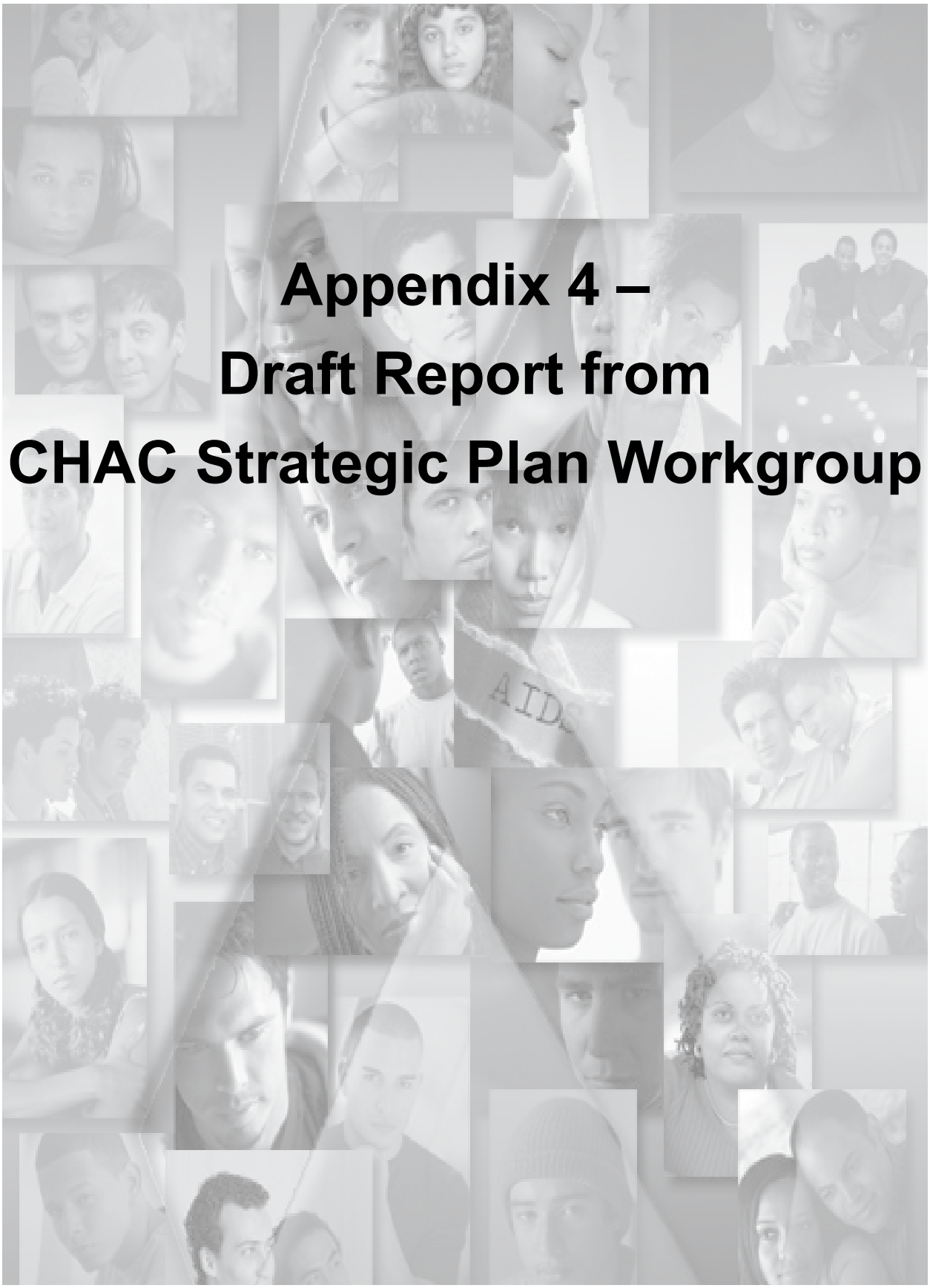
Appendix 4



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 - Proprosed 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 - Proprosed 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.

