Abstract Book

2011 National HIV Prevention Conference
The Urgency of Now:

August 14-17, 2011
Hyatt Regency Atlanta
& Atlanta Marriott Marquis
Atlanta, Georgia
The Abstract Book contains all conference abstracts listed in the order that they are presented. More than 950 abstracts were submitted by authors from the United States and other countries, and each abstract was reviewed by five peer reviewers. Conference Track Co-Chairs prepared the overall program by combining abstracts and invited speaker presentations into sessions.
**Track A**
**AR01 - The Role of the Black Family in the Progression of HIV in the AAMSM Community**
Room: Baker (Hyatt Regency Atlanta)

**Abstract 1543 - The Role of the Black Family in the Progression of HIV in the AAMSM Community**
**Author(s):** Christopher R. Roby; Mark A. Colomb

African America men who have sex with men (AAMSM) suffer rejection from the most basic vital social network needed, the family. The Black Family is the nucleus by which these individuals learn clarification, decision-making, and human sexuality. Thus when the nucleus is removed from AAMSM's social structure they are left defenseless and ill-equipped to deal with intimate social interactions properly. Due to family rejection AAMSM often engage in high risk sexual behaviors that place them at great risk for contracting HIV.

This roundtable will discuss the Black Family and its role as it relates to the transmission of HIV among AAMSM, human sexuality, religion, and homophobia. This roundtable will allow participants to examine other factors that contribute to high rates of HIV among AAMSM rather than just focusing on their sexual behaviors. The participants will be able to: 1) define the role of the Black Family as it relates to transmission and prevention HIV among AAMSM; 2) identify formal institutions that hold symbolic meaning for AAMSM inside the Black Family; 3) assess not only the sexual behaviors of AAMSM but the family experiences that drive them to those behaviors.

By providing a lecturette, group discussion and interactive activities utilizing handouts and newsprint to educate participants on the Black Family and its role in HIV transmission and prevention the road to recovery for this once solid institution can begin to recover. Theories surrounding The Black Family, origin of homosexuality, and preparation for bias will evoke interactive discussion on how to salvage AAMSM ties to The Black Family. By starting to have the conversations that have eluded us for the past three decades participants will be empowered to return to their prospective areas and challenge The Black Family to take a stand and become part of the solution and not the problem.

**Track A**
**AR02 - Understanding The Effects Of First Generation American Cultural Traditions On HIV Prevention**
Room: Courtland (Hyatt Regency Atlanta)

**Abstract 1807 - Understanding the Effects Of First Generation American Cultural Traditions On HIV Prevention**
**Author(s):** Lydie Marc

HIV/AIDS prevention programs internationally have increased over the years due to research and surpassing barriers. Though these prevention programs are provided, there is still a need to break the barriers caused by lack of knowledge, stigma, etc. In some cultures, the barrier of tradition can hinder the ability to provide adequate preventive information. Within the United States, we are considered a melting pot of diverse individuals and culture. These individuals are composed of diverse races, ethnicity, etc. Fortunately, HIV prevention programs have advanced over the past decades to provide information to all types of persons. The language barriers are gradually starting to decrease as an issue with aid from multiple health research sources. Though we are able to surpass the language barriers, there are still barriers that can cause a stall in advancement of HIV prevention programs, such as traditions within a culture. As a country composed of diverse individuals, the United States consist of an increasing amount of first generation American youth. With the numbers of teens infected and affected by HIV/STDs steadily increasing, working through barriers based off traditions can be very effective.

Facilitators, will provide examples of barriers that are produced by tradition and stigma within a community affecting first generation American youth. The purpose of the presentation will be to determine effective procedures to reach first generation American youth and adults without insulting the tradition within their culture. Creating and learning the
culture of the community served will aid in implementing HIV/AIDS prevention programs. Utilizing current prevention programs offered to address different cultures can provide clarification in 1) Understanding and defining cultural competency in first generation American youth, 2) differentiating stats based off demographics, 3) Focusing on HIV prevention programs provided for youth and applying to first generation American youth, and 4) Awareness of certain stigmas about HIV/AIDS which can hinder the comprehension and effectiveness of a program.

By understanding the effects of first generation American cultural traditions on HIV prevention, HIV/AIDS program can expand the number of youth affected. This presentation will provide health educators and other health professionals an avenue to reach clients. They will also be able to provide information increasing the knowledge of HIV/AIDS to the first generation American youth.

Track C
CR01 - The Social Network: Utilizing Social Networks as a Tool of Engagement in HIV/AIDS Prevention
Room: Cairo (Hyatt Regency Atlanta)

Abstract 1872 - The Social Network: Utilizing Social Networks as a Tool of Engagement in HIV/AIDS Prevention
Author(s): Derrick Briggs

With the rise in popularity of social networking Internet sites, it is imperative that we begin utilizing them not only as tools to disseminate HIV prevention awareness and education, but also as tools of engagement. With the advent of new technologies, people are utilizing the Internet more and more as a mode of primary communication to negotiate sexual and emotional relationships. In 2010, Reuters released survey results indicating that nearly 4 out of 5 women, and 3 out of 5 men, say that they believe that texting, Facebook, and other social networking tools cause new couples to jump into bed faster.

Facilitators will present and discuss utilization of social network sites such as Facebook, Youtube, and MySpace to help disseminate social marketing campaigns and supplement community-level intervention programs. Using examples from recent GMHC campaigns, the conversation will explore the ways in which social network sites can be used by agencies to engage with target audiences. For example, in 2010, GMHC launched a Facebook fan page to supplement its I Love My Boo social marketing campaign, which ran in subway cars and stations throughout New York City. The fan page has a current membership of 2,863 fans and has become a site for community dialogue and direct engagement on a local, national, and international level.

HIV/AIDS programs can utilize emerging technologies to engage with individuals and communities about HIV awareness, prevention, and/or testing. Investing in new technologies and training staff to navigate social network sites will be vital in reaching and engaging clients and communities as more and more people rely on these sites to negotiate relationships, particularly sexual ones.

Track C
CR02 - Fostering New HIV Prevention Researchers: NIH grant mechanisms and models of success
Room: Hong Kong (Hyatt Regency Atlanta)

Abstract 1646 - Fostering New HIV Prevention Researchers: NIH Grant Mechanisms and Models of Success
Author(s): Susannah Allison; Cynthia Grossman

This roundtable session will provide early career stage investigators submitting their first NIH grant application with information about funding mechanisms available to them. The panel will include program officers from NIMH's Division of AIDS Research (DAR) and investigators who have NIH funding through career development mechanisms, both newly awarded and those who have successfully transitioned to secure additional funding.

Program officers will moderate the session, discuss research priorities, and provide an overview of selected grant mechanisms most appropriate for new investigators with an emphasis on mentored career opportunities (K awards).
Panelists will consist of funded, early career stage investigators conducting HIV prevention science who can describe challenges and strategies for competing successfully for NIH funding.

The goal of the roundtable is to demystify the NIH grant application process, provide a point of contact with DAR for new investigators and connect funded investigators with those seeking funding.

**Track C**

**CR03 - Advancing Economic Opportunities for Women Living with HIV/AIDS One Microenterprise Circle at a Time**  
**Room: Singapore/Manila (Hyatt Regency Atlanta)**

**Abstract 1988 - Advancing Economic Opportunities for Women Living with HIV/AIDS One Microenterprise Circle at a Time**  
**Author(s): Vanessa Johnson**

A HIV/AIDS diagnosis represents a severely disruptive life event. Once diagnosed with HIV, health and social implications come to bear, from troublesome symptoms to severe illness, from drops in employment and socioeconomic status to stigmatizing social encounters. Furthermore, social and economic circumstances generate and amplify the very conditions that enable the epidemic to thrive: Isolation and lack of financial support. This is particularly true for women living with HIV/AIDS. Poverty is one of the most impactful social determinants for women living with HIV/AIDS. Approximately two-thirds of women living with HIV/AIDS had average annual incomes of $10,000 (Kaiser Family Foundation, 2007).

Microenterprise has become a useful and valuable income generating alternative for people who have a chronic illness and/or disability. People living with a chronic illness and/or disability who participate in microenterprise programming often report an increased feeling of worth or an emotional equity that becomes an enhancement to their health treatment, family and community. In the area of HIV/AIDS, research provided by the CDC indicates that microenterprise interventions have the potential of not only enhancing financial self-sufficiency but also of reducing risky sexual behavior amongst women living in the United States (Sherman et al. 2006). Additional research indicates that financial sustainability can increase social empowerment among women who participate in microenterprise work (CDC Consultation on Microenterprise as HIV/STI Prevention, 2008). In 2010, NAPWA created the Microenterprise Circle (ME Circle) as the second component for its peer leadership development program, Common Threads. The purpose of the ME Circle is to help women living with HIV/AIDS make a strategic and timely transition to economic self-sufficiency. The ME Circle is currently serving 2 cohorts of Common Threads graduates from Orangeburg, SC and Dallas, TX. This roundtable discussion will provide attendees with the opportunity to: 1) examine whether microenterprise programming for women living with HIV/AIDS results in increased financial self-sufficiency and/or enhanced social empowerment; 2) explore whether microenterprise programming can enhance community based HIV prevention activities; 3) learn from women living with HIV/AIDS how their participation in microenterprise programming has impacted their lives; and 4) exchange information about other domestic microenterprise efforts.

Despite the need for continued work and research, there is a need to support the development of microenterprise programming in the United States for women living with HIV/AIDS. Such programs have the potential of helping women living with HIV/AIDS gain self-management of their own lives as well as improved health outcomes via income generating activities.

**Track C**

**CR04 - Project CORRE (Cyber Outreach Risk Reduction Education): Elements for HIV Internet Outreach**  
**Room: Vancouver/Montreal (Hyatt Regency Atlanta)**

**Abstract 1514 - Project CORRE (Cyber Outreach Risk Reduction Education): Elements for HIV Internet Outreach**  
**Author(s): Jason Black; Amy Leonard, MPH; Eric Roland**
With the advancement of social and sexual networking sites and their popularity among MSM, HIV prevention programs are either adding internet outreach to their existing prevention methods or finding ways to alter their existing internet outreach programs. While social and sexual networking continues to evolve mobile apps on smart phones, new social networking privacy settings prevention programs are attempting to keep up, searching for direction on conducting HIV prevention via the internet, while referring to the 2008 HIV/STD Internet Guidelines. Furthermore, lack of research on the efficacy of the internet as a prevention tool results in uncertainty among HIV service organizations about how to best utilize this medium to effectively reach the MSM population.

Legacy Community Health Services was an innovator in the area of HIV prevention on the internet, developing guidelines that were incorporated in the national guidelines. As challenging as it has been, the agency's program has strived to keep up with the changing technology. Facilitators will present and discuss several methods that can increase the effectiveness of internet HIV prevention. These methods include: 1) techniques to define performance indicators of internet outreach; 2) tools to document program outcome objectives; 3) instructions for engaging individuals online in a dialogue on HIV risk reduction; and, 4) quantitative and qualitative evaluation methods for internet outreach.

Internet outreach can be a very useful technique for reaching individuals accessing social networking sites. It reaches individuals in an environment that is comfortable and appealing, while maintaining some level of anonymity, thus lending itself to a more receptive audience for HIV risk reduction education. In order to have a successful online prevention program and effectively reach high-risk MSM who use the internet, organizations need to be able to define and document internet prevention activity, as well as train health educators to communicate risk reduction education online. By providing HIV prevention programs with additional guidance and tools, internet outreach can be an effective means of reducing risk among MSM.

Track D
DR01 - Girls Leading Our Way:  An Empowerment Approach to HIV Prevention among Black Female Teenagers
Room: Hanover C (Hyatt Regency Atlanta)

Abstract 1435 - Girls Leading Our Way:  An Empowerment Approach to HIV Prevention among Black Female Teenagers
Author(s): Valerie Rochester; Ronneal Mathews

The HIV/AIDS epidemic has had a tremendous impact on adolescent and young adult females. As reported by the District of Columbia Department of Health, one out of every 100 District residents ages 13-24 is living with HIV/AIDS. Among newly reported cases, 42% are female. Disturbingly, of women and girls living with HIV in the District, 91% are Black. Despite these devastating statistics, there are few programs that specifically target Black women and girls and address the need for holistic HIV/AIDS prevention that addresses the reality of their lives, empowers them to protect themselves from HIV infection, and provides comprehensive information about sexual and reproductive health.

As part of the Office on Women's Health Straight Talk on Preventing HIV Initiative, the Black Women's Health Imperative developed G.L.O.W. (Girls Leading Our Way) to address the need for more gender and culturally appropriate HIV prevention programming for Black women and girls. G.L.O.W. is an empowerment project for girls ages 12-17, in the District of Columbia, designed to enhance and support effective communication between female teenagers and their adult female family members about the importance of sexual health, including HIV prevention as part of our overall health and wellness.

Facilitators will present and discuss with the group lessons learned from the project and provide insight into some potential best practices for working with Black women and girls. Key points include: 1) data collection methods which contribute to the knowledge base about effective prevention programs for Black women and girls, 2) strategies for ensuring HIV prevention program sustainability and buy-in, and 3) strategies for creating a program design that is flexible and responsive to the needs of program participants.
HIV/AIDS infection among Black girls is a complex mix of economic, social, cultural, biological, environmental, and behavioral factors. Young Black girls can benefit from a comprehensive approach to HIV/AIDS infection which takes all of these factors into account. G.L.O.W. addresses many of these factors by: 1) Engendering a sense of cultural and gender pride, 2) Equipping young Black girls with the education and skills necessary to improve their health, 3) Involving Black women and girls in the creation planning, implementation, and evaluation of programs, and 4) Creating programs that are specifically tailored for and relevant to the realities of Black girls lives.

Track D
DR03 - Implementing event-based rapid and Nucleic Acid Amplification Testing: lessons and strategies from the BART project
Room: Hanover E (Hyatt Regency Atlanta)

Abstract 1941 - Implementing Event-based Rapid and Nucleic Acid Amplification Testing: Lessons and Strategies from the BART Project
Author(s): Peter E. Thomas; Pollyanna Chavez; Audrey Aaron-Moffitt; Steven Ethridge; Patrice Green; Kevin Delaney; Patrick Sullivan

Despite on-going prevention efforts, racial and ethnic minorities and men who have sex with men (MSM) remain disproportionately impacted by the US HIV epidemic. Black Americans are 7-20 times as likely to be living with HIV as whites and nearly half of HIV-infected MSM report being unaware of their HIV serostatus. Since 2003, CDC has developed new models for reaching undiagnosed HIV-infected persons. These models have proven effective in many non-clinical settings, including gay pride festivals and social events that attract large numbers of African Americans. Discussions on HIV testing generally focus on diagnostic outcomes and the behaviors of those who are tested. However, to increase the impact of HIV testing among populations with high prevalence of undiagnosed HIV infection, more discussion of successful operational models and effective testing strategies for implementing HIV testing among high-risk groups is needed. CDC's BART (Behavioral Assessments and Rapid Testing) project partnered with local health agencies to test African Americans and MSM of color, using event-based counseling and testing models. The project provided HIV rapid testing, counseling, and confidential HIV test results to high-risk populations attending social and cultural events. During 15 BART project events, we tested a total of 4,940 persons, including 1,355 (27%) who had never been tested before, found an overall positivity rate of 2.4% (range by event 01%), and confirmed linkage to care for nearly all of those newly diagnosed. The proportion of new infections among those tested varied (range by event 0 - 6%). At 4 events, nucleic acid amplification testing (NAAT) was offered to screen for acute HIV infections among persons with a negative rapid test result.

This roundtable discussion will use lessons learned from the BART project and the field experiences of roundtable participants to identify and discuss the benefits and challenges of implementing event-based testing. Topic areas will include: testing technology, counseling and testing capacity, stigma, recruitment, and referrals for non-local attendees who screen with positive test results. We will also discuss newly developed models for implementing HIV screening in social settings, indicators for evaluating HIV testing events, and different practices for maintaining confidentiality and maximizing timeliness when offering HIV rapid testing and NAAT at events and festivals.

With knowledge about new strategies to screen high-risk populations who are hard to reach, HIV testing staff can create population-specific and event-specific models for HIV screening in social settings. Given a better understanding of the key elements for implementing rapid and NAAT HIV screening at events, program managers can improve their capacity to plan, implement, and evaluate event-based HIV testing in many areas including: processing, marketing, recruitment, counseling and testing methods, logistics, partnerships, laboratory selection, specimen processing, preparedness for HIV-infected persons, and reporting results for NAAT. Lessons learned for promoting and monitoring linkage to care will assist organizations working with underserved populations at risk for HIV. In addition, this roundtable will be an opportunity to discuss the need for and utility of a tool kit for implementing event-based HIV testing at the local level.
Track D
DR04 - The Changing Context of HIV Prevention: Impact on Capacity Building for CBOs, CPGs, Health Departments
Room: Hanover F/G (Hyatt Regency Atlanta)

Abstract 1597 - The Changing Context of HIV Prevention: Impact on Capacity Building for CBOs, CPGs, Health Departments
Author(s): AJ King; Rosemary C. Veniegas; Alice Gandelman

The National HIV/AIDS Strategy (NHAS) calls for the implementation of combination HIV prevention approaches. Such approaches can include expanded HIV testing programs, the use of biomedical interventions including antiretrovirals, vaccines, and microbicides, and the integration of multiple evidence-based HIV, substance abuse and mental health prevention and treatment models for individuals living with HIV or at high risk for HIV infection. Current models of HIV prevention capacity building and technical assistance are focused on planning, implementation and evaluation of evidence-based behavioral interventions and public health strategies. Community-based organizations (CBOs), community planning groups (CPGs), health departments (HDs) and other HIV prevention partners will require enhanced capacity building to plan, implement, and monitor combination prevention in an evolving HIV prevention and healthcare landscape.

Combination prevention will require the addition of new information, skills, and technical proficiencies among CBOs, CPGs, HDs and other HIV prevention partners. First, all stakeholders will need to be familiar with a broader array of evidence-based interventions (EBIs) beyond those found in the field of HIV prevention. There is currently no unified compendium of EBIs across HIV, sexually transmitted diseases, substance abuse, and mental health. Second, planners and HDs will need to critically examine the relative contributions of approaches included within local prevention portfolios to maximize the use of public resources. Best practices for combination prevention have yet to be identified. Third, electronic health data specific to HIV prevention will need to be embedded in public health systems and incorporated into contracted services. Combination HIV prevention requires tested and sustainable data management, program implementation, and intervention delivery contexts.

This roundtable will engage CBOs, planners, and HDs in a dialog about capacity building for the next generation of HIV prevention services. Enhanced capacity building assistance is needed at multiple levels in order to realize the vision of the NHAS and to prepare for changes in healthcare systems. Capacity building for combination prevention approaches such as post-exposure prophylaxis with motivational interviewing could benefit both HIV CBO staff and medical providers. Community planning groups may benefit from information and technology exchange regarding adapting and blending evidence-based models for HIV, sexually transmitted diseases, substance abuse, and mental health programs. Health departments may benefit from technical consultations designed to enhance the use of cost effectiveness analysis and multi-platform surveillance in decisions about allocating and prioritizing HIV prevention resources. Other HIV prevention partners, including those who generate evidence-based HIV, STD, substance abuse, and mental health prevention interventions, will be challenged to broaden their models to incorporate feasible combination approaches for use in community-based and public health settings. A roundtable summary will be developed and disseminated as a resource for other capacity building assistance providers and consumers.

Track D
DR17 - Defining, Selecting, and Establishing a Successful Community Advisory Board
Room: A707 (Atlanta Marriott Marquis)

Abstract 1656 - Defining, Selecting, and Establishing a Successful Community Advisory Board
Author(s): Oscar Marquez; Monica Nuno

Recruiting, retaining, coordinating activities (e.g. scheduling meetings or conference calls), and developing bylaws for a Community Advisory Board (CAB) are among some of the challenges that organizations face when putting together a CAB for HIV prevention programs. Though CABs and/or Review Panels are important components of any HIV
prevention program, a portion of these groups are relinquished to a symbolic representation due to the lack of understanding of the duties that they are intended to perform. Not only can CABs provide input in planning, developing and implementing programs, but in some cases it is a contractual requirement from the funder.

Shared Action will present and discuss how to build a strong and effective CAB that could potentially contribute to better support and enhance the implementation of effective HIV Prevention Services. The key elements to be discussed for the implementation of a CAB for an HIV Prevention program include the five following points.: 1. Define and choose the CAB model that works for the program; 2. Establish purpose and goals of a CAB and its members; 3. How to recruit the appropriate candidates; 4. Develop systems for an effective CAB. For example, one of these methods could include conducting interviews with potential candidates to assure a match with your program needs. Another example of a procedure is establishing an orientation meeting or conference call to introduce staff and other CAB members, clarify expectations, and answer any questions that might arise. Lastly, 5. Use of innovative technologies to support the CAB. Here, for example, there are websites that can be created exclusively for the CAB to access specific documents and provide feedback, use chatrooms or Web forums to interact with other CAB members, and a private space that can be used to communicate with program staff and address program's issues.

Choosing the right model and recruiting committed members who are good fit for the program are key elements to a successful CAB. A strong CAB will help to provide valuable feedback and support to implement a more efficient and effective program. It is imperative that the agency understands the role of a CAB clearly, and the CAB's processes so that the agency is able to use it more effectively. As financial resources and availability of experts are limited, CABs can play a pivotal role in sustaining and enhancing the implementation of an HIV Prevention Program.

Track F
FR01 - Center for Disease Control and Prevention's National HIV Prevention Monitoring and Evaluation Plan
Room: Piedmont (Hyatt Regency Atlanta)

Abstract 1609 - Center for Disease Control and Prevention's National HIV Prevention Monitoring and Evaluation Plan
Author(s): Janet Heitgerd; Richard Wolitski; Stan Lehman; Dale Stratford

The Centers for Disease Control and Prevention (CDC) is developing a comprehensive National HIV Prevention Monitoring and Evaluation (M&E) Plan. The purpose of the plan is to ensure that its funded HIV prevention activities are accountable, aligned with the goals of the 2010 National HIV/AIDS Strategy (NHAS), and have maximum impact on the course of the HIV epidemic. The plan will 1) describe CDC's Division of HIV/AIDS Prevention (DHAP) M&E activities and data sources, 2) discuss how M&E data are being used to assess DHAP's HIV prevention efforts at the national, state, and local levels, and 3) overview the M&E reports being produced that address the extent to which the Division's HIV prevention efforts are making a difference.

DHAP currently conducts two related national-level monitoring and evaluation activities, with evaluation questions and indicators focused on the overall purpose and audience. HIV Prevention Results Monitoring at a national level is concerned with the outcomes and impact (i.e., results) of national HIV prevention activities (e.g., How successful are HIV prevention efforts at reducing the HIV transmission rate. HIV Prevention Program Performance Monitoring is focused on program planning and service delivery of state and local HIV prevention programs by DHAP funded grantees (e.g., How many persons were newly identified as HIV-positive as a result of participating in CDC-funded interventions?). These activities are being integrated and expanded upon to form the basis for a comprehensive CDC National HIV Prevention M&E Plan. During this roundtable, facilitators will present and discuss with the group how CDC's National HIV Prevention M&E Plan 1) provides an integrative framework for current national, state, and local-level monitoring and evaluation efforts utilizing all data sources available to DHAP; 2) supports a strategy for the use, reporting, and dissemination of national M&E data by the Division to key stakeholders in a timely and transparent manner; and 3) enables national, state, and local prevention programs to align with NHAS and with their priority populations.

An M&E plan is critical for associating activities and accomplishments, as well as for setting directions to successfully meet program goals and objectives. CDC's National HIV Prevention M&E plan is intended to help guide the agency's
HIV prevention strategy, programmatic and research priorities, and allocation of resources over time for more effective HIV prevention at the national, state, and local levels and ensuring its efforts are making a difference over the course of the epidemic.

Track F
FR09 - Achieving Prevention Justice for Women
Room: Kennesaw (Hyatt Regency Atlanta)

Abstract 1951 - Achieving Prevention Justice for Women
Author(s): Brook Kelly; Waheedah Shabazz-El; Sonia Rastogi

Despite the devastating impact of HIV in the lives of women of color, there continues to be a relative dearth of attention to targeting HIV education and testing, as well as developing effective interventions for women. There has been little research on confronting the root causes of high incidence rates among women of color, nor evaluation of which interventions may actually reduce the incidence of HIV in women. A lack of accurate data collection and research to understand the drivers of the HIV epidemic among women has led to a scarcity of acceptable or proven options and interventions targeted to prevent HIV among women. This workshop will focus on advocacy opportunities to better meet women's HIV prevention needs.

Moderated by Brook Kelly, PWN's Human Rights Attorney, facilitators will explore the current context of HIV prevention among women including emerging trends, key issues, and gaps in knowledge that must be considered to implement a prevention cocktail approach for women. These topics will include 1) background on recent or current clinical trials such as the National Institute's of Health HPTN 064 trial (ISIS study of women at risk for acquiring HIV and the GRACE study: what do they tell us and what is missing?; 2) current prevention models that use an integrated approach to prevention, such as integrating HIV prevention and care into sexual and reproductive prevention and health services; 3) the effects of structural issues such as poverty, race, gender, incarceration and discrimination on the potential for successful interventions; and 4) gaps in knowledge about HIV prevention for women.

By identifying successes and gaps in current HIV prevention research for women, prevention and treatment advocates can

- Build a better understanding of the current HIV prevention landscape for women;
- Discuss emerging trends and key issues in prevention research, and nuances that must be considered to increase applicability to women;
- Learn about existing advocacy efforts to improve HIV prevention for women; and
- Network with others interested in advocating for improved HIV prevention for women.

Track G
GR01 - Strategies and Tools for Integrating Mental Health, Substance Abuse and HIV Prevention
Room: Inman (Hyatt Regency Atlanta)

Abstract 1158 - Strategies and Tools for Integrating Mental Health, Substance Abuse and HIV Prevention
Author(s): John Anderson, PhD

A solid working knowledge of mental health and substance abuse issues is essential for understanding how to help people protect themselves from HIV infection, how to help those who are already infected from transmitting the virus to others, and how to reduce adverse health consequences among those living with HIV.

Working with people who have both mental health and substance abuse disorders is a common challenge for those working on the front lines of HIV prevention. Front line prevention workers may be uncertain about how to identify problems and prioritize goals. In part, this arises from the fact that the relevant service delivery systems (i.e., medical
care, mental health care, substance abuse treatment, and prevention services) each have their own goals, language, and set of assumptions about what is best for their clients.

It is also important to note that the prevalence of psychiatric disorders is relatively high among adults receiving care for HIV disease in the United States. Bing and his colleagues (Bing et al., 2001) enrolled a nationally representative probability sample of 2864 adults receiving care for HIV. Nearly half of the sample screened positive for a mental health disorder, nearly 40% reported using an illicit drug other than marijuana, and more than 12% screened positive for drug dependence. More than one third of the study sample screened positive for major depression and over a quarter of the sample screened positive for a less severe form of depression called dysthymia.

This roundtable will include a review and discussion of the relationships between mental health issues (e.g., depression, anxiety, HIV-related cognitive impairment, stigma, disclosure, trauma, sexual abuse, etc.), substance abuse disorders, HIV risk behavior, and health-related behaviors (e.g., adherence to HIV medications, decisions to get tested, accessing care, engaging care, etc.) for people at high risk for acquiring HIV and for people living with HIV/AIDS. This roundtable will facilitate a discussion on effective HIV prevention strategies for the seriously mentally ill.

Practical strategies for assessing and responding to both mental health (e.g., depression, anxiety, HIV-related cognitive impairment, stigma, disclosure, trauma, sexual abuse, etc.) and substance abuse issues will be reviewed and discussed. This roundtable will utilize one to two case studies to illustrate concepts and promote skills-building. Screening tools will be presented.

The integration of mental health substance abuse and HIV prevention has some real practical implications for HIV prevention program development and implementation. Some of which include the following: 1) in order to begin the process of integration, agencies should examine their own current capacity in terms of how brief interventions are applied, how they conduct screenings, and make appropriate referrals, 2) agencies may need a basic level of training in order to successfully address integration of services and truly determine what types of services can be addressed “in-house” and what needs must be handled through referrals, and 3) there is a critical need to look at how referral systems and referrals are established, maintained and tracked.

Track G
GR02 - Achieving Health Equity by Addressing Social Determinants of Health and Program Collaboration and Service Integration
Room: Spring (Hyatt Regency Atlanta)

Abstract 1221 - Achieving Health Equity by Addressing Social Determinants of Health and Program Collaboration and Service Integration
Author(s): Kim Williams; Thurka Sangaramoorthy; Arun Skaria; Ana Penman-Aguilar; Kathleen McDavid Harrison

Opportunities for health begin in our neighborhoods, jobs, schools, and homes. Achieving health equity requires a holistic approach to lessen vulnerability to disease and decrease disease exposure and transmission, while also including a broad portfolio of policy, research, and interventions. While effective interventions that address individual-level risk factors exist, optimal health outcomes in all communities require a broad range of strategies that address complex and integrated social and environmental factors (e.g., poverty, lack of access to quality health care, lower educational attainment, racism, etc.) as well. The Centers for Disease Control and Prevention’s (CDC’s) National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) has adopted a comprehensive plan to eliminate health disparities that includes holistic methods for disease tracking, prevention, and control. Developing and sustaining key collaborations between national, local, territorial, tribal and state partners is vital to this approach.

Program Collaboration and Service Integration (PCSI) is a key example of a structural-level intervention that blends interrelated health issues and prevention strategies to facilitate comprehensive and holistic delivery of HIV/AIDS, viral hepatitis, STD, and TB services to achieve health equity. Other strategies addressing social determinants of health...
(SDH) in research, surveillance, communication, policy, programs, capacity building, and partnerships are necessary requisites for a more balanced portfolio that promotes optimal health.

The proposed session will offer an opportunity for partners to present efforts to achieve health equity by incorporating SDH and/or PCSI approaches for populations disproportionately affected by HIV/AIDS, viral hepatitis, STD, and TB.

By supporting policies and activities that address structural-level determinants and strengthening collaborative work across disease areas and integrating services, we can reduce the impact of HIV, viral hepatitis, STDs, and TB on individuals and communities and increase their opportunities for healthy living. As such, SDH and PCSI approaches are critical mechanisms through which we can promote and achieve health equity.

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**Track D**

**LBR01 - The Changing Roles of CBOs: Addressing the Need for Holistic Approach Towards Total Wellness**

**Room:** A703 (Atlanta Marriott Marquis)

**Abstract 2031 - The Changing Roles of CBOs: Addressing the Need for Holistic Approach Towards Total Wellness**

**Author(s):** Manh T. Nguyen; Charles W. Martin; Lincoln Pettaway

Community-based organizations (CBOs) have always played an important and necessary role in public health providing and mobilizing prevention, education and HIV testing. Over the years, they have strategized and redeveloped plans based on the understood needs, trends and goals of the different communities they serve. Being a CBO in a high impact area, South Beach AIDS Project, Inc. (SoBAP) has recognized the need to develop more comprehensive programs transitioning to a holistic approach towards complete wellness. Along with the primary focus of reducing rates of HIV infection with enhanced counseling and testing, SoBAP has developed a total wellness center addressing the need for free sexually transmitted infection (STI) screenings and established a research component to collect data focusing on interventions studies within communities of color. Through the adoption of strategic management models that are expansive, comprehensive, and sensitive in nature, SoBAP utilizes the changing roles of CBOs to enhance services addressing the direct need of the community. South Beach AIDS Project has supplemented traditional HIV testing with other STI screening such as Syphilis. Soon, in collaboration with the Department of Health, a complete health screening will be developed to provide additional testing like HEP-C, gonorrhea, cholesterol screening, etc. These services have been added to acknowledge the correlation between STIs and HIV/AIDS diagnosis and their prevalence within our community. South Beach AIDS Project considers the ethos of our clients symptoms and attempts to address their well being through the acknowledging the whole person by addressing complete total health.

The facilitators will discuss how South Beach AIDS Project's management implements health care coverage to their targeted community, in a holistic fashion through the listed methods by detailing how this traditional community-based organization has evolved into a learning organization that seamlessly integrates management strategies which incorporate information systems, double-loop learning, open-systems, just-in-time training, social learning, and human performance enhancement strategies. Hence, the proposed management model considers internal and external factors that directly influence productivity at the organizational level. An acute sensitivity to community needs requires community-based organizations to identify and work with key stakeholders to meet the growing and ever-changing needs of the community. In this way South Beach AIDS Project has managed to distinguish itself from other major construction within the larger social fabric.

The implications of transitioning community-based organizations into learning organizations are greater than the blustering of local agency capacity. The management models proposed in this round table discussion provide resources which agencies can not only use to better serve their constituents but also create a process from which agencies can continuously learn how to tailor services to communities needs, perform organizational audits, and provide community assessments for deficiencies while utilizing, constructively and affirmatively unconventional resources within the community. As a result of the rich data these communities are able to produce, this holistic approach also provides practical suggestions for community-based organizations to develop strategic alliances with academics, policymakers, and corporations on the local, national, and international level.
Abstract 2032 - Producing “Ask Me, Tell Me/Pregúntame, Dime” a Bilingual HIV Prevention Video for MSM
Author(s): Mary Ann Chiasson, DrPH; Jose Nanin, EdD, CHES

Nationally more than half (53%) of all new HIV infections occur among MSM, with young black and Latino men disproportionately affected. These worrisome findings highlight the urgent need for culturally competent, novel HIV prevention interventions for MSM. To help fill the gap in effective online interventions for this population, we initiated the prevention project, HIV Is Still A Big Deal (www.hivbigdeal.org) to create theory-based, video interventions for MSM that are engaging, free, and easily accessible from the privacy of a personal computer. Following extensive formative work which included focus groups and large-scale online behavioral surveys, we produced four video dramas with a professional cast and crew. The videos, designed to promote critical thinking about HIV disclosure, HIV testing, substance abuse, and condom use, were informed by developmental, social, and cognitive-constructivist learning theories and strategies. The first three episodes of the ongoing series with a continuing cast, The Morning After, the Test and Ask Me, Tell Me Ask Me/Pregúntame, Dime are 10-13 minute videos directed by award winning filmmaker Todd Ahlberg. They are scripted dramas and fictional stories with carefully crafted plots and characters based on reality.

Facilitators will present and discuss the production of our prevention video series for MSM including the challenges of producing a bilingual video drama in English and Spanish. We will describe the decision-making process from start to finish: choosing the behavioral theory underlying the design of the intervention, pre-production, production and post-production of the videos. The discussion will include methods for identifying video topics through focus groups and interviews with members of the target population; scriptwriting, cast and crew selection, location scouting, shooting the video, editing (sound and color), dissemination, and effectiveness evaluation. Because The Morning After was found to reduce high risk behavior in MSM in both quasi-experimental and randomized controlled trials, multiple methods of evaluation will be discussed.

Since AIDS was first described among MSM in 1981, highly effective group and individual level, theory-based counseling interventions have been developed but few are widely available. Many of these interventions have several features in common that greatly increase their cost and severely limit the number of men that can be reached. Most prominent among these are the need for highly trained staff to deliver complex, multisession interventions. Reducing HIV transmission among MSM in the future depends on the extent to which exposure to proven HIV prevention interventions can be expanded to the millions of men at risk. The Internet's borderless geographic and demographic social networks offer the potential to change both community norms and individual behavior cost-effectively. This could be accomplished through the widespread availability of low-intensity video interventions like those described at this roundtable, alone, or coupled with high-intensity interactive single and multi-session online interventions.

Abstract 2086 - Defending Medicaid at the State and Federal Level: Update and Advocacy Agenda
Author(s): Amy Killelea; Robert Greenwald

States are facing unprecedented budget crises, which are putting an additional strain on struggling Medicaid programs. This is particularly troubling given that Medicaid’s role in providing early intervention and access to comprehensive care, treatment, and prevention services is essential to stemming the tide of new infections and meeting the prevention goals of the NHAS. Recent federal budget proposals, such as the one drafted by
Representative Ryan in April, would fundamentally alter and weaken the entire Medicaid program if enacted. The HIV advocacy community must be prepared to defend Medicaid against short-sighted budget proposals that drop people from coverage or limit access to essential care and treatment. Eliminating early access to care through Medicaid has huge implications for prevention efforts, given that linkage to regular care reduces HIV transmission rates. Defending Medicaid is critical given health care reform's Medicaid expansion, which eliminates the disability requirement currently in place in most states and expands eligibility to people up to 133% FPL in 2014.

The federal budget negotiations currently in process as well as similar state budget battles will have a significant impact on Medicaid advocacy. Our presentation will update advocates on the recent and most significant Medicaid challenges at the state and federal levels, emphasizing why it is critical for HIV advocates to ensure that Medicaid is able to meet the prevention, care and treatment needs of the thousands of people living with HIV and AIDS who currently depend on the program as well as the thousands more who will move into Medicaid as a result of health care reform's Medicaid expansion in 2014. We will focus on the following challenges: recent federal budget proposals (which will be taken up by Congress over the next several months) to block grant Medicaid or cap funding; eligibility cuts (with an update on ongoing state and federal actions over health care reform's maintenance of effort provision and whether states should be granted waivers of this requirement); state cuts to optional benefits (focusing on cuts to prescription medications); and state cuts to provider reimbursement rates. For each challenge, we will also discuss opportunities for advocacy to shore up and defend the Medicaid program, including an update on bridge to 2014 Medicaid strategies, such as state application for an 1115 waiver to immediately cover pre-disabled people living with HIV. The 1115 waiver update will be particularly timely as the federal guidance to states on how to use 1115 waivers to expand care to people living with HIV is expected within the next couple of months.

With information about the major threats to Medicaid as well as the opportunities to address those challenges, advocates will have the tools to ensure that Medicaid is able to meet the prevention, care and treatment needs of people living with and at risk for HIV and AIDS. It is particularly important to ensure that HIV advocates are well-versed in Medicaid issues as thousands of currently uninsured people living with HIV will move into Medicaid in 2014.
Abstract 1186 - A Prospective Study of the Onset of Sexual Behavior and Risk in Perinatally HIV-Infected Youth
Author(s): Katherine S. Elkington; Reuben N. Robbins; Ezer Kang; Claude A. Mellins

Perinatally HIV-infected (PHIV+) youth are surviving into adolescence and young adulthood. For a cohort not expected to survive past childhood, clinicians and family members are now faced with new challenges in caring for perinatally HIV infected (PHIV+) youth as these youth tackle the challenges of adolescence, including their sexual development, while managing a chronic, stigmatized and transmittable illness, for which there are important public health implications. Understanding the sexual development of PHIV+ youth is vital to provide them with developmentally appropriate HIV prevention programs.

Using pooled data (N = 417) from two longitudinal studies focused on HIV among youth (51% female; 39% HIV+) and their caregivers (92% female; 46% HIV+), we compared the rate of sexual onset over adolescence across four youth-caregiver combinations: PHIV+ youth with HIV+ caregivers (12%); PHIV+ youth with HIV- caregivers (27%); HIV- youth with HIV+ caregivers (34%); and HIV- youth with HIV+ caregivers (27%). We used an age-centered growth curve model to estimate the onset of youth's sexual behavior (oral sex, penetrative sex, and unprotected intercourse) across adolescence. We then tested whether caregiver or youth demographic characteristics were associated with youth's sexual onset over time.

Approximately half of the caregivers were HIV+; two-thirds of caregivers reported being a biological parent. On average, caregivers reported having some high school education and having a household earning of less than $20,000 (69% met criteria for living below the poverty line). Thirty-nine percent of youth included in our analyses were HIV+; 50% were female and most reporting being African American/Black (53%) or Hispanic/Latino (40%).

Overall, youth in our sample had a similar prevalence of sexual onset by age 13 (4%) as the national average (6%). In multivariate growth curve analyses, youth unaffected by HIV (i.e. HIV- youth with HIV- caregivers) reported the steepest rate of onset (i.e. the number of youth who become active by a given age) of penetrative and unsafe sex in the sample. Youth infected or affected by HIV (HIV+ caregiver) in our sample appeared to be sexually delayed. Compared to HIV- youth with HIV- caregivers, youth with HIV+ caregivers reported a slower rate of onset of penetrative sex across the adolescent years; this difference emerged irrespective of youth's HIV status.

The more prominent role of caregiver HIV infection with respect to reduced youth sexual activity and risk warrants continued investigation. Family-based programs that involve HIV infected caregivers may be particularly effective as they tackle critical issues related to communication about sexual risk behavior and potential transmission.

Abstract 1703 - Hablando Claro: Adapting an EBI to Meet the Needs of Intergenerational Latina Family-Based Dyads
Author(s): Lilia Espinoza, MPH, PhD; Melawhy Garcia-Vega, MPH; Natalia Gatdula, BS

Latinas are at increasing risk of HIV infection and are more often infected by their primary heterosexual partners. Furthermore, Latina youth of immigrant mothers often find themselves dealing with very different sexual risk contexts when compared to their mothers and female family elders. Culturally tailored family and gender-based interventions emphasizing and integrating Latino family values such as familismo, personalismo, and comunitarismo present potentially promising approaches to HIV prevention among Latinas. Although some evidence-based interventions (EBIs) mention cultural values, there are few that demonstrate and measure how they have been integrated into HIV prevention programming. Hablando Claro, a culturally adapted intervention of the Teen Health Project, is a family-
based HIV prevention intervention with goals of increasing sexual knowledge, developing safer sex skills, and increasing voluntary HIV testing among intergenerational Latina family dyads.

Spanish-speaking Latina immigrants with teen daughters (12-18 years) living in Los Angeles County were recruited by promotoras (community health workers) for participation in a two-day 8 hour intervention. The intervention consisted of charlas (Spanish-language educational sessions) held at community based organizations and health care facilities with joint and generation-specific interactive sessions facilitated by age-matched promotoras.

The intervention consisted of charlas facilitated by trained age-matched promotoras. The pilot phase of the project used a one group pretest/posttest study design to measure changes in knowledge of HIV/AIDS and intention to test for HIV. Participant data were collected at pre-charla, immediate post-charla and 3-month follow-up; assessment included sexual risk behavior and knowledge and STI and HIV testing behaviors. Latina dyads engaged in an interactive charla supplemented with hands-on activities centered on: HIV/AIDS knowledge and stigma, STI knowledge, condom use and negotiation, domestic violence and resources for assistance, communication styles, mental health, sexuality, and basic sexual and reproductive anatomy/physiology.

In addition to the charlas, participants were involved in monthly support groups to address additional issues regarding Latina HIV/AIDS risk contexts as suggested by charla participants and include HIV/AIDS and stigma, communication, relationships, body image and self esteem, and female sexual health. These supplemental activities are designed to build healthier Latino communities through fostering female intergenerational-family dyad relationships and communication and involving their male partners and family members who often contribute to Latina risk.

A total of 396 Latinas (171 adults, 225 youth) participated in the charlas and completed pre-and post-charla surveys. The majority of the participants (n=360; 91%) completed a 3-month follow-up survey. Statistically significant increases in HIV knowledge, intergenerational communication, safer sex behaviors and HIV testing behaviors as well as generational differences were observed at follow-up. The intervention was able to demonstrate sustained increases in family-based communication in terms of the number of sexual risk-related conversations and the breadth of sexual risk-related topics discussed. The Hablado Claro intervention demonstrated the potential impact of greater family involvement and a familistic intervention design on Latina HIV/AIDS prevention. Future directions include using an experimental design and involving male sexual partners in the intervention.

Abstract 1715 - Relationships and Sexual Behavior: A Closer Look among Urban Middle School Youth
Author(s): Karin K. Coyle; Pamela M. Anderson; James D. Walker; Heather M. Franks; Lisa J. O'Connor

Early adolescence is a valuable window to focus prevention efforts; however, current interventions often lack a focus on the context in which sexual behavior is likely to occur, namely, in relationships. Understanding more about adolescents romantic relationships may provide insights regarding important leverage points for HIV prevention interventions. This paper describes relationship and sexual behaviors in a sample of urban middle school youth drawn from the baseline data of a randomized trial funded by the NIH (NINR).

Baseline data were collected by trained survey administrators. Students with consent and assent to take part in the study completed the confidential and voluntary survey using personal digital assistants (PDAs) during one class period at their schools. The study sample of 7th grade youth from 10 schools will be accrued over multiple years (2010-2011). At the time of abstract submission, the sample included 264 youth representing 3 of 10 study schools. By the time of the conference, the sample will include youth from 5 of the 10 study schools.

The majority of students (97%) are ages 12 or 13; 53% are female and 47% male. Most youth reported they are African American (37%) or Hispanic/Latino(a) (40%). Students were asked about relationship status. Just under half (46%) reported that they had gone out on date alone with a boy or girl that they liked; similarly, 46% reported going on a group date. Three-fourths (75.6%) of the youth reported ever having a boyfriend or girlfriend, and 53% reported having a current boyfriend or girlfriend; girls were more likely than boys to report having a current partner (62% versus 44%, respectively). Of those students with current partners, most (approximately 51.5%) had been going with their partner for 3 months or less; nearly 4 of 10 (39%) reported dating their partner for 3 months to over a year. Most
youth (61.5%) noted that they spend from 1 to 4 hours alone with their partners each week; in general, boys reported spending more time alone with their partners than did girls. Of the students with a boyfriend or girlfriend, nearly all (97%) reported that they had kissed someone. Fewer (39%) reported touching someone's private parts (body parts covered by underwear or bra). Over one-fifth (21%) reported ever having vaginal sex; 15% reported oral sex. Boys with a current partner were more likely to report vaginal and oral sex than were girls with a current partner. Of note, sexual behaviors were more frequent among youth with a current partner. For example, 12% of all students reported ever having vaginal sex versus 21% of youth with a current partner. A more in-depth analysis will examine associations between relationship status and sexual behaviors.

Young adolescents are involved in relationships, which is consistent with normal adolescent development. Examining relationship status as the context of sexual risk taking for urban middle school youth can provide additional insights for developing more salient and accessible prevention interventions (e.g., addressing risk associated with multiple partners, examining risk of spending time alone with a partner).

Abstract 1937 - Is Older Really Wiser: Frequency of Condom Use in a College Population
Author(s): Jarrett Lewis; Theresa Okwumabua, PhD; Scotty Craig, PhD; Courtney Peasant; Lloyd Thomas; Ebony Barnes

Over 5,000 youth between the ages of 13 and 24 were diagnosed with HIV/AIDS in 2006, accounting for 14% of all new cases in the U.S. that year. It is estimated that of the 19 million new STI cases reported each year, youth between the ages of 15 and 24 constitute almost half of them. The consistent and correct use of condoms during sexual intercourse has been found to be an efficacious method in the prevention of the transmission of STIs and HIV. However, more information on the frequency of use of condoms in at-risk populations, such as the college community, is imperative. The present study explores differences in college students reported use of condoms during sexual intercourse (vaginal, oral, and anal) based on their age and classification in school (i.e., freshman, sophomore, junior, senior).

Data for this study were drawn from a larger randomized trial designed to increase knowledge, testing, and safer sex practices among college students. Participants included 55 women (79.7%) and 14 men (20.3%) between the ages of 18 and 41. Sixty two percent of the participants identified as African American and 21% as Caucasian. During the pre-intervention phase of the larger study, participants responded to several questionnaires that included items about their frequency of condom use during vaginal, anal, and oral sex, as well as their sexual behaviors and attitudes including their perceived risk of contracting a STI and/or HIV.

Preliminary data analyses indicate that younger students reported using condoms more frequently than their older counterparts. A moderate, but significant relationship between educational classification and condom use during vaginal sex ($r=.386; p=.001$) was also found. More specifically, students self-identified as freshman ($p<.01$), sophomore ($p<.01$), or junior ($p=.034$) reported higher frequency of condom use compared to students who identified themselves as a senior.

These findings suggest that as college students continue in their matriculation, their frequency of condom use significantly decreases. Further investigation of factors contributing to this decrease in preventive measures in college populations for the transmission and/or contraction of STIs and HIV, such as condom use, is vital. The implication of these findings for prevention and intervention programs must also be explored.

Track A
A03 - Exploring the underlying psychological factors contributing to HIV risk for MSMS
Room: Courtland (Hyatt Regency Atlanta)

Abstract 1239 - Reasons for Unprotected Sex among Men Who Have Sex with Men: An Event-level Analysis
Author(s): H Fisher Raymond; Ron Stall; Willi McFarland
The global associations between sexual risk taking and enduring patterns of personal behavior such as substance use have been well documented in HIV research among MSM. However, enduring patterns of behavior may also be challenged by context specific disinhibition. Such situational and event-level explanations for sexual risk taking, especially in the context of UAI in serodiscordant partnerships, are less understood. We describe reasons for UAI at the event-level among MSM’s serodiscordant and serodiscordant partnerships.

A cross-sectional survey was conducted among MSM (N=1046) in San Francisco using time-location sampling in 2008. Partnership-level data including partner’s HIV status and counts of anal sex acts (e.g., unprotected insertive vs. receptive) with the 5 most recent partners were collected. A series of event-level questions (e.g. mood, alcohol/drug use at last sex) were asked. Participants also self-reported their own HIV status.

Three-hundred-forty-two HIV-negative men reported UAI in 550 seroconcordant negative partnerships, 105 HIV-positive men reported UAI in 228 seroconcordant partnerships, 46 HIV-negative men reported UAI in 66 serodiscordant partnerships and 46 HIV-positive men reported UAI in 63 serodiscordant partnerships. Comparing across pairing types, HIV-positive pairs and HIV-negative/HIV-positive pairs were more likely to report URAI (87.4% & 85.7% vs. 76.5% for HIV-negative pairs & 76.1% for HIV-positive/HIV-negative pairs, p<.05) and UIAI (84.8% & 92.0% vs. 72.3% for HIV-negative pairs & 56.3% for HIV-positive/HIV-negative pairs, p<.01) at last sex. In terms of mood during the last episode of UAI, men in HIV-negative pairs were more likely to report feeling infatuated or being in love (p=.01), and men in HIV-negative/HIV-positive pairs were less likely to report being in a really good mood (p<.01) and more likely to report wanting to escape daily life for a while (p<.01) compared to other pairings where UAI occurred. HIV-negative/HIV-positive pairs were also more likely to report either themselves or their partners were feeling the effects of drug(s) at last UAI (p<.01). Other most cited reasons for URAI and UIAI among serodiscordant partnerships include undetectable viral load, seropositioning, and withdraw before ejaculation.

Event-level factors associated with sexual risk taking need to be taken into consideration when planning HIV prevention interventions as a specific focus on contingency management. Interventions to reduce HIV risk taking among MSM need to include skills building around mood, managing daily life and substance use as contexts that may lead HIV-negative men to engage in risky sex in serodiscordant partnerships.

Abstract 1536 - High Prevalence of Depression and Loneliness Exacerbate HIV Risk among Urban MSM Attending Sex Parties
Author(s): Jackie White, MPH; Sari L. Reisner, MA; Kenneth H. Mayer, MD

Private sex parties are an emerging risk environment for HIV among men who have sex with men (MSM). High rates of depression and loneliness have been observed among MSM relative to the general adult male population; however, a dearth of research has explored depression and loneliness among MSM who regularly attend private sex parties. This is particularly concerning given that depressed or lonely MSM who regularly attend private sex parties may be at escalated risk for engaging in unprotected anal sex in this setting.

In 2009, 103 MSM who reported regularly attending sex parties in the prior 12 months completed an interviewer-administered assessment. Data collected included demographics, HIV-related behaviors, the 20-item Center for Epidemiologic Studies Depression Scale (CES-D) assessing clinically significant depressive symptoms, the 10-item UCLA Loneliness Scale, and problematic alcohol use measured by the CAGE. We constructed two multivariable logistic regression models to examine the associations of demographics, behavioral HIV risk factors, and other psychosocial variables to: Model 1: depressive symptoms (CES-D score =/>16); and Model 2: loneliness (UCLA Loneliness Scale score =/>30). Both models adjusted for age and educational attainment.

Participants had a mean age of 44 years (SD = 10.9); 72% identified as gay; 59% were white, and 52% were HIV-infected. Nearly one-third (32%) reported engaging in serodiscordant unprotected anal sex (SDUA) and the majority (60%) reported engaging in one or more acts of unprotected anal sex (UAS) all at the most recent sex party they attended in the preceding 12 months. In total, 47% and 21% met criteria for depression and loneliness, respectively. Model 1: Having been diagnosed with a sexually transmitted infection (STI) in the prior 12 months (aOR = 3.08; 95%CI: 1.11-8.53), problematic alcohol use (aOR = 5.74; 95%CI: 1.96-16.84), and engaging in SDUA at the most
recent sex party attended (aOR = 3.79; 95%CI: 1.19-12.09) were independently associated with a higher odds of clinically significant depressive symptoms. Model 2: problematic alcohol use measured by the CAGE (aOR = 5.13; 95%CI: 1.50-17.59), reporting no active health insurance (aOR = 18.23; 95%CI: 1.14-291.09), and engaging in UAS at the most recent sex party attended (aOR = 2.75; 95%CI: 1.82-9.23) were independently associated with a higher odds of loneliness.

Findings suggest that depressed and/or lonely urban MSM who regularly attend private sex parties engage in behaviors in the sex party context that place them at increased risk for the acquisition or transmission of HIV and other STIs. HIV prevention interventions are needed to reach MSM who attend sex parties and should address highly co-prevalent psychosocial factors, including depression and loneliness, as well as substance use, that may amplify sexual risk-taking and HIV/STI risk in this setting.

**Abstract 1864 - Intimate Partner Violence, Minority Stress and Sexual Risk-taking among U.S. MSM**

**Author(s):** Rob Stephenson; Patrick Sullivan

Recent research suggests that men who have sex with men (MSM) experience a significantly higher prevalence of Intimate Partner Violence (IPV) than heterosexual men. However, little research has examined how the experience of IPV is associated with sexual risk-taking among MSM. Additionally, little research has examined how the experiences of homophobia and racism and are associated with both the experience of IPV and sexual risk-taking. The current research explores the intersections of IPV, homophobia and sexual risk-taking among a national sample of US MSM, to understand the extent to which sexual risk-taking is shaped by the minority stress experienced by MSM.

A national, internet-based survey of US MSM (N = 2,086) recruited from social networking sites was conducted in 2010. From a subset of these data (n = 1,575), five outcomes were modeled using logistic regression: physical violence victimization, sexual violence victimization, physical violence perpetration, sexual violence perpetration, and sexual risk-taking as defined by unprotected anal intercourse (UAI) at last sexual encounter with a male partner. IPV was limited to a one-year recall period. Models controlled for age, race/ethnicity, homosexual identity, education, employment, HIV status, experiences of homophobic discrimination, experiences of racism, internalized homophobia, UAI, and experiences of IPV.

Approximately 48% of MSM in the internet survey reported UAI at last sex. MSM reported IPV prevalence rates of 8.8% for physical victimization, 3.6% for sexual victimization, 4.3% for physical perpetration, and 0.8% for sexual perpetration. MSM who reported experiencing homophobia were more likely to report IPV physical victimization (OR: 1.25, 95% CI: 1.14, 1.37), IPV sexual victimization (OR: 1.28, 95% CI: 1.11, 1.47), and physical perpetration of violence (OR: 1.70, 95% CI: 1.25, 2.31). MSM who reported engaging in UAI were more likely to report perpetrating physical violence (OR: 2.21, 95% CI: 1.29, 3.79), conversely, MSM who reported UAI were also more likely to report perpetrating physical violence (OR: 2.08, 95% CI: 1.12, 3.85). Racism was associated with increased odds of IPV sexual victimization (OR: 1.19 95% CI: 1.06, 1.34).

To date there has been a dearth of research on IPV among MSM, and almost no attention has been paid to the intersection of violence and sexual risk taking among MSM. The high prevalences of IPV and UAI among MSM reported here suggest an immediate and pressing need for violence support and counseling services geared towards MSM. IPV screening should be routinely incorporated into routine HIV/STI counseling and testing, with a focus on discussions around the relationship between sex and violence. The associations identified between racism, homophobia and both IPV and UAI point to the need for prevention messages to address the social, cultural and attitudinal contexts in which MSM take sexual risks in order to reduce HIV/STI incidence.

**Abstract 2070 - Neighborhood Characteristics and Individual Level Factors Associated with HIV-related Stigma among African American MSM**

**Author(s):** Laura Hester
HIV-related stigma negatively impacts individuals living with HIV through experiences of discrimination and social isolation. To what extent perceived stigma is shaped by individual factors and/or the social environment has not been explored. This study sought to examine individual and neighborhood characteristics of African American men who have sex with men (AA MSM) and their associations with perceptions about HIV-related stigma.

The study was conducted in Baltimore, Maryland from August 2008 to June 2009. Participants were at least 18 years of age, identified as male and African American/black, self-reported two or more sex partners including at least one male sex partner in the prior 90 days; reported unprotected sex and were willing to take an HIV test. To assess perceptions of HIV-related stigma, two questions were asked: If I were to talk to people in my neighborhood about HIV they would think that 1) I have HIV and 2) I am homosexual. A dichotomous variable was constructed to indicate no perception of stigma (disagree to both questions) versus any perception of stigma (agree with either or both). Participants self-reported age and sexual identity.

To describe neighborhood characteristics of study participants, the residential address of each participant was geocoded using ArcMap 9.3 software, and were linked to census block groups (2000 US Census File 1 and File 3 (US Census Bureau). Variables included were: median household income per census block group, percent black race, percent in poverty, percent in labor force. Bivariate statistics and multivariate logistic regression were used to compare individual-level variables (HIV status, age and sexual identity) and neighborhood characteristics with any perceived HIV-related stigma.

Over half of the sample agreed with HIV-stigma related statements (54.5%). No differences were observed by HIV status or sexual identity. Age was marginally associated with stigma with a greater proportion of older participants (aged 30 years old or older) not perceiving HIV-related stigma.

Study participants resided in census blocks characterized as predominately black race (mean=80%), low employment (mean=53%), 31% living in poverty and 36% who did not graduate from high school.

Logistic regression showed significant negative associations between stigma and age. Specifically, older age was associated with decreased concern that if someone talked about HIV neighbors would think the individual is HIV-positive or gay, adjusting for other census-block variables, sexual identity and HIV status. Effect modification of percent black census blocks by sexual identity was significant indicating that greater black census block is associated with lower perceived stigma among straight/bisexuals compared to gay.

Perceived HIV-related stigma was prevalent. Results show that racial composition of residential block shapes perceptions differently by sexual identity, where gay-identified men perceive greater stigma in blocks with greater percent black residents. These findings suggest further research on the role of neighborhood as a social context within which AA MSM exist.

Track A
A08 - How Intimate Partner Violence and Stigma Impact HIV Risk in Minority Women Populations
Room: Vancouver/Montreal (Hyatt Regency Atlanta)

Abstract 1242 - What Girls Won't Do for Love: HIV-risk among Adolescent Females Driven by a Relationship Imperative
Author(s): Jerris L. Raiford, PhD; Puja Seth, PhD; Nikia D. Braxton, MPH; Ralph J. DiClemente, PhD

Rates of HIV and other sexually transmitted infections (STIs) continue to increase among African American youth. Adolescents are engaged in the developmental task of establishing a positive sense of self personally (self-identity) and in relation to others (relational identity). Some adolescents view intimate partners and their role in dating relationships in unhealthy ways. Adolescents with a stronger relational identity than self-identity view intimate relationships as imperative to a positive self-concept, which can lead to feelings of worthlessness if not in a relationship, tolerance for high-risk sexual behavior, and partner abuse. Furthermore, a sex-ratio imbalance in the African American community may lead African American females to perceive they have few alternatives to unhealthy
relationships. Given that individuals who perceive poor relationship alternatives are more willing to engage in high-risk sexual activity to maintain the relationship, the present study assessed the association among a relationship imperative, perception of relationship alternatives and HIV-related risk factors among African American females.

We recruited 715 African American females, 15 to 21 years, and assessed HIV-related risk behaviors (e.g., unprotected sex, partner violence) via the ACASI, including whether females endorsed a relationship imperative, defined as having a partner at all times is important to me and their perception of alternatives to their current relationship. Participants also provided a vaginal swab specimen for STI testing. Logistic regression analyses controlled for demographics and an important contextual factor, fear of abuse resulting from condom negotiation, to predict the likelihood adolescents endorsing a relationship imperative would also report high-risk behaviors.

Females who endorsed a relationship imperative (n=206, 29%), compared to those who did not (n=509, 71%), were less likely to inform their partner of being treated for an STI (OR=2.9, p=.02) and more likely to: have less power in their relationship (OR=2.2, p=.001), perceive themselves being unable to refuse sex in multiple high-risk situations (OR=1.9, p=.001), have had anal sex (OR=1.8, p=.002), report unprotected sex at last sex with a casual (OR=2.0, p=.02) and main partner (OR=1.5, p=.03), report sex while their partner was high on alcohol/drugs (OR=1.5, p=.03), report abuse by a partner (OR=1.5, p=.02), and report recent relationship abuse (OR=1.6, p=.05). Furthermore, participants with a perceived inability to refuse sex were more likely to test STI-positive (OR=3.9, p=.05). Finally, perceiving oneself to have few relationship alternatives interacted with the belief that being in a relationship is imperative to predict higher frequency of sex while high on alcohol/drugs (R2=.048, p=.04) and less sexual communication self-efficacy (R2=.033, p=.003).

These results suggest that African American adolescent females engage in higher sexual risk behaviors if they believe a relationship is imperative and that few relationship alternatives are available. We suggest future research identify the role a sex-ratio imbalance and subsequent power imbalance may play in African American females willingness to engage in sexual risk behaviors. HIV prevention programs should address these issues among females and target males and females when addressing the power imbalance that may persist in this community and its effect on HIV risk.

