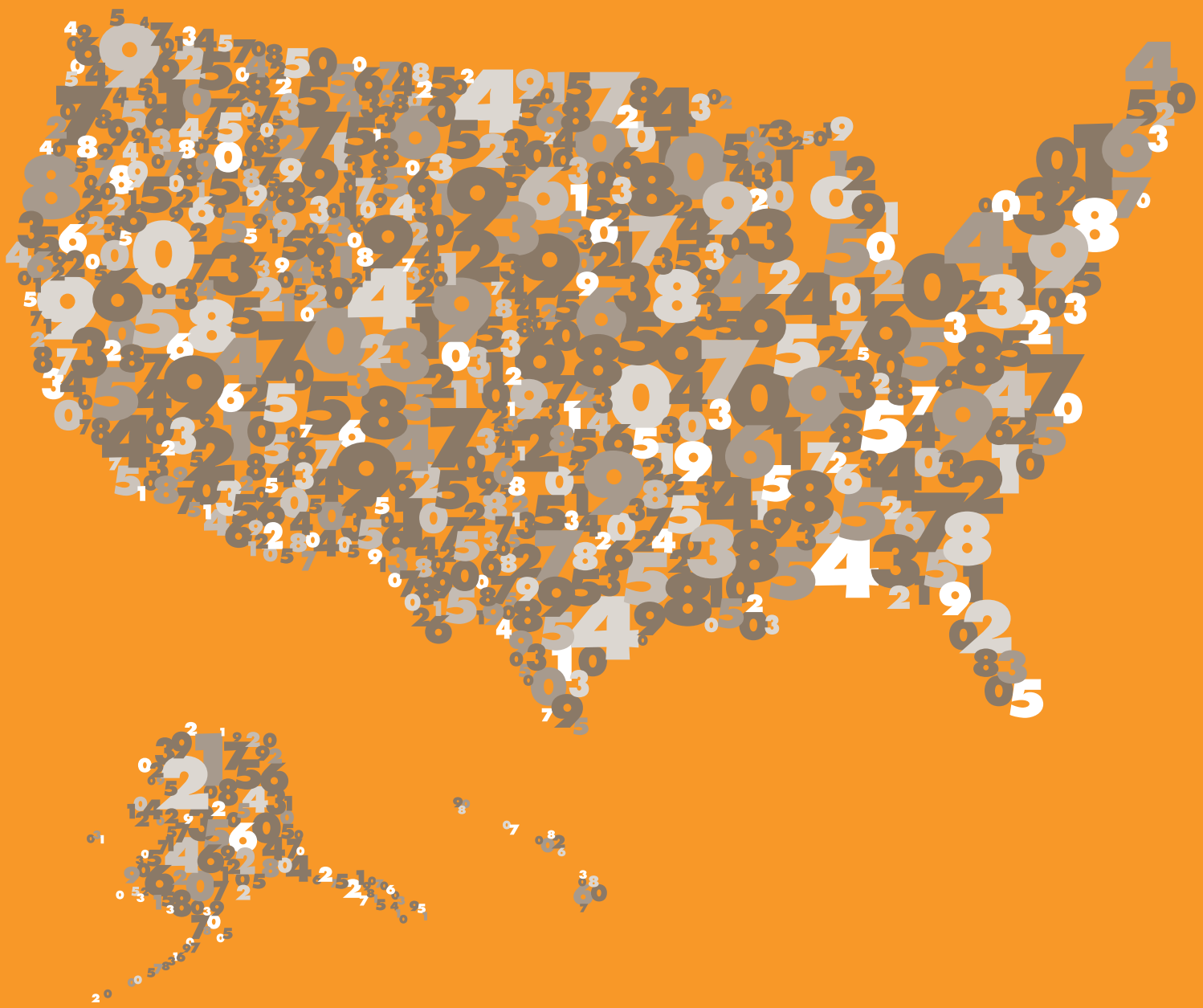
THE NATIONAL HIV PREVENTION INVENTORY:

THE STATE OF HIV PREVENTION ACROSS THE U.S.



A REPORT BY NASTAD AND
THE KAISER FAMILY FOUNDATION
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NASTAD™
NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

THE HENRY J. KAISER FAMILY FOUNDATION

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EXECUTIVE SUMMARY

Recent data from the Centers for Disease Control and Prevention (CDC) indicate that the HIV/AIDS epidemic in the United States (U.S.) is far from over. An estimated 56,000 people become infected with HIV each year, 40% higher than previously estimated. In addition, infections have remained at this level for more than a decade and certain populations bear the brunt of the impact, particularly Black Americans and gay and bisexual men of all races/ethnicities. These trends underscore the continuing importance of HIV prevention in the U.S. While the CDC plays the central, federal role in the nation's HIV prevention response, much of what is considered "HIV prevention" is actually decentralized to and carried out by state and local health departments, who have primary responsibility for coordinating and delivering HIV prevention services, as they do for public health activities more generally in the U.S.

This report, based on a survey of 65 health departments, including all state and territorial jurisdictions and six U.S. cities, provides the first, comprehensive inventory of HIV prevention efforts at the state and local levels. It is intended to offer a baseline picture of how HIV prevention is delivered across the country in an effort to provide policymakers, public health officials, community organizations, and others with a more in depth understanding of HIV prevention and the role played by health departments in its delivery.

READ ON

KEY FINDINGS

Funding for HIV Prevention Has Been Relatively Flat in Recent Years; While Funding from CDC Represents Just Over Half the Nation's Prevention Budget, States Provide Key Share

Funding for HIV prevention was $581 million in FY 2007, ranging from less than one million dollars in four smaller states (Idaho, North Dakota, South Dakota, and Wyoming), to more than $20 million in six large states which account for significant shares of the nation's HIV/AIDS prevalence and have longer-standing epidemics (California, Florida, Massachusetts, New Jersey, New York, and Texas). Just over half of prevention funding (58%, or $337 million) was provided by CDC. More than a third (35% or $205 million) was provided by 38 state and local governments, in some cases acting to supplement CDC support and in others providing the bulk of funding for their HIV prevention response. Since FY 2004, funding has been relatively flat, with the exception of an increase in FY 2007 of $35 million in federal funding for a CDC initiative to expand HIV testing; 22 of the 30 jurisdictions with increases in the last year received expanded HIV testing grants.

Jurisdictions with Greater Numbers of People Living with HIV/AIDS Have the Largest Prevention Budgets, but do not Rank at the Top in Funding Per Person with HIV/AIDS

The investment in HIV prevention varies across the country, reflecting differences in population size, epidemic burden, state and local contributions, local capacity, and other factors. In general, those states with the greatest numbers of people living with HIV/AIDS also have the largest HIV prevention budgets. However, when analyzed per person living with HIV/AIDS, low prevalence states as a group received the highest HIV prevention funding per case ($1,617), followed by high prevalence states, who received about half as much ($826), moderate prevalence states ($811) and high-to-moderate prevalence states ($652), a pattern largely driven by CDC funding; by contrast, state funding per person with HIV/AIDS was proportionate to prevalence. There were also regional variations in the HIV prevention investment, which largely tracked HIV prevalence.

An Array of HIV Prevention Services is Provided Across the Country, Including Health Education and Risk Reduction Activities, Partner Services, and HIV Testing

Health departments provide an array HIV prevention services, primarily a core set that consists of health education and risk reduction (HE/RR) activities, HIV testing and screening, and partner services. Other activities and services include HIV laboratory support, prevention community planning, and public education and media campaigns. Some jurisdictions also offer post exposure prophylaxis, needle and syringe access, and drug substitution services. In general, jurisdictions with lower prevalence spent a greater share of their budgets on program administration, laboratory support, and community planning compared to those with higher prevalence, who in turn allocated greater shares to direct prevention services (HE/RR, testing, partner services). This likely reflects the need for a jurisdiction to have at least a minimum amount of funding in place to support operation of a prevention program, and the economies of scale that are generally more achievable in higher prevalence jurisdictions, which also face greater demand for services .

Health Departments Are Increasingly Moving to Routine Population-Based HIV Screening, While Continuing More Targeted Efforts to Reach Those at Higher Risk

All states use targeted HIV testing strategies, which are designed

to reach populations at highest risk. An increasing share is moving to implement routine HIV screening, recommended by CDC for all adults/adolescents (ages 13-64), all pregnant women, and newborns, although this varies by population group: 42 jurisdictions report conducting routine HIV screening for pregnant women, 17 for newborns, and six for adults/adolescents.

Health Departments Face Numerous Challenges, Primarily Due to Funding Shortages, Which Affect Their Prevention Capacity and Have Resulted in Some Scaling Back

Health departments reported facing several challenges in delivering HIV prevention programs, most often citing: funding (52 jurisdictions); training and capacity building for local partners (45); capacity of local partners to provide needed services (43); and data collection and reporting requirements (43). These challenges affected their prevention capacity in several areas including the ability to deliver prevention services to high-risk populations, recruit clients into programs, and retain clients once there. Challenges also led to some scaling back of prevention services, particularly community-level HE/RR programs (29 jurisdictions); individual/group level HE/RR (24), public information/media campaigns (26), and community planning (25). Given these challenges, states were asked what they would choose to scale-back, if they had the flexibility to do so (e.g., if not required under grant agreements), and to scale-up, if resource constraints were not a factor. Two main areas were identified for scaling-back: community planning (29) and abstinence-only-until-marriage education programs (22). If scale-up were possible, the top areas identified by states were partner services (17), HIV screening in health care settings (17), structural level interventions (16), and evaluation activities (15).

CONCLUSION

The ability of state and local jurisdictions to address challenges and meet HIV prevention needs in their communities going forward remains uncertain. The limitations cited above were identified at the early stages of the current economic downturn, a situation which has significantly worsened since that time. In a recent budget survey conducted by NASTAD, twenty-two jurisdictions reported state revenue reductions in FY 2009, including 12 with existing or expected cuts to HIV prevention specifically, with more cuts anticipated for FY 2010. In addition, federal HIV prevention funding was flat between FY 2007 and FY 2009, including funding provided by CDC to states for HIV prevention activities.

At the same time, the Obama Administration has signaled a strong interest in reinvigorating the domestic HIV prevention response, including through the development of a National HIV/AIDS Strategy for the country. In addition, the President's FY 2010 budget request includes a $53 million increase for domestic HIV prevention efforts, although funding levels will not be finalized by Congress until later this year. These developments, as well as the larger fiscal health of the nation, will need to be closely monitored to assess their continued effects on HIV prevention in the United States.

INTRODUCTION

Recent data from the Centers for Disease Control and Prevention (CDC) indicate that an estimated 56,000 people become infected with HIV each year in the United States (U.S.), 40% higher than previously estimated. In addition, infections have been at this level for more than a decade with certain populations bearing the brunt of the impact, particularly Black Americans and gay men and bisexual men of all races/ethnicities. Such trends indicate that the HIV epidemic in the U.S. is far from over and underscore the continuing importance of HIV prevention.

While the CDC plays the central, federal role in guiding and funding the national HIV prevention response in the U.S. — approximately 84% of all federal funding for domestic HIV prevention is channeled through the CDC[1] — much of what is considered "HIV prevention" is actually decentralized to states, and in some cases, localities, which have primary responsibility for coordinating and delivering HIV prevention services, as they do public health activities more generally.[2,3] , In addition, because HIV/AIDS varies across the country, the prevention response is necessarily localized in order to address the unique contexts and environments within different communities. As a result, it is often difficult to obtain information about how HIV prevention is organized and delivered in state and local jurisdictions across the country.

This report, based on a survey of 65 state, territorial and local health departments, including all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, the six U.S.-affiliated Pacific jurisdictions (American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Northern Mariana Islands and the Republic of Palau), and six "directly-funded" localities (Chicago, Houston, Los Angeles County, New York City, Philadelphia and San Francisco), provides the first, comprehensive inventory of HIV prevention efforts at the state and local levels. It first provides background on HIV prevention, including an overview of its history, the role of federal and local partners, and its current funding mechanisms. Survey methods are then described, followed by survey findings on funding, programs and services, and challenges. *Detailed tables with data by jurisdiction are provided in an Appendix.*

BACKGROUND

What is HIV Prevention?

At a very broad level, "HIV prevention" consists of programs, activities, and services that aim to prevent, or reduce, HIV transmission, targeting both those who are HIV positive and those who are not yet infected. It includes multiple types of interventions and programs designed to reach individuals, families, and communities at different stages of risk. Examples of the types of activities and services that are used to prevent or reduce, directly or indirectly, HIV transmission include:

- HIV prevention counseling, testing and referral services, including behavioral risk assessment;
- HIV screening (population-based HIV testing) for adolescents, adults, pregnant women and newborns in health care settings;
- Partner services (PS) (for the sexual or drug using partners of those

[1] Kaiser Family Foundation analysis of data from OMB and DHHS, December 2008.
[2] The Tenth Amendment of the United States Constitution specifies that "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."
[3] Institute of Medicine. The Future of the Public's Health in the 21st Century. National Academies Press: Washington DC; 2002.

newly diagnosed with HIV) including partner elicitation, notification, and counseling;

- Health education and risk reduction (HE/RR) activities, including individual, group, and community level interventions that serve both HIV-negative and HIV-positive individuals;
- Comprehensive Risk Counseling and Services (CRCS);
- Screening, testing and treatment for other sexually transmitted diseases (STD);
- Prevention of mother-to-child transmission through antiretroviral therapy;
- Condom promotion and distribution;
- Needle and syringe access programs;
- Occupational and non-occupational post-exposure prophylaxis;
- Substance use/abuse services, including treatment and drug substitution therapy;
- Public information programs and media campaigns;
- Mental health services;
- HIV prevention community planning;
- Laboratory support;
- HIV/AIDS epidemiological and behavioral surveillance; and
- Infrastructure and capacity building activities that support prevention delivery (e.g., quality assurance, collaboration and coordination, evaluation).

In addition, research is underway to assess the potential for antiretroviral therapy to serve as a prevention intervention. Antiretroviral therapy reduces HIV viral load (the amount of virus in the body) and some studies have suggested that it may, therefore, reduce the likelihood of HIV transmission.[4] (Note: HIV/AIDS treatment and support services are generally considered part of and funded through the HIV/AIDS care system and are therefore not included in the scope of this report.)

How is HIV Prevention Organized in the United States?

The first local HIV prevention response began as early as 1982 in those jurisdictions where AIDS cases were initially reported. Federal funding to states for HIV prevention through CDC, and for treatment through the Health Resources and Services Administration (HRSA), first began to flow in the mid-1980s. These new funds led most states to establish AIDS-specific offices and "AIDS Director" positions to oversee their response and today, all states have such directors in place. In many cases, AIDS Directors also have responsibility for other public health programs including broader communicable disease activities, STD prevention and control, viral hepatitis prevention, and tuberculosis (TB) control.

State and local HIV prevention efforts are governed and structured by state-specific laws, regulations, and policies that address disease detection, surveillance, and reporting, screening and testing, partner notification, and the authorities and roles of different service providers.[5] Whereas the federal government can provide recommendations to states and localities about whether or not a disease, such as HIV, should be reportable, who to target for HIV testing, and how to deliver other HIV prevention interventions, each state must decide whether to follow such recommendations and often must pass laws or enact regulations and policies enabling them to do so, although sometimes receipt of federal funding depends on it.

At the federal level, the CDC, through the Division of HIV/AIDS Prevention (CDC-DHAP), plays the main role in guiding the federal HIV prevention response, providing national recommendations and guidance, tracking the epidemic, and providing funding to states and localities. More than half of CDC-DHAP's HIV domestic prevention budget is allocated directly to state and local health departments each year, with the remainder provided to community-based organizations, research, evaluation, capacity building and training, surveillance, communications, laboratory science, and data management.

[4] Quinn TC, Wawer MJ, Sewankambo N, et al. Viral load and heterosexual transmission of human immunodeficiency virus type 1. Rakai Project Study Group. N Engl J Med 2000;342:921—9;. Cohen MS, Kashuba ADM. Antiretroviral Therapy for Prevention of HIV Infection: New Clues From an Animal Model PLoS Medicine 2008; 5(2): e30-60; Cohen MS, Hellmann N , Levy JA, DeCock K, Lange J. The spread, treatment, and prevention of HIV-1: evolution of a global pandemic J. Clin. Invest 2008; 118(4): 1244-1254.

[5] See, for example: The Kaiser Family Foundation, statehealthfacts.org; UCSF, National HIV/AIDS Clinicians' Consultation Center, State HIV Testing Laws Compendium, www.ucsf.edu/hivcntr/StateLaws/Index.html.

CDC-DHAP funding is provided to states and localities through cooperative agreements with 65 jurisdictions[6], including all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, the six U.S.-affiliated Pacific jurisdictions (American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Northern Mariana Islands and the Republic of Palau), and six "directly-funded" localities (Chicago, Houston, Los Angeles County, New York City, Philadelphia and San Francisco[7]). Initially, funding was allocated by formula, based on AIDS case burden. Over time, additional funding has been provided to health departments through supplemental and competitive awards and special initiatives. Today's cooperative agreement awards represent an aggregate of original formula awards and additional funding added over time.

States and localities also receive some federal prevention funding from other parts of the CDC and from other federal agencies at the Department of Health and Human Services (DHHS), such as the Substance Abuse and Mental Health Services Agency (SAMHSA), HRSA, and the Office of Population Affairs (OPA). In addition, many states and some localities allocate their own government funding to support HIV prevention, although they are not required to do so. Finally, some non-governmental entities, such as foundations and pharmaceutical and diagnostic companies, also provide funding to states and localities for HIV prevention.

As part of the CDC-DHAP cooperative agreements, health departments are required to ensure that a core set of HIV prevention services and activities are provided in their jurisdiction, either by providing them directly (e.g., at their own facilities or sites or through sub-contracts with provider agencies) or documenting their availability through other means. [See Pull-out box 1] Because HIV prevention needs and public health system infrastructures vary across the country, the cooperative agreement mechanism allows for flexibility on the part of health departments to determine the design and delivery of their HIV prevention programs within these broader guidelines.

Cooperative agreements also require that health departments convene an "HIV prevention community planning group" (CPG) which includes multiple sectors and representatives who reflect the current epidemic in a jurisdiction. Together, the health department and CPG develop a comprehensive HIV prevention plan that identifies prioritized target populations, both living with and at greatest risk for HIV, and describes what interventions will best meet the needs of each population. Health departments use the comprehensive plan to guide the development of their HIV prevention portfolios and the allocation of CDC-DHAP HIV

PULL OUT BOX 1:
CDC-DHAP HIV Prevention Cooperative Agreement Activities

- Health education and risk reduction activities, including prevention for HIV-infected persons
- HIV prevention counseling, testing, and referral services
- Partner services
- Public information programs
- HIV prevention community planning
- Collaboration and coordination
- Perinatal transmission prevention
- Quality assurance
- Evaluation
- Capacity-building activities
- STD prevention activities (separate health department cooperative agreement)
- Laboratory support
- HIV/AIDS epidemiological and behavioral surveillance (separate health department cooperative agreement)

[6] This report focuses on HIV prevention programs administered by the 65 health departments that receive direct funding from CDC-DHAP. In a jurisdiction, other entities, including, but not limited to, non-HIV/AIDS public health programs, such as substance abuse and maternal and child health; other governmental programs, such as education and corrections; and community-based and other not-for-profit organizations may also receive funding for the delivery of HIV prevention services and activities that is not funneled through the established health department HIV prevention program. The funding received and the services delivered by these entities, as well as funding for HIV sur veillance and STD prevention and treatment, are not included in this report. References to "health departments" and "states" refer to HIV prevention programs that are directly funded by CDC-DHAP to provide HIV prevention, unless otherwise specified.