Appendix A: Work Group Participants

ADIMORA, Ada, M.D., M.P.H.
Associate Professor of Medicine
UNC Div. of Infectious Diseases
CB#7030, Bioinformatics Building
130 Mason Farm Road, 4th Floor
Chapel Hill, NC 27599-7030
Phone: (919) 966-2536
Fax: (919) 966-6714
Email: adimora@med.unc.edu

AUERBACH, Judith D., Ph.D.
Vice President, Public Policy and Program Development
American Foundation for AIDS Research
1150 17th Street, N.W., Suite 406
Washington, D.C. 20036
Phone: (202) 331-8600
Fax: (202) 331-8606
E-mail: judy.auerbach@amfar.org

AYALA, George, Psy.D.
Director of Education
AIDS Project Los Angeles
Client Health Education, Prevention and Treatment Education
Research and Evaluation Divisions
3550 Wilshire Blvd., Suite 300
Los Angeles, CA 90010
Phone: (213) 201-1600
Email: GAyala@apla.org

BAKER, A. Cornelius
1707 Columbia Road, NW
Washington, DC 20009
Phone: (202) 234-3661
Fax: (202) 234-3661
E-mail: acorneliusbaker@hotmail.com

BEADLE DE PALOMO, Frank
Director
The Center for Community Based Health Strategies
Academy for Educational Development
1825 Connecticut Ave, NW
Washington, DC 20009-5721
(202) 884-8883
(202) 884-8474
E-mail: fbeadle@aed.org

BOLAN, Gail A., M.D.
State of California
Department of Health Services
Chief, STD Control Branch
850 Marina Bay Parkway, Bldg P, 2nd Floor
Richmond, CA 94804-6403
Phone: (510) 620-3400
Fax: (510) 620-3180
E-mail: gbolan@dhs.ca.gov

BOYER, Cherrie, B., Ph.D.
Professor
Department of Pediatrics
Division of Adolescent Medicine
University of California, San Francisco
Box 0503, Laurel Heights 245
San Francisco, CA 94143-0503
Phone: (415) 476-2184
Fax: (415) 476-6106
E-mail: BoyerC@peds.ucsf.edu

CARGILL, Victoria A. (Vicki), M.D., M.S.C.E.
Director of Minority Research, Director of Clinical Studies
Office of AIDS Research
National Institutes of Health
5635 Fishers Lane
Bethesda, MD 20892
Phone: (301) 402-2932
Fax: (301) 480-5304
Email: vc52x@nih.gov

CLEVELAND, Janet, M.S.
Deputy Director for Prevention Programs
National Center for HIV, STD, and TB Prevention
Division of HIV/AIDS Prevention
Centers for Disease Control & Prevention
1600 Clifton Rd., N.E., MS E-35
Atlanta, GA 30333
Tel: (404) 639-5200
Fax: (404) 639-0897
Email: jcc9@cdc.gov

COHEN, Deborah A., M.D., M.P.H.
Health RAND Corporation
1700 Main Street
Santa Monica, CA 90405
Phone: (310) 393-0411 ext 6023
Fax: (310) 393-4818
E-mail: dcohen@rand.org

COHEN, Myron S., M.D.
J. Herbert Bate Professor
Medicine, Microbiology and Immunology
Chief, Division of Infectious Diseases
Director, Centers for Infectious Disease
4th Floor Bioinformatics Building
University of North Carolina at Chapel Hill
130 Mason Farm Road
Chapel Hill, NC 27599
Phone: (919) 966-2536
Fax: (919) 966-6714
Email: mscohen@med.unc.edu

CONSTANTINE, Niel, M.D.
Professor of Pathology, University of Maryland
School of Medicine, Baltimore
Institute of Human Virology
725 West Lombard St.
Baltimore, MD 21201
Phone: (410) 706-2788
Fax: (410) 706-2789
E-mail: constant@umbi.umd.edu

DES JARLAIS, Don C. Ph.D.
National Development and Research Institutes, Inc.
71 West 23rd Street
8th Floor
New York, NY 10010
Phone: (212) 256-2548
Fax: (917) 438-0894
E-mail: dcdesjarla@aol.com

ELDRED, Lois
Chief, Demonstration and Evaluation Branch
Division of Science and Policy
Health Resources and Services Administration, HIV/AIDS Bureau
17349 Parklawn
Room 7C-07
Rockville, MD 20857
Phone: (301) 443-3327
Fax: (301)443-4965
Email: LEldred@HRSA.GOV

