

North Dakota



Comprehensive HIV Prevention Plan

2010 ADDENDUM

Developed and prepared by the
North Dakota Community Planning Group for HIV Prevention
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NORTH DAKOTA
DEPARTMENT *of* HEALTH

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CPG wishes to acknowledge and thank all of the individuals who have contributed to this HIV Comprehensive Plan. Their hard work and dedication is what makes HIV prevention possible.

CPG has dedicated this plan to the memory of the individuals we have lost in the battle against AIDS. May their spirit remain to inspire those who continue their work, so we may finally bring an end to this epidemic.

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North Dakota Community Planning Group Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ACOA	Adult Children of Alcoholics
BSSV	Behavioral Social Science Volunteers
CAA	Community Action Agencies
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CPG	Community Planning Group
CSCC	Children's Services Coordinating Committee
CTR	Counseling, Testing, Referral Services
CTS	Counseling and Testing Sites
DAETC	Dakota AIDS Education & Training Center
DEBI	Diffusion of Effective Behavioral Interventions
DOE	Department of Education
DPI	Department of Public Instruction
EPI	Epidemiological
GLBT	Gay, Lesbian, Bisexual and Transgender
GLSEN	Gay Lesbian Straight Educators Network
HERR	Health Education and Risk Reduction Activities
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for People with AIDS
HPV	Human Papilloma Virus
IDU	Injecting Drug Use(r)
MMS	Male-to-Male Sexual Contact
MSM	Men Who Have Sex with Men
NA	Native American
NNAAPC	National Native American AIDS Prevention Center
NMAC	National Minority AIDS Council
OPOP	Optimal Pregnancy Outcome Program
OOJ	Out of Jurisdiction
PCM	Prevention Case Management
PCRS	Partner Counseling and Referral Services
PEMS	Program Evaluation Monitoring System
PFLAG	Parents and Friends of Lesbians and Gays
PIR	Parity, Inclusion, Representation
PLWA	Person Living with AIDS
POL	Popular Opinion Leader
RAC	Regional Advisory Council
RFP	Request for Proposal
RW	Ryan White
SEA	State Economic Area
SHEP	School Health Education Profile
STD	Sexually Transmitted Disease
TA	Technical Assistance
YRBS	Youth Risk Behavioral Survey
WIC	Women Infants and Children

CHAPTER 1

INTRODUCTION

North Dakota Community Planning Group Mission Statement

To develop a comprehensive HIV prevention plan targeting North Dakota's defined high-risk populations with scientifically-based prevention interventions that are responsive to the identified needs within these populations.

North Dakota CPG continually pursues collaborative efforts in education, cultural awareness, and elimination of the stigma of HIV/AIDS.

Introduction to Planning

The North Dakota Community Planning Group (CPG) presents the *2010 Addendum* to the *2009-2012 Comprehensive HIV Prevention Plan*. This document replaces the *2004 Comprehensive HIV Prevention Plan* and all addendums to that plan.

HIV prevention community planning is an ongoing collaborative planning process in which the North Dakota Department of Health works in partnership with the community to implement a CPG to develop a comprehensive HIV prevention plan that best represents to the needs of populations infected with or at risk for HIV.

The North Dakota Department of Health uses this HIV prevention plan as a guide for funding decisions to determine the best needs for the HIV prevention programs with the goal of improving the effectiveness of state, local, and territorial health departments' HIV programs by strengthening the scientific basis, community relevance, and population or risk-based focus of prevention interventions. This evidence-based planning process incorporates guidelines put forth by U. S. Centers for Disease Control and Prevention (CDC) in the HIV Prevention and Community Planning Guidance. It also contains information about the characteristics of the priority populations and about the interventions in place to address the needs of these populations.

This plan is intended as a guide for HIV prevention and care workers throughout North Dakota. It is meant to be a resource and tool for communities as they organize prevention strategies to help reduce the incidence of HIV/AIDS in North Dakota.

Individuals who are affected by, or interested in, HIV prevention will find this to be a useful tool in HIV prevention planning. The information found in this plan will give individuals, organizations and communities a better understanding of the HIV prevention

strategies and of the challenges that face North Dakota communities. This plan is for anyone interested in or impacted by HIV/AIDS.

Origins and Purpose of HIV Prevention Community Planning

In 1993, the CDC directed states and localities that receive federal funding for HIV prevention to conduct a community planning process. HIV prevention community planning was built around the following principles:

1. HIV prevention community planning reflects an open, candid and participatory process in which differences in cultural and ethnic background, perspective, and experience are essential and valued.
2. HIV prevention community planning is characterized by shared priority-setting between health departments administering and awarding HIV prevention funds and the communities for whom the prevention services are intended.

Priority-setting accomplished through a community planning process produces programs that are responsive to high-priority, community-validated needs within defined populations. Individuals at risk for HIV infection and those with HIV infection play key roles in identifying prevention needs not adequately met by existing programs and in planning for needed services that are culturally appropriate. HIV prevention programs developed with input from affected communities are likely to be successful in garnering the necessary public support for effective implementation and in preventing the transmission of HIV infection.

In 2003, the CDC set three major goals for HIV prevention community planning. The three major goals are:

1. Community planning supports broad-based community participation in HIV prevention planning.
2. Community planning identifies priority HIV prevention needs (i.e., a set of priority target populations with specific interventions identified for each target population) in each jurisdiction.
3. Community planning ensures that HIV prevention resources target those priority populations and interventions set forth in the comprehensive HIV prevention plan.

To ensure that the HIV prevention community planning process is carried out in a participatory manner, the CDC expects community planning groups (CPGs) to address the following *Guiding Principles of HIV Prevention Community Planning*:

1. The health department and community planning group must work collaboratively to develop a comprehensive HIV prevention plan for the jurisdiction.
2. The community planning process must reflect an open, candid and participatory process in which differences in cultural and ethnic background, perspective and experience are essential and valued.
3. The community planning process must involve representatives of populations at greatest risk for HIV infection and people living with HIV/AIDS (PLWHA).
4. The fundamental tenets of community planning are parity, inclusion and representation (often referred to as PIR).
 - *Parity* is defined as the ability of members to participate equally and carry out planning tasks and duties.
 - *Inclusion* is defined as meaningful involvement of members with an active voice in decision-making.
 - *Representation* is defined as the act of serving as an official member who reflects the perspective of a specific community.
5. An inclusive community planning process includes representatives of various races and ethnicities, genders, sexual orientations, ages and other characteristics such as educational backgrounds, professions, and levels of expertise.
6. The community planning process must actively encourage and seek out community participation.
7. Nominations for membership should be solicited through an open process, and candidate selection should be based on criteria established by the health department and the community planning group.
8. An evidence-based process for setting priorities among target populations should be based on the epidemiological profile and the community services assessment.
9. Priority-setting for target populations must address populations for which HIV prevention will have the greatest impact.

10. The set of prevention interventions and activities for prioritized target populations should have the potential to prevent the greatest number of new infections.

What is a Comprehensive HIV Prevention Plan?

In 1994, the Centers for Disease Control and Prevention (CDC) mandated that all programs receiving HIV prevention funds implement a comprehensive community planning process. The plan is developed using a process in which state health departments, community representatives and members of the identified risk populations all participate. That community planning process is now a key component of national prevention efforts. The role of those involved is two-fold. The community planning group, regardless of structure, is charged with:

1. Identifying and prioritizing target populations for HIV prevention that reflect the epidemiological make-up of the respective area; and
2. Identifying prevention interventions based on sound behavioral theory, which are anticipated to be programmatically cost-effective in working with the priority populations.

Through the community planning process, the plan identifies individuals at increased risk and interventions used in reaching those populations. The community planning group is expected to regularly review, revise and refine community plans indicated by new or enhanced surveillance data, intervention research, needs assessment, resource inventory, program policy, or technological transferring of information.

The essential elements of a comprehensive HIV prevention plan include:

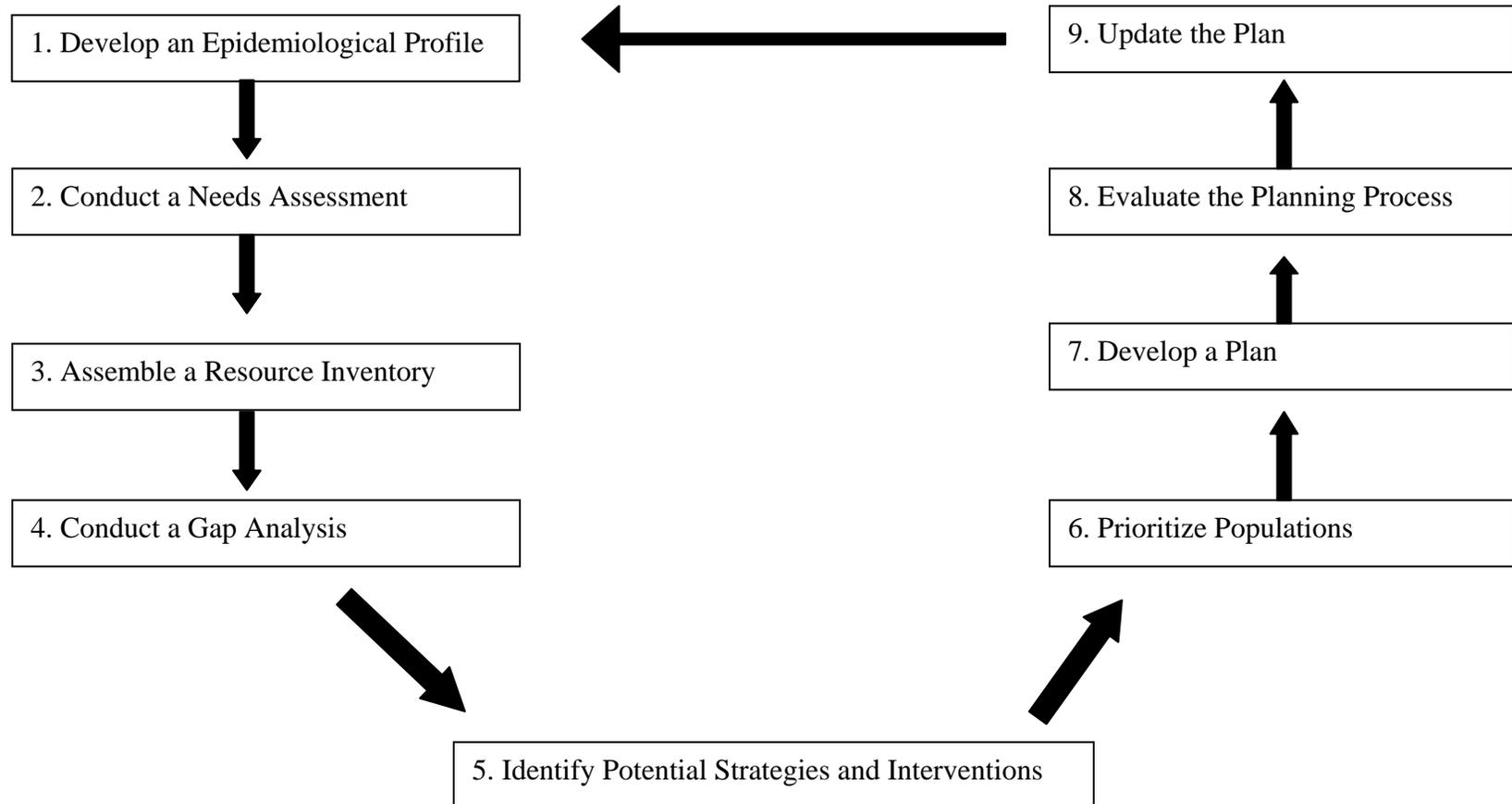
1. **Epidemiological Profile** describes the impact of the HIV epidemic in the jurisdiction and provides the foundation for prioritizing target populations.
2. **Community Services Assessment** describes the prevention needs of populations at risk for HIV infection, the prevention activities/interventions implemented to address these needs and service gaps.
3. **Prioritized Target Populations** focuses on the set of target populations (identified through the epidemiological profile and community services assessment) that require prevention efforts due to high rates of HIV infection and high incidence of risky behavior.

4. **Appropriate Science-Based Prevention Activities/Interventions** is a set of prevention activities/interventions (based on intervention effectiveness and cultural/ethnic appropriateness) necessary to reduce transmission in prioritized target populations.
5. **Letter of Concurrence/Concurrence with Reservations/Non-Concurrence** is a written response from the CPG whether the health department application does or does not, and to what degree, agree with the priorities set forth in the comprehensive HIV prevention plan.

The steps to HIV prevention community planning are illustrated on the following page.

Nine Steps to HIV Prevention Community Planning

In conjunction with a comprehensive HIV prevention plan, the CDC outlines nine steps to HIV prevention community planning in order to complete the cycle of plan development. The nine steps are:



HIV Prevention Community Planning in North Dakota

The North Dakota CPG is a statewide planning group established in 1994 to facilitate collaboration among its members and to ensure that quality, non-duplicative HIV prevention services are available throughout North Dakota. The CPG is comprised of a diverse group of individuals who accurately reflect the HIV epidemic in North Dakota's communities. Members include public health professionals, HIV/AIDS service providers, businesses, civic leaders and persons living with HIV/AIDS (PLWH/A). Membership is open to the public and achieved through an application process.

The priority populations, needs and interventions included in this plan are the result of a prioritization process undertaken by CPG members. CPG members are individuals who represent North Dakota communities most affected by the HIV epidemic and they bring a wealth of personal knowledge and experience to the planning process. This knowledge of community norms and values is combined with an examination of behavioral science data about effective HIV prevention techniques and the study of local and national HIV/AIDS epidemiological data in order to formulate the recommendations included in this plan.

It is the charge of the CPG, after reviewing the epidemiological data and trends, to determine where to focus HIV prevention services to prevent as many new infections as possible, given the limited federal funding available. It is the CPG's hope that this plan will help to accomplish this. The CPG acknowledges that this does not diminish the needs of other populations in North Dakota and encourages efforts to find increased funding to serve these populations.

CPG members are dedicated to eliminating the spread of HIV/AIDS.

Community Planning Group Profile

The CPG profile was derived from information collected from members by means of the *CPG Member Survey* and the *North Dakota CPG for HIV Prevention Supplemental Form for CPG Member Profile*. The information reflects the way in which members answered the various questions.

Ideally, the CPG membership should reflect the current HIV/AIDS epidemic in the state. A summary of the group's demographics, along with a comparison of these demographics to the state's HIV/AIDS epidemic during 2008, is explained on the next page. For a complete breakdown, please see Chapter 2: Epidemiological Profile.

The number of new HIV diagnoses has increased in recent years. From 2004 to 2008, 62 new HIV diagnoses were reported, compared with 57 in the previous five years. Fourteen new cases were diagnosed in 2008.

Gender

The 2009 North Dakota CPG consisted of 13 active members. Of the 13 members, 38 percent (5) were male and 62 percent (8) were female.

In 2008, 93 percent (13) of newly reported HIV cases were among men and 7 percent (1) of newly reported HIV cases were among women.

Age

Seven percent (1) of CPG members are ages 19 to 24. Twenty-three percent (3) reported are ages 25-34. Fifteen percent (2) of members are ages 35 to 44. Fifty-four percent (7) are 45 and older.

Forty-three percent (6) of individuals reported with HIV in 2008 were between the ages of 35 and 44. There were no new cases reported younger than 14. Fourteen percent (2) of new HIV cases were reported in those ages 15 to 24; twenty-one percent (3) in those ages 25 to 34; and 14 percent (2) in those ages 45 to 54. No cases were reported for individuals ages 55 to 64, and 7 percent of the cases (1) were 65 and older.

Ethnicity/Race

None of the CPG members reported their ethnicity to be Hispanic or Latino.

Eighty-five percent (11) of CPG members are white, 15 percent (2) are American Indian.

During 2008, 79 percent (11) of diagnosed cases were white, not Hispanic; 14 percent (2) were black, not Hispanic; 7 percent (1) were American Indian. There were no cases reported for Hispanics or Pacific Islanders.

Risk Factor

Men who have sex with men (MSM) accounted for 31 percent (4) of the group's risk factors. Sixty-two percent (8) indicated heterosexual, 8 percent (1) indicated injection drug use (IDU). Two of the 13 CPG members reported that they are living with HIV/AIDS.

Expertise

The following tables represent the expertise of the CPG as reported by the members:

Table 1-1 CPG's Primary Expertise	
Primary Expertise Category	Number of Members
Epidemiologist	3
Behavioral or Social Scientist	0
Evaluation Researcher	0
Intervention Specialist	0
Health Planner	0
Community Organization	4
PLWH/A	2
Community Representative	2
Other	2
Total	13

Table 1-2 CPG's Secondary Expertise	
Secondary Expertise Category	Number of Members
PLWH/A	0
Behavioral or Social Scientist	0
Evaluation Researcher	0
Intervention Specialist	0
Health Planner	1
Community Organization	4
Community Representative	3
Other	5
Total	13

CHAPTER 2

EPIDEMIOLOGICAL PROFILE

An epidemiological profile is a description of the current status, distribution and impact of an infectious disease or other health-related condition in a specified geographic area.

Summary

- At the time of the 2000 U.S. Census, North Dakota had 642,200 residents, 92.4 percent of whom were white.
- The median household income was \$34,604, with 11.9 percent of individuals and 8.3 percent of households below the poverty level.
- From 1984 to 2008, 441 cases of HIV/ AIDS were reported to the North Dakota Department of Health, 265 (60%) of which were diagnosed in North Dakota.
- Thirty-five percent of all cases reported in North Dakota were AIDS at first diagnosis.
- There were 188 people known to be living in North Dakota with HIV/ AIDS as of Dec. 31, 2008, while 142 people with HIV/ AIDS died in North Dakota between 1984 and 2008.
- Eighty-five percent of all HIV/ AIDS cases diagnosed in the state between 1984 and 2008 were between the ages of 20 and 49.
- The average HIV/ AIDS incidence rate (excluding infection in foreign countries) from 2004 to 2008 for blacks was 10.2 per 100,000, whereas it was 1.4 per 100,000 and 2.6 per 100,000 for whites and American Indians, respectively.
- Male-to-male sexual relations remains the most frequently reported risk factor for HIV/ AIDS; however, there has been an increase in reports of heterosexual relations, with 32 percent of cases diagnosed in North Dakota between 2004 and 2008 identifying this risk.
- There were 2,370 HIV tests reported in North Dakota during 2008, two of whom were positive.
- The North Dakota CARES Program serves 73 (39%) of the 188 people living with HIV/ AIDS in North Dakota, 78 percent of whom are male.
- The rates of chlamydia and gonorrhea are highest among blacks at 2,757.9 per 100,000 and 485.2 per 100,000, respectively.

- Racial and ethnic minorities comprise the majority of all TB disease cases in North Dakota at 63 percent.
- There were 58 cases of chronic hepatitis B, two cases of acute hepatitis B, two cases of acute hepatitis A and 578 cases of hepatitis C reported in North Dakota in 2007.
- The most common co-morbidity with HIV between 2004 and 2008 was hepatitis C, with 32 percent of all co-morbidities.

Introduction

The North Dakota Department of Health (NDDoH) receives funding from the U.S. Centers for Disease Control and Prevention (CDC) to collect information about HIV infection and AIDS diagnoses among North Dakota residents. The HIV/AIDS data are used to characterize and predict the changing epidemic at the local, regional and national levels. North Dakota HIV/AIDS data are summarized annually to help the NDDoH to:

- Monitor the incidence and estimated prevalence of HIV/AIDS in the state.
- Assess the risks for HIV infection and develop effective HIV prevention programs.
- Develop surveillance methods to allow for a more current estimate and characterization of HIV/AIDS risks and needs.
- Justify necessary federal and state funding to support continued HIV/AIDS prevention, services and surveillance activities.

This report includes HIV/AIDS data regarding North Dakota residents for the reporting period ending Dec. 31, 2008.

HIV Surveillance in North Dakota

In North Dakota, HIV/AIDS became a reportable condition in 1984, at which time the NDDoH established a surveillance system to track newly diagnosed HIV/AIDS cases. Standardized case report forms are used by regional field epidemiologists to collect socio-demographic information, mode of exposure, laboratory and clinical information, vital statistics (i.e., living or dead), and referrals for treatment of services. HIV surveillance data may underestimate the level of recently infected people because some infected individuals either do not know they are infected or have not sought medical care. Additionally, new cases are reported at all points along the clinical spectrum of disease when first diagnosed. Consequently, HIV infection data may not necessarily represent the characteristics of people who have recently been infected with HIV.

Methods

HIV Surveillance Data

A diagnosis of AIDS and/or HIV is legally reportable in North Dakota and must be reported to the department of health according to North Dakota Century Code Chapter 23-07-01 and North Dakota Administrative Code Chapter 33-06-01. Reports of HIV/AIDS cases can be provided by physicians, hospitals, laboratories and other institutions. These data are stored in the HIV/AIDS Reporting System (HARS) database. Statistics and trends presented in this report were derived from HIV/AIDS case data reported to the NDDoH cumulatively from 1984 through Dec. 31, 2008. To protect the privacy of individuals diagnosed with HIV or AIDS, no county data will be released. Data reported as persons with HIV/AIDS should be interpreted as individuals who have either been diagnosed with HIV or AIDS the first time diagnosed, as some people may have progressed to AIDS before ever being diagnosed with HIV.

HIV Counseling and Testing Data

There are 31 HIV counseling, testing and referral (CTR) sites throughout North Dakota that provide free services to “at-risk” individuals. These sites include local public health units, community-based organizations and college health facilities. HIV counseling and testing data are collected to analyze the characteristics of the population accessing the services in an attempt to reach the populations most at risk for HIV infection.

North Dakota CARES Program Data

The North Dakota CARES (Comprehensive HIV/AIDS Resources and Emergency Services) Program provides financial assistance for medical services and antiretroviral medication to HIV/AIDS clients who qualify through the Health Resources and Service Administration (HRSA) under Part B of the Ryan White HIV/AIDS Treatment Modernization Act of 2006. North Dakota CARES data are collected to assess the population of HIV/AIDS clients who are receiving medical care.

STD Surveillance Data

The Sexually Transmitted Disease (STD) Program offers STD clinical services, including testing and treatment. The program conducts statewide surveillance to determine STD incidence and trends. In addition, the program conducts partner counseling and referral services for people with gonorrhea, syphilis and complicated chlamydia to reduce the spread of these diseases.

