2014 to 2017 HIV Prevention Plan

Arizona Jurisdiction

A Report to the Centers for Disease Control & Prevention

Prevention Planning Group of Arizona
and the
Office of HIV Prevention
Bureau of Tobacco and Chronic Disease
Arizona Department of Health Services

2014 to 2017 Arizona Jurisdiction HIV Prevention Plan

For services provided from January 2014 to January 2017

Collaboratively developed by the
Prevention Planning Group of Arizona
and the
Office of HIV Prevention
Bureau of Tobacco and Chronic Disease
Arizona Department of Health Services

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September 8, 2014

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2920 Brandywine Road, MS E-15
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RE: PS12-1201 Comprehensive HIV Prevention Programs for Health Departments
Grant Number 1U62PS003635-01
Letter of Concurrence with 2014 Interim Progress Report

Dear Mr. Messick,

On behalf of the members of the HIV Prevention Planning Group of Arizona (PPGA), we are pleased to provide this **letter of concurrence** to the Arizona Department of Health Services, HIV Prevention Program in response to Funding Opportunity Announcement PS12-1201.

The PPGA has reviewed the Arizona Jurisdictional HIV Prevention Plan that is to be submitted to the Centers for Disease Control and Prevention (CDC) and **concurs** that the Jurisdictional HIV Prevention Plan describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease.

The PPGA has reviewed PS12-1201 requirements, and a variety of local and national data including the CDC High Impact Prevention Guidance, current Arizona epi data, Ryan White Part A and B, and ADAP service utilization data, needs assessment data, analysis of the Arizona Continuum of Care Cascade, quality improvement reports, and Prevention Program resource allocations. The Jurisdictional Plan has been made available to Ryan White Programs, consumers, service providers and community stakeholders for input.

The PPGA is excited to be quickly moving forward with integrated prevention and care planning with the Ryan White Part A and B programs serving Arizona, as supported by the joint CDC/HRSA guidance issued in April 2014. We believe our integration activities demonstrate thoughtful, responsive commitment to ending the HIV epidemic in Arizona.

We appreciate the CDC's continued support of Arizona's prevention efforts.

Sincerely,

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John Sapero
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Acknowledgements

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Executive Summary

As of 2012, approximately 17,000 people in Arizona were living with HIV; of those individuals, an estimated 18% (1,641) were unaware of their HIV infection. Only half of all people living with HIV (PLWH) in Arizona are engaged in primary medical care, and just 36% of PLWH who know their status are on antiretroviral treatment and have a suppressed viral load. This is unacceptable. Because having a lower viral load prolongs the lives of persons with HIV and decreases the risk of transmission to others, it is imperative that Arizona increase the number of individuals who know their HIV status, are engaged in medical care, and treatment adherent.

Many states have similar statistics. On July 13, 2010 the White House released the National HIV/AIDS Strategy (NHAS). The Strategy recognizes the connection between prevention, care, and treatment in reducing new infections and improving the health of people living with HIV. The Strategy also emphasizes the central importance of reducing disparities in HIV prevention and care and in reducing the stigma and discrimination associated with HIV.

In 2012, the Centers for Disease Control (CDC) re-prioritized HIV prevention funding to support the NHAS by directing resources to High Impact HIV Prevention. This approach is designed to maximize the impact of prevention efforts by utilizing strategies that are scientifically proven to be effective, cost effective, and scalable (targeted to the right populations in the right geographic areas).

In Arizona, there are approximately 500 new HIV cases each year. The HIV Prevention Program and the PPGA have established a goal to **reduce new HIV infections in Arizona by 25% by 2017**. To accomplish this, a series of goals and objectives have been developed to implement activities that will maximize Arizona's potential to reduce new HIV infections, improve linkage to and engagement in primary medical care for PLWH, improve treatment adherence, and ultimately, increase the number of individuals who are virally suppressed.

Prevention planning for Arizona has been divided into three regions (Northern, Central, and Southern) based on population disbursal, alignment with geographic boundaries for federally-funded care services, and the concentration and similarity of target populations. Target populations have been determined for each Region:

- **Northern Region:** MSM of all races and ethnicities, Hispanics, and American Indians

- **Central Region:** MSM of all races and ethnicities, Hispanics, and African Americans/Blacks, especially women

- **Southern Region:** MSM of all races and ethnicities, Hispanics, and Injection Drug Users in Pima County

The following goals and activities have been developed with the effectiveness, scalability, cost, and the potential impact of each intervention in mind:

2014 to 2017 HIV PREVENTION PLAN GOALS AND ACTIVITIES (January 2014 to January 2017)

GOAL 1 Increase, **by at least 10% each year**, the number of HIV tests conducted health departments funded by the HIV Prevention Program. **Yearly goals: 2014: 25,400/ 2015: 28,000/ 2016: 31,000**

GOAL 2 By January 2017, facilitate enhancements in the HIV continuum of care in Maricopa County so that **75% of individuals who are diagnosed by an entity funded by the HIV Prevention Program attend their first comprehensive HIV medical appointment within 30 days** of the date of their diagnosis.

GOAL 3 Each year, **at least 85% of newly diagnosed individuals** are interviewed for Partner Services. Additionally, **90% of HIV positive clients** who actively seek Partner Services are interviewed within three business days.

GOAL 4 Increase the percentage of individuals referred to the Anti-Retroviral Treatment and Access to Services (ARTAS) programs by funded HIV testing and Partner Services providers, from **40 percent in 2013 to 85 percent in 2016**.

GOAL 5 Increase the number of high-risk negative persons who are screened for behavior risks and enrolled in individual-level and/or group-level evidence-based interventions, **from 7% of total participants in 2013 to 20% of total participants in 2014. Maintain or increase this percentage each year.**

GOAL 6 Increase number of condoms distributed by the HIV Prevention Program, **from 167,000 in 2013 to 334,000 in 2016**.

GOAL 7 Increase the percentage of condoms distributed by the HIV Prevention Program to people living with HIV, **from 23% of overall condoms distributed in 2013 to at least 60% in 2016**.

GOAL 8 Each year, **evaluate consumer and provider interest in Pre-exposure Prophylaxis (PrEP) and Non-occupational Post-Exposure Prophylaxis (nPEP),** and collaborate as possible to support related activity in the jurisdiction.

GOAL 9 Each year, **monitor and analyze local and state health polices** to assure they promote goals for HIV prevention and care services, including but not limited to expanded HIV testing, Affordable Care Act coverage of HIV prevention services, and the elimination of barriers to accessing medical care.

GOAL 10 By April 2015, **expand consumer- and provider-centric content on HIVAZ.org**, including step-by-step guides for engagement in care and provider referrals, video walkthroughs of various aspects of care, reminder systems, and comprehensive enrollment information for Ryan White services and other HIV care programs.

GOAL 11 Each year, implement **at least two scalable social marketing campaigns, utilizing traditional and new media,** to support HIV testing and prevention initiatives.

GOAL 12 Each year, **establish relationships with stakeholders in target populations within the jurisdiction,** to facilitate mobilization efforts to promote HIV testing, improve linkages to care, and increase participation/collaboration in HIV prevention and care planning, and service delivery.

GOAL 13 By December 31, 2016, **integrate HIV prevention and care planning statewide.**

GOAL 14 **Remain supportive** of efforts of non-funded entities to provide syringe access and disposal programs.

The Arizona Jurisdiction

In 2012, Arizona's population was estimated at 6,553,255. Arizona's population continues to grow as in previous years. The most populous counties experienced an increase in population whereas lesser populated counties remained relatively stable or decreased in size. The state's population grew by 70,750 from 2011 to 2012 according to the U.S. Census Bureau's estimates (Table 1). This represents an Arizona annual growth rate of 1.1%. The three most populous counties in Arizona, Maricopa (+61,925), Pima (+2,825), and Pinal (4,373) have the largest increases in terms of absolute numbers.

Arizona's least populated county, Greenlee (2012: 8,802), has the largest rate of increase, 2.3%. Maricopa, which is Arizona's most populous county, has the second highest rate of increase (1.6%). Five out of the twelve counties (Cochise, La Paz, Navajo, Santa Cruz, and Yuma) in Arizona which have a population of less than 250,000 actually had decreases in population.

The state is 113,909 square miles in area, divided into fifteen counties. Fifty-seven percent is under state and federal jurisdiction, and sixteen percent is privately or corporately owned. Federally owned lands include six national

forests: Kaibab, Coconino, Apache- Sitgreaves, Prescott, Tonto, and Coronado. There are twenty three national parks, monuments and historic sites in Arizona from Grand Canyon National Park and Monument to Canyon de Chelly with its Anasazi ruins.

More than a quarter of the area of the state is reservation land that is home to 22 federally recognized American Indian tribes. The largest tribal land areas include 25,000 acres of the Navajo Nation, the largest American Indian reservation in the US, and the entire Tohono O'odham Nation, the second largest reservation in the country. The smallest is the 85-acre Tonto Apache Reservation near Payson. Tribal lands are separate jurisdictions having their own tribal governments, laws and law enforcement units. Approximately 18% of tribal members reside on tribal lands, while 82% reside in urban settings. Some counties have high proportions of American Indians among their population. Seventy-seven percent of Apache County, 48% of Navajo County, and 29% of Coconino County residents are American Indians.

INCIDENCE/PREVALENCE

The State of Arizona experienced an 18% increase in new HIV cases from 2011 to 2012; however, the amount of AIDS cases decreased by 10% from 2011 to 2012. The result was a total HIV/AIDS case increase of 12% from 2011 to 2012 with the majority of new HIV cases among white (342 or 39%), MSM (541 or 61%) and those ranging in age from 20-44 (644 or 74%). Correspondingly, the majority of new AIDS cases presented amongst white (141 or 43%), MSM (163 or 50%) within the age ranges of 20-44 years of age (190 or 58%). The PLWH population in 2012 consisted of 15,288 with existing HIV disease. This combined HIV/AIDS prevalence of 15,288 represents a 4% or 583 person increase from 2011 and a 7% or 1,046 person increase from 2010. PLWH race/ethnicity categories are 57% White, 26% Hispanic, 11% African American, 4% American Indian/Alaska Native, 1% Asian/Pacific Islander and 1% Multi-racial. Gender ratios present at 87% male and 13% female. Additionally, the age categories for PLWH are: 1% under 19 years of age, 34% from 20-44 and 65% over age 45.