ELUMA, Fabian, MD PhD, MPH
Public Health Advisor
HIV Branch, CSAP/SAMHSA/HHS
1 Choke Cherry Road, #4-1120
Rockville, MD 20857
Phone: (240) 276-2481
Fax: (240) 276-2410
E-mail: Fabian.Eluma@SAMHSA.HHS.GOV

FULLILOVE, Robert E., Ed.D.
Associate Dean
Columbia University
Mailman School of Public Health
617 West 168th Street
New York, NY 10032
Phone: (212) 740-7292
Fax: (212) 795-4222
Email: ref5@columbia.edu

FUTTERMAN, Donna, M.D.
Professor of Clinical Pediatrics
Director, Adolescent AIDS Project
Montefiore Medical Center
111 East 210 Street
Bronx, NY 10467
Phone: 718-882-0322
Fax: 718-882-0432
Email: futterma@aecom.yu.edu

HARRISON, Timothy P., Ph.D.
Program Staff Specialist
OHAP/OPHS/OS/DHHS
200 Independence Ave., SW
Room 736E
Washington, DC 20201
Phone: (202) 690-7324
Fax: (202) 690-7560
E-mail: cbates@osophs.dhhs.gov

HICKMAN, Deborah, Reverend
President/CEO
Sisters Together and Reaching, Inc. (STAR)
1505 Eutaw Place
Baltimore, MD 21217
Phone: (410) 383-1903
Fax: (410) 383-7856
E-mail: Debbie7rev@aol.com

HOLTGRAVE, David, Ph.D.
Professor and Chair
Dept. of Health, Behavior & Society
Bloomberg School of Public Health
The Johns Hopkins University
Hampton House, Suite 280
624 N. Broadway
Baltimore, MD 21205
Phone: (410) 955-2314
Email: dholtgra@jhsph.edu

KATES, Jennifer, M.A., M.P.A.
Vice President and Director of HIV Policy
Kaiser Family Foundation
Washington Office/Public Affairs Center
1330 G Street, NW
Washington, DC 20005
Phone: (202) 347-5270
Fax: (202) 347-5274
E-mail: jkates@kff.org

LEVI, Jeffrey, Ph.D. (Oct 25th only)
Assistant Research Professor
Department of Health Policy
Deputy Director
Center for Health Services Research and Policy
MP-Health Policy Advisor
School of Public Health and Health Services
2021 K Street, N.W., Suite 800
Washington, DC 20006
Phone: (202) 530-2363
Fax: (202) 296-0025
Email: jlevi@gwu.edu

LIBERTI, Thomas
Chief, Bureau of HIV/AIDS
Florida Department of Health
4052 Bald Cypress Way, Bin A09
Tallahassee, FL 32399
Phone: (850) 245-4477
Fax: (850) 414-0038
E-mail: tom_liberti@doh.state.fl.us

MANN, Dorothy
Executive Director
Family Planning Council
206 South Broad Street
10th Floor
Philadelphia, PA 19102
Phone: (215) 985-2616
Fax: (215) 732-0916
E-mail: dorothy@familyplanning.org

MAYS, Vickie, Ph.D.
Professor, UCLA
Department of Psychology
1189 Franz Hall
Los Angeles, CA 90095-1563
Phone: (310) 206-5159
Fax: (310) 206-5895
E-mail: mays@ucla.edu

MCDONALD, Sandra
President/Founder
OUTREACH, Inc.
PO Box 110248
Atlanta, GA 30311
Phone: (404) 696-3400
Email: msmac159@aol.com

MCGUIRE, Jean, Ph.D. **Co-Chair**
Lorraine Snell Visiting Professor
Northeastern University
Institute on Urban Health Research
Bouve College of Health Sciences
360 Huntington Avenue
Stearns Center, Suite 503
Boston, MA 02115
Phone: (617) 373-7729
Fax: (617) 373-7309
E-mail: j.mcguire@neu.edu