Viral Hepatitis Surveillance Data

The Hepatitis Program receives reports of hepatitis A, B and C acute and chronic infections from various reporting sources. Acute hepatitis infections are investigated to determine postexposure immunoprophylaxis. Basic demographic information is collected on chronic hepatitis B and C cases. Morbidity is based on reported positive lab results. There is under-reporting of both acute and chronic infections in North Dakota. Morbidity is also based on U.S. Centers for Disease Control and Prevention (CDC) case definitions. Hepatitis C virus infection past or present (chronic hepatitis C) classification is given to those infected with the hepatitis C virus and the numbers do not distinguish between resolved and active infections. Hepatitis B virus infection, chronic classification is given to those infected with the hepatitis B virus and includes both confirmed and probable cases. Case interviews and partner notification are not included. Year 2005 is baseline year for viral hepatitis data due to the implementation of a electronic reporting system and more stringent follow-up. Current date was not de-duplicated prior to 2005.

Women of child-bearing age, 14-44 years, that are hepatitis B positive, are followed-up to determine if they are pregnant. Pregnant women who are hepatitis B positive are then followed by the perinatal coordinator in the immunization program. The coordinator ensures the hospital has hepatitis B immune globulin (HBIG) for administration to the baby at time of delivery. The coordinator also confirms the baby is given the hepatitis B vaccine series and ensures serology testing is done at completion of the vaccine series to ensure the child is not infected and immune to the hepatitis B virus.

Hepatitis C Testing and Hepatitis A and B Vaccination

There are 12 HIV CTR sites throughout North Dakota that are offer hepatitis C screening and counseling and hepatitis B and A vaccinations free-of-charge for those in high risk populations.

Population Profile of North Dakota

Population

North Dakota is a rural state with a population of 642,200, according to the 2000 U. S. Census. There are 356 incorporated communities. Nine cities have populations above 10,000; 15 cities have populations above 2,500. County populations in North Dakota range from 767 to 123,138 people. Four counties, two along the eastern border with Minnesota, account for 49 percent of the state's population, demonstrating the complexity of population dispersion in North Dakota.

Demographic Composition

The demographic composition describes who is living in North Dakota. The population is broken down by gender, age and race/ethnicity. At the time of the 2000 U.S. Census, the population was split almost evenly between males and females. The median age was 36.2 years. The majority of the population was white (92.4%), while African Americans and American Indians comprised 0.6 percent and 4.9 percent, respectively.

	Number	Percentage
Gender		
Male	320,524	49.9
Female	321,676	50.1
Age		
Median age (years)	36.2	N/A
Race/Ethnicity		
White	593,181	92.4
Black or African American	3,916	0.6
American Indian and Alaska Native	31,329	4.9
Asian	3,606	0.6
Native Hawaiian and Other Pacific Islander	230	0.0
Some other race	2,540	0.4
Two or more races	7,398	1.2

* Due to rounding, totals may not add up to 100%

Social Characteristics

The social characteristics of North Dakota include education, marital status, and place of birth. These characteristics describe the social background and interaction of the population of North Dakota.

A majority (83.9%) of the population 25 and older had graduated from high school at the time of the 2000 U.S. Census. More than half (56.8%) of the population older than 15 years of age was married. Only 1.9 percent of the population was born in a country other than the United States. Of those who were foreign born, 33.1 percent originated from Europe and 23.1 percent originated from Asia.

Table 2 – Social Characteristics of General Population	Number	Percentage
Education of People Aged 25 Years and Older		
High school graduate or higher	342,629	83.9
Bachelor's degree or higher	89,843	22.0
Marital Status of People Aged 15 Years and Older		
Never married	141,300	27.6
Now married, not separated	290,833	56.8
Separated	3,610	0.7
Widowed	36,702	7.2
Divorced	39,836	7.8
Place of Birth		
Native born	630,086	98.1
Foreign born	12,114	1.9
Region of Origin of Foreign Born		
Europe	4,008	33.1
Asia	2,793	23.1
Africa	793	6.5
Oceania	121	1.0
Latin America	1,373	11.3
Northern America	3,026	25.0

* Due to rounding, totals may not add up to 100%

Economic Characteristics

Economic characteristics describe the lifestyle of the population of North Dakota, as well as the ability to access medical care. Economic characteristics include annual household income level and the percentage of the population living below the poverty level.

In 2000, 68.6 percent of the population had an income level of between \$15,000 and \$74,999. The mean earnings per household was \$42,510, and the median household income was \$34,604. Almost 12 percent (11.9%) of individuals and 8.3 percent of households were below the poverty level.

Table 3 – Economic Characteristics of General Population		Number	Percentage
Households at Income Level			
Less than \$10,000		28,417	11.0
\$10,000 to \$14,999		20,575	8.0
\$15,000 to \$24,999		41,324	16.1
\$25,000 to \$34,999		39,618	15.4
\$35,000 to \$49,999		47,810	18.6
\$50,000 to \$74,999		47,549	18.5
\$75,000 to \$99,999		17,389	6.8
\$100,000 to \$149,999		9,698	3.8
\$150,000 to \$199,999		2,229	0.9
\$200,000 or more		2,625	1.0
Total Household Income			
Mean earnings (dollars)		42,510	N/A
Median household income (dollars)		34,604	N/A
Below Poverty Level			
Individuals		73,457	11.9
Households		13,890	8.3

* Due to rounding, totals may not add up to 100%

Trends in HIV/AIDS in North Dakota

Cumulative HIV/AIDS Data

HIV/AIDS has been a reportable condition in North Dakota since 1984. The cumulative reported infections include cases newly diagnosed in the state, as well as cases diagnosed elsewhere who moved to North Dakota. As of Dec. 31, 2008, a cumulative total of 441 HIV/AIDS cases have been reported in North Dakota, including 162 AIDS cases and 279 HIV (non-AIDS) cases. Of the cumulative total HIV/AIDS cases, 188 were known to still be living in North Dakota as of Dec. 31, 2008. Table 4 outlines the cumulative cases and those still living in North Dakota.

Table 4 -- Profile of HIV/AIDS Population	Cumulative Cases		Living in ND	
	Number	Percentage*	Number	Percentage*
Disease Status at Diagnosis				
HIV	277	63	112	64
AIDS	164	37	67	36
Gender				
Male	372	84.	147	78
Female	69	16	41	22
Age Group at Diagnosis				
≤ 12	6	1	3	2
13 - 19	11	2	1	1
20 - 29	128	29	43	23
30 - 39	172	39	80	43
40 - 49	85	19	36	19
50 - 59	29	7	16	9
≥ 60	10	2	3	2
Race/Ethnicity				
American Indian	42	10	18	10
Black	47	11	28	13
Hispanic (all races)	12	3	7	4
Asian/Pacific Islander	2	1	2	1
White	338	77	133	71
Risk Factors				
Hemophilia/Coagulation disorder	12	3	2	1
Heterosexual relations	78	18	62	33
Injecting drug use (IDU)	57	13	19	10
Male to male sexual relations (MSM)	227	51	83	44
MSM/IDU	35	8	9	5
Perinatal	7	2	3	2
Blood/tissue transfusion	8	2	1	1
No risk identified	17	4	7	4
Total	441		188	

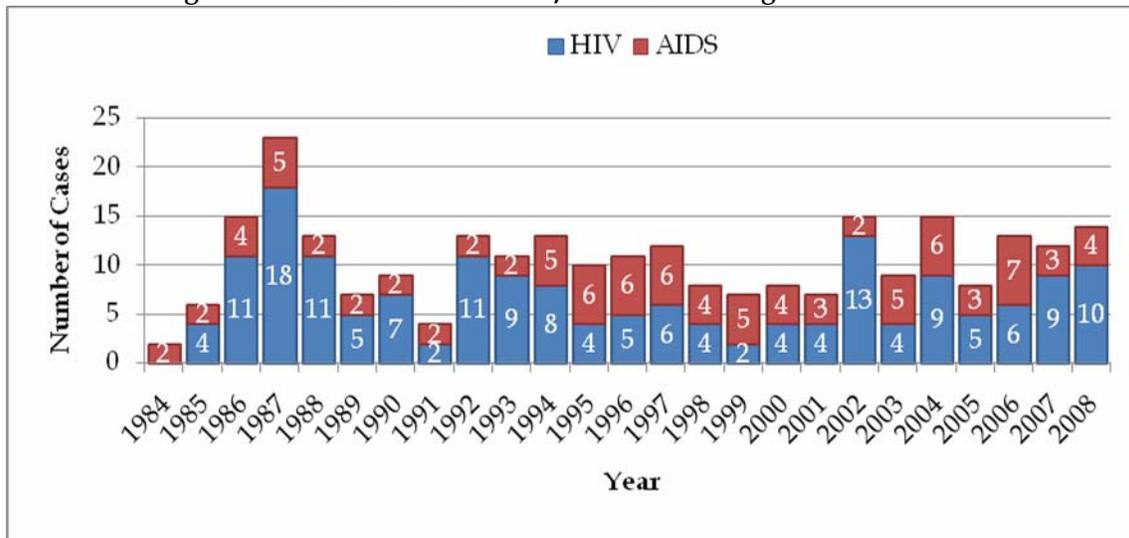
* Due to rounding, totals may not add up to 100%

Incidence of HIV/AIDS 1984 - 2008

The following figures describe HIV/AIDS cases that were diagnosed in North Dakota, and exclude cases that were diagnosed elsewhere and moved to the state.

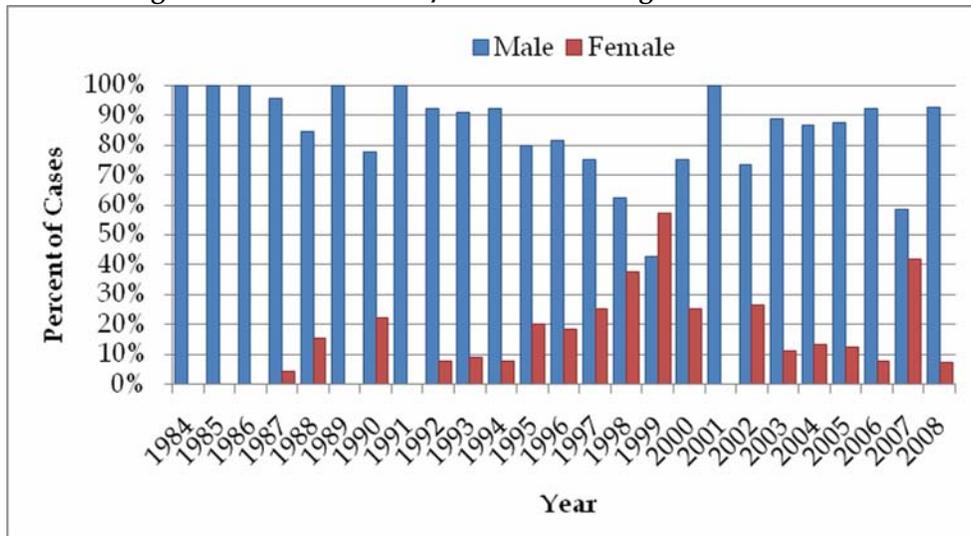
Due to North Dakota's low incidence of HIV/AIDS, trends in diagnosis and reporting are difficult to interpret. On average, there are 10 cases per year that are diagnosed in North Dakota. Thirty-five percent of the cases diagnosed in North Dakota since 1984 were classified as AIDS at the time of diagnosis. In total, 265 HIV/AIDS cases were diagnosed in the state between 1984 and 2008.

Figure 1 -- Disease Status of HIV/AIDS Cases Diagnosed 1984 - 2008



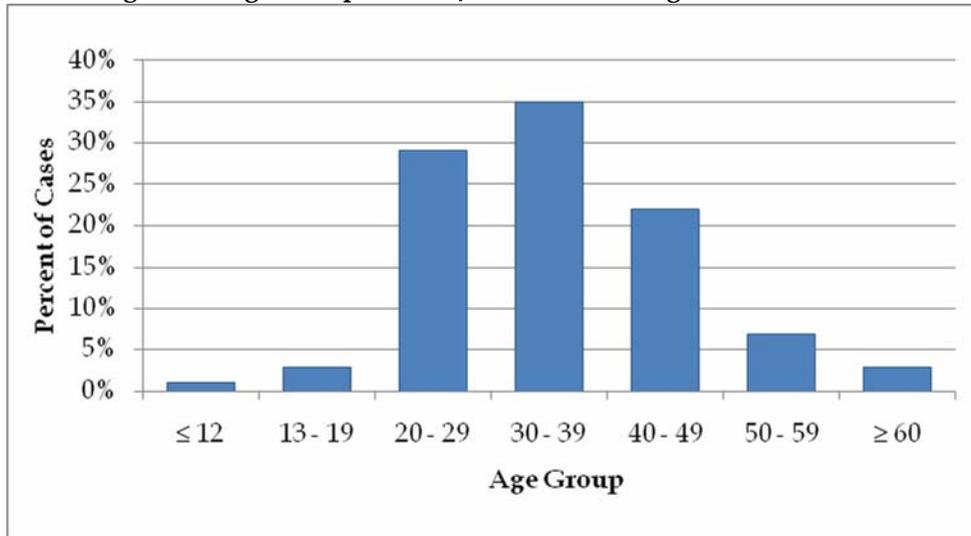
There is a clear gender disparity in the diagnosis of HIV/AIDS. Eighty-five percent of all cases diagnosed in North Dakota since 1984 are male. However, the proportion of women diagnosed with HIV/AIDS has been increasing in the last 15 years.

Figure 2 - Gender of HIV/AIDS Cases Diagnosed 1984 - 2008



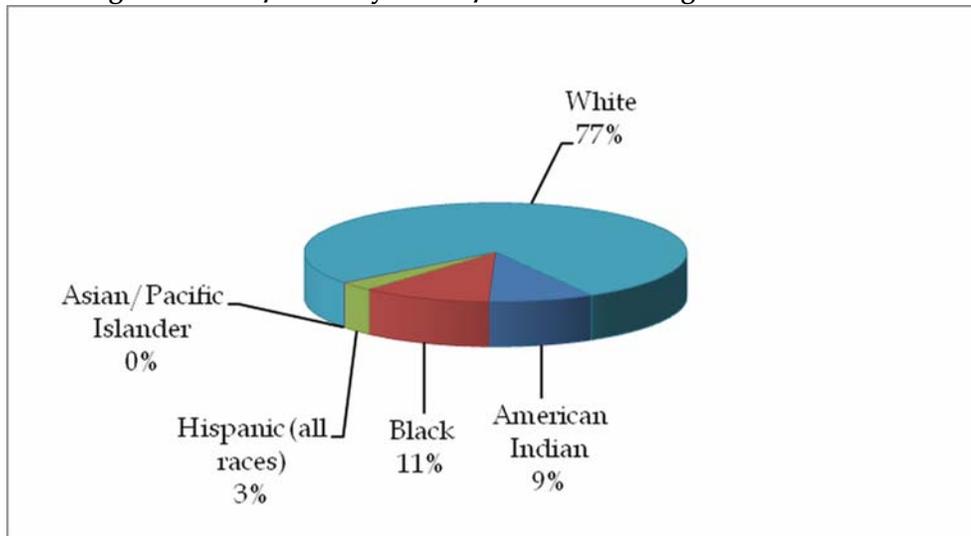
The predominant ages affected by HIV/AIDS were 30 to 39-year-olds. Eighty-five percent of all HIV/AIDS cases diagnosed in the state fall between the ages of 20 and 49.

Figure 3 - Age Groups of HIV/AIDS Cases Diagnosed 1984 - 2008



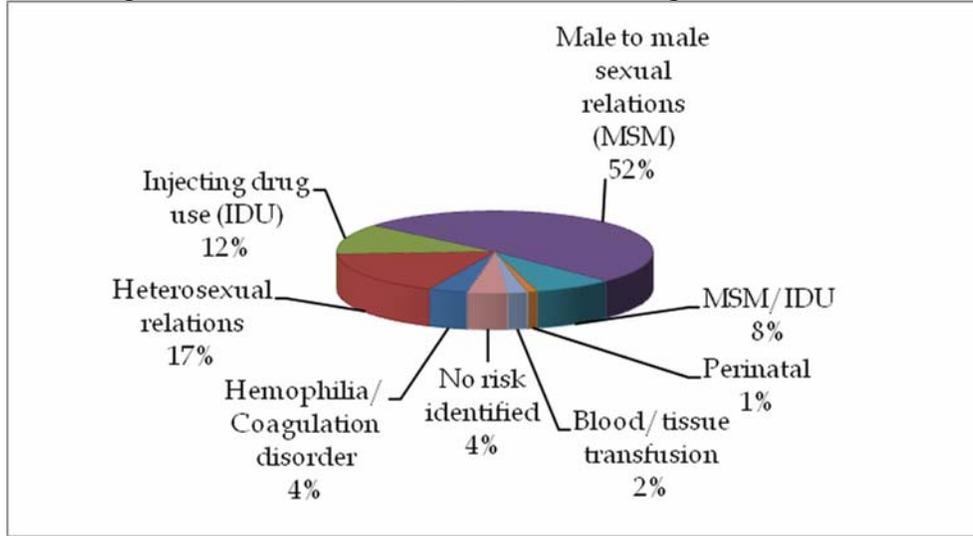
Although they make up less than 1 percent of the population of North Dakota, blacks are 11 percent of all HIV/AIDS cases diagnosed in the state. A similar disparity is seen with American Indians, who make up 4.9 percent of the state population, and account for 9 percent of all HIV/AIDS diagnoses in the state.

Figure 4 - Race/Ethnicity of HIV/AIDS Cases Diagnosed 1984 - 2008



Male-to-male sexual relations remain the most frequently reported risk factor associated with HIV/AIDS, with heterosexual relations in a distant second place. More than half of all HIV/AIDS cases diagnosed in North Dakota reported having male-to-male sexual relations. In the last 15 years, however, reports of heterosexual relations as a risk factor have increased in conjunction with the increase in female HIV/AIDS diagnoses. Injecting drug use remains a major risk factor associated with HIV/AIDS in North Dakota.

Figure 5 - Risk Factors of HIV/AIDS Cases Diagnosed 1984 - 2008

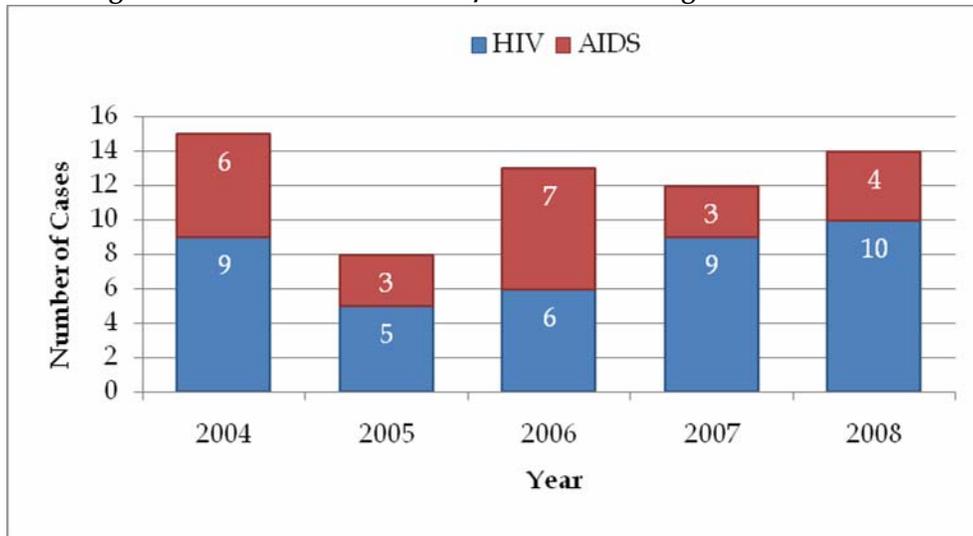


Incidence of HIV/AIDS 2004 - 2008

The following figures describe HIV/AIDS cases diagnosed in North Dakota between 2004 and 2008. These figures are intended to present an in-depth look at HIV/AIDS trends during this time period.

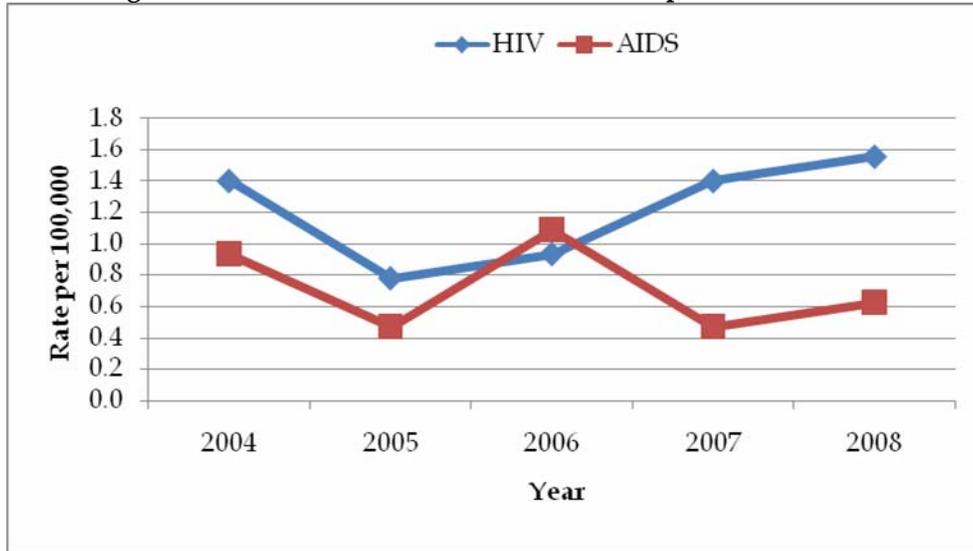
Between 2004 and 2008, 62 cases of HIV/AIDS were diagnosed in North Dakota. Of those cases, 37 percent were classified as AIDS at diagnosis.

Figure 6 - Disease Status of HIV/AIDS Cases Diagnosed 2004 - 2008



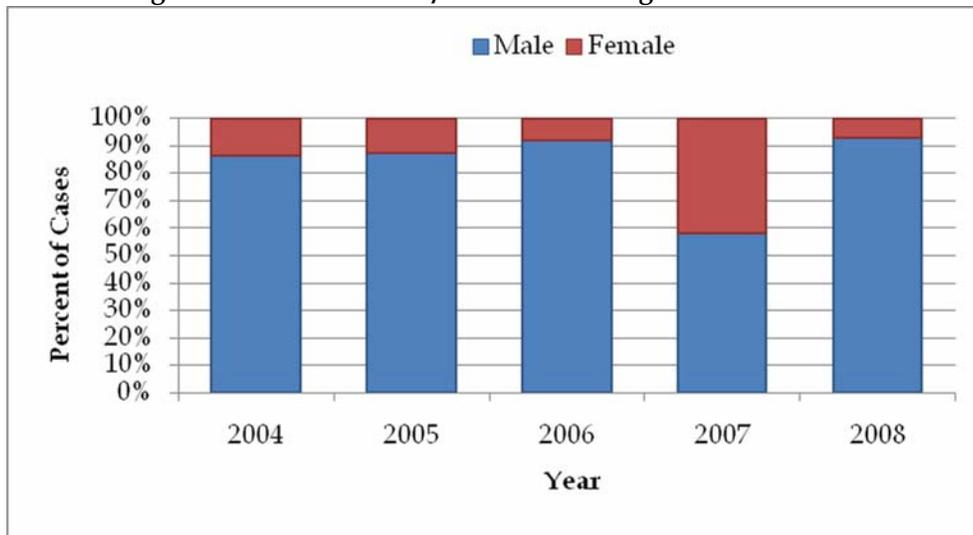
There was an average incidence rate of 1.9 per 100,000 for HIV/AIDS between 2004 and 2008. The incidence rate of HIV (non-AIDS) has been higher than that of AIDS over the last five years. The average incidence rate of HIV over this time period was 1.2 per 100,000, while for AIDS it was 0.7 per 100,000.