TABLE 1: ARIZONA REPORTED EMERGENT CASES 2012

	Emergent HIV			Emergent AIDS			Emergent HIV & AIDS		
	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000
By Gender									
Male	411	63.9	12.61	137	21.3	4.2	548	85.2	16.82
Female	77	12.0	2.34	18	2.8	0.55	95	14.8	2.88
TOTAL	**488**	**75.9**	**7.45**	**155**	**24.1**	**2.37**	**643**	**100.0**	**9.81**
By Age									
Under 2	1	0.2	0.59	0	0.0	0.00	1	0.2	0.59
2-12	7	1.1	0.7	0	0.0	0.00	7	1.1	0.7
13-19	15	2.3	2.39	3	0.5	0.48	18	2.8	2.87
20-24	99	15.4	20.87	9	1.4	1.9	108	16.8	22.76
25-29	82	12.8	18.47	16	2.5	3.6	98	15.2	22.08
30-34	68	10.6	15.67	23	3.6	5.3	91	14.2	20.97
35-39	55	8.6	13.56	21	3.3	5.18	76	11.8	18.74
40-44	49	7.6	11.65	21	3.3	4.99	70	10.9	16.64
45-49	48	7.5	11.65	24	3.7	5.83	72	11.2	17.48
50-54	34	5.3	7.96	17	2.6	3.98	51	7.9	11.94
55-59	17	2.6	4.28	10	1.6	2.52	27	4.2	6.8
60-64	7	1.1	1.9	6	0.9	1.63	13	2.0	3.53
65 and Above	6	0.9	0.62	5	0.8	0.51	11	1.7	1.13
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
TOTAL	**488**	**75.9**	**7.45**	**155**	**24.1**	**2.37**	**643**	**100.0**	**9.81**
By Race/Ethnicity									
White Non-Hispanic	189	29.4	4.98	67	10.4	1.76	256	39.8	6.74
Black Non-Hispanic	90	14.0	31.4	17	2.6	5.93	107	16.6	37.33
Hispanic	157	24.4	7.94	53	8.2	2.68	210	32.7	10.63
***A/PI/H Non-Hispanic**	10	1.6	4.64	6	0.9	2.78	16	2.5	7.43
****AI/AN Non-Hispanic**	34	5.3	12.31	12	1.9	4.34	46	7.2	16.65
*****MR/O Non-Hispanic**	8	1.2	N/A	0	0.0	N/A	8	1.2	N/A
TOTAL	**488**	**75.9**	**7.45**	**155**	**24.1**	**2.37**	**643**	**100.0**	**9.81**
By Mode of Transmission									
+MSM	299	46.5	N/A	74	11.5	N/A	373	58.0	N/A
++IDU	39	6.1	N/A	16	2.5	N/A	55	8.6	N/A
MSM / IDU	21	3.3	N/A	7	1.1	N/A	28	4.4	N/A
Heterosexual	72	11.2	N/A	22	3.4	N/A	94	14.6	N/A
+++O/H/TF/TPR	6	0.9	N/A	0	0.0	N/A	6	0.9	N/A
++++NRR/UR	51	7.9	N/A	36	5.6	N/A	87	13.5	N/A
TOTAL	**488**	**75.9**	**7.45**	**155**	**24.1**	**2.37**	**643**	**100.0**	**9.81**

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race
+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

TABLE 2: ARIZONA ESTIMATED PREVALENCE 2012

	Prevalent HIV			Prevalent AIDS			Prevalent HIV & AIDS		
	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000
By Gender									
Male	6297	41.2	193.25	6828	44.7	209.55	13125	85.9	402.79
Female	1177	7.7	35.72	986	6.4	29.93	2163	14.1	65.65
TOTAL	**7474**	**48.9**	**114.05**	**7814**	**51.1**	**119.24**	**15288**	**100.0**	**233.29**
By Age									
Under 2	1	0.0	0.59	0	0.0	0.00	1	0.0	0.59
2-12	63	0.4	6.29	3	0.0	0.30	66	0.4	6.59
13-19	50	0.3	7.96	21	0.1	3.34	71	0.5	11.31
20-24	301	2.0	63.44	76	0.5	16.02	377	2.5	79.46
25-29	524	3.4	118.05	238	1.6	53.62	762	5.0	171.66
30-34	795	5.2	183.21	470	3.1	108.31	1265	8.3	291.52
35-39	822	5.4	202.73	701	4.6	172.89	1523	10.0	375.61
40-44	1049	6.9	249.34	1208	7.9	287.14	2257	14.8	536.48
45-49	1267	8.3	307.56	1715	11.2	416.31	2982	19.5	723.87
50-54	1197	7.8	280.27	1514	9.9	354.50	2711	17.7	634.77
55-59	692	4.5	174.35	978	6.4	246.40	1670	10.9	420.75
60-64	377	2.5	102.47	512	3.3	139.16	889	5.8	241.63
65 and Above	317	2.1	32.63	378	2.5	38.91	695	4.5	71.54
Age Unknown	19	0.1	NA	0	0.0	NA	19	0.1	NA
TOTAL	**7474**	**48.9**	**114.05**	**7814**	**51.1**	**119.24**	**15288**	**100.0**	**233.29**
By Race/Ethnicity									
White Non-Hispanic	4106	26.9	108.09	4419	28.9	116.33	8525	55.8	224.41
Black Non-Hispanic	923	6.0	321.97	888	5.8	309.76	1811	11.8	631.74
Hispanic	1922	12.6	97.26	2044	13.4	103.44	3966	25.9	200.70
***A/PI/H Non-Hispanic**	116	0.8	53.84	96	0.6	44.56	212	1.4	98.40
****AI/AN Non-Hispanic**	234	1.5	84.71	302	2.0	109.33	536	3.5	194.05
*****MR/O Non-Hispanic**	173	1.1	N/A	65	0.4	N/A	238	1.6	N/A
TOTAL	**7474**	**48.9**	**114.05**	**7814**	**51.1**	**119.24**	**15288**	**100.0**	**233.29**
By Mode of Transmission									
+MSM	4401	28.8	N/A	4769	31.2	N/A	9170	60.0	N/A
++IDU	733	4.8	N/A	862	5.6	N/A	1595	10.4	N/A
MSM / IDU	482	3.2	N/A	818	5.4	N/A	1300	8.5	N/A
Heterosexual	830	5.4	N/A	822	5.4	N/A	1652	10.8	N/A
+++O/H/TF/TPR	130	0.9	N/A	73	0.5	N/A	203	1.3	N/A
++++NRR/UR	898	5.9	N/A	470	3.1	N/A	1368	8.9	N/A
TOTAL	7474	48.9	114.05	7814	51.1	119.24	15288	100.0	233.29

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race
+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

TABLE 3: HIV/AIDS Incidence/Prevalence in Arizona 2008 to 2012

Summary HIV/AIDS Incidence/Prevalence in Arizona 2008-2012					
	2008	**2009**	**2010**	**2011**	**2012**
NEW HIV	479	443	405	398	488
NEW AIDS	220	214	224	171	155
TOTAL NEW HIV/AIDS	699	657	629	569	643
Total HIV	6720	6888	6866	7142	7474
Total AIDS	6673	7127	7376	7563	7814
Total HIV/AIDS	**13393**	**14015**	**14242**	**14705**	**15288**

TABLE 4: Arizona Incidence Among Males 2012

Arizona HIV/AIDS Incidence Among Males 2012, by Mode of Transmission		
Mode of Transmission	**Number of Cases**	**% Total**
*MSM	374	68.1
**IDU	40	7.2
MSM/IDU	28	5.1
High Risk Heterosexual Contact	41	7.5
***Presumed Heterosexual Contact	51	9.3
Vertical	3	0.5
No Risk Reported	12	2.2

TABLE 5: Arizona Incidence Among Females 2012

Arizona HIV/AIDS Incidence Among Females 2012, by Mode of Transmission		
Mode of Transmission	**Number of Cases**	**% Total**
*MSM	N/A	N/A
**IDU	15	15.8
MSM/IDU	N/A	N/A
High Risk Heterosexual Contact	53	55.8
***Presumed Heterosexual Contact	22	23.16
Vertical	3	3.2
No Risk Reported	2	2.1

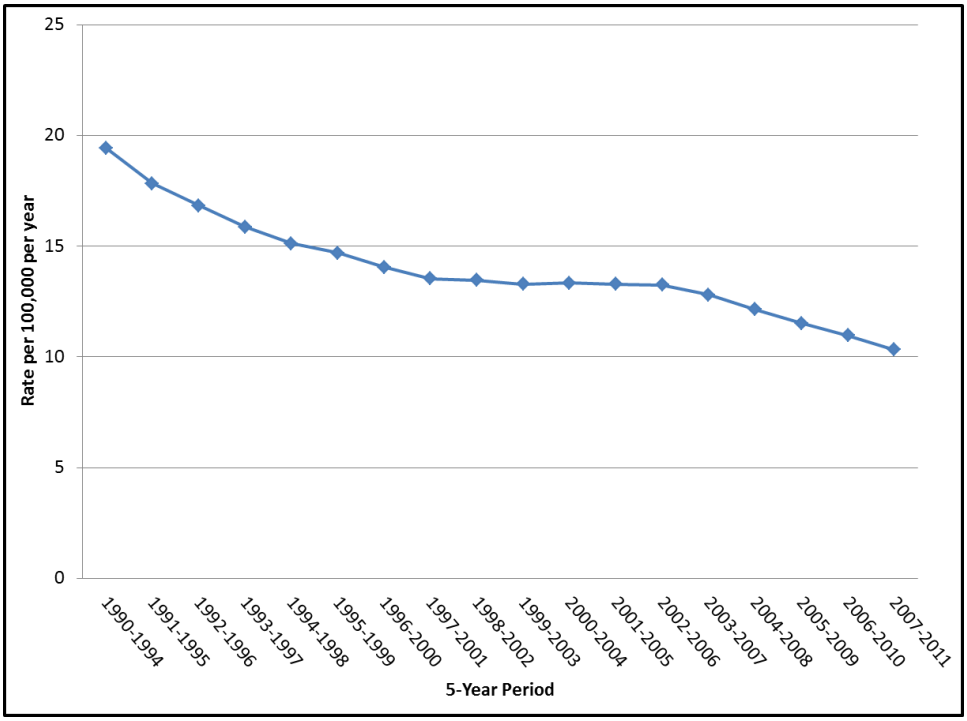


FIGURE 1: Arizona 5-Year Emergent HIV/ AIDS Case Rate Trend

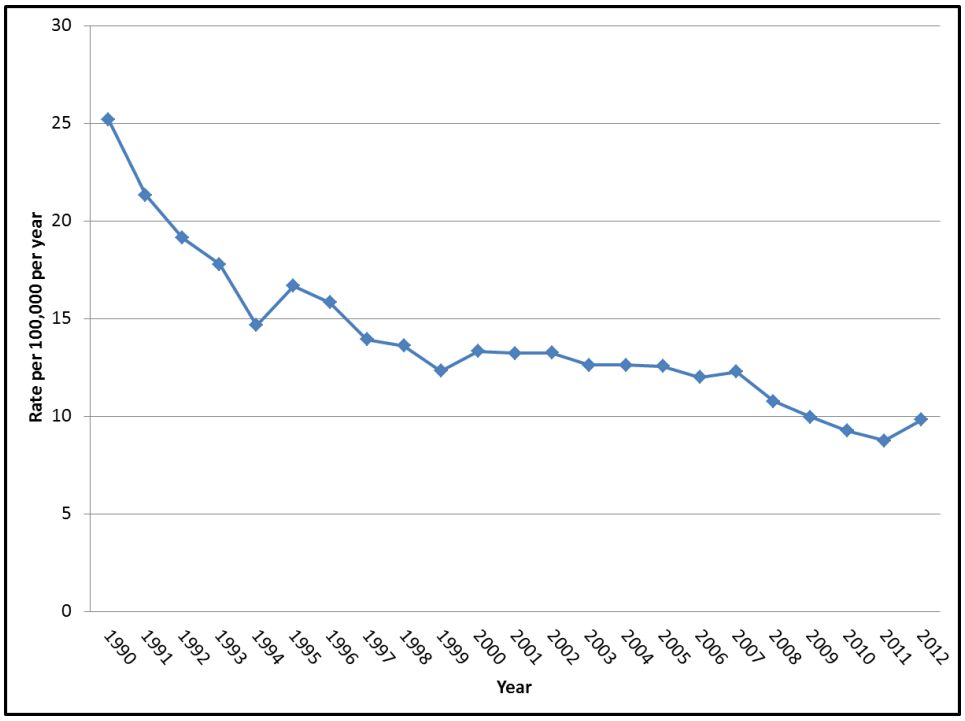


FIGURE 2: Arizona Emergent HIV/AIDS Case Trend by Single Year

Figure 1 shows the 5-year average rates which have less year-on-year variance than the single-year rates. The five-year emergent HIV/AIDS case rate declined steadily throughout the 1990s, leveling off from the 1998-2002 time period and is beginning to decline slightly again starting with the 2003-2007 time period. The 5-year rates have had an overall decline for the past decade. The 2007-2011 5-year rates are 23% lower than the rate for of 2000-2004.