MILAN, Jesse, J.D.
Vice President for Global Health Convergence
Constella Group, LLC
One Thomas Circle, NW
Suite 200
Washington, DC 20005
Phone: (202) 777-0945
Fax: (301) 775-9694
E-mail: jmilan@constellagroup.com

OLDHAM, Frank Jr.
Executive Director
National Association of People with AIDS
(NAPWA-US)
8401 Colesville Road, Suite 750
Silver Spring, MD 20910
Phone: (240) 247-1028
Fax: (240) 247-0574
Email: foldham@napwa.org

ROBERTS, George W., Ph.D. **Co-Chair**
National Center for HIV, STD, and TB Prevention
Division of HIV/AIDS Prevention
Associate Director for Prevention Partnerships
Centers for Disease Control & Prevention
1600 Clifton Rd., N.E., MS E-35
Atlanta, GA 30333
Phone: (404) 639-5200
Fax: (404) 639-5260
Email: **gwr2@cdc.gov**

ROCK, Debbie
Executive Director
Baltimore Pediatric HIV Program, Inc
2800 Maryland Avenue
PO Box 25535
Baltimore, MD 21217
Phone: (410) 225-2600
Fax: (410) 225-0742
Email: debbierock@att.net

SANCHEZ, Idalia
Associate Director for Policy and
Chief, Policy Development Branch
Division of Science and Policy
Health Resources and Services Administration, HIV/AIDS Bureau
5600 Fishers Lane
PKLN/7-18
Rockville, MD 20857
Phone: (301) 443-3617
Email: ISanchez@hrsa.gov

SANDERS, Edwin C. II., Rev.
Pastor
Metropolitan Interdenominational Church
2128 11th Avenue, North
Nashville, Tennessee 37208
Phone: (615) 726-3876
Fax: (615) 259-9210
E-mail: mic1981@aol.com

SCOFIELD, Julie M.
Executive Director
NASTAD
444 N. Capitol Street, NW, Suite 339
Washington, DC 20001
Phone (202) 434-8090
Fax (202) 434-8092
Email: jscofield@NASTAD.org

SIMMONS, Ron, Ph.D.
President, Us Helping Us, Inc.
3636 Georgia Avenue, NW
Washington, DC 20010
Phone: (202) 446-1100
Fax: (202) 204-0806
E-mail: Ronsuhu@aol.com

SMITH, Shepherd
President, The Institute for Youth Development
P.O. Box 16560
Washington, DC 20041
Phone: (703) 433-1640 ext 101
Fax: (703-433-1645
Email: ssmith@youthdevelopment.org
Email: jvalenzuela@youthdevelopment.org

SWEET, Donna, M.D.
Professor of Medicine
Dept. of Internal Medicine
KU School of Medicine - Wichita
1010 North Kansas
Wichita, KS 67214
Phone: (316) 268-5984
Fax: (316) 291-7944
E-mail: dsweet@kumc.edu

TEMOSHOK, Lydia, Ph.D
Professor of Medicine & Psychiatry
University of Maryland School of Medicine
Director, Behavioral Medicine Services
Institute of Human Virology
725 West Lombard St. Room N146
Baltimore, MD 21201
Phone: (410) 706-2621
Fax: (410) 706-3243
E-mail: temoshok@umbi.umd.edu

TIERNEY, Steven, Ed.D.
Deputy Director
San Francisco AIDS Foundation
995 Market Street, Suite 200
San Francisco, CA 94103
Phone: (415) 487-3034
Email: STierney@SFAF.org

VALDISERRI, Ronald O., M.D., M.P.H.
Deputy Director
National Center for HIV, STD, and TB Prevention
Centers for Disease Control & Prevention
1600 Clifton Rd., N.E., MS E-07
Atlanta, GA 30333
Phone: (404) 639-8002
Fax: (404) 639-8600
Email: rov1@cdc.gov

VERMUND, Sten H., M.D.
Vanderbilt University Institute for Global Health
Professor, Pediatrics, Medicine
Pediatric Infectious Disease
Room 319, Light Hall
2215 Garland Ave
Nashville, TN 37232
Phone: (615) 322-9373
Fax: (615) 322-9400
Email: sten.vermund@vanderbilt.edu