Figure 7 - Incidence Rate of HIV and AIDS Reported 2004 - 2008



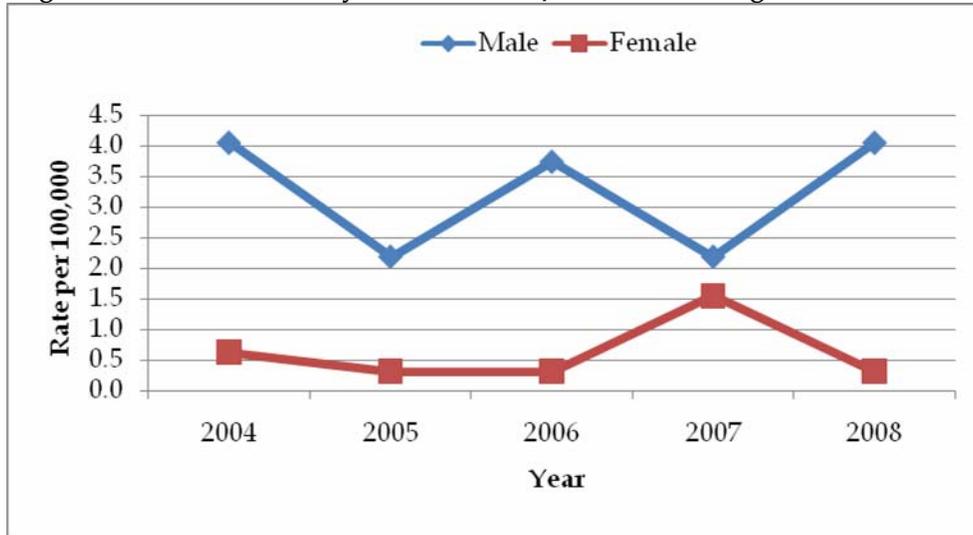
Although the majority of HIV/AIDS cases diagnosed between 2004 and 2008 were male, the percentage of cases that were female increased in recent years. Between 2004 and 2008, 16 percent of HIV/AIDS diagnoses were female, while females comprised 15 percent of all HIV/AIDS diagnoses since 1984.

Figure 8 - Gender of HIV/AIDS Cases Diagnosed 2004 - 2008



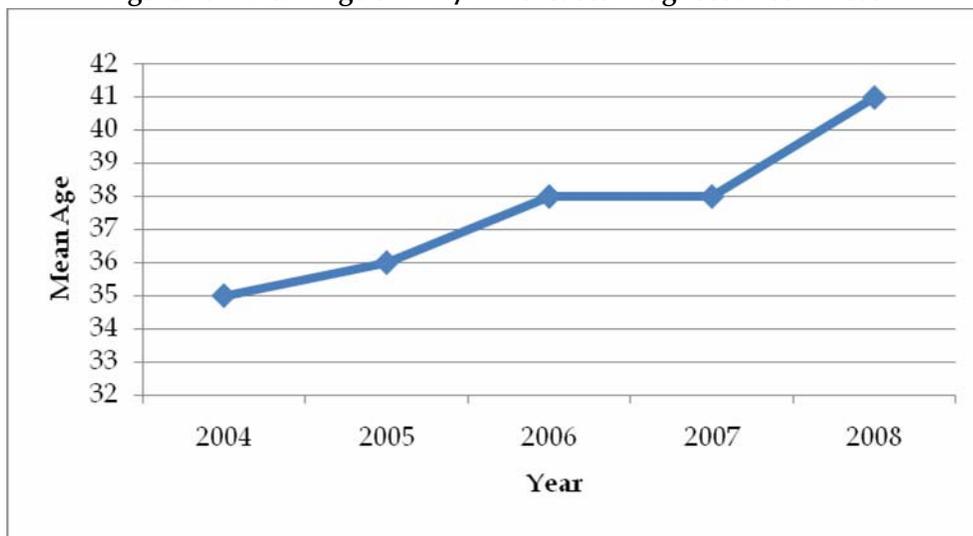
The increase in HIV/AIDS among women can be seen in the incidence rates from 2004 to 2008. The incidence rate of HIV/AIDS in females was 1.6 per 100,000 in 2007, whereas it was 0.6 per 100,000 in 2004.

Figure 9 - Incidence Rate by Gender of HIV/AIDS Cases Diagnosed 2004 - 2008



The mean age of individuals diagnosed with HIV/AIDS between the years of 2004 and 2008 is 38. This is consistent with the mean age of HIV/AIDS cases diagnosed in North Dakota since 1984, which is 36.

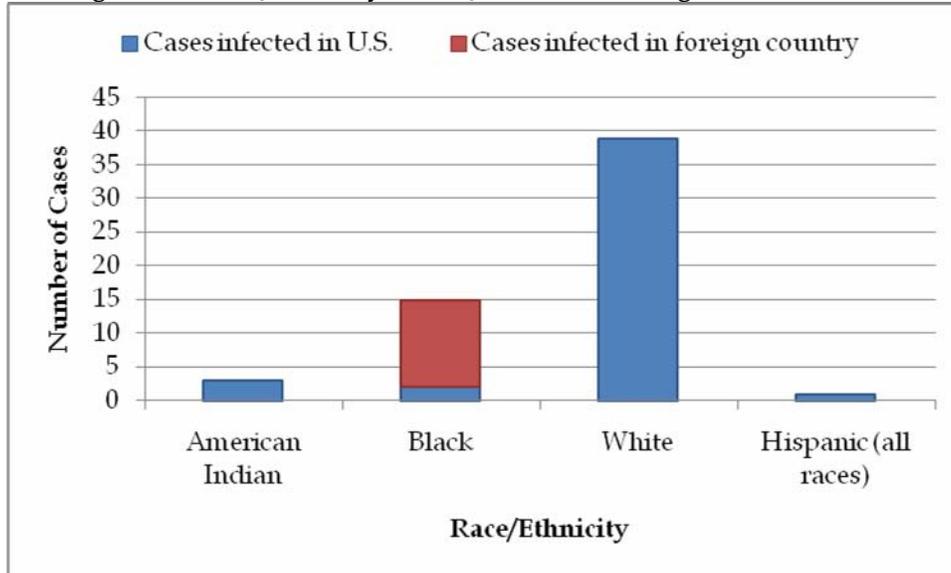
Figure 10 - Mean Age of HIV/AIDS Cases Diagnosed 2004 - 2008



Between 2004 and 2008, 24 percent of HIV/AIDS cases diagnosed in North Dakota identified themselves as black. However, it is important to note that 87 percent of these cases were actually diagnosed in a foreign country. Due to the limitations of the

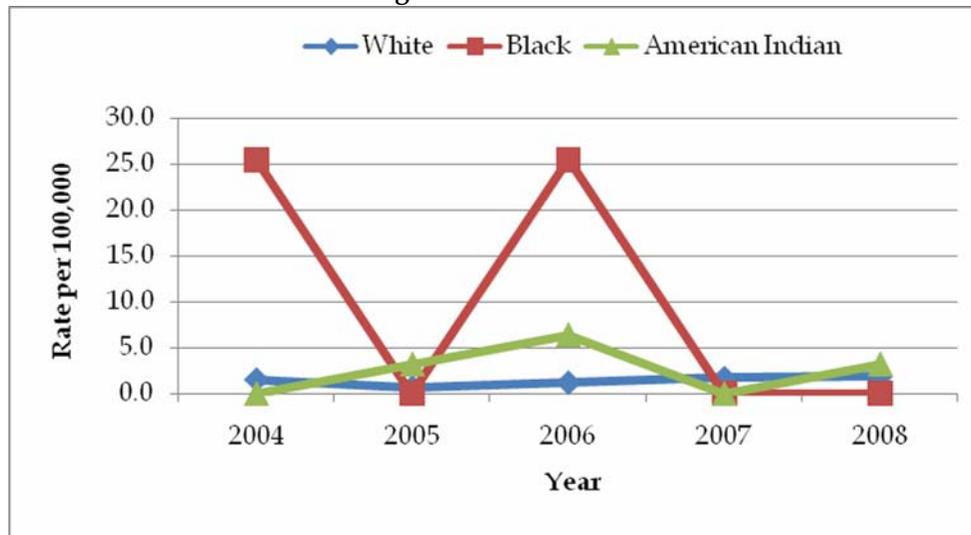
HIV/AIDS reporting software, individuals diagnosed in other countries must be counted towards North Dakota incidence if it is their first state of residence after entering the United States.

Figure 11 - Race/Ethnicity of HIV/AIDS Cases Diagnosed 2004 - 2008



The HIV/AIDS incidence rate for blacks in North Dakota is also significantly higher than that of whites and American Indians. The average HIV/AIDS incidence rate from 2004 to 2008 for blacks was 10.2 per 100,000, whereas it was 1.4 per 100,000 and 2.6 per 100,000 for whites and American Indians, respectively.

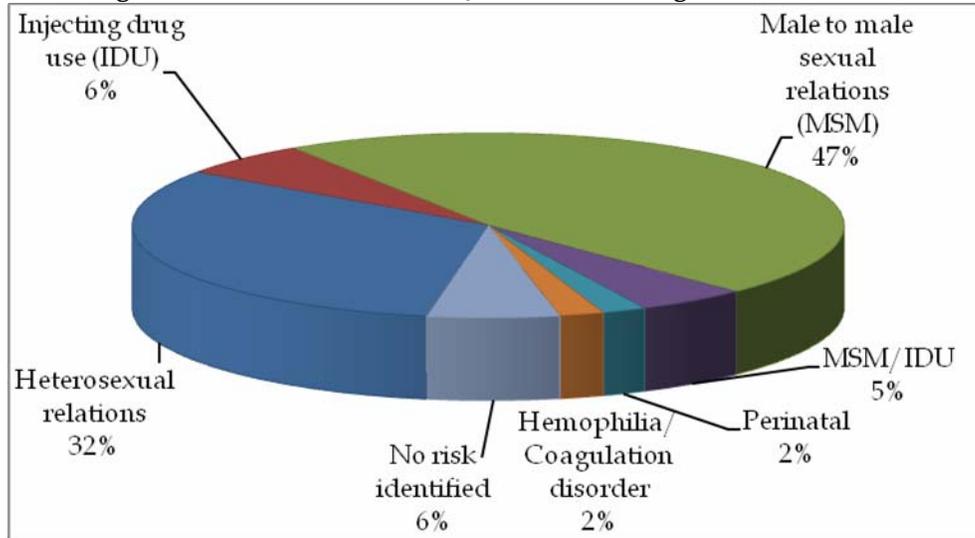
Figure 12 - Incidence Rate by Race/Ethnicity of HIV/AIDS Cases Diagnosed 2004 - 2008 Excluding Cases Diagnosed in Other Countries



While male-to-male sexual relations remained the most frequently reported risk factor for HIV/AIDS between 2004 and 2008, heterosexual relations was also a major risk

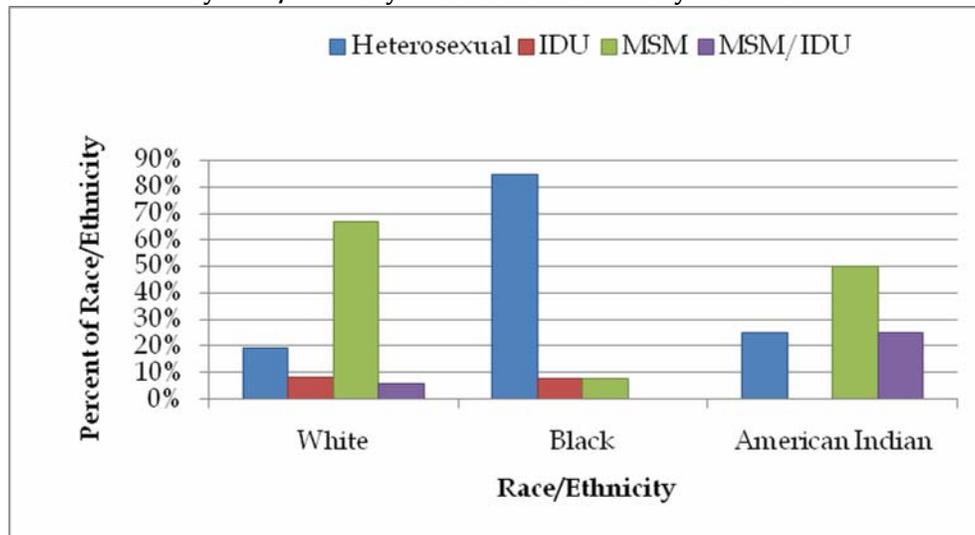
factor identified. Thirty-two percent of HIV/AIDS cases diagnosed between 2004 and 2008 reported having heterosexual relations. Only 18 percent of the cumulative HIV/AIDS cases reported having heterosexual relations.

Figure 13 - Risk Factors of HIV/AIDS Cases Diagnosed 2004 - 2008



The race/ethnicity groups reported different risky behaviors at diagnosis of HIV/AIDS between 2004 and 2008. A greater proportion of newly diagnosed white HIV/AIDS clients reported having male-to-male sexual relations than any other race, whereas a greater proportion of newly diagnosed black HIV/AIDS clients reported having heterosexual relations than any other race.

Figure 14 - Percentage of HIV/AIDS Cases Diagnosed 2004 - 2008 by Race/Ethnicity That Identified a Risky Behavior

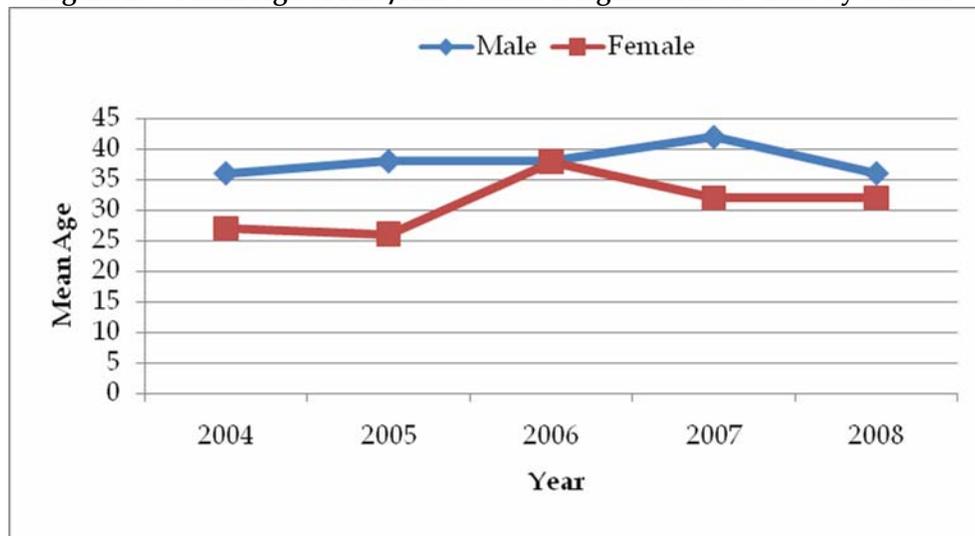


HIV/AIDS and Gender 2004 - 2008

Gender plays an important role in the prevention of HIV/AIDS. Generally, males have been affected the most by the epidemic because they comprise the majority of HIV/AIDS cases in the United States. However, in recent years, HIV/AIDS among females has been increasing. The following figures analyze the effect of gender on HIV/AIDS in North Dakota.

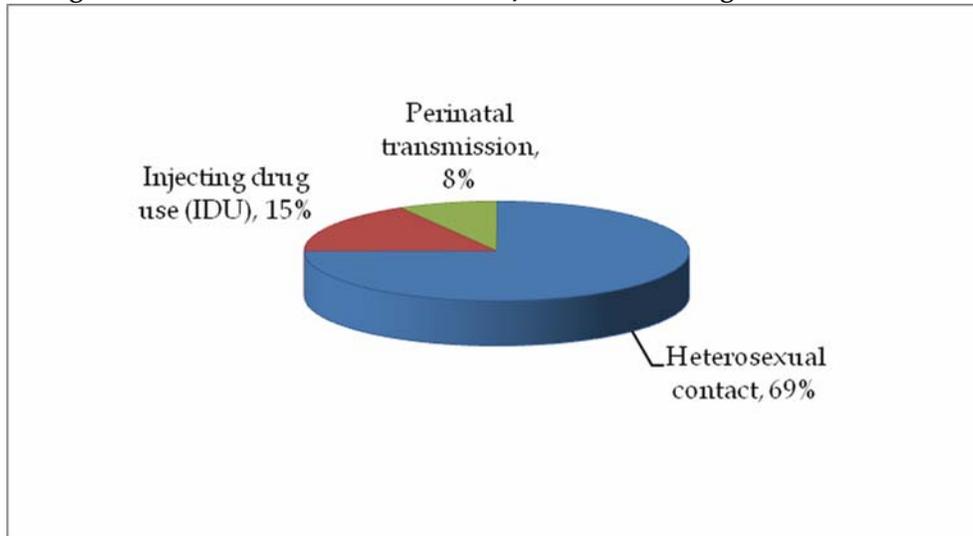
Females diagnosed with HIV/AIDS in North Dakota between 2004 and 2008 were, on average, younger than their male counterparts at the time of diagnosis. Females were diagnosed with HIV/AIDS at an average age of 31, which is seven years younger than the average age at which males were diagnosed.

Figure 15 - Mean Age of HIV/AIDS Cases Diagnosed 2004 - 2008 by Gender



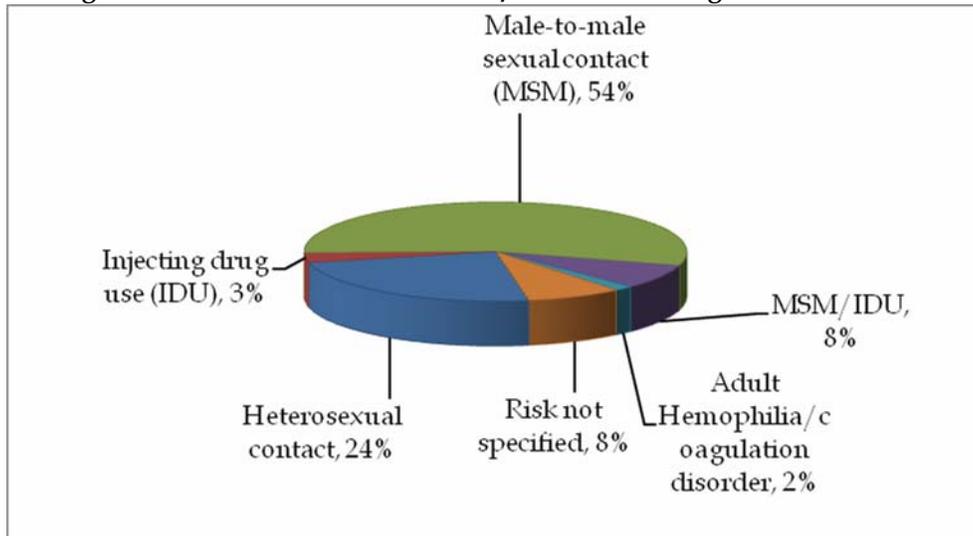
The risk factors reported by males and females at the time of their HIV/AIDS diagnosis varied greatly from 2004 to 2008. As was expected, a higher proportion of females than males reported having heterosexual relations. Unexpectedly, a higher proportion of females than males reported injecting drug use as a risk factor.

Figure 16 - Risk Factors of Female HIV/AIDS Cases Diagnosed 2004 - 2008



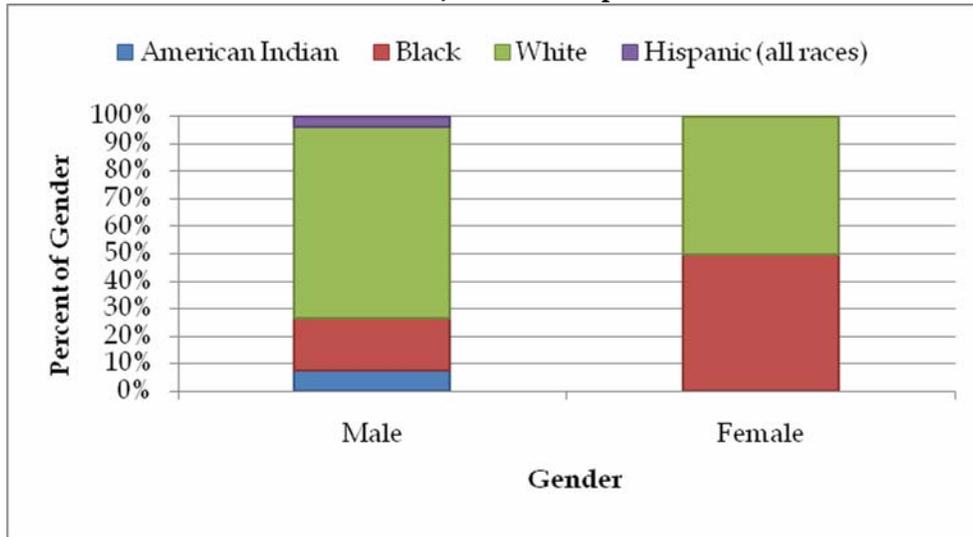
Between 2004 and 2008, a higher proportion of males reported having heterosexual relations, and a lower proportion reported injecting drug use than the cumulative HIV/AIDS cases.

Figure 17 - Risk Factors of Male HIV/AIDS Cases Diagnosed 2004 - 2008



A higher proportion of females than males diagnosed with HIV/AIDS between 2004 and 2008 were black. Also, no females diagnosed during this time period were American Indian.