The single-year rates have fluctuated more than the 5-year rates, but a similar pattern is present (Figure 2). These rates also declined through the 1990's. The 2012 single-year rate is 26% lower than the rate for the year 2000. However, the rate for 2012 (9.81) is slightly higher than in 2011 (8.75). According to the most recent estimates of the Center for Disease Control and Prevention (CDC), the 2011 estimated HIV/AIDS diagnosis rate for Arizona was under the national rate of 19.1 per 100,000 population (CDC slide set, HIV Surveillance, through 2011data http://www.cdc.gov/hiv/topics/surveillance/resources/slides/general/index.htm).

FIGURE 3: Arizona HIV/ AIDS Prevalence Trend

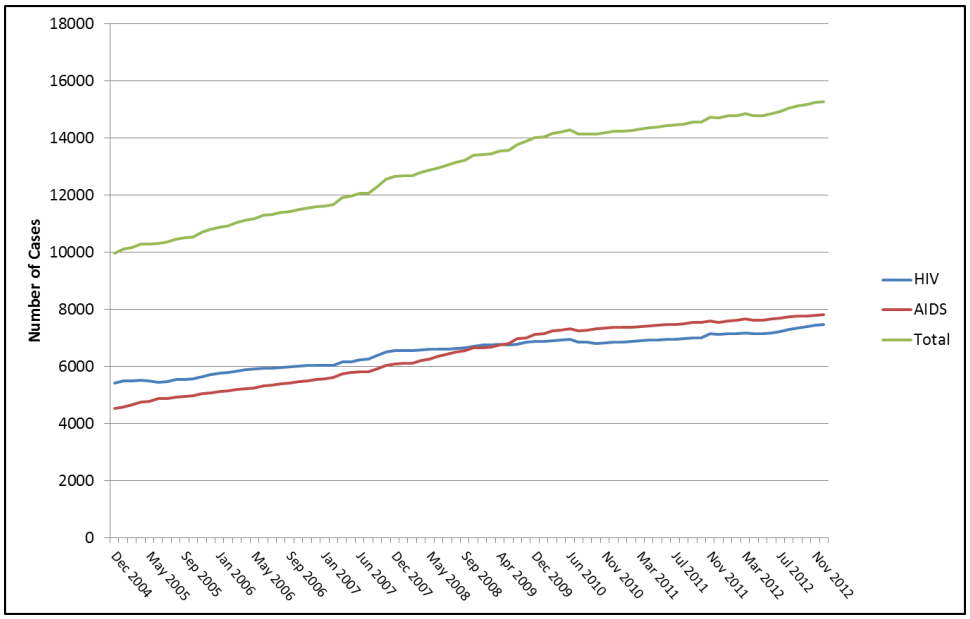


Figure 3 shows the number of HIV/AIDS cases in Arizona. Arizona is currently considered a moderate morbidity state, with CDC-estimated prevalence in the middle rate category among states with well-established confidential name-based HIV reporting. Prevalence numbers have continued to rise in Arizona, but this is expected given that the population of Arizona has been increasing every year for the past decade. As of December 2012, prevalence of reported HIV infection is 233.29 cases per 100,000 persons. Currently, there are 15,288 persons living with HIV/AIDS in Arizona, a rise of 21% in 5 years. The increase in prevalence rates may be due to the efficacy of multi-drug treatments for HIV infection, which have sharply reduced the number of HIV-related deaths.

[1]*The Arizona Department of Health Services rates may differ from the rates provided by the Center for Disease Control (CDC) because the CDC applies statistical adjustments on their rates in order to control for underreporting and reporting delay.*

Of the 12,657 prevalent cases in the state five years ago, only 11% currently report residing in another state or died in another state. Among prevalent cases, 23.5 % were diagnosed in another state.

In June 2009, the number of persons living with AIDS in Arizona surpassed the number of persons with HIV infection who have not been diagnosed with AIDS (Figure 3). Because the burden of HIV-related disease is greater among persons with AIDS, treatment, utilization, and continuity of care are an increasingly critical issues. Nevertheless, as of December 2012 the number of people with AIDS and HIV are close to converging again.

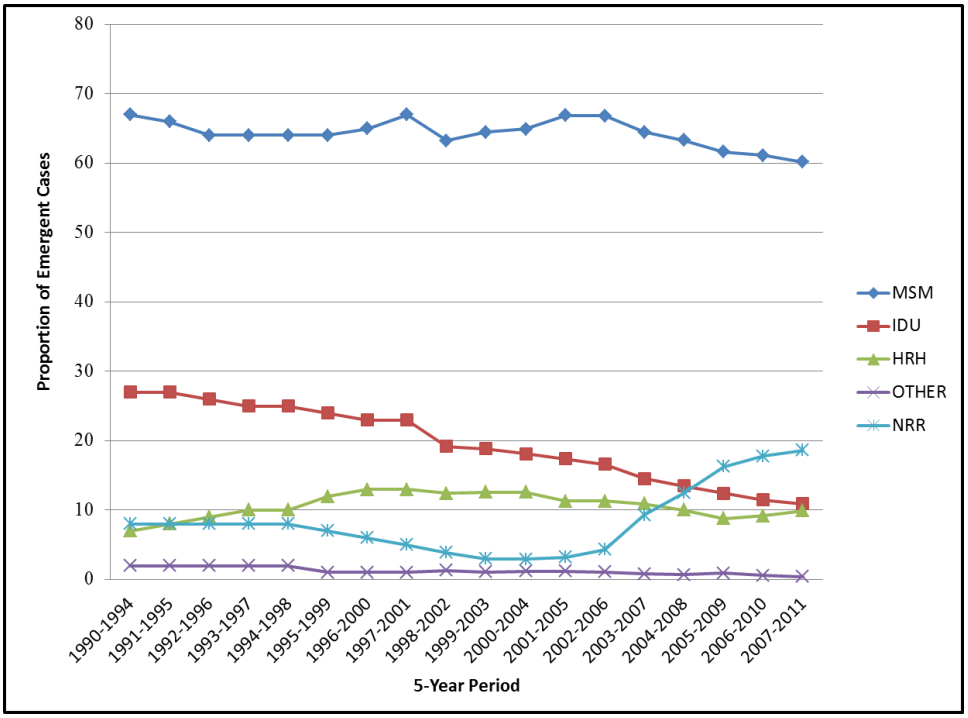


FIGURE 4: Arizona Percentage of Emergent Cases by Reported Risk Behavior, 1990-2011

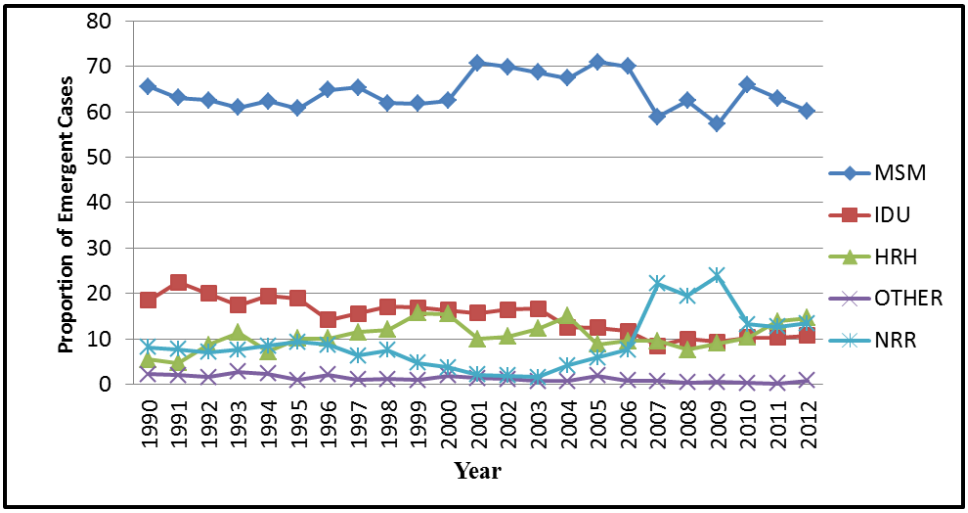
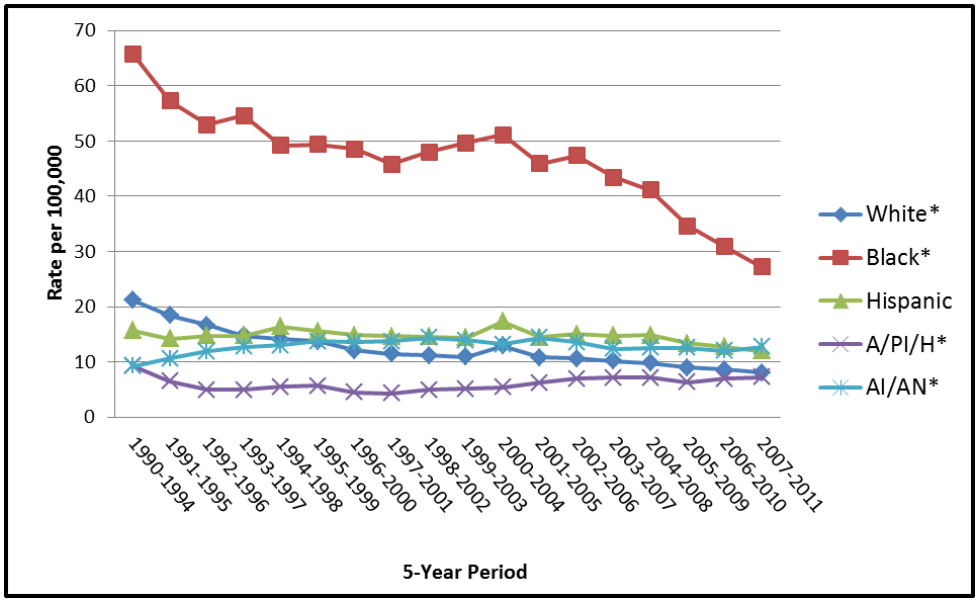


FIGURE 5: Estimated Single-Year Emergent HIV/AIDS Rates by Risk

Among all the risk groups in Figure 5, men who have sex with men (MSM) account for the largest proportion of emergent HIV/AIDS cases in Arizona. In 2012, the proportion of emergent cases that were MSM-related was 60.2%, the highest among all risk groups. However, the single-year MSM rate has declined from 65.85% in 2010 to 60.2% in 2012. The downward trend in rates among MSM has been mirrored by a similar upward trend among persons with no reported risk (NRR), which has increased from 7.6% in 2006 to 13.5% in 2012.

FIGURE 5: Arizona 5-Year Emergent HIV/AIDS by Race/Ethnicity



*Non-Hispanic, A/PI/H=Asian/Pacific Islander/Native Hawaiian, AI/AN=American Indian/Alaska Native

Rates of HIV/AIDS prevalence and emergence differ sharply between Black Non-Hispanics and other racial/ethnic groups in Arizona. According to the most recent 5-year emergent rates (Figure 5), the rate of HIV/AIDS emergence in Black Non-Hispanics is 164% higher than the statewide average. The single-year rates show the same pattern; the 2012 emergent HIV/AIDS rate among Black Non-Hispanics in Arizona is 281% greater than the statewide average. These results are consistent with national data. The CDC estimates Black Non-Hispanics made up 46% of new 2011 HIV diagnoses despite composing only 12% of the overall population (CDC slide set, HIV Surveillance by race/ethnicity, through 2011data http://www.cdc.gov/hiv/topics/surveillance/resources/slides/general/index.htm).

