aapf
Atlanta AIDS Partnership Fund

Comprehensive Plan Environmental Scan for Greater Atlanta

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TABLE OF CONTENTS

INTRODUCTION AND BACKGROUND

Formed in 1991, the Atlanta AIDS Partnership Fund (AIDS Fund) is a collaborative funding partnership between The Community Foundation for Greater Atlanta, the United Way of Metropolitan Atlanta, the National AIDS Fund, the Elton John AIDS Foundation, the Red Ribbon Foundation, the Design Industries Foundation Fighting AIDS, Fashion Cares 2007 and Style Atlanta. Its mission is to support the metropolitan Atlanta community's HIV/AIDS advocacy, prevention education and support services through funding and leadership. The AIDS Fund accepts applications from nonprofit organizations in a 23-county area (See AIDS Fund Service Area, Diagram 1).

AIDS Fund Service Area

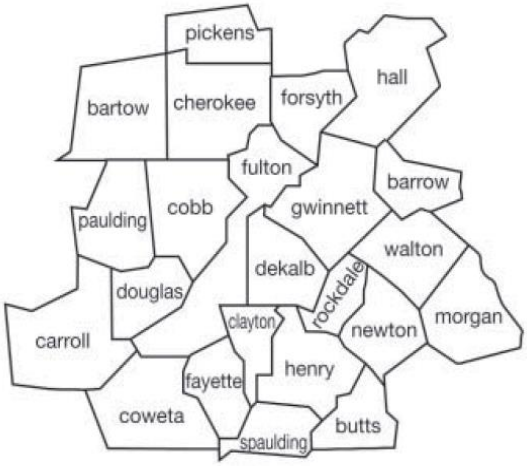

Diagram 1

The AIDS Fund adds value to its work through its "Community Partnership" model. Through community partnerships the AIDS Fund works to foster greater collaboration between AIDS Serving Organizations and to strengthen the community's ability to proactively and comprehensively address critical and timely issues facing both HIV-positive individuals and the overall HIV/AIDS prevention and care community.

The AIDS Fund's collaborative partners established a Leadership Team to increase the region's awareness and involvement by bringing focused, strategic attention and leadership to address the HIV/AIDS crisis in metro Atlanta. Dr. David Satcher, President of the Center for Primary Care, Morehouse School of Medicine and former US Surgeon General, and Sandy Thurman, Visiting Professor, Global Health, Rollins School of Public Health at Emory University and former Director of National AIDS Policy under the Clinton administration, are co-chairs of the Leadership Team (See Leadership Team Membership, Chart 1).

Leadership Team

- David Satcher, Co-Chair (Morehouse School of Medicine)
- Sandy Thurman, Co-Chair (Rollins School of Public Health - Emory University)
- Chris Allers (United Way)
- Stuart Brown (Georgia Division of Public Health
- Jim Curran (Rollins School of Public Health)
- Kevin Fenton (CDC - NCHHSTP)
- Kandy Ferree (National AIDS Foundation)
- Helene Gayle (CARE)
- Honorable John Lewis (5th Congressional District, Georgia)
- Milton Little (United Way)
- Alicia Philips (Community Foundation)
- Rev. Raphael Warnock (Ebenezer Baptist Church)

Chart 1

Recent stakeholder input from national and local funders, grantees and other community leaders has provided strong perspective and rationale for this strategy to address the region's HIV/AIDS crisis:

- There is an urgent, unmet demand to galvanize the community around the severity of the epidemic and the

need for a serious, comprehensive community response to AIDS in metro Atlanta
- National AIDS funders experienced above average fundraising success in the past year and are optimistic about additional resources on local and national levels for partners as well as a willingness to support the AIDS Fund operating costs and strategic leadership activities through leadership grants
- Local and national partners repeatedly affirmed the AIDS Fund's unique positioning as a past and future provider of community-wide and national leadership
- Although the AIDS Fund has always done more than grantmaking, its board development, strategic leadership and fund development capacities have never been adequately resourced

A. DEMOGRAPHIC DATA

As new data become available, this section will be updated.