Figure 18 - Percent of HIV/AIDS Cases Diagnosed 2004 - 2008 by Gender That Identified a Racial/Ethnic Group

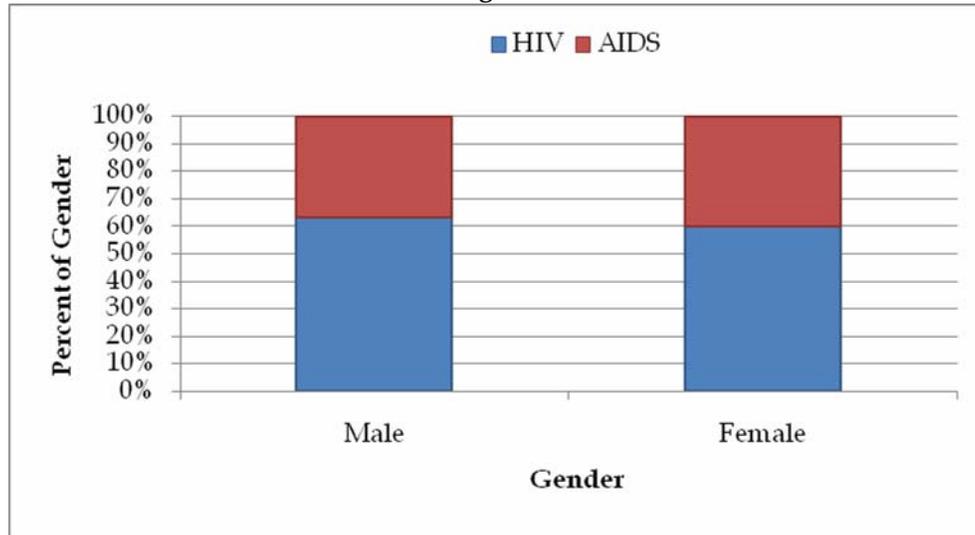


Factors that Affect Disease Status at HIV/AIDS Diagnosis

Many factors may influence whether an individual will be classified as having HIV (non-AIDS) or AIDS at the initial HIV/AIDS diagnosis. Limited access to medical care and social stigma are examples of possible influences on disease status at diagnosis. The following figures address some of these issues by analyzing HIV/AIDS cases diagnosed in North Dakota between 2004 and 2008.

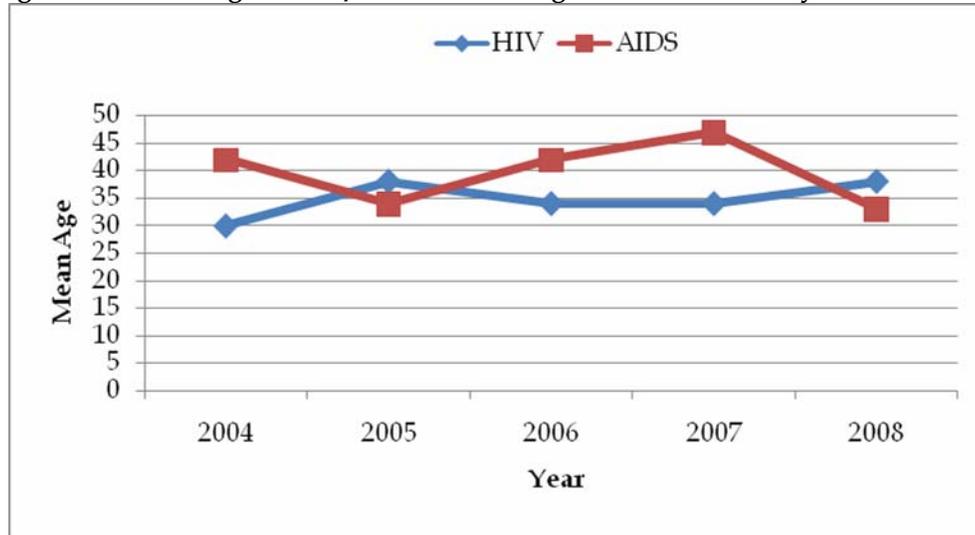
Gender is a factor that may affect disease status at diagnosis of HIV/AIDS. Between 2004 and 2008, a slightly higher proportion of females were classified as having AIDS at their initial HIV/AIDS diagnosis.

Figure 19 – Percent of HIV/AIDS Cases Diagnosed 2004 - 2008 by Gender With HIV or AIDS at Diagnosis



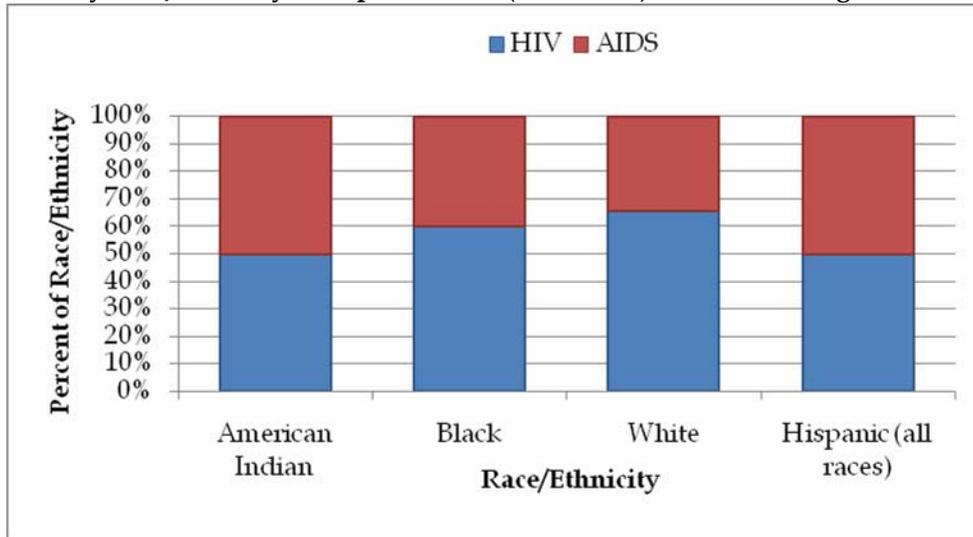
On average, individuals who were diagnosed with AIDS at their initial HIV/AIDS diagnosis between 2004 and 2008 were older than those diagnosed with HIV (non-AIDS). The average age of HIV/AIDS clients with AIDS at their initial diagnosis was five years older than those with HIV (non-AIDS).

Figure 20 – Mean Age of HIV/AIDS Cases Diagnosed 2004 - 2008 by Disease Status



Fifty percent of American Indians diagnosed with HIV/AIDS in North Dakota from 2004 to 2008 were diagnosed with AIDS. Of black and white HIV/AIDS clients diagnosed during this same time period, 40 percent and 34 percent, respectively, were diagnosed with AIDS.

Figure 21 - Percentage of HIV/AIDS Cases Diagnosed 2004 - 2008 by Race/Ethnicity Group With HIV (non-AIDS) or AIDS at Diagnosis



Vital Status of HIV/AIDS Cases

Of the 441 HIV/AIDS cases reported since 1984, only 188 were known to be living in North Dakota as of Dec. 31, 2008. Of the cases not currently living in the state, some have died and some have moved. The following figures concentrate on the characteristics of HIV/AIDS mortality in North Dakota.

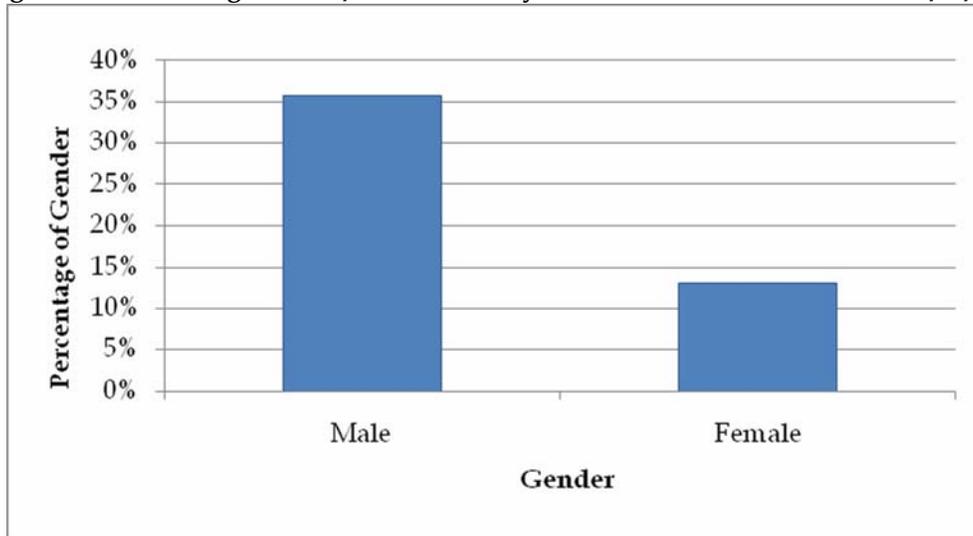
Of the 441 HIV/AIDS cases reported in North Dakota since 1984, 85 have moved out of the state and 168 have died.

Figure 22 - Residency Status of HIV/AIDS Cases Reported 1984 - 2008 as of 12/31/08



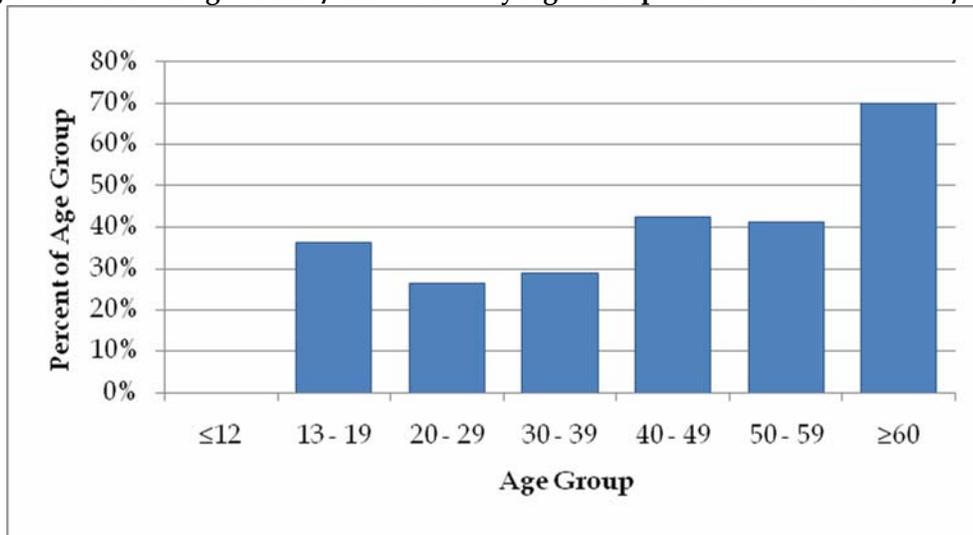
Thirty-six percent of all male HIV/AIDS cases reported in North Dakota have died, while only 13 percent of all female cases have died.

Figure 23 - Percentage of HIV/AIDS Cases by Gender Who Have Died as of 12/31/08



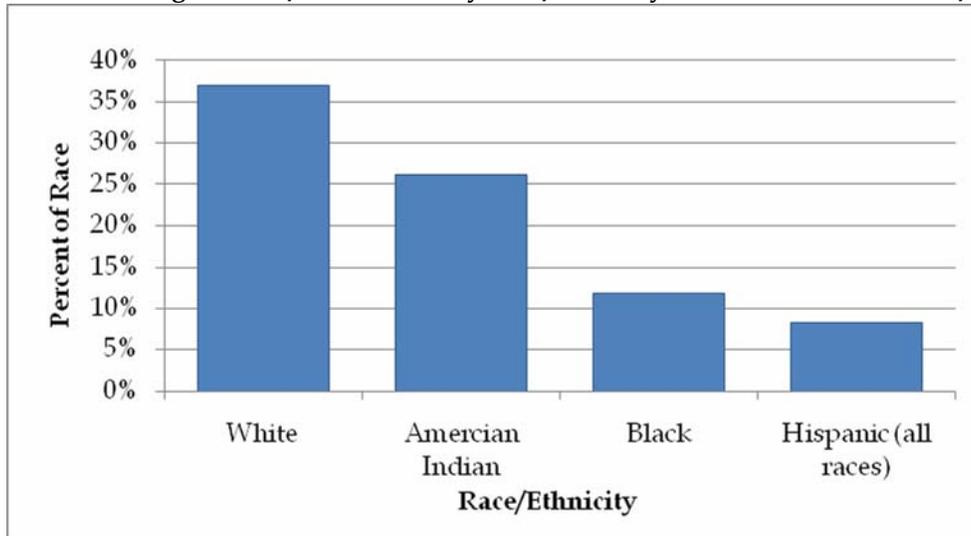
On average, 39 percent of all HIV/AIDS cases reported in North Dakota who were between the ages of 13 and 59 at diagnosis have died. None of the cases who were 12 years old and younger have died. Seventy percent of the cases who were 60 and older at diagnosis have died.

Figure 24 - Percentage of HIV/AIDS Cases by Age Group Who Have Died as of 12/31/08



Whites have the highest mortality rate of all races/ethnicities among HIV/AIDS cases diagnosed in North Dakota. Thirty-seven percent of all white HIV/AIDS cases have died, while only 12 percent of all black HIV/AIDS cases have died. American Indians have the second highest mortality rate, with 26 percent of all HIV/AIDS cases of that race having died.

Figure 25 - Percentage of HIV/AIDS Cases by Race/Ethnicity Who Have Died as of 12/31/2008



HIV Counseling and Testing

There are 31 HIV counseling, testing and referral (CTR) sites throughout North Dakota that provide free services to “at-risk” individuals. These sites include local public health units, community action facilities, and college health facilities. The CTR sites provide not only HIV testing, but also risk reduction counseling to those being tested. Referrals for specialized services also may be provided at the CTR sites. The following data were collected from state CTR sites and other testing facilities that submitted *HIV Counseling and Testing Report* forms.

In 2008, 2,370 tests for HIV were performed at CTR sites in North Dakota. Of those tested, there were two positive tests for a positivity rate of 0.08 percent. Most of the HIV testing during 2008 was performed at local public health units (60%). Seventeen percent of tests were performed at colleges and universities, 8 percent were performed in jails or prisons and 16 percent were performed in other types of facilities, such as community action and family planning. Males made up 61 percent of individuals tested for HIV at CTR sites in North Dakota during 2008, and 100 percent of the positives identified from these sites. The majority of individuals tested at state CTR sites were white and between the ages of 19 and 34.

Table 5 – Characteristics of Individuals Tested for HIV in North Dakota during 2008

	Total Tests		Positive Tests	
	Number	Percentage ¹	Number	Percentage ^{1,2}
Gender				
Male	1,451	61	2	100
Female	919	39	0	0
Race/Ethnicity				
White	1,891	80	2	100
Black	118	5	0	0
Asian/Pacific Islander	30	1	0	0
American Indian	255	11	0	0
Multiple races	15	1	0	0
Unknown	61	3	0	0
Age Group				
≤ 13	5	1	0	0
13 - 18	145	6	0	0
19 - 24	1,074	45	0	0
25 - 34	716	30	1	50
35 - 44	257	11	1	50
≥ 45	173	7	0	0
Total	2,370		2	

¹ Due to rounding totals may not add up to 100%.

² In this case, percentage refers to percentage of total positive tests.

The most common risk behaviors reported by individuals receiving HIV testing at state CTR sites during 2008 were sex without a condom (40%), sex with a female (28%), sex with a male (22%), sex with an IDU (3%) and sex while using drugs or alcohol (3%).

Table 6 – Risk Factors of Individuals Tested for HIV in North Dakota during 2008

Risk Factors	Responses	
	Number	Percentage ¹
Sex with male	931	22
Sex with female	1,197	28
Sex without condom	1,752	40
Sex with an IDU	115	3
Sex with MSM	6	0
Sex with HIV positive	14	0
IDU	68	2
Sex with anonymous partner	49	1
Sex while using drugs/alcohol	117	3
No Indicated Risk	77	2
Total	4,326	

¹ Due to rounding totals may not add up to 100%.

North Dakota CARES Program

North Dakota CARES (Comprehensive HIV/AIDS Resources and Emergency Services) is a program that assists low-income North Dakota residents living with HIV or AIDS to access confidential health and supportive services. In order to be a part of the CARES program, one must be a resident of North Dakota, have a net income of less than 400 percent of the Federal Poverty Level (FPL) and have proof of HIV infection.

Services available for clients in the North Dakota CARES Program include case management, drug assistance, outpatient services, supportive services and emergency assistance. This program is funded by a federal grant, and services available are subject to change because of changes in funding.

Currently, the North Dakota CARES Program serves 73 (39%) of the 188 people living with HIV/AIDS in North Dakota. The majority of clients are male (77%), which can be compared with the 78 percent of males living in North Dakota with HIV/AIDS. The highest risk factors for clients include 40 percent heterosexual contact and 37 percent MSM. Following behind was injecting drug use with 10 percent, MSM/IDU with 8 percent, perinatal transmission with 3 percent, 1 percent had hemophilia, and 1 percent were unknown or undecided. Forty-four percent of the clients have been diagnosed with AIDS, while 56 percent have not yet met the criteria for AIDS diagnosis.

Sexually Transmitted Diseases Other Than HIV/AIDS

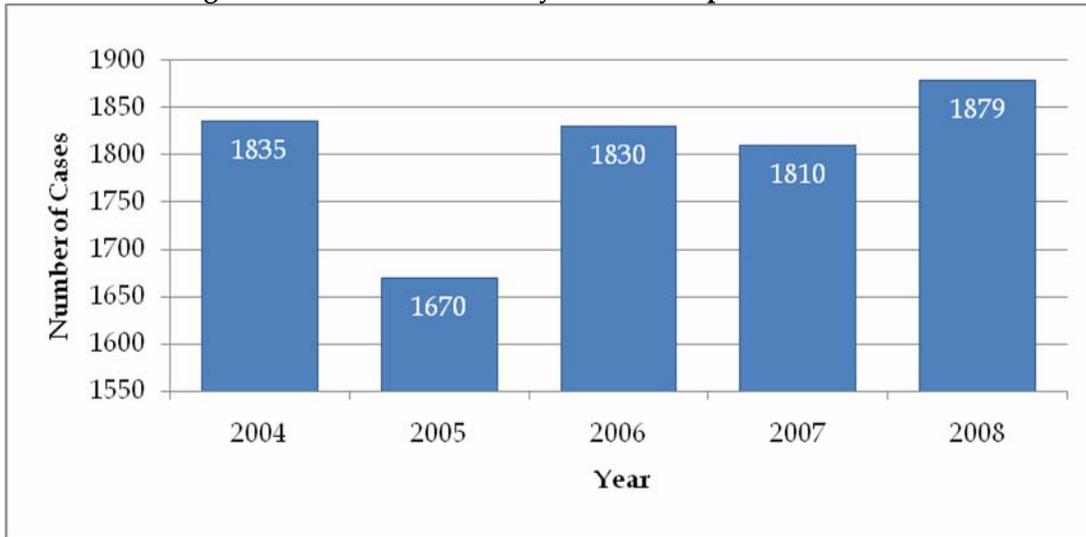
Surveillance of sexually transmitted diseases (STDs) other than HIV/AIDS is an important part of HIV/AIDS prevention. Individuals with STDs, such as chlamydia, gonorrhea, and syphilis are two to five times more likely to contract HIV from an infected individual than those without an STD. Also, an HIV-infected individual with another STD is more likely to transmit HIV to a sex partner than an individual with only HIV.

Chlamydia

Infections caused by the bacterium *Chlamydia trachomatis* occur in more than one million Americans every year. If left untreated, chlamydia can cause pelvic inflammatory disease and sterility in women.

The average annual number of chlamydia cases reported in North Dakota was 1,805 between 2004 and 2008. In 2007, the incidence rate of chlamydia in North Dakota was 281.3 per 100,000. This is lower than the national average of 370.2 per 100,000, and was the 38th highest rate of all 50 states.

Figure 26 - Number of Chlamydia Cases Reported 2004 - 2008

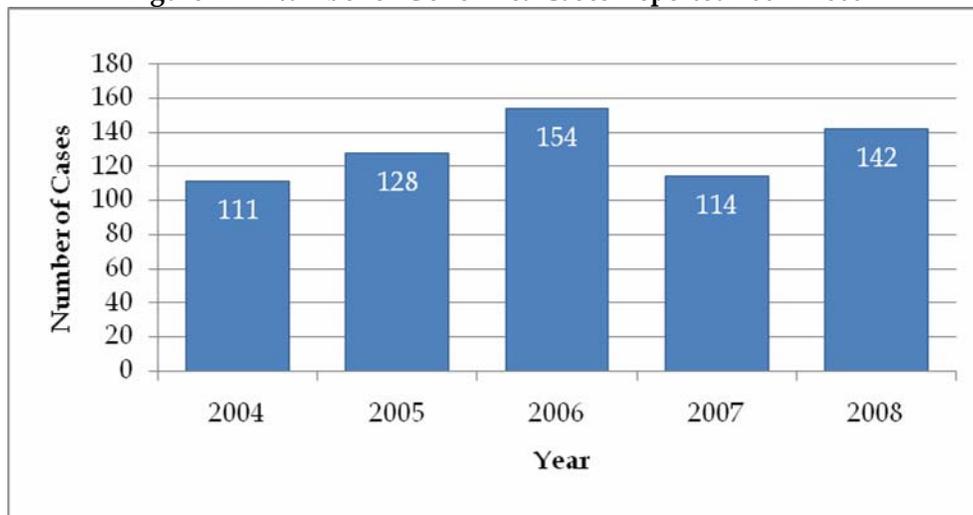


Gonorrhea

Gonorrhea is caused by the bacterium *Neisseria gonorrhoeae*, and accounts for an estimated 700,000 new infections per year in the United States. Complications of gonorrhea are similar to that of chlamydia.

There was an average of 130 cases of gonorrhea per year reported in North Dakota between 2004 and 2008. In 2007, the incidence rate was 18.2 per 100,000, which was ranked 45th in the United States.

