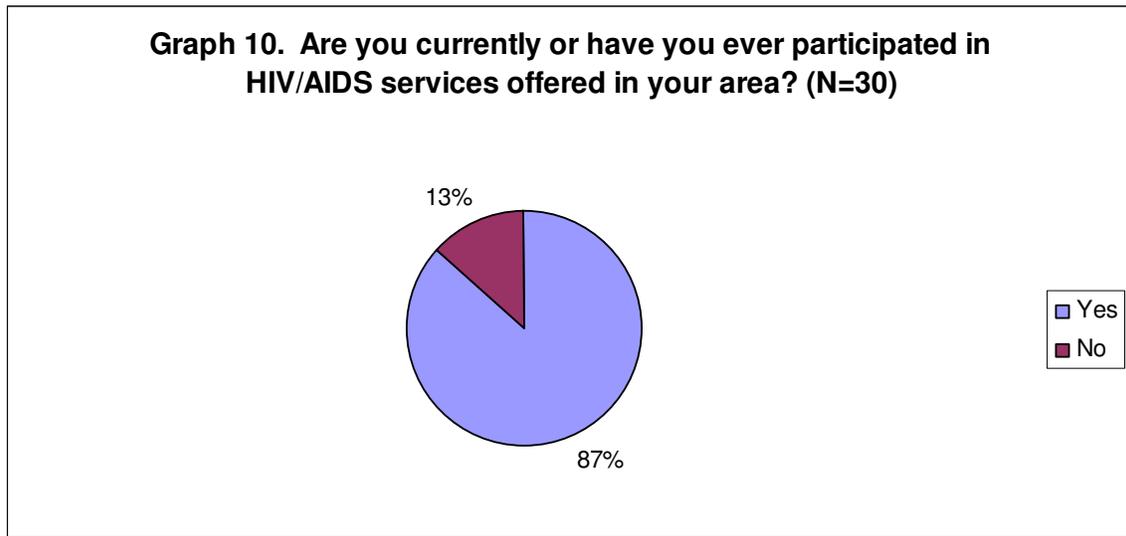
transportation, outreach, public health fairs, church HIV/AIDS ministries, interventions, and care teams.



Graph 10 shows respondents' participation in local HIV/AIDS services. Eighty-seven percent (87%) reported participating in HIV/AIDS services offered in their communities. Graph 11 illustrates the services in which respondents had participated. The services most widely participated in were: Community HIV/AIDS Activities, HIV/AIDS Education, and Care and Treatment. The services least participated in were Case Management and HIV Testing. Other activities listed included serving on the boards of AIDS Service Organizations or Community-Based Organizations; National Latino AIDS Awareness Day; Care Teams; and Housing.

Respondents who indicated no participation in HIV/AIDS services were asked to identify reasons why they were not participating. Four respondents answered this question, identifying a range of issues. These included a negative reputation of the local

HIV/AIDS community-based organization; stigma; fear of confidentiality being breached through participation; and lack of caring.



*Summary of Qualitative Items*

Respondents were asked about programs or services that they felt were needed for African American MSM in their communities. Nineteen respondents answered this question, and several themes emerged from their responses. A need for more education and prevention programs in general was expressed by many respondents. In particular, “Many Men, Many Voices” was mentioned as a program that needed to be promoted and implemented more frequently. Also, many responses were related to young AAMSM in their communities. There were recommendations for youth programs targeting not only HIV/AIDS awareness and education, but also life skills training through internships and experiential learning. Another theme that was discussed was the need for affirmation and acceptance on the part of AIDS service organizations.

Respondents were also asked about issues that they face as AAMSM in their respective communities. A major theme that emerged was the idea of fear and stigma. Fifteen respondents named fear and/or stigma as a major issue facing them in their communities. However, not all respondents indicated what kind of stigma they were referring to (stigma associated with being gay/bisexual, stigma associated with HIV infection). Homophobia was a theme that emerged that was closely related to fear and stigma issues. Several respondents mentioned internalized homophobia within the AAMSM community, as well as homophobia within the larger African American community. Issues of disclosure were also a major theme. Respondents were concerned about how to communicate with intimate partners about their HIV status, and the legal implications of not disclosing. Another theme that emerged was the idea of an AAMSM community identity. Three respondents identified issues around networking with other MSM and getting them to participate in AAMSM and/or HIV-related activities. Larger societal issues, such as socioeconomic status and access to services, were also mentioned.

### *Results of Discussion Forum*

The moderated discussion following the survey reinforced themes that emerged in the survey. When asked about problems facing AAMSM in their communities, there were two main categories of responses: issues relating to sexual identity and issues relating to HIV.

Issues relating to sexual identity included fear of losing family and friends after coming out, stereotypes, lack of safe spaces for AAMSM, division and lack of infrastructure among MSM, and lack of AAMSM leaders. Many of these issues are at the community level of influence, involving community norms and culture. Issues relating to HIV were more individual in nature and included fear of getting tested, fear of confidentiality breaches, insensitivity from medical professionals, and perceived economic costs of getting tested.

When asked about the perception of HIV as a problem in our community, the idea of generational differences was raised. Younger people were perceived to be less worried about the spread of HIV than the older generation, who has witnessed many of its members die. Younger people were perceived to enjoy taking risks and not be concerned about their partners' HIV/STD status. Also, new medications are helping people to live longer and manage the disease more effectively than before, so the immediate threat is not as visible as it once was.

A major theme that emerged from a discussion about HIV services is the lack of promotion of health and wellness programs among AAMSM communities. Participants mentioned word of mouth as a primary mode of advertising, pointing out a lack of large media promotion (billboards, public service announcements, etc.). Some called for more aggressive campaigns beyond World AIDS Day and National Testing Day. There was disagreement about how community-based organizations and AIDS service organizations should market themselves; some agencies have removed any mention of HIV/AIDS or "gay" from their name and signage in an effort to draw in more people, while others

disagreed with that approach because it promotes the homophobia and stigma that is so pervasive in communities.

Participants gave several reasons for lack of AAMSM participation in programs, including fear of getting tested, fear of being “outed,” ignorance, fear of the ramifications of a positive result, religious norms, and division within AAMSM communities. Generational gaps were once again discussed, citing that young AAMSM have not been properly engaged in the development and implementation of HIV prevention programs. Young AAMSM were also mentioned as the targets of “chicken hawks,” or older men who seek out younger men as sexual partners. This was seen as contributing to feelings of mistrust among AAMSM and lack of a cohesive community identity.

Participants offered solutions to the challenges in engaging the AAMSM community in prevention programs as well. These solutions fell into two major categories: community factors and structural factors. Community factors included an increase in affirmation and support among AAMSM, with an emphasis on learning how to foster honesty, healthy relationships, and support. Several participants discussed the importance of valuing oneself and others, and the need for respect. Structural factors included a call for an AAMSM resource center similar to the Women’s Resource Center, and the development of a strong network among AAMSM.

#### Conclusions and Recommendations

The results of this study provide some direction for future assessment and activities. Young AAMSM were a population of concern to many who participated in the forum. Participants expressed concern about their potential risk factors and challenges in recruiting them to participate in HIV prevention programs. This was reinforced in the fact that young AAMSM participation in the forum itself was low. Future programs should place special emphasis on determining the unique needs of young AAMSM as well as identifying young AAMSM to serve as peer health educators and recruiters for prevention programs.

Another area of focus is the concept of an AAMSM community in the state. The ability of AAMSM to form a cohesive community is linked to the concept of AAMSM identity. Participants reported a number of different identity labels, and such a diversity of labels can sometimes hinder group cohesion. Therefore, prevention programs should be cognizant of the ways in which AAMSM identify themselves and be as inclusive as possible in their program development and marketing.

In addition to addressing the specific needs of AAMSM in their respective communities, prevention programs should also endeavor to address stigma and homophobia in the larger African-American community. The majority of participants indicated that stigma, fear, and homophobia were major issues that needed to be addressed both in prevention programs and in the community. Developing initiatives to impact stigma and homophobia, coupled with the development of “safe spaces” for AAMSM, may foster more trust and validation among AAMSM and consequently increase participation in HIV prevention programs.

There were several limitations to this study. First, the small sample size (n=37) makes it difficult to generalize these results to the statewide AAMSM population. Second, the majority of participants were attending the SC HIV/STD Conference, which caters mainly to service providers; the general AAMSM population representation was not as high. Also, the majority of participants were HIV-positive, a statistic that is not representative of the state's AAMSM population. The low percentage of participants who were "young AAMSM" has also been identified as a limitation.

Further study should be conducted to determine the needs of AAMSM statewide. Because there are four sites across the state that have been identified to target AAMSM in their respective cities, these sites should also be utilized to access the target population for participation in focus groups. Participants at each site should be divided into two groups—younger AAMSM ages 18-25, and AAMSM 26 and older. The results of these focus groups can be used to inform the development of HIV prevention programs statewide, as well as unique characteristics specific to each geographic location.