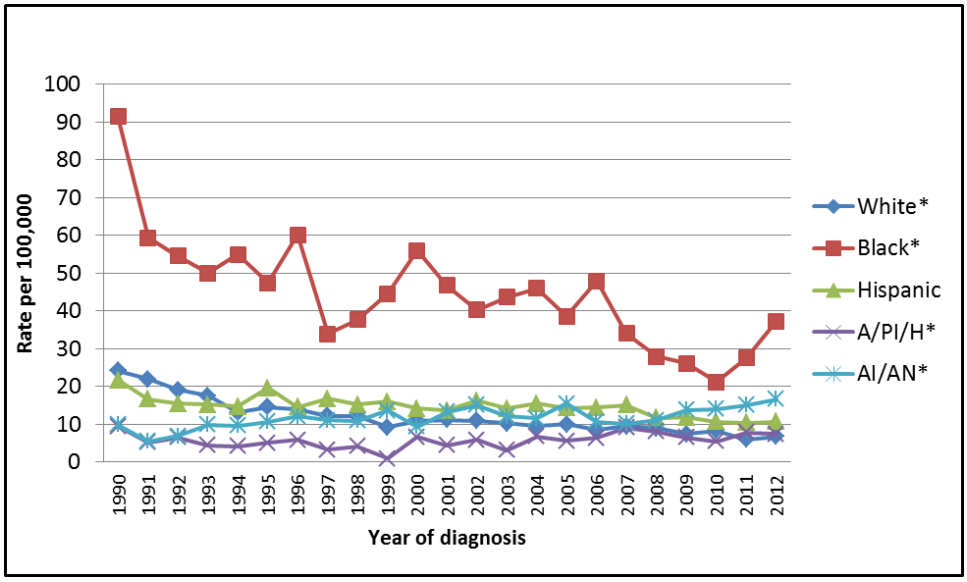


FIGURE 6: Single-Year Emergent HIV/AIDS Rates by Race/Ethnicity

*Non-Hispanic, A/PI/H=Asian/Pacific Islander/Native Hawaiian, AI/AN=American Indian/Alaska Native

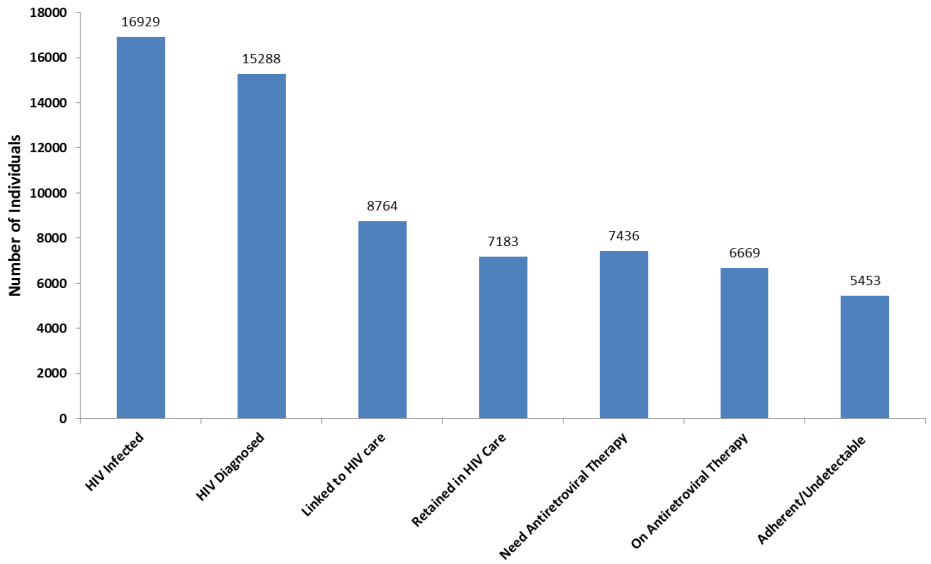
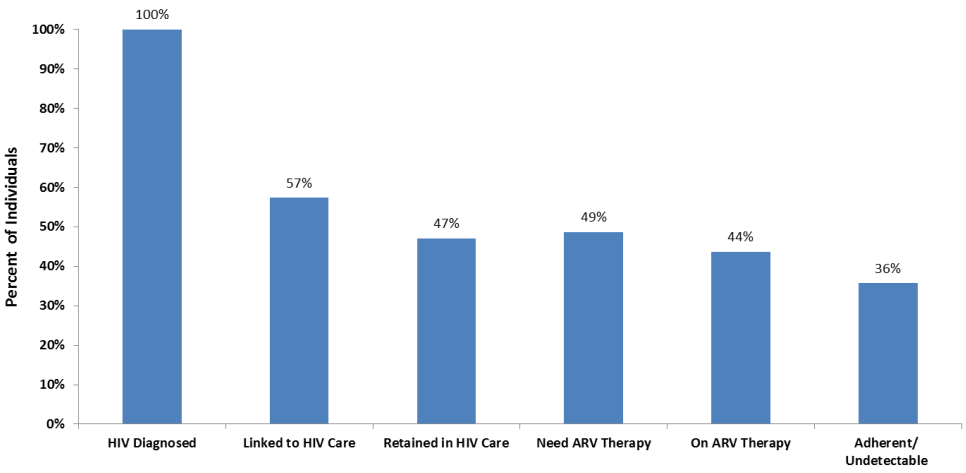


FIGURE 7: Arizona HIV Continuum of Care 2012—Prevalent Cases

THE ARIZONA HIV CONTINUUM OF CARE

The HIV Continuum of Care—sometimes also referred to as the HIV treatment cascade—is a model that is used by Federal, state and local agencies to identify issues and opportunities related to improving the delivery of services to people living with HIV across the entire continuum of care. The Arizona HIV Continuum of Care was created using data from eHARS (electronic HIV/AIDS Reporting System), an analysis of unmet needs, and ADAP (AIDS Drug

FIGURE 8: 2012 Engagement in Care (percentages)



Definitions:

HIV-Infected: Prevalent cases and estimated unaware cases of HIV infection (end of year).

HIV-Diagnosed: Prevalent cases that have been diagnosed.

Linked to HIV Care: Prevalent cases with a documented lab test, doctor visit or medication use in the calendar year.

Retained in HIV Care: Prevalent cases with a documented lab test, doctor visit or anti-retroviral (ARV) use in this calendar year and last calendar year.

Need ARV Therapy: Prevalent cases whose last CD4 count of the calendar year was less than 350/µL, whose last viral load of the calendar year was greater than 100,000 copies/mL , who had a documented opportunistic infection or who had documented ARV use during the calendar year.

On ARV Therapy: Prevalent cases with documented ARV use or whose last viral load of the calendar year was undetectable

Adherent/ Undetectable: Prevalent cases whose last viral load of the calendar year was undetectable.

Assistance Program) information. The number of Total HIV Infected has been calculated using the CDC's national estimate of the percent of people who are unaware they are HIV positive (18.1%).

As shown in Figure 7, in 2012 there were 16,929 HIV infected individuals in Arizona: an estimated 1,641 who are unaware of their HIV status, and 15,288 individuals who have been diagnosed as being HIV positive. Of the 15,288 who are aware of their status, only 8,765 were linked to care. Of that number, 7,183 of HIV positive Arizonians are retained in care. 7,436 HIV positive Arizonians need anti-retroviral (ARV) therapy, and 6,669 HIV positive individuals are on ARV therapy. Finally, only 5,453 HIV positive individuals have an undetectable viral load.

ARIZONA CONTINUUM OF CARE: 2012 ENGAGEMENT IN CARE

Looking at the percentages of HIV cases in Arizona, as shown in Figure 8, just over half of all individuals diagnosed with HIV (aware of their HIV status) are linked to care (57%). However, less than half (47%) are retained in care. Only 36% of individuals in Arizona who are aware of their HIV status have an undetectable viral load. When 100% of HIV positive Arizonans are linked to and retained in care, a greater number of individuals will be on ARV therapy. This would increase the percentage of individuals with an undetectable viral load. Data suggest that HIV-infected persons with undetectable viral load are less infectious, and may be less likely to transmit HIV via sexual contact.

PREVENTION PLANNING: A REGIONAL APPROACH

For prevention planning purposes, Arizona has been delineated into three distinct geographically differentiated regions, each with specific public health concerns and HIV Prevention challenges.

The Northern Region of the jurisdiction is comprised of Mohave, Yavapai, Coconino, Gila, Navajo and Apache Counties. The Northern Region 2012 combined population was estimated to be 785,415. The largest city, Flagstaff is located in Coconino County and had a 2012 estimated population of 67,468. Much of the Northern Region is tribal land and/or national forest, which contributes to its rural or "frontier" vastness. The sparse population density poses many challenges both for prevention and care of persons living with HIV. Key HIV prevention issues in the Northern Region include rural health care delivery concerns and disparities, transportation, stigma, limited service delivery areas by county and other health departments or providers due to population density, and access to resources. Federally-funded HIV care in Mohave County is provided by both the Las Vegas TGA Ryan White Part A Program and the Arizona Ryan White Part B Program.

Figure 8: Arizona Counties

The Central Region of the jurisdiction is comprised of Maricopa and Pinal Counties, and had an estimated population of 4,364,094 in 2012. The Central Region includes Phoenix, the state's capitol, which is the second-fastest growing metropolitan area in the country and one of the largest cities in the US by land area. Phoenix' 2012 population was estimated to be more than 1,488,750 people. The Central Region accounts for more than 70% of the state's HIV prevalence. Key prevention issues affecting the Central Region include ethnic/racial disparities, especially within the Black community, stigma, lack of sexual health education in schools, and access to care issues.

TABLE 6: NORTHERN REGION INCIDENCE 2007 TO 2011

	Emergent HIV			Emergent AIDS			Emergent HIV & AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	90	2.7	4.69	79	2.4	4.12	169	5.1	8.81
Female	25	0.7	1.27	8	0.2	0.41	33	1.0	1.68
TOTAL	115	3.4	2.96	87	2.6	2.24	202	6.1	5.21
By Age									
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2-12	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
13-19	3	0.1	0.79	1	0.0	0.26	4	0.1	1.05
20-24	11	0.3	4.17	7	0.2	2.65	18	0.5	6.82
25-29	24	0.7	10.36	8	0.2	3.45	32	1.0	13.82
30-34	15	0.4	7.75	10	0.3	5.17	25	0.7	12.91
35-39	20	0.6	10.17	13	0.4	6.61	33	1.0	16.78
40-44	9	0.3	4.16	11	0.3	5.08	20	0.6	9.24
45-49	17	0.5	6.67	13	0.4	5.10	30	0.9	11.77
50-54	8	0.2	2.94	11	0.3	4.05	19	0.6	6.99
55-59	5	0.1	1.86	7	0.2	2.61	12	0.4	4.47
60-64	1	0.0	0.39	1	0.0	0.39	2	0.1	0.78
65 and Above	2	0.1	0.29	5	0.1	0.71	7	0.2	1.00
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
TOTAL	**115**	**3.4**	**2.96**	**87**	**2.6**	**2.24**	**202**	**6.1**	**5.21**
By Race/Ethnicity									
White Non-Hispanic	46	1.4	1.81	35	1.0	1.38	81	2.4	3.19
Black Non-Hispanic	4	0.1	9.04	1	0.0	2.26	5	0.1	11.30
Hispanic	16	0.5	3.22	11	0.3	2.22	27	0.8	5.44
***A/PI/H Non-Hispanic**	3	0.1	7.34	2	0.1	4.90	5	0.1	12.24
****AI/AN Non-Hispanic**	42	1.3	5.51	35	1.0	4.59	77	2.3	10.11
*****MR/O Non-Hispanic**	4	0.1	N/A	3	0.1	N/A	7	0.2	N/A
TOTAL	**115**	**3.4**	**2.96**	**87**	**2.6**	**2.24**	**202**	**6.1**	**5.21**
By Mode of Transmission									
+MSM	43	1.3	N/A	46	1.4	N/A	89	2.7	N/A
++IDU	19	0.6	N/A	6	0.2	N/A	25	0.7	N/A
MSM / IDU	16	0.5	N/A	13	0.4	N/A	29	0.9	N/A
Heterosexual	18	0.5	N/A	6	0.2	N/A	24	0.7	N/A
+++O/H/TF/TPR	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
++++NRR/UR	19	0.6	N/A	16	0.5	N/A	35	1.0	N/A
TOTAL	**115**	**3.4**	**2.96**	**87**	**2.6**	**2.24**	**202**	**6.1**	**5.21**