WYATT, GAIL., Ph.D.
Professor Department of Psychiatry
and Biobehavioral Sciences
UCLA Neuropsyciatric Institute
Director, Sexual Health Program
Associate Director, UCLA AIDS Institute
Sex Therapist
Los Angeles, CA 90024-1759
Phone: (310) 825-0193
Fax (310) 206-9137
Email: GWyatt@mednet.ucla.edu

WHEELER, Darrell, Ph.D., M.P.H.
Hunter College School of Social Work
129 E. 79th St
New York, New York 10021
Phone: (212) 452-7491
Fax: (212) 452-7098
Email: dwheeler@hunter.cuny.edu

ZORRILLA, Carmen D., M.D.
Professor, Obstetrics and Gynecology
University of Puerto Rico School of Medicine
Principal Investigator: CEMI, PR-CCHD, PR HVTU
Maternal and Infant Studies Center (CEMI)
P.O. Box 365067
San Juan, PR 00936-5067
Tel: (787) 753-5913
Fax: (787) 771-4739
Email: czorilla@rcm.upr.edu

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

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.	
OBJ #	**Activities**
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.	
OBJ #	**Activities**
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).

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.	
OBJ #	**Activities**
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.	
OBJ #	**Activities**
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

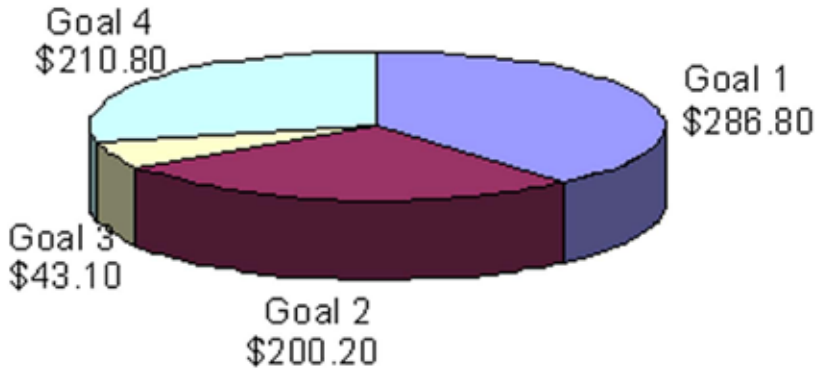
The Division of HIV/AIDS Prevention's budget has been cut by about 20 million over the past several years, and was further decreased by an additional $6 million in FY 2006. The Plan has been instrumental in determining funding priorities for these diminishing resources.

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
Overarching 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.	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 2. Trend in gonorrhea rates reported each year 3. Trend in primary and secondary syphilis cases reported each year 4. Estimated number of new perinatally acquired AIDS cases diagnosed each year	• Between 2000-2004, the number of people aged 13-24 years of age diagnosed with HIV/AIDS increased from 2,929 to 3,465. • Between 2000-2004, the rate of gonorrhea declined from 128.7 to 113.5 cases per 100,000 population. • Between 2000-2004, the rates of P&S syphilis increased slightly from 2.1 to 2.7 cases per 100,000 populations. • Between 2000-2004, the estimated number of perinatally-acquired AIDS cases declined from 124 to 48 cases.

Goal	Indicators	Outcomes
Goal 1: 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.	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. 2. SHAH data monitoring condom use of persons diagnosed with HIV for >12 months when status of partner was unknown. 3. SHAS data monitoring sharing of needles among HIV-infected IDUs diagnosed for >12 months.	• From 1999-2003, % of students practicing safer sex or abstinence increased from 85%-88%. • Between 2001-2004, % of condom use among HIV-infected persons increased slightly from 12.3% to 13.4%. • 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.
Goal 2: 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.	1. CDC's CTS measures % of HIV-positive test results from publicly funded counseling and testing sites with post-test counseling sessions. 2. HIV/AIDS Monitoring System measures % of HIV cases diagnosed at least one month before progression to AIDS.	• From 2000-2003, % of HIV-positive test remained stable at 69%-71% • From 2000-2004, % of diagnosed HIV cases increased slightly from 76%-78%

