

# CDC HIV Prevention Strategic Plan:

## Extended Through 2010



October 2007



**WE ARE NOW** in the third decade of the HIV/AIDS epidemic and although HIV prevention efforts have grown substantially over time and we have made important progress, major unmet needs remain. HIV continues to pose a significant threat to Americans' health and well-being, with African Americans and men who have sex with men (MSM) of all races most severely affected. While African Americans account for 13 percent of the population, they account for nearly half of HIV diagnoses in 2005 (49% in 33 states with longstanding confidential name-based reporting) and nearly half of the people estimated to be living with HIV (47%). MSM also account for half of new HIV diagnoses in 2005 (49% in the 33 states with confidential name-based reporting) and nearly half of people estimated to be living with HIV (45%).

Reducing the toll of HIV among these groups requires a collaborative and intensive effort by government, partners, and the private and public sectors. The Centers for Disease Control and Prevention (CDC) is intensifying its own efforts to address the epidemic among African Americans and MSM. Targeted initiatives are underway, new HIV testing recommendations have been published, and new partnerships with community leaders have been established. CDC will continue to direct the majority of its resources to strategies, programs, and research for groups disproportionately affected by the epidemic and is working to expand the use of proven interventions and develop new approaches for reaching these populations.

There is no simple solution for eliminating HIV in the U.S. A complex set of historical, structural, environmental, and cultural factors – including racism, discrimination, poverty, denial, stigma, homophobia, and limited access to health care present significant challenges and further complicate efforts to comprehensively address the HIV/AIDS epidemic among disproportionately affected populations such as MSM and communities of color. Addressing these factors can have an important impact on the HIV epidemic.

*CDC's HIV Prevention Strategic Plan Through 2005 (2001 Plan)* has served as a valuable guide for CDC action. CDC has used the *2001 Plan* to identify needs for new and expanded prevention programs and initiatives, establish priorities, and direct and target resources. Importantly, the *2001 Plan* established a vision not only for CDC, but for the nation as a whole. It set forth an overarching public health goal of cutting new HIV infections in half—providing a vision of what could be accomplished with a significantly expanded investment in HIV prevention in the United States and with

the full implementation of the activities outlined. While the *2001 Plan* was never fully implemented and progress did not accelerate at the desired rate through 2005, CDC remains committed to the aspirational goal of major reductions in HIV infection. CDC will therefore work with a range of partners to update the *2001 Plan* and its overarching goals and develop a new long-range plan to guide the nation through 2020.

In the interim, CDC has developed the *HIV Prevention Strategic Plan: Extended Through 2010 (Extended Plan)* to guide the agency's efforts for the next 3 years and to define a realistic, short-term goal at a time when challenges have increased and resources for prevention are not commensurate with prevention needs. Since 2001, HIV diagnoses and risk behaviors have increased among MSM; syphilis rates have increased nationally; and more people are living with HIV than ever before – many of whom are unaware of their infection – which increases the potential for continued HIV transmission. While prevention needs have actually increased, treatment advances have unfortunately contributed to a sense of complacency about the seriousness of HIV/AIDS. An extended strategic plan to address these challenges is essential. The short-term goal and milestones in this *Extended Plan* were endorsed by the CDC /HRSA Advisory Committee on HIV and STD Prevention and Treatment (CHAC).

This *Extended Plan* maintains the focus on core prevention priorities expressed in the *2001 Plan*: reducing the number of new infections, increasing knowledge of HIV status, and promoting linkages to care, treatment, and prevention services. In addition, new objectives have been added to make urgent priorities more explicit, including: preventing new HIV infections among MSM and African Americans; addressing stigma and discrimination; promoting the use of rapid HIV tests; addressing the role of acute infection in HIV transmission; and increasing routine HIV testing in medical settings.

CDC is dedicated to helping people live longer, healthier lives by preventing new HIV infections and protecting the health of those already infected. While continuing to challenge us as a nation, CDC believes the short-term goal and milestones outlined in this *Extended Plan* can be achieved through the implementation of refined and targeted approaches.

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# Centers for Disease Control and Prevention HIV Prevention Strategic Plan: Extended Through 2010

## Introduction

**T**his plan extends the *HIV Prevention Strategic Plan Through 2005 (2001 Plan)* published by the Centers for Disease Control and Prevention (CDC) in January 2001. The short-term goal, milestones, and accompanying objectives are based on general and specific recommendations from the CDC and HRSA Advisory Committee on HIV and STD Prevention and Treatment (CHAC), formerly known as the Advisory Committee for HIV and STD Prevention. The *HIV Prevention Strategic Plan: Extended Through 2010 (Extended Plan)*, which will serve as CDC's strategic guide for HIV prevention through 2010, includes a short-term goal of reducing new HIV infections by 5 percent per year or at least 10 percent by the end of 2010. To achieve this goal, the *Extended Plan* includes an expanded set of objectives and performance indicators that make priorities more explicit and ensure that key issues are effectively addressed. Twelve new objectives have been added, 20 existing objectives have been modified, and one objective was deleted (42 objectives total, compared to 27 in the *2001 Plan*). The *Extended Plan* also incorporates 17 additional performance indicators (25 total, compared to 11 previously).

## Background of the *CDC HIV Prevention Strategic Plan, 2001-2005*

**T**he development of the original five-year strategic plan involved more than 100 experts from inside and outside the government: experts in behavioral science, medicine, and the other disciplines required to address the HIV epidemic, including community-based HIV prevention providers, state and local health departments, members of infected and affected communities. These experts examined a situation analysis of the current epidemic, as well as a response analysis of CDC's current activities. They then divided into workgroups to develop prioritized objectives and strategies to address each of the goals. The goals included rank-ordered objectives



and strategies. The process for developing the *2001 Plan* covered a two-year period that began in CDC in November 1998. The first meeting with the external participants was held in February 2000. Between February and April 2000, the workgroups held five face-to-face meetings and had 16 telephone conference calls to develop and refine their goals and to establish objectives and strategies to achieve the goals. In April 2000, CDC held meetings with each workgroup to evaluate their draft work plans. Gaps, omissions, overlaps, and ambiguities were identified and discussed. In June 2000, the draft strategic plan was presented to the Advisory Committee for HIV and STD Prevention (ACHSP). The plan was revised based on comments received from the ACHSP, external partners, and internal CDC review. In December 2000, the revised plan received endorsement from the ACHSP and was published in January 2001. The *2001 Plan* established a vision for the nation regarding what could be accomplished with a significantly expanded investment in HIV prevention.

## **CDC Activities to Implement the 2001-2005 HIV Prevention Strategic Plan**

**W**hile the *2001 Plan* was never fully implemented and HIV prevention resources in the United States declined slightly through 2005, the *2001 Plan* has been a valuable tool for directing efforts at CDC. Each fiscal year, the Division of HIV/AIDS Prevention (DHAP) in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention holds a retreat to review and discuss the plan's goals and objectives. DHAP agrees on ten priority objectives that guide funding for new projects with a particular focus on populations and risk groups disproportionately affected by HIV/AIDS.

Although progress has not accelerated at the desired rate, there has been significant progress and movement in HIV prevention and hope for the future. Many people – both infected and uninfected – are being reached by prevention programs and engaging in safer behaviors:

- One of the most obvious achievements in HIV prevention is the dramatic decline in mother-to-child HIV transmission. While there were 1,650 documented cases of mother-to-child transmission in 1991, today there are estimated to be fewer than 150 cases each year.

- There have been declines in risk behavior among youth. From 1991-2005, the proportion of youth who reported engaging in sexual intercourse decreased from 54 percent to 47 percent. During the same time period, the proportion of youth who reported using condoms increased from 46 percent to 63 percent.
- In September 2006, CDC published "*Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health-Care Settings*" to make voluntary HIV testing a routine part of medical care for Americans aged 13-64. These *Revised Recommendations* are a major step forward in reducing HIV acquisition and transmission and allowing people to know their HIV status.
- Rapid HIV testing technology, combined with innovative approaches, is showing promising results. Several rapid testing demonstration projects funded by CDC as part of the 2003 initiative, "Advancing HIV Prevention: New Strategies for a Changing Epidemic," report increased numbers of tests and increased proportions of persons receiving their test results, and a high percentage of persons knowing their HIV infection. This is a sign of significant progress in increasing Americans' knowledge of their HIV status.
- There has been a strong commitment among men who have sex with men (MSM) to address threats to HIV prevention, such as methamphetamine use.
- Studies repeatedly show that the majority of HIV-infected persons take steps to protect partners and prevent HIV transmission, once they know they are infected.

In addition, the focus on eliminating racial and ethnic disparities in new HIV infection rates has led CDC to better target prevention approaches. For example, through the Minority AIDS Initiative (MAI) CDC has continued to directly fund minority-serving community-based organizations (CBOs) for HIV prevention in communities of color. MAI funding has greatly enhanced CDC's ability to provide resources directly to CBOs located in and serving minority communities, and has enhanced CDC's ability to provide a range of services to disproportionately affected racial and ethnic communities.

CDC also realigned prevention programs that focus on persons at highest risk for transmitting HIV; conducted applied research to identify and evaluate evidence-based prevention interventions that have been shown to reduce risk behaviors; supported dissemination of effective interventions; implemented population-based behavioral

surveillance and an HIV incidence surveillance system to supplement HIV/AIDS case surveillance; established strong linkages for prevention and quality medical care services; promoted rapid HIV testing in both clinical and non-clinical settings; and launched new efforts to enhance prevention services for persons living with HIV and to develop new strategies to diagnose HIV infection. Most recently, CDC directed \$45 million of 2007 agency funds to expand access to HIV testing among disproportionately affected populations, particularly African-Americans.

## CHAC Strategic Plan Workgroup

**A**t its May 2005 meeting, the CHAC asked CDC to identify the reasons for not achieving the overarching goal of the *2001 Plan* (reduce new HIV infections in the United States by 50% by 2005). While several factors were identified, the primary reason cited was the lack of expanded funding on a national level to fully implement the activities outlined in the *2001 Plan*. The resources required to implement the *2001 Plan* were estimated at the time of publication to be an additional \$300 million annually.

At the same meeting, the CHAC also expressed a strong interest in updating the *2001 Plan*, unanimously passed a motion to form a CHAC Strategic Plan Workgroup to facilitate updating the *2001 Plan*, and unanimously passed a motion to extend the plan through 2008 (and later extended it through 2010).

The CHAC focused its review on the four domestic goals of the original *2001 Plan*. Goal 5, “Assisting in reducing HIV transmission and improving HIV/AIDS care and support in partnership with resource-constrained countries” was not included since the President launched the President’s Emergency Plan for AIDS Relief (PEPFAR). There is a separate set of PEPFAR goals and measures and CDC is assisting the U.S. government in achieving PEPFAR goals.

The CHAC Strategic Plan Workgroup was comprised of 30 individuals from health departments, universities, affected communities, advocates, partner organizations, and members of the CHAC (Appendix 1). The Workgroup was tasked with the following responsibilities:

- 1) Provide advice to CDC on ways to update the *2001 Plan* to guide the agency and its federal partners in formulating new strategies, activities, and directions to reduce HIV infection in the United States.



- 2) Develop recommendations for HIV prevention programs, surveillance, and research that can reduce HIV incidence based on current resources and the best available science.
- 3) Review the *2001 Plan* to identify limitations or flaws in previous HIV prevention activities, missed opportunities in establishing priorities, and actions to advance the plan in the future.
- 4) Determine whether the overarching goal to reduce new HIV infections in the United States by 50% is feasible and realistic, based on available resources.

The Workgroup held two meetings: October 24-25, 2005 and May 4-5, 2006. Additional communications occurred through conference calls, emails, and intermittent mailings. The Workgroup also received in-depth information about CDC's current activities related to the domestic goals and objectives of the *2001 Plan* and data on the 11 performance indicators, as well as samples of relevant articles and reports on HIV prevention activities for review and consideration (Appendix 2).

Updating the *2001 Plan* was a two-year process and incorporated input from a diverse set of stakeholders. In July 2006, the CHAC issued a draft report of the Workgroup activities and recommendations to CDC (Appendix 3).

At its November 2006 meeting, the CHAC reviewed and discussed preliminary findings and recommendations of the CHAC Strategic Plan Workgroup. Further, the CHAC recommended that the *2001 Plan* be extended for five years to 2010 (Appendix 4) and suggested that CDC develop accountable, realistic, reasonable, attainable, and measurable indicators to monitor progress of the Strategic Plan.

At its May 2007 meeting in Atlanta, Georgia, the CHAC recommended that the plan begin in 2007 and end in 2010. The CHAC also made other recommendations that are reflected in this document.

## **CDC Response to CHAC Recommendations and Major Considerations of the Plan**

**T**he CHAC Strategic Plan Workgroup provided recommendations for revising the domestic goals in the original *2001 Plan*, and suggested several major considerations.

## *Recommendations Regarding Goals and Objectives*

**C**DC identified a short-term goal through 2010 and chose to call the four original domestic goals short-term milestones in this *Extended Plan*. CDC modified short-term milestones 1-3 and extended all four milestones to 2010. The Workgroup recommended deleting the original Goal 4, “By 2005, strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions and evaluate prevention programs.” CDC, however, retained that goal (as short-term milestone 4) because the ability to measure progress toward the overall short-term goal and other milestones articulated in the *Extended Plan* rely on the ongoing capacity to perform surveillance and evaluation activities.

To revise the milestones, CDC reviewed and analyzed information from several resources including: trends in HIV diagnoses, behavioral surveillance data; data on risk behavior among people living with HIV; proportion of people at risk for HIV; reach of HIV prevention interventions; and implementation of the “Revised HIV Testing Recommendations for Adults, Adolescents, and Pregnant Women in Health-Care Settings.”

Of the 34 new objectives recommended by the Workgroup, CDC incorporated more than half (12 new objectives and 13 modified objectives). CDC did not incorporate the others as they were duplicative or were not within the mission of CDC.

Specifically, CDC added new objectives and modified existing objectives as follows:

- Made more explicit the focus on African-American and MSM communities.
- Added new objectives that
  - address advances in understanding about the importance of acute HIV infection, the role of incarceration in the HIV epidemic, and technical advances in HIV rapid testing.
  - underscore the priority to increase HIV screening in medical care settings.
  - reflect recent data about disparities in knowledge of one’s HIV infection, especially among MSM.

## *Recommendations Regarding Implementation*

**T**he Workgroup also cited lack of support for the *2001 Plan* from some partner groups, and made an overarching recommendation that there be increased partnering with the medical community and the private sector.

Partnerships have always played a key role in progress toward HIV prevention in the United States, and both traditional and expanded partnerships will be essential to efforts to accelerate progress. CDC began building public/private partnerships with multiple sectors in the late 1980s, including efforts to engage leaders from the business and faith community, civic and social organizations, media and entertainment, philanthropy, and labor in the collective fight against HIV. These programs have evolved and been built to address emerging challenges over time, with a particular emphasis on ensuring reach and impact among minority populations disproportionately impacted by HIV.

In recent years, CDC has had a particular focus on expanding partnerships necessary to implement recommendations for routine HIV testing in health-care settings and to accelerate progress in reducing new infections among African Americans. The success of these efforts requires deepening and expanding relationships with the traditional medical community and with African-American leaders from all sectors of society.

Since the release of the Revised HIV Testing Recommendations in 2006, CDC has engaged in an intensive effort to assist stakeholders in preparing to implement HIV screening in health-care settings. CDC has engaged community partners, grantees, other federal agencies, the private sector, and state and local health departments in this process. Several examples include working with the Health Resources and Services Administration (HRSA), the National Association of Community Health Centers, the American Hospital Association, and a wide range of professional medical associations to increase the number of clinical sites that offer HIV testing as part of routine medical care and to develop referral and linkage procedures for HIV-infected and high-risk uninfected persons to additional prevention and treatment services. CDC also is collaborating with the Substance Abuse and Mental Health Services Administration (SAMHSA) on implementation plans for HIV screening in substance abuse treatment programs.

To accelerate prevention progress in reducing infections among African Americans, CDC is working to both build upon existing partnerships and programs and make new connections with African-American leaders who have the power and influence to expand the reach of HIV prevention to more at-risk African Americans. Additionally, CDC and state and local health departments are expanding efforts to partner with African-American small businesses in multiple cities to reach their communities with HIV prevention information and links to testing services. To further engage new partners in the fight against HIV and AIDS, CDC held a meeting in March 2007 to bring together a range of African-American leaders from all walks of life to discuss additional actions that entertainers, civic leaders, business leaders, and the faith community can take to intensify HIV prevention efforts for African Americans. Building upon these efforts will continue to be a key CDC priority to implement this *Expanded Plan*.

### *Recommendations Regarding Stigma and Discrimination*

**T**he Workgroup also recommended adding a goal focused on stigma and discrimination. CDC recognizes that interventions to reduce stigma and discrimination are important and need to be addressed. While CDC did not include a specific goal on these issues, the *Extended Plan* addresses stigma and discrimination in several objectives. Given the difficulty of measuring the impact of stigma and discrimination on HIV transmission, CDC will also continue to investigate effective models for discerning behavior change associated with reducing stigma and discrimination.

CDC is also addressing stigma and discrimination through the Revised Recommendations for HIV Testing, which call for HIV screening in health-care settings for all persons aged 13-64. By making HIV testing a routine part of medical care for everyone – rather than targeting certain individuals based on perceived risk behavior – these recommendations help to further reduce stigma and discrimination. Research shows that more patients accept HIV testing when it is offered routinely to everyone.

Additionally, the accelerated community mobilization begun in March 2007 as part of the Heightened National Response to the HIV/AIDS Crisis among African Americans will work to reduce stigma by encouraging an open dialogue about HIV/AIDS

in places where African Americans live, work, play, and worship. Connecting HIV/AIDS prevention to broader efforts to reduce stigma, discrimination, racism, homophobia, joblessness, sexual violence, homelessness, and substance abuse can play a key role in reducing the impact of HIV/AIDS among African Americans. Together with its partners, CDC hopes to change the community perceptions that inhibit those at risk from seeking early HIV diagnosis and treatment and adopting healthy behaviors that prevent the spread of HIV.

## **Looking Ahead: The Future of HIV Prevention Strategic Planning at CDC**

**W**hile advances in HIV treatment have greatly improved the lives of HIV-infected people, HIV remains a serious and fatal disease. In 2005, over 16,000 Americans with AIDS died. As a nation, we must continue to invest in prevention. As with many other diseases, Americans tend to focus more on treating than preventing HIV. For example, in FY 2006, only 5 percent of the domestic HIV/AIDS budget went to prevention, including prevention research and programs. While treatment and care for those already infected remains critical, we must intensify our collective efforts to prevent people from becoming infected in the first place. The scale of our response must be commensurate with the challenges.

CDC remains committed to a strong prevention response. However, government support alone will not be sufficient. The support of the public and private sectors, as well as community organizations, is essential.

The *CDC HIV Prevention Strategic Plan: Extended Through 2010* consists of a carefully considered set of short-term milestones and objectives for the nation's prevention priorities that will guide CDC's efforts for the next 3 years. CDC does not anticipate a significant expansion of HIV prevention funding during that time. This *Extended Plan* remains rooted in the best available science and builds on important progress already made in recent years. The plan refines objectives to ensure a focus on populations now at greatest risk and application of new technology and the latest science. We believe the short-term milestones can be achieved through refined, targeted approaches. These milestones challenge us to accelerate progress with available resources.



CDC will begin an in-depth, comprehensive, and inclusive process to develop a new long-range strategic plan. That plan, when completed, will provide a blueprint for HIV prevention activities through 2020 that is aligned with CDC's Health Protection Goals and integrated with other infectious diseases such as viral hepatitis, STD, and TB. As with the development of the original HIV Prevention Strategic Plan goals (2001-2005), the plan will be based on input from many sectors, including advocates from affected and at-risk communities, public health officials, academics, health-care providers, and others. CDC plans to identify the most important outcomes in surveillance, research, program, and evaluation and will develop indicators to closely monitor progress.

## Goals and Objectives of the CDC HIV Prevention Strategic Plan: Extended Through 2010

### Short-Term Goal:

*“Reduce the number of new HIV infections in the United States by 5% per year, or at least by 10% through 2010, focusing particularly on eliminating racial and ethnic disparities in new HIV infections.”*

<b>Short-Term Milestone 1:</b> By 2010, decrease by at least 10% the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention interventions.	
<b>Transmission Objectives</b>	
1	Among people living with HIV, increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission.
2 Modified	Among men who have sex with men (MSM), increase the proportion who consistently engage in behaviors that reduce risk for transmission of HIV.
3 Modified	Among sexually active, HIV-infected women and HIV-infected sexually active heterosexual men, increase the proportion who consistently engage in behaviors that reduce risk for transmission of HIV.
4 Modified	Among injection drug users (IDUs), increase the proportion who abstain from drug use or, for those who do not abstain, use harm reduction strategies to reduce risk of HIV transmission.
5 Modified	Among adolescents living with HIV, increase the proportion who consistently engage in behaviors that reduce risk for transmission of HIV, particularly among out-of-school high-risk youth.
6 New	Increase the proportion of persons living with HIV who effectively access partner notification services.
7 New	Among persons living with HIV, increase the proportion who receive evidence-based interventions, including mental health, substance abuse, and other appropriate interventions for co-morbid conditions.
8 New	Among persons with acute HIV infection, increase the proportion reached by appropriate HIV behavioral interventions.
9 New	Increase the proportion of persons living with HIV who disclose their HIV infection before a risk encounter with a new partner and increase the proportion of persons at risk for HIV infection who disclose their HIV status before their first risk encounter with a new partner.
10 Modified	Increase the proportion of HIV-infected pregnant women who are routinely tested and access prevention interventions including antiretroviral medication, caesarean sections (when appropriate) and infant formula feedings to interrupt perinatal transmission of HIV.

(cont) **Short-Term Milestone 1:** By 2010, decrease by at least 10% the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention interventions.

**Acquisition Objectives**

1a Modified	Among men who have sex with men (MSM), increase the proportion who consistently engage in behaviors that reduce risk for acquisition of HIV.
2a New	Increase the number of proven effective behavioral prevention interventions for African Americans and other racial and ethnic groups disproportionately affected by HIV/AIDS.
3a New	Increase the number of proven effective behavioral prevention interventions for MSM.
4a Modified	Among at-risk sexually active women, and at-risk sexually active heterosexual men, increase the proportion who consistently engage in behaviors that reduce risk for HIV acquisition.
5a Modified	Among adolescents, increase the proportion who consistently engage in behaviors that reduce risk for acquisition of HIV, particularly among out-of-school high-risk youth.
6a Modified	Among injection drug users (IDUs), increase the proportion who abstain from drug use or, for those who do not abstain, use harm reduction strategies to reduce risk of HIV acquisition.
7a	Increase the proportion of people at risk for HIV who are tested for STDs and treated appropriately
8a Modified	Increase the number of and access to proven effective biomedical HIV prevention interventions including circumcision, vaccines, microbicides, and oral chemoprophylaxis.
9a	Reduce the number of workers who are occupationally exposed to and infected with HIV.
10a Modified	Continue to support the safety of blood, tissue and organ supplies in the United States.

**Short-term Milestone 2:** By 2010, through voluntary testing, increase from the current estimated 75% to 80% the proportion of HIV-infected people in the United States who know they are infected.

	<b>Objectives</b>
1 New	Increase the percentage of all ethnic/racial minorities who, if infected, are aware of their HIV infection, with a focus on African Americans.
2 New	Increase the percentage of all MSM who, if infected, are aware of their HIV infection.
3 Modified	Increase the number of providers who routinely provide screening in health care settings (e.g., STD clinics, substance abuse treatment programs, family planning clinics, emergency rooms, community health centers), as well as voluntary counseling and testing (VCT) in non-clinical venues (e.g., social venues, street outreach).
4 New	Increase the use of rapid testing technology that is user friendly and produces same day results.
5 New	Increase availability of HIV screening to incarcerated persons.
6 Modified	Improve access to voluntary, client-centered counseling and testing (VCT) in high seroprevalence communities and populations at risk, focusing particularly on populations with high rates of undiagnosed infection.
7 New	Reduce structural and policy barriers to implementing routine HIV screening (e.g., barriers to rapid testing, counseling and consent requirements).

**Short-term Milestone 3:** By 2010, increase from the current estimated 50% to 65% the proportion of newly diagnosed HIV-infected people in the United States, who are linked to appropriate prevention, care and treatment services.

	<b>Objectives</b>
1 Modified	Increase the proportion of persons newly diagnosed with HIV who are successfully linked to medical care within 3 months of learning their HIV infection or being re-identified as HIV-infected but out of care, including African Americans and other racial and ethnic groups disproportionately affected by HIV/AIDS.
2 Modified	Increase the proportion of persons newly diagnosed with HIV who are successfully linked to culturally competent, science-based prevention services.
3 Modified	Integrate prevention services, including adherence to treatment and partner notification services for persons diagnosed with HIV and AIDS, into the delivery of patient care in both public and private sectors.
4 Modified	Reduce the disparities, stigma and discrimination in access to prevention and care services that are experienced by communities of color, women, and MSM.
5	Increase the proportion of HIV care providers offering routine, periodic STD screening and treatment to HIV-infected clients.
6	Promote the optimal level of medical services for patients diagnosed with HIV to benefit individual health and reduce the likelihood of further transmission of HIV.
7	Increase the proportion of correctional facility detainees (incarcerated for at least 30 days) identified as HIV-infected who are provided HIV prevention, treatment and care services and who, upon release, are successfully linked to those services in the communities to which they return.
8	Increase the proportion of HIV care providers offering routine, periodic TB screening and treatment to HIV-infected clients.
9 Modified	Increase the proportion of persons newly diagnosed with HIV (including pregnant women) who need substance abuse treatment services that are successfully linked to those services.
10 Modified	Increase the proportion of persons newly diagnosed with HIV who need social and mental health services that are successfully linked to those services.



**Short-term Milestone 4:** By 2010, strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions and evaluate prevention programs.

	<b>Objectives</b>
1 Modified	Improve the capacity to measure incidence of new infections; track the prevalence of disease and its complications; monitor the transmission and prevalence of drug resistant virus; monitor behaviors, including behaviors that increase the risk of HIV infection (among persons who are HIV-uninfected) and behaviors that increase the risk of HIV transmission and the risk of disease progression (for persons who are living with HIV); and provide locally relevant data for community planning.
2	Increase the number of evidence-based interventions and the proportion of prevention providers funded by CDC who successfully provide demonstrably effective HIV prevention interventions.
3	Support realistic and feasible evaluation efforts to ensure the delivery of interventions at the highest possible quality.

## HIV Prevention Strategic Plan Performance Indicators

In February 2002, CDC defined 11 measurable performance indicators (noted in Appendix 3) to monitor the progress toward implementing the overarching and four domestic goals and objectives of the *2001 Plan*. The indicators were selected based on the appropriateness of the measure for the specific goal or objective of the *2001 Plan*, practicality of the measure, and the current and future availability of HIV data. These were the same indicators CDC used for other required reporting including Government Performance and Results Act (GPRA), Office of Management and Budget Program Assessment Rating Tool (PART), and the Healthy People 2010.

To appropriately address the focus on African Americans and MSM in the objectives of the *Extended Plan*, CDC reviewed the original 11 performance indicators included the *2001 Plan* to determine if some indicators needed to be modified or retained or if new ones needed to be added. CDC also added incidence measures for MSM, African Americans, and Hispanics based on a motion from the CHAC on May 8, 2007. Currently, there are 25 performance indicators. Of this number, 17 are new indicators, six are modified, and two were unchanged. Since 2002, CDC has developed new data collection systems and has also included process indicators to measure the impact of prevention interventions. The outputs of these new systems are reflected in the new performance indicators.

## Short-term Goal (Indicators 1-5)

### 1. Reduce the rate of HIV transmission by HIV-infected persons. (new)

Measure	FY	Target	Reporting Date
Decrease the rate of HIV transmission by HIV-infected persons.	2010	XX%	11/2012
	2009	XX%	11/2011
	2008	XX%	11/2010
	2007	XX%	11/2009
	2006	XX%	11/2008
	2005	[Trend Data]	11/2007
	2004	[Trend Data]	11/2007
	2003	Baseline	11/2007

Data Source: Calculations of HIV incidence and prevalence, utilizing HIV/AIDS Incidence Surveillance System and special prevalence studies.

### 2. Decrease the number of pediatric AIDS cases. (unchanged)

Measure	FY	Target	Result/Reporting Date
Decrease the number of pediatric AIDS cases, from the 1998 base of 241 cases.	2010	<75 cases	11/2011
	2009	<75 cases	11/2010
	2008	<75 cases	11/2009
	2007	<100 cases	11/2008
	2006	<100 cases	11/2007
	2005	[Trend Data]	68
	2004	[Trend Data]	50
	2003	[Trend Data]	71
	2002	[Trend Data]	105
	2001	Baseline	121

Data Source: HIV/AIDS Reporting System (e-HARS).

### 3. Decrease the annual HIV incidence. (new)

Measure	FY	Target	Reporting Date
Decrease the annual HIV incidence.	2010	X.X/100,000	2012
	2009	X.X/100,000	2011
	2008	X.X/100,000	2010
	2007	X.X/100,000	2009
	2006	X.X/100,000	2008
	2005	X.X/100,000	2007
	2004	X.X/100,000	2007
	2003	Baseline1	2007

Data Source: HIV/AIDS Incidence Surveillance in 34 areas.

### 3a. Decrease the number of new HIV cases among MSM. (new)

Measure	FY	Target	Reporting Date
Decrease the number of new HIV cases among MSM.	2010	X	2012
	2009	X	2011
	2008	X	2010
	2007	X	2009
	2006	X	2008
	2005	X	2007
	2004	X	2007
	2003	Baseline1	2007

Data Source: HIV/AIDS Surveillance in 33 states.

**3b. Decrease the annual HIV incidence among African Americans. (new)**

Measure	FY	Target	Reporting Date
Decrease the annual HIV incidence among African Americans.	2010	X.X/100,000	2012
	2009	X.X/100,000	2011
	2008	X.X/100,000	2010
	2007	X.X/100,000	2009
	2006	X.X/100,000	2008
	2005	X.X/100,000	2007
	2004	X.X/100,000	2007
	2003	Baseline1	2007

Data Source: HIV/AIDS Incidence Surveillance in 34 areas.

**3c. Decrease the annual HIV incidence among Hispanics. (new)**

Measure	FY	Target	Reporting Date
Decrease the annual HIV incidence among Hispanics.	2010	X.X/100,000	2012
	2009	X.X/100,000	2011
	2008	X.X/100,000	2010
	2007	X.X/100,000	2009
	2006	X.X/100,000	2008
	2005	X.X/100,000	2007
	2004	X.X/100,000	2007
	2003	Baseline1	2007

Data Source: HIV/AIDS Incidence Surveillance in 34 areas.



#### 4. Reduce the black:white ratio of HIV/AIDS diagnoses. (new)

Measure	FY	Target	Result/Reporting Date
Reduce the black:white rate ratio of HIV/AIDS diagnoses.	2010	8.2:1	11/2011
	2009	8.2:1	11/2010
	2008	8.4:1	11/2009
	2007	8.4:1	11/2008
	2006	8.7:1	11/2007
	2005	[Trend Data]	8.69:1
	2004	[Trend Data]	9.17:1
	2003	[Trend Data]	9.90:1
	2002	[Trend Data]	10.32:1
	2001	Baseline	10.94:1- Data are from 33 areas with stable HIV reporting

Data Source: HIV/AIDS Reporting System (e-HARS).