[7] The six (6) directly funded localities were funded per a Congressional directive in the late 1980s.

prevention funding. They are not required to allocate other non-DHAP funds based on the priorities identified in the comprehensive plan, although some do.

Within a jurisdiction, HIV prevention services are delivered both directly and indirectly by health departments, depending on the jurisdiction's laws and regulations, capacity, and the specific activity or service being delivered. Indirect service delivery is conducted through contracts, grants, and other mechanisms, primarily with local and county health departments, community-based organizations, and other non-HIV public health programs including STD prevention and control, viral hepatitis prevention, HIV/AIDS care and treatment, TB prevention and control, immunization, family planning and reproductive health, substance abuse, and mental health. CDC-DHAP also directly funds some community-based organizations to provide HIV prevention activities. These organizations are required to coordinate activities with state health department HIV prevention efforts.

METHODOLOGY

All 65 state, territorial, and local jurisdictions that receive direct federal funding from CDC-DHAP for HIV prevention were surveyed by NASTAD and KFF between February and March 2008. This includes all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, the six U.S.-affiliated Pacific jurisdictions, and six directly-funded localities. The survey was developed by NASTAD and KFF in consultation with NASTAD's Prevention Advisory Committee, which consists of representatives from health departments around the country. The survey[8] was designed to obtain an inventory of HIV prevention funding, services, and other relevant information (funding data were not collected for HIV surveillance or STD prevention and treatment services which are provided through separate cooperative agreements), After the survey field period, extensive follow-up was conducted with non-responders. A total of 58 health departments responded to the survey including all states, the District of Columbia, Puerto Rico, and the six directly-funded jurisdictions; the territorial jurisdictions that did not respond represented less than 0.2% of people estimated to be living with AIDS at the end of 2006.[9] All data were reviewed for completeness and accuracy. Follow up was conducted with specific jurisdictions and data were adjusted where appropriate. Data are from FY 2007, unless otherwise noted. A subsequent survey was conducted in February 2009 by NASTAD to obtain data on the impact of state general revenue cuts to HIV/AIDS programs, including for HIV prevention. Thirty-seven states responded to the survey. In addition to surveying health departments, documents from CDC were reviewed.

[8] http://www.nastad.org/Docs/Public/Resource/2009426_FINAL%20National%20HIV%20Prevention%20Program%20Inventory%20Survey.pdf.
[9] http://cdc.gov/hiv/topics/surveillance/resources/reports/2006report/table12.htm.

FINDINGS

Prevention Funding

While the majority of prevention funding comes from the federal government, state and local funding makes up a key component of the HIV prevention budget. In some cases, state and local funding serves to supplement CDC support, and, in others, it represents the bulk of prevention funding in the jurisdiction. Jurisdictions with greater numbers of people living with HIV/AIDS have the largest prevention budgets, but do not rank at the top when measured by funding per person living with HIV/AIDS. (See Figure 1 and Table 1). Most HIV prevention funding is channeled by health departments to external entities through contracts, grants, and other mechanisms. Since FY 2004, funding for HIV prevention has been relatively flat.

Funding by Source

- In FY 2007, HIV prevention funding at health departments, from all sources combined (federal, state, local, and non-governmental sources), totaled $581,336,729 million. Funding ranged from less than one million dollars in four smaller states (Idaho, North Dakota, South Dakota, and Wyoming), to more than $20 million in six large states which account for significant shares of the nation's HIV/AIDS prevalence and have longer-standing epidemics (California, Florida, Massachusetts, New Jersey, New York, and Texas).
- Just over half of the prevention budget (58%, or $337,006,029) was provided by CDC. CDC base funding ranged from $642,291 in South Dakota to $26,831,744 in New York State.
- More than a third (35% or $205,265,640 million) of the budget was provided by state and local governments, in some cases acting to supplement CDC support and in others providing the bulk of funding for their HIV prevention response. Thirty-eight jurisdictions (including 33 states and five directly funded cities) provided such funding, ranging from $5,968 in Arkansas to $60,000,000 in New York State. Five jurisdictions provided more in combined state and local funding than they received from the federal government (California, Illinois, Massachusetts, New York, and Pennsylvania). Nineteen jurisdictions did not provide any state or local funding for HIV prevention (See Figure 2).
- Almost all jurisdictions in the Northeast provided state funding (10 of 11), compared to eight of 13 in the Midwest, 12 of 18 in the South, and eight of 15 in the West.[10]
- States with high HIV/AIDS prevalence were more likely to provide state funding, including 9 of the 10 states with the greatest numbers of people living with HIV/AIDS. These 9 states include at least one

TOTAL FY 2007 HIV PREVENTION FUNDING TO HEALTH DEPARTMENT HIV PREVENTION PROGRAMS BY SOURCE $581,336,729

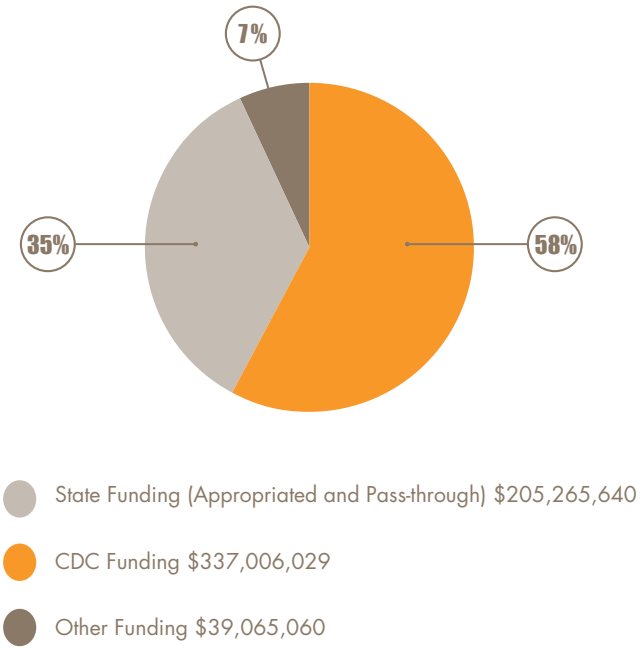


FIG. 1

[10] U.S. regions as defined by CDC: Midwest: Chicago, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, North Dakota, Nebraska, Ohio, South Dakota and Wisconsin; Northeast: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, New York City, Pennsylvania, Philadelphia, Rhode Island, Vermont; South: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Houston, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia; West: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Los Angeles County, Montana, New Mexico, Nevada, Oregon, San Francisco, Utah, Washington and Wyoming.

of the six directly funded cities and reflect older, longer-term epidemics. By comparison, only two of the 10 states reporting the fewest cases contributed state funding.

- The remaining seven percent of the FY 2007 prevention budget ($39,065,060) was provided by other federal agencies and non-governmental sources.

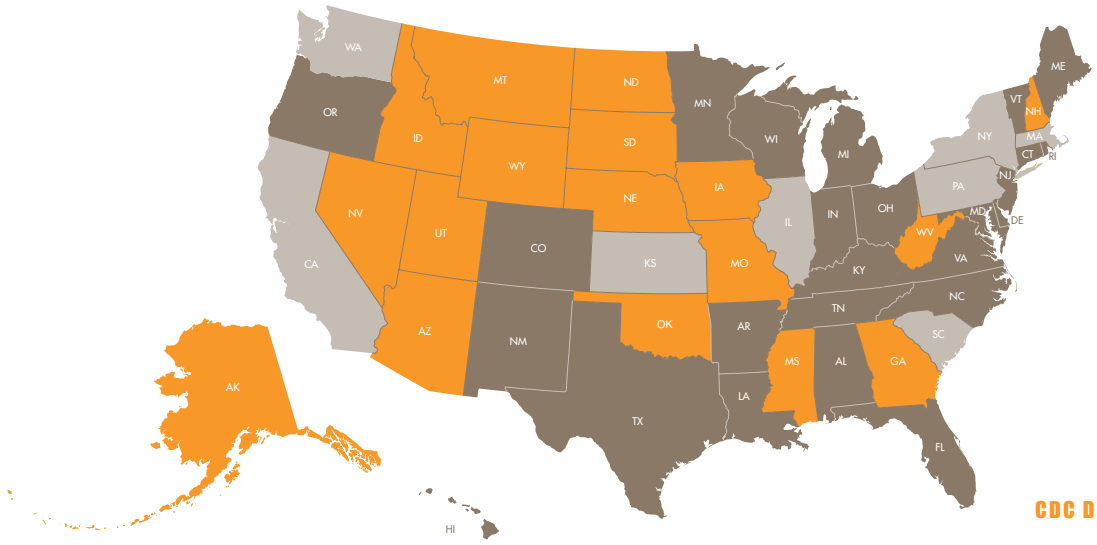
Measuring the HIV Prevention Investment

The investment in HIV prevention varies across the country, reflecting differences in population size, epidemic burden, the amount of state and local contributions, the adequacy of state and local infrastructure to deliver services, and other factors. Measuring the investment in HIV prevention is complex and there is no standardized method for doing so. Two methods to assess investment were used here:

- **Funding per capita,** a measure of the investment in HIV prevention relative to a jurisdiction's overall population, which captures the size of the larger population potentially at risk for becoming infected with HIV. While this is a measure sometimes used to compare the public health investment across states more generally[11] , it does not capture the dynamic of an infectious disease, such as HIV, given the relationship between HIV incidence (new infections) and HIV prevalence (number living with HIV/AIDS).
- **Funding per living HIV/AIDS case**,[12] a measure of investment in HIV prevention relative to a jurisdiction's existing HIV disease burden. This measure captures the size of the population potentially at risk for transmitting HIV (See Figures 3a – 3d and Table 1) and therefore more directly accounts for the relationship between incidence and prevalence.

FIG. 2

STATE/LOCAL FUNDING IN COMPARISON TO CDC-DHAP FUNDING



CDC DIRECTLY-FUNDED JURISDICTIONS

- No state/local funding (19 jurisdictions)
- State/local funding less than CDC-DHAP funding (31 jurisdictions)
- State/local funding greater than CDC-DHAP funding (7 jurisdictions)
- New York City
- Chicago
- Philadelphia
- Houston
- San Francisco
- Los Angeles County

[11] See, for example: Trust for America's Health, Shortchanging America's Health 2009, March 2009.
[12] 2005 living HIV/AIDS cases were the most recent data available for this purpose.
See http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2008supp_vol13no3/default.htm.

Funding per capita:

- In FY 2007, funding per capita averaged $1.93 nationally, ranging from $0.41 in Utah to $11.30 in Washington, D.C. Washington, D.C. also had the highest per capita funding from CDC-DHAP ($11.15) and New York had the highest per capita state funding allocation ($3.11). High prevalence states as a group received the highest funding per capita ($2.63) and low prevalence states received the lowest ($0.94).
- Some smaller jurisdictions received more funding per capita or per HIV/AIDS case than larger jurisdictions, likely reflecting the need

For each measure, results were examined by prevalence group (high, high-to-moderate, moderate, and low)[13] and by region of the country (Midwest, Northeast, South, and West).

FIG. 3A **POPULATION MEASURE BY PREVALENCE CATEGORY:HIV PREVENTION FUNDING PER CAPITA**

Prevalence Category	2007 Census Population Estimates	Total Prevention Funding Per Capita	DHAP Funding Per Capita	State Prevention Per Capita
High	166,184,263	$2.63	$1.36	$1.00
High-to-Moderate	82,105,542	$1.13	$0.63	$0.39
Moderate	35,757,581	$0.97	$0.79	$0.18
Low	17,573,771	$0.94	$0.98	$0.01
TOTAL	301,621,157	$1.93	$1.09	$0.68

FIG. 3B **PREVALENCE MEASURE BY PREVALENCE CATEGORY: HIV PREVENTION FUNDING PER LIVING HIV/AIDS CASE**

Prevalence Category	Living HIV and AIDS Cases	Total Prevention Funding Per HIV/AIDS Case	DHAP Funding Per HIV/AIDS Case	State Prevention Funding Per HIV/AIDS Case
High	529,672	$825.77	$426.43	$315.24
High-to-Moderate	142,555	$652.27	$409.82	$222.60
Moderate	42,553	$811.21	$644.44	$148.46
Low	10,170	$1,617.32	$1,583.81	$23.70
TOTAL	724,950	$801.90	$452.20	$283.14

FIG. 3C **POPULATION MEASURE BY REGION: HIV PREVENTION FUNDING PER CAPITA**

Region	2007 Census Population Estimates	Total Prevention Funding Per Capita	DHAP Funding Per Capita	State Prevention Funding Per Capita
Midwest	66,388,795	$1.00	$0.66	$0.27
Northeast	54,680,626	$4.45	$1.93	$2.01
South	110,454,786	$1.34	$1.03	$0.22
West	70,096,950	$1.75	$0.92	$0.76
TOTAL	301,621,157	$1.93	$1.09	$0.68

FIG. 3D **POPULATION MEASURE BY REGION: HIV PREVENTION FUNDING PER LIVING HIV/AIDS CASE**

Region	Living HIV and AIDS Cases	Total Prevention Funding Per HIV/AIDS Case	DHAP Funding Per HIV/AIDS Case	State Prevention Funding Per HIV/AIDS Case
Midwest	86,710	$768.83	$507.51	$208.21
Northeast	195,762	$1,244.22	$540.40	$561.64
South	306,219	$484.90	$371.71	$77.82
West	136,259	$899.88	$471.18	$392.15
TOTAL	724,950	$801.90	$452.20	$283.14

[13] For the purposes of this Inventory, prevalence groups were defined using cumulative AIDS cases as follows: High: California, District of Columbia, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, Texas, and Virginia; High to Moderate: Alabama, Arizona, Colorado, Connecticut, Indiana, Michigan, Mississippi, Missouri, North Carolina, Ohio, South Carolina, Tennessee, and Washington; Moderate: Arkansas, Delaware, Hawaii, Kansas, Kentucky, Minnesota, Nevada, New Mexico, Oklahoma, Oregon, Rhode Island, and Wisconsin: Low: Alaska, Idaho, Iowa, Maine, Montana, Nebraska, New Hampshire, North Dakota, South Dakota, Utah, Vermont, West Virginia, and Wyoming.

for a minimum level of funding necessary in any jurisdiction to establish an HIV prevention response.

Funding per living HIV/AIDS case:

- Funding per case averaged $802[14] across the country, ranging from $50 in Mississippi to $4,799 in North Dakota. North Dakota, which received all of its funding from CDC-DHAP, also had the highest CDC-DHAP funding per case. Massachusetts had the highest state funding per case ($1,320).
- Low prevalence states as a group received the highest HIV prevention funding per case ($1,617), followed by high prevalence states, who received about half as much ($826), moderate prevalence states ($811) and high-to-moderate prevalence states ($652), a pattern largely driven by CDC funding; by contrast, state funding per person with HIV/AIDS was proportionate to prevalence.
- The top 10 states by disease burden accounted for two-thirds of HIV/AIDS prevalent cases (67%), but represented only about half of the U.S. population (52%) and 49% of HIV prevention funding. They represented a larger share of overall state funding for HIV prevention (70%) compared to CDC-DHAP (40%). Of these top ten states, only one did not allocate state resources for HIV prevention. The average state contribution across these states was $14,643,988, an amount larger than the total HIV prevention budgets for 41 other jurisdictions.
- There were also regional variations in the HIV prevention investment, largely reflecting prevalence differences as well, with jurisdictions in the Northeast having the highest per capita ($4.45) and per person living with HIV/AIDS ($1,244) funding by region. The Midwest had the lowest per capita spending ($1) followed by the South ($1.34) and the South had the lowest per person living with HIV/AIDS funding ($485).

Internal and External Funding Mechanisms

The majority of HIV prevention funding in FY 2007 (60% or $360 million) was channeled by state and directly-funded city health departments to external entities through contracts, grants, and other mechanisms (See Table 2). Most jurisdictions (45) reported allocating more funding externally than they did internally. The main recipients of external funding were community-based organizations and local health departments ($283 million) and, to a lesser extent, other public agencies such as corrections and substance abuse treatment facilities. Higher prevalence states channeled nearly three times more funding externally than internally ($239.3 million compared to.$83.5 million). Lower prevalence states allocated similar amounts externally and internally ($3.98 million compared to $3.7 million).

Funding Trends

Nationally, HIV prevention funding at health departments increased by $43.9 million or almost eight percent, between FY 2004 and FY 2007. Most of the increase is attributable to additional funding of $34.5 million between FY 2006 – 2007 for the CDC's Expanded and Integrated Human Immunodeficiency Virus (HIV) Testing for Populations Disproportionately Affected by HIV, Primarily African Americans initiative which provided grants to a subset of 23 jurisdictions. Of the 30 jurisdictions with funding increases in the last period, 22 received funding under this initiative. Overall funding increases were much smaller between FY 2004 and FY 2005 (2%, or $9.7 million) and FY 2005 and FY 2006 (>1% or $1.3 million), and the majority of jurisdictions actually experienced reductions in their funding during these periods (29 had decreases between 2004 and 2005; 36 had decreases between 2005 and 2006). Without the CDC expanded testing initiative, total funding over the three-year period was relatively flat.

[14] Funding per HIV/AIDS case is significantly higher than per capita funding because the number of people living with HIV/AIDS is considerably smaller than the overall population.

PROGRAMS AND SERVICES

An array of HIV prevention services is provided across the country, with most prevention funding allocated to three core areas—health education and risk reduction (HE/RR) activities for both HIV-positive and HIV-negative individuals, HIV screening/testing, and partner services—a reflection of public health recommendations and guidelines and CDC cooperative grant agreement requirements. In FY 2007, health departments spent approximately $350.2 million on these activities (60% of total funding), including $152.1 million on HIV testing/screening and partner services (26%) and $198 million on HE/RR (34%).

The remaining resources supported other CDC-required activities and services [See Pull out box 1], such as community planning and public information/media; other federal funding initiatives like abstinence-only-until-marriage programming; other prevention strategies beyond those required and/or funded by the federal government including, but not limited to, needle and syringe access programs (N/SAP), drug substitution programs, non-occupational post-exposure prophylaxis (nPEP), and structural level interventions [See Pull out box 2]; and costs associated with program administration.

Health Education / Risk Reduction

Health departments spent the greatest portion of their HIV prevention funding—more than one-third or $198 million in FY 2007—on HE/RR services targeting populations at risk for or living with HIV/AIDS. All health departments reported providing these services, with 25 spending more on HE/RR than any other HIV prevention activity or service. HE/RR interventions target individuals and communities; those who are at risk and those who are HIV-positive; and are designed to affect knowledge, attitudes, beliefs, and skills in order to promote the reduction of risky behaviors. Many HE/RR interventions are part of CDC-DHAP "prevention packages," sets of interventions which have been rigorously evaluated and diffused for use by health departments, community-based organizations, and other service providers. The most well known CDC-DHAP efforts in this area are the Diffusion of Effective Behavioral Interventions and Replicating Effective Programs projects (DEBI/REP) [See Pull out box 3] and the Compendium of HIV Prevention Interventions with Evidence of Effectiveness (Compendium). Almost all health departments (56) reported funding at least one intervention in the DEBI/REP projects. Thirty-four reported funding interventions from the Compendium (See Figure 4 and Tables 3 and 4).

In addition to the CDC-DHAP supported interventions, many health departments developed and evaluated interventions specific to the needs their jurisdictions, known as "home grown" interventions.