Stacy W. Smallwood, MPH  
January 31, 2008

**HIV/STD/Hepatitis Prevention, Care and Support, and Other Services\* (as of 6/30/09)**

County	Health Department Services													CDC Funded Activities 04012 (HIV Prevention)		CDC Funded Activities 07768				
	DHEC Health Region	DHEC Clinic-Based HIV Counseling, Testing and Referral (CTR) Services	DHEC Rapid HIV Testing	DHEC HIV/STD Partner Services (PS)	DHEC HIV Prevention Health Education/ Risk Reduction (HEPR) Services	DHEC Comprehensive Risk Counseling/ Services (CRCS)	DHEC STD Screening & Treatment Services	DHEC Family Planning HIV Services (Title X Funding)	DHEC Adult Viral Hepatitis Vaccination Initiative	DHEC Viral Hepatitis C Testing	DHEC TB Control Programs	DHEC Training and Capacity Building Assistance	Community-Based Building	Community-Based CTR	Community-Based Health Education and Risk Reduction Service*	Perinatal Prevention Program	HIV Expanded Testing in Hospital Settings	HIV Expanded Testing in CBO Settings	HIV Prevention MSM Supplemental	CDC Directly Funded CBOs
Abbeville	1	X		X	A	A	X		X	X	X	A								
Aiken	5	X		X	X	A	X		X	X	X	A								
Allendale	5	X		X	A	A	X		X	X	X	A								
Anderson	1	X	X	X	X	X	X		X	X	X	A	A	A						
Bamberg	5	X		X	A	A	X		X	X	X	A		A						
Barnwell	5	X		X	A	A	X		X	X	X	A								
Beaufort	8	X		X			X		X	X	X	A	X	X						
Berkeley	7	X		X	A	A	X		X	X	X	A		A						
Calhoun	5	X		X	A	A	X		X	X	X	A		A						
Charleston	7	X	X	X	X	X	X	X	X	X	X	A	X	X	X	X				
Cherokee	2	X		X	A	A	X		X	X	X	A	A	A						
Chester	3	X		X			X		X	X	X	A		A						
Chesterfield	4	X		X	A		X		X	X	X	A								
Clarendon	4	X		X	A	A	X		X	X	X	A								
Colleton	8	X		X			X		X	X	X	A		A						
Darlington	4	X		X	A	A	X		X	X	X	A								
Dillon	4	X		X	A	A	X		X	X	X	A								
Dorchester	7	X		X	A	A	X		X	X	X	A		A						
Edgefield	1	X		X	A	A	X		X	X	X	A								
Fairfield	3	X		X	A	A	X		X	X	X	A		A						
Florence	4	X		X	X	X	X		X	X	X	A					X	X		
Georgetown	6	X		X			X		X	X	X	A		A						
Greenville	2	X	X	X	X	X	X		X	X	X	A	X	X	X	X				
Greenwood	1	X		X	A	A	X		X	X	X	A								
Hampton	8	X		X			X		X	X	X	A	X	X						
Horry	6	X		X			X		X	X	X	A		X						
Jasper	8	X		X			X		X	X	X	A		A						
Kershaw	4	X		X	A	A	X		X	X	X	A								
Lancaster	3	X		X			X		X	X	X	A		A						
Laurens	1	X	X	X	X	X	X		X	X	X	A								
Lee	4	X		X	A	A	X		X	X	X	A								
Lexington	3	X		X	A	A	X		X	X	X	A		A						
Marion	4	X		X	A	A	X		X	X	X	A								
Marlboro	4	X		X	A		X		X	X	X	A								
McCormick	1	X		X	A	A	X		X	X	X	A								
Newberry	3	X		X	A	A	X		X	X	X	A		A						
Oconee	1	X		X	A	A	X		X	X	X	A		A						
Orangeburg	5	X	X	X	X	X	X	X	X	X	X	A	X	X	X	X				
Pickens	2	X		X	A		X		X	X	X	A	A	A						
Richland	3	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X			X
Saluda	1	X		X	A	A	X		X	X	X	A								
Spartanburg	2	X	X	X	X	X	X		X	X	X	A	X	X						
Sumter	4	X		X	X	X	X	X	X	X	X	A		X						
Union	2	X		X	A	A	X		X	X	X	A	A	X						
Williamsburg	6	X		X			X		X	X	X	A		A						
York	3	X		X			X		X	X	X	A		X						

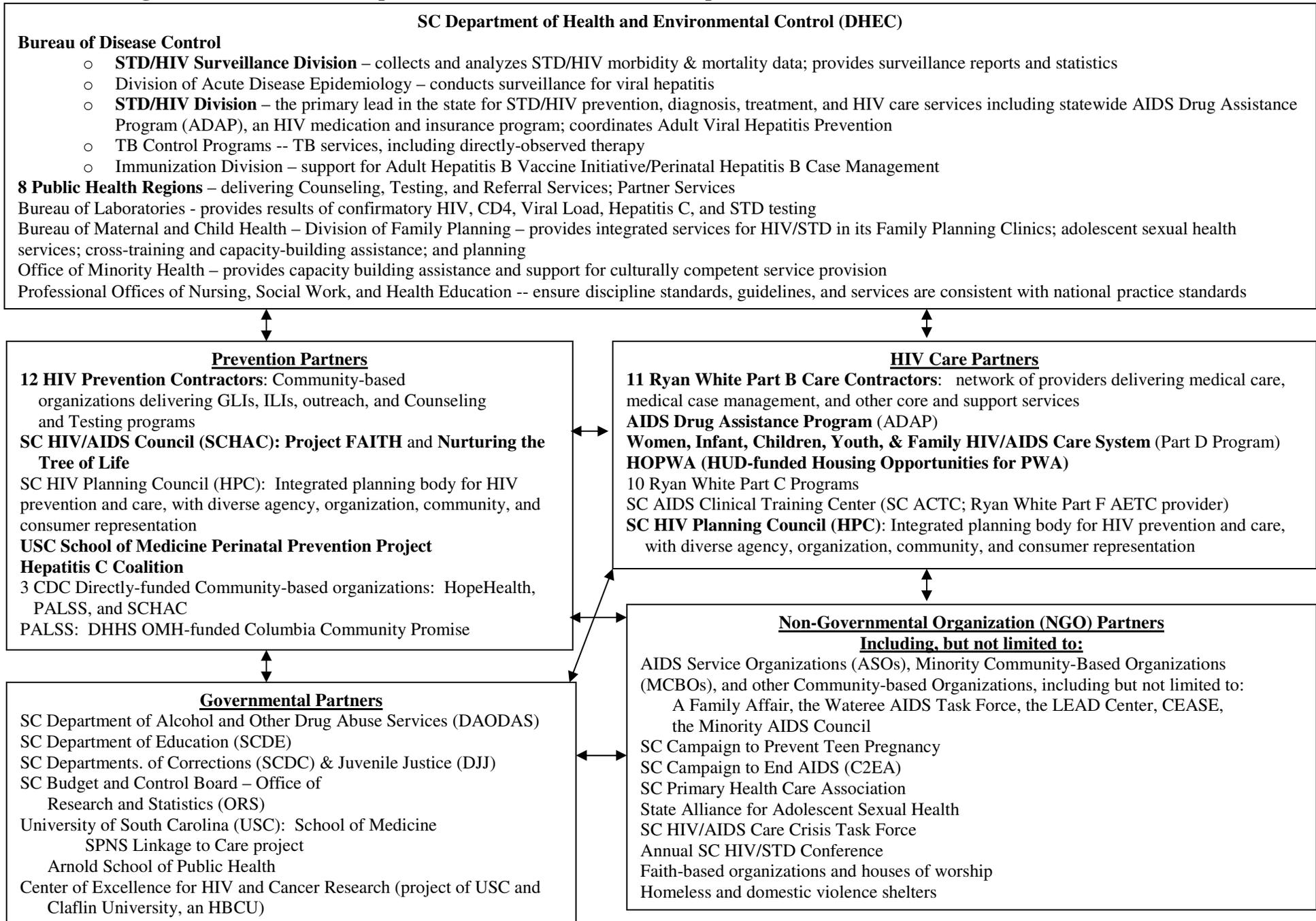
\*X=counties where services are provided in that county; A=services are available to residents but provided outside the county