Abstract 1361 - Intimate Partner Violence as an Impediment to HIV/STI Intervention Efficacy among Young African American Women

Author(s): Puja Seth, PhD; Jerris L. Raiford, PhD; Gina M. Wingood, ScD, MPH; Ralph J. DiClemente, PhD; Lashun Robinson

Intimate partner violence (IPV) is considered a serious public health concern and is associated with adverse health outcomes among diverse groups of women. Higher rates of IPV have been reported among African American couples. Experiences of IPV can adversely affect women's physical, psychological, and sexual health as well as overall healthcare costs. Specifically, IPV has been associated with high-risk sexual behavior and sexually transmitted infections (STIs). Given that HIV/STIs disproportionately affect young African American women, it is pertinent to examine factors, such as IPV, that can potentially impact risky sexual behaviors and STIs. This study extends upon previous findings by examining the impact of IPV on the efficacy of an HIV/STI prevention intervention program designed for young African American women.

Eight hundred forty-eight African American women, 18-29 years, were randomly assigned to either the HIV/STI intervention condition or the general health promotion (control) condition. Data collection occurred from October 2002 through March 2006 at baseline (N=848) and at 6- (N=663) and 12-month (N=668) follow-up. Participants completed an Audio Computer Assisted Survey Interview assessing sociodemographics, intimate partner violence, and risky sexual behaviors. Subsequently, participants provided vaginal swab specimens for STIs (i.e., Chlamydia, Gonorrhea, Trichomonas (TV)). IPV was defined as ever experiencing verbal, physical or sexual abuse by a male sexual partner.

The results indicated that 50% of the women (N=424) endorsed ever experiencing IPV by a male partner. Binary generalized estimating equation models assessed the impact of IPV at baseline on risky sexual behavior and STIs.
over the 12-month follow-up period. Age, intervention group, and baseline outcome measures were included as covariates. IPV significantly predicted having multiple sexual partners during the past 12 months (AOR=1.31, 95% CI=.98-1.74, p=.05) and inconsistent condom use during the past 6 months (AOR=1.38, 95% CI=1.01-1.90, p=.04) over the 12 month follow-up period. Significant interactions between IPV and study condition were also found. Post hoc-analyses utilizing a layered-chi-square technique examined the interactions further for interpretation. Among women who did not experience any IPV, women in the control condition were more likely to test positive for TV (3.8% vs. 1.2%, AOR=5.88, 95% CI=1.03-33.33, p=.05) and report having a risky sexual partner (22.5% vs. 16.5%, AOR=1.85, 95% CI=.95-3.57, p=.05) than women in the intervention condition over the 12 month follow-up period. However, among women who reported ever experiencing IPV, there were no significant differences between the intervention and control conditions in testing positive for TV or having a risky sexual partner.

IPV may thwart the use of safe sex practices that prevent disease acquisition. Despite being enrolled in an HIV/STI prevention program, if women reported experiences of IPV, those in the intervention were not significantly less likely to test positive for TV or have a risky sexual partner than women in the control condition. These findings underscore the need to develop culturally-sensitive, combined HIV and IPV prevention programs Currently, no HIV prevention programs that address IPV in reducing HIV/STI risk have been published for high risk African American women.

Abstract 1432 - A Qualitative Study of Social Norms and their Impact on Native Women's HIV Risk

Author(s): Hannabah Blue; Robert Foley

Social norms play a significant role in the development of HIV risk behaviors and the buy-in of community membership as the acceptability of those behaviors. In Native communities, social norms, which are often intertwined with cultural norms, play a heightened role due to the often closed nature of the community, the communal culture, and the complex intersection of social and sexual networks. The National Native American AIDS Prevention Center (NNAAPC), in partnership with 3 Native community-based organizations (CBOs) conducted community assessments to identify norms that served as determinants of HIV risk, and understand how these norms might impact other moderating and mediating factors of risk. The results were used to construct community-wide social marketing messages.

During 2008 and 2009, NNAAPC and the three Native CBOs, which serve the White Earth Reservation in Minnesota, the Eight Northern Pueblos of New Mexico, and the Denver Native community in Colorado, conducted phone interviews and focus groups. Twelve to fifteen phone interviews and two focus groups were conducted in each community. Participants were recruited using a purposeful sample; local stakeholders helped to identify and recruit participants. Participants were a combination of service providers and community members. Interviews and focus groups were transcribed, coded, and then analyzed using a grounded theory approach. Communities were analyzed separately, resulting in identified and linked core phenomena, causal conditions, intervening conditions, strategies/actions, and consequences for each community.

Dominant themes that were repeated across all three communities included: stigma and shame around HIV, low perceived risk, and HIV taboos.

For participants from the White Earth Reservation and surrounding area, stigma and shame about HIV was the identified core phenomenon. As a strategy to cope with existing stigma, Native women adopted maladaptive habits of not talking about HIV. The silence in turn perpetuated norms around shame about talking about it, as it was perceived that since it was not discussed, it must not be acceptable to discuss it.

In the Eight Northern Pueblos of New Mexico, it was found that among participants, a low perception of personal risk among Native women resulted from a profound lack of local awareness of HIV, lack of experience with people living with HIV, and poor education about HIV in the community. In the Denver Native community, Native women participants held the belief that condoms were only appropriate for pregnancy prevention. Thusly, the community was not using condoms for HIV prevention. This was the result of the core phenomenon of low perception of personal risk.
NNAAPC created social marketing messages that would: 1) resonate with the culture of the community, 2) address the identified core phenomenon or action/strategy community members adopted to deal with the phenomenon, and 3) encapsulate the message and appropriate imagery for diffusion in each of the three communities. These messages carefully seek to counter the norms in the community that serve to perpetuate risk for HIV. Overtime, these messages, when reinforced through other means, and the continued efforts of the CBOs can begin to change norms, and ultimately change HIV risk behavior.

Track B
B01 - Monitoring HIV Risk: Findings From the National HIV Behavioral Surveillance System, 2008-2010
Room: Piedmont (Hyatt Regency Atlanta)

Author(s): Alexandra M. Oster; Teresa J. Finlayson; Catlann Sionean; Isa J. Miles; Kathy M. Hageman; Amanda J. Smith; Elizabeth A. DiNenno

The National HIV Behavioral Surveillance System (NHBS) is CDC’s system for monitoring risk behaviors, HIV testing, and use of HIV prevention services among persons at risk for HIV infection. NHBS surveys three at-risk populations in annual rotating cycles: men who have sex with men (MSM), injection drug users (IDUs), and heterosexuals at increased risk for HIV infection (HET). This group oral presentation will consist of an overview of the importance and methods of NHBS followed by three presentations on the key indicators and findings from each cycle of NHBS Round 2 (2008-2010).

NHBS Round 2 was conducted in 21 cities, which had accounted for more than 66% of urban AIDS cases in the United States in 2004. NHBS-MSM is conducted using venue-based, time-space sampling. NHBS-IDU and NHBS-HET are conducted using respondent-driven sampling, a peer-recruitment method. Using Round 2 data, we conducted descriptive analyses to assess key indicators of HIV risk, testing, and prevention (among participants who did not report previously testing positive for HIV infection) and HIV prevalence (among all participants tested).

In 2008, 9,299 MSM were interviewed; 8,175 did not report being HIV-infected, of whom 54% had unprotected anal intercourse with a male partner during the preceding 12 months and 5% had injected drugs. Among MSM not reporting HIV infection, 69% had been tested for HIV during the preceding 12 months, 35% had been tested for syphilis during the preceding 12 months, and 18% had participated in an individual- or group-level HIV behavioral intervention during the preceding 12 months. Of all 8,153 MSM tested for HIV infection, 19% were positive (white MSM, 16%; black MSM, 28%; Hispanic MSM, 18%; other MSM, 17%); 44% of those positive were unaware of their infection.

In 2009, 10,497 IDUs were interviewed; 9,652 did not report being infected with HIV, of whom 35% shared syringes and 58% shared other injection equipment during the preceding 12 months; unprotected vaginal or anal sex with an opposite-sex partner in the preceding 12 months was reported by 70% of male IDUs and 73% of female IDUs. Forty-nine percent had been tested for HIV during the preceding 12 months, 17% had participated in an individual-level HIV behavioral intervention and 9% in a group-level intervention during the preceding 12 months. Of all 10,073 participants tested for HIV infection, 9% were positive; 44% of those who tested positive were unaware of their infection.

Preliminary data indicate that, in 2010, approximately 10,000 at-risk heterosexuals were interviewed, among whom more than 98% were tested for HIV infection. Final data on risk behaviors, use of prevention services, and HIV test results will be available for the presentation.

NHBS provides estimates for key risk, testing, and prevention behaviors in populations at high risk for HIV infection. NHBS data allow CDC to assess HIV-related disparities and determine prevention and program needs. We will discuss how NHBS data are and will be used in monitoring the National HIV/AIDS Strategy and the CDC Division of HIV/AIDS Prevention Strategic Plan.
Abstract 1751 - Prevention Services and Condom Use in Washington, DC: NHBS Data from Three at Risk Populations  
**Author(s):** Manya Magnus; Irene Kuo; Gregory Phillips II; Anthony Rawls; James Peterson; Tiffany West-Ojo; Nnemdi Kamanu-Elias; Yujiang Jia; Jenevieve Opoku; Alan E. Greenberg

Washington, DC (DC) has among the highest HIV/AIDS rates in the US, with 3.2% of adults and adolescents and 7.1% of black men living with HIV/AIDS. With a low proportion of residents accessing group (GLI) or individual-level (ILI) evidence-based prevention interventions (PI) as measured by National HIV Behavioral Surveillance (NHBS), associations between risk reduction behavior and PI lack sufficient power when performed on an annual basis. The purpose of this analysis was to assess condom use associated with uptake of HIV PIs among three populations participating in NHBS: heterosexuals at high risk for HIV (HET), men who have sex with men (MSM), and injection drug users (IDU).

Data on HIV-negative participants &gt;18 years old in NHBS-HET (HET), -MSM (MSM), and -IDU (IDU) were analyzed using descriptive methods and unweighted multivariable logistic regression.

Between 2006 and 2009, 1,803 (750H, 500M, 553I) individuals participated in NHBS in DC: 64% were male, 81% were black, and 59% were 18-44 years old (yo); 9.7% were HIV+ (4.7%H, 14.4%M, 11.7%I). Condom use at last vaginal and/or anal sex differed by cycle (29%H, 73%M, 24%I, p&lt;0.001). 26% reported receiving HIV PI in the last year: 13% GLI and 19% ILI. IDUs were more likely than HET or MSM to report exposure to PIs (43%I vs. 18%H and 18%M, p&lt;0.001), as well as blacks versus non-blacks: GLI (15% vs. 6.3% p&lt;0.001) and ILI (21% vs. 12%, p&lt;0.001). After adjusting for race, age, gender, and cycle, women versus men (OR 1.4, 95% CI 1.0-2.0), blacks versus non-blacks (2.5, 1.2-5.2), and IDUs versus non-IDUs (3.7, 2.4-5.7) were more likely to have participated in a GLI. IDUs were more likely than non-IDUs to have been exposed to an ILI (3.3, 2.3-4.8). After adjustment, those using PIs were more likely to use condoms at last sex (1.5, 1.2-1.9), as well as blacks versus non-blacks (1.8, 1.1-2.8), 18-34 yo versus &gt; 35 yo (1.9, 1.4-2.5), and those in MSM cycle versus other cycles (7.3, 4.5-11.6); women were less likely than men to use condoms (0.6, 0.5-0.8).

Despite differential utilization of PI based on race, gender, and designated high risk population, these data reveal a consistent association between condom use and uptake of PI in DC over 3 cycles of NHBS. Efforts to improve dissemination of innovative population-specific PIs may have the capacity to slow the HIV epidemic in DC.

Abstract 1961 - Unrecognized HIV Infection among Injection Drug Users in Baltimore  
**Author(s):** Danielle German; Andrea Villanti; Vivian Towe; Colin Flynn; David Holtgrave

Baltimore has a strong legacy of HIV prevention among injection drug users (IDUs). This study examined the extent to which HIV-positive IDUs were aware of their HIV status and explored associated socio-demographic characteristics and service utilization.

Injection drug users anonymously completed behavioral surveys and voluntary HIV testing as part of the 2009 wave of the National HIV Behavioral Surveillance System in Baltimore, Maryland. Participants were recruited using respondent driven sampling, with remuneration for survey participation, HIV testing, and successful peer referral. Non-seed participants (n=510) who tested HIV-positive but did not report positive HIV status were those defined as having unrecognized HIV infection. Descriptive statistics and logistic regression were conducted in Stata.

HIV prevalence was 16.1% and prevalence of unrecognized infection was 47.6%. Socio-demographic characteristics, drug use patterns, and injection risk behaviors were not significantly associated with unrecognized infection. Compared to those who were aware of their HIV status, those who were not aware were more likely to report any unprotected sex in the past year (O.R.: 2.47, 95% C.I.:1.00, 6.07) and less likely to visit a doctor in the past year (O.R.: 0.23, 95% C.I.: 0.06, 0.91). Twenty-eight percent of those with unrecognized infection had never tested for HIV. Of those who had tested, 36% had been tested in the past year. Main reasons for not testing among those with unrecognized infection were: afraid of being HIV+ (65%), worried someone would find out results (38%), no time...
(34%), perceived low risk (24%), worried about social consequences (24%), worried about names reporting (24%), and no health insurance (21%).

There is a continued need for targeted HIV prevention among Baltimore injection drug users. Prevention for positives activities could be enhanced by increasing the proportion of IDUs who are aware of their status. Respondent driven sampling methods may be useful for enhancing targeted HIV testing.

Abstract 2005 - High HIV Seropositivity among Heterosexuals at Risk in Miami Confirmed by Two Different Sampling Methods

Author(s): David Forrest; Gabriel A. Cardenas; Dano W. Beck; Marlene Lalota; Lisa R. Metsch; Xierong Wei; Jeffrey A Johnson; S Michele Owen; Thomas M Liberti

The U.S. HIV/AIDS epidemic disproportionately impacts minority and lower-income populations. This analysis seeks to compare findings among lower-income heterosexual populations sampled using two different methods.

As part of the National HIV Behavioral Surveillance System among heterosexuals at increased risk of HIV Infection (NHBS-HET), we conducted two cross-sectional studies of low-income heterosexually active adults in Miami-Dade County, Florida. The NHBS-HET1 cycle (2007) used venue-day-time (VDT) sampling and the NHBS-HET2 cycle (2010) used respondent-driven sampling (RDS). With VDT sampling, participants (18-50 years old) were recruited at randomly selected venues (primarily retail businesses) in areas with both high poverty and HIV/AIDS rates. With RDS, participants with lower income or education levels (18-60 years old) were recruited through a modified chain-referral method. In both studies, anonymous interviews and HIV tests were conducted in English or Spanish and dried blood spot (DBS) specimens were collected for confirmatory (Western blot) and future testing that included an avidity based test for recent infection (modified Bio-Rad 1/2 Plus O). Participants reporting injection drug use (IDU) and males reporting sex with another male (MSM) were excluded from this analysis (N=577 for NHBS-HET1, N=456 for NHBS-HET2).

Both HET cycles had similar demographics and socioeconomic characteristics; the majority were black (79%), lower income (<$15,000) (78%), and had a high school education or less (79%). Approximately half did not have health insurance (59%) and had not visited a health care provider in the past 12 months (49%). Many participants had been arrested in the past 12 months (27%).

Drug use and sexual risk behaviors were also similar for both cycles. Both cycles had high levels of heavy alcohol use (30%) and illicit drug use (52%). Many participants had been in alcohol or drug treatment (30%) and met criteria for depression (46%). Both samples had high levels of unprotected vaginal and/or anal sex (85%) and approximately half reported testing for HIV during the past 12 months (57%).

HIV seropositivity was 5.7% for NHBS-HET1 and 7.7% for NHBS-HET2. Over one-third of infections (40%) were previously undiagnosed. Of those previously undiagnosed, many (81%) reported unprotected vaginal or anal sex in the past 12 months. HIV-positive test results in the NHBS-HET1 sample were associated with crack use in the past 12 months compared to no crack use in the past 12 months (14.9% vs. 4.5%, p=0.001) and self-reported hepatitis C infection (20.0% vs. 5.5%, p=0.05). HIV-positive test results in the NHBS-HET2 sample were associated with female gender (11.6% vs. 3.6%, p=0.001), crack use in the past 12 months (19.4% vs. 5.8%, p<0.001), and self-reported hepatitis C infection (23.5% vs. 7.0%, p=0.011). Results for recency testing on stored DBS (excluding MSM and IDUs) suggest that 4.5% of HIV-positive NHBS-HET1 participants and 7.1% of HIV-positive NHBS-HET2 participants were infected within the previous 12 months (HET1 vs. HET2 recency p=0.67).

Our findings document high rates of heterosexually acquired HIV infection in lower-income communities of Miami using two different sampling methods. Both methods may be useful for reaching populations of heterosexuals at increased risk for infection.
Track C
C01 - Getting to First Base with HIV Vaccines, Microbicides, and PrEP
Room: Singapore/Manila (Hyatt Regency Atlanta)

Abstract 1247 - Getting to First Base with HIV Vaccines, Microbicides, and PrEP: How Do We Get Home?
Author(s): Katharine Kripke; Cornelius Baker; Roberta Black; Yvette Edghill Spano; Kenneth Mayer; Lynn Paxton; Mitchell Warren

After years of struggle, the past two years have finally seen proof of principle that HIV vaccines, microbicides, and pre-exposure prophylaxis (PrEP) can prevent sexual transmission of HIV in humans. So far, each approach has been demonstrated to be only partially effective, and the effectiveness of microbicides and PrEP were highly dependent on adherence. What do these results mean for the way forward? What do communities need to know about these scientific breakthroughs? How can these partially effective interventions, each of which has only been proven in a single population, be developed into highly effective interventions that are broadly applicable or appropriately targeted?

In this panel discussion, speakers will discuss the implications of the recent vaccine (Rv144 Thai trial), microbicide (CAPRISA 004) and PrEP (iPrEx) efficacy trial results, and provide an overview of efforts underway to further develop each approach. For each prevention strategy, the speakers will discuss what additional development is needed before the intervention can reach its full potential as part of the HIV prevention toolkit. The speakers will present the material in terms of what community educators, health providers, health administration officials, and other responders need to know about these areas of research. Following the presentations, there will be a moderated discussion among the panelists and participants about the intersections between these prevention strategies as we gradually move from proof of principle through further product development and implementation science to practical application.

Track C
C07 - Routinizing HIV Testing
Room: Hong Kong (Hyatt Regency Atlanta)

Abstract 1364 - Increase in HIV Testing After Using ACTS to Introduce Routine Screenings at Bronx School-based Clinics
Author(s): HM Lane, MPHIL; ND Hoffman, MD; ME Rogers, FNP; S Stafford; DC Futterman, MD

In New York City (NYC), youth 13-29 account for 33% of all new HIV infections. Among NYC high school students, 62% of 12th graders report ever having had sex. Nationally, >50% of HIV+ youth 13-24 are unaware of their HIV status and only 19% of 12th graders have ever had an HIV test. Instituting routine HIV screening in a school-based health program can dramatically increase the number of youth who know their HIV status, and help diagnose and link positive youth to care.

The Bronx, a borough of NYC, has an HIV prevalence rate of 1.3%. A routine HIV testing initiative was launched in 7 high school clinics that serve approximately 9,600 students representing 47% of the student population at the targeted schools. In 2010, 53% of those enrolled were female, 58% Latino, and 32% Black. Approximately 60% of enrolled students have at least 1 visit a school year.

Montefiore’s Adolescent AIDS Program (AAP) and the Montefiore School Health Program (MSHP) launched an initiative to routinely offer HIV testing to all students accessing the clinic. We trained clinical providers in ACTS (Advise, Consent, Test, Support), a streamlined HIV testing method that reduces the HIV pretest counseling to 1-2 minutes. We also utilized the ACTS implementation framework of buy-in, implementation planning, training, and monitoring & evaluation. Implementation planning included changing multiple administrative systems to facilitate offer, documentation, and implementation of the HIV test. To sustain the initiative, we provided ongoing technical assistance to individual clinics and shared feedback on progress through newsletters and staff meeting presentations.
The clinics instituted rapid oral HIV testing technologies in late 2009 to enable providers to deliver results during the same clinical visit.

The routine HIV testing initiative was launched in February 2010. In the 4 months (Oct 09-Jan 10) prior to the initiative launch, the clinics tested a combined total of 326 clients. In the four months (Feb 09-Jun 10) after the launch, these same clinics tested 901 clients, an increase of 176%. Comparing baseline testing rates with the same time period one year later (Oct 10-Jan 11), a 130% increase was sustained into the following school year. There was variation in improvement between schools, (58% to 487%), with 3 clinics increasing their testing rates more than 4-fold. Since the launch of the initiative, 1,986 students have been tested for HIV, reaching nearly 35% of students who had accessed services. One HIV+ client was identified, and was linked to care.

Routine HIV testing is feasible to implement in school-based clinics reaching 13-18-year-old adolescents, who often do not seek other routine health care. ACTS is a useful tool for scaling up routing testing. Incorporating oral rapid testing into clinic flow is also feasible, and is particularly useful when reaching youth populations. While reaching more than 1/3 of clients, work is still needed to make testing routine. Specific attention should be paid to leadership, administrative and supply needs, staff training, and providing feedback.

Abstract 1442 - Implementing the Social Network Strategy for HIV Testing: The New York City Experience

Author(s): N M Leblanc; A V King; M Malave; B Cutler; B W Tsoi

While the number of new HIV diagnoses in New York City (NYC) has decreased since 2001, the proportion of individuals with concurrent HIV and AIDS diagnoses has remained unchanged. Additionally, certain populations, such as teens/young adults and young men who have sex with men (MSM) have rising diagnosis rates. CDC's pilot programs using the social network recruitment strategy (SNS) for HIV testing in non-clinical settings were more effective in identifying HIV positive people than traditional outreach models. With PS07-768 funds, NYC Department of Health and Mental Hygiene (NYCDOHMH) funded six agencies to conduct HIV testing using SNS.

In 2008, the NYCDOHMH funded six agencies in NYC to implement HIV testing programs using SNS. The NYCDOHMH trained the six funded contractors on SNS prior to program implementation. At-risk populations targeted included African and Caribbean immigrants, injection drug users (IDUs), MSM, members of the house ball communities, commercial sex workers (CSWs), sex party promoters and heterosexual-identified MSM.

In 2009, DOHMH hired a technical assistance coordinator (TAC) to provide agency-specific TA and program monitoring. Additionally, DOHMH held contractor meetings to identify and troubleshoot challenges, review data quality and collection activities, and share best practices. DOHMH also provided a supplemental training on coaching recruiters to identify and motivate high risk people from their network, network associates (NAs), to test for HIV. To improve agencies program evaluation capacity, DOHMH later required submission of monthly reports on recruiter engagement activities and quarterly SNS flow diagrams. In January 2011, DOHMH provided training on using a network mapping program to create SNS diagrams.

From October 2008 to September 2010, 2538 NAs were tested, 85% were people of color, 81% were men and 32% were MSM. The confirmed seroprevalence was 2.6% (range: 0.0% to 4.5%). NAs who are MSM had the greatest confirmed seroprevalence of all reported risk factors at 5.1%.

Programs with lower sero-positivity rates and/or fewer generations of NAs becoming recruiters demonstrated difficulty with recruiter engagement, especially coaching. Indiscriminate recruiter screening practices and using a restrictive target population resulted in fewer high-risk NAs tested. Other factors associated with poor performance included frequent staff turnover, poor documentation of overall testing activities and poor follow-up of positive clients. Some agencies also found that recruiters who were African immigrants or CSWs had difficulty referring NAs to test. These recruiters reported concern that referring an NA for HIV testing may imply that they are HIV positive, threatening their ability to earn a living (CSWs) or their standing in the community (immigrants).
We found programs using SNS with HIV testing in non-clinical settings were more effective in finding HIV positive individuals than using traditional outreach testing strategies. However, SNS may not be applicable for all populations.

Factors associated with better program performance include strong and consistent recruiter engagement, stable staffing, and strong program tracking and organization. Use of SNS diagrams and recruiter tracking forms may help with program monitoring and evaluation. Additional trainings, particularly around recruiter engagement, may also enhance program performance.

Abstract 1850 - Toward Universal HIV Testing: Is the CDC Recommendation of “Opt-Out” Screening the answer?
Author(s): Anish P. Mahajan, MD, MSHS, MPH; Saloniki James, MPH; Janni Kinsler, PhD; Rishi Manchanda, MD, MPH

More than 20% of HIV-positive persons in the U.S. are unaware of their infection. Fewer than half of all Americans have ever been tested for HIV. To increase testing offers and patient acceptance of screening, the Centers for Disease Control & Prevention (CDC) recommends routine opt-out HIV screening, in which patients are told they will undergo testing unless they decline. Some consumer and legal groups contend that opt-out screening may diminish patient autonomy. The research objective of this study was to determine if CDC recommended opt-out screening is associated with greater testing offers and patient acceptance of screening than routine opt-in and risk-based testing in ambulatory care.

At 2 Los Angeles safety-net clinics, participatory research methods were used to create 3 HIV screening interventions: a) physician-initiated opt-out, b) nurse-initiated opt-out, c) nurse-initiated opt-in. Using a quasi-experimental time samples design, each intervention was implemented in each clinic for a 2-month interval over a 6 month period. Chi-square test was used to assess differences in testing offers and patient acceptance of screening between the interventions and risk-based testing (pre-trial standard of care). Multivariate logistic regression was used to identify demographic correlates of screening refusal. All patients, ages 18 to 64, presenting to the clinics during the 6 month trial were eligible for screening.

Relative to risk-based testing, all of the interventions increased offers of testing (11% vs. 25%; p < 0.0001) and actual testing rates (7% vs. 14%; p < 0.0001). Although offer rates were similar between opt-out and opt-in interventions, the physician offer rate was greater than that of nurses (28% vs. 22%; p < 0.0001). Overall percentages of patients accepting screening in opt-out and opt-in interventions were similar (59% vs. 56%; p= 0.09), but physician-initiated opt-out was associated with greater screening acceptance than nurse-initiated opt-out (65% vs. 54%; p< 0.0001). In multivariate analysis, history of recent HIV test, increasing age, female gender, and African-American ethnicity were associated with refusing HIV screening (p< 0.001).

Routine HIV screening in ambulatory care is feasible, and resulted in a greater than 2-fold increase in the percentage of clinic patients offered screening and a substantial increase the proportion undergoing testing. The CDC recommendation for opt-out screening was not associated with greater patient acceptance of screening compared to opt-in screening.

Even in the context of a quality improvement program directed at improving HIV detection, an opt-out screening strategy in ambulatory care does not assure universal offering of HIV testing; additional interventions may be needed. The potential risk of CDC recommended opt-out screening to patient autonomy may be avoided without limiting testing offer and acceptance rates by implementing routine opt-in screening instead.

Author(s): Donata Green, PhD; Judith Griffith, RN; Michael Burke, PhD; Paula Eguino-Medina

CDC recommends opt-out HIV testing of pregnant women to increase early detection. Despite perinatal HIV testing recommendations from CDC and ACOG guidelines that have been released for more than a decade, not all pregnant women are tested for HIV in the US. The estimated overall transmission rate remains nearly 3 times as high (2.8%) as the less than 1% achievable when appropriate treatment is received.
OTTL is a national marketing program under the CDC's Act Against AIDS campaign and the first HIV prevention effort with a focus on healthcare providers. The goal of OTTL is to increase testing of pregnant women in the first and third trimester using an opt-out approach.

OTTL focuses on obstetric providers in all clinical settings. Key campaign messages for the program were disseminated through: 1) outreach to key stakeholders; 2) promotion at medical and midwifery conferences through exhibits and workshops; 3) placement of campaign advertisements in obstetric journals; 4) trade media advertising; 5) electronic media communications; 6) materials dissemination; and 7) an accredited curriculum to further promote awareness and implementation of the recommendations among OB/GYN residents and midwifery students. Process evaluation was conducted to assess exposure of OTTL to providers and whether the program was implemented as planned. Outcome evaluation was conducted to examine the impact of the key messages on knowledge, awareness and implementation of CDC's HIV testing recommendations. This presentation will highlight the implementation and evaluation of OTTL.

From May 2007 through December 2010, a total of 15,524 kits and 130,000 patient pieces were disseminated. Overall, conference outreach and media activities yielded over 1.2 million exposures to the campaign. Twenty outreach activities and 68 stakeholder promotional/educational activities occurred. Results from the DocStyles surveys revealed that providers who reported having seen OTTL materials (20%) were significantly more likely to report awareness of CDC's recommendations [X2(1) = 25.43, P<.001], implementation of the recommendations [X2 (1) =38.50, P<.05], and include HIV testing as a regular screening test for all patients (i.e., universal testing) [X2 (1) = 4.98, P<.05]. Although only 25% of providers who took the ACOG survey were aware of OTTL and only 47% of those aware were currently using one or more OTTL materials, willingness to use the materials ranged from 63% for the provider resource/tip sheet to 72% for the comprehensive perinatal testing handout.

LESSONS LEARNED: There are positive benefits to packaging and promoting CDC recommendations for health care providers. OTTL results indicate that promotion of CDC recommendations to obstetric care providers may result in an increase in desired HIV testing behaviors. The volume of OTTL materials ordered by providers indicated their interest in these resources. This national program was an excellent best practice program showing involvement of key stakeholders to increase OTTL exposure.

CCT1
CCT1-2 - Factors that Enhance or Impede Access to HIV Care and Treatment
Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 1287 - HIV Testing Histories and Risk Factors Reported by Migrants Tested for HIV by Three CBOs
Author(s): J D Schulden; B Song; E Valverde; M A Borman

Migrants/recent immigrants (migrants) in the U.S. constitute a large population that is vulnerable to HIV and other sexually transmitted diseases (STDs), and can be difficult to reach for HIV testing using clinically based approaches. Additional approaches are needed to increase the participation of these frequently mobile populations, many of whom may be undocumented and fearful of disclosure through contact with medical providers, in HIV testing, prevention, care, and treatment.

CDC's Advancing HIV Prevention (AHP) initiative aimed to reduce barriers to early HIV diagnosis and increase participation of racial, ethnic, and hard-to-reach populations such as migrants in HIV-related services. One of several AHP projects that addressed these barriers funded three community-based organizations (CBOs) to demonstrate the feasibility of conducting rapid HIV testing with migrants. The CBOs conducted rapid HIV testing and counseling at a range of sites, including migrants' work, commercial, and social venues in five states. Individuals were recruited as a convenience sample, and rapid HIV testing was offered to persons who were at least 13 years old, who stated that they were not infected with HIV, and who provided informed consent. Those who were tested were asked about their sociodemographics, HIV/STD risk factors, and HIV testing and immigration histories. Univariate and multivariate analyses were conducted using data from migrants who were born outside the continental U.S.
A total of 5247 persons were tested; 6 (0.1%) were HIV-positive. Of 3135 persons who completed surveys, 2778 (89%) were born outside the continental U.S. (70% of these were from Mexico, 24% from Caribbean/Latin American countries, and 5% from African countries); 60% were male. Their reported risk factors during the past year included 2 or more sex partners (44%), sex while high or drunk (30%), transactional sex (27%), and having an STD diagnosis (6%). The migrants’ characteristics and risk factors varied substantially by CBO. Fifty-eight percent had never been tested for HIV. On multivariate analysis, poor English proficiency and being born in Mexico were associated with no prior testing. Among males, giving money or goods for sex in the past year was associated with no prior testing.

The CBOs delivered rapid HIV testing to migrants in non-clinical settings and observed low HIV infection rates. However, the frequency of self-reported risk factors among participants was relatively high, and more than half had never been tested for HIV. Greater efforts are needed, using innovative approaches, to ensure that migrant populations have access to HIV testing, prevention, and related services. Understanding factors that are associated with migrants' having never previously tested for HIV may help focus these efforts.

Abstract 1744 - ART Coverage and Predictors of Detectable Viral Load in the Ryan White System of Care
Author(s): Jennifer N. Sayles; Mike Janson

Despite continued HIV prevention efforts, 21% of those with HIV/AIDS are unaware of their status, and new HIV infections nationally have not demonstrated significant declines. Approaches that utilize HIV treatment as prevention are increasingly recognized as a critical component of the HIV prevention toolbox. Studies have shown that individuals with suppressed HIV viral load have a low risk of transmitting HIV. Therefore, optimizing antiretroviral therapy (ART) coverage and viral suppression among HIV-positive individuals in large systems of care can be an effective mechanism to improve both individual health outcomes and reduce HIV transmission at the population level.

Our analysis included Ryan White (RW) patients utilizing HIV care sites funded by the Office of AIDS Programs and Policy (OAPP) from March 2009-February 2010. The unit of analysis was the most recent HIV-1 viral load (VL) for each patient. The mean and cumulative VL, along with the percentage of patients with an undetectable VL (<200 copies/mL) were mapped by resident zip-code, medical outpatient site, service planning area, and health district in Los Angeles County (LAC). Mean VL was further stratified by patients demographic, behavioral, and clinical characteristics. Multivariate logistic regression analysis was conducted to determine factors associated with detectable VL.

Among RW patients with at least one VL measure in that year (n = 12,725), 72% had an undetectable VL, and the mean VL for all patients was 16,798 copies/mL. ART coverage among patients with at least one medical outpatient visit was 94%, and 76% of patients on ART had an undetectable VL. ART use did not significantly differ by gender or race.

In multivariate regression analysis controlling for demographic, clinical, and behavioral factors, African-Americans were more likely (AOR = 1.49, CI: 1.31-1.70) and Asian/Pacific Islanders were less likely (AOR = 0.59, CI: 0.43-0.80) to have a detectable VL compared to Whites. Those who were more likely to have a detectable VL were patients whose household income was equal to or less than 100% of the federal poverty level (AOR = 1.23, CI: 1.11-1.36), patients who recently used substances (AOR = 1.37, CI: 1.19-1.58), and patients who were recently incarcerated (AOR = 1.31, CI: 1.11-1.55). Those who were less likely to have detectable VL were patients who were currently on ART (AOR = 0.63, CI: 0.53-0.76), patients retained in HIV care (AOR = 0.60, CI: 0.53-0.68), and patients with a CD4 count greater than 500 (AOR = 0.15, CI: 0.13-0.17).

Although ART coverage within the LAC RW system of care was high, results of the analysis demonstrate significant differences in VL by socio-demographic characteristics, behavioral risk group, and clinical status. RW patients who were African-American, living in poverty, used drugs, and were recently incarcerated were more likely to have detectable VL after controlling for ART use. These findings inform HIV prevention and testing strategies targeting populations at high risk for transmitting HIV.
Author(s): Carlos del Rio; Brooke Hixson; Emily McCollum; Takeia Horton; Jeffery Roman; Mary Helen Borck; Garcelia Burchell; Michael Banner

Poverty and lack of economic self-sufficiency are associated with HIV susceptibility and poorer health status among those living with HIV. In the US, while the GDP per capita is $47,000, 14% of people are considered living in poverty. In Baton Rouge and Atlanta this percentage is 17%. This pilot program focused on alleviating feelings of economic desperation among impoverished persons living in urban areas with HIV prevalence. This study aimed to assess the effectiveness of a financial education intervention on participants economic and social empowerment, expecting that positive outcomes from this pilot program would lay the foundation for a larger economic intervention such as an integrated microfinance and HIV prevention program.

The intervention programs, a series of economic empowerment/personal finance classes, were held in Baton Rouge, Louisiana (n=48 participants) and Atlanta, Georgia (n=15 participants) with persons living with and at-risk for HIV. Data were collected at baseline and at program conclusion via pre- and post-tests. Matched pairs t-tests were used to analyze change in general well-being, financial management skills, and feelings of self-efficacy.

In general, participants were African American (n=62, 98%), heterosexual (n=52, 83%), unemployed (n=46, 73%), and poor [defined as having an annual household income below $20,000] (n=53, 84%). While the Louisiana site was predominately female (n=33, 69%), the Atlanta site was comprised only of men. After participating in the program, Louisiana participants felt more positive about their lives (t=2.96, p=.005) and personal accomplishments (t=2.57, p=.014), were more confident in their ability to handle money (t=3.08, p=.004) and money records (t=5.66, p<.001), and were more comfortable discussing money with others (t=2.22, p=.032). Similarly, Georgian participants were more happy about their personal lives (t=3.67, p=.003) and felt more skilled at money management (t=2.58, p=.022).

This program increased feelings of self-worth and economic self-efficacy and may offer an important foundation for novel interventions focusing on addressing HIV prevention from a microfinance angle.

Abstract 1870 - DV and HIV Systems Learning to Support One Another  
Author(s): J Foster; A Nunez; C Robertson

Women who are survivors of domestic violence have an increased risk for HIV and STDs. Unless the survivors identifies concern about their sexual risk, the DV system will often ignore this aspect of their safety. The DV system often has little knowledge of HIV, the heightened risk their clients may present with, and how to deal with this. Similarly, the HIV system often knows little about how to screen for DV and how a positive screen may have implications for prevention services or medical care if the survivor is HIV+. Both systems know little about how to support one another.

The efforts of this project focus on both the DV and HIV systems. The project originated in Philadelphia, PA and is currently used in both Chicago and Louisiana. In the DV system, the intervention targets advocates, residential staff and counselors. In the HIV system, the targeted staff are HIV prevention staff, and case managers.

Over the past 5 years, through funding from the Office on Woman's Health, a project was developed which focuses on assisting both systems to work in support of one another. The DV staff are trained in HIV in the context of DV and the HIV staff are trained in DV in the context of HIV. HIV staff are then trained to teach DV staff how to provide sexual safety planning for their clients. The HIV staff then provide monthly check-ins to support DV staff in further developing their sexual safety planning skills.

Once the project moved beyond Philadelphia, the training has been delivered through distance training, allowing us to expand access to the project.
There have been significant results in both knowledge as well as change in behavior for the DV staff. For both the in-person and the distance training, DV staff increased their discussions about HIV, referrals for HIV testing and the development of sexual safety plans by 50-60%.

The HIV staff have applied the information about DV in their work. An additional lesson learned is the importance is educating HIV staff to think of sexual safety without condoms, due to the possible danger to survivors if they were to attempt to use condoms.

There have also been strong partnerships developed between the HIV agencies and the DV agencies, this has been particularly true at the distance sites, where the DV agencies indicated they often would refer directly to staff and would request additional training for DV staff in related topics.

**CCT3**

CCT3-2 - Learning from other struggles to strengthen our movement

**Room:** Spring (Hyatt Regency Atlanta)

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**Abstract 1762 - Harvesting our Diverse Strengths: Strategies for Successful Cross-Population Meetings and Processes**

**Author(s):** Julie Davids

Community mobilization on HIV prevention often requires reaching across lines of race, class, gender, professional training, educational level, faith and sero-status. With limited time and resources, how can we harness our differences to create stronger and more successful prevention efforts? The planning, conduct and follow-up of meetings of diverse stakeholders are key elements of community mobilization success. However, little support has been provided to ensure that meeting planners have a full range of skills and innovative options for productive, positive facilitation and participation across diverse groups.

The traditional setting for meetings, across a range of planning settings and geographies, is based on following an agenda, with specific times for formal presentation of information, discussion, debate, and decision-making. Innovative social leaders have developed a range of different tools for participatory "co-learning" environments that incorporate community/relationship building, storytelling and making room for unexpected outcomes that can spur unique outcomes and progress.

The HIV Prevention Justice Alliance (HIV PJA) is a national coalition of people living with HIV, advocates and organization united in our work towards improved HIV prevention policy in the United States. Our members have identified the need for improved and innovative strategies for cross-community alliances and meeting tools. We provide support for building the skills of a range of HIV prevention stakeholders (including people living with HIV, representatives of vulnerable and marginalized communities, policy-makers and service providers) to plan and hold successful meetings and sustaining diverse alliances and coalitions for mobilization and policy change.

The HIV PJA has found that twinning traditional training on meeting facilitation with innovative approaches such as "open space" can result in significantly increasing the capacity of prevention stakeholders to reach across boundaries of difference and develop new approaches for HIV prevention policy and implementation. Modeling these facilitation techniques in our own training has provided an engaging, successful mechanism for improving HIV community mobilization.

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**Track D**

D01 - Recent Experiences in HIV Risk Reduction with African American MSM

**Room:** Hanover C (Hyatt Regency Atlanta)

**Abstract 1542 - The Effectiveness of the POL Intervention on Young AA MSM in the Jackson Metropolitan Area**

**Author(s):** Christopher Roby
African American Men who have Sex with Men (AAMSM) are among the highest of all risk groups in the United States impacted by HIV/AIDS. In Mississippi, AA account for 37.01% of the state’s population according to the U.S. Census Bureau, while accounting for 73% of people Living with HIV as 2010. AAMSM are the subgroup most impacted by this devastating disease in the state of Mississippi, accounting for over 53% of HIV cases among reported exposure categories in the state. Due to this overwhelming increase of new HIV incidence in the state of Mississippi the CDC sent a team to the Jackson Metropolitan area to address the 20% increase from 2005 to 2006.

Data were collected through a pre and post-test assessment administrated by the Young Health Intervention for Men (yHIM) staff at My Brother's Keeper, Inc. before and after completing the POL intervention to test three hypotheses. The population was 48 YAAMSM ages 18-25 in the Jackson Metropolitan Area. The data were coded for input into various statistical procedures of the Statistical Package for the Social Sciences (SPSS-X). A paired sample t-test was conducted with the pre and posttest assessments. Statistical significance was determined at the .05 level of probability.

H1 :The mean score of the participant's HIV/AIDS Knowledge is higher in the posttest than in the pretest was tested. There was a mean score of 6.46 with a standard deviation of 1.145 on the pre-test and a mean of 7.41 with a standard deviation of .725 on the post test. A significant increase from the pretest to the posttest was found with a p<.005. H2: The mean score of the participants knowledge of the POL intervention and community are greater in the posttest then in the pretest. There was a mean of 3.16 on the pretest with a standard deviation of 1.068 and a mean of 4.38 with a standard deviation of 0.861 on the posttest. A significant increase from the pre to posttest was found with a p<.05. H3: The mean score of the participant's risky behaviors are lower in the posttest than in the pretest. There was a mean score of 24.23 with a standard deviation of 2.275 on the pretest and a mean of 21.38 with a standard deviation of 2.959 on the posttest. A significant decrease from the pretest to the posttest was found with a p<.05. All hypotheses were accepted and null hypothesis were rejected.

The findings surrounding this research showed the POL intervention to be effective among YAAMSM, ages 18-25, in the Jackson Metropolitan Area. Based upon the findings in this research it is deducted that individuals within social networks share similar behaviors, knowledge, and values. Therefore it's the recommendation of the researchers that this intervention be tailored and adopted to other parts of rural Mississippi with high cases of HIV prevalence among AAMSM.

Abstract 1732 - Outreach and Education to African-American MSM in Smaller Metropolitan Areas

Author(s): Vanessa Grandberry; Wendy Nakatsukasa-Ono

Many HIV prevention programs for African-American Men who have sex with men (MSM) are created based on studies in large metropolitan areas. Organizations in smaller metropolitan areas are tasked with using the same HIV prevention programs to reach their local populations. Smaller metropolitan areas discover many prevention programs designed to reach African American MSM are not transferrable without modification. Is it possible to modify these programs based in large metropolitan areas to reach African-American MSM in areas where African-Americans represent a smaller percentage of the population?

The African-American Testing Project (AATP) is an HIV testing and counseling program targeting African-American MSM. Brothers Link is an HIV Prevention program based on Many Men, Many Voices. Both programs are run through Center for MultiCultural Health (CMCH) in Seattle, WA. The two programs combine outreach efforts to reach African-American MSM in Seattle and King County in Washington State.

To create a new niche market for HIV testing and counseling, CMCH with Public Health Seattle/King County (PHSKC) created two new programs. First, the AATP was created with a slight modification from other testing programs. Secondly Brothers Link, a program based on the Many Men, Many Voices intervention created by the CDC. With other programs at CMCH clients were given the option to have their blood glucose and cholesterol checked while receiving other services. The existing cholesterol testing program would be connected to the new AATP and to Brothers Link.
AATP clients were allowed to receive cholesterol testing while also receiving HIV testing and counseling. Another modification to the testing would be an incentive with clients receiving cash for testing. The goal of the program was to reach African-American MSM through a widening of the outreach bandwidth. In addition high risk straight identified men were accepted into the program with the hope that some would identify behaviorally as MSM. In creating Brothers Link, CMCH chose to implement the intervention over weekend retreats. During retreats AATP staff would provide their services, making participants in Brothers Link eligible to receive the AATP incentives with the incentives received for Brothers Link.

Results: From January 2009 through December 2010 AATP tested 734 African-American men. Of those 328 were MSM either through identity or behavior, and 406 were heterosexual. 93 African-American MSM participated in one of 8 Brothers Link retreats during the same period of time.

Lessons Learned: When creating HIV prevention services for African-American MSM in smaller metropolitan areas an organization must discover or create a specific niche. By combining outreach of the AATP and Brothers Link, men who may have identified as heterosexual but behaviorally as MSM were given the opportunity to qualify for the Brothers Link retreats. Many of these men discovered AATP and Brothers Link through the outreach efforts and through word of mouth about incentives.

Abstract 1800 - North Carolina MSM Task Force and Safe Space Initiative

Author(s): Constance S. Jones; Douglas K. Griffin; Martha S. Buie; Jacquelyn M. Clymore; Evelyn M. Foust

Minority men who have sex with men (MSM) are disproportionately bearing the burden of new HIV disease diagnoses and syphilis in NC. In 2009, the highest rate of HIV disease was among adult/adolescent, black males (106 per 100,000). This rate was more than eight times greater than the rate for adult/adolescent, non-Hispanic white males (13 per 100,000). Also in 2009, NC experienced a significant outbreak of new syphilis cases (an 84% increase in cases over early syphilis cases reported in 2008).

The proportion of male syphilis cases co-infected with HIV was 45 percent. Persons with ulcerative STDs, are more likely to transmit HIV if they are positive, or to become infected with HIV if a sex partner is HIV positive. In March 2010, NC established a statewide Syphilis Elimination Response Team (SERT) which included an education and testing campaign, intensified partner notification efforts and non-traditional approaches to better access and engage the MSM population. Traditional approaches to accessing this population remains enormously challenging in the Deep South, where MSM community members continues to report discrimination, homophobia and stigma, which are commonplace and create barriers to prevention and care.

The SERT created a statewide MSM Task Force to address the serious concern that there may be subsequent increases in HIV and Syphilis morbidity in NC. The seven regional teams that comprise the task force are establishing safe Spaces and plugging into existing MSM social networks, and supporting activities around HIV/STD prevention.

Members of the statewide MSM Task Force include MSM community volunteers, community based and AIDS service organizations, and state and local HIV/STD personnel. The primary goal of task force members is to identify and support safe Space activities and venues in their geographical areas, solicit topics of interest from the community for discussion, and to provide useful health information and critical linkage to health care for those in need.

More than 600 MSM were reached from May 3, 2010 through January 31, 2011 during events sponsored and supported by the MSM Task Force. The events included the Charlotte/Raleigh Black Gay Pride Expo, the NC Gay Pride in Durham, the D-Up Clash of the Champions House Ball, an Evening of Hope with Jeanne White-Ginder, Dinner and a Movie nights, Freaky Fridays, the Pink Bash social mixer; and, awareness sessions which focused on domestic violence, substance abuse, and interpersonal relationships. Accessing the minority MSM community in NC is often hindered by the experiences of MSM who daily face homophobia, stigma, isolation, and fear. Effective prevention interventions must be able to access existing MSM social networks, fill knowledge gaps about sexual health and relationships, utilize current technologies, provide practical information about self esteem and access to resources. These elements are critical in order to make a difference in the lives of these MSM and help reduce the rate of HIV and syphilis in this population.
Abstract 1993 - Lessons Learned from a Retreat on Retention of Black MSM in the BROTHERS Study

Author(s): Christopher C. Watson; Gregory D. Victorianne; Johnathan P. Lucas; HPTN 061 Black Caucus Members

Black MSM are disproportionately affected with HIV despite having lower prevalence of sexual risk behaviors than their white counterparts. The underrepresentation of African American MSM in HIV research highlights the urgent need to obtain specific information about the diversity of Black MSM cultures while finding ways to recruit and more importantly retain them in research studies. HPTN 061 offers a unique opportunity to characterize the epidemic among Black MSM if we can find creative ways to retain them in the study.

The retention retreat was held at the National Conference Center in Leesburg, Virginia from the evening of Friday December 3, 2010 - Sunday December 5, 2010 with a charge to assess the current retention trends of the study to identify barriers and other issues and to come up with recommendations to improve the retention of participants in the study.

The BROTHERS (HPTN 061) study is a community-level pilot study being conducted in 8 US communities to determine the feasibility and acceptability of a multi-component HIV-prevention intervention with African American MSM recruited through various social marketing campaigns coupled with venue based recruitment techniques. The participants of the retention retreat consisted of most of the members of the HPTN-061 Black Caucus and a few invited guests. In all a total of 18 individuals participated in the retreat. The retreat was organized in a manner that would facilitate open dialogue, and the stimulation of ideas using a working group model to draw on the collective wisdom of those assembled.

The issues and concerns that emerged from the group process were collapsed into three major areas of focus: (1) Burden/Benefit Analysis, (2) Intervention Delivery, and (3) Community Engagement. Specific recommendations to address the various retention issues were developed from these three key over-arching focus areas. Recommendations were further categorized as being immediately implementable or longer term. Black MSM have competing demands and prioritize their lives differently than do other MSM populations. Successful retention of Black MSM in HIV research must be planned for proactively and not as an afterthought. The benefits of participation must outweigh the burden and this is not always clear in the lives of Black MSM. Issues of the intervention such as length of interviews, clinic hours, transportation, and compensations must be looked at differently for Black MSM. Finally issues surrounding the historical mistreatment of Black men, racism, and homophobia must also be about of an effective retention plan for Black MSM.

Track D

D03 - Changing DEBI's Wardrobe: Adapting Evidence-Based Interventions to Related, but Distinct, Audiences

Room: Hanover F/G (Hyatt Regency Atlanta)

Abstract 1421 - CHICAS Program: Adapting SISTA to Meet the Needs of Latina Transgenders in Los Angeles County

Author(s): Lelenia Ramirez-Navarro

In Los Angeles County 4.93% of transgender individuals who took an HIV test in 2007 received a positive test result for the first time, compared to 1.35% of all tests administered. Additionally, during the 2007 HIV Counseling and Testing Week transgender individuals who tested had a 14.3% positivity rate. Transgender individuals are disproportionately represented among new HIV-positives and among individuals who access HIV testing.

The Chicas intervention is intended to serve Latina transwomen in the eastern and southeastern portions of Los Angeles County. Outreach is conducted throughout the community and group sessions are held at community centers (i.e. community room at public use space).
Chicas is an adaptation of SISTA which addresses the lives of Latina transwomen. A few key adaptations for Latina transwomen include a discussion on what it means to be transgender utilizing the trans umbrella, modifying the scenarios to ones that transwomen can relate to and adding a discussion about drugs use and sex. These adaptations were based on formative evaluation with Latina transwomen. Additionally, the T-SISTA: A Resource Guide for Adapting SISTA for Transwomen of Color and the Resource Guide for Adapting SISTA for Latinas were utilized to guide the adaptation process. Chicas is delivered in 5 sessions corresponding with the original SISTA sessions. The group is conducted twice a week over a 3 week period. A Latina transgender staff facilitates the group alongside a volunteer peer-facilitator. We offer HIV counseling and testing (HCT) services at each session as well as referrals to social and medical services. We conduct monthly social events that discuss different topics that clients have shown an interest in (i.e. immigration law, housing etc.). A 30-day follow-up is conducted with each client.

During October 2009-January 2011 we conducted 279 outreach encounters of which 61 were linked into a service (Chicas group, HCT or STD testing). During this time we conducted 7 groups with a total of 71 Latina transwomen enrolled. Sixty two participants completed the intervention, an 87% completion rate. At the conclusion of each session an evaluation form is distributed to each participant. Participants are asked to rate the statements on a scale from 1-100 with 100 being excellent. Below are the average responses:I feel more pride in myself as a Latina transwomen(96); I am confident I can start a discussion about condom use with my partner(94); I am confident I can apply these coping skills in my life(99).

The Chicas intervention which was adapted from SISTA is an appropriate and valuable HIV prevention intervention for Latina transwomen. Participants reported increased confidence in reducing their HIV risk. A strong connection between the group facilitator and the participant, and providing a structured group setting has proven to impact the clients and keep them engaged in the Chicas group.

**Abstract 1554** - Implementing Community PROMISE with Older Adults at Risk and Older Adults Living with HIV

**Author(s):** Luis Scaccabarozzi; Hannah Tessema

Nationally, according to the CDC, people over the age of 50 now account for almost 27% of those infected with HIV, and they comprise the fastest growing segment of the HIV-positive population. By 2015, half the people living with HIV in the U.S.A. will be over 50. In New York City the epidemic's North American epicenter and a strong predictor of national trends a third of the city's 100,000-plus infected individuals are over 50, and the proportion is growing steadily. Older Adults lack targeted HIV primary and secondary prevention information. Currently none of the CDC-funded prevention interventions or programs specifically target older adults.

Targeted high-HIV incidence areas in four boroughs in NYC (Manhattan, Queens, Brooklyn, and the Bronx).

A NYC Council- and NYC Department of Health and Mental Hygiene-funded demonstration project on HIV and Older Adults that includes a tailored version of Community PROMISE, targeting older adults living with and at risk for HIV, now in its third year, Community PROMISE reaches primarily MSM and transgender of color and women of color and is conducted in English and Spanish.

Over 20 Role Model Stories (RMSs) have been developed in English and Spanish targeting women of color, MSM, transgender individuals, and high-risk heterosexual men. Over 80 senior peer educators have been trained in 3 years, maintaining a consistent team of senior peers. Over 5,000 older adults have been reached in New York City, with over 2,000 of them tested for HIV.

**Lessons Learned:**

HIV-positive people over 50 are largely stigmatized by HIV-phobia, homophobia, and ageism. Integrating HIV treatment and are into the RMSs has been essential in targeting older adults living with HIV. Social isolation and loneliness are important factors to take into account when developing RMSs targeting older adults at risk for and living with HIV.
Low perception of risk, lack of knowledge of HIV, and poor condom use skills among older adults places many at risk for HIV and STDs. Important factors influencing behavior that need to be taken into account when developing RMSs for older adults include: perceived susceptibility, self-efficacy, communication and negotiation, positive and negative moods, cultural norms about sexuality and gender roles, and social inequities.

Abstract 1798 - The Adaptation of an Evidence-based HIV Intervention for Latinas: A Community-based Approach to Research Practice

Author(s): Gina M. Wingood; Ralph J. DiClemente; Kira Villamizar

The CDC encourages health departments and community-based organizations to use evidence-based behavioral interventions in their HIV prevention programs. In practice, service providers frequently adapt these interventions to encourage community ownership and increase their acceptability and uptake by community members. Yet, few of these community-based adaptations have been assessed for efficacy.

The AMIGAS HIV sexual risk-reduction intervention was implemented at the Miami-Dade County Health Department, Office of HIV/AIDS.

The development and assessment of AMIGAS, an HIV prevention intervention for culturally and ethnically diverse Latinas. AMIGAS is a linguistic and cultural adaptation of SiSTA, a widely disseminated HIV prevention intervention that was originally developed for African American women. The adaptation process used the ADAPT-ITT model.

From October 2008 to October 2009, a total of 252 Latinas 18-25 years of age were randomized to the 4-session AMIGAS intervention or a 1-session general health comparison. Participants completed ACASI assessments at baseline and 3- and 6-month follow-ups. Over the entire 6-month follow-up period, AMIGAS participants reported greater self-efficacy for using condoms and negotiating safer sex, and more consistent condom use. This is the first linguistic and cultural adaptation of an HIV sexual risk-reduction intervention by a health department to demonstrate efficacy among Latinas. Key contributing factors to this success were high levels of commitment and effort by health department staff throughout the process, and a strong partnership and effective collaboration with other community agencies, university-based researchers, and the funding agency (CDC). The experience of adapting and assessing the efficacy of AMIGAS enhanced the health department's capacity to conduct future HIV prevention-related research. Greater efforts are needed to engage health departments and other community-based agencies in conceptualizing, adapting, implementing, and evaluating HIV prevention interventions.

Abstract 1820 - YEP: Empowering Young MSM of Color in Phoenix

Author(s): Bridget White

In Phoenix, many young MSM of color (YMSMC) face a triple threat of stigma because of their sexuality, race/ethnicity, and socio-economic status. The combined effects of these factors put YMSMC at high risk for contracting HIV/AIDS. With 34% of new HIV/AIDS infections occurring in persons aged 13-29 (www.cdc.gov), it is critical to empower these youth with the knowledge, skills, and mindsets they need in order to make healthy decisions.

The core activities of the Youth Empowerment Project (YEP) take place in a project space called the YEP House, a 1500-square foot space centrally located in downtown Phoenix.

YEP is a CDC-funded intervention provided by the collaborative effort of Native Health, Southwest Center for HIV/AIDS, and Valley 1n10. YEP provides a safe and welcoming space where at-risk youth ages 14-24 engage in an adaptation of the MPowerment Project, in which youth support each other in making healthy lifestyle choices and building community. Daily activities include practice for youth-led performance groups and sports teams, GED classes, advocacy group meetings, and risk-reduction counseling.
Thanks to continuous improvements in communication among the three collaborating agencies, the agencies commitment to the youth targeted by this project, and the dedication of the youth themselves to their and their friends health and well-being, YEP has experienced great success in providing a safe and empowering space valued by youth as place where they feel at home. During each month in 2010, YEP had an average of 275 youth contacted by outreach and an average of 120 unduplicated youth visits to the House, 70% of which were by young MSM of color. Furthermore, an average of 17 new young MSM of color attended the House for the first time each month in 2010, thanks mostly to word-of-mouth informal outreach conducted by our youth in their schools, communities, and circles of friends. The adoption of safer sex practices and healthy decision-making is evident in conversations among the youth, their willingness to engage in testing, and the completion of their risk-reduction goal plans.

The YEP collaborative has learned a great many lessons that have helped inform our decisions and develop best practices for working with at-risk youth. First, future efforts to provide an intervention for the young transgender population must take into account that many young people do not identify with the transgender label and that marketing for the project must reflect that fact with creative approaches to reaching this population. A second lesson is that the success of risk-reduction counseling depends heavily on the counselor's relationship with the youth and the adaptability of the counselor-his/her ability to flexibly meet clients needs outside a traditional clinical structure. Lastly and perhaps most importantly, Mpowerment's holistic approach to HIV prevention and therefore the social, inclusive nature of the YEP House have proven highly effective in attracting youth to the project, building their trust, and popularizing the importance of safer sex practices.

**Track D**

**D05 - A Look in the Mirror: Identifying and Overcoming Provider Barriers to the Delivery of Effective HIV Prevention and Care**

**Room: Hanover D (Hyatt Regency Atlanta)**

**Abstract 1501 - HIV Testing Secret Shopper Project: Indiana's Community Participatory Research Model**

**Author(s):** Beth Meyerson; Andrea Perez

Do we really know how HIV testing services are experienced by those who use them? Asking someone to report about their experience with testing would burden an already worried individual. Recall from people who have tested in the past year for HIV may also help, but the information may be skewed by time. Quality assessment visits by funders may also help, but the perspective is not from the point of someone accessing the service. Client satisfaction surveys have potential if not threatening future services.

A community participatory research model was developed in November 2010 to evaluate Indiana HIV testing sites using secret shoppers. This presentation will discuss how this model was developed and how communities can replicate this evaluation method. The HIV Testing Secret Shopper Project is an example of a participatory research project. Community participants determined and conducted all aspects of the project: research goal, methodology, implementation and data analysis. The consultant researcher facilitated the project and helped to develop community capacity to replicate projects of this kind.

Thirty HIV-negative community researchers were selected as secret shoppers to be tested for HIV at the 33 sites funded by the Indiana Department of Health. Community researchers reflected the demographics and experiences of service populations. In February 2011, each site will receive visits from three different community researchers over a three week period. Community researchers will evaluate: messaging and provider communication (including stigmatization), access to services (cultural/linguistic, availability, setting, appropriate, referrals), and whether they would return for a future test. Phone follow up of referrals provided in response to the researchers visit story will provide a random test of the referral network.

This project emerged from Indiana's new HIV Prevention Research Agenda. Provider behavior was one of six priorities. The CPG wanted to explore how providers facilitate/inhibit access to comprehensive prevention services, and the impact of service location and organization. This project emerged from community discussion about how provider behaviors could best be understood through new eyes. The CPG wanted to apply knowledge gained from
HIV testing visits to improve testing through program and policy change. Contracted HIV testing sites were the initial focus, and there are plans to expand to other testing sites as well as other prevention services over time.

This project was the first community participatory research experience for the Indiana CPG. Lessons learned from this experience will be shared. While there was excitement over the prospect of gaining new insight about HIV testing access, there was concern that providers would feel targeted. The language of secret shopper was replaced by HIV Testing Visitor. As the community wanted to test this model for its value and replication potential, great care was taken to assure that community researchers had no current or prior relationship with test sites as a staff member, volunteer, funder or as partner to someone who had these connections. There was tremendous learning about how communities can take ownership and direct their own research project, as there was a history of deference to academic researchers.

Abstract 1817 - Mainstreaming Language Access in Healthcare Facilities

Author(s): Dina Refki; Maria-Paz Avery; Angela Dalton; Richard Cotroneo; Wilma Waithe; Dara Shapiro

With New York State's foreign-born population reaching approximately 3.9 million in 2000, AIDS service providers across the state are facing major challenges in communicating effectively with their immigrant, Limited English Proficient (LEP) patients. The research literature suggests that there are several important determinants of institutionalization of linguistic access. These factors include (a) leadership commitment; (b) workforce diversity; (c) availability of systemic data collection of LEP patient linguistic needs in the community; (d) understanding and enforcement of policies, procedures and processes for language access; (e) strategic planning; and (f) partnership and collaborations with community-based organizations (Wilson-Stronks, & Galvez, 2006). A multi-level research project was undertaken to contribute to advancing the institutionalization of language access by examining the conditions that have been identified as critical to providing effective language assistance for LEP patients, and by identifying strategies that can alleviate barriers to creating these ideal conditions. The research provides a conceptual framework to enable the mainstreaming of language access. In addition, to help healthcare facilities institutionalize language access, a list of core competencies for medical interpreters are developed through gauging the perspectives of interpreters in the field.