PULL OUT BOX 2:
What are the structural level interVentions?

Structural interventions refer to public health interventions that promote health by altering the structural context within which health is produced and reproduced. Structural level interventions differ from many public health interventions in that they locate, often implicitly, the cause of public health problems in contextual or environmental factors that influence risk behavior, or other determinants of infection or morbidity, rather than in characteristics of individuals who engage in risk behaviors.[15]

[15] K. M. Blankenship, S. R. Friedman, S. Dworkin, and J. E. Mantell. Structural Interventions: Concepts, Challenges and Opportunities for Research. J Urban Health. 2006 January; 83(1): 59–72.

FIG. 4 **TOP PROVIDED DEBI/REP IN HEALTH DEPARTMENT HIV PREVENTION PROGRAMS**

Intervention (Number of Jurisdictions)	Target Population(s)	Target Level	Intended Positive Influence(s) *
SISTA (36)	Sexually active African American women	Group Level	Negotiation skills; Assertive communication skills; Increased condom use
Mpowerment (32)	Young men who have sex with men	Community Level	HIV prevention; Safer sex skills; and Risk reduction messages
Health Relationships (29)	Men and women living with HIV/AIDS	Group Level	Reinforcing coping skills to address stress; Decision-making skills about disclosure of HIV status; Risk reduction; Adoption of protective behaviors
Voices / Voces (28)	Heterosexual African American and Latino men and women who visit STD clinics	Group Level	Increased condom use
Many Men, Many Voices (24)	Black men who have sex with men (MSM) who may or may not identify themselves as gay	Group Level	Cultural, social, and religious norms; Interactions between HIV and other STD; Sexual relationship dynamics; Social influences that racism and homophobia have on HIV risk behaviors
Population Opinion Leader (24)	Key opinion leaders	Community Level	Increased and sustained communications about HIV risk reduction messages to friends and acquaintances

*www.effectiveinterventions.org

Thirty-three health departments funded "home grown" interventions. Thirty of these health departments also evaluated these interventions for effectiveness.

PULL OUT BOX 3:
What are DEBI and REP?

The Diffusion of Effective Behavioral Interventions (DEBI) project was designed to bring science-based, community, group, and individual-level HIV prevention interventions to community-based service providers and state and local health departments. The goal is to enhance the capacity to implement effective interventions at the state and local levels, to reduce the spread of HIV and STD, and to promote healthy behaviors (http://www.effectiveinterventions.org/).

The programs in Replicating Effective Programs (REP) project are tested, science-based behavioral interventions with demonstrated evidence of effectiveness in reducing risky behaviors, such as unprotected sex, or in encouraging safer ones, such as using condoms and other methods of practicing safer sex. The interventions are translated into everyday language and put into user-friendly packages of materials (http://www.cdc.gov/hiv/topics/prev_prog/rep/).

HIV Screening and Testing

HIV testing is the use of diagnostic tests designed to determine the serostatus of individuals. "HIV screening" is the testing of all people within a given population or location. The importance of HIV testing was recently underscored by new CDC recommendations and related efforts designed to increase the share of people with HIV who know their HIV status.[16] Research indicates that risk behavior is reduced once a person knows his or her HIV status . Additionally, linkages to HIV/AIDS care and treatment and additional HIV prevention services can be made. HIV testing also offers the opportunity to provide counseling and other services to both HIV-positive and HIV-negative individuals, another important HIV prevention strategy. Specific findings from the survey are as follows:

Targeted and Routine HIV Testing

Health departments use both targeted approaches to HIV testing and routine screening approaches. "Targeted HIV counseling, testing, and referral (HIVCTR)" are efforts designed to reach individuals in specific high-risk groups, such as gay and bisexual men, injection

[16] Marks G, Crepaz N, Senterfitt JW, Janssen RS. Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implica tions for HIV prevention programs. J Acquir Immune Defic Syndr 2005;39:446–53.

drug users, and partners of known HIV-positive individuals. Routine HIV screening is designed to reach all individuals within a given population who present at a venue where HIV testing is available, e.g., hospital emergency departments, health department STD clinics, and labor and delivery departments. CDC now recommends that routine HIV screening be offered in health care settings to all persons in the general population, ages 13-64, with repeat screening at least annually for those at high risk. HIV testing is also recommended for all pregnant women and for any newborn whose mother's HIV status is unknown. All venues where health care is delivered are encouraged to offer HIV testing. CDC is in the process of revising recommendations for targeted HIV counseling, testing, and referral (HIVCTR) in non-clinical settings.

All health departments report conducting targeted HIVCTR to reach populations at risk. Most (42) also report conducting routine HIV testing/screening in health care settings, although this varied by population as follows (See Figure 5 and Table 5):

- Pregnant women (42)
- Newborns (17)
- General population, ages 13-64 (6)

Confidential and Anonymous Testing

HIV testing is delivered either confidentially or anonymously. Confidential testing records a person's name with his or her test result; anonymous testing does not. Testing modalities differ based on the type of specimen tested (whole blood, serum, or plasma; oral fluid; urine); the method of specimen collection (blood draw/venipuncture; finger prick; oral swab); where the specimen is processed (laboratory or point-of-care); and the time it takes to get results. Four primary types of HIV testing are conducted by health departments: conventional blood testing, conventional oral fluid testing, rapid blood testing, and rapid oral fluid testing. Conventional testing collects specimens orally or through blood draw. Specimens are processed in a laboratory and results are usually available to a client within a few days to two weeks. Rapid HIV test specimens are collected orally or through a finger prick and can be processed immediately, with results available to a client in as little as ten minutes.[17] Positive rapid tests require a confirmatory test using conventional testing methods.

All health departments conduct confidential HIV testing. In addition, most (46) also offer anonymous testing, although in 11 jurisdictions, anonymous testing options funded by health departments are not available (See Table 6). Even in jurisdictions where anonymous testing funded by health departments is offered, most testing is conducted confidentially. Only three jurisdictions

ROUTINE HIV TESTING/SCREENING IN HEALTH CARE SETTINGS, BY POPULATION

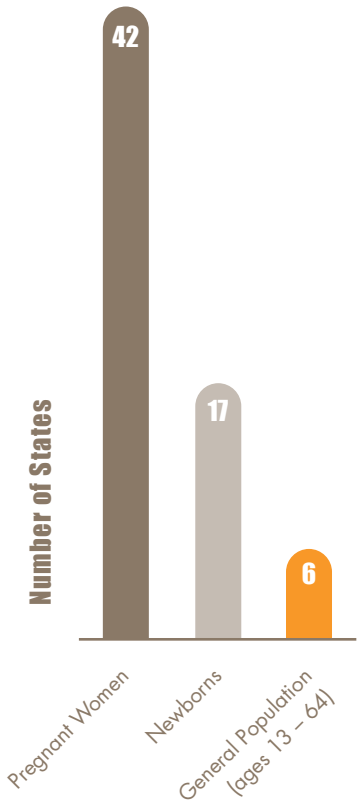


FIG. 5

[17] http://www.kff.org/hivaids/6094.cfm.

reported conducting more than half of their tests anonymously (Hawaii, Maine, and Vermont) including one (Hawaii) that only conducts anonymous testing. Rapid HIV testing, which was first approved for use in the U.S. by the Food and Drug Administration in 2002[18], has becoming increasingly common; by 2007[19], health departments reported that almost half (48%) of HIV tests conducted were rapid.

HIV Testing Venues and Settings

Most HIV testing by health departments was conducted in health-department-operated clinical settings; 35 health departments reported that 50% or more of their testing is conducted in such settings (See Table 7). A smaller subset (15) reported that the majority of their testing efforts are conducted in community-based settings. Only one health department reported using non-health-department-operated clinical settings as the main sites for testing.

Routine HIV testing/screening is implemented in both traditional and non-traditional health care venues (See Figures 6a and 6b). The most common venues were as follows:

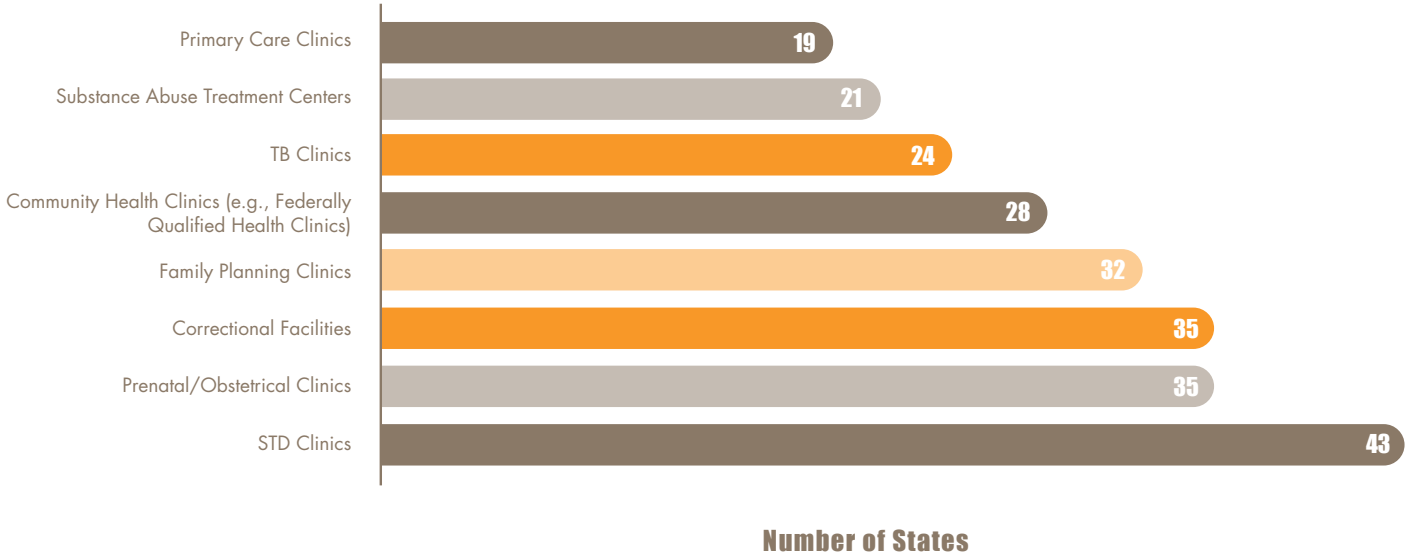
- STD clinics (43)
- Correctional institutions (35)
- Pre-natal / obstetrics clinics (35)
- Family planning clinics (32)
- Labor and delivery departments (29)
- Community health centers (28)

Health departments are increasingly implementing routine HIV screening. In the past year, most jurisdictions reported expanding existing screening efforts or initiating screening in new venues, with the greatest increases in the following venues:

- Hospital emergency departments (18)
- STD clinics (17)
- Correctional institutions (15)
- Community health centers (15).

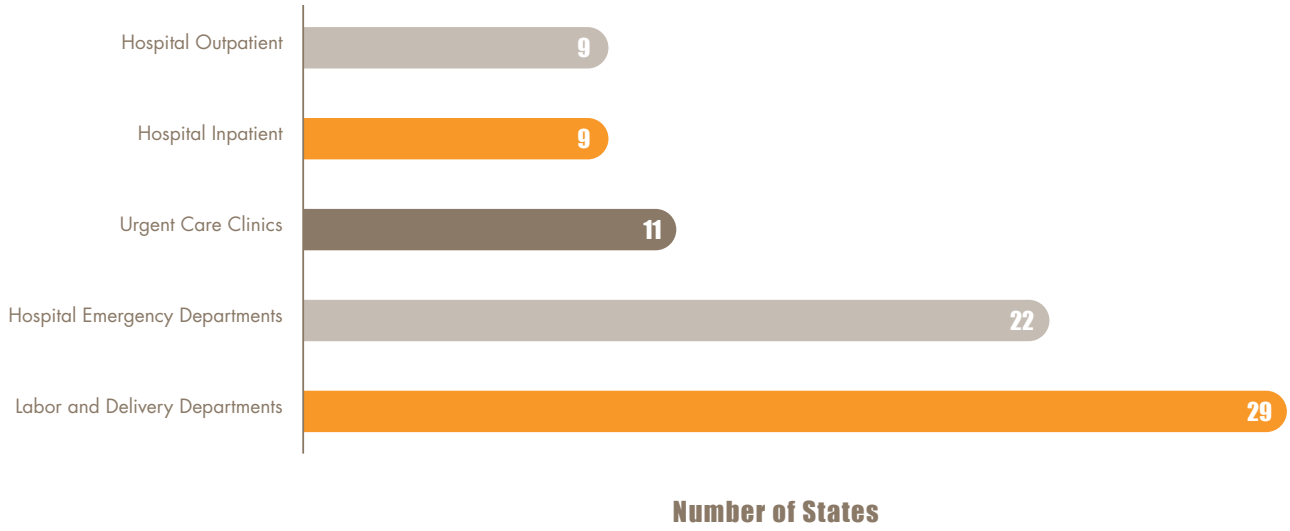
HEALTH DEPARTMENT TESTING IN COMMUNITY BASED SETTINGS

FIG. 6A



[18] http://www.fda.gov/ForConsumers/ByAudience/ForPatientAdvocates/HIVandAIDSActivities/ucm125097.htm
[19] http://www.nastad.org/Docs/highlight/2008717_NASTAD_Rapid_Testing_Implementation_Report_071608.pdf.

HEALTH DEPARTMENT TESTING IN HOSPITAL-BASED SETTINGS



HIV Testing Policy Changes

States have also implemented policy changes in response to the CDC's revised HIV testing recommendations (See Table 8). Since February 2007, 15 states have changed policies to reflect CDC's recommendations, including five that also anticipate making further changes in the future. Eight additional states also anticipate changing testing policies in the future in light of the CDC's recommendations. A majority of policy changes implemented or proposed focus on two primary issues: the removal of requirements for separate written consent for HIV testing (referenced 21 times) and the requirement for HIV testing of pregnant women and / or newborns (generally in the form of "opt-out" testing) (referenced 11 times).

Partner Services (PS)

Identifying partners of those living with HIV is a key component of HIV prevention programs. HIV partner services are designed to elicit, notify, and counsel partners of persons who are known to be HIV-positive. [See Pull out box 4] HIV partner services are most often delivered by in-person health department disease investigation teams, and, to a lesser extent, by clients themselves, clinicians, or community-based organizations. Most health departments (33) reported conducting HIV partner services in conjunction with other program areas, predominately STD programs and general disease surveillance programs. Many health departments reported they would scale up partner services if resources were available (17).

Because of the complex and sensitive nature of reaching partners of those who are HIV-positive, many jurisdictions reported having statutes and regulations in place that limit which non-health department

PULL OUT BOX 4:
What are partner services?

Partner services are a broad array of services that are offered to people with HIV, syphilis, gonorrhea, or chlamydia and their partners. Partner services include partner elicitation, a process through which infected persons are interviewed to elicit information about their partners; partner notification, a process through which partners can be confidentially notified of their possible exposure or potential risk; and partner counseling, a process through which infected persons who choose to notify their own partners are provided counseling and support and through which infected persons and their partners are provided client-centered counseling to help them reduce behavioral risks for acquiring or transmitting infection. Seehttp://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm#Definition_and_Overview_of_Partner_Services

personnel can deliver all or some of the three components of partner service as follows:

Community-based organizations are prohibited from conducting the following components of partner services:

- Partner elicitation (5)
- Partner counseling (8)
- Partner notification (25)

Clinicians are prohibited from conducting the following components of partner services:

- Partner elicitation (3)
- Partner notification (11)

Health departments reported that community-based organizations were more likely to conduct partner elicitation and partner counseling than clinicians (33 vs. 22 and 28 vs. 22, respectively), while clinicians were more likely to conduct partner notification (17 vs. 9).

HIV/AIDS surveillance data, specifically HIV case reports of newly diagnosed individuals, are often used to identify partners of persons recently diagnosed with HIV/AIDS, as recommended by CDC in recently revised guidelines on partner services . Most jurisdictions (44) reported using surveillance data to conduct partner services;[20] 13 do not. Because of the confidentiality protections put in place to protect persons living with HIV, including statutes and/or regulations in some cases, some jurisdictions were not permitted to use surveillance data for this purpose, including four of the 13 jurisdictions that do not use surveillance data for this purpose. In situations where HIV surveillance data are not used to identify partners, clients are the primary source of information for follow-up (See Table 9).

Community Planning

All directly-funded health departments are required by CDC-DHAP to convene HIV prevention community planning groups and to develop comprehensive HIV prevention plans. The allocation of prevention funding within a jurisdiction is informed by the community planning process. Health departments structure their planning processes and groups in different ways. Most health departments (54) reported that they develop a comprehensive HIV prevention plan every three to five years; half (29) develop plans only once every five years. Only one reported developing a plan annually.

A majority of health departments (39) convened a single HIV-prevention-specific community planning group for their jurisdiction. Thirteen used local and regional planning groups, either as stand-alone bodies or to feed into a single jurisdiction-wide planning group and 15 health departments convened combined HIV prevention/care planning groups, five of which developed integrated HIV prevention/care comprehensive plans (See Table 10 and Figure 7).

Community planning groups had an average of 30 members (ranging from 13 to 50 members) including individuals from infected and affected communities and government representatives. On average, community planning groups tended to be larger in the jurisdictions with the greatest number of people living with HIV/AIDS (35 members) than in jurisdictions reporting the fewest 2005 (24).

Public Information / Media Campaigns

Health departments reported spending $10.8 million (less than two percent of total HIV prevention funding) on public information media campaigns. Such efforts are used to communicate information about HIV/AIDS—targeting both the general public and specific audiences — and are implemented in most jurisdictions in the U.S. Almost all (53) health departments indicated that they have conducted or funded

[20] http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm.

public information media campaigns at some point, including 46 reporting current campaigns. Of the five jurisdictions that had never conducted a campaign, lack of funding was the primary reason cited (See Table 11).

Health department campaigns provide general awareness about HIV/AIDS to constituents in their jurisdiction and also target specific populations at risk for HIV infection. Figure 8 presents the audiences most likely to be targeted for campaigns, and Figure 9 presents the messaging themes most likely to be used. The top target audiences reported by health departments were the general public and gay and bisexual men (38 each), followed by African Americans (36); the top message theme was HIV testing. In order to provide supplemental information about HIV prevention and/or to answer questions, health department campaigns generally drive audiences to additional resources including hotlines (39) and/or websites (28). (See Table 12).

To support their public information media campaigns, a majority of health departments (36) purchased media space such as radio or television air time and public transportation advertisement space. Some also used donated media space (15) and/or a combination of purchased and donated space (24).

Campaigns also use a variety of platforms and distribution channels to reach target audiences including television, radio, outdoor platforms (billboards, bus shelters, etc.), print (newspapers, magazines, etc.), and the Internet. The primary media platforms and distribution channels used by health departments to run campaigns are print (41), radio (39), and outdoor platforms (37).