Figure 27 - Number of Gonorrhea Cases Reported 2004 - 2008

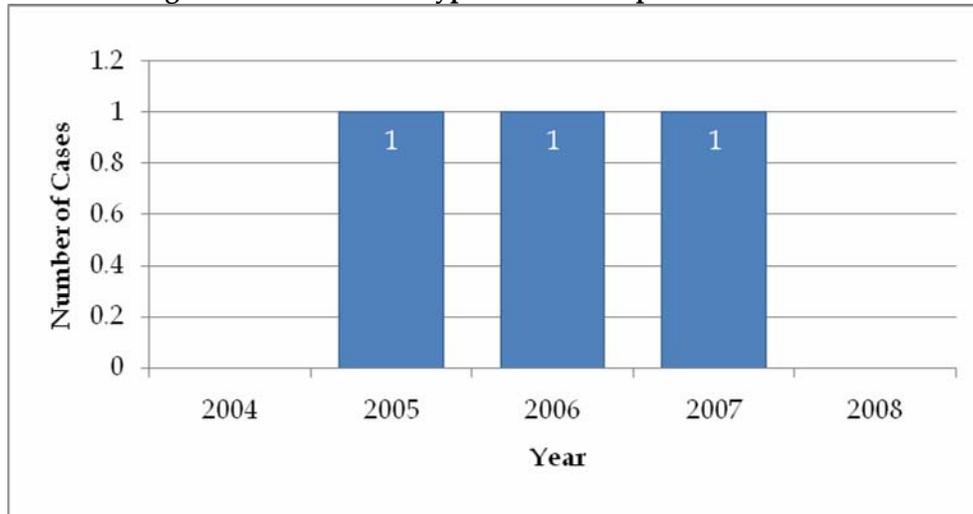


Syphilis

Syphilis, also known as the great imitator because of its indistinct signs and symptoms, is caused by the bacterium *Treponema pallidum*. In 2007, over 40,000 Americans reported having any stage of syphilis. If left untreated, syphilis can cause complications that range in severity from a rash to death.

Between 2004 and 2008, three cases of syphilis were reported in North Dakota. In 2007, North Dakota’s primary and secondary syphilis incidence rate was ranked 49th in the United States with 0.2 per 100,000.

Figure 28 - Number of Syphilis Cases Reported 2004 - 2008



For both chlamydia and gonorrhea, more females than males were reported to have these infections in 2008. The majority of chlamydia and gonorrhea cases were reported in people 15 to 29 years old. As with HIV/AIDS, there is a clear racial disparity with chlamydia and gonorrhea. Blacks have the highest rates of these diseases, with 2,757.9 per 100,000 for chlamydia and 485.2 per 100,000 for gonorrhea.

Table 7 - Chlamydia and Gonorrhea Cases Reported in 2008	Chlamydia	Gonorrhea
Number by Gender		
Male	620	50
Female	1,259	92
Number by Age Group		
<15	10	0
15-19	517	35
20-24	869	57
25-29	336	24
30-34	83	11
35-39	36	5
40-44	20	3
45-54	5	7

Table 7 - Chlamydia and Gonorrhea Cases Reported in 2008	Chlamydia	Gonorrhea
Number by Age Group, continued		
55-64	1	0
>64	0	0
Rate by Race/Ethnicity		
Black	2,757.9	485.2
American Indian	1,145.9	95.8
Hispanic	423.8	25.7
White	194.12	7.4
Asian	143.5	27.7
Total	1,879	142

* Due to rounding, totals may not add up to 100%

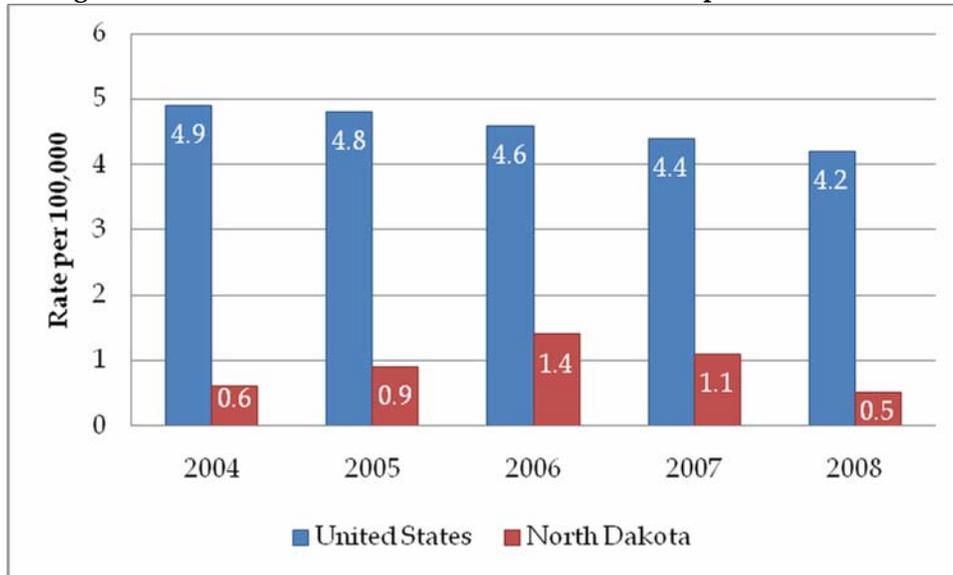
Tuberculosis

Tuberculosis (TB) is an infection caused by a group of bacteria called the *Mycobacterium tuberculosis* complex. TB can infect many parts of the human body, but it is only infectious when the bacteria are aerosolized, as in cases of disease in the lungs, larynx, or mouth. Without proper treatment, TB can be a deadly disease. The mortality rate is increased in people with HIV infection. An HIV-infected individual is 10 times more likely to develop TB disease than an HIV-negative one because of the virus's ability to weaken the immune system. Also, TB disease causes HIV to progress to AIDS more quickly than HIV-positives without TB.

HIV and TB co-infection is a worldwide problem. It is estimated that 75 percent of the people living in sub-Saharan Africa are infected with HIV. Of those HIV-infected individuals, one-third or more may develop TB disease. In America, there is an estimated 468,000 people with HIV-TB co-infection. While America may only comprise four percent of the global total of HIV-TB co-infected individuals, it is still a serious public health problem. The following figures describe the epidemiology of TB in North Dakota from 2004 to 2008.

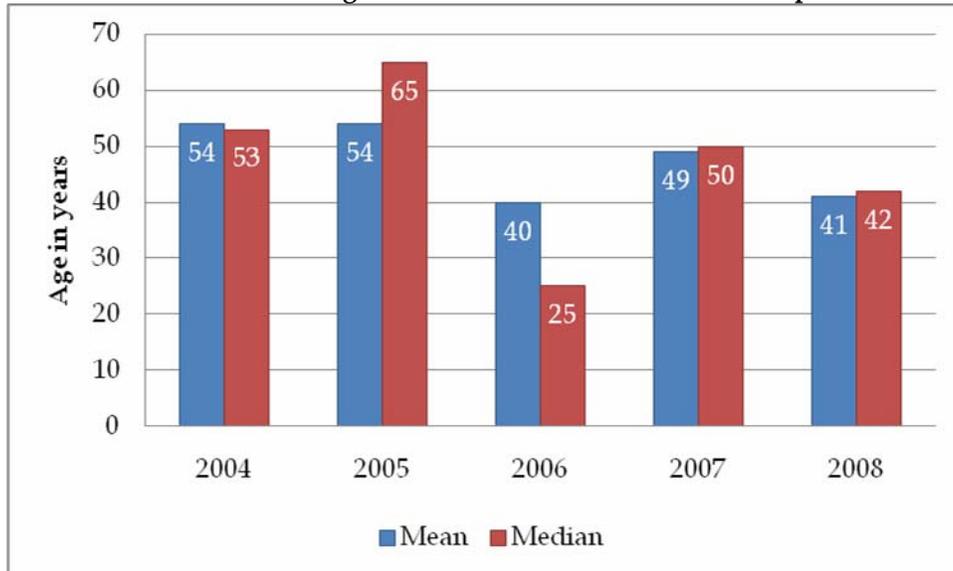
Between 2004 and 2008, there were 30 cases of TB disease reported in North Dakota. The number of annual TB cases ranged from three to ten, resulting in incidence rates between 0.5 and 1.4 per 100,000. This is well below the national average of 4.2 to 4.9 per 100,000.

Figure 29 - Incidence Rate of Tuberculosis Disease Reported 2004 - 2008



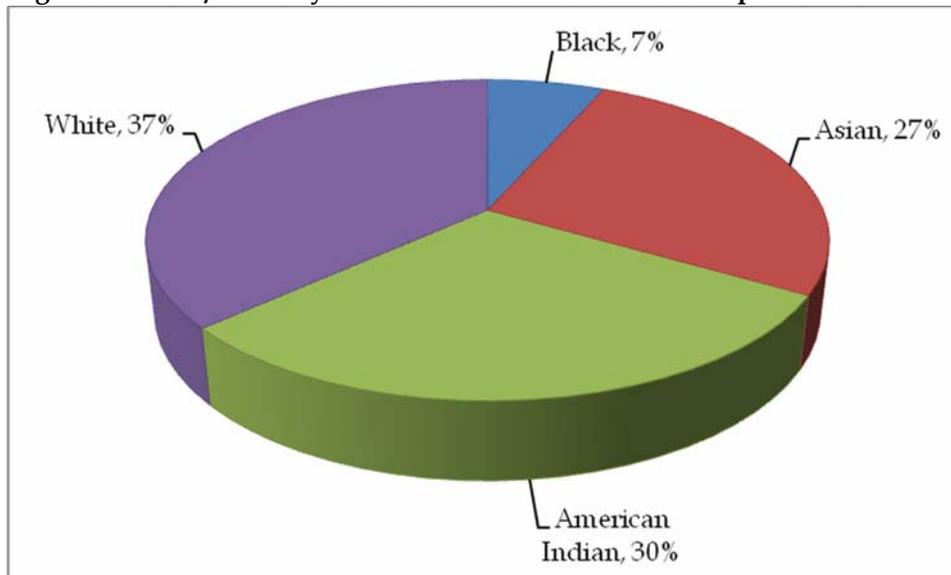
The mean and median ages of TB disease cases remained consistent between 2004 and 2008. The overall mean and median ages for this time period were 48 and 47.

Figure 30 - Mean and Median Ages of Tuberculosis Disease Cases Reported 2004 - 2008



There is a distinct racial disparity among cases of TB disease, with the majority of them being of a racial or ethnic minority. From 2004 to 2008, 37 percent of the cases were white, while the other 63 percent were American Indians, Asian and black.

Figure 31 - Race/Ethnicity of Tuberculosis Disease Cases Reported 2004 - 2008



Viral Hepatitis

Hepatitis is inflammation of the liver, and it can be caused by many factors, including viruses. Two of the viruses that cause hepatitis, hepatitis B (HBV) and hepatitis C (HCV), frequently infect individuals with HIV/AIDS. Co-infection occurs frequently because the risk factors for infection are very similar between HBV, HCV and HIV. HBV is most commonly acquired through high-risk sexual activities, and HCV is most commonly transmitted through needle-sharing. HIV and HBV co-infection increases the likelihood of chronic HBV infection and serious liver complications. HIV and HCV co-infection can cause liver damage to occur more rapidly than HCV alone.

Hepatitis B

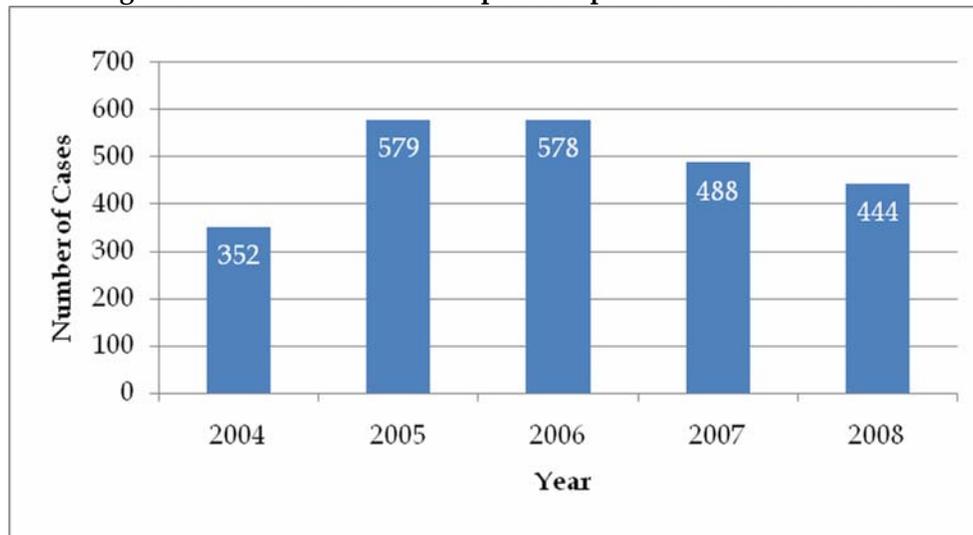
Since the introduction of the HBV vaccine, there has been a dramatic drop in new hepatitis B infections in the United States, with 208,000 in 1980 and 46,000 in 2006. It is estimated that 1.25 million people in the United States have chronic hepatitis B infection. In North Dakota, 58 cases of chronic hepatitis B were reported in 2008.

Hepatitis C

An estimated 3.2 million people in the United States are chronically infected with HCV, making it the most common chronic bloodborne infection. Among individuals who are infected with HIV, 25 percent are also infected with HCV.

There was an average of 488 cases of chronic hepatitis C reported each year in North Dakota between 2004 and 2008.

Figure 32 – Cases of Chronic Hepatitis C per Year from 2004 – 2008

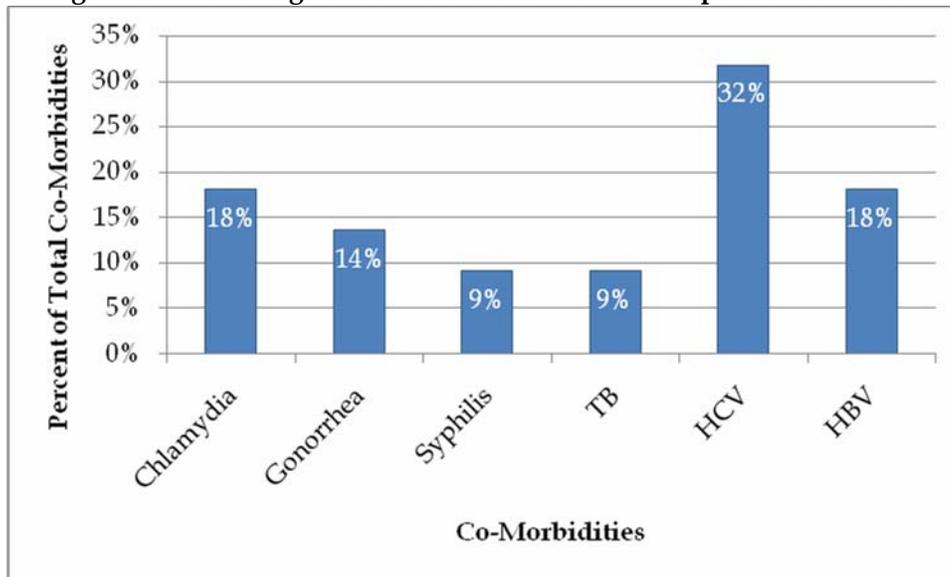


HIV/AIDS Co-infection

Co-infection with other diseases of public health importance is a common occurrence among HIV/AIDS patients because of the nature of the disease and the risky behavior associated with it. The devastating effects of HIV to the immune system make people more susceptible to certain diseases, such as TB. High risk sexual behaviors not only put people at risk for HIV but also chlamydia, gonorrhea, syphilis and HBV. Finally, injection drug users are at risk for acquiring HIV and HCV. Co-infection with HIV is a complicated and dangerous condition.

Between 2004 and 2008, 117 cases of HIV/AIDS were reported to the NDDoH, 17 percent of which reported co-infection with one or more of the following diseases during the same time period: chlamydia, gonorrhea, syphilis, TB, HCV and HBV. The most common co-infection was HCV, with 32 percent of all the co-morbidity reports.

Figure 33 - Percentage of Co-morbidities with HIV Reported 2004 - 2008



Certain risk behaviors were more frequently associated with specific HIV co-infections. Heterosexual contact was most frequently associated with HIV and chlamydia co-morbidity. The most common risk factor associated with HIV and gonorrhea co-morbidity and HIV and syphilis co-morbidity is male-to-male sexual contact. HCV and HIV co-infection was associated with male-to-male sexual contact, injecting drug use and hemophilia/coagulation disorder.

Table 8 – Risk Factors of HIV/AIDS Cases with Co-Morbidities 2004 - 2008

Risk Factors	Co-Morbidities					
	Chlamydia	Gonorrhea	Syphilis	TB	HCV	HBV
Male-to-male sexual contact (MSM)	0	2	2	0	2	0
Injecting drug use (IDU)	1	0	0	0	0	0
MSM/IDU	0	0	0	0	2	1
Heterosexual contact	3	1	0	2	0	2
Hemophilia/coagulation disorder	0	0	0	0	1	0
Risk not specified	0	0	0	0	2	1

Technical Notes

Case Definition Changes

The CDC AIDS case definition has changed over time based on knowledge of HIV disease and physician practice patterns. The original definition was modified in 1985. In 1987, definition revisions incorporated a broader range of AIDS opportunistic infections and conditions and used HIV diagnostic tests to improve the sensitivity and

specificity of the definition. In 1993, the definition expanded to include HIV-infected individuals with pulmonary tuberculosis, recurrent pneumonia, invasive cervical cancer, or CD4 T-lymphocyte counts of less than 200 cells per ml or a CD4+ percentage of less than 14. As a result of the 1993 definition expansion, HIV-infected persons were classified as AIDS earlier in their course of disease than under the previous definition. Regardless of the year, AIDS data are tabulated in this report by the date of the first AIDS defining condition in an individual under the 1993 case definition.

The case definition for HIV infection was revised in 1999 to include positive results or reports of detectable quantities of HIV virologic (non-antibody) tests. The revisions to the 1993 surveillance definition of HIV include additional laboratory evidence, specifically detectable quantities from virologic tests.

The perinatal case definition for infection and remission of symptoms among children younger than 18 months who are perinatally-exposed to HIV was changed to incorporate the recent clinical guidelines and the sensitivity and specificity of current HIV diagnostic tests in order to more efficiently classify HIV-exposed children as infected or not infected.

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CHAPTER 3

COMMUNITY SERVICES ASSESSMENT

Resource Inventory

A resource inventory describes the existing community capacity for HIV prevention by identifying the current HIV prevention and related resources and activities in a project area, regardless of funding source.

What Is the Purpose of a Resource Inventory?

The purpose of a resource inventory is to assess existing community resources for HIV to determine the community's capacity to respond to the epidemic.

What Is the Minimum Information Needed for a Resource Inventory?

- Name, address, and other contact information for the organization being surveyed
- Funding amount
- Funding source (e.g., CDC, other public or private funding)
- Geographic project area
- Targeted populations
- Number of individuals served in a year
- Whether or not the organization focuses specifically on HIV prevention
- Strategies or interventions used

STD/HIV/AIDS Provider Services Survey

The CPG used a survey to assess what STD/HIV/AIDS prevention and care services are being provided by organizations throughout North Dakota, which populations are being targeted, and whether the level of services is adequate for each of those populations. The survey included questions about the provider agencies, services provided, populations served, sources of funding, barriers encountered, and training and capacity-building needs of the agencies' staffs. The survey also solicited opinions about what service gaps existed. This survey will be conducted every five years and the results of the 2008 survey are described below.

The survey was sent to 96 individuals at agencies that were likely to provide STD/HIV/AIDS services. Sixty-nine agencies responded, for a response rate of 72 percent. The organizations surveyed included HIV/AIDS prevention and care providers, Community Based Organizations (CBOs) and Counseling, Testing and

Referral (CTR) sites funded by the NDDoH HIV/AIDS and STD Programs. Also included were gay/lesbian/bisexual/transgender resource centers, family planning organizations, mental health centers, community health centers, government social service agencies, housing/shelter programs, local public health units, substance abuse programs, Red Cross affiliates, student health centers, family planning clinics and correctional facilities.

The survey was conducted by American Red Cross on behalf of the NDDoH. The survey was made available between May and July of 2008. Organizations were surveyed by mail and telephone.

Due to the fact that many of the providers did not return the survey, the responses reported here may not be representative of all prevention and care providers in North Dakota. In addition, they may not reflect all services or service gaps present in the state.

Organization/Agency Principal Function

Survey participants were asked to identify the principal function of their organization or agency from a list of 14 options, including “Other,” which allowed the participants to specify the principal function in a text response. Only five of the 14 options were selected in survey participants’ responses, with one of these, “Public Health Agency,” accounting for more than 61 percent of the total number of responses. The complete breakdown of responses is included in Table 3-1.

Table 3-1 Principal Functions of Participant’s Agency		
Organization Type	Number of Respondents	Percentage
Community-Based Organization	11	16
Public Health Agency	42	61
College/University/Community College	4	6
Tribal Clinic/Indian Health	2	3
Community Mental Health Center	0	0
Housing/Shelter	0	0
Health Care Facility	0	0
Religious Institution	0	0
Government Social Service Agency	0	0
Private, For-Profit Agency	0	0
Adult/Youth Corrections	7	10
Community Health Center	0	0
Other	3	4
Total	69	100

Geographic Area

Survey participants were asked to identify the geographic area that best described their service area. Overall, 71 percent reported their service area as rural, 19 percent as urban, and 7 percent as correctional/institutional. (See Table 3-2.)

Table 3-2 Geographic Regions Being Served by Providers		
Populations Being Served	Number of Respondents	Percentage
Urban	13	19
Rural	49	71
Institutional Setting (Incarcerated)	7	10
Total	69	100

Services Provided

Survey participants were asked if their organizations provided HIV/ AIDS prevention services. Sixty-two of the respondents (90%) replied that their organization *did* provide HIV/ AIDS prevention services. Survey participants also were asked to indicate what prevention services they offered from a list of 18 activities and services. They were able to choose as many options as applied. Of the sixty-two agencies providing services, the most prevalent services include distribution of STD/HIV/ AIDS educational materials (89%); condom distribution (68%); referrals to counseling, testing, or medical/support groups (61%); on-site HIV counseling, testing and referral; and individual risk reduction counseling and education (50%). A complete breakdown of the responses may be found in Table 3-3.

Table 3-3 Prevention Services Provided		
STD/HIV/AIDS Prevention-Related Activities and/or Services Offered	Number of Respondents	Percentage
On-Site HIV Counseling, Testing and Referral	32	52
Voluntary Partner Counseling and Referral	9	15
Individual Risk Reduction Counseling and Education	31	50
HIV-Negative Multi-Session Support Groups	0	0
HIV-Positive Multi-Session Support Groups	1	2
Safer-Sex Skills-Building Groups, Workshops	4	6
Sessions Targeting Those in Alcohol and/or Drug Treatment	5	8
Peer Education Programs	2	3
School-Based Education	11	18

Table 3-3 (cont.) Prevention Services Provided		
STD/HIV/AIDS Prevention-Related Activities and/or Services Offered	Number of Respondents	Percentage
Street/Community Outreach	5	8
Mass Media Campaign	1	2
Condom Distribution	42	68
Telephone Information and Counseling	7	11
HIV Referrals	38	61
HIV Prevention Case Management	7	11
STD/HIV/AIDS Educational Materials	55	89
STD Screening and Treatment	9	15
Other	5	8

Clients Served by Risk Category

Survey participants were asked to identify which populations their agencies reached with their HIV/STD/hepatitis-related prevention activities and/or services. Participants could choose from eight options. Of the 62 agencies that responded that their agency provided HIV prevention services, 61 percent estimated that their agency reached high-risk heterosexual, 40 percent reported reaching MSM, and only 13 percent reported reaching IDUs.