This study gauges the perspectives of program planners, practitioners, healthcare professionals, administrators and front-line workers about best practices and promising strategies that can facilitate the adoption and institutionalization of language access in health care. A focus group and a strategy roundtable were conducted. Findings informed the development of a conceptual framework for mainstreaming language access into the operations of healthcare facilities. The development of a preliminary list of core competencies was informed by an extensive consultation of literature, a review of healthcare interpreter training curricula, and solicitation of the perspectives of curricular developers, interpreters, policy makers, health administrators and healthcare providers. Two survey instruments with both close-ended and open-ended questions were administered to examine the attitudinal and perceptual consensus and difference between two cohorts of respondents: healthcare interpreter trainers and curriculum developers, and practicing interpreters and interpreters-in-training, regarding the core competencies essential to providing high quality health care interpreting training. Telephone and in-person follow-up interviews were conducted with trainers and interpreters to gather additional insights into language access education and service delivery.

The Framework covers four areas of functionality within organizations; (a) policies, protocols, goals & objectives; (b) systems & infrastructure; (c) service systems & organizational characteristics; and (d) evaluation mechanism. The list of core competencies that fall under three categories: Knowledge Base; Skill Base; and Professional Attributes.

Findings of this research suggest that effective and sustainable implementation of language access in healthcare settings depends on mainstreaming language access into exiting systems, operations, policies and protocols. The conceptual framework ensures the successful and synergistic integration of language access. With the rising number of LEP individuals, the increasing emphasis on making HIV testing a routine part of medical care and increasingly complex medical protocols for people living with HIV, progress in mainstreaming language access is critical to the success of our HIV prevention, testing and health care services.
Abstract 1959 - Changing Provider Attitudes to Improve Engagement of Black MSM in Prevention Programs

Author(s): G.F. Campos; D.K. McCurdy; A. Gandelman

The escalating HIV disparity in Black MSM in the US continues to be of great concern for many state health departments. A survey conducted by the Louisiana State Health Department uncovered a need for cultural competency training for providers working with Black MSM. A CBA request was made to the California Prevention Training Center to help improve providers understanding of challenges Black MSM experience that impact risk behaviors and access to services. The goal of this project was to change knowledge and attitudes in order to improve implementation of, and access to HIV prevention services for African American MSM.

Sixty three HIV prevention providers attending a state-wide conference in New Orleans and Metairie attended one of three trainings, sponsored by the Louisiana State Health Department.

We developed a one day training using survey results from Louisiana providers, recent data and research about the social context unique to Black MSM, and existing CAPTC curriculum on this topic. Pre-course assessments indicated 73% (N=33) of participants believed multiple sex partners accounted for the disproportionate HIV rates among Black MSM, vs. 27% due to homophobia. Apathy/denial in the MSM community (42%) and difficulty accessing MSM (38%) were identified as primary provider challenges. Trainings covered the social context of disparity among Black MSM, including the impact of stigma, homophobia and racism. A holistic asset-based assessment comprised of strength-based strategies was also presented as means to respond to the stigma and blame many Black MSM experience from their communities and providers.

Participants who completed training evaluations (n=46) demonstrated significant increases (p<0.05 for all items) in their perceived ability to use strength-based counseling techniques, identify strategies to improve prevention work with MSM, and understand the social factors that influence risk behavior among Black MSM. These increases were maintained at 3-month follow-up. Participants also stated intentions to better reach MSM (33%) and begin using strength-based approaches and tools (28%). At follow-up 42% of respondents stated that multiple sex partners accounted for high rates of HIV in MSM (31% decrease from baseline), and 39% due to homophobia (12% increase from baseline). Respondents also identified how they incorporated the training into their work, including better engaging the MSM community (28%), using new strategies (23%), demonstrating more sensitivity (23%), and considering larger structural changes (14%). Participants requested additional training/TA in working with PLWHIV, young MSM, and transgender communities.

Lessons Learned:
Training can shift HIV provider attitudes and change intentions to engage Black MSM in HIV prevention services. Consideration of structural changes for HIV prevention was also discussed. Providers recognize the need to address relevant social contexts and assess prevention challenges using a holistic, asset-based approach. Additional training and technical assistance is recommended to more effectively respond to stigma and work with heterogeneous MSM communities, including African-American MSM.

Abstract 1975 - Continuum of Services: From Preliminary Positive to Primary Care

Author(s): Mark Drake, LCSW

Linking newly identified positives to care must be the cornerstone of a counseling and testing program. High positivity rates and large annual test numbers lose their ability to impress when rates of linkage to care are low. A well-coordinated client management system utilizing secure technology improves linkage to care rates in a community based setting.

Community based organization with a large-scale counseling and testing program and primary medical care onsite. Over 3,000 tests are completed annually with a consistently high (~3%) positivity rate. Linkage to care is managed by Counseling and Testing Coordinator and Wellness Manager.
NO/AIDS Task Force (NATF) has successfully created an electronic tracking system to help newly identified positive clients get into care. The Counseling and Testing Coordinator (C/T) and Wellness Manager monitor this tracking system. During pre-test counseling, client is informed of the process of getting into care, how it works, and why it's important to access care. Upon delivery of preliminary positive result, the client completes the confirmatory test and is notified that the Wellness Manager will contact the client when the confirmatory result is received. Wellness Manager works with primary medical care to schedule the client for his/her first medical appointment within two weeks of receiving confirmatory result. C/T and Wellness Manager keep track of all new positives in a shared, secured database. Information in the database includes: testing number, client first name, confirmatory lab number, date of preliminary test, date of confirmatory test, date client received confirmatory result, date of client's first scheduled medical appointment, date client attended first medical appointment, date client completed case management paperwork, and a section for notes (reason(s) client did not make appointment, client seeking care elsewhere, etc). Once a client is enrolled in care, the Wellness Manager is able to access medical records to ensure the client has made appointments and is adhering to care.

The database allows us to track clients along the stages from C/T to care in order to increase retention and ensure access of HIV related services. Our loss-to-follow up with clients has decreased as tracking of clients has become more efficient. Throughout the years, over 90% of clients testing preliminary positive through NATF are known have enrolled in primary medical care. Since the agency tests nearly 3,000 individuals annually, with a consistently high (usually around 3%) positivity rate, tracking clients from testing to care makes for accurate and efficient monitoring and reporting of testing data. By creating a secured, electronic database, NATF has been able to successfully follow clients as they travel through the continuum of HIV services from preliminary positive to primary medical care. Both the C/T and Wellness Manager can update and modify the database from any of our offices, at any time by logging on to the secured database. Linkage to care does not require the creation of a unique position within a counseling and testing program to increase retention and ensure access of HIV related services. Two fulltime employees, working closely together using simple technology can achieve high results.

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**Track D**

**D27 - Harnessing the Power of Faith-Based Communities to Address HIV**

**Room: A707 (Atlanta Marriott Marquis)**

**Abstract 1330 - Working Together: Fostering Collaborative Relationships Between Faith Communities and HIV/AIDS Service Providers**

**Author(s):** James Tesoriero; Alma Candelas; Dan O'Connell; Susan Gieryic; Bethsabet Justiniano

Fostering collaborative partnerships between faith communities and HIV/AIDS service providers to advance HIV prevention and health care efforts is a goal of the New York State Department of Health (NYSDOH) AIDS Institute (AI) Faith Communities Project (FCP). In 1997, the NYSDOH AI conducted a statewide survey to assess existing HIV prevention activities in faith communities and their willingness to work with HIV Prevention Specialists. The creation of the FCP was in direct response to the survey results. However, the willingness of AI contractors to partner with faith communities around HIV prevention activities was not assessed. In 2008, eight years after a community level intervention was implemented, a survey was administered to AI funded contractors to evaluate existing practices.

The AI FPC worked with the Office of Program Evaluations and Research (OPER) to revise and mail survey to community-based organizations and health care providers funded to provide HIV prevention, supportive services, health care, and treatment to persons impacted by HIV/AIDS. Targeted AI funded contractors in NYS.

A statewide survey, similar to the one that was administered to faith communities in 1997, was modified and mailed to AI funded contractors to gather information on existing faith based HIV prevention activities; assess their willingness to work with faith communities, and identify barrier or challenges to establishing and sustaining collaborative relationships with faith communities to advance HIV prevention and health care efforts.

In 2008, surveys were completed by 171 (60.0%) of the 283 HIV/AIDS service agencies contacted. The majority of statewide surveys returned were from urban areas (84%). A little more than half of all agencies (52.3%) provided
HIV-related education/prevention services to faith-based organizations. The type of services provided most often were HIV literature distribution (73.4%), On-site HIV/AIDS education (73.4%), off-site HIV-AIDS education (69.6%) and HIV testing (65.8%). AI funded contractors serving black communities were more likely to report providing services to faith-based organizations. A little more than half (51%) of agencies have heard of the FCP, with 38.3% participation in one or more FCP events. Encouragingly, almost all (95%) of agencies were "Very Interested" (57.8%) or "Somewhat Interested" (37.3%) in providing HIV-related education/prevention services to faith-based organizations. However, agencies stated that the lack of resources, volunteers, and staff and failure to receive approval from faith leader(s) in the community to implement HIV/AIDS prevention activities are the main barriers to providing HIV/AIDS prevention programs to faith organizations.

Lessons/Conclusions: The AI contractors were very or somewhat interested in working with faith communities. On-site HIV/AIDS education, and HIV testing are services currently provided to faith communities. Lack of approval from faith leader(s) and limited resources are barriers to partnership development. Partnership building activities between faith communities and HIV/AIDS service providers are essential to reach vulnerable communities most impacted by HIV/AIDS. Working together fosters greater understanding of issues and best practices for a successful HIV prevention and care services framework. The FCP offers a unique opportunity for HIV/AIDS service providers to leverage the additional resources necessary to initiate and sustain partnerships with faith-based organizations.

Authors: Makeba D'Abreu; Pernessa Seele

Research has shown that faith institutions can effectively address the health concerns of Blacks. However, faith institutions sometimes lack the capacity and experience to effectively address these health concerns. Local and state health departments as well as community-based organizations (CBO’s) and AIDS Service Organizations (ASO’s) do not always have the cultural competence and experience needed to assist faith institutions in addressing these health concerns. A program is needed that would not only help build the capacity of faith institutions to address HIV/AIDS in their respective communities, but also build the capacity of health departments, CBO's and ASO's to mobilize, train and equip the faith community in a culturally competent manner, to address HIV/AIDS.

Community Based Organizations, Health Departments and Faith Based Institutions throughout the United States and Dependent Territories

The National Week of Prayer for the Healing of AIDS (NWPHA) is an integral part of the Balm In Gilead's Faith Community Mobilization Model. The Faith Community Mobilization Model includes the following stages: awareness, engagement, capacity development, community mobilization and advocacy. The Balm In Gilead seeks to create awareness among its churches through the promotion of the National Week of Prayer for the Healing of AIDS (NWPHA). Through its promotion, individuals learn about the prevalence of HIV/AIDS. During the engagement stage, faith institutions are encouraged to develop programs that would address HIV/AIDS. During the Community Mobilization stage, the church is charged to create community partnerships or mobilize the faith institutions to address HIV/AIDS. During the Advocacy stage, the Balm In Gilead provides technical assistance to support faith institutions as they collaborate and utilize their collective bargaining power to influence policy and policy makers.

The National Week of Prayer was first launched in March 1988 as the Harlem Week of Prayer with 50 churches in Harlem, New York City. It has since evolved to reach an estimated 29,000 churches in throughout the U.S., the Territories and England. A program that was first intended reach Christians of African descent is now reaching people from diverse backgrounds who represent over 20 religious backgrounds. Over 300 health departments, AIDS Service Organizations and other community-based organizations, have partnered with the Balm In Gilead to launch their own NWPHA locally. Most faith institutions that participate in the National Week of Prayer are from the South (34%) or Northeastern (30%) parts of the United States and represent Baptist (25%) and AME (18%) Christian denominations. The Balm In Gilead has successfully used the Community Mobilization Model to encourage churches to participate in the National Week of Prayer:
1. Implementing a system to monitor and follow-up with church's participation is crucial to monitoring the NWPHA.
2. More churches in the Midwest and Northwest should be encouraged to participate in the National Week of Prayer for the Healing of AIDS
3. Utilizing the existing African American Denominational Health Initiative structure will assist the Balm In Gilead in its promotion of the National Week of Prayer for the Healing of AIDS

Track D
D30 - Expanding Evidence-Based HIV Prevention Activities among Transgender Persons
Room: Hanover E (Hyatt Regency Atlanta)

Abstract 1205 - DEBs for Young Transgender Persons of Color: Operational Research to Identify Successes and Challenges
Author(s): Melanie Sovine, PhD; Deborah Gelaude, PhD; Robert Swayzer III, DrPH; Jeffrey Herbst, PhD

Transgender communities in the United States experience high rates of HIV/STD infection. Social isolation, stigma, discrimination and victimization increase the likelihood of transgender persons engaging in unsafe behaviors and present unique challenges for HIV prevention service delivery. A 2008 meta-analysis of 20 studies found an HIV seropositivity rate of 56% among African American male to female (MTF) transgender persons, and elevated rates for Latino (16%) and White (17%) MTF persons. To address the HIV prevention needs of transgender persons of color, CDC funded CBOs to deliver HIV prevention programs to this population. Only CBOs with prior experience or capacity to deliver services to transgender populations were selected for funding, and all CBOs received training and technical assistance to deliver evidence-based behavioral interventions supported by CDC's DEBI project. The goals of this presentation are to (1) identify challenges and issues encountered by implementing CBOs, and (2) describe a framework of support that can result in improved implementation of interventions to young transgender persons of color.

Five CBOs received funding to deliver HIV prevention programs for young transgender persons of color aged 13-24 under a 5-year cooperative agreement with CDC from 2006 to 2010. All CBOs were located in metropolitan statistical areas with the highest reported HIV/AIDS incidence and prevalence among young men of color who have sex with men (Note: surveillance statistics for transgender populations are currently not available for all jurisdictions). DEBI programs included SiSTA (2 CBOs) and Mpowerment (3 CBOs).

Operational research was conducted to systematically review 4 years of annual progress reports (APRs) submitted by the CBOs as part of a required CDC reporting process. Data from APRs were abstracted using a qualitative content analysis approach to identify patterns and themes. Internal CDC and grantee communications, interim progress reports, site visit reports, and technical assistance/program monitoring reports were also reviewed.

Results: The qualitative analysis identified challenges and successes implementing programs with this population. Grantees consistently struggled with effectively relating the DEBI programs to meet the unique needs of the target population. Other specific challenges included building trust and rapport with community gatekeepers, hiring culturally appropriate staff, having the capacity to adapt programs for young transgender persons of color, and being able to meet non-HIV-related needs such as housing, food, substance-use treatment, and medical care. Factors associated with successful program delivery included the establishment of a safe space for participants, and being able to access technical assistance offered by CDC and other capacity building support services.

Lessons Learned: Three areas for further research include: (1) increasing target population readiness for highly structured DEBI interventions, (2) identifying aspects of grantee organizational structure and capacity to facilitate service delivery with young transgender persons, and (3) improving peer leadership and advocacy when working with transgender populations.

Abstract 1375 - Adapting Safety Counts for High-Risk Transgender Women
Author(s): Martin J. Downing, Jr., PhD; Rosemary C. Veniegas, PhD; Kiesha McCurtis, MPH; Cathy J. Reback, PhD
HIV/AIDS infection and transmission is a primary health concern for many transgender women (TGW) in Los Angeles County (LAC), California. A recent study revealed that 52% sampled from service programs in LAC reported an HIV-positive serostatus (Edwards et al., 2007). The risks for HIV among this population are influenced by several co-factors including substance use, unemployment, and transphobia. As a result of their marginal socioeconomic status, many TGW engage in high levels of substance use, hormone misuse, sex work, and unprotected sex. While the risks are staggering, there are currently no evidence-based interventions (EBI) targeted to TGW, and the National HIV/AIDS Strategy calls for a renewed focus on prevention for this population. Furthermore, the LAC HIV Prevention Plan recommends that curricula for TGW be tailored to meet their unique needs and address the multiple co-factors influencing their risk.

A community-based HIV prevention setting in Hollywood, CA located in the hub of the sex work district for TGW, and identified as a hot spot area of emerging HIV prevalence.

Safety Counts is a cognitive-behavioral intervention that has been effective in reducing high-risk sexual and drug-use behaviors among injection and noninjection drug users. Through a series of structured group and individual sessions, this program assists participants in developing risk reduction goals and the necessary steps to achieving them. Intervention staff encourages HIV and hepatitis testing, provides community referrals, and reinforces the importance of social support. Consistent with procedures (action steps outlined by the CDC in their Map of Adaptation Process (MAP) for adapting EBIs (McKleroy et al., 2006), the concept of implementing Safety Counts for high-risk TGW resulted from collaboration with members of the target population through a series of development meetings and focus groups.

Adaptations to the original intervention were developed under the guidance of a newly-formed local advisory board. The key characteristics modified include: expanded eligibility, HIV and hepatitis curriculum tailored to the risk factors and needs of TGW (e.g., sex work, hormone misuse, transphobia, being clocked, and culturally sensitive data collection forms that identify TGW risk behaviors). These modifications have strengthened the appropriateness of Safety Counts for high-risk TGW while maintaining the core elements, theoretical basis, and internal logic of this intervention. Additionally, the adapted intervention now includes referrals and resources relevant to TGW (e.g., hormone therapy, employment assistance) and success stories by members of the LAC transgender community. Because success stories are an integral component to encouraging risk reduction during structured group sessions, the adaptation offers all TGW who complete the four-month intervention an opportunity to video-record their personal success story for use in future Safety Counts cycles.

LESSONS LEARNED: The MAP is invaluable for agencies considering adapting an EBI. Having assessed, selected, and prepared Safety Counts for high-risk TGW (Action Steps 1-3), the adapted elements are pilot tested (Step 4) before full implementation (Step 5) to ensure feasibility and efficacy of the intervention. Furthermore, CBO's should consider those variables required for reporting by the funding agency when modifying any data collection forms.

Abstract 1695 - Trans-experience and Sexual Health in Underserved Communities
Author(s): Renato Barucco; Luis Freddy Molano

Access to healthcare, support services, and educational initiatives targeting the transgender community in underserved urban areas is deficient with very few agencies nation-wide able to provide culturally appropriate services. It is very important for service providers to recognize the specificity of the transgender communities and provide adequate services.

Community Healthcare Network (CHN) is a not-for-profit organization that provides access to affordable, culturally-competent and comprehensive community-based primary care, mental health and social services for diverse populations in underserved communities throughout New York City. The Transgender Program was implemented at CHN - Bronx Health Center in 2004 to offer to the increasing number of patients of trans-experience comprehensive and understanding access to healthcare in a safe environment at a family health center utilizing an integrated approach. The incidence of STIs was significantly high (gonorrhea, chlamydia, syphilis and hepatitis).
The Transgender Family Program in the Bronx has been providing medical and supportive care since 2004. In recent years, the staff has been focusing on educational activities designed to increase health literacy level and sense of self-efficacy and clinical outcomes. The measurable positive results come from a comprehensive implementation of educational activities that include and integrate individual level interventions, support groups, workshops, DEBI's interventions, and home grown interventions.

Since 2007, the rate of HIV infections and sexually transmitted infections drastically dropped, with one single, non-sexual sero-conversion since November 2007. At the end of the presentation, participants will be able to identify appropriate and sensitive ways for service providers to approach consumers of trans-experience in addiction to an effective vocabulary to develop cultural competent workshops. Participants will learn how to integrate the different components of patient education specifically for the transgender communities. The workshop will include a presentation of outcomes utilizing both clinical indicators (STI's screenings results) and patient perspective (questionnaire).

Creating and implementing HIV/AIDS and STI's educational programs specifically targeting the transgender communities improves successful outcomes significantly decreasing the rate of HIV and STI's infection, increasing patients health literacy, and improving overall quality of life. The presentation will include a brief introduction supported by literature, research and general field information. The core of the session will include case studies and real-life experiences reported through a questionnaire submitted to 75 individuals of trans-experience living in the Bronx who participated in the interventions.

Abstract 1840 - Successful Adaptation of Healthy Relationships for HIV+ Latino MSM and MtF Transgender Individuals

Author(s): Victor Camarena-Martinez

Since 1997 Latinos have become the predominant group affected by HIV in Los Angeles County. In 2006, 47% of the individuals living with AIDS are Latinos and 69% are MSM. In addition, HIV positivity rate among male to female transgender individuals is the highest in the County, ranging from 18% to 42%. Culturally and linguistically appropriate HIV prevention interventions are needed to respond to these priority populations.

Urban setting in Los Angeles County. The intervention was delivered in CBO's and ASO's, using the peer based model.

This intervention also included HIV Counseling and Testing Referral Services, all newly diagnosed MSM and TG individuals were linked to healthy Relationships. In addition, outreach workers were placed at HIV medical settings and received referrals in house from Case Managers and other HIV providers. Healthy Relationships is a five-session, small-group intervention, the adaptation was made for MSM and TG individual living with HIV/AIDS and focused on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills. The intervention also included a one, two and three month's follow up.

Although MSM and MtF TG program participants share the same HIV status, these two communities have many differences in resources, education and safer sex practices. The formative phase to adapt this intervention was crucial in order to assess their different needs and develop culturally and linguistically appropriate materials. The communication styles and their behaviors were dissimilar. Due to the stigma associated with HIV/AIDS within the Latino community, confidentiality and privacy was very instrumental to have for a successful intervention. Keeping constant contact with program participants was very effective. After the HR intervention, clients still needed a sense of belonging and face social isolation. Therefore, having booster sessions and social educational events for HIV positive clients were instrumental in strengthening their social support system with positive individuals.
Abstract 1422 - Good to Great: Using Technical Assistance to Enhance HIV Testing Programs

Author(s): M Pillinger; AV King; MC Malave; B Culter; MM Sweeney; BW Tsoi

New York City (NYC) has among the highest AIDS case rates in the US. In 2006, the NYC Department of Health and Mental Hygiene (DOHMH) began funding HIV testing programs in clinical and non-clinical settings. These programs have helped to greatly increase HIV testing. DOHMH has used the strategic provision of technical assistance (TA), as well as monitoring and evaluation activities, to improve program performance and data reporting.

DOHMH provided TA to over 70 funded testing programs in clinical facilities and community-based organizations (CBOs) throughout NYC.

Under the initial performance-based reimbursement structure, funded agencies were reimbursed solely for each rapid HIV test provided. Later, separate payment points were added for confirmatory testing and linkage to care (LtC).

In 2009, TA Coordinators (TACs) were hired to provide agency-tailored feedback and TA to each funded agency and to ensure program accountability. TACs meet with agencies on a quarterly basis to review program-specific data, discuss successes and challenges, and share best practices related to outreach, LtC, and program monitoring. Once agencies have identified strategies for improvement, TACs assist them in developing an action plan. DOHMH also organizes biannual provider meetings at which agencies have the opportunity to review performance data, discuss best practices, and provide feedback to DOHMH staff.

Feedback received through the TA process has guided DOHMH in revising its own policies, including adjusting the contract reimbursement structure.

We reviewed the performance of funded programs from April 2008 to March 2010. After commencing TA, programs demonstrated overall performance improvement, the percentage of confirmed positives who were newly diagnosed increased from 56% to 72% (p<0.05) and LtC increased from 71% to 76% (p<0.05). Overall, testing programs in clinical settings had higher confirmatory and LtC rates than CBO programs.

Programs received different levels of TA based on contract portfolio. In comparing performance improvement across levels of TA, we found that programs receiving more intensive TA displayed greater improvement in their ability to identify new positives (30% vs. 10% increase) and link them to care (14% vs. 5% increase) than did programs receiving less TA.

Since the introduction of performance-based reimbursement, programs had increased rapid testing and improved reporting of testing results. The additional payment points for confirmatory testing and LtC improved reporting for these variables.

The NYC DOHMH took a multi-pronged approach to assist funded programs in improving program performance and reporting. We saw improvement after the institution of performance-based reimbursement and the provision of TA. Creating discrete payment points for rapid testing, confirmatory testing and linkage to care services led to improved performance and better data reporting. We suggest that the primary mechanisms by which TA improves performance include providing feedback on performance and reporting, enhancing accountability, disseminating best practices and strengthening monitoring and evaluation. Having dedicated health department staff to provide TA enabled us to tailor assistance to agency needs and to better monitor agency performance.

Abstract 1521 - Social Network HIV Testing at a Youth Clinic in Oakland, CA

Author(s): Yamini Oseguera-Bhatnagar; Damon Francis, MD; Michael D’Arata, FNP; Alex Williams

There is a generalized HIV epidemic in African American and Latino communities throughout the United States. Unfortunately, HIV testing programs receive the fewest resources and face the greatest challenges in precisely these same communities. The social and developmental issues affecting youth add to these challenges. We urgently need high-yield HIV testing programs for youth in African American and Latino communities.
Downtown Youth Clinic (DYC) is located at the East Bay AIDS Center in Oakland, CA, where HIV among African Americans has been declared a local emergency. Since 2003, the clinic has provided comprehensive sexually transmitted infection screening, HIV treatment and prevention services to youth ages 13-24 regardless of insurance status.

From January to June 2010, we conducted a social network HIV testing program at DYC. HIV positive youth who were patients in our clinic referred acquaintances for HIV testing. We paid $10 to index patients for each person they referred and $20 to each of their contacts that received an HIV test. We provided counseling to all youth tested.

We tested 78 contacts of 11 index patients in our clinic. Thirteen (17%) were HIV positive on rapid testing, 11 (14%) of those for the first time. All were African American or Latino. Eleven were men who have sex with men, and 2 were transgender women. They ranged from age 19 to 25. Seven of 13 were newly linked to HIV primary care services, and 6 remained in care as of January 2011. Of those lost to follow-up, 4 did not even receive confirmatory testing.

Over the same time period, we tested 291 other youth in the surrounding community. Of those, 2 (0.7%) tested HIV positive, and both had tested positive in the past.

Our social network HIV testing program led to a much higher percentage of newly diagnosed people compared to other types of testing. The high proportion of newly diagnosed people also suggests there is a large number of HIV-positive youth unaware of their status in our community. All patients who tested positive were African American or Latino, a sign that social network testing could potentially help reduce HIV-related ethnic disparities.

Despite our best efforts to create a youth-friendly atmosphere, to maintain strict confidentiality, and to reach out repeatedly following positive test results, our linkage-to-care results are somewhat discouraging. We speculate that fear of unintended disclosure to peers testing at the same time—either through visible emotional distress or the extra time for confirmatory testing—was a significant reason that youth left before getting confirmatory tests. The problem may be mitigated if counselors perform confirmatory tests when delivering initial results, either through phlebotomy or dual rapid test protocols.


Author(s): J.D. O'Neal; M.R. Golden; J.D. Stekler

Background: The Rapid Test Study is an ongoing, real time comparison of different rapid HIV antibody tests designed to establish which is best at detecting primary HIV infection. Few prior studies have compared client acceptance of and preference for different HIV tests and specimen collection methods in settings where multiple tests have been performed.

Methods: Men who have sex with men (MSM) and a small number of transgender men and women seeking HIV testing at either the Public Health - Seattle & King County STD Clinic, the University of Washington Primary Infection Clinic, or Gay City Health Project were offered participation in the study. Testing procedures included three rapid HIV antibody tests (OraQuick ADVANCE Rapid HIV-1/2 Antibody Test performed on oral fluids and fingersticks and UniGold Recombigen HIV Test performed on fingersticks) and venipuncture for ELISA and pooled HIV nucleic acid amplification testing (NAAT). During the recruitment/informed consent process, participants were informed about the unique traits and technologies of each individual test being performed, along with their associated window periods. After completion of testing procedures, subjects were asked to complete a short survey to rate each test on a scale of 1-5 based on their preference for the specimen collection method and to rate their trust in that test (based on the timing of their visit relative to any recent risks for HIV acquisition, the specific test, the test's estimated window period, and the specimen collection method). Subjects were also asked which one test they would choose to get, taking all factors into account.

Results: 199 subjects have completed the survey to date. Mean scores for specimen collection methods were as follows: OraQuick (oral fluids) 4.29, OraQuick (fingerstick) 3.94, UniGold (fingerstick) 3.76, EIA (venipuncture) 3.3,
HIV NAAT (venipuncture) 3.36. Mean scores for trust were: OraQuick (oral fluids) 2.92, OraQuick (fingerstick) 3.99, UniGold (fingerstick) 4.05, EIA (venipuncture) 4.66, HIV NAAT (venipuncture) 4.95. When asked which single test they would choose to get, 49% chose venipuncture for HIV NAAT, 19% chose OraQuick (fingerstick), 17% chose UniGold (fingerstick), 9% chose venipuncture for EIA, and 6% chose OraQuick (oral fluids).

Discussion: Although subjects preferred less invasive collection methods, the majority would opt for a less preferable collection method in exchange for greater sensitivity and the chance of picking up newer infections. However, we have only recently incorporated the 4th generation rapid HIV antibody/antigen combination test into the protocol and do not yet have the corresponding data. Furthermore, because the survey was conducted after testing information was provided during the informed consent process, these findings may only be applicable to MSM who seek frequent HIV testing and already have knowledge about HIV tests and their “window periods.” Better strategies are needed to streamline and increase access to HIV testing that is both highly sensitive and specific and takes client preferences into account.

Abstract 1863 - Enhancing HIV Testing Practices: Routinizing Testing through Electronic Medical Record (EMR) Technology

Author(s): Michelle M Del Toro; Ann K Avery; Aleece Caron; Peter J Greco; David C Kaelber

Since 2006, the CDC has recommended HIV testing for all individuals ages 13 to 64 at least once in their lifetime; yet testing is far from routine in many health care systems. Our baseline evaluation found that the majority of medical encounters, 65.3% in 2008 and 63.2% in 2009, had never been tested for HIV within our system. Educational efforts alone have not been effective at changing provider behavior and systems changes are needed to bridge the gap between policy and practice.

Urban safety-net hospital and associated community-based health centers in Cleveland, Ohio that has been using EMR for over a decade for comprehensive outpatient care.

This initiative is a multi-pronged approach to integrate HIV testing into routine clinical practice through the modification of EMR reminders in conjunction with provider education and practice-based reporting. A systems-based approach will increase the likelihood that patients are tested for HIV at least once in their life. EMR data was used to establish baseline and ongoing site-specific inpatient and outpatient HIV testing rates and missed opportunities for testing (defined as having never been tested in our system) and generate stakeholder buy-in for systems change. In July 2010, the health maintenance (HM) checklist of our EMR was modified to include HIV testing once for individuals ages 13 to 64. Additionally, the Division of Infectious Disease educational component on HIV was revised to combine a 15-minute didactic module with 45-minute facilitated small group discussion of case scenarios. These sessions focus on improving communication skills and increasing comfort level and knowledge with respect to HIV screening, Ohio testing laws, and providing test results.

Inpatient and outpatient encounters of individuals ages 13 to 64 between January 2008 and December 2010 were reviewed. Patients previously diagnosed HIV+ were excluded. 524,074 outpatient clinic encounters and 49,046 encounters of hospitalized individuals met the inclusion criteria and were analyzed to determine whether the encounter included an HIV test and whether the individual had been tested within our system. Despite an increase in HIV testing at baseline (from 2008 to 2009), only a small proportion of eligible patients were tested (4.0%). Similar to the outpatient findings, most inpatients had never been tested with over a third as many men (77.8%) never tested compared to women (50.4%). Six months after implementation, testing nearly doubled in outpatient clinics (from 3,851 encounters with orders during 1/2010-6/2010 to 6,313 encounters during 7/2010-12/2010). Additionally, there was a significant decline in the proportion of encounters with patients never tested for HIV (from 58.1% to 53.9% of encounters; p<0.001) across the system during the same time period. The greatest gain of first time testers was among men (from 2.9% to 6.1%; p<0.001), especially minorities.

In clinic settings where EMRs are adopted and utilized for preventive health reminders, the addition of HIV testing reminders can effectively and efficiently increase HIV testing. The intervention also provides a means to reduce health disparities in testing for HIV.
Abstract 1427 - Women's HIV Prevention and Reproductive Health Services in the Correctional Setting

Author(s): Mary Gwynn; Emily Gold; Jessica Cisternelli

There is a need for reproductive health and HIV prevention and education for incarcerated women as they approach release back into their communities. Although many correctional facilities offer at least basic reproductive health services, the "us and them" culture "behind the wall" is not conducive to inmates utilizing these services. The issue becomes how to educate incarcerated women about their risk for HIV infection, to persuade them to find out their HIV status, equip them with effective prevention tools and to engage them in care both while and after incarceration.

Correctional facilities and the community Family Planning clinic

Health Imperatives' Hyannis Family Planning (HFP) site provides free basic gynecological examinations, sexually transmitted disease and infection (STI) screening, reproductive health counseling, HIV rapid testing and infectious disease education and prevention to incarcerated women in the county correctional facility.

Gynecological examinations by a nurse practitioner and counseling on reproductive health issues are offered monthly to women inside Barnstable County Correctional Facility at no cost to the inmates or facility. Currently, an average of 8-10 women are seen each month for STI screening and treatment, breast and pelvic examinations as well as education regarding reproductive health conditions. In addition, at least two 6-week prevention and education groups are conducted each year. All groups and services are voluntary. However, inmates are given time off their sentence for attending the groups. Topics covered in the groups are anatomy & physiology, birth control methods, STIs, HIV, viral hepatitis, risk reduction, safer sex techniques, and healthy relationships. Recently, the participants requested eating disorders be added. Initially groups were held in the evenings in a meeting room near the housing unit. Over time, the number of women requesting to attend grew so large, the Director of Women's Education Programming asked the HFP staff to facilitate the groups in the housing units. It is after participating in the group sessions that many women request individual appointments with the counselors and nurse practitioner. The women are encouraged to continue their reproductive care after release from incarceration and are given supported referrals to HFP. Those not returning to the Cape Cod area are given supported referrals to one of the 8 other Health Imperatives Family Planning clinics throughout the region.

Respecting the culture of corrections means to realize the limits of services possible within the system. This realization is what allowed the project in.

Incarcerated women are in need of these services and to have connections with the community. This is a transient, under-served and high risk population in need of infectious disease education, prevention and follow-up services that frequently falls through the cracks. Given the opportunity, they want to be equipped with effective prevention tools and to have access to on-going reproductive health care. This project's success was achieved, in large part, by having the same HFP staff working inside the facility as the women would see in the clinic on the outside. 20-25% of the women seen during incarceration came to the clinic to continue receiving services upon release.

Abstract 1779 - Necessary Elements in the Development and Delivery of a Comprehensive Program for Community Re-entry

Author(s): Samuel MacMaster; Tonia Middleton; John Shevlin

Clear links have been established connecting incarceration and HIV prevention needs. It appears that individuals are at the highest point of risk for HIV as they re-enter the community. However, for the two million individuals who are currently incarcerated, navigating the various service delivery systems as they return to the community creates additional barriers and further exacerbates this risk and serve as fuel for health disparities. The purpose of this
presentation is to provide a description of the efficacy of a program designed to provide a comprehensive approach to substance use treatment needs, employment, family issues, and HIV risks. A discussion of twelve key ingredients necessary for program success that have been identified within the program will be discussed.

The Treatment Access Project for Staten Island is a collaborative initiative between Community Health Action of Staten Island, New York State Division of Parole (Staten Island Bureau), Arthur Kill Correctional Facility, and community businesses.

The goal of the project is to reduce health disparities in HIV by fostering substance abuse treatment access and service engagement. A seamless continuum of targeted HIV, substance abuse treatment, family counseling, case management, and employment services are provided to African American and Hispanic/Latino men and women who are returning to the community after incarceration.

The program has successfully demonstrated its ability to reach identified program outcomes. Important to this ability are twelve key ingredients, or elements, that have been identified through an ongoing process evaluation. These elements relate specifically to: the host agency and the manner in which the program was implemented; the specific competencies and individual characteristics provided by the staff; the types of services and the manner in which these were delivered by the program; and strong community support. While these elements must be viewed with extreme caution, they serve as a starting point for identifying elements that may be required for successful comprehensive programs.

Track A
LB1 - Determinants of Behavior
Room: A705 (Atlanta Marriott Marquis)

Abstract 1606 - Multilevel Factors Associated with Sexual Risk Behavior among Young Black MSM
Author(s): Susan Kegeles; Greg Rebchook; John Peterson; Dave Huebner; Agatha Eke; Wayne Johnson; Robert Williams; Lance Pollack

Young Black MSM (YBMSM) are at high risk for HIV in the U.S., with seroprevalence estimates of 17% (vs. 9% for other young gay/bisexual men), and an estimated 4-5% annual incidence rate. Yet few quantitative studies have examined multilevel factors that are associated with why YBMSM are vulnerable to contracting and transmitting HIV. This study examines determinants of sexual risk behavior across individual, interpersonal, social, and structural factors.

In 2009, YBMSM aged 18-29 (mean=23 years), recruited at bars and clubs, completed anonymous, self-administered surveys in Dallas and Houston, Texas (N=646). We used scales we developed comprising 3-6 items to assess many psychosocial issues (all alphas > .69), as well as single-item variables. Statistical analyses utilized chi-square and t-tests to determine differences between men who did and did not engage in unprotected anal intercourse (UAI) with a male partner in the previous 2 months.

In this sample of YBMSM, 36% reported UAI, 75% identified as gay and 24% as bisexual, 50% had to borrow money in the past year, 33% had been incarcerated, and 13% had experienced homelessness. At the individual level (intrapsychic and sexual experience issues), variables associated with UAI are: higher rates of internalized homophobia, depression, and negative condom attitudes; lower gay pride and self-efficacy to have safe sex; having been forced to have sex before (p<.001), having more treatment optimism (p<.01), and being less spiritual (p<.05). At the interpersonal level, UAI is associated with more frequently having sex within the context of difficult partnerships (e.g., had sex to keep from losing partner) and having a boyfriend (p<.001). Social-level variables, as well as variables that may be indicative of the impact of broader structural issues on YBMSM, were also related to UAI, including: having sex in difficult situations (e.g., while self or partner drunk), lower safer sex norms, experiencing more homophobia, having less than a 12th grade education and having been homeless before (p<.001), experiencing more racism, having less social support, lack of money (p<.01), not being employed full-time, and having been incarcerated before (p<.05).
YBMSM face considerable social, structural and psychological challenges which are related to increased sexual risk behavior. Most individual-level variables we examined were significantly different for YBMSM who engaged and did not engage in UAI, as were interpersonal variables. Issues that affect the context of YBMSM's lives, particularly racism, homophobia, poverty, low education and incarceration, are also related to risky sexual behavior. In addition, social and structural issues may have indirect effects on risky behavior as they influence individual and interpersonal issues, which should be further explored. HIV prevention interventions that try to impact issues at multiple levels are needed. This may include interventions that address, for example, mental health services to help depressed YBMSM and targeting internalized homophobia and self-efficacy; attempts to reduce societal homophobia; and tying HIV prevention to programs to help men obtain more education and jobs. Intervention strategies that solely focus on one level may not be as effective as multilevel approaches.

Abstract 2024 - An Approach to Identify the Impact of Social Determinants of Health on AIDS Diagnosis Rates

Author(s): Ruiguang Song; H. Irene Hall; Kathleen McDavid Harrison; Tanya T. Sharpe; Lillian S. Lin; Hazel D. Dean

The purpose of this study was to develop a statistical tool that brings together standard, accessible, and well-understood analytic approaches and uses area-based information and other publicly available data to identify social determinants of health (SDH) that significantly affect the morbidity of a specific disease.

We used data from the national HIV surveillance system and the American Community Survey. Morbidity and socioeconomic variables in the two data systems were linked through geographic areas that can be identified in both systems. Correlations with AIDS diagnosis rates were used to measure the impact of socioeconomic factors in certain geographic areas. Partial correlations (controlling for the effects of covariates) were used to distinguish direct and indirect impacts of SDH variables.

We developed an easily explained approach that can be used by a data analyst with access to publicly available data sets and standard statistical software to identify the impact of social determinants of health (SDH) that significantly affect the morbidity of a specific disease. We found that the AIDS diagnosis rate was highly correlated with the population density, the proportions of race/ethnicity groups, and the proportion of people in unmarried status in an area. The impacts of poverty, education level, and unemployment were mostly indirect and interacted with other SDH variables.

Area-based measures of socioeconomic variables can be used to identify risk factors associated with a disease of interest. However, the health effects of demographic and socioeconomic variables are complex. The impact can be direct or indirect through other SDH variables. The magnitude or even the direction of the impact can be changed due to interactions between variables. A simple correlation analysis is not adequate to identify potential interactions. The complexities of measuring contributions of SDH variables to disease morbidity should be considered when developing intervention and prevention programs.

Abstract 2097 - Variations in and Correlates of Discrimination among Racial/Ethnic Minority MSM Living in Los Angeles

Author(s): George Ayala; Jay P. Paul; Ross Boylan; Steve E. Gregorich; Kyung-Hee Choi

Past studies have shown that experiences of social discrimination are associated with negative health outcomes among racial/ethnic minority men who have sex with men (MSM). However, few studies have explored sources and types of discrimination or how these experiences vary among MSM of color.

A chain-referral sample of 403 African American, 393 Asian and Pacific Islander (API), and 400 Latino MSM (aged 18+) was recruited in Los Angeles County, CA from May 2008 to October 2009. Participants were asked about lifetime and past year experiences of racism and homophobia; perceived racism in the mainstream gay community; perceived homophobia among heterosexual friends; and perceived homophobia within their families of origin. We conducted chi square tests and multiple logistic regression analysis to examine variations in and correlates to experiences of racism and homophobia among these three racial/ethnic groups of men.
Lifetime and past year experiences of racism and homophobia were reported across racial/ethnic groups. Most notably, African American and Latino MSM were statistically more likely to report that in the prior year they were stopped by the police, verbally threatened, and physically threatened or attacked by others than were API MSM. Latinos were least likely to report racism in the gay community. However, Latino MSM were more likely than African American and API MSM to experience homophobia in the past year. Latino and API MSM were more likely than African American MSM to report feeling family pressure to get married to a woman. API MSM compared to African American and Latino MSM were more likely to feel that acting masculine was important to their families of origin. Total number of financial difficulties (OR=1.24, 95% CI, 1.13 - 1.35) and lifetime history of incarceration (OR=1.50, 95% CI, 1.22 - 1.84) were each positively associated with lifetime experiences of racism. Being born outside of the U.S. was positively associated with lifetime experiences of homophobia (OR=1.29, 95% CI, 0.64 - 0.89), as was self-identifying as gay, homosexual, or same gender loving (OR=2.20, 95% CI, 1.73 - 2.79). Conversely, having been married was negatively associated with lifetime experiences of homophobia (OR=0.75, 95% CI, 0.64 - 0.89). Financial hardship was each positively associated with lifetime and past year experiences of homophobia (respectively, OR=1.19, 95% CI, 1.10 - 1.28, and OR=1.21, 95% CI, 1.14 - 1.28).

Types and sources of racist and homophobic experiences vary across racial/ethnic minority groups of MSM. African American MSM, followed by Latino MSM, reported harsher or more explicit forms of racism from society in general than API MSM. Latino MSM were least likely to report racism in the mainstream gay community but more likely to report having experienced homophobia in the past year. Understanding the differential salience and correlates of racism and homophobia among MSM of color is key to developing tailored support programs for this group. More research is needed to understand the differential impact of social discrimination on African American, Latino, and API MSM.

Abstract 2100 - Social Contexts and Substance use among Ethnic Minority MSM at Risk for HIV: Prevention Implications

Author(s): Jay P. Paul; George Ayala; Ross Boylan; Steve E. Gregorich; Kyung-Hee Choi

Substance use has been associated with risk for HIV among men who have sex with men (MSM). There are several decades of research on the epidemiology and correlates of alcohol and drug use among primarily white MSM. Although racial/ethnic minority MSM are at high risk for HIV, few studies have identified specific contributing factors for substance use in this risk group. Consequently, there is little empirical evidence to inform the development of HIV prevention programs that specifically target risk related to substance use.

A chain-referral sample of 400 Latino, 403 African American, and 393 Asian and Pacific Islander MSM (aged 18+) was recruited in Los Angeles County, CA between May 2008 and October 2009. Using audio computer-assisted self-interview (A-CASI) methods, participants were asked about use of alcohol and illicit drugs in the prior 6 months, lifetime experiences of racism and homophobia within the general community, perceived racism within the mainstream gay community, perceived homophobia within their family and among their heterosexual friends, social support, attendance at a place of worship, sexual identity, and the ethnic and sexual orientation make-up of the places where they socialized and places where they cruised for sex. Logistic regression models examined the associations of these variables to alcohol use and drug use, controlling for race/ethnicity, age, nativity, education, employment, HIV status, and financial marginality/instability.

In our sample, alcohol was used by 65%; 44% reported some illicit drug use. The use of alcohol was positively associated with experiences of racism in the general community (OR=1.13; CI, 1.00, 1.26), socializing in places with a mixed gay/heterosexual crowd (vs. heterosexual only) (OR=1.58; CI, 1.12, 2.23), a bisexual identity (vs. heterosexual identification) (OR=1.32; CI, 1.00, 1.74), and advice-giving social support (OR=1.41; CI, 1.04, 1.91). Alcohol use was negatively associated with religious attendance (OR=0.92; CI, 0.86, 1.00). The use of illicit drugs was positively associated with racism in the general community (OR=1.27; CI, 1.13, 1.42), socializing in places which were mostly gay-identified (OR=1.58; CI, 1.02, 2.45) and negatively associated with social support that provided validation for one’s experiences (OR=0.74; CI, 0.57, 0.94), and religious attendance (OR=0.85; CI, 0.78, 0.93).
Our data indicate that for MSM of color, significant positive relationships exist between substance use and racism experienced in the general community, as well as socializing in settings that are at least partially gay-identified. The impact of social support varied with respect to type received. Attendance at a place of worship was protective with respect to use of both alcohol and drugs. These findings point to the need to learn more about the contributions of racism and other forms of discrimination to alcohol and illicit drug use, as well as the pressures that may exist for such use within particular social contexts or subcultures. Further work is needed to understand the health-protective vs. potentially risk-promoting types of social ties or forms of social support including involvement in religious groups. This may help to identify appropriate health promotion interventions for this population.

Track B
LB4 - Approaches to Understanding the Epidemic Among African American Populations
Room: A703 (Atlanta Marriott Marquis)


*Author(s):* Benjamin K. Ngugi

Although surveillance data for HIV/AIDS are routinely collected across the US, little is known about the epidemiological patterns of the pandemic among African-born populations living in the country. We examined HIV/AIDS epidemiology among persons living in the US who identified themselves as born in Africa focusing on modes of transmission by age, sex and country of birth over a range of years for three jurisdictions: Massachusetts, New York State and Washington District of Columbia.

We requested data from the surveillance programs in each jurisdiction. We collated and analyzed the data on key patterns focusing on comparative trends across the jurisdictions and African countries of birth.

There were 2,410 African-born persons from over 33 countries living with HIV/AIDS during 2001-2007. In Massachusetts, the mode of transmission for 59.3% was presumed to be heterosexual. There are more males than females living with HIV/AIDS in New York. In Washington DC, half of all African-born HIV cases were from Ethiopia. The mode of transmission is unknown for 39% of cases. Heterosexual contact is the main mode of identified HIV transmission (35%).

Current levels of HIV/AIDS in the African-born immigrants indicate that existing HIV prevention efforts are not reaching these populations. Better information gathering is needed in this population as well as innovative interventions including culturally-appropriate messaging to stem the epidemic in the US.

**Abstract 2017** - The Influence of Father-son Relationships on the Structural Context of HIV Risk among Black Men

*Author(s):* Alanna Stone; Brandi Park; Bernard Owens; Thurka Sangaramoorthy; Lisa Bowleg

The HIV epidemic disproportionately affects Black men in the United States, particularly in the South. While public health advocates stress addressing the various structural contexts driving this racial disparity, few studies have investigated how father-son relationships among Black men influence these contexts. The present study qualitatively explored how father-son relationships among Black men in the South factor into the structural context of HIV risk.

In 2010, we conducted 30 semi-structured in-depth interviews in Atlanta, GA with men, ages 18-65, who self-identified as Black or African American and self-reported as HIV negative/unknown status. We incorporated convenience sampling methods through posters, fliers and snowball sampling in metropolitan Atlanta. The interview topics contained contextual domains including childhood upbringing, life stressors, coping strategies, condom use and HIV testing practices.

The majority of participants identified absent/neglectful relationships with their biological fathers as a source of trauma in their formative experiences and current adult lives. Major themes emerging were: (1) deficient father-son relationships as normative; (2) incarceration as major contributor; (3) negative impact on mental health; (4) exposure
to alcohol and substance abuse; (5) search for alternative male role models; and (6) varied influence on participants relationships with their own children. Based on these findings, we propose a conceptual model whereby absent/neglectful father-son relationships among Black men may adversely influence their mental health, exposure to alcohol/substance abuse and other individual-level behaviors that can lead to incarceration. Ultimately, this creates structural contexts of increased HIV risk and a potentially repetitive cycle between the men who have these experiences and deficient relationships with their own children.

The men in this study experienced absent/neglectful relationships with their biological fathers, often due to incarceration and resulting in a fragmented sense of manhood development. The nature of these relationships represented the beginning of a cyclical pathway of absent/poor male role modeling, adverse mental health, exposure to alcohol/substance abuse and incarceration - all of which have implications for exposure to structural contexts of elevated HIV risk that may persist through several generations of Black men. Future research should investigate the potential relationship between the nature of father-son relationships and structural HIV risk among larger probability-based samples of Black men. In addition, public health interventions targeting Black men should consider incorporating components of positive male mentorship and fatherhood training to interrupt this cycle of absent/neglectful fathers that may directly and indirectly lead to sustained exposure to structural contexts with heightened HIV risk.

Abstract 2052 - Community-Academic Partnership to Conduct Demographic Surveillance: First Step to Effective HIV/AIDS Community-Based Participatory Research

Author(s): Yancey, EM; Hoffman, LM; Bryant, LO; Wingfield, JH; Collins, D; Armstrong-Mensah, E; Alema-Mensah, E; Cureton, S

The HIV/AIDS epidemic has been called a public health emergency in the African American community. Georgia ranked ninth highest in the US for estimated rates of adult cases living with AIDS. Seventy-eight percent of newly diagnosed HIV cases and 75% of AIDS cases were among African Americans who represented only 30% of the population. Seventy-two percent of HIV cases in metropolitan Atlanta were African Americans.

HIV Risk Reduction Research: Demographic Surveillance of Metropolitan Atlanta included ten contiguous counties; Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Fulton, Gwinnett, Henry, and Rockdale.

Healthy communities require sustained partnership efforts of diverse civic and community-based organizations, individuals, and healthcare professionals. Our community-academic partnership was developed following the prescribed steps informed by community-based participatory research (CBPR) development. We identified metropolitan Atlanta areas where African Americans were most adversely affected by the HIV/AIDS epidemic in order to concentrate prevention efforts in those areas. We assessed zip code data including population, ethnic composition, race, age, per capita income, education, and gender distribution.

Our community-academic partnership conducted the surveillance with assistance of Centers for Disease Control and Prevention, Georgia Department of Human Resources, and Atlanta Regional Commission representatives. We worked together identifying 15 zip code areas with majority African American populations and significantly high AIDS rates. African Americans represented 81% of the 565,057 total population study area of which 36% were between ages 18-44. Wide per capita income range among African Americans yielded a $14,499 mean income. Two zip codes had 49.4% and 45.4% living below poverty level. Thirty-two percent of males and 28% females were high school graduates; 22% of males and 25% females had some college; 15% of males and 23% females had an associate through graduate/professional degree. Although the 15 zip codes were similar on ethnic, gender, and age measures, they varied considerably on per capita income and education indicators. Importantly, US poverty income level (<$4,999) was a statistically significant predictor of AIDS rates. Income above $4,999 and education were not statistically significant predictors. These data were used to inform the next step: developing and implementing an ethnically sensitive community engaged HIV/AIDS risk reduction project.

Conducting a community-academic partnership led demographic surveillance as the first step in CBPR 1) helps to assure identification of appropriately targeted communities, 2) strengthens community involvement/support, 3)

Author(s): Jenevieve Opoku; Ryan Wiegand; Charles Wu; Ashley Murray; Yujiang Jia; Kim Elmore; Anna Satcher-Johnson; Tiffany West-Ojo; Nnemdi Kamanu-Elias; Madeline Sutton

Washington D.C. (DC) is among cities with the highest rates of HIV in the United States (US), with nearly 10 times the US rate of HIV infection diagnoses, and higher than comparable urban areas, such as Baltimore, Philadelphia, and New York City. Blacks are disproportionately affected in DC, with a prevalence of diagnoses of HIV infection that is 4.7% compared with 1.8% among whites; a disparity that is not fully explained by examining individual-level risk factors. Exploring structural and social determinants of health among blacks living with HIV infection in DC may be a vital next step to better understand HIV-related health disparities in DC. We explored community-level social determinants among blacks living with HIV infection in DC to inform and strengthen local HIV prevention efforts.

Data from the Enhanced HIV Surveillance Reporting System (eHARS) for adults and adolescents (ages 13 and over) living in DC at the end of 2008. Social determinants of health data for blacks (i.e., home ownership, poverty, unemployment, and education) were derived from the Year 2000 US Census for 188 DC census tracts, of which 185 tracts were suitable for analysis. Individual level eHARS data were aggregated to the census tract level for cases residing in DC at the time of diagnosis. Social determinant data downloaded from the census were divided into quartiles, summed and averaged into two separate negatively coded indices for blacks: 1-residence and income index (home ownership, transience, median household income, poverty and unemployment), and 2-education and wealth index (owner-owned housing value, level of education). Data were analyzed using R (Version 2.13.0). Generalized linear mixed models were produced using the created indices and individual variables to model the HIV prevalence ratio for blacks in a census tract.

Census tract information was available for 8,789 blacks living with HIV at the end of 2008. Results indicate that an increase in the residence and income index (RR=1.14, 95% CI: 1.03-1.26) and the total number of housing vacancies (RR=1.08, 95% CI: 1.02-1.14) were associated with an increase in the HIV rate among blacks in a census tract. Models constructed of individual social determinant measures for blacks suggested that an increase in poverty (RR=1.10, 95% CI: 1.03-1.18) and a decrease in home ownership (RR=1.11, 95% CI: 1.05-1.17) are associated with an increase in the HIV rate among blacks in a census tract.

This analysis suggests that housing vacancies, home ownership and poverty are important social determinants for blacks living with HIV infection in DC. HIV prevention efforts in DC should be strengthened in black communities with high poverty and housing vacancies and low rates of home ownership. These data also highlight the need for further research to refine social determinant measures and highlight their impact with disproportionately affected blacks in DC in an effort to reduce HIV-related health disparities.
Bullying is a form of violence that is characterized as an aggressive behavior that is unprovoked and intended to cause harm. Prior studies have found that lesbian, gay, bisexual and transgender (LGBT) youth experience high levels of bullying related to their sexuality and this harassment can lead to engagement in risk behaviors, depression, and suicide. Harassment or discrimination due to one's racial identity can also lead to negative health outcomes, increased levels of anxiety and depression, increased drug use and low self-esteem. Further, there is evidence of persistent racial discrimination within LGBT communities as well as reports of anti-LGBT discrimination within communities of color. Ethnic/racial minority young men who have sex with men (YMSM) may experience dual levels of stigma and maltreatment due to both their sexuality and their race. The aim of the current study was to assess the prevalence and perceptions of racial and sexual identity-based maltreatment among a sample of HIV-infected ethnic/minority YMSM and whether it plays a role in the emotional distress of these youth.

Participants were enrolled at one of eight HIV/AIDS Bureau (HAB)/Special Projects of National Significance (SPNS) Initiative-funded demonstration sites, each with its own outreach, linkage, and retention strategies. Young (aged 13-24), HIV-infected ethnic/minority MSM were enrolled and administered a standardized face-to-face interview by local study staff between June 1, 2006 and August 31, 2009. Uni- and bivariate analyses were used to describe participants and prevalence of racial and sexuality-related bullying. We used the Center for Epidemiologic Studies Depression Scale (CES-D) to measure depressive symptomatology. A logistic regression model to identify significant predictors for having a CES-D score >16 was performed.

We found that 36% and 85% of participants experienced racial and sexuality-related bullying respectively. There was a significant association between experiencing a high level of sexuality-related bullying and depressive symptomatology (p=.03), having attempted suicide (p=.03), and experiencing parental abuse (p=.05). More than two-thirds of the young men in this sample experienced some form of parental abuse. In a multivariable logistic regression model, experiencing any racial bullying and a high level of sexuality-related bullying were significant predictors of having a CES-D score≥16, with adjusted odds ratio (OR) of 1.83 and 2.29 respectively.

These findings contribute to the existing literature regarding the negative experiences and daily stressors facing LGBT youth with regard to both their ethnic minority and LGBT identities. We found an association between experiencing a high level of bullying related to sexuality and both depressive symptoms and attempting suicide. The extreme nature and devastating consequences that harassment has on gay youth may be related to a lack of social support to buffer these negative experiences as well as high levels of parental abuse. The association of suicide attempts and sexuality-related bullying but not racial bullying may reflect a strong sense of racial identity that can counterbalance these negative messages. Future interventions for racial/ethnic minority YMSM should provide assistance in achieving a positive view of self that encompasses both their racial and sexual identities.
experiences of discrimination may also influence membership of a riskier, marginalized social network (eg. networks with high burden of disease) where the opportunity for HIV transmission is heightened. Since racial disparities in HIV have not been explained by risk behavior, and racial/ethnic minorities experience discrimination more often than whites, the relationship between discrimination and social networks may help explain how racial/ethnic minority drug users remain disproportionately affected by HIV/AIDS.

We investigated the association between discrimination and risky sexual networks using data from the Social Ties Associated with Risk of Transition (START) study. START is a prospective cohort study (n=652) among non-injection drug users and a cross-sectional sample of newly initiated injection drug users (duration of injection ≤ 3 years) recruited through respondent driven sampling and targeted street outreach in ethnographically mapped New York City neighborhoods of high drug activity. Racial discrimination, discrimination due to drug use, and discrimination due to incarceration were assessed independently and jointly as the exposure of interest. The outcome, risky sexual networks was based on the median distribution of having a total of 4 or more sexual networks of male or female gender and networks that participated in transactional sex. Chi-square tests were used to identify crude effects and log-binomial regression was used to estimate the prevalence ratio between each type of discrimination and increased sex networks after adjusting for important covariates.

Most participants were Black, male, had less than a high school education, made less than $5,000 income/year and the median age was 33. Those who experienced discrimination due to race (40.0% vs. 27.4%; p=0.002) and drug use (36.8% vs 27.6%; p=0.018) were significantly more likely to have increased sexual risk networks. Discrimination due to incarceration was not related to size of sexual risk networks. After adjustment, discrimination due to drug use and race remained independently associated with increased sexual networks. After accounting for discrimination due to drug use and race simultaneously, those who experienced discrimination due to drug use (PR:1.31; 95%CI: 1.02-1.67) and race (PR:1.29; 95%CI: 1.00-1.66) remained significantly more likely to have increased sexual networks.

These data highlight the importance of drug use- and race-based discrimination and its potential influence on high risk social network formation and subsequent HIV transmission. Future studies should be conducted using a longitudinal approach such that temporality of these relationships can be determined. Further examination of the mechanism of risk conferred to one's social network through processes of discrimination is warranted.

Abstract 1587 - Male Youth Engaged in Sex Work: Health Disparities and Outcomes in Early Adulthood

Author(s): Mackey Friedman, MPH; Michael P. Marshal, PhD; Thomas E. Guadamuz, PhD

Previous research on male youth engaged in sex work has indicated profound health disparities that include higher rates of depression, sexually transmitted infections (STI), and substance use than their non-sex-working peers, as well as high HIV prevalence rates (25% across studies in North America). Because of the cross-sectional, descriptive nature of previous research in this area, the phenomenon of male sex work is poorly understood, especially its effect on long-term health outcomes. This study, to the best of our knowledge, is the first to temporally examine health outcomes in young males engaged in sex work, using a longitudinal, nationally representative, school-based probability sample.

We conducted a secondary data analysis using data from Waves III (2001-2002, late adolescence) and IV (2007-2008, young adulthood) in Add Health, a prospective cohort study of health-related behaviors of youth and their outcomes in young adulthood. Participants were defined as males engaged in sex work if they were male (n=7167) and had reported ever receiving payment for sex at wave III (n=246). We used multiple logistic regression to analyze predictors of sex work at wave III and health outcomes at wave IV, controlling for wave III outcomes and sociodemographic covariates.

3.4% of male youth reported receiving payment for sex at wave III. Male youth engaged in sex work were more likely to be black and of sexual minority orientation than their peers. Male youth engaged in sex work had four times the odds of any STI than their peers (OR=4.1, p<.05), twice the odds of depression (OR=1.8, p<.05), and reported more frequent recent use of cigarettes, marijuana, and cocaine (all p's<.001). After adjusting for race, age, ethnicity, and sexual identity, substance use variables were still significantly associated with transactional sex (p<.001). A history of
receiving money for sex by Wave III predicted depression and recent frequency of substance use at Wave IV even after controlling for these outcomes and sociodemographics at Wave III.

This study provides additional evidence of disparities in negative health outcomes, including substance use, sexually transmitted infections, and depression, between males engaged in sex work and their peers, using data from a large-scale, school-based national probability sample. These outcomes appear to persist many years into early adulthood and may be considered sequelae of sex work experience. While engaging in sex work can be considered an HIV risk behavior in and of itself, these findings indicate that it may also increase concurrent HIV risk behaviors by contributing to higher individual levels of depression and substance use in both the present and future. HIV prevention interventions with male youth and young adults would benefit from greater attention to sex work experience and its psychosocial aftereffects. Further investigation is needed to understand the mechanisms of, and relationships between, the correlates of sex work engagement, its precursors, and its associated outcomes.

