



Appendix 3 –

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

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

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

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

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

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

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

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

Baseline data, performance progress data, and projected targets:

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

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

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

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

Baseline data, performance progress data, and projected targets:

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

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

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

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

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

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

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

Supplemental Activities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Baseline data, performance progress data, and projected targets:

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

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

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

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

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

Data source: CDC. HIV/AIDS Reporting System

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

Supplemental Activities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplemental Activities

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

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

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

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

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

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

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

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

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

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

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

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

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

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