Table 3-4 illustrates the risk populations being reached by agencies providing HIV prevention services.

Table 3-4 Population Reached by Risk Category		
Populations Reached by STD/ HIV/AIDS Prevention Activities and/or Services	Number of Respondents	Percentage
Men Who Have Sex With Men (MSM)	25	40
Injection Drug Users	8	13
Young Adults- Ages 13-24	14	23
Persons With HIV/AIDS	25	40
Bisexuals	12	19
General Population	32	52
Heterosexuals	38	61
Women Only	1	2

HIV/AIDS Care-Related Services

Survey participants were asked whether or not their organization provided HIV/AIDS care-related services and, if so, what services they provided. Of the 62 respondents who replied that their organization *did* provide HIV/AIDS care-related services, 26 percent provided services to the incarcerated, 13 percent had services for mentally ill, 13 percent had services for low socioeconomic status, 13 percent provided services to homeless clients, and 11 percent had services for substance abuse. See Table 3-5 for the complete breakdown of care-related services.

Table 3-5 Care and Support for PLWH/A		
Populations Reached by STD/ HIV/AIDS Prevention Activities and/or Services	Number of Respondents	Percentage
Pregnant	5	8
Trading Sex for Drugs/Money/Shelter	5	8
Homeless	8	13
Sex Workers	4	6
Substance Abusers	7	11
Of Low Social-Economic Status	8	13
Incarcerated	16	26
Mentally Ill	8	13
Visually or Hearing Impaired	4	6
Migrant Workers	3	5
Medical Professional	4	6
Developmentally Disabled	4	6
Infected With STDs	6	10
Other	6	10

Barriers to STD/HIV/AIDS Prevention and Care-Related Services

When asked to identify significant barriers to, or difficulties in the provision of, STD/HIV/AIDS prevention and STD/HIV/AIDS care-related services, survey participants most often selected a small size of target population, followed closely by insufficient funding and insufficient staffing. These barriers were more often cited for prevention services than for care services.

Out of the 45 participants who responded to this question, 31 percent identified the small size of the priority populations as a significant barrier to provision of services. In addition, 29 percent of the agencies identified insufficient funding as a significant barrier to, or difficulty in the provision of, prevention and care services; and 13 percent identified that the target population was not aware of the services as barriers to providing services.

Due to the limited amount of agencies that responded to these questions, actual barriers may not be accurately reflected. The complete breakdown of barriers to prevention and care services is included in Table 3-6.

Table 3-6 Barriers in Providing STD/HIV/AIDS Prevention and Care Services		
Barriers	Number of Respondents	Percentage
Lack of Convenience Clinic Hours for Clients Served	2	4
Limited Funding and Staffing	13	29
Small Size of Target Population	14	31
Target Population Not Aware of Services	6	13
Problems of Accessibility for the Target Population	4	9
Staff Retention	1	2
Insufficient Coordination, Collaboration Among Prevention Providers	4	9
Lack of Bilingual Materials	1	2
Other	0	0

Unmet Needs of Agencies Providing STD/HIV Prevention and Care Services

In addition to the questions about services provided, respondents were also asked what unmet needs the agencies were facing. Of the respondents who answered this question, the needs were more educational materials, a need for more presentations and/or trainings and the desire to see more advertising for the HIV counseling and testing sites. These needs are going to be looked at in greater detail to formulate a plan to address the unmet needs of the service providers in North Dakota.

Coordination of Services

Coordination of services among statewide agencies is crucial in providing HIV prevention throughout North Dakota. One major contributing factor in the ability to provide HIV prevention activities is the lack of community-based organizations and the capacity to support agencies that provide HIV-related services. To help compensate for this gap, services are coordinated through various agencies around the state. The following is a summary of the agencies that provide HIV prevention activities.

Community Action Agencies (CAA)

CAAs are referral agencies that provide resources (i.e., emergency services, food commodities, self-reliance and money management programs, housing, counseling, WIC services, etc.) to low-income individuals throughout North Dakota. CAAs serve all counties in the state through their eight regional offices.

Five CAAs (Fargo, Grand Forks, Dickinson, Williston and Minot) are funded by the HIV Prevention Program to provide HIV counseling, testing and referral services. The Ryan White (RW) Program has collaborated with CAAs throughout the state to make them aware of the services provided through the RW Program so they may act as a referral source to persons living with HIV/AIDS (PLWH/A) using their services. The RW Program information has been well received by the CAAs, and the RW program coordinator has been asked on several occasions to provide RW Program information at local and regional community action planning meetings.

Additionally, the RW Program recruited a local CAA to participate in a tri-state grant application with South Dakota and Montana to apply for Housing Opportunities for People with AIDS (HOPWA) funding through Housing and Urban Development (HUD). The tri-state HOPWA proposal was accepted for funding over a three-year period, providing PLWH/A in North Dakota access to HOPWA funds for the first time. The program is now in its third year and is currently providing housing assistance services to 11 clients. The CAA and the RW Program have continued a collaborative relationship to facilitate referrals between programs for services to PLWH/A in North Dakota.

In 2007, the American Red Cross agreed to be the provider for the HIV capacity-building position for HIV Prevention Program.

North Dakota Department of Public Instruction (DPI) -- Coordinated School Health

Coordinated school health programs assist schools in coordinating with their community's health services, counseling, healthy staff, family and community involvement, healthy school environment, nutrition services, physical education, and a comprehensive school health education program. This unit is the liaison with the Department of Health in children's and health issues.

The Youth Risk Behavioral Survey (YRBS) and HIV/AIDS education coordinator for DPI in the past has served as an advisory member of the ND CPG. Currently, this position is vacant.

Greater Grand Forks HIV/AIDS Network, Inc.

The Greater Grand Forks HIV/AIDS Network, Inc. is a nonprofit, community-based organization comprised of individuals interested in, or involved in, HIV/AIDS education or service in the greater Grand Forks area. The network serves as a resource for HIV/AIDS prevention information and education and works to improve services for individuals and families who are affected by HIV/AIDS.

The following is the mission statement of the Greater Grand Forks HIV/AIDS Network Inc.:

1. To be a resource of information for individuals and groups involved with HIV/AIDS.
2. To share HIV/AIDS information on the local level.
3. To promote HIV/AIDS prevention education.
4. To increase awareness and compassion for individuals and the families of individuals who are affected by HIV/AIDS.
5. To ensure linkages between appropriate public and voluntary agencies involved with HIV/AIDS.

HIV Prevention Program staff receives the monthly Greater Grand Forks HIV/AIDS Network, Inc. meeting minutes via email.

Family Planning Program

The North Dakota Family Planning Program helps men and women take responsibility for their reproductive health through education, counseling and medical services. Family planning services are available to all regardless of age, gender, race, nationality, religion, disability or ability to pay.

The women's health coordinator for the Family Planning Program will coordinate with the NDDoH HIV/AIDS Program and the American Red Cross on a project to promote a Women's and Girls' HIV/AIDS awareness day, pending grant approval. The funding opportunity is being made possible through the Office on Women's Health in the U. S. Department of Health and Human Services.

If funding is approved, Family Planning and the HIV/AIDS Programs will create a packet outlining a statewide campaign addressing awareness and prevention for women and teens. The packet will be distributed to public health agencies, tribal health agencies, family planning clinics, HIV CTR sites, school nurses and the DPI teacher training centers.

CHAPTER 4

PRIORITIZED TARGET POPULATIONS

Target populations are populations that are the focus of HIV prevention efforts because they have high rates of HIV infection and high levels of risky behavior.

In HIV prevention community planning, priority-setting should lead to programs that respond to high-priority, community-validated needs within defined populations. Each CPG develops two products that are the basis for the comprehensive prevention plan:

- Target (or high-risk) population priorities.
- Recommended interventions for each target population.

Target Populations and Priority-Setting

When selecting target populations during the 2008 planning year, the CPG reviewed the prior year's process and the current epidemiological data to determine if the current priority populations would need to be re-prioritized. It was concluded that it was appropriate to add an additional target population to include North Dakota's largest minority population, American Indians. The following process was used while selecting target populations for the 2008 planning year. There are no changes to the prioritized target populations for the 2010 Addendum.

Essential Steps of Priority-Setting

In selecting North Dakota's priority populations during the 2008 planning year, the CPG considered the seven key steps in setting priorities for target populations.

1. Identify target populations: Identify and define which populations to consider.
2. Determine factors: Decide which factors the CPG will use to set priorities for target populations.
3. Weight factors: Assign a weight (level of importance) to each factor.
4. Rate target populations using factors: Use the factors to rate each target population.
5. Score target populations using factors: Determine a score for each factor by multiplying the rating by the weight.
6. Rank target populations: For each target population, add the factor scores together. Compare the total scores to determine an overall rank.

7. Review ranking and prioritize target populations: Review the results and agree upon the final list of target populations.

Identifying Target Populations

The North Dakota CPG began the process of defining its target populations by reviewing available epidemiological data, needs assessments, YRBS data, Census Bureau data, gap analysis information, focus group summaries, incidental data and the target populations selected in prior years. Key issues considered were:

1. What populations does the epidemiological data identify as being at risk for transmitting or becoming infected with HIV?
2. What does the community services assessment identify as the prevention needs of populations at risk?
3. What current programs for specific target populations need to continue?
4. Has there been a change in the populations infected/affected?

After reviewing all the available data and considering the CDC’s Advancing HIV Prevention Initiative, the group decided upon the following target populations: HIV-infected individuals, men who have unprotected sex with men, at-risk American Indians, unprotected heterosexual contact, and injecting drug users.

Determine Factors

In selecting the factors to use to set priorities for target populations, the CPG considered the following core set of factors:

**Table 4-1.
Factors Considered by CPG To Set Priorities for Target Populations**

FACTOR	DEFINITION	DISCUSSION
AIDS Incidence	The number of AIDS cases diagnosed in a defined population in a specified period, often a year.	Because of a comprehensive national AIDS surveillance system, AIDS incidence data are among the most reliable and complete population-based epidemiological data available. AIDS incidence data may help CPGs understand the extent to which AIDS has affected a given population relative to another. In considering AIDS incidence data, however, CPGs should be aware that recent declines in AIDS incidence are attributable largely to antiretroviral therapies. Currently, differences in AIDS

FACTOR	DEFINITION	DISCUSSION
AIDS Incidence, continued	The number of AIDS cases diagnosed in a defined population in a specified period, often a year.	incidence among groups (e.g., by race/ethnicity or age) may represent differences in treatment success or in access to or use of health care.
AIDS Prevalence	The number of people living with AIDS in a defined population on a specific date.	AIDS prevalence data show the number of people living with advanced HIV disease. While AIDS incidence data show the total number of AIDS diagnoses in a specified period in time, prevalence data show how many people are living with AIDS, regardless of when they were diagnosed.
AIDS Mortality	The number of deaths among people with AIDS in a specified period, often a year.	Like AIDS incidence and AIDS prevalence data, AIDS mortality data can be useful in understanding the extent to which the epidemic has affected a given population relative to another. Recent declines in AIDS deaths are attributable largely to antiretroviral therapies. Differences in AIDS deaths among groups (e.g., by race/ethnicity or age) may represent differences in treatment success or differences in access to, or use of, health care.
HIV Incidence (diagnosed)	The number of new HIV cases diagnosed in a defined population in a specified period, often a year.	<p>The number of new HIV infections diagnosed among people who received HIV tests during a specified period of time, usually a year. The data do not show the total number of HIV infections because not everyone is tested. Nor do the data show when HIV infections occurred; people may be tested years after infection.</p> <p>To distinguish between HIV incidence among people with and without AIDS, we refer to diagnosed HIV (including AIDS) incidence and diagnosed HIV (not AIDS) incidence. In general, diagnosed HIV (not AIDS) incidence represents people infected with HIV more recently than people represented by AIDS incidence data.</p>

FACTOR	DEFINITION	DISCUSSION
<p>HIV Prevalence (diagnosed, including AIDS)</p>	<p>The number of people living with diagnosed HIV (including people with AIDS) in a defined population, on a specified date.</p>	<p>This factor shows the total number of people diagnosed with HIV or AIDS, minus those who have died, at a given point in time. Diagnosed HIV prevalence includes only people who have been tested, diagnosed and reported; people who were tested anonymously are not included.</p> <p>Almost all new areas have HIV reporting. However, two years of HIV reporting data are considered the minimum for projecting trends. Diagnosed HIV (not AIDS) prevalence represents those people living with HIV infection but not AIDS.</p>
<p>Other Indicators of Risk Behaviors</p>	<p>Other data sets that may signal HIV risk behaviors occurring within the target population.</p>	<p>Adolescent sexual activity: Teenage pregnancy is sometimes a marker for early initiation of unprotected sex and an indication of high-risk behaviors. Take care in interpreting these data because teenage pregnancy may be intentional.</p> <p>Other behavioral data: Depending on local data collection and research systems, CPGs may be able to access local population studies of behaviors associated with HIV transmission, such as anal intercourse or needle-sharing, and studies of the determinants of high-risk behaviors.</p>
<p>Riskiness of Population Behaviors</p>	<p>The nature and relative risk of behaviors that occur in the target population.</p>	<p>This factor considers the relative risk of behaviors among target populations. The risk for HIV transmission and acquisition associated with the highest risk behaviors is well understood. The three most risky behaviors for transmitting HIV are, in descending order of risk, the use of HIV-infected injection equipment, unprotected receptive anal sex with an infected partner and unprotected vaginal sex with an infected male partner.</p>

FACTOR	DEFINITION	DISCUSSION
Multiple High-Risk Behaviors	The extent to which multiple high-risk behaviors occur within the target population.	This factor considers the occurrence of more than one high-risk behavior within a given population. For example, men who have unsafe sex with men and inject drugs are engaging in multiple high-risk behaviors.
Difficulty of Meeting Population Needs	The complexity of needs and whether the population has been reached by current programs, whether service providers have capacity, etc.	CPGs may use a variety of data sets, such as racial/ethnic composition, population density (urban, rural, frontier), education (especially level of completion and literacy rates), socioeconomics, service utilization, etc., to determine risk on a population. Review all available data and information sets, including the results of the gap analysis. If data gaps exist, your CPG may want to commission original research as part of the needs assessment. In addition, CPGs may need to “qualify” which information/data sets they will consider.
Barriers to Reaching the Population	The extent to which barriers to providing HIV prevention programs exist in a high-risk population.	CPGs may consider the following sociodemographic characteristics when looking for indicators of barriers: cultural, linguistic, socioeconomic status, family or social network structures, gender and sexual orientation studies, religion and spiritual beliefs, consumer preferences, provider preferences, and community norms and values. Studies that focus on knowledge, attitudes, behaviors and beliefs also will provide information about barriers.

The following seven factors are the criteria CPG uses to rank the priority populations for North Dakota: AIDS incidence, AIDS prevalence, HIV incidence, HIV prevalence, key indicators of risk behavior, riskiness of population behaviors and barriers to reaching the population.

Weight Factors

In order to distinguish the level of importance of the factors selected, it was decided that numeric weights would be assigned and a scale of “1” through “5” would be used,

with “5” representing the most important and “1” the least important. The following is a chart reflecting the weights assigned to each factor.

Factors	Weight
AIDS Incidence	4
AIDS Prevalence	2
HIV Incidence	5
HIV Prevalence	3
Key Indicators of HIV-Risk Behaviors	4
Riskiness of Population Behaviors	5
Barriers to Reaching the Population	5

Rating Target Populations

The rating scale is a simple two-point scale (yes/no) used to determine the value of each factor. A “yes” was given a value of “2” and a “no” was given a value of “1.”

Scoring Target Populations Using Factors

To determine each factor’s score, the factor’s rating was multiplied by its weight. Tables 1 through 4 show how the final score was obtained for each target population.

Table 4-2 Men Who Have Unsafe Sex with Men			
Factor	Weight	Rating	Score
AIDS Incidence	4	2	8
AIDS Prevalence	2	1	2
HIV Incidence	5	2	10
HIV Prevalence	3	1	3
Key Indicators of Risk Behaviors	4	2	8
Riskiness of Population Behaviors	5	2	10
Barriers to Reaching the Population	5	2	10
Total Score			51

Table 4-3 Unprotected Heterosexual Contact			
Factor	Weight	Rating	Score
AIDS Incidence	4	1	4
AIDS Prevalence	2	1	2
HIV Incidence	5	1	5
HIV Prevalence	3	2	6
Key Indicators of Risk Behaviors	4	2	8
Riskiness of Population Behaviors	5	2	10
Barriers to Reaching the Population	5	1	5
Total Score			40

Table 4-4 Injection Drug Use			
Factor	Weight	Rating	Score
AIDS Incidence	4	1	4
AIDS Prevalence	2	1	2
HIV Incidence	5	1	5
HIV Prevalence	3	1	3
Key Indicators of Risk Behaviors	4	2	8
Riskiness of Population Behaviors	5	1	5
Barriers to Reaching the Population	5	2	10
Total Score			37

Table 4-5 At-Risk American Indians (Unprotected Heterosexual Contact, IDU, MSM)			
Factor	Weight	Rating	Score
AIDS Incidence	4	2	8
AIDS Prevalence	2	1	2
HIV Incidence	5	2	10
HIV Prevalence	3	1	3
Key Indicators of Risk Behaviors	4	2	8
Riskiness of Population Behaviors	5	2	10
Barriers to Reaching the Population	5	2	10
Total Score			51

Ranking Target Populations

The scores were added and the target populations were rank-ordered by placing them in order given their overall scores.

As stated before, in light of CDC's Advancing HIV Prevention Initiative, HIV-positive individuals are North Dakota's number-one priority population, followed by MSM, people who engage in unprotected heterosexual contact, and IDUs. American Indians will be the number-one minority target population.

CHAPTER 5

PREVENTION ACTIVITIES/INTERVENTIONS

An intervention is a specific activity (or set of related activities) intended to change the knowledge, attitudes, beliefs, behaviors, or practices of individuals and populations to reduce their health risk. An intervention has a distinct process and outcome objectives and protocol outlining the steps for implementation.

Potential Strategies and Interventions

In formulating possible prevention interventions, the CPG reviewed all interventions currently being delivered, assessed their effectiveness and discussed whether to continue them in the upcoming year. Technical assistance (TA) facilitated by the Inter Tribal Council of Arizona and CDC staff was provided to guide the group in the selection of interventions. The TA was very helpful in assisting the group reach a consensus on appropriate interventions and also targeting the interventions to the appropriate populations.

The CPG also utilized the seven categories of interventions as recommended by the CDC and described in the following table in considering both currently funded interventions and possible future interventions.

Intervention Type	Definition/Description
<p>1. Individual-Level Interventions (ILI)</p>	<p>Health education and risk-reduction counseling provided to one individual at a time. ILIs assist clients in making plans for individual behavioral change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services (e.g., substance abuse treatment) in both clinic and community settings in support of behaviors and practices that prevent transmission of HIV. They help clients make plans to obtain these services.</p>
<p>2. Group-Level Interventions (GLI)</p>	<p>Health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wider range of skills, information, education and support.</p>

Intervention Type	Definition/Description
<p>3. Outreach</p>	<p>HIV/ AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients’ neighborhoods or other areas where clients typically congregate. These interventions usually include distribution of condoms, bleach, sexual responsibility kits and educational materials.</p>
<p>4. Prevention Case Management (PCM)</p>	<p>Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing and individualized prevention counseling, support and service brokerage.</p>
<p>5. Partner Counseling and Referral Services (PCRS)</p>	<p>A systematic approach to notifying sex and needle-sharing partners of HIV-positive individuals of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS help partners gain early access to individualized counseling, HIV testing, medical evaluation, treatment and other prevention services.</p>
<p>6. Health Communication/ Public Information (HC/PI)</p>	<p>The delivery of planned HIV/ AIDS prevention messages through one or more channels to target audiences. The messages are designed to build general support for safe behavior, support personal risk-reduction efforts and/or inform people at risk for infection about how to obtain specific services.</p>
<p>7. Other Interventions</p>	<p>Category to be used for those interventions that cannot be described by the definitions provided for the other six types of interventions. This category includes community-level interventions (CLI).</p>

Priority Target Populations, Interventions and Strategies

It is important to note that with the exception of American Indians, the subpopulations (i.e., youth/young adults, adults) under each risk-based population are not prioritized but have been deemed by the CPG as important subpopulations to target interventions to reach the risk-based populations.

For the purposes of funding allocation, the health department will allocate funding to MSM, unprotected heterosexual contact and then IDU. At-risk American Indians are prioritized as the number-one minority population and will receive funding accordingly. While PLWH/A is required to be each state's number one priority, it is not required that the greatest amount of funding be spent on this population. However, for the 2009-2011 planning cycle, prevention for positives will be an area that receives more focus than in the previous planning years.

It is recognized that funding patterns, in general, may not reflect funding allocations due to the lack of capacity within the state to develop and implement HIV prevention programs for the identified target populations at this time.

Interventions

#1 Priority Population: HIV-Infected Individuals

Intervention #1: Prevention for Positives

Subpopulations: HIV-positive individuals

Intervention Strategy: This intervention will be based on an adapted version of the intervention Healthy Relationships. It is a small-group intervention for men and women living with HIV/AIDS. It is based on social cognitive theory and focuses on developing skills, building self-efficacy and positive expectations. It also will provide an opportunity for social networking and support.

Intervention #2: Partner Services

Subpopulations: HIV-positive individuals

Intervention Strategy: Provide notification to sex and needle-sharing partners of HIV-positive individuals of their possible HIV exposure and assist them in gaining early access to counseling, HIV testing, medical evaluation, treatment and other prevention services.

#2 Priority Population: MSM

Intervention #1: HIV Counseling, Testing and Referral

Subpopulations: All

Intervention Strategy: Provide risk-reduction counseling and testing services to people at risk for, or infected with, HIV and their partners. Provide appropriate referrals.

Intervention #2: Partner Services

Subpopulations: HIV-positive individuals

Intervention Strategy: Provide notification to sex and needle-sharing partners of HIV-positive individuals of their possible HIV exposure and assist them in gaining early access to counseling, HIV testing, medical evaluation, treatment and other prevention services.