Abstract 2044 - Community Mobilization: Mobilizing Transgender Communities and Allies to Respond to the AIDS Epidemic
Author(s): Vel S. McKleroy, MPH, BSW; JoAnne Keatley, MSW; Miguel Martinez, MSW, MPH

National HIV/AIDS Strategy (NHAS) recommends a focus on groups with the largest numbers of new infections based on the group’s estimated relative risk of infection. This is concerning since the national HIV surveillance system does not report data separately for transgender persons. Given the current financial climate, it is critical to mobilize communities to take action. “The burden of addressing the HIV epidemic among gay and bisexual men and transgender individuals does not rest with the government alone. Early in the epidemic, the lesbian, gay, bisexual and transgender (LGBT) community developed its own education campaigns and institutions to reduce HIV infection in the wake of inaction by government and other institutions. Continuing these efforts is important to our success (NHAS, pg 14).”

A representative from CDC’s Division of HIV/AIDS Prevention (DHAP) will provide a brief overview of NHAS and sections that could potentially impact DHAP’s HIV prevention efforts among transgender persons including surveillance and programmatic activities. Subsequent discussion will focus on 1) what is currently being done by community stakeholders to monitor and characterize the HIV epidemic among transgender persons; 2) community mobilization efforts among transgender persons and their allies; and 3) lessons learned by some jurisdictions that have implemented or are planning to implement programs and/or social marketing campaigns for transgender persons.

The proposed roundtable will provide an opportunity for participants to share strategies for mobilizing transgender communities and allies to respond to the HIV epidemic from within their own networks.

Track A
A09 - Migrants among Us: Finding Forgotten Faces in the HIV Epidemic
Room: Courtland (Hyatt Regency Atlanta)

Abstract 1304 - Qualitative Investigation into the Use of HIV Educational Videos among Black African Immigrants
Author(s): Yvette Calderon; Adebola Adedimeji, PhD; Ethan Cowan, MD MS; Mohamed Kaba, MD; Aba Asibon; Christopher Brusalis; Jason M. Leider; Laurie J. Bauman

The population of black African immigrants in the U.S. is growing rapidly and has disproportionately high rates of HIV and AIDS. Efforts to increase participation in HIV testing have been unsuccessful within this population for several reasons, including their reluctance to access health care for prevention, the stigma of HIV, cultural beliefs, and concerns over immigrant status. Our previous research showed that pre- and post-test HIV counseling videos increased HIV testing rates in an urban emergency department (ED), however, many West Africans who were first diagnosed as HIV+ already had AIDS. We conducted focus groups to identify strategies to improve earlier HIV testing in this community.
We conducted 2 focus groups with 14 West African immigrant participants, one with 6 Nigerian females aged 25-50 years and one with 8 males aged 25-45 years. Six male participants were from Cote d’Ivoire and the other 2 male participants were from Mali. African leaders in the Bronx community, including a physician and behavioral scientist, recruited participants. Each group was shown HIV videos currently used in Project BRIEF, an ED-based HIV testing and counseling program. Comments were solicited by gender-matched trained facilitators on the videos cultural sensitivity and relevance to black African immigrants. Two of the co-authors (YC & AA) independently read the transcripts, coding for major themes.

Participants indicated that a culturally-tailored approach to HIV video prevention messaging is necessary to encourage testing within the black African immigrant community. Male participants recommended that messages be delivered by respected members of the African community. Female participants said videos should emphasize the importance of fertility and family to increase the appeal of HIV testing. Both groups wanted less explicit sexual references and placed an emphasis on the importance of HIV testing as part of general health and well-being. They stressed the need to involve clergy and other influential individuals from the African community in the implementation of an HIV testing program. Misconceptions about HIV/AIDS, concerns regarding immigrant status, and fear of stigma were cited as barriers to the success of current HIV testing programs among African-born immigrants. Participants expressed their reluctance to access healthcare services in traditional medical venues.

This investigation revealed strategies for tailoring HIV testing and counseling videos to remove the specific barriers that African immigrants in the U.S. experience. Different messages and approaches may be necessary to engage male and female black Africans. HIV testing sites located outside of traditional medical venues may have greater appeal for this community. Continued qualitative research is needed to identify messages and implementation strategies that can increase voluntary HIV testing among diverse sectors of the African born community.

Abstract 1497 - Adapting the Safety Counts EBI for Migrant Latino Farmworkers

Author(s): Richard C. Wascher-Tavares; Fen Rhodes; Charles A. Anderson; Jonny Andia; Robin T. Higashi; Sara Scott

Studies report the prevalence of HIV among U.S. farmworkers ranging from as low as 2.6% to as high as 13% of all farmworkers, with most reporting rates at least 10 times higher than the overall U.S. population. Efforts to address HIV risk and injection practices among border area and migrant farmworkers have been largely ineffective and uncoordinated, and are complicated by factors such as: farmworkers migratory status, fear and avoidance of interaction with non-community members, education and language barriers, and cultural beliefs and values regarding sexual practices, sexual identity, and a preference for intravenous (vs. oral or inhaled) substances.

National Community Health Partners (NCHP, formerly Arizona-Mexico Border Health Foundation) conducted a 4-month pilot adaptation of the Safety Counts Evidence-Based Intervention for migrant farmworkers in Yuma County, Arizona, where over 90% of farmworkers are Latino, and about 80% are male.

NCHP conducted outreach, HIV testing, and HIV prevention education in Yuma County with migrant farmworkers who reported drug use within the past 90 days. A total of 42 participants were enrolled in the adapted Safety Counts intervention between February - June 2006. The goals of the project were: (a) to determine the effectiveness of the adapted tools and procedures in overcoming known barriers to HIV prevention and treatment among migrants; (b) collect feedback from participants regarding their interest in the intervention and their perceived strengths and weaknesses of the project; and (c) enhance the adapted materials in preparation for further piloting among migrant communities in other parts of the United States.

RESULTS: The mechanics of the adaptation effectively bridged many of the barriers typically associated with HIV prevention in the migrant population, and participants responded positively to the intervention. LESSONS LEARNED: Key components of the adaptation include: (a) education about risk behaviors: including identification of specific cultural beliefs, values and practices that increase HIV risk (e.g. women who carry or use condoms are promiscuous, or men who have sex with multiple partners are more masculine); (b) mode of education delivery: fotonovelas (comic books), which were important both to accommodate low-literacy populations and as 'traveling' educational tools to be
disseminated by farmworkers to other farmworkers along migratory routes); also, employment of former migrants as peer educators (Spanish-speaking non-migrant Latinos were less effective than former migrants); (c) venue: meeting locations and service providers chosen by trusted community members and close to agricultural fields; and (d) flexibility in the duration of the intervention: abbreviated to accommodate short growing seasons and crop movements; and (e) strong relationships with farm owners (to gain access to workers with minimal job interference) and health providers at local or mobile health clinics (to earn workers’ trust in the confidentiality of services and separation from immigration officials).

The materials that NCHP developed for the Safety Counts Adaptation for Migrant Farmworkers are currently under review by the CDC to be piloted in other migrant farmworker communities in the U.S. as part of the approval process for a proposed DEBI.

**Abstract 1680 - Using Rapid Ethnographic Assessment to Identify the Prevention Needs of Migrant Workers in North Carolina**

**Author(s):** Thurka Sangaramoorthy; Petra Vallila-Buchman; Rachel Robitz; Pete Moore; Jacquelyn Clymore

Rapid ethnographic assessments have been used nationally and internationally since the 1970s to identify factors that contribute to poor health outcomes. They complement other forms of public health data collection, and are an effective and relatively inexpensive way to solicit community feedback and provide timely, practical recommendations to local programs. They are especially useful for exploring emerging issues and the needs of hard-to-reach populations. Dramatic demographic shifts occurring in North Carolina in recent years require adaptation of STD/HIV programs to meet the needs of new immigrant populations. A substantial proportion of new immigrants are young, unaccompanied, Latino men who experience high work-related mobility and lack of access to health care. There is growing data documenting frequent use of sex workers among migrant men, yet little is known about these interactions. In May 2010, the CDC Division of STD Prevention conducted an exploratory rapid assessment to better understand the STD/HIV risk behaviors and prevention needs of migrant men and the sex workers who provide services to them, and to provide recommendations for improving services.

Using a rapid assessment approach, we carried out field observations and key informant interviews with 28 providers from state and local HIV/STD and rural health programs, community based organizations and law enforcement/legal service agencies. We solicited information on the social, work and residential contexts in which migrant men experience risk, the availability of sexual health services, and recommendations for improving services. Data were analyzed using NVivo7.

Findings from the rapid assessment indicate that Latino migrant men in North Carolina are at increased risk for STD/HIV due to recurrent contact with sex workers, lack of knowledge about STDs, inconsistent use of condoms, and lack of available prevention services. The assessment identified contextual barriers to risk reduction, including law enforcement policies that discourage condom use, lack of Spanish-speaking public health staff, lack of program knowledge about how to reach mobile populations, and lack of coordination among key agencies. Recommendations to the program included strengthening outreach in identified work, residence and entertainment venues where Latino migrant men and their sex partners congregate, engaging with local law enforcement and other agencies to clarify and strengthen policies that promote risk reduction, and increasing coordination with stakeholder organizations that provide services to Latino men and their sex partners.

Rapid assessment is a useful approach for gathering exploratory data on emerging public health problems and populations. Rapid assessments provide a mechanism for soliciting valuable input from a variety of local stakeholders and community members that can be used to adapt and improve STD prevention programs.

**Abstract 2069 - Characterizing the Sexual Behavior of Labor Mexican Migrants: Practices, Partners, Contexts, and HIV Risk**

**Author(s):** Melbourne F. Hovell; M. Gudelia Rangel; Xiao Zhang; Carol L. Sipan; Ahmed Asadi-Gonzalez; Jennifer A. Zellner; Rodolfo Corona; Norma J. Kelley; Carlos Magis-Rodriguez
Previous research suggests unauthorized labor Mexican migrant and immigrants (MMI) in the U.S. are at high risk for HIV infection. This study examines sexual behaviors, characteristics of sexual partners, and contexts of sexual practices in the U.S. among a population-based sample of deported MMIs in the border city of Tijuana, Mexico.

We conducted a cross-sectional, population-based survey of MMIs repatriated to Tijuana from August through November 2009. An anonymous, interviewer-administered questionnaire was completed by 642 MMI males. We calculated population estimates of MMI’s socio-demographic profile, migration history, sexual behavior, characteristics of sexual partners, and contextual factors surrounding their last sexual encounter during the previous 12 months in the U.S.

Deported MMIs were relatively young (Mean=31.7 years, SD=9.2) and with low levels of educational attainment (13.7% had completed high school or a higher degree). Half (49.3%) were married or cohabiting. Median length of stay in the U.S. during the previous 12 months was 11 months (25th percentile=0.2; 75th percentile = 12). About 59.8% of MMIs had sex during the previous 12 months in the U.S. Last sexual encounters in the U.S. included vaginal sex (94.3%), insertive anal sex (13.0%), receptive anal sex (0.2%), given oral sex (23.4%), and received oral sex (30.5%). Rates of condom use were 29.5% for vaginal sex, 13.9% for insertive anal sex, 0% for receptive anal sex, 13.2% for given oral sex, and 11.4% for received oral sex. Most MMIs last sexual partners in the U.S. were female (97.7%), 18 to 35 years old (71.3%), and born in Mexico (64.8%). Among sexual partners born in the U.S. (26.5%), the majority was Latino or Hispanic (68.2%). Almost 1 out of 4 were casual partners (18.3%) or sex workers (5.1%). About 56.5% met their last sexual partner in the U.S. A third (33.6%) of their last sexual partner was an injecting drug user. Less than half (48.8%) were sure their last sexual partner did not have HIV. For 14.8% of MMIs, last sexual encounter in the U.S. did not take place in a home. Consumption of alcohol (30.0%) or other drugs (7.9%) prior to or during sex was also relatively common.

These findings suggest high risk for HIV infection among labor MMI males based on low rates of condom use, high-risk sexual partners, and the contexts in which their sexual practices in the U.S. take place. Results from this study can help to better assess the level of HIV risk, increase our understanding of the factors that contribute to HIV infection, and identify targets of future binational HIV prevention interventions aimed to reduce HIV risk among labor MMIs in the U.S.

Track B
B02 - Monitoring the HIV Epidemic Among MSM
Room: Piedmont (Hyatt Regency Atlanta)

Abstract 1384 - Challenging Life Situational Factors Associated with HIV Status among Young, High-Risk Gay and Bisexual Men
Author(s): Gordon Mansergh; Stephen Flores; Sharon Hudon; David McKirnan; Grant Colfax; Beryl Koblin

Men who have sex with men (MSM) accounted for more than half of all new infections in the United States from 2005-2008. Approximately 23% of the new infections were among young MSM, between 13-24 years of age. Challenging life situations (e.g., low income, history of incarceration, substance abuse) and other factors have been associated with high-risk behaviors among young MSM (YMSM). However, few studies have examined these factors by HIV status.

Convenience sampling for a behavioral intervention trial was conducted from 2005-2006 in four US cities (Los Angeles, San Francisco, Chicago, New York). Eligible MSM reported substance use during anal sex and unprotected sex with a non-primary partner in the prior 6 months. Participants used an audio-computer assisted instrument to answer questions concerning their demographic characteristics and risk behavior. The dependent variable was reported HIV serostatus (negative, positive, unknown). This baseline assessment analysis was limited to YMSM aged 18-29 years. Chi-square and logistic regression analyses were used to determine differences by HIV serostatus.
Of the 1,580 men who completed baseline survey, 27% (n=409) were 18 - 29 years of age, namely YMSM. 65% (266/409) of the YMSM were HIV-negative and 18% (74/409) were HIV-positive. The YMSM were 36% white, 26% Latino, 20% black/African American, and 19% mixed/other races. A majority of the sample had some college education (66%), was currently employed (59%), had annual incomes of $20,000 or more (51%), and self-identified as heterosexual/gay (86%).

In logistic regression analysis, HIV-positive YMSM (vs. HIV-negative) were more likely to have an incarceration history (OR= 3.2, 95% CI= 1.9 - 5.5), been homeless in the last 3 months (OR=2.0, CI= 1.1 - 3.7), traded sex for money or drugs in last 3 month (OR=2.4, CI= 1.4 - 4.0), had no income or less than $10,000 (OR=3.5, CI=1.9 - 6.5; OR=4.4; CI=2.2 - 8.8), had a history of alcohol (OR=2.5, CI= 1.2 5-5) or drug (OR=3.1, CI= 1.6 - 6.1) treatment, and been unemployed (OR=2.5, CI= 1.5 - 4.3). HIV-positive YMSM (vs. unknown serostatus) were more likely to have had no income or less than $10,000 (OR=3.4, CI=1.5 - 7.7; OR=3.6; CI=1.5 - 9.0) and a history of drug treatment (OR=4.1, CI= 1.4 - 11.8). YMSM of unknown serostatus (vs. HIV-negative) were more likely to have an incarceration history (OR=1.8, CI=1.0-3.1), been forced to do something sexually before the age of 16 (OR=2.0, CI=1.2 - 3.5) and to be unemployed (OR=1.9, CI= 1.1 - 3.2).

In this sample of high-risk, substance-using YMSM, HIV-positive and unknown serostatus MSM present particularly challenged life situations compared to high-risk HIV-negative MSM. HIV-positive and unknown serostatus YMSM may require multilevel interventions to address the myriad of issues they face.

**Abstract 1747 - Age Differences in High Prevalence of Sexual Concurrency and Concurrent UAI Among U.S. MSM**

**Author(s):** Eli S. Rosenberg; Christine M. Khosropour; Patrick S. Sullivan

Men who have sex with men (MSM) represent the largest HIV risk-group in the US and the only group for whom incidence is increasing. HIV incidence in young MSM is increasing disproportionately, although while the majority of new infections are still reported among older men. Sexual concurrency is believed to accelerate HIV transmission and may contribute to observed increases in HIV incidence among MSM. However, limited information is available on concurrency and age differences among MSM or on the extent to which MSM in concurrent relationships engage in unprotected anal intercourse (UAI).

Data are from baseline responses in a prospective online study of MSM aged &gt;8805; 18 years, having &gt;8805; 1 male sex partner in the past 12 months, and recruited from social networking websites. Pair-wise sexual concurrency in the previous 6 months (p6m) among up to 5 recent partners was measured using an interactive sexual timing calendar. UAI in the p6m was assessed for each partner. Measures of concurrency and concurrent UAI were compared across age groups using the Cochran-Armitage Test for Trend.

Among 3,008 MSM with a male sex partner in the p6m reporting 10,862 partnerships, 44% indicated concurrent partnerships in the p6m. Participants ages 18-19 years indicated 34%, 20-24 years: 41%, 25-29 years: 43%, 30-39 years: 46%, 40-49 years: 52%, 50+ years: 47% (p &lt; .0001) . Among those with multiple sex partners, 60% indicated concurrent partners in the p6m. Participants ages 18-19 years indicated 49%, 20-24 years: 57%, 25-29 years: 61%, 30-39 years: 62%, 40-49 years: 70%; 50+ years: 62% (p &lt; .0001). Overall, 16% of participants indicated concurrent partnerships and had UAI with each of 2 concurrent partners. Among those with multiple partners, 23% had concurrent UAI; among those with concurrent partners, 39% had concurrent UAI.

In this largest analysis of MSM partnerships to date, concurrency in the previous 6 months was common and four times higher as has been reported among heterosexual males in the previous 12 months. Unprotected anal intercourse with two concurrent partners was also common and may be catalyzing the transmission of HIV among MSM. Older men were significantly more likely than younger men to have multiple sex partners concurrently, presenting a greater opportunity for both HIV and STD transmission. Different social norms between age groups may help to explain this difference. Further characterization of concurrency among MSM is necessary.

**Abstract 1767 - Using HIV Incidence Surveillance to Examine Racial/ethnic Disparities in HIV Testing among Young MSM**

**Author(s):** Nakelsky, S; Hu, V; Sheng, Z; Kahn, E; Taylor, L; Bingham, T
While CDC recommends annual testing for all people at high-risk of HIV, MSM in Los Angeles County (LAC) may not be adhering to these guidelines. Understanding distinctions in HIV testing behaviors between subpopulations of MSM is important to promote appropriate testing frequency to decrease unrecognized HIV infection. We compared HIV testing behaviors among young men who have sex with men (YMSM) by race/ethnicity to better design and allocate HIV testing resources.

Using data collected through the Enhanced HIV/AIDS Reporting System (eHARS) and HIV Incidence Surveillance (HIS) activities, we examined HIV testing behaviors among YMSM by race/ethnicity. To calculate rates of new HIV diagnoses, we assumed 4% of males aged 13-29 years were MSM. We examined the proportion of cases diagnosed with AIDS within 6 months of HIV diagnosis (i.e. late detection) and used the Serologic Testing Algorithm for Recent HIV Serocconversion (STARHS) to estimate the proportion of cases diagnosed within 12 months of acquiring HIV (i.e. recent infection). Using HIS data, we also examined the proportion of new cases who were first time testers.

In 2008, 553 MSM aged 13-29 years were newly diagnosed and reported to the LAC Department of Public Health eHARS. Latinos represented the largest proportion of new cases (44%) among YMSM, followed by blacks (25%) and whites (21%). Black YMSM were disproportionately affected with a new HIV diagnosis rate of 30 per 1000 compared with 9 and 8 for whites and Latinos, respectively. Late detection of HIV was the same (17%) among Latinos, blacks, and whites. Of the 459 YMSM diagnosed with non-AIDS HIV, 256 (56%) had a STARHS result available. More whites (50%) were recently infected compared with 37% of blacks and 36% of Latinos (p=0.07 for white vs. black/Latino). Among the 302 cases with testing history data available, 26% of Latino YMSM reported the HIV positive test was their first HIV test compared with 11% of blacks (p=0.01) and 10% of whites (p=0.01).

Approximately 56% of male LAC residents aged 13-29 years are Latinos. Accordingly, Latinos represented nearly half of the HIV cases among YMSM in LAC. Compared with other YMSM, Latinos were more likely to learn they were already HIV positive at their first test. This finding may indicate a barrier to HIV testing for Latino YMSM that may not be present among whites and blacks. Additionally, blacks remain disproportionately impacted by HIV. Despite similar testing behaviors for blacks and whites, HIV diagnosis rates were over three times higher for blacks than whites or Latinos. We conclude that blacks and Latinos would benefit from earlier HIV testing. This can be achieved through targeted social campaigns emphasizing the importance of early and frequent testing for young black and Latino MSM.

**Abstract 1946 - A Mathematical Evaluation of the Effect of Disclosure on HIV Transmission Risk in MSM**

**Author(s):** Ann A. O’Connell; Sandra Reed

Men who have sex with men (MSM) remain disproportionately represented in national HIV/AIDS statistics. Currently, 69% of all adolescent/adult HIV diagnoses involve males and 49% of these cases can be traced exclusively to male-to-male sexual contact. Extant research regarding the relationship between HIV disclosure and risky sexual behavior has produced mixed results (Kalichman & Nachimson, 1999; Simoni & Pantalone, 2005). This paper presents a detailed review of the mathematical model for disclosure-related HIV transmission risk suggested by Pinkerton and Osmond (2007), and summarizes the application of the model to baseline data from a randomized clinical trial (RCT) of the effectiveness of the exposing Yourself (EY) disclosure intervention currently underway.

Baseline data for the RCT included 100 HIV-positive MSM, recruited in a large, Midwestern city. Participants were primarily Caucasian (n =53, 53%) or African American (n = 39, 39%), and their average age was 41.0 years (SD=10.2). At baseline, participants provided specific information on their last 5 sexual encounters, and were randomized into treatment condition. In preliminary analyses, no differences between treatment groups were found.

Sexual encounters were reported by 89 men at baseline. Results of disclosure and condom use are presented for their first reported sexual encounter. Of those who reported an encounter, 63 said they either disclosed or had sex with someone to whom they had previously disclosed and 26 men did not disclose (P(Disclosure) = D = 70.8%). Among these 63 men, 46 men reported having anal sex (P(agrees to intercourse | disclosure) = S = 73.0%). Among
the 26 men who did not disclose their status, 13 men reported having anal sex (P(agree to intercourse | no disclosure) = 50\%). Among the 46 men who had intercourse after disclosure, 19 men reported always using a condom (P(condom use during anal sex | disclosure) = K = 41.3\%). Among the 13 non-disclosures engaging in anal sex, 6 reported using a condom (P(condom use | no disclosure) = C = 46.2\%).

Following Pinkerton et al., an overall probability of transmission can be estimated from: P(D,K,C) = DS(1 - eK)a + (1-D)(1 - eC)a. We used the same assumptions for HIV transmission probabilities as Pinkerton, et al.: P(transmission through unprotected intercourse) = a; P(condom effectiveness at preventing HIV) = e. We can calculate the effectiveness of disclosure (E(K, C)) by looking at relative reduction in risk, E(K, C) = 1 - [S(1 - eK)]/(1 - eC)]. Using e = .90 we find E(K, C) = .215. The effectiveness of disclosure at reducing risk of transmission relative to non-disclosure is 21.5\%.

Our results are preliminary and do not take into account as of yet the seroconcordance of partners. Overall, 44\% of our participants indicated their partner was also positive. At baseline the disclosure and non-disclosure condom-use rates are relatively equal, and the agree-to-sex rate after disclosure is high. The greatest benefits of disclosure could occur as S decreases or K increases. As we gather data post-intervention, modeling the probabilities of disclosure and condom use and estimating reduction in transmission risk holds promise as we further understand the effectiveness of disclosure as an intervention strategy.

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**Track B**

**B09 - Data for Prevention Programs for Transgendered Persons**

**Room:** Spring (Hyatt Regency Atlanta)

**Abstract 1212 - Including Transgender Individuals in Biomedical HIV Prevention Intervention Trials: Lessons Learned from the BuMP Study**

**Author(s):** Sarah Colvario; Jenna Rapues; Deirdre McDermott Santos; Susan Scheer; Moupali Das; Grant Colfax

Transgender populations experience a high degree of social stigma and disempowerment, and also suffer from disproportionate levels of HIV infection and substance use. However limited effort has been made to include transgender individuals in research studies and assess their risk behaviors. Additionally, respondents risk behaviors with transgender partners are rarely ascertained. Omission of transgender individuals from biomedical HIV prevention intervention research further contributes to the marginalization of this community.

BuMP is a series of pharmacologic trials of medications to reduce methamphetamine use and associated sexual risk among methamphetamine-dependent MSM. In recognition of the high-risk status of transgender populations, the BuMP inclusion criteria was modified to include transgender individuals. This decision presented a number of technical challenges with regard to adapting an existing HIV behavioral risk survey for the transgender population.

BuMP collects information on sexual behaviors pertaining to specific genitalia (e.g. vaginal sex, insertive anal sex) to determine HIV risk. Respondents answer questions using an audio-computer assisted self-interview (ACASI) survey tool with imbedded skip instructions and patterns designed to reduce participant burden by allowing respondents to bypass questions that do not pertain to them, based on self-reported gender or sex. The new transgender-inclusive criteria for BuMP required supplementary qualifying follow-up questions about genitalia, because self-reported gender does not always correlate with gender assigned at birth or current anatomy. To minimize potential offense and discomfort for transgender respondents, study staff garnered input from the San Francisco Transgender Advisory Group, composed of providers and community members, during development of these follow-up questions.

Additionally, supplemental sections were added, with accompanying skip instructions, to determine participants risk behaviors with transgender partners to capture risk engagement with partners of all genders. Once the questionnaire was created, staff pilot tested the new ACASI to correct any reported inconsistencies. Data from the pilot test was validated before the new questionnaire was implemented.

We added 225 new questions to the risk assessment to capture a myriad of possible behavioral risk and partner type permutations. Prior to adding these changes, the median time to complete the baseline survey (the most exhaustive session) was 21.1 minutes (IQR = 16.4-27.9). To date, 58 participants have completed the new questionnaire.
The median time to complete the new baseline survey was 24.7 minutes (IQR=18.7-32.9). Study participants have not reported any difficulties from the new ACASI. Our survey development approach has resulted in a transgender-inclusive tool that (1) correctly captures gender demographics, (2) assesses HIV risk behavior longitudinally, (3) reduces burden for all participants, and (4) uses culturally appropriate and sensitive language to determine sexual behavior pertaining to specific genitalia for transgender individuals.

We conclude that it is feasible to modify an ongoing study questionnaire and make it transgender inclusive without significantly increasing participant burden. Surmounting the technical and cultural challenges involved in collecting data about transgender participants and transgender partners will assist in furthering the body of knowledge for this understudied yet vulnerable high-risk group and will increase the generalizability of the study's findings.

Abstract 1491 - Correlates of HIV infection among transfemales: San Francisco, 2010
Author(s): Jenna Rapues; Tracey Packer; Erin Wilson; Grant Colfax; H. Fisher Raymond

Transfemales bear a disparate burden of HIV infection. Studies on HIV infection and behaviors among transfemales are lacking or out of date; to our knowledge there are no representative data on this population. Current data are needed to inform and prioritize HIV/AIDS prevention interventions for transfemales.

During 2010, we conducted a study of transfemales in San Francisco using respondent driven sampling to recruit a diverse sample of transfemales. Eligible participants identified as being assigned a male sex at birth, while currently identifying as female or transgender, and were residents of San Francisco.

314 transfemales were recruited into the study. In terms of race / ethnicity, the sample was 6.7% Asian, 28.0% Black, 16.6% White, 30.6% Latina and 18.2% Other race. The overwhelming majority (89.9%) had a high school or less education. Among the 298 participants from whom HIV test results were available, 123 (41.3%) were HIV-positive. HIV prevalence was high among both transfemales who ever injected drugs (46.3%) and those who never injected drugs (38.9%). In bivariate analysis, HIV-infected transfemales were more likely to be Black (p <0.001), identify as transgender rather than female (p = 0.02), not have ever taken hormones (p = 0.01), not have ever had any gender confirmation surgeries (p = 0.02), have health insurance (p = 0.04), have injected illicit drugs in the past 12 months (p = 0.03) and have had 3 partners in the past six months (p = 0.03).

In San Francisco, HIV prevalence among transfemales is higher than any other behavioral risk population except MSM-IDU. These data also show an upward trend in HIV infection within the transfemales population when compared to previous data collected. Similar to patterns of HIV prevalence among MSM, Black transfemales are at elevated risk for HIV compared to other racial/ethnic groups of transfemales. Surprisingly, characteristics typically found to be associated with HIV risk among transfemales such as age, education, income, country of birth and behaviors such as commercial sex work, non-IDU substance use, alcohol use, history of arrest, unprotected vaginal and / or anal intercourse were not bivariately associated with HIV-infection. However, our findings do suggest that transfemales who do not access gender confirmation services are more likely to be HIV-infected compared to transfemales who are engaged in gender transition. This finding points to the potential importance of programs that make gender transition services accessible to individuals wishing to transition, and the potential of these programs to reduce HIV infections among this high-risk population. Our study provides current HIV-prevalence estimates for transfemales and suggests avenues to pursue for both future research and HIV prevention interventions.

Abstract 1591 - First Federal Support for Community Based Syringe Exchange Programs: A Panel Presentation by SAMHSA Grantees
Author(s):
In March 2010, President Obama signed an appropriations act modifying the ban on the use of Federal funds for syringe exchange programs (SEPs). In July 2010, implementation Guidance for Syringe Services Programs (SSPs) was issued to SAMHSA and CDC. SAMHSA developed agreements with 10 existing grantees approving the use of Federal funds to support programs making direct referrals from existing SEPs to treatment. This initiative was the first of its kind following the modification of the ban. Existing research indicates that SEPs benefit people in active addiction, reduce the spread of HIV and other blood borne pathogens, and is cost effective. SEPs also offer access to substance abuse treatment, HIV prevention counseling (including partner notification), and other services to this population. Furthermore, with increased access to sterile syringes, injection drug users can better protect themselves and their drug and sexual partners. The 10 grantees currently working with SEPs conduct activities under several modalities: methadone maintenance, harm reduction, outreach engagement, and pharmacy voucher programs.

The 10 TCE/HIV SAMHSA funded sites are located in Delaware, Illinois, Connecticut, Puerto Rico, New York, New Jersey, Pennsylvania and Massachusetts.

Each of the SAMHSA sites expanded and enhanced their existing services by collaborating with local SEPs. The goal of these projects include increasing admission to treatment, increasing HIV testing, decreasing risky behavior, and improving overall health of injection drug users.

As a result of this SAMHSA Initiative local programs have access to support from the Federal government, local health departments and law enforcement officers. Preliminary evaluation data suggests each of the grantees are successfully reaching an underserved population. Collaboration between treatment programs and SEPs create a gateway to care, testing, and treatment for long-term heroin users in a non-threatening environment.

**Track C**

**C11 - Interventions & Clinical Trials: Enrollment, Retention, and Inclusion Issues**  
**Room: Hong Kong (Hyatt Regency Atlanta)**

**Abstract 1566 - HPTN 064 (ISIS): Identifying and Retaining US Women at Increased Risk of HIV Infection**  
**Author(s):** Danielle F. Haley; Jonathan P. Lucas; Harmony C. Waller; Elizabeth A. DiNenno; Lydia E. Soto-Torres; Jessica E. Justman; Sally L. Hodder

HIV/AIDS is a leading cause of death among young women of color in the US; two-thirds of new infections in US women occur in Black women, despite the fact that Black women constitute only 13% of the US female population. To realize major reductions in new HIV cases among women, evidence-based approaches must be found that reliably diminish HIV incidence in at-risk women. However, scant HIV incidence data exist for US women, impeding the ability to design robust HIV prevention trials. In addition, women considered most at risk for HIV are also some of the most difficult to retain in HIV prevention trials, further hampering the ability to not only define HIV-incidence among women in the US, but to also identify the characteristics that put these women at increased risk of infection. HPTN 064, the Women's HIV SeroIncidence Study (ISIS), has applied novel methodology to both enroll and retain women at risk for HIV infection in a longitudinal HIV incidence study.

Ten US communities with high rates of poverty and HIV seroprevalence located in the following municipalities (Atlanta GA; Decatur GA; Baltimore MD; Newark NJ; New York NY; Raleigh NC; Durham NC; and Washington DC) were selected to enroll a large cohort of women at risk for HIV infection.

Eligibility criteria included age 18-44 years, residing in a census tract/zip code with high poverty rates and HIV prevalence, and self-reported behavior and/or a recent sexual partner with at least one behavior related to HIV acquisition risk (e.g., incarceration history, drug and/or alcohol use). Communities were defined based on the National HIV Behavioral Surveillance (NHBS) methodology (among heterosexuals at increased risk), which combines US Census poverty data with state health department HIV prevalence data and using a standardized algorithm to identify census tracts or zip codes where there is a high risk of HIV transmission. Ethnography was conducted within the highest ranking zip codes/census tracts in each community to identify community gatekeepers and venues where women most at risk congregate. Venue-based sampling was used to recruit women who were then followed 6-12
months after enrollment to determine HIV incidence. Retention has been closely monitored and maintained through a variety of approaches, including on-going community engagement, social media, social marketing campaigns, phone calls and mailings to participants, home visits, and inter-team retention workshops.

A cohort of 2,098 sexually active women, median age 29 years was enrolled over approximately 14 months. Race of study participants is as follows: Black or African American 88%, White 8%, American Indian/Native Alaskan 1.7%, Asian 0.3%, Other 5%. Twelve percent of participants were Hispanic. To date, 93% have completed their 6-month follow-up visit, and of the women who have reached the 12-month timepoint, 93% have been retained in the study.

Excellent study retention rates in populations of women from marginalized communities may be attained but require multiple strategies including effective community outreach and collaboration with community organizations.

**Abstract 1607 - Preventing Clinical Trial Co-Enrollment through Biometric Identification: Experiences of HIV Prevention Trials in Western Kenya**

**Author(s):** Lisa Mills; Kawango Agot; Elizabeth Bukusi; Craig R. Cohen; Lut van Damme; Arthur Ogendo; Fredrick Owino; Josephine Odyoo; Anthony Otieno; Fred Motende

Participant co-enrollment in simultaneous biomedical intervention trials can be unsafe and scientifically problematic, but is difficult to prevent. Three HIV prevention trials in western Kenya undertook a novel collaboration, using identical biometric methods for participant identification and periodic intra-study merging of these identification data, to prevent and/or identify co-enrollment by participants. The three HIV prevention trials had partially overlapping enrollment timing, catchment areas, and eligibility criteria, making detection of co-participation imperative. Two were pre-exposure prophylaxis trials (Partners PrEP in HIV discordant couples, FemPrEP in high-risk women) and one was a trial of early antiretroviral therapy for the prevention of transmission in serodiscordant couples (HIV Prevention Trials Network Study 052, or HPTN052). The study teams also agreed to focus their recruitment efforts in different geographic regions within the shared catchment area, in order to avoid co-enrollment.

All studies implemented identical hardware, software, and methodologies for fingerprinting to identify study participants at each study visit. Study-specific biometric identifier databases for participants were developed; these did not include other identifying information and did not store fingerprint images directly (to protect confidentiality). These databases were merged at regular intervals to determine if participants had been screened and/or enrolled in one study before participating in another. All activities were IRB-approved from all relevant authorities for each study.

Following initial challenges in standardizing fingerprint capture methodology across sites and optimizing accuracy of database merging procedures, the team was able to successfully determine retrospectively that 2 out of 4891 screened participants had screened for more than one study. One of these was excluded at screening. The other had gone on to be enrolled into two studies, the only co-enrollment among 1488 total enrolled participants. The relevant study teams worked with one another, their protocol teams, and the co-enrolled participant/couple to resolve the case, resulting in the withdrawal of the participant from the second of the two studies into which she had enrolled.

Overall acceptability and operational ease of fingerprinting for biometric participant identification were high in the western Kenya setting of the 3 HIV prevention trials which collaborated in this initiative. Biometric participant identification using fingerprinting offers great potential for prevention of co-enrollment. Successful implementation of such methodologies could yield benefits in safety of study participants and scientific validity of intervention trials. Care must be taken to ensure consistency of procedures across sites/studies and to validate whether database merging and querying for co-participation is effective and timely, in order to prospectively prevent participants from enrolling in multiple studies. Issues of participant autonomy, safety, scientific validity, confidentiality and research ethics must be carefully managed when implementing such novel collaborations between studies.

**Abstract 1866 - Development of a Black Caucus in a Community Level HIV Prevention Intervention for Black MSM**

**Author(s):** Christopher Watson; Leo Wilton; Lawrence Bryant; Jonathan Lucas; Gregory Victorianne; Sheldon Fields; Darrell Wheeler; HPTN 061 Black Caucus
Black men who have sex with men (MSM) in the United States (US) have experienced extremely high rates of HIV infection since the onset of the AIDS epidemic (CDC, 2010). Current research has identified high rates of STIs, infrequent HIV testing, late diagnosis of HIV infection, and sexual networks as key factors associated with increased HIV risk for Black MSM (Millett et al., 2007).

The HPTN 061 (The Brother's Study) is a feasibility study of a multi-component HIV prevention intervention for approximately 2,500 Black MSM in six US cities (Atlanta, Boston, New York City, Los Angeles, San Francisco, and Washington, DC). The Black Caucus is reflective of a community based participatory research method where Black Caucus members have actively engaged in the development and implementation of this feasibility study. The Black Caucus was developed at the ground level by a team of Black MSM researchers and community members who were affiliated with HPTN 061.

The objective of this formative project is to describe the development and implementation of the Black Caucus as a culturally grounded model for the integration of Black MSM in clinical trials and research in the HIV Prevention Trials Network (HPTN 061, the BROTHERS Study). HPTN 061 assesses the feasibility of a community level, multi-component HIV prevention intervention for 2,500 Black MSM in six cities in the US, in preparation for a community-level randomized trial to evaluate the efficacy of the intervention in reducing HIV incidence among Black MSM. A key emphasis of HPTN 061 is to assess the effectiveness of reducing HIV incidence rates among Black MSM through a multi-site HIV prevention intervention that incorporates HIV/STI testing and referral to care, identification of undiagnosed HIV/STI infections, referral of sexual partners for enrollment into the study, connecting Black MSM to health care and other services using trained peer navigators, and examination of socio-cultural, psychological, and substance use factors associated with HIV protective and risk behavior among Black MSM.

Qualitative interviews were conducted with key stakeholders involved in the development and implementation of the Black Caucus for HPTN 061. Qualitative themes that emerged from the interviews focused on the salience of addressing key socio-cultural factors for Black MSM (e.g., cultural distrust), cultural competencies of researchers and clinical staff affiliated with the project, under-representation of Black MSM in HIV clinical trials, and under-representation of Black MSM HIV prevention researchers. The Black Caucus provides culturally grounded expertise in the direction of HPTN 061, community engagement, study design and implementation (e.g., retention), and the analysis, interpretation, and dissemination of data from Black MSM perspectives. Significantly, these findings indicate the dire need for the sustained emphasis on culturally grounded HIV prevention research efforts in Black MSM communities. There is a critical need for innovative approaches to address the void in efficacious and culturally relevant community level HIV/STI prevention interventions for Black MSM. This involves the development, implementation, and evaluation of culturally relevant networks at the ground level within community level HIV prevention interventions from Black MSM perspectives.

Track D
D04 - Changing Course: Issues and Challenges in Implementing Effective Risk Reduction Interventions
Room: Hanover E (Hyatt Regency Atlanta)

Abstract 1322 - Optimizing Your DEBIs: Ways to Enhance the Success of Evidence-based Interventions
Author(s): Marlene Glassman

While increased attention is being placed on biomedical and structural interventions, evidence-based behavior change interventions are the backbone of HIV prevention and important vehicles for reducing HIV risk behavior. Agencies throughout the US implement behavioral interventions through CDC’s Diffusion of Effective Behavioral Interventions (DEBI) project for at-risk populations ranging from young men of color who have sex with men to African American women and Latinas. Implementing agencies want their interventions to achieve optimal performance so that clients have the greatest chance to reduce their risk of HIV infection. The way interventions are implemented has a direct impact on the results clients can achieve from their participation in the intervention. Operational research (OR) has emerged as a way to help agencies identify implementation problems and create and test strategies to address them. In addition, implementation research, monitoring and evaluation, quality assurance,
technical assistance and training, and capacity-building assistance are other approaches community-based organizations (CBOs) can use to help ensure successful implementation. This presentation will provide an overview of these approaches and identify strengths and challenges when used to improve DEBI implementation.

Based on the specific intervention, DEBIs can be implemented in diverse settings, including CBOs, health care facilities, gay bars, and street corners. Regardless of the setting, proper implementation is of utmost importance because clients are less likely to achieve the objectives of the intervention if it is not properly implemented.

Through literature reviews on operational research and its use in HIV prevention, the Operational Research Team in CDC's Division of HIV/AIDS Prevention has identified ways OR can be used to strengthen the implementation of DEBIs. OR can help identify problems and can be used to identify and test strategies to solve them. Examples of OR questions are, how can we know if we're recruiting the right target population's that can be done to retain more clients; and how can we know we're maintaining fidelity to core elements? The team also developed a working definition for OR when applied to HIV prevention, generated OR questions for various types of interventions, and examined how OR differs from implementation research and other approaches used to monitor and improve implementation.

OR is one of many approaches that can be used to strengthen intervention implementation. CDC staff will share information on OR for the study and testing of ways to strengthen DEBIs. Other approaches, such as monitoring and evaluation and quality assurance, are considered and compared to the OR approach. CBOs have choices in the ways they can monitor intervention delivery and take action to enhance DEBI performance. With information on various approaches, CBOs will be equipped to consider which ones provide the best fit for their implementation challenges.

**Abstract 1377 - Ethnographic Methodologies Used to Inform Adaptation of Effective Behavioral Interventions**

**Author(s):** Aaron J. Shipman; Terry W. Stewart; Patricia Coury-Doniger; Linda De Santis; Anne Freeman; Alice Gandelman; Ann Schwartz

Community Based Organizations (CBOs) and AIDS Service Organizations (ASOs) wanting to implement Effective Behavioral Interventions (EBIs) often encounter interventions which do not address specific population needs. Many agencies in this situation have used their own adaptations based on what felt right or what made sense? Others have created their own interventions as a way to meet the needs of their communities. Many of these agencies find that their adapted and created interventions have worked well for their communities and agencies. Unfortunately, others, usually after great expenditures of time, energy, and money, have discovered that such interventions have not served their communities.

CBOs, ASOs, and state and local health departments across the United States wishing to adapt interventions to better meet their intervention population's needs.

In order to assist agencies that need to adapt interventions, the National Network of STD/HIV Prevention Training Centers, in collaboration with CDC, has developed two courses, Using Focus Groups for Adapting Effective Behavioral Interventions and Interviewing and Observations for Adapting Effective Behavioral Interventions, to help provide structured, scientific approaches to inform effective adaptations. Both of these courses offer a strong, solid base from which to gather data and to utilize the data to adapt an EBI effectively.

RESULTS: Beginning with the pilot deliveries of the courses in February 2009 to present, 278 participants representing over 110 agencies attended one of the two adapting courses. Participants reported that after receiving a concretized definition of adapting and specific examples, they were already engaged in adapting. When stating reasons for adapting to meet the needs of their identified intervention population, participants cited unique cultural, racial/ethnic, and geographic needs, for example, adapting the language to reflect regional slang for sexual behaviors and drug using behaviors of MSM adolescents. Further, course participants noted that having a systematic approach to adaptations would increase the likelihood of their adaptations being successful with their intervention populations, would enable them to better document and evaluate their adaptations, and avoid reinvention. Post course evaluations
reflected satisfaction with the course and a willingness and confidence to use qualitative data gathering and analysis when adapting an EBI.

LESSONS LEARNED: Providing user friendly training on how to utilize qualitative data gathering and analysis for adapting EBIs allows agencies to better meet the unique needs of their intervention populations.

Abstract 1438 - Why do Community Based Organizations (CBOs) Discontinue Implementing an Evidence Based HIV Prevention Intervention.

Author(s): Scott Tebbetts; Susan Kegeles; Greg Rebchok; Lance Pollack

Considerable effort has been made to encourage CBOs to adopt HIV prevention evidence-based interventions (EBIs). CBOs expend scarce resources attempting to implement EBIs, but very little is known about why some organizations discontinue implementing an EBI while other organizations continue to implement it over time. Since the Mpowerment Project (MP) is one of few EBIs targeting MSM, and the only program specifically developed for young MSM, an increasing number of agencies have been adopting the intervention to target MSM in their communities. In a longitudinal, collaborative study with 72 CBOs implementing the MP, this presentation will examine why 23 agencies discontinued implementation.

Semi-structured telephone interviews were conducted with 1-5 people from each CBO at baseline, 6, 12, and 24 months. We conducted 532 interviews with 329 individuals from agencies implementing MP. Participants were asked about agency characteristics and demographics, organizational issues, attitudes toward the MP, community issues, funding issues, and open-ended questions about how they implemented the intervention, including implementation of each core element. T-tests and chi-square tests were computed on baseline data to compare the 49 agencies that continued to implement the MP through 24 months with the 23 agencies that discontinued implementation. 14 CBOs that discontinued implementation also participated in an open-ended interview about their decision to discontinue implementation. Responses were entered into a database near verbatim as much as possible and then coded.

Agencies that discontinued (vs. continued) implementing the MP by the 24 month follow-up had a smaller annual budget (p<.001, approximately 3 times smaller), fewer staff to run the intervention (p<.05), had been implementing the MP for less than half as long at baseline (p<.05); and slightly: less trust in their executive director (p<.10), lower perceived agency efficacy to implement the MP (p<.10), and lower perceived agency efficacy to secure necessary funding (p<.10). Discontinued agencies came from both urban and rural areas and focused on a variety of target population age ranges and ethnicities. More than half the agencies discontinued the MP between baseline and the 6-month follow-up, and thus did not attempt to implement it for very long. Qualitative data showed CBOs that discontinued it showed an incomplete understanding of the MP before implementation, did not plan for it, and never achieved full implementation.

Agencies and funders need a better understanding of an EBI before attempted implementation, including the overall intervention, its core elements and why they are all necessary, and the financial and human resources required. Planning for implementation is essential, and more work should be done to educate agencies about an EBI prior to attempting implementation. Agencies attempting to implement an EBI without such planning and knowledge risk underfunding and understaffing the intervention, thus jeopardizing sustainability and investments of scarce resources. As a result, agencies may prematurely conclude that the EBI cannot work in their community or for their target population. Based on these findings, we developed tools to help educate CBOs and their funders about the MP prior to implementation, which will be

Abstract 2090 - Strengthening HIV Prevention Programs: The Role of Capacity Building Assistance Strategic Plans in Program Success

Author(s): Kimberly Murray; Maria Alvarez

In 2010, the CDC awarded $42 million via PS10-1003 to 133 community-based organizations (CBOs) to support their implementation of HIV prevention programs targeting individuals at high risk for acquiring or transmitting HIV infection. Funded CBOs often are concerned about maximizing the use of these resources in order to achieve
programmatic goals. Moreover, CBOs recognize the need to adjust seamlessly to changes in the external environment, such as the implementation of the National HIV/AIDS Strategy, in order to remain sustainable. Planning and implementing a coordinated capacity building assistance (CBA) response is critical in order to assist CBOs in implementing, monitoring, and sustaining their HIV prevention programs across and beyond the life of their 5-year cooperative agreements. However, although support exists (through PS09-906 CBA providers), CBOs often do not access CBA services due to the perceived stigma associated with requesting CBA. A tailored, proactive strategy is needed to normalize CBA and ensure that each CBO gets the unique support it needs.

CBO needs assessments and CBA strategic plans have been developed for PS10-1003-funded CBOs in 31 states and/or U.S. territories.

Between November 2010 and April 2011, 10 PS09-906-funded CBA providers specializing in organizational infrastructure and program sustainability collaborated with PS10-1003 CBOs to develop CBA strategic plans for each of the 133 newly funded CBOs. The development of these strategic plans involved a 3-prong process that consisted of (1) relationship building, review of program materials, and systematic data collection; (2) face-to-face field visits; and (3) creation and formal acceptance of tailored CBA strategic plans. The CBA providers utilized a comprehensive CBO needs assessment tool that was designed to capture nuances in capacity in three domains: Evidence-Based Interventions and Public Health Strategies, Monitoring and Evaluation, and Organizational Infrastructure. In addition, enhancements were made to the CBA Request Information System (CRIS) to provide a secure, online application in which to store the completed CBO needs assessments and CBA strategic plans. This application allows the Capacity Building Branch to determine whether submitted requests for CBA are linked to strategic plan priorities.

This presentation will provide an overview of the CBO assessment and strategic planning process, a snapshot of the organizational profiles, a summary of the CBA needs most frequently reported by CBOs across the nation, and recommendations for a cost-effective and proactive strategy for addressing the identified CBA needs on a national level.

LESSONS LEARNED: Taking a proactive approach to assessing CBA needs is an effective means of normalizing CBA services while developing a strategy to ensure that CBOs have the support they need to implement, monitor, and sustain their HIV prevention programs. This requires close collaboration and trust between both CBA providers and CBOs receiving CBA services, and between the CDC program consultants and project officers who oversee cooperative agreements. In addition, CDC-funded CBA providers and consultants must be prepared to address the resultant increase in CBA requests generated by CBOs. Finally, there are opportunities for coordination of training and technical assistance services between the CDC, grantees, and local and state health departments to meet jurisdictional CBA needs.

Track D
D07 - Bringing the Social Media Revolution to HIV Prevention
Room: Hanover F/G (Hyatt Regency Atlanta)

Abstract 1168 - Using Technology and Social Media for Outreach, Health Communication and Partner Services
Author(s): Stephan Adelson; Rachel Kachur

Virtual communities have replaced many traditional forms of general socialization and are being used to find life partners and to facilitate sexual encounters. These new forms of communication and socialization have presented new opportunities and challenges for all of public health. Community-Based organizations struggle to find ways to communicate with target populations and develop effective and sustainable programs, policies, and practices for the use of social media and online communities in their prevention and education activities. Departments of health often receive internet locating information on partners of patients testing positive for HIV and other infections and are challenged in using this information effectively to conduct partner services. Additionally, there is a general lack of understanding of what populations access what technologies and what online social media tools are best for which activities in the vast arena of social media.
All of public health needs a basic understanding of the Internet and other technologies as they exist today. Departments of health need examples of effective partner services programs that effectively use technology. Community-based organizations need examples of use for social media and HIV education prevention activities. Facilitators will present data on Internet use in the United States and show what social media tools and venues are popular and being used which specific populations. The presenters will introduce the most popular social networking and social media websites and provide program examples of programs currently using those tools for partner services, outreach and health communication. This session will also discuss policy development and provide tips and recommendations for the use of technology-based tools in HIV prevention, education, and health communication activities.

In understanding the Internet and what is possible for programs within online communities, CBOs and HDs will be better prepared to use these technologies effectively in their programs. The speaker has extensive experience working with CBOs and HDs and will discuss, who is and who is not online, what sites are popular, what social media tools are being used by what populations and will provide examples, tools and resources.

Abstract 1462 - Using Social Network Methodology to Locate and Identify Undiagnosed HIV-positive MSM and Transgender Women

Author(s): Joshua L. Riley, MS; Ashley R. Bragg; Cathy J. Reback, PhD, Jesse B. Fletcher

There are approximately 13,500 persons in Los Angeles County (LAC) who are HIV-positive and unaware of their status. At-risk gay/bisexual men and other MSM and transgender women (TGW) are at increased risk of HIV acquisition and transmission due to substance use, high-risk sexual behaviors, and multiple co-factors including homelessness, poverty, mental illness, lower educational attainment, incarceration cycles, and homophobia and transphobia.

A community-based HIV prevention setting in Hollywood, CA located in the hub of the sex work district for MSM and TGW, and identified as a hot spot area of emerging HIV prevalence.

Peer recruiters were trained to identify and coach members of their social, sexual, and drug-using network (associates), who have a negative or unknown HIV status, to seek HIV counseling and testing. Social network associates who completed HIV testing were then eligible to become recruiters. Incentives were provided to both recruiters and associates.

From March 2010 through December 2010, 70 recruiters were enrolled, and 707 associates received an oral rapid HIV test. Of the 707 associates, 93.8% were MSM and 6.2% were TGW; 46.5% identified as gay, 28.7% heterosexual, 23.1% bisexual, and 1.7% responded don't know; 38.3% were Caucasian/white, 37.9% African-American/black, 16.7% Latino/a/Hispanic, 2.8% American Indian/Alaskan Native, 1.8% Asian, and 2.5% mixed or other. For the 12-month recall period, 84.4% of the associates self-reported homelessness or a marginal housing status, 74.3% reported no health coverage, and 38.0% reported having been incarcerated. Ninety-four percent reported any substance use; the most frequently used substances were alcohol (80.6%), methamphetamine (69.6%), powder cocaine (36.5%), crack cocaine (30.8%), heroin (19.7%), ecstasy (18.8%), and amyl nitrite (16.5%). Needle sharing was also high (43.4%). Sixty-five percent reported sex with a male partner and, among those, 47.2% reported inconsistent condom use. Associates reported an average of 15.7 sexual partners (SD=6.15), 36.9% reported sex with a sex worker, 27.9% and 23.9% reported sex in exchange for money and drugs, respectively; and 47.4% reported sex with an IDU. Of the 707 associates, 54/707 (7.6%) were preliminary positive; however, 41/707 (5.8%) were believed to be identified new positives. Of these 41 707 identified new positives, 15/707 (2.1%) were confirmed positive on site; the other 26 preliminary positives remained unconfirmed or were confirmed at another site. Of the 70 recruiters, 47 (67.1%) recruited 1 or more network associate and 34 (48.6%) were previous network associates. The number of network associates recruited ranged from 1 to 167, with an average of 15 (SD=28.0) associates per recruiter. Of the 41 new preliminary positive results identified, 11 (26.8%) were recruited by two recruiters.

Lessons Learned: A social network model is effective for reaching and testing high-risk individuals and identifying undiagnosed HIV-positive individuals. Educating recruiters to build trust and rapport with associates could serve to
minimize the number of known positives who test only for the incentive. Implementation of a rapid testing algorithm is an important next step as it would increase the number of associates who immediately complete confirmatory testing on-site and eliminate the need for a return appointment.

**Abstract 1495 - Just Us? A Success Story of Engaging Young Adults Belonging to Communities of Color Online**

**Author(s):** D. Levine; S. Bull; L. Bresl

The sexual health of young adults in the United States is a hot topic, and for good reason:
- Although 15 - 24 year-olds represent only one-quarter of the sexually active population, they account for nearly half of all new sexually transmitted infections each year.
- Young people age 13-24 make up 17% of all HIV cases reported in 2008 (http://www.guttmacher.org/pubs/FB-ATSRH.html).

As these significant statistics continue to rise, so is the use of social networking amongst adolescents and young adults. Nearly three quarters (73%) of online young adults use social networking sites, like Facebook and MySpace. Teens from lower income families (those earning less than $30,000 annually) are more likely to use online social networks than teens from wealthier households, with more than 80% of teens from less well-off households using social networks. Because of the large population of young adults on these sites, they are becoming a viable avenue for sexual health education and attitude change. However, there is limited precedent as to how to effectively engage target audiences using social media.

The study takes place on Facebook, the largest social networking site online (Comscore, 2011).

ISIS partnered with the University of Colorado to create a study which involved two Facebook pages Just/Us and 18-24news. Young adults of color aged 18-24 were recruited and incentivized to participate in a research study, where they were randomly assigned to one of the two Facebook pages. Each participant completed an initial survey, and two follow-up surveys over the next 6 months.

The study looked at whether exposure to the sexual health content on the intervention Facebook page influenced the participants attitudes towards sexual health including safe sex and HIV testing. ISIS developed a variety of engagement strategies, including young adult-facilitated discussions around HIV/AIDS and other sensitive health topics, blogs, polls, videos, and sexual health resource links. ISIS program staff developed a content grid that was followed to ensure all pertinent information was covered through the multimedia delivery methods.

Over 1,500 participants were recruited using face-to-face and online strategies; 950 were exposed to sexual health content. Interns were hired to stimulate conversation around the sexual health topics that were posted on the Just/Us Facebook page. As a result, in-depth conversations around HIV, STDs and broader sexual health topics ensued for over ten months (June 2010-March 2011).

We developed a varied, multimedia engagement strategy, including blogs, polls, and videos to covered relevant sexual health topics in youth-friendly language, delivered via a social networking platform. Interns were hired from the community who prompted discussions on many sensitive and controversial topics by study participants.

It was found that the combination of posting a variety of media, intern-facilitated discussions using a conversational style that resonated with the target population and the presence of sensitive and relevant topics to young adults led to a long-term and engaging intervention. It was also found that consistent updating of content and rotation of new interns enabled the engaged conversations to continue long-term.

**Abstract 1601 - Get Live Stay Live-Promoting HIV Testing among Young MSM of Color Using Online Social Media**

**Author(s):** Deb Levine

Young African American and Latino men ages 18-24 chiefly reside in the Mission and Bayview Districts of San Francisco. These populations report a cultural stigma related to homosexual activity that can translate into sexual behaviors that increase HIV risk. Because of this perceived and/or actual stigma, the young men are often reluctant
to avail themselves of HIV testing services in their own neighborhoods for fear of being singled out, ostracized or worse. Another obstacle is the characteristic pressure that young African American and Latino men feel against identifying themselves as gay, bisexual or transgendered men; this suppression of sexual identity has been proven to increase HIV risk. HIV testing for young men of color has become a priority in light of epidemiological data released by the U.S. CDC that indicates increasing HIV infection rates in this population.

Social media outreach for young African American and Latino men ages 18-24 chiefly residing in the Mission and Bayview Districts of San Francisco and referral to 3 partnering HIV testing clinics in San Francisco

ISIS cultivated a MySpace community and sent weekly bulletins and message blasts encouraging them to get their routine screenings at one of the get Live, Stay Live (GLSL) participating clinics. Online outreach consisted of weekly MySpace blasts, bulletin postings, event blasts that coordinated with an event going on in the Bayview or Mission neighborhoods of San Francisco, and blog posts on the Get Live, Stay Live MySpace. Tweets outlining free HIV testing for youth MSM in San Francisco were sent to Twitter followers consisting of partner organizations that serve at risk youth.

ISIS cultivated a MySpace community of over 2600 Friends. Established partnerships with 3 HIV testing clinics and provided cultural competence training to clinic staff. Online outreach included 20 weekly MySpace blasts, 10 bulletin postings, 3 event blasts that coordinated with an event going on in the Bayview or Mission neighborhoods of San Francisco, and 2 blog posts. 2 Tweets outlining free HIV testing for young MSM in San Francisco sent to over 1000 Twitter followers consisting of partner organizations serving at risk youth. 755 GLSL website page-views. GLSL collaborated with 12 San Francisco-based artists and MySpace groups with large African American and Latino males following, like Big Rich, Roach Gigz and Beeda Weeda and sent blasts to their 10,000 San Francisco-based fans. As a result, 348 young Latino and African American men tested at the 3 primary program testing sites.

Key lessons: It is important to employ members of the community to do the online outreach. When promoting testing and sexual health services, target online arenas where straight Latino and African Americans are to reach them with information about services for when they do engage in homosexual behavior. The online discussion works better if it's framed around the cultural and environmental issues that are seen as barriers to routine testing (poverty, unemployment, lack of access). Popular but low cost incentives are useful to create an initial draw to services.

Abstract 1691 - Health Education/Risk Reduction Referrals to Non-clinical HIV Testing Settings: Outcomes and Implications for Program Planning

Author(s): Philip Morris; Kevin Sitter; Susan M. Sabatier; Brian D. Lew; Karen E. Mark

Knowing one's HIV status is vital for both HIV prevention and treatment. HIV-infected individuals who are unaware of their HIV status are most likely repeat testers who have not tested in the last year. These intermittent testers have higher seropositivity rates than never tested and routine testers.

Health Education/Risk Reduction (HE/RR) Prevention and C&T programs administered by the State Health Department

Using HE/RR and C&T process monitoring data from 2008 - 2010, we analyzed HE/RR clients HIV testing history and risk behaviors. We matched clients HE/RR testing referrals to their C&T testing outcome and examined positivity rates based on HE/RR Reported testing history and risk behaviors.

RESULTS: HIV testing history was available for 41,262 (75.6%) HE/RR clients, of whom 11% self-reported being positive. Of the 36,701 self-reported non-positives, 17% reported never having been tested, 28% had tested within
one year (routine testers), 33% had tested more than one year ago (intermittent testers), and 20% had tested but did not report a date of their last test.

HE/RR testing was offered to 27,934 (75%) non-positive clients. Of those offered, testing was accepted by 26,669 (95%) clients, of whom 19,709 (74%) accepted testing at the encounter and 6,960 (26%) accepted a referral to testing. Matching was significantly higher for those who tested at the encounter compared to those referred [10,053 (51%) versus 520 (7%); p < 0.001].

Of the 10,573 linked clients, 89 (0.84%) tested positive. Those who did not recall their last test date had the highest positivity rate (1.26%), followed by routine testers (0.69%), intermittent testers (0.53%), and never testers (0.51%; p=0.007). The positivity rate of high-risk clients (transgender persons, MSM, IDU, and partners of positives) was 1.16%. No differences were seen by race or gender. Positivity rate was highest among those with positive partners (4.57%). Of the 89 HE/RR clients testing positive, 33 (37%) were referred to HIV medical care, compared to 46% in the C&T program.