#### 5. Reduce the Hispanic:white ratio of HIV/AIDS diagnoses. (new)

Measure	FY	Target	Result/Reporting Date
Reduce the Hispanic:white rate ratio of HIV/AIDS diagnoses.	2010	3.3:1	11/2011
	2009	3.3:1	11/2010
	2008	3.4:1	11/2009
	2007	3.4:1	11/2008
	2006	3.5:1	11/2007
	2005	[Trend Data]	3.53:1
	2004	[Trend Data]	3.66:1
	2003	[Trend Data]	4.05:1
	2002	[Trend Data]	4.11:1
	2001	Baseline	4.6:1- Data are from 33 areas with stable HIV reporting

Data Source: HIV/AIDS Reporting System (e-HARS).

## Short-term Milestone 1 (Indicators 6-9)

### 6a. Decrease the percentage of youth who have ever had sexual intercourse. (modified)

Measure	FY	Target	Result/Reporting Date
Decrease the percentage of students in 9th through 12th grade who have ever had sexual intercourse.	2009	46.6	2010
	2007	46.7	2008
	2005	46.8	2006
	2003	46.7	2004
	2001	45.6	2002

Data Source: Youth Risk Behavioral Surveillance System (YRBSS). The YRBSS is conducted in odd-numbered years so there are no data for 2000 and 2002, and the target is set for 2009 rather than 2010.

### 6b. Increase condom use among sexually active youth. (modified)

Measure	FY	Target	Result/Reporting Date
Increase condom use among sexually active students in 9th through 12th grade.	2009	63.2	2010
	2007	63.0	2008
	2005	62.8	2006
	2003	63.0	2004
	2001	57.9	2002

Data Source: Youth Risk Behavioral Surveillance System (YRBSS). The YRBSS is conducted in odd-numbered years so there are no data for 2000 and 2002, and the target is set for 2009 rather than 2010.

**7. Decrease risky sexual and drug using behaviors among persons at risk for transmitting HIV. (modified)**

Measure	FY	Target	Reporting Date
Decrease risky sexual and drug using behaviors among persons at risk for transmitting HIV.	2010	XX	11/2011
	2009	XX	11/2010
	2008	XX	11/2009
	2007	Baseline	11/2008

Data Source: Medical Monitoring Project.

**8. Decrease risky sexual and drug using behaviors among persons at risk for acquiring HIV. (new)**

Measure	FY	Target	Result/Reporting Date
Decrease risky sexual and drug using behaviors among persons at risk for acquiring HIV.	2010	MSM – 46%	12/2012
	2009	HRH- XX	12/2011
	2008	IDU- XX	12/2010
	2007	MSM – 47%	12/2009
	2006	Baseline	HRH – 12/2008
	2005	Baseline	IDU – 12/2007
	2004	Baseline	MSM – 47%

Data Source: National HIV Behavioral Surveillance System.

**9. Increase the proportion of persons at risk for HIV who received HIV prevention interventions. (new)**

Measure	FY	Target	Result/Reporting Date
Increase the proportion of persons at risk for HIV who received HIV prevention interventions.	2010	MSM - 22%	12/2012
	2009	HRH - XX	12/2011
	2008	IDU - XX	12/2010
	2007	MSM - 20%	12/2009
	2006	Baseline	HRH- 12/2008
	2005	Baseline	IDU- 12/2007
	2004	Baseline	MSM- 18.9%

Data Source: National HIV Behavior Surveillance System.

**Short-term Milestone 2 (Indicators 10-12)**

**10. Increase the proportion of HIV-infected people in the United States who know they are infected. (new)**

Measure	FY	Target	Result/Reporting Date
Increase the proportion of HIV-infected people in the United States who know they are infected.	2009	79%	6/2011
	2007	77%	6/2009
	2005	74.5%	6/2007
	2003	Baseline	74.5%

Data Source: Special studies using eHARS.

**11. Increase the proportion of persons with HIV-positive test results from publicly funded counseling and testing sites who receive their test results. (modified)**

Measure	FY	Target	Result/Reporting Date
Increase the proportion of persons with HIV-positive test results from publicly funded counseling and testing sites who receive their test results.	2010	91%	10/2011
	2009	90%	10/2010
	2008	88%	10/2010
	2007	87%	10/2009
	2006	86%	10/2008
	2005	85%	10/2007
	2004	[Trend data]	84%
	2003	[Trend data]	81%
	2002	[Trend data]	81%
	2001	Baseline	81%

Data Source: Counseling, Testing, and Referral System-Program Evaluation and Monitoring System.

**12. Increase the proportion of people with HIV diagnosed before progression to AIDS. (unchanged)**

Measure	FY	Target	Result/Reporting Date
Increase the proportion of people with HIV diagnosed before progression to AIDS.	2010	80%	11/2011
	2009	80%	11/2010
	2008	79%	11/2009
	2007	79%	11/2008
	2006	78%	11/2007
	2005	[Trend data]	78.1%
	2004	[Trend data]	77.9%
	2003	[Trend data]	78.0%
	2002	[Trend data]	78.1%
	2001	Baseline	78.0% Data are from 33 states with stable HIV reporting

Data Source: eHARS.



## Short-term Milestone 3 - (Indicators 13-17)

### 13. Increase the percentage of HIV-infected persons in publicly funded counseling and testing sites who were referred to PCRS. (new)

Measure	FY	Target	Reporting Date
Increase the percentage of HIV-infected persons in publicly funded counseling and testing sites who were referred to PCRS.	2010	XX%	11/2010
	2008	Baseline	11/2009

Data Source: Program Evaluation and Monitoring System.

### 14. Increase the percentage of HIV-infected persons in publicly funded counseling and testing sites who were referred to HIV prevention services. (new)

Measure	FY	Target	Reporting Date
Increase the percentage of HIV-infected persons in publicly funded counseling and testing sites who were referred to HIV prevention services	2010	XX%	11/2011
	2009	XX%	11/2010
	2008	Baseline	11/2009

Data Source: Program Evaluation and Monitoring System.

**15. Increase the percentage of HIV-infected persons in publicly funded counseling and testing sites who were referred to medical care and attended their first appointment. (new)**

Measure	FY	Target	Reporting Date
Increase the percentage of HIV-infected persons in publicly funded counseling and testing sites who were referred to medical care and attended their first appointment.	2010	XX%	11/2011
	2009	XX%	11/2010
	2008	Baseline	11/2009

Data Source: Program Evaluation and Monitoring System.

**16. Increase the percentage of HIV-infected persons in medical care who initiated medical care within three months of diagnosis. (modified)**

Measure	FY	Target	Result
Increase the percentage of HIV-infected persons in medical care who initiated medical care within three months of diagnosis	2010	XX%	11/2011
	2009	XX%	11/2010
	2008	XX%	11/2009
	2007	Baseline	11/2008

Data Source: Medical Monitoring Project.

**17. Increase the proportion of people at the time of HIV diagnosis with a CD4 count greater than 350. (new)**

Measure	FY	Target	Result
Increase the proportion of people at the time of diagnosis with a CD4 count greater than 350.	2010	36%	11/2011
	2009	35%	11/2010
	2008	34%	11/2009
	2007	33%	11/2008
	2006	32%	11/2007
	2005	31%	11/2006
	2004	[Trend data]	29.9%
	2003	[Trend data]	28.1%
	2002	[Trend data]	29.9%
	2001	Baseline	29.0%

Data Source: eHARS.

## Short-term Milestone 4 - (Indicators 18-21)

### 18. Increase the number of states with mature, name-based HIV surveillance systems. (modified)

Measure	FY	Target	Result/Reporting Date
Increase the number of states with mature, name-based HIV surveillance systems.	2010	43	11/2011
	2009	37	11/2010
	2008	35	11/2009
	2007	34	11/2008
	2006	33	11/2007
	2005	[Trend data]	33
	2004	[Trend data]	33
	2003	[Trend data]	32
	2002	[Trend data]	29
	2001	Baseline	29

Data Source: HIV/AIDS Reporting System (eHARS).

### 19. Increase the percentage of HIV prevention program grantees using PEMS to monitor program implementation. (new)

Measure	FY	Target	Result/Reporting Date
Increase the percentage of HIV prevention program grantees using PEMS to monitor program implementation.	2010	80%	11/2011
	2009	65%	11/2010
	2008	45%	11/2009
	2007	20%	11/2008
	2006	Baseline	0

Data Source: Program Evaluation and Monitoring System.

**20. Increase the number of evidence-based prevention interventions that are packaged and available for use in the field by prevention program grantees. (new)**

Measure	FY	Target	Result/Reporting Date
Increase the number of evidence-based prevention interventions that are packaged and available for use in the field by prevention program grantees.	2010	24	11/2011
	2009	21	11/2010
	2008	18	11/2009
	2007	15	11/2008
	2006	[Trend Data]	14
	2005	[Trend Data]	14
	2004	[Trend Data]	11
	2003	[Trend Data]	10
	2002	[Trend Data]	7
	2001	Baseline	5

Data Source: Replicating Effective Programs (REP) Project data.

**21. Increase the number of agencies trained each year to implement Diffusion of Effective Behavioral Interventions (DEBIs). (new)**

Measure	FY	Target	Result/Reporting Date
Increase the number of Agencies trained each year to implement DEBIs.	2010	1,100	2/2011
	2009	1,100	2/2010
	2008	1,100	2/2009
	2007	1,100	2/2008
	2006	[Trend Data]	987
	2005	[Trend Data]	1,114
	2004	[Trend Data]	1,068
	2003	[Trend Data]	417
	2002	[Trend Data]	53
	2001	Baseline	0

Data Source: Diffusion of Effective Behavioral Interventions (DEBI) Tracking Database.

## **Appendices**

Appendix 1 – November 2006 CHAC Meeting Minutes

Appendix 2 – List of CHAC Strategic Plan Workgroup Members

Appendix 3 - CDC Summary Report of Activities Addressing Plan  
(submitted to CHAC)

Appendix 4 – Draft Report from CHAC Strategic Plan Workgroup

A collage of various black and white photographs of people of different ages and ethnicities. Some photos show individuals in profile, some looking directly at the camera, and some in groups. One photo in the center shows a person holding a sign that says "AIDS".

# Appendix 1 – November 2006 CHAC Meeting Minutes

Department of Health and Human Services  
Centers for Disease Control and Prevention  
Health Resources and Services Administration



CDC/HRSA Advisory Committee on  
HIV and STD Prevention and Treatment  
November 13-14, 2006  
Washington, DC

DRAFT Record of the Proceedings

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## **Attachment 1 List of Participants**

### **CHAC Members**

Dr. Jean McGuire, Co-Chair  
Mr. Jesse Milan, Jr., Co-Chair  
Ms. Renee Austin  
Dr. Dorothy Brewster-Lee  
Ms. Theresa Devlin  
Dr. Fernando Garcia  
Rev. Debra Hickman  
Dr. Edward Hook III, M.D.  
Mr. Thishin Jackson  
Dr. Dennis Leoutsakas  
Mr. Thomas Liberti  
Dr. John Martin  
Dr. Judy Goforth Parker  
Dr. Donna Sweet  
Dr. Lydia Temoshok  
Dr. Carmen Zorrilla

### **CHAC Ex-Officio Representatives**

Dr. Pradip Akolkar (FDA)  
Mr. Christopher Bates  
(HHS Office of HIV/AIDS Policy)  
Ms. Beverly Watts Davis (SAMHSA)  
Mr. William Grace (NIH)

### **Designated Federal Officials**

Dr. Kevin Fenton (CDC)  
Dr. Deborah Parham Hopson (HRSA)

### **HHS, CDC and HRSA Representatives**

Dr. Laura Cheever  
Ms. Janet Cleveland  
Ms. Holly Conner  
Dr. John Douglas, Jr.  
Dr. Hazel Dean  
Ms. Teresa Durden  
Mr. Michael Evanson  
Ms. Paulette Ford-Knights  
Dr. Fernando Garcia  
Ms. Shelley Gordon  
Dr. Robert Janssen  
Ms. Amanda Jonas  
Ms. Faye Malitz  
Mr. Jose Morales  
Dr. Douglas Morgan  
Mr. Michael O'Rourke  
Ms. Amy Pulver  
Dr. George Roberts  
Ms. Idalia Sanchez  
Ms. Margie Scott-Cseh  
Ms. Adelle Simmons  
Mr. Stephen Smith  
Dr. Howell Wechsler  
Dr. Steven Young

## **Guest Presenters and Members of the Public**

Ms. Deborah Arrindell (American  
Social Health Association)

Mr. Sean Barry (Community HIV/  
AIDS Mobilization Project)

Mr. Matthew Brenner  
(National Association of County  
and City Health Officials)

Ms. Kenisha Brooks (The Hidden  
Garden at ParkWest Health)

Ms. Diana Bruce (AIDS Alliance)

Mr. Luigi Buitrago (Washington, DC  
Administration for HIV Policy and  
Programs)

Ms. Kimberly Carbaugh (Association  
of Nurses in AIDS Care)

Ms. Audrey Chan (Association of  
State and Territorial Health Officials)

Ms. Holly Conner (Public)

Mr. Bo Cumbo (Gilead Sciences, Inc.)

Dr. Fabian Eluma (Substance Abuse and  
Mental Health Service Administration)

Ms. Donna Gallagher (New England  
AIDS Education and Training Center)

Mr. Michael Gipson (Washington,  
DC Administration for HIV Policy and  
Programs)

Dr. Laura Hanen (National Alliance of  
State and Territorial AIDS Directors)

Dr. David Holtgrave (Johns Hopkins  
Bloomberg School of Public Health)

Ms. Rachel Jankowski (AIDS Alliance)

Ms. Jennifer Kates  
(Kaiser Family Foundation)

Ms. Linnea Laestadius  
(MayaTech Corporation)

Mr. Nathan Linsk  
(University of Illinois-Chicago)

Dr. Marsha Martin (Washington, DC  
Administration for HIV Policy and  
Programs)

Ms. Deborah McKinney  
(National Minority AIDS Council)

Ms. Suzanne Miller (The AIDS Institute)

Ms. Asua Ofosu (National Association of  
Social Workers)

Mr. Murray Penner (National Alliance of  
State and Territorial AIDS Directors)

Mr. Nestor Roche (Washington, DC  
Administration for HIV Policy and  
Programs)

Mr. Carl Schmid (The AIDS Institute)

Mr. Greg Smiley (American Academy of  
HIV Medicine)

Mr. Shepherd Smith (The Institute for  
Youth Development)

Ms. Thelma King Thiel (Hepatitis  
Foundation International)

Ms. Sara Thomas (Sexuality Information  
and Education Council of the United  
States)

Ms. Evelyn Tomaszewski (National  
Association of Social Workers)

Ms. Josefina Valdez (AIDS Action)

Ms. Shay Welch (Public)

Mr. Guy Weston (Baltimore Eligible  
Metropolitan Area)

Dr. David Wiley (Texas State University)

Ms. Jen Heitel Yakush (Sexuality  
Information and Education Council  
of the United States)

Ms. Jamie Zamora (AIDS Action)

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
HEALTH RESOURCES AND SERVICES ADMINISTRATION**

**CDC/HRSA ADVISORY COMMITTEE ON  
HIV AND STD PREVENTION AND TREATMENT**

**November 13-14, 2006  
Washington, DC**

**Draft Minutes of the Meeting**

The Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA) convened a meeting of the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment (CHAC). The proceedings were held at the Hotel Washington in Washington, DC on November 13-14, 2006.

**Opening Session**

Dr. Jean McGuire and Mr. Jesse Milan, Jr., the CHAC co-Chairs, called the meeting to order at 8:42 a.m. on November 13, 2006. They welcomed the attendees to the proceedings and opened the floor for introductions. The list of participants is appended to the minutes as Attachment 1.

Dr. McGuire and Mr. Milan informed CHAC that they sent a letter to Dr. Ronald Valdiserri, the former Designated Federal Official (DFO) for CDC, to formally acknowledge his years of dedicated service to CHAC.

## HRSA Update

Mr. Stephen Smith, Senior Advisor to the HRSA Administrator, covered the following areas in his report. HRSA observed the 15th anniversary of the Ryan White Comprehensive AIDS Resources Emergency Act (CARE Act) during its grantee conference in August 2006. The conference served as a time of remembrance, renewal and re-commitment. The grantees reflected on the significant amount of progress that has been made in treating the HIV/AIDS epidemic, such as collaborations with CDC on the HIV testing recommendations. The grantees also acknowledged that these efforts must continue to achieve greater progress in the future.

The pending bill on reauthorization of the CARE Act reflects the Administration's themes, including HIV counting, core services, better coordination among CARE Act Titles, and improved accountability. These themes are consistent with the President's principles of serving the neediest first and better targeting of resources. The CARE Act has not been re-authorized to date, but HRSA will continue to implement the current law and support the reauthorization process as opportunities arise. After the reauthorization bill is passed, HRSA will make diligent efforts to ensure that grantees have all necessary information and guidance to implement the new provisions.

HRSA is pleased that the President's FY'07 budget request includes an additional \$95 million for new activities under the domestic HIV initiative. The House and Senate marked up the President's budget with different proposed budgets. HRSA and all other federal agencies are operating under a continuing resolution through November 17, 2006. HRSA will continue to monitor the current Congressional session on the HHS appropriation for FY'07, but significant changes from the President's budget request are not anticipated.

HRSA is continuing its analysis of 2005 CARE Act data in preparation of completing a final report. Preliminary results of the data analysis showed that CARE Act-funded service providers served a total of 954,323 duplicated clients in 2005. Of these clients, >33% were women and >70% were persons of color. The >4.06 million visits for healthcare services that were reported in 2005 represented a 1% increase over the number of healthcare visits reported in 2004. CARE Act services currently reach >500,000 individuals.

HRSA will continue several ongoing activities and implement new initiatives in FY'07 to improve its ability to deliver HIV/AIDS care. Close collaborations with CDC on new HIV testing recommendations will be continued. Funding will be allocated to support a number of new initiatives under the Special Projects of National Significance (SPNS) grant program. Ten grants will be awarded under the SPNS jail-based initiative for grantees to implement and evaluate innovative methods for linking persons living with HIV/AIDS (PLWHA) who are incarcerated or recently released from local jails to primary medical care and ancillary services.

A new SPNS grant program totaling >\$6.5 million will be implemented to support innovative oral healthcare for PLWHA. The SPNS Information Technology Networks of Care Initiative will award funds to support organizations that promote the enhancement and evaluation of existing electronic information network systems to serve PLWHA in underserved communities. The SPNS Case Management Initiative will identify case management models and services that are most important for improving access to and retaining patients in care.

The Minority AIDS Initiative (MAI) will fund five new projects from one to multiple years. The MAI activities will focus on (1) HIV care for women of color; (2) intervention strategies to help clinics retain patients in care; (3) an evaluation of MAI activities; (4) an assessment of the needs of tribal providers who serve American Indians/Alaska Natives in AIDS Education and Training Center (AETC) regions; and (5) a study on issues and barriers to increasing the capacity of health professions immigrants to provide HIV care in the United States.

HRSA established new resources to support its HIV/AIDS programs and activities. The TARGET Center is a new web site and help desk that will provide two major services. A centralized source will be available for CARE Act programs to obtain technical assistance. Grantees will be provided with a “virtual community” to learn about and share ideas. The National Perinatal HIV Consultation and Referral Service Hotline will provide three major services. Around-the-clock advice will be given on standard and rapid HIV testing in pregnancy. Consultation will be offered on the use of anti-retroviral therapy (ART) during pregnancy, labor and delivery, and the postpartum period. HIV-infected pregnant women will be linked to appropriate health care.

HRSA will undertake several efforts to improve the quality of its HIV/AIDS programs and activities. Client-level data and National Quality Center guidelines will be used to develop quality indicators for the HRSA HIV/AIDS Bureau (HAB) and HIV/AIDS care and services provided by grantees. Quality training, support and technical assistance will be provided to HAB staff and grantees. HRSA recently completed a quality initiative of AIDS Drug Assistance Program (ADAP) processes with eight Title II states. Most of the eight states showed significant improvements in the quality of ADAP outcomes. HRSA is now exploring strategies to widely disseminate the quality improvement models to all states.

HRSA will continue its global HIV/AIDS activities through the President’s Emergency Plan for AIDS Relief (PEPFAR). PEPFAR’s accomplishments to date include implementation of the HIVQUAL model in 142 hospital sites in Thailand and an expansion of the HIVQUAL model to Uganda, Namibia and Mozambique in FY’06. I-TECH implemented clinical mentoring in three new countries in 2006 and is currently providing clinical training in 25 countries. Training of rapid HIV testing in Namibia led to an increase in post-test counseling from 20% in 2005 to 66% in 2006. HRSA expects PEPFAR to continue to be supported as a \$15 billion initiative over five years.

HRSA will continue to closely monitor Medicare Part D and the impact of the donut hole on clients who receive HIV/AIDS services under the CARE Act. The “donut hole” is the gap in coverage when no insurance for prescription drugs would be available. After total drug costs reach \$2,250, a patient would pay an additional \$2,850 out-of-pocket before coverage would continue under Medicare Part D. The donut hole will not affect ~70%-80% of Medicare beneficiaries living with HIV who qualify for low-income subsidies. Due to the high cost of ART, however, Medicare beneficiaries living with HIV who do not qualify for additional assistance would need to consider strategies to obtain lower drugs costs in the “catastrophic” coverage level.

HRSA informed grantees that ADAPs could assist with Medicare Part D costs and provide ART to clients affected by the donut hole. HRSA also advised grantees to encourage Medicare beneficiaries to contact state ADAPs to explore opportunities for assistance with the cost of ART. Medicare beneficiaries also have the option of considering Part D plans that have higher premiums, but provide partial coverage to compensate for or completely eliminate the donut hole. HRSA has not yet developed cost estimates of the impact of the donut hole on CARE Act grantees.

HRSA grantees in Alabama, Louisiana, Mississippi and Texas are still recovering from the devastation of Hurricanes Katrina and Rita. The most significant challenges of grantees in these states are tracking clients who were displaced, meeting CARE Act requirements and restrictions, and adhering to conditions of awards. HRSA will continue to closely collaborate with grantees in these states to overcome these barriers.

HRSA took several actions to improve its readiness to respond to emergencies. An Emergency Operations Center and “e-Room” were established to provide an electronic system to collect data from grantee project officers in all HRSA bureaus. The Office of Commissioned Corps Affairs (OCCA) was established in May 2006 to provide a centralized point for deployments and all other HRSA officer activities. OCCA will oversee implementation of the HHS Secretary’s vision for a transformed Commissioned Corps to ensure that the future force is prepared to meet the nation’s public health and emergency needs.

Mr. Smith thanked CHAC for its vital role in improving HIV/AIDS prevention, care and treatment throughout the nation and the world. He emphasized that the knowledge, experience and dedication of each CHAC member are invaluable to HRSA and HHS as future policies are established for HIV/AIDS care and treatment. He added that HRSA would continue to rely on CHAC’s expertise, guidance and recommendations to inform this process in the future.

On behalf of CHAC, Mr. Milan thanked HRSA for developing innovative strategies to assist CARE Act grantees. He was aware that legislative barriers and resource constraints adversely impact HRSA’s ability to administer its HIV/AIDS programs. Despite these challenges, however, funding for the new FY’07 projects illustrates HRSA’s diligent efforts and continued commitment to ensure that constituencies represented by CHAC are served.



Mr. Milan also commended HRSA for playing a critical role in ensuring that CHAC's voice was heard during ongoing efforts to reauthorize the CARE Act. Most notably, CHAC's proposed definitions for core medical services and other recommendations are being considered in current legislative drafts.

Other CHAC members joined Mr. Milan in applauding HRSA for allocating funds to implement and support the new FY'07 activities, particularly the MAI and SPNS initiatives. However, several members expressed concerns about certain aspects of some of HRSA's HIV/AIDS activities.

- HRSA's new jail-based initiative does not reflect coordination with a similar activity that CDC previously conducted. Lessons learned, experiences and important findings from CDC's jail-based effort should be reviewed.
- The change in the CARE Act law will require HRSA to add HIV to the formula for distribution of Title I and II dollars in 2007. Clients who receive HIV/AIDS services under the CARE Act in states with no name-based reporting system will suffer adverse impacts as a result of this change. HSRA should provide technical assistance to help jurisdictions in converting to a name-based reporting system because some areas might require up to four years to make this transition.
- HRSA has not broadly communicated information on its new HIV/AIDS activities and resources. Most notably, many providers have no knowledge of HRSA's National Perinatal HIV Consultation and Referral Service Hotline.
- HRSA should made stronger efforts to assist grantees in assuring continuity of care to clients who would be affected by the Medicare Part D donut hole.
- HRSA has not clearly described its efforts to collect client-level data. Most notably, CHAC has no knowledge of whether these data reflect capacity issues at various sites or if this activity is coordinated with the Centers for Medicare and Medicaid Services (CMS).

Mr. Smith, other HRSA staff, and Dr. Deborah Parham Hopson, the HAB Director and CHAC DFO for HRSA, provided additional details about HRSA's HIV/AIDS activities in response to CHAC's comments, questions and concerns.

- HRSA is currently collaborating with CDC to coordinate its new jail-based SPNS initiative.
- HSRA will continue to implement the 2000 CARE Act legislation in the absence of reauthorization. HRSA will adhere to the change in the legislation to add HIV to the formula for distribution of Title I and II dollars by 2007. Only HIV data from jurisdictions with HIV reporting systems will be used. Only name-based data that have been accepted and certified by CDC will be used. AIDS data will be accepted



from states that do not have name-based HIV reporting systems. The change in the legislation will primarily affect the allocation of funds, but will not necessarily impact delivery of care to clients who receive services under the CARE Act.

- HRSA is conducting several activities in preparation for the change in the CARE Act legislation that must be implemented in 2007. In the absence of an FY'07 budget and reauthorization of the CARE Act, modeling is being performed to identify jurisdictions that will be affected. Communications with grantees about the change in the legislation were initiated in 2000 and will continue. Close collaborations with jurisdictions with no name-based reporting systems will continue. Assistance will continue to be provided to jurisdictions that lose CARE Act dollars each year to help these grantees to prioritize funds and assure continued delivery of essential services to patients. The House bill proposed a transition period for jurisdictions to convert to name-based reporting systems, but the Senate bill did not contain the same language.
- HRSA is identifying strategies for community health centers (CHCs) to provide care to persons with HIV. HRSA is aware that many care systems are currently at capacity and are unable to provide care to new patients.
- HRSA recognizes that some states, territories and eligible metropolitan areas will receive less funds under Titles I and II in 2007 compared to 2006 based on the President's FY'07 budget. Even with decreased funding, however, all jurisdictions will be held harmless in 2007 according to the law.
- HRSA is pleased that ADAP waiting lists were decreased from eight to four states: Alaska, Montana, South Carolina and West Virginia. HRSA will attempt to spread ADAP dollars in these four states to ensure continued delivery of services to Medicare beneficiaries living with HIV who would be impacted by the donut hole. However, many patients who are on ADAP waiting lists still receive medication through established relationships between ADAPs and Pharmacy Assistance Programs.
- HRSA took action on formal motions that CHAC passed during previous meetings. The HHS Secretary provided Congress with HRSA's data runs for consideration in developing draft proposals of the CARE Act reauthorization. HRSA convened several consultations with grantees on the severity of need index and is now identifying a more quantitative strategy to analyze these data under Title I supplemental dollars.
- HRSA will use its established mailing lists of AETCs, CHCs, grantees, special interest groups and other organizations to broadly disseminate information on its HIV/AIDS activities and resources. Articles about HRSA's National Perinatal HIV Consultation and Referral Service Hotline were recently published in peer-reviewed journals targeted to obstetricians/gynecologists and family practitioners.

- HRSA is conducting several activities to assess the capacity of grantees to report client-level data. At the next meeting, HRSA will provide CHAC with an overview of its ongoing efforts to collect client-level data from grantees.

Dr. Kevin Fenton, Director of the CDC National Center for HIV, Hepatitis, STD and TB Prevention (NCHHSTP) [proposed], reported that similar to HRSA, CDC has also taken several actions to assist jurisdictions in converting to name-based reporting systems. Since 1999, states and local jurisdictions have been strongly encouraged to undertake this effort. Specific guidance and technical assistance have been provided to states and local jurisdictions, including methods to implement name-based reporting and strategies to assure data quality.

Legislative reviews were performed to assist states and local jurisdictions in examining barriers to converting to name-based reporting systems. New approaches are now being explored for CDC to more rapidly complete the data certification process. However, CDC is currently facing two major barriers to its ongoing role in providing assistance to states and local jurisdictions that still have not made the transition to a name-based reporting system: (1) addressing the backlog of HIV/AIDS cases reported over the past 25 years and (2) capturing new diagnosed HIV/AIDS cases.

Mr. Milan concluded the session by asking CHAC to provide him or Dr. McGuire with suggestions on resource needs for HIV/AIDS treatment and care for FY'07 and beyond that should be recommended to HRSA or the HHS Secretary. He confirmed that any suggestions proposed by the members would be presented and considered as potential formal motions during CHAC's review of its business items on the following day.

## **CDC Update**

Dr. Fenton covered the following areas in his report. Several reasons served as the basis for CDC to revise and release its HIV testing recommendations for healthcare settings in September 2006. Many HIV-infected persons access health care, but are not tested for HIV until symptoms are present. Effective treatment is available. Awareness of HIV infection leads to substantial reductions in high-risk sexual behavior. High levels of knowledge about HIV result in a decreased need for pre-test counseling. A great deal of experience with HIV testing is available, including rapid tests. Existing evidence is inconclusive about the benefits of prevention from typical counseling for persons who test negative

Key language from CDC's revised HIV testing recommendations is highlighted as follows. For adults and adolescents, routine and voluntary HIV screening should be provided to all persons 13-64 years of age in healthcare settings. Screening should not be based on risk. HIV screening of persons with known risk should be repeated at

least annually. Opt-out HIV screening should be offered with an opportunity for persons to ask questions and decline testing. HIV consent should be included with general consent for care.

Prevention counseling in conjunction with HIV testing in healthcare settings is not required. Patients who test positive for HIV should be linked to clinical care, counseling, support and prevention services. HIV-negative patients who are known to be at high risk should be advised of the need for periodic re-testing and offered or referred to prevention counseling. The recommendations are intended for all healthcare settings, but not for community-based organizations (CBOs) or other non-clinical settings.

Recommendations on referral to care were not changed from CDC's previous guidance. For example, CDC still recommends referrals or linkages to care for all HIV-positive persons. Physicians should initiate screening in low-prevalence settings. Continued screening would no longer be warranted if a jurisdiction demonstrated an HIV prevalence of <1/1,000.

For pregnant women, universal opt-out HIV screening should include HIV in the prenatal screening test panel. Consent for prenatal care should include HIV testing. A second HIV test should be offered to pregnant women in the third trimester who are known to be at risk for HIV or those who are in key jurisdictions or high HIV prevalence healthcare facilities. Opt-out rapid HIV testing should be offered to women with an undocumented HIV status during labor and delivery. ART should be initiated on the basis of a rapid HIV test result. Newborns should be tested if the mother's HIV status is unknown.

CDC will launch its new Adult Hepatitis B Vaccination (HBV) Initiative in 2007. New HBV recommendations will be published in the Morbidity and Mortality Weekly Report (MMWR) in November 2006 and will call for venue-based vaccination of adults. The new initiative will maximize previous accomplishments in hepatitis B elimination efforts in the United States and will also take advantage of new synergies that are now available across CDC programs as a result of the agency-wide reorganization.

Four key strategies will be highlighted in the Adult HBV Initiative: (1) prevent perinatal HBV transmission; (2) implement universal infant vaccination; (3) implement catch-up vaccination for all children and adolescents <19 years of age; and (4) vaccinate adults in groups known to be at risk for HIV. Vaccination programs played a tremendous role in the dramatic reduction of the incidence of acute hepatitis B in the United States from 1984-2004. However, targeted interventions are still needed because the decline in the incidence of hepatitis B has remained flat in certain subgroups over the past few years.

In addition to publishing the new HBV recommendations, CDC will also conduct other activities under the Adult HBV Initiative. Access to free adult HBV in the United States will be increased. States and local jurisdictions will be encouraged to use savings in the federal 317 program to purchase vaccine. Plans will be developed to direct vaccine to HIV, STD and other clinics with high hepatitis B prevalence.