**HIV/STD/Hepatitis Prevention, Care and Support and Other Services\* (continued)**

		State-funded Activities			SAMHSA	HIV Care and Support Services						Other Prevention Initiatives		
		DHEC Health Region	SCHAC Project FAITH (State funding)	SCHAC Nurturing the Tree of Life		DAODAS Early Intervention Services (SAMHSA funding)	Ryan White Part B: Care and Medical Case Management	Ryan White ADAP	Ryan White Part C: Early Intervention Services (HRSA funding to CHC)	Ryan White Part D: Women, Infants, Children, and Family Services	Ryan White Part F: SC AIDS Clinical Training Center	HOPWA (HUD funding)	SPNS/USC SOM Linkage to Care Project	SCCTTP Teen Pregnancy to Care Prevention
Abbeville	1				A	X	A	A	A	X			X	
Aiken	5	X		X	X	X	A	A	A	X		X	X	X
Allendale	5				A	X	A	A	A	X			X	X
Anderson	1	X		X	A	X	A	A	A	X		X	X	X
Bamberg	5	X	X	X	A	X	A	A	A	X			X	X
Barnwell	5				A	X	A	A	A	X		X	X	
Beaufort	8	X			X	X	X	A	A	X		X	X	
Berkeley	7				A	X	A	A	A	X		X	X	
Calhoun	5			X	A	X	A	A	A	X			X	
Charleston	7	X		X	X	X	X	X	A	X		X	X	X
Cherokee	2				A	X	A	A	A	X			X	
Chester	3				A	X	A	A	A	X			X	
Chesterfield	4	X			A	X	X	A	A	X		X	X	
Clarendon	4				A	X	A	A	A	X		X	X	
Colleton	8				A	X	X	A	A	X		X	X	
Darlington	4				A	X	X	A	A	X			X	
Dillon	4			X	A	X	A	A	A	X			X	X
Dorchester	7				A	X	A	A	A	X			X	X
Edgefield	1				A	X	A	A	A	X			X	
Fairfield	3				A	X	A	A	A	X			X	X
Florence	4	X		X	X	X	X	A	A	X			X	X
Georgetown	6	X			A	X	A	A	A	X			X	
Greenville	2	X		X	X	X	X	X	A	X			X	X
Greenwood	1				X	X	A	A	A	X			X	X
Hampton	8				X	X	X	A	A	X		X	X	
Horry	6	X		X	X	X	A	A	A	X			X	
Jasper	8				A	X	X	A	A	X			X	X
Kershaw	4	X			A	X	A	A	A	X		X	X	X
Lancaster	3	X			A	X	A	A	A	X			X	X
Laurens	1				A	X	A	A	A	X			X	
Lee	4				A	X	A	A	A	X			X	
Lexington	3	X		X	A	X	A	A	A	X			X	
Marion	4	X		X	A	X	A	A	A	X			X	
Marlboro	4	X		X	A	X	A	A	A	X		X	X	
McCormick	1				A	X	A	A	A	X			X	X
Newberry	3				A	X		A	A	X			X	
Oconee	1			X	A	X	A	A	A	X			X	X
Orangeburg	5	X	X	X	X	X	A	A	A	X			X	X
Pickens	2				A	X	A	A	A	X		X	X	
Richland	3	X	X	X	X	X	X	X	X	X	X	X	X	X
Saluda	1				A	X	A	A	A	X			X	
Spartanburg	2	X		X	X	X	X	A	A	X		X	X	X
Sumter	4	X	X	X	A	X	A	A	A	X		X	X	
Union	2				A	X	A	A	A	X		X	X	
Williamsburg	6				A	X	A	A	A	X		X	X	X
York	3			X	X	X	X	A	A	X		X	X	

\*X=counties where services are provided in that county; A=services are available to residents but provided outside the county

This figure (**Appendix E**) presents an **Overview of South Carolina’s Coordination and Linkage Partners**. **Partners/Organizations noted in bold print receive DHEC funds for HIV prevention and/or care services.**



**Health Department-Based HIV Prevention Program Models By Region  
CY2009**

<b>Region w/Counties</b>	<b>Funded Program Models</b>
<b>1. Abbeville, Anderson, Edgefield, Greenwood, Laurens, McCormick, Oconee, Saluda</b>	Counseling, Testing and Referral Services (CTRS) Partner Services (PS) Comprehensive Risk Counseling and Services (CRCS) Individual Level Intervention (ILI)
<b>2. Cherokee, Greenville, Pickens, Spartanburg, Union</b>	Counseling, Testing and Referral Services (CTRS) Partner Services (PS) Comprehensive Risk Counseling and Services (CRCS) Individual Level Intervention (ILI) American Red Cross (GLI) SISTA (GLI) VOICES/VOCES (GLI)
<b>3. Chester, Fairfield, Lancaster, Lexington, Newberry, Richland, York</b>	Counseling, Testing and Referral Services (CTRS) Partner Services (PS) Comprehensive Risk Counseling and Services (CRCS) Individual Level Intervention (ILI)
<b>4. Chesterfield, Clarendon, Darlington, Dillon, Florence, Kershaw, Lee, Marion, Marlboro, Sumter</b>	Counseling, Testing and Referral Services (CTRS) Partner Services (PS) Comprehensive Risk Counseling and Services (CRCS) Individual Level Intervention (ILI) American Red Cross (GLI) VOICES/VOCES (GLI) Outreach
<b>5. Aiken, Allendale, Bamberg, Barnwell, Calhoun, Orangeburg</b>	Counseling, Testing and Referral Services (CTRS) Partner Services (PS) Comprehensive Risk Counseling and Services (CRCS) Individual Level Intervention (ILI) American Red Cross (GLI) SISTA (GLI) VOICES/VOCES (GLI)
<b>6. Georgetown, Horry, Williamsburg</b>	Counseling, Testing and Referral Services (CTRS) Partner Services (PS)
<b>7. Berkeley, Charleston, and Dorchester</b>	Counseling, Testing and Referral Services (CTRS) Partner Services (PS) Comprehensive Risk Counseling and Services (CRCS) Individual Level Intervention (ILI) American Red Cross (GLI)
<b>8. Beaufort, Colleton, Hampton, Jasper</b>	Counseling, Testing and Referral Services (CTRS) Partner Services (PS)

**Funded HIV Prevention Program Models by Organization  
CY2009**

<b>Organization</b>	<b>Funded Program Models*</b>
1. ACCESS Network, Inc. <b>(Beaufort, Colleton, Hampton, Jasper)</b>	Community-Based Counseling and Testing plus Outreach
2. Acercamiento Hispano/Hispanic Outreach <b>(Fairfield, Lexington, Newberry, Richland, Saluda)</b>	Community-Based Counseling and Testing plus Outreach VOICES/VOCES
3. AID Upstate, Inc. <b>(Anderson, Greenville, Oconee, Pickens)</b>	Community-Based Counseling and Testing plus Outreach** Healthy Relationships Individual Level Intervention Many Men, Many Voices+ Comprehensive Risk Counseling and Services (CRCS) VOICES/VOCES
4. CARETEAM, Inc. <b>(Georgetown, Horry, Williamsburg)</b>	Community-Based Counseling and Testing plus Outreach Individual Level Intervention
5. Catawba Care Coalition <b>(Chester, Lancaster, York)</b>	Community-Based Counseling and Testing plus Outreach** Individual Level Intervention (Fundamentals of Prevention Counseling Model and Project RESPECT Model) SISTA VOICES/VOCES
6. HopeHealth <b>(Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro)</b>	Outreach for Community-Based Counseling and Testing Many Men, Many Voices (3MV)++ SISTA VOICES/VOCES
7. Lowcountry AIDS Services <b>(Berkeley, Charleston, and Dorchester)</b>	Community-Based Counseling and Testing plus Outreach** Many Men, Many Voices+ Mpowerment SISTA
8. LRADAC <b>(Lexington, Richland)</b>	VOICES/VOCES
9. OCAB CAA, Inc. <b>(Bamberg, Calhoun, Orangeburg)</b>	Community-Based Counseling and Testing plus Outreach VOICES/VOCES
10. PALSS <b>(Lexington, Richland)</b>	Community-Based Counseling and Testing plus Outreach** Healthy Relationships Partners in Prevention Female Version
11. SADAC <b>(Cherokee, Spartanburg, Union)</b>	Community-Based Counseling and Testing plus Outreach SISTA VOICES/VOCES
12. SCHAC	Community-Based Counseling and Testing plus Outreach+ Many Men, Many Voices+

\*All Individual Level Interventions are funded to be delivered using the Fundamentals of Prevention Counseling model, except at Catawba Care Coalition, which is using this model as well as the Project RESPECT model. \*\*Outreach includes services delivered via the Internet in addition to face-to-face interventions. +Indicates funding provided from DHEC's Expanded Testing Grant for community education targeted to African American MSM. ++Indicates funding provided from DHEC's MSM Supplemental Grant for community education targeted to African American MSM.

Created December 12, 2005/Revised March 16, 2009.

# South Carolina HIV Services Network Provider Chart (as of 6/01/09)

**SC Department of Health & Environmental Control**

**Ryan White Part B Service Providers  
(RW core services/specialty care\*)  
Target Pop: Adults/Older Youth**

**Regional HIV  
Pediatric/Family providers  
(RW core services\*)**

**Ryan White Part C Service Providers  
(RW core services/primary care\*)  
Target Pop: Adults/Older Youth**

- AID Upstate\*\*** (Greenville, Oconee, Pickens & Anderson)
- ACCESS Network (Beaufort, Jasper, Colleton & Hampton)
- CARETEAM (Horry, Williamsburg & Georgetown)
- Catawba Care Coalition (York, Chester & Lancaster)
- HopeHealth (Chesterfield, Darlington, Marlboro, Dillon, Marion & Florence)
- HopeHealth Edisto (Orangeburg, Bamberg & Calhoun)
- HopeHealth Lower Savannah (Aiken, Barnwell & Allendale)
- University of South Carolina** (Richland, Lexington, Fairfield, Newberry, Kershaw, Lee, Sumter & Clarendon)
- Piedmont Care (Spartanburg, Cherokee & Union)
- MUSC Trident Care Coalition/Lowcountry AIDS\*\* Services** (Charleston, Berkeley & Dorchester)
- Upper Savannah Care Services (Abbeville, Laurens, Greenwood, Saluda, McCormick & Edgefield)

**Regional HIV  
Pediatric/Family providers  
(RW core services\*)**

- Greenville Hospital System – Pediatric Infectious Disease** (Greenville)
- University of South Carolina School of Medicine – Dept. Pediatrics** (Columbia)
- Medical University of South Carolina (MUSC)– Pediatric Infectious Disease Dept.** (Charleston)