In 2005, 50% (4,758,325 persons)of Georgia's population (9,072,576);52% of the State's African American population; 66% of the Hispanic population; and, 39% of the poor, reside in the AIDS Fund Service Area. Of the AIDS Fund Service Area's population, 65% resided in the four most urbanized counties: Fulton (915,623/20%), DeKalb (677,959/15%), Cobb (663,818/15%) and Gwinnett (726,273/16%). The largest concentrations of minorities within the AIDS Fund Service Area reside in the counties of Fulton (55%), DeKalb (70%) and Cobb (37%).

B. HIV/AIDS EPIDEMIOLOGICAL DATA

As new data become available, this section will be updated.

Atlanta ranks 9th in the nation for HIV/AIDS. Of reported AIDS cases in Georgia, 69% are within the AIDS Fund Service Area, primarily in Fulton and DeKalb Counties. From January 1, 2003 through December 31, 2004, there were 12,791 current AIDS cases (prevalence) and 2,141 new AIDS cases (incidence). For 2004-05, there were 26,400 people living with HIV/AIDS (prevalence) with 11,654 (43%) diagnosed AIDS cases and 14,746 HIV cases.

Georgia ranks 8th among all states in the rate of AIDS cases among African Americans, and the rate among Hispanics is similarly high given the lower census rate in Georgia. In the AIDS Fund Service Area, AIDS is the leading cause of death among African American men and women ages 20 to 44, and HIV infections among younger African American Men who have Sex with Men (MSM) has reached epidemic proportions.

From 1981 to the end of 2004, the cumulative estimated number of diagnoses of AIDS in the United States was 944,305, and the estimated number of new diagnoses of AIDS

in the United States was 42,514.[1] The epidemic has affected every region of the country, but none more severely than the Southeastern region and in the Deep Southern States in particular. [2] From 2000 to 2003, the Deep South (Alabama, Georgia, Louisiana, Mississippi, North Carolina, and South Carolina) documented a 35.6% increase in new AIDS cases, compared to only 4% in other Southern states and 5.2% nationally.[2] Within the Deep South, Georgia has borne the heaviest burden from AIDS. Among the 50 States, Puerto Rico, and the District of Columbia (DC), Georgia ranked 8th in cumulative AIDS cases (28,026), 7th in the number of new AIDS cases (1,635), 8th in the number of persons living with AIDS (PLWA) (14,190), and 8th in AIDS rate per 100,000 population (22.9).[3] Among all cities in the country, since 1991 Atlanta's Eligible Metropolitan Area (Atlanta EMA) [Ryan White Part A designation] has ranked 9th and has consistently ranked from 7th to 12th in the number of PLWAs.[4] Within the EMA, the Atlanta Metropolitan Statistical Area documented 19,457 cumulative AIDS cases (1981 – 2004; ranked 8th among cities of 500,000 population or higher), which is 69% of Georgia's cumulative AIDS cases, and a case rate of 26.6 (ranked 9th), which is higher than rates reported by 46 States.[4]

1. HIV/AIDS Cases by Demographic Characteristics and Exposure Category

The impact of HIV/AIDS on racial/ethnic groups, women and men, diverse HIV risk exposure groups, and different age groups is discussed in the following sections. The proportion of cases within each demographic group was examined noting the number of new AIDS cases (AIDS incidence) and the number of people living with HIV/AIDS (AIDS and HIV prevalence combined).