HEALTH DEPARTMENT COMMUNITY PLANNING GROUP MEMBERSHIP STRUCTURE

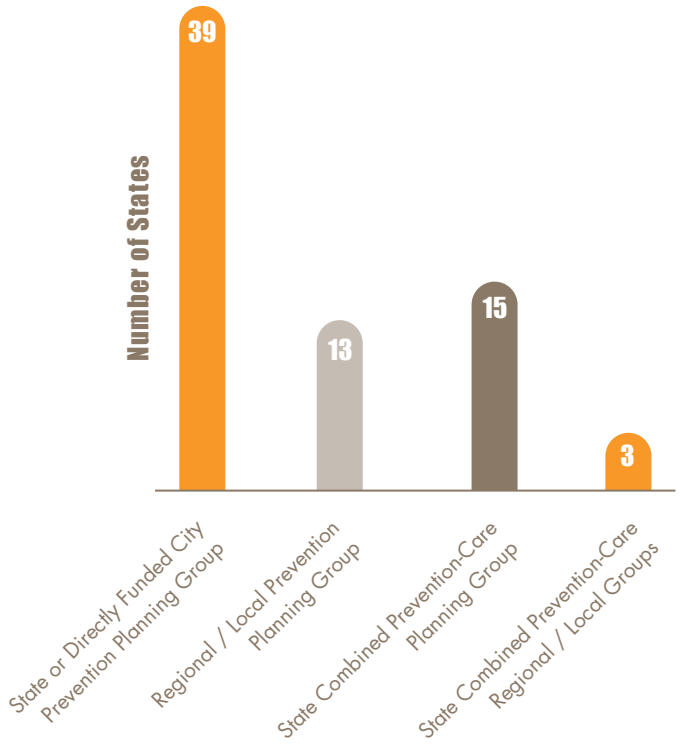


FIG. 7

Other HIV Prevention Activities and Services

In addition to the activities and services required by CDC-DHAP, health departments also reported administering and/or funding other HIV prevention programs in their jurisdictions, including Needle and Syringe Access Programs (N/SAP), Drug Substitution Programs, and Non-occupational Post-Exposure Prophylaxis Programs (nPEP). These services were sometimes operated by other non-HIV public health programs or community-based organizations, with health departments providing funding, training and technical assistance, provision of complementary services such as HIV testing and partner services, and/or data collection and monitoring (See Figure 10 and Table 13).

FIG. 8 **MOST COMMON TARGET AUDIENCES FOR PUBLIC INFORMATION MEDIA CAMPAIGNS**

HIV Prevention Campaign Audience	Number of Jurisdictions
General public	38
Gay men and other MSM	38
African Americans	36
Young people	32
Latinos	30

FIG. 9 **MOST COMMON THEMES FOR PUBLIC INFORMATION MEDIA CAMPAIGNS**

HIV Prevention Campaign Audience	Number of Jurisdictions
HIV testing (knowing one's status)	52
General awareness	41
Condom use	25
Stigma and discrimination	19
Substance use / abuse and HIV risk	18

Needle and Syringe Access Programs (N/SAPS).

N/SAPs are designed to increase the availability of sterile syringes and needles through exchange programs (exchange of used needles and syringes for new ones), pharmacy sales, and physician prescription. Exchange programs often include other important services like disease screening, testing, and vaccination; medical care; overdose prevention; and referrals for other services[21] ; and disposal. By law, federal funds cannot be used to support N/SAP so any funding they receive must be from state or local governments or the private sector. Twenty-four health departments reported that there was an N/SAP operating in their jurisdiction, a subset of which is funded (18) and/or administered (12) by the health department itself. Ten of the 24 N/SAP programs were reported by the states reporting the most HIV/AIDS cases in 2005 and their directly-funded cities. Most of these programs were located in the West (7) and the Northeast (9).

Drug Substitution Programs.

Drug substitution programs provide services designed to prevent HIV infection associated with injection drug use through provision of pharmaceutical alternatives such as methadone and buprenorphine. Thirteen health departments reported operating drug substitution programs, either as part of their HIV prevention program or another part of the health department. Three health departments provided funding for drug substitution programs; two provided program administration; and six provided other support. Most of the 13 programs in operation were administered (9) and/or funded (9) by other, non-HIV-prevention health department programs. Seven of the 13 drug substitution programs were reported by the states reporting the most HIV/AIDS cases in 2005 and their directly-funded cities. Most of these programs were located in the West (5) and the Northeast (5).

Non-Occupational Post-Exposure Prophylaxis (nPEP) Programs.

nPEP is the provision of antiretroviral drugs to prevent HIV infection after unanticipated sexual or injection-drug-use exposure. nPEP offers a 28-day course of antiretroviral drugs and is initiated within 72 hours of exposure to blood, genital secretions, or other potentially infectious body fluids of a person known to be HIV infected.[22] Ten health departments reported operating an nPEP program either as part of their HIV prevention program or through other parts of the health department. Of those operating nPEP programs, HIV prevention programs administered seven of them, provided funding to eight,

HEALTH DEPARTMENT HIV PREVENTION PROGRAMS OPERATING SELECT HIV PREVENTION SERVICES

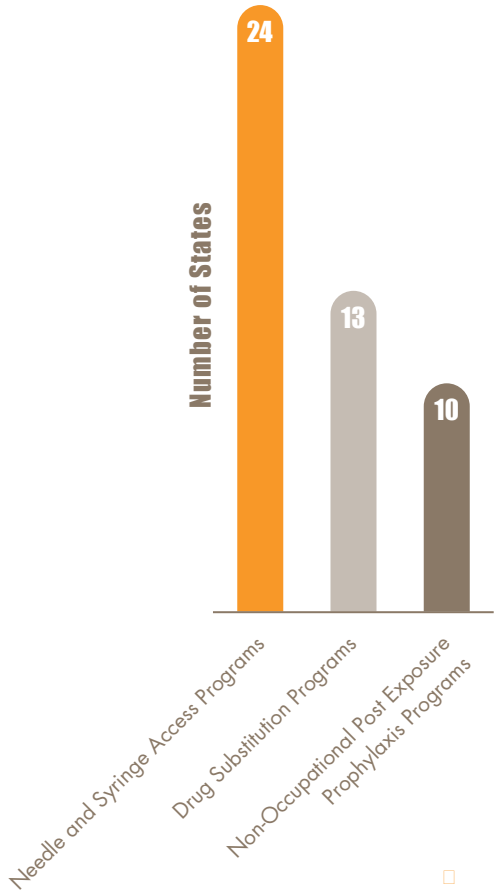


FIG. 10

[21] http://www.drugpolicy.org/reducingharm/needleexchan/.
[22] http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm.

and other kinds of support to six. Six of the 10 nPEP programs were reported by the states reporting the most HIV/AIDS cases in 2005 and their directly-funded cities. Most of these programs were in the West (4) and the Northeast (3).

Integration / Collaboration

To better meet the needs of persons at risk for and living with HIV, health departments often develop relationships with traditional public health programs as well as other programs and partners to deliver HIV prevention services. Integration of HIV prevention into traditional public health services takes many forms. In some cases, a single health department administrator, such as the AIDS Director, provides direct oversight of staff and budgets for the HIV prevention program as well as other public health programs. This is particularly the case for HIV prevention and HIV care and treatment programs, with 48 jurisdictions reporting that a single administrator has budget oversight for both areas and 46 reporting staff oversight. This kind of integration with HIV prevention was less frequent for other areas. For example, in the case of STD programs, 29 jurisdictions reported that a single administrator oversees either the budgets or staff of both. The area with the least integration of budget and staff oversight was TB programs, with only nine jurisdictions reporting joint budget oversight and eight reporting joint staff oversight.

To carry out program integration, most jurisdictions reported convening integrated program meetings with other areas, including partner services programs (48), STD programs (48), and HIV care and treatment programs (47). Fifty-one jurisdictions reported that their HIV prevention program conducts collaborative projects with the health department's STD program. TB was the area least cited for these kinds of joint activities (16).

Some jurisdictions also report integrating HIV prevention services with other areas at the client-level (e.g., HIV testing provided during an STD screening visit). This was most commonly the case for partner services (40 jurisdictions), STD programs (39), and HIV care and treatment programs (38). Fewer jurisdictions reported client-level integration of HIV prevention with viral hepatitis (26) and TB (16) programs (See Figure 11).

Health departments also report other kinds of collaborations ranging from simple information sharing to shared decision making about projects. These types of collaborations are most commonly reported with education, family planning, corrections, and substance abuse programs and least common with business and civic organizations, mental health programs, and housing programs (See Figure 12).

FIG. 11 **INTEGRATION / COLLABORATION WITHIN HEALTH DEPARTMENTS**

Program	Single Admin Provides Staff Oversight	Single Admin Provides Budget Oversight	Inter-program Meetings	Collaborative Projects	Client-level Service Integration
HIV/AIDS Care and Treatment	46	48	47	47	38
HIV/AIDS Surveillance	34	37	48	48	23
Partner Services	38	43	48	47	40
STD Program	29	29	48	51	39
Viral Hepatitis Program	28	26	45	43	26
TB Program	9	8	33	37	16

HEALTH DEPARTMENT HIV PREVENTION PROGRAM REPORTING RELATIONSHIPS WITH EXTERNAL PROGRAMS AND PARTNERS

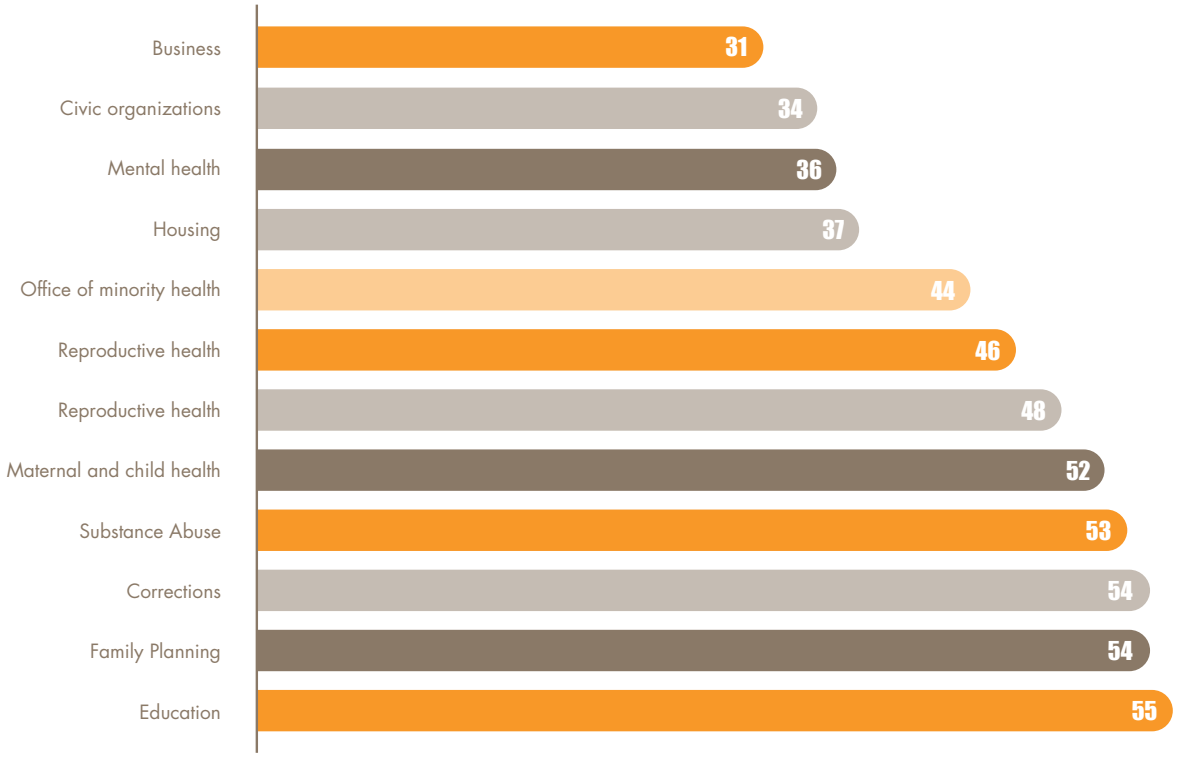


FIG. 12

CHALLENGES

Jurisdictions were asked to report on challenges faced in implementing HIV prevention programs related to funding, capacity, and policy, and to rank these by order of significance. The "most cited" challenges, based on the number of health departments reporting a specific challenge in their jurisdiction, are as follows:

- Funding (52)
- Training and capacity building for community/clinical partners (45)
- The capacity of community/clinical partners to provide services (43)
- Data collection and reporting requirements (43)

The top three ranked challenges were funding, the capacity of community/clinical partners to access target populations, and the capacity of community/clinical partners to provide services (See Figure 13).

FIG. 13 TOP RANKED CHALLENGES FACED BY HEALTH DEPARTMENT HIV PREVENTION PROGRAMS (N=57)

Rank	
1	Funding
2	Capacity of community / clinical partners to access target population
3	Capacity of community / clinical partners to provide services
4	Workforce
5	Data collection and reporting requirements
6	Training and capacity building for community / clinical partners
7	Policies (e.g., the presence or absence of a policy)
8	Availability of prevention services
9	Conservative political environments
10	Difficulty meeting the needs of rural populations

Health departments were also asked to report whether they faced consequences related to the challenges they face. The top ranked consequences were: the lack of availability of prevention interventions to reach high-risk populations; the inability to recruit clients into prevention programs; and difficulties with client retention in prevention programs (See Figure 14).

FIG. 14 **CONSEQUENCES OF THE CHALLENGES FACED BY HEALTH DEPARTMENTS (N=57)**

Rank	
1	Appropriate prevention interventions are not available for high-risk populations
2	Clients are not able to be proactively recruited into prevention programs
3	Clients are not able to be retained in prevention programs
4	Fewer community based partners are currently funded
5	Targeted high-risk individuals are not be tested
6	Resources are diverted from actual programming to meet the needs of other requirements
7	Relationships with non-traditional partners have not been established
8	Fewer community based partners are in existence
9	Inability to fill prevention staff positions due to lack of qualified technical expertise
10	Inability to fill prevention staff positions due to lack of resources

Of note, the top five ranked consequences are all situated at the client level. These consequences may constrain the ability of health departments to provide activities and services that work to keep those who are HIV-negative uninfected and to identify people living with HIV and connect them to services, the two primary goals of HIV prevention. Because of the challenges they face, health departments reported having to scale back certain HIV prevention activities and services. The most common areas reported for scaling back[23] were community level interventions (HE/RR), followed by public information campaigns. Additionally, 16 health departments report having had to scale back targeted HIVCTR (See Figure 15).

SCALING BACK AND SCALING UP HIV PREVENTION SERVICES

To assess perspectives on the future of their HIV prevention efforts, health departments were asked to identify specific activities and services they would 1) scale back if no barriers stood in the way and 2) scale up[24] if sufficient human and fiscal resources were available. Responses to these questions are one way to gauge how health departments would ideally maximize the effectiveness of activities and services and the efficiency of resource allocation within their HIV

PREVENTION PROGRAM AREAS HEALTH DEPARTMENTS REPORT TO SCALE BACK DUE TO CHALLENGES

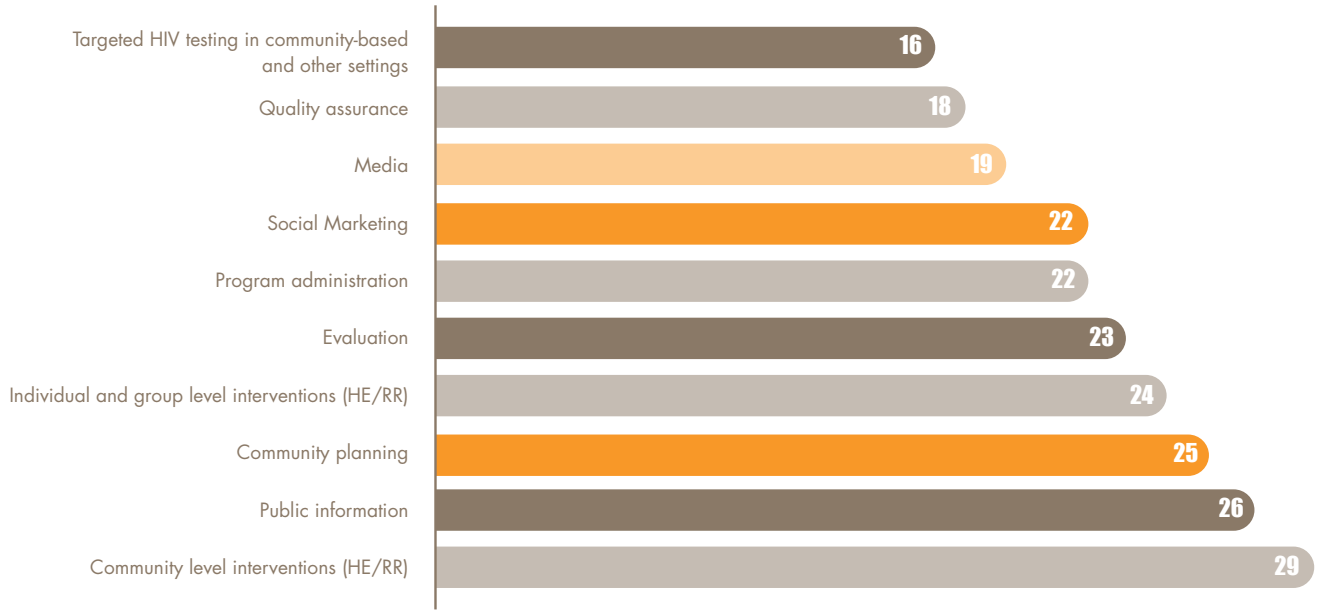


FIG. 15

[23] Scale back was defined as reducing resources, human and/or financial, to decrease emphasis on a particular strategy, service, or activity.
[24] Scale up was defined as increasing resources, human and/ or financial, to enhance emphasis on a particular strategy, service, or activity in order to have optimal public health impact.

PROGRAM AREAS HEALTH DEPARTMENTS WOULD SCALE BACK IF NO BARRIERS EXISTED

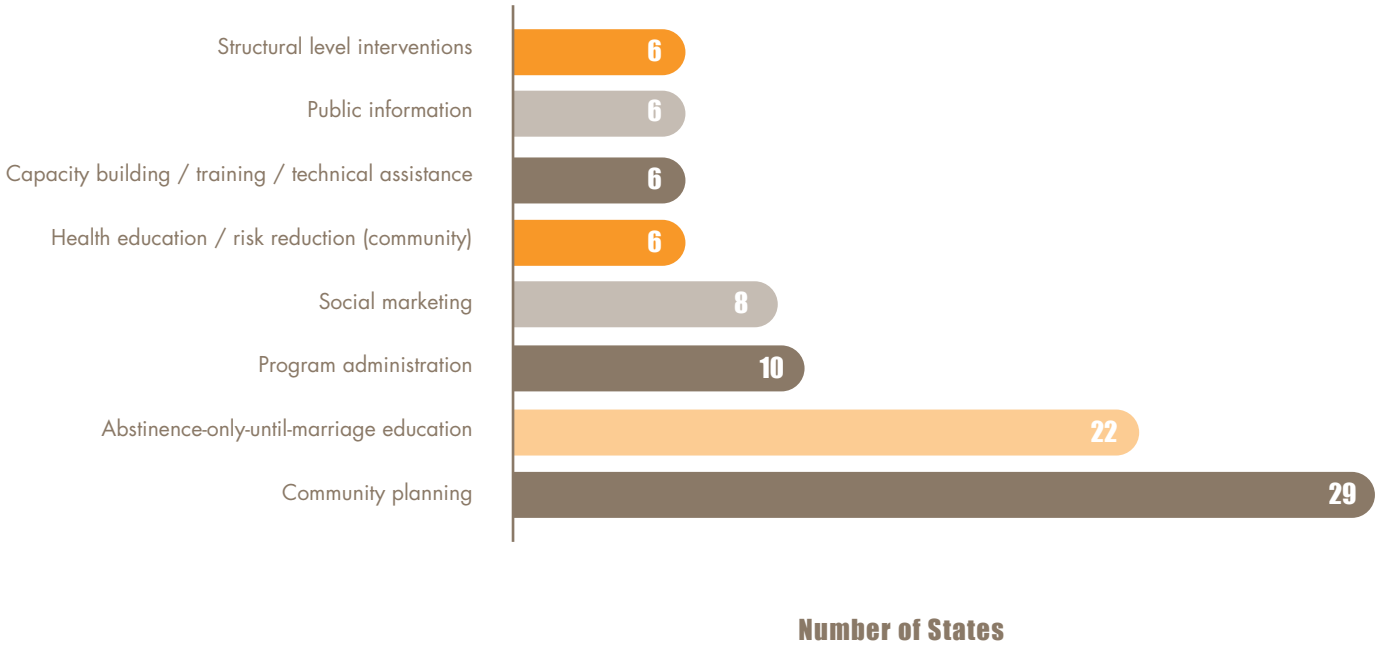


FIG. 16

prevention programs. For example, areas identified for scaling back may reflect services and activities that are mandated or required—per CDC-DHAP cooperative agreements, state and local legislation, or institutionally—but not necessarily considered to be as high a priority given limited HIV prevention resources, the impact of HIV/AIDS within a jurisdiction, and the unique HIV prevention needs of a jurisdiction. Areas identified for scaling up may reflect those where new needs have arisen or where funding is less likely to be available.