Vaccination capacity will be strengthened in specific sites, jurisdictions and settings where HBV should be provided. A request will be made to support local HBV coordinators. Training and technical assistance will be provided to HBV providers. Vaccination programs will be evaluated and improved. Approaches will be explored to make intensive investments over the next five years to truly eliminate hepatitis B in the United States.

The CDC Global AIDS Program (GAP) is continuing its participation and investment in global AIDS initiatives through PEPFAR. PEPFAR represents the single largest U.S. government investment in global HIV/AIDS activities. GAP is serving as a leader in implementing a public health evaluation strategy to collect and aggregate data across PEPFAR programs. GAP is also engaged in ongoing efforts for the Department of State and U.S. Agency for International Development to more closely collaborate with countries and embassies to plan initiatives, report data, and promote one U.S. government investment of HIV/AIDS and other health issues in different countries in FY'07 and thereafter.

New programmatic initiatives will be incorporated into PEPFAR in FY'07 based on findings from initial activities. More emphasis will be placed on prevention for HIV-positive persons; the relationship between HIV and alcohol; gender inequalities in terms of access to care and quality of services; and prevention of vertical transmission of HIV.

CDC played a major role in two developments that occurred in 2006 regarding STDs. The Food and Drug Administration (FDA) licensed use of the quadrivalent human papillomavirus (HPV) vaccine in June 2006 in females 9-26 years of age. The HPV vaccine is effective against HPV types 6/11/16/18 and the prevention of cervical cancer, genital warts, and cervical, vaginal and vulvar pre-cancerous or dysplastic lesions.

CDC's expertise was instrumental in the Advisory Committee on Immunization Practices (ACIP) making final recommendations on the HPV vaccine in June 2006. ACIP recommended routine use of the HPV vaccine for females 11-12 years of age; initiation of the vaccination series beginning at 9 years of age; and catch-up vaccination for females through 26 years of years. ACIP's statement on the HPV vaccine will be published in the MMWR in the first half of 2007. Data on the efficacy of the HPV vaccine in males are expected to be released in 2007 or 2008.

CDC established several workgroups throughout the agency to continuously monitor the impact of the HPV vaccine through communications and evaluations of vaccine uptake, safety and impact. GlaxoSmithKline is expected to apply for FDA licensure of its bivalent vaccine for HPV types 16/18 in 2007.

CDC is continuing to provide guidance on financial issues related to the HPV vaccine. The catalogue price of the vaccine is \$120/dose for the three-dose series. Negotiations are underway to establish CDC's contract price of \$96/dose. The Vaccines for Children Program will pay for the cost of the vaccine at no cost to children <19 years who

meet the following eligibility criteria: Medicaid recipients, uninsured persons, Native Americans/Alaska Natives, or under-insured and vaccinated persons at participating federally qualified health centers and rural health clinics.

The Merck Patient Assistance Program can be used to pay for the cost of the HPV vaccine in the private sector for persons who meet the following eligibility criteria: persons >19 years of age, uninsured persons, and persons with an annual household income <200% of the federal poverty level. Efforts are underway for Merck to receive signed forms from applicants and complete the approval process for payment in less than 10 minutes.

CDC compiled the newest evidence to update and release its STD Treatment Guidelines in July 2006 for use as a standard protocol for STD treatment in the United States. Key language from the guidelines is outlined below:

- Additional focus on appropriate screening and treatment of STDs among men who have sex with men (MSM).
- More emphasis on the benefits of re-screening for chlamydia and gonorrhea.
- Recommendations for partner-delivered therapy for chlamydia and gonorrhea if other strategies to reach partners would not be likely to succeed.
- New recommendations for treatment of chlamydia in pregnant women.
- New treatment recommendations to reduce transmission of herpes simplex virus type 2 (HSV-2).
- Information on available new medications for treatment of trichomoniasis.
- An update on the HPV vaccine and its licensure.
- New evidence on the effectiveness of male latex condoms in reducing the risk of pelvic inflammatory disease, HSV-2, HPV and HPV-associated diseases.
- Stronger recommendations for HBV vaccination of unvaccinated adults seeking care in venues that provide services to high-risk adults.
- Stronger recommendations for routine HIV testing for persons seeking evaluation and treatment for STDs, including opt-out testing.

CDC used several venues to widely disseminate the updated STD Treatment Guidelines, including a publication in the August 4, 2006 edition of the MMWR, distribution of hard copies upon request, the availability of hard copies on the CDC web



site, a video podcast, user-friendly pocket guides and wall charts for a broader range of stakeholders, and presentations at multiple professional meetings.

At the center level, NCHHSTP will conduct several activities to support its FY'07 strategic imperatives. To "maximize public health impact," NCHHSTP will align staff, strategies, goals, investments and performance to maximize its impact on the health and safety of populations. NCHHSTP established three FY'07 priorities to support this strategic imperative. The elimination of TB, syphilis and perinatal HIV will be accelerated. The implementation of hepatitis B, HPV and other vaccine-preventable STDs will be enhanced. The incidence and consequences of HIV/AIDS, hepatitis C and STDs will be decreased, particularly in racial/ethnic minority groups and resource-constrained countries.

To "ensure accountability," NCHHSTP will sustain public trust and confidence by making the most efficient and effective use of investments in NCHHSTP. NCHHSTP established two FY'07 priorities to support this strategic imperative. Information about HIV, viral hepatitis, STD and TB prevention investments will be more easily and readily available to the public. Funding investments for HIV/AIDS, viral hepatitis, STD and TB prevention will be published on the NCHHSTP web site.

To "strengthen public health science," NCHHSTP will create and disseminate knowledge and innovations for persons to protect their health now and in the future. NCHHSTP established three FY'07 priorities to support this strategic imperative. Training will be provided to promote scientific excellence within NCHHSTP. The ethical framework for HIV, viral hepatitis, STD and TB research will be adapted and refined. Workforce development will be promoted through internal and external research funded by CDC and its partners.

To "provide leadership," NCHHSTP will leverage its unique capabilities, partnerships and networks to improve the health system. NCHHSTP established three FY'07 priorities to support this strategic imperative. NCHHSTP's governance relationships and strategic priorities will be clarified and implemented. Leadership will continue to be provided at both national and international levels to improve health outcomes related to HIV, viral hepatitis, STD and TB prevention. Meetings will be convened with federal partners to enhance collaboration.

To "promote customer centricity," NCHHSTP will market tools that persons desire and need to choose health. NCHHSTP established three FY'07 priorities to support this strategic imperative. Existing partnerships will be sustained and strengthened. New and non-traditional partnerships will be developed to enhance the prevention and control of HIV, viral hepatitis, STD and TB. A communications plan that delivers accessible and comprehensive health messages to partners and the public will be developed.

To "strengthen global health efforts," knowledge and tools developed by CDC and NCHHSTP will be extended to promote health protection around the world. NCHHSTP

established two FY'07 priorities to support this strategic imperative. The successful implementation of PEPFAR will be facilitated and supported. Collaboration with global surveillance, research and program partners will be fostered for the prevention and control of HIV/AIDS, viral hepatitis, STD and TB globally.

NCHHSTP established two new strategic imperatives that will be implemented in FY'07. For "workforce development," NCHHSTP will facilitate and support the CDC-wide diversity initiative, employee career development planning and cross-training to meet future human capital needs. NCHHSTP established three FY'07 priorities to support this strategic imperative. Collaborative efforts will be undertaken with the CDC Office of Diversity to disseminate information on diversity policies, actions and initiatives related to diversity issues and trends. NCHHSTP managers will be educated on available resources to assist in recruitment and retention of a diverse workforce. Existing NCHHSTP resources will continue to be used to support training and career development.

For "surveillance and strategic information," NCHHSTP will harmonize data collection, analysis and distribution. NCHHSTP established two FY'07 priorities to support this strategic imperative. A cross-divisional surveillance workgroup will be convened to identify opportunities to harmonize data collection. The feasibility of producing an integrated annual surveillance report on HIV/AIDS, viral hepatitis STD and TB in the United States will be explored.

In addition to the strategic imperatives, NCHHSTP will also place strong emphasis on two other areas to make substantial gains over the next few years. For "program collaboration and service integration," integrated services might include HIV, STD and hepatitis B and C counseling and testing (C&T); partner services and referrals to additional prevention or care; and hepatitis A and B immunization. Integration will be focused at the field or client level where the interface between the system and the consumer occurs. For purposes of this strategic imperative, NCHHSTP defines "integration" as an opportunity that results in integrated services for clients regardless of the agency structure.

NCHHSTP conducted several activities in 2006 to support this strategic imperative. Internal workgroups were formed. The NCHHSTP Director made site visits to explore opportunities for program integration. A new initiative was developed to cross-train project officers and program consultants. New information technology tools were designed to facilitate cross-collaborations within NCHHSTP. Efforts are underway to recruit and fill a new position for the NCHHSTP Associate Director for Program Integration.

For "health disparities," NCHHSTP will attempt to improve the health of populations disproportionately affected by HIV, STDs, TB and other related diseases or conditions to advance toward eliminating health disparities. Target populations for this strategic imperative will include racial/ethnic minority groups, women, incarcerated persons, and

other communities and persons disproportionately affected by infectious diseases.

Several NCHHSTP divisions conducted activities in 2006 to support this strategic imperative. The Division of Tuberculosis Elimination convened a consultation in May 2006 and launched the “Stop TB in the African American Community” web site. The Division of STD Prevention (DSTDP) revised and released the “National Plan to Eliminate Syphilis in the United States.” The Division of HIV/AIDS Prevention (DHAP) held a series of consultations and is now developing comprehensive plans to enhance HIV prevention among African Americans (AAs). The need to incorporate STD, TB and viral hepatitis prevention strategies for AAs was emphasized during the consultations.

CDC and its partners will sponsor the 2007 National HIV Prevention Conference on December 2-5, 2007 in Atlanta, Georgia. The conference is being designed to ensure that the needs of an evolving HIV prevention climate in the United States are met. Several CHAC members attended a planning meeting in October 2006 to provide advice on the agenda, speakers, abstracts, topics and other aspects of the conference. Similar to previous conferences, CDC expects CHAC to be strongly represented at the 2007 National HIV Prevention Conference.

Several personnel changes occurred in NCHHSTP’s senior leadership after the previous CHAC meeting. Staff were appointed to serve in acting positions for the NCHHSTP Deputy Director, Associate Director for Health Disparities, Associate Director for Science, and Associate Director for Laboratory Sciences. NCHHSTP management will make every effort to fill the acting positions with permanent staff in 2007.

CHAC supported CDC’s revised HIV testing recommendations that call for routine testing. However, several members expressed concerns with some aspects of the guidelines and made suggestions for CDC to consider in addressing these issues.

- CDC’s revised HIV testing recommendations conflict with its 2001 HIV C&T guidelines and language in cooperative agreements. For example, the revised HIV testing guidelines advise grantees to collect an enormous amount of data and enter this information into the Program Evaluation and Monitoring System (PEMS). However, these actions cannot be taken with routine testing because information must be gathered directly from patients and informed consent must be obtained to provide HIV counseling. This approach would result in a two-tiered system in each state if CDC’s revised HIV testing recommendations, 2001 HIV C&T guidelines, language in cooperative agreements, and PEMS data requirements are not changed to be consistent. CDC should resolve this dilemma as efforts are made to implement the revised HIV testing recommendations.
- CDC should develop HIV testing algorithms for private laboratories.
- CDC should create and disseminate printed information on HIV testing and the



rationale for including the test in the regular battery of tests.

- CDC's revised HIV testing recommendations do not acknowledge that existing laws requiring confirmatory tests are a major barrier to streamlining routinized testing. These laws also undermine linkages to care for emergency room patients and hard-to-reach populations. Most notably, one week is still required to obtain results of confirmatory HIV tests.
- CDC's revised HIV testing recommendations do not consider rapid confirmatory tests that are used in other countries. The antiquated approach of post-test counseling in the United States requires patients to present again to providers at a later time to obtain test results. This strategy results in missed opportunities to reach at-risk patients and address behaviors to reduce transmission of HIV.
- CDC should make plans at this time to ensure that persons who are newly diagnosed with HIV as a result of the revised HIV testing guidelines are linked to care.
- CDC's revised HIV testing recommendations do not federally recognize Native Hawaiians or provide a voice for this population.
- CDC's revised HIV testing recommendations do not acknowledge that health departments serve as a major barrier to grantees providing services to the "new faces" of HIV, such as women in Alaska and Alaska Native women.
- CDC's revised HIV testing recommendations do not include interventions and strategies specifically for small and rural areas.

Dr. Fenton and other CDC representatives provided additional details on CDC's activities in response to CHAC's specific questions, comments and concerns.

- CDC's revised HIV testing recommendations are designed to provide greater opportunities for HIV testing of at-risk populations in healthcare settings. CDC will publish updated guidelines for HIV testing in community settings in 2007 to assist CBOs in streamlining and modernizing HIV testing activities.
- CDC will expand existing models and best practices in the field throughout the country to implement the revised HIV testing guidelines. For example, the CDC Division of HIV/AIDS Prevention convened a meeting in October 2006 with various federal, provider and medical partners to obtain input on implementing the revised HIV testing guidelines in terms of funding allocations, expansion of existing best practices and models, and provision of capacity-building and training. Feedback from the partners will be captured in CDC's implementation guidelines for the revised HIV testing recommendations that will be released in 2007.
- CDC's revised HIV testing recommendations contain extremely clear guidance for providers to obtain consent from and accurately diagnose patients. For example, providers are advised not to administer HIV testing without the knowledge and full consent of the patient and to only give results of the test to the patient. Local

jurisdictions are also advised to identify and resolve legal barriers to HIV testing. Providers who do not comply with CDC's guidance on diagnosis and confidentiality would be at a greater risk to be sued by patients.

- CDC's revised HIV testing recommendations clearly identify and define "high-risk" populations, settings and behaviors for annual routine HIV testing, such as persons who present to STD clinics and drug treatment settings or individuals who report >2 sexual partners in the past year.
- CDC's Infertility Prevention Program is a top priority in DSTDP in terms of resources and need. The national reported rate of chlamydia is nearly 1 million cases. Reported cases of gonorrhea increased over the past year for the first time since the late 1990s. Both of these infections have enormous disparities. The prevalence of chlamydia and gonorrhea in family planning clinics and other sentinel settings has either flattened or slightly increased. CDC is aware that stronger actions need to be taken for chlamydia and gonorrhea, particularly screening in non-public sectors and wider screening and coverage of the currently recommended population of sexually active women <26 years of age.
- CDC will review and update its existing HIV C&T guidance to resolve any conflicts with the revised HIV testing recommendations.
- CDC will closely collaborate with partners to link persons who are newly diagnosed with HIV as a result of the revised HIV testing recommendations to care. The recommendations strongly emphasize, cite solid articles and describe CDC's demonstration projects on the importance of linkages to care. CDC will use newly-diagnosed HIV-positive persons as a mechanism to advocate for more HIV prevention funding.
- CDC will hold a meeting on the following day with PEMS stakeholders in an effort to reach agreement on a C&T data collection form. CDC and the stakeholders will also explore the possibility of developing a shorter form for STD clinics for opt-out purposes. A third form will be considered as well for settings not funded by CDC to collect minimal data on testing.
- CDC has prioritized and is currently taking actions to develop new HIV testing algorithms in 2007. CDC is aware that current tests are outdated and do not reflect the range of new HIV tests on the market.
- CDC will review, consider and expand excellent models of practice for inclusion in implementation guides of the revised HIV testing guidelines. The guidance on practice will cover the development of consent and testing forms, appropriate materials to display in waiting rooms, information to personally give to patients, and pre-test information in languages that would be understandable to persons undergoing routine HIV testing.
- CDC expects to partner with a professional organization to analyze existing laws and develop model language for confirmatory tests to facilitate streamlining of HIV testing.

- CDC will review its STD Treatment Guidelines to ensure that this guidance does not conflict with previous recommendations on STD treatment.
- CDC's domestic recommendations on HIV testing in the United States has no influence on the overall PEPFAR initiative. However, CDC's guidance might play a role in routine HIV testing administered by individual global partners.

Dr. McGuire noted that CHAC's discussions on CDC's activities are typically dominated by HIV/AIDS. As a result, she thanked Dr. Fenton for including CDC's viral hepatitis and STD activities in his comprehensive update. She conveyed that this information would assist CHAC in providing guidance on both HIV and STD prevention and treatment.

Similar to Mr. Milan's request during the HRSA session, Dr. McGuire also asked CHAC to make suggestions on CDC's activities that should be considered as potential formal motions for submission to the CDC Director or HHS Secretary. She listed four issues for CHAC to consider in this effort:

- The catalogue price of the HPV vaccine of \$120/dose versus CDC's proposed contract price of \$96/dose.
- The Adult HBV Initiative, such as the actual value of catch-up vaccination for all children and adolescents <19 years of age; integration of hepatitis A into the Adult HBV Initiative; and minimal savings from the federal 317 program for states and local jurisdictions to purchase HBV vaccine.
- CDC's efforts to integrate its HIV/AIDS, viral hepatitis, STD and TB prevention programs, particularly the need for more solid accountability, transparency and communications.
- The need for CDC to develop a strategic and time-sensitive approach to monitor the extensive amount of effort and resources that will be devoted to implementing the revised HIV testing recommendations. The need for CDC to create an effective process to address false-positive test results and other potential consequences of the revised HIV testing recommendations.

## **Update on the CDC National HIV Prevention Strategic Plan**

Dr. McGuire concluded the session by confirming that CHAC would continue to discuss CDC's revised HIV testing recommendations to further address concerns raised by the members.

Dr. George Roberts, Associate Director for Prevention Partnerships in NCHHSTP and co-chair of the CHAC Strategic Plan Workgroup, covered the following areas in his report. From May 2005-May 2006, CHAC approved the establishment of the workgroup to review performance of the 2001-2005 Strategic Plan and make recommendations for updating the Strategic Plan during a three-year extension. The workgroup was formed with two co-chairs and 30 members. The workgroup convened two face-to-face meetings and presented its report to CHAC during the previous meeting.

The workgroup established several objectives to fulfill its charge. Priority goals, objectives and broad strategies of the Strategic Plan would be reexamined. Progress to date in reaching the goals and objectives would be discussed. Reasons for the nation not achieving some of the goals would be discussed. Gaps and necessary revisions in the goals and objectives would be identified. Recommendations would be made for prioritizing objectives under each goal. Strategies would be recommended to revise the Strategic Plan to achieve greater progress and success.

Numerous activities were conducted from July 2005-May 2006 for the workgroup to achieve the objectives. Background materials were reviewed, such as relevant articles by CDC and external researchers, related plans, guidelines and technical information. Presentations were made on several issues, including CDC's funding and activities for each goal, racial disparities, biomedical interventions and prevention effectiveness.

Strategies to increase the likelihood of reducing HIV transmission by 50% were presented to the workgroup from community, health department, care and policy perspectives. Progress and barriers to reaching goals and objectives were reviewed. Recommendations were made on updating the goals and objectives.

The workgroup identified a number of barriers to achieving the goals and objectives. The Strategic Plan was not accompanied by a social marketing campaign to increase public awareness and engage stakeholders. Endorsement of the Strategic Plan at national and community levels was lacking and led to minimal coordination and collaboration. The scope and relevance of the Strategic Plan to other federal agencies were not well defined.

The Strategic Plan did not delineate macro-level and structural factors that influence HIV transmission. Resources were inadequate. Targeting of the Strategic Plan to MSM and communities of color was ineffective. Effective preventive interventions were lacking for communities of color, particularly AAs and MSM. HIV prevention, C&T and

care systems were disconnected.

Several common themes emerged from the workgroup's discussions on updating the Strategic Plan. An overarching racial/ethnic disparities goal should inform implementation of objectives and strategies for all goals. A clear distinction should be made between goals and objectives related to PLWH and seronegative persons at risk of HIV infection. Goals and objectives related to care should be better specified, particularly for maintaining persons in care. Stronger language should be developed to emphasize the need for routine and available HIV testing in multiple settings, including non-healthcare facilities.

Interventions should be targeted to structural and social norms that lead to risk. Biomedical strategies should accompany behavioral interventions. Interventions should be targeted to persons with acute HIV infection as a strategy to interrupt transmission during highly infectious periods. Targeting for populations at highest risk of acquiring and transmitting HIV should be improved and based on incidence rather than prevalence.

The workgroup's major recommendations are highlighted as follows. To maintain the overarching numeric goal for reducing new infections, AAs should be prioritized at the highest level, within the overarching goal, and within each individual goal. MSM should be prioritized within the goals as appropriate. Racial/ethnic minority populations with a disproportionate burden of disease or incidence should be prioritized.

Under goal 1, separate prevention goals should be created for PLWH and seronegative persons at risk of infection. Goals on testing and linkage to care should be updated. A new goal should be added to address stigma and discrimination. Goal 4 on surveillance and capacity-building should be eliminated because strategies and objectives for these issues should be included in all goals.

The workgroup proposed five specific goals for the updated Strategic Plan:

- Goal 1: By 2008, decrease by at least Y% the number of PLWH at risk of transmitting HIV.
- Goal 2: By 2008, decrease by a least Y% the number of persons at risk of acquiring HIV.
- Goal 3: Increase the percentage (from X% to Y%) of persons [of HIV-positive persons] in the United States who know their HIV infection status through routine testing in diverse settings.
- Goal 4: By 2008, increase from the current estimated ??% to ??%, the proportion of persons with HIV who are receiving appropriate prevention, care and treatment services.
- Goal 5: Increase public awareness of HIV and reduce HIV-related stigma and discrimination.

The workgroup recommended several issues that should be considered in updating all goals and objectives across the Strategic Plan.

- Improve all goals and objectives to achieve better targeting. For example, testing efforts should be differentially targeted by prevalence and incidence. The efficacy of improving interventions with the most infectious persons should be determined. Specificity should be increased for populations and settings where linkages to care would occur.
- Develop and use improved models to differentially assess efficacious and cost-effective interventions and describe an optimal mix of interventions. Include an expanded focus on system and structural interventions and necessary mobilization in this framework.
- Analyze resources at the objective level to allow goal targets and funding allocations to be adjusted and monitored over time.
- Develop a strategy regarding expanded resources for care.
- Develop a mechanism to appropriately align evaluation and capacity-building activities and resources in prior goal 4 across the new goals and objectives.
- Establish resources, necessary federal and other partners, and other scale-up models.
- Acknowledge that success of the updated Strategic Plan will depend on taking different approaches, clearly defining a road map, and implementing a detailed mobilization strategy.
- Monitor and annually report on progress of the goals.

To guide the discussion, Dr. McGuire and Mr. Milan informed CHAC that CDC needs specific guidance to take next steps on the updated Strategic Plan. For example, CHAC should consider whether the originally proposed three-year extension should be expanded for an additional two years for a five-year updated Strategic Plan. CHAC should identify solid strategies for CDC to allocate HIV prevention resources. CDC should not be placed in a position of attempting to achieve the updated Strategic Plan goals in the current environment of inadequate resources.

CHAC applauded CDC's efforts to support the workgroup's charge of updating the Strategic Plan. Most notably, CDC provided data and a wealth of expertise to assist the workgroup in making recommendations. Several CHAC members made suggestions for CDC to consider in finalizing the updated Strategic Plan.

- A strong disclaimer should be included in the Strategic Plan to emphasize that the goals cannot be achieved without adequate resources. The language should also note that insufficient funding was the major cause of the failure to reach the previous Strategic Plan goal of reducing HIV transmission by 50%.



- CDC should leverage resources with federal partners and other sectors over time to develop a National Plan for HIV Prevention, Treatment and Care.
- CDC should take advantage of existing opportunities to pilot HIV prevention initiatives in collaboration with federal partners. For example, 5% of Substance Abuse and Mental Health Service Administration (SAMHSA) block grants is set aside for HIV/AIDS in key states, but this option should be expanded and available to all states. The 5% set-aside in SAMHSA block grants is not restricted in terms of pre-/post-test counseling and wraparound services. Due to current and future budget cuts, communities must be able to take advantage of HIV/AIDS dollars from sources other than CDC.
- The Strategic Plan should not be extended for an additional two years at this time due to current uncertainties, such as the upcoming implementation of CDC's revised HIV testing recommendations, existing flaws in PEMS and severe budget constraints.
- CDC should sponsor another workgroup meeting to identify and discuss other priority populations for HIV prevention, such as AA heterosexual men, AA women, youth, Hispanics and Alaska Natives. Prioritization of MSM and AAs in the Strategic Plan could be misinterpreted to mean that HIV is only a problem in these two populations.
- CDC should develop accountable, realistic, reasonable, attainable and measurable indicators to monitor progress of the Strategic Plan.

Dr. Robert Janssen, Director of DHAP, clarified that DHAP has not yet formally responded to the workgroup's recommendations on the updated Strategic Plan because internal discussions are still underway. However, he described several actions DHAP is considering to finalize the updated Strategic Plan.

DHAP intends to target resources to HIV testing of AAs and MSM if funds are allocated in the FY'07 appropriation for the President's rapid HIV testing initiative. DHAP is currently obtaining input from external partners on its heightened response to the HIV epidemic in the AA community. DHAP expects to release a concrete plan from this effort in early 2007. The guidance will reflect feedback DHAP gathered from its previous consultations and other activities to address the HIV epidemic in the AA community. DHAP will develop new strategies and use existing methods to sustain previous mobilization efforts in the AA community.

DHAP's senior leadership will convene a budget and strategic planning retreat on November 28, 2006 that will include a review of all Strategic Plan objectives and identification of the top ten priorities across all goals. In preparation of the retreat, DHAP developed and added new objectives to the Strategic Plan goals that are consistent with the workgroup's recommendations.

DHAP is collaborating with and obtaining input from both internal and external partners to develop a model for allocating resources and analyzing the impact of the HIV

epidemic. DHAP expects to review results of the model in January or February 2007. The data will assist DHAP in determining whether existing HIV prevention interventions are appropriate or if new models should be developed focusing on cost-effectiveness, the efficacy of interventions and the impact of the HIV epidemic.

DHAP incorporated stigma into each objective to address the workgroup's new goal on this issue. CDC's revised HIV testing guidelines also address stigma by recommending universal screening instead of testing on the basis of risk factors.

DHAP will develop performance indicators to monitor progress on the Strategic Plan. DHAP expects to create annual targets for national HIV incidence and will develop other annual measures after CDC's existing monitoring systems are refined.

Dr. Janssen concluded his comments by expressing strong support of the workgroup's proposed recommendation for an additional two-year extension for a five-year updated Strategic Plan.

## **Panel Presentations on Issues Impacting the Strategic Plan**

**Ms. Jennifer Kates**, Vice President and Director of HIV Policy at the Kaiser Family Foundation and a Strategic Plan Workgroup member, described issues that would affect the Strategic Plan. Of the total FY'06 federal budget of \$2.6 trillion, \$21.1 billion or <1% was devoted to HIV/AIDS prevention, care, treatment and research. Although this amount represented a small percentage of the total FY'06 federal budget, federal funding for HIV/ AIDS dramatically increased from \$0 in 1981 to \$22.8 billion in the President's FY'07 budget request.

In FY'06, 55% of the federal HIV/AIDS budget was mandatory as a result of Medicaid, Medicare, Supplemental Security Income, Social Security Death Index, and Federal Employees Health Benefits programs. The remaining 45% of the federal HIV/AIDS budget was discretionary as a result of annual Congressional appropriations for the CARE Act and HIV/AIDS research, global, housing and prevention programs. Discretionary funding decreased from 1981-2006 because more persons are now living with HIV and are eligible for mandatory care and income assistance programs. For example, 50% of federal funding for HIV/AIDS was allocated to research in FY'82, while 58% was allocated to care and treatment and only 4% was allocated to prevention in FY'06.

Federal agencies are the primary recipients of domestic HIV prevention funding with the majority of these dollars allocated to CDC. Of \$869 million in federal funding for domestic HIV prevention in FY'06, CDC received \$719 million or 83%. CDC distributes these funds to states, cities, CBOs and other programs. Other recipients of HIV



prevention funds include other federal agencies, state and local governments and private-sector groups.

CDC's federal funding for domestic HIV prevention increased from \$0 in FY'82 to \$719 million in FY'06 based on nominal dollars. However, the FY'06 amount is nearly the same as FY'92 dollars based on inflation. The President's budget requests for domestic HIV prevention increased from \$872 million in FY'05 to \$956 million in FY'07. Of the President's FY'07 budget request of \$956 million for domestic HIV prevention, \$808 million or 85% would be allocated to CDC, including a \$93 million proposed increase.

In FY'05, CDC/DHAP distributed \$374.6 million or 59% of its total \$633.8 million budget to state and local health departments. DHAP allocated the remainder of the budget to capacity-building, intramural programs, directly funded CBOs, research, program evaluation and interagency agreements. DHAP's HIV prevention funds to the top ten states in FY'05 ranged from ~\$77.3 million to New York to ~\$15.8 million to Massachusetts.

CDC's HIV prevention budget is an important factor that CHAC must consider in providing guidance on the updated Strategic Plan. For example, CDC's revised HIV testing guidelines for routine screening are targeted to persons 13-64 years of age. According to the most recent U.S. Census estimates, ~200 million persons account for this population in the United States. Of this population, ~1.2 million are HIV-positive. Of this population, ~250,000 are HIV-positive and do not know their status. CDC's resources are targeted to reaching this population, informing these persons of their status, and making linkages to care.

Of ~1.2 million HIV-positive persons in the United States, 25% are undiagnosed, 25% are diagnosed and not in care, and 50% are in care. PLWHA had the following insurance coverage based on 1996 data: 31% with private insurance, 29% with Medicaid, 13% with Medicaid/Medicare, 6% with Medicare, and 20% uninsured. More recent data collected in 2002 from 17 HIV clinics throughout the country showed a change in insurance coverage of PLWHA: 34% with Medicaid, 16% with private insurance, 13% with Medicaid, 4% with Medicaid/Medicare, and 28% uninsured.

Data collected from 25 states from 1994-2000 showed that private insurance accounted for 33% of PLWHA at the time of diagnosis, Medicaid accounted for 22%, other public or government programs accounted for 19%, and no insurance accounted for 27%. Data collected in 2004 from 35 areas showed that 61% of AIDS diagnoses were made >12 months after HIV diagnoses.

Data collected in 2002 on HIV testing by facility and diagnosis showed that hospitals, emergency rooms and community clinics diagnosed most HIV-positive patients. Data collected in 2003 on PLWHA by awareness of serostatus showed that undiagnosed persons were more likely to be AA and Hispanic based on race/ethnicity and MSM and heterosexual based on transmission.

Ms. Kates summarized key points for CHAC to consider in providing further guidance to CDC on implementation of the updated Strategic Plan. The Strategic Plan and revised HIV testing recommendations target two populations: all persons 13-64 years of age for routine screening and a subset or <1% of the population that is estimated to be HIV-positive and undiagnosed. The undiagnosed population is more likely to be uninsured persons of color, rely on public assistance, infected through sexual contact, and present to emergency rooms and community clinics.

Linkages to the care system will be critical in implementing the updated Strategic Plan and revised HIV testing recommendations because ~50% of diagnosed persons have no access to care and 39% are diagnosed late. ADAP waiting lists; other barriers to the care system; and resources from federal, state and local systems will need to be addressed to implement the Strategic Plan.

**Dr. David Holtgrave**, of Johns Hopkins Bloomberg School of Public Health, provided additional data on issues that will affect the Strategic Plan. Since the mid-1980s, successful HIV prevention programs have led to a decrease in the number of new infections in the United States from 160,000/year to ~40,000/year. The investment in HIV prevention also resulted in societal cost-savings. Modeling has been performed to estimate the number of new infections that would have occurred each year without HIV prevention programs. The scenarios projected that ~1.5 million infections were prevented in the United States from 1985-2000.