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race
+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

TABLE 7: CENTRAL REGION INCIDENCE 2007 TO 2011

	Emergent HIV			Emergent AIDS			Emergent HIV & AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	1603	61.9	15.00	663	25.6	6.21	2266	87.5	21.21
Female	227	8.8	2.14	96	3.7	0.91	323	12.5	3.05
TOTAL	1830	70.7	8.60	759	29.3	3.57	2589	100.0	12.17
By Age									
Under 2	5	0.2	0.74	0	0.0	0.00	5	0.2	0.74
2-12	5	0.2	0.14	0	0.0	0.00	5	0.2	0.14
13-19	77	3.0	3.76	8	0.3	0.39	85	3.3	4.15
20-24	315	12.2	22.27	40	1.5	2.83	355	13.7	25.10
25-29	344	13.3	21.08	98	3.8	6.01	442	17.1	27.09
30-34	286	11.0	18.36	100	3.9	6.42	386	14.9	24.78
35-39	270	10.4	17.67	113	4.4	7.40	383	14.8	25.07
40-44	217	8.4	14.92	137	5.3	9.42	354	13.7	24.35
45-49	153	5.9	10.63	91	3.5	6.32	244	9.4	16.94
50-54	82	3.2	6.27	91	3.5	6.96	173	6.7	13.23
55-59	50	1.9	4.36	37	1.4	3.23	87	3.4	7.59
60-64	13	0.5	1.28	29	1.1	2.86	42	1.6	4.14
65 and Above	13	0.5	0.52	15	0.6	0.60	28	1.1	1.11
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
TOTAL	1830	70.7	8.60	759	29.3	3.57	2589	100.0	12.17
By Race/Ethnicity									
White Non-Hispanic	864	33.4	6.84	346	13.4	2.74	1210	46.7	9.58
Black Non-Hispanic	216	8.3	21.15	79	3.1	7.74	295	11.4	28.89
Hispanic	630	24.3	9.73	292	11.3	4.51	922	35.6	14.24
***A/PI/H Non-Hispanic**	41	1.6	5.75	11	0.4	1.54	52	2.0	7.29
****AI/AN Non-Hispanic**	55	2.1	12.87	25	1.0	5.85	80	3.1	18.72
*****MR/O Non-Hispanic**	24	0.9	N/A	6	0.2	N/A	30	1.2	N/A
TOTAL	**1830**	**70.7**	**8.60**	**759**	**29.3**	**3.57**	**2589**	**100.0**	**12.17**
By Mode of Transmission									
+MSM	1151	44.5	N/A	389	15.0	N/A	1540	59.5	N/A
++IDU	126	4.9	N/A	70	2.7	N/A	196	7.6	N/A
MSM / IDU	107	4.1	N/A	33	1.3	N/A	140	5.4	N/A
Heterosexual	137	5.3	N/A	72	2.8	N/A	209	8.1	N/A
+++O/H/TF/TPR	10	0.4	N/A	0	0.0	N/A	10	0.4	N/A
++++NRR/UR	299	11.5	N/A	195	7.5	N/A	494	19.1	N/A
TOTAL	**1830**	**70.7**	**8.60**	**759**	**29.3**	**3.57**	**2589**	**100.0**	**12.17**

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race
+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

TABLE 8: SOUTHERN REGION INCIDENCE 2007 TO 2011

	Emergent HIV			Emergent AIDS			Emergent HIV & AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	277	8.3	7.82	187	5.6	5.28	464	13.9	13.10
Female	53	1.6	1.46	26	0.8	0.72	79	2.4	2.17
TOTAL	**330**	**9.9**	**4.60**	**213**	**6.4**	**2.97**	**543**	**16.3**	**7.57**
By Age									
Under 2	5	0.1	2.49	0	0.0	0.00	5	0.1	2.49
2-12	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
13-19	14	0.4	1.98	2	0.1	0.28	16	0.5	2.27
20-24	42	1.3	8.02	10	0.3	1.91	52	1.6	9.93
25-29	55	1.6	11.36	26	0.8	5.37	81	2.4	16.73
30-34	54	1.6	12.44	16	0.5	3.69	70	2.1	16.12
35-39	33	1.0	7.75	35	1.0	8.22	68	2.0	15.97
40-44	34	1.0	7.90	40	1.2	9.30	74	2.2	17.20
45-49	35	1.0	7.46	31	0.9	6.60	66	2.0	14.06
50-54	31	0.9	6.57	27	0.8	5.72	58	1.7	12.30
55-59	14	0.4	3.18	14	0.4	3.18	28	0.8	6.36
60-64	7	0.2	1.78	6	0.2	1.52	13	0.4	3.30
65 and Above	6	0.2	0.53	6	0.2	0.53	12	0.4	1.05
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
TOTAL	**330**	**9.9**	**4.60**	**213**	**6.4**	**2.97**	**543**	**16.3**	**7.57**
By Race/Ethnicity									
White Non-Hispanic	145	4.3	3.78	95	2.8	2.48	240	7.2	6.25
Black Non-Hispanic	34	1.0	14.28	21	0.6	8.82	55	1.6	23.10
Hispanic	128	3.8	4.67	84	2.5	3.07	212	6.4	7.74
***A/PI/H Non-Hispanic**	7	0.2	4.12	3	0.1	1.77	10	0.3	5.89
****AI/AN Non-Hispanic**	12	0.4	6.31	8	0.2	4.21	20	0.6	10.51
*****MR/O Non-Hispanic**	4	0.1	N/A	2	0.1	N/A	6	0.2	N/A
TOTAL	**330**	**9.9**	**4.60**	**213**	**6.4**	**2.97**	**543**	**16.3**	**7.57**
By Mode of Transmission									
+MSM	183	5.5	N/A	99	3.0	N/A	282	8.5	N/A
++IDU	30	0.9	N/A	17	0.5	N/A	47	1.4	N/A
MSM / IDU	12	0.4	N/A	7	0.2	N/A	19	0.6	N/A
Heterosexual	49	1.5	N/A	49	1.5	N/A	98	2.9	N/A
+++O/H/TF/TPR	5	0.1	N/A	0	0.0	N/A	5	0.1	N/A
++++NRR/UR	51	1.5	N/A	41	1.2	N/A	92	2.8	N/A
TOTAL	**330**	**9.9**	**4.60**	**213**	**6.4**	**2.97**	**543**	**16.3**	**7.57**

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race
+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

The Central Region defines the geographic service delivery area for federally-funded HIV care provided by the Phoenix EMA Ryan White Part A Program.

The Southern Region of the jurisdiction includes Yuma, Pima, Santa Cruz, Cochise, Graham and Greenlee Counties. The 2011 population for this Region was 1,438,306. Pima County has the state's second highest prevalence (16%) and is home to Tucson, the state's second largest city. Four counties (Yuma, Pima, Santa Cruz, and Cochise) border Mexico. Hispanics account for a large percentage of the population of Southern Region counties, with the largest being in counties along the international border.

Key HIV prevention issues in the Southern Region include rural health care delivery concerns and disparities, transportation, stigma, limited service delivery areas by county and other health departments or providers due to population density, access to resources, and border issues.

The Ryan White Part B Program provides HIV care in the Southern Region, as do several other federally-funded programs.

ACTIVITIES FUNDED BY THE HIV PREVENTION PROGRAM

The HIV Prevention Program utilizes CDC funds to contract with public health departments, hospitals/clinics, and community-based organizations statewide to provide comprehensive HIV prevention services, as follows:

ALL REGIONS

HIV screening is available in all counties in the state through the local health departments, regional behavioral health authorities, and in local community-based organizations and hospital emergency departments in the Maricopa and Pima County areas. Additionally, although not covered by Prevention Program funding, testing is available through private providers and other organizations throughout the state.

The state of Arizona requires that only the state or local health departments may provide partner notification services.

Partner Services is provided by county health departments to all people living with HIV, regardless of when or where they were diagnosed. Partner Services is a free range of services that assist HIV positive people with confidentially notifying their sexual and/or injection drug use (IDU) partners about possible exposure to HIV. Partner Services also helps people living with HIV to medical care and support services, and monitors these individuals to ensure engagement in care occurs.

Condom distribution is facilitated statewide through collaboration with county health departments, Ryan White funded providers, case management organizations, testing and linkage to care programs, faith based organizations, Federally Qualified Health Centers and community-based organizations.

Other statewide programmatic activities include the provision of technical assistance for capacity building and training to funded and non-funded partners, the facilitation of community mobilization efforts, engagement in policy development, prevention planning, and the implementation of social marketing/media initiatives.

MARICOPA COUNTY

Maricopa County accounts for approximately 70% of the HIV epidemic in Arizona.

The HIV Prevention Program funds a variety of prevention services in Maricopa County. The Program has collaborated with Maricopa Integrated Health System (MIHS) to provide opt-out HIV testing in the Maricopa Medical Center emergency department. As of January 2014, the program tested more than 12,000 adults, with 77 confirmed positives (.28% positivity rate). The success of this project has resulted in its expansion to an additional emergency department in the burn unit and four MIHS community clinics.

MIHS is also contracted to provide Antiretroviral Treatment and Access to Services (ARTAS). ARTAS is an individual-level intervention focusing on linkage to medical care and specifically to medication treatment services in an effort to lower infectiousness and risk of transmission for positive individuals.

While initially tied to MIHS' emergency department opt-out testing project, ARTAS has been expanded to include any new and returning-to-care HIV positive individuals referred from other providers.

The implementation of opt-out, routine HIV testing programs increased HIV testing in Maricopa County by 652% from 2010 to 2012.

An opt-out testing program in the Maricopa County Jail System tests incarcerated individuals when they receive their initial medical screening. Upon diagnosis, inmates are evaluated for the need to begin antiretroviral therapy while incarcerated, and are linked to a Ryan White Part A funded medical case manager who provides education and release planning. The program conducts more than 15,000 tests each year, and has an approximately two percent positivity rate.

Southwest Center for HIV and TERROS, Inc. are contracted to provide behavioral interventions for people living with HIV and High-Risk Negative individuals. Choosing Life: Empowerment! Action! Results! (CLEAR) is an individual-level intervention that focuses on reducing behaviors that may increase risk of HIV transmission or infection with other sexually transmitted diseases, and improving ability to maintain better health. Healthy Relationships is a five-session, small group intervention focused on building skills related to disclosure of HIV status to family, friends, and sex or needle sharing partners, and establishing safer sexual behaviors. The delivery of these interventions is focused on Men who have Sex with Men (MSM), Injection Drug Users (IDU), homeless persons, young adults, and Black women and their partners. Both programs provide services to any positive person regardless of demographic.

PIMA COUNTY

Pima County accounts for approximately 16% of the HIV epidemic in Arizona.

The HIV Prevention Program allocated Category C funding to implement an expanded testing project at University of Arizona Medical Center (UAMC) in Tucson. In late 2013, UAMC began offering opt-out HIV testing in two emergency departments in its hospital network.

Southern Arizona AIDS Foundation and COPE have been subcontracted by Pima County Health Department to provide the CLEAR and ARTAS behavioral interventions.

YAVAPAI COUNTY

Yavapai County Community Health Services is funded to provide HIV prevention education for LGBT youth (a population of interest in the Northern region of the state).

Mohave County is unique in that Ryan White funded care services are provided by both the Las Vegas Part A Program and the Arizona Part B Program.

MOHAVE COUNTY

A Medical Assistant position has been funded at North Country Healthcare to perform enhanced continuity of care between Ryan White programs and the HIV Prevention program, provide linkage to care services, and facilitate Partner Services activities for Mohave County Department of Public Health. North Country Healthcare also provides basic HIV prevention and health education.