The top activities and services identified for scaling back were (See Figure 16):

- Community planning (29)
- Abstinence-only-until-marriage education (22)
- Program administration (10)

The top activities and services identified by health departments for scaling back were not directly related to client-level service provision (community planning and program administration) or represented services that have been found through rigorous research to be ineffective (abstinence-only-until-marriage education).

The top activities and services identified for scaling up were (See Figure 17):

- Partner services (17)
- HIV screening in health care settings (17)
- Structural level interventions (16)
- Evaluation (15)

The top activities and services identified by health departments for scaling up were directly related to client-level service provision (partner services and HIV screening), represented interventions that intend to alter structures that influence individual behaviors (structural level interventions) or were related to activities that gauge the effectiveness of other activities and services (evaluation).

PROGRAM AREAS HEALTH DEPARTMENTS WOULD SCALE UP IF RESOURCES WERE AVAILABLE

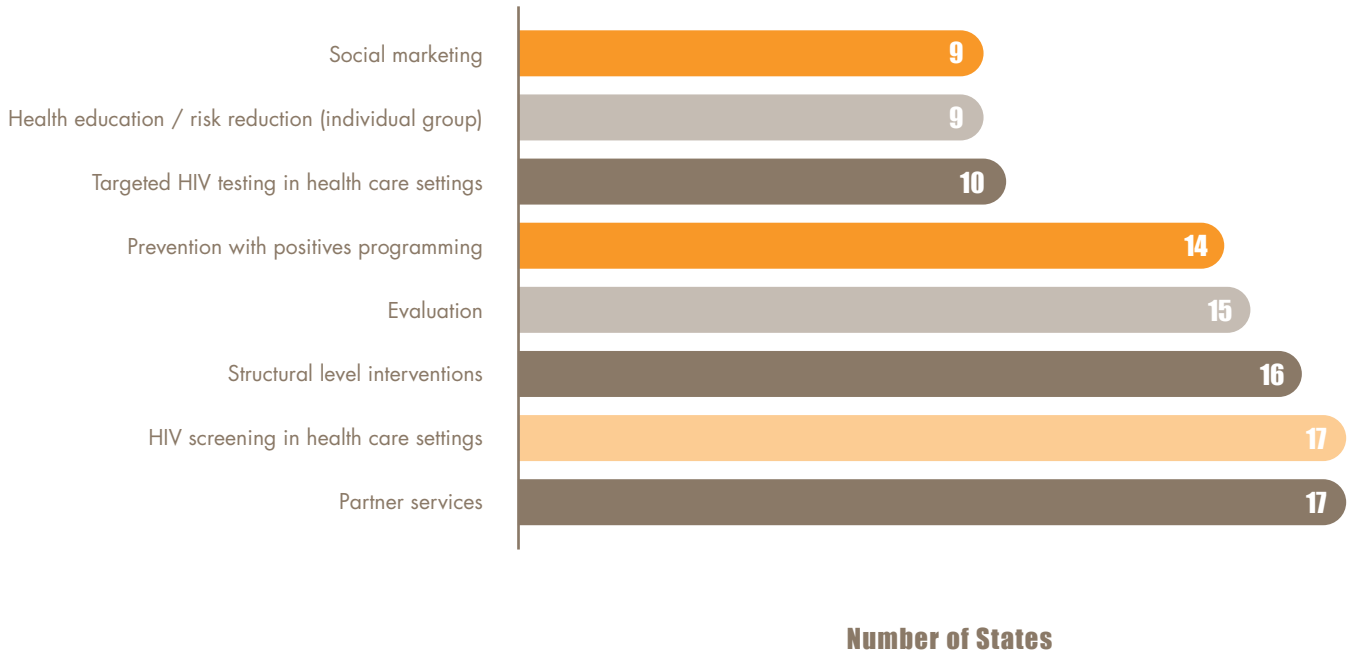


FIG. 17

CONCLUSION

Going forward, the ability of state and local jurisdictions to address HIV prevention challenges and meet prevention needs in their communities remains uncertain. Current limitations cited above were identified at the early stages of the current economic downturn, a situation which has significantly worsened since that time. In a recent budget survey conducted by NASTAD, twenty-two jurisdictions reported state revenue reductions in FY 2009, including 12 with existing or expected cuts to HIV prevention specifically, with more cuts anticipated for FY 2010. In addition, federal HIV prevention funding was flat between FY 2007 and FY 2009, including funding provided by CDC to states for HIV prevention activities.

At the same time, the Obama Administration has signaled a strong interest in reinvigorating the domestic HIV prevention response, including through the development of a National HIV/AIDS Strategy for the country. In addition, the President's FY 2010 budget request includes a $53 million increase for domestic HIV prevention efforts, although funding levels will not be finalized by Congress until later this year. These developments, as well as the larger fiscal health of the nation, will need to be closely monitored to assess their continued effects on HIV prevention in the United States.

APPENDICES

TABLE 1 - FY 2007 FUNDING FOR STATE PREVENTION PROGRAMS

Jurisdiction*	CDC/DHAP 04012 Funding (FY 2007)	CDC/DHAP 07768 Funding (FY 2007)	CDC/other Funding (FY 2007)	Other Federal Agency Funding (FY 2007)	State/Local Appropriated Funding (FY 2007)	State Pass-through Funding (FY 2007)**	Other Funding (FY 2007)	TOTAL Funding (FY 2007)
Alabama	$2,215,318	$0	$0	$0	$300,000	$0	$0	$2,515,318
Alaska	$1,417,620	$0		$0	$0	$0	$0	$1,417,620
Arizona	$3,127,962	$0	$0	$0	$0	$0	$0	$3,127,962
Arkansas	$1,775,880	$0	$0	$0	$5,968	$0	$0	$1,781,848
California	$35,708,316	$1,451,600	$435,074	$0	$39,303,000	$13,491,258	$4,544,070	$81,442,060
Colorado	$4,641,482	$0	$0	$0	$3,063,023	$0		$7,704,505
Connecticut	$6,260,601	$690,000	$0	$0	$5,301,883	$0	$0	$12,252,484
Delaware	$1,897,423	$0	$0	$311,000	$333,200	$0	$0	$2,541,623
District of Columbia	$5,100,000	$1,461,874	$88,000	$0	$0	$0	$0	$6,649,874
Florida	$18,875,918	$4,854,571	$0	$0	$6,978,752	$0	$0	$30,709,241
Georgia	$8,300,000	$1,922,906	.	$0	$0	$0	$0	$10,222,906
Hawaii	$2,041,254	$0	$0	$0	$1,387,975	$0	$0	$3,429,229
Idaho	$895,714	$0	$0	$0	$0	$0	$0	$895,714
Illinois	$9,568,568	$1,904,924	$0	$0	$10,229,141	$1,249,060	$3,971,000	$25,673,633
Indiana	$2,547,329	$0	$0	$0	$568,903	$0	$0	$3,116,232
Iowa	$1,649,372	$0	$0	$46,187	$0	$0	$0	$1,695,559
Kansas	$1,753,653	$0	$0	$0	$101,892	$0	$0	$1,855,545
Kentucky	$1,903,812	$0	$0	$0	$250,000	$0	$0	$2,153,812
Louisiana	$4,925,143	$1,432,500	$0	$0	$1,500,000	$0	$35,000	$7,892,643
Maine	$1,635,777	$0	$0	$0	$141,000	$0	$0	$1,776,777
Maryland	$9,798,682	$2,769,495	$0	$922,000	$1,088,563	$0	$0	$14,578,740
Massachusetts	$8,917,212	$690,000	$429,099	$551,274	$19,637,010	$0	$0	$30,224,595
Michigan	$6,386,659	$957,131	$0	$66,400	$3,308,931	$0	$0	$10,719,121
Minnesota	$3,171,739	$0	$0	$0	$1,304,000	$0	$0	$4,475,739
Mississippi	$1,835,920	$0	$0	$0	$0	$0	$0	$1,835,920
Missouri	$3,892,209	$690,000	$0	$0	$0	$0	$0	$4,582,209
Montana	$1,267,199	$0	$0	$0	$0	$0	$0	$1,267,199
Nebraska	$1,284,241	$0	$0	$53,600	$0	$0	$0	$1,337,841
Nevada	$2,756,285	$0	$0	$0	$0	$0	$0	$2,756,285
New Hampshire	$1,612,682	$0	$0	$0	$0	$0	$0	$1,612,682
New Jersey	$13,922,139	$1,528,000	$0	$0	$14,593,100	$0	$0	$30,043,239
New Mexico	$2,277,559	$0	$0	$0	$930,000	$0	$0	$3,207,559
New York	$48,039,972	$6,494,000	$0	$0	$60,000,000	$810,000	$26,752,188	$141,286,160
North Carolina	$4,021,357	$1,179,000	$0	$0	$2,000,000	$0	$0	$7,200,357
North Dakota	$695,879	$0	$0	$0	$0	$0	$0	$695,879
Ohio	$5,355,284	$713,800	.	$0	$1,506,907	$0	$0	$7,575,991
Oklahoma	$2,434,358	$0	$0	$0	$0	$0	$0	$2,434,358
Oregon	$3,018,171	$0	$0	$0	$794,982	$0	$0	$3,813,153
Pennsylvania	$11,007,258	$1,931,500	$0	$0	$10,000,000	$4,027,454	$100,000	$23,038,758
Puerto Rico	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R
Rhode Island	$1,600,000	$0	$0	$0	$175,000	$0	$0	$1,775,000
South Carolina	$4,346,788	$955,000	$1,728,749	$1,034,294	$6,827,306	$0	$0	$14,892,137
South Dakota	$642,291	$0	$0	$0	$0	$0	$0	$642,291
Tennessee	$3,913,051	$955,000	$0	$0	$900,000	$0	$0	$5,768,051
Texas	$18,613,159	$1,050,500	$6,108,518	$0	$2,247,321	$0	$603,047	$28,622,545
Utah	$1,073,914	$0	$0	$0	$0	$0	$0	$1,073,914
Vermont	$1,460,681	$0	$0	$0	$100,000	$0	$0	$1,560,681
Virginia	$4,895,570	$706,700	$0	$0	$1,398,055	$0	$0	$7,000,325
Washington	$3,738,530	$0	$0	$0	$7,955,428	$0	$0	$11,693,958
West Virginia	$1,684,760	$0	$0	$0	$0	$0	$0	$1,684,760
Wisconsin	$2,792,802	$0	$393,346	$75,000	$1,034,300	$0	$0	$4,295,448
Wyoming	$787,249	$0	$0	$0	$0	$0	$0	$787,249
Total	$293,484,742	$34,338,501	$9,182,786	$3,059,755	$205,265,640	$19,577,772	$36,005,305	$581,336,729

*Funding for Directly-funded cities is included with their respective states.
**State pass-through funds removed from aggregated total to prevent double counting (CDC funding received by state and passed to directly funded cities).
***This number was calculated by NASTAD and the Kaiser Family Foundation
N/R=Not Reported; N/A=Not Applicable (Unable to Calculate)

TABLE 1 - FY 2007 FUNDING FOR STATE PREVENTION PROGRAMS (CONTINUED)

Jurisdiction*	2007 Census Population Estimates	Total FY 2007 HIV/AIDS Funding Per Capita***	DHAP FY 2007 HIV/AIDS Funding Per Capita***	State FY 2007 HIV/AIDS Funding Per Capita***	2005 Reported Living HIV and AIDS Cases (Ryan White)	Total Funding per 2005 Ryan White HIV/AIDS Case***	Total DHAP Funding per 2005 Ryan White HIV/AIDS Case***	Total State Funding per 2005 Ryan White HIV/AIDS Case***
Alabama	4,627,851	$0.54	$0.48	$0.06	9,147	$274.99	$242.19	$32.80
Alaska	683,478	$2.07	$2.07	$0.00	490	$2,893.10	$2,893.10	$0.00
Arizona	6,338,755	$0.49	$0.49	$0.00	9,707	$322.24	$322.24	$0.00
Arkansas	2,834,797	$0.63	$0.63	$0.00	4,288	$415.54	$414.15	$1.39
California	36,553,215	$2.23	$1.02	$1.08	90,583	$899.09	$410.23	$433.89
Colorado	4,861,515	$1.58	$0.95	$0.63	9,623	$800.63	$482.33	$318.30
Connecticut	3,502,309	$3.50	$1.98	$1.51	8,849	$1,384.62	$785.47	$599.15
Delaware	864,764	$2.94	$2.19	$0.39	2,721	$934.08	$697.33	$122.45
District of Columbia	588,292	$11.30	$11.15	$0.00	12,789	$519.97	$513.09	$0.00
Florida	18,251,243	$1.68	$1.30	$0.38	81,745	$375.67	$290.30	$85.37
Georgia	9,544,750	$1.07	$1.07	$0.00	21,156	$483.22	$483.22	$0.00
Hawaii	1,283,388	$2.67	$1.59	$1.08	2,048	$1,674.43	$996.71	$677.72
Idaho	1,499,402	$0.60	$0.60	$0.00	589	$1,520.74	$1,520.74	$0.00
Illinois	12,852,548	$2.00	$0.89	$0.80	27,924	$919.41	$410.88	$366.32
Indiana	6,345,289	$0.49	$0.40	$0.09	7,545	$413.02	$337.62	$75.40
Iowa	2,988,046	$0.57	$0.55	$0.00	1,338	$1,267.23	$1,232.71	$0.00
Kansas	2,775,997	$0.67	$0.63	$0.04	2,288	$810.99	$766.46	$44.53
Kentucky	4,241,474	$0.51	$0.45	$0.06	3,480	$618.91	$547.07	$71.84
Louisiana	4,293,204	$1.84	$1.48	$0.35	14,875	$530.60	$427.40	$100.84
Maine	1,317,207	$1.35	$1.24	$0.11	881	$2,016.77	$1,856.73	$160.05
Maryland	5,618,344	$2.59	$2.24	$0.19	26,717	$545.67	$470.42	$40.74
Massachusetts	6,449,755	$4.69	$1.49	$3.04	14,872	$2,032.32	$645.99	$1,320.40
Michigan	10,071,822	$1.06	$0.73	$0.33	11,799	$908.48	$622.41	$280.44
Minnesota	5,197,621	$0.86	$0.61	$0.25	5,195	$861.55	$610.54	$251.01
Mississippi	2,918,785	$0.63	$0.63	$0.00	7,351	$249.75	$249.75	$0.00
Missouri	5,878,415	$0.78	$0.78	$0.00	9,888	$463.41	$463.41	$0.00
Montana	957,861	$1.32	$1.32	$0.00	297	$4,266.66	$4,266.66	$0.00
Nebraska	1,774,571	$0.75	$0.72	$0.00	1,269	$1,054.25	$1,012.01	$0.00
Nevada	2,565,382	$1.07	$1.07	$0.00	5,843	$471.72	$471.72	$0.00
New Hampshire	1,315,828	$1.23	$1.23	$0.00	1,010	$1,596.71	$1,596.71	$0.00
New Jersey	8,685,920	$3.46	$1.78	$1.68	31,987	$939.23	$483.01	$456.22
New Mexico	1,969,915	$1.63	$1.16	$0.47	2,055	$1,560.86	$1,108.30	$452.55
New York	19,297,729	$7.32	$2.83	$3.11	110,846	$1,274.62	$491.98	$541.29
North Carolina	9,061,032	$0.79	$0.57	$0.22	18,774	$383.53	$277.00	$106.53
North Dakota	639,715	$1.09	$1.09	$0.00	145	$4,799.17	$4,799.17	$0.00
Ohio	11,466,917	$0.66	$0.53	$0.13	14,676	$516.22	$413.54	$102.68
Oklahoma	3,617,316	$0.67	$0.67	$0.00	4,296	$566.66	$566.66	$0.00
Oregon	3,747,455	$1.02	$0.81	$0.21	4,001	$953.05	$754.35	$198.70
Pennsylvania	12,432,792	$1.85	$1.04	$0.80	24,895	$925.44	$519.73	$401.69
Puerto Rico	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rhode Island	1,057,832	$1.68	$1.51	$0.17	2,004	$885.73	$798.40	$87.33
South Carolina	4,407,709	$3.38	$1.20	$1.55	13,550	$1,099.05	$391.28	$503.86
South Dakota	796,214	$0.81	$0.81	$0.00	309	$2,078.61	$2,078.61	$0.00
Tennessee	6,156,719	$0.94	$0.79	$0.15	12,724	$453.32	$382.59	$70.73
Texas	23,904,380	$1.20	$0.82	$0.09	54,384	$526.30	$361.57	$41.32
Utah	2,645,330	$0.41	$0.41	$0.00	1,919	$559.62	$559.62	$0.00
Vermont	621,254	$2.51	$2.35	$0.16	418	$3,733.69	$3,494.45	$239.23
Virginia	7,712,091	$0.91	$0.73	$0.18	16,899	$414.24	$331.51	$82.73
Washington	6,468,424	$1.81	$0.58	$1.23	8,922	$1,310.69	$419.02	$891.66
West Virginia	1,812,035	$0.93	$0.93	$0.00	1,323	$1,273.44	$1,273.44	$0.00
Wisconsin	5,601,640	$0.77	$0.50	$0.18	4,334	$991.10	$644.39	$238.65
Wyoming	522,830	$1.51	$1.51	$0.00	182	$4,325.54	$4,325.54	$0.00
Total	301,621,157	$1.93	$1.09	$0.68	724,950	$801.90	$452.20	$283.14