2. Racial/Ethnic Patterns in HIV/AIDS Epidemiology

Nationally, AIDS affects People of Color disproportionately in many areas with respect to Census population data. Within the AIDS Fund Service Area, less than 32% of the population is comprised of People of Color, but accounted for almost 74% of all current HIV/AIDS cases and over 82% of all new AIDS cases.[4] As with national trends, AIDS in Georgia is one of the top five causes of death among African Americans in 2002 and although comprising only 30% of all Georgia's residents, African Americans account for 76% of all current HIV/AIDS cases.[4] (See Table 2 for 2005 AIDS Incidence)

Current epidemiological data indicate that non-Hispanic African Americans are disproportionately affected by HIV/AIDS in the AIDS Fund Servivce Area. The total number of new AIDS cases was 1,599 of whom 76% were non-Hispanic African Americans, 17% were non-Hispanic Whites, and 5%

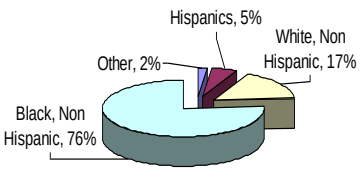

Table 2

[1] CDC MMWR 2005
[2] Reif, et al., American Journal of Public Health, June 2006
[3] Kaiser Family Foundation, State Health Facts,
[4] Georgia DHR, AIDS in Georgia Fact Sheet, January 2006

were Hispanics. Among the 26,400 people currently living with HIV/AIDS, 69% were non-Hispanic African Americans, 26% were non-Hispanic Whites, and 4% were Hispanics. Compared to last year's Epidemiological Report, the total number of people living with HIV/AIDS among Hispanics rose by almost 20% (from 884 to 1,056). HIV testing data recorded a 2.2% seropositive rate among African Americans in 2005 in Georgia, and a 2.9% rate within the AIDS Fund Service Area counties. Both rates are higher than the overall Statewide and AIDS Fund Service Area-wide rates of 1.7% and 2.3%, respectively.[4]

3. Gender Patterns in HIV/AIDS Epidemiology

Although national, state, and EMA epidemiologic data suggest that HIV/AIDS prevalence and AIDS incidence has increased over the years among women, some of this change may be due to a proportionate decrease in the number of male cases. Data indicate that HIV/AIDS continues to affect more men than women, with men comprising 77% of AIDS cases in 2004, 80% of living AIDS and current HIV cases. Approximately 60% of all women with AIDS in Georgia reside within the AIDS Fund Service Area. African Americans represent about 80% of all AIDS cases among women in Georgia.[4] 2005 HIV Counseling and Testing data indicate a seroprevalence rate less than 1% among women in Georgia.[5]

When Race and Gender are examined together, the disproportionate impact of HIV/AIDS on Georgia's Non-Hispanic African American community is further highlighted. Compared to African Americans living in the other 49 States, Puerto Rico, and DC, males in Georgia ranked 7th highest in cumulative AIDS cases (13,744), 5th highest in current AIDS cases (7,194), and 3rd highest (after New York and Florida) in 2004 AIDS cases (882), and females ranked 6th highest in cumulative AIDS cases (4,434), current AIDS cases (2,752), and AIDS cases (370).[1]

4. Age Group Patterns in HIV/AIDS Epidemiology

The age group most affected by HIV/AIDS was 20 to 44 years: 71% of all AIDS incidence, and 54% of all HIV/AIDS prevalence cases were in this bracket. The next highest group was individuals aged 45 years or more (27% AIDS incidence; 45% HIV/AIDS prevalence). Youth 13 and younger, and those aged 13 to 19 represented the lowest numbers, both groups accounting for about 1% of new cases and less than 1% of all current living cases.

5. Exposure Category Patterns in HIV/AIDS Epidemiology

Four categories of HIV exposure risk were examined: men who have sex with men (MSM), injecting drug users (IDU), MSM and IDU (MSM/IDU), and Heterosexual non-IDU (Heterosexual). The number of cases among the other exposure risk categories (e.g., Hemophilia/coagulation disorder; risk not reported; adult other) was small and inferences of impact from these data would not be reliable. Looking at the current data,

[5] Georgia DHR, HIV Counseling and Testing Service, 2005 data

MSM/Non-IDU accounted for the highest AIDS incidence (35%) and HIV/AIDS prevalence (45%), followed by Heterosexuals (28% and 11% respectively), IDU (6% and 13% respectively), and MSM/IDU (3% and 5% respectively).