Intervention #3: Outreach

Subpopulations: All

Intervention Strategy: Outreach activities that provide high-risk populations with HIV prevention education, risk reduction supplies and referrals to HIV prevention services. Outreach services will be conducted in environments where the target populations congregate or can be accessed (i.e., bars/nightclubs, adult book stores, coffee shops, health fairs, powwows, internet chat rooms, etc.). This activity is based on the theory of diffusion of innovation.

Intervention #4: Internet Outreach

Subpopulations: All

Intervention Strategy: The purpose of this web site is to provide factual information on HIV/AIDS and to also provide a forum for users to ask HIV/AIDS related questions anonymously. The primary focus is to provide men who have sex with men (MSM) with a web site that speaks directly to their needs.

Intervention #5: Health Communication/Public Information

Subpopulations: All

Intervention Strategy: Use HIV speakers to provide education to schools, colleges and other interested organizations.

Implement public education and awareness campaign that provides high-risk populations with HIV prevention education, risk reduction supplies and referrals to HIV prevention services. This campaign will also provide information on the HIV/AIDS program website www.ndhealth.gov/hiv, which provides HIV prevention and care, including information on HIV testing in N.D.

#3 Priority Population: Unprotected Heterosexual Contact

Intervention #1: HIV Counseling, Testing and Referral

Subpopulations: All

Intervention Strategy: Provide risk-reduction counseling and testing services to people at risk for, or infected with, HIV and their partners. Provide appropriate referrals.

Intervention #2: Partner Services

Subpopulations: HIV-positive individuals

Intervention Strategy: Provide notification to sex and needle-sharing partners of HIV-positive individuals of their possible HIV exposure and assist them in gaining early access to counseling, HIV testing, medical evaluation treatment and other prevention services.

Intervention #3: Outreach

Subpopulations: All

Intervention Strategy: Outreach activities that provide high-risk populations with HIV prevention education, risk reduction supplies and referrals to HIV prevention services. Outreach services will be conducted in environments where the target populations congregate or can be accessed (i.e., bars/nightclubs, adult book stores, coffee shops, health fairs, powwows, internet chat rooms, etc.). This activity is based on the theory of diffusion of innovation.

Intervention #4: Health Communication/Public Information

Subpopulations: All

Intervention Strategy: Use HIV speakers to provide education to schools, colleges and other interested organizations.

Implement a public education and awareness campaign that provides high-risk populations with HIV prevention education, risk reduction supplies and referrals to HIV prevention services. This campaign will also provide information on the HIV/AIDS program website www.ndhealth.gov/hiv, which provides HIV prevention and care, including information on HIV testing in N.D.

#4 Priority Population: American Indians

Intervention #1: HIV Counseling, Testing and Referral

Subpopulations: All

Intervention Strategy: Provide risk-reduction counseling and testing services to people at risk for, or infected with, HIV and their partners. Provide appropriate referrals.

Intervention #2: Partner Services

Subpopulations: HIV-positive individuals

Intervention Strategy: Provide notification to sex and needle-sharing partners of HIV-positive individuals of their possible HIV exposure and assist them in gaining early access to counseling, HIV testing, medical evaluation, treatment and other prevention services.

Intervention #3: Outreach

Subpopulations: All

Intervention Strategy: Outreach activities that provide high-risk populations with HIV prevention education, risk reduction supplies and referrals to HIV prevention services. Outreach services will be conducted in environments where the target populations congregate or can be accessed (i.e., bars/nightclubs, adult book stores, coffee shops, health fairs,

powwows, internet chat rooms, etc.). This activity is based on the theory of diffusion of innovation.

Intervention #4: Health Communication/Public Information

Subpopulations: All

Intervention Strategy: Use HIV speakers to provide education to schools, colleges and other interested organizations.

Implement a public education and awareness campaign that provides high-risk populations with HIV prevention education, risk reduction supplies and referrals to HIV prevention services. This campaign will also provide information on the HIV/AIDS program website www.ndhealth.gov/hiv, which provides HIV prevention and care, including information on HIV testing in N.D.

Intervention #5: GoodHealth TV™

Subpopulations: All

Intervention Strategy: GoodHealth TV™ is a unique education system designed to connect American Indians and Alaska Natives with health information, culture, and local programs and services available in their communities. GoodHealth TV™ will play HIV/AIDS messaging across all North Dakota GoodHealth TV™ units. One minute of messaging will play three times per clinical operating day. A schedule will be developed based upon these terms to air the HIV/AIDS messages that are developed.

#5 Priority Population: IDU

Intervention #1: HIV Counseling, Testing and Referral

Subpopulations: All

Intervention Strategy: Provide risk-reduction counseling and testing services to people at risk for, or infected with, HIV and their partners. Provide appropriate referrals.

Intervention #2: Partner Services

Subpopulations: HIV-positive individuals

Intervention Strategy: Provide notification to sex and needle-sharing partners of HIV-positive individuals of their possible HIV exposure and assist them in gaining early access to counseling, HIV testing, medical evaluation treatment and other prevention services.

Intervention #3: Outreach

Subpopulations: All

Intervention Strategy: Outreach activities that provide high-risk populations with HIV prevention education, risk reduction supplies and referrals to HIV prevention services. Outreach services will be conducted in environments where the target populations congregate or can be accessed (i.e., bars/nightclubs, adult book stores, coffee shops, health fairs, powwows, internet chat rooms, etc.). This activity is based on the theory of diffusion of innovation.

Intervention #4: Health Communication/Public Information

Subpopulations: All

Intervention Strategy: Use HIV speakers to provide education to schools, colleges and other interested organizations.

Implement public education and awareness campaign that provides high-risk populations with HIV prevention education, risk reduction supplies and referrals to HIV prevention services. This campaign will also provide information on the HIV/AIDS program website www.ndhealth.gov/hiv, which provides HIV prevention and care, including information on HIV testing in N.D.

CHAPTER 6

TECHNICAL ASSISTANCE

Technical assistance (TA) is the provision of training and skills development that assists groups or agencies in performing their jobs better.

Why Is TA Important to Community Planning?

CPGs and health departments across the country have access to TA in the areas of program planning, implementation and evaluation. CPGs are responsible for identifying their own TA needs and the needs of any community-based providers.

Technical Assistance

Implementing interventions in North Dakota has presented some unique challenges. North Dakota is primarily a rural state with low incidence of HIV. Also, the lack of community-based organizations and the lack of capacity to support these agencies is an ongoing challenge. Implementing interventions is further compounded by the severe stigma of HIV and the attitude that HIV does not happen in North Dakota.

Since 2002, the area of selection and implementation of evidence-based interventions has continued to be the primary area where TA is required. In 2009 the NDDoH and CPG received TA from the Inter Tribal Council of Arizona and CDC for selecting and implementing appropriate evidence-based interventions for North Dakota. During this session CPG concluded that the best allocation of our resources should be utilized to increase testing for those most at risk. The concepts of social marketing strategies were presented to the group. This type of campaign is something the CPG would be interested in pursuing.

The CPG also gained a better understanding for the importance of planning in order to implement successful programs and as such 2010 will be a year for planning rather than implementing. Further TA may be requested for support in planning and implementing a social marketing campaign that will focus on reaching those at highest risk to increase counseling and testing.

The second area TA will focus is on the implementation of rapid HIV testing. Issues that may require TA include training CTR staff, revising counseling from a two-session method of pre- and post-test counseling to a one-session method, and issues surrounding the possible increase in HIV-positive diagnoses. Also, TA may be

requested to learn how rapid testing can be utilized to increase testing in our highest risk populations. As this program is developed, TA will be requested as necessary.

Conclusion

The HIV Prevention Program is embarking in a strategic direction where TA is requested to build on areas that will directly impact the capacity of the CPG, CBO infrastructure and program staff. Program staff is now familiar with the CDC Capacity-Building Request Information System (CRIS) and will continue to use this resource as needed.

CHAPTER 7

MONITORING AND EVALUATION

Evaluation is the process of examining and appraising the worth or value.

How Is Evaluation Relevant to HIV Prevention?

Evaluation serves three primary purposes in HIV prevention:

1. To determine the extent to which HIV-prevention efforts have contributed to a reduction in HIV transmission.
2. To improve programs to meet that goal more efficiently.
3. To be accountable to stakeholders by informing them of progress made in HIV prevention nationwide.

Evaluation

PEMS provides a standardized, confidential data collection system to monitor activities funded as part of CDC's HIV Prevention Program and track the implementation of the Advancing HIV Prevention Initiative by CDC grantees.

PEMS contains the standardized data variable required by the program announcement. The standardized data variables will facilitate improvement in five key areas:

1. Data collection
2. Reporting
3. Analysis
4. Interpretation
5. Program delivery

The PEMS coordinator also participates in regularly scheduled conference calls. The purpose of the conference calls is to share information, to keep everyone informed of any system changes or updates and to field questions regarding PEMS.

Quality Assurance for Counseling, Testing and Referral (CTR) Sites

All of the policies and procedures for the CTR sites are reviewed and updated annually. These policies emphasize CDC's 2006 *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women*. CTR program forms are standardized to ensure the level of quality is consistent at all CTR sites and that the clients' needs are being addressed. These forms include the risk assessment and reduction plan and a guide to be used by the counselor to ensure all areas are addressed during the counseling session. The risk assessment and reduction plan was coordinated with the STD and hepatitis program manager so that one risk assessment could be created for HIV, STDs and hepatitis. This assessment form allows for greater coordination of services between these programs.

The HIV Prevention Program developed a quality assurance (QA) plan for the state-funded HIV CTR sites. A quality assurance guide specific to the CTRs was developed, along with standard forms that are used to document the site visits. The guide is given to all sites prior to a quality assurance site visit. The document was designed to provide guidance on quality assurance practices for sites conducting HIV counseling, testing and referral. All CTR sites receive a QA site visit every two years.

The following quality assurance practices/activities are addressed during the quality assurance site visits:

Accessibility and Appropriateness of Services

1. The facility should be easy to find and easily accessible.
2. Hours of operation should be posted, and extended/weekend hours should be available if possible.
3. Appropriate services and referrals for clients' needs should be offered and documented.
4. Clients should be counseled and tested in a room that ensures their privacy and confidentiality.
5. Culturally appropriate and age-specific educational materials should be available. Condoms, lubricants, safer sex kits and other relevant supplies should be available as appropriate.

Compliance with Policies and Procedures

1. Confidentiality policy
2. Record maintenance and retention policy

3. HIV testing schedule and procedures
4. Policy for OraSure HIV-1 oral specimen collection devices
5. Policy for Clearview HIV 1/2 assay and controls procedures
6. Clearview Complete reactive/nonreactive control log is being properly conducted and sent to the HIV program staff every six months.
7. Guidelines for provision of HIV counseling, testing and referral services
8. Protocols for HIV prevention counseling

Staff Performance/Proficiency

1. All staff conducting HIV counseling and testing must have the appropriate training.
2. All staff conducting HIV counseling and testing should be observed by a supervisor at least once a year to be sure they are providing adequate counseling and testing services. Appropriate, timely feedback should be given to the counselor.

Collection, Handling and Storage of Specimens

1. Universal precautions must be implemented when appropriate.
2. Specimens must be properly collected, labeled, stored and mailed.

Record Review

1. Records must be stored in a double lock secure filing system.
2. A minimum of two records are reviewed to ensure that all paperwork is properly filled out and maintained.

Partner Services (PS)

The HIV surveillance coordinator annually reviews and updates as necessary the Partner Services (PS) policies and procedures according to CDC guidelines. These policies are included in the CTR sites' policies and procedures. The PS forms are standardized to ensure that all clients and their partners receive follow-up and appropriate referrals.

Public Health Education and Awareness Programs

A survey is implemented at the counseling and testing sites to ascertain where the client heard about testing (i.e., hotline, website, billboard, etc.). Any materials that are considered for public information are also evaluated through a materials review committee that consists of CPG members and are also evaluated by the public information department within the health department. Any materials that have been produced for media campaigns also have undergone evaluation through independent focus groups to determine the best way to reach our target audiences. These funded agencies also are monitored fiscally and must submit monthly billing statements as part of their contract. These statements are reviewed by program staff prior to payment to ensure the request is consistent with contract activities.

Conclusion

As other programs are developed (i.e., rapid testing, outreach, prevention for positives), policies and procedures will be created and implemented to ensure the programs that are delivered are meeting their goals and objectives, are effective and are reaching the intended target audience.

Attachments

- Attachment A: Open Meeting Protocols and Bylaws**
- Attachment B: Meeting Ground Rules**
- Attachment C: Grievance Procedure**
- Attachment D: Conflict Management Policy**
- Attachment E: Conflict of Interest Disclosure Statement**

Attachment A

Section I: North Dakota CPG Open Meeting Protocol

Open Meetings

CPG meetings shall be open to the public unless indicated otherwise. Information relative to an individual's HIV status, sexual orientation or other confidential information will not be associated with a name.

At the discretion of the co-chairs, members of the general public may participate in open discussion, with the following exceptions:

- Making motion and/or voting
- Nominating and/or approval of candidates for elections
- Personnel matters concerning CPG or NDDoH staff, or other personnel matters where individuals, individual behavior or other sensitive information is discussed
- The co-chairs may limit the total time of discussion and/or length of time a person from the general public is allowed to speak at the allocated time slot in the agenda.

Public Conduct: Members of the general public attending a CPG meeting shall conduct themselves in a respectful manner.

- Respectful engagement and decorum must be maintained at all times.
- Personal attacks and/or inappropriate comments directed at members will not be tolerated.

The meeting notices will be posted at the meeting venue and filed with the North Dakota Secretary of State's office.

Operational Guidelines

1. Members of the public are allowed to ask questions specific to the agenda items at the allocated time slot in the agenda.
2. Three minutes are allowed to ask questions unless the co-chairs regulate the time limit at their discretion based on available time.
3. Any member of the public wishing to speak shall request the opportunity by raising his or her hand and waiting to be granted the opportunity by the co-chairs.

4. Any questions or issues outside the ongoing meeting agenda will be put on the next agenda. This is to ensure that the current meeting agenda is deliberated on within the specified time.

Section II: North Dakota CPG Bylaws

Article I: Name

The name of this group will be the ND HIV Prevention Community Planning Group.

Article II: Mission

The CPG is funded by Centers for Disease Control and Prevention (CDC). The overall mission of the CPG is to develop a comprehensive HIV prevention plan targeting North Dakota's defined high-risk populations with scientifically based prevention interventions that are responsive to the identified needs within these populations.

North Dakota CPG continually pursues collaborative efforts in education, cultural awareness and the elimination of the stigma of HIV/AIDS.

This mission will be accomplished in collaboration with the North Dakota Department of Health (NDDoH) by achieving the three major goals and eight objectives of HIV Prevention Community Planning found in the HIV Prevention Community Planning Guide (*Guidance*).

GOAL ONE: Community planning supports broad-based community participation in HIV Prevention Planning.

- Objective A: Implement an open recruitment process (outreach, nominations and selection) for CPG membership.
- Objective B: Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and nongovernmental agencies.
- Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.

GOAL TWO: Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

- Objective D: Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.
- Objective E: Ensure that prioritized target populations are based on an epidemiologic profile and a community service assessment.

- Objective F: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.

GOAL THREE: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

- Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the health department application for federal HIV prevention funding.
- Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

The NDDoH will complete the annual application for federal HIV prevention funds based on the CPG's comprehensive HIV prevention plan. The CPG will be asked to assess the responsiveness and effectiveness of this application for funding in accomplishing priority prevention needs as identified in the CPG's plan. Furthermore, the comprehensive HIV prevention plan also may be used to secure additional funding.

Article III: Membership

Section 1. Number of Members

The CPG shall consist of no less than 15 members and no more than 25. The number of members that can be supported by the budget may vary and it is advisable that the co-chairs be aware of the budget in terms of membership. A vacancy shall not prevent the CPG from conducting business.

Section 2. Recruitment Efforts

The CPG membership will reflect, as closely as possible, the demographics of current HIV/AIDS cases in North Dakota such as current/former substance abusers, members of gay, lesbian, bisexual, and transgender populations; people of color; youth/young adults; and those who are infected or affected by HIV/AIDS.

All CPG members are encouraged to recruit new members throughout the planning year based on needs identified by the membership committee with consideration given to parity, inclusion and representation. Prospective members/recruits will remain advisory members until they are accepted as voting members prior to the new planning.

Section 3. Application Process

Applications will be reviewed annually and also when there is a vacancy as provided for in Section 1 of Article III. Potential members must fill out an application form and

send it to the state appointed co-chair. New member applications will be reviewed by the membership committee for selection of members.

Section 4. Orientation

New members will receive an orientation packet and will go through new member orientation at the first meeting of each year. The co-chairs are responsible for helping new members learn about CPG and how the process works.

Section 5. Term of Membership

CPG members may serve on the CPG indefinitely.

Section 6. Voting Members

Voting members include anyone supported by the budget for membership purposes, co-chairs and anyone who has lodged an accepted formal application for membership and has signed the Conflict Management Policy Agreement.

Section 7. Advisory Members

Advisory members attend CPG meetings for professional input only. Advisory members may be contractors who attend CPG meetings on a regular basis. These members don't have to apply for CPG membership. Their interest to be a part of the group can be indicated informally through the co-chairs or the group can elect to solicit their participation. Advisory members may join the group at any time. This group provides professional capacity to the CPG and does not vote.

Section 8. Voting

The CPG is made up of voting members and advisory members. Advisory members may attend meetings, serve on subcommittees and take part in all CPG activities except voting/participating in consensus. Voting members may attend meetings, serve on subcommittees and take part in all CPG activities and may vote/participate in consensus. Both voting and advisory members are permitted and encouraged to express their opinions at any and all CPG gatherings and participate fully in reaching the goals of the CPG.

Article IV: Roles and Responsibilities

Section 1. Community Planning Group

The HIV Prevention Community Planning Guide requires that members of the CPG have the capacity to ensure participatory planning. Three criteria have been identified to ensure this capacity: parity, inclusiveness and representation (PIR). For more details about PIR please refer to the *HIV Prevention Community Planning Guide*.

The CPG is responsible for developing a comprehensive HIV prevention plan on a five-year planning cycle that corresponds with the federal grant cycle. The CPG will be

asked to assess the responsiveness and effectiveness of the application for federal funding written by the NDDoH as it relates to accomplishing the priority prevention needs identified in the CPG's plan. The CPG also will review the NDDoH proposed budget for concurrence with the plan but does not allocate resources.

The following roles and responsibilities for the CPG have been identified either in the HIV Prevention Community Planning Guide and/or by the CPG:

- Support the mission of the CPG and follow the ground rules for respectful actions, interactions and reactions during all CPG gatherings.
- Elect the community co-chair and co-chair Elect, who will work with the state appointed co-chair.
- Attend regularly scheduled CPG meetings and participate as an active member.
- Adopt a statewide perspective as a CPG member.
- Serve on a standing or ad hoc committee.
- Recruit new candidates for CPG membership as needed.
- Establish priority interventions for identified populations at risk on a statewide basis using key data (i.e., epidemiologic profile, community services assessment, etc.).
- Develop a statewide comprehensive plan for HIV primary and secondary prevention on a five-year planning cycle that corresponds with the federal grant cycle.
- Collaborate with the NDDoH in reviewing and finalizing key community planning activities.
- Review the NDDoH application to CDC for federal HIV prevention funds, including the proposed budget, and develop a written response (letter of concurrence) describing whether the NDDoH application does or does not, and to what degree, agree with the priorities set forth in the comprehensive HIV prevention plan.
- Assess the efficiency and effectiveness of the planning process.
- Support the roles and responsibilities of the CPG, as defined in Article III of the bylaws.

Section 2. Community Co-Chair

The community co-chair will serve for a period of one year and may serve no more than three consecutive years. Appointments will be from January 1 to December 31 of each year.

The specific responsibilities of the community co-chair are as follows:

- Support the mission of the CPG.

- Ensure that the planning process used by the CPG meets the specific requirements and intent expressed in CDC's HIV Prevention Community Planning Guide.
- Work together with the state appointed co-chair to ensure that meetings are conducted in accordance with the North Dakota Century Code and the CPG bylaws.
- Ensure that the planning process and priorities defined in the comprehensive HIV prevention plan represent the need for adequate prevention services statewide.
- Share responsibility with the state appointed co-chair for guiding the CPG in its work and for assuming the responsibilities addressed in Article III.
- Chair the membership committee.
- Represent the CPG group only when directed to do so by the CPG

Section 3. Community Co-Chair Elect

The CPG annually will select a community co-chair elect, whose primary responsibility will be to serve in the absence of the community co-chair. To be eligible to serve as co-chair elect, a minimum of one year of experience with the group is required. The community co-chair elect will serve a term of one year and may serve a maximum of three consecutive years.

Section 4. North Dakota Department of Health

The NDDoH will complete the annual application for federal HIV prevention funds based on the CPG's comprehensive HIV prevention plan and is responsible for supporting the HIV prevention community planning process (via funding, staff and/or contractor resources, and leadership). The specific responsibilities of the NDDoH are divided into three areas: leadership responsibilities, technical responsibilities and logistical responsibilities. In addition, the NDDoH will select an employee or designate a representative as the state appointed co-chair and will define the length of term.

Leadership responsibilities may include:

- Involving different units of the health department in supporting the planning process.
- Promoting community participation from diverse groups.
- Ensuring that the CPG fully understands its roles and responsibilities.
- Providing guidance and support to the CPG co-chairs and members.
- Provide regular updates to the CPG on successes and barriers encountered in implementing the HIV prevention services described in the comprehensive HIV prevention plan.
- Report progress and accomplishments to CDC.

Technical responsibilities may include:

- Furnishing epidemiologic data and information about defined populations or interventions.
- Compiling a profile of existing community resources.
- Assisting in conducting needs assessments and analyzing data.
- Providing information concerning effective strategies for HIV prevention.
- Allocating funds based on priorities set forth in the prevention plan.

Logistical responsibilities may include:

- Developing a comprehensive work plan with targeted completion dates.
- Managing the logistics of committee meetings.
- Disseminating materials to CPG.

Section 5. State Appointed Co-Chair

The specific responsibilities of the state appointed co-chair are as follows:

- Coordinate and facilitate the CPG process, including arranging meetings and preparing documents and reports as needed.
- Develop work plans for and provide guidance to the CPG.
- Arrange for technical assistance for the CPG as needed.
- Prepare and submit to the NDDoH HIV/AIDS Program manager the CPG's Comprehensive HIV Prevention Plan for submission to CDC with the grant application.
- Work with the HIV Prevention Program to provide expertise and technical assistance to the CPG, including on going training on HIV prevention planning and the interpretation of epidemiologic and evaluation data, to ensure that the planning process is comprehensive and scientifically valid.
- Work with the HIV Prevention Program to ensure program effectiveness through specific evaluation activities, including planning, conducting or contracting for outcome evaluation studies; providing technical assistance in evaluation; or ensuring the provision of evaluation technical assistance to funding recipients.
- Maintain regular communication with the CPG, the HIV Prevention Program and CDC.