TABLE 9: HIV Prevention Program Resource Allocations for 2014

HIV PREVENTION PROGRAM RESOURCE ALLOCATIONS FOR 2014

Required Program Components	**$2,706,586**
HIV Testing in Healthcare Settings	$1,510,614
Category A (Health Departments)	*$646,082*
Category B (Emergency Departments, Jails, Outreach Testing)	*$422,162*
Category C (Testing/Linkage to Care Expansion Projects)	*$442,370*
Comprehensive Prevention Activities *(Partner Services, Linkage to Care, Interventions for HIV Positive Persons and High-Risk Negatives)*	$1,120,972
Condom Distribution	$75,000
Recommended Program Activities	**$85,022**
Social Marketing/Media/Community Mobilization	$85,022
Program Administration/Monitoring/Evaluation	**$1,137,608**
Includes funding allocated to personnel, program monitoring and evaluation, jurisdictional prevention planning, policy initiatives, professional outside services, laboratory/testing supplies, and general operating expenses.	
TOTAL FUNDS	**$3,929,216**

OTHER PREVENTION AND CARE SERVICES IN THE JURISDICTION

- The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid program. AHCCCS provides medical care and supportive services to low-income individuals.
- Federal Ryan White Programs fund a variety of primary medical care and support services statewide, which are available to people living with HIV and affected individuals who do not qualify for any other care programs.
- The Ryan White Part B AIDS Drug Assistance Program (ADAP) provides access to medications, medical care and copay assistance.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) provides substance abuse and mental health services, HIV screening, and linkage to care services.
- The Centers for Disease Control (CDC) directly funds service providers in Tucson (Pima County) to offer HIV prevention programs targeting Injection Drug Use (IDU) populations.
- The Social Security Administration provides disability benefits to people living with HIV who cannot work.
- The Veterans Administration provides services at health centers located throughout Arizona.
- Indian Health Services provides healthcare to American Indian and Alaskan Native peoples.
- Housing Opportunities for Persons Living With AIDS (HOPWA) programs help people living with HIV/AIDS maintain their current living environments. HOPWA may also be able to provide emergency rent, mortgage and utility payments, and rental assistance.
- Maricopa Integrated Health System (MIHS) Copa Care program is a sliding fee discount policy for MIHS patients receiving services at any MIHS facility, and/or the McDowell Healthcare Center (HIV clinic).
- The Arizona AIDS Education and Training Center (AETC) provides training/ technical assistance to medical professionals and clinical providers.

For a comprehensive listing of HIV-related services throughout the Arizona Jurisdiction, visit HIVAZ.org

The Prevention Planning Group of Arizona

For more than 14 years, the Prevention Planning Group of Arizona (PPGA) has been overseeing the planning and delivery of HIV prevention services in the Arizona jurisdiction. Statewide membership has been very diverse, representing funded and collaborative partners, people living with HIV, and other stakeholders. Participation had been strong until the release of the CDC's guidelines for PS-12-1201 funded activities in 2011. These guidelines established mandated activities and funding priorities, and eliminated the resource allocation activities previously completed by the PPGA. The significant changes to the roles and responsibilities of the PPGA were negatively received, and the transition to follow the new guidance was poorly managed. Participation dwindled. From a group of nearly 30 people, only a handful of members were participating in PPGA activities by March 2013, when a new Office Chief for the HIV Prevention Program was hired.

In collaboration with the Jurisdiction's CDC Project Officer, the new Office Chief undertook an assessment of the membership of the PPGA, and the then current activities of the planning body. Major findings of this assessment were that diminished participation and membership decline was related to the

majority of PPGA members losing interest in participating, due the elimination of resource allocation authority in the revised PS12-1201 guidance, and relationship issues that developed during the transition to the new grant guidance contributed to an unfulfilling volunteer experience.

Based on this evaluation, it was determined that the HIV Prevention Program would receive technical assistance from CDC partners to revitalize the PPGA, align the group's activities to address the PS12-1201 guidance, and explore integration of planning activities with Ryan White care services planning bodies. The jurisdiction's CDC Project Officer determined that the Arizona Jurisdictional Plan did not fully address CDC requirements, and requested that a revised plan be submitted once the PPGA was reorganized.

Since April 2013, the HIV Prevention Program has received ongoing technical assistance from its Project Officer, CDC partners and peer programs to complete these activities.

In May 2013, the HIV Prevention Program received a joint CDC/HRSA letter supporting (and recommending) the integration of prevention and care planning. The HIV Prevention Program approached the jurisdiction's HIV planning bodies for care services to begin integration discussions. These entities are:

- Phoenix EMA Ryan White Part A Planning Council (central Arizona services)
- Arizona Ryan White Part B Planning Consortium (statewide services)
- Las Vegas TGA Planning Council (Mohave County services).

In June 2013 the HIV Prevention Program formally announced it would "sunset" the membership and organizational structure of the existing PPGA. Taking its place would be three smaller interim planning entities, each focused on region-specific service areas: central Arizona (Maricopa and Pinal counties), northern Arizona, and southern Arizona. These interim groups would be

tasked with the establishment of a revised Jurisdictional Plan, and oversee the implementation of the Plan while the integration of prevention/care planning was completed over the next two years .

In February 2014, The Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) and the Centers for Disease Control and Prevention (CDC) announced an accelerated timeline for the integration of prevention and care planning. Coordinated plans are now expected to be established by September 2016. As such, the HIV Prevention Program decided to begin integrating much more quickly with the Ryan White planning councils overseeing the jurisdiction's care services. The original plan of establishing three interim planning bodies has been revised. There will be no further activity to establish any other interim regional planning bodies. Instead, the existing Central Region planning body will be complimented with membership from the Northern and Southern Regions, to facilitate comprehensive statewide prevention planning. Discussions regarding expediting integrated care/prevention planning are now occurring with the Arizona Ryan White Planning bodies.

As of March 2014, the HIV Prevention Program has a representative on the Las Vegas TGA Planning Council. Full integration of prevention and care planning entities is now expected to occur by the spring of 2015. During the transition period, the PPGA will continue to seek input from stakeholders, community members and providers statewide. The PPGA will also establish a schedule to report progress related to completing activities and achieving goals.

THE ENGAGEMENT PROCESS

Once the decision to reinvigorate HIV prevention planning was made, and a new PPGA structure and planning process was established, a strategy for the recruitment of new members and the engagement of stakeholders was developed by the PPGA co-Chairs. The following objectives were created:

- Identify key stakeholders to involve in the process that represent the full HIV continuum of care—prevention, care and treatment
- Ensure diverse representation, including people infected/affected by HIV, community leaders, representatives of other planning bodies, service organizations, governmental entities, and youth
- Establish a streamlined procedural framework and membership structure to promote engagement and facilitate integration with care planning entities in the near future
- Include mechanisms to allow consumers and providers to provide input

Stakeholder engagement began in the summer of 2013. Key stakeholders representing AIDS Service Organizations, governmental entities, Prevention Program providers, planning bodies, non-elected community leaders, and community-based organizations were invited to participate. Members of the HIV infected/affected community were recruited via materials displayed by service providers and/or distributed at consumer-focused activities (such as congregate meals) or during events (such as Gay Pride). Beginning in May 2013, the HIV Prevention Program held monthly informal meetings to introduce prospective members to the Program and review prevention planning needs and participation requirements. On September 9, 2013, the Central Region Prevention Planning Group of Arizona officially met for the first time to begin revising the prevention plan for the jurisdiction.

PPGA MEMBERSHIP *as of March, 2014*

Christina Floyd, Community Co-Chair (Black AIDS Task Force)

John Sapero, Program Co-Chair

Angela Hughey, ONE Community

Bert Jacobs, Community Member

Brad Wishon, 1 Voice Community Center

Brin Scott, TERROS, Inc.

Carmen Batista, Ryan White Part A Program

CJ Minott, Youth Community Member

Deborah Reardon-Maynard, AZDHS, HIV Prevention Program

Jeremy Bright, Community Member

Jon Welsh, Southwest Center for HIV/AIDS

Justin Owen, Non-Elected Community Leader, Phoenix Pride

Kevin Hilzendeger, Project Hardhat

Kit Kloeckl, Aunt Rita's Foundation

Luiza Valdez, Youth Community Member

Lynea Adams, Southwest Center for HIV Prevention Interventions Manager

Mandee Rowley, Phoenix Shanti

Stacey Jay Cavaliere, One n Ten

Patrick Stout, Community Church of Hope

Randall Furrow, Chair—Ryan White Part A Planning Council

Roxanne Ereth, AZDHS, STD Prevention Services

Tom Hencz, Echo Magazine

GUIDING PRINCIPLES USED IN HIV PREVENTION PLANNING

To address the challenges of the epidemic in the United States, advance the prevention goals of the NHAS, and maximize the effectiveness of current HIV prevention methods, CDC's Division of HIV/AIDS Prevention pursues a High-Impact Prevention approach. This approach uses combinations of scientifically proven, cost-effective, and scalable interventions targeted to populations and geographic areas most affected by the epidemic, and promises to greatly increase the impact of HIV prevention efforts. HIP is also designed to maximize the impact of prevention efforts for all Americans at risk for HIV infection, including gay and bisexual men, communities of color, women, injection drug users, transgender women and men, and youth.

When revising Arizona's HIV Prevention Plan, the PPGA established the following guiding principles to ensure that goals, objectives and activities support High Impact Prevention:

Population-focused: Activities included in the plan will address the needs of populations living with, and/or most at-risk of contracting HIV in each Region of the Arizona jurisdiction.

Cost effective: Activities will be evaluated to ensure that they can be realistically implemented with the resources available to the HIV Prevention Program and its collaborative partners.

Scalable: The plan will identify goals and objectives that are appropriately scaled to the needs of each Region in the jurisdiction.

Demonstrable Impact: All activities included in the plan will have strong potential to reduce HIV infections.

STAKEHOLDER INPUT

The HIV Prevention Program has conducted multiple activities to engage stakeholders to inform the development of the 2014 to 2016 Jurisdictional HIV Prevention Plan:

- Consumers are invited to attend each PPGA meeting and provide input. During these meetings, non-PPGA members are encouraged to participate as if they were members, and have the opportunity to engage in dialog throughout the entire meeting.
- A prevention rapid assessment of MSM living in Maricopa County was conducted by the Prevention Program in late 2013, and prevention questions have been included on the 2014 Ryan White Part B Statewide Needs Assessment.
- Prevention Program staff conducted in-person site visits of each funded partner statewide, and met with representatives and consumers of local community-based organizations during these trips. During these site visits, participants were asked to identify the strategies and used to engage the community to take part in HIV testing and describe the local linkage to care procedures.
- In January of each year, a mandatory contractor training is conducted, which is open to the public to attend. More than 70 people (including 13 members of the public) attended the 2014 meeting, which included presentations and discussions regarding gaps and barriers to HIV testing and linkage, the Affordable Care Act as it relates to HIV, and a session seeking feedback on the usability of HIVAZ.org from both a provider and consumer perspective.
- In March 2014, the HIV Prevention Program and PPGA hosted a Continuum of Care Summit, to better understand how long it takes for a newly diagnosed individual to attend their first comprehensive medical appointment, measured from the date of diagnosis. More than 20 providers of services throughout the care continuum took part, offering input related to barriers and gaps that were both provider and consumer centric. This group will continue to meet quarterly to address linkage to care/engagement issues.

Highlights of the 2013 MSM Prevention Rapid Assessment:

83% of respondents had been tested for HIV at least once

74% felt that MSM should have an HIV test every 3 to 6 months

5% identified as being homeless or in housing transition

89% had access to the internet

58% had utilized an online dating/friendship network

- Members of the PPGA attended the Ryan White Part C/D Regional Quality Improvement meeting, seeking input regarding retention in care and collaborative opportunities to improve linkage to care timeframes. Participants included consumers and providers representatives. PPGA members also attended a two-day HIV-centric Quality Training provided by the National Quality Center, a HRSA-funded organization.