6. Sexually Transmitted Disease (STD) and Hepatitis Infection Rates

Among the STDs, gonorrhea, syphilis, and chlamydia are the most critical to examine. Nationally gonorrhea case rates have decreased, syphilis case rates may have stabilized, and chlamydia case rates continue to rise slightly annually; however, among Southeastern States all three STDs are annually increasing and continue to be some of the highest levels in the country.[6] Chlamydia and gonorrhea are underreported generally, and overrepresented specifically among women and African Americans. One in every four women aged 15 to 44 who had lifetime multiple sex partners reported an STD, with a 7% Chlamydia positive testing rate, 80% of whom are asymptomatic.[21]

In terms of case rates and total number of cases, in 2004 Georgia was the 3rd highest for primary and secondary syphilis, 5th highest for gonorrhea, and 8th highest for Chlamydia in the nation. Residents of the AIDS Fund Service Area accounted for 47% of the gonorrhea cases, 49% of the Chlamydia cases, and 94% of the syphilis cases in Georgia.[21, 7] The City of Atlanta ranks 2nd (after San Francisco) in syphilis case rate, 18th in gonorrhea case rate, and 20th in Chlamydia case rate among major metropolitan areas across the nation. Half of Georgia's counties with the highest STD rates lie in the AIDS Fund Service Area; Fulton County ranked 5th highest and DeKalb County ranked 16th highest in the nation in primary and secondary syphilis case rate,[21] although census data rank them 55th and 76th in population among all counties in the nation.[5] Notably the four counties with the higher rates of syphilis than Fulton county include four of the 20 largest population centers in the nation (Los Angeles, Cook, New York, and San Francisco counties).

African American residents in the AIDS Fund Service Area account for over half of all gonorrhea and Chlamydia cases and over one-third of syphilis cases. Women in the AIDS Fund Service Area are more affected by Chlamydia (81%), men are more affected by syphilis (95%), and women and men are equally affected by gonorrhea. Rates in the City of Atlanta and in Fulton and DeKalb Counties are vastly higher than national or Georgia statewide rates. (See Table 3, 2004 STD Rates/100,000)

2004 STD Rates/100,000					
	City of Atlanta[6]	Fulton County[6]	DeKalb County[6]	GA[6]	US[7]
Chlamydia	658.4	682.80	554.81	394.7	319.6
Gonorrhea	337.9	353.86	278.51	181.7	113.5
Primary/Secondary Syphilis	34.6	24.18	7.99	6.3	2.7

Table 3

[6] Georgia DHR, Sexually Transmitted Diseases in Georgia Fact Sheet, January 2006
[7] CDC STD Surveillance, 2004

C. ON-GOING OR PREVIOUS PLANNING ACTIVITIES

Since 2003, the AIDS Fund has embarked on a couple of community planning activities. The AIDS Fund convened meetings of AIDS Service Organizations (ASOs) leadership and community stakeholders to formulate community-wide plans to combat the HIV/AIDS crisis in Greater Atlanta. These activities culminated with the David Gibbs Report (Gibbs Report) issued on April 21, 2006.

The Gibbs Report provided several recommendations. The key recommendation was to conduct a community HIV/AIDS strategic planning process to develop a comprehensive, Metro Atlanta plan for reducing new cases and the ill-effects of HIV/AIDS, including the cultivation of relationships with public, private, and nonprofit leaders and resource providers and the identification of community-based leaders as new AIDS Fund board prospects.

Several other current and on-going planning activities are occurring or have occurred within the AIDS Fund Service Area. A description of each plan follows in Table 4.