The rate of HIV transmission from PLWH to seronegative partners dramatically decreased from ~100% in the early stage of the epidemic to 4% in 1990. These data showed that at least 96% of PLWH were not transmitting HIV in a given year. HIV transmission rates are estimated to be 8.8%-10.8% in persons who are unaware of their HIV seropositivity and 1.7%-2.4% in persons who are aware of their HIV seropositivity. C&T play a major role in the significant differences in HIV transmission rates between the two groups. A paper that is in press showed a strong relationship between resources and HIV incidence after 1985.

The overarching national goal in the 2001 Strategic Plan was to reduce the number of new HIV infections in the United States from an estimated 40,000 to 20,000 per year by 2005 with a particular focus on eliminating racial/ethnic disparities in new HIV infections. The November 18, 2005 edition of the MMWR contained an article on HIV/AIDS diagnoses collected from 33 states with name-based reporting systems from 2001-2004. Over the four-year period, 157,252 diagnoses were made in the 33 states. These data suggested that HIV incidence in the United States was well over 40,000/year in the United States in 2005.

Sub-goal 1 in the 2001 Strategic Plan was by 2005, to decrease by at least 50% the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention interventions. Progress on this goal is uncertain due to unclear language and the lack of national sexual behavior data. However, a published study showed that HIV-positive

persons reduced risk behaviors by 68% after learning of their HIV seropositive. Other data showed that ~11.7%-11.9% of the general U.S. population were at heightened risk of HIV due to sexual transmission, drug use risk behaviors or a current STD.

Sub-goal 2 in the 2001 Strategic Plan was by 2005, to increase from the current estimated 70% to 95% the proportion of HIV-infected persons in the United States who know they are infected through voluntary C&T. The lack of progress on this goal was demonstrated by CDC's estimate of a 73%-76% awareness level of HIV in 2005.

Sub-goal 3 in the 2001 Strategic Plan was by 2005, to increase from the current estimated 50% to 80% the proportion of HIV-infected persons in the United States who are linked to appropriate care and treatment services. The lack of progress on this goal was demonstrated by a 2004 Institute of Medicine report that estimated only 49.7% of persons in need of highly-active ART actually received therapy.

For the updated Strategic Plan, the national goal should be maintained to reduce new HIV infections in the United States to 20,000/year or less by 2010 and place particular emphasis on racial/ethnic health disparities. However, the goal should be expanded to monitor progress with annual report cards on the national investment; develop process measures for policy implementation, reduce barriers and service delivery; and assess annual outcomes. The goal will continue to be important because 5-26.3 million persons are seronegative, but have behavioral risks for HIV infection. CDC has estimated that ~1.1 million PLWH are in the United States. Of this population, ~25% are unaware of their status.

A meta-analysis showed that after PLWH obtain C&T, ~16% will still continue to engage in risk behaviors. Based on these data, several sub-goals should be considered for the updated Strategic Plan. Risk behaviors should be decreased and serostatus awareness should be promoted. Care and treatment should be available to all persons who need these services.

Information should be more widely disseminated to the general public to combat stigma of HIV. CDC should partner with the National Institutes of Health (NIH) to invest in and conduct research on new interventions to decrease stigma. Serostatus-specific HIV prevention efforts should be targeted to HIV-positive persons; recently tested HIV-negative persons who are at continued behavioral risk of infection; persons who are unaware of their HIV status; and the general population.

A paper that is in press analyzed the potential impact of HIV seropositivity awareness on HIV incidence via C&T. The data showed that prevented HIV infections could be achieved by lowering the transmission rate from 9% to 2%. An analysis that is currently under review for publication examined the costs and consequences of four HIV testing scenarios. The analysis showed that if HIV screening rates were increased to 52% in the target population, ~65 million persons would need to be tested and ~56,000 seropositive persons would be reached. Total program costs of this effort were

estimated at ~\$864 million. The gross cost per avoided infection was estimated at \$237,149. To provide care and treatment for newly-diagnosed persons, ~\$961.3 million would need to be set aside in the first year. Overall, the analysis demonstrated that ~\$1 billion would be needed to support a new Strategic Plan.

Dr. Holtgrave summarized several issues for CHAC to consider in providing additional guidance to CDC on implementing the Strategic Plan. C&T and serostatus awareness are important interventions, but are not sufficient to achieve an “HIV disease elimination” program. As a result, HIV prevention interventions should be designed to include individual, dyad, family, group, community and structural levels, such as laws, policies, environments and social determinants. HIV prevention interventions should also focus on sexual, perinatal and parenteral transmission, including interventions for small groups, communities and housing. Structural interventions should be designed to strengthen social capital at the community level to impact STDs, AIDS and teen pregnancies.

HIV prevention programs have changed the course of the epidemic in the United States, but additional progress must be made to further reduce the number of new infections. Previous efforts should be scaled-up to conduct activities in the future and allocate resources for these initiatives. HIV prevention programs have decreased incidence, but flat funding of these activities must be addressed. Targeted HIV C&T might have substantially more public health benefits than opt-out testing at the same cost.

Additional promotion of serostatus awareness via C&T might decrease the national annual incidence of 40,000 new HIV infections to 25,000-30,000 for a true HIV disease elimination program in the United States. However, serostatus awareness will play a minimal role in further reductions in incidence. A multi-component, multi-level and comprehensive National Plan for HIV Prevention, Treatment and Care for the United States is urgently needed as soon as possible. The new national plan should be supported by substantial resources to provide high-quality HIV care and treatment to persons newly diagnosed with HIV through C&T campaigns.

To guide the discussion, Dr. McGuire and Mr. Milan emphasized the importance of CHAC providing guidance on models and resources for implementation of the updated Strategic Plan and the need to develop a new National Plan for HIV Prevention, Treatment and Care.

Several CHAC members suggested additional issues that should be considered in implementing the updated Strategic Plan.

- A new strategy should be developed to collect surveillance data on diseases to ensure these variables are clearly defined.
- Data from the HIV prevention economic models should be re-analyzed to determine cost-savings from HIV-positive persons who were diagnosed, received care and engaged in safer practices.

- The intersection between violence and HIV should be included in structural interventions.
- CDC should attempt to allocate resources and take other actions at this time to advance toward an HIV disease elimination program.
- Quantifiable goals should be incorporated into the updated Strategic Plan to assist in obtaining a justified budget that is based on the science and actual numbers of HIV-positive persons.
- CHAC should make strong recommendations for increased funding to reduce the number of new HIV cases. For example, language could be included in the updated Strategic Plan or a companion document to emphasize that new resources will be needed to implement the prioritized interventions and other innovative strategies to further decrease the number of new HIV infections per year.
- The Strategic Plan should outline approaches to address new barriers to providing HIV prevention, education treatment and care in the future. For example, the change in the CARE Act legislation for HIV-positive persons to be identified through name-based reporting systems in 2007 might undermine these efforts.

## Public Comment Period

**Mr. Carl Schmid**, of The AIDS Institute (TAI), made comments on two topics CHAC discussed during the meeting. First, TAI acknowledges the importance of implementing a reauthorized CARE Act in 2007. A delay in implementing the new law in 2008 would create major funding disruptions in several states and local jurisdictions. HIV case counts must be included in 2007 according to the legislation and some states do not have HIV case counts that have been accepted by CDC.

Second, TAI strongly supports CDC's revised HIV testing recommendations that call for routine voluntary HIV testing in healthcare settings, but certain aspects of the guidelines should be addressed. The broader HIV/AIDS community should be included in CDC's implementation plans for the revised HIV testing recommendations. Written information on HIV should be developed and disseminated because the guidance does not require prevention counseling through informed consent. Other components that would be included in consent and post-test counseling processes should be widely communicated to constituents.

TAI is pleased that CDC's revised HIV testing recommendations reflect its previous suggestions on opt-out testing, the provision of basic HIV information, and the distribution of materials in multiple languages. TAI is interested in learning about the implementation plans for the revised HIV testing recommendations and looks forward to collaborating with CDC in this effort.



**Ms. Thelma King Thiel**, of Hepatitis Foundation International (HFI), urged CDC and HRSA to target prevention, care and treatment efforts to persons <16 years of age. The Strategic Plan should describe primary prevention and educational interventions to encourage young persons to adopt healthy lifestyle behaviors and strongly recommend implementation of these efforts in schools. HFI's previous and ongoing training sessions, evaluations and other joint projects with diverse groups at federal, state, local and private levels have shown that hepatitis testing would save healthcare dollars.

Ms. King Thiel particularly thanked CDC for assisting HFI in developing and widely distributing school-based products. She confirmed that HFI would continue to collaborate with CDC, SAMHSA, schools and other organizations to widely promote primary prevention among youth.

**Dr. Marsha Martin**, of the Washington, DC Administration for HIV Policy and Programs (AHPP), informed CHAC that the majority of HIV testing occurs in privately-financed medical settings. However, no efforts are being made in the private sector to assist grantees in collecting data to manage HIV screening and coordinate care.

The HIV epidemic cannot be appropriately managed unless both public and private systems are included in a coordinated effort for purposes of data, care and other components. For example, AHPP has no data on persons who are screened by healthcare maintenance organizations, student health centers and other private healthcare settings because CDC only requires reports of HIV-positive results from private facilities.

Dr. Martin urged CDC and HRSA to make stronger efforts to assist grantees in integrating data from both public and private sources. She provided CHAC with background materials on AHPP's campaign that was launched to routinize HIV screening.

With no further discussion or business brought before CHAC, Mr. Milan recessed the meeting at 4:40 p.m. on November 2006.

## **Panel Presentations on National HIV and STD Strategies for Youth**

Dr. McGuire reconvened the CHAC meeting at 8:32 a.m. on November 14, 2006 and yielded the floor to the first presenter.

**Dr. Howell Wechsler**, Director of the CDC Division of Adolescent and School Health (DASH), provided an update on CDC's adolescent sexual and reproductive health activities. Of all high school students in the United States, 47% are sexually experienced. Persons 15-24 years of age account for nearly 50% or 9.1 million of all

new STDs acquired each year. Based on data from 33 states with confidential name-based HIV infection reporting systems, an estimated 4,824 HIV cases occur annually among persons 15-24 years of age. Persons 15-19 years of age account for 831,000 of all pregnancies that occur each year.

Recent trends in STD, HIV and teen pregnancies are summarized as follows. Since the early 1990s, the percent of sexually active youth has decreased and the use of condoms and contraception has increased among sexually active youth. Improved screening has led to increased rates of some STDs. Pregnancy rates have decreased overall, but smaller reductions were seen in ethnic/minority youth. Most recent data suggest that rates are not continuing to decrease and have remained level in most states.

Racial/ethnic populations are disproportionately affected by these trends. The rate of sexual intercourse is 68% among AA high school students compared to 51% among Hispanics and 43% among whites. AA adolescents represent 70% of all HIV/AIDS cases among persons 13-19 years of age. Data from 2004 showed that Hispanics accounted for ~83% of teen births compared to 61% among AAs and ~27% among whites. The 47% decline in teen birth rates among AAs was the largest compared to whites and Hispanics.

CDC recently published a paper on the percentage of high school students who ever had sexual intercourse by race/ethnicity from 1991-2005. The data showed a dramatic reduction in AA students who had sexual intercourse through the 1990s, but the decrease has stopped since 2001. The slight reduction in sexual intercourse among Hispanic adolescents was not statistically significant.

DASH, DHAP, DSTDP and the CDC Division of Reproductive Health formed an internal Workgroup on Adolescent Sexual and Reproductive Health (WASRH) which developed a report on CDC activities in this area. The four divisions allocated a total of \$77.3 million to conduct 192 different youth projects in three categories: (1) research on adolescent sexual and reproductive health; (2) direct services for HIV, STD and pregnancy prevention; and (3) training, technical assistance and capacity-building programs for adolescent sexual and reproductive health.

For the research category, the four divisions have conducted studies on sexual risk behaviors, pregnancy, STDs and HIV. The projects were designed as observational, surveillance, intervention or primary prevention studies in various units and settings, such as individual, group, family or community units and clinic, community, school or juvenile justice settings. A three-phased activity was conducted to identify, package and disseminate evidence-based interventions. Collaborations were established with national organizations and state teen pregnancy coalitions to assist local groups in selecting, adapting and implementing science-based programs.

For the direct services category, the four divisions provided STD screening and

treatment, HIV C&T, training for peer-based education and support, social marketing campaigns, prevention education, behavioral interventions, infrastructure development, surveillance and program evaluation. Funding was awarded to ten CBOs to offer prevention programs to young MSM of color.

Of the populations served across sites, ~50%-80% were <21 years of age. At least 10% of youth were included in 35 state and local health departments that were funded to provide program services. Seven CDC programs targeted or provided services to HIV-infected youth or youth at high risk for HIV, such as MSM, female sex workers, homeless youth and youth in juvenile justice systems. CDC supported comprehensive STD prevention systems through its Infertility Prevention Program, 50 state health departments and seven local health departments.

For the capacity-building assistance category, the four divisions provided information, technical assistance, training and technology for persons and organizations to improve service delivery and effectiveness. These services were targeted to education agencies at state, territorial and local levels, national NGOs, state teen pregnancy coalitions, Title X regional training centers and CBOs. The capacity-building activities were designed for utilization of science-based approaches to promote adolescent reproductive health, consumer outreach, recruitment, training, leadership development and strategic planning.

Dr. Wechsler concluded his update by responding to CHAC's request during the previous meeting for more information on CDC's adolescent sexual and reproductive health activities. The Health Education Curriculum Analysis Tool (HECAT) was developed to provide evidence-based guidance to schools on selecting curricula that would most likely be effective in improving the health of young persons. HECAT has been undergoing the HHS clearance process for more than one year.

DASH provided input on a document that was developed by the Office of Population Affairs on a scientific process for abstinence-only grantees to plan abstinence programs with a more rigorous approach. This document has been undergoing the federal clearance process for 1.5 years. Two evidence-based interventions developed by DHAP are still undergoing the HHS clearance process.

Dr. Wechsler also pointed out that materials were distributed to CHAC. One handout described individual projects and funding amounts for 17 national non-governmental organizations that were awarded to support HIV prevention for youth over the next five years. Another handout described additional HIV projects conducted by other grantees. Overall, Dr. Wechsler was pleased that CDC's current activities are eliminating silos and barriers to streamlining services for young persons.

**Dr. Jose Morales**, of HRSA, described HRSA's services for adolescents living with HIV/ AIDS. HRSA is an access agency with programs that are designed to provide care to persons with HIV, ensure the quality of care, include secondary prevention and decrease transmission. Under Title IV of the CARE Act, HRSA implements 17 programs



specifically for youth living with HIV/AIDS and provides services to this population on the basis of gender, race/ethnicity and exposure. HRSA's total budget for the 17 youth programs is ~\$4 million. Demographics of clients in Title IV programs are 2% transgender with an equal balance between males and females, 65% AA, 20% Hispanic, 34% with heterosexual contact, 26% MSM, and 24% perinatal.

HRSA's Title IV programs on sexual and reproductive health for adolescents are guided by the following strategies. Additional morbidity should be limited with annual gynecological tests and PAP smears for young female adolescents. Appropriate routine testing of STDs should be administered to young female adolescents. Mother-to-child transmission should be prevented with ART. Early prenatal care should be available to improve health. ART should be provided to neonates. HRSA's Title IV programs are required to link to Title X programs and include family planning services through either referrals or onsite pregnancy tests.

HRSA takes several actions to monitor the quality of care of Title IV programs for adolescents. Close communication and coordination are maintained with grantees through regular contact with project officers, compliance site visits and technical assistance. Under the National Quality Center, grantees can use the HIVQUAL method and other quality processes to focus on annual syphilis testing, Pap smears and other testing for other STDs. HRSA's focus on quality in 2007 will assist providers in improving efforts to obtain Pap tests.

HRSA established several criteria to determine the success of its Title IV programs for youth. Activities should be client-centered to meet the needs of clients from both developmental and geographical perspectives. Interventions should be designed to be client-driven, non-judgmental and caring. Services and systems should be integrated to serve different types of youth, including gay, lesbian, bisexual, transgender, heterosexual and street youth. Referrals should be incorporated into programs to decrease the loss of clients. Collaborative efforts should be undertaken with testing sites to reduce the time between discovery of HIV infection and entry into care.

Peers should be used for case finding, C&T and speaking to youth. Youth should be trained and employed for outreach, education and C&T. Youth should be educated to deliver education in schools and other community settings. Case finding should be performed in high-risk situations and should be consistent in reaching these areas. Multiple strategies should be implemented to reiterate consistent messages. The role of peers should be obvious and identifiable. Appropriate services should be offered to establish trust with potential clients.

HRSA is currently funding eight demonstration projects under the SPNS initiative targeting young MSM of color. The projects are focusing on outreach, care and prevention for young HIV-infected men 13-24 years of age. Three key objectives were established for the projects. Innovative outreach strategies would be supported to assist HIV-infected persons learn their status. HIV-infected persons would be linked

with primary care services that are appropriate for youth. Transmission of HIV infection would be prevented among target clients. The grantees are now completing the third year of the five-year funding cycle of the young MSM of color initiative and have established a web site with strategies, project summaries and other information to monitor progress and resources.

AETCs are using a variety of tools to educate providers on offering education, training and other services for adolescents living with HIV/AIDS. For example, the Pennsylvania/Mid-Atlantic AETC developed a series of reference tools on case finding, primary and secondary prevention for adolescents, clinical risk assessment and screening. HRSA will continue its close collaborations with CDC to ensure that project officers in the two agencies coordinate prevention, care and treatment efforts with the same grantee. The partnership has served as a valuable mechanism for HRSA and CDC project officers to communicate on a regular basis, share information and maximize resources.

Dr. Morales confirmed that HRSA will continue to develop innovative strategies to address challenges in its Title IV programs for adolescents. The most effective C&T models will be identified to find and retain infected youth in care. Assistance will be provided to transition youth to adult care systems to ensure continuity of care and other services.

**Mr. Shepherd Smith**, of The Institute for Youth Development, described strategies to incorporate public health principles into HIV/AIDS prevention for youth. The primary predictor of an individual acquiring HIV or another STD is the number of lifetime sexual partners. The age of sexual debut plays a significant role in the number of lifetime sexual partners. Two studies showed tremendous differences between adolescents with sexual debut at <14 years of age versus those with sexual debut at >17 years of age. The risk of acquiring an STD was 30-fold higher and the risk of having >6 sexual partners by 20 years of age was 7.5-fold higher with early sexual debut compared to delayed sexual debut. The results were similar between sexually active males and females.

A study showed that the median age at sexual debut was 14.5 years among HIV-positive females compared to 15.5 years among HIV-negative females. The median number of lifetime partners, acquisition of any STD and rates of unprotected vaginal sex were higher in HIV-positive females, but regular condom usage was the same between the two groups.

A study showed that forced or unwanted sex among female teens was higher at earlier ages. A study was conducted with students in grades 9-12 who reported having >4 sexual partners during their lifetime. The findings showed that this population is at highest risk, but have the lowest usage of condoms on a regular basis. By race/ethnicity and gender, young AA males were found to be at highest risk compared to Hispanics, whites and females.

Findings from all of these studies emphasize the need to better articulate the benefits of delayed sexual debut and a reduction in sexual partners. Activities targeted to youth do not clearly communicate the following messages: “more risk with more sexual partners;” “less risk with fewer sexual partners,” and “virtually no risk with one lifetime uninfected partner.” Youth programs also do not specifically target messages to young males about forced or unwanted sex with females.

Several factors have a positive influence on youth. Data show that parents, particularly those with high monitoring of their children, are the primary influence on delayed sexual debut. Youth who eat dinner with their parents >5 times per week are less likely to use alcohol, tobacco or marijuana compared to youth who infrequently eat dinner with parents 0-2 times per week. Shared family meals facilitate accountability, bonding and communication. Youth who develop refusal skills regarding sexual activity are less likely to attempt suicide or engage in other risky behaviors.

A study showed that youth were extremely challenged by achieving perfect use of contraception because the subjects chose intimacy rather than correct usage. In a study with males who were taught about condom use during college, 60% did not discuss condom use with partners before sex; 43% put condoms on after starting sex; 42% wanted to use condoms, but had none available; 40% did not leave space at the tip of the penis; 32% lost erections in association with condom use; 30% placed the condom on upside down; and 15% removed the condom before ending sex.

Mr. Smith pointed out that several conclusions can be reached based on data from the youth studies. One lifetime partner should be a universal goal and mentioned often in HIV prevention messages. Emphasis should be placed on limiting the number of partners. All youth should be encouraged to delay sexual debut. More attention and resources should be directed toward gay, AA and Hispanic youth. Specific programs should be developed to reduce the number of partners in these populations.

More education should be provided to parents about their responsibility to the sexual health of their children. More support should be offered to after-school programs. NCHHSTP should closely collaborate with DASH to develop more youth programs. For example, DASH has developed strong relationships with numerous youth-serving organizations, while NCHHSTP has the science base and expertise in HIV/AIDS and STDs. DASH’s organizational network and NCHHSTP’s knowledge should be combined to jointly provide HIV and STD education to adolescents.

**Dr. David Wiley**, Professor of Health Education at Texas State University, described several efforts schools can undertake to end the conspiracy of silence regarding HIV and STD prevention and treatment for youth. Data were collected and evaluated on the characteristics of effective curriculum-based programs. The focus on behavior should be specific and narrow, such as delaying sex or using condoms. Theoretical approaches with demonstrated efficacy in influencing other risky health-related behaviors should be replicated.

Clear messages should be communicated about sex and protection against STDs or pregnancy. Basic rather than detailed information should be provided. Peer pressure should be addressed. Communication skills should be taught. Interactive activities should be incorporated. The age, sexual experience and culture of young persons in the program should be reflected. Programs should last at least >14 hours. Leaders should be carefully selected and trained.

In terms of laws for sexuality and STD/HIV education in U.S. schools, the District of Columbia and 19 states require sexuality education, while 32 states do not have this requirement. The District of Columbia and 36 states require STD and HIV/AIDS education, while 15 states do not have this requirement. The content of these requirements varies among states, such as a full-fledged curriculum approved by the state, local rather than state control of the law, guest presenters speaking to a class, or distribution of materials to students. Title V grantees must adhere to eight federal mandates of an abstinence educational or motivational program.

Federal funding for abstinence-only sexuality education progressively increased over the years with Texas serving as the largest recipient in 2005. Texas has no approved curriculum for sexuality education, but a textbook was developed for this purpose. However, the textbook does not mention contraception and uses “scare tactics” about the possibility of being prosecuted for rape or sex with a minor.

Texas spends >\$9 billion each year to address teen pregnancies and the consequences of unintended births. In 2004 alone, these costs included \$165 million for public health care, \$83 million for child welfare, \$161 for incarceration of youth of teen mothers, and \$349 million for lost tax revenues. Taxpayers in Texas spent \$15.1 billion to support >745,000 teen births between 1991-2004.

Dr. Wiley encouraged all states to consider available options to improve HIV and STD prevention and treatment programs for youth. For example, existing state mandates should be reviewed to determine if federal funding can be more flexible to discuss all sexual options with youth.

The Florida, Kansas and South Carolina Departments of Education convene “Finding Common Ground Summits” with supplemental abstinence funding from CDC. Staff from abstinence-only, planned parenthood, comprehensive and family programs attend the summits in an effort to identify areas where agreement can be reached at the local level, such as sharing resources at health fairs and presenting packets of materials to school districts from all programs.

Cadre members are trained and team-building activities are conducted to develop more effective youth programs. Action planning summits are held six months later and activities are followed at the state level. The summits have been extremely successful in convening staff from various programs with diverse perspectives to communicate, collaborate and cooperate in HIV and STD prevention and treatment programs for youth. Efforts are underway to replicate the summits in more states.

HECAT provides evidence-based guidance to schools on designing, selecting and evaluating appropriate curricula for youth. However, HECAT is still undergoing the HHS clearance process and cannot be distributed to schools at this time. CHAC should make a strong recommendation to the HHS Secretary to expedite the clearance process for immediate dissemination of HECAT to schools.

A stronger focus should be placed on developing and distributing culturally-appropriate materials to underserved populations, particularly AA and Hispanic youth. School board members, administrators and teachers should be trained and informed about solid data that show linkages between student health outcomes and academic achievement. Assistance should be provided to schools on developing policies for HIV, human sexuality education and testing. Schools should be supported with advocacy and skills on managing controversies related to HIV and STD prevention and treatment programs for youth.

Several CHAC members made suggestions for CDC and HRSA to consider in refining national strategies to prevent and treat HIV and STD infection in youth.

- More emphasis should be placed on involuntary sexual debut through force, domestic violence or other types of abuse in the home. Appropriate messages on this issue should be developed and delivered beginning at the first-grade level.
- A clear distinction should be made between “functional” and “dysfunctional” families. For example, youth who eat dinner with their parents >5 times per week could be just as likely to engage in risky behaviors as those who share meals with their parents on a more infrequent basis.
- Stronger efforts should be made to engage the media in youth initiatives because the vast majority of advertisements and entertainment programs promote sex.
- Parents should be educated about the critical importance of serving as true role models. For example, adolescents will be less likely to follow parental advice if parents have multiple sex partners, give birth to children out of wedlock, and engage in the same risky behaviors as youth.
- HRSA should include pregnancy prevention and hepatitis B and HPV vaccination in its strategies to limit additional morbidity of STDs among youth.
- HRSA should reconsider its focus on annual syphilis testing because this infection has a larger impact on older adults than youth. Emphasis should be placed on the ongoing chlamydia epidemic because this infection primarily affects persons <20 years of age.
- Copies of articles should be distributed and references should be provided for studies that are used to support youth programs. Inaccurate data will continue to serve as a barrier to effective implementation of HIV and STD prevention and treatment initiatives for youth. For example, a study cited in one of the panel presentations on infection rates with HIV prevention tools was flawed in several



areas. The study showed that condoms resulted in an 80% infection rate of HIV after a decade of use. However, no data from any other source have shown that condoms led to even an 8% infection rate per year. Oral acyclovir and vaccines were described as HIV prevention tools in the study, but no data have been published in this area. The study referred to a decade of female condom use, but efficacy data have not been collected in this area for the past ten years. No solid data were provided to support the statement that 75% of persons were infected after a decade of life with no knowledge of the population or discordant couples.

- More emphasis should be placed on reaching high-risk youth in the non-general population. For example, curriculum- or school-based programs would not be effective for AA and Hispanic youth, high school dropouts, homeless youth with no family foundation or youth sex workers.
- Innovative strategies should be developed to reach youth who use the Internet for sex. For example, HIV prevention and other health education materials could be developed and posted on the “My Space” web site, chat rooms and other Internet tools used by youth.

## CHAC Business

Mr. Milan informed CHAC that Dr. McGuire would no longer serve as the CHAC co-Chair after the current meeting because her term would expire on November 30, 2006. Dr. Temoshok raised the possibility of CHAC making a formal recommendation to extend Dr. McGuire’s term for an additional year due to her ongoing involvement in the Strategic Plan Workgroup and other CHAC activities.

Dr. Fenton clarified that this request would most likely not be honored because Dr. McGuire has served for two consecutive terms as a member and co-Chair. However, he explained that Dr. McGuire could still be involved in CHAC’s activities as a workgroup member or external consultant. The participants applauded Dr. McGuire’s diligent efforts, dedication and commitment during her outstanding service as the CHAC co-chair.

Mr. Milan entertained a motion to approve the previous minutes. A motion was properly placed on the floor and seconded by Drs. Leoutsakas and Garcia, respectively. CHAC **unanimously approved** the May 17-18, 2006 Meeting Minutes with no changes or further discussion.

Mr. Milan reviewed issues that the members raised during the meeting or suggested to him and Dr. McGuire off-line as CHAC’s potential formal motions or letters of advice to the CDC Director, HRSA Administrator or HHS Secretary.

- FY’07, FY’08 and FY’09 budgets for HIV, STD and hepatitis prevention, treatment and care.

- Strategic Plan issues: (1) creation of a coordinated National HIV Strategic Plan with cross-sector and cross-agency resources; (2) a related or separate Strategic Plan for AAs; (3) an additional two-year extension for a five-year Strategic Plan, including annual targets, resource requirements and strategies for AAs; and (4) development of models for resources needed for each year of the Strategic Plan.
- Issues related to CDC's revised HIV testing recommendations: (1) projections of newly-diagnosed HIV cases identified through the new HIV testing initiatives; (2) implementation in both public and private sectors; (3) standardized language or best practices for HIV testing consent forms; and (4) development of HIV testing algorithms for private laboratories.
- Refined projections by HRSA on the current number of PLWH affected by the Medicare Part D donut hole and strategies to ensure continued HIV care for these clients.
- Completion of the HHS clearance process for HECAT.
- STD issues: (1) consistent messages to implement CDC's STD Treatment Guidelines; and (2) future activities and resources by DASH and DSTDP to reduce the number of STD infections in the United States.
- Inadequate funding of the CDC Division of Viral Hepatitis and the need for more resources for hepatitis prevention, C&T and vaccine distribution.
- Response by HRSA, CMS and NIH on treatment and care for newly-diagnosed HIV-positive persons.
- Development of medical protocols by HRSA and CMS for HIV and STD testing and treatment.
- CDC's approaches to resolve problems with PEMS data elements.
- Specific language in the reauthorized CARE Act to allow for a transition period for states that have not converted to name-based reporting systems.
- Recognition of HRSA's outstanding efforts during a time with no reauthorization of the CARE Act.

CHAC extensively discussed the issues Mr. Milan proposed as potential formal motions or letters of advice to the agencies. The deliberations resulted in CHAC making ten formal motions to the CDC Director, HRSA Administrator or HHS Secretary. All ten of the formal motions were properly placed on the floor and seconded by voting members and **unanimously approved** by CHAC.

1. CHAC recommends that the HHS Secretary seek supplemental funding in the FY'07 budget to meet current program needs for domestic HIV, STD and hepatitis prevention, treatment and care.

2. CHAC recommends that the HHS Secretary request FY'08 and FY'09 budget levels for domestic HIV, STD and hepatitis prevention, treatment and care which move beyond historic flat funding levels and provide significant new resources to meet program and domestic needs.
3. CHAC recommends that CDC revise the draft HIV Prevention Strategic Plan with the following changes. The first two bullets under the "summary of recommendations" on page 5 should be deleted. The third bullet should be modified with the following language: "Prioritize racial, ethnic and sexual minority populations as well as demographic groups with disproportionate burden of disease/incidence where funding prioritization is linked to the degree of burden/incidence. On the basis of current epidemiology, highest priority in implementation of the Strategic Plan should be given to high-risk AAs and MSM within the goals as appropriate."
4. CHAC recommends that CDC extend the Strategic Plan to 2010 and include annual indicators of progress.
5. CHAC recommends that the HHS Secretary take the following actions: (1) The HHS Secretary should initiate the development of a multi-sectoral National Plan for HIV Prevention, Treatment and Care that addresses activities of all sectors and includes all relevant federal agencies. (2) The HHS Secretary should provide CHAC with a status report on progress in developing the National Plan by the next CHAC meeting. (3) The HHS Secretary should request that the President support and impanel a committee to develop the National Plan. (4) The HHS Secretary should meet with CHAC or its co-Chairs on the development of the National Plan.
6. CHAC recommends that CDC develop projections for the number of newly identified HIV-positive persons who might be identified through its new HIV testing initiatives. CHAC further recommends that CDC develop models for financial resources needed to successfully implement the updated HIV Prevention Strategic Plan.
7. CHAC recommends that HRSA continue to refine its estimates of the number of HIV-positive persons who would be impacted by the Medicare Part D donut hole. CHAC further recommends that HRSA develop strategies to support and maintain health coverage for these individuals.
8. CHAC recommends that the HHS Secretary expedite final clearance of the HECAT curriculum for STDs among youth because this evidence-based guidance is a critical need in the field.
9. CHAC recommends that CDC develop projections and models of needed resources for promoting national control of HPV, genital herpes, chlamydia, gonorrhea and syphilis.
10. CHAC recommends that the co-Chairs draft a letter to the HHS Secretary with the formal motions approved during the meeting and a delineation of percent increases for the funding requests.