LESSONS LEARNED: State-supported HE/RR and C&T activities can be matched and evaluated using current data systems. Un-matched clients may have tested outside our system, tested within our system but had insufficient matching information, or did not test. Only 5% of diagnoses in HARS from 2006 to 2009 came from C&T. Thus, being able to monitor all HIV testing in the state would be ideal to fully understand the testing behavior of clients referred by HE/RR as well as where the highest yield testing occurs. Further understanding of barriers to testing for those referred out is critical for HE/RR program modifications. Because of high positivity rates among persons with positive partners, high risk clients, and persons who could not recall their last test date, it is especially important to effectively link these clients to testing.

Abstract 1787 - Working on Program Implementation and Fidelity among Community-based Organizations (CBOs):
The DEBI Experience
Author(s): Jonny Andia; Juli Powers; Ricky Washer-Tavares; Naima Cozier; Charles Collins

Evidence-based behavior change interventions (EBIs) are part of the national strategy to reduce the incidence of HIV in the nation. This presentation describes the Centers for Disease Control and Prevention’s (CDC) national Diffusion of Effective Behavioral intervention (DEBI) project experience in assuring intervention fidelity during program implementation among community-based organizations. Effective strategies during program implementation are fundamental to maintain optimal levels of intervention fidelity and to obtain desired outcomes. During this presentation, CDC staff and Capacity Building Assistance providers will discuss procedures to optimally transfer research into practice: training, technical assistance, monitoring and evaluation and fidelity checklist procedures.

A national sample of CBOs who are implementing the Safety Counts and SHIELD interventions.

CDC and CBA providers (JSI Research & Training Institute and the Border Health Foundation) conceptualized and develop multiple program implementation and quality assurance tools to implement the Safety Counts and SHIELD intervention. Examples of these tools are monitoring and evaluation; fidelity checklists and recruitment and retention training modules. These tools are used by CBA providers during formal technical assistance among national community-based organizations implementing both interventions.

Capacity Building Assistant providers CBA will discuss how they worked with CDC and CBOs to develop technical assistance (e.g., monitoring and evaluation, recruitment and retention and intervention fidelity checklists) for two DEBIs, Safety Counts and SHIELD. In addition, CDC staff will discuss outcomes related to the implementation of these tools among CBOs who are implementing these interventions.

LESSONS LEARNED
The provision of CBA during the dissemination and implementation of evidence-based interventions is fundamental to ensure optimal levels of intervention fidelity and outcomes. Further enhancement of technical assistance procedures by CBA providers, (e.g., monitoring and evaluation) and quality assurance methods will determine effective implementation of EBI interventions.
Abstract 1854 - I Heart QM: One CBO's Experience with Quality Management  
Author(s): Joshua Ferrer

The CDC's Diffusion of Effective Behavioral Interventions (DEBI) project offers CBOs the opportunity to implement a variety of HIV-prevention interventions which have been piloted, rigorously evaluated, and proven for their effectiveness in clinical settings. However, little data is available to demonstrate the effectiveness of interventions when implemented by CBOs in real-life settings. Furthermore, many small and mid-size CBOs have little to no experience in conducting outcome monitoring on interventions nor access to ready funding to implement outcome monitoring and may face resistance in attempting to do so.

Cascade AIDS Project (CAP) was one of the grantees for the CDC's first Community-based Organization Behavioral Outcomes Project (CBOP) on the Healthy Relationships intervention with HIV+ MSM from 2006-2008 in the Portland, Oregon metropolitan area.

CBOP collected risk behavior data from intervention participants at baseline and at 90-day and 180-day follow-ups to determine the intervention's impact on risk behaviors. CAP hired a Prevention with Positives Coordinator and Research Project Monitor to implement and facilitate the intervention and outcome monitoring project respectively. CAP also undertook other efforts to create buy-in and reduce resistance around CBOP and outcome monitoring in general through creation of an agency-wide Quality Management committee and other initiatives such as inter-departmental Plan, Do, Study, Act cycles designed to increase awareness of quality management.

Results: From December 2006 through January 2007, 105 individuals were enrolled in Healthy Relationships and CBOP meeting CDC goals. 78 (74%) completed the 90-day follow-up while 75 (71%) completed the 180-day follow-up. Participants reported a willingness to participate in the project, in some cases even declining incentives offered for participation. Buy-in from agency staff was secured through presentations, trainings and staff incentives for referrals which also helped to increase awareness across the agency of the importance of quality management and outcome monitoring. CBOP results indicated that overall participant risk behavior declined following the intervention at 90-day and 180-day follow-ups but that the mean percent of recent unprotected sex acts remained high. This information, which speaks to the high prevalence of serosorting amongst HIV+ MSM in the project, has been used to make additional enhancements to the material currently presented in the Healthy Relationships intervention at CAP.

Lessons Learned: Outcome monitoring provides helpful information for the implementing CBOs on the effectiveness of interventions conducted in real-life settings, including the data needed to improve EBI implementation, client satisfaction and overall quality assurance. Implementing outcome monitoring, even on a small scale, can be helpful in creating a culture of quality management at CBOs and in times of limited resources and shrinking budgets can be a useful and effective way to ensure that interventions and other programs being implemented are achieving their desired results.
Three CBOs targeting young African American and Latino MSM (AID Atlanta (Atlanta, GA), CALOR (Chicago, IL), and Family Health Centers (San Diego, CA)) for their MPs currently participate in an outcome monitoring project (May 2010 to September 2012). Data are collected from MP participants at enrollment (baseline), and three (follow-up 1) and six (follow-up 2) months. This is the first CDC outcome monitoring study to use client-administered, handheld computers to collect behavioral risk data from participants of an HIV prevention intervention.

MP combines outreach, discussion groups, creation of safe spaces, social opportunities, and marketing to reach gay/bisexual men. AID Atlanta targets African Americans aged 18 to 29 (Evolution); CALOR targets Latinos aged 13 to 24 (Unidad); and Family Health Centers targets African Americans, Asians, and Latinos aged 14 to 24 (In The Mix). CDC staff will present cross-agency outcomes; agency staff will present program-related information; and CAPS staff will discuss MP capacity building efforts at these agencies.

To date, 275 baseline surveys, 94 follow-up 1 surveys, and 24 follow-up 2 surveys have been collected. Preliminary analysis indicate MP is reaching high-risk, minority MSM: 84% of Evolution participants are African Americans; 99% of Unidad participants are Latinos; and the Family Health Centers sample is 49% Hispanic, 21% white, 11% Asian, and 9% African American. At baseline, 53% of participants reported unprotected sex with male partners in the previous three months (29% with non-primary partners and 13% with partners of unknown/serodiscordant HIV status). Average number of male partners with whom participants reported having unprotected sex with was 2.12. Additionally, 19% of participants reported some difficulty telling a male sex partner not to do something risky; 28% indicated their gay/bi/transgender friends always use condoms when having sex with new partners. Analyses of longitudinal outcomes will be conducted in mid-2011, and findings will be presented in this session.

Based on the individuals enrolled in this outcome monitoring project, MP appears to be reaching high-risk, African American and Latino MSM in these communities. Baseline analyses indicate risky sexual behavior among participants and their peers, as well as moderately low self-efficacy for condom use. Reliable, self-reported data collection tools originally developed for research settings were also successfully used by CBO staff. As a result, participant data were immediately accessible, allowing the CBOs to make adjustments to their MPs as necessary. These findings suggest that other CBOs implementing MP may benefit from the use of outcome monitoring tools/procedures and electronic, client-administered data collection tools.

Track D
D21 - Integrating the Social Networks Strategy Into An Existing CTR Program targeting African American MSM
Room: Hanover C (Hyatt Regency Atlanta)

Abstract 1303 - Integrating the Social Networks Strategy Into An Existing CTR Program targeting African American MSM
Author(s): Donna McCree; Greg Millett, MPH; Perry Halkitis, PhD, MS, MPhil; Chanza Baytop, Melanie Thompson, Jonathan Ellen; Sandra Kupprat, MS, MA

Gay, bisexual, and other MSM are the population most severely affected by HIV in the United States. Representing approximately 2% of the adolescent and adult population, they accounted for 53% of all new HIV infections in 2006. Among MSM, African American/Black MSM is the subgroup most disproportionately affected. Identifying and evaluating methods for improving knowledge of HIV status through HIV testing is an important HIV prevention strategy. This group presentation will highlight best practices, challenges and lessons learned from integrating the social network strategy (SNS) into existing HIV counseling, testing and referral programs (CTR) in four cities on the east coast of the United States.

The study was conducted at three community-based organizations (CBOs) in the District of Columbia, Atlanta, and New York and the Baltimore City Health Department (BCHD).
Results are from a study to evaluate the relative effectiveness of alternate venue testing, SNS, and partner services for identifying previously undiagnosed, 18-64 year old, HIV+ AA MSM and linking them to medical care and prevention services. Under SNS, HIV+ and high risk HIV (-) persons (called recruiters) are enlisted to identify and recruit persons from their social, sexual, or drug-using networks (called network associates) for HIV testing. This session will describe how the SNS was adapted for and integrated into existing testing programs at each of the sites and highlight challenges and lessons learned.

RESULTS: Dedicated staff was assigned to oversee and implement the SNS at each of the sites. After receiving multiple trainings and booster sessions from CDC, site staff developed and implemented a SNS tailored for their specific testing program. Testing began in June 2008. A total of 325 men were tested through SNS at the CBO sites and 47 (15%) were new HIV+ cases. A total of 22 men were tested through SNS at the BCHD site; none were new positives.

LESSONS LEARNED: The SNS requires a detailed plan, dedicated staff, and on-going input from clients and staff for successful implementation. SNS plans may require several modifications before success is achieved. CBO staff dedicated to outreach may be retrained on the SNS in lieu of hiring new staff. Staff training with booster sessions and a focus on how to coach recruiters is essential. Use of incentives that are adequate by community standards can increase participation in testing.

Track D
D32 - The Role of the Clinic in Prevention of Secondary HIV Transmission
Room: A707 (Atlanta Marriott Marquis)

Abstract 1451 - Does HIV/AIDS case management bring about positive outcomes? Results from Five Diverse Programs in ConnectHIV
Author(s): Susan Rogers; Caitlin Corcoran; Myriam Hamdallah; Stacey Little

Case management (CM) has functioned as an essential service to assure timely access to and coordination of medical and psychosocial services for persons living with HIV/AIDS (PLWHA). While individual programs employing case management have been assessed, comparative studies of different approaches to case management have rarely been studied. A recent public-private partnership between the Pfizer Foundation and the community (2007-2010) entitled ConnectHIV funded a number of CM programs with the primary objective of linking PLWH into high-quality care and treatment services. A national cross-site evaluation was conducted to identify whether the CM conducted by five diverse programs were associated with positive client outcomes, if certain CM interventions were more effective than others and what program/organizational factors and best practices may account for these more effective interventions.

A longitudinally designed study included one-on-one interviews conducted with approximately 400 clients in five programs at intervention baseline, post and end line which included five measures representing a common set of indicators developed collaboratively by the program staff and the evaluators. Generalized Estimated Equations (GEE) models were built to determine clients change over time while controlling for client level confounders of age, gender and whether clients were on HIV medications at baseline. Qualitative data on program best practices and factors that may be accounting for differences between grantee client outcomes were analyzed using E-Z text software.

The five CM interventions were associated with significant positive client outcomes (p<.05) from either baseline to post and/or baseline to end line across three client outcomes (HIV disease management knowledge; HIV medication adherence in the last 7 days, and viral load) and from baseline to post on two other outcomes (CD4 count and perceived health status). Two of the CM interventions demonstrated significantly more positive outcomes (increased knowledge of HIV disease management and CD4 count) than the others which may be due to staffing patterns (larger number of full-time staff and client/staff ratio); a stronger organizational funding profile; and a larger service network. It also may be due to best practices of substantive involvement of physicians in disease management/adherence counseling; strong quality assurance practices; and well-supported partnerships to respond to client needs.
HIV/AIDS case management with PLWHA can bring about positive client outcomes related to increased knowledge of disease management, medical adherence and improved health indicators. CM interventions can be quite diverse and more comparative research/evaluation needs to be conducted to assess what intervention components and organizational factors contribute most to positive client outcomes. Implications of the present study were that such factors as the quality of healthcare provider contact with clients, client/staff ratio, the size of referral/service networks, and quality of referral partnerships can lead to more positive client outcomes.

Abstract 1518 - Secondary Prevention Counseling among HIV-Infected Persons with Detectable Viral Loads

Author(s): H. Elsa Larson, BA; Michelle A. Lally, MD, MSc

Secondary HIV prevention focuses on prevention of HIV transmission by HIV-infected persons. Recommendations from the Centers for Disease Control and Prevention advise medical professionals to screen all HIV-positive patients for risk behavior and provide HIV prevention counseling. In addition to behavioral risk reduction, recent evidence suggests that adherence to antiretroviral therapy (ART) may lower plasma viral load (PVL) and decrease infectivity to partners. HIV-positive patients with detectable PVLs and behavioral risk factors are at highest risk for transmission and may require more intensive prevention messages than other patients. This retrospective cohort study aimed to determine if this unique group of high-risk patients received HIV prevention counseling, and how these patients differed from other patients.

A chart review was performed to identify high risk cases in one HIV care clinic in Providence, Rhode Island. Cases were eligible if they were not on antiretroviral therapy, had a PVL of >3500 copies/ml, and had been a clinic patient within the past two years. This resulted in 90 cases included for analysis, representing approximately 7% of the overall clinic population of 1300 patients. Variables included dates of visit, laboratory PVL counts, sexual and drug risk behavior, number of exposed partners, positive STI test results, alcohol and other drug use, and receipt of risk reduction counseling. Cases were dichotomized to the high risk (n=61) or low risk (n=29) group based on risk behavior. High risk was defined as having 1 or more episodes of unprotected sex or needle-sharing with 1 or more uninfected partners or a positive STI result. Low-risk was defined as no sexual contact or needle sharing or 100% condom use.

Mean age of the cohort was 37 years. Men accounted for 75% of cases and 75% of men were men who had sex with men. Number of clinic visits ranged from 1-19 over 24 months. Receipt of prevention counseling did not differ by high or low risk group. Groups did not differ by demographic variables or risk factor variables. However, level of engagement in care differed significantly by risk group (P=0.02).

All clinic patients with detectable (PVL > 3500) viral loads received secondary HIV prevention counseling. Among this cohort, those with reported behavior that may lead to HIV transmission were less engaged in care. This research suggests secondary HIV prevention efforts may benefit from overall evaluation of a clinic population's risk for secondary transmission. Interventions to improve linkages to care should prioritize patients with detectable PVLs who disclose sexual or drug risk behavior with uninfected partners. Additional research is needed to identify and overcome the perceived and real barriers to care among this group of high-risk patients.

Abstract 1945 - A Randomized, Controlled Trial of SafeTalk: A Safer Sex Program for People Living with HIV/AIDS

Author(s): Carol E. Golin; Jo Anne L. Earp; Catherine A. Grodensky; Shilpa N. Patel; Chirayath Suchindran; Megha Parikh; Kemi Amola; Zulfiya Chariya

Programs to help people living with HIV/AIDS practice safer sex are needed to prevent transmission of HIV and other sexually transmitted infections. Motivational Interviewing (MI), a nonjudgmental, client-centered counseling approach, may be an effective means to enhance safer sex practices of people living with HIV/AIDS (PLWH). We tested the impact of SafeTalk, a multi-component MI-based safer sex program, on HIV-infected patients risky sexual behavior.

We enrolled 490 sexually active adult HIV-infected patients from one of three clinical sites in North Carolina and randomized them to receive the 4-session SafeTalk intervention (n=248) versus a heart-healthy attention-control
The SafeTalk program consisted of four structured MI sessions, a series of 4 CD-booklet pairs that prepare patients for each MI session and provide tailored safer sex information, and booster letters. The CD/booklet series uses patient characters, including vignettes, to model mastery over behavior change and demonstrate empathy. The sessions/booklet/CDs provide: 1) choices of safer sex topics; 2) assessment of personal relationships, sexual activities, motivation and self-efficacy for chosen behaviors; 3) values clarification; 4) consideration of pros and cons; 5) goal-setting; and 6) standardized information choices. We used audio-computer assisted self-interviews to assess unprotected anal/vaginal intercourse (UAVI) with at-risk partners (UAVI-AR) in the past 3 months at baseline and 4, 8 and 12 months after enrollment. We used Poisson regression to compare the difference in the number of risky sexual acts between the two arms at enrollment. Taking into account the correlation among longitudinal measures, we used the Generalized Estimating Equation procedure to test the difference between the treatment groups to determine treatment effects on UAVI-AR over time.

There was no significant difference in the proportion of people having unprotected sex between the two arms at enrollment. Controlling for baseline risky behavior and site, SafeTalk reduced the average number of UAVI-AR acts at 8-month follow-up by 87% compared with controls (p < 0.0001). SafeTalk significantly reduced the number of UAVI-AR acts at 8 and 12 months from 2.00 at baseline to 0.27 while in controls it increased from 1.1 to 1.9.

MI delivered to HIV positive patients monthly in clinic over a four month period and enhanced by audiovisual materials can provide an effective behavioral prevention intervention for a heterogeneous group of people living with HIV. The individualized nature of MI and the tailored nature of the SafeTalk materials allowed the counselors to tailor the program to each client's unique needs and behaviors. In response to the growing number of people living with HIV, a compelling need exists to support effective prevention programs, such as SafeTalk that can be easily disseminated and incorporated into the clinical setting.

**Abstract 2083 - HIV Self-Management Education: Improving Health Outcomes of Newly HIV-Diagnosed Adults in New York City**

**Author(s):** Terri Wilder; Clayton Robbins

In 2009, 3,396 people living in New York City (NYC) were newly diagnosed with HIV. Among this sample, 75.8% had care initiation within 3 months of diagnosis and 8.5% initiated care later than 3 months. Additionally, in a convenience sample of 94 HIV-positive adults living in NYC who completed a biopsychosocial health behavior survey as part of a needs assessment, it is estimated that 22% were not in care, 32% were not taking antiretrovirals, and 40% were engaging in high-risk HIV transmission behavior. There exists a great need to improve health outcomes in NYC for HIV-positive persons. Early HIV education and self-management skills can improve engagement in care, treatment adherence, and reduce high risk behaviors.

HIV self-management education programming for persons newly-diagnosed with HIV was developed in New York City

To improve knowledge about HIV among newly HIV-diagnosed persons in NYC, the NYC DOHMH developed and will pilot a new HIV self-management education program. These free, interactive workshops are coordinated by the NYC DOHMH and led by individuals living with HIV. Extensive literature review identified drivers of behaviors and effective strategies to change behavior. Focus groups and surveys with persons living with HIV identified population strengths and needs among those surveyed. Interviews with local, regional, and national HIV service providers and HIV-positive peer leaders suggested best practices for what may lead to behavior change among adults. Curricula for a one-session introduction workshop and 2-session intensive workshop were written based on extensive research. Newly HIV-diagnosed adults will be recruited from HIV testing and service sites. Change in participants knowledge, beliefs, intentions, and behaviors will be assessed through pre- and post-test measures.

The literature review, focus groups, surveys and interviews revealed that facilitating behavior change requires addressing a number of biological, psychological, and social determinants of health. HIV-positive participants in the surveys and focus groups exhibited strong performance on some behavioral precursors to the desired outcomes including self-assertiveness, stress coping, and depression coping. The sample population exhibited low performance
on other precursors including HIV disclosure, grief coping, perceived control over health outcomes, patient-provider relationship, and social support. Best practices for facilitating behavior change among HIV-positive adults included utilizing peer leadership, building social support, teaching self-monitoring skills, and incorporating experiential exercises. Preliminary implementation findings will be shared.

An intervention utilizing chronic disease self-management principles and a bio-psycho-social approach to behavior change was well accepted by HIV service providers, HIV-positive peer leaders, and HIV-positive adults sampled. The literature has demonstrated the effectiveness of HIV self-management education for improving health outcomes and contributing to a reduction in new HIV infections. HIV education programs that are implemented by a health department, facilitated by peer leadership, and offered in community-based venues have the ability to provide skills-building, improve health outcomes, and fill a gap in services for persons newly diagnosed with HIV.

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**Track E**  
**E02 - Linkage to Care: Understanding the Barriers**  
**Room: Cairo (Hyatt Regency Atlanta)**

**Abstract 1154 - Missed Connections: HIV Infected Persons Never in Care**  
**Author(s):** P. Garland; E. Valverde; L. Beer; J. Fagan; C. Hart

Surveillance data from five health jurisdictions participating in the Never in Care pilot project indicate that up to 25% of persons diagnosed with HIV in 2007 had not received HIV medical care 12-25 months later; this group has not been well described. We contacted HIV-infected persons who had not accessed HIV medical care in these jurisdictions to gain insight for intervention.

HIV-infected persons with diagnoses reported to the HIV/AIDS Reporting System (HARS) in 5 health jurisdictions from 11/2008-12/2009 were sampled. Eligible persons were those diagnosed >=90 days previously and with no reported CD4 or viral load results to indicate that they had entered HIV medical care. Sampled persons were contacted first by mail and/or telephone and then by home visit, using contact information in the case record, supplemented by other data sources routinely used for field investigation. Repeated contact attempts were made, as needed. Eligible persons were invited to participate in an interview and blood draw for CD4 testing, encouraged to seek HIV medical care, and provided with referrals. Surveillance data were monitored for subsequent entry to care.

We performed univariate and bivariate analyses, and chi-square tests to assess differences in proportions.

Of 4,885 persons with reported diagnoses, 1,067 were eligible for follow-up: 134 (13%) were interviewed, 87 (8%) refused, and 846 (79%) were not located. Of respondents, 63% were black, non-Hispanic; 52% were <35 years old; 75% were male; 77% were US-born; 54% were >6 months from diagnosis; and 58% had <= high school education. Of 98 respondents for whom CD4 count was measured, 47% had counts <350 cells/uL and 20% had counts <200 cells/uL. Respondents were more likely than non-respondents to be men who have sex with men (p=0.01), and to be U.S. born (p=0.04). The top 5 reasons for not entering care were: lack of money/insurance (57%); not wanting to think about HIV+ status (55%); feeling good/healthy (54%); feeling depressed (44%); and not wanting to disclose HIV+ status (43%). Of those who cited lack of money/insurance, 97% met a common eligibility threshold for public HIV care (income <300% of Federal poverty level). Of all respondents, 54% had a medical visit not related to HIV <=12 months before the interview and 76% said they were fairly to very likely to enter HIV care within the next 3 months (only 20% of these actually did). Among factors respondents said would encourage care entry, the top 2 were money/insurance (39%) and feeling sick (31%).

Repeated attempts to reach many HIV-infected persons who had not entered care >=3 months after diagnosis were unsuccessful, underscoring the importance of addressing barriers to care entry, including costs of care, at diagnosis. Many of those who were found and offered referrals did not enter care, despite reporting an intention to do so. Some may need information about eligibility for publicly funded care, education about the personal and community health benefits of care, and ongoing support to overcome barriers to care.
Abstract 1511 - Using Case Management to Connect HIV-positive Women Leaving Jail to Post-Release HIV Care and Services

Author(s): Dorothy Murphy; Marcia Erving; Jeannette Webb; Arlette Brooks; Chyvette T. Williams, PhD

Urban neighborhoods with high rates of incarceration often have elevated rates of HIV/AIDS. Urban jails provide significant opportunities, therefore, to address HIV/AIDS. While linking HIV-positive jail detainees to primary care and support services upon release may improve treatment outcomes and reduce transmission of HIV in these communities, only about 15% of women in Cook County Jail keep their initial post-release primary care appointment and many either have no case managers or have fallen out of case management.

Enhancing Linkages to HIV Primary Care and Services in Jail Settings Initiative is a multi-site demonstration project. The project described here uses data from Chicago, IL.

A collaboration between the jail, a community-based organization and a university school of public health began providing transitional case management (CM) to HIV-positive women that begins in the jail and continues into the community. The program emphasizes working with and supplementing existing Ryan White CM services.

From August 2009 to Oct 2010, 96 women were offered program services, 86 accepted and 75 enrolled in the evaluation component. About half of the women had a CD4 count below 350. Discharge planning in the jail's health clinic included case managers who continued that role after the women were released. Keeping initial post-release appointments for primary care increased 3-fold and almost half of women accessed primary care within 3 months of release. Linking to Ryan White CM helps achieve continuity of care and services. HIV-positive women entering jail are receptive to transitional CM, and early indicators show substantial increases in post-release care. Women's needs are extensive. Motivation and readiness for change vary among women, and substance use and mental health issues are significant challenges in keeping women engaged in care. Linking transitional and Ryan White CM appears feasible and has the potential to increase the effectiveness and efficiency both programs.

Abstract 1706 - Assessing Linkage to Care in an AIDS Drug Assistance Program in Washington, DC

Author(s): Damber Gurung; Sonya Bayone; Gunther Freehill; Angelique Griffin; Rowena Samala; Charles Wu; Siva Rangarajan; Shannon Hader; Paul J Weidle

The AIDS Drug Assistance Program (ADAP) is an important source of prescription drugs for persons with HIV infection and limited or no insurance. In Washington DC, our program served more than 3,000 clients in 2009 with drug expenditures exceeding $14,000,000. The objective of this analysis was to assess how well our ADAP program identified clients in need of antiretroviral therapy (ART) and the rate and rapidity with which they started ART.

We developed a computerized method to link service utilization data, ADAP eligibility data, prescription filling data, and laboratory data from the HIV/AIDS Reporting System (HARS) to assess utilization patterns and persistence of coverage, to identify ADAP eligible clients not using the prescription benefit, and to characterize the virologic response of clients utilizing ADAP. We used data from calendar year 2009 at the HAHSTA in Washington DC to test the system's capacity to identify ADAP clients in need of ART and their timeliness initiating ADAP-supported therapy.

In 2009, 3,212 clients were served by ADAP, 451 (14%) had a CD4 cell count (cells/μl) measured while not prescribed ART within ADAP. CD4 cell counts were 0 - 49 for 48 clients (11%), 50 - 199 for 103 clients (23%), 200 - 349 for 85 clients (19%), and > 350 for 215 clients (48%). Of the 236 clients with CD4 cell counts < 350, 159 (67%) did not have a viral load < 1,000 copies/ml indicating they were likely not on ART from another source. Of these 159 clients, 81 (51%) had started ART in ADAP by the end of 2009 at a median of 11 days (interquartile range [IQR], 1 - 21.5) after their CD4 cell count was measured: 67 (83%) within 30 days, 10 (12%) within 31 - 60 days, and 4 (5%) more than 60 days. Fifty eight (36%) clients eligible for ART had not started therapy in ADAP by the end of 2009 at a median of 112 days (IQR, 68-218) after their CD4 cell count measurement and 20 (13%) were pending evaluation (< 30 days elapsed since date of CD4 cell count measurement).
Many 2009 ADAP clients eligible for, but not prescribed ART, started therapy during that year documenting the utility of this essential public drug assistance program. To improve pharmacy coverage for ART within ADAP, barriers to starting ART for clients with low CD4 cell counts and effective means to overcome them, such as outreach services by case management services or providers for access and linkage to care, should be explored.

Abstract 2080 - Returning for Confirmatory Test Results: The Link between Test and Treat in Rapid HIV Testing
Author(s): Elwin Wu; Moira Mendoza; Blakeley Lowry; Lynnette Ford

The "test and treat" strategy was designed to reduce the transmission of HIV at the population level by increasing the number of individuals who are aware that they are infected via expanded testing efforts, and then linking newly diagnosed HIV-infected individuals to medical care and prevention services. Subsequent behavior change following knowledge of an HIV-positive status combined with the initiation of HAART to suppress viral loads can reduce the likelihood of HIV transmission through risk behaviors. Currently, HIV testing efforts often rely on rapid HIV test assays, which require individuals who have reactive test results to complete a confirmatory HIV test, for which the results are available one week later. Thus, the success of the test and treat strategy is mediated by completing the confirmatory HIV test and returning for the results. We analyzed HIV testing data from a community-based HIV testing and counseling center in New York City to determine the prevalence and predictors of not returning for confirmatory HIV test results among newly diagnosed HIV-infected individuals.

Using data from one of the largest AIDS service organizations in New York City, we analyzed 9234 cases consisting of individuals received an HIV test from 2008 to 2011 at the agency's on-site, off-site, or mobile testing units.

Among the 9234 individuals tested for HIV, 372 (3%) were newly diagnosed as HIV-positive. Of these individuals, 39 (14%) refused confirmatory HIV testing, 83 (30%) did not return for their confirmatory HIV test results, and 153 (56%) returned for their confirmatory HIV test results. In the multivariate analyses, a heterosexual sexual orientation (AOR=4.9; 95%CI=1.0-22.9), residence in an apartment/house (AOR=5.8, 95%CI=1.2-28.1), and receiving an HIV test off-site or in the mobile testing unit (AOR=3.3, 95%CI=1.2-9.4) were significantly associated with non-return for confirmatory HIV test results.

We found that a substantial proportion (45%) of individuals who were newly diagnosed with HIV infection would not have progressed to the treatment phase after initial testing. Our data supports the need for strategies and interventions that focus on ensuring individuals return for their confirmatory results, particularly in the context of mobile and off-site HIV testing. Future research should examine the reasons that individuals do not return for their confirmatory HIV test results.

Track F
F10 - Funding Priorities at the State and Local Levels
Room: Regency Ballroom V (Hyatt Regency Atlanta)

Abstract 1285 - Funding Allocations for CDC-supported HIV Prevention Program Activities: United States, 2008-2009
Author(s): Argelia Figueroa; Choi Wan; Mesfin Mulatu

How did health departments (HDs) allocate CDC funding for HIV prevention program activities in 2008 and 2009, and how did the overall allocation at the national level compare with the national HIV epidemic?

Fifty-nine state and local HDs (50 states, 6 directly-funded cities, Washington, D.C., Puerto Rico, and the U.S. Virgin Islands) that receive annual funding from CDC for HIV prevention program activities.

In 2010, CDC provided 59 HDs a report form to complete and return to CDC. The form included questions about how HDs allocated their CDC funding for HIV prevention program activities in 2008 and 2009. Allocations were reported separately for persons with HIV/AIDS and for five major activities: counseling, testing, and referral (CTR); partner services (PS); health education/risk reduction (HE/RR); community planning (CP); and evaluation. Funds allocated
for HE/RR were reported by the race/ethnicity and HIV risk of clients. To minimize the grantees reporting burden, HDs were not asked to provide CTR allocations by race/ethnicity and risk. Instead, CDC estimated the allocation percentages at the national level by using the CDC national HIV monitoring and evaluation (NHM&E) data for each year of interest. Submitted forms were reviewed for data completeness (e.g., allocations given for each major activity) and consistency (e.g., amounts for HE/RR should equal the sum of the allocations for both race/ethnicity and HIV risk). Analyses include data from all 59 grantees.

In 2008 and 2009, 12% ($34 million) and 11% ($33 million), respectively, of the total funding ($293 million in both years) were allocated to provide HIV prevention services to HIV-infected persons across the 59 HDs. The funding allocation to HE/RR and CTRPS represented the majority of the prevention funding allocation (73% and 74% of the total allocated in 2008 and 2009, respectively). For HE/RR, HDs allocated $103 million in both years. For CTRPS, HDs allocated $113 million in 2008 and $115 million in 2009. The HE/RR and CTR allocations by race/ethnicity and by risk were similar in 2008 and 2009. In 2009, 62% of the HE/RR allocations and 57% of the estimated CTR allocations were specifically for minority populations; African Americans received the highest amounts (38% of the HE/RR funding and 36% of the CTR funding). In 2009, HDs allocated the highest percentage of HE/RR and CTR funds to high-risk heterosexuals (38% and 43%, respectively). Comparing the national HIV epidemic and these national-level allocations, we found that MSM accounted for 54% of new HIV/AIDS cases, but only 27% of HE/RR and 10% of CTR allocations, respectively. African Americans accounted for 52% of new HIV/AIDS cases, but only 38% of HE/RR and 36% of CTR allocations.

The majority of CDC funding was allocated to HE/RR and CTRPS. For both of these, the funding was mainly for African Americans, high-risk heterosexuals, and MSM. Differences between the national HIV epidemic and the national level allocations of health department HIV prevention funds were found. Limitations of the results will be discussed.

Abstract 1324 - Effects of State HIV Prevention Budget Cuts in California

Author(s): Feng Lin; Arielle Lasry; Annette Ladan; Stephanie Sansom

Due to a statewide budget crisis, the California State Office of AIDS (SOA) sustained large cuts in HIV prevention funding between fiscal years 2008-2009 (FY0809) and 2009-2010 (FY0910). As a result, the SOA had to scale back HIV prevention activities. In 2006, an estimated 13% of people living with HIV/AIDS in the U.S. were residents of California, and in 2008, about 10% of new HIV cases were reported among Californians. Given the magnitude of the HIV epidemic in California, we examined the effect of the budget cuts on the number of Californians living with or at risk for HIV who were unable to receive prevention services.

We analyzed SOA data for FY0809 and FY0910. We restricted the analysis to jurisdictions that do not receive direct funding for HIV prevention from the Centers for Disease Control and Prevention, in particular, Los Angeles and San Francisco. We analyzed SOA data to describe the pre- and post-cut prevention budgets, the number of local agencies that received state HIV prevention funds, and the number of individuals receiving services. We estimated the number of individuals who would have received a positive HIV diagnosis and the number of individuals who would have received health education and risk reduction (HERR) services during FY0910 had the budget not been reduced. We assumed that the proportion of people who tested positive and the proportion of HERR clients who were positive was the same in FY0910 as in FY0809.

In FY0809, the SOA allocated $19.1 million to its HIV prevention programs, including $4.8 million to counseling, testing and partner services (CTPS) and $14.3 million to HERR. State funds went to 99 local prevention agencies. The number of persons served by CTPS was 92,869, among whom 82,456 were notified of test results and 823 were notified of a positive HIV diagnosis. The number of unique clients served with HERR was 13,459, including 2,176 positive clients and 11,283 negative clients.

The SOA reduced its allocation to HIV prevention by $13.2 million (69%) from FY0809 to FY0910. This reduction included $1.6 million (34%) from CTPS and $11.6 million (81%) from HERR. The cuts resulted in 63% (64%) fewer local agencies that received state HIV prevention funds. The number of persons served by CTPS decreased by 39,809 (43%), resulting in an estimated 384 (47%) fewer individuals notified of a positive HIV diagnosis. The number
of unique clients served with HERR services decreased by 10,073 (75%), resulting in an estimated 1,076 (49%) fewer positive clients and 8,997 (80%) fewer negative clients.

The SOA budget cuts resulted in a large drop in HIV prevention services. The elimination of services is likely to make it more challenging to curb the HIV epidemic in California, and considering the proportion of all U.S. HIV cases that reside in California, jeopardize achievement of national HIV prevention goals.

Abstract 1632 - Expanding our Reach: Health Departments, HIV Testing in Health Care Settings and Rapid Test Technologies
Author(s): Liisa Randall; Natalie Cramer

State and local health departments have made considerable efforts to adjust HIV testing programs and policies to be responsive to CDC's Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings and to enhance program effectiveness through use of rapid HIV tests.

On-line assessments of state and local health department HIV testing/screening programs.

In 2010, NASTAD conducted with the 65 CDC funded state and local health departments an assessment of health department efforts to implement HIV testing in health care settings and an assessment of health department efforts to implement rapid HIV testing. Both of the 2010 assessments were follow-up to prior assessments conducted by NASTAD in 2007 for testing in health care settings and 2006 and 2008 for rapid testing, thus allowing for an understanding of trends over time.

The number of states that require specific consent for HIV testing decreased by one half, from 34 states in 2007 to 17 in 2010. In 2010, 42% of states had legal mandates to provide pre-test counseling compared with 27% in 2007. By 2010, the number of health departments implementing HIV testing in health care settings increased from 35 to 55. Emergency departments, correctional facilities and community health clinics are the most challenging environments in which to implement HIV testing. Reimbursement is a major barrier to routine HIV testing.

Use of rapid tests has expanded and is now provided in 2,938 unique sites. All but one health department uses it and 64% reported plans for further expansion. Rapid testing is an important tool for highly targeted testing, with 98% of health departments using it in community-based venues. Rapid tests account for 61 percent of all tests conducted by health departments in both 2008 and 2010. Forty-six percent of health departments allow HIV test providers to refer clients to medical care for HIV without a confirmatory test result but 56% report that Ryan White providers refuse to accept new clients without confirmatory results. Ten health departments reported using combinations of rapid tests at point of care, compared with just two in the prior survey and 46% expressed interest in adopting this practice.

As a result of the findings from the survey data, NASTAD recommends:
- Continue to support health departments to implement HIV testing in health care settings though not at the expense of targeted HIV testing programs.
- Collaboration with professional organizations at the state and national levels to develop education and training opportunities supporting HIV testing to facilitate buy-in from providers.
- Collaboration with CDC, the Association for Public Health Laboratories (APHL) and others to identify and support technology transfer for emerging testing technologies.
- Support and engagement in state and national/federal-level advocacy to require Medicaid and other third-party payers to reimburse health care providers for routine HIV testing at adequate rates.
It is estimated that 4 to 5 million people in the United States are infected with the hepatitis C virus. Many of those infected do not know their status due to insufficient availability and accessibility of screening. The objective of the study was to evaluate the OraQuick HCV rapid antibody test in community-based organizations (CBOs) serving populations at high risk for HCV infection.

Individuals who met HCV risk criteria were tested by oral swab rapid test and enzyme immunoassay (EIA) HCV-antibody test via blood draw at six CBO test sites in New York City. The OraQuick device was evaluated by comparing results to the EIA and performing confirmatory ribonucleic acid polymerase chain reaction (PCR) testing for discordant results. The perceptions of research staff were assessed through a short survey at the end of each patient visit, and during a focus group discussion at the conclusion of the study around the potential benefits and challenges of using the rapid testing platform in the CBO setting.

Overall, 97.5% of rapid test results matched those of the EIA. In six of the seven discordant pairs, the rapid test result agreed with the confirmatory PCR result. Research staff preferred using the rapid test and identified challenges with phlebotomy and locating clients to provide results that would be overcome with rapid testing. CBOs would benefit from reduced risk of needle stick injury to staff and increased testing capacity, while clients may benefit from a less invasive testing procedure and more rapid access to education, counseling, and referrals.

The OraQuick rapid HCV test has accuracy comparable to the current standard EIA test. As happened when rapid HIV testing was implemented, HCV screening programs serving high-risk populations can potentially reach a larger number of individuals and expand testing into non-traditional settings using rapid testing technology. While a rapid test will not overcome the challenges facing HCV-infected clients in accessing medical care, CBOs are well positioned to provide supportive services like health insurance enrollment, support groups, education about liver care, and entry into substance use treatment.

Abstract 1385 - Impact of HIV/HCV Co-infection on HIV Clinical Outcomes in the District of Columbia
Author(s): Sarah Willis; Angelique Griffin; Tiffany West; Irene Kuo; Amanda Castel

CDC estimates that almost one-third of those infected with HIV are also infected with hepatitis C virus (HCV), and among certain sub-populations such as injection drug users (IDUs), estimates of HIV/HCV co-infection range from 50-90%. Research has shown that HIV negatively impacts HCV disease progression and reduces the effectiveness of available treatments; however less is known about the role HCV infection plays on HIV disease progression. Routinely reported HIV and HCV surveillance data were examined to determine the extent of HIV/HCV co-infection in the District of Columbia (DC) and assess the impact of HCV infection on HIV clinical outcomes and mortality.

The Link Plus probability matching program was used to match HIV/AIDS cases reported to the DC Department of Health (DC DOH) between 2000 and 2009 (n=10,215) and chronic HCV cases reported to the DC DOH during the same period (n=16,235). Cases were linked by name, date of birth, sex, and race and potential matches were reviewed for accuracy. Bivariate analyses were performed to detect differences among HIV/HCV co-infected and HIV mono-infected individuals with regard to viral load and CD4 count (at time of diagnosis and most recent results) and mortality. Logistic regression was used to identify the association between HIV/HCV co-infection and progression to AIDS and mortality.

1,151 matches were identified between the registries. More than two-thirds (67.2%) of the matches were male, the majority (90.4%) were non-Hispanic black, and almost half (48.1%) were diagnosed with HIV between 40 and 49 years of age. In addition, 40.3% of the matches were infected with HIV through injection drug use. More than half (58.7%) of the matches were diagnosed with HCV >3 months prior to HIV infection, approximately one-third (27.1%) were diagnosed concurrently (within 3 months), and the remaining (14.2%) were diagnosed with HCV more than 3 months after HIV diagnosis.

Viral load and CD4 counts at time of diagnosis among individuals diagnosed with HCV prior to or concurrently with HIV were not significantly different from HIV mono-infected individuals (median viral load: 10,716 copies/ml vs.
18,629 copies/ml\(^3\) vs. 339 cells/\(\mu\)l, \(p=0.06\)); there were significant differences between the most recent viral load and CD4 counts between co-infected and HIV mono-infected cases (median viral load: 90 copies/ml\(^3\) vs. 74 copies/ml\(^3\), \(p=0.03\); median CD4: 371 cells/\(\mu\)l vs. 423 cells/\(\mu\)l, \(p<0.01\)).

Adjusting for time from HIV diagnosis, there was no significant difference between co-infected and HIV mono-infected cases progressing to AIDS (aOR 1.12; 95% CI 0.95, 1.31). Death occurred more frequently among co-infected cases than among HIV mono-infected cases (aOR 1.31; 95% CI 1.06, 1.63).

This study suggests that HIV/HCV co-infected cases may have poorer HIV clinical outcomes over time, as evidenced by higher viral loads and lower CD4 counts among co-infected cases at their most recent test. Additional research is necessary to more fully understand the impact of chronic HCV on HIV and how best to manage this co-infection among subpopulations with high rates of co-infection, such as IDUs.

**Abstract 1549** - Integrating HCV Screening within HIV CTR Framework: Highly Accepted Intervention in a Cohort of Inmates/Detainees

**Author(s):** Eduardo Nettle, Vicki Sherwin

Individuals navigating in and out of the criminal justice system share a disproportionate burden of infectious diseases. Inmates and detainees are less likely to have established systems of care prior to incarceration, which is generally where inmates first receive some kind of health care. This period provides critical opportunities to offer screening, prevention, education, and health promotion services, and create linkages to care during and after incarceration. While HIV screening and support initiatives are well established in Massachusetts correctional settings, Hepatitis C (HCV) screening and support services are not, despite an estimated HCV seroprevalence approximately 20 times that of the general population. Given the similarities between these two epidemics, integrating HCV screening into HIV Counseling, Testing and Referral Services (CTRS) is a logical next step.

The Barnstable County Sheriff’s Department (BCSD) is a jail and short-term (≤ 2.5 years) sentencing facility in Cape Cod, Massachusetts, that houses men and women. This facility experiences a significant volume of rapid inmate/detainee movement in and out of the facility.

BCSD offers voluntary HIV CTRS to all inmates and detainees throughout their period of detention. In July 2009, BCSD began offering HCV testing in addition to HIV screening, to assess if those testing for HIV would also test for HCV. HCV education is offered to all testers and additional support and education services are provided to those testing HCV positive. Supported referrals to community-based primary and specialty care providers are made for post-release HCV follow-up.

Results: From July 2009 through June 2010, 360 inmates opted to test for HIV. Of these, 324 also accepted a test for HCV (90%) and 81 tested positive (25%). All 81 inmates first learned about their HCV serostatus through this testing initiative. Testers were distributed evenly across age groups, however 35% of those testing HCV positive were under age 30, indicating a younger group of inmates acquiring HCV infection. Among those testing positive, the predominant reported risk behavior was injection drug use; 93% reported ever injecting drugs and 62% reported injection drug use in the 12 months prior to incarceration.

Lessons learned: Integration of HCV screening is highly accepted and extremely effective at identifying HCV infection in a short-term incarceration setting. HCV screening in this jail identified younger individuals with recent IDU behavior. Further assessment of this issue would help inform education, support services, and medical care for young male and female inmates with recent histories of IDU and early stage HCV.

**Abstract 1584** - Integrating HIV Prevention with Hepatitis C Co-infection Programs

**Author(s):** Luis Scaccabarrozzi, Lisa Frederick, John Denelsbeck
Many U.S. HIV treatment and prevention education programs focus entirely on HIV, even as HIV and hepatitis C (HCV) co-morbidity prevalence continues to increase. Because HIV/HCV co-infection requires specialized attention, ACRIA developed an HIV/HCV co-infection curriculum addressing the specialized needs of individuals living with both infections. About 1/4 of people with HIV in the U.S. also have HCV. Studies indicate that 80-90% of active or former substance users with HIV are co-infected with HCV, and injection drug use continues to play a significant role in the transmission of blood-borne diseases such as HCV and HIV. As needle exchange programs have increased the availability of clean needles, risky sexual behavior is emerging as a more common means of transmission. The incidence of HCV among men who have sex with men is on the increase, especially among men with HIV who engage in sexual activity with other HIV-positive men, often ignoring that they are also at risk for HCV and other STIs.

A national program completed in over 15 cities nationwide, and locally in NYC.

A CDC-funded project initiated by the NYS Department of Health and ACRIA to reach a variety of social service-providing agencies that target communities at high risk for HIV and hepatitis C: HIV service organizations, LGBT organizations, agencies and programs within the criminal justice system, and substance using centers

A curriculum specifically addressing HIV/HCV co-infection issues, including signs/symptoms, HIV and HCV treatments, and safer injection practices was developed. This curriculum was used as the basis for several train the trainer, peer education, and education/treatment counselor trainings. Another curriculum on how to integrate hepatitis education and prevention into different work settings was developed targeting correctional facilities, IV and substance use service providers, and community-based organizations serving high-risk communities. For clients, individualized counseling and tailored group workshops were provided at local homeless shelters, hospitals, harm reduction/needle exchange sites, prisons, and GLBT social service agencies in New York City.

Lessons Learned:
- The development of an HIV/HCV co-infection curriculum is essential to meeting the special needs of individuals living with both HIV and Hepatitis C.
- Programs specializing in HIV treatment and prevention education can enhance their services and better meet the needs of co-infected clients through the adoption and integration of a co-infection curriculum.

Next Steps:
- Creating HIV programs that are inclusive of hepatitis as well as other STIs
- Providing easy-to-understand information helping non-medical service providers to become part of the prevention/treatment/care continuum.
1. Communication Strategies to Promote Implementation
2. Training
3. Technical Assistance
4. Evaluation

CDC believes that ARTAS will be a widely implemented intervention in the upcoming years. Expected results include a new training initiative within the next two years to insure training for all health departments funding agencies to implement the intervention as well as those that are considering funding agencies to implement the intervention. Technical assistance will be an important element in successful program implementation.

Many state health departments are already funding community-based organizations to implement ARTAS. Technical assistance will be important in the roll-out of this intervention. The original study sites noted the need to have a full-time Linkage Coordinator on staff to implement the intervention successfully. While this person could be someone already working in the agency, having the individual identified was beneficial. From the original sites, some had trouble recruiting participants within the original timeframe defined. Once they expanded the eligible criteria to being within 12 months of diagnosis, many more clients became eligible and were linked to medical care. There were multiple issues that required agency preparation including: safety protocols, the establishment of partnerships with medical providers/agencies, defining the disengagement processes, supervision, and monitoring and evaluation.

Abstract 2040 - HIV Testing at a Free Mobile Dental Clinic in North Carolina

Author(s): Pamela W. Klein; Catie H. Cunningham; Perry M. Tsai; Rebekah C. L. Macfie; Bill Blaylock; Jacquelyn M. Clymore; Peter A. Leone

Despite efforts to expand HIV testing in clinical settings, many individuals are still unaware of their HIV status. Many persons at-risk for HIV acquisition access dental care more frequently than general medical care. Integrating HIV testing into a dental care model can provide HIV testing services to a population that would be missed by other HIV testing efforts in clinical settings.

The North Carolina Missions of Mercy (NC MOM) provides free dental services to underserved persons. The NC MOM clinics take place over 2-days and occur monthly across North Carolina; NC MOM clinics serve 400-1000 patients per clinic, depending on the site. Patients are provided with x-rays, dental cleanings, fillings, extractions, and other services. Free rapid HIV testing was introduced to the NC MOM clinic in New London, NC on Saturday, April 16, 2011.

Routine, opt-out HIV testing (OraQuick Advance on oral fluid) was administered by members of the UNC Student Health Action Coalition (SHAC); 7 volunteers assisted with this NC MOM clinic. Patients were swabbed for HIV testing after the collection of medical history and vital signs. Patients were provided with pamphlets informing them of local free HIV testing resources. Results were given either after patients were triaged for dental care or after the completion of dental services. Opt-in counseling for personal risk-assessment and risk reduction was provided by trained SHAC counselors. Free condoms were also made available upon receipt of results. The protocol for a reactive rapid HIV test required that blood be drawn by a trained phlebotomist and brought to UNC (Chapel Hill, NC) for Western Blot confirmation and syphilis testing; if confirmed, local Disease Intervention Specialists would be notified. Patients with preliminary positive results would also be informed of HIV control measures and provided with contact information for a local HIV provider group.

Approximately 160 patients attended the New London NC MOM clinic; 141 (88%) were approached for opt-out HIV testing. Acceptance of testing was 90% (n=127/141). Over 95% of patients were reached for delivery of results (n=121/127). Only 34 patients (28%) who received their results elected for opt-in risk assessment/reduction counseling. There were zero preliminary positive tests. Tested patients were 32% black (n=40/127), 13% Hispanic (n=16/127), and 55% white (n=70/127); 56% of testers were female (n=70/127). The average patient age was 38 years (standard deviation=15 years). Approximately 45% (n=57/127) had never before been tested for HIV.
Integration of HIV testing into the mobile dental setting was feasible and acceptable. Patients at mobile dental clinics are in need of HIV testing; nearly 50% had never before been tested for HIV. Barriers included not interfering with dental patient flow and providing HIV test results to patients after major dental procedures. Future NC MOM clinics could integrate point of care tests for other infectious diseases and HIV testing/counseling performed by dental students to increase sustainability. Providing HIV testing in this unique dental setting improves access to HIV testing for underserved populations that may not be reached through other HIV prevention efforts.

Abstract 2066 - Overestimation of Clinic Attendance by Individuals Seeking HIV Primary Care

Author(s): Rodriguez, AE; Cardenas, GA; Goldstein, MH; Jeanty, YJ; Metsch, LR

Regular attendance at primary medical care physician appointments is essential for HIV-infected individuals in order to regulate patients viral load, control ongoing HIV transmission, and decrease mortality. In many instances, clinicians rely on patients self-report to assess adherence to clinic attendance. We investigated the accuracy of patients self-perception of appointment adherence when compared to data from our Electronic Medical Records database (EMR).

Study methods included study interviews and medical record abstractions. We conducted face-to-face interviews with a systematic sample of diverse HIV-infected adult patients attending an HIV primary care clinic in Miami, Florida, from March 2010 to February 2011. Participants were asked questions about their clinic attendance over the past 12 months, including the number of appointments, missed appointments and perception about their overall clinic attendance. We then reviewed their EMR for this information. Participants were rated as excellent if they had not missed any scheduled appointments, very good/good if they missed 1 appointment and fair/poor if they missed more than 2 scheduled appointments in the previous 12 months. A Cohen’s Kappa statistic for rater agreement was used to compare the patient’s self-report to extracted attendance data from the EMR for appointments up to 12 months prior to the interview.

Among 373 study participants, 55.8% were male, 67.3% were Black and 28% were Hispanic. The mean age was 46.7 and the median was 47. The average number of appointments in the prior 12-months was 5.2 according to self-reports and 4.6 when calculated using the EMR, with a correlation of 0.286 (N=364, p<0.001). While 56.6% of participants self-reported that they did not miss any appointments in the past 12 months, the EMR showed that 37.5% of participants did not miss appointments. We computed a Cohen’s Kappa statistic comparing the patients that missed one or more appointments in the medical record to the patients who missed one or more appointments in the self-report and found a fair level of agreement (N= 0.279, p<0.001). Of the participants that missed at least 1 appointment, 54.9% reported it was because of a scheduling conflict, 42.3% forgot they had an appointment, 10.5% were sick or hospitalized, and 6.3% reported a lack of insurance. In addition, 26% of the participants that rated themselves as having excellent attendance were rated as fair/poor by EMR analysis, and 47.7% of the participants that rated themselves as having very good/good attendance were rated as fair/poor by EMR analysis.

Successful treatment of HIV disease requires consistent and accurate patient monitoring by HIV primary care providers. Our data showed that a significant proportion of HIV-infected individuals tend to overestimate their clinic attendance. Clinicians should be cognizant that patient’s self-report is not always accurate when assessing adherence to clinic care. Additionally, efforts should be made to provide more frequent medical appointment reminders as well as flexible appointment scheduling options to enhance medical care adherence.

Abstract 2094 - Rapid Partner Services Protocol to Complement Acute HIV Infection Testing in an STD Clinic Setting

Author(s): Ellen Rudy, PhD; Frank Ramirez; Thelma McClinton; Getahun Aynalem; Peter R. Kerndt

Acute HIV Infection (AHI) is a stage of enhanced HIV transmission. Identification of AHI persons leads to early medical treatment and modified risk behaviors that may significantly reduce HIV transmission. Timely partner services of AHI cases may serve as a complementary tool to further identify newly-diagnosed HIV persons. The community-embedded Disease Investigator Specialist program has been shown to significantly reduce the time to interview of a new HIV case. The objective of this analysis to evaluate the effectiveness of a streamlined partner services program in conjunction with an AHI testing program to identify newly-diagnosed HIV positive cases.
AHI pooled nucleic acid amplification testing (NAAT) was routinely completed for all HIV negative patients attending the AIDS Healthcare Foundation's (AHF) Men's Wellness Clinic in Los Angeles County and specimens were processed at the local public health laboratory (PHL). A designated PHL staff immediately and directly reported positive AHI results by phone to the Los Angeles County Sexually Transmitted Disease Programs (STDP) Partner Services Field Director. The Field Services Director immediately routed the cases to the AHF's embedded Disease Investigator Specialist to schedule an interview with the AHI case to elicit partners contact information. Partners were contacted and if eligible were scheduled for an HIV test.

AHF tested 2718 patients for AHI in 2010. Of those, 18 were positive for AHI. Of the 18 cases, 7 partners were initiated with a partner index of 0.39. Of the 7 partners 3 were newly diagnosed with HIV; 3 were previously HIV positive; and 1 partner refused follow-up. Average time between specimen collection date and the date results were reported to the Partner Services Field Director was 11 days. Average time between the date of reported results and the date the case was interviewed by the embedded DIS was 6 days with a range of 0 to 22 days.

Streamlined reporting protocols between the laboratory, Field Services, and the diagnosing clinic lead to the successful identification of 3 new HIV cases out of 18 original AHI cases. Considering the infectious stage of AHI cases, rapid follow-up of partners can enhance the preventive impact of AHI testing in identifying newly diagnosed HIV persons. Health departments should consider partnerships with local laboratories and clinics to minimize the time between a patient's visit date and first partner services interview date.

**Track B**

**LB5 - Perinatally HIV-Infected Women, Native Americans, & Adolescents**

**Room: A703 (Atlanta Marriott Marquis)**

**Abstract 1278 - Achieving a More Coordinated National Response to Eliminate Mother-to-Child HIV Transmission in the United States**

**Author(s):** Lauren Fitz Harris; Carolyn Burr; Joan Miller; Songhai Barclift; Lauren Broussard; Pat Flynn; Pat Garcia; Ed Handelsman; Celine Hanson; Ebony Johnson

Since 2008, CDC and other stakeholders have developed a new framework to eliminate mother-to-child HIV transmission (EMCT) in the U.S. Implementation requires strong collaboration among governmental and non-governmental stakeholders. The EMCT plan fully incorporates the goals of the National HIV/AIDS Strategy (NHAS), i.e., to reduce new HIV infections, increase access to care and improve health outcomes for people living with HIV, reduce HIV-related disparities and achieve a more coordinated national response.

To address each of the goals of the NHAS, a group of 56 stakeholders comprising experts from federal agencies, state health departments, clinical care settings and national professional organizations have been convened to work collaboratively to refine and implement the national EMCT framework by: 1) enhancing collaboration among field experts from various agencies and disciplines; 2) assessing EMCT-related activities currently under way and supporting those activities as needed; 3) developing and implementing action plans that address all six components of the EMCT framework; and 4) assigning stakeholders specific activities set within realistic timeframes to implement the EMCT framework.

In December 2009, key stakeholders with expertise in the fields of HIV, maternal and child health, surveillance, program, policy and research were convened to review and provide input into the EMCT framework as well as to discuss a collaborative effort to implement it. Stakeholders interested in participation were subsequently placed in six complementary and interconnected workgroups, each of them representing an essential functional aspect of the EMCT framework: 1) Reproductive Health, Family Planning Services and Preconception Care, 2) Comprehensive Case-Finding, 3) Comprehensive Care, 4) Case Review and Community Action, 5) Research and Long-term Monitoring, and 6) Data Reporting and Surveillance. Co-chairs for each of the groups were named and the EMCT stakeholders group reconvened in August, 2010 in conjunction with a perinatal HIV prevention institute at the Ryan White All Grantees Meeting. At this meeting, each of the workgroups developed specific action plans. The
stakeholders reconvened in December 2010 to further refine the action plans while addressing cross-cutting themes. Implementation is currently underway.

Each of the six workgroups developed at least 5 actions for implementation with specific timelines and assignments. Some examples of actions underway include: define outcome and performance measures for delivery of reproductive care for HIV-infected persons and utilizing them through Ryan White and Title X programs; implement quality measures (e.g., Joint Commission and National Quality Forum) for HIV testing of pregnant women in labor and delivery; develop and disseminate clinical and psychosocial standards for EMCT case management; and develop a modified FIMR-HIV Prevention Methodology for case review and community action for multiple perinatal infections in lower HIV-incidence areas; conduct studies to further understand the sources of excessive cases of perinatal transmission and optimize perinatal HIV exposure reporting.

The NHAS goals can be achieved through collaborations among stakeholders addressing specific populations. Integrating federally-funded activities requires long-term planning, ongoing communication and agency support. Providing leadership and support of stakeholders work can achieve a more coordinated national response to the epidemic.

**Abstract 20070** - HIV Following STDs in Philadelphia Adolescents

**Author(s):** Anschuetz, GL; Newbern, EC; Eberhart, MG; Baker, JM; Brady, KA; Asbel, LE; Johnson, CC; Schwarz, DF

**Background/Objectives:** Philadelphia has close to the highest prevalence of sexual risk behaviors (2009 YRBSS) and reportable STD rates in adolescents for the US. STD rates for adolescents in 2010 were 3,762.0 per 100,000 for Chlamydia trachomatis (CT), 954.1 for gonorrheal infections (GC), and 7.3 for primary and secondary syphilis (PS). These 2010 adolescent rates are 38% and 7% higher for CT and GC, respectively. The PS syphilis increase began earlier – 21% higher in 2010 compared with 2008. These increases in adolescent STDs result from the prevalence of these STDs in their sexual networks and the risk behaviors of adolescents. We felt it was important to consider the relationship between adolescent STDs and subsequent HIV as we experience this STD surge and anticipate one for HIV.

**Methods:** The retrospective cohort used for these analyses includes 75,288 individuals screened for CT and GC infections in the Philadelphia High School STD Screening Program (PHSSSP). All STD tests (CT, GC, and syphilis) reported to the Philadelphia Department of Public Health (PDPH) for these individuals were included in the analysis if 1) they had at least 1 test while aged 11-19 years and 2) were born between 1985 and 1993. Individuals were matched to PDPH HIV surveillance data using available identifiers. Only HIV diagnosis occurring simultaneously or subsequent to adolescent STD diagnoses was included. Gender stratified analysis included the HIV risk for CT, GC, and syphilis combined and separately; time to HIV infection; and population attributable risk percents. Available factors were considered for their effect on these STD-HIV relationships.

**Results:** Thirty-two percent of the 36,253 females and 13% of the 39,035 males in the cohort had an adolescent STD reported. Between ages 13 and 24 years, 52 females and 202 males received an HIV diagnosis. Ever having an STD during adolescence or either CT or GC alone were significantly associated subsequent HIV (40% to 480% increased HIV risk). HIV risk was also higher as the number of adolescent CT infections for females and GC infections for males increased. Preventing all adolescent STDs could avert roughly 3 to 6 HIV diagnoses annually as the 150,000 Philadelphia adolescents aged 11 to 19 years progress into young adulthood.

**Conclusions/Implications:** The current surge in teen STD rates is worrisome, because HIV diagnoses in young adults are already on the rise in Philadelphia. Without effective interventions for HIV and STDs, the rates of HIV in those who are currently teens will only continue to increase. Effective interventions focused on risk behaviors as well as structural factors that increase STD and HIV risks need to be launched immediately.

**Abstract 2022** - Prevention of Second Generation’s Perinatal HIV Transmission: Characteristics of Perinatally HIV-infected Pregnant Women, NYC

**Author(s):** Balwant S. Gill; Annette E. Brooks; Karla T. McFarlane; Janine I. Brewton; Colin W. Shepard
In NYC, about 80% of surviving perinatally HIV-infected children have reached adolescence and young adulthood. We describe characteristics of perinatally infected mothers and compare them to HIV-infected mothers with other HIV risks.

Data were collected from medical records of HIV-exposed deliveries 2005-2010 from 16 NYC sites (65% of NYC’s HIV-exposed deliveries) participating in CDC’s Enhanced Perinatal HIV Surveillance project. Two-tailed Fisher exact test was used to compare characteristics.

Among 1,678 HIV-exposed infants born 2005-2010, 22 are HIV-infected (1.3%) and 1,410 (84.0%) are uninfected [246 (14.7%) have an indeterminate status]. One hundred and seven infants (6.4%) were born to mothers with perinatal HIV transmission risk and 1,571 infants to mothers with other risks [62 (6.4%) injection drug use (IDU) risk, 1,032 (61.5%) heterosexual risk, 476 (28.4%) without a specified CDC risk and one (<.1%) with transfusion risk]. Two (1.9%) of 107 infants born to perinatally infected mothers were infected, 4 (6.5%) of 62 infants born to mothers with a history of IDU were infected, 13 (1.3%), of 1,032 infants born to mothers with heterosexual risk were infected, and 3 (0.4%) of 476 infants born to mothers without a specified risk were infected (the infant born to a mother with a transfusion risk was uninfected). As a comparison, 10 (0.7%) of the 1,492 infants born to mothers in the cohort who received any prenatal antiretroviral therapy (ART), regardless of risk, were infected.