Plan Name	Priorities or Goals	Service Area	Focus / Success / Challenges
AIDS Fund	1. Client Services 2. Prevention Interventions 3. Advocacy	Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Morgan, Newton, Paulding, Pickens, Rockdale, Spalding, Walton	Focus • Service delivery Success Factors • Impact on community Challenges • No uniform definition used for impact on community
State of Georgia Comprehensive HIV Services Plan 2006 - 2009	Goal 1: Improve access to HIV-related core services Goal 2: Improve the quality of health care and health outcomes Goal 3: Eliminate health disparities and barriers to care Goal 4: Enhance collaboration and communication with partners statewide	State of Georgia	Focus • Provides the goals, objectives, and strategies that will be used to guide the further development and monitoring of the state's HIV/AIDS health care delivery system Success Factors • Measurements and indicators are aligned to each goal and objective Challenges • No evidence that

			service providers or community members are aware of and align with this plan
Comprehensive HIV Prevention Plan	• To assess the existing community resources to determine the community's capacity to respond to the epidemic. These resources should include fiscal, personnel, and program resources, as well as support from public (federal, state, county, municipal), private and volunteer sources • To identify populations whose activities put them at risk • To define high-risk populations based on the current epidemiological profile and the HIV trends in communities • To identify unmet HIV prevention needs within the defined populations • To prioritize HIV prevention strategies and interventions for the defined populations • To adopt the principle of participatory planning, which identifies needs and makes decisions based upon the principles of parity, inclusion, and representation (PIR) • To assist in the development of a comprehensive HIV prevention plan consistent with high priority HIV prevention needs	State of Georgia	Focus • Plan used as the foundation for resource and program allocation decisions regarding HIV prevention in Georgia Success Factors • None identified Challenges • No stated goal of reducing the HIV infection rate
Ryan White, Part A	1. Primary Care 2. Drug Reimbursement 3. Oral Health 4. Case Management 5. Mental Health Counseling 6. Substance Abuse Counseling 7. Support Services a. Food b. Emergency Assistance c. Psycho-Social Support d. Transportation e. Linguistic Services f. Health Education/Risk Reduction g. Legal Services h. Childcare i. Buddy	AIDS Fund Service Area except Butts, Hall and Morgan	Focus • Service delivery Success Factors • Number of services provided • Number of unduplicated clients • Quality of services Challenges • Focuses only on Part A services, priorities and activities • Limited prevention activities

	8. Quality Management 9. Housing 10. Early Intervention Services 11. Home Health 12. Hospice		
Ryan White, Part B	1. AIDS Drug Assistance Program 2. Health Insurance Continuation Program 3. Laboratory Services 4. Primary Care and Support Services 5. Minority AIDS Initiative (Peer Advocate Programs)	AIDS Fund Service Area except Dekalb and Fulton	Focus • Service delivery Success Factors • Number of services provided • Number of unduplicated clients • Quality of services Challenges • Each of the 16 Consortia need to align their priorities to these priorities • Limited prevention activities
Ryan White, Part D	Provide links between medical and support services by providing funding for: 1. Family-centered primary and specialty medical care 2. Support services 3. Logistical support and coordination Special focus - identify HIV-positive pregnant women and connect them with care that can improve their health and prevent perinatal transmission	AIDS Fund Service Area except Butts, Hall and Morgan	Focus • HIV positive women and children Success Factors • Number of services provided • Number of unduplicated clients • Quality of services Challenges • Limited targeted population
City of Atlanta Housing Opportunities for Persons with AIDS	1. Increase of affordable housing units/beds for dually diagnosed people living with HIV/AIDS 2. Building capacity of the existing HIV/AIDS housing systems 3. Shifting funds into housing and out of support services not directly related to housing	In addition to the AIDS Fund Service Area: Dawson, Harelson, Heard, Jasper, Lamar, Meriweather, and Pike AIDS Fund Service Area except Hall and Morgan	Focus • Service delivery Success Factors • Number of services provided • Number of unduplicated clients • Quality of services Challenges • Focuses mainly on housing and support services • Limited prevention activities
State of	Primarily provides housing	Hall and Morgan	Focus