In addition to approving the ten formal motions, CHAC also took actions to address other issues. CHAC agreed that CDC would complete the development of the goals, objectives and targets in the Strategic Plan. CDC would finalize and distribute the Strategic Plan to each CHAC member no later than March 31, 2007 in preparation of a discussion of the document during the May 2007 meeting.

CHAC identified several items to be placed on the next meeting agenda:

- Progress report by DSTDP on CHAC's formal motion to promote national control of HPV, genital herpes, chlamydia, gonorrhea and syphilis.
- Presentation by CDC and HRSA on prevention strategies with the Internet, text messaging and other technologies that could be used to reach young MSM of color and other high-risk populations.
- Presentation by CDC and HRSA on HIV prevention, care and treatment targeted to Native Americans, Alaska Natives and Native Hawaiians.
- Update by HRSA on the CARE Act.
- Presentation by an HHS representative on the HHS department-wide strategic plan and its relationship to HIV and STDs.
- Overview by CDC on its approaches to generate, collect and utilize surveillance data, particularly information gathered on MSM.
- Progress report by CDC on the ongoing development of laboratory algorithms for HIV testing and confirmation in the context of rapid HIV tests.

## **Public Comment Period**

Ms. Shay Welch emphasized the critical need for federal agencies to gather HIV data in Indian Country. Existing systems do not collect or report HIV data in Indian Country despite the disproportionate and alarming rate of HIV infection. Education and other HIV activities targeted to Indian Country are limited. Tribes have government-to-government relationships and are not captured in federal data sets. American Indians are frequently misclassified in reporting systems. The HIV epidemic is causing a reduction in the overall Indian population.

Ms. Welch urged CHAC, HHS, CDC, HRSA and the Indian Health Service to serve as voices for indigenous people and consult with Indian Country. For example, CHAC and the federal agencies could convene a workgroup of American Indians to obtain feedback on effective and culturally-appropriate HIV prevention, care and treatment strategies for tribes.

## Closing Session

Mr. Milan announced that the current proceedings would be the final CHAC meeting in the 25th year of HIV/AIDS. He thanked the members for their continued support, dedication and commitment to PLWHA in the United States. He was extremely proud that the passion, expertise, advocacy and knowledge of the CHAC members have significantly contributed to improving the quality of life of PLWHA. Mr. Milan looked forward to continuing to participate in CHAC's efforts to end the HIV epidemic through prevention and provide service to persons in most need.

The next CHAC meeting would be held on May 7-8, 2007 in Atlanta, Georgia. With no further discussion or business brought before CHAC, Mr. Milan adjourned the meeting at 12:11 p.m. on November 14, 2006.

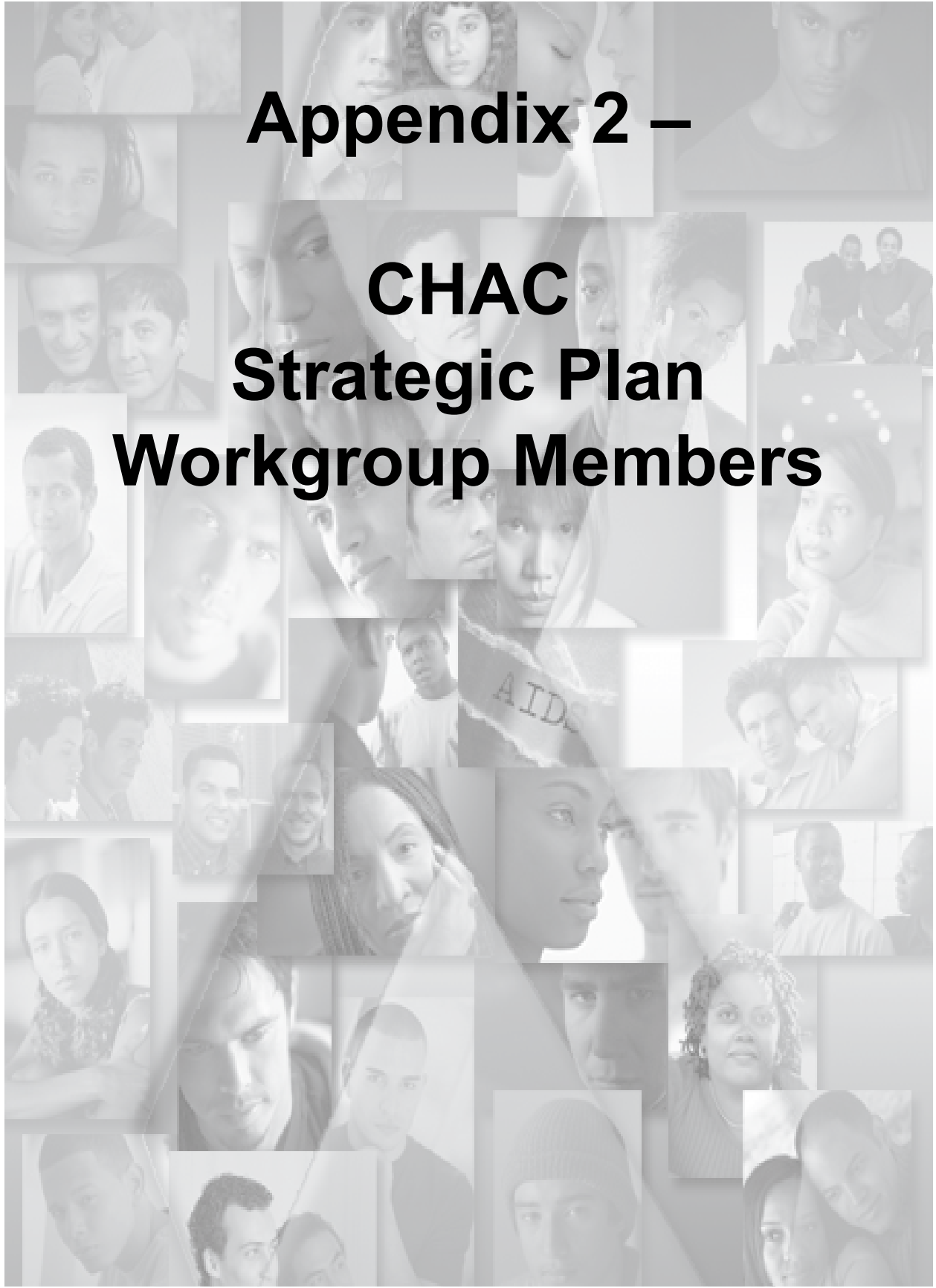
I hereby certify that to the best of my knowledge, the foregoing Minutes of the proceedings are accurate and complete.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Jean Flatly McGuire, Ph.D., Co-Chair  
CDC/HRSA Advisory Committee on  
HIV and STD Prevention and Treatment

\_\_\_\_\_  
Date

\_\_\_\_\_  
Jesse Milan, Jr., JD, Co-Chair  
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# Appendix 2 –

# CHAC Strategic Plan Workgroup Members

Appendix 2

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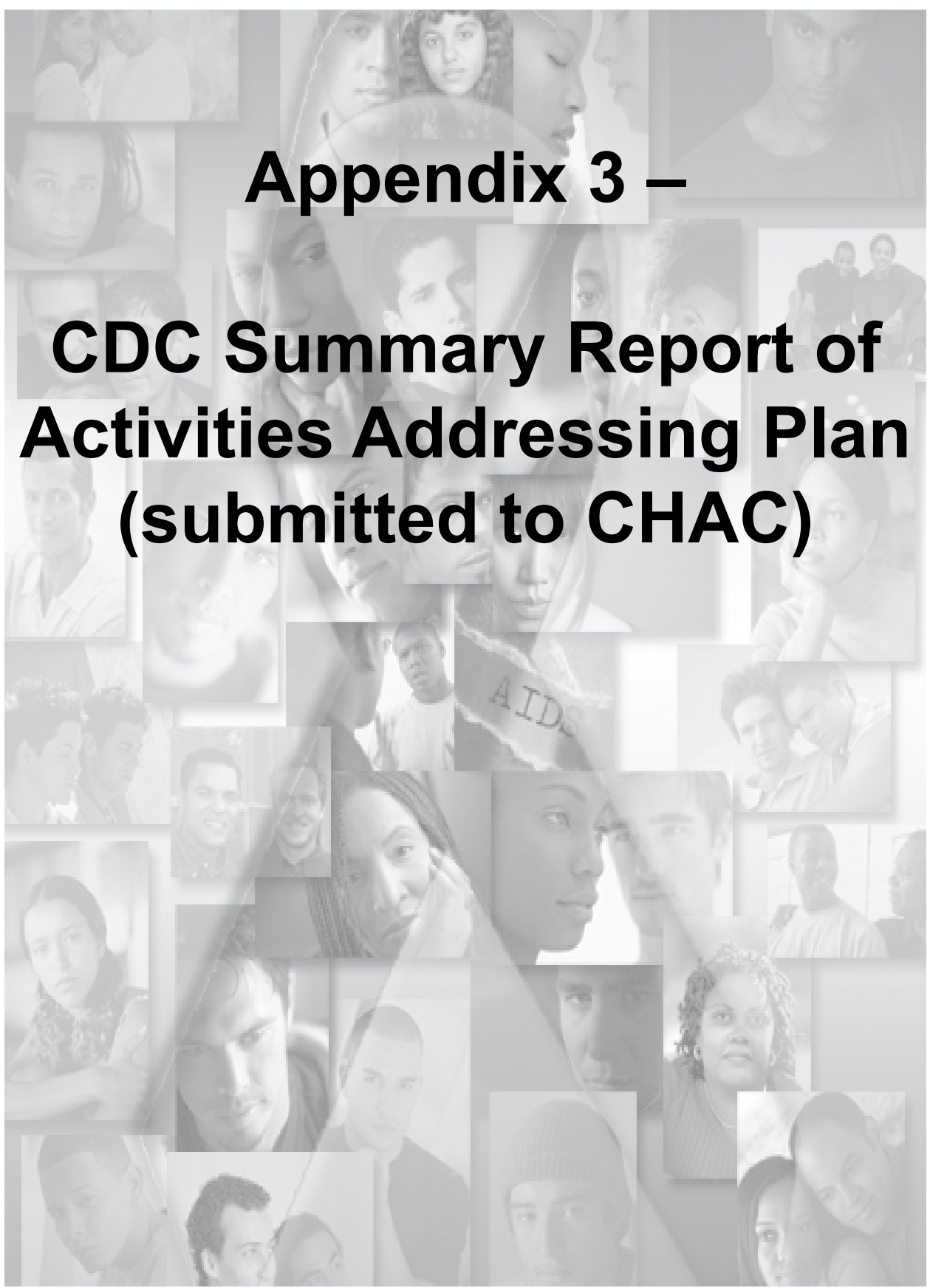
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# Appendix 3 –

## CDC Summary Report of Activities Addressing Plan (submitted to CHAC)

## **CDC HIV Prevention Strategic Plan Through 2005 Highlights of CDC Activities that Address the Goals and Objectives**

***Goal 1- “By 2005, decrease by at least 50% the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention interventions.”***

CDC has currently implemented three indicators to monitor the progress towards achieving Goal 1. The first indicator is “the percentage of students in 9th through 12th grade who report that they have never had sexual intercourse; or, if they have had sexual intercourse, not in the past month; or, who have had sexual intercourse in the past 3 months and used a condom.” The most recent data for this indicator from 2003 showed that 87.5% of 9-12th graders had never had sexual intercourse; 12.3% had sex, but not in the past month, and 21.3% had sex in the past 3 months but used a condom.

The second indicator is “among persons diagnosed with HIV infection for >12 months and interviewed in the Supplement to HIV/AIDS Surveillance (SHAS) project, the percentage who did not use a condom at last vaginal/anal sex when the status of the partner was unknown.” The most recent data for this indicator from 2004 showed 13.4% of HIV-infected persons did not use a condom at last sex with their partner of unknown status.

The third indicator is “among persons diagnosed with HIV infection >12 months and interviewed in SHAS, the percent of injection drug users (IDUs) who shared a needle or syringe with someone in the past 12 months.” The most recent data for this indicator from 2004 showed that 7% of HIV-infected persons shared needles.

## Performance Indicators (5, 6, & 7) for Goal 1 with baseline data, performance progress data, and projected targets

**Indicator 5:** The percentage of students in 9th through 12th grade who report they have never had sexual intercourse; or, if they have had sexual intercourse, not in the past month; or, who have had sexual intercourse in the past 3 months and used a condom.

*Baseline data, performance progress data, and projected targets:*

Year 1999 (baseline):	85.0% of 9th-12th graders had never had sexual intercourse
Year 2001 (performance):	86.1% of 9th-12th graders had never had sexual intercourse (12.2% had sex, but not in past month and 19.1% had sex in the past 3 months, but used a condom)
Year 2003 (performance):	87.5% of 9th-12th graders had never had sexual intercourse (12.3% had sex, but not in the past month, and 21.3% had sex in the past 3 months, but used a condom)
Year 2005 target:	88%

*Data Source: CDC. Youth Risk Behavior Surveillance System (YRBSS)*

\*YRBSS is conducted in odd numbered years so there are no data for 2000 and 2002, and the target is set for 2009 rather than 2010.

**Indicator 6:** Among the persons diagnosed with HIV infection for >12 months and interviewed in SHAS,\* the percentage who did not use a condom at last vaginal/anal sex when the status of the partner was unknown.

*Baseline data, performance progress data, and projected targets:*

Year 2001 (baseline):	12.3% did not use a condom at last vaginal/anal sex with a partner whose HIV status was negative or unknown
Year 2002 (performance):	13.9%
Year 2003 (performance):	17%
Year 2004 (performance):	13.4%
Year 2005 target:	10%
Year 2010 target:	8%

Data source: CDC. Supplement to HIV/AIDS Surveillance (SHAS) Project

\* The Supplement to HIV/AIDS Surveillance (SHAS) project is conducted in the following states: Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Kansas, Maryland, Michigan, Minnesota, New Jersey, New Mexico, South Carolina, Texas, and Washington; and the following cities: Houston and Philadelphia. CDC summarizes data from SHAS project and examines the representativeness of these data. This indicator will not be available after 2004 because CDC will discontinue this project in mid-2004. To replace SHAS, CDC is developing a more representative surveillance system for the entire HIV-infected population in the United States in mid-2004.

**Indicator 7:** Among persons diagnosed with HIV infection for >12 months and interviewed in SHAS,\* the percent of injection drug users (IDUs) who shared a needle or syringe with someone in the past 12 months.

Year 2001 (baseline):	7%
Year 2002:	3%
Year 2003:	5%
Year 2004:	7%
Year 2005 target:	3%
Year 2010 target:	1%

Data source: CDC. Supplement to HIV/AIDS Surveillance (SHAS) Project

\*The Supplement to HIV/AIDS Surveillance (SHAS) project is conducted in the following states: Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Kansas, Maryland, Michigan, Minnesota, New Jersey, New Mexico, South Carolina, Texas, and Washington; and the following cities: Houston and Philadelphia. CDC summarizes data from SHAS project and examines the representativeness of these data. This indicator will not be available after 2004 because CDC will discontinue this project in mid-2004. To replace SHAS, CDC is developing a surveillance system for the entire HIV-infected population in the United States.

## Supplemental Activities

In addition to the three performance indicators, CDC has implemented programs and activities that focus on decreasing the numbers of persons at high risk for acquiring or transmitting HIV infection, specifically relating to Objectives 1, 2, and 4 of Goal 1.

CDC's HIV/AIDS surveillance system is the nation's key source of information used to track the epidemic. Surveillance activities provide demographic, laboratory, clinical, and behavioral risk data that are used to identify populations at greatest risk for HIV infection. In 2001, CDC began implementation of a national, population-based incidence surveillance system to provide estimates of HIV incidence using a testing technology known as STARHS (Serologic Testing Algorithm for Recent HIV Seroconversion). STARHS is a way of analyzing HIV-positive blood samples to determine if an HIV infection is recent. To date, 34 areas that cover approximately 90% of the epidemic in the United States have been funded for HIV incidence surveillance. CDC expects to have incidence data available in 2006. This new national system for measuring the rate of new HIV infections in the United States is expected to provide the clearest picture yet of the magnitude of the domestic HIV epidemic, as well as aid CDC in more effectively targeting HIV prevention efforts to promote decreases in the incidence of new HIV infections.

CDC has also implemented the National Behavioral Surveillance System (NHBS) to learn more about risk behaviors among groups of persons at high risk for HIV infection, trends in these behaviors over time, and exposure to and use of HIV prevention services. As of 2004, CDC has funded 25 Metropolitan Statistical Areas (MSAs) to implement behavioral surveillance for three groups at highest risk for acquiring HIV infection: men who have sex with men (MSM), injection drug users (IDUs), and heterosexuals practicing high-risk sexual behaviors. These groups will be surveyed every 3 years so that trends in risk behaviors can be monitored and effective HIV prevention programs can be developed and implemented that encourage the adoption of behaviors that place these groups at lower risk for HIV infection or transmission.

In an effort to assure that scientifically sound interventions are available to prevention service providers, planners, and others who request science-based interventions, CDC has conducted a systematic literature review of HIV prevention interventions that have been formally evaluated and shown to reduce the risk of HIV transmission. The results of this review are compiled in the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness (Compendium)*. The *Compendium* provides up-to-date information about interventions with evidence of reducing sex-and/or drug-related risks, and the rate of HIV/STD infections. These interventions have been effective with a variety of populations, e.g., clinic patients, heterosexual men and women, high-risk youth, incarcerated populations, IDUs, and MSM.

The Diffusion of Effective Behavioral Interventions (DEBI) project is an additional activity that brings evidence-based prevention interventions to the field. The DEBI project



involves development and distribution of intervention resource materials, training on the interventions, and technical assistance and other capacity building strategies around the interventions. Currently, CDC has diffused 14 evidence-based prevention interventions to health department and community-based organization (CBO) partners through regional DEBI trainings. From January 2003 through November 2005, 251 regional DEBI trainings have occurred. More than 1500 CBOs and 329 local or state health departments have participated in these trainings and approximately 5000 individuals have been trained on one or more of the DEBIs.

CDC's Advancing HIV Prevention (AHP) initiative, launched in April 2003, expanded and strengthened prevention efforts by adding new prevention strategies based on proven public health approaches that have been used successfully in preventing other infectious diseases. The four AHP strategies are:

- Make HIV testing a routine part of medical care
- Implement new models for diagnosing HIV infections outside medical settings
- Prevent new infections by working with persons diagnosed with HIV and their partners
- Further decrease perinatal HIV transmission

In support of the AHP initiative, CDC provided funding for seven 2-year demonstration projects to health departments, CBOs, and primary care providers to test the feasibility of the four AHP strategies and provide detailed information that could be used to implement the strategies widely.

***Objective 1: Among people living with HIV, increase the proportion who consistently engage in behaviors that reduce risk for HIV transmission or acquisition.***

Two AHP demonstration projects focused on implementing new models of diagnosing HIV infection outside medical care settings and preventing new infections by working with persons diagnosed with HIV and their partners. The first project, "Incorporating HIV Prevention into Medical Care Settings," used an intervention called Positive S.T.E.P.S (Striving to Engage People) to explore the effects of clinic-based repeated, brief prevention counseling on patient behaviors and sexually transmitted diseases (STDs). The project was implemented in HIV outpatient clinics. It provided an opportunity to reach large numbers of HIV-infected individuals who visit the clinic on a regular basis, to implement safer-sex and needle-sharing intervention, to integrate the intervention with routine clinical care, and to involve nurses and physicians in the intervention. Because some individuals, after testing positive for HIV, fail to change risky behaviors, ongoing, brief prevention counseling is a cost-effective measure that can be incorporated into routine care for HIV-infected individuals.

CDC supported six sites in implementing the *2003 Incorporating HIV Prevention into Medical Care Settings Guidelines*—recommendations developed by CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America, to help health care providers incorporate HIV prevention into the medical care of people with HIV. The six sites assessed the impact of the guidelines on reported risk behaviors, STD rates, tailored risk reduction counseling, and referrals. As of August 2005, 1109 persons had enrolled in the program, the intervention had been delivered to all patients attending the clinics, and the clinics were conducting 6- and 12-month follow-up assessments.

The second AHP demonstration project, “Prevention Case Management for People Living with HIV/AIDS,” was a client-centered HIV prevention activity that combined HIV risk-reduction counseling and traditional case management to provide intensive, on-going, individualized prevention counseling and support. Nine CBOs were funded in Maryland, Massachusetts, Michigan, Missouri, California, Pennsylvania, New York, and Washington, D.C., to provide specialized assistance through prevention case management, to HIV-infected persons with multiple and complex HIV risk-reduction needs. Through this project, CDC’s aim was to monitor risk reduction behavior change of HIV-infected persons by providing individualized, multiple-session HIV reduction counseling to prevent the transmission or acquisition of HIV, assess risks of other sexually transmitted infections, and ensure appropriate diagnosis and adequate treatment.

In 2005 and 2006, CDC published in its *Morbidity and Mortality Weekly Report* preliminary findings from a study of MSM in the National HIV Behavioral Surveillance System (NHBS), results of a meta-analysis study of high-sexual behavior in persons aware and unaware of their serostatus, and results of a second meta-analysis of HIV prevention interventions for people living with HIV.

Data from NHBS on HIV prevalence and unrecognized HIV infection among MSM in five cities found an overall HIV prevalence rate of 25%. Rates varied by race/ethnicity and rates were highest among African-American MSM (46%), followed by white MSM (21%), and Hispanic MSM (17%). Among the HIV-infected MSM, 48% were unaware that they were infected with HIV.

Data from a meta-analysis of high-risk sexual behavior in persons aware and unaware that they were infected with HIV found that the prevalence of high-risk sexual behavior was reduced substantially after people became aware they were infected with HIV. Overall, the prevalence of unprotected anal or vaginal intercourse with any partner was an average of about 50% lower in persons aware of their status compared to those who were not and 68% lower with HIV-negative partners. A second meta-analysis of HIV prevention interventions for people living with HIV showed that interventions with HIV-infected persons led to significant reductions in unprotected sex and acquisition of STDs. These recent data show that high levels of unrecognized HIV infection exist

in some sub-populations, that persons substantially reduce HIV risk behaviors once they become aware of their HIV infection and that effective prevention intervention can further reduce HIV risk behaviors among persons living with HIV.

***Objective 2: Among men who have sex with men (MSM), increase the proportion who consistently engage in behaviors that reduce risk for HIV acquisition or transmission.***

Three of the 14 DEBI interventions are specifically targeted to MSM: Many Men, Many Voices; Mpowerment; and Popular Opinion Leader (POL). In response to an outbreak of HIV among males attending colleges in the Research Triangle area of North Carolina, the North Carolina Department of Health implemented the Men's Health Initiative to adapt and test the effectiveness of the POL intervention as a prevention strategy focusing on primarily African-American men who have sex with men and women (MSM/W), 18-30 years of age in three geographic areas and one college campus in North Carolina. The intervention was previously tested among primarily white gay men and African-American women living in subsidized housing. The goal of the POL is to identify, train and enlist the help of key opinion leaders to help change social norms through engaging in risk reduction conversations with friends. The reported outcomes of the North Carolina Men's Health Initiative using POL showed that a total of 264 POLs (15% of the target population) were trained for the intervention, 226 in the community and 38 on campus; 1302 conversations were held by POLs, 822 by community POLs and 480 by campus POLs; and eight booster sessions and four reunions were held. The North Carolina Department of Health heralded the POL as a successful intervention for the targeted population claiming that it created a safe, non-sexual environment for African-American MSM/W that did not exist previously, promoted sexual wellness for African-American men regardless of their sexual orientation, and created new community advocates and empowered POLs to do more for the community.

***Objective 3: Among adolescents increase the proportion who consistently engage in behaviors that reduce risk for HIV acquisition or transmission.***

The Youth Risk Behavior Surveillance System (YRBSS) is a key tool used by CDC to monitor adolescent HIV risk behaviors. From 1991-2003, YRBSS data showed that the proportion of high school students who have ever had sex, showed a significant decline from 54.1% to 46.7%. During the same time period, the percentage of high school students who had their first sexual intercourse before age 13 also declined significantly, from 10.2% to 7.4%, and the percentage of students who had four or more lifetime sex partners also declined significantly, from 18.7% to 14.4%. Finally, the percentage of students who used a condom during their last sexual intercourse increased significantly, from 46.2% in 1991 to 63% in 2003. The YRBSS data are collected every other year and allow CDC to monitor sexual activity among high school students and risk behavior mechanisms to reduce the acquisition and transmission of HIV in this population.

One of CDC's 14 DEBI interventions, "Street Smart: Reducing HIV Risk among Runaway and Homeless Youths," is specifically targeted toward adolescents. Street Smart is a multi-session, skills-building program designed to help groups of runaway youth reduce unprotected sex, number of sex partners, and substance use.

***Objective 4- Among injecting drug users (IDUs), increase the proportion who abstain from drug use or, for those who do not abstain, use harm reduction strategies to reduce risk for HIV acquisition or transmission.***

In November 2005, CDC released the most recent HIV/AIDS surveillance data from the 33 states with longstanding confidential name-based HIV surveillance systems.

One of the notable findings in the data is a decline in HIV/AIDS diagnoses among IDUs from 2001-2004. During this 3-year period, there was an estimated annual percentage decline of 3.9% per year among IDUs, suggesting that prevention activities targeted toward this group are contributing to reduced HIV transmission rates.

One DEBI intervention targeted to female sex partners of male IDUs, MSM who do not self-identify as gay, and other populations at risk is "Community PROMISE: Peers Reaching Out and Modeling Intervention Strategies." This is a community-level intervention that promotes progress toward consistent HIV prevention through community mobilization and distribution of small-media materials and risk-reduction supplies.

***Goal 2: "By 2005, through voluntary counseling and testing, increase from the current estimated 70% to 95% the proportion of HIV-infected people in the United States who know they are infected."***

CDC has currently implemented two indicators to monitor progress towards achieving Goal 2. The first indicator is "the percentage of HIV-positive test results from publicly-funded counseling and testing sites with post-test counseling sessions." The most recent data for this indicator from 2003 show that 71% had post-test counseling sessions. The second indicator is "the percentage of HIV cases diagnosed before progression to AIDS." The most recent data for this indicator from 2004 show that 78% of persons were diagnosed with HIV before progression to AIDS.

## Performance Indicators (8 & 9) for Goal 2 with baseline data, performance progress data, and projected targets

**Indicator 8:** The percentage of HIV-positive test results from publicly-funded counseling and testing sites with post-test counseling sessions.

*Baseline data, performance progress data, and projected targets:*

Year 2000 (baseline):	69.3%
Year 2001 (performance):	71.3%
Year 2002 (performance):	71%
Year 2003 (performance):	71%
Year 2004:	Data not yet available
Year 2005 target:	75%
Year 2010 target:	80%

Data source: CDC. HIV Counseling and Testing System (CTS)

**Indicator 9:** The percentage of HIV cases diagnosed before progression to AIDS.

*Baseline data, performance progress data, and projected targets:\**

Year 2000 (baseline):	76%
Year 2001 (performance):	77%
Year 2002 (performance):	77%
Year 2003 (performance):	78%
Year 2004 :	78%
Year 2005 target:	79%
Year 2010 target:	85%

Data source: CDC. HIV/AIDS Reporting System

\* The baseline estimate of 70% for Goal 2 was based on modeling methods that yield broad-based estimates that cannot measure year-to-year changes with confidence. As a surrogate indicator for which year-to-year changes are available, we use persons who already have AIDS at the time they are initially diagnosed with HIV. Trends in the percentage of HIV cases that are diagnosed before AIDS should parallel the trends in the proportion of HIV-infected persons who know their serostatus, and therefore, this is a useful indicator of progress toward Goal 2. Similar to Goal 1, the data are only currently available from the 30 states with longstanding confidential HIV reporting.

## Supplemental Activities

In addition to the two indicators, CDC has implemented programs and activities that focus on increasing the proportion of HIV-infected people who know they are infected. In the United States, CDC estimates 1,039,000-1,185,000 persons are infected with HIV, and that 25% (approximately 250,000) are not aware of their infections and risk for transmitting HIV. As part of the AHP initiative, identifying persons with undiagnosed HIV infection and linking them to medical care and prevention services is a national priority.

### ***Objective 1: Increase the motivation of at-risk individuals to know their infection status and decrease real and perceived barriers to HIV testing.***

One of CDC's most promising AHP demonstration projects is the Social Networks. CDC funded nine CBOs to implement a social networks approach to reach high-risk individuals with HIV counseling, testing, and referral services. The project involved training HIV-infected and high-risk individuals in communities of color to reach out through their social, sexual, and drug-using networks and encourage their peers who may be at risk to be tested. Preliminary data from October 3, 2003-September 4, 2004 indicated that of newly identified positives, prevalence rates were highest among MSM (16%), MSM/IDU (15%), and transgender individuals (20%). The recruiters most effective at identifying undiagnosed HIV infections were MSM (15%) and transgender (20%), suggesting that transgender and MSM networks might be more likely to include persons with undiagnosed HIV infection. Additionally, 82% of network associates tested were at high risk (had unprotected sex in the past year, exchanged sex for drugs or money, had an STD, or shared drug injection equipment). Preliminary findings published in the June 24, 2005 MMWR showed that 33 recruiters in seven cities referred 814 high-risk individuals for counseling and testing. Of those, 46 were newly diagnosed as HIV positive, representing a prevalence of 5.7 percent—almost six times that typically seen in publicly funded HIV counseling and testing sites.

This Social Networks demonstration project has proven to be a viable strategy for reaching and providing counseling, testing, and referral services to persons with undiagnosed HIV infection and an efficient and effective route to access HIV-infected persons or those at very high risk for HIV. CDC believes that the Social Networks Project can enhance counseling, testing and referral programs (targeted testing), partner, counseling and referral services, and aid in priority setting for interventions and target populations, such as undiagnosed HIV infections among MSM of color and African-American women. At the September 2005, Executive meeting of the National Alliance of State and Territorial AIDS Directors, CDC provided plans to operationalize the social networks project for implementation in the states. CDC issued a "Dear Colleague" letter to partners in September 2005, and is in the process of developing a social networks toolkit and project information that will be available on the CDC Web site, as well as Grantee Procedural Guidance and a training curriculum that includes technical assistance for grantees targeting MSM and women of color.



***Objective 3: Increase the number of providers who routinely provide voluntary, client-centered counseling and testing (VCT) in health care settings (e.g., STD clinics, substance abuse treatment programs, family planning clinics, emergency rooms, community health centers), as well as in non-clinical venues (e.g., social venues, public assistance programs, street outreach).***

CDC is currently revising recommendations for HIV testing of adults, adolescents and pregnant women in health care settings. These will update previous recommendations with the intended purpose of increasing routine, voluntary HIV screening of patients in health care settings. Further, CDC expects the new recommendations will result in substantial increases in HIV testing and increases in the proportion of persons who know their HIV status. Key elements of these recommendations include: 1) Routine, voluntary HIV screening in all health care settings, (cost-benefit analyses have shown the routine HIV screening is cost-effective at HIV seroprevalence rates as low <0.1%); 2) Normalization of HIV testing -- meaning that HIV testing should be incorporated into the routine medical screening panel at that facility; 3) Incorporation of informed consent for the HIV test into the facilities' general medical consent process with an "opt-out" approach, whereby the patient can specifically decline the HIV test if so desired; 4) Strong encouragement of prevention counseling in settings where risk behaviors are routinely ascertained (e.g., STD clinics), but counseling does not have to be linked to routine screening in health care settings.