The Prevention Planning Group of Arizona has committed to the following range of ongoing activities to ensure an effective and comprehensive engagement process:

- Public announcement of all PPGA meetings and events, via email, blogs, community events calendars, and other communication mechanisms
- HIVAZ.org will provide the PPGA with an easily accessible internet presence, which will include the posting of meeting notices, meeting minutes, documents and other information
- Continued PPGA member participation on the Ryan White Planning Councils while integration activities are completed
- Assessments conducted by the PPGA
- Participation on assessments conducted by other programs/entities
- Continued analysis of entry/engagement in care, and surveillance/epi data
- Input gathered from consumers during community events/activities
- Input gathered at contractor meetings, provider networking opportunities, provider-centric events, etc.

DATA REFERENCED DURING THE DEVELOPMENT THIS PLAN

- Rapid Assessment of Prevention Needs/Messaging Preferences/Media Access of MSM in Maricopa County
- HIV Prevention Program Annual Progress Report for 2012, and Interim Progress Report for 2013
- A utilization and cost-benefit analysis of an HIV Prevention Program-funded emergency room opt-out testing program conducted by Maricopa Integrated Health System
- 2012 Ryan White Part A Pathways to Care Study (Linkage to Care Analysis)
- 2012 Ryan White Part A Needs Assessment of people living with HIV in Maricopa and Pinal County
- 2010 Ryan White Part B Needs Assessment of people living with HIV throughout Arizona
- Las Vegas and Phoenix Ryan White Part A Comprehensive Plans
- Ryan White Part A Grant Application, including a comprehensive section addressing early intervention strategies to engage people who are newly diagnosed/returning to care to enter medical care
- Ryan White Part B Grant Application
- Arizona Statewide Coordinated Statement of Need
- HIV epidemiological data for Arizona, including zip code-based incidence/ prevalence information and the Arizona Continuum of Care defined by age, county, gender and race/ethnicity
- National epidemiological data, and other relevant information

POPULATIONS TO BE ADDRESSED BY THIS PLAN

The CDC's High Impact Prevention Strategy recognizes that while all Americans are affected by the HIV epidemic, some populations bear an especially heavy burden and account for the largest numbers of HIV infections. Success in HIV prevention can only be achieved by addressing these disparities and working to achieve health equity. Nationally, the most hard-hit populations include Men who have Sex with Men (MSM) of all races and ethnicities, African Americans/Blacks, Hispanics/Latinos, Injection Drug Users (IDU) and Transgender Individuals.

Prevention planning for Arizona has been divided into three regions (Northern, Central, and Southern) based on population disbursal, alignment with geographic boundaries for federally-funded care services, and the concentration and similarity of target populations. Target populations have been determined based on epidemiological data from the Arizona Department of Health Services (ADHS), HIV Epidemiology Program's 2012 Annual Report, and input from the Ryan White Part A Planning Council, all Ryan White Grantees (A, B, C and D), Maricopa County Department of Public Health, HIV focused non-profit agencies, community members and other key stakeholders.

Northern Region

- MSM of all races and ethnicities
- Hispanics
- American Indians

Central Region

- MSM of all races and ethnicities
- Hispanics
- African Americans/Blacks (AA/B), especially women

Southern Region

- MSM of all races and ethnicities
- Hispanics
- Injection Drug Users (Pima County)

2014 to 2017 Jurisdictional Plan Goals and Activities

For services provided from January 2014 to January 2017

HIV TESTING and OTHER STATUS AWARENESS EFFORTS

GOAL 1	Increase, **by at least 10% each year**, the number of HIV tests conducted health departments funded by the HIV Prevention Program. **Yearly goals: 2014: 25,400/ 2015: 28,000/ 2016: 31,000**
Scale of Activity	**Increase** activities.
Rationale	Approximately 18% of Arizonans living with HIV are unaware they are infected with the disease. The National HIV/AIDS Strategy discusses that to reduce new HIV infections, it is critical that people become aware of their HIV status and take appropriate action to preserve their health. Additionally, studies have shown that individuals diagnosed with HIV take steps to reduce the likelihood of transmitting the disease to others.

Activity	Description	Completed By
1.1	Conduct a needs assessment of funded and non-funded providers to determine methods to facilitate increased targeted HIV testing for high-prevalence populations.	Q1 2015
1.2	Based on this assessment, implement at least two activities during each grant year	Q4 2015 Q4 2016

Activity	Description	Completed By
1.3	Establish baseline values for HIV testing in each Region and define numeric goals for each year.	Q4 2014
1.4	Implement quarterly reporting mechanism to monitor and share progress.	Q4 2014
1.5	Implement the use of Determine fourth-generation testing materials by all Prevention Program-funded entities.	Q4 2014 (est.)
1.6	Explore collaboration with Walgreens or other appropriate partners to expand testing in high incidence/prevalence areas, where target populations live, and/or during events such as National HIV Testing Day.	Q3 2015
1.7	Each year, recruit at least one new hospital/Federally Qualified Health Center to implement routine, opt-out testing.	Q4 2015 Q4 2016
1.8	Maintain collaboration with entities that have partnered with the HIV Prevention Program to implement opt-out testing programs (Maricopa Integrated Health Systems, University of Arizona Medical Center, and the Maricopa County Jail).	Ongoing
1.9	For every individual who accesses Partner Services, entities providing these services will identify and engage at least one partner to complete HIV testing.	Ongoing

COMPREHENSIVE PREVENTION FOR POSITIVES

GOAL 2	By January 2017, facilitate enhancements in the HIV continuum of care in Maricopa County so that **75% of individuals who are diagnosed by an entity funded by the HIV Prevention Program attend their first comprehensive HIV medical appointment within 30 days** of the date of their diagnosis.
Scale of Activity	**Increase** activities.
Rationale	Linkage to care helps ensure people living with HIV receive life-saving medical care and treatment, and helps reduce their risk of transmitting HIV. Additionally, national research has shown that the faster an individual engages in medical care, the more likely they are to remain adherent to their treatment, resulting in a longer life span and reduced medical care costs.

Activity	Description	Completed By
2.1	Establish a Continuum of Care workgroup, comprised of diverse stakeholders to identify factors to identify issues that prolong newly diagnosed individuals entry to care, including program enrollment challenges, wait times for medical appointments, and other client- and provider-centric issues.	Q1 2014 Meet Each Quarter
2.2	Conduct an assessment of a sample number of individuals accessing care via Medicaid, Ryan White programs, and private insurance (if possible), to determine baseline indicators for entry to care timeframes. Prioritize identified issues and develop and implement a plan to address them.	Q3 2014
2.3	Conduct a Pathways to Care assessment of providers who are not common to traditional HIV continuum of care networks, to better understand how individuals who are newly diagnosed and returning to care are referred to care.	Q2 2015
2.4	Establish referral relationships with health insurance plans within the jurisdiction that provide HIV-related case management, patient navigator, or other services offered to HIV clients. Distribute to information to HIV providers.	Q2 2015
2.5	Develop an action plan to improve relationships, streamline processes, increase provider knowledge, etc.	Q3 2015
2.6	Implement quarterly reporting mechanism to monitor and share progress	Q1 2016

COMPEHENSIVE PREVENTION FOR POSITIVES

GOAL 3	Each year, **at least 85% of newly diagnosed individuals** are interviewed for Partner Services. Additionally, **90% of HIV positive clients** who actively seek Partner Services are interviewed within three business days.
Scale of Activity	**Maintain** the current level of activity.
Rationale	Partner Services can reduce the spread of HIV by facilitating the confidential identification and notification of partners who may have been unknowingly exposed to HIV, providing them with HIV testing, and linking them to prevention and care services. In Arizona, state law mandates that public health agencies must be the sole providers of Partner Services. Therefore, the existing infrastructure for the delivery of Partner Services will be maintained.

Activity	Description	Completed By
3.1	Continue to collaborate with public health agencies to provide Partner Services.	Ongoing
3.2	Provide capacity building and technical assistance to agencies providing Partner Services to meet the goals established above.	Ongoing
3.3	Promote the availability of Partner Services to consumers and providers.	Ongoing

GOAL 4	Increase the percentage of individuals referred to the Anti-Retroviral Treatment and Access to Services (ARTAS) programs by funded HIV testing and Partner Services providers, from **40 percent in 2013 to 85 percent in 2016**.
Scale of Activity	**Increase** activities.
Rationale	Individual and small-group interventions have been shown to significantly reduce risk behaviors among people who have been diagnosed with HIV to help insure they do not transmit the virus to others. Anti-Retroviral Treatment and Access to Services (ARTAS) is an individual-level, multi-session, time-limited intervention with the goal of linking recently diagnosed persons with HIV to medical care soon after receiving their positive HIV diagnosis. ARTAS has been shown to be particularly effective in engaging individuals who may be challenged to self-manage their entry into care.

Activity	Description	Completed By
4.1	Define policies and procedures for providers of HIV testing and Partner Services, to establish automatic referral mechanisms to ARTAS programs.	Q1 2015
4.2	Assess provider training and technical assistance needs to improve client referrals to ARTAS programs.	Q1 2016
4.3	Provide training and technical assistance to improve the abilities of funded provider's employees to engage individuals to respond positively to referrals to ARTAS programs.	Q2 2015 Ongoing
4.4	Promote ARTAS programs to appropriate funded and non-funded providers.	Ongoing

INTERVENTIONS FOR HIGH-RISK NEGATIVE INDIVIDUALS

GOAL 5	Increase the number of high-risk negative persons who are screened for behavior risks and enrolled in individual-level and/or group-level evidence-based interventions, **from 7% of total participants in 2013 to 20% of total participants in 2014. Maintain or increase this percentage each year.**
Scale of Activity	**Maintain** the current level of activity.
Rationale	Individual and small-group interventions for people who are at high risk for HIV infection can reduce risk behavior and can play an important role in comprehensive HIV prevention strategies.

Activity	Description	Completed By
5.1	Collaborate with providers to increase the number of spaces available to high-risk negative persons in CLEAR and Healthy Relationships interventions.	Q2 2014
5.2	Revise programming guidelines to allow for up to 10% of participants in funded interventions to be high-risk negative persons.	Q2 2014
5.3	Collaborate with Maricopa Integrated Health Systems to implement the Partnerships for Health intervention in up to four integrated home health clinics.	Q3 2014
5.4	Revise enrollment procedures for all funded interventions to require that all enrollees in all individual-level and group-level interventions complete a behavioral risk survey as part of the intake process, and that reporting of this requirement is provided to the HIV Prevention Program each month.	Q3 2014
5.5	Implement quarterly reporting mechanism to monitor and share progress.	Q3 2014

CONDOM DISTRIBUTION

GOAL 6	Increase number of condoms distributed by the HIV Prevention Program, **from 167,000 in 2013 to 334,000 in 2016**.
Scale of Activity	**Increase** activities.
Rationale	Condom use is the most effective method to reduce risk of HIV infection during sexual activity. Correct and consistent use of male condoms is estimated to reduce the risk of HIV transmission by 80 percent.

Activity	Description	Completed By
6.1	Establish online condom request initiative via HIVAZ.org.	Q1 2015
6.2	Each year, recruit at least two additional partners for targeted condom distribution to High-Risk Negative and/or Positive individuals. These entities may include pharmacies, community-based organizations, bars, adult entertainment venues, etc.	Q4 Each Year
6.3	Evaluate condom distribution initiatives established in other jurisdictions, and implement as possible.	Ongoing

CONDOM DISTRIBUTION

GOAL 7	Increase the percentage of condoms distributed by the HIV Prevention Program to people living with HIV, **from 23% of overall condoms distributed in 2013 to at least 60% in 2016**.
Scale of Activity	**Increase** activities.
Rationale	According to the CDC, taking medicines for HIV infection can reduce the risk of an HIV-infected person transmitting the infection to another by as much as 96%, and consistent use of condoms reduces the risk of getting or transmitting HIV by about 80%. Using both condoms and antiretroviral therapy reduces the risk of HIV acquisition from sexual exposure by 99.2%.