Georgia Housing Opportunities for Persons with AIDS	assistance (emergency, shelter, transitional and/or permanent)		• Service delivery Success Factors • Number of services provided • Number of unduplicated clients • Quality of services Challenges • Focuses mainly on housing and support services • Limited prevention activities
Georgia Division of Mental Health, Developmental Disabilities and Additive Diseases	• Provide treatment and support services to people with mental illnesses and addictive diseases • Support to people with mental retardation and related developmental disabilities	State of Georgia	Focus • Service delivery Success Factors • Number of services provided • Number of unduplicated clients • Quality of services Challenges • No specific HIV/AIDS initiatives • Significantly overburdened system of care

Table 4

Conclusion

None of the plans reviewed provide a comprehensive, strategic direction that encourages, develops and implements solutions to the HIV/AIDS epidemic across the Greater Atlanta Area. Each plan is either focused on its individual funding or services provided or focused only on HIV prevention and not HIV service delivery. There is a community planning gap that the AIDS Fund comprehensive planning process can fill.

D. COMPARISON OF PLANNING ACTIVITIES IN TWO SELECTED CITIES

Washington, DC and Chicago were chosen to compare Atlanta's planning activities with those cities' efforts. These cities were identified because of the similarity of their overall populations and the impact of HIV/AIDS.

1. Washington, DC

Although Washington DC has the highest per capita rate of HIV/AIDS in the United States, the community response to the epidemic is not formally organized by a comprehensive regional coalition. However, this has begun to change due to several recent developments.

In 2005, the Washington AIDS Partnership (www.washingtonaidspartnership.org) – D.C.'s largest private funder of HIV/AIDS prevention and care services – commissioned a study which lead to the report titled, *HIV/AIDS in the Nation's Capital: Improving the District of Columbia's Response to a Public Health Crisis*, by the DC Appleseed Center and Hogan & Hartson L.L.P., August 10, 2005.

This report called for sweeping reforms in the District government's response to the city's HIV/AIDS epidemic and making specific recommendations for improvement. The report has been embraced by the District government and a broad cross-section of stakeholders as a "blueprint for change." Since the report release, several key recommendations have been implemented, including: an overhaul of the District's system for collecting and analyzing HIV and AIDS epidemiologic data; a citywide HIV testing campaign designed to make HIV testing a routine part of all medical care; and a citywide condom distribution program. DC Appleseed (www.dcappleseed.org) – a local not-for-profit community advocacy group - is now working to ensure that additional needed changes are made by playing an ongoing monitoring role, as well as conducting further research and advocacy in several areas, including: HIV prevention among drug users; HIV prevention education in DCPS; condom distribution; HIV/AIDS surveillance; and mental health services related to HIV/AIDS.

In part due to response to this report and also to meet CDC requirements for community planning to for Title I and II, the District of Columbia's Department of Health HIV/AIDS ADMINISTRATION (www.dchealth.dc.gov) and the office of the Mayor have formed the *HIV Prevention Community Planning Group (HPCPG), the Ryan White CARE Act Title I Health Services Planning Council, and the Mayor's Task Force on HIV/AIDS.*

The HPCPG is the group that guides HIV prevention in the District of Columbia, along with the DC Department of Health's HIV/AIDS Administration (HAA). Members of the HPCPG include residents of the District who are interested in HIV prevention, researchers and academics, healthcare providers, and staff from community-based organizations. CPG members reflect the diversity of the HIV/AIDS epidemic in the District. The HPCPG is responsible for determining which populations are in greatest need of HIV prevention services, as well as deciding what are the best ways to meet those needs. HAA, in turn, is responsible for implementing and funding programs and services that match the HPCPG's recommendations.

In December 2005, the City's Administration on HIV Policy and Program department (AHPP) convened "A Community Conversation on HIV Planning." Bringing together community partners from the Washington Eligible Metropolitan Area (EMA), AHPP took

the first step in constructing a roadmap to prioritize the needs of District residents and to strategize about the allocation of scarce resources. More than 150 members of the HIV Prevention Community Planning Group (HPCPG) and the Ryan White CARE Act Title I Health Services Planning Council (PC), including community activists, health care providers, people living with HIV and AIDS, epidemiologists, behavioral and social scientists, and government officials, participated in the "Community Conversation."