TABLE 2 - FY 2007 FUNDING ALLOCATION; INTERNAL HD OR EXTERNAL ALLOCATION*

Jurisdiction	Total Internal Allocation (FY 2007)	Total External Allocation** (FY 2007)	External: CBOs / NGOs (FY 2007)	External: Local Health Departments (FY 2007)	External: Other Public Agencies (FY 2007)	External: Other (FY 2007)	Other Allocation (FY 2007)	Unknown	Total FY 2007 HIV Prevention Funding (FY 2007)
Alabama	$1,086,013	$1,429,305	$970,816	$300,000	$158,489	$0	$0	$0	$2,515,318
Alaska	--	--	--	--	--	--	--	$1,417,620	$1,417,620
Arizona	$1,113,641	$2,014,321	$1,132,235	$882,086	$0	$0	$0		$3,127,962
Arkansas	$1,369,971	$411,877	$340,000	$0	$0	$71,877	$0		$1,781,848
California	$7,319,000	$46,500,000	$15,500,000	$31,000,000	$0	$0	$0	$250	$53,819,250
Chicago	$4,745,283	$7,823,530	$7,823,530	$0	$0	$0	$0	$60	$12,568,873
Colorado	$2,916,482	$4,788,023	$3,730,419	$957,604	$100,000	$0	$0		$7,704,505
Connecticut	$2,294,080	$9,268,404	$7,411,096	$1,081,743	$0	$775,565	$0	$690,000	$12,252,484
Delaware	$1,200,000	$1,206,643	$1,056,643	$0	$0	$150,000	$0	$134,980	$2,541,623
District of Columbia	$4,400,000	$1,900,000	$1,900,000	$0	$0	$0	$0	$349,874	$6,649,874
Florida	$9,866,919	$20,842,322	$7,598,648	$7,357,601	$1,290,619	$4,595,454	$0		$30,709,241
Georgia	$4,000,000	$6,222,906	$3,100,000	$2,000,000	$0	$1,122,906	$0		$10,222,906
Hawaii	$1,570,161	$1,859,068	$1,834,068	$0	$25,000	$0	$0		$3,429,229
Houston	$3,315,211	$3,590,963	$3,058,718	$0	$286,992	$245,253	$0		$6,906,174
Idaho	$265,610	$630,104	$308,343	$306,761	$0	$15,000	$0		$895,714
Illinois	$3,193,855	$11,159,965	$3,896,527	$1,674,411	$5,589,027	$0	$0		$14,353,820
Indiana	$1,876,593	$1,239,639	$648,489	$565,250	$25,900	$0	$0		$3,116,232
Iowa	$802,721	$892,838	$381,487	$371,351	$34,000	$106,000	$0		$1,695,559
Kansas	$720,000	$1,135,545	$925,545	$160,000	$50,000	$0	$0		$1,855,545
Kentucky	$656,464	$1,497,348	$1,195,970	$301,378	$0	$0	$0		$2,153,812
Los Angeles County	$7,920,832	$17,018,361	$13,769,234	$611,411	$2,237,716	$400,000			$24,939,193
Louisiana	--	--	--	--	--	--	--	$7,892,643	$7,892,643
Maine	--	--	--	--	--	--	--	$1,776,777	$1,776,777
Maryland	$3,611,450	$10,967,290	$3,950,990	$5,382,200	$1,634,100	$0	$0		$14,578,740
Massachusetts	$4,831,937	$25,392,658	$22,162,947	$1,644,158	$1,585,553	$0	$0		$30,224,595
Michigan	$2,028,472	$7,819,251	$2,571,060	$3,391,731	$285,000	$1,571,460	$871,398		$10,719,121
Minnesota	$2,419,369	$1,956,370	$1,383,575	$436,346	$86,449	$50,000	$100,000		$4,475,739
Mississippi	$0	$1,835,920	$0	$1,835,920	$0	$0	$0		$1,835,920
Missouri	$2,014,679	$2,181,497	$126,574	$2,054,923	$0	$0	$386,033		$4,582,209
Montana	$446,766	$820,433	$384,870	$300,630	$7,235	$127,698	$0	$0	$1,267,199
Nebraska	$520,330	$817,511	$0	$0	$0	$817,511	$0		$1,337,841
Nevada	$646,155	$2,110,130	$541,495	$1,568,635	$0	$0	$0		$2,756,285
New Hampshire	$483,803	$1,005,274	$819,292	$185,982	$0	$0	$123,605		$1,612,682
New Jersey	$6,032,678	$24,010,561	$19,959,362	$1,685,234	$1,354,300	$1,011,665	$0		$30,043,239
New Mexico	$1,507,559	$1,700,000	$1,700,000	$0	$0	$0	$0		$3,207,559
New York	$0	$0	$0	$0	$0	$0	$87,881,744	$500	$87,882,244
New York City	$19,870,000	$34,300,000	.	.	.	.	$0	$43,916	$54,213,916
North Carolina	$1,600,357	$4,421,000	$3,200,000	$971,000	$250,000	$0	$0	$1,179,000	$7,200,357
North Dakota	$416,000	$279,879	$0	$84,879	$115,000	$80,000	$0		$695,879
Ohio	$1,506,907	$6,069,084	$0		$0		$0		$7,575,991
Oklahoma	$1,226,419	$1,207,939	$828,184	$179,658	$0	$200,097	$0		$2,434,358
Oregon	$974,267	$2,838,886	$185,000	$2,172,165	$281,095	$200,626	$0		$3,813,153
Pennsylvania	$1,865,647	$13,271,116	$5,191,323	$5,965,047	$0	$2,114,746	$461,811		$15,598,574
Philadelphia	$2,439,268	$9,028,370	$9,028,370	$0	$0	$0	$0		$11,467,638
Puerto Rico	--	--	--	--	--	--	--	--	--
Rhode Island	$500,000	$1,275,000	$1,275,000	$0	$0	$0	$0		$1,775,000
San Francisco	$4,256,498	$11,918,377	$8,841,422	$1,731,237	$1,345,718	$0	$0	$0	$16,174,875
South Carolina	$3,196,802	$11,695,335	$2,181,456	$9,291,879	$0	$222,000	$0		$14,892,137
South Dakota	$339,524	$302,767	$258,561	$0	$0	$44,206	$0		$642,291
Tennessee	$2,754,823	$2,869,000	$1,225,000	$1,644,000	$0	$0	$0	$144,228	$5,768,051
Texas	$3,465,585	$18,245,782	$6,937,310	$7,108,370	$4,200,102	$0	$0	$5,004	$21,716,371
Utah	$443,814	$630,100	$446,350	$140,250	$0	$43,500	$0		$1,073,914
Vermont	$653,994	$721,600	$621,600	$0	$0	$100,000	$185,087		$1,560,681
Virginia	$2,603,923	$4,396,402	$2,678,976	$1,067,926	$352,750	$296,750	$0		$7,000,325
Washington	$1,573,597	$10,120,361	$2,594,321	$7,456,081	$0	$69,959	$0	$0	$11,693,958
West Virginia	$706,912	$762,761	$507,761	$123,000	$0	$132,000	$215,087		$1,684,760
Wisconsin	$905,520	$3,389,928	$2,071,507	$504,000	$814,421	$0	$0		$4,295,448
Wyoming	$564,957	$222,292	$86,122	$109,000	$25,670	$1,500	$0		$787,249
Total	$137,040,848	$360,014,036	$178,340,196	$104,603,847	$22,135,136	$14,565,773	$90,224,765	$13,634,852	$600,914,501

*FY2007 pass through funding from California, Illinois, New York State, Pennsylvania and Texas to their directly funded cities (Chicago, Houston, Los Angeles County, New York City, Philadelphia and San Francisco) could not be disaggregated from the totals in this table. Therefore, the totals for these jurisdictions and for the U.S. total are inflated by $19,577,772, the amount of the states' pass through funds.

**Total external allocation may not equal the sum of the four external categories because some states did not report category data. Note: A dash (--) indicates category was not applicable to the jurisdiction.

TABLE 3 - HEALTH DEPARTMENT HEALTH EDUCATION / RISK REDUCTION PROGRAMS-DIFFUSION OF EFFECTIVE BEHAVIORAL INTERVENTIONS AND REPLICATING EFFECTIVE PROGRAMS

Jurisdiction	Currently funding DEBI or REP projects	DEBI / REP Interventions															Total
		Sisters Informing Sisters About Topics on AIDS (SISTA)	Mpowerment	Making Proud Choices	Video Opportunities for Innovative Condom Education and Safer Sex (VOICES / VOCES)	Health Relationships	Safety Counts	Comprehensive Risk Counseling and Services (CRCS)	Many Men, Many Voices (3MV)	Community Promise	Real AIDS Prevention Project (RAPP)	Popular Opinion Leader (POL)	Street Smart	Partnership for Health	Project Smart	Project Respect	
Alabama	Yes	X	X	X	X												4
Alaska	Yes		X			X											2
Arizona	Yes		X				X	X									3
Arkansas	Yes	X							X								2
California	Yes																0
Chicago	Yes								X	X	X						3
Colorado	Yes	X	X			X	X		X			X					6
Connecticut	Yes	X															1
Delaware	Yes																0
District of Columbia	Yes	X				X	X	X				X					5
Florida	Yes	X	X		X	X			X	X	X	X	X	X			10
Georgia	Yes	X			X	X	X			X	X	X					7
Hawaii	Yes	X	X													X	3
Houston	Yes	X			X					X		X	X				5
Idaho	Yes	X	X										X				3
Illinois	Yes	X	X		X							X					4
Indiana	No																0
Iowa	Yes	X	X		X	X	X	X		X			X		X		9
Kansas	No																0
Kentucky	Yes	X				X	X		X			X					5
Los Angeles County	Yes	X	X		X	X	X	X	X		X	X				X	10
Louisiana	Yes		X														1
Maine	Yes					X		X									2
Maryland	Yes	X	X		X	X			X								5
Massachusetts	Yes	X	X		X	X	X		X	X	X	X	X			X	11
Michigan	Yes	X	X						X			X					4
Minnesota	Yes				X			X		X		X	X				5
Mississippi	Yes	X				X			X		X	X					5
Missouri	Yes	X	X		X	X		X	X	X	X	X	X			X	11
Montana	Yes	X	X			X		X	X					X			6
Nebraska	Yes	X	X		X			X	X	X							6
Nevada	Yes		X					X		X			X				4
New Hampshire	Yes				X	X		X									3
New Jersey	Yes	X			X	X	X		X								5
New Mexico	Yes		X		X	X	X		X	X	X	X		X		X	10
New York	Yes	X	X		X	X	X		X	X	X	X	X			X	11
New York City	Yes																0
North Carolina	Yes	X			X						X					X	4
North Dakota	Yes											X					1
Ohio	Yes	X	X		X	X	X		X	X	X	X					9
Oklahoma	Yes	X							X								2
Oregon	Yes		X							X							2
Pennsylvania	Yes	X	X		X	X	X			X	X	X	X				9
Philadelphia	Yes		X	X	X	X	X		X	X	X	X				X	10
Puerto Rico	Yes				X												1
Rhode Island	Yes				X												1
San Francisco	Yes	X					X			X							3
South Carolina	Yes	X	X		X	X			X							X	6
South Dakota	Yes	X					X			X		X	X				5
Tennessee	Yes	X			X	X			X			X	X				6
Texas	Yes	X	X		X	X	X			X		X				X	8
Utah	Yes		X		X	X	X			X		X	X				7
Vermont	Yes	X	X			X		X			X		X				6
Virginia	Yes	X	X		X	X	X		X	X		X	X			X	10
Washington	Yes		X			X	X		X					X			5
West Virginia	Yes	X	X											X			3
Wisconsin	Yes	X	X		X	X	X		X				X				7
Wyoming	Yes										X						1
Total		36	32	2	28	29	21	12	24	21	15	24	16	5	1	11	

TABLE 4 - HEALTH DEPARTMENT HEALTH EDUCATION / RISK REDUCTION PROGRAMS-OTHER INTERVENTIONS

Jurisdiction	Currently funding interventions from the CDC's Compendium of HIV Prevention Interventions with Evidence of Effectiveness	Currently funding interventions from the National Institutes of Health's HIV/AIDS Prevention Program Archive (HAPPA)	Currently funding other locally-developed ("home-grown") interventions	Currently funding other interventions (including individual level interventions, syringe exchange, outreach, etc.)	Currenlty evaluate the effectiveness of funded non-DEBI/REP HIV prevention interventions locally
Alabama	--	--	Yes	--	Yes
Alaska	Yes	--	Yes	Yes	--
Arizona	Yes	--	--	--	Yes
Arkansas	--	--	--	Yes	--
California	Yes	--	Yes	--	Yes
Chicago	Yes	--	--	--	--
Colorado	Yes	--	Yes	--	--
Connecticut	Yes	--	--	Yes	--
Delaware	--	--	--	--	Yes
District of Columbia	Yes	--	--	--	Yes
Florida	--	--	--	Yes	Yes
Georgia	Yes	--	--	--	--
Hawaii	--	--	Yes	Yes	Yes
Houston	Yes	--	--	--	--
Idaho	--	--	Yes	--	Yes
Illinois	Yes	--	Yes	--	--
Indiana	Yes	--	Yes	--	Yes
Iowa	Yes	Yes	Yes	--	--
Kansas	Yes	--	Yes	--	Yes
Kentucky	Yes	--	--	--	Yes
Los Angeles County			Yes		--
Louisiana	--	--	Yes	--	Yes
Maine	--	--	Yes	--	--
Maryland	Yes	--	Yes	--	Yes
Massachusetts	Yes	Yes	Yes	Yes	--
Michigan	Yes	Yes	Yes	--	Yes
Minnesota	Yes	--	Yes	--	--
Mississippi	--	--	--	--	--
Missouri	--	--	Yes	--	Yes
Montana	--	--	Yes	--	Yes
Nebraska	--	--	Yes	--	--
Nevada	--	--	--	Yes	--
New Hampshire	--	--	Yes	--	--
New Jersey	Yes	--	Yes	--	Yes
New Mexico	Yes	--	Yes	--	Yes
New York	Yes	--	--	Yes	Yes
New York City	--	--	Yes	--	Yes
North Carolina	Yes	--	--	--	--
North Dakota	--	--	--	Yes	Yes
Ohio	Yes	--	--	--	Yes
Oklahoma	Yes	--	--	--	Yes
Oregon	--	--	--	Yes	--
Pennsylvania	Yes	--	Yes	--	--
Philadelphia	Yes	--	Yes	--	--
Puerto Rico	Yes	--	Yes	--	--
Rhode Island	Yes	--	Yes	--	Yes
San Francisco	Yes	--	Yes	--	Yes
South Carolina	Yes	--	--	Yes	--
South Dakota	Yes	--	--	--	Yes
Tennessee	--	--	Yes	--	Yes
Texas	Yes	Yes	--	Yes	--
Utah	--	--	Yes	Yes	Yes
Vermont	--	--	Yes	--	Yes
Virginia	Yes	--	Yes	Yes	--
Washington	Yes	Yes	--	Yes	--
West Virginia	--	--	--	Yes	--
Wisconsin	--	--	--	Yes	Yes
Wyoming	--	--	--	Yes	--
Total	34	5	33	18	30

Note: A dash indicates a response of no or not applicable for the jurisdiction.

TABLE 5 - ROUTINE HIV TESTING/SCREENING CONDUCTED BY HEALTH DEPARTMENTS

Jurisdiction	Routine HIV Testing/Screening for Adolescents and Adults	Routine HIV Testing/Screening for Pregnant Women	Routine HIV Testing/Screening for Newborns
Alabama	--	Yes	Yes
Alaska	--	Yes	--
Arizona	--	Yes	--
Arkansas	--	Yes	Yes
California	--	Yes	--
Chicago	--	Yes	Yes
Colorado	--	--	--
Connecticut	Yes	Yes	--
Delaware	--	Yes	--
District of Columbia	--	--	--
Florida	--	Yes	--
Georgia	--	Yes	--
Hawaii	--	--	--
Houston	--	Yes	Yes
Idaho	--	--	--
Illinois	--	Yes	Yes
Indiana	--	Yes	--
Iowa	--	Yes	--
Kansas	--	Yes	Yes
Kentucky	--	Yes	--
Los Angeles County	--	Yes	--
Louisiana	--	Yes	Yes
Maine	--	Yes	--
Maryland	--	--	--
Massachusetts	--	--	--
Michigan	--	Yes	--
Minnesota	--	Yes	Yes
Mississippi	Yes	Yes	Yes
Missouri	--	Yes	Yes
Montana	--	--	--
Nebraska	--	--	--
Nevada	--	Yes	Yes
New Hampshire	--	Yes	--
New Jersey	Yes	Yes	Yes
New Mexico	--	--	--
New York	--	Yes	--
New York City	--	Yes	Yes
North Carolina	--	--	--
North Dakota	--	Yes	--
Ohio	--	--	--
Oklahoma	--	Yes	Yes
Oregon	--	Yes	--
Pennsylvania	--	--	--
Philadelphia	--	Yes	--
Puerto Rico	--	Yes	--
Rhode Island	--	Yes	Yes
San Francisco*	--	Yes	--
South Carolina	Yes	Yes	--
South Dakota	--	Yes	Yes
Tennessee	--	Yes	--
Texas	Yes	Yes	--
Utah	--	--	--
Vermont	Yes	Yes	--
Virginia	--	--	--
Washington	--	Yes	--
West Virginia	--	--	--
Wisconsin	--	Yes	Yes
Wyoming	--	--	--
Total	6	42	17

*Responses not provided, so data from California were used for San Francisco.

Note: A dash indicates a response of no, unknown, or not applicable from the jurisdiction.

TABLE 6 - ANONYMOUS HIV TESTING CONDUCTED BY HEALTH DEPARTMENTS

Jurisdiction	Legal Requirement Prohibiting Anonymous HIV Testing	Legal Requirement to Offer Anonymous HIV Testing	Offers Anonymous HIV Testing	Percent of HIV Tests that are Anonymous
Alabama	Yes	--	--	--
Alaska	--	--	Yes	--
Arizona	--	Yes	Yes	1%
Arkansas	--	--	--	--
California	--	Yes	Yes	33%
Chicago		Yes	Yes	2%
Colorado	--	Yes	Yes	10%
Connecticut	--	--	Yes	5%
Delaware	--	--	Yes	1%
District of Columbia	--	--	Yes	--
Florida	--	Yes	Yes	3%
Georgia	--	--	Yes	9%
Hawaii	--	--	Yes	100%
Houston	--	Yes	Yes	20%
Idaho	Yes	--	--	--
Illinois	--	Yes	Yes	46%
Indiana	--	--	Yes	11%
Iowa	Yes	--	--	--
Kansas	--	Yes	Yes	5%
Kentucky	--	Yes	Yes	40%
Los Angeles County	--	Yes	Yes	20%
Louisiana	--	Yes	Yes	10%
Maine	--	--	Yes	60%
Maryland	--	--	Yes	8%
Massachusetts	--	--	Yes	5%
Michigan	--	Yes	Yes	23%
Minnesota	--	--	Yes	12%
Mississippi	Yes	--	--	--
Missouri	--	Yes	Yes	10%
Montana	--	Yes	Yes	40%
Nebraska	--	Yes	Yes	40%
Nevada	Yes	Yes	Yes	--
New Hampshire	--	--	--	--
New Jersey	Yes	--	Yes*	2%
New Mexico	--	Yes	Yes	--
New York	--	Yes	Yes	15%
New York City	--	Yes	Yes	4%
North Carolina	NR	NR	NR	NR
North Dakota	--	--	--	--
Ohio	--	Yes	Yes	15%
Oklahoma	--	--	Yes	4%
Oregon	--	--	Yes	23%
Pennsylvania	--	Yes	Yes	10%
Philadelphia	--	--	Yes	15%
Puerto Rico	--	--	--	--
Rhode Island	--	Yes	Yes	40%
San Francisco	--	Yes	Yes	22%
South Carolina	Yes	--	--	--
South Dakota	--	--	Yes	10%
Tennessee	Yes	--	--	--
Texas	--	Yes	Yes	4%
Utah	--	Yes	Yes	6%
Vermont	--	--	Yes	55%
Virginia	--	Yes	Yes	3%
Washington	--	Yes	Yes	25%
West Virginia	--	--	--	--
Wisconsin	--	Yes	Yes	32%
Wyoming	--	--	Yes	6%
Total	8	28	46	

* The Commisioner of Health made an exception for 16 sites in New Jersey.