- Beaufort Jasper Hampton Comprehensive Health Services, Inc. (Ridgeland)
- CareSouth Carolina (Society Hill)
- Catawba Care Coalition (Rock Hill)
- HopeHealth (Florence)
- Low Country Health Care Systems (Fairfax)
- New Horizon Family Health Services, Inc. (Greenville)
- Richland Community Health Care Association (Columbia)
- Roper Care Alliance (Charleston)
- Sandhills Medical Foundation, Inc. (Jefferson)
- Spartanburg Regional Healthcare System (Spartanburg)

**\*Core services: medical, medications, oral health, substance abuse, mental health, case management; \*\*Part D Consumer Advocacy**

↔ Indicates joint family

**Text in Bold Type Indicates Part D–funded Service Providers**

# NEEDS ASSESSMENT FOR RAPID HIV TESTING IMPLEMENTATION IN THE HEALTH DEPARTMENT

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Prepared for the South Carolina Department of Health  
and Environmental Control (DHEC)

November 2008

By the Center for Applied Research and Evaluation Studies  
Department of Family and Preventive Medicine  
Emory University School of Medicine



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## Background

This needs assessment was a collaboration between the Southeast AIDS Training and Education Center (SEATEC) and the South Carolina Department of Health and Environmental Control (DHEC). The purpose was to assess the training needs of DHEC personnel regarding the implementation of rapid HIV testing. With input from DHEC and the South Carolina HIV/AIDS Clinical Training Center, the needs assessment survey was modified from previous assessments conducted by SEATEC. The survey instrument was finalized in July 2008 and was completed by 181 DHEC personnel in eight regions across South Carolina in August 2008. Data entry and analysis was performed by SEATEC. Descriptive results of the survey are included in this report. A copy of the survey instrument is included as a reference.

## Region

	Percent	Number of Respondents
1	6.6	12
2	11.6	21
3	16.6	30
4	7.7	14
5	9.9	18
6	7.2	13
7	10.5	19
8	8.3	15
Region unreported	21.5	39
<b>Total</b>	<b>100%</b>	<b>181</b>

### 1. What is your primary position as a health care worker?

	Percent	Number of Respondents
MD	0.6	1
NP	8.8	16
RN	60.9	109
LPN	1.7	3
Lab/Phlebotomist	5.7	10
Disease Investigation Specialist	12.1	23
Social Worker	4.4	8
Health Educator	3.3	6
Other*	2.5	5
<b>Total</b>	<b>100%</b>	<b>181</b>

\*Other write-ins: APRN, CNA, human services coordinator

### 2a. What is your age?

	Percent	Number of Respondents
Under 25	1.2	2
25-39	27.1	46
40-54	41.8	71
55+	30.0	51
<b>Total</b>	<b>100%</b>	<b>170</b>

**2b. What is your gender?**

	Percent	Number of Respondents
Male	7.2	13
Female	92.8	167
Transgender	--	--
<b>Total</b>	<b>100%</b>	<b>180</b>

**2c. Are you of Hispanic, Latino/a or Spanish origin?**

	Percent	Number of Respondents
Yes	2.2	4
No	97.8	177
<b>Total</b>	<b>100%</b>	<b>181</b>

**2d. What is your racial background?**

	Percent	Number of Respondents
American Indian/Alaskan Native	--	--
Asian	0.6	1
Black or African-American	23.8	43
Native Hawaiian/Other Pacific Islander	0.6	1
White	72.9	132

**3. How many years have you been working in STD/Family Planning?**

	Percent	Number of Respondents
0-10	63.3	112
11-20	23.7	42
21-30	10.2	18
31-40	2.8	5
<b>Total</b>	<b>100%</b>	<b>177</b>

**4. During your employment, have you received any formal training on HIV?**

	Percent	Number of Respondents
Yes	82.2	143
No	17.8	31
<b>Total</b>	<b>100%</b>	<b>174</b>

**5. Which educational methods do you find useful for receiving continuing professional educational/training in HIV/STD issues?**

	Percent	Number of Respondents
Clinical case discussions	49.7	90
Clinical practicum	30.4	55
Skill- building sessions	33.7	61
Lecture –based/ didactic presentation	61.9	112
Interactive small group discussion	44.2	80
Panel discussion	20.4	37
Internet-based learning	30.4	55
Role-playing sessions	23.2	42
Self-teaching/ home study/ reading	25.4	46
Video/ audio conferencing	39.8	72
Videotapes/ CD –ROM	37	67
Other*	3.9	7

\*Other write-ins: discipline specific, statewide sharing, podcast, webinar, preventive health maintenance courses

**6. Please indicate which HIV/AIDS clinical management training topics would be of interest to you.**

	Percent	Number of Respondents
None at this time	8.8	16
Rapid HIV testing	44.2	80
Pre-test counseling	34.8	63
Post-test counseling	43.1	78
Primary HIV infection	29.8	54
Clinical manifestations of HIV/AIDS	37.6	68
Oral manifestations of HIV/AIDS	32	58
State law and HIV	47	85
Ryan White care services (ADAP)	29.3	53
Antiretroviral treatment (ART)	26.5	48
Referral sources for HIV/AIDS patients	43.6	79
HIV/AIDS and street drug interactions	30.4	55
HIV/AIDS drug interactions	26	47
Opportunistic infections	33.1	60
Post exposure prophylaxis	29.8	54
Other*	3.3	6

\*Other write-ins: explanation of lab work, how to tell someone they have HIV, pre-existing conditions that may cause false + for HIV

**7. Please indicate which HIV psychosocial training topics would be of interest to you.**

	Percent	Number of Respondents
None at this time	23.2	42
Cultural competency	19.9	36
Substance use/abuse	45.9	83
Other*	1.1	2
Multiple diagnoses (i.e. HIV and mental and addiction)	52.5	95
Psychiatric	38.1	69

\*Other write-ins: MSM-teen populations (HIV) pre+ post test counseling

**8. Which of the following factors limit your ability to participate in HIV continuing professional education/ training programs?**

	Percent	Number of Respondents
I do not need training	2.8	5
Personal interest in topic	10	5.5
Time away from practice	46.4	84
Funds	34.3	62
Inconvenient training dates/times	22.1	40
Don't know where to get training	6.1	11
Support from administration	16	29
Support from peers	2.2	4
Inconvenient training location	30.9	56
Other*	7.7	14

\*Other write-ins: heavy work load, limited clinical practice, offered to DIS/HIV staff only, plans to retire at the end of the year so part time, work hourly only, work only part time

**9. At present, what kinds of HIV test are used routinely (available each day) by your health department?**

	Percent	Number of Respondents
Conventional blood test (blood draw, need to return on a later date for result)	98.8	179
Conventional oral test (such as Orasure-oral fluid test, need to return on a later date for result)	1.1	2
Rapid test (such as Oraquick- get result the same day)	--	--
Other	--	--
Don't know	--	--

**10. Consider current HIV testing methods available at your facility, how often do you offer HIV testing?**

	Percent	Number of Respondents
I offer it to all patients	71	134
I offer it only to patients with history of STDs	15.5	28
I offer it only to patients who appear to be HIV infected	3.9	7
I offer it only if the patient request it	11	20
I don't offer it to patients	5	9
Other*	11.6	21

\*Other write-ins: annual exam and pregnancy test, any patient asking STD blood work, due to time only by request, I do it when I see patients, I do not every day, I do not draw blood for the test, I offer even if they've never had an STD, I offer to most FP and all STD, I offer to patients that come for yearly check up, if patient is HIV+ I refer to Ryan White nurse, if patient ask I offer, nurses address in clinic, offer to all STD patients, offer to all TB patients, offer to all clients with high risk factors, offered to family planning/STD patients, used a screening tool in TB programs

**11. If rapid HIV testing is available at your health department, how often do you offer it to patients?**

	Percent	Number of Respondents
I offer it to all patients	12.2	22
I offer it only to patients with history of STDs	6.1	11
I offer it only to appear to be HIV infected	3.9	7
I offer it only if the patient request it	8.8	16
I don't offer it to patients	12.7	23
Rapid HIV testing not available at my health department	30.9	56
Other*	18.2	33

\*Other write-ins: all appropriate staff put in place, always available but offered rarely, certain nurses offer it every week, clients at high risk, contact to HIV, employees exposed, FP patients during IE and AE, generally meet with patients after testing, high risk ENT from DIS, high risks, HIV contact, I would offer if wanted rapid results, limited staff, need to refer FP/STD clients to HIV nurse/HIV program, offered at local community health departments, once a week, only people able to understand same day results, only exposed employee (3), only people mentally stable enough to receive same, on Wednesdays, when nurses order it, when social workers are available.

**12. Which of the following factors prevent you from offering rapid HIV testing within the health department setting?**

	Percent	Number of Respondents
Time to complete test	18.8	34
Time to give results	18.8	34
Concern with follow –up	12.2	22
Do not think HIV testing is appropriate in the HD setting	2.2	4
Payment/cost for HIV testing	5.5	10
Other*	24.9	45
Testing resources not available at my facility	36.5	66
Concern with providing results to patient	17.7	32
Space availability/confidential location	6.6	12
Comfort with topic	7.2	13
Unclear referral process for persons testing positive	7.2	13

\*Other write-ins: all staff available, department head, do not have rape test, handled by RN, lab director not satisfied with Ora-quick method, lab personnel do not offer the test, MSW staff may not be present if needed, no staff trained—two-day training prohibit staff attendance, not approved by lab director, not available (5), not offered to FP and STD programs, not ready for, not trained, offered at MD office, personnel, protocol- cannot test clients unless they are at high risk, provide education only, seeing patients continuously, staffing (3), strong social work team need to be put in place, these nurses have never been taught, time (2), unsure why it is not offered, we have a Ryan White nurse that handles HIV concerns, will be soon.