Activity	Description	Completed By
7.1	Redevelop existing consumer-centric marketing materials for the Pharmacy Condom distribution project. Create provider-specific materials.	Q2 2014
7.2	Establish and implement consumer- and provider-centric marketing initiatives for the Pharmacy Condom Distribution program.	Q3 2014
7.3	Create training component for participating partners, teaching how to promote the program and engage consumer buy-in.	Q3 2014
7.4	Evaluate marketing initiatives and Pharmacy Condom Distribution program success; revise strategies as needed.	Q2 2015 Q2 2016
7.5	Each year, recruit at least two new partners to take part in the Pharmacy Condom Distribution program.	Q4 Each Year

PRE-EXPOSURE PROPHYLAXIS (PrEP) AND NON-OCCUPATIONAL POST-EXPOSURE PROPHYLAXIS (nPEP)

GOAL 8	Each year, **evaluate consumer and provider interest in Pre-exposure Prophylaxis (PrEP) and Non-occupational Post-Exposure Prophylaxis (nPEP),** and collaborate as possible to support related activity in the jurisdiction.
Scale of Activity	**Maintain** the current level of activity.
Rationale	Pre-exposure Prophylaxis (PrEP) is a newer HIV prevention method. People who are at high risk for getting HIV can take a daily pill (branded Truvada) to reduce their risk of getting the disease. PrEP must be used in combination with safer sex practices to reduce the risk of sexually acquired HIV infection. While PrEP has been proven effective, the cost of medications has made insurance companies and assistance programs resistant to approving its use by non-HIV positive individuals. Providers have reported strong personal support for PrEP, but limited interest from consumers, and challenges with prescription cost/coverage have diminished their willingness to proactively promote PrEP to their clients. In late 2013, the Office of HIV Prevention learned that one of its contractors (Maricopa County Department of Public Health) had initiated a pilot program to refer High Risk Individuals with positive STD screening results for PrEP evaluations. Four Maricopa County medical providers have agreed to provide no-cost PrEP evaluations for referred clients, and to assist with prescription coverage and/or enrollment in pharmaceutical assistance programs. The Prevention Program has promoted this pilot to Maricopa County providers and is partnering to monitor outcomes. The HIV Prevention Program has not identified a need to fund nPEP activities in the jurisdiction. The Program evaluates need on an annual basis.

Activity	Description	Completed By
8.1	Routinely monitor consumer and provider interest in Pre-exposure Prophylaxis (PrEP) and Non-occupational Post-Exposure Prophylaxis (nPEP), and as possible collaborate with partners to support and implement activities.	Ongoing
8.2	Partner with Maricopa County Department of Public Health (MCDPH) STD clinic to pilot a referral program for High-Risk MSM to be evaluated for Pre-exposure Prophylaxis (PrEP).	Q2 2014
8.3	Evaluate the MCDPH pilot program for PrEP referrals, and determine future actions	Q2 2015

POLICY DEVELOPMENT

GOAL 9	Each year, **monitor and analyze local and state health polices** to assure they promote goals for HIV prevention and care services, including but not limited to expanded HIV testing, Affordable Care Act coverage of HIV prevention services, and the elimination of barriers to accessing medical care.
Scale of Activity	**Maintain** the current level of activity.
Rationale	Policy decisions made at local and state levels should be supportive of HIV prevention, care and treatment initiatives. HIV-related issues should be considered when developing all health policies.

Activity	Description	Completed By
9.1	Evaluate local and state policies on a regular, ongoing basis to assure access to HIV prevention and care services.	Ongoing
9.2	Regularly engage in local and state health policy development activities to assure that all health policies are supportive of the goals of HIV prevention and care services.	Ongoing
9.3	As appropriate and able, take action/provide input on proposed health policies. When the Prevention Program cannot be directly involved, educate community stakeholders to strengthen the impact of their actions.	Ongoing
9.4	Collaborate with at least two medical settings each year to establish or modify internal policies to promote routine, opt-out HIV testing in their emergency departments.	Yearly
9.5	Establish dialog with Medicaid, insurance programs, and other key stakeholders to encourage adoption of Pre-Exposure Prophylaxis (PrEP) coverage.	Q4 2014
9.6	Assess the need/feasibility of proposing legislation and or policies condom use by the adult entertainment industry in Arizona.	Q1 2015

GOAL 10	By April 2015, **expand consumer- and provider-centric content on HIVAZ.org,** including step-by-step guides for engagement in care and provider referrals, video walkthroughs of various aspects of care, reminder systems, and comprehensive enrollment information for Ryan White services and other HIV care programs.
Scale of Activity	**Increase** activities.
Rationale	Increasingly, the public is utilizing internet resources for HIV testing, care and referral information. HIVAZ.org is Arizona's first free comprehensive online database of HIV testing, treatment and care services. The site has been collaboratively developed in with Aunt Rita's Foundation, a Phoenix-based AIDS service organization. Expansion of the content available on the site is intended to facilitate entry into medical care, provide tools to assist consumers to remain adherent to their treatment plans, and increase provider knowledge of referral opportunities.

Activity	Description	Completed By
10.1	Enter into collaboration with Aunt Rita's Foundation, Ryan White Programs, and key stakeholders to transition client and provider-focused Ryan White Program content to HIVAZ.org.	Q2 2014
10.2	Establish high-level, step-by-step "roadmap" content on HIVAZ.org that guides medical providers on referral processes, testing procedures, eligibility guidelines and other information.	Q3 2014
10.3	Expand consumer-and provider-centric content to encourage self-referrals, reduce fear/stigma of testing and entry to care, etc. Additionally, establish online condom distribution mechanism.	Q1 2015
10.4	Promote HIVAZ.org in all materials as the statewide go-to online resource for testing, treatment and care information.	Ongoing
10.5	Develop and implement marketing initiative to medical care and supportive service providers, informing them of the availability of HIVAZ.org as a referral resource.	Q2 2015

SOCIAL MARKETING & MEDIA

GOAL 11	Each year, implement **at least two scalable social marketing campaigns, utilizing traditional and new media,** to support HIV testing and prevention initiatives.
Scale of Activity	**Increase** activities.
Rationale	The National HIV/AIDS Strategy discusses that outreach and engagement through traditional media (radio, television, and print) and networked media (such as online health sites, search providers, social media, and mobile applications) must be increased to educate and engage the public about how HIV is transmitted and to reduce misperceptions about HIV transmission. Efforts will be made to utilize and build upon World AIDS Day (December 1st) and National HIV Testing Day (June 27th), as well as other key dates and ongoing activities throughout the year.

Activity	Description	Completed By
11.1	Develop and implement a yearly scalable media plan that includes at least two social marketing efforts to educate the public about HIV, reduce HIV-related stigma, and/or encourage HIV testing/engagement in care. An evaluation of CDC-developed media will be included as part of this plan.	Q3 Each Year, for implementation the following year.
11.2	Develop and implement a yearly scalable media plan to promote National HIV Testing Day, World AIDS Day, and other HIV testing, education and awareness events.	Q3 Each Year, for implementation the following year.
11.3	Evaluate the effectiveness of the previous year's media efforts.	Q2 Each Year

COMMUNITY MOBILIZATION

GOAL 12	Each year, **establish relationships with stakeholders in target populations within the jurisdiction,** to facilitate mobilization efforts to promote HIV testing, improve linkages to care, and increase participation/collaboration in HIV prevention and care planning, and service delivery.
Scale of Activity	**Increase** activities.
Rationale	The Prevention Planning Group of Arizona (PPGA) and the HIV Prevention Program recognize the need to interact and support community-driven efforts to provide HIV education and awareness, identify and address health disparities, and activate the public to take part in HIV testing and care programs.

Activity	Description	Completed By
12.1	Engage key stakeholders in the African-American/Black community in Maricopa County (including elected and non-elected leaders, community-based organizations, faith-based leadership, and people infected/affected by HIV) to take part in prevention and care planning efforts.	Q4 2014
12.2	Conduct a prevention assessment targeting the African-American/Black community in Maricopa County.	Q2 2015
12.3	Engage key stakeholders in American Indian communities in Maricopa County (including elected and non-elected leaders, community-based organizations, faith-based leadership, and people infected/affected by HIV) to take part in prevention and care planning efforts.	Q4 2014
12.4	Conduct a prevention assessment targeting American Indians in the jurisdiction.	Q2 2015
12.5	Engage key stakeholders in the Hispanic community in Maricopa County (including elected and non-elected leaders, community-based organizations, faith-based leadership, and people infected/affected by HIV) to take part in prevention and care planning efforts.	Q4 2015
12.6	Conduct a prevention assessment targeting Hispanics in the jurisdiction.	Q2 2016
12.7	Facilitate strategic partnerships among key stakeholders, HIV prevention and care programs, state, local and tribal governments, public health associations, and other entities receiving HIV-related funding (Indian Health Services, Veterans Administration, service organizations, etc.).	Ongoing

GOAL 13

By December 31, 2016, **integrate HIV prevention and care planning statewide.**

Scale of Activity	**Increase** activities.
Rationale	In May 2013, the Prevention Program received a joint CDC/HRSA letter supporting the integration of prevention and care planning, especially among prevention planning bodies and Ryan White Program planning entities. Integrated planning was expected to be completed by 2016. A restructuring of the Prevention Planning Group of Arizona had been initiated in 2013, with statewide expansion occurring over the next two years. Efforts will now focus on integration with Ryan white planning bodies overseeing service delivery in the jurisdiction.

Activity	Description	Completed By
13.1	Establish collaboration with the Phoenix EMA Ryan White Part A Planning Council (Maricopa and Pinal County), Ryan White Part B Planning Group (all of Arizona), and the Las Vegas TGA Ryan White Part A Planning Council (Mohave County).	Q2 2014
13.2	Develop a plan for the integration of Prevention Planning Group of Arizona activities into the activities of the Phoenix EMA and Las Vegas TGA Ryan White Planning Councils.	Q3 2014
13.3	Develop a plan for the integration of Prevention Planning Group of Arizona activities into the activities of the Ryan White Part B Planning Group.	Q1 2015
13.4	Complete integration activities and issue a comprehensive plan for service delivery.	Q4 2016

SYRINGE ACCESS AND DISPOSAL PROGRAMS

GOAL 14	**Remain supportive** of efforts of non-funded entities to provide syringe access and disposal programs.
Scale of Activity	**Maintain** the current level of activity.
Rationale	Syringe access and disposal programs are a proven, cost-effective strategy to reduce HIV infection among Injection Drug Users (IDU). Arizona law established strict guidelines for these types of programs, and only Pima County has approved this activity to take place. Since the HIV Prevention Program is unable to fund these types of activities, the Program will remain collaborative and supportive of providers who are able to meet legal requirements with alternative funding.

Activity	Description	Completed By
14.1	Support entities providing syringe access and disposal programs, as able.	Ongoing
14.2	Provide HIV-related capacity building, technical assistance, education and other non-monetary support to providers of syringe access and disposal programs, as requested.	Ongoing

Conclusion

The 2014 to 2017 Arizona Jurisdiction HIV Prevention Plan is the result of many hours of research, review, and discussion completed by the members of the Prevention Planning Group of Arizona, the staff of the HIV Prevention Program, and a variety of collaborative partners. The creation of this Plan represents a shift in how HIV Prevention Services are implemented in Arizona, focusing on collaboratively developed initiatives, dynamic service delivery, and the monitoring of health outcomes. The Prevention Planning Group of Arizona and the Office of HIV Prevention believe that the goals and activities identified in this Plan support the goals of the National HIV/AIDS Strategy, and those of the CDC's High Impact Prevention approach.