Compared to mothers with other risks, perinatally infected mothers were younger at the time of delivery [92.5% vs. 19.2% < 25 years of age (p<.0001)], more likely to be US born [85.1% vs. 45.0% (p<.0001)], significantly less likely to use illicit drugs [6.5% vs. 23.2% (p<.0001)], and tended to have fewer sexually transmitted diseases during pregnancy [17.8% vs. 23.7% (p=NS)]. They were significantly more likely to have received any prenatal care [98.1% vs. 93.4% (p=0.05)], to be diagnosed with HIV before pregnancy [100% vs. 75.1% (p<.0001), to have received any prenatal ART [99.1% vs. 88.2% (p=.0005)], and to deliver by C-section [80.4% vs. 55.9% (p<.0001)]. Significantly fewer had an undetectable viral load close to the time of delivery [33.6% vs. 52.4% (p=.0002)] and significantly more had an HIV viral load >1,000 copies/ml close to the time of delivery [32.7% vs. 14.6% (p<.0001)].

Perinatally HIV-infected mothers were more likely to have taken measures to prevent HIV transmission before and around the time of delivery, such as, receiving prenatal care, receiving prenatal ART, delivering by C-section, and were less likely to use illicit drugs. However, a high proportion had high viral loads close to delivery, which confers a higher risk of HIV transmission to their newborns. The perinatal HIV transmission rate was 1.9% for infants born to perinatal mothers despite receiving the necessary interventions for perinatal prevention. Although, perinatal HIV transmission is at historic lows, now that the majority of U.S. perinatally infected children are of child-bearing age, there are unique challenges to perinatal prevention, and enhanced surveillance is warranted for years to come.

Abstract 2059 - Reclaiming Our Voice: Two Spirit Health and Human Service Needs in New York State
Author(s): Harlan Pruden

The indigenous peoples of North America have many cultural traditions that have often been misrepresented or suppressed through the colonization process. Many of these are significantly different perspectives about sex, gender and sexuality than those imported from Western Europe. In the 21st century, one tradition that was nearly lost is what is generically referred to as Two-Spirit, contemporarily known as lesbian, gay, bisexual or transgender Native peoples. A detailed report on the findings of first-ever two-spirit needs assessment will be taken up with recommendations on how to best fill the gaps and work with this highly marginalized and stigmatized sub-population.

This project was originally conceived as a series of focus groups with two-spirit and LGBT Native people in cities across New York State. The goal of the focus groups was to investigate risk and protective factors, sources of health care and healing, issues of historical trauma, and other culturally specific issues that affect the health and well-being of this community. Also included in this report is an analysis of quantitative data collected for a larger project on LGBT health and human service needs in New York State. Nearly 3,500 valid responses were included in this survey project, allowing racial and ethnic comparisons in health and human services disparities within the LGBT community. Just under 100 responses were from American Indians/Native people or two-spirit people.
Very little is known about LGBT Native people and their specific experiences of health and human services disparities. New research using a large national study of LGBT American Indians found a high rate of HIV prevalence and partner concurrency and strong relationships between discrimination and physical pain, impairment, and poor health. Smaller studies, like the NYS first-ever state-wide needs assessment, of LGBT American Indians/two-spirit have found high rates of victimization, child abuse and historical trauma. These studies have also revealed problems with mental health and HIV risk behaviors.

The report calls for additional Infrastructure for two-spirit organizations; Culturally Relevant Mental Health, Substance Abuse Services and HIV/AIDS Services; Cultural programming for this highly marginalized and stigmatized sub-population both within the LGBT and Native communities and as a result a high-at-risk segment within our country that is current slipping through the cracks within the health and human service sector.
Abstract 1507 - Engagement of Massachusetts Physicians in HIV Prevention: Results of an On-Line Survey
Author(s): Jaclyn M. White; Matthew J. Mimiaga; Kenneth H. Mayer

Scaling up HIV prevention interventions in health care settings could prove effective in decreasing the number of new HIV infections. Given that many persons at-risk for HIV visit a generalist regularly, and recent data suggest that antiretrovirals may be helpful in decreasing HIV infection, understanding generalists and other providers' utilization of HIV prevention modalities is important.

Between July and October, 2010, Massachusetts-based generalists (e.g., internal medicine, family and pediatric providers) and HIV specialists were invited via professional list-serves to fill out an on-line survey of their knowledge, attitudes, and beliefs about biomedical and other HIV prevention modalities.

Of the 178 eligible physicians (141 HIV specialists and 47 generalists) who completed the survey, 76.4% were white, 55.9% were female, 10% were men who have sex with men (MSM) and 2 were HIV-infected. The majority of providers were trained in infectious diseases (ID; 57.3%), followed by internal medicine (IM; 23%), family medicine (FAM; 9%) and pediatrics (PED; 7%). The most commonly reported HIV prevention strategy was HIV testing and counseling (98.3%), followed by individual health education (86.5%), and the provision of condoms, lubricant or other barrier protection (66.9%). When asked about the provision of antiretrovirals to block HIV infection before exposure (Pre-exposure Prophylaxis: PrEP), the majority (56.6%) said they would prescribe PrEP if it were moderately effective with mild side effects. In separate, bivariate analyses, ID providers were significantly more likely than IM (OR=3.67; p<0.0001); FAM (OR=5.20; p<0.0001) or PED (OR=13.57; p<0.0001) providers to have prescribed antiretrovirals to block HIV infection after an occupational exposure (occupational Post-Exposure Prophylaxis: oPEP) and significantly more likely than IM (OR=2.12; p=0.002); FAM (OR=5.30; p=0.002) or PED (OR=2.57; p=0.002) providers to have prescribed antiretrovirals to block HIV infection after a sexual or injection drug use exposure (non-occupational Post-Exposure Prophylaxis: nPEP). However, ID providers were less likely than IM (OR=0.64; p=0.001); FAM (OR=0.09; p<0.001) or PED (OR=0.11; p<0.001) providers report the provision of condoms, lubricant or other barrier protection. In separate multivariable, age-adjusted models, HIV specialists were more likely than generalists to provide a range of HIV prevention interventions including: individual health education (Model_1: aOR=3.31; p=0.02); partner services (Model_2: aOR=6.50; p=0.002); oPEP (Model_3: aOR=12.47; p<0.0001) and nPEP (Model_4: aOR=11.13; p<0.0001). Additionally, knowing someone with HIV was significantly associated with the provision of individual health education (Model_1: aOR=7.21; p=0.03) and MSM were more likely than non-MSM to have prescribed nPEP (Model_4: aOR=4.53; p=0.04) and PrEP (Model_5: aOR=20.39; p=0.01).

The advent of effective biomedical interventions such as PrEP provide an opportunity to prevent new cases of HIV, yet PrEP provision requires the delivery of a comprehensive package of counseling and other services. Findings suggest that HIV and other infectious disease specialists are more likely than generalists to administer a variety of HIV prevention interventions. Given that primary prevention is essential to reducing HIV incidence rates and generalists are best able to deliver these services, future studies should assess generalists’ attitudes, comfort and capacity to provide comprehensive preventative care in order to prevent HIV infection among at-risk persons.

Abstract 1517 - Sexual Risk Behavior and Viremia among MSM in the HIV Outpatient Study
Author(s): Marcus D. Durham; Jim Richardson; Kate Buchacz; DerShung Yang; Kathy Wood; John T. Brooks

Background: The extent to which men who have sex with men (MSM) in HIV care engage in unsafe sexual behaviors has not been well described. We studied MSM enrolled in a contemporary cohort of HIV-infected patients in care to assess the frequency of clinical and socio-behavioral correlates of unprotected sex.
Method: Between March 2007 and July 2010 a convenience sample of HOPS participants were queried by telephone audio computer-assisted self-interview (TACASI) about risk behaviors including: sexual activity and disclosure of HIV status to sexual partners. Using additional clinical data obtained through chart abstraction, we explored the association of viral load and CD4+ cell count with unprotected sex among HIV-infected persons in logistic regression analyses.

Results: Among 902 MSM (median age = 47 years, median CD4+ cell count = 527 cells/mm3, 95% prescribed HAART) surveyed, 704 (78%) were sexually active in the past 6 months; 92% (N=649) reported engaging in any unprotected sex (54% anal, 1% vaginal or 91% oral). Of the 382 MSM who had unprotected anal sex (UPA), 43% and 57% had unprotected insertive and receptive anal sex, respectively with a partner whose HIV status was negative or unknown (PNU). For MSM with available viral load data who reported UPA with a PNU, 14% had a viral load > 400 copies/ml (range 406 – 1,391,690; median 10,240). In multivariable analysis, the odds of engaging in UPA with a PNU were higher for patients age less than 50 years (odds ratio [OR] = 2.1; 95% confidence interval [95% CI] 0.9 – 4.8 for ≤ 29 years old; OR = 2.1, 95% CI 1.3 – 3.5 for 30-39 years old; OR = 1.6, 95% CI 1.1 – 2.4 for 40-49 years old). injection drug users (OR = 4.7, 95% CI 1.3 – 17.0), patients with > 1 sex partner (OR = 2.4, 95% CI 1.4 – 4.1 for 2 partners; OR = 5.5, 95% CI 3.7 – 8.4 ≥ 3 partners), and patients who did not disclose their HIV status to all partners (OR = 1.6, 95% CI 1.1 – 2.4). Race/ethnicity, drug or alcohol use, history of AIDS, CD4 cell count, viral load and antiretroviral experience at time of survey were not associated with engaging in UPA with a PNU.

Conclusion: Over half of the 704 sexually active HIV-infected MSM surveyed in the HOPS engaged in UPA, including 14% with a detectable viral load who reported engaging in UPA with a PNU. Providers should routinely ask MSM about sexual risk behaviors and offer brief sexual risk reduction messages and referrals to more intensive counseling as warranted.

Abstract 1857 - Integrating Partner Services (P.S.) in a Clinical Setting: CARES Partner Services Outreach Model
Author(s): Travis Tanner; Manny Rios; Amanda Chi

Decreased funding has caused most CBOs in the greater Sacramento area to close, which has led to fewer people getting tested for HIV. Partner Services (P.S.) is a vital component of HIV prevention and early detection, however implementation of a sustainable and effective P.S. program is challenging.

An effective P.S. program that incorporates multiple clinical departments has been established at CARES in Sacramento, California.

Designated HIV Test Counselors also work as P.S. providers. Counselors have moved from simply offering P.S. to a much more assertive approach that involves coordination with multiple clinic departments, intensive follow up with clients and coordination with Sacramento County Disease Investigators. P.S. Counselors use motivational interviewing and assertiveness to promote partner disclosure as a behavioral norm. Medical and mental health providers and Case Managers are trained to bring up the subject of partners with HIV-positive clients at every encounter. If a provider determines that there is a need for P.S. counseling, the on-call counselor is paged and P.S. is immediately provided. Moreover, P.S. providers are paged at the end of each new patient intake, making partner disclosure an integral part of the new patient's experience in care. Additionally, P.S. counselors facilitate workshops and make announcements in patient therapeutic groups, such as the Alcohol and Other Drugs (AOD) group, where clients are learning to make partner disclosure a part of their recovery process by making amends. Counselors work closely with county disease investigators and follow-up with each client extensively. In addition to multiple referrals from clinical providers, P.S. counselors actively track new diagnoses and contact them via phone or meet with them at clinic appointments.

Results: From January 2010 to December 2010, the P.S. counselors at CARES have provided 1,248 P.S. counseling sessions to clients. As a result, we tested 840 sexual and/or needle sharing partners of HIV-positive individuals. Of the 840 partners 338 (40.2%) were MSM; 194 (23%) reported using illegal drugs or alcohol concurrently with sexual activity; 50 (5.9%) were IDUs and 460 (54.8%) reported that they were unsure of their partner's sexual/needle-use
behavior. Of the 840 partners tested, 28 were found to be HIV-positive. The seropositivity rate among these 840 partners is 3.3%. More recently, from December 1, 2010 to January 31, 2011, we have significantly increased our reach by utilizing the aforementioned assertive approach. In January 2011 alone we tested 214 partners. In the month of January 2011, 26 individuals tested positive for HIV and our seropositivity rate for the month was 4.2%. Compared to previous months in 2010 this is a 90.9% increase in seropositivity rate.

Lessons Learned: Providing P.S. is a critical component to an effective HIV prevention program. In order to implement a sustainable and effective P.S. program it is essential to have designated P.S. counselors who are also cross trained as HIV test counselors. Coordination with clinical staff in multiple departments and intensive follow up with each client are the keys to a successful program.

Abstract 1939 - Factors Associated with HIV Treatment Access among HIV+ Adults Engaging in HIV Case Management Services

Author(s): Tomas Soto; Goldie Komaie; Mallory Johnson

HIV treatment access and retention in care remains a major problem in the United States. It is estimated that between one-third to two-thirds of persons with known HIV infection are not in regular outpatient HIV care. In Chicago, it is estimated that 52% of persons living with HIV/AIDS (PLWHA) are out of care. Our current understanding of the structural and client level factors that impact HIV treatment access and treatment adherence for Chicago area PLWHAs is limited. This study aims to collect client level data to identify system and individual level barriers to access/retention in care and inform future access and linkage to care intervention strategies.

Between June and October 2010, we administered a telephone interview survey to 412 HIV+ clients, who called our centralized case management intake at the AIDS Foundation of Chicago to enroll in HIV case management services. Callers range from newly diagnosed and engaging in HIV services for the first time to being actively involved in their HIV care and calling for specific case management services. Two trained Intake and Referral Specialists conducted the phone interviews. We obtained verbal consent from all clients before initiating the survey. Fewer than 5 clients refused to be interviewed. The interview conducted in both English and Spanish, took 10-15 minutes to administer. The interview survey was adapted from several validated instruments currently being used in research projects addressing engagement and adherence to care. Areas assessed include general health and treatment questions, treatment beliefs and antiretroviral treatment adherence, HIV disclosure among family and friends, HIV-related stigma, substance use, mental health, and service needs. We conducted significant testing to assess differences in responses across the key outcomes areas.

The sample was 75% men, 65% African American, 85% U.S.-born, with a mean age of 40. We asked all callers three questions about their beliefs about medications; 31% strongly agree or agree that doctors prescribe too many medications? 33% that doctors place too much trust in medications and 16% that medications do more harm than good. African Americans were significantly more likely to have negative attitudes and beliefs about medications. African Americans also reported being nearly twice as likely to avoid getting treatment because someone might find out compared to Whites (19.7% vs.10.6%). Among clients on antiretroviral therapy, Whites and Hispanics were over three times more likely than African Americans to take their HIV medications as prescribed. For clients not taking HIV medications, African Americans were significantly more likely to never want to take HIV medications.

We found significant differences between African Americans and women in rates of HIV disclosure, social support, beliefs about medications and self-reported stigma. These findings are consistent with other studies that suggest these factors may impact access and retention in linkage to care. Case managers working with clients should routinely assess clients HIV treatment beliefs, HIV disclosure, social support and experiences with stigma. Future access and linkage to care interventions should incorporate HIV treatment education and stigma management strategies.

Track A
A10 - MARI: Black and Hispanic HIV Prevention Researchers Working in Black and Hispanic Communities
Room: Courtland (Hyatt Regency Atlanta)
Abstract 1620 - MARI: Black and Hispanic HIV Prevention Researchers Working in Black and Hispanic Communities, 2011

Author(s): (ADD Jose Nanin; Carl Sneed; Scyatta Wallace; Myriam Torres as presenters)Leigh Willis; Ted Castellanos; Silvia Amesty; Emma (EJ) Brown; Jose Nanin; Guillermo Prado; Carl Sneed; Myriam Torres; Scyatta Wallace; Patrick Wilson

Blacks and Hispanics in the United States continue to be disproportionately affected by the HIV/AIDS epidemic and account for an estimated 64% of incident HIV infections (2006). Innovative and culturally appropriate research remains an imperative component of addressing the epidemic in black and Hispanic communities. MARI supports research by investigators who have cultural and community ties to blacks and Hispanics affected by the HIV/AIDS epidemic. MARI investigators contribute to filling the gaps of information regarding how public health can more effectively conduct research and deliver programmatic interventions that are culturally appropriate in black and Hispanic communities. MARI-supported research efforts are consistent with the National HIV/AIDS Strategy (NHAS) goals of: 1) reducing HIV incidence, and 2) reducing HIV-related racial/ethnic disparities.

MARI currently funds research studies in several cities and regions with disproportionately high rates of HIV prevalence: New York City (NYC), New York; Miami, Florida; Los Angeles, California; Columbia, South Carolina; and Lake City, Florida.

Ongoing MARI studies include: 1) an evaluation of HIV testing in Exchange Syringe Access Program (ESAP) pharmacies that provide syringe/needle exchange services for intravenous drug users (IDUs) in New York; 2) interviews and surveys with black men who have sex with men (BMSM) to learn about resiliency factors that affect HIV prevention and care efforts; 3) interventions with black and Hispanic families to improve sexual health outcomes for their youth; 4) qualitative evaluations with young, heterosexual, recently incarcerated black men to help tailor targeted HIV testing and prevention efforts; 5) evaluations to facilitate HIV testing with pregnant Latinas; and 6) mixed methods research with black men in rural areas to understand facilitators and barriers to HIV testing.

To date, MARI researchers have: provided HIV testing for over 100 IDUs through NYC pharmacies and identified IDUs with new HIV infections; learned about HIV resiliency and risk from BMSM through over 100 internet diary dialogue and quantitative surveys; learned lessons from black and Hispanic families about sexual health dialogue with their youth; interviewed over 20 recently incarcerated young black men regarding HIV prevention and testing, and their work is ongoing. Lessons learned from MARI investigator data are actively being: translated into more effective HIV prevention and intervention tools for black and Hispanic communities; presented at national and international conferences; and published in peer-reviewed journals. Many MARI investigators have also successfully competed for larger research awards and used their initial MARI research data as the foundation for their ongoing HIV/AIDS research in black and Hispanic communities.

MARI research is a vital component of helping to reduce the incidence of HIV and HIV-related racial/ethnic disparities, consistent with NHAS goals. This session will describe the progress of MARI investigators and highlight lessons learned, especially where programmatic translation has been particularly successful. The ongoing success and impact of MARI research underscore the importance of programs like MARI and how well they contribute to our understanding and resolution of the domestic HIV/AIDS epidemic.

Track B
B03 - Mapping and Geographic Analysis to Monitor the Epidemic
Room: Piedmont (Hyatt Regency Atlanta)

Abstract 1224 - HIV and Social Determinants of Health: A Spatial Examination of a 3-Site Pilot Study, 2006-2008

Author(s): Zanetta Gant, PhD, MS; Stacy Cohen; Denise Hughes; Xiuchan Guo; Devon Williford; Jeffrey A. Stover; Mark R. Stenger

HIV continues to disproportionately affect communities across the United States. Social determinants of health (SDH; social and environmental factors that may influence health outcomes) are a new driving force behind strategies
to reduce health disparities and promote health equity. The geographic area in which a person lives (including racial
distribution and poverty indicators) can play a role in the social and sexual networks within that community, which in
turn can influence HIV risk behaviors. To better understand subpopulation inequities in HIV rates, we examined the
potential relationship between SDH and HIV diagnosis rates.

In a CDC-led pilot study of three states (Colorado, Virginia, Washington State), data on HIV diagnoses from 2006
through 2008 among adults and adolescents aged 13 and over were linked to census tract level SDH variables.
Characteristics of persons diagnosed with HIV (race/ethnicity, sex, age, and transmission category obtained for
geographic mapping) and characteristics of the communities in which they live (total population, percent below
poverty and percent minority obtained from the U.S. Census Bureau) were analyzed. Percent below poverty and
percent minority were categorized into quartiles (0-10%, >10-20%, >20-40%, >40%), and all characteristics were
examined at the state, county, and census tract levels. Geographic mapping was used to identify patterns and
determine how percent below poverty and percent minority were associated with HIV diagnosis rates (divided into
quartiles). Chi-square tests for significance (p<0.05) were used to identify trends.

We analyzed 5,450 HIV diagnoses from 2006 through 2008 in the three states. At the county level, two-thirds (65.6%)
of persons diagnosed with HIV resided in counties with 0-10% of the population living below poverty, and 38.0%
resided in counties with minority races/ethnicities accounting for >40% of the population. At the census tract level,
over half (56.2%) of the persons diagnosed with HIV resided in census tracts with 0-10% of the population living
below poverty, and 45.8% resided in census tracts with minority races/ethnicities accounting for >40% of the
population. When examining the linear trend between the community characteristics and HIV diagnosis rates, a
pattern emerged: as percent minority increased, the HIV diagnosis rate increased at the county and census tract
levels. No clear association was seen between percent below poverty and HIV diagnosis rates.

From 2006 through 2008 in the three states, most persons newly diagnosed with HIV resided in counties and census
tracts with minorities representing higher percentages of the population. Additionally, as the percentage of minorities
increased, the HIV diagnosis rates also increased. CDC is currently working with 29 jurisdictions throughout the
United States to further investigate the relationship between HIV diagnosis rates and SDH at the census tract level.
By understanding the differences in HIV rates by SDH and geographic spatial analyses, public health agencies can
better monitor the epidemic, provide knowledge and awareness to those specific areas and populations
disproportionately impacted, and allocate funds for more targeted prevention and testing efforts.

Abstract 1573 - Local Regional Differences in Risky Sexual Behavior among Latino MSM

Author(s): Ying-Tung Chen; Frank Galvan; Lori Mizuno; Mohsen Bazargan

Decades of research have documented the risk of HIV infection posed by unprotected sexual intercourse and certain
drug use practices. Public health units and research institutions have monitored the spread of HIV in a particular
region based on cases of infection reported by particular high-risk groups, such as men who have sex with men and
injection drug users. However, another informative way of assessing the potential differential spread of HIV in a
particular region is to examine reports of high-risk sexual behaviors rather than focusing on HIV cases reported by
specific high-risk groups. A benefit of this approach is that, since the focus is on specific high-risk behaviors,
inferences can be made about the potential future growth of HIV in particular local regions. Using this information,
public health organizations and HIV service providers can then better determine how to allocate limited HIV
prevention resources. This study sought to examine the potential spread of HIV by looking at regional differences in
reported high-risk sexual behaviors among primarily Latino men who have sex with men (MSM) in Los Angeles
County. We focused on primarily Latino MSM because since 1997 the largest number of AIDS cases in Los Angeles
County has been among Latinos and the largest proportion of AIDS cases among Latinos has been among MSM.

Participants consisted of MSM (including young MSM, MSM who have sex with women and MSM who also inject
drugs) who answered a risk assessment as part of their involvement in various programs of Bienestar Human
Services, a Latino AIDS service organization. Among a total of 4,884 MSM, more than 94% of the participants were
Latino. Regional differences were assessed through assignments to specific Service Planning Areas based on
participants self-reported zip codes. Los Angeles County is divided into eight Service Planning Areas by the County
government for health planning purposes. High-risk sexual behavior was the primary outcome variable of interest. Variables that were included as potential covariates in the analysis were age, HIV status, drug use and alcohol use. Bivariate and multiple linear regression analyses were used to determine if there were regional differences in reported high-risk sexual behavior after controlling for the presence of relevant covariates. In our analyses, SPA 4 was chosen as the reference group because it had the largest number of persons living with HIV. In addition, SPAs 1 and 5 were combined with 2 because 1 and 5 had smaller HIV percentages and were contiguous to SPA 2.

The combined SPA 2 (1+2+5) and SPA 7 had statistically lower levels of risk behavior compared to SPA 4 after controlling for the presence of other variables in our model.

These findings suggest that regional differences exist in reported risk behaviors among Latino MSM which could have potential impact in the future regional distribution of HIV in Los Angeles County. Further research is necessary to determine the factors that may account for these differences and the implications of this for public policy and HIV prevention resource allocations.

**Abstract 1700 - AIDSVu: Mapping HIV Surveillance Data and Promoting HIV Testing**

**Author(s):** Jennifer Taussig; Patrick S. Sullivan

HIV surveillance data are often released and displayed in tabular reports that are not accessible to non-scientific users. AIDSVu is a web site that seeks to make HIV prevalence data widely accessible, comprehensible and locally relevant by 1) mapping it and providing a visually stimulating way for internet users to understand and appreciate the data and, 2) providing web site functionality that promotes HIV prevention behaviors such as locating HIV testing sites.

AIDSVu is a web site that is periodically updated with new HIV prevalence data and HIV prevention-oriented content. AIDSVu appeals to a wide-cross section of viewers including policy makers, researchers, government agencies, community-based organizations, health departments, faith institutions, youth, and other members of the general public.

AIDSVu is developed by a cross disciplinary team of epidemiologists, public relations and marketing experts, and creative web site designers with expert guidance from multiple advisory committees. Collectively, these groups work together to ensure scientific integrity of the data and to promote greater understanding and use of HIV prevalence data at the state and local levels. To ensure national comparability and de-duplication of cases, AIDSVu's HIV surveillance-related data is drawn from CDC's national HIV surveillance database. A primary feature of AIDSVu is a map overlay that allows web site users to locate HIV testing centers in their community. Action-oriented content such as that you can do in your community to address HIV is promoted on the web site, including encouraging individuals to get HIV tested by providing links to local testing sites. AIDSVu aims to reach youth through viral dissemination by facilitating the posting of HIV prevention oriented messages on social networking sites such as Facebook and Twitter. Public discussion and peer referral to AIDSVu is also anticipated to help reduce stigma associated with HIV testing.

AIDSVu will launch the next iteration of its web site in spring 2011 with the display of state and county level HIV prevalence data by race/ethnicity, sex and age groups. Evaluation will be implemented through description of the number of hits to the site, number of users locating HIV testing sites, number of users coming from an AIDSVu link posted on social networking sites, and time spent on the web site. These metrics will help evaluate the reach of the web site and patterns of use.

Critical to the success of AIDSVu so far has been the establishment of strong working relationships with state HIV Surveillance Coordinators and CDC. Additionally, the project is guided significantly by a Technical Advisory Group with representation from NASTAD, Kaiser Family Foundation, CDC, and members of the Council of State Territorial Epidemiologists HIV Subcommittee. Pairing surveillance data with prevention messages and action can be an effective way to facilitate greater knowledge and awareness about HIV's impact locally, and to give individuals information about what they can do to address the issue on both a personal and community level.
Track B
B10 - Use of CD4/Viral Load for Monitoring and Prevention
Room: Spring (Hyatt Regency Atlanta)

Abstract 1392 - Reductions in Injection-related Risk Behaviors Following Successful Virologic Suppression among IDUs Treated with HAART
Author(s): Ryan P. Westergaard; Douglas Richesson; Shruti H. Mehta; Gregory D. Kirk

Recent research has generated optimism that the test and treat strategy will lead to reductions in HIV incidence through decreased community viral load (CVL). It is generally accepted that suppression of HIV viremia through highly active antiretroviral therapy (HAART) decreases the risk of HIV transmission, but whether this benefit is offset through increases in transmission risk behaviors by treated individuals remains unclear. We sought to determine whether achieving virologic suppression in response to HAART was associated with a change in the frequency of injection-related risk behaviors.

We measured quantitative HIV RNA levels semiannually for injection drug users (IDUs) who were recruited into a community-based longitudinal cohort study in Baltimore, Maryland. At every study visit, IDUs were asked to report whether they engaged in any injection drug use, shared needles, or attended shooting galleries in the previous six months. A sexual history, including the number of sexual partners and recent diagnosis of sexually transmitted infections (STI), was also obtained. Frequency of risk behaviors were compared among visits when the HIV RNA was below the detectable limit (400 copies/ml) and visits when HIV RNA was elevated.

Among 767 study participants, HIV RNA and risk behavior data were available for 7278 person-visits. Participants were predominantly male (67.4%), African American (93.9%), and the majority had received HAART prior to the study period (61.3%). Compared to when HIV RNA was elevated, any IDU was reported at significantly fewer visits when participants had achieved an undetectable HIV RNA (25.7% vs. 47.4%, p<0.001). Similar reductions were observed for needle sharing (13.2% vs. 25.2%, p<0.001) and shooting gallery attendance (2.3% vs. 4.8%, p<0.001). There was no difference in the number of sex partners reported at visits with and without virologic suppression, although participants were slightly more likely to report a recent STI if the HIV RNA was undetectable (3.3% vs. 2.5%, p=0.046). In multiple logistic regression models adjusted for age, gender and CD4 count, virologic suppression remained significantly associated with decreased odds of each of the injection-related 3 risk behaviors. Treating HIV RNA as continuous variable, we found that for every log increase in HIV RNA, the odds of needle sharing decreased by 25% (OR 1.25 p<0.001).

Injection-related HIV transmission risk behaviors decrease for IDUs who achieve virologic suppression in response to HAART, although the risk of acquiring sexually-transmitted infections may increase in this setting. Effective engagement in HIV care may be beneficial for reducing risky behavior as well as for preventing HIV disease progression. Changes in risk behaviors concomitant with decreases in HIV viral load may need to be taken into consideration when modeling HIV incidence trends and developing intervention strategies.

Track C
C08 - Innovative Uses of Technology
Room: Vancouver/Montreal (Hyatt Regency Atlanta)

Abstract 1255 - HealthMpowerment.org: Feasibility and Acceptability of an Internet Intervention for Young Black MSM
Author(s): Lisa B Hightow-Weidman; Beth Fowler; Derrick M Matthews; Emily Pike; Jessica Kibe; Regina McCoy; Adaora A. Adimora

Young Black men who have sex with men (BMSM) are disproportionately affected by HIV/AIDS in the United States and continue to experience a rapidly increasing HIV incidence. We designed a tailored, theory-based interactive
HIV/STI prevention website for young BMSM, called HealthMpowerment.org (HMP). The intervention was based on the IOM's Integrated model of behavior theory that incorporates several theories of health behavior. We conducted extensive formative work with the target population to develop and test the site. Our initial satisfaction, content acceptability, and usability findings supported the use of the internet in general and specifically, HMP, to deliver risk reduction messages and increase uptake of healthy behaviors among young BMSM. Key interactive features of HMP include live chats, multi-level quizzes, personalized health and hook-up/sex journals, and decision support tools for assessing and changing risk behaviors.

We conducted a randomized controlled trial comparing HMP to currently available HIV/sexually transmitted infections (STI) websites. Subjects were asked to log onto the websites and spend at least 30 minutes on the site per week for four weeks. Follow-up assessments were performed at one month (intervention completion) and three months (two months after intervention completion). Participants completed a written diary documenting how much time they spent online on the sites. We present findings demonstrating feasibility and acceptability of delivering the intervention to the target population of young BMSM.

Between September 2009 and January 2010 we enrolled 50 young (age 18-30), BMSM and randomized them to either HMP (n=25) or to the control websites (n=25). Participants completed their one-month follow-up evaluations in person and three-month evaluations online. We had 90% and 78% retention rates at one and three month follow-ups, respectively and found a trend toward higher levels of satisfaction with the HMP website compared to control sites. We report a trend among intervention participants toward greater intentions to use condoms and to engage in preparatory condom use behaviors, as well as increased positive attitudes toward engaging in safer sexual behaviors over the next three months. Based on feedback from exit interviews with study participants we found HMP to be relevant to the prevention needs of young BMSM.

The primary goal of the current study was to assess the feasibility and acceptability of delivering a novel, theory-based and tailored internet intervention to young BMSM. To our knowledge, HMP is the first online intervention developed by and for young BMSM Overall users found the intervention acceptable and expressed high levels of satisfaction. Further, we were able to engage and retain both those in the intervention and the control arms to participate over the duration of the study. Exit interviews suggested that participants had limited knowledge about the availability of websites providing information on HIV/STIs specifically for young BMSM. Additionally, there was overwhelming support for moving forward with additional development and dissemination of the HMP website. Future larger trials, combining internet and mobile phone technologies, are planned to test HMP among larger and more diverse populations of young BMSM.

Abstract 1681 - Recruitment and Retention of Racial/Ethnic Minorities in an Online HIV Behavioral Risk Study of MSM

Author(s): Christine M. Khosropour; Patrick S. Sullivan

There is great interest in internet-based HIV prevention approaches. Although internet-based HIV prevention interventions have shown promise, there are barriers in conducting online HIV prevention research among men who have sex with men (MSM), including: (1) an under-representation of black and Hispanic MSM, (2) a lack of biological outcomes on study participants, and (3) an inability to retain participants in the research study for a period sufficient to assess outcome measures. The current study aimed to address these barriers by developing methods to recruit and retain MSM, including minority MSM, in an online prospective HIV behavioral risk study.

Internet-using MSM were recruited through banner advertisements on social networking sites from August - December 2010. Men were eligible to participate in the 12-month study if they were: (1) over 18 years of age, (2) white, black, or Hispanic, (3) had a male sex partner in the past 12 months, and (4) willing to complete an at-home HIV test. Consenting men who completed the baseline survey and self-reported being HIV-negative were sent an at-home HIV test kit. Participants were randomized to receive either SMS (text message) or online follow-up surveys every two months; follow-up surveys are ongoing, and are initiated only to participants who have returned their HIV test kit.
Over 15 weeks, 895 men completed the baseline survey and were sent an at-home HIV test kit. Of those, 563 (62.9%) were white, 157 (17.5%) were black, and 175 (19.5%) were Hispanic. To date, 78% (696) of participants have returned the at-home test kit, including 80.3% (452) of white participants, 70.1% (110) of black participants, and 76.6% (134) of Hispanic participants (p=0.02). To date, 85.4% of participants have been retained at the first follow-up time point. There is a significant difference in retention by race/ethnicity: 86.8% of white, 76.1% of black, and 89.3% of Hispanic participants have been retained (p=0.02). Overall retention rates of participants receiving SMS follow-up surveys (87.4%) compared to online follow-up surveys (83.7%) are similar, but black participants randomized to receive SMS surveys are significantly more likely to be retained than those who receive online surveys (91.4% vs 68.8%, respectively; p=0.01).

Because the development of online HIV prevention interventions is of interest, improving methods to effectively test online interventions is critical. Our data suggest that it is possible to create successful longitudinal online studies of MSM that enroll an adequate representation of racial/ethnic minorities, collect biological outcome measures from participants, and retain participants in the study through follow-up time points. However, the lower kit return and retention rates among black study participants indicate that new methods to engage black participants in online research are needed; our data suggest that data collection via SMS may be one method to increase retention of black participants.

**Abstract 1687** - At-home HIV testing of MSM Enrolled in an Online HIV Behavioral Risk Study

**Author(s):** Christine M. Khosropour; Patrick S. Sullivan

The number of internet-based research studies, including HIV prevention studies, has increased dramatically in the past decade due to the ease of collecting data online and the ability to reach geographically diverse study populations at low cost. However, the inability to obtain biological outcomes on participants recruited online has forced researchers to rely on self-reported HIV status. We sought to demonstrate the feasibility and acceptability of conducting at-home HIV testing as part of a national, online HIV behavioral risk study of men who have sex with men (MSM).

Internet-using MSM were recruited through banner advertisements on social networking sites from August - December 2010. Men were eligible to participate in the study if they were: (1) over 18 years of age, (2) white, black, or Hispanic, (3) had a male sex partner in the past 12 months, and (4) willing to complete an at-home HIV test. Consenting men who completed the baseline survey and self-reported being HIV-negative were mailed an at-home HIV test kit. Participants mailed their blood specimen collection card included in the kit to laboratory and then called to receive their test results. Follow-up is ongoing, and participants testing positive receive online follow-up surveys every two months, which query participants on their access to medical care and partner services since their diagnosis. At-home test kits will be sent again to HIV-negative participants at the Month 12 follow-up time point.

During the 15 week recruitment period, 895 men consented and were sent an at-home HIV test kit. To date, 78% (696) of participants have returned the at-home test kit, including 80.3% (452) of white participants, 70.1% (110) of black participants, and 76.6% (134) of Hispanic participants (p=0.02). To date, 24 participants have tested HIV-positive (3.4% test positivity). This includes 2.4% (11) of white participants, 8.2% (9) of black participants, and 3.0% (4) of Hispanic participants. All participants with confirmed positive HIV test results were reported to their state's health department. Twelve of these participants have reached the first follow-up time point and completed the online survey. Of those, 8 reported being seen by a health care provider for HIV medical care and 7 have received counseling for being HIV-positive.

As an increased number of online HIV prevention interventions are developed, there is need to collect biological outcomes on participants. Our data suggest that it is feasible and acceptable to collect biological specimens from participants recruited into an online study. Over 3% of participants who reported being HIV-negative tested positive for HIV, indicating that reliance on self-reported HIV status in such studies may be inaccurate. The prevalence of HIV among those testing was higher among black study participants, which is consistent with other studies. Our preliminary data also suggest that most participants who use an at-home test and receive their results via telephone are linked into HIV medical care and services.
Abstract 1754 - Reaching HIV-positive Women: Using Louisiana Public Health Information Exchange (LaPHIE) to Improve Access to Care

Author(s): Manya Magnus; Jane Herwehe; Wayne Wilbright; Amy Zapata; Lisa Longfellow; Susan Bergson; Ke Xiao

Louisiana is severely impacted by the HIV epidemic, ranking 4th highest in AIDS case rates in the US with women representing 33% of new diagnoses in 2008. The Louisiana Public Health Information Exchange (LaPHIE) is a bi-directional health information exchange (HIE); the first of its kind to link State Public Health surveillance data with electronic medical record data to identify HIV-positive persons out of care or unaware of their status. LaPHIE notifies staff in clinics and EDs when an identified person presents, allowing immediate assessment and referral into care. LaPHIE offers an opportunity to identify and facilitate HIV treatment for out of care women accessing the LSU system.

LaPHIE alerts and responses were tracked via electronic journaling. As a comparator to persons identified, 201 time-matched proxy women who received care following a 12 month break were randomly selected from the LSU clinic population. Associations between age, treatment types, CD4, and viral loads were assessed. Multivariable methods including GEE were conducted.

Between 2/1/09 and 8/31/10, LaPHIE alerts identified 258 unduplicated HIV-positive women (n=97) and men (n=161); 82.2% of those aware of status had at least one non-HIV visit (missed opportunity) before being identified. Women identified by LaPHIE compared to proxy women were less likely to have CD4 counts <200 (40.6% vs. 61.3%, p<0.001), which persisted after adjustment for age in GEE (beta 62.26, p=0.02). No significant differences were found regarding age, ARV treatment, or PCP prophylaxis. Among the proxy sample, no differences were found between samples despite 80% power to detect a difference of 5 CD4 cells or greater if one existed.

Among out of care women, those identified through LaPHIE had higher CD4 counts than women who returned via other mechanisms after a break in care; this suggests that real time HIE is effective at identifying women earlier in the course of their infection rather than remaining out of care until developing AIDS. LaPHIE is an innovative use of public health alerts embedded in health care workflow, leveraging information to improve individual and population health. HIV-positive women out of care who access non-HIV care represent a subpopulation likely to benefit from this system.

Track C
C15 - Social Determinants of Health
Room: Hong Kong (Hyatt Regency Atlanta)

Abstract 2079 - Addressing Social Determinants of Health to Establish a Holistic Approach to Reduce HIV Infection Inequities

Author(s): Kathleen McDavid Harrison; Thurka Sangaramoorthy; Kim Williams; Donna McCree; Sha Juan Colbert; Tanya Sharpe

The impact of HIV infection on vulnerable populations in the United States has been dramatic, and very hard to ignore. This session will consider the role of social determinants of health in addressing HIV-related health disparities. Social determinants of health are the social and economic factors and conditions that impact the health and well-being of people and their communities. We will discuss the importance of addressing the social and physical environments in which persons affected by HIV infection live, work, and play in designing and implementing appropriate HIV prevention and intervention activities. This session will aim to discuss a holistic approach to reduce inequities in rates of HIV infection.

We will discuss four topics:
- Theory- To implement a holistic approach to reduce inequities in rates of HIV infection, it is important to understand theories and perspectives related to social determinants of health (SDH). The social determinants of health
perspective theorizes that social and economic factors, not individual behaviors and characteristics, are largely responsible for differences in health outcomes among certain populations.
- Data - Public health decision making is data driven. Measuring inequities in HIV infection is often focused on differences among racial and ethnic population groups. However, race/ethnicity may artificially mask determinants of who is infected with HIV; these social determinants of health can include poverty, homelessness, lack of education, unemployment, and a host of other contributing factors to risk behaviors. We offer a discussion on measurement of variables traditionally used to describe disparities in rates of HIV infection and make suggestions to collect new variables that can describe inequities.
- Research and Practice - The development of science-based approaches requires a broad array of multilevel, multi-method, and multidisciplinary approaches governed by strategic partnerships to reduce disparities. We will discuss development, implementation, and evaluation of evidence-based prevention intervention approaches to reduce HIV disparities.
- Translating Knowledge into Practice - There is a critical need to support policies and programs that address interventions that focus on the social determinants of health. Reducing health inequities will require a broad portfolio of policy, research, interventions, and programs to decrease exposure, lessen vulnerability, and ultimately decrease disease transmission.

All people should have the opportunity to make the choices that allow them to live a long, healthy life, regardless of their income, education or ethnic background. To reduce the rates of HIV infection among vulnerable populations we must establish a holistic framework that not only considers the role of individual-level factors (such as injection drug use or unprotected sex), but also considers the role of a person's environment (such as unemployment, poor education, low income). This session will offer participants an opportunity to think about a holistic approach to reducing inequities in the rates of HIV infection.

CCT1
CCT1-3 - Cracking the Prison Code
Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 1309 - HIV Prevention for Women Partners of Incarcerated Men. An Overlooked Part of the Discussion
Author(s): Katie Kramer; Mary Bowers; Megan Comfort; Judith Labiner-Wolfe; Barry Zack

While increasing emphasis is placed on HIV prevention programs for incarcerated men, women who are involved in sexual relationships with incarcerated male partners are often overlooked. The United States is the number one incarcerator in the world, currently housing 2.4 million adults in correctional facilities. An estimated 20% of incarcerated men are married and approximately 50% of incarcerated men have a primary female partner who they plan to reunite with once released.

It has been well documented that incarcerated men are disproportionately impacted by multiple health conditions. Rates of HIV/AIDS in US prisons are 2 times the national rate while rates of Hepatitis C are estimated to be as high as 49%. But data has also indicated that women who have a partner with a history of incarceration are at increased risk of HIV and STD infection. These women are primarily low-income women of color for whom racism, poverty and sexism contribute to an increased risk for HIV and whose life stressors are exacerbated by the partner's imprisonment. As we continue to make the link between public health and correctional health, it is critical to dialogue about best practices that serve women partners of incarcerated men.

Programs serving women partners of incarcerated men have been implemented in Chicago, Forth Worth, Huntsville, Los Angeles, New York, San Francisco, Tampa, and Washington, D.C.

The intended audience is researchers, program administrators, funders, and government agencies who are interested in programs serving communities impacted by incarceration.
Since few programs are designed specifically for this population, the US Department of Health and Human Services, Office on Women's Health, recently awarded cooperative agreements to eight community-based organizations to design and implement innovative and gender responsive HIV prevention programs to meet the unique risks and needs of women within their communities who have currently incarcerated or recently released male partners. This presentation will provide an overview of the eight program models. All programs include outreach activities, eligibility screening, testing, and individual and/or group level behavioral interventions.

Site visits or conference calls were conducted with key program and evaluation staff from each of the grantee organizations to gather data on their first year of program implementation. Results indicate that a total of 442 women participated in a group and/or individual level intervention. Each organization developed its own intervention design yet there were cross-cutting themes and lessons learned across all organizations including: 1) recruitment of eligible women is challenging given that many women hesitate to identify their relationship status with incarcerated male partners, 2) once identified, women are eager to connect with other women in similar circumstances, 3) women have good overall knowledge of HIV but low level of perceived personal risk, 4) if other life needs/stressors (e.g. parenting, intimate partner violence, mental health/substance abuse) are addressed within an HIV prevention program, women are more able to prioritize HIV risk reduction, and 5) many women with incarcerated male partners have a history of incarceration themselves that must also be addressed within the context of an HIV prevention program.

Abstract 1664 - Tracking Linkage to HIV Care for Former Prisoners: A Public Health Priority

Author(s): Brian Montague, DO, MS, MPH; David Rosen, MD PhD; Liza Solomon, MHS, DrPH; Traci Green, PhD; Michael Costa; Jacques Baillargeon, PhD; David Wohl, MD; David Paar, MD; Josiah Rich, MD MPH

Improving testing and uptake to care amongst highly impacted populations is a critical element of Seek, Test, and Treat strategies for reducing HIV incidence in the community. Since the early years of the HIV epidemic, HIV has disproportionately impacted prisoners. The prevalence of HIV within correctional settings ranges is up to 3 times that of the general population and it is estimated that 14% of all Americans with HIV pass through the correctional system every year. For those incarcerated for long durations, incarceration may provide an opportunity to initiate therapy in an effective and highly structured manner. Unfortunately, HIV treatment is frequently disrupted or discontinued after release from prison. In a study of HIV infected prisoners leaving corrections in Texas, only 5% filled antiretroviral prescriptions in time to avoid an interruption in care, and 30% had filled prescriptions by 60 days post release. Though the development of adequate programs to support linkage to care is a recognized priority, no adequate scalable metrics exist to evaluate the success of these programs.

This project reviews the success of linkage to care following release from incarceration for those infected with HIV in RI, TX, North Carolina and Puerto Rico.

Beginning in 2010, Ryan White Care programs were required to submit Client Level Data to HRSA for program reporting and quality improvement review. We developed a model for assessing the adequacy of linkage to care based on linkage of corrections release data to this reported Clinical Level Data obtained directly from Ryan White care programs. The datasets will be linked using the encrypted Unique Client Identifier (eUCI) established by HRSA. From the linked datasets, measures of time to first service in the community as well as clinical indicators of patient status at the time of the first service in the community will be generated. These measures will be compared across sites to identify high performing and low performing sites with regard to linkage to care. Follow-up qualitative and quantitative analyses will allow determination of correlates of linkage success.

Based on test data, the feasibility of generation of eUCIs based on data available from corrections was established. Validation of the eUCI as a means to link large datasets is being performed in RI and in TX. Results of this validation are anticipated to be available in April of 2011. Large scale linkage across all study sites will begin in September of 2011. Linkage to care is a critical element of the Seek Test and Treat strategy of reducing HIV incidence in the community. The availability of Client Level Data reporting by Ryan White care programs offers an unprecedented opportunity to assess the adequacy of linkage to care for persons with HIV leaving corrections. The use of the EUCI as a means of linkage allows for the development of metrics for linkage adequacy that maintain the confidentiality of
protected health information. The ability to utilize aggregated Client Level Data from HRSA would as part of these assessments would greatly improve the scalability of these metrics.

**Abstract 1793 - HIV/STD Prevention in Correctional Facilities: Los Angeles County's Approach on Providing Public Health Programs**  
**Author(s):** Kyle Gordon; Joanne Oliver

Ranking as the world’s largest correctional facility, L.A. County jails have an average population of 160,000 inmates a year. This number includes individuals that recidivate within the same year. The average length of stay is 45 days. Incarcerated persons typically have lower educational levels and lack adequate health care. In-custody public health programs may be the first opportunity to educate inmates on HIV/STD testing, prevention and education, and Transitional Case Management (TCM) for those who are already HIV positive, with emphasis on connecting clients to medical care and other community support services.

Los Angeles County correctional facilities include Men's Central Jail, Twin Towers Correctional Facility, Century Regional Detention Facility, Pitchess Detention Center-South Facility, Pitchess Detention Center-East Facility and North County Correctional Facility. Programs are available to all inmates. Although certain programs are only available to specific sub-populations and the security level of inmates can restrict program availability.

Various public health programs were offered to inmates during the 2010 calendar year, including HIV/STD testing and prevention education, condom distribution, and Transitional Case Management (TCM). A total of 18,500 inmates tested for HIV. Of those tested, 3% (n=650) came back confirmed as HIV+. Almost half of the confirmation test results were either newly diagnosed, or were not previously receiving HIV related services within the jail. Twelve thousand five hundred STD tests were given to inmates who self identified as being gay, bisexual or transgender, and 10% (1,281) of those tests came back positive for either, syphilis, chlamydia, or gonorrhea. Additionally, the gay and transgender inmates took advantage of condoms and 11,450 were distributed. HIV/STD education and prevention classes were administered to 11,500 inmates. Additionally 872 HIV+ inmates were screened for TCM services; 205 inmates were released prior to these services being offered.

: Providing prevention programs inside correctional facilities is a very efficient way to engage high risk inmates. The structural setting of the jail provides a captive audience where clients are sober and can fully take advantage of prevention services. Appropriate steps have been made to streamline services to high risk individuals; yet prevention services need to be expanded to provide an opportunity for inmates who may fall through the cracks. For example, currently heterosexual males are not viewed as a priority population at high risk. This means these individuals do not adequately fit into a risk category to receive TCM services. TCM services are necessary in order to re-engage HIV+ inmates with HIV medical services within the correctional facility. Furthermore, clients are encouraged to utilize medical and support services upon reentry.

**Abstract 2004 - Breaking into Prison: Capacity Building for Agencies Wanting to Work in Correctional Settings**  
**Author(s):** Barry Zack; Katie Kramer

Today, for the first time in its recorded history, the United States, incarcerates more than one in every 100 adults. Approximately 97% of incarcerated persons will eventually be released from prisons and return to our communities. Incarcerated populations are disproportionately at risk and impacted by multiple health conditions and illnesses. Rates of HIV/AIDS in US prisons are 2 times the national rate while rates of HCV are estimated to be as high as 49%. As well, rates of mental illness have been documented in 45-64% of incarcerated populations and rates of substance use have been documented as high as 75%.

Many who are incarcerated come from poor communities, where healthcare services are largely underutilized or inaccessible. Therefore, the period of incarceration presents a significant opportunity to make a difference in addressing public health issues that disproportionately impact incarcerated populations and consequently the communities they return to upon release. Communities cannot wait until people come home; we need to start on the inside, by bringing public health into prison.
Prisons and other detention settings (incarceration or correctional facilities) are defined as locked facilities directly or indirectly administered by the Federal Bureau of Prisons, State Department of Corrections or the County Sheriff.

The intended audience for this presentation is researchers, program administrators, funders, and/or government agencies that are currently or looking to provide programs or conduct research in a prison setting.

This presentation will provide recommendations on how to break into prison. From the first knock on the door to long term program or research sustainability, the community-prison collaboration is both rewarding as well as filled with system-wide cultural challenges. This workshop will include information on (1) understanding the culture of prisons and other detention settings, (2) gaining permission from the institution; (3) program and evaluation design for success; 4) establishing an informed consent/client agreement process within a coercive environment, and (4) handling issues of confidentiality and privacy.

Developing and sustaining a working relationship in order to provide HIV (and other health) programs in a prison setting requires a unique skill-set. The success of maintaining a collaborative relationship in this setting relies on: (1) developing relationships with key institutional/system personnel, (2) working with correctional systems that are open and committed to working differently than their status quo, and (3) integrating correctional priorities into program and research protocols.

CCT2
CCT2-2 - Compounding stigmas: Magnifying vulnerability for MSMs
Room: Singapore/Manila (Hyatt Regency Atlanta)

Abstract 1658 - The Impact of HIV-Stigma within Gay Communities on Disclosure to Sexual Partners for Black MSM
Author(s): Jason D. P. Bird ; Dexter R. Voisin

Nearly thirty years into the HIV/AIDS epidemic, rates of infection are once again rising, especially among African American Men who have Sex with Men (MSM), where stigmatizing judgments about HIV continue to persist. While the gay community has the potential to serve as an important source of social support for MSM, some research suggests that HIV-related stigma extends into the gay community. Unfortunately, there is little literature regarding HIV-related stigma within the gay community, making it difficult to understand how stigma impacts issues of sexual communication and HIV-disclosure. This study sought to explore the experiences and perceptions of stigma for HIV-infected MSM and the impact of HIV-related stigma on intentions to disclose one's HIV status to sexual partners.

This study utilized grounded theory to generate substantive theories regarding the phenomenon of HIV-disclosure for Black MSM. Data were collected through one-on-one, face-to-face interviews with twenty participants. Data analysis followed a systematic and standardized format that included three primary processes: open-coding, where data was examined for saturation around broad themes; axial coding, where interconnections between the themes were explored; and selective coding, where the data was developed into a theoretical narrative. To strengthen analytic rigor, the results were discussed in consultation with qualitative working groups comprised of faculty and doctoral students.

Nearly half of the participants identified significant concerns about HIV-related stigma and distrust within gay communities, where one might expect a more supportive environment. There was an expressed apprehension about being judged as deficient, treated as outcasts, and/or excluded from sexual and supportive networks if information about their HIV-positive status were to become widely known. For some of the men in this study, this anticipated stigma was reinforced by the negative beliefs they held prior to seroconverting. The anticipation of discrimination based on HIV-related stigma seemed to intensify the participants desire to control who was informed about their HIV status and stood as a primary barrier to their disclosing, especially to casual and anonymous sexual partners.

An HIV-positive status is a deeply private attribute and fears about HIV-related stigma are a resilient barrier to disclosure. The unanticipated consequence of HIV-related stigma within the gay community is the implicit message
that controlling HIV-status information is imperative to self-protection. This data has practice, policy, and research implications. Regarding practice, interventions need to account for the social aspects of sexual negotiation, facilitate more effective communication between HIV+ and HIV- individuals, and reduce HIV-related stigma. Regarding policy, public health campaigns should focus on increasing information within marginalized communities and funding should be directed towards interventions that collaboratively engage HIV-positive and HIV-negative individuals. Finally, future research should examine the sexual risk assumptions made by HIV-positive and HIV-negative individuals and the ways that HIV stigma is produced and sustained within gay communities.

**Abstract 1743 - It Gets Better: Resolution of Internalized Homophobia and Associations with Positive Health Outcomes among MSM**

**Author(s):** Ron Stall; Michael Plankey; Steven Shoptaw; Joan Chmiel

**Background:** The dominant goal of research on gay men's health has been to document and explain greater vulnerabilities among MSM to a set of important health disparities. However, resiliences against the development to health problems also exist among gay men that may provide important insights into the epidemiology of health problems in this population. We will describe patterns of resolution of internalized homophobia (IHP) among MSM over time; the associations between early life events and resolution of internalized homophobia; and describe the associations that resolution of internalized homophobia has with health outcomes.

**Methods:** Participants were 1,541 men from the Multicenter AIDS Cohort Study (MACS), an ongoing, prospective study of the natural history of HIV infection among MSM in four US cities. Respondents completed a retrospective survey that asked about past life events and conditions including a measure of internalized homophobia while they were coming out. Participants also completed the internalized homophobia scale relevant to the past 12 months. A series of logistic regressions were conducted to look at early life events associated with resolution of internalized homophobia (perceptions of masculinity attainment, gay related victimization, discrimination) and the effect of homophobia resolution on psychosocial health outcomes (depression, stress, Intimate partner violence, substance use, sexual compulsivity).

**Results:** Over 68% of participants had high levels of IHP during the period of time when they first realized they were attracted to men, but only 22.8% of men endorsed high IHP over the past 12 months. The proportions of high IHP currently was significantly different by age, race/ethnicity, education and income levels with a greater proportion of men having high IHP who were younger, racial/ethnic minorities, less educated and lower earners. Men who experienced gay related victimization when they were adolescents were significantly more likely to have high levels of IHP during the time they realized a same-sex attraction. However, these early life experiences did not have a significant impact on internalized homophobia in their current lives. Men who resolved their homophobia had significantly higher odds of healthy outcomes; no depression (2.14), low stress (1.67), no intimate partner violence (1.35) and no sexual compulsivity (1.76) compared to those who were unable to resolve their internalized homophobia. Men who resolved feelings of internalized homophobia were two times less likely to experience syndemics compared to those who no longer had high IHP.

**Conclusions/Implications:** This study demonstrates a pattern of IHP resolution among a cohort of MSM who came of age during a time when few program existed to promote IHP resolution. This suggests a natural resilience among MSM that, if understood and applied to intervention development, could be used to reduce health disparities among MSM.

**Abstract 1746 - Adversity and Syndemic Production among MSM: A Life-Course Approach**

**Author(s):** Amy Herrick; Sin How Lim; Michael Plankey; Joan Chmiel; Thomas Guadamuz; Uyen Kao; Steven Shoptaw; David Ostrow

**Objectives:** Syndemic conditions (two or more co-occurring health problems) are hypothesized to be a driving force for HIV transmission among MSM. However, why and through what mechanisms syndemics exist and are sustained among populations of MSM remain poorly understood. The Theory of Syndemic Production suggests that negative early life events (victimization, discrimination, etc.) lead to the development of syndemics. This exploratory study
presents data to test a theory of syndemic production that suggests negative life experiences lead to the development of syndemic conditions among adult MSM.

Methods: Participants were 1,551 men from the Multicenter AIDS Cohort Study (MACS), an ongoing, prospective study of the natural history of HIV infection among MSM in four US cities. Participants completed a survey measuring adverse event and conditions throughout their life. We tested whether these life course events were related to the presence of a syndemic in an individual (two or more of the following co-occurring health conditions: depression, stress, substance use, intimate partner violence, sexual compulsivity, intimate partner violence). We created a model in which life events of a particular period were entered as blocks representing the following 4 life stages: 1) Early life events (victimization, homophobic environment, etc), 2) Period of coming out (internalized homophobia), 3) Adulthood (sexual assault, discrimination), 4) Last 5 years (marginalization, internalized homophobia, etc.). In the first model the blocks were ordered chronologically in order to look at the life course impact of adversity on syndemic production. The second model was done in reverse order to look at the impact of early life events after controlling for proximal events.

Results: The majority of the adversity variables were significantly associated with both the syndemic condition and the five component psychosocial health outcomes. The block containing early life events contributed significantly to syndemics production after controlling for sociodemographic factors. Physical abuse, childhood victimization, masculinity attainment and social connectedness were the strongest predictors in the early life block. Regarding adversity in adult life, only discrimination remained significant after controlling for all other types of adversity. The events and conditions measuring adversity in the last five years had the largest impact on syndemic production. In the second model the final block, early life events, remained positively correlated to syndemic production after controlling for all adulthood and current events and conditions. This model suggests that early life events are significantly associated with syndemic production even after controlling for current and more proximal events and conditions.

Conclusions/Implications: This study presents data to suggest that health and risk among men who have sex with men are produced across the life course. In particular homophobic events against youth may be important in producing poor health among adult MSM. Studying syndemic production as it occurs across the life course may help inform innovative interventions that will effectively disentangle interconnecting health problems and promote health among MSM.

Abstract 1895 - How Do Young HIV+ Black MSM Negotiate Expressions of Same-Sex Attraction in the South?

Author(s): Erik Valera; Justin C. Smith, MPH; Lisa B. Hightow-Weidman, MPH, MD

HIV continues to disproportionately affect Young Black men who have sex with men (BMSM). In 2008, 63% of new HIV diagnoses in the US among MSM were Black, with BMSM in the south most impacted. Sexuality-related stigma and discrimination emerging from one's own support system and/or social network creates a hostile environment and has been shown to precipitate early sexual debut. Family rejection on the basis of sexual orientation has been linked to health risks that include; attempted suicide, depression, illicit drug use, and risky sexual behavior among lesbian, gay, bisexual and transgender (LGBT) youth. We explored how varying degrees of comfort young HIV-infected BMSM have in expressing their same-sex attraction with those closest to them impacts their experiences of stigma and discrimination.

Part of a multi-site HRSA SPNS initiative to conduct outreach, testing and linkage to medical care specific to young HIV+MSM of color, Project STYLE (Strength Through Youth Livin Empowered) operated in the Triangle region of North Carolina (Raleigh -Durham- Chapel Hill) from July 2006 through Aug 2009. The STYLE cohort (N=81) consists of HIV-infected MSM of Color from a 12 county region. Participants were enrolled while entering or reengaging (after >6months out) in HIV medical care.

The men of STYLE men were 17-24yrs old (Median= 21), median sexual debut with a male was 16yrs (range 4-21) and identified; 89% Black, 11% Latino/Hispanic. 62 % identified as Gay/Homosexual, 22 %bisexual, 1% heterosexual, 15% other. Ninety-five percent reported being either comfortable or very comfortable with their sexual
orientation, 50% reported symptoms consistent with clinical depression (>16 on CES-D), and 15% had ever attempted suicide. Analyzing 48 semi-structured qualitative interviews from Black participants we asked, how comfortable are you talking to the people most important in your life about same sex attraction? Twenty-eight percent (n=14) responded feeling very comfortable, 42% (N=28) comfortable to some degree, and 28% (n=14) not comfortable at all. Seventy-three percent (N=35) reported faith/spirituality was important in their lives, 21% (n=10) somewhat important, and 6% (n=3) unimportant. 52% (N=25) reported that their MSM behavior conflicts with their ideas of faith and/or spirituality. Respondents reported more comfort speaking with females closest to them than males, friends more than family, and LGBT’s more than heterosexuals. Messages about homosexuality received while growing up include; religious condemnation, increased discrimination and alienation, hostile remarks, and inevitability of AIDS, HIV or other STD's.

For young black MSM in the south, stigma and discrimination associated with sexuality is often mitigated by enduring silence. Self expression is suppressed out of fear of being ostracized or out of respect for others discomfort with notions of same sex attraction. Expression of same sex desire is generally stifled within faith based communities that recognize same sex attraction as in direct conflict with religious doctrine. HIV prevention programs serving young Black MSM should foster communication skills that both empower them to engage in dialogue about sexuality with those closest to them and enable them to safely and successfully contend with and challenge adverse environments.