***Objective 4: Increase the percentage of people who know their results after testing.***

One AHP demonstration project focused on the use of rapid HIV testing among high-risk populations in nonclinical settings. The "Routine Rapid HIV Testing of Inmates in Short-Stay Correctional Facilities," was targeted to persons entering the correctional system. High rates of HIV and STDs have been documented among this group of people, and currently, only a fraction of jails routinely test for HIV on entry. People incarcerated for less than 30 days are unlikely to receive traditional HIV counseling and testing, and, if they do, they may be released before their test results from traditional testing are available. Routine rapid testing would facilitate initial testing, delivery of results, confirmatory testing, and appropriate referral to care, treatment, and prevention services within the facility or in the community. CDC funded state health departments in Florida, Louisiana, New York, and Wisconsin to assess the feasibility of rapid HIV testing in short-stay correctional facilities. From January 2004 through March 2005, 16,676 inmates were tested and 256 (1.5%) were reactive.



**Goal 3: “By 2005, increase from the current estimate 50% to 80% the proportion of HIV infected people in the United States who are linked to appropriate prevention, care, and treatment services.”**

CDC has currently implemented one indicator to monitor the progress toward achieving Goal 3: “the percentage of HIV/AIDS cases in care within three months of diagnosis.” The most recent data for this indicator from 2004 show that 85.2% of persons were in care within three months of diagnosis.

### **Performance Indicator (10) for Goal 3 with baseline data, performance progress data, and projected targets**

**Indicator 10:** Percentage of HIV/AIDS cases in care within three months of diagnosis.

Year 2001 (baseline):	78.8%
Year 2002 (performance):	79.1%
Year 2003 (performance):	80.4%
Year 2004 (performance):	85.2%
Year 2005 target:	82%
Year 2010 target:	85%

*Data source: CDC. Supplement to HIV/AIDS Surveillance (SHAS) Project.*

\*The SHAS project is conducted in the following states: Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Kansas, Maryland, Michigan, Minnesota, New Jersey, New Mexico, South Carolina, Texas, and Washington; and the following cities: Houston and Philadelphia. CDC summarizes data from SHAS project and examines the representativeness of these data. This indicator will not be available after 2004 because CDC will discontinue this project in mid-2004. To replace SHAS, CDC is developing a surveillance system for the entire HIV-infected population in the United States.

### **Supplemental Activities**

***Objective 1: Reduce disparities in access to prevention and care services experienced by communities of color, women, and special needs populations.***

Since Fiscal Year 1999, CDC has implemented over 70 HIV prevention projects targeted to high-risk racial and ethnic minority populations supported through the Minority AIDS Initiative (MAI). CDC receives direct MAI appropriations from Congress and additional MAI resources from the Discretionary Fund of the Secretary of the Department of Health and Human Services. Funds are awarded through cooperative agreements to state and local health departments; national, regional, and local organizations; CBOs, (including faith-based organizations); and universities, to specifically target HIV prevention to communities of color which are disproportionately affected by the HIV/

AIDS epidemic. MAI has greatly enhanced CDC's ability to provide direct funding to CBOs and has allowed CDC to allocate significant resources to communities of color and high-risk populations, such as gay men of color, and to MSAs with the highest number of AIDS cases in racial and ethnic minorities. MAI funding enhances HIV program efforts in three categories: 1) technical assistance and infrastructure support; 2) increasing access to prevention and care; and 3) building strong community linkages.

In 2005, CDC implemented the "Translation/Adaptation of Science-Based Interventions for Communities of Color, Women, Substance Abusers, IDUs, and other High Risk Groups" project. The aim of this MAI project is to translate proven HIV prevention interventions identified in the *CDC Procedural Guidance for Selected Strategies and Interventions for Community-Based Organizations*, for culturally appropriate use in different at-risk communities. Using the Guidance, funded grantees will conduct formative research to assess the match between the intervention, the target population, and the organization. The organization will then adapt and tailor the selected intervention and pre-test materials with members of the target population. The adapted and tailored intervention or components will be pilot-tested and a logic model detailing intervention activities will be developed. CDC expects to use the results of this project in future program guidance and training for directly-funded CBOs on how to adapt and tailor interventions shown to be effective in research settings for use among at risk populations. Further, this project will enhance the way that proven interventions are used in the community by giving CBOs the tools they need to adapt effective science-based programs into practical strategies for use in at risk communities.

A second MAI project is the "Evaluation of Innovative HIV Prevention Interventions for IDUs and High Risk Minority Populations." The purpose of this project is to identify and evaluate innovative HIV prevention interventions for injection drug users and high-risk minority populations that have been developed by CBOs with substantial input from served communities. These programs have exhibited an ability to reduce HIV risk behaviors although they have not undergone formal outcome evaluations. Through this project, CBOs will examine the effectiveness of their interventions in reducing sexual risk behaviors (including sexual abstinence), increasing HIV testing, and changing knowledge and attitudes regarding HIV risk. Those programs proving effective may then be disseminated through CDC's DEBI project.

CDC also supports intramural training for minority researchers through the Research Fellowships on HIV Prevention in Communities of Color Program and extramural training through the Minority HIV/AIDS Research Initiative (MARI). The goal of the Research Fellowship is to recruit, mentor, train, and retain investigators with expertise in conducting public health research. The project is specifically designed for minority post-doctoral fellows and aims to increase the quality and quantity of research to reduce HIV infection in communities of color most heavily impacted by HIV, and to increase the overall number of minority racial and ethnic investigators within CDC.

The goals of the MARI are to conduct HIV epidemiologic and prevention research

of direct public health importance to communities of color (namely African-American and Hispanic) that have been deeply affected by the HIV epidemic, and to build HIV prevention research capacity in communities in which little research of this type has been conducted. Currently, 13 junior investigators at 12 sites are participating in MARI. This prevention research capacity building project aims to serve as a catalyst for improved HIV prevention efforts in communities of color, ultimately helping to reduce disparities in services experienced by these groups.

***Objective 4: Promote the optimal level of medical services for patients diagnosed with HIV to benefit individual health and reduce the likelihood of further transmission of HIV.***

CDC has funded several activities which enhance the level of medical services for HIV-infected persons. One was the AHP demonstration project, "Prevention Case Management (PCM) for Persons Living with HIV/AIDS." In November 2005, CDC officially changed the name of PCM to comprehensive risk counseling and services (CRCS). CRCS is a client-centered HIV prevention activity that combines HIV risk reduction counseling and traditional case management to provide intensive, on-going, individualized prevention counseling and support. CDC funded nine CBOs in Maryland, Massachusetts, Michigan, Missouri, California, Pennsylvania, New York, and Washington, D.C., to provide specialized CRCS to HIV-infected persons with multiple and complex HIV risk reduction needs. As of January 2006, 480 persons have been enrolled in the CRCS; of these 66% were African American and 14% were Hispanic. The primary referrals provided through this program were for housing assistance, drug counseling and treatment, mental health services, Ryan White case management, and psychosocial support groups.

***Objective 5: Increase the proportion of persons diagnosed with HIV who are successfully linked to medical care no later than 3 months after learning their HIV status or re-identified as being HIV infected but out of care.***

In an effort to enhance the proportion of HIV-infected people who are linked to HIV care in a timely manner, CDC has funded the Antiretroviral Treatment Access Studies (ARTAS) I & II. Both studies examine the impact of linkage case management on getting HIV-infected persons into care. In the linkage case management approach, a person who has recently received an HIV diagnosis is assigned a linkage case manager to ensure that he or she accesses HIV primary care. Results from the ARTAS I study show that when individuals with a recent HIV diagnosis meet with a linkage case manager up to 5 times in a 3-month period, they have a greater chance of being linked to care. To further test these results, the ARTAS II demonstration project was implemented to compare rates of linkage (to HIV care providers) before and after instituting the linkage case management. These findings will enhance the understanding about how well linkage case management works in typical HIV program settings. The primary objective of this demonstration project is to reach a 75% rate of HIV care use associated with linkage

case management after six months of follow up. The 10 collaborating sites for ARTAS II include five local or state health departments and five CBOs, each with at least one ARTAS II linkage case manager. As of August 2005, 137 HIV-infected persons had been enrolled.

To further improve linkage of HIV-infected persons into appropriate care and treatment, in 2005 CDC implemented the MAI project, "Characterizing HIV Diagnosed Persons that are Not in Care." Through this project, quantitative and qualitative data are being collected about those persons infected with HIV who are not receiving care; quality of care and severity of need for care; and barriers to receiving care, prevention and support services at the local level. This data will provide a means of evaluating new prevention initiatives that focus on the provision of prevention services and linkage to care for persons living with HIV. Further, this project will provide supplemental surveillance data to characterize persons who have a diagnosis of HIV infection and who are not receiving care. This information will be critical in understanding the additional burden on health care delivery systems when persons are successfully linked into care. As an enhanced surveillance activity it will also provide an opportunity to evaluate existing methods of laboratory reporting for HIV.



**Appendix 4 –  
Draft Report from  
CHAC Strategic Plan Workgroup**

**CDC/HRSA Advisory Committee  
for HIV and STD Prevention  
and Treatment (CHAC)**

**HIV Prevention Strategic Plan  
Work Group Summary and Report**

**October 24, 2006**

**CDC/HRSA Advisory Committee for  
HIV and STD Prevention and Treatment  
HIV Prevention Strategic Plan Work Group Summary and Report**

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## Introduction

During its May 2005 meeting, CHAC stressed the need to identify reasons for not achieving the overarching goal (i.e., to reduce new HIV infections in the U.S. by 50% by 2005, with a focus on eliminating racial/ethnic disparities) of the national HIV Prevention Strategic Plan. The CHAC also expressed a strong interest in updating the Plan and, therefore, unanimously passed a motion to form a Work Group to facilitate this effort.

At that time, the CHAC decided to restrict the focus of its review and proposed update of the Plan to four of the five goals established in 2001. "Global HIV" was not to be included because other agencies have developed international activities since that time to address this goal. The CHAC recommended that CDC not develop a new Plan at this point. Instead, the Work Group was tasked with the following responsibilities:

1. Provide advice on ways to update the existing Plan to guide CDC and its federal partners in formulating new strategies, activities, and directions to reduce HIV infection in the United States.
2. Develop recommendations for HIV prevention programs, surveillance and research that can reduce HIV incidence based on current resources and the best available science.
3. Review the existing Plan to identify limitations or flaws in previous HIV prevention activities, missed opportunities in establishing priorities, and actions to advance the Plan in the future.
4. Determine whether the overarching goal to reduce new HIV infections in the United States by 50% is feasible and realistic based on available resources.

A small committee (of ten people), comprised of CHAC members, CDC staff, and external partners, was formed in July, 2005 to (1) identify work group members who would have responsibility for developing recommendations, (2) develop a process for gathering input from the work group, and (3) plan a face-to-face meeting for deliberating about recommendations that would be submitted to the CHAC. The committee was chaired by CHAC co-chair, Dr. Jean McGuire. CDC appointed Dr. George Roberts to serve as its co-chair. After several conference calls, the committee identified more than 30 individuals to join the previously identified members of the committee to serve as the HIV Prevention Strategic Plan Work Group (see Appendix A for a list of participants).

The Work Group met face-to-face twice: first on October 24-25, 2005; and then on May 4-5, 2006. Additional communications occurred during conference calls, e-mails, and intermittent mailings. The Workgroup received information about CDC's current activities relating to the Strategic Plan, as well as samples of relevant articles and reports for their review and consideration. The following report provides a synthesis of the thematic discussions and recommendations that resulted over the course of the two face-to-face meetings.

## **Overall Benefits of the National HIV Prevention Strategic Plan**

The Plan has served as a tremendously valuable tool for CDC. CDC uses the Plan as a living document to link HIV prevention programs, activities, and budget allocations to specific goals and objectives. CDC also uses the Plan as a guide in identifying new and expanded programs and initiatives, establishing priorities, directing and targeting resources, and ensuring that objectives are appropriately weighted and prioritized. CDC holds an annual retreat for senior staff to review and discuss activities and resources related to all 27 objectives under the Plan goals. The top ten objectives are also prioritized during the retreat to guide funding and program activities with a particular focus on populations and risk groups.

The Plan has had positive impacts on CDC programs. Because of the Plan's goals, the focus on persons at highest risk of transmitting HIV and becoming infected was enhanced. Prevention services were prioritized for persons living with HIV. CDC used the Advancing HIV Prevention initiative to develop new strategies to diagnose HIV infection. Strong linkages were established for prevention and quality medical care services. Rapid testing was promoted in both clinical and non-clinical settings. Behavioral interventions are now more effective and evidence-based through the Prevention Research Synthesis (PRS) and Diffusion of Effective Behavioral Interventions (DEBI) projects.

CDC developed six national surveillance systems to monitor the complete pathway of HIV in the areas of behaviors, incidence, HIV cases, prevalence, morbidity, and AIDS cases and deaths. In addition, CDC developed the Program Evaluation and Monitoring System (PEMS) to better monitor and evaluate HIV prevention programs that are implemented by community-based organizations (CBOs) and health departments. PEMS assists CDC in identifying what services are provided, the populations receiving services, behavioral and service utilization outcomes reported by clients, the reach of programs to target populations, and the relationship between exposure to services and changes in behavioral outcomes.

The Plan's focus on eliminating racial and ethnic disparities in rates of HIV infections has led to better targeting of prevention approaches. CDC has directly funded minority and minority service community-based organizations for HIV prevention in communities of color since FY'99. From 2002-2006, CDC awarded funds to 658 minority CBOs; state, local, surveillance, research and evaluation activities; minority fellowship programs; and communications, partnerships and policy development projects to increase HIV prevention in communities of color. CDC also formed an internal work group to address the disproportionate impact of HIV/AIDS among African Americans, focusing on assessing current activities and identifying unfilled gaps. This effort resulted in CDC convening three consultations in 2005-2006 with African Americans, African American MSM, and faith-based organizations. CDC is developing a comprehensive action plan to address the ongoing HIV/AIDS crisis in African American communities.

## Barriers to Reaching the Plan's Goals

The Work Group identified a number of factors that hindered progress toward achieving the Plan's goals and objectives. The following list includes barriers related to leadership, resources, policies, and levels of intervention:

- Insufficient leadership and strategic partnering
  - Absence of national leadership / sense of urgency to market the Plan
  - Lack of community / broad-based buy-in for the Plan
  - Lack of partnership coordination & collaborative action
    - The scope of the Plan was too narrow to include all of the potential partners needed to bring about prevention
    - Inadequate interconnection w / other federal partners (SAMSHA, etc.)
- Inadequate resources
  - Flat funding during the period of the Plan
  - Impact of intervening emergencies such as the 9/11 disaster
  - Reduced and diverted resources among community-based organizations
  - Lack of adequate investments in communities of color
  - Lack of access to services for highest risk populations such as MSM, youth, and women
- Obstructive federal policies / practices
  - Prohibitions against funding needle exchange
  - OMB/GAO program reviews of organizations serving gay populations
  - Shifting policies / distorted information on abstinence and condom use
  - Blocked release of compendium, adolescent health curriculum etc
  - Leadership gaps / capacity issues at CDC
- Inadequate framework & interventions
  - Neglect of macro & structural factors that facilitate HIV transmission
  - Insufficient targeting of interventions to highest risk groups
  - HIV exceptionalism (treating HIV differently from other diseases)
  - HIV-related stigma
  - Disconnect between prevention messages and counseling and testing strategies
  - No national social marketing campaign
  - Inadequate capacity building to deliver effective prevention services and interventions
- Prevention fatigue
  - Prevention “fatigue and burnout” caused communities to ignore CDC’s prevention messages

## Considerations for Updating the Strategic Plan

The Work Group identified a number of concerns and suggestions for updating the Plan. Some of the important themes that arose from these deliberations included:

- Develop an overarching racial/ethnic disparities goal to inform the implementation of objectives and strategies for all goals in the updated Plan.
- Distinguish between goals and objectives that relate to persons living with HIV and seronegative persons at risk of HIV infection.
- Emphasize the importance of creating greater specificity within the Plan for goals and objectives related to care, particularly for maintaining persons in care.
- Write stronger language that stresses making HIV testing routine and available in multiple settings including and beyond health care.
- Address structural and social norms that lead to HIV risk, and to target these areas for intervention.
- A resource analysis at the objective level needs to occur in order to allow goal targets and funding allocations to be adjusted and monitored
- Biomedical interventions must be explicitly included, as should appropriate focus on interventions with acute / more highly infectious individuals
- A mechanism for appropriately aligning the evaluation and capacity building activities and resources of prior Goal 4 across the new goals/objectives must be developed
- Appropriate federal partners should be identified for each objective
- Progress on goals needs to be monitored and reported annually
- There should be a strategy regarding expanded resources for care
- Improve all goals / objectives to achieve better targeting
  - Target testing efforts differentially regarding prevalence / incidence
  - Determine efficacy of improving interventions w/ most infectious people
  - Increase specificity of care linkage goal
- Success of the updated Plan will depend on taking different approaches, clearly defining a road map, and implementing a detailed mobilization strategy.
- Improved models for assessing differentially efficacious/cost-effective interventions must be developed and used to describe an optimal mix of interventions
  - Expanded focus on system/structural interventions and the needed mobilization must be a part of this framework
- Scale up models including resources and needed federal and other partners must be established

- A review of the current models of replication package development, dissemination, fidelity, effectiveness and provider/agency burden must be undertaken
  - Uptake of cross-cutting components more important than package development / use

## Summary of Recommendations

### General

- Maintain over-arching numeric goal for reducing cases
  - Prioritize African Americans at the highest level (within overarching goal and within each goal)
  - Prioritize men who have sex with men within the goals as appropriate
  - Prioritize racial and ethnic minority populations with disproportionate burden of disease / incidence
- Update the Goals
  - Create separate prevention goals for persons living with HIV and sero-negative persons at risk of infection
  - Update testing and linkage to care goals
  - Add new goal addressing stigma and discrimination
  - Drop goal 4 (maintain the strategies across goals)

### Specific Recommendations for Existing Plan's Goals and Objectives

***Proposed Goal 1: By 2008, decrease the number of HIV infected persons transmitting HIV. (Percentage decrease to be determined.)***

#### Objectives - Proposed Revisions

1. Among persons living with HIV at behavioral risk of transmission, increase the proportion who receive evidence-based interventions, including mental health, substance abuse, and other appropriate interventions for co-morbid conditions. [Provide key activities for adolescents, including HIV-positive children. Adolescents should be included in a separate objective.]
2. Increase the proportion of persons with HIV who are routinely tested for STDs and appropriately treated and referred for partner notification.
3. Among persons with acute HIV infection, increase the proportion engaged in appropriate HIV behavioral interventions, including partner referral.
4. Increase the proportions of HIV-infected pregnant women who receive anti-retroviral medication to interrupt perinatal transmission of HIV. [Suggest objective be expanded to ensure that "related medically necessary services and appropriate

medication” are also available to HIV-infected pregnant women.]

5. Increase the percent of HIV-positive IDUs who reduce sharing of needles and have access to clean needles and drug treatment.
6. Increase the proportion of persons living with HIV who effectively access partner disclosure services.
7. Increase the proportion of HIV care providers who perform risk assessment and provide appropriate intervention and referrals.
8. Reduce legal, regulatory, and policy barriers to implementing effective HIV prevention at federal, State, and local levels. [Issue should be revised as a broad statement or guiding principle across the entire Plan rather than a Goal 1 objective.]

***Proposed Goal 2: By 2008, decrease the number of persons at risk of acquiring HIV. (Percentage decrease to be determined.)***

### **Objectives - Proposed Revisions**

1. Increase the proportion of persons at risk for HIV who have access to free condoms. [Expand language to “create an environment of expected condom use for women.”] [CDC should be advised to conduct these activities in partnership with communities to increase support.]
2. Increase the proportion of persons at risk for HIV who have access to evidence-based risk prevention interventions, including mental health, substance abuse, and other appropriate intervention for co-morbid conditions.
3. Increase the proportion of incarcerated and transitioning persons who have access to prevention services. (Define “transitioning” as persons on parole, probation, etc.) [Activities for adolescents who enter/exit juvenile systems should be added.]
4. Increase the proportion of IDUs who do not share needles and have access to clean needles and drug treatment.
5. Increase the proportion of in-school and out-of-school high-risk youth who have access to evidence-based prevention, including STD screening and treatment.
6. Increase the proportion of healthcare providers who perform sexual, drug, and other risk assessments and provide appropriate interventions and referrals.
7. Reduce legal, regulatory, and policy barriers to implementing effective HIV prevention at federal, State, and local levels (e.g., rapid testing restrictions, increased taxes on alcohol, etc.) [This issue should be revised as a broad statement or guiding principle across the entire Plan rather than a Goal 2 Objective.]
8. Increase the proportion of HIV-negative partners and discordant “couples” who are aware of the status of their partners.



***Proposed Goal 3: Increase the percentage of [HIV positive] people in the US who know their HIV infection status through routine testing in diverse settings. (Percentage increase to be determined.)***

**Objectives - Proposed Revisions**

1. Increase the percentage of African Americans who know their HIV status
2. Increase the percentage of all ethnic / racial minorities with disproportionate burden of disease / incidence who know their HIV status
3. Increase the percentage of all gay and other MSM who know their HIV status
4. Increase the percentage of IDU, substance users, mentally ill, STD, and other co-morbidities who know their status
5. Increase the opportunity for all inmates to be tested
6. Reduce the barriers (including stigma and discrimination) and increase opportunities so that all providers can test routinely in clinical and non-clinical settings
7. Increase the use of and disseminate rapid testing technology that is user friendly and produces same day confirmed results
8. Increase the percentage of people who are tested (early) and during acute infections and who have knowledge of their HIV status

***Proposed Goal 4: By 2008, increase from the current estimate the proportion of people with HIV who are receiving appropriate prevention, care, and treatment services. (percentage increase to be determined)***

**Objectives - Proposed Revisions**

1. Increase the percentage of HIV positive African Americans who are linked to appropriate prevention, care, and treatment services within 3 months of diagnosis
2. Increase the percentage of all HIV positive racial / ethnic minorities with disproportionate burden of disease / incidence who are linked to appropriate prevention, care, and treatment services within 3 months of diagnosis
3. Increase the percentage of HIV positive gay and other MSM who are linked to appropriate prevention, care, and treatment services within 3 months of diagnosis
4. Increase the percentage of HIV positive IDU, substance users, mentally ill, STD and other co-morbidities who are linked to appropriate prevention, care, and treatment services within 3 months of diagnosis
5. Increase the opportunity for all HIV positive inmates who are linked to appropriate prevention, care, and treatment services within 3 months of diagnosis
6. Ensure that all HIV positive persons receive comprehensive prevention services that include adherence, disclosure, and sexual risk reduction in their care settings within 3 months of diagnosis (Monitor to assure that HIV positive persons receive



optimal medical care for their own health)

7. Increase the number of culturally competent science-based prevention services for racial and ethnic minorities, gay men, and other MSM
8. Monitor the extent of multi-drug resistant virus among HIV positive people to prevent the potential development of bio-disparity
9. Increase the proportion of HIV care providers, offering routine, periodic reproductive services, and STD and TB screening and treatment to HIV-infected clients
10. Increase the proportion of persons diagnosed with HIV needing substance abuse treatment and social and mental health services that are successfully linked to those services

***Proposed Goal 5: Increase public awareness of HIV and reduce HIV-related stigma and discrimination.***

**Suggestion:** Awareness of the Plan should also be increased in the medical community and private sector to ensure that these groups partner with CDC in meeting the targets.

## **Final Comments and Recommendations**

Several themes and recommendations were repeated throughout the deliberations of the Work Group. The following comments represent a consensus feeling among the participants:

- The health emergency among African Americans must compel a statement about the priority of prevention for this group at this time.
- There is a critical need to continue to focus on MSM and the broader group of high-risk HIV-positive persons.
- Most of the revised objectives are directed to patients; but providers, medical associations, and healthcare institutions should also serve as targets. Success of the updated Plan will depend on taking different approaches, clearly defining a road map, and implementing a detailed mobilization strategy.
- CDC, HRSA, and other federal agencies should develop and deliver a unified message to constituents: “Every individual in the country should be tested for HIV and know their status. All HIV-positive persons should be linked to treatments, care, and preventions services.” Clear delivery of this message will reduce stigma in certain populations and eliminate need to update the existing Plan or develop a new Plan with new objectives.
- CDC alone cannot address the issues in the Plan. A national Plan should be developed at this time. The Work Group should serve as the initial voice for this effort.

Recognizing that the Strategic Plan is already functioning in an extension to 2008 and recognizing that there were many Work Group recommendations that can begin to inform CDC efforts even in the absence of updated goals and objectives, the CHAC requests that CDC report back to the CHAC at its next meeting regarding:

- How it plans to align resources and strategies to optimize impact given current levels of funding; how it would adjust strategies assuming the roles of other federal and private partners
- Given the above, how it plans to address concerns regarding scale-up, translational research, CBO capacity, and related cross-plan recommendations coming out of the Workgroup.

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## Appendix B: Current Goals and Objectives of the National HIV Prevention Strategic Plan

<b>Goal 1:</b> By 2005, decrease by at least 50% the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention interventions.	
<b>OBJ #</b>	<b>Activities</b>
1	Among people living with HIV, increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission or acquisition.
2	Among men who have sex with men (MSM), increase the proportion who consistently engage in behaviors that reduce risk for HIV acquisition or transmission.
3	Among adolescents, increase the proportion who consistently engage in behaviors that reduce risk for HIV acquisition or transmission.
4	Among injecting drug users (IDUs), increase the proportion that abstain from drug use or, for those who do not abstain, use harm reduction strategies to reduce risk of HIV acquisition or transmission.
5	Among at-risk sexually active women (including women who have sex with other women), and at-risk heterosexual men, increase the proportion who consistently engage in behaviors that reduce risk for HIV acquisition or transmission.
6	Increase the proportion of people at risk for HIV who are tested for STDs and treated appropriately.
7	Increase the proportion of HIV-infected pregnant women who routinely receive HIV counseling, accept HIV testing and choose to take antiretroviral medication to interrupt prenatal transmission of HIV.
8	Support HIV vaccine research.
9	Reduce the number of workers who are occupationally exposed to and infected with HIV.
10	Continue to monitor and support the safety of blood, tissue and organ supplies in the United States.

**Goal 2:** By 2005, through voluntary counseling and testing, increase from the current estimated 70% to 95% the proportion of HIV-infected people in the United States who know they are infected.

<b>OBJ #</b>	<b>Activities</b>
1	Increase the motivation of at-risk individuals to know their infection status and decrease real and perceived barriers to HIV testing.
2	Improve access to voluntary, prevention counseling, testing and referral in high seroprevalence communities and populations at risk, focusing particularly on populations with high rates of undiagnosed infection.
3	Increase the number of providers who routinely offer CTR for HIV in health care settings (e.g., STD clinics, substance abuse treatment programs, family planning clinics, emergency rooms, community health centers), as well as in other non-clinical venues (e.g., social venues, public assistance programs, street outreach).

<b>Goal 3:</b> By 2005, increase from the current estimated 50% to 80% the proportion of HIV-infected people in the United States, who are linked to appropriate prevention, care and treatment services.	
<b>OBJ #</b>	<b>Activities</b>
1	Reduce the disparities in access to prevention and care services that are experienced by communities of color, women and special-needs populations.
2	Integrate prevention services, including adherence to treatment, for persons diagnosed with HIV and AIDS into the delivery of patient care in both public and private sectors.
3	Increase the proportion of persons who have been diagnosed with HIV who are successfully linked to culturally competent, science-based prevention services.
4	Promote the optimal level of medical services for patients diagnosed with HIV to benefit individual health and reduce the likelihood of further transmission of HIV.
5	Increase the proportion of persons diagnosed with HIV who are successfully linked to medical care no later than 3 months after learning their HIV status or re-identified as being HIV-infected but out of care.
6	Increase the proportion of correctional facility detainees (incarcerated for at least 30 days) identified as HIV-infected who are provided HIV prevention, treatment and care services and who, upon release, are successfully linked to those services in the communities to which they return.
7	Increase the proportion of HIV care providers offering routine, periodic STD screening and treatment to HIV-infected clients.
8	Increase the proportion of HIV care providers offering routine, periodic TB screening and treatment to HIV-infected clients.
9	Increase the proportion of persons diagnosed with HIV, including pregnant women, needing substance abuse treatment services that are successfully linked to those services.
10	Increase the proportion of persons diagnosed with HIV needing social and mental health services that are successfully linked to those services.

**Goal 4:** Strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions and evaluate prevention programs.

<b>OBJ #</b>	<b>Activities</b>
1	Develop an integrated monitoring system to measure incidence of new infections, track the prevalence of disease, monitor behaviors that increase the risk of HIV infection, and provide locally relevant data for community planning.
2	Increase the number of evidence-based interventions and the proportion of prevention providers funded by CDC who demonstrate effectiveness in providing these interventions.
3	Continue to support realistic and feasible evaluation efforts to ensure the highest possible quality of service and intervention delivery.

## Appendix C: CDC's HIV Funding

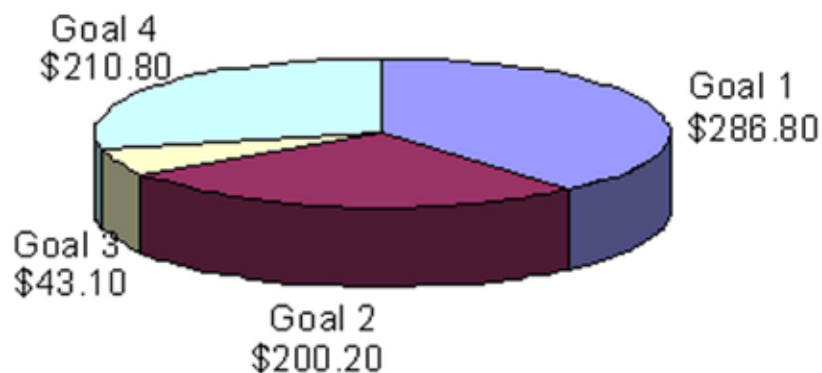
The Division of HIV/AIDS Prevention's budget has been cut by about 20 million over the past several years, and was further decreased by an additional \$6 million in FY 2006. The Plan has been instrumental in determining funding priorities for these diminishing resources.

CDC's total domestic HIV budget was \$741 million in FY'04. By goal, \$286.8 million (or 39%) was allocated to goal 1 activities. By focus area, the vast majority of resources were dedicated to the top five objectives for youth, HIV-positive persons, MSM, at-risk sexually active women and heterosexual men, and IDUs.

\$200.2 million (or 27%) was allocated to goal 2 activities. Of the total funding for this goal, 95% was allocated to extramural activities for counseling, testing and partner referral services. The \$200.2 million was distributed evenly across the four objectives of increasing motivation to test, access to testing, making VCT routine, and increasing return of results.

\$43.1 million (or 6%) was allocated to goal 3 activities. Allocations went to the top three priorities for reducing disparities in access to care, integrating prevention services, and increasing linkages to culturally-competent prevention services.

Finally, \$210.8 million (or 28%) was allocated to goal 4 activities. Of the total funding for this goal, 45% was dedicated to surveillance, 12% was dedicated to technical assistance, 11% was dedicated to program evaluation, and 32% was dedicated to research, intervention/implementation and policy development. By objective, the \$210.8 million was allocated in order of priority to surveillance, interventions, and evaluation (see Appendix G for more detailed budget information).



**Allocation of funds (in millions) across goals**

## Appendix D: Measuring Success in Achieving Plan's Goals

One of the ways to measure success toward attaining the goals of the Plan is to monitor changes in the epidemic using data provided by national surveys and surveillance systems. CDC identified 12 measurable performance indicators in 2002 to monitor annual progress toward achieving Plan goals. The indicators are based on quantitative measures for specific goals or objectives and the current and future availability of data. Baselines were established for 2000 and performance targets were determined for 2005 and 2010. CDC designed the HIV prevention performance indicators to be consistent with standardized measures used for other federal activities.