**13. How comfortable do you feel performing the following action in a professional setting?**

	Very Comfortable	Comfortable	Somewhat Comfortable	Uncomfortable	Very Uncomfortable
Offering the rapid test for HIV	27.6	9.4	19.4	11	21.5
Performing rapid test for HIV	19.3	8.3	15.5	16	29.3
Reading results of a rapid test for HIV	21.5	8.3	16.6	14.4	27.1
Giving a preliminary positive HIV test result	19.9	10.5	18.2	18.2	26
Providing medical referrals to someone with HIV/AIDS	29.3	12.7	17.7	16	17.1
Reporting HIV cases to appropriate agencies	37	13.3	16	13.3	13.3

	Very Comfortable	Comfortable	Somewhat Comfortable	Uncomfortable	Very Uncomfortable
Referring HIV patients to Partner Counseling Referral Services (PCRS)	29.9	11.6	14.4	17.1	17.7
Referring HIV patients to cases management & prevention services	31.5	13.3	16	17.1	15.5

**14. Are you aware of the CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health–Care Settings that were published September 2006?**

	Percent	Number of Respondents
Yes	50.8	91
No	49.2	88
<b>Total</b>	<b>100%</b>	<b>179</b>

**15. Do these new recommendations make it more likely that you will offer HIV testing to patients within the health department setting?**

	Percent	Number of Respondents
Yes	77.1	64
No	22.9	19
<b>Total</b>	<b>100%</b>	<b>83</b>

**16. Do you feel that you have adequate resources to counsel and refer HIV+ patients based on their needs?**

	Percent	Number of Respondents
Yes	60.5	104
No	39.5	68
<b>Total</b>	<b>100%</b>	<b>172</b>

## 16a. Please list your top three needs to be met so you can adequately refer HIV+ patients:

Question 16a provided three blank spaces that were numbered one through three where respondents could list their top three needs in numerical order. Answers with “(2)” after the answer represent that more than one person wrote that answer. The number in between the parentheses is the number of people who wrote that answer. There were 49 respondents who filled out an answer for number one, 33 respondents for number two, and 20 respondents for number three. Below are the answers that were given by respondents

### Number one needs:

- A class on telling people they are HIV positive
- Clients need more resources for transportation
- Counseling for HIV clients (2)
- Designated person to test and for counseling
- Doctors/clinics
- Don't know resources
- Experience
- Have more staff (2)
- HIV disease process
- How to deal with situational cases from patients and families
- I need basic information on the disease
- I would like practice telling people diagnostic
- Inadequate space
- In-service
- Knowledge about available resources (3)
- Lack of social work in clinical settings
- Learn more about HIV rapid test (2)
- List of referrals (2)
- Limited resources
- More training (4)
- Need course on pre and post for HIV clients
- Need more education on HIV
- Need more referral services
- Need personal information on all documents
- Practice
- RN who are able to post test counsel HIV+ patients
- Social/caseworker (2)
- Update on information
- We have DIS counseling clients

### Number two needs:

- Addressing HIV issues
- Available medications
- Being able to counsel someone with a positive result
- Comfort level
- Community resources
- Designated funds
- Difficulty knowing how to test
- Don't offer rapid testing
- How to refer
- I'm only RN trained
- Increase knowledge
- Increase staffing

- Information on available resources (3)
- Information on adequate interpreting CD4/ viral load
- Interpretation of labs
- Lack of nursing staff
- Laws
- Learn more about post test counseling
- List of private infectious disease types
- Money, staff
- More post-test counseling and services
- Need coping education
- Need training and counseling skills
- New written materials appropriate for clients
- PCPs for high risk patients
- Protocol for follow up for HIV+ patients
- Provide education
- Retraining on rapid testing
- Sick patients don't want to be identified
- Transportation

### Number three needs:

- Appropriate resources in community
- Available HIV medications (2)
- Follow up instructions
- Increase staffing
- Lack of qualified individuals
- Learn more procedures
- Need care management services
- Need courier services
- Need education on what is next after diagnosis
- Need to be trained
- Need to know how to report results
- Observe HIV+ encounter/ results being given
- Proper referral steps
- Scheduling issues-decrease staff
- Social support
- Time out of clinic to prepare results
- What other testing to do with referral

**NEEDS ASSESSMENT FOR RAPID HIV TESTING IMPLEMENTATION IN THE HEALTH DEPARTMENT**

Region \_\_\_\_\_

1. What is your primary **position** as a health care worker (Select **ONE**)?  
 MD  NP  RN  LPN  Lab/Phlebotomist  Disease Investigation Specialist (DIS)  
 Social Worker  Health Educator  Other (specify) \_\_\_\_\_
2. Please provide the following demographic information: **(Items 2a-2d)**  
2a) What is your **age**? \_\_\_\_\_ (years)                      2b) What is your **gender**?  Male  Female  Transgender  
2c) Are you of **Hispanic, Latino/a or Spanish** origin?  Yes  No  
2d) What is your **racial background**? **[Please select all that apply]**  
 American Indian/Alaskan Native                       Native Hawaiian/Other Pacific Islander  
 Asian     White  
 Black or African-American
3. How many **years** have you been working in STD/Family Planning? \_\_\_\_\_ **[Please round up to the nearest whole year]**
4. During your employment, have you received any **formal training on HIV**?  Yes  No
5. Which **educational methods** do you find useful for receiving continuing professional education/training on HIV/STD issues? (Select **ALL** that apply)  
 Clinical case discussion     Internet-based learning  
 Clinical practicum     Role-playing sessions  
 Skill-building sessions     Self-teaching/home study/reading  
 Lecture-based/didactic presentation                                       Video/audio conferencing  
 Interactive small group discussion                                       Videotapes/CD-ROM  
 Panel discussion     Other (specify) \_\_\_\_\_
6. Please indicate which **HIV/AIDS clinical management training topics** would be of interest to you. (Select **ALL** that apply)  
 None at this time     Ryan White care services (ADAP)  
 Rapid HIV testing     Antiretroviral treatment (ART)  
 Pre-test counseling     Referral sources for HIV/AIDS patients  
 Post-test counseling     HIV/AIDS and street drug interactions  
 Primary HIV infection     HIV/AIDS drug interactions  
 Clinical manifestations of HIV/AIDS                                       Opportunistic infections  
 Oral manifestations of HIV/AIDS     Post exposure prophylaxis  
 State law and HIV     Other (specify) \_\_\_\_\_
7. Please indicate which **HIV psychosocial training topics** would be of interest to you. (Select **ALL** that apply)  
 None at this time     Multiple diagnoses (i.e. HIV and mental illness and addiction)  
 Cultural competency     Psychiatric sequelae of HIV/AIDS  
 Substance use/abuse  
 Other (Specify) \_\_\_\_\_
8. Which of the following factors **limit your ability to participate** in HIV continuing professional education/training programs? (Select **ALL** that apply)  
 I do not need training     Don't know where to get training  
 Personal interest in topic     Support from administration  
 Time away from practice     Support from peers  
 Funds     Inconvenient training location  
 Inconvenient training dates/times     Other (specify) \_\_\_\_\_
9. At present, what **kinds of HIV tests** are used routinely (available each day) by your Health Department?  
 Conventional blood test (blood draw, need to return on a later date for result)  
 Conventional oral test (such as OraSure - oral fluid test, need to return on a later date for result)  
 Rapid test (such as Oraquick – get result the same day)  
 Other (Please describe) \_\_\_\_\_  
 Don't know

10. Considering **current HIV testing methods available at your facility**, how often do you offer HIV testing?  
(Select **ALL** that apply)
- I offer it to all patients
  - I offer it only to patients with a history of STDs
  - I offer it only to patients who appear to be HIV infected
  - I offer it only if the patient request it
  - I don't offer it to patients
  - Other (specify)\_\_\_\_\_
11. If **rapid HIV testing** is available at your Health Department, how often do you offer it to patients? (Select **ALL** that apply)
- I offer it to all patients
  - I offer it only to patients with a history of STDs
  - I offer it only to patients who appear to be HIV infected
  - I offer it only if the patient requests it
  - I do not offer it to patients
  - Rapid HIV testing not available at my Health Department
  - Other (specify)\_\_\_\_\_
12. Which of the following factors **prevent** you from offering **rapid HIV testing** within the Health Department Setting?  
(Select **ALL** that apply)
- Time to complete test
  - Time to give results
  - Concern with follow-up
  - Do not think HIV testing is appropriate in the HD Setting
  - Payment/Cost for HIV test
  - Other (specify)\_\_\_\_\_
  - Testing resources not available at my facility
  - Concern with providing results to patient
  - Space availability/Confidential location
  - Comfort with topic
  - Unclear referral process for persons testing positive

13. How **comfortable** do you feel performing the following actions in a professional setting?

	Very Comfortable		Somewhat Comfortable		Very Uncomfortable
a) Offering the rapid test for HIV	1	2	3	4	5
b) Performing rapid test for HIV	1	2	3	4	5
c) Reading results of a rapid test for HIV	1	2	3	4	5
d) Giving a preliminary positive HIV test result	1	2	3	4	5
e) Providing medical referrals to someone with HIV/AIDS	1	2	3	4	5
f) Reporting HIV cases to appropriate agencies	1	2	3	4	5
g) Referring HIV patients to Partner Counseling Referral Services (PCRS)	1	2	3	4	5
h) Referring HIV patients to case management & prevention services	1	2	3	4	5

14. Are you aware of the CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings that were published September 2006?  
 Yes                       No → **Go to Question 16**

15. Do these new recommendations make it more likely that you will offer HIV testing to patients within the Health Department setting?  
 Yes                       No

16. Do you feel that you have adequate resources to counsel and refer HIV+ patients based on their needs?  
 Yes → **Go to END**                       No

16a. If no to Question 16 please list your top three needs to be met so you can adequately refer HIV+ patients

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

-----END-----

**Thank you for completing this survey.**  
**We look forward to working with you in the future.**

## **HIV Prevention Community-Based Funding Overview: Updated for CY 2015**

In calendar year 2012, the Centers for Disease Control and Prevention (CDC) provided a five-year HIV prevention grant to South Carolina. DHEC received this funding and developed a Request for Applications (RFA) from the CDC grant in order to fund community-based organizations (CBOs) for targeted prevention efforts throughout South Carolina. This funding represents a new direction in HIV prevention, and is designed to achieve a higher level of impact with every federal HIV prevention dollar.