Track D
D06 - The Second Wave: Enhancing Syringe Services for Maximal Public Health Benefit
Room: Hanover F/G (Hyatt Regency Atlanta)

Abstract 1619 - Peer-Delivered Syringe Exchange: User-to-User Community-based HIV Prevention in New York City
Author(s): Emily Winkelstein

HIV transmission among injection drug users (IDUs) and their sexual partners remains high. Annual hepatitis C (HCV) incidence rates among injectors range from 10% to 40%, and overall prevalence exceeds 50% among people who have injected drugs for at least five years. Syringe exchange is effective in reducing HIV and HCV infections, but disparities in transmission rates based on geography, age, race/ethnicity and gender remain due to persistent gaps in access to sterile injection equipment. Available estimates suggest that syringe coverage by syringe exchange programs (SEPs) for heroin injectors in New York City in 2008 amounted to only 2 syringes for every 100 injections.

IDUs conduct secondary syringe exchange throughout New York State as part of the Peer-Delivered Syringe Exchange (PDSE) Program.

An in-depth analysis was conducted of PDSE, a syringe access model in New York that trains IDUs to conduct secondary syringe exchange with members of their social networks and other contacts. The analysis drew upon findings from multiple methods, including focus groups, qualitative interviews with IDUs conducting PDSE, health department officials, and other key stakeholders, and a quantitative survey of SEPs implementing PDSE.

Results: Aggregate data collected from 9 SEPs indicate that between March 2009 and March 2010, PDSE was responsible for nearly 1/3 of all syringes distributed by these programs. PDSE can expand syringe coverage to marginalized and high-risk IDUs who are unable or unwilling to access traditional syringe exchange services such as women, people of color, youth and sex workers. Qualitative findings indicate that PDSE increases cultural competency of SEP staff and promotes healthier IDU communities though linkages to care and health promotion education. Lessons Learned: Widespread implementation of PDSE and similar secondary syringe exchange models should be promoted to increase sterile syringe coverage, reduce HIV and hepatitis C transmission and promote healthier behaviors and norms among IDUs. Drug-related stigma contributes to a lack of PDSE worker integration into SEPs, hindering overall program efficacy. Program eligibility criteria may pose a barrier to maximizing IDU participation in PDSE. Secondary syringe programs should provide adequate support, training and development opportunities to IDUs while minimizing barriers to broad participation.
Persons who use drugs (PWUD) (i.e., opiates and stimulants) and engage in heterosexual activities are at sexual risk for HIV that can be reduced by psychosocial interventions. Our previous systematic review and meta-analysis (SR-MA) results published in 2002 included 33 individual and network interventions conducted in the United States (US) that were published during 1988-1999. We updated our SR-MA work to include studies published by August 2009 and to include structural interventions. We examined effectiveness of 49 sexual risk-reduction intervention studies with PWUD (outcomes: unprotected sex, condom use, number of sex partners). We compared the updated and previous MA results. The 49 interventions included the previous 33 U.S. interventions (published 1988-1999), 10 new U.S. interventions (published 1999-2009), and 6 new worldwide interventions (published 1988-2009).

We conducted comprehensive searches for sexual risk-reduction intervention studies (experimental or quasi-experimental designs, 1988 - August 2009) using MEDLINE, EMBASE, CINHAL, CENTRAL, and PsychINFO. Sexual risk outcomes were independently extracted by two reviewers. Effect sizes were converted to odds ratios (OR) and entered into MA using a random effects model; an OR < 1.0 indicated less unsafe sexual behavior in experimental groups at follow-up.

Of the 49 studies, 44 compared psychosocial interventions to shorter, control educational interventions, 7 compared psychosocial interventions to minimal interventions, and 2 compared all three interventions. Psychosocial interventions had modest additional benefit compared to shorter, control educational interventions (k = 44; OR, 0.87; 95% confidence interval [CI], 0.77-0.97), and a much larger positive effect compared to minimal interventions (k = 7; OR, 0.62; 95% CI, 0.47-0.83). The summary results for the U.S.-based studies in the updated MA (k = 38; OR, 0.87; 95% CI, 0.77-0.99) and in the previous MA (k=33; OR, 0.86; 95% CI, 0.76-0.98) were similar. The summary results for the interventions that were compared to minimal interventions were similar in the updated (k = 7; OR, 0.62; 95% CI, 0.47-0.83) and previous MA (k = 3; OR, 0.60; 95% CI, 0.43-0.85). Cumulative MA showed significant effect (OR = 0.88; 95% CI, 0.78 - 0.99) by 1996, similar to previous MA results. U.S.-based studies (k = 38; OR, 0.87; 95% CI,0.77-0.99) and non-U.S.-based studies (k=6; OR = 0.82; 95% CI,0.63-1.06) had a small effect, and both results were similar to the previous U.S. MA results (k=33; OR, 0.86; 95% CI, 0.76-0.98). Individual (k = 43; OR, 0.83; 95% CI, 0.73-0.94), network (k = 4; OR, 0.75; 95% CI, 0.47-1.18), and structural (k = 2; OR, 0.75; 95% CI, 0.60-0.94) interventions had similar effects.

Psychosocial interventions in comparison to minimal interventions provided a 38% reduction in odds of sexual risk behavior, justifying offering them to PWUD, especially in settings with nominal interventions. The updated (1988-2009) and previous MA of US-based studies (1988-1999) had similar results when compared to educational interventions. U.S.-based studies had similar results compared to studies conducted in other countries. Developing interventions with stronger relative effects to reduce sexual risk behaviors must remain a high priority given the importance of sexual transmission of HIV among PWUD in settings with extensive interventions.

Abstract 1799 - Advancing Perinatal HIV Prevention within Syringe Access Programs: Lessons from New Jersey's ARCH Nursing Program

Author(s): L. Dutton; L. Berezny; B. Campbell; L. Pasahow; J. Simpson; C. Tobin; D. Tolsma; S. Paul; D. Storm

A major challenge to perinatal HIV prevention efforts in the U.S. is reaching women of reproductive age at high-risk for HIV who do not access medical care. Many of these hard-to-reach women are injection drug users. To address this challenge, the New Jersey Department of Health and Senior Services, Division of HIV/AIDS Services (DHAS) embarked upon a novel prevention program in partnership with five syringe access programs (SAPs) and HIV-educators in a university school of nursing.

The Access to Reproductive Care and HIV Services (ARCH) nurses provide care at SAPs sponsored by community-based agencies in five cities across New Jersey.
The ARCH program utilizes nurses to enhance the services of SAPs by offering basic health and health education services. While serving both genders, the program specifically targets women at risk for HIV with prevention interventions and identifies women who are HIV-infected and/or pregnant and refers them to prenatal and HIV care. The ARCH nurses counsel about reproductive health and reducing vertical HIV transmission, conduct pregnancy and STD testing, offer adult vaccines, teach safer injection practices, provide wound care consultations, and arrange referrals for preconception and HIV specialty care. Regular workshops for the nurses organized by the HIV nurse educators provide a forum to exchange information and increase their skills and knowledge through continuing education. The educators provide technical assistance and develop materials adaptable for each site. Collaborations with other NJDHSS services including STD, hepatitis and TB, expand the reach of the ARCH services.

An evaluation of the first 9 months of the project utilized weekly reports to NJDHSS to describe the initial work. ARCH nurses delivered care at 2064 client visits (48% women, 52% men), providing sexual risk reduction counseling at 392 visits, wound consultation at 493, information on safer injection techniques at 1000, hepatitis C screening or referral at 135, and counseling on overdose prevention at 239;18/27 pregnancy tests were positive and 23 pregnant women were referred to prenatal care, some whom were HIV positive. Lessons Learned: Several factors were critical to the evolution of this program. A university-based technical assistance partner, including experts in nursing education and perinatal HIV prevention, helped trouble-shoot programmatic and administrative issues that arose and provided tailored training. ARCH nurses established ongoing patient relationships with very high-risk women. Often, the nurses teaching safer injection practices opened the initial door to this relationship. The harm reduction environment supported clients return visits to the nurses for health education. The program capitalized on other state-funded programs to provide expanded services, specifically STD and hepatitis testing. A challenge to the current operation of SAPS is the difference in organizational cultural between community-based syringe access programs and the drug treatment centers to which they refer patients. ARCH nurses play a key role in bridging this cultural divide. Lessons learned in the start-up of a novel nurse-run prevention program will inform future programs that seek to harmonize harm reduction and perinatal prevention efforts.

**Track D**

**D10 - Developing and Evaluating Structural Interventions that Promote HIV Prevention Behaviors**

**Room: Hanover C (Hyatt Regency Atlanta)**

**Abstract 1842 - Development of a Compendium of Effective Structural Interventions for HIV Prevention**

**Author(s):** Shayna D. Cunningham, PhD; Rachel Golden, DrPH; Emily Newman, MA; Josefina J. Card, PhD

HIV prevention programs have traditionally focused on changing risky sexual and drug injection use behaviors by working directly with individuals or small groups. Increasingly, however, attention is also being given to structural factors, i.e., the physical, social, cultural, political, economic, legal, and/or policy aspects of an environment that may impede or facilitate sustained behavior change. Structural interventions work by changing the context within which health behaviors are produced or reproduced and, in doing so, remove barriers to risk reduction or build barriers to risky behaviors. While several collections of effective behavioral programs exist to facilitate their replication in new contexts, no equivalent resource is available for structural interventions. This project aimed to develop a Compendium of Effective Structural Interventions to provide information about and materials to replicate structural interventions that have demonstrated effectiveness in preventing HIV transmission.

The Compendium is intended for HIV practitioners working in the United States and abroad. It is comprised of structural interventions from around the world.

Structural interventions were selected for inclusion in the Compendium by a Scientist Expert Panel based on the quality of their implementation, scientific rigor of their evaluation, and positive impact on HIV risk behavior or HIV and other sexually transmitted infection (STI) transmission rates. Relevant materials (e.g., copies of laws/policies, manuals of operation, evaluation instruments, etc.) were obtained from the developer(s). A detailed description of each intervention was generated including: an overview of the rationale and history of the intervention and specifics about how it was originally implemented; a summary of the methodology and results of the original evaluation; and a
list, including links for where to download, implementation and evaluation materials that are available. Field tests were conducted to assess the usefulness and clarity of the prototype book and associated website.

A wide variety of structural HIV prevention interventions have been implemented throughout the world, but few have been rigorously evaluated. Eighteen interventions were selected for inclusion in the Compendium. Those profiled exemplify the range of structural HIV prevention programs that exist and illustrate creative ways in which their impacts have been assessed. The field tests revealed that the Compendium is a useful resource to learn about and replicate effective structural interventions (5.4 out of 7), clearly written (5.6 out of 7), and well organized (5.2 out of 7). Suggestions for improvement included incorporating reviews of the different classes of interventions represented (e.g., needle-exchange programs, social marketing campaigns) so as to provide greater context for the model interventions that were selected for inclusion, providing more detail about known replications of the interventions, and presenting more information about the challenges faced and lessons learned during the development, implementation, and evaluation of each intervention. Overall, the Compendium was shown to be good model to promote more widespread dissemination and replication of effective structural HIV prevention interventions. The evaluation study designs described may also be used to assess the impact of other structural programs.

Abstract 2023 - From the White House to Our House: Local Implementation of the National HIV/AIDS Strategy

Author(s): Bernadette Sangalang; Judith Auerbach

In order for the National HIV/AIDS Strategy (NHAS) goals to be reached, they must be operationalized at the local level, including within public health departments and community based organizations that provide HIV prevention services.

In 2010, the San Francisco Department of Public Health (SFDPH) announced its new Directions for HIV prevention, aimed at halving new infections in the city and reducing HIV-associated disparities. This new set of priorities led to a call for proposals in early 2011 and culminated in funds for HIV prevention activities being awarded to community-based organizations on March 9, 2011. As a result of this process, San Francisco AIDS Foundation (SFAF) was awarded five different HIV prevention program contracts. In planning for the implementation of these new contracts in the upcoming fiscal year, SFAF was presented with the opportunity to align its programmatic activities not only with its own strategic goals, but also with those of the local health department and the NHAS.

Once the SFDPH contracts were announced, SFAF program staff, in collaboration with the SFAF Evaluation Director, developed a logic model, a tool commonly used to visually represent the relationships between a program’s resources, planned activities, and anticipated results for each of the five programs that were awarded: (1) Community-based HIV testing; (2) Health Education/Risk Reduction (HERR) for males who have sex with males (MSM); (3) Addressing HIV-related disparities among African American MSM; (4) A community space to serve as a central hub for HIV testing, HERR, and Prevention with Positives services for low-income MSM; and (5) Citywide syringe access services. Our process involved collaborative meetings to clarify the target population, overall goal, and theory driving the program's approach; identifying program resources/inputs, activities, outputs, and outcomes; and identifying the connections between these and strategic goals at the organizational, local and national levels.

Graphic examples of the various program logic models will be presented. Each illustrates unique pathways that link programmatic activities to their intended short- and long-term outcomes. Shared attributes that emerged among all the logic models were the linkages between the various program outcomes and the SFAF strategic goals (increase HIV status awareness, reduce new HIV infections, and ensure access to care), the stated priorities of the SFDPH's HIV prevention plan (reduce new HIV infections through increased status awareness, addressing individual and social drivers, harm reduction, and structural change), and the NHAS goals (reduce new HIV infections, increase access to care, reduce HIV-associated disparities). SFAF program staff are using the logic models to inform program design, budget, implementation, and evaluation of progress toward intended outcomes.

The NHAS calls for a national response to the HIV epidemic that can be operationalized at the local level by public health departments and community based organizations. Logic models are an effective way to build capacity among
staff at community-based organizations to chart the progress of their programs and to articulate how their activities have the potential to help achieve both local and national goals.

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**Track D**

**D12 - Using a Participatory Action Research Framework and Evidence Based Curricula to Prevent HIV Infection among Youth and Related Adults Living in Public Housing**

**Room: Hanover D (Hyatt Regency Atlanta)**

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**Abstract 1226.1 - Utilizing Participatory Action Research Framework to Prevent HIV Infection among Youth Living in Public Housing**

**Author(s):** Susan Dragon-Hart

Multiple studies document the disproportionate rates of HIV infection and HIV/AIDS diagnoses among persons of color in the U.S. Residents living in public housing around the Boston area reflect a diverse group of ethnic minorities. For example, Haitians and Hispanics/Latinos represent more than half of the public housing residents in Somerville, MA. Ethnic enclaves within public housing can help perpetuate cultural biases, myths, and fears related to HIV/AIDS. Utilizing a participatory action research framework helps to prevent HIV infection through activities that build and sustain community capacity to address social issues surrounding HIV/AIDS.

The Wayside Community Action Project (CAP) targeted Haitian and Latino youth and their caregivers, and involved other community stakeholders such as public housing authorities, local hospitals, community police, and provider organizations in Somerville and Waltham, MA.

The Wayside CAP was funded by the Center for Substance Abuse Prevention to provide HIV/AIDS prevention services in four public housing developments. The project utilized a participatory action research (PAR) framework to engage and include the expertise of public housing residents and other community stakeholders to build upon and sustain existing systems in the community. PAR assumes that in order to gain true understanding of the social issues such as HIV/AIDS and substance abuse, we need to acknowledge that the true experts are the local people who live in the community affected by the social issues. Consistent with the PAR approach, local informants (youth and adults) otherwise called insider-evaluators worked with the evaluation team from Brandeis University in the study design, data collection, data analysis, the interpretation of the study findings, and presentations back to their communities. In order to participate fully in the evaluation, insider-evaluators were trained and supported in research methods and the implications of conducting research such as issues of confidentiality.

From 2004 to 2008, Wayside CAP provided services to 727 individuals living in or near public housing. The primary target population consisted of 248 individuals who participated in evidence-based curricula in addition to the community action project: 99 youths and 149 caregivers. One of the key project objectives was to increase accurate knowledge about HIV/AIDS. Based on 50 matched pairs from youth baseline to post-test, there was a statistically significant improvement in correct responses to the HIV knowledge measure based on 24 questions (p < .01). This finding, which controlled for participant clustering by group and public housing development, provides strong evidence of a direct effect of project programming on participants knowledge of HIV and HIV risk factors. Most of this gain was retained at six-month follow-up. Other outcome measures showed a pattern of improvement that was not statistically significant. Information on how programs can incorporate local experts as members of the program team may be informative to the strategies applied in the process of engaging, recruiting, and retaining participants as well as obtaining positive outcomes.

**Abstract 1226.2 - Incorporating Evidence-based Curricula for Minority Youth with Community Capacity Building Efforts in Low Income Neighborhoods**

**Author(s):** Meelee Kim; Peter Kreiner

Residents living in low income neighborhoods around the Boston area reflect a diverse group of ethnic minorities. While there are cultural differences within and among ethnic groups, there are some shared common factors that place individuals living in public housing at increased risk of HIV/AIDS: discrimination; stigma; poverty; high mobility;
isolation; and marginalized status. Ethnic enclaves within low income neighborhoods can help perpetuate cultural biases, myths, and fears related to HIV/AIDS. While utilizing evidence based prevention curricula provide organizations with some assurance that their programs can anticipate positive impact, little is known about how to utilize them in such a way that they are culturally appropriate.

The Center for Substance Abuse Prevention funded the following two projects in October 2008 to provide substance abuse and HIV/AIDS prevention services to youth ages 13-17 living in low income neighborhoods around the Boston area. 1) The Grove Hall Getting Healthier Project (GH2), a collaborative effort led by the Institute for Health and Recovery, engages stakeholders in a 4 square mile community in the Boston area which consists of approximately 68% black or African American and 23% Hispanic or Latino. 2) The Wayside Community Action Project (CAP) provides HIV/AIDS and substance abuse prevention services in three public housing developments in Somerville and Waltham, MA where Haitians and Hispanics/Latinos represent about two thirds of the public housing residents.

Both projects aim to reduce risk factors and increase protective factors for HIV and substance use among youth utilizing evidence based curricula. The GH2 incorporates HIV StoryBook with two substance abuse curricula, Project ALERT and Project Towards No Drug Abuse while the CAP uses Focus on Kids with their own Community Mobilization Video Project, designed to promote critical thinking about media influences. However, they infuse the evidence based curricula into a community building strategy by creating a sustainable infrastructure among key stakeholders in the community. Part of the strategy is to impart evaluation and program facilitation skills with key leaders within the community.

The projects are currently in their third year and therefore results are preliminary. One of the main objectives for both projects is to increase accurate knowledge about HIV/AIDS. From November 2009 to January 2011, 62 youth outcomes surveys were collected from the Wayside CAP. There is a statistically significant improvement in correct responses to the HIV knowledge measure based on 33 questions (p<0.05). Most of this gain was retained at the 6-month follow-up. From March, 2010 to January, 2011, 64 youth outcome surveys were collected as part of GH2. Using the nine-question measure of HIV knowledge included in the required CSAP questionnaire, we found a non-significant improvement from baseline to exit. Follow-up surveys are still being collected.

Information on how to incorporate evidence-based prevention curricula for minority youth living in low income neighborhoods with efforts towards community capacity building may enable more sustainable and positive outcomes. The projects will share effective methods for adapting the evidence-based curricula to fit the cultural aspects of the communities involved.

Track D
D16 - CDC Turning Research into Practice with Healthy Relationships (HR)
Room: Hanover E (Hyatt Regency Atlanta)

Abstract 1812 - CDC Turning Research into Practice with Healthy Relationships (HR)
Author(s): Alpa Patel-Larson; Mary Neumann; Kimberly Hearn Murray; Deanna Campbell

Over the last two decades, many behavioral interventions conducted in research settings have shown efficacy in changing HIV-related risk behaviors. However, there has been limited information about the experiences of service providers and the outcomes of clients receiving HIV prevention activities by community-based organizations in real-world settings.

Healthy Relationships (HR) is an efficacious behavioral intervention (EBI) developed in the late 1990s for clients living with HIV. It is delivered in five 2-hour sessions to groups of 8-12 participants with the same gender or sexual orientation. Using movie clips, educational videos, role plays, and demonstrations, facilitators lead discussions on topics related to decision-making and coping skills for disclosing their HIV status to family, friends, and sexual partners, and for building healthier and safer relationships. Multiple agencies in various communities throughout the U.S. have delivered HR to thousands of clients. Any service provider who delivers or plans to deliver HR or similar EBIs may benefit from this session.
The Division of HIV/AIDS Prevention (DHAP) at CDC follows a research to practice model: Starting with Research, Research Synthesis, Packaging and Translation, Dissemination and Training, Program Support and Ongoing Technical Assistance, Monitoring and Evaluation, Impact Assessment, and circling back to further research. Different Branches within DHAP are responsible for the various steps in the sequence. Using this model, the results from each Branch's projects can directly contribute to public health advances in the research and practice of HIV prevention and move EBIs from evaluation by researchers into implementation by service providers.

Each presenter will discuss steps for moving HR from research into practice and the experiences, outcomes, and implications of the various projects in the sequence. The Prevention Research Branch evaluated the evidence of HR's effectiveness and packaged and beta-tested it with 8 agencies for dissemination. The Capacity Building Branch trained trainers and over 1300 facilitators, has provided training and/or technical assistance to over 500 agencies, and assesses agencies implementation fidelity. The Prevention Program Branch has funded and monitored HR implementation at 32 community-based organizations serving clients living with HIV/AIDS since 2004. The Program Evaluation Branch conducted a sexual behavior outcome monitoring project of HR from 2006-2008, including the experiences of 7 community-based organizations delivering and monitoring HR. Overall, the sexual risk behaviors of clients (e.g. number of partners, number of unprotected anal or vaginal sexual events) significantly declined after participation in the intervention. The results of each step in the research to practice model show that HR and other EBIs can be utilized in the field, even with limited resources, and can lead to continual improvement of agency services and positive changes in client behaviors. As more EBIs are evaluated in the field, coordination and communication of findings can improve HIV prevention services and further reduce HIV/AIDS morbidity.

Track D
D33 - Harnessing the Power of New Media for HIV Prevention
Room: A707 (Atlanta Marriott Marquis)

Abstract 1157 - Developing National On-Line HIV Prevention Program Evaluation Training
Author(s): David Davis

Monitoring and evaluation of HIV prevention programs to improve effectiveness and inform decision-making is crucial in a period of limited resources. The Centers for Disease Control and Prevention (CDC) currently funds 59 state and local health departments and approximately 130 community-based organizations to conduct HIV prevention. To assist grantees in monitoring and evaluating programs funded by the CDC, a series of on-line training modules and recorded webinars covering all aspects of HIV prevention program evaluation are being developed. The issue is how to communicate the basics of program evaluation in a way that evaluation can be used by programs at all levels of evaluation experience and expertise to improve their prevention programs.

The on-line training modules are being developed by CDC in Atlanta, GA. Thirty of the planned 52 modules are completed and are available on the Internet to any grantee who requests access.

The National HIV Prevention Program Monitoring and Evaluation (NHM&E) Training project, which started in 2007, consists of a series of on-line, on-demand training modules and webinars covering the data collection and other evaluation activities required of or recommended to agencies conducting HIV prevention funded by CDC. It focuses on the use of the NHM&E standardized variables for program improvement, resource allocation, and development of performance indicators. The project began by assessing the needs of the grantees and, over the past three years, has designed, developed, and implemented a blended learning program that offers grantees access to a wide range of training materials for use as learning aids for the funded agency or teaching aids for the agency to use to instruct their staff and grantees.

Prior to this project, only two people from each funded agency received training directly from CDC. Currently, more than 1,000 people are registered to received the training electronically, a number that is constantly increasing as new agencies are funded and new staff are hired. Webinars have used a total of more than 600 phone lines, many with multiple listeners on each line. Training materials have also been used to provide technical assistance and virtual site visits. Over the long term, this should lower the cost per person trained. Evaluation of each training module and
webinar, both during development and after release, has shown that grantee participation during the development and delivery of the training adds significant credibility to the training materials. In webinars, information presented by peers appears to be more favorably received by grantees than material presented by CDC representatives. On-line training modules that are interactive and multi-media (sound, animation, etc.) are better received than modules that are text-based. This approach significantly increases the time, money, and expertise required to develop the training materials, though developments in technology are making this interactivity easier each year.

Abstract 1295 - Tailored Text Message-Based Intervention for HIV-Positive MSM: Results of a Proof-of-Concept Study

Author(s): Jennifer D Uhrig; Carla M Bann; Megan E Lewis; Robert D Furberg; Curtis Coomes; Jennie Harris; Peyton Williams; Lisa Kuhns; Nicole Martin

The purpose of this study was to develop and pilot test a text message based intervention for HIV-positive MSM receiving clinical care at Howard Brown Health Center (HBHC) in Chicago, IL. The intervention provided tailored messages to promote medication and appointment adherence, sexual and substance use risk reduction, social support, general health and wellness, and patient involvement in care. The intervention featured bidirectional messaging and dynamic tailoring of content, i.e., participant responses to certain items administered via text message were used to update the content participants received at different points during the intervention. This presentation will discuss key findings from the intervention's process and outcome evaluation.

We reviewed the literature to identify messages previously developed for PLWH and developed new messages to fill gaps based on the key topical areas. A small sample of experts, providers, and HIV-positive MSM reviewed and provided feedback on the messages before they were finalized. English-speaking, HIV-positive MSM over age 25 who allowed us access their medical records, had cell phones, and were amenable to receiving text messages during the 3 month intervention were eligible. We enrolled 52 participants. At enrollment, participants completed a Web-based survey using a private computer terminal at HBHC. We used the survey data to tailor the types of messages participants received and establish a baseline for evaluation. To minimize potential attrition from loss of cell phone service and to offset the costs associated with monthly text-message plans, each participant received an incentive of $25 upon enrollment and $10 per month for the 3-month intervention. Participants completed a Web-based follow-up survey at HBHC at the conclusion of the intervention. We conducted paired t-tests and McNemar tests to test for differences from baseline to follow-up.

Most participants (98%) indicated that the messages were easy to understand, that they trusted the information in the messages (89%), always read the messages (86%), and felt the messages gave them good advice (84%). The majority said that they liked the messages, learned something new from the messages, the messages helped them remember to take their HIV medication, informed them of HBHC services/resources, grabbed their attention, would motivate PLWH to act in ways that would prevent further transmission, and to be involved in their health care. The majority reported that the messages were interesting, convincing, and said something important to them. Most participants said that having programs like this one is very important (88%). A small percentage (11%) indicated that they were very concerned that people could see the text messages they got from the study. We detected a statistically significant increase from baseline to follow-up in HIV knowledge (p < .001) and perceived social support (p=.011), and a statistically significant decrease in number of missed medication days (p=.041).

Participants indicated strong receptivity to both the messages and the intervention, and we detected a difference in three key outcomes targeted by the intervention. These findings suggest a full-scale study with longer-term follow-up is warranted to confirm and expand upon findings from this proof-of-concept study.

Abstract 1529 - Addressing HIV Testing, Prevention, Care, and Support Service Referral Needs in California

Author(s): Daniel Coronado; Dawn Munoz; Calvin Lee; Bunny Furlo; Brian Lew; Sandy Simms; F. E. Harrison; Melissa Beaupierre
The National HIV/AIDS Strategy asks health departments to provide local information on where to access care and support services disseminated online. In a time of limited resources, effectively utilizing existing resources across funding streams is critical.

California Department of Public Health, Center for Infectious Diseases, Office of AIDS (OA)

Leveraging CDC and NPIN resources, OA established a Service Referral Telephone Line, Live Chat, and Website which may serve as a model for other states. A recording refers callers seeking non-service referral information to other resources. One person answers calls/chats during business hours. We describe telephone/chat and Web interactions over 6 months.

In 6 months, 4,568 calls were received (over 750 calls per month). 2,439 (53%) selected an option provided on the recording; the others hung up. Thirteen percent selected Spanish information. Sixty four percent of calls occurred during business hours and 14% sought operator assistance. 1,159 (47%) called for general information, 637 (26%) for Service Referral information (over 100 per month), 409 (17%) for emotional support and 234 (10%) for STD information. 338 calls were answered (approximately 50 per month); 96% were in English, half were male, 28% from LA, 20% from the SF area, 32% from other high prevalence counties (Contra Costa, Fresno, Kern, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, San Mateo, Santa Clara, Solano, and Sonoma), 19% from other counties and 1% from outside California. 103 (34%) were for information about HIV test sites, 19 (6%) for prevention, 17 (6%) for care, 6 (2%) for ADAP/treatment, 7 (2%) for post-exposure prophylaxis (PEP) and 29 (9%) for insurance. 61 (20%) were for information about exposure risk/test accuracy and 33(11%) for other information. We assisted approximately 32 chats a month. In 5 months, there were 159 chats; 9% from LA, 14% from the SF area, 29% from high prevalence counties, 28% from other counties and 20% from outside California. 16 (12%) were for information about HIV test sites, 2 (2%) for prevention, 3 (2%) for care, 6 (4%) for ADAP/treatment, 2 (2%) for PEP and 9 (7%) for insurance. 55 (41%) were for information about exposure risk/test accuracy and 26 (19%) for other information. In 5 months, there were 9,340 website visits (over 1,800 a month), 65% of which were from outside California. Among searches in California, 5% were from LA, 7% from SF, 12% from other high prevalence counties and 11% from other counties. 1,337 (14%) were for information about HIV test sites, 235 (3%) for prevention, 596 (6%) for care.

Lessons Learned: With over 14,000 contacts in 6 months, we demonstrate that by utilizing existing information resources, a comprehensive service referral system can provide service and general information to many users without overwhelming even minimal telephone/chat staff. To enhance the utility of this service, we have identified service categories not included in the NPIN database (PEP, acute HIV diagnosis and benefits counseling) and plan increased marketing of this resource to county health departments, providers, consumers and advocacy groups.

Track E

E03 - Maintaining Linkage & Access to Care: Barriers to Virologic Suppression
Room: Cairo (Hyatt Regency Atlanta)

Abstract 1575 - Using HIV Surveillance Data to Evaluate Outcome of Site Randomized Interventions in the TLC-Plus Study

Author(s): Hall HI; Jia Y; Griffin, AB; Brady, KA; Grigg, RL; Sayegh, MA; Torian, LV; El Sadr, W

Modeling studies suggest intensified HIV testing, linkage to HIV care and antiretroviral treatment with viral suppression may be associated with reduced HIV transmission and ultimately control of the HIV epidemic. As studies to prove these concepts are implemented, population data to monitor outcomes of these interventions are needed. US HIV surveillance systems are a potential source of outcome data.

In the US, CDC and local health departments have supported programs to increase HIV testing and strengthen linkage to care and treatment. The NIH-funded Testing and Linkage to Care Plus Treat (TLC-Plus) (HPTN 065) study, conducted in Washington, DC and the Bronx, NY, includes components to study enhanced linkage of HIV+ individuals to care and achievement of viral suppression with ARV use.
Routinely collected HIV laboratory data available in the surveillance system were assessed for completeness and used to determine site aggregated outcomes prior to randomization of the study components. The baseline data were used to conduct a 1:1 restricted randomization of HIV test sites and HIV care sites. The TLC-Plus Study randomized 20 HIV test sites in each municipality (with largest number of HIV+ve diagnoses in 2008) to a financial incentive (FI) strategy or standard of care (SOC) to determine the feasibility and effectiveness of FI in increasing linkage of HIV-infected patients to HIV care sites. In addition, 20 HIV care sites in each municipality (with largest number of patient in care in 2008) were randomized to FI versus SOC to assess feasibility and effectiveness of FI in achieving viral suppression.

Intensive work with the departments of health and individual sites verified surveillance data were sufficiently complete to assess site outcomes. In some care sites the number of patients based on surveillance was lower than self-reported site data, due to differences in definitions, lack of site databases to accurately enumerate patients or difficulty in identifying site of care within the current surveillance data.

At baseline, 10 percent of selected testing sites (n=4) had more than 100 newly diagnosed HIV+ patients, 45% of sites (n=18) sites had fewer than 10 in the previous year. The median rate of linkage to care within 3 months from these testing sites was 69% (IQR 50%-86%) in the Bronx and 57% (IQR 33%-73%) in Washington, DC. Non-intervention municipalities had similar rates of linkage to care.

In the twenty highest volume sites, the median number of patients in care was 251 in the Bronx and 221 in Washington, DC; seven sites had >1000 patients in care. Median percent of patients with viral suppression (<400 copies/mL) at these sites were 69% (IQR 65%-75%) in the Bronx and 64% (IQR 56%-72%) in Washington DC.

Surveillance data provide a single, transparent, reproducible, standardized criterion for assessing lab outcomes. Surveillance data were successfully aggregated by site to inform randomization at baseline. With adherence to best practices, surveillance data have the potential to inform and monitor aggregate site study outcomes.

Abstract 1709 - Antiretroviral Drug Use and Virologic Response from the AIDS Drug Assistance Program in Washington, DC

Author(s): Damber Gurung; Sonya Bayone; Gunther Freehill; Angelique Griffin; Rowena Samala; Charles Wu

The AIDS Drug Assistance Program (ADAP) is an important source of prescription drugs for people with HIV infection and limited or no insurance. This objective of this analysis study was to quantify viral suppression among ADAP participants in Washington DC.

We developed a computerized method to link service utilization data, ADAP eligibility data, prescription filling data, and laboratory data from the HIV/AIDS Reporting System (HARS) to assess utilization patterns, persistence of coverage, to identify ADAP eligible clients not using the benefit, and to characterize the virologic response of clients utilizing ADAP. We used data from calendar years 2007, 2008 and 2009 at HAHSTA in Washington DC to evaluate trends in ART use and virologic suppression among ADAP clients.

The ADAP program served 2,022 clients in 2007 and 2,403 clients in 2008 (19% increase) and 3,212 clients in 2009 (34% increase). There were 20,540 prescriptions for ART filled by 1,670 clients in 2007, 23,611 prescriptions for ART by 1,920 clients in 2008 (15% increase), and 38,865 prescriptions for ART by 2,616 clients in 2009 (36% increase). Between 2007, 2008 and 2009 the relative volume of protease inhibitor prescriptions was 39%, 42% and 41%, NNRTI prescriptions was 8%, 6% and 5%, integrase inhibitor prescriptions was 0.1%, 2% and 4%, and entry inhibitor prescriptions was 0.4%, 0.3% and 0.4%, respectively. Of available viral load tests that could be linked to the time when a client was taking ART in ADAP, viral load was <400 copies/ml for 421 (74%) of 566 clients in 2007, 480 (77%) of 624 clients in 2008, and 753 (83%) of 911 clients in 2009.

The ADAP program in Washington DC absorbed a large increase in clients and prescription volume between 2007 and 2009 and most clients achieved a desirable clinical benefit, as measured by viral load <400 copies/ml, demonstrating effectiveness of the ADAP program was maintained.
Abstract 1893 - Where Care and Prevention Coalesce: Pacific AIDS Education and Training Centers Needs Assessment Process
Author(s): Joanne Keatley, MSW; Michael Reyes, MD, MPH

PAETC's previous needs assessments had consisted primarily of a convenience sample survey compiling provider impressions of HIV care and its challenges. However, 2008's dramatic events including drastic state and local budget cuts and infrastructural shifts demanded a more comprehensive assessment including how these developments affected the ability of HIV institutions and clinicians to provide care and screening to all patients.

PAETC is a regional network of 15 local sites in 4 states (AZ, CA, NV, HI) that includes the U.S. Pacific Jurisdictions. PAETC implemented the needs assessment process to provide more effective training, education and capacity development to our clinical partners as part of a 5-year competitive application to HRSA.

PAETC's needs assessment blended both prevention and clinical assessment questions to achieve a more complete environmental scan of the state of HIV care, comorbidities and case finding. We analyzed our region's epidemiology (HIV and comorbidities), infrastructure (including clinical institutions, public health services and benefits), and key informant interviews of HIV clinician and systems level (state/county) leaders.

Findings from the needs assessment included: a substantial shift in the emerging epidemic in some localities (increases in younger and older people testing positive; increases among transgender women; increases among African American women); substantial infrastructure shifts including major cuts to basic services such as ADAP; major increases in Ryan White clients due to loss of health insurance from job losses; clinics and ancillary services closing down; and patients presenting at diagnosis with AIDS. Reports from clinicians on their experiences with patients included: difficulty retaining patients in care (60%), especially patients with psychosocial issues (80%); difficulty with adherence (64%); resistance to HIV medications (24%); treatment failure (12%); managing lipids (20%); and STI screening (8%). Some providers were uncomfortable with patients based on socio-demographic characteristics including: sexual orientation (20%); transgender status (20%); homelessness (16%); race/ethnicity (12%), incarceration (12%); and gender (8%). Many clinics reported restructuring HIV care to make access easier for hard-to-reach patients. There was a universal cry from systems-level key informants to provide support for earlier case finding via screening and testing programs, in order to reduce the number of late diagnosis.

Lessons learned:
An increased focus on understanding local, state and regional epidemiology and infrastructure substantially shifted the focus of our region's program planning. This was particularly dramatic in some areas where both the epidemiological shifts and the clinical and benefit infrastructure available to assist them had dramatically changed. Both the types of training and the method of providing support moved the organization toward long term longitudinal capacity building at a clinic and provider level. PAETC is emphasizing the role of clinicians in prevention with a renewed emphasis on working with non-HIV clinicians to train them to help identify those living with HIV who are unaware of their status or simply not in care.

Abstract 2018 - Brief Clinic-wide Intervention Promotes Retention in Care among HIV Patients
Author(s): Gary Marks; Jason Craw; Faye Malitz; Robert Mills; Meg Sullivan; Thomas Giordano; Jeanne Keruly; Michael Mugavero; Allan Rodriguez; Tracey Wilson

Background. Improving HIV patients attendance for primary medical care is a prerequisite to controlling patients' viral loads more effectively and interrupting ongoing HIV transmission. We implemented and evaluated a brief, clinic-wide intervention delivered to HIV patients during clinic visits to improve retention in care.

Methods. Six HIV clinics participated in the intervention, which consisted of brochures handed to patients, posters in exam/waiting rooms, and verbal messages delivered to patients by their healthcare providers about the importance of keeping all scheduled appointments. The intervention year ran from May 2009 to May 2010. We assessed patients attendance for primary medical care after they made their first visit (presumed exposure to the intervention) during that year. In the pre-intervention year (immediately preceding year that served as a comparison group) we assessed attendance after patients made their first visit during that year. Outcomes were (1) proportion of all primary care
appointments kept (omitting cancelled appointments) after the patient's first visit in the relevant year and (2) the percentage of patients who kept two consecutive and three consecutive primary care appointments following their first visit during the relevant year. We used GEE estimation methods in linear and log binomial regression models to control for repeated measures per patient, adjusting for age and viral load. During the intervention year, 50 patients per clinic were surveyed quarterly after their medical exams and asked whether they received components of the intervention.

Results. A total of 12,963 distinct patients were included across both years of the analysis. Of these, 7,891 patients (61%) were in both the pre-intervention and intervention years. Mean age was slightly higher in the intervention than pre-intervention year (46.2 vs. 45.9, p < 0.05). There were no year-to-year differences in race/ethnicity (64% black or sex (65% male). The percent of patients with undetectable viral load (<400 copies) was higher in the intervention than pre-intervention year (73% vs. 67%, p < 0.01); the percent with CD4 cell counts less than 350 was the same in each year (39%). The proportion of kept appointments for primary care was higher in the Intervention year (71%) than the pre-intervention year (68%, p < 0.001). A larger percentage of patients kept two consecutive appointments in the Intervention year (53%) compared with the pre-intervention year (48%; p < 0.001); a significant difference was also observed for keeping three consecutive appointments (41% vs. 36%, p < 0.001). Eighty-one percent (913/1126) of patients reported in surveys that they had received at least one verbal message from their provider about the importance of regular care; 60% (672/1128) of patients reported they had been offered a brochure by clinic staff.

Conclusion. A brief, low-cost, low effort, clinic-wide intervention consisting of brochures, posters, and verbal messages from healthcare providers produced modest improvement in HIV patients attendance for primary medical care. Ensuring delivery of all components of the intervention remains a challenge. Stronger effects might have been observed had all patients received the brochure and message components of the intervention.

Track F
F08 - Measuring Cost Effectiveness in Prevention
Room: Regency Ballroom V (Hyatt Regency Atlanta)

Abstract 1261 - Cost-Effectiveness of HIV Prevention Interventions in the United States: A Systematic Review
Author(s): Ya-lin A. Huang; Arielle Lasry; Angela B. Hutchinson; Stephanie L. Sansom

The Centers for Disease Control and Prevention (CDC) announced a funding opportunity in 2010 to facilitate the development and implementation of Enhanced Comprehensive HIV Prevention Plans (ECHPPs) for Metropolitan Statistical Areas (MSAs) most affected by the HIV epidemic. The purpose of ECHPPs are to identify optimal combinations of HIV prevention, care, and treatment services to reduce HIV risk and incidence. Fourteen interventions and strategies were required to be included in the ECHPPs. As the grantees are encouraged to prioritize their intervention plans based on strong scientific evidence, the Prevention Economics Team in the Division of HIV/AIDS Prevention at the CDC conducted a systematic review of published cost-effectiveness analyses of HIV prevention interventions and generated a summary table to help support the ECHPP of each jurisdiction.

We built a cost-effectiveness of HIV/AIDS prevention interventions database (CHAD) from published sources using systematic searches of 6 bibliographic databases and manual search procedures. Studies with key cost-effectiveness outcomes, e.g., cost per QALY gained, cost per life year gained, cost per HIV infection averted, or cost per new HIV diagnosis, were eligible for our database. References were excluded if they were not written in English, evaluated programs outside the U.S., or were neither an original study nor a review. A team of health economic scientists reviewed the included studies and abstracted core elements into the database, such as intervention details, time horizon, perspective, data sources, and key cost-effectiveness outcomes. Each identified study was evaluated by two independent reviewers. Costs were converted into 2009 U.S. dollars. As a result of the review, we created a table of the required 14 intervention types that included the number of published cost-effectiveness studies related to each and a summary of cost-effectiveness findings.

The search generated 3,370 studies published before February 2010. Based on our exclusion criteria, a total of 45 studies were eligible for review. There were 3 or more studies identified in CHAD for the following seven required
interventions: routine, opt-out HIV screening in clinical settings (9); partner services (9); prevention of perinatal transmission (8); adherence to antiretroviral medications (5); HIV testing in non-clinical settings (3); non-occupational post-exposure prophylaxis (3); and early initiation of highly active antiretroviral treatment (3). There were 1 or 2 studies identified for the following four interventions: behavioral interventions for people living with HIV (2); condom distribution for HIV-positive and high-risk populations (1); structural interventions (1); and linkage to HIV care (1). For retention or re-engagement in care, STD screening to reduce HIV acquisition, and linkage to non-HIV medical care and to social services, we could identify no published analyses. In the summary table, within each intervention type with 3 or more studies, the identified cost-effectiveness results were generally consistent with one another.

Our review provides valuable information on the cost-effectiveness of evidence-based HIV prevention interventions. Nevertheless, we found gaps in the literature. High quality economic evaluations to fill these gaps are needed to guide the most efficient use of HIV prevention funds.

Abstract 1318 - How Much Can We Pay for a New HIV Diagnosis and Still Be Cost-Effective?

Author(s): Paul G. Farnham; Stephanie L. Sansom; Angela B. Hutchinson

Screening for human immunodeficiency virus (HIV) to detect new infections is a key HIV prevention tool. However, program managers are often uncertain about how much they can spend to identify one additional case of HIV and still have a cost-effective intervention. We developed a model relating the cost per new HIV diagnosis in sexually transmitted disease (STD) clinic settings to the cost per HIV infection averted (program cost divided by infections averted) and the cost per quality-adjusted life year (QALY) saved by the intervention (program cost minus HIV treatment costs saved in the numerator, QALYs saved in the denominator).

The cost per new HIV diagnosis was based on the costs of testing infected and uninfected persons and the proportion of persons who tested positive (prevalence). The base case costs of testing an infected and uninfected person, derived from STD clinic data, were $85 and $20, respectively, and the prevalence was 0.008. To estimate the infections averted from identifying a new HIV diagnosis, we calculated the reduction in the annual transmission rate between persons who were aware of their HIV infection and those who were unaware (0.0624). We multiplied each infection averted by lifetime HIV treatment costs ($367,134) to estimate total treatment costs saved and by 6.433 to obtain total QALYs saved. We compared the cost per QALY saved ratio against thresholds of $0/QALY for cost-savings and $100,000/QALY for cost-effectiveness. All costs were in $US2009.

We assumed that all individuals newly learned their serostatus and there were no false positives or negatives in the testing process. Only direct HIV testing costs and the benefits of reduced HIV transmission from index patients who learned their status were included. The time frame of the analysis was one year.

The cost per new HIV diagnosis was $2,528, the cost per infection averted was $40,516, and the cost per QALY saved was less than zero. For the cost per QALY saved to equal zero (cost-saving threshold), the cost per new diagnosis could increase to $22,909 either through an increase in the cost of testing an uninfected person from $20 to $184, an increase in the cost of testing an infected person from $85 to $20,466, or from a decrease in prevalence from 0.008 to 0.0009.

To reach the cost-effectiveness threshold, the cost of testing an uninfected person could increase to $508, the cost of testing an infected person could increase to $60,610, or the intervention could be applied in a population with a prevalence as low as 0.0003. The cost per new diagnosis could increase to $63,053.

Because HIV is expensive to treat and diagnosis appears to reduce transmission to partners, the cost per new HIV diagnosis can increase up to $22,909 in a STD clinic setting and still be cost-saving and up to $63,053 and still be cost-effective. The analysis shows that investment in HIV screening is cost-effective for a wide range of testing costs and variations in prevalence.

Abstract 1393 - Cost-Effectiveness of the NHAS Goal of Increasing Linkage to Care for HIV-Infected Persons

Author(s): Paul G. Farnham; Stephanie L. Sansom; Angela B. Hutchinson; Chaitra Gopalappa
Timely initiation of antiretroviral therapy (ART) can improve the health of the infected person and reduce transmission. Initiation of ART, however, requires linkage to care, and it has been estimated that only about 65% of HIV-infected people are linked to care within three months of diagnosis. One of the goals of the National HIV/AIDS Strategy for the United States (NHAS) is to increase this proportion to 85%. We estimated the cost-effectiveness of increasing linkage to care (LTC) in an STD clinic setting serving men who have sex with men (MSM).

We used the Progression and Transmission of HIV/AIDS (PATH) model to analyze the impact of increasing the proportion of MSM linked to care within three months of diagnosis from 65% to 85%. PATH is an individual Monte Carlo simulation health state transition model that estimates costs and quality-adjusted life years (QALYs) for HIV-infected patients from infection to death. Given a median CD4 count at diagnosis of 429 cells/µl in this STD clinic setting and guidelines recommending treatment initiation at a CD4 count of 350 or fewer cells/µl, we assumed that immediate LTC implied initiating ART at a CD4 count of 350 cells/µl. For the current scenario where 65% of MSM had immediate LTC, we assumed another 15% were linked at a CD4 count of 200 cells/µl and 20% were linked at a CD4 count of 36 cells/µl (e.g., when hospitalized). For the NHAS goal scenario of 85% with immediate LTC, 10% were assumed linked at 200 cells/µl and 5% at 36 cells/µl. We limited the benefits of LTC to the index case and not to partners who avoided infection. We assumed that once linked, individuals were retained in care. We ran the PATH model for 10,000 iterations for each scenario with the above linkage assumptions.

The costs in the model, measured in 2009$, included testing, inpatient and outpatient health care utilization, and treatment costs. Due to limited data, they did not include costs associated with increasing LTC. We conducted a threshold analysis to determine how much could be spent to link the additional 20% to care and remain cost-effective.

The mean discounted costs and QALYs lost to infection were $398,116 and 4.92 under the current scenario and $412,764 and 4.49 under the NHAS goal scenario. The incremental cost-effectiveness ratio (ICER) was $33,850 per QALY gained, indicating that increasing linkage to care to meet the NHAS goal was cost-effective (ICER < $100,000 per QALY gained). Interventions to increase LTC could cost as much as $143,126 per person before they reached the $100,000 per QALY gained cost-effectiveness threshold.

Achieving the NHAS LTC goal can be cost-effective in settings in which patients are diagnosed with CD4 counts of around 400 cells over a wide range of costs for interventions to increase LTC.

**Abstract 1902 - Cost and Cost-Effectiveness Considerations for Jail Linkage Services**

**Author(s):** Hillary Superak; Zhou Yang; Curt Beckwith; Steve Resch; Alison Jordan; Irshad Shaikh; Steve Pinkerton

EnhanceLink is a multi-site demonstration project designed to develop several models of effective community linkage for HIV+ jail releases in diverse settings medium to large jails, in metropolitan areas at different stages of the HIV epidemic, in regions of the country with varied drug use patterns. Programs emphasize linkage to HIV clinical services as well as ancillary services such as substance abuse treatment, mental health care, housing, and employment. The Rollins School of Public Health of Emory University, partnering with Abt Associates, Inc., was funded to establish an Evaluation and Support Center for the project.

Longitudinal client-level data, comprised of interviews and clinical data at jail enrollment (baseline) and 6 months post-release (follow-up) are being collected on 1000 clients. Data are currently available from nine sites for the cost analysis. The main outcome of interest is linkage to community care, defined as obtaining at least one CD4 count post-release; sustained linkage, defined as two CD4 counts over six months, is a secondary outcome of interest. Cost data were collected during the first quarter of 2010, after the linkage programs were well-established at all study sites. Linkage rates are averaged over multiple quarters. We have conducted cost analyses to investigate the cost per client served, per medical linkage, per sustained linkage, and per sustained linkage with suppressed virus. Using clinical data we are exploring cost-effectiveness from a societal perspective: do the linkage interventions save money by averting new HIV infections, which cost $972,000 each in 2010 dollars? Estimates on the likelihood of linkage in the absence of case management are taken from the literature.
(Preliminary Results) Linkage rates vary by site: 25-79% of clients are linked; 10-77% of persons have sustained linkages; 10-33% have undetectable viral loads at 6 months. Mean per-client cost is $1,954. The cost per linked client averages $5,523 and $9,921 per sustained linkage. The mean cost per client with undetectable viral load at the 6 month follow-up visit is $17,493. Our projections suggest that the EnhanceLink program would prevent at least 2 infections at the end of 10 years, yielding a cost-effectiveness ratio of approximately $750,000 per additional infection prevented. Given that HIV infections have a lifetime cost estimated at $972,000, the linkage programs appears to be cost-saving at a societal level.

The cost for maintaining the EnhanceLink interventions is substantial for an individual jail, but the intervention appears to be cost-saving from a societal perspective over a 10 year time period. Collaborations between public health entities and the criminal justice system are necessary to sustain interventions that in the long run benefit the community.

Track G
G05 - Service Integration in Marginalized Populations
Room: Inman (Hyatt Regency Atlanta)

Abstract 1592 - The HIV Health Literacy Model: A Multi-Level Approach for Capacity Building to Integrate HIV Prevention
Author(s): Luis Scaccabarrozzi; Lisa Frederick; John Denelsbeck

Culturally and linguistically appropriate prevention, treatment, and care education must be provided to adults in a multi-level approach that is tailored to each individual, group, and community so that they may increase their knowledge, participation, and decision-making skills.

Bringing together HIV service providers, local and statewide government, health administrators, researchers in targeted cities throughout the United States.

An Elton John Foundation funded program. A multi-level intervention (prevention, treatment, and care education to clients, education to non-medical service providers, technical assistance to agencies providing services for people living with HIV, individualized sessions for clients, and culturally and linguistically appropriate material) that allows for a continuum of care and a better understanding and use of information to empower individuals and communities affected by HIV.

In its fourth year, this initiative has been able to create social marketing campaigns targeting older adults and service providers (HIV testing campaign and HIV awareness campaign for older adults); tailor/adapt a CDC behavioral intervention (Community PROMISE) targeting older adults living with HIV and older adults at risk for HIV; provide HIV testing for older adults that provides access care for those who test positive; and provide trainings, capacity building, and technical assistance to over 600 agencies/programs in NYC.

Lessons Learned: (1) Multi-level approaches that are tailored to individuals and communities are working effectively to reach culturally and linguistically underserved populations, (2) Creating collaborations and partnerships with agencies to reach those communities and bringing the services to each community, as opposed to providing services on-site, is a more effective way to gain access to communities in need. (3) Gaining trust and credibility from the community and individuals improves response for improved access to care and treatment. (4) Creating a program that is tailored to culturally and linguistically disadvantaged communities leads to effective response from participants. (5) Creating a program that is tailored and allows for active participation is important when working with adults. (6) Providing easy-to-understand medical information is important for individuals to become empowered.

Next Steps: (1) Assess the impact and health outcomes of multi-level prevention, care, and treatment programs in community-based settings. (2) Create programs that involve the community in developing, planning, and implementing educational material that is effective in creating a response. (3) Community involvement is needed in
creating an evaluation and research plan to assess the impact of a multi-level approach. (4) Create an effective adult education dynamic.

Abstract 1792 - The RISE Intervention: A Practice-based Intervention to address HIV & Violence against Women

Author(s): Quinn Gentry; Aleisha Langhorne; Lisa Diane White

HIV prevention research continues to highlight the intersection between HIV and violence against women. However, relevant interventions based on these research findings are not readily available. This has resulted in community-based organizations lacking gender specific approaches to adequately address HIV prevention among women experiencing violence.

The RISE Intervention is in its third year of pilot implementation in Atlanta, GA, where it is emerging as a best practice in applying black feminist theory as a conceptual framework for working at multiple levels of HIV/AIDS education to reach female survivors of violence within diverse social service settings.

The purpose of the RISE intervention is to engage female survivors of violence in relevant HIV prevention education aimed at: (1) increasing their knowledge about their risk for HIV, (2) committing to HIV testing and counseling, and (3) strengthening their ability to set safe sex goals. The RISE intervention is the first of its kind in that it applies black feminist theory in all aspects of program design, implementation, and evaluation as a way to provide HIV prevention education in a format and context that is relevant to female survivors of violence. The RISE intervention is conducted by HIV prevention educators called RISE Champions. RISE Champions are matched with RISE Advocates who are service providers and counselors at domestic violence shelters, homeless programs for women, and women-centered substance abuse treatment facilities. RISE Champions and RISE Advocates participate in sensitivity training regarding the need for and approach to integrating HIV prevention into existing client service models.

Select 2009-10 program results include: (1) trained 19 HIV prevention educators as RISE Champions to serve as the frontline staff for integrating HIV prevention into domestic violence and related settings; (2) engaged 11 domestic violence and women-centered health agencies as collaborative partners for integrating HIV services into existing service provision; (3) provided technical assistance for 18 domestic violence service providers and women-centered providers to advocate for the RISE program within their agencies serving as RISE Advocates; (4) implemented 16 Healthy Love Party group-level HIV prevention interventions; (5) engaged 117 female survivors of intimate partner violence in group-level HIV prevention education sessions; (6) engaged 57 female survivors of intimate partner violence in individual-level HIV prevention education sessions; and (7) linked 35 female survivors of intimate partner violence to HIV testing and counseling services at SisterLove.

Consistent with black feminist theory, providing female survivors of violence with group-level and individual-level interventions balanced HIV prevention knowledge and skills-building with a safe space to discuss personal risk factors in a more private setting. In like manner, our collaborative partners have unique situations and conditions that must be taken into account when planning to implement integrated approaches to violence and HIV. Working with a designated RISE Advocate inside each collaborating organization proved very effective in gaining conceptual buy-in and logistical support for integrating HIV prevention education into existing social services.

Abstract 1932 - The Substance Abuse and Mental Health Services Administration Rapid HIV Testing Pilot

Author(s): Kirk James, MD; Willie Tompkins, PhD; Naomi Tomoyasu, PhD; Resa F. Matthew, PhD; Kevin Hylton, PhD; Sherrye McManus, MSW, MSPH

Racial and ethnic minorities have been disproportionately affected by HIV/AIDS, and represent the majority of new AIDS cases (70%), new HIV infections (54%), prevalent HIV/AIDS cases (65%), and AIDS deaths (72%) (CDC, 2006). The spread of HIV disease in the United States has been partly fueled by the use of both illicit and non-illicit drugs. In addition to HIV transmission associated with individuals sharing syringes and other drug equipment, HIV transmission can also occur through sexual contact with injection drug users who are HIV positive. Moreover, the use of both injected and non-injected drugs increases the risk of HIV/AIDS because of the potential for impaired decision making regarding sexual risk behavior. Thus, it is critical that individuals with a substance abuse history be tested for
HIV as an integral part of their treatment. If they are found to be HIV seropositive, the integration of testing as part of their treatment will allow for the opportunity of a timelier and more appropriate referral for care and reduce further HIV transmission.

Substance abuse and mental health treatment settings.

Individuals at risk for HIV/AIDS transmission due to substance abuse and/or mental health disorders are screened, tested, and referred to quality treatment and other support services. Clients with a reactive test are offered confirmatory testing, and persons with HIV are case managed and referred for HIV treatment services.

To date, 6,687 individuals were tested. Of these individuals, 66.5% were male and 33% were female. The racial and ethnic groups included African Americans (48.5%), Whites (43.8%), and Latinos (30%). African Americans were more likely to be tested in outpatient drug and alcohol clinics (28.5%), while Whites were more likely to be tested in shelter/transitional housing settings (38.3%) and Latinos in other community settings (29.5%). Various high risk behaviors were reported including sexual risk behaviors (55.4%), drug risk alcohol use (57%), and binge drinking behavior (29.8%).

**Track G**

**LB3 - Innovative Interventions**  
**Room:** A705 (Atlanta Marriott Marquis)

**Abstract 20100 - Microfinance and HIV Prevention among High Risk Women and Adolescent Females**  
**Author(s):** Katherine A. McQueston; Lynne M. Morgan

Since the mid 1970's, when the Grameen Bank in Bangladesh piloted the idea of small loans for poor people with no access to credit as a means of poverty alleviation, micro-finance emerged as an effort to decrease the 140 million people living on less than $1.25 a day. Without access to financial resources, many women turn to commercial sex work or face financial dependence on their husbands, placing them at risk for sexually transmitted infections including HIV. We searched MEDLINE, Cochrane Collaboration, EconLit, ProQuest, PsychINFO, ScienceDirect and Web of Knowledge. We furthered our search through manual reference reviews and by contacting experts in microfinance. After creating and piloting a data collection form, two, and independent researcher's extracted relevant data. We contacted authors to obtain missing data, and used a qualitative method for analysis. The searches provided 3,785 studies from which we manually identified and included eight studies.

Aid agencies endorse microfinance as a way to decrease opportunities for HIV infection in vulnerable women populations, yet little data support this method. The objective of this paper is to assess the effects of microfinancing in reducing HIV high-risk behavior and HIV transmission for women and adolescent females in high HIV prevalent areas. We found that, though study design and quality differed, our qualitative results showed that microfinance did not decrease HIV risk behavior. Seven of the eight studies indicated that loans alone were not sufficient to support behavior change, but independent control of money, and loans with education did reinforce positive behaviors. Adverse events occurred in two studies, in which women's trade routes brought them to harm.

We conclude microfinancing alone is not sufficient to produce effective change in women's behavior to decrease the spread of HIV/AIDS. Further research could suggest alternative routes of HIV prevention in this population.

**Abstract 2043 - CAB HIVTALK PROJECT- Cab Drivers as Advocates for HIV Prevention in Palm Beach County, Florida**  
**Author(s):** Yolanda De Venanzi

The HIV epidemic is a serious threat to the Hispanic community in the US. In Florida, Hispanics account for 21.5% of the population and nationally, Hispanics represented 22% of the AIDS cases and 21% of the HIV cases in 2008*. Also the AIDS case rate among Hispanics is almost four times greater than the rate among whites. Florida is #2 state
in the US for new HIV cases in women and children. These facts highlight challenges that can be addressed by HIV prevention interventions targeted at the Hispanic communities.

A targeted Community PROMISE intervention was implemented in the city of Lake Worth, Florida where 29.7% of the population is of Hispanic origin**. The specific site is a cab station located in a corner where high risk Hispanics, male and female sex workers, and others hang out. Most people have never had HIV prevention education or information about HIV tests.

Community PROMISE workers and Peer Advocate volunteers reached Hispanic high risk community members and passengers to discuss culturally appropriate role model stories that address different stages of change towards safer sex behaviors. The project highlights the successful engagement of Hispanic cab drivers as HIV prevention volunteers by promoting their commitment and ownership of the intervention through targeted recruitment, training, motivational meetings, recognition; and active participation in planning HIV prevention events.

Since April 2010 eight Hispanic cab drivers have distributed over 3,600 stories that depict Hispanic role models starting to think about how to reduce their risks of HIV infections or acting in safer ways. The cab drivers have been instrumental in giving out over 4,000 safer sex kits to individuals and to brothel managers, as well as giving out other educational materials about teenagers and HIV, STDs, HIV testing sites and many other resources. They participated in an HIV prevention outreach event on September 4th reaching 200 men; and on December 2010's WAD 400 men were reached with HIV prevention messages; and 57 referrals for HIV testing were given. 60% of these referrals were for people that got tested for the first time. Women's AIDS awareness day - March 2011- was also a successful awareness event at this site. The impact on the neighborhood has been very positive and as individuals the cab drivers have developed leadership and event organizing skills.

LESSONS LEARNED: Involving Hispanic cab drivers in providing prevention messages through an HIV talk to passengers and to high risk people who hang out at the cab station proved to be an effective method of reaching male and female sex workers and passengers who otherwise wouldn't be getting the prevention messages. A participative approach in decision making and event planning proved to increase engagement and ownership of the intervention by the volunteers. Culturally appropriate educational material and events helped in overcoming cultural barriers in promoting safer sexual behaviors. Some aspects on how to reach illiterate people were also implemented.

*Florida US HIV/AIDS 2009 Update  
Retrieved from http://www.doh.state.fl.us/disease_ctrl/aids/Minority/LatinoIndex.html on April 17, 2011.