### Summary of goal indicators and outcomes

Goal	Indicators	Outcomes
<p><b>Overarching goal:</b> Reduce the number of new HIV infections in the United States from an estimated 40,000 to 20,000 per year by the year 2005, focusing particularly on eliminating racial and ethnic disparities in new HIV infections.</p>	<ol style="list-style-type: none"> <li>1. Measure the number of persons 13-24 years of age diagnosed with HIV/AIDS in 30 areas with at least a four-year history of implementing named-based reporting</li> <li>2. Trend in gonorrhea rates reported each year</li> <li>3. Trend in primary and secondary syphilis cases reported each year</li> <li>4. Estimated number of new perinatally acquired AIDS cases diagnosed each year</li> </ol>	<ul style="list-style-type: none"> <li>• Between 2000-2004, the number of people aged 13-24 years of age diagnosed with HIV/AIDS increased from 2,929 to 3,465.</li> <li>• Between 2000-2004, the rate of gonorrhea declined from 128.7 to 113.5 cases per 100,000 population.</li> <li>• Between 2000-2004, the rates of P&amp;S syphilis increased slightly from 2.1 to 2.7 cases per 100,000 populations.</li> <li>• Between 2000-2004, the estimated number of perinatally-acquired AIDS cases declined from 124 to 48 cases.</li> </ul>

Goal	Indicators	Outcomes
<p><b>Goal 1:</b> By 2005, decrease by at least 50% the number of persons in the United States at risk for acquiring or transmitting HIV infection by delivering targeted, sustained, and evidence-based HIV prevention interventions.</p>	<ol style="list-style-type: none"> <li>1. YRBS data monitoring % of 9th-12th grade students who reported safe sexual behaviors defined as a) never having engaged in sexual intercourse b) not sexually active in past 3 months c) if sexually active in past 3 months, used condom.</li> <li>2. SHAH data monitoring condom use of persons diagnosed with HIV for &gt;12 months when status of partner was unknown.</li> <li>3. SHAS data monitoring sharing of needles among HIV-infected IDUs diagnosed for &gt;12 months.</li> </ol>	<ul style="list-style-type: none"> <li>• From 1999-2003, % of students practicing safer sex or abstinence increased from 85%-88%.</li> <li>• Between 2001-2004, % of condom use among HIV-infected persons increased slightly from 12.3% to 13.4%.</li> <li>• Between 2001-2004, % of those who shared of needles among HIV-infected persons decreased from 7% to 3% in 2001, but increased to 7% in 2004.</li> </ul>
<p><b>Goal 2:</b> By 2005, through voluntary counseling and testing, increase the current estimated 70%-95% the proportion of HIV-infected people in the United States who know they are infected.</p>	<ol style="list-style-type: none"> <li>1. CDC's CTS measures % of HIV-positive test results from publicly funded counseling and testing sites with post-test counseling sessions.</li> <li>2. HIV/AIDS Monitoring System measures % of HIV cases diagnosed at least one month before progression to AIDS.</li> </ol>	<ul style="list-style-type: none"> <li>• From 2000-2003, % of HIV-positive test remained stable at 69%-71%</li> <li>• From 2000-2004, % of diagnosed HIV cases increased slightly from 76%-78%</li> </ul>



Goal	Indicators	Outcomes
<p><b>Goal 3:</b> By 2005, increase from the current estimate of 50% to 80% the proportion of HIV infected people in the United States who are linked to appropriate prevention, care, and treatment services.</p>	<p>1. SHAS monitors % of HIV/AIDS cases in care within 3 months of diagnosis</p>	<ul style="list-style-type: none"> <li>From 2000-2004, data shows % of HIV-infected who received medical care within 3 months increased from 79%-85%</li> </ul>
<p><b>Goal 4:</b> By 2005, strengthen the capacity nationwide to monitor the epidemic, develop, and implement effective HIV prevention interventions and evaluate prevention programs.</p>	<p>1. Measures the number of states and territories with integrated, confidential, name-based HIV/AIDS case surveillance systems.</p>	<ul style="list-style-type: none"> <li>January 2001, 33 states and 2 territories had implemented HIV case surveillance systems</li> <li>By April 2006, all states and territories had some form of HIV reporting: 43 states use name-based reporting, two use name-to-code reporting, and 6 use code identifiers</li> </ul>

Indicators for Goal 1 measure abstinence, sexual intercourse and condom use among students in grades 9-12. The indicator is designed to measure youth who have never had sexual intercourse, abstained from sexual intercourse in the past three months, and used condoms in the past three months. Data from the Youth Risk Behavioral Survey (YRBS) showed a substantial increase in safer sex behaviors among adolescents from 1999-2003.

Indicators also measure condom use during vaginal or anal sex among persons diagnosed with HIV infection for >12 months who did not know the HIV status of their partners; and the sharing of needles or syringes among persons diagnosed with HIV infection for >12 months. Data from the Supplement to HIV/AIDS Surveillance (SHAS) show minimal changes in the indicators from 2001 to 2004 because prevention activities targeted to PLWH are a new component of CDC's overall HIV prevention efforts.

Indicators for Goal 2 measure the percentage of HIV-positive test results from publicly-funded counseling and testing sites with post-test counseling sessions and the percentage of HIV cases diagnosed before progression to AIDS. The percentage of HIV-positive tests remained relatively stable from 69%-71% from 2000-2003, while the percentage of diagnosed HIV cases slightly increased from 76%-78% from 2000-2004.

The indicator for Goal 3 measures the percentage of HIV/AIDS cases in care within three months of diagnosis. Available data showed an increase in the indicator from 79%-85% between 2000 and 2004.

The indicator for Goal 4 measures the number of state and territories with integrated, confidential, name-based HIV/AIDS case surveillance systems. As of January 2001, 33 states and two territories had implemented HIV case surveillance using the same confidential system as AIDS for named-based HIV case reporting. Three states converted names to codes for HIV reporting. Seven states and Puerto Rico used coded identifiers for HIV reporting. Six states had no HIV reporting system at that time. As of April 2006, all states and territories have some form of HIV reporting: 43 states use name-based reporting, two use name-to-code reporting, and five and the District of Columbia use coded identifiers.

In summary, most of the indicators for the above goals produced stable results for behaviors and incidence, while CDC notes significant progress in efforts to implement national HIV surveillance and to link HIV-infected persons to care (see Appendix G for more detail about these indicators).

## **Appendix E: Progress Toward Reaching the Goals of the Plan**

While available data do not demonstrate success in achieving the overall goal of reducing HIV infections by half, there is evidence of considerable progress in implementing activities that meet the objectives of the national HIV Strategic Plan. The table that follows highlights major activities undertaken by CDC in support of objectives outlined in the Plan (see Appendix G for a more comprehensive review of these activities).

Summary of progress toward reaching goals	
Goal	Progress/Activities
<b>Goal 1</b>	<p><b>PLWH</b></p> <ul style="list-style-type: none"> <li>Released program announcements for Serostatus Approach to Fighting the HIV Epidemic framework in 2001 and Advancing HIV Prevention Initiative in 2003</li> <li>PCM demonstration project awarded funds to 9 CBOs to evaluate effects of PCM on HIV transmission risk behaviors and health of PLWH</li> <li>Published report of 12 interventions that show significant reduction in unprotected sex and STD acquisition in PLWH.</li> </ul> <p><b>MSM</b></p> <ul style="list-style-type: none"> <li>North Carolina Men's Health Initiative developed for DEBI intervention targeting AA MSM</li> <li>Researching Brothers y Hermanos study to understand risk and experiences of AA and Latino MSM</li> </ul> <p><b>Youth</b></p> <ul style="list-style-type: none"> <li>Supports dissemination of 3 interventions for at-risk, homeless, runaway, and HIV-positive youth.</li> </ul> <p><b>IDUs</b></p> <ul style="list-style-type: none"> <li>Supports dissemination of 3 interventions for IDUs</li> <li>Conducted research on intervention trials for HIV+ and HIV- IDUs and safety trials of Tenofovir.</li> </ul> <p><b>Heterosexuals</b></p> <ul style="list-style-type: none"> <li>Supports dissemination of 4 interventions for clinic patients, female sex workers, female partners of IDUs, and AA women</li> <li>Research activities include a video-based intervention in STD clinics, projects for incarcerated men, and safety of a microbicide to prevention heterosexual HIV transmission</li> </ul>

Goal	Progress/Activities
<p><b>Goal 2</b></p>	<p><b>Increasing motivation to HIV testing</b></p> <ul style="list-style-type: none"> <li>• Recommends annual testing for MSM and routine offering of testing to reduce stigma</li> <li>• Conducted social networks demonstration for HIV positive and high-risk persons that increased prevalence of undiagnosed HIV among peer referrals</li> <li>• Collaborating with state partners to design comic books in English and Spanish with HIV-related stories to be launched in Los Angeles</li> <li>• Launched PCRS demonstration projects in 2003 to offer rapid testing among persons who were exposed to an HIV-positive partner</li> </ul> <p><b>Improving access to HIV testing</b></p> <ul style="list-style-type: none"> <li>• Increased rapid testing availability for non-healthcare workers and migrant farm workers at 10 sites from 2004-2006</li> <li>• Distributed more than half a million OraQuick devices to 252 US organizations from 2003-2005</li> </ul> <p><b>Increasing routine VCT in healthcare settings</b></p> <ul style="list-style-type: none"> <li>• Launched demo projects of rapid HIV screening in 11 clinics at 5 sites nationwide.</li> <li>• Evaluating alternative procedures for pre-test counseling prior to HIV testing.</li> </ul> <p><b>Increasing number of persons who return for HIV test results</b></p> <ul style="list-style-type: none"> <li>• Data collected in two cycles from 2003-2005 show rate of return for results from 92%-95.4% among persons with negative and preliminary positive rapid test results.</li> <li>• Of persons with preliminary positive results, 86% returned for confirmatory test results.</li> </ul>

Goal	Progress/Activities
<p><b>Goal 3</b></p>	<p><b>Reducing disparities in access to care</b></p> <ul style="list-style-type: none"> <li>• Five different data sources from the HIV/AIDS Surveillance Report show 82%-88% of whites and AAs were prescribed antiretroviral therapy.</li> <li>• From 2004-2006, CDC conducted demonstration project on rapid testing in Historically Black Colleges and Universities. Demonstrated capacity to provide direct referrals to case management and care.</li> </ul> <p><b>Integrating prevention services</b></p> <ul style="list-style-type: none"> <li>• CDC and other federal agencies published guidelines incorporating HIV prevention into medical care of PLWH.</li> <li>• Prevention in Care social marketing campaign launched to promote usage of guidelines among partners, providers, and patients.</li> </ul> <p><b>Increasing proportion of HIV-infected persons linked to prevention services</b></p> <ul style="list-style-type: none"> <li>• Provided funding to National Network of STD/HIV Prevention Training Centers and AETCs to develop extensive training for medical care providers of HIV-infected patients.</li> <li>• The training was designed to assist HIV care providers incorporate science-based interventions to help their patients reduce risk behaviors. 3,400 services providers completed the training by 2006.</li> </ul> <p><b>Promoting optimal level of medical services</b></p> <ul style="list-style-type: none"> <li>• HHS guidelines for use of antiretroviral agents widely used to improve and optimize level of medical care</li> </ul> <p><b>Increasing linkage to care within 3 months</b></p> <ul style="list-style-type: none"> <li>• ARTAS randomized trial showed 78% of persons with case management care visited clinician at least twice in 6 months compared to 60% with standard care.</li> </ul>

Goal	Progress/Activities
<p><b>Goal 4</b></p>	<p><b>Monitoring the epidemic</b></p> <ul style="list-style-type: none"> <li>• Developed integrated surveillance system to measure the incidence of new infections, track the prevalence of disease, monitor behaviors that place persons at risk for HIV, and provide locally relevant data for community planning.</li> <li>• Funds 34 areas to conduct population-based HIV incidence surveillance; plans to provide precise estimate of recent HIV seroconversions by the end of 2006.</li> <li>• Collects NHBSS data each year from 25 metropolitan statistic areas throughout the United States with the largest number of AIDS cases. Uses these data to guide the development and implementation of effective behavioral interventions for high-risk populations.</li> </ul> <p><b>Implementing effective interventions</b></p> <ul style="list-style-type: none"> <li>• Identified 14 evidence-based interventions under the DEBI program.</li> <li>• Since 2004, diffused 12 of the 14 interventions to CBOs and health departments.</li> </ul> <p><b>Evaluating programs and interventions</b></p> <ul style="list-style-type: none"> <li>• Developed and released PEMS in 2004 to 42 health departments and 27 CBOs.</li> <li>• Currently analyzing final data and developing dissemination plans for PEMS.</li> </ul>



## Appendix F: CDC Discussion of Barrier for Each Goal

Additional barriers and challenges have been recognized by CDC. These insights are described below in reference to each goal.

**Goal 1.** Despite numerous HIV prevention activities for this goal, there are several challenges in further reducing HIV risk behaviors. Effective interventions for African American and Latino MSM, and other priority populations, do not exist or have not been packaged for dissemination. Intertwining epidemics of substance abuse, poor mental health, STDs, poverty, violence and other structural factors play a critical role in placing persons at risk for HIV. The effects of HIV treatment have impacted public perception about the severity of and susceptibility to HIV.

“Prevention burnout and fatigue” are causing some communities to ignore CDC’s prevention messages. Barriers exist to scaling-up the dissemination of evidence-based interventions and adequately meeting the demands of communities. Resources have not been sufficiently allocated to specific activities and local needs of certain communities. Minimal progress has been made in determining the optimal mix of prevention strategies to achieve the greatest impact at both national and local levels.

**Goals 2 and 3.** While there are numerous HIV prevention activities for goal 2 of the Plan, there are several challenges in increasing VCT. Most HIV testing is performed outside of public health settings. HIV counseling and testing sites that are supported by CDC dollars only administer ~5% of all HIV tests in the United States. State laws impact the legality and feasibility of implementing rapid test programs. Reimbursement issues have not been resolved to date. The integration of HIV screening programs into existing care settings poses a number of barriers.

Similarly, there are several challenges in increasing linkages to appropriate HIV prevention, care and treatment services. Traditional disparities in accessing care still exist among some groups (e.g., racial and ethnic minorities, MSM, injection drug users). Competing priorities, time constraints, and other barriers are significant issues for HIV care providers. Reimbursement issues for case management are unresolved. Activities to develop and sustain capacity to collect high-quality data on clinical outcomes and access to care are extremely difficult for health departments, providers and CBOs to implement.

**Goal 4.** Although numerous HIV prevention activities have been implemented for this goal, several challenges remain related to monitoring, evaluating, and delivering programs. Variations in reporting policies and priorities for HIV surveillance increase complexity. The tension between monitoring treatment and care versus incidence has not been resolved to date. The intervention portfolio and pipeline for HIV are limited for MSM of color and other specific populations. Efforts to adapt and tailor existing interventions for certain groups are extremely difficult.

Community norms play a critical role in the content of interventions and “appropriate” or “acceptable” messages to deliver. Several issues related to PEMS have not been sufficiently addressed, such as privacy and confidentiality for non-infected persons, data collection versus expanded testing, and lack of capacity and resources to compile PEMS data. Local needs continue to compete with federal capacity in the areas of scaling-up surveillance systems or interventions, and to provide assistance in the face of shrinking resources and restrictions on new hires and travel.

There are additional reasons why CDC has not achieved the overarching goal to reduce new infections by half:

1. Policy limitations affect what interventions are implemented and how resources are directed.
2. Scientific factors such as the epidemiology and transmission dynamics of HIV in the United States, behavioral factors, and public “optimism” with HIV treatment.
3. Contextual factors influence HIV transmission in the United States, including gender inequality and other societal issues; poverty, homelessness and other socioeconomic issues; mental health and substance abuse; and stigma, racism and homophobia.

HIV transmission is ongoing. HIV rates and transmission among MSM, African Americans, and heterosexual women continue to play a critical role in the HIV epidemic. “Prevention fatigue” has increased the difficulty in sustaining behavioral interventions.

Better interventions have not been developed to address geographic, risk, and racial/ethnic diversities of the HIV epidemic in the United States. Methamphetamine use serves as a strong barrier to implementing behavioral interventions. National data are not available on risk behaviors among out-of-school, homeless and runaway youth. Legislative barriers still exist in implementing new HIV testing and counseling and models. Issues related to stigma have not been adequately addressed in the United States.

## **Appendix G: CDC Report of HIV Prevention Strategic Plan Activities and Progress**

### **Background and Purpose**

Since the publication of the CDC HIV Prevention Strategic Plan Through 2005, CDC has identified 10 performance indicators to measure and monitor the progress of the overarching national goal and four domestic goals of the Plan. In addition, CDC monitors and measures its progress regarding activities to achieve the goals and objectives in the Plan. CDC has realigned prevention programs; conducted research to identify and disseminate interventions that are scientifically effective, have been formally evaluated, and shown to reduce the risk of HIV transmission; implemented a national, population-based incidence surveillance system as a supplement to HIV and AIDS case surveillance activities; and launched a new initiative that supports the HIV prevention work of the past two decades.

This Summary Document highlights selected activities that address the overarching national and four domestic goals, and presents a summary analysis of the current performance data for the goal indicators, and assesses the overall impact of CDC efforts in achieving the Plan's goals.

### **State of the U.S. Epidemic**

**Overarching National Goal: Reduce the number of new HIV infections in the United States from an estimated 40,000 to 20,000 per year by the year 2005, focusing particularly on eliminating racial and ethnic disparities in new HIV infections. [FY 2004 Funding: \$741 million]<sup>1,2</sup>**

CDC estimates that currently approximately 1.0 to 1.2 million people in the United States are infected with HIV and about a quarter, 250,000 – 300,000, are unaware they are HIV-infected. CDC believes that HIV transmission from people who are unaware of their infection status accounts for more than half of the estimated 40,000 new HIV infections that occur each year. The majority of the new HIV infections are among

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<sup>1</sup> The funding amounts presented here represent amounts spent in 2004 by CDC's National Centers on goals 1 - 4 of CDC's HIV Strategic Plan. They exclude amounts spent on Goal 5 (to assist in reducing HIV transmission and improving HIV/AIDS care and support in partnership with resource-constrained countries) and amounts for centralized rent, utilities, and program support at CDC. They include funding transferred to CDC from HHS for the Minority AIDS Initiative.

<sup>2</sup> This figure represents amounts spent in 2004 by CDC's National Centers on goals 1-4 of CDC's HIV Strategic Plan. It excludes amounts for centralized rent, utilities and program support and includes funding transferred to CDC from HHS for the Minority AIDS Initiative.

African Americans and other people of color. Indeed, African Americans are the hardest hit racial and ethnic population bearing a disproportionate burden of illness and death from the HIV/AIDS epidemic. Data from 2004 indicate that African Americans account for 50% of the new HIV/AIDS cases reported in 33 states and two territories with confidential name-based HIV reporting, and account for 51% of the people who died with AIDS. The rate of HIV/AIDS diagnoses for African-American women is 23 times the rate for white women; and the rate of HIV/AIDS diagnoses for African-American men is 8 times the rate for white men. Moreover, despite the significant declines in perinatal HIV transmission, a national success story, African-American children still remain at disproportionate risk. In 2004, 71% of infants reported as having HIV/AIDS were African American, and 63% of U.S. children younger than 13 years of age who had a new AIDS diagnosis were African American.

## Summary Analysis of Performance Indicators

CDC has implemented four indicators to monitor progress of the Overarching National Goal. Indicator 1 examines the number of people 13-24 years of age diagnosed with HIV/AIDS. Trends in HIV/AIDS diagnoses among young persons <25 years of age are currently our best indicator of trends in new HIV infections (incidence), because these persons are likely to have been infected relatively recently. The trends in this indicator have increased between 2000 (baseline: 2,928 HIV/AIDS cases) and 2004 (performance for most current year: 3,465 HIV/AIDS cases). This increase may be interpreted in one of two ways: 1) there is a true increase in incidence; or 2) something has happened that has affected our measurement of this indicator (i.e., ascertainment bias: for example, an increase in the proportion of new infections diagnosed).

The group where increases are most prominent is men who have sex with men (MSM); trends in other risk groups appear to be stable or decreasing. Other data, such as trends in sexually transmitted diseases (STDs) in MSM, and increases among MSM in substance use (e.g., methamphetamine use) combined with sexual risk taking behaviors, suggest that high risk behaviors may also be rising within this risk group.

Indicator 2 explores the rate of gonorrhea cases reported each year. Trends in gonorrhea rates were selected as an indicator because this STD is an important indicator of risk behaviors that may put individuals at risk for HIV. This indicator may also be useful to monitor Goal 1 of the *Plan*. Between 2000 and 2004, the rate of gonorrhea declined from 128.7 cases per 100,000 population to 113.5 cases per 100,000 population. This trend may be interpreted to mean that there has been a decline in true gonorrhea transmission thereby suggesting a decline in sexual risk behaviors. As with HIV trends, gonorrhea rates can also be affected by changes in screening patterns (especially in women) and changes in reporting practices. Trends in gonorrhea have been declining steadily since the 1970s and have only recently begun to level. Since gonorrhea is largely a disease of adolescents and young adults,

declines may have also been influenced by declines in risk-taking behaviors in that population (e.g., increases in abstinence, improved partner selection, serial monogamy) and increases in condom use. As with HIV, minorities are disproportionately affected by gonorrhea; in 2004, nearly 70% of reported gonorrhea cases were among African Americans. The rate of gonorrhea was nearly 19-fold greater in African Americans, 3-fold greater in American Indian/Alaska Natives and 2-fold greater in Hispanics, compared with whites.

Indicator 3 highlights rates of syphilis cases reported each year. Trends in primary and secondary (P&S) syphilis were selected as an indicator because this STD is an important indicator of risk behaviors that may put individuals at risk for HIV. Historically, P&S syphilis has tracked well with trends in HIV, possibly because of the similarity in populations and risk behaviors for acquisition. This indicator may also be useful in monitoring Goal 1 of the *Plan*. Between 2000 and 2004, the rate of P&S syphilis increased from 2.1 cases per 100,000 population to 2.7 cases per 100,000 population; when the rates are stratified by men and women, the increases are occurring in men. This trend may be interpreted to mean that there has been a true increase in P&S syphilis and high-risk sexual behaviors in men. P&S syphilis rates can also be affected by changes in screening and reporting practices. As with HIV and gonorrhea, syphilis disproportionately affects African Americans. In 2004, the rate of P&S syphilis was nearly 6-fold higher in African Americans than whites, and 41% of reported P&S syphilis cases were among African Americans.

Indicator 4 focuses on the number of perinatally-acquired AIDS cases diagnosed each year. This indicator is a measure of effectiveness of screening pregnant women for HIV and implementing effective interventions to prevent mother-to-child transmission. Trends in new perinatally-acquired AIDS cases have been monitored since early in the epidemic. As prevention of mother-to-child HIV transmission (MTCT) and treatment for perinatally infected infants and their mothers have improved, the number of new cases of perinatally-acquired AIDS has dramatically declined. Between 2000 and 2004, the estimated number of new perinatally-acquired AIDS cases declined from 124 to 48 cases and may be approaching the theoretical number of transmission events that would occur if optimal prevention strategies were applied to all pregnant HIV-infected women. African American infants are disproportionately affected; in 2004, 60 (71%) of the 84 cases of HIV/AIDS in infants born to HIV-infected mothers and reported to CDC from 25 health departments with longstanding confidential name-based HIV reported were African American.

## **Selected Activities**

Two major activities addressing the overarching goal are: the CDC Minority AIDS Initiative (MAI) program, and the “Advancing HIV Prevention (AHP): New Strategies for a Changing Epidemic,” launched in April 2003.

CDC, through the MAI program, addresses the health disparities experienced in racial and ethnic communities. Since Fiscal Year (FY) 1999, Congressional language has included MAI resources to specifically target HIV prevention services to communities of color through direct funding of community-based organizations (CBOs). In FY 2005, CDC used MAI funding to make over 150 awards for distinct projects. CDC provided over \$33 million in MAI funds to CBOs to provide HIV prevention services, over \$27 million to support capacity building, and approximately \$10 million for research, evaluation, and demonstration projects. MAI funding has greatly enhanced CDC’s ability to provide resources directly to CBOs located in and serving minority communities and enhanced our ability to provide a range of HIV prevention services to disproportionately affected racial and ethnic communities.

The AHP initiative represents a multi-agency collaboration within the Department of Health and Human Services, allowing CDC to strengthen partnerships and create ones with public and private entities and federal agencies to better address national efforts aimed at reducing HIV transmission. AHP has four key strategies: 1. incorporate voluntary HIV testing a routine part of medical care; 2. implement new models for diagnosing HIV infections outside medical settings; 3. prevent new infections by working with persons diagnosed with HIV and their partners; 4. further decrease mother-to-child HIV transmission. Through AHP, CDC has placed increased emphasis on diagnosing individuals who are unaware of their HIV-positive status, particularly high-risk groups such as men who have sex with men (MSM), injection drug users (IDUs), and disproportionately affected racial and ethnic communities; and increasing access to quality medical care, treatment, and ongoing prevention services for people living with HIV. The initiative’s four key strategies are incorporated throughout CDC’s HIV prevention program funding of CBOs and state and local health departments. In support of the initiative, CDC provided funding for 11 demonstration projects to develop models and demonstrate efficacy for implementing the AHP strategies to 13 health departments, 21 CBOs, and 15 sites.

## **Overall Impact of the Overarching National Goal**

At this point, we have no national measure of the number of new HIV infections (incidence) in the United States. While the number of persons currently living with HIV (prevalence) has increased each year--in large part due to improvements in medical treatments-- indirect measures suggest that HIV incidence has been stable or has possibly increased from 2001 through 2005. It should be noted that the 50% decline called for by the overarching goal was predicated upon receiving additional resources.



While some increases in funding were provided to CDC, and were used for prevention programs for high-risk racial and ethnic minority populations, these were not sufficient to mount a national program to reduce transmission by half.

We have been successful in lowering infections among some sub-populations and risk groups. For example, perinatal HIV transmission continued to decline as indicated by reductions in HIV/AIDS cases among children born to HIV-infected mothers. Increased testing of pregnant mothers, highly-active-antiretroviral therapy, and surgical delivery of infants through C-sections all contributed to the decline. Declines in HIV and AIDS cases, likely indicative of declines in HIV transmission, were also seen among injection drug users, possibly due to changes in needle sharing practices, changes in drug using behavior, and access to sterile injecting equipment.

**Goal 1: By 2005, decrease by at least 50% the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention interventions. [FY 2004 Funding: \$286.8 million;39% of total] <sup>3</sup>**

## Background

Of the estimated number of persons living with HIV in the United States, 47% are African American, 34% are white, 17% are Hispanic, <1% are Asian/Pacific Islander, and <1% are American Indian/Alaskan Native. By mode of exposure, an estimated 45% of persons living with HIV are MSM, 22% are IDUs, 5% are both MSM and IDUs, 27% were exposed through heterosexual contact, and 1% had an undetermined exposure.

## Summary Analysis of Performance Indicators

CDC has developed three indicators (Indicators 5-7) to monitor Goal 1. Indicator 5 monitors the percentage of students in 9th through 12th grade who reported safer sexual behaviors defined as: a) never having engaged in sexual intercourse, b) were not sexually active in the past 3 months, or, c) if they had sexual intercourse in the past 3 months, they used a condom. Data are from CDC's Youth Risk Behavior Survey (YRBS). Trends in the sexual behaviors of adolescents may indicate how well messages to reduce sexual risk are being incorporated into the lives of young

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<sup>3</sup>The funding amounts presented here represent amounts spent in 2004 by CDC's National Centers on goals 1 - 4 of CDC's HIV Strategic Plan. They exclude amounts spent on Goal 5 (to assist in reducing HIV transmission and improving HIV/AIDS care and support in partnership with resource-constrained countries) and amounts for centralized rent, utilities, and program support at CDC. They include funding transferred to CDC from HHS for the Minority AIDS Initiative.



people. Between 1999 and 2003, the percentage of 9th-12th graders who engaged in safer sexual behaviors increased from 85% to 88% (the percentage who were abstinent increased from 50% to 53% during this period). These data include only youth attending school and may not be representative of youth not in school, who may be at higher risk for HIV.

Indicator 6 monitors the percentage of persons diagnosed with HIV infection for >12 months who did not use a condom at last vaginal/anal sex when the status of the partner was unknown. Condom use among HIV-infected persons who have sex with HIV-negative persons or those whose status is unknown is an important indicator of ongoing risk behaviors that lead to HIV transmission. The data for this indicator are from the Supplement to HIV/AIDS Surveillance (SHAS) project. Between 2001 and 2004, the percentage of HIV-infected persons interviewed in SHAS who did not use a condom with a partner of unknown serostatus increased slightly from 12.3% to 13.4%. The SHAS project conducted in-depth interviews with a large number HIV-infected persons in a selected number of cities and states; however, the sampling methods were not uniform in these areas (some used convenience sampling and others used population-based sampling). Therefore, small year-to-year fluctuations in the data may be due to differences in samples of persons interviewed rather than true changes in behaviors. Also, during interviews, HIV-infected persons may not provide accurate information about sexual activities because of fear of negative feedback or stigma. CDC discontinued the SHAS project in 2004, and, in its place, CDC has funded the Morbidity Monitoring Project (MMP). MMP will interview a population-based sample of HIV-infected persons in care and out of care. This new approach should provide more useful data; the first data from this project should be available in 2007.

Indicator 7 is the percentage of HIV-infected IDUs (diagnosed for >12 months) who shared a needle or syringe with some in the past 12 months; data come from the SHAS project. This indicator decreased from 7% to in 2001 to 3% in 2002 and increased to 7% in 2004. As stated above, small year-to-year fluctuations in this indicator may not be meaningful due to the sampling limitations of the SHAS project. The percentage of persons sharing needles and works is nevertheless very low and supports the declining trends we are seeing in new HIV diagnoses among IDUs.

All three indicators for Goal 1 lack a direct measurement of who actually received interventions that may have had impact on changing behaviors. CDC has developed the Program Evaluation and Monitoring System (PEMS) to collect the data to address this problem. CDC is currently working with its partners to identify the best ways to implement PEMS.

### **Selected Activities**

To address Goal 1, CDC conducted the Prevention Research Synthesis project to identify behavioral interventions with solid scientific evidence of efficacy. Based on the findings from this project, CDC develops and provides culturally competent, evidence-

based HIV prevention interventions for persons at risk of acquiring or transmitting HIV through the Replicating Effective Programs (REP) and the Diffusion of Effective Behavioral Interventions (DEBI) project. These prevention interventions target specific racial and ethnic groups and subpopulations at high risk for HIV. CDC funds 65 state and local health departments, 161 directly-funded CBOs, and other partners to provide these interventions across the United States. To build the capacity among CDC partners; the agency also provides training and materials to implement these interventions. Currently, there are 14 CDC supported evidence-based prevention interventions that target both HIV-infected and uninfected persons. CDC has diffused 11 of those interventions to funded grantees. The interventions have been designed to exclusively target high-risk groups but are also adaptable to other groups. For example, 79% of directly-funded CBOs provide evidence-based prevention interventions for high-risk sexually active MSM and their partners; 58% of directly-funded CBOs provide interventions for sexually active IDUs and their partners; and 82% of directly-funded CBOs provide interventions serving high-risk sexually active women and their partners. CDC also provides DEBI trainings to individuals, state and local health departments, and directly and indirectly-funded CBOs. These efforts are complemented by an extensive capacity building assistance (CBA) program which aims to help grantees effectively implement scientifically based prevention programs. In 2004, CDC provided funding to 27 organizations to provide CBA in the adaptation, tailoring, and implementation of HIV prevention interventions for people living with HIV or AIDS, their serodiscordant partners, and others at very high risk of HIV infection.