CDC's and DHEC's new approach features better population-based and geographic targeting of resources and a stronger focus on supporting the highest-impact prevention strategies. This approach embodies the commitment to [high impact HIV prevention](#) using scalable, cost-effective interventions with demonstrated potential to reduce new infections to yield a major impact on the HIV epidemic. High impact prevention is essential to achieving the HIV prevention goals of [the National HIV/AIDS Strategy](#) (NHAS) which was announced in 2010.

The purpose of the 2012 RFA was to support implementation of high impact, comprehensive HIV prevention programs to achieve maximum impact on reducing new HIV infections. The overall goals to be accomplished are reducing the number of new HIV infections, increasing access to care, improving health outcomes for people living with HIV, and promoting health equity. This will be accomplished by increasing HIV testing, linking HIV positive persons to medical care and other essential services, and increasing program monitoring and accountability. Specifically for purposes of this RFA, funds are provided in alignment with the *NHAS* to:

- A. Focus HIV prevention efforts in communities and local areas where HIV is most heavily concentrated to achieve the greatest impact in decreasing the risks of acquiring HIV.
- B. Increase targeted HIV testing in non-healthcare settings to identify undiagnosed HIV infection, with a program minimum of at least a 1.0% rate of newly identified HIV positive tests annually.
- C. Increase access to care and improve health outcomes for people living with HIV by linking them to continuous and coordinated quality care and much needed medical, prevention and social services.
- D. Expand targeted HIV prevention efforts using a combination of effective, evidence-based approaches, including delivery of integrated and coordinated behavioral and structural HIV prevention interventions.
- E. Reduce HIV-related disparities and promote health equity.

Two funding categories were offered. For "core prevention" funding, as a result of the funding awards announced in 2012 and continuing with programs funded in 2015, DHEC shifted CBOs' HIV targeted testing efforts overall to the state's priority populations as follows:

- Increased targeted testing numbers from 3,800 planned in CY2011 to 5,053 in CY2015 (a 33% increase).
- Increased testing for African American men who have sex with men (AAMSM) from 4.8% planned testing in CY2011 to 12.9% in CY2015.
- Increased testing for white MSM from 11.5% in CY2011 to 12.6% in CY2015.
- Increase testing to AAMSM and other priority populations in the areas of highest incidence and prevalence.
- Funding allocations for targeted testing account for 58% of the overall core prevention funding awards.
- Funding allocations targeted to AAMSM account for 100% of the funding for behavioral interventions to high-risk negative persons in the core prevention awards.
- Funding allocations were awarded to programs serving the 11 counties with the greatest numbers of HIV incidence and HIV prevalence cases as of CY2009-CY2010. Funding continues in 2015 to those counties which continue to have the greatest incidence and prevalence HIV/AIDS numbers.

The second funding category was for a demonstration project which provided awards totaling \$455,000 to community-based programs. They were all targeted towards prevention with positives in the framework of linkages to and retention in continuum of care programs in the seven areas of South Carolina with the greatest numbers of HIV/AIDS prevalence. Funding continues through December 2015 when the project closes.

**DHEC-Funded Community-Based HIV Prevention Program Models by Organization  
CY2015 – Funded By CDC Grant PS12-1201**

<b>Organization</b>	<b>Funded Program Models**</b>
<b>ACCESS Network, Inc.</b> <i>(Beaufort*, Colleton, Hampton, Jasper)</i>	Targeted HIV Testing
<b>Acercamiento Hispano/Hispanic Outreach</b> <i>(Aiken, Kershaw, Lexington*, Newberry, Richland*, Saluda, Sumter*)</i>	Targeted HIV Testing
<b>AID Upstate, Inc.</b> <i>(Anderson, Greenville*, Greenwood, Laurens, Oconee, Pickens, Spartanburg*)</i>	Targeted HIV Testing Healthy Relationships WILLOW Many Men, Many Voices Antiretroviral Treatment and Access to Services (ARTAS) Linkages to and Retention in Care for persons living with HIV/AIDS
<b>CARETEAM, Inc.</b> <i>(Georgetown, Horry*, Williamsburg)</i>	Targeted HIV Testing Antiretroviral Treatment and Access to Services (ARTAS) Linkages to and Retention in Care for persons living with HIV/AIDS
<b>Catawba Care</b> <i>(Chester, Lancaster, York*)</i>	Targeted HIV Testing Many Men, Many Voices Antiretroviral Treatment and Access to Services (ARTAS) Linkages to and Retention in Care for persons living with HIV/AIDS
<b>HopeHealth</b> <i>(Bamberg, Calhoun, Darlington, Florence*, Marion, Marlboro, Orangeburg*)</i>	Targeted HIV Testing Healthy Relationships Antiretroviral Treatment and Access to Services (ARTAS) Linkages to and Retention in Care for persons living with HIV/AIDS
<b>Lowcountry AIDS Services</b> <i>(Berkeley, Charleston*, and Dorchester)</i>	Targeted HIV Testing Healthy Relationships WILLOW Many Men, Many Voices Antiretroviral Treatment and Access to Services (ARTAS) Linkages to and Retention in Care for persons living with HIV/AIDS
<b>PALSS</b> <i>(Fairfield, Kershaw, Lexington*, Newberry, Richland*, Sumter*)</i>	Targeted HIV Testing Healthy Relationships Antiretroviral Treatment and Access to Services (ARTAS) Linkages to and Retention in Care for persons living with HIV/AIDS
<b>SCHAC</b> <i>(Kershaw, Lee, Lexington*, Richland*, Sumter*)</i>	Targeted HIV Testing Healthy Relationships Many Men, Many Voices Antiretroviral Treatment and Access to Services (ARTAS) Linkages to and Retention in Care for persons living with HIV/AIDS
<b>USC School of Medicine</b> <i>(Midlands area*)</i>	Comprehensive Risk Counseling and Services (CRCS)

<b>Expanded HIV Testing – Clinical Grantee Program Sites</b>
<b>Care South Innovations</b> <i>(Pee Dee area*)</i>
<b>Eau Claire Cooperative</b> <i>(Midlands area*)</i>
<b>Fetter Health Care Network</b> <i>(Charleston area*)</i>
<b>Greenville Hospital System –Greenville Memorial Hospital</b> <i>(Greenville*)</i>
<b>Medical University of South Carolina (MUSC)</b> <i>(Charleston area*)</i>
<b>Sumter Family Health Center</b> <i>(Sumter*)</i>

\*Indicates counties that are among the top 11 in South Carolina for the number of recent (in CY 2012 – CY 2013), newly-identified HIV infections and the number of persons living with HIV/AIDS

\*\*All community-based, nonclinical grantees also provide targeted condom distribution programs.

**DHEC Health Department-Based HIV Prevention Program Models By Region  
CY2015 – Funded By CDC Grant PS12-1201**

<b>DHEC Region w/Counties</b>	<b>Funded Program Models</b>
<p><b>Upstate:</b> <i>Abbeville, Anderson, Cherokee, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Spartanburg, Union</i></p>	<p>Routine, Opt-Out HIV Testing Partner Services (PS) Antiretroviral Treatment and Access to Services (ARTAS) Comprehensive Risk Counseling and Services (CRCS) Prevention Counseling Condom Distribution</p>
<p><b>Midlands:</b> <i>Aiken, Barnwell, Chester, Edgefield, Fairfield, Kershaw, Lancaster, Lexington, Newberry, Richland, Saluda, York</i></p>	<p>Routine, Opt-Out HIV Testing Partner Services (PS) Antiretroviral Treatment and Access to Services (ARTAS) Comprehensive Risk Counseling and Services (CRCS) Prevention Counseling Condom Distribution</p>
<p><b>Pee Dee:</b> <i>Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, Williamsburg</i></p>	<p>Routine, Opt-Out HIV Testing Partner Services (PS) Antiretroviral Treatment and Access to Services (ARTAS) Comprehensive Risk Counseling and Services (CRCS) Prevention Counseling Condom Distribution</p>
<p><b>Lowcountry:</b> <i>Allendale, Bamberg, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg</i></p>	<p>Routine, Opt-Out HIV Testing Partner Services (PS) Antiretroviral Treatment and Access to Services (ARTAS) Comprehensive Risk Counseling and Services (CRCS) Prevention Counseling Condom Distribution</p>

## CHAPTER 4: RECOMMENDED HIV PREVENTION INTERVENTIONS

### Introduction

For more than twenty-five years in South Carolina, 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 high-risk persons how to reduce their risks of infection and about the importance of knowing their HIV status by getting tested. 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. Health communication/public information initiatives have raised the awareness of policy makers and other community leaders. These initiatives have utilized the mass media and the Internet, supported abstinence programs among youth and others, promoted condom use among sexually active adults and involved individuals in providing peer education.