Goal	Indicators	Outcomes
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.	1. SHAS monitors % of HIV/ AIDS cases in care within 3 months of diagnosis	• From 2000-2004, data shows % of HIV-infected who received medical care within 3 months increased from 79%-85%
Goal 4: By 2005, strengthen the capacity nationwide to monitor the epidemic, develop, and implement effective HIV prevention interventions and evaluate prevention programs.	1. Measures the number of states and territories with integrated, confidential, name-based HIV/AIDS case surveillance systems.	• January 2001, 33 states and 2 territories had implemented HIV case surveillance systems • 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

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**
Goal 1	**PLWH** • Released program announcements for Serostatus Approach to Fighting the HIV Epidemic framework in 2001 and Advancing HIV Prevention Initiative in 2003 • PCM demonstration project awarded funds to 9 CBOs to evaluate effects of PCM on HIV transmission risk behaviors and health of PLWH • Published report of 12 interventions that show significant reduction in unprotected sex and STD acquisition in PLWH. **MSM** • North Carolina Men's Health Initiative developed for DEBI intervention targeting AA MSM • Researching Brothers y Hermanos study to understand risk and experiences of AA and Latino MSM **Youth** • Supports dissemination of 3 interventions for at-risk, homeless, runaway, and HIV-positive youth. **IDUs** • Supports dissemination of 3 interventions for IDUs • Conducted research on intervention trials for HIV+ and HIV- IDUs and safety trials of Tenofovir. **Heterosexuals** • Supports dissemination of 4 interventions for clinic patients, female sex workers, female partners of IDUs, and AA women • Research activities include a video-based intervention in STD clinics, projects for incarcerated men, and safety of a microbicide to prevention heterosexual HIV transmission

Goal	Progress/Activities
Goal 2	**Increasing motivation to HIV testing** • Recommends annual testing for MSM and routine offering of testing to reduce stigma • Conducted social networks demonstration for HIV positive and high-risk persons that increased prevalence of undiagnosed HIV among peer referrals • Collaborating with state partners to design comic books in English and Spanish with HIV-related stories to be launched in Los Angeles • Launched PCRS demonstration projects in 2003 to offer rapid testing among persons who were exposed to an HIV-positive partner **Improving access to HIV testing** • Increased rapid testing availability for non-healthcare workers and migrant farm workers at 10 sites from 2004-2006 • Distributed more than half a million OraQuick devices to 252 US organizations from 2003-2005 **Increasing routine VCT in healthcare settings** • Launched demo projects of rapid HIV screening in 11 clinics at 5 sites nationwide. • Evaluating alternative procedures for pre-test counseling prior to HIV testing. **Increasing number of persons who return for HIV test results** • 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. • Of persons with preliminary positive results, 86% returned for confirmatory test results.

Goal	Progress/Activities
Goal 3	**Reducing disparities in access to care** • Five different data sources from the HIV/AIDS Surveillance Report show 82%-88% of whites and AAs were prescribed antiretroviral therapy. • 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. **Integrating prevention services** • CDC and other federal agencies published guidelines incorporating HIV prevention into medical care of PLWH. • Prevention in Care social marketing campaign launched to promote usage of guidelines among partners, providers, and patients. **Increasing proportion of HIV-infected persons linked to prevention services** • 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. • 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. **Promoting optimal level of medical services** • HHS guidelines for use of antiretroviral agents widely used to improve and optimize level of medical care **Increasing linkage to care within 3 months** • 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.

Goal	Progress/Activities
Goal 4	**Monitoring the epidemic** • 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. • Funds 34 areas to conduct population-based HIV incidence surveillance; plans to provide precise estimate of recent HIV seroconversions by the end of 2006. • 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. **Implementing effective interventions** • Identified 14 evidence-based interventions under the DEBI program. • Since 2004, diffused 12 of the 14 interventions to CBOs and health departments. **Evaluating programs and interventions** • Developed and released PEMS in 2004 to 42 health departments and 27 CBOs. • Currently analyzing final data and developing dissemination plans for PEMS.

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][1,2]

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

[1] 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.

[2] 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] [3]

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

[3]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%] [4]

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

[4]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 increasing 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.l million; 6% of total] [5]

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.

[5] 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 HIVAIDS," 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] [6]

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

[6] 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. Date 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.