In 2003, CDC launched the AHP initiative. The goal of the initiative is to reduce HIV transmission in the United States, particularly by expanding HIV testing and increasing the number of people who are aware of their infection. AHP focuses primarily on populations at high risk for acquiring and transmitting HIV, such as MSM, IDUs, heterosexual men and women, adolescents, and persons infected with HIV; the majority of which are racial and ethnic minorities. Through AHP, CDC refocused its prevention strategy by placing greater emphasis not only on diagnosing individuals who are unaware of their HIV status but also providing prevention services to HIV-infected persons. CDC has also directed community planning groups across the country to make people living with HIV their highest priority target population.

One key AHP strategy is to “prevent new infections by working with people diagnosed with HIV and their partners.” Results from two AHP demonstration projects: “Prevention Case Management for Persons Living with HIV/AIDS” and “Incorporating HIV Prevention into Medical Settings” has led CDC to embark on a modification of the Comprehensive Risk Counseling and Services (CRCS), formerly referred to as Prevention Case Management, guidelines to better coordinate case management for persons living with HIV with other federal agencies.

Another key AHP strategy is to further decrease perinatal HIV transmission. Effective interventions can reduce perinatal HIV transmission to less than 2% among HIV-infected pregnant women. For this reason, CDC is striving to ensure that no child is born in the

United States whose HIV status (or whose mother's HIV status) is unknown. Reduction of perinatal HIV transmission is one of the nation's most remarkable HIV prevention successes. In supporting implementation of this strategy, CDC is working with partners to promote routine prenatal HIV testing using an "opt-out" approach (i.e., pregnant women are told that an HIV test will be included in the standard group of prenatal tests and that they may decline the test), developing guidance for using rapid tests during labor and delivery or immediately post partum, providing training in conducting prenatal testing, and monitoring the integration of routine prenatal testing into medical practice.

## **Overall Impact of Goal 1**

Between 2001 and 2005, CDC broadened the scope of its programs to include prevention programs for people living with HIV and increased the focus on the most effective prevention interventions. Through the AHP initiative, CDC provided increased funding for identifying and promoting prevention services for those living with HIV, particularly in the context of medical care. CDC identified proven behavioral interventions for those at risk for becoming infected with HIV as well as those at risk for transmitting HIV and translated those into packages for use by grantees. Thousands of HIV prevention service providers were trained on provision of these interventions beginning in 2002. CDC provided support for adapting and tailoring interventions for specific groups at risk for HIV and encouraged grantees to target services for those high-risk communities. CDC also increased access to and provision of HIV testing, one of the most effective interventions for preventing HIV transmission. People who know they are infected they are likely to change their behavior. The agency continued to work to develop and test new interventions including antiretroviral prophylaxis through trials in the United States and internationally, microbicides through laboratory studies and animal models, and prepared international sites for large scale HIV vaccine trials.

**Goal 2: By 2005, through voluntary counseling and testing, increase from the current estimated 70% to 95% the proportion of HIV-infected people in the United States who know they are infected. [FY 2004 Funding: \$200.2 million; 27.0% ]<sup>4</sup>**

## **Background**

CDC is very concerned about the estimated 25% of HIV-infected persons (approximately 250,000-300,000) in the United States who are unaware of their infections and at risk for unknowingly transmitting HIV. As part of the AHP initiative, identifying persons with undiagnosed HIV infection and linking them to appropriate care is a national priority. With this new priority, CDC has focused many of its efforts on making testing a routine part of medical care and instituting new models for diagnosing HIV infections in non-clinical settings, with the ultimate goal of increasing the proportion of HIV-infected persons who know their serostatus.

## **Summary Analysis of Performance Indicators**

CDC has developed two indicators (Indicators 8 and 9) to monitor progress on Goal 2. Indicator 8 is the percentage of HIV-positive tests performed in publicly-funded clinics that were associated with post-test counseling sessions. Data for this indicator are from CDC's Counseling and Testing System (CTS). Between 2000 and 2003, the number of tests accompanied by post-test counseling sessions remained relatively stable at 69% to 71%. CTS may not be able to measure this percentage very well because of the difficulties many clinics have in entering post-test counseling sessions into the system, especially when these sessions occur long after the test was performed. As HIV rapid testing is implemented more widely, individuals may increasingly be able to get their test results and receive post-test counseling at their initial visit, and this indicator may show improvement. Within the next year, CTS will be incorporated into the Program Evaluation Monitoring System (PEMS) which may yield more complete and higher quality information.

Indicator 9 is the percentage of HIV cases diagnosed at least one calendar month before progression to AIDS. The data for this indicator are from the HIV/AIDS Reporting System. Between 2000 and 2004, the percentage of persons diagnosed before progression to AIDS has increased slightly from 76% to 78%; while this increase may not yet be statistically significant, the trend is encouraging. The current data are only available for 30 states with longstanding name-based HIV reporting policies; as more

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<sup>4</sup>The funding amounts presented here represent amounts spent in 2004 by CDC's National Centers on goals 1 - 4 of CDC's HIV Strategic Plan. They exclude amounts spent on Goal 5 (to assist in reducing HIV transmission and improving HIV/AIDS care and support in partnership with resource-constrained countries) and amounts for centralized rent, utilities, and program support at CDC. They include funding transferred to CDC from HHS for the Minority AIDS Initiative.

states adopt name-based HIV reporting, the data will become increasingly representative. In the past two years through the AHP initiative and other activities, CDC has focused resources on expanding testing into new venues, targeting existing testing programs toward higher risk populations, and implementing rapid testing technology into its programs. CDC is also developing new guidelines for testing in medical care and non-medical care settings. With these efforts, it is anticipated that many more infected persons will be diagnosed earlier, and this indicator will show continued improvement.

## **Selected Activities**

CDC currently provides nearly \$100 million per year for counseling and testing activities to health departments and to directly funded CBOs. Efforts to expand HIV testing in both clinical and non-clinical settings were central to the AHP initiative, as well as the promotion of the use of rapid HIV tests for quick diagnosis of one's serostatus. From 2003-2005, CDC purchased and distributed more than 500,000 rapid HIV tests to 197 health departments and CBOs in 36 states. Through March 2005, 264,422 persons were tested and 3,694 (1.4%) persons tested HIV positive. In jurisdictions that have implemented rapid HIV testing, the rate of receipt of test results has increased from 60%-65% to more than 95%. Nearly all HIV-negative persons receive their test result on the day of testing; all persons with reactive rapid tests receive a preliminary positive result, and more than 90% return to receive their confirmatory positive test result.

In 2003, CDC funded four demonstration projects specifically designed to increase HIV testing rates in specific populations at high risk for HIV infection through the use of rapid testing. For example, eight CBOs in seven cities were funded to implement rapid HIV testing in non-clinical settings such as bars and parks. As of December 2005, 25,412 persons had been tested for HIV, and 336 had confirmed positive results (HIV-positivity = 1.3%). Also through funding to four state health departments, routine rapid HIV testing of inmates in short-stay correctional facilities was conducted. As of April 2006, 31,329 inmates had received a rapid HIV test. Overall, more than 99% of inmates received their HIV test results and the overall positivity rate was 0.8% (range 0.2%-1.4%). CDC is also offering HIV testing in alternative venues and populations, such as Historically Black Colleges and Universities, gay pride events and minority gay pride events, and at sites that serve migrant and seasonal farmers, transgendered persons, or American Indians.

To reach persons infected with HIV who do not have access to traditional medical settings, CDC funded demonstration projects for diagnosing HIV infections outside medical settings. One of the most promising projects is "Using Social Network Strategies to Reach Persons at High Risk for HIV infection in Communities of Color." Through funding to nine CBOs in seven cities, HIV-infected and high-risk individuals in communities of color were trained to conduct outreach through social, sexual, and drug-using networks and encourage their peers to be tested. Through December, 2005, 427 recruiters participating in the project referred 3,225 persons in their networks. Of these persons, 222 were HIV-infected and 179 were newly identified HIV infections.



The seropositivity rate across all sites was 5.5%, approximately three times higher than the seropositivity rate found in publicly funded HIV test sites (1.5%). The social networks strategy has proven to be a viable strategy for reaching and providing CTR services to persons with undiagnosed HIV infection and an efficient and effective route to access HIV-infected persons or those at very high risk for HIV. In 2005, CDC formally encouraged funded grantees to implement the social networks strategy, and in November 2005, CDC held a Social Networks grantees' meeting to discuss and review their project experiences, opportunities and challenges to the broader adoption of the social networks model. CDC is currently developing a social networks tool kit, an implementation manual, and training curriculum that includes technical assistance strategies to CDC grantees targeting MSM and women of color.

To complement these efforts, CDC is currently revising and updating three important HIV guidance documents. The first, "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings," is expected to be published in mid-2006. The guidelines are being revised to recommend HIV screening in all health care settings of all persons aged 13-64, will recommend including HIV testing as part of the general consent for care, and will propose that traditional HIV prevention counseling is not required in conjunction with HIV testing in health care settings. The second, "Revised Guidelines for HIV Counseling, Testing, and Referral for Non-Health Care Settings," is expected to be published in late 2007. These revisions will specifically address both traditional and new models of counseling, testing, and referral and will be aimed at a variety of settings, such as bars, drug or alcohol prevention and treatment programs, CBOs, and faith-based organizations. The third, "HIV Partner Counseling and Referral," is expected to be published in early to mid 2007 and will be integrated into the agency guidelines for STD partner services.

In the President's 2007 budget an increase of \$90 million is requested for a rapid HIV testing initiative targeted in health care and non-clinical settings and among incarcerated persons and IDUs. The intent is to reach those high-risk persons who do not access current testing services.

The structure of CDC program activities convey the importance of people knowing their status following HIV testing. Program announcements have measurable outcomes that are in alignment with performance goal(s), which include increasing the proportion of HIV-infected people who know they are infected, as well as increasing HIV prevention outreach and education efforts to high-risk populations to encourage them to know their HIV status. To ensure this focus, upon the delivery of test results persons are linked to services through HIV Partner Counseling and Referral Services (PCRS).

## **Overall Impact of Goal 2**

CDC has increased emphasis on knowledge of serostatus to facilitate entry into effective care and prevention services and because it reduces risk behavior by nearly

two thirds among those who learn they are HIV-infected. Despite over 50,000 new HIV diagnoses every year, and more people knowing they are living with HIV, at least 250,000 people are unaware they are living with HIV. CDC has increased testing through distribution of rapid HIV tests which have augmented receipt of positive test results - 84% in 2004, up from 81% in 2003 in publicly funded testing venues, encouraging use of oral fluid testing that increases testing by 30%, testing new strategies for outreach including recruiting people through their social networks where nearly 6% are found to be positive, and supporting established and proven interventions including PCRS.

**Goal 3: By 2005, increase from the current estimate of 50% to 80% the proportion of HIV-infected people in the United States who are linked to appropriate prevention, care and treatment services. [FY 2004 Funding: \$43.1 million; 6% of total] <sup>5</sup>**

## Background

For the past decade, CDC has estimated 40,000 new HIV infections occur annually in the United States. One factor involved in this stable rate is the delay between receiving an HIV diagnosis and seeking HIV primary care. It is estimated that of the 670,000 adults in the United States aware of their HIV infection, about one-third fail to receive timely care. This is, in part, because about 40% of those testing positive delay care for a year or more. With CDC's increased focus on ensuring that people are aware of their HIV status, delays in seeking care may become more problematic. When people delay care, they fail to get the benefits of care, including ongoing counseling which leads to behavior change and reduced HIV transmission and initiation of highly active antiretroviral therapy which reduces HIV levels and can decrease the risk of transmission. To address this issue, CDC has prioritized linking HIV-infected persons to appropriate prevention, care and treatment services soon after receiving an HIV positive test result, and has implemented various programs and activities focused on this goal and related objectives.

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<sup>5</sup> The funding amounts presented here represent amounts spent in 2004 by CDC's National Centers on goals 1 - 4 of CDC's HIV Strategic Plan. They exclude amounts spent on Goal 5 (to assist in reducing HIV transmission and improving HIV/AIDS care and support in partnership with resource-constrained countries) and amounts for centralized rent, utilities, and program support at CDC. They include funding transferred to CDC from HHS for the Minority AIDS Initiative.



## Summary Analysis of Performance Indicators

CDC has one indicator (Indicator 10) to monitor this goal: the percentage of HIV/AIDS cases in care within three months of diagnosis. The data source for this indicator is the SHAS interview project (described above). Between 2001 and 2004, the percentage of HIV-infected persons interviewed in SHAS who said they received medical care within three months of their initial diagnosis increased from 79% to 85%. While SHAS data are not fully representative due to sampling methods explained under Indicator 6 above, this trend is encouraging. Most patients interviewed in the SHAS project were in care at the time of interview, and, therefore, SHAS may overestimate the true percentage of persons who received care within three months of diagnosis. When CDC begins to receive data from its Morbidity Monitoring Project (MMP) in 2007, it is anticipated that more representative data for this indicator will be available.

## Selected Activities

The AHP initiative focused CDC's efforts on conducting HIV prevention with the large population of HIV-infected persons, collaborating with other federal agencies as well as primary medical care providers to ensure that HIV-infected persons receive specialized individually tailored assistance based on their HIV risk reduction needs.

Two AHP demonstration projects support this goal. Through funding to six sites, CDC implemented the "Incorporating HIV Prevention into Medical Care Settings," to assist clinicians in incorporating HIV prevention into the medical care of HIV-infected individuals; while assessing their impact on patient-reported risk behaviors, STD rates, tailored risk-reduction counseling, and referrals. As of August 2005, 2,086 patients have been screened; 1,109 were enrolled in a measurement cohort, and all patients attending the clinics were given the Positive Striving to Engage People (S.T.E.P.S) intervention. A second project, "Prevention Case Management for People Living with HIV/AIDS," provided funding to nine CBOs in seven states and Washington, D.C. to provide specialized Comprehensive Risk Counseling and Services to HIV-infected persons with multiple and complex HIV risk reduction needs. As of January 2006, 480 persons have been enrolled in this program; of these 66% were African-American and 14% were Hispanic. The primary referrals provided through this program were for housing assistance, drug counseling and treatment, mental health services, Ryan White CARE Act (RWCA) case management, and psychosocial support groups.

A third demonstration project focusing on linkage to prevention, care and treatment for HIV-infected individuals is the "Antiretroviral Treatment and Access Studies II" (ARTAS II) that is based on the significant findings of the ARTAS I clinical trial of linking newly diagnosed HIV-infected persons to care. The ARTAS I trial revealed a 31% improvement in the first use of HIV clinic care after six months of follow-up for case management clients compared to standard one-time referrals, and also found a 37% improvement in the use of HIV clinical care twice after 12 months of follow-up in

the case management group compared to the standard one-time referrals. In 2004, CDC provided funding to 10 sites for the ARTAS II study. The goal of this project is to determine whether a 75% rate of linkage to care can be attained in non-research settings. As of August 2005, 182 persons living with HIV had been approached and screened for participation, and 137 participants have been enrolled.

To monitor the quality of services for HIV-infected persons, CDC, in collaboration with the Health Resources and Services Administration (HRSA) and the National Institutes of Health (NIH), developed the Morbidity Monitoring Project (MMP), a nationally representative, population-based surveillance system to assess clinical outcomes, behaviors, and the quality of HIV care. Data are being collected from a national probability sample of HIV-infected persons receiving care in the United States, and describes the clinical and virologic status of recruited patients, the HIV care and support services, as well as quality of services being received and the prevalence and occurrence of co-morbidities related to HIV disease. In 2004, CDC provided funds to 20 states and six cities to collect information in facilities across the United States. Data for planning, evaluation, monitoring, and allocation of resources will be available in 2007.

Through the Diffusion of Effective Behavioral Interventions (DEBI) project, seven of the 14 interventions are designed to meet the prevention needs of people living with HIV and to teach prevention providers at the community level how to recruit individuals into prevention with positive interventions or build the capacity to teach medical clinicians how to provide appropriate prevention messages to their HIV-infected patients. The interventions with a special emphasis on recruitments include: Healthy Relationships, Holistic Health Recovery, and Partnership for Health.

Finally, CDC has augmented efforts to work with HRSA realizing that increases in HIV diagnoses will result in increases in need for treatment and care services. CDC and HRSA have established an ongoing collaboration to ensure that prevention, care and treatment services are well coordinated among their grantees. For example, CDC and HRSA are working together with the National Association of Community Health Centers (NACHA) to promote HIV testing as part of routine medical care. CDC is also working with HRSA to develop uniform HIV testing policies for grantees; strategies to link newly diagnosed persons to care and treatment services; re-entry procedures to link HIV-infected individuals to HIV prevention and treatment services in the community; training of providers; and procedures to provide HIV/STD prevention services for high-risk uninfected persons either on-site or through referral mechanisms to CDC supported programs in the community.

### **Overall Impact of Goal 3**

Referral to clinical and prevention services is routinely provided to clients through CDC funded testing programs. In addition, CDC, in collaboration with federal, state, and community partners has implemented a number of discrete activities to increase

the proportion of HIV-infected people who are linked to appropriate prevention, care, and treatment services and to provide prevention services to those living with HIV. These activities include development of guidelines, funding demonstration projects, translation of proven behavioral interventions for people living with HIV, and research and surveillance projects.

CDC has developed new guidelines for Comprehensive Risk Counseling and Services (CRCS) which links high-risk HIV-positive and -negative individuals to appropriate services as well as provides risk-reduction services. In a project with nine CBOs, 480 persons were enrolled and clients have been linked to housing assistance, drug counseling and treatment, mental health services, RWCA case management and psychosocial support groups.

CDC, in collaboration with HRSA, NIH, and the Infectious Diseases Society of America (IDSA), published guidelines for “Incorporating HIV Prevention into Medical Care.” In an AHP demonstration project, over 1,000 HIV-infected patients were enrolled in a project incorporating the STEPs intervention. Several health departments were funded to implement medical staff provided interventions for people living with HIV including Partnerships for Health and Sisters Informing Sisters on Topics about AIDS (SISTA). In addition, CDC has funded a project to teach physicians how to provide appropriate prevention messages to their HIV-infected patients. CDC developed the “Antiretroviral Treatment and Access Studies I and II” and showed that a linkage case manager can significantly increase linkage to care and adherence to antiretroviral therapies; a demonstration project is ongoing.

To improve care for pregnant women and to reduce perinatal transmission, CDC is evaluating Perinatal Prevention Case Management and is evaluating interventions for adherence to antiretroviral therapies among children perinatally infected with HIV.

To monitor quality of care, CDC has been conducting the Hospital Outpatient Study collecting data on 8,000 patients in 10 HIV-specialty clinics across the United States. CDC recently launched the population-based MMP that will assess quality of care and risk behaviors among those in care. MMP will also be the basis for a study to identify those not in care and look at factors to explain their lack of care and how to link them to care and prevention services.

Overall, CDC’s major roles in Goal 3 are linking people tested in agency programs to appropriate services, improve prevention services for people in care, and monitor the quality of their care and their risk behavior. However, as previously indicated, SHAS data (our current indicator) are not fully representative of the population of interest.

**Goal 4: By 2005, strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions and evaluate prevention programs. [FY 2004 Funding: \$210.8 million; 28% of total] <sup>6</sup>**

## **Background**

CDC's HIV/AIDS surveillance system is the nation's key source of information used to track the epidemic. CDC funds HIV/AIDS surveillance in 65 areas to monitor the number and characteristics of persons who have been diagnosed with HIV and trends in the incidence of HIV-related morbidity and mortality.

In July 2005, CDC formally recommended that all states and territories adopt confidential name-based surveillance systems to report HIV infections. CDC policy is to accept HIV infection and AIDS case surveillance data only from areas conducting confidential name-based HIV reporting because this reporting has been shown to routinely achieve high levels of accuracy and reliability. As of April 2006, 43 states and 5 territories have adopted confidential, name-based HIV reporting.

## **Summary Analysis of Performance Indicators**

For Goal 4, CDC has one performance indicator (Indicator 11): the number of states and territories with integrated, confidential, name-based HIV/AIDS case surveillance systems for adults and adolescents. Prior to the advent of highly effective HIV therapies, data on AIDS (which has been reported through name-based systems since the beginning of the epidemic) was reasonably adequate to monitor the epidemic; however, as the proportion of HIV-infected persons progressing to AIDS has declined, it is increasingly important to have information on the larger population of HIV-infected persons who have not yet developed AIDS. Data from the HIV/AIDS case surveillance system are used as the basis for the fair allocation of both prevention and care resources by multiple federal agencies. In states with confidential, name-based HIV reporting, the state and local health departments retain the names of persons in their case registries to assist them in follow-up of epidemiologically important cases and de-duplication of cases from multiple jurisdictions; names are not sent to the federal government. This is the same method as that used for AIDS cases. In 2000, there were 32 states and 2 territories with name-based HIV/AIDS case surveillance systems. By 2006, these numbers increased to 43 states and 5 territories. The remaining states

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<sup>6</sup>The funding amounts presented here represent amounts spent in 2004 by CDC's National Centers on goals 1 - 4 of CDC's HIV Strategic Plan. They exclude amounts spent on Goal 5 (to assist in reducing HIV transmission and improving HIV/AIDS care and support in partnership with resource-constrained countries) and amounts for centralized rent, utilities, and program support at CDC. They include funding transferred to CDC from HHS for the Minority AIDS Initiative.

use non-name-based systems with coded identifiers. These have not been shown to allow adequate de-duplication of cases, and they are much more costly because of the extensive follow-up needed to confirm codes. At all levels of government where name-based data are held, elaborate security and confidentiality procedures have been put into place to protect the confidentiality of individuals. It is hoped that a uniform national HIV/AIDS case surveillance system will be implemented by the end of the decade. An important impetus for states to move to name-based reporting has been the Ryan White CARE Act, which requires the use of HIV data to make resource allocations for HIV/AIDS care and treatment.

## **Selected Activities**

CDC currently funds a total of 34 areas to conduct a population-based incidence surveillance system using the Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS). STARHS is a way of analyzing HIV-positive blood samples to determine whether an HIV infection is recent or has been long-standing. The system is expected to provide the clearest picture yet of the magnitude of the domestic HIV epidemic, as well as aid CDC in more effectively targeting HIV prevention efforts to promote decreases in the incidence of new HIV infections. Data on estimates of incidence are expected in mid-2006.

In addition to assessing infection and disease trends, CDC conducts the ongoing National HIV Behavioral Surveillance (NHBS) system to monitor risk behaviors, testing, and use of prevention services among three groups of persons at risk for HIV infection: MSM, IDUs, and high-risk heterosexual adults. Data are collected from one group per year in 25 metropolitan statistical areas across the United States. Data collection began for MSM in 2004; for IDUs in 2005; and for high-risk heterosexuals in 2006. The information collected in NHBS will be used to develop and implement effective HIV prevention programs for these high-risk groups.

In conjunction with tracking disease trends and monitoring risk behaviors, the provision of locally relevant data for community planning is an integral component of this goal. In 2004, CDC funded four organizations under the new CBA program to provide assistance and training to state and local health departments and HIV prevention community planning groups to assure high-quality incidence, prevalence and behavioral profile reporting. Through this program, organizations are required to provide CBA to help community planning groups understand surveillance data, particularly how to apply locally relevant information to community planning activities.

The DEBI project is CDC's primary means of disseminating scientifically proven, evidence-based interventions to funded grantees. Over the past 3 years, CDC has diffused 11 of the 14 interventions to CBOs and health departments, and provided 274 DEBI trainings to 1,525 CBOs; 400 county, city, state, and territorial health departments; and 5,362 individuals.



In 2004, CDC responded to the need for more accurate and timely data for monitoring HIV prevention programs by designing and implementing the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that aims to strengthen the capacity to monitor and evaluate CDC-funded HIV prevention programs supported or delivered by health departments and CBOs. PEMS is being rolled out and developed in phases. It was first released in late 2004 to 42 health departments and 27 CBOs with the goal of improving reporting capabilities between the CDC, health departments, and CBOs. The system includes a standardized set of HIV prevention data variables to measure and track prevention processes and outcomes, such as HIV counseling and testing results, client risk factors for HIV transmission, service utilization, and detailed risk behaviors. Also to monitor the implementation of quality evidence-based behavioral programs and interventions, data from PEMS will include detailed information on the program services as intended and actually delivered to clients. This information will enable CDC and funded-grantees to demonstrate successful programs as well as modify program activities to improve service delivery and achieve programmatic goals.

## **Overall Impact of Goal 4**

From 2001 through 2005, CDC revamped its surveillance system, its CBA program, and program evaluation system. CDC has argued for the implementation of name-based HIV reporting and 43 states and 5 territories now have name-based HIV reporting systems. CDC has implemented a national surveillance system to estimate HIV incidence with the first estimates expected in 2006. A national behavioral surveillance system in 25 MSAs has been implemented with a focus on MSM, IDUs, and high-risk heterosexuals. CDC is also implementing a population based system for monitoring quality of care and risk behaviors of those living with HIV.

With the development of prevention packages of proven behavioral interventions, CDC has revamped its CBA program. There is a greater focus on using such proven interventions and thus a need for training. Over 5,000 individuals have been trained on how to provide these services.

CDC is in the process of implementing PEMS. Currently, 220 directly-funded agencies are using PEMS to collect data on their services, target populations, and budgets. Over time, more providers are expected to use the system as CDC directly funded agencies provide their contract agencies (indirectly funded) access to PEMS. The system will be used to collect information on individual clients to help understand the quality and outcome of services. When it is fully implemented in a couple of years, it will provide valuable data to service providers for improving services and to policy makers to better guide programs and direct resources.

## WORKING DRAFT

### CDC's Goals and Objectives for HIV Prevention Strategic Plan Activities and Progress Made

#### Overarching National Goal

**Reduce the number of new HIV infections in the United States from an estimated 40,000 to 20,000 per year by 2005, focusing particularly on eliminating racial and ethnic disparities in new HIV infections.**

1. By 2005, decrease by at least 50% the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention interventions.
2. By 2005, through voluntary counseling and testing, increase from the current estimated 70% to 95% the proportion of HIV-infected people in the United States who know they are infected.
3. By 2005, increase from the current estimated 50% to 80% the proportion of HIV-infected people in the United States who are linked to appropriate prevention, care and treatment services.
4. By 2005, strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions and evaluate prevention programs.

#### Goal 1

**By 2005, decrease by at least 50% the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention interventions.**

Objective 1: Among people living with HIV, increase the proportion who consistently engage in behaviors that reduce risk for HIV transmission or acquisition.

Objective 2: Among men who have sex with men (MSM), increase the proportion who consistently engage in behaviors that reduce risk for HIV acquisition or transmission.

Objective 3: Among adolescents, increase the proportion who consistently engage in behaviors that reduce risk for HIV acquisition or transmission.



Objective 4: Among injecting drug users (IDUs), increase the proportion who abstain from drug use or, for those who do not abstain, use harm reduction strategies to reduce risk for HIV acquisition or transmission.

Objective 5: Among at risk sexually active woman (including women who have sex with other women), and at-risk heterosexual men, increase the proportion who consistently engage in behaviors that reduce risk for HIV acquisition or transmission.

Objective 6: Increase the proportion of people at highest risk for HIV who are tested for STDs and treated appropriately.

Objective 7: Increase the proportion of HIV-infected pregnant women who routinely receive HIV counseling, accept HIV testing and choose to take antiretroviral medication to interrupt perinatal transmission of HIV.

Objective 8: Support HIV vaccine research.

Objective 9: Reduce the number of workers who are occupationally exposed to and infected with HIV.

Objective 10: Continue to monitor and support the safety of blood, tissue and organ supplies in the United States.

## Goal 2

**By 2005, through voluntary counseling and testing, increase from the current estimated 70% to 95% the proportion of HIV-infected people in the United States who know they are infected.**

Objective 1: Increase the motivation of at-risk individuals to know their infection status and decrease real and perceived barriers to HIV testing.

Objective 2: Improve access to voluntary, client-centered counseling and testing (VCT) in high seroprevalence communities and populations at risk, focusing particularly on populations with high rates of undiagnosed infection.

Objective 3: Increase the number of providers who routinely provide VCT in health care settings (e.g., STD clinics, substance abuse treatment programs, family planning clinics, emergency rooms, community health centers), as well as in nonclinical venues (e.g., social venues, public assistance programs, street outreach).

Objective 4: Increase the percentage of people who know their results after testing.

### Goal 3

**By 2005, increase from the current estimated 50% to 80% the proportion of HIV-infected people in the United States who are linked to appropriate prevention, care and treatment services.**

Objective 1: Reduce the disparities in access to prevention and care services that are experienced by communities of color, women and special-needs populations.

Objective 2: Integrate prevention services, including adherence to treatment, for persons diagnosed with HIV and AIDS into the delivery of patient care in both public and private sectors.

Objective 3: Increase the proportion of persons who have been diagnosed with HIV who are successfully linked to culturally competent, science-based prevention services.

Objective 4: Promote the optimal level of medical services for patients diagnosed with HIV to benefit individual health and reduce the likelihood of further transmission of HIV.

Objective 5: Increase the proportion of persons diagnosed with HIV who are successfully linked to medical care no later than 3 months after learning their HIV status or re-identified as being HIV-infected but out of care.

Objective 6: Increase the proportion of correctional facility detainees (incarcerated for at least 30 days) identified as HIV-infected who are provided HIV prevention, treatment and care services and who, upon release, are successfully linked to those services in the communities to which they return.

Objective 7: Increase the proportion of HIV care providers offering routine, periodic STD screening and treatment to HIV-infected clients.

Objective 8: Increase the proportion of HIV care providers offering routine, periodic TB screening and treatment to HIV-infected clients.

Objective 9: Increase the proportion of persons diagnosed with HIV, including pregnant women, and needing substance abuse treatment services who are successfully linked to those services.

Objective 10: Increase the proportion of persons diagnosed with HIV and needing social and mental health services who are successfully linked to those services.

## Goal 4

**By 2005, strengthen the capacity nationwide to monitor the epidemic, develop, and implement effective HIV prevention interventions and evaluate prevention programs.**

Objective 1: Develop an integrated surveillance system to measure incidence of new infections, to track the prevalence of disease, to monitor behaviors that place people at risk for HIV infection and to provide locally relevant data for community planning.

Objective 2: Increase the number of evidence-based interventions and the proportion of prevention providers funded by CDC who successfully provide demonstrably effective HIV prevention interventions.

Objective 3: Support realistic and feasible evaluation efforts to ensure the delivery of interventions of the highest possible quality.

### **List of HIV Prevention Strategic Plan Performance Indicators**

1. Estimated number of HIV/AIDS cases diagnosed among persons 13-24 years of age in 30 areas with longstanding HIV reporting.
2. Rate of gonorrhea cases reported each year.
3. Rate of primary and secondary syphilis cases reported each year.
4. Estimated number of new perinatally acquired AIDS cases diagnosed each year.
5. The percentage of students in 9th through 12th grade who reported safer sexual behaviors defined as: a) never having engaged in sexual intercourse, b) not sexually active in the past 3 months, or, c) if sexually active in the past 3 months, used condoms.
6. Among persons diagnosed with HIV infection for >12 months and interviewed in the Supplement to HIV/AIDS Surveillance project, the percentage who did not use a condom at last vaginal/anal sex when the status of the partner was unknown.
7. Among persons diagnosed with HIV infection for >12 months and interviewed in the Supplement to HIV/AIDS Surveillance project, the percent of injection drug users (IDUs) who shared a needle or syringe with someone in the past 12 months.
8. The percentage of HIV-positive test results from publicly-funded counseling and testing sites with post-test counseling sessions.

9. Percentage of HIV cases diagnosed before progression to AIDS.
10. Percentage of HIV/AIDS cases in care within three months of diagnosis.
11. Number of states and territories with integrated, confidential, name-based HIV/AIDS case surveillance systems for adults and adolescents.