HIV prevention refers to all of 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 behaviors 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* provides guidance for prevention interventions with identified high-risk negative persons, including usage of CDC’s *Compendium of HIV Interventions with Evidence of Effectiveness* (updated through mid-2009). Interventions listed in the *Compendium* are disseminated nationwide through the *Diffusion of Effective Behavioral Interventions (DEBI)* project. This chapter presents choices of interventions including many from *AHP*, the *Compendium*, and *DEBI* that will help local providers realize their goals.

### Deciding Whom To Target

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

- Priority consideration is 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 providers should work 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.

## Intervention Categories and Definitions

CDC classifies categories of interventions as shown in Table 1 with their definitions.

<b>Table 1: Intervention Categories and Definitions</b>
<b>Health Education and Risk Reduction (HE/RR)</b>
<b>---Individual Level Intervention (ILI)</b> Intervention with a skills component provided to one person at a time.
<b>---Group Level Intervention – (GLI)</b> Intervention with a skills component provided to more than one person at a time.
<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.
<b>---Outreach (OUT), including Internet Outreach (I-OUT)</b> Face-to-face or Internet-based interventions with high-risk individuals conducted in places or on websites where those individuals meet. Outreach is conducted for the purpose of recruiting clients into CTR, CBCT, CRCS, and other prevention or care services, as needed, as well as for the distribution of risk reduction supplies in the face-to-face settings.
<b>Health Communication/Public Information (HC/PI)</b> The delivery of HIV prevention messages through one or more channels (in person to large groups, through print materials, on hotlines, on the radio or television, via the Internet) to target audiences.
<b>Counseling, Testing &amp; Referral (CTR) Services, 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.
<b>Partner Services (PS)</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. PS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.
<b>Comprehensive Risk Counseling and Services (CRCS)</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.
<b>Capacity Building (CB)</b> Activities for strengthening the public health HIV prevention infrastructure for systems to ensure the quality of services, improve the ability to assess community needs and provide technical assistance in all aspects of program planning and operations.
<b>Social Networking Strategies (SNS)</b> Community-based strategies used to identify persons with undiagnosed HIV infection within various networks and link them to medical care and prevention services.

## 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 HPC 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, providers should consider the following before selecting an intervention:

- Who should I target? (See page 4.1, *Deciding Whom To 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 an intervention plan analysis such as the one just noted, the most appropriate strategies or interventions may be selected from the following table. The interventions listed represent the consensus recommendations of the S.C. HIV Panning Council as reviewed by the HPC's Prevention Committee and presented originally for consideration at the June 16, 2009 HPC meeting. Subsequent updates to the interventions list were made in 2010 and 2011; the current recommendations follow.

**Table 2: HIV Prevention Priority Populations and Recommended Interventions<sup>1</sup> 2010 – 2014**  
**With Special Considerations for South Carolina**  
*Updated as of August 30, 2011*

Priority Populations (ranked)	Recommended Interventions (not ranked)
1. Persons Living With HIV/AIDS (PLWHA)	<ul style="list-style-type: none"> <li>▪ <i>Fundamentals of Prevention Counseling (FoPC)</i></li> <li>▪ <i>Project RESPECT</i></li> <li>▪ <i>Comprehensive Risk Counseling and Services (CRCS)</i><sup>2</sup></li> <li>▪ <i>CLEAR</i><sup>3</sup></li> <li>▪ <i>Healthy Relationships</i></li> <li>▪ <i>Women Involved in Life Learning from Other Women (WiLLOW)</i><sup>4</sup></li> <li>▪ <i>Community PROMISE</i><sup>5</sup></li> <li>▪ Outreach using portions of <i>Popular Opinion Leader</i> or <i>FoPC</i> as a model.</li> <li>▪ Internet Outreach<sup>6</sup></li> <li>▪ Social Networking Strategies<sup>7</sup></li> <li>▪ Partner Services<sup>8</sup></li> </ul>
2. African American Men who Have Sex with Men (AAMSM)	<ul style="list-style-type: none"> <li>▪ <i>Fundamentals of Prevention Counseling (FoPC)</i></li> <li>▪ <i>Project RESPECT</i></li> <li>▪ <i>CRCS</i><sup>2</sup></li> <li>▪ <i>Many Men, Many Voices (3MV)</i></li> <li>▪ <i>American Red Cross Talking Drums</i></li> <li>▪ <i>Popular Opinion Leader (POL)</i></li> <li>▪ <i>D-Up: Defend Yourself</i><sup>9</sup></li> <li>▪ <i>Community PROMISE</i><sup>5</sup></li> <li>▪ Outreach including Internet Outreach<sup>6</sup></li> <li>▪ Counseling, Testing and Referral (CTR) Services<sup>10</sup></li> <li>▪ Social Networking Strategies<sup>7</sup></li> <li>▪ Partner Services<sup>8</sup></li> </ul>
3. African American Women who Have Sex with Men (AAWSM)	<ul style="list-style-type: none"> <li>▪ <i>Fundamentals of Prevention Counseling (FoPC)</i></li> <li>▪ <i>Project RESPECT</i></li> <li>▪ <i>CRCS</i><sup>2</sup></li> <li>▪ <i>Sister to Sister</i><sup>11</sup></li> <li>▪ <i>SISTA</i></li> <li>▪ <i>VOICES</i></li> <li>▪ <i>American Red Cross Talking Drums</i></li> <li>▪ <i>Sisters Informing, Healing, Living, and Empowering ( SiHLE)</i><sup>12</sup></li> <li>▪ <i>Project START</i></li> <li>▪ <i>POL</i></li> <li>▪ <i>Real AIDS Prevention Project (RAPP)</i></li> <li>▪ <i>Community PROMISE</i><sup>5</sup></li> <li>▪ Outreach including Internet Outreach<sup>6</sup></li> <li>▪ CTR Services<sup>10</sup></li> <li>▪ Social Networking Strategies<sup>7</sup></li> <li>▪ Partner Services<sup>8</sup></li> </ul>

<p>4. African American Men who Have Sex with Women (AAMSW)</p>	<ul style="list-style-type: none"> <li>▪ <i>Fundamentals of Prevention Counseling (FoPC)</i></li> <li>▪ <i>Project RESPECT</i></li> <li>▪ <i>CRCS<sup>2</sup></i></li> <li>▪ <i>VOICES</i></li> <li>▪ <i>American Red Cross Talking Drums</i></li> <li>▪ <i>Nia<sup>13</sup></i></li> <li>▪ <i>Project START</i></li> <li>▪ <i>POL</i></li> <li>▪ <i>Community PROMISE<sup>5</sup></i></li> <li>▪ <i>Outreach including Internet Outreach<sup>6</sup></i></li> <li>▪ <i>CTR Services<sup>10</sup></i></li> <li>▪ <i>Social Networking Strategies<sup>7</sup></i></li> <li>▪ <i>Partner Services<sup>8</sup></i></li> </ul>
<p>5. White Men who Have Sex with Men (WMSM)</p>	<ul style="list-style-type: none"> <li>▪ <i>Fundamentals of Prevention Counseling (FoPC)</i></li> <li>▪ <i>Project RESPECT</i></li> <li>▪ <i>CRCS<sup>2</sup></i></li> <li>▪ <i>POL</i></li> <li>▪ <i>Mpowerment</i></li> <li>▪ <i>Community PROMISE<sup>5</sup></i></li> <li>▪ <i>Outreach including Internet Outreach<sup>6</sup></i></li> <li>▪ <i>CTR Services<sup>10</sup></i></li> <li>▪ <i>Social Networking Strategies<sup>7</sup></i></li> <li>▪ <i>Partner Services<sup>8</sup></i></li> </ul>
<p>6. Injecting Drug Users (IDUs)</p>	<ul style="list-style-type: none"> <li>▪ <i>Fundamentals of Prevention Counseling (FoPC)</i></li> <li>▪ <i>Project RESPECT</i></li> <li>▪ <i>CRCS<sup>2</sup></i></li> <li>▪ <i>American Red Cross Talking Drums</i></li> <li>▪ <i>Study to Reduce Intravenous Exposures (STRIVE)<sup>14</sup></i></li> <li>▪ <i>Safety Counts</i></li> <li>▪ <i>POL</i></li> <li>▪ <i>Community PROMISE<sup>5</sup></i></li> <li>▪ <i>Outreach including Internet Outreach<sup>6</sup></i></li> <li>▪ <i>CTR Services<sup>10</sup></i></li> <li>▪ <i>Social Networking Strategies<sup>7</sup></i></li> <li>▪ <i>Partner Services<sup>8</sup></i></li> </ul>
<p>7. Hispanics/Latinos</p>	<ul style="list-style-type: none"> <li>▪ <i>Fundamentals of Prevention Counseling (FoPC)</i></li> <li>▪ <i>Project RESPECT</i></li> <li>▪ <i>CRCS<sup>2</sup></i></li> <li>▪ <i>VOCES</i></li> <li>▪ <i>Salud, Educacion, Prevencion y Autocuidado (SEPA)</i></li> <li>▪ <i>SISTA-adapted for Latinas<sup>15</sup></i></li> <li>▪ <i>Take Care of Yourself</i></li> <li>▪ <i>POL</i></li> <li>▪ <i>Community PROMISE<sup>5</sup></i></li> <li>▪ <i>Outreach including Internet Outreach<sup>6</sup></i></li> <li>▪ <i>CTR Services<sup>10</sup></i></li> <li>▪ <i>Social Networking Strategies<sup>7</sup></i></li> <li>▪ <i>Partner Services<sup>8</sup></i></li> <li>▪ <i>Health Communication/Public Information</i></li> </ul>