**US Census Bureau  
Retrieved from  
http://quickfacts.census.gov/qfd/states/12/1239075.html on April 17,2011

Abstract 2074 - Snapshot Project: Sneaking a Peek at a Tool for Enhancing HIV Prevention for Women/Girls  
Author(s): Anna Forbes

In June 2010, the Department of Health and Human Services (HHS) Office on Women's Health (OWH), with UNAIDS, convened a two-day Forum entitled Bringing Gender Home: Implementing Gender-Responsive HIV/AIDS Programming for US Women and Girls. There, 200 researchers, service providers, government officials and advocates discussed models of gender-responsive programming and strategies for promoting integration of these approaches into our domestic HIV response.

Using PEPFAR and Global Fund resources, countries where HIV incidence is highest among women and girls have developed valuable gender-responsive approaches. By adapting and applying some of these, we can both enhance the effectiveness of HIV prevention services for U.S. women and girls while maximizing the number of lives saved with our tax dollars. The OWH Snapshot Project, designed around the structure of the National HIV/AIDS Strategy (NHAS), seeks to communicate these lessons and promote discussion of their domestic utility as a way to enhance the gender-responsiveness of the NHAS.
Following the national Forum, OWH recruited expert authors and worked in virtual space with Women's Health Issues (WHI), a peer-reviewed journal focused on the social, health care, and policy factors that shape women's health. To take the Forum one step further, we engaged leading experts on women and HIV to examine the Forum's content and, based on their deep experience, pinpoint the policy and practice changes required to implement the Forum's recommendations. The results will be unveiled in late September in a dedicated issue of WHI that we will put into the hands of thousands of people living with HIV, policy-makers, funders, advocates, service providers.

This OWH Snapshot provides a real-time look at the status of the U.S. response to HIV among women and girls and what it will take to move us forward. Its authors point to structural interventions -- such as the IMAGE study in South Africa as an approach to reducing risk and how criminalization laws in Mississippi enhance risk. Models from Nigeria and Washington DC illustrate how integrating HIV prevention and reproductive health care can extend the reach of both. Specialists describe the demonstrable effective approaches to promoting HIV prevention among transgender women, those in Native American communities and U.S. territories, those in detention or incarceration systems, those surviving violence, and those living with HIV, among others.

We cannot yet document the results of this project. This presentation will provide an overview of this new tool that stakeholders committed to reducing HIV incidence among women and girls can use to inform their involvement in NHAS roll out. The Snapshot offers a wide range of strategies and approaches that are under-utilized or new to the U.S. We know what factors exacerbate women's vulnerability to HIV. As we implement the NHAS, we need to talk more about what to do, specifically, to mitigate it.

We know what we need. The NHAS offers us an historic opportunity to lower HIV incidence among women and girls. The OWH Snapshot is a tool for adding to the NHAS gender responsiveness, thus contributing to that goal.
Track C
CR05 - From Where I Stand: A HIV prevention social marketing campaign for black gay men
Room: Cairo (Hyatt Regency Atlanta)

Abstract 1991 - From Where I Stand: A HIV Prevention Social Marketing Campaign for Black Gay Men
Author(s): Charles Stephens; Osamudiame Uzzi; Kevin Hatcher; Louis Graham; Andre Toone; Clinton Jolliffi; Steven Igarashi; Chase Andrews

Community Based Organizations have been effective in implementing individual HIV interventions for black gay men such as HIV testing, condom distribution and group level behavioral interventions such as Many Men, Many Voices. Though significant work has been done in these areas, more can be done to address structural barriers in relation to HIV prevention amongst black gay and bisexual men on a community level. In response to this, AID Atlanta, Inc. an AIDS service organization, established a working group comprised of service providers, community members, and researchers to create, develop, implement and evaluate the social marketing campaign From Where I Stand to address HIV stigma and homophobia affecting black gay community in Atlanta, GA.

Facilitators will discuss the development process for the From Where I Stand campaign including concept formation, branding, creating culturally appropriate messages, message testing, scriptwriting, storyboarding, and conducting photo and film shoots. Furthermore, facilitators will present and discuss the campaign products consisting of social network media, printed materials, short videos, billboards and other campaign related paraphernalia (t-shirts, messenger bags etc) as well as the iterative approach to release campaign products.

Social marketing campaigns can be an effective way to address structural issues, such as stigma, which can have a profound effect on individuals in marginalized communities’ ability to uptake HIV/AIDS services. Community based organizations need greater capacity building support around creating and conducting localized social marketing campaigns. This will assist in increasing access and decreasing barriers to HIV/AIDS prevention and support services for populations most at risk of HIV infection.

Track D
DR05 - Bringing to Light HIV Prevention for American Asians and Pacific Islanders (APIs) in the U.S.
Room: Hanover C (Hyatt Regency Atlanta)

Abstract 1590 - Bringing to Light HIV Prevention for American Asians and Pacific Islanders (APIs) in the U.S.
Author(s): Maria Luisa V. Tungol; Sima M. Rama; Darrel H. Higa; Nicole C. Crepaz; Choi K. Wan; Yuko Mizuno; Walter K. Chow

In spite of relatively low reported HIV and AIDS cases among American Asian and Pacific Islanders (APIs) in the U.S., APIs are the only group among all racial/ethnic groups with statistically significant percentage increases in annual HIV diagnosis rates, according to the CDC's HIV/AIDS surveillance data for 2001-2004 from 33 states, the most recent published trend data available. It is noteworthy that CDC's surveillance report did not include numbers from states where most APIs reside (e.g. California, Hawaii, Washington, and Oregon), and thus HIV and AIDS cases among APIs could be underreported. Additionally, findings from CDC's Behavioral Risk Factor Surveillance System, a nationwide population-based survey, indicate that APIs are significantly less likely than other racial/ethnic groups to report ever having been tested for HIV (32.6% API vs. 43.5% others). The population categorized as API is very diverse as it includes more than 49 ethnic groups and 100 languages. Limitations in surveillance reports, low HIV testing rates, and missing or misclassified race/ethnicity information on records pose significant challenges in fully understanding the scope of the impact of HIV/AIDS among diverse API communities. Current literature also indicates that APIs may be engaging in similar or even higher levels of HIV risk behavior compared to other racial groups and that different API groups are at different levels of risk for HIV transmission and infection. With federal and local
funding, several programs that promote HIV testing and counseling, better race/ethnicity classification systems, and culturally tailored HIV prevention are being developed and implemented in various API communities throughout the U.S. Unfortunately, information on these programs and their impact is limited in the published literature. Sharing lessons learned from these programs will facilitate a better understanding of the epidemic on API communities and inform the development, evaluation and dissemination of effective HIV prevention programs for APIs.

The discussion will focus on programmatic activities implemented in the API communities that are not always highlighted in published literature, with particular emphasis on ways to improve HIV testing; innovative strategies that address sociocultural and structural factors associated with HIV transmission risk that are unique to diverse groups of APIs; challenges and successes in planning, implementation, and evaluation of these strategies; and how to effectively share useful information about these programs across diverse API communities.

Identifying and tackling challenges of API HIV prevention efforts requires actively sharing useful information from communities, model organizations, researchers, and funding agencies. Information gathered in the discussion can be used to guide prevention efforts and allocate limited resources to maximize HIV prevention results for this understudied population. One of the goals of the U.S. National HIV/AIDS Strategy is for CDC to work with states with the largest API populations to implement the best combination of HIV prevention approaches to reach APIs at greatest risk for infection. Sharing field insights on lessons learned from implementing HIV prevention programs tailored to the needs of API communities is imperative in achieving this goal and in addressing alarming trends in HIV infection.

Track D
DR06 - From Uncertain Beginnings to a Renewed Beginning: Supporting the development of prevention capacity for CBOs
Room: Hanover D (Hyatt Regency Atlanta)

Abstract 1878 - From Uncertain Beginnings to a Renewed Beginning: Supporting the Development of Prevention Capacity for CBOs
Author(s): Casillas, D; Henry, L

During the past 14 years, the Technology Transfer Team (3T) at UT Southwestern has actively participated in shaping HIV prevention in the United States from HIV education and street outreach to the replication, dissemination, and implementation of effective behavioral interventions (EBI). Over this course of time we have grown and learned alongside countless partners whose sole desire it is to see HIV eradicated from our world. While we continue to work towards this common goal we have to acknowledge the hurdles that we have faced since the introduction of EBIs and the realization that many CBOs are still experiencing challenges to effectively planning and delivering EBIs. As a result, EBIs are often being implemented with little to no planning on the part of the CBO that to support fidelity to the core elements and intent of these once efficacious interventions. The recently released funding announcement 10-1003 and our position as a capacity building assistance (CBA) provider have brought together the perfect opportunity to develop a model of CBA that may encourage a renewed beginning to delivering relevant HIV prevention in 2011.

During the past four years, 3T has provided intensive CBA with nine CBOs in Florida, Massachusetts, New Hampshire, New York, North Carolina, and Texas to develop an infrastructure that strengthens their capacity to implement EBIs. 3T staff provided hands-on coaching, on-site assessment and observation, and customized training with CBOs that meets their needs to implement the Popular Opinion Leader (POL); Many Men, Many Voices (3MV); and Healthy Relationships (HR) interventions. Facilitators will present, discuss, and share with the group our experiences working intensively with these nine CBOs implementing EBIs targeted to African American and Latino men who have sex with men (MSM). This round table will provide an opportunity for CBOs implementing EBIs to share the success and challenges they have experienced planning, implementing, adapting, and evaluating their interventions. Facilitators will share information about the importance of seeking capacity building assistance and the opportunities available to support CBO staff's ability to deliver highly efficacious interventions with their respective intervention populations.
Capacity building assistance providers are available to provide support, coaching, mentoring, and guidance to CBOs implementing EBIs. CBOs that take advantage of these free services will discover new approaches and methods to strengthen their capacity to plan, prepare, adapt, implement, and evaluate their respective EBIs. These new approaches and/or methods will likely result in the CBOs increased ability to maintain fidelity to EBIs today and sustain them well into the future.

Track D
DR07 - What is CARE without Prevention? The effectiveness of a combined CPG and RW Planning Council
Room: Hanover E (Hyatt Regency Atlanta)

Abstract 2001 - What is CARE without Prevention? The effectiveness of a combined CPG and RW Planning Council
Author(s): Samantha Hughes

The combination of a Community Planning Group(CPG) and Ryan White Planning Council (RWPC) provides communication between prevention agencies and care service providers. Sharing the same community table provides insight into prevention behavioral change and care service activities. The two organizations can share new behavioral interventions, epidemiological data, services available for community members, opportunity for collaboration, counseling testing information, and new medication information. The combination can increase recruitment for DEBIs by collaborating and educating medical case managers on services provided.

Facilitators will present and discuss the successes of a combined Community Planning Group and Ryan White Planning Council. 1) benefits of shared data, 2) community outreach; 3) services provided; 4) bi-state collaborations; 5) in-depth involvement of community members 6) linkage-to-care and opt-out testing programs

The combination of the Community Planning Group and Ryan White Planning Council enable the Kansas City Transitional Grant Area Planning Council to meet the Early Identification of Individuals with HIV/AIDS (EIIHA) requirements for planning councils and implement the National HIV/AIDS Strategy.

Track D
DR08 - Making LINKS: Lessons from Implementing and Navigating Key Steps from Selecting to Adapting an EBI
Room: Hanover F/G (Hyatt Regency Atlanta)

Abstract 1345 - Making LINKS: Lessons from Implementing and Navigating Key Steps from Selecting to Adapting an EBI
Author(s): Asonganyi, S.A; MPH; Lumby, E.C; MPH

Selecting an evidence-based intervention (EBI) has a decisive influence on the future success and sustained effectiveness of an HIV Prevention program. Lack of a firm understanding of the important pre-selection steps of formative evaluation in the community and at the agency level guides the adaptation process can negatively affect the expected outcomes of an intervention.

This session targets persons who are responsible for planning and/or delivering HIV prevention interventions for populations high-risk and/or racial/ethnic minority populations. Upon completion of this oral group session, participants will be able to:
- Discuss the link between selecting an EBI and the critical pre-implementation considerations before implementing an adapted EBI
- Identify the specific guiding principles prior to implementing an EBI, more specifically the necessary progressive steps from selection to adaptation
- List challenges and related solutions to EBI selection and adaptation
The facilitators will present and discuss how to efficiently coordinate the selection and adaptation process in a cost-effective (time and money) manner. Additionally, facilitators will share and discuss an adaptation tool product that will facilitate a logical comprehensive adaptation consideration process for community based organizations (CBOs) seeking to move from having selected to adapting an EBI. This adaptation tool will assist the organization adapt key characteristics of an intervention while maintaining fidelity to the core elements.

The Behavioral and Social Science Volunteer (BSSV) Program has provided Capacity Building Assistance (CBA) to CBOs for over 14 years. Currently funded by the Centers for Disease Control and Prevention (CDC), the BSSV Program provides CBA to community-based organizations across the nation (and in U.S. territories) in order to improve the delivery and effectiveness of HIV prevention services for high-risk and/or racial/ethnic minority populations. More specifically, the CBA is focused on helping CBOs to plan and implement evidence-based interventions (EBIs); adapt EBIs for new settings and populations. The program's network consists of over 300 professional volunteers across the nation that offer free, CBA for CBOs. For the purposes of this group oral session, upon completion, participants will be provided with skills and resources that will enable them enhance the delivery and effectiveness of EBIs in HIV Prevention programming for high-risk and/or racial/ethnic minority populations in their organizations. Upon completion of this session, participants will have a solid understanding of conducting a comprehensive selection and adaptation process before linking to the implementation of an effective adaptation strategy that ensures the success of their EBI.

Track E
ER01 - Community Driven Responses to Late Diagnosis of HIV: From the Bottom Up
Room: Hong Kong (Hyatt Regency Atlanta)

Abstract 1603 - Community Driven Responses to Late Diagnosis of HIV: From the Bottom Up
Author(s): Ifeoma Udoh; Megan Dunbar; Ben Plumley; Sandra McCoy; Nancy Padian; Meridith Minkler; Carla Dillard Smith; Angel Fabian

Late diagnosis of HIV infection is a key driver of the racial and ethnic disparities of the epidemic in Alameda County, California, and in particular the City of Oakland. Although late diagnosis is a problem nationally, Alameda County data show an almost two-fold increase in late diagnosis over the last decade (from 39% overall to 57% since 1998). African Americans and Latinos are less likely to test than Caucasians, and therefore more likely to test late and receive a dual HIV and AIDS diagnosis. Late diagnosis means that opportunities to reduce onward transmission, either through behavior change or reduced infectivity from treatment, are missed. Current HIV programming lacks a targeted approach to routine testing and linkages to care; the new test and treat recommendations have yet to be implemented in Oakland. There is a need to explore both the structural and individual level barriers to strengthening HIV programming in Oakland, and develop community driven responses to address late diagnosis.

The Pangaea Global AIDS Foundation will present and discuss an innovative NIH supported project that utilizes community-based participatory research (CBPR) to engage community and other stakeholders to address late diagnosis in Oakland. CBPR is an ideal method for communities to identify barriers and partner in designing and implementing appropriate program models to address late diagnosis. The study's initial efforts in 1) collaborative data collection; 2) bi-directional information sharing; 3) developing recommendations; and 4) testing models of implementation will be presented. The discussion will also focus on: 1) Meaningful and active use of community advisory boards; 2) Strategies for collaborations with key community agencies and partners who have limited history of such engagement; 3) Developing a process of sharing available data and effective program models with community leaders, and 4). Designing a community -driven response to addressing a key public health issue (late diagnosis).

CBPR is a tool to engage local stakeholders to develop evidence-based programs that address late diagnosis in a community from the ground up. Alameda County is an ideal candidate for this type of research given the history of the State of Emergency among African Americans, declared 10 years ago, and the increasing significance of the epidemic among Latino groups. Lessons for other researchers interested in applying CBPR as a strategic approach
to engaging community partners in studying and developing a systematic response to late diagnosis will be presented.

Track E
ER02 - The Promise of PrEP? Moving from Randomized Trials to Program Implementation
Room: Singapore/Manila (Hyatt Regency Atlanta)

Abstract 1693 - The Promise of PrEP? Moving from Randomized Trials to Program Implementation
Author(s): Grant Colfax; Judith Auerbach

PrEP is the first intervention for MSM proved through a randomized controlled trial to reduce HIV incidence. Whether PrEP delivery is acceptable and sustainable in real world settings that serve high-risk MSM, as well as other population groups, remains an open question, and is subject to considerable debate.

Facilitators will present and discuss with the group the challenges and barriers to possible PrEP implementation projects, using data from the literature and community experience to frame the discussion. Points for discussion will include: 1) community preparedness and support for PrEP; 2) concerns about the "medicalization" of HIV prevention via PrEP implementation; 3) the ethical issues PrEP raises, including the provision of ART to those who are HIV-uninfected; 4) whether and how PrEP can be implemented in resource-challenged settings; 5) the potential for risk compensation among those who take PrEP; 6) adherence; and 7) drug resistance.

While PrEP holds great promise, its effectiveness in reducing HIV infections at the community level remains to be determined. PrEP raises important questions about the allocation of medical and prevention resources and the balance between individual benefit and public good. Determining barriers and what resources are needed for PrEP can only begin with frank and evidence-based discussions of its potential risks and benefits. We must initiate these discussions to determine whether PrEP’s potential can begin to be realized as an effective prevention intervention among high-risk MSM and other population groups.

Track F
FR02 - Expanding HIV Testing and Health Reform
Room: Baker (Hyatt Regency Atlanta)

Abstract 1409 - Expanding HIV Testing and Health Reform
Author(s): Carl Schmid; Kali Lindsey

The Patient Protection and Affordable Care Act presents an opportunity for coverage by various payers of preventive services, including HIV testing. Coverage is primarily determined by the grade given to the service by the US Preventive Service Task Force (USPSTF). The current grade for routine HIV testing has been identified as one barrier to expanding coverage for routine HIV testing. However there are other barriers including state laws, promotion of the service, federal regulation and interpreting the current Grade A for testing those who are at risk.

Despite the current USPSTF recommendation for testing for those at increased risk for HIV which encompasses those with individual risk factors; those receiving care in a high-risk clinical setting; and those receiving care in a high-prevalence clinical setting many states with jurisdictions that will meet this criteria are still without sufficient information or coverage to expand access to HIV testing. The significant logistical and practical difficulties of identifying individual risk factors and high risk and high prevalence settings can act as barriers to testing.

Facilitators will present and discuss with the group how and where HIV testing is being covered by 1) private insurers; 2) State Medicaid Programs; 3) Medicare; and 4) other potential payers, where possible. For each payer the authors will highlight key successes in expanding coverage of HIV testing and the remaining obstacles for expanding coverage. The authors will describe specific real practices that are occurring at the state and local level and solicit from audience members their experiences in obtaining coverage for HIV testing.
Increasing coverage for HIV testing will help further the goal of the National HIV/AIDS Strategy to increase the percentage of people who are aware of their HIV status. Expanding coverage for HIV testing will also increase accessibility for the service during a time that state, local, and federal resources are severely constrained. Highlighting the opportunities and focusing on both the successes and potential obstacles should assist HIV testing program coordinators and HIV advocates to take progressive steps to improve coverage in their area in the future.

**Track F**

**FR03 - Stepping Up in Faith for HIV/AIDS through Building collaborative, Inclusive Faith & Secular Community Partnerships**

**Room: Courtland (Hyatt Regency Atlanta)**

**Abstract 1428 - Stepping Up in Faith for HIV/AIDS through Building Collaborative, Inclusive Faith & Secular Community Partnerships**

**Author(s):** Oliver W. Martin III; Dee Bailey

**ISSUE:** There is a vital need to establish partnerships with diverse sectors of the Faith Community for the development of sustainable HIV and AIDS prevention and intervention programs. We know when individuals acquire knowledge, capacity and opportunities to implement their education they have a better chance of avoiding acquisition and transmission of HIV infection. In recent years however, the national strategy of HIV prevention education has shifted away from basic education for the entire community. Houses of worship have come to play an increasingly important role in providing Comprehensive HIV 101 education to fill this gap in service. Our model of stepping Up In Faith for HIV and AIDS (SUIF) addresses the major social justice issue of disseminating basic HIV 101 Prevention Education throughout our communities. SUIF creates a space and vehicle through which our faith community partners can build capacity to provide Comprehensive HIV Prevention Education to vulnerable and general populations. Participating within the collaborative model creates access to the expertise of multiple partners who provide a complement to each other around issues of HIV and AIDS. Faith-based organizations have the unique opportunity of reaching the thousands of people looking to them for guidance, and culturally appropriate referrals to local social services. For many in our diverse communities, the extraordinary value and potential to reach community individuals through the faith sector is already being demonstrated in a variety of successful initiatives and collaborations.

**KEY POINTS:** This Round-table Discussion will highlight and demonstrate an evolving formula of collaboration that has been paving the roads to successful HIV and AIDS efforts. Participants will discuss successful strategies for community model replication. The discussion will include: 1) Creating a Stepping Up in Faith Community Program in your urban and rural settings; 2) Accessing local and national tools and resources needed to implement age appropriate Comprehensive HIV Prevention Education in your house of worship; 3) Key strategies to consider as you bring community partners to the joint planning table; 4) Building a sustainable faith in Action for HIV and AIDS Community Partnership

**IMPLICATIONS:** This initiative demonstrates how it is possible to build a more sustainable Comprehensive HIV Prevention health education and service delivery system within houses of worship which are strategically positioned to play a significant role in reducing HIV infection rates. The bridging of Comprehensive HIV Prevention Education for houses of worship with CBO and local Health Departments, provides an alternative for faith settings currently not able to provide Comprehensive HIV Prevention on their own

**Track F**

**FR04 - Mobilizing Black Gay Leadership in Response to the HIV Epidemic**

**Room: Dunwoody (Hyatt Regency Atlanta)**

**Abstract 1955 - Mobilizing Black Gay Leadership in Response to the HIV Epidemic**

**Author(s):** Cornelius A. Baker; Leo Rennie; Russell Brewer; Venton Jones; Ernest Hopkins
At the National HIV Prevention Conference in 2005, CDC reported data from a 5-city study that found 46% of black gay/MSM were HIV positive compared with 21% of white men. Of the black men that tested HIV positive, 67% were unaware of their HIV status. This study resulted in a new era of community mobilization among black gay leaders in the United States, including creation of the National Black Gay Men's Advocacy Coalition in 2006.

During the past five years, NBGMAC has advanced several policy initiatives and worked to coalesce community leaders for a more effective response to the HIV epidemic. These efforts have included regular town hall meetings, surveys, a partnership with the National Black Women's HIV/AIDS Network, and a meeting of national LGBT leaders.

Among its initiatives over the last five years, in 2009, NBGMAC in partnership with the Evelyn and Walter Haas, Jr. Fund convened a group of leaders from government, philanthropy, and national and community-based AIDS Service Organizations (ASOs) to mobilize leadership in response to the HIV epidemic among black gay men in the U.S. and to inform the development of a National HIV/AIDS Strategy (NHAS).

The NHAS highlights the impact of the disproportionate burden of HIV on black gay men and the need for local and national efforts to address this situation.

Facilitators will discuss with the group findings from the leadership summit and review five years of black gay advocacy coordinated at the national level. The major components of the summit report include: 1) Providing a snapshot of the HIV epidemic in black America and among black gay men; 2) An introduction to the coalition; 3) Understanding the factors contributing to the HIV epidemic among black gay men compared to white gay men; 4) Providing a snapshot of the national and local response to the HIV epidemic among black gay men, this includes initiatives of the NIH, CDC, SAMHSA, other federal agencies and corporate funders; 5) Final summit recommendations in response to the HIV epidemic among black gay men. The participants will also review a report on the first five years of coalition activities its impact on HIV prevention program and policy at the national level. The participants will discuss additional efforts to promote the leadership of black gay men at the local, state and national level to mobilize a more effective community response.

The NHAS offers an opportunity to advance efforts to address the HIV epidemic among black gay men. The leadership of black gay men is essential in health promotion, service delivery and advocacy activities to reduce the health disparity of HIV among this population. Coalition efforts at the local and national level can be beneficial to achieving the NHAS goals. Engagement of black gay community leaders and their partners can serve as effective mechanisms to improve the response to the epidemic.

**Track F**

**FR05 - Holding the Line: Black CBO's and Adapting to a New Era in HIV Prevention**

**Room: Piedmont (Hyatt Regency Atlanta)**

**Abstract 1665 - Holding the Line: Black CBOs and Adapting to a New Era in HIV Prevention**

**Author(s):** C. Baran; P. Wilson

The landscape of HIV prevention is rapidly changing. The National HIV/AIDS Strategy (NHAS) is bringing policy and priorities into focus. The emergence of viable models for PrEP and microbicides is historic. Test and treat continues to gain momentum. And progress is being made on vaccine development. The game is changing in fundamental ways. All HIV service providers will need to embrace some, if not all of these trends, if they are going to remain viable. It may require substantial restructuring and some rethinking how we work.

Many smaller Black-serving community-based organizations tend to be built on prevention services, rather than care. For these organizations, two-thirds of the NHAS is directly related to their work reducing new infections and reducing disparities. Thus, changes in federal, state, and local policy and funding priorities will have significant implications for organizations which rely on direct and indirect federal funding for programs.
As the various biomedical interventions rise to preeminence, CBO’s with a heavy focus on behavioral interventions will need to adapt. This may not mean abandoning behavioral interventions. But it could mean that organizations will need to identify ways to incorporate biomedical interventions into their existing program portfolios, if they are to remain viable.

Black-led and Black-serving CBOs are a critical component of the domestic HIV prevention infrastructure. Such organizations provide vital services, often to communities untouched by larger institutions such as hospitals and the historically white ASOs, but which are heightened risk for HIV infection. These organizations also maintain an unparalleled credibility within their communities. Advances in prevention technology and infrastructure will not be successful if Black CBOs aren’t at the table and able to advocate for themselves and their communities at every step.

The first step will be gaining a comprehensive understanding of the new technologies and the NHAS. There will be many opportunities at the conference to gain information about both. This roundtable will allow for a facilitated discussion among Black CBO executives, staff, clients, and stakeholders, about how to be best positioned as new technologies are rolled out, and the NHAS becomes operationalized. Black AIDS Institute staff will present findings from a national survey of Black CBOs regarding their readiness for new technologies and understanding of the NHAS. Participants will gain an important perspective on how to identify new program opportunities and maximize their impact in the new era of HIV prevention. The discussion will be focused on Black organizations, but open to all who are interested.

Track F
FR11 - HIV Education and Healthcare Access with Immigrants: The Use of Community Mobilization Models
Room: Fairlie (Hyatt Regency Atlanta)

Abstract 1711 - HIV Education and Healthcare Access with Immigrants: The Use of Community Mobilization Models
Author(s): Andrew Spieldenner; Lina Sheth; Erika Morillo; Sapna Mysoor

Asians, Latinos and Pacific Islanders account for the largest immigrant groups in the US. Immigrants experience structural barriers related to HIV education services and healthcare access, particularly in the current anti-immigrant political atmosphere. Structural barriers can include: the dearth of healthcare institutions that are specifically tailored to immigrant groups like Asians, Latinos and Pacific Islanders, the lack of culturally and linguistically appropriate services available for immigrant communities, or even increased AIDS stigma and homophobia from their native community. The Latino Commission on AIDS and the Asian and Pacific Islander Wellness Center have implemented community mobilization initiatives to encourage health care access amongst various immigrant populations.

The Latino Commission on AIDS has implemented the Mobilizing Emerging Hispanic Populations (MEHP) model in Charleston, Seattle, Albuquerque and Fort Lauderdale. Findings from MEHP activities have shown a difference across regions. In more established communities, those involved in MEHP activities have been majority LGBT. In newer communities, those involved have been majority of non-Latinos. The LGBT presence could be indicative of the more established populations focusing on the more marginalized parts of the population that still lack access to healthcare. The non-Latino participants could be indicative of the institutional power. In Albuquerque, those involved identified potential partners and a work plan that included: six National Latino AIDS Awareness Day events throughout the state, primarily with an emphasis on HIV and LGBT awareness. In Charleston, this resulted in a workgroup forming focused on one National Latino AIDS Awareness Day event in the state, primarily with an emphasis on HIV testing. MEHP has been a useful tool in assisting community members and service providers with concrete steps to address the lack of healthcare access for Latinos.

Asian & Pacific Islander Wellness Center has implemented the Banyan Tree Project (BTP) using a national community mobilization model built upon three core elements: leadership development, social marketing and National Asian & Pacific Islander HIV/AIDS Awareness Day. Thus far, BTP has worked with traditional health and HIV-focused community based organizations and community leaders across 25 cities in the US and Pacific Island Jurisdictions. To increase our reach and target broader and more mainstream networks of Asians & Pacific Islanders, BTP is now utilizing social media and engaging with ethnic-specific social justice organizations as well as political and community leaders. The current strategy includes integrating HIV and stigma awareness into discussions on other
important community concerns such as immigration and health care reform. The combination of these three core elements to mobilize communities appears to indicate an opportunity to increase knowledge of HIV risk and access to healthcare for Asians and Pacific Islanders.

This workshop will frame the context of HIV and immigration and use the two case studies to highlight challenges of working in communities that at various levels of readiness to address these issues. Community readiness is an integral part of community mobilization. The workshop is an opportunity to dialogue about lessons learned in the implementation of structural, community and individual level interventions that aim to increase access to healthcare.

**Track F**
**FR13 - American AIDS Orphans: Needing and Leading Prevention**
**Room: Kennesaw (Hyatt Regency Atlanta)**

**Abstract 1453 - American AIDS Orphans: Needing and Leading Prevention**
**Author(s):** Yannik McKie; Chris Norwood; Iretta Rivera

American AIDS Orphans and youth living with HIV+ parents (usually a single mother) form a group with high levels of HIV risk behaviors yet they have received little research, programming and policy attention. Experiences of these HIV-affected youth, themselves, demonstrate a collapsed social world where ordinary prevention outreach and approaches are insufficient. We examine, through their own testimony, the social context of the overwhelming HIV risks these youth face and a holistic mentoring program which addresses their unique needs by training older teens with HIV+ parents to be mentors for younger children in the same difficult situation.

Health People's Kids Mentoring Kids is in the South Bronx and linked with the McKie Foundation in Atlanta.

The social context for Kids-Mentoring-Kids is to foster prevention through a program model that addresses the severely disrupted lives of American AIDS orphans and HIV-affected youth: per personal testimony/assessment, the risk context for these youth included gun-running, arrest and jail, substance abuse, routine unsafe sex, multiple foster care placements which drove the youth to a psych ward, teen subject to sexual abuse after being placed in adult homeless shelter on mother’s death: routine sense of stigma, isolation, depression. Kids-Mentoring-Kids creates a safe, supportive environment where these youth can help each other; the older kids see they have a role in society and the younger ones get mentors who truly understand them.

Over 16 years, more than 80 HIV-affected teens trained as mentors; no known HIV contracted by teens; only two known pregnancies, significantly less attraction to drugs than similar youth. Teen mentors have high graduation rate; bolster school success of mentees by helping with homework. High retention of both groups. Mentees will go to mentors with important problems, including suicide ideation, they wont first discuss with an adult. American AIDS orphans and HIV-affected youth have been largely ignored---they are not, for example, mentioned once in the new National AIDS Plan; yet they form a distinct American youth population with multiple HIV risks reinforced by their social isolation, lack of support, family collapse, and sense of being societal outcasts. Experience with these youth and assessment over many years shows that acute needs are 1.) Stable, standby guardianship and subsidized guardianship in place so they are not further injured by multiple or inappropriate placements when a parent dies and 2.) holistic social support---like that of a targeted mentoring program in which the older teens mentor the younger kids---that restores them to a safe community where they can appreciate their own value and potential, while learning to solve challenging problems through mutual support from children in the same situation.
Abstract 2054 - Transgender Health Equity: A Community Dialogue
Author(s): Tyler Andrew TerMeer, MS; Francisco Ruiz, MS

Throughout the epidemic the needs of transgender populations have not been adequately addressed and public health investment (financial and human) remains paltry in comparison to the burden of HIV/STDs in this population. It is imperative for stakeholders including federal agencies, state and local health departments and service providers recognize the distinct needs of transgender populations. This dialogue requires further examination with an increased emphasis on subpopulations of trans-identified persons of all races and ethnicities.

A combination of approaches must exist when creating a comprehensive HIV prevention tool-kit that addresses the nuances and diversity of trans-identified populations. In the spring of 2011, NASTAD conducted a comprehensive assessment of state and local health departments’ efforts targeting transgender populations. Facilitators will present findings that examine existing HIV/STDs programs, resource allocation methods, data collection and implementation of new and innovative approaches in addressing these epidemics among trans-people.

This roundtable will provide the opportunity for stakeholders to review findings of NASTAD’s assessment, to discuss the impact of HIV and STD on transgender populations and to identify recommendations for health departments to better address HIV and STD among transgender populations of all races and ethnicities.
Tuesday, August 16, 2011
Roundtable Sessions
7:30AM-8:15AM

Track D
DR09 - The Use of ICT (Information, Communication, Technology) to Supplement Traditional HIV Prevention Services
Room: Hanover C (Hyatt Regency Atlanta)

Abstract 1271 - The Use of ICT (Information, Communication, Technology) to Supplement Traditional HIV Prevention Services
Author(s): Oscar Marquez; Miguel Chion

In the past years, the HIV Prevention Field has experienced a decline in funding. While some providers have turned to the use of ICT services (Information, Communication, Technology) in an effort to be more cost effective, in general, there is a lack of capacity on how to use this platform effectively for HIV Prevention Services. Due to this deficiency, there are several components and steps that are not being taken, and that are necessary to yield a better utilization of these services. For instance, it is common for agencies to want to use the latest technology/service, such as Facebook or other social networking sites, as tool. However, the agency needs to conduct an assessment to determine if the audience for which this product is being developed actually utilizes or would utilize this service.

Shared Action staff will discuss its lessons learned and best practices of using multiple ICT platforms. Specifically, Shared Action currently uses ICT platforms as a form of capacity building and will cover how these services can also be used by HIV prevention agencies. Among the topics that will be discussed are: 1. Brief overview of the role of ICT in HIV Prevention; 2. Provide several tools and examples used in ICT such as protocols, web technology, and free software (i.e., open source); 3. Developing plans to use ICT for CBA and HIV prevention services; 4. Offer examples of how to match the activity with the technology [focusing] on the problem/need, not the technology. For example, at times there might be a need to provide an information transfer activity for which webinars are ideal; 5. Converse about the need to assess both the individual and organization’s capacity to adopt the use of ICT for their practice. For instance, some agencies systems do not have the programs like Flash which would be necessary to access online trainings.

If the proper steps are taken in setting up the platform, ICT can greatly benefit providers of different branches (i.e., CBA, Health Departments, frontline staff). When ICT is utilized effectively, some of the benefits it can bring is increase knowledge around specific topics, maximize the use of the already scarce financial resources, capitalize on the use of new technologies that potential clients already use for their personal use, create appealing services for broader audiences, and shorten the distance between the provider and a physically remote client.

Track D
DR10 - Forty-Seven Pages Later: CBO Assessment Best Practices
Room: Hanover D (Hyatt Regency Atlanta)

Abstract 1997 - Forty-Seven Pages Later: CBO Assessment Best Practices
Author(s): Pamela Tassin; Shaune D. Freeman

Capacity building assistance (CBA) for HIV prevention programs has evolved over the past 10-15 years. Strategies to establish CBA services that incorporate structure, accountability, efficiency, and enhanced outcomes continue to be developed. Best practices and lessons learned have been critical to the overall improvement of CBA. Assessing CBA needs is a fundamental step before providing quality CBA services.

Facilitators will present and discuss with the group their six-month experience with conducting the CDC CBO Assessment Tool with assigned recipients of HIV prevention grants under Funding Opportunity Announcement (FOA) PS10-1003. Members of the CDC-funded Building and Nurturing Communities of Color (BANCC) CBA team will
discuss the following points: 1) the CBO Assessment Tool and the Strategic Plan for Enhanced CBO Capacity overview and process; 2) internal CBA team strategies used to successfully complete the assessments; 3) assessment challenges and how they were overcome; and, 4) benefits to using this CBA action planning model for CBA recipients.

The early stages of implementation are the most critical for the provision of newly-funded HIV service organizations. The CBA action planning model awards the opportunity to learn upfront what is most needed by recipient agencies so that CBA efforts are based upon clearly stated needs. CBA providers are critical links to this action planning process and have much to share on what works best in assessing organizational needs.

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**Track D**

**DR11 - Helping HIV+ Women Gain Control of Their Health**

*Room: Hanover E (Hyatt Regency Atlanta)*

**Abstract 1286 - Helping HIV+ Women Gain Control of their Health**

**Author(s): Cora E. Giddens**

We are seeing fewer HIV (+) women, when compared to HIV (+) men; participate in Healthy Relationships (HR) intervention, while infection rates continue to rise, especially in our women of color. Over the past 5 years our agency conducted 74 cycles of HR; 32 were women's groups. We recruited 258 women: 187 started the intervention (72%); however, only 122 attended all 5 sessions (65%). We find many of the women we recruit for HR face challenges that include lack of child care, unsupportive families, domestic violence, drug/alcohol addiction, transportation, and health/medical issues. We need to find additional ways to help HIV (+) women participate in the entire cycle so they can receive full benefit of this intervention. This five-session, small group intervention with people living with HIV/AIDS is based on the Social Cognitive Theory and focuses on the development of coping skills needed to reduce stress and make healthier decisions regarding whether, when, and how to: disclose to family and friends, disclose to sexual partners, and build healthier/safer sexual relationships.

We are continually faced with and often hear about challenges of recruitment and retention when conducting HR groups with women. Facilitator will present a selection of the challenges HIV (+) women face in participating fully in HR and strategies we use to help them do so. For example, supplying the women with referrals to contact for help with their challenges during the first session has shown to help with their commitment to complete the groups. Facilitator will also lead a discussion of challenges and strategies, pooling the knowledge and experiences of the session participants.

We believe that it is imperative that those of us in direct client care share our successes and lessons learned while recruiting and retaining clients for HR. We need to be supportive and encouraging of each other and our clients in every way possible to ensure that our HIV (+) women have the skills and self-efficacy to access and negotiate needed care and support. We also believe providers need to reinforce for women the concept of helping their families by caring for their selves. We will present the challenges and offer strategies to help HIV (+) women examine their risks, develop skills to reduce their risks, and receive feedback from others.

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**Track D**

**DR12 - DASH into Schools: Bringing HIV Interventions for Youth to a Broad Audience**

*Room: Hanover F/G (Hyatt Regency Atlanta)*

**Abstract 1269 - DASH into Schools: Bring HIV Interventions for Youth to a Broad Audience**

**Author(s): Sharon E. Wong; John C. Cantfield**

Approximately 18% of all new HIV infections are among young people who are 13-24 years of age. Schools have direct contact with more than 56 million youth for at least 6 hours a day over 13 critical years of their social, physical, and intellectual development. While schools represent a key venue for implementing behavior change interventions...
with youth, navigating local control and gaining access to schools can be extremely challenging for health organizations.

CDC’s Division of Adolescent and School Health (DASH) leads federal efforts to support high quality, evidence-based HIV prevention education in our nation’s schools. Facilitators from CDC/DASH will present and discuss with the group: 1) the challenges and opportunities in partnering with schools; 2) how to talk about HIV prevention in language that motivates schools and school systems; and, 3) how to partner with DASH-funded partners in education agencies.

By understanding the intersections between the outcome goals for health organizations and schools, HIV prevention activities can be instituted successfully in schools to bring effective interventions to large numbers of youth. A starting point for this collaboration can be through DASH-funded partners in 49 state education agencies and 16 local education agencies across the nation.

Track D
DR19 - Program Sustainability for HIV Prevention Program
Room: A703 (Atlanta Marriott Marquis)

Abstract 1868 - Program Sustainability for HIV Prevention Program
Author(s): Leandro E. Rodriguez Ramos; Kevin Williams

As we moved forward with the National AIDS Strategy, while undergoing an economic recession and national funding cuts, organizations are faced with a series of challenges in managing and sustaining their HIV prevention efforts beyond the funding cycles. Organizations are being forced to look at creative ways to sustain their programs and services. This entails a new series of strategies to be developed even before programs are designed and implemented, in order to ensure continuity of services after the funding cycle ends.

Facilitators will present and discuss with the group several approaches to ensure program sustainability. These approaches include the creation of a program sustainability framework and map, identifying strategies for levels of sustainability, and devising specific steps for sustaining an HIV Prevention program. Participants will get an understanding of this comprehensive approach and will learn how to hold the sustainability conversation from the beginning of program design and throughout the implementation process.

Sustainability requires a thorough understanding of organizational capacity. This is achieved through a continual assessment of the organization. A scan of the internal and external environment is an important part of the sustainability planning process. Capacity building is a key strategy for the promotion and sustainability of health prevention programs. Capacity building generally refers to the skills, infrastructure, and resources of organizations and communities that are necessary to effect and maintain behavior change, thus reducing the level of risk for disease, disability, and injury. After this presentation, participants will understand that program sustainability plan should start with the grant writing process. That there are ample resources available for building the capacity of an organization. Participants will also discuss how to cultivate a pool of funding sources, develop a marketing plan, and develop and follow-up with an evaluation plan.

Track D
DR20 - Positive and Proactive: Implementing empowerment based programming in HIV primary care settings.
Room: A705 (Atlanta Marriott Marquis)

Abstract 1524 - Positive and Proactive: Implementing Empowerment Based Programming in HIV Primary Care Settings
Author(s): Noel Ramirez, LSW, MPH (cand.); Jill Foster, MD

Risk reduction interventions targeting urban HIV positive Urban Young Men who have Sex with Men of Color (UYMSMC) are often brief (less than 6 weeks) and are facilitated outside of HIV primary medical care facilities.
Although these interventions address risky sexual behavior among this population, UYMSMC remain disengaged in medical care and represent a significant portion of people living with HIV and AIDS in the metropolitan Philadelphia area. Lack of long-term programming and limited attention to group programming in HIV care practices result in HIV/AIDS medical practices being unsure of how to retain and engage this hard to reach population in medical care.

The Facilitator will present and discuss with the group a pilot program, SWEAT (Sexuality With Education And Truth) conducted in a Pediatric HIV/AIDS practice in Philadelphia. SWEAT is a three-pronged approach to engaging UYMSMC who were identified as lost to HIV care and/or newly diagnosed with HIV. The SWEAT program includes continuous long-term programming: a group level intervention, street team leadership development program and a men's health seminar series. Topics in this discussion will include: 1) exiting programs targeting HIV positive UYMSMC; 2) Responses of UYMSMC from focus group and initial cohort of SWEAT; 3) Responses from staff regarding how programming has increased CQI initiatives; 4) a summary of key process objectives to consider when implementing programming like this in clinical practices.

Implementing long-term empowerment based leadership development programming in HIV medical practices can garner positive health outcomes among this hard to reach population: engagement in medical care, increased adherence to ART medications, decreased STI acquisition and successful transition to adult care. Programming such as this is highly beneficial to consumers because it provides them with professional and leadership development opportunities, improved relationships with medical providers and staff, reduces anxiety and distrust of medical services and offers additional reasons to seek and maintain treatment at their HIV primary care program.
Abstract 1722 - Preventing HIV/AIDS Epidemic among Asian Americans and Pacific Islanders through Behavioral and Social Intervention

**Author(s):** LeQuyen Tran; Frances E. Ashe-Goins

The Model Minority Myth goes beyond marginalizing Asian Americans and Pacific Islanders in academics and the workplace but it is apparent in our views of Asian Americans and Pacific Islanders health. The proportion of API living with HIV/AIDS is small relative to other racial/ethnic groups; therefore, they are often overlooked by most HIV/AIDS preventive and education programs. The most recent data from the CDC indicates that API have the highest rate of newly diagnosed HIV infections and the lowest HIV testing rates than any other racial/ethnic group. One in three API who are infected with HIV do not know of their HIV status; 2/3 of Asian Americans and Pacific Islanders have never been tested for HIV. API women have a higher percentage increase diagnose of HIV than men. The lack of HIV prevention and education programs that target API population is a contributing factor to the increase in HIV infection rates among Asian Americans and Pacific Islanders. First, we must recognize that API is a diverse community comprise of 40 different ethnic groups, and over 100 languages. Issues that need to be address in HIV prevention interventions and education programs are language and culture barriers, and also lack of health data due to underreporting and misclassification.

We want to tackle this growing epidemic by promoting awareness in the community and HIV education through increase HIV prevention interventions and testing in API community. We will have an open discussion about best practice for API community in this area of prevention. First, we want to discuss the different barriers that are hindering API from obtaining HIV prevention education and HIV testing. Then, we will discuss approaches to overcome these barriers and how to incorporate these strategies into HIV prevention and education programs. Studies have shown that cultural competency training of healthcare providers and public health practitioners do have a positive impact on HIV testing among API. We also want to include behavioral interventions like skills training on safer sex practices and condom negotiation. We believe it is necessary to dedicate part of the discussion to API women who have the lowest HIV testing rates. In addition, the majority (83%) of API women contract HIV through heterosexual contact unlike injected drug use for African American and Latina women. Social intervention like breaking culture barriers such as addressing gender norms will help empower women to feel less stigmatize or shame to go get tested or carry condoms. It is critical to discuss about opportunities where these women feel most comfortable to access HIV prevention education and HIV testing. Lastly, we want to share resources on funding for research and community intervention programs to community organizations and advocacy groups.

Integrating evidence-based prevention strategies from behavioral and social intervention approaches to HIV/AIDS prevention programs will reduce the risk of HIV infections and increase HIV testing among API. This will facilitate awareness in API community. Increase awareness on this silent epidemic will encourage more grant and funding opportunity for research into this area.

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**Track D**

DR30 - Project Saved! Engaging and Building the Capacity of African American Clergy for HIV Prevention

**Abstract 1892 - Project SAVED! Engaging and Building the Capacity of African American Clergy for HIV Prevention**

**Author(s):** Jacqueline F. Hampton, PhD; Ross Fleming, III; James EK Hildreth, PhD, MD; Mark Thompson, DMin; David Cooper; Johnny B. Woodhouse, MDiv; Leroy M. Mitchell, III, DTH; Welton T. Smith, DMin; Jemaryn S. Williams; Sharon L. Crawford, PhD

HIV/AIDS continues to disproportionately impact underserved African Americans specifically in the Southern US. Critical to prevention and reduction of incidence rates for this population is access to testing, utilization of testing resources and linking persons to care once diagnosed. This population has not been effectively served by CBOS and HDS for a variety of reasons. Engaging, partnering and building the capacity of African American clergy to provide or facilitate testing and prevention resources for this population cannot be underscored. In fact, when pastors are actively engaged in capacity building and the development of action plans to increase access and use of HIV
Prevention services for underserved populations they have been more effective than CBOS and health departments with increasing testing rates and identifying care services.

Facilitators will discuss Project SAVED a CDC Community HIV Capacity Building initiative and its effectiveness in 1) utilizing a community participatory model for capacity building; 2) delivery of capacity building for clergy; 3) developing culturally competent strategies for HIV testing and linking underserved African Americans to care; 4) engaging and sustaining clergy and community stakeholders for HIV prevention. Clergy will participate in the roundtable to discuss their participation in planning CBA and their successful matriculation from CBA recipient to implementation of an action plans that increase opportunities for underserved populations to access testing and care services.

Building the capacity and empowering clergy to take ownership of HIV from a community epidemic standpoint has yielded successful outcomes regarding HIV testing and linkages to care for traditionally marginalized and underserved populations. This is highly beneficial to the prevention paradigm for it fills a gap in much needed services. Further, clergy involvement is critical as we seek to develop structural interventions and innovations that have an impact on at-risk behaviors and the health promoting decision making on behalf of persons at risk. Clergy also offer spiritual guidance which is essential for prevention and healing.

Track E
ER03 - Can PrEP Be a Force for HIV Prevention Justice?
Room: A701 (Atlanta Marriott Marquis)

Abstract 1758 - Can PrEP Be a Force for HIV Prevention Justice?
Author(s): Julie Davids

For the first time, a multi-country trial has shown that the use of the oral anti-HIV drug Truvada, by HIV negative gay men, MSM and transgender women, decreased rates of HIV transmission. CDC has released an interim guidance on the use of PrEP in gay men and other men who have sex with men.

But these results and guides beg many questions about ethics, equity, access and human rights.

The HIV Prevention Justice framework acknowledges that HIV prevention cannot be separated from human rights, thereby changing both the way we look at HIV prevention and how we advocate for it. Prevention Justice places the people and communities that are most affected by the epidemic at the forefront of policy efforts. Further, it acknowledges and incorporates challenges beyond HIV, such as LGBT marginalization, in interventions and policy.

How can research breakthroughs in PrEP and other biomedical interventions be harnessed to be a force of HIV prevention justice, increasing the real-world effectiveness of interventions for marginalized populations?

PrEP trial investigators, community advocates and human rights activists will lead a roundtable discussion with audience participation on the following key points:

What are the human rights and HIV prevention justice implications, possibilities and challenges of PrEP?

What are the questions of access and ethics around new prevention technology, in and beyond gay, MSM and/or transgender communities?

What are, and should be, the mechanisms of community input and transparency in decision-making processes regarding PrEP and other biomedical interventions?

What are the issues of access and equity for vulnerable and marginalized populations, including gay men of color, transgender people and/or youth?
How do the social drivers of HIV in the United States, including LGBT marginalization, lack of affordable housing and mass imprisonment, intersect with the challenges of determining and implementing PrEP access policies?

Could the interest in new prevention tech can bring new players in the fight for much-needed new resources in the fight against HIV?

PrEP may be a powerful tool in our prevention toolbox, but access and successful utilization is dependent on a range of economic and social issues affecting those most at risk of HIV. The HIV Prevention Justice framework is an important way to explore and improve HIV prevention interventions, and will help pave a path to the most effective use of this important breakthrough.

**Track F**

**FR06 - Priority setting for HIV Interventions in Enhanced Comprehensive HIV Prevention Plans for Metropolitan Statistical Areas**

**Room:** Baker (Hyatt Regency Atlanta)

**Abstract 1327** - Priority Setting for HIV Interventions in Enhanced Comprehensive HIV Prevention Plans for Metropolitan Statistical Areas

**Author(s):** Feng Lin; Arielle Lasry

In 2006, more than one million people were estimated to be living with HIV and about 56,000 new infections occurred in the United States. The epidemic is primarily concentrated in urban areas - 82% of reported AIDS cases were residing in metropolitan statistical areas (MSAs). In 2010, the Centers for Disease Control and Prevention (CDC) funded a demonstration program to develop Enhanced Comprehensive HIV Prevention Plans (ECHPPs) for 12 MSAs that represent 44% of the HIV epidemic. The funded MSAs will develop ECHPPs that align each jurisdiction's prevention activities with the National HIV/AIDS Strategy (NHAS). In addition, the ECHPPs are expected to identify the optimal combination of HIV interventions to prevent the most new HIV infections within each jurisdiction.

Facilitators will present and discuss a CDC-prepared tool intended to support the process for prioritizing the interventions in the ECHPP. The tool includes: 1) a procedure that helps grantees assess the importance of expanding fundings for each HIV prevention intervention already being implemented or under consideration; and 2) a table that helps grantees establish funding requirements for each intervention, rank the importance of each intervention and determine the order in which they should be funded. Detailed step-by-step instructions for carrying out the priority setting process will be presented. The procedures are designed to help grantees explain the HIV prevention targets they have chosen, along with the corresponding interventions and how their planned budget allocations will help achieve the targets.

The CDC will collaborate with the 12 MSAs to use the tool. Lessons learned from the process will be disseminated and the tool will be revised accordingly to continue to promote the optimal allocation of HIV prevention resources in all jurisdictions for the greatest reduction of new HIV infections.

**Track F**

**FR07 - Advocating for and Delivering HIV/STD Prevention Among Older Adults**

**Room:** Courtland (Hyatt Regency Atlanta)

**Abstract 1512** - Advocating for and Delivering HIV/STD Prevention Among Older Adults

**Author(s):** Nathan M. Schaefer; Hanna Tessema

Currently, one in six new HIV diagnoses occur among people over 50, but the CDC has yet to fund targeted prevention interventions for older adults. About one-third of all people living with HIV in the United States are 50 years of age or older, a figure that will grow to one-half by 2017. Over the next decade, the aging of the HIV-positive population will place great demands on the health care and social service systems. We must develop and implement
new and targeted HIV and STI prevention and standards of care for older adults to both effectively prevent new diagnoses and fully address the needs of those already living with HIV.

The facilitator will: 1) discuss an overview of epidemiological trends, which include disparities across race and sexual behavior, the impact of HIV testing, the role of medical and other service providers, data about sexual and substance use behaviors, and physiological changes that put older adults at risk for HIV; 2) discuss ways to improve surveillance systems to better track this information; 3) examine the significance of the biological impact of HIV on aging bodies and how this affects prevention (including mortality, mental health, drug interactions, and impacts on the heart, brain and liver) and co-morbidities; 4) look at the context in which older adults with HIV live, including the multi-faceted impact of HIV- and sexuality-related stigma; 5) discuss the existence of and need for tailored/adapted behavioral interventions targeting older adults at risk for HIV and older adults living with HIV; 6) discuss social service and healthcare programs designed to care for older adults and people living with HIV; 7) discuss how HIV prevention and messages can be integrated into existing aging and senior services and the need to work with and across federal, state and local government HIV and aging departments; 8) present policy recommendations for HIV prevention and care for people over age 50.

Effectively addressing the needs and concerns of older adults with and at-risk for HIV will require a coordinated and targeted response from federal, state, and local health and aging agencies, and community-based providers, to: proactively assess older patients for sexual health risks and screen for HIV, among other STIs; fund the development, tailoring, and targeting of HIV prevention interventions for older adults, including MSM, women, African-Americans and other racial/ethnic groups; conduct more clinical and prevention research relevant to and including people over 50 living with and at-risk of HIV; update standards of care to better ensure healthcare providers screen and properly treat people for HIV/STIs and comorbidities; and properly train healthcare providers and senior services staff, and other caregivers to address the needs of older adults with HIV and those most at-risk.

Track F
FR08 - Progress in Preventing HIV Among Gay Men through the National HIV/AIDS Strategy
Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 1539 - Progress in Preventing HIV among Gay Men through the National HIV/AIDS Strategy
Author(s): Carl Schmid; Ernest Hopkins

According to the CDC, gay men and other men who have sex with other men (MSM) of all races and ethnicities continue to be the risk group most severely affected by HIV. There is an urgent need to expand access to proven HIV prevention interventions for gay and other MSM, as well as to develop new approaches to fight HIV in this population. One of the principal goals of the National HIV/AIDS Strategy is to reduce HIV incidence in the United States. Another is to reduce health disparities. In order to achieve these goals it calls for a focus on those communities most at risk, including gay and bisexual men, and acknowledges that prevention resources for gay men have not been adequate. In order to achieve the goals outlined in the Strategy, it recognizes that we need to do a better job for gay men or it will not be successful, and then the Strategy outlines some specific recommendations for gay men. The roundtable will highlight the goals of the Strategy that impact gay men and offer an assessment of how implementation is proceeding.

The Strategy identifies a numbers of goals and steps to decrease the number of infections among gay men. With the input of attendees, the facilitator will identify them and offer an assessment of how they have been implemented since the Strategy's release, along with the federal agency implementation plans. Key recommendations include: 1) intensify prevention efforts in communities where HIV is most heavily concentrated; 2) expand targeted efforts using effective, evidence based approaches; 3) adopt community-level approaches to reduce infections in high-risk communities; 4) reduce stigma and discrimination; 5) educate people about HIV and how it can be prevented; 6) increase testing; 7) better coordination among federal, state and local entities; and 8) work with the LGBT community. The roundtable will explore positive steps that have been made toward implementation and identify weaknesses and barriers. Audience members will offer their own assessments and suggestions for future action.
As the Strategy states, the United States cannot reduce the number of HIV infections nationally without better addressing HIV among gay and bisexual men. The assessment of the Strategy at this point will help the federal government and its partners achieve the goals of the Strategy and decreasing HIV among gay men. The assessment will serve as an opportunity to identify best practices and policies so that others may follow them. The assessment can also serve as a catalyst for the federal government and its partners to intensify their efforts in certain areas in order to achieve the goals of the Strategy.

Track G
GR03 - Integration of Sexual and Reproductive Health with HIV: Achieving an Effective Prevention Model for Women
Room: Inman (Hyatt Regency Atlanta)

Abstract 1631 - Integration of Sexual and Reproductive Health with HIV: Achieving an Effective Prevention Model for Women
Author(s): Naina Khanna; Jennifer Marshall; Sonia Rastogi; Brook Kelly

Women of color of childbearing age are disproportionately impacted by HIV. African-American women represent 65% of new AIDS diagnoses among women and 32% of new infections among women are between the ages of 13 to 29 years. An integrated service delivery approach that serves the reproductive health and HIV prevention needs of women is necessary to meet the needs of women living with and at risk for HIV. Women continue to present late for HIV testing, and nearly a third of women diagnosed with HIV progress to AIDS within a year of initial diagnosis. Over 80% of women testing positive acquired HIV through heterosexual sex. While millions of women receive at least one reproductive health service a year, only a small percentage of women are tested for HIV every year. Although mother-to-child transmission in the U.S. has been virtually eliminated with appropriate care and treatment, women with HIV continue to experience discriminatory attitudes towards childbearing and parenting and suffer stigma related to reproductive choices. To truly meet the needs of women, information and services must be linked on site and through strong collaborative relationships so that women vulnerable to acquiring HIV receive appropriate counseling and women living with HIV receive high-quality and non-stigmatizing sexual and reproductive healthcare services.

Panelists will present best practice models for integrated sexual and reproductive health and HIV service delivery to improve health outcomes, early diagnosis of HIV and STI's, and increase quality of life for women living with and at risk for acquiring HIV. As a result of HIV test reimbursement rates, HIV-related stigma, and perceptions that women are not at risk, women are significantly less likely to receive HIV prevention and to be tested. This leads to late testing, poor health outcomes, and increased obstetric and gynecological health risks. Memphis Center for Reproductive Health (MCRH), a reproductive health clinic in Memphis, TN will outline its model of successful integration of HIV testing into a reproductive health facility, as well its training model to increase competence of HIV providers in the Memphis Transitional Grant Area to provide preconception counseling and fertility options to HIV-positive.

As HIV testing becomes increasingly routinized and HIV care moves into a chronic care management model, the integration of HIV services with sexual and reproductive health services is a critical step in meeting the prevention, diagnosis, linkage and care needs of women. The benefits of this service integration are three-fold: this model 1. comprehensively meets the sexual, reproductive, HIV, and family planning health needs of women, 2. counsels and empowers women to make choices relevant to their health, and 3. combats stigma in the community by educating clients and community medical providers.

Track G
GR04 - Breaking Down the Barriers: Recruitment, Testing and Linkage to Care for YMSM in Los Angeles
Room: Spring (Hyatt Regency Atlanta)

Abstract 1808 - Breaking Down the Barriers: Recruitment, Testing and Linkage to Care for YMSM in Los Angeles
Author(s): Greg Wilson; Martha Chono-Helsley; Miguel Martinez
Geography, transportation, trust, fear and denial are huge barriers for HIV+ YMSM in Los Angeles. Lack of HIV services in parts of Los Angeles compounded with a lack of trust of service providers deter YMSM from seeking HIV testing and care services. From April 2010-November 2010, 75 newly identified cases among youth under age 25 were found in Los Angeles County. 45% of these youth have been linked to care services. Where are the other 55%? Are the systems (Medi-Cal, ADAP, etc) so intimidating that clients get frustrated and give up? What are agencies, organizations and HIV services doing to help facilitate better linkage to care services?

The roundtable discussion will focus on sharing innovative methods for HIV testing recruitment, care provider support networks and strategies for linkage to care specific to YMSM of color. Facilitators will present a working model that was implemented 2008 in Los Angeles to address issues of HIV testing and linkage to care for young African American and Latino MSM. The model serves as a catalysis for discussion regarding 1) community mobilization efforts specific to youth and HIV testing; 2) recruitment strategies for HIV testing and linkage to care; and 3) holistic support resources.

With access to information on how agencies, organizations and HIV care services are working to provide HIV testing to hard to reach populations, overcoming barriers to access and building successful client retention, this session will provide lessons learned and best practices for those trying to build a continuum of HIV care network. With this knowledge, HIV prevention educators, HIV testing counselors, PCRS staff, Partner Service staff, clinical administrators and public health investigators can better develop a linkage to care network and support resources in order to retain HIV positive youth as they navigate through the HIV/AIDS system of care.
Abstract 1351 - Performance of a New, Rapid, Point-of-Care Test for Identifying HIV Infected Individuals
Author(s): Lisa A. Kurtz; Keith Kardos; Graham Yearwood; Geraldine Guillon; Mark Fischl; Michele Roehler; Stephen R. Lee

Since the first approval of a CLIA waived rapid, point-of-care (POC) HIV test in 2004, use of rapid HIV tests has expanded dramatically. The availability of these rapid tests has expanded testing in non-traditional locations and assisted in the identification of HIV positive subjects. The need for improvement in the sensitivity of rapid HIV tests, particularly in early (acute) infection, has been highlighted in recent studies in high incidence populations. We have developed a new, rapid HIV test with improved seroconversion sensitivity that has been characterized vs. a 3rd generation EIA. The new test utilizes a modification of the OraQuick platform and delivers results in 10 minutes.

The rapid HIV test detected seroconversion within an average of 1.13 days of 3rd gen EIA (n=24 panels). The prototype assay was 100% concordant with the HIV-2 samples (n=169). The rapid test was also completely concordant with EIA when tested with the worldwide serological panel (n=15) specimens, detecting all major genotypes. Specificity was 100% in both plasma (300/300) and whole blood (500/500) specimens.

Abstract 1381 - A Cost Effective Program to Resolve Discordant Rapid Test Results in Florida’s HIV Testing Program
Author(s): Tom Bendle; Marlene LaLota; Pat Simmons; Melissa Cox; Melinda Waters; Tom Liberti

Rapid HIV screening has been increasingly available and accepted at publicly funded HIV test sites in