Note: A dash (--) indicates a response of no or not applicable from the jurisdiction.

NR indicates no information reported from the jurisdiction.

TABLE 7 - PERCENT OF HIV TESTING CONDUCTED IN A JURISDICTION BY SETTING

Jurisdiction	Community-Based Settings (e.g., community based organizations, mobile vans)	Health-Department-Operated Clinical Settings including State and Local Health Departments (e.g., STD clinics, TB clinics)	Non-Health-Department-Operated Clinical Settings (e.g., emergency departments, urgent care clinics)	Other Settings (including corrections, substance abuse treatment programs, homeless shelters, colleges and universities)
Alabama	35%	60%	5%	0%
Alaska	95%	5%	0%	0%
Arizona	70%	30%	0%	0%
Arkansas	10%	75%	10%	5%
California	16%	22%	0%	62%
Chicago	32%	68%	0%	0%
Colorado	4%	96%	0%	0%
Connecticut	79%	21%	0%	0%
Delaware	35%	65%	0%	0%
District of Columbia	60%	1%	39%	0%
Florida	37%	62%	1%	0%
Georgia	22%	77%	1%	0%
Hawaii	19%	54%	6%	21%
Houston	60%	40%	0%	0%
Idaho	47%	53%	0%	0%
Illinois	40%	50%	10%	0%
Indiana	35%	31%	15%	19%
Iowa	40%	60%	0%	0%
Kansas	15%	70%	15%	0%
Kentucky	10%	90%	0%	0%
Los Angeles County	89%	0%	2%	9%
Louisiana	26%	67%	1%	5%
Maine	25%	75%	0%	0%
Maryland	28%	56%	5%	11%
Massachusetts	50%	20%	30%	0%
Michigan	15%	68%	17%	0%
Minnesota	15%	59%	25%	1%
Mississippi	0%	100%	0%	0%
Missouri	40%	60%	0%	0%
Montana	75%	25%	0%	0%
Nebraska	64%	36%	0%	0%
Nevada	20%	75%	5%	0%
New Hampshire	45%	42%	13%	0%
New Jersey	25%	25%	50%	0%
New Mexico	56%	44%	0%	0%
New York	--	--	--	--
New York City	8%	64%	27%	2%
North Carolina	--	--	--	--
North Dakota	28%	72%	0%	0%
Ohio	18%	63%	19%	0%
Oklahoma	15%	65%	15%	5%
Oregon	23%	77%	0%	0%
Pennsylvania	17%	61%	0%	22%
Philadelphia	40%	46%	14%	0%
Puerto Rico	10%	80%	10%	0%
Rhode Island	50%	5%	45%	0%
San Francisco	56%	22%	8%	14%
South Carolina	11%	89%	0%	0%
South Dakota	--	--	--	--
Tennessee	5%	93%	2%	0%
Texas	57%	24%	4%	15%
Utah	30%	70%	0%	0%
Vermont	90%	10%	0%	0%
Virginia	7%	93%	0%	0%
Washington	10%	90%	0%	0%
West Virginia	20%	80%	0%	0%
Wisconsin	60%	40%	0%	0%
Wyoming	0%	59%	14%	27%
Total	53	54	28	14

Note: A dash indicates a response was not reported by the jurisdiction.

TABLE 8 - REPORTED CHANGES TO HEALTH DEPARTMENT HIV TESTING BY VENUE

Jurisdiction	Venues						
	STD Clinics	Community Health Clinics (e.g., Federally Qualified Health Clinics)	Substance Abuse Treatment Centers	Prenatal / Obstetrical Clinics	Labor and Delivery Departments	Primary Care Clinics	Family Planning Clinics
Alabama	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Alaska	Yes	--	--	Yes	--	--	--
Arizona	Yes	Yes	Yes	--	--	--	Yes
Arkansas	Yes	--	Yes	Yes	Yes	--	Yes
California	Yes	--	--	Yes	Yes	Yes	Yes
Chicago	Yes	Yes	--	--	--	--	--
Colorado	--	--	--	--	--	--	--
Connecticut	Yes	Yes	Yes	Yes	Yes	--	--
Delaware	--	--	--	--	--	--	--
District of Columbia	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Florida	--	--	--	Yes	Yes	--	--
Georgia	Yes	--	Yes	Yes	--	Yes	Yes
Hawaii	Yes	--	--	--	--	--	--
Houston	Yes	Yes	--	Yes	Yes	--	--
Idaho	--	--	--	--	--	--	Yes
Illinois	--	--	--	Yes	Yes	--	--
Indiana	Yes	--	--	Yes	Yes	--	Yes
Iowa	Yes	Yes	Yes	Yes	--	--	Yes
Kansas	Yes	Yes	Yes	Yes	--	Yes	Yes
Kentucky	Yes	Yes	--	Yes	--	--	Yes
Los Angeles County	Yes	--	--	Yes	Yes	--	--
Louisiana	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Maine	Yes	--	--	--	--	--	--
Maryland	Yes	--	--	Yes	--	--	--
Massachusetts	--	--	--	--	--	--	--
Michigan	Yes	Yes	--	--	Yes	--	--
Minnesota	Yes	--	--	Yes	Yes	--	--
Mississippi	Yes	--	--	Yes	--	--	Yes
Missouri	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Montana	--	--	--	--	--	--	--
Nebraska	Yes	--	--	--	--	--	Yes
Nevada	Yes	--	Yes	Yes	Yes	--	Yes
New Hampshire	Yes	Yes	Yes	--	--	Yes	Yes
New Jersey	Yes	Yes	Yes	Yes	Yes	Yes	Yes
New Mexico	--	--	--	--	--	--	--
New York	--	--	--	--	--	--	--
New York City	Yes	Yes	--	Yes	Yes	Yes	Yes
North Carolina	--	--	--	--	--	--	--
North Dakota	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ohio	--	--	--	--	--	--	--
Oklahoma	Yes	Yes	Yes	--	--	Yes	Yes
Oregon	Yes	Yes	--	Yes	--	--	Yes
Pennsylvania	Yes	Yes	Yes	Yes	--	--	Yes
Philadelphia	Yes	Yes	Yes	--	Yes	Yes	Yes
Puerto Rico	Yes	--	Yes	--	Yes	--	Yes
Rhode Island	Yes	Yes	Yes	Yes	Yes	Yes	Yes
San Francisco	Yes	Yes	--	Yes	Yes	Yes	--
South Carolina	Yes	Yes	--	Yes	--	--	Yes
South Dakota	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Tennessee	Yes	Yes	--	Yes	Yes	Yes	Yes
Texas	Yes	--	Yes	Yes	Yes	--	Yes
Utah	Yes	Yes	--	--	--	--	--
Vermont	Yes	Yes	--	--	Yes	Yes	Yes
Virginia	--	--	--	--	--	--	--
Washington	--	--	--	Yes	Yes	--	--
West Virginia	--	--	--	--	--	--	--
Wisconsin	--	--	--	Yes	Yes	--	--
Wyoming	Yes	Yes	--	Yes	Yes	Yes	Yes
Total	43	28	21	35	29	19	32

Note: "Yes" indicates a response of maintained routine HIV testing/screening since February 2007, expanded routine HIV testing/screening since February 2007, or initiated routine HIV testing/screening since February 2007 from a jurisdiction. A dash indicates a response of ended routine HIV testing/screening since February 2007, never implemented routine HIV testing/screening in this setting, or not applicable from the jurisdiction.

TABLE 8 - REPORTED CHANGES TO HEALTH DEPARTMENT HIV TESTING BY VENUE

Jurisdiction	Venues							Total
	Hospital Emergency Departments	Urgent Care Clinics	Hospital Inpatient	Hospital Outpatient	TB Clinics	Correctional Facilities	Other Venues	
Alabama	--	--	--	--	Yes	Yes	--	9
Alaska	--	--	--	--	Yes	--	--	3
Arizona	--	--	--	--	Yes	Yes	--	6
Arkansas	--	--	--	--	Yes	Yes	--	7
California	Yes	Yes	Yes	Yes	--	Yes	--	10
Chicago	Yes	--	--	--	--	Yes	--	4
Colorado	--	--	--	--	--	Yes	--	1
Connecticut	--	--	--	--	--	--	--	5
Delaware	--	--	--	--	--	--	--	0
District of Columbia	Yes	Yes	Yes	Yes	Yes	Yes	--	13
Florida	--	--	--	--	--	--	Yes	3
Georgia	Yes	--	--	--	Yes	Yes	--	8
Hawaii	--	--	--	--	--	Yes	--	2
Houston	Yes	Yes	--	--	--	Yes	--	7
Idaho	--	--	--	--	--	--	--	1
Illinois	--	--	--	--	--	--	--	2
Indiana	Yes	--	--	--	--	Yes	--	6
Iowa	--	--	--	--	Yes	Yes	--	7
Kansas	--	--	--	--	Yes	Yes	--	8
Kentucky	--	--	--	--	Yes	--	--	5
Los Angeles County	--	--	--	--	--	--	--	3
Louisiana	Yes	Yes	Yes	Yes	Yes	Yes	--	13
Maine	--	--	--	--	--	--	--	1
Maryland	Yes	Yes	--	--	--	--	--	4
Massachusetts	--	--	--	--	--	--	--	0
Michigan	Yes	--	--	--	--	Yes	--	5
Minnesota	--	--	--	--	--	--	--	3
Mississippi	--	--	--	--	Yes	Yes	--	5
Missouri	Yes	Yes	--	--	Yes	Yes	--	11
Montana	--	--	--	--	--	--	--	0
Nebraska	--	--	--	--	--	Yes	--	3
Nevada	--	--	--	--	--	Yes	--	6
New Hampshire	--	--	--	--	--	Yes	Yes	7
New Jersey	Yes	--	--	Yes	Yes	Yes	--	11
New Mexico	--	--	--	--	--	--	--	0
New York	--	--	--	--	--	--	Yes	1
New York City	Yes	Yes	Yes	Yes	Yes	Yes	--	12
North Carolina	--	--	--	--	--	--	--	0
North Dakota	--	--	--	--	--	Yes	--	8
Ohio	--	--	--	--	--	--	--	0
Oklahoma	--	--	--	--	Yes	--	--	6
Oregon	Yes	--	--	--	Yes	Yes	--	7
Pennsylvania	--	--	--	Yes	Yes	Yes	--	8
Philadelphia	Yes	Yes	Yes	Yes	Yes	Yes	--	12
Puerto Rico	Yes	--	--	--	--	Yes	--	6
Rhode Island	Yes	Yes	Yes	Yes	Yes	Yes	--	13
San Francisco	Yes	--	Yes	--	--	--	--	7
South Carolina	Yes	--	--	--	Yes	Yes	--	7
South Dakota	Yes	Yes	Yes	Yes	Yes	Yes	--	13
Tennessee	Yes	--	Yes	--	Yes	--	--	9
Texas	--	--	--	--	Yes	Yes	--	7
Utah	Yes	--	--	--	--	Yes	--	4
Vermont	--	--	--	--	--	Yes	--	6
Virginia	--	--	--	--	--	--	--	0
Washington	--	--	--	--	Yes	Yes	--	4
West Virginia	--	--	--	--	--	--	--	0
Wisconsin	--	--	--	--	--	--	--	2
Wyoming	Yes	Yes	--	--	--	Yes	--	9
Total	22	11	9	9	24	35	3	

TABLE 9 - HEALTH DEPARTMENT PARTNER SERVICES PROGRAMS

Jurisdiction	Program Holding Purview of Partner Services					HIV/AIDS Surveillance Data and Partner Services		
	HIV/AIDS program	STD program	Combined HIV/STD programs	State disease surveillance	Other (including Local Health Authorities)	HIV/AIDS surveillance data used to conduct HIV Partner Services	Statutes and / or regulations prohibiting the use of HIV/AIDS surveillance data for Partner Services	Statutes and / or regulations mandating / allowing the use of HIV/AIDS surveillance data for HIV Partner Services
Alabama	--	Yes	--	--	--	--		--
Alaska	--	--	Yes	--	--	Yes	--	Yes
Arizona	Yes	Yes	--	--	--	Yes	--	--
Arkansas	--	--	Yes	--	--	Yes	--	Yes
California	Yes	Yes	--	--	--	--	Yes	--
Chicago	--	--	Yes	--	--	--	--	--
Colorado	--	--	Yes	--	--	Yes	--	Yes
Connecticut	--	Yes	--	--	--	Yes	--	--
Delaware	--	Yes	--	--	--	Yes	--	--
District of Columbia	Yes	--	--	--	--	Yes	--	--
Florida	--	Yes	--	--	--	Yes	--	Yes
Georgia	Yes	--	--	--	--	--	--	--
Hawaii	--	--	Yes	--	--	--	Yes	--
Houston	--	--	Yes	--	--	Yes	--	Yes
Idaho	Yes	--	--	Yes	--	Yes	--	Yes
Illinois	Yes	--	Yes	--	--	Yes	--	Yes
Indiana	--	--	Yes	Yes	--	Yes	--	--
Iowa	--	--	Yes	--	--	Yes	--	Yes
Kansas	--	Yes	--	--	--	Yes	--	Yes
Kentucky	--	Yes	--	--	--	--	--	--
Los Angeles County	--	--	Yes	--	--	--	--	--
Louisiana	--	--	Yes	--	--	Yes	--	--
Maine	--	--	Yes	--	--	Yes	--	Yes
Maryland	Yes	--	--	--	--	Yes	--	--
Massachusetts	Yes	Yes	--	--	--	--	Yes	--
Michigan	--	Yes	--	--	--	Yes	--	--
Minnesota	--	--	Yes	--	--	Yes	--	Yes
Mississippi	--	--	Yes	--	--	Yes	--	Yes
Missouri	--	--	Yes	--	--	Yes	--	--
Montana	--	Yes	--	--	--	--	--	--
Nebraska	--	Yes	--	--	--	Yes	--	Yes
Nevada	--	--	--	--	Yes	Yes	--	--
New Hampshire	Yes	Yes	Yes	Yes	--	Yes	--	--
New Jersey	Yes	--	--	--	--	Yes	--	--
New Mexico	--	--	Yes	Yes	--	Yes	--	--
New York	--	Yes	--	--	--	Yes	--	--
New York City	Yes	Yes	--	--	--	Yes	--	Yes
North Carolina	.	.	.	.	.	--	--	--
North Dakota	Yes	--	--	--	--	Yes	--	--
Ohio	--	--	Yes	--	--	Yes	--	--
Oklahoma	--	--	Yes	--	--	Yes	--	--
Oregon	--	Yes	--	--	--	Yes	--	Yes
Pennsylvania	Yes	--	--	--	--	--	--	--
Philadelphia	--	--	--	--	Yes	--	Yes	--
Puerto Rico	--	--	Yes	--	--	Yes	--	--
Rhode Island	Yes	--	--	--	--	Yes	--	Yes
San Francisco	Yes	--	--	--	--	--	--	--
South Carolina	--	--	Yes	--	--	Yes	--	Yes
South Dakota	Yes	--	--	--	--	Yes	--	--
Tennessee	--	--	Yes	--	--	Yes	--	Yes
Texas	--	--	Yes	--	--	Yes	--	Yes
Utah	--	--	Yes	--	--	Yes	--	--
Vermont	--	--	Yes	--	--	--	--	--
Virginia	--	--	Yes	--	--	Yes	--	Yes
Washington	--	--	--	--	Yes	Yes	--	Yes
West Virginia	--	--	Yes	--	--	Yes	--	--
Wisconsin	Yes	--	--	--	--	Yes	--	Yes
Wyoming	--	--	Yes	--	--	Yes	--	--
Total	17	16	28	4	3	44	4	22

Note: A dash indicates a reponse of no or not applicable from the jurisdiction.

TABLE 10 - HEALTH DEPARTMENT HIV PREVENTION COMMUNITY PLANNING GROUPS

Jurisdiction	Type of Community Planning Group						Number of Planning Group Members	Frequency of Community Planning Grou Meetings	Frequency of Comprehensive Plan Development	Integrated Prevention-Care Comprehensive Plan?
	State or Directly Funded City Prevention Planning Group	State Prevention Planning Group	State Prevention Planning Group with Regional / Local Feeds	Regional / Local Prevention Planning Groups	State Combined Prevention-Care Planning Group	State Combined Prevention-Care Regional / Local Groups				
Alabama	Yes	Yes	--	--	--	--	35	Quarterly	Every 5 years	No
Alaska	Yes	Yes	--	--	--	--	20	Other	Every 3 years	No
Arizona	Yes	--	Yes	Yes	--	--	32	Quarterly	Every 5 years	No
Arkansas	Yes	--	Yes	Yes	--	--	40	Bi-monthly	Every 4 years	No
California	--	--	--	--	Yes	Yes	46	3 times / year	Every 5 years	No
Chicago	Yes	--	--	--	--	--	42	Monthly	Every 3 years	No
Colorado	Yes	Yes	--	--	--	--	35	Other	Every 3 years	No
Connecticut	--	--	--	--	Yes	--	40	Monthly	Every 3 years	No
Delaware	--	--	--	--	Yes	--	25	As needed	Every 5 years	No
District of Columbia	Yes	Yes	--	--	--	--	31	Monthly	Every 3 years	No
Florida	Yes	--	Yes	Yes	--	--	23	Other	Every 3 years	No
Georgia	Yes	Yes	--	--	--	--	41	Quarterly	Every 5 years	No
Hawaii	--	--	--	--	Yes	--	28	9 times / year	Every 5 years	No
Houston	Yes	--	--	--	--	--	22	Monthly	Every 5 years	No
Idaho	--	--	--	--	Yes	Yes	21	Other	Every 3 years	No
Illinois	Yes	--	Yes	Yes	--	--	35	Monthly	Every 3 years	No
Indiana	Yes	Yes	--	--	--	--	24	Bi-monthly	Every 3 years	No
Iowa	--	--	--	--	Yes	--	45	Bi-monthly	Every 3 years	Yes
Kansas	Yes	Yes	--	--	--	--	25	Other	Every 5 years	No
Kentucky	--	--	--	--	Yes	--	29	Monthly	Every 5 years	Yes
Los Angeles County	--	--	--	Yes	--	--	28	Monthly	Every 5 years	No
Louisiana	Yes	Yes	--	--	--	--	18	Quarterly	Every 3 years	No
Maine	Yes	Yes	--	--	--	--	15	Other	Every 4 years	No
Maryland	Yes	Yes	--	--	--	--	30	Other	Every 5 years	No
Massachusetts	Yes	Yes	--	--	--	--	40	Monthly	Every 5 years	No
Michigan	--	--	--	--	Yes	--	40	Quarterly	Every 3 years	No
Minnesota	Yes	Yes	--	--	--	--	26	Other	Every 3 years	No
Mississippi	Yes	Yes	--	--	--	--	25	Monthly	Every 3 years	No
Missouri	Yes	--	Yes	Yes	--	--	31	Other	Every 5 years	No
Montana	Yes	Yes	--	--	--	--	36	Quarterly	Every 3 years	No
Nebraska	--	--	--	--	Yes	--	35	Quarterly	Every 5 years	Yes
Nevada	--	--	--	Yes	--	--	30	Monthly	Every 5 years	No
New Hampshire	--	--	--	--	Yes	--	24	Other	Every 3 years	Yes
New Jersey	Yes	Yes	--	--	--	--	25	Bi-monthly	Every 3 years	No
New Mexico	Yes	--	Yes	Yes	--	--	30	Monthly	Every 3 years	No
New York	Yes	Yes	--	--	--	--	50	5 times / year	Every 5 years	No
New York City	Yes	--	--	--	--	--	50	Monthly	Every 4 years	No
North Carolina	--	--	--	Yes	--	--	17	Bi-monthly	Every 5 years	No
North Dakota	Yes	Yes	--	--	--	--	13	Quarterly	Every 5 years	No
Ohio	--	--	--	Yes	--	--	14	Monthly	Every 5 years	No
Oklahoma	Yes	--	Yes	Yes	--	--	24	Bi-monthly	Every year	Yes
Oregon	Yes	Yes	--	--	--	--	30	Other	Other	No
Pennsylvania	Yes	Yes	--	--	--	--	45	Bi-monthly	Every 5 years	No
Philadelphia	Yes	--	--	--	--	--	35	Monthly	Every 5 years	No
Puerto Rico	Yes	Yes	--	--	--	--	31	Monthly	Every 5 years	No
Rhode Island	Yes	Yes	--	--	--	--	25	Monthly	Every 5 years	No
San Francisco	Yes	--	--	--	--	--	36	Monthly	Every 5 years	No
South Carolina	--	--	--	--	Yes	--	31	Quarterly	Every 5 years	No
South Dakota	Yes	--	Yes	Yes	--	--	24	Quarterly	Every 5 years	No
Tennessee	--	--	--	--	Yes	Yes	25	Annually with quarterly calls	Every 3 years	No
Texas	Yes	Yes	--	--	--	--	36	Quarterly	Every 4 years	No
Utah	Yes	Yes	--	--	--	--	26	Day long monthly meetings for 1st quarter of year	Every 5 years	No
Vermont	--	--	--	--	Yes	--	25	Bi-monthly	Every 3 years	No
Virginia	Yes	Yes	--	--	--	--	30	Bi-monthly	Every 5 years	No
Washington	Yes	--	Yes	Yes	--	--	32	Bi-monthly	Other	No
West Virginia	Yes	Yes	--	--	--	--	26	Quarterly	Every 4 years	No
Wisconsin	--	--	--	--	Yes	--	26	Other	Other	No
Wyoming	--	--	--	--	Yes	--	28	Quarterly	Every 5 years	No
Total	39	25	9	13	15	3				5

Note: A dash (--) indicates a response of no or not applicable from the jurisdiction.