### Special Considerations for South Carolina

<p><sup>1</sup>Interventions Guidance:</p> <ul style="list-style-type: none"> <li>▪ <i>Provisional Procedural Guidance for Community-Based Organizations:</i> <a href="http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance.htm">http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance.htm</a></li> <li>▪ <i>Compendium of HIV Interventions with Evidence of Effectiveness:</i> <a href="http://www.cdc.gov/hiv/resources/reports/hiv_compendium/index.htm">http://www.cdc.gov/hiv/resources/reports/hiv_compendium/index.htm</a>;</li> <li>▪ <i>Replicating Effective Programs Plus:</i> <a href="http://www.cdc.gov/hiv/topics/prev_prog/rep/index.htm">http://www.cdc.gov/hiv/topics/prev_prog/rep/index.htm</a>;</li> <li>▪ <i>Diffusion of Effective Behavioral Interventions (DEBI) Project:</i> <a href="http://www.effectiveinterventions.org/">http://www.effectiveinterventions.org/</a></li> </ul>
<p><sup>2</sup>CRCS: An intensive, individual level, client-centered risk reduction intervention for people at high risk for HIV infection or transmission. <a href="http://www.cdc.gov/hiv/topics/prev_prog/CRCS/index.htm">http://www.cdc.gov/hiv/topics/prev_prog/CRCS/index.htm</a></p>
<p><sup>3</sup>CLEAR: The intervention is labor intensive and may not be suitable for use in the designed format. Certain components may be suitable for use but would be considered adaptation if not implemented the way it was intended. Staff need to be a licensed MSW or Counselor. Staff must be specifically employed to deliver the intervention. Clients need to be high functioning and dedicated to completing the intervention for it to be successful. This intervention works better with students who attend high school and college. Components of this intervention can be integrated with CRCS. Agency readiness is important because it depends on agency funding due to facilitator needing to be a licensed therapist or clinical social worker.</p>
<p><sup>4</sup>WILLOW: This intervention is for heterosexual women, regardless of race or ethnicity, living with HIV/AIDS who are 18 – 50 years of age and who have known their HIV serostatus for at least six months. Organizations implementing WILLOW should utilize two facilitators, one of which must be HIV+ who has been trained in the WILLOW curriculum. Due to the cost of this program, agencies should seek outside funding sources.</p>
<p><sup>5</sup>Community PROMISE: Funding needs to be secured outside of DHEC to fully support the budget for the intervention. There also needs to be specific dedicated staff to successfully conduct the intervention to ensure effectiveness and fidelity to the intervention. PROMISE has been considered for use in S.C. priority populations older than the currently prioritized age demographic. More research is needed on whether it can be used with older adults (beyond the current upper age limits of the priority populations).</p>
<p><sup>6</sup>Internet Outreach: Uses <i>National Guidelines for Internet-based STD and HIV Prevention: Accessing the Power of the Internet for Public Health:</i> <a href="http://www.ncsddc.org/upload/wysiwyg/documents/IG-FINAL.pdf">http://www.ncsddc.org/upload/wysiwyg/documents/IG-FINAL.pdf</a>. There should be flexibility in Internet outreach to include length of the online sessions sometimes in excess of the standard of five to ten minutes per session.</p>
<p><sup>7</sup>Social Networking Strategies: A Community-Based Strategy for Identifying Persons with Undiagnosed HIV Infection. <a href="http://www.cdc.gov/hiv/resources/guidelines/snt/index.htm">http://www.cdc.gov/hiv/resources/guidelines/snt/index.htm</a></p>
<p><sup>8</sup>Partner Services: Services offered to persons with HIV and other STDs and their sexual or needle-sharing partners. Services include identifying infected persons and confidentially notifying their partners of their possible exposures. <a href="http://www.cdc.gov/nchhstp/partners/Recommendations.html">http://www.cdc.gov/nchhstp/partners/Recommendations.html</a></p>
<p><sup>9</sup>D-Up: Funding needs to be secured outside of DHEC to fully support the intervention budget. This intervention is costly, approx. \$200,000/year; needs program-specific staff dedicated solely to it who are properly trained &amp; understand the population being served.</p>
<p><sup>10</sup>CTR Services include:</p> <ul style="list-style-type: none"> <li>▪ Clinic-based testing offered in DHEC health departments' clinics and routine health care settings including hospital emergency departments.</li> <li>▪ Testing provided through various methodologies, including rapid testing, using a DHEC-approved type of test.</li> <li>• Community-based testing in venues offering access to hard-to-reach, high-risk populations when the setting is aligned with all CDC and DHEC policies/protocols/quality assurance standards. Counselors must allow time to provide pre-post test counseling, administer the test, develop a client-centered risk reduction plan and make referrals. Counseling will be the only chance for some to learn risks and the value of knowing HIV status.</li> <li>• Referrals must be offered to all clients receiving preliminary and confirmed HIV positive test results.</li> </ul>
<p><sup>11</sup>Sister to Sister: (Individual level and group level) The target population for Sister to Sister is sexually active African American women 18-45 years old who have male partners and are attending primary health care clinics (e.g., family planning, women's health reproductive care, etc.). It is recommended that organizations choosing to implement Sister to Sister should ensure the intervention is implemented by specially trained female health care provider(s) who have completed the 1-day training session. Organizations must integrate and use all core intervention materials.</p>
<p><sup>12</sup>SiHLE: This is an age-defined intervention targeted to sexually experienced African American adolescent females ages 14 – 18. Agencies and/or organizations implementing SiHLE should utilize one adult and two peer facilitators who have been trained in the SiHLE curriculum as recommended in the program literature. Due to the cost of this program, agencies should seek outside funding sources. Agencies should have certified counseling staff or a referral source in place for needed services that may be required.</p>
<p><sup>13</sup>Nia: It is recommended that organizations choosing to implement Nia utilize two facilitators one male and one female who have been trained in Nia.</p>
<p><sup>14</sup>STRIVE: This intervention is specifically for Hepatitis C (HCV) positive IDUs.</p>
<p><sup>15</sup>SISTA-adapted for Latinas: A community/cultural assessment must be done to learn about where the women live, their culture, risk behaviors, and other HIV risk factors. Utilize the SISTA Resource Guide for Adapting SISTA for Latinas. Facilitators should: 1) Be trained facilitators in the SISTA curriculum; 2) Be Latina or Hispanic women who are knowledgeable about and can demonstrate cultural competence with the target population and speak the same language and dialect as the population; 3) Be able to create a culturally sensitive environment; 4) Be knowledgeable about HIV transmission and prevention. The intervention may be conducted with heterosexually active Latina/Hispanic women ages 18up; it should maintain the theoretical framework/core elements of SISTA.</p>
<p><b>Notes on Other Interventions</b></p>
<p><i>Safe in the City</i> DVD is recommended for use in STD/HIV clinics with waiting rooms accessible only to adults. The intervention tools (posters, condoms, video) need to be viewed by staff so that they may answer questions from clients. It is encouraged that intervention materials be used as education for sexually active adults with tools from other interventions. Video can be used in VOICES/VOCES.</p>
<p><i>Capacity Building</i> is also a recommended intervention but is not specific to a population.</p>
<p><i>Partners in Prevention:</i> This previously recommended intervention has been moved here as a historical reference but is no longer actively recommended for two reasons: 1) The content has not been updated in a very long time; and 2) More current interventions, such as Healthy Relationships and 3MV, are derived from the original PIP intervention and its related prevention research.</p>

## 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, some 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 accompany the test as well as from the CDC HIV Test Form. DHEC uses a CDC-developed, web-based reporting process, *Program Evaluation Monitoring System (PEMS)* for reporting ILIs, GLIs, CLIs, CRCS and Outreach. These data collection and evaluation systems are described in more detail in Chapter 8. Additional details can also be found at: [http://www.cdc.gov/hiv/topics/evaluation/health\\_depts/guidance/monitoring.htm](http://www.cdc.gov/hiv/topics/evaluation/health_depts/guidance/monitoring.htm)

For information on the *Advancing HIV Prevention (AHP)* initiative and more details on the effectiveness of HIV prevention interventions, the following links may be useful:

- CDC's *Advancing HIV Prevention* initiative:  
[http://www.cdc.gov/hiv/topics/prev\\_prog/AHP/default.htm](http://www.cdc.gov/hiv/topics/prev_prog/AHP/default.htm)
- *What Intervention Studies Say About Effectiveness*:  
<http://www.aed.org/Publications/upload/InterventionEffectiveness.pdf>