The groups looked at the following topics:

- Washington EMA-wide Jurisdictional Issues
- Care &Treatment
- Prevention
- Sub-Populations
- Data Needs

Report of work group results and recommendations:
http://www.dchealth.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/hiv_aids/pdf/community_planning_report.pdf

MAYOR'S 2007 HIV/AIDS SUMMIT: On April 4, 2007, the Mayor's Task Force on HIV/AIDS - more than 120 leaders from government, provider, faith-based, and community organizations - spent more than five hours communicating and generating ideas about how this community, and particularly the HIV/AIDS Administration (HAA), can improve the response to this epidemic.
http://doh.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/hiv_aids/pdf/mayors_hiv-aids_summit_report.pdf

D.C.'s historical lack of an organized community wide coalition has led to community service providers organizing much of the community-wide HIV/AIDS awareness events, such as the Washington AIDS Walk, the National AIDS Awareness Marathon Training Event, and Capital Pride Week. The main organization in this outreach is the Whitman-Walker Clinic (www.wwc.org). Whitman-Walker Clinic is the largest provider of HIV/AIDS services in the D.C. metropolitan area. Established in 1973, the Clinic is a nonprofit, volunteer-based health organization dedicated to providing high-quality, comprehensive, integrated and accessible health care services to people living with and affected by HIV/AIDS.

2. Chicago

In sharp contrast to the state of the HIV/AIDS community coalition in the District of Columbia, the AIDS Foundation of Chicago (www.aidschicago.org) has actively worked to make themselves a "local and national leader in the fight against HIV/AIDS. Collaborating with community organizations to develop and improve HIV/AIDS services; fund and coordinate prevention, care, and advocacy projects; and champion effective, compassionate HIV/AIDS policy." The AIDS Foundation of Chicago has positioned themselves as a leader and key-collaborator in all areas of the HIV/AIDS Community: *Prevention, Care, Advocacy, Funding, and Community Awareness.*

The AIDS Foundation of Chicago (AFC) is in the final year of their current Strategic Plan (http://www.aidschicago.org/about_afc/strategic_vision1.php) – the plan was formulated in 2004 with the input of 150 individuals who helped shape the 2005-2007 Strategic Vision: the members of AFC's Service Providers Council, people living with HIV/AIDS, public health and medical professionals, advocates, policymakers, faith leaders, donors, researchers, and others. The key goals of AFC's plan highlight the areas in most need of attention in the region's HIV/AIDS services:

- Deepen community ties and promote individual empowerment among African Americans, Latinos, women, youth, and men of all races who have sex with other men to reduce HIV transmission and improve HIV/AIDS services.
- Maximize scarce resources to meet the changing needs of people living with and at risk for HIV/AIDS and ensure that the HIV/AIDS prevention and care services we coordinate and fund are of the highest quality.
- Advocate locally, statewide, and in the nation's capital for increased government resources for HIV/AIDS services, science-based HIV prevention strategies, and public policies and laws that help decrease AIDS stigma and protect the rights of people living with the disease.

3. Conclusions

In both of these communities, the planning that has taken place has not included all of the community leaders in the discussion. In both cases, the planning activity has been limited to the narrow scope of HIV/AIDS providers only. This has hindered efforts to mobilize and involve the community-at-large in HIV/AIDS prevention and care issues. The HIV/AIDS organizers have involved the community-at-large only when issues surrounding funding arise. Interestingly, the lead organizations in both cities have identified advocacy and policy change as key piroities that will impact the work, along with quality of life issues.

Both cities have experienced difficulty in implementing the plans created by the HIV/AIDS provider community, and both communities note that the decline in local, state, and federal governmental funding for HIV/AIDS has contributed to ongoing, and in some cases intractable, problems for those living with HIV/AIDS.

E. APPENDIX