TABLE 11 - MEDIA CAMPAIGNS

Jurisdiction	Ever or Currently Operating		How Media Space Secured			Media Platform Used					Audience Driven to Following Resources			
	Ever Operated Media Campaign	Currently Operate or Fund Media Campaign	Purchased	Donated	Combination / Match	Television	Radio	Outdoor (billboards, bus shelters, etc.)	Print (newspaper, magazine, etc.)	Online	Hotline	Website	SMS / Text Messaging	Other
Alabama	Yes	Yes	--	--	Yes	--	--	--	--	--	Yes	--	--	--
Alaska	Yes	Yes	Yes	Yes	--	--	Yes	--	Yes	--	Yes	--	--	Yes
Arizona	Yes	--	--	--	--	--	Yes	--	Yes	--	--	--	--	Yes
Arkansas	Yes	Yes	--	--	Yes	--	Yes	Yes	Yes	Yes	Yes	--	--	Yes
California	Yes	Yes	Yes	--	Yes	--	Yes	Yes	Yes	Yes	Yes	Yes	--	--
Chicago	Yes	Yes	Yes	--	--	Yes	Yes	Yes	Yes	--	Yes	--	--	--
Colorado	Yes	Yes	Yes	--	--	--	--	Yes	Yes	--	--	--	--	Yes
Connecticut	Yes	Yes	--	--	Yes	--	Yes	Yes	--	--	Yes	--	--	--
Delaware	Yes	Yes	Yes	--	--	Yes	Yes	Yes	--	Yes	Yes	Yes	--	--
District of Columbia	Yes	Yes	Yes	--	--	--	--	Yes	Yes	Yes	Yes	Yes	--	--
Florida	Yes	Yes	--	--	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	--
Georgia	Yes	Yes	Yes	--	--	--	Yes	Yes	Yes	--	Yes	--	--	--
Hawaii	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	--	Yes	--	Yes
Houston	Yes	Yes	Yes	--	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	--	--
Idaho	Yes	Yes	Yes	--	Yes	Yes	Yes	Yes	Yes	Yes	--	Yes	Yes	--
Illinois	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	--	--
Indiana	Yes	Yes	Yes	Yes	--	--	Yes	--	Yes	--	Yes	--	--	--
Iowa	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Kansas	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Kentucky	Yes	Yes	Yes	Yes	--	Yes	Yes	Yes	Yes	Yes	Yes	--	--	Yes
Los Angeles County	Yes	Yes	Yes	--	--	Yes	Yes	Yes	Yes	Yes	Yes	Yes	--	--
Louisiana	Yes	--	Yes	Yes	--	--	Yes	--	Yes	--	Yes	--	--	--
Maine	Yes	Yes	Yes	--	--	--	Yes	--	Yes	Yes	--	Yes	--	--
Maryland	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	--	Yes	Yes	--	--
Massachusetts	Yes	Yes	Yes	--	--	--	--	Yes	Yes	Yes	Yes	Yes	--	--
Michigan	Yes	Yes	--	--	Yes	--	Yes	--	Yes	--	Yes	--	--	--
Minnesota	Yes	Yes	Yes	Yes	--	--	Yes	Yes	Yes	Yes	Yes	Yes	--	--
Mississippi	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Missouri	Yes	Yes	Yes	--	--	--	Yes	Yes	Yes	Yes	--	--	--	Yes
Montana	Yes	Yes	Yes	--	--	Yes	--	Yes	Yes	--	--	--	--	Yes
Nebraska	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	--	Yes	Yes	--	--
Nevada	Yes	Yes	Yes	--	--	--	--	Yes	Yes	Yes	--	--	--	Yes
New Hampshire	--	--	--	--	--	--	--	--	--	--	--	--	--	--
New Jersey	Yes	Yes	Yes	--	Yes	Yes	Yes	Yes	Yes	--	Yes	--	--	--
New Mexico	Yes	Yes	Yes	--	--	Yes	Yes	Yes	--	--	--	--	--	Yes
New York	Yes	Yes	Yes	--	--	--	Yes	Yes	--	--	Yes	Yes	--	--
New York City	Yes	Yes	--	--	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	--	--
North Carolina	Yes	Yes	--	--	Yes	Yes	Yes	--	--	--	--	Yes	--	--
North Dakota	Yes	Yes	--	--	Yes	--	Yes	Yes	Yes	Yes	Yes	Yes	--	--
Ohio	Yes	Yes	Yes	--	--	--	--	Yes	--	--	Yes	--	--	--
Oklahoma	Yes	--	Yes	Yes	--	--	--	Yes	--	Yes	--	--	--	--
Oregon	Yes	Yes	--	--	Yes	--	--	Yes	Yes	Yes	Yes	Yes	--	--
Pennsylvania	Yes	Yes	--	--	--	--	--	--	--	Yes	Yes	Yes	--	--
Philadelphia	Yes	--	Yes	Yes	Yes	--	Yes	Yes	Yes	Yes	--	--	--	Yes
Puerto Rico	Yes	Yes	--	Yes	--	Yes	Yes	--	Yes	--	Yes	--	--	--
Rhode Island	Yes	Yes	--	--	Yes	Yes	--	Yes	Yes	Yes	Yes	Yes	--	--
San Francisco	Yes	Yes	Yes	--	--	--	--	Yes	Yes	Yes	--	Yes	--	Yes
South Carolina	Yes	--	--	--	Yes	Yes	Yes	Yes	Yes	--	Yes	--	--	--
South Dakota	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Tennessee	Yes	--	--	Yes	--	--	Yes	--	Yes	--	Yes	--	--	--
Texas	Yes	Yes	--	--	Yes	--	Yes	Yes	Yes	Yes	--	Yes	Yes	Yes
Utah	Yes	Yes	Yes	Yes	Yes	--	Yes	--	Yes	Yes	Yes	Yes	--	--
Vermont	Yes	Yes	Yes	Yes	--	--	Yes	--	Yes	Yes	Yes	Yes	--	--
Virginia	Yes	Yes	--	--	Yes	--	Yes	Yes	Yes	--	Yes	Yes	--	--
Washington	Yes	Yes	Yes	--	--	--	Yes	--	--	--	Yes	--	--	Yes
West Virginia	Yes	--	Yes	--	--	--	--	--	Yes	--	Yes	--	--	--
Wisconsin	Yes	Yes	Yes	--	--	--	--	--	--	Yes	Yes	Yes	--	--
Wyoming	Yes	Yes	Yes	--	Yes	Yes	Yes	Yes	--	--	Yes	Yes	--	--
Total	53	46	36	15	24	20	39	37	41	28	39	28	3	14

Note: A dash indicates a response of no or not applicable for the jurisdiction.

TABLE 12 - MEDIA CAMPAIGNS (PART 1)

Jurisdiction	Campaign Messaging Theme						
	General Awareness	Testing	Condom use	Delay of sexual debut	Abstinence	Stigma & Discrimination	Substance use / abuse and HIV risk
Alabama	Yes	Yes	--	--	--	Yes	--
Alaska	Yes	Yes	Yes	--	--	Yes	Yes
Arizona	Yes	Yes	--	--	--	--	--
Arkansas	Yes	Yes	--	--	--	--	--
California	Yes	Yes	--	--	--	--	--
Chicago	Yes	Yes	Yes	--	--	Yes	Yes
Colorado	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Connecticut	Yes	Yes	--	--	--	--	--
Delaware	Yes	Yes	--	--	--	--	--
District of Columbia	--	Yes	Yes	--	--	--	--
Florida	Yes	Yes	--	--	--	--	--
Georgia	Yes	Yes	--	--	--	--	--
Hawaii	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Houston	Yes	Yes	Yes	--	Yes	Yes	Yes
Idaho	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Illinois	Yes	Yes	Yes	Yes	--	Yes	Yes
Indiana	Yes	Yes	--	--	--	--	--
Iowa	--	--	--	--	--	--	--
Kansas	--	--	--	--	--	--	--
Kentucky	Yes	Yes	--	--	--	--	--
Los Angeles County	Yes	Yes	Yes	--	--	Yes	--
Louisiana	--	Yes	--	--	--	--	--
Maine	--	Yes	Yes	--	--	Yes	--
Maryland	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Massachusetts	Yes	Yes	Yes	--	--	--	Yes
Michigan	--	Yes	Yes	--	--	--	--
Minnesota	Yes	Yes	Yes	--	--	Yes	--
Mississippi	--	--	--	--	--	--	--
Missouri	Yes	Yes	--	Yes	--	--	--
Montana	Yes	Yes	--	--	--	--	--
Nebraska	Yes	Yes	--	--	--	--	--
Nevada	Yes	Yes	--	--	--	--	Yes
New Hampshire	--	--	--	--	--	--	--
New Jersey	Yes	Yes	--	--	--	--	--
New Mexico	--	Yes	--	--	--	Yes	--
New York	--	Yes	--	--	--	Yes	--
New York City	Yes	Yes	Yes	--	--	Yes	Yes
North Carolina	--	Yes	--	--	--	--	--
North Dakota	Yes	Yes	--	--	--	--	--
Ohio	Yes	Yes	--	--	--	--	--
Oklahoma	Yes	Yes	Yes	--	--	--	--
Oregon	--	Yes	Yes	--	--	Yes	Yes
Pennsylvania	Yes	Yes	Yes	--	--	--	Yes
Philadelphia	--	Yes	--	--	--	--	--
Puerto Rico	Yes	Yes	--	--	--	--	--
Rhode Island	Yes	Yes	Yes	Yes	Yes	Yes	Yes
San Francisco	--	--	--	--	--	--	Yes
South Carolina	Yes	Yes	Yes	--	--	--	--
South Dakota	--	--	--	--	--	--	--
Tennessee	Yes	Yes	--	--	--	--	--
Texas	Yes	Yes	--	--	--	Yes	--
Utah	--	Yes	Yes	--	--	--	--
Vermont	Yes	Yes	Yes	--	--	Yes	Yes
Virginia	--	Yes	--	--	--	--	--
Washington	Yes	Yes	Yes	--	--	--	Yes
West Virginia	Yes	Yes	Yes	--	--	--	--
Wisconsin	Yes	Yes	--	--	--	--	--
Wyoming	Yes	Yes	Yes	--	--	--	Yes
Total	41	52	25	7	6	19	18

Note: A dash indicates a response of no or not applicable for the jurisdiction.

TABLE 12 - MEDIA CAMPAIGNS (PART 2)

Jurisdiction	Target Audience									
	General public	Young people	Pregnant women	African Americans	Latinos	Asian / Pacific Islander / Native Hawaiian	American Indian / Alaskan Native	MSM	Transgender persons	IDUs
Alabama	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Alaska	Yes	Yes	--	--	--	--	Yes	--	--	Yes
Arizona	--	Yes	--	--	--	--	--	Yes	--	--
Arkansas	Yes	--	Yes	Yes	Yes	Yes	Yes	Yes	--	Yes
California	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Chicago	Yes	Yes	Yes	Yes	Yes	--	--	Yes	Yes	Yes
Colorado	Yes	--	--	Yes	Yes	--	--	Yes	--	Yes
Connecticut	--	--	--	Yes	Yes	--	--	--	--	--
Delaware	Yes	--	Yes	Yes	Yes	--	--	Yes	--	--
District of Columbia	Yes	--	--	--	--	--	--	--	--	--
Florida	--	Yes	Yes	Yes	Yes	--	--	Yes	--	--
Georgia	--	--	--	--	--	--	--	Yes	--	--
Hawaii	Yes	Yes	Yes	--	--	Yes	--	Yes	Yes	Yes
Houston	Yes	Yes	Yes	Yes	Yes	--	--	Yes	Yes	--
Idaho	Yes	Yes	--	Yes	Yes	--	--	--	--	Yes
Illinois	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	--
Indiana	Yes	Yes	Yes	Yes	--	--	--	Yes	--	--
Iowa	--	--	--	--	--	--	--	--	--	--
Kansas	--	--	--	--	--	--	--	--	--	--
Kentucky	Yes	--	--	Yes	Yes	--	--	--	--	--
Los Angeles County	--	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Louisiana	Yes	--	--	--	--	--	--	--	--	--
Maine	--	--	--	--	--	--	--	Yes	--	--
Maryland	Yes	Yes	Yes	Yes	Yes	--	--	Yes	--	--
Massachusetts	Yes	--	--	--	--	--	--	--	--	Yes
Michigan	Yes	--	--	Yes	--	--	--	Yes	--	--
Minnesota	Yes	Yes	--	Yes	--	Yes	Yes	Yes	--	--
Mississippi	--	--	--	--	--	--	--	--	--	--
Missouri	Yes	Yes	--	Yes	Yes	--	--	Yes	--	--
Montana	Yes	Yes	--	--	--	--	Yes	Yes	--	--
Nebraska	Yes	Yes	--	Yes	Yes	Yes	Yes	Yes	--	--
Nevada	Yes	Yes	Yes	Yes	Yes	--	--	Yes	Yes	Yes
New Hampshire	--	--	--	--	--	--	--	--	--	--
New Jersey	Yes	Yes	--	Yes	Yes	--	--	--	--	--
New Mexico	--	--	--	--	Yes	--	--	Yes	--	--
New York	Yes	--	--	Yes	Yes	Yes	Yes	--	--	--
New York City	Yes	Yes	--	Yes	Yes	Yes	Yes	Yes	Yes	--
North Carolina	Yes	Yes	Yes	Yes	Yes	--	--	Yes	Yes	--
North Dakota	Yes	--	--	--	--	--	Yes	Yes	--	--
Ohio	Yes	--	--	--	--	--	--	--	--	--
Oklahoma	--	Yes	--	Yes	--	--	--	Yes	--	--
Oregon	--	Yes	--	Yes	Yes	--	--	Yes	--	Yes
Pennsylvania	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Philadelphia	--	--	--	Yes	--	--	--	Yes	--	--
Puerto Rico	Yes	--	--	--	--	--	--	--	--	--
Rhode Island	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	--	Yes
San Francisco	--	--	--	--	--	--	--	Yes	--	--
South Carolina	--	Yes	--	Yes	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--	--	--	--	--
Tennessee	Yes	--	--	--	--	--	--	--	--	--
Texas	--	--	--	Yes	--	--	--	Yes	--	--
Utah	Yes	Yes	--	--	Yes	--	--	Yes	--	--
Vermont	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Virginia	--	Yes	--	Yes	Yes	--	--	--	--	--
Washington	Yes	Yes	--	Yes	Yes	--	--	Yes	--	Yes
West Virginia	--	--	--	Yes	--	--	--	Yes	--	--
Wisconsin	Yes	Yes	--	Yes	Yes	Yes	Yes	Yes	--	--
Wyoming	Yes	Yes	--	--	--	--	--	--	--	--
Total	38	32	17	36	30	14	16	38	12	15

Note: A dash indicates a response of no or not applicable for the jurisdiction.

TABLE 13 - OTHER PROGRAMS

Jurisdiction	Operates Needle/ Syringe Access Program	Operates drug substitution (e.g., methadone) program(s)	Operates non-occupational post-exposure prophylaxis (PEP) program
Alabama	--	--	--
Alaska	--	--	--
Arizona	--	--	--
Arkansas	--	--	*
California	Yes	--	Yes
Chicago	Yes	Yes	--
Colorado	--	--	--
Connecticut	Yes	--	--
Delaware	Yes	Yes	--
District of Columbia	Yes	*	--
Florida	--	--	--
Georgia	--	--	--
Hawaii	Yes	Yes	--
Houston	--	--	--
Idaho	--	--	--
Illinois	Yes	--	Yes
Indiana	--	--	--
Iowa	--	--	--
Kansas	--	--	--
Kentucky	--	--	--
Los Angeles County	Yes	Yes	Yes
Louisiana	--	--	Yes
Maine	--	--	--
Maryland	Yes	Yes	--
Massachusetts	Yes	Yes	Yes
Michigan	--	--	--
Minnesota	Yes	--	--
Mississippi	--	--	--
Missouri	--	--	--
Montana	--	--	--
Nebraska	--	*	--
Nevada	--	--	--
New Hampshire	Yes	--	--
New Jersey	Yes	--	--
New Mexico	Yes	--	Yes
New York	Yes	--	--
New York City	Yes	--	Yes
North Carolina	--	--	--
North Dakota	--	--	--
Ohio	--	--	--
Oklahoma	--	--	--
Oregon	Yes	--	--
Pennsylvania	--	Yes	--
Philadelphia	Yes	Yes	Yes
Puerto Rico	Yes	--	Yes
Rhode Island	Yes	--	--
San Francisco	Yes	Yes	Yes
South Carolina	--	--	--
South Dakota	--	--	--
Tennessee	--	--	--
Texas	--	Yes	--
Utah	--	Yes	--
Vermont	Yes	Yes	--
Virginia	--	--	--
Washington	Yes	Yes	--
West Virginia	--	--	--
Wisconsin	Yes	--	--
Wyoming	--	--	--
Total	24	13	10

Note: A dash indicates a response of no from the jurisdiction.

* indicates state reported "unknown"

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