Section 6. Shared Responsibilities

The specific responsibilities outlined in the HIV Prevention Community Planning Guide to be shared between the CPG and the NDDoH are divided into six areas: process management, membership selection, input mechanisms, planning funds, new member orientation, and evaluation of the community planning process.

Process Management: Develop procedures/policies that address membership, roles, and decision-making, specifically:

- Composition of the CPG; selection, appointment, and duration of terms to ensure that the CPG membership reflects, as much as possible, the

epidemic in the jurisdiction (i.e., age, race/ethnicity, gender, sexual orientation, geographic distribution and risk for HIV infection).

- Roles and responsibilities of the CPG, its members, and its various components (i.e., committees, work groups, regional groups, etc.).
- Process to prospectively identify potential conflicts(s) of interest and methods for resolution of conflicts(s) of interest for CPG members.
- Methods for reaching decisions; attendance at meetings; and resolution of disputes identified in planning deliberations.

Membership Selection: Develop and apply criteria for selecting CPG members.

- Special emphasis should be placed on procedures for identifying representatives of at-risk, affected, and socio-economically marginalized groups that are underserved by existing HIV prevention programs.

Input Mechanisms: Determine the most effective input mechanisms for the community planning process.

- The process must be structured to best incorporate and address needs and priorities identified at the community level.
- The process should include strategies for obtaining input from key populations (e.g., IDUs, MSM, youth, undocumented immigrants, etc.) that may not be CPG members.

Planning Funds: Provide input on the usage of planning funds.

- Support CPG meetings, public meetings and other means for obtaining community input.
- Facilitate involvement of all participants in the planning process, particularly those individuals with and at risk for HIV infection.
- Support capacity development for inclusion, representation and parity of community representatives and for other CPG members to participate effectively in the process.
- Provide technical assistance to health departments and CPG by outside expertise.
- Ensure representation of the CPG (governmental and nongovernmental) at necessary regional or national planning meetings.
- Support planning infrastructure for the HIV prevention community planning process
- Collect, analyze and disseminate relevant data.
- Monitor and evaluate the community planning process.

Provide a thorough orientation for all new members as soon as possible after appointment. New members should understand the:

- Goals and core objectives, roles, responsibilities, and principles outlined in the HIV Prevention Community Planning Guide.
- Procedures and ground rules used in all deliberations and decision-making.
- Specific policies and procedures for resolving disputes and avoiding conflicts of interest that is consistent with the principles of the HIV Prevention Community Planning Guide.

Evaluate the community planning process to ensure that it is meeting the core objectives of community planning.

Article V: Governance

Section 1. Meetings

Attendance

All CPG members are expected to attend each regularly scheduled meeting. Approximately five meetings will be held each planning year. More than one unexcused absence, without prior approval from the co-chairs, is grounds for immediate dismissal. Other than the first meeting of the year, dates for subsequent meetings will be decided on at the close of the current meeting. Additional CPG meetings or committee/task force meetings may be scheduled as necessary.

Agenda

A preliminary agenda will be determined by the group at the end of each meeting, and the final agenda will be sent to CPG members at least one week before the next meeting.

Ground Rules for Respectful Actions, Interactions and Reactions

The CPG ground rules will be read at the start of each CPG gathering and will be followed by all CPG members. The group can make additions or changes to the ground rules at any time. Changes to the ground rules have to accrue group consensus (Attachment A).

Executive sessions

CPG can elect to go into executive sessions where the public will not be allowed into the meeting. Notice of executive sessions will be posted on the door at the meeting venue.

Open Meetings

CPG meetings shall be open to the public unless indicated otherwise. Information relative to an individual's HIV status, sexual orientation or other confidential information will not be associated with a name. **At the discretion of the co-chairs,**

members of the general public may participate in open discussion, with the following exceptions:

- **Making motions and/or voting**
- **Nominating and/or approving candidates for elections**
- **Personnel matters concerning CPG or NDDoH staff, or other personnel matters where individuals, individual behavior or other sensitive information is discussed**
- **The co-chairs may limit the total time of discussion and/or length of time a person from the general public is allowed to speak.**

Public Conduct: Members of the general public attending a CPG meeting shall conduct themselves in a respectful manner.

- **Respectful engagement and decorum must be maintained at all times.**
- **Personal attacks and/or inappropriate comments directed at members will not be tolerated.**

Section 2. Quorum

A quorum of the CPG must be present at any regular or specially scheduled meeting in order for the CPG to engage in formal decision-making. A quorum is defined as one-third of the voting CPG members. Meetings can be held without a quorum present but any decisions made during those meetings will be advisory only.

Section 3. Decision-Making Process

All CPG processes will be guided by the CPG's ground rules. Decisions will be made by consensus if at all possible. If there is no consensus, decisions will be made by a two-thirds majority vote.

A two-thirds majority vote should be substituted for consensus only as follows:

Once a motion and a second are on the floor, there will be 10 minutes of discussion, which include a question-and-answer period, followed by a vote. If consensus is not reached, the group will break into small groups for 15 minutes of discussion, followed by five minutes of full group process discussion, followed by a vote. If consensus is still not reached, the small group process will be repeated, followed by a vote. If consensus is not reached, a two-thirds majority vote will be taken. Motions may be amended at any time as long as the person who originally made the motion agrees to the changes.

Section 4. Officers

The officers will serve for a year and will be eligible for reelection for up to three terms. Elections will be done through a simple majority vote. Officers will enjoy a \$100 honorarium per meeting as an incentive for the work that they will be doing.

Secretary

- Shall be responsible for taking minutes of all CPG proceedings and routing them to members. The minutes will serve as a reference for research purposes and in the development of the CPG's comprehensive HIV prevention plan; as such they will contain summaries of discussions, decisions and concepts.
- Shall pass out and retain attendance records, to indicate who was present and for use in determining who is eligible to vote.
- Shall maintain record of existing committees and their membership.

Timekeeper

- Shall be responsible for keeping time with regards to the agenda.
- Shall assist with facilitating meetings by helping regulate time.
- Shall consult with co-chairs before and after meetings.

Historian

- Shall be responsible for maintaining records, significant event details and a scrapbook in order to uphold institution memory.
- Shall periodically share/review their records with the members.

Section 5. Elections and Term

Co-Chairs

The NDDoH will select an employee or a designated representative as the state appointed co-chair and will define the length of the term. The CPG will select the community co-chair who will serve a term of one year and may serve a maximum of three consecutive years. The co-chairs share responsibility for guiding the CPG in accomplishing its mission and goals.

The CPG will annually select a community co-chair elect, whose primary responsibility will be to serve in the absence of the community co-chair. To be eligible to serve as co-chair elect, a minimum of one year of experience with the group is required. The community co-chair elect will serve a term of one year and may serve a maximum of three consecutive years.

Section 6. Conferences and Workshops

Members who have at least one year invested with the group are eligible to attend conferences or workshops on behalf of the CPG, provided they actively participate on the CPG for one year after attending the said conference or workshop and agree to give a full report to the group detailing the experience and what was learned. In addition, each CPG member attending conferences or workshops must also sign a code of conduct prior to leaving for the conference or workshop.

Section 7. Proxies

A CPG member may designate a proxy to attend a meeting in her/his absence. The CPG member is responsible for briefing the proxy on current issues under review, as

well as the roles, responsibilities and other norms the CPG may have adopted. The member must fax or send a brief letter or electronic mail message to the CPG co-chairs prior to the start of the meeting. This letter must specify the CPG member's name, the proxy's name, and meeting date(s) for which the member will be absent. If this letter is not received or does not have the required information, CPG member will be listed as absent without proxy representation. This also will apply to those members assigning a proxy for a partial full-group meeting absence.

CPG members will be allowed to designate a proxy only two times during the year. Any additional situations in which a proxy is designated will result in a loss of voting privileges, with the following exceptions:

- If additional proxies are needed as a result of a chronic illness of the member or member's family member/significant other, the member will be asked to submit a letter clarifying the situation to the CPG co-chairs. These materials will be kept confidential.
- If additional proxies are needed as a result of an emergency, the member may pursue the grievance process (Article VIII).

Section 8. Member Removal

An individual member of the CPG is eligible to be a member for an unlimited number of years. The CPG shall have the right to remove CPG members for good cause. A two-thirds majority is required for removal.

A vote to remove any member must be preceded by the full grievance procedure as outlined in Article VIII, and all CPG members must be notified at least one week prior that a removal vote will be taken. Members can submit complaints for member removal to the governance committee chairperson. The chairperson will bring the complaint to the governance committee for discussion and investigation. If complaint merits a vote, the committee chairperson will notify members for voting.

Section 9. Co-Chair Removal

Upon election the co-chair will be placed on a three-month probationary period where his/her performance will be evaluated by the governance committee. The governance committee shall make appropriate recommendations for continuation or removal. After the community co-chair is beyond the probationary period, the CPG shall have the right to remove a community co-chair for good cause. A two-thirds majority vote is required for removal.

The CPG cannot automatically remove a state appointed co-chair, but it may recommend removal to the NDDoH. A two-thirds majority vote is required for such a recommendation.

A vote to remove either co-chair must be preceded by the full grievance procedure as outlined in Article VIII and all CPG members must be notified at least one week prior that a removal vote will be taken.

Section 10. Conflict Between Co-Chairs

If a conflict should occur between the co-chairs, the remainder of the CPG members will decide the issue by a two-thirds majority vote.

Section 11. Annual Recognition

CPG members who have had an exemplary record and have made significant contribution to CPG can be recommended for recognition by members through the governance committee. A nomination form will be made available at the last meeting of the year. Recognition ceremony will take place at the first meeting of each year.

Article VI: Committees

Committee members will be appointed by a two-thirds majority vote. Each committee will address a specific mandate, task or project (see Sections 1-7 below); report progress back to the entire group; and bring issues as needed to the group for action. All committees shall have a chair person and a secretary. The committees have a responsibility to deliberate on their mandate and report back as appropriate. The secretaries of the committees and the chairperson will develop a timeline on how to accomplish their mandate and maintain appropriate records on business. Committee members can serve up to three years, and vacancies will be filled as needed. Upon completion of a three-year term new members will be reelected. Old members can reapply for reelection but preference will be given to new members.

Section 1. Executive Committee

- Shall consist of the CPG co-chairs, the CPG secretary and the HIV Program manager.
- Shall review recommendations from the governance committee.
- Shall handle administrative issues as needed.
- HIV Program manager will have the tie-breaker vote during voting.

Section 2. Governance Committee

- Shall have no fewer than three members.
- Shall review CPG's governance policy and make appropriate recommendations as needed.
- Shall evaluate co-chair performance periodically and give appropriate feedback to the members.
- Shall coordinate the selection of members for the annual recognition ceremony for members.
- Shall coordinate member-removal process.

Section 3. Grievance Committee

- Shall consist of no fewer than three members.
- Shall make recommendations and deliberations on member grievances.
- Shall review and uphold the grievance policy.
- Shall not include co-chairs as members.
- Shall coordinate member removal process.

Section 4. Membership Committee

- Shall consist of no fewer than three members.
- Shall review new member applications and select qualified individuals with regard to parity, inclusion and representation (PIR).

Section 5. Materials Review Committee

- Shall have membership as recommended by CDC guidance.
- Shall review all materials as indicated in the CDC guidance.
- Shall meet as needed and in accordance to approved protocol to approve materials from NDDoH and other contractors.

Section 6. MSM Website Committee

- Shall consist of no fewer than three members.
- Shall coordinate the implementation, maintenance and updating of the MSM website.
- Shall give updates to members about the website.

Section 7. Special Committees

- CPG will elect special committees to coordinate specific tasks or projects.
- These committees shall dissolve when the mandate is achieved.

Article VII: Conflict of Interest

Conflict of interest occurs when (1) an appointed voting member of the CPG has a direct or fiduciary interest (which include ownership, employment, contractual, creditor, or consultative relationship to, or board or staff membership) in an organization (including any interest that existed at any time during the 12 months preceding his/her appointment) with which the CPG had a direct, financial and /or recognized relationship and (2) when a member of the CPG knowingly takes action or makes a statement intended to influence the conduct of the CPG in such a way as to confer any financial benefit on the member, family member(s) or any organization in which he/she is an employee or has a significant interest.

All CPG members are encouraged to identify conflicts of interest or request a review of a potential conflict of interest of another member.

In the event of a conflict of interest and/or during the period of review of conflict of interest, the members involved may participate in the discussion of the matter in conflict/question but shall abstain from voting on the matter. All members will sign the Conflict Management Policy agreement form (Attachment C).

Article VIII: Grievance Policy

The CPG seeks to accomplish its mission in the most effective manner possible. To this end, the policy of the CPG is to resolve conflicts as they arise using an appropriate conflict management mechanism. All prospective members must sign the Conflict Management Policy (Attachment C) before they become CPG voting members.

Grievance Procedure

In December of each year, eligible voting members of the CPG will elect four members to serve a one-year term on the Grievance Committee.

The Grievance Committee shall meet as soon as is convenient after they have been elected to elect a Chair-person for the Grievance committee.

In the event that any CPG member has a grievance, he/she must file a written letter of grievance that must be delivered to the Grievance Committee chair-person, with copies to each of the CPG co-chairs, within 30 days of the date of the incident of grievance.

The Grievance Committee must meet and reach a decision within two weeks of the date that the letter of grievance was received by the chairperson. The Grievance Committee will review the fact of the situation and will decide by a simple majority vote whether the grievance has merit. If the Grievance Committee decides the grievance has merit, it will decide by a simple majority vote, if necessary, on the action that is to be taken to rectify the grievance.

In the event of a tie vote, the committee chairperson will cast the tie-breaking vote. The decision of the Grievance Committee is final unless a tie-breaking vote by the committee chairperson is required. In the event of an impasse or tie in the voting process, the committee chairperson reserves the right to reopen the discussion. If the second discussion fails to break the stalemate, the committee chairperson reserves the right to submit the tie-breaking vote. If such a vote is required, and the CPG member who filed the grievance is unsatisfied with the results, he/she may file a written letter of grievance within 10 days of the Grievance Committee's decision with the HIV Program manager.

The HIV Program manager will respond in writing to the CPG Grievance Committee and the CPG member who filed the grievance within 10 working days. In such a case, the decision of the HIV Program manager is final.

Upon request, a copy of the Conflict Management Policy Agreement and Grievance Procedure is available from the state-appointed co-chair.

Article IX: Amendments and Ratification

This charter goes into effect upon a simple majority vote of those present at the CPG meeting. Amendments have to be approved by a two-thirds majority decision. A special committee will then be formed to effect the proposed changes.

Article X: Dissolution

This CPG has been formed to assist the NDDoH in HIV prevention. The CPG will continue to function as long as a need for its mission exists. A two-thirds majority decision of the CPG membership will dissolve its charter.

Attachment B

NORTH DAKOTA HIV PREVENTION COMMUNITY PLANNING GROUP

Ground rules for Respectful Actions, Interactions, and Reactions

Ground rules will be read at the beginning of each meeting in accordance to Article V in the CPG by laws.

1. Respect: in the spoken word, in vocal intonation, and in body language.
2. A person will hold the floor for no more than three minutes. No filibustering.
3. Speak one at a time. No cross talk or whispering.
4. No smoking.
5. Attentive active listening. Can we hear with eloquence?
6. Protecting each other's integrity in this dialogue will be paramount.
7. Opening to self-examination and trust building will begin with me.
8. Meetings will begin and adjourn on time.
9. Speak briefly and to the point for questions being considered.
10. Refrain from repeating a point that has already been made.
11. Let all speakers finish their thoughts without interruption.
12. Points of clarification may be made at any time.
13. Speakers must be recognized by the person conducting the meeting.
14. If more than one person wishes to speak, a sequence will be established by the person conducting the meeting.

Voting members take precedent over the general public in speaking.

Attachment C

NORTH DAKOTA HIV PREVENTION COMMUNITY PLANNING GROUP GRIEVANCE PROCEDURE

In December of each year, eligible voting members of the North Dakota HIV Prevention Community Planning Group (CPG) will elect three members to serve one-year terms on the Grievance Committee.

The Grievance Committee shall meet as soon as is convenient after they have been elected to elect a chairperson and a secretary for the Grievance Committee.

In the event that any CPG member has a grievance, he/she must file a written letter of grievance that must be delivered to the Grievance Committee chairperson, with copies to each of the CPG co-chairs, within 30 days of the date of the incident of grievance.

The Grievance Committee must meet and reach a decision within two weeks of the date that the letter of grievance was received by the chairperson. The Grievance Committee will review the facts of the situation and will decide by a simple majority vote whether the grievance has merit. If the Grievance Committee decides the grievance has merit, it will decide by a simple majority vote, if necessary, on the action that is to be taken to rectify the grievance.

In the event of a tie vote, the chairperson will cast the tie-breaking vote.

The decision of the Grievance Committee is final unless a tie-breaking vote by the committee chairperson is required. In the event of an impasse or tie in the voting process, the committee chairperson reserves the right to reopen the discussion. If the second discussion fails to break the stalemate, the committee chairperson reserves the right to submit the tie-breaking vote. If such a vote is required, and the CPG member who filed the grievance is unsatisfied with the results, he/she may file a written letter of grievance within 10 days of the Grievance Committee's decision with the HIV/AIDS Program manager at the North Dakota Department of Health.

The HIV/AIDS Program manager will respond in writing to the CPG Grievance Committee and the CPG member who filed the grievance within 10 working days. In such a case, the decision of the HIV/AIDS Program manager is final.

Upon request, a copy of the Conflict Management Policy Agreement is available from the co-chairs.

Attachment D

NORTH DAKOTA HIV PREVENTION COMMUNITY PLANNING GROUP CONFLICT MANAGEMENT POLICY AGREEMENT

Despite good intentions, disagreement and conflict are possibilities in any group or coalition that enjoys a membership of diverse backgrounds and interests. It is imperative to have a system in place that can allow for dispute resolution without negative consequences to any party involved. All grievances must be submitted in writing and in accordance with Article VIII in the North Dakota HIV Prevention Community Planning Group (CPG) bylaws.

The principles that guide the dispute resolution process within the North Dakota CPG are as follows:

1. Maintain a climate of fairness and mutual respect.
2. Distinguish between the person and the problem at hand.
3. Identify and build upon areas of mutual agreement.
4. Distinguish between interests and positions. (This essentially translates to determining the motivating factor behind a party's given interests, which then come to bear on a situation as a particular position.)
5. Develop options for mutual gain.
6. Use objective criteria such as fairness, effectiveness and factual information for discussion and decision-making.
7. Establish a common goal that includes the concerns of all parties involved.
8. Either party involved in a dispute can pursue grievance procedures or withdraw from the process at any time.

In some instances, special meetings may be called to resolve disputes.

If these steps are followed, the Grievance Committee must decide on an outcome that has met at least some of the interests of all participants. This decision will then be recorded in the meeting minutes submitted by the Grievance Committee to the co-chairs. As outlined in Article VIII of the CPG bylaws, any party involved in a dispute brought before the Grievance Committee can appeal the committee's decision to the HIV/AIDS Program manager. The decision rendered from this appeal is final.

I understand the above and agree to comply with the provisions set forth.

Member's Signature

Date

Attachment E

NORTH DAKOTA HIV PREVENTION COMMUNITY PLANNING GROUP CONFLICT OF INTEREST DISCLOSURE STATEMENT

Definition

Due to the intricate pattern of agency connections, contractual and subcontractual relationships between local public health units and community-based organizations, and the inevitability of conflict of interest, the participating members of the North Dakota Department of Health suggest that the North Dakota HIV Prevention Community Planning Group (CPG) adopt the following policy to make the community planning/ advisory process as nonpartisan as possible. This policy also addresses the potential for conflict of interest in awarding of contracts and the distribution of prevention funds through the HIV Prevention community planning process.

Policy Description

Members of the CPG shall complete the attached form listing their agency affiliations. These affiliations may include, but are not limited to, family members on the staff of a health department or agency, participation on an agency's board of directors, officers of a health department or agency, employees of a health department or agency, volunteer relationships with an agency, contractual relationships with an agency and subcontractual relationships with an agency.

The membership of the CPG shall make such affiliations known prior to any group discussions concerning specific agencies or like services delivered by their affiliated agency. Membership shall not be excluded from participating in group discussions concerning services delivered by agencies they are affiliated with.

CPG Group participants shall refrain from voting on agency-specific business in which the participant has any affiliation with the agency being considered in the voting process.

Enforcement Policy

Members found to be in violation of this conflict of interest policy shall be asked to refrain from such violations. If the member consistently fails to comply with such requests, and has at least three verbal reprimands from any of the co-chairs, the member shall have his or her participation rights revoked for one year (12 months). If a voting member is found to be in violation and has his or her participation revoked, the position shall be left open for the remainder of the calendar year.

Agencies found to be in violation of this conflict of interest policy also may be asked to refrain from participation and shall not be considered for funding by the North Dakota Department of Health for a period of one year (12 months).

Additional Provisions

In the event of an impasse or tie in the voting process, the state-appointed co-chair reserves the right to reopen the discussion. If the second discussion fails to break the stalemate, the state-appointed co-chair reserves the right to submit the tie-breaking vote.

**NORTH DAKOTA HIV PREVENTION COMMUNITY PLANNING GROUP
CONFLICT OF INTEREST DISCLOSURE FORM**

The North Dakota HIV Prevention Community Planning Group (CPG) has members who are professionally or personally affiliated with organizations that have, or might in the future request or receive, funds for HIV/AIDS prevention or patient care activities or services. Because of this potential conflict of interest, this form has been adopted by the CPG and approved by the North Dakota Department of Health and must be completed by all members in accordance with the by-laws of the CPG.

By my signature below, I certify that:

1. I have read, understand and support **Article VII** of the CPG’s bylaws and have received, read, understand and support the Conflict of Interest Policy Disclosure Statement.
2. Listed below is/are organization(s) with which I am presently affiliated. If in the future my affiliation(s) change(s), I will notify the chairperson of the Governance Committee.

Organization:	
Title:	Period of Affiliation:

Organization:	
Title:	Period of Affiliation:

Organization:	
Title:	Period of Affiliation:

Organization:	
Title:	Period of Affiliation:

(Please attach additional pages if necessary.)

3. The following is true to the best of my knowledge and ability:
 Neither I nor my immediate family have received or intend to receive any gratuities, favors or anything of material value by a representative of a community-based organization which might alter my ability to work objectively in the community planning process.

 CPG Member’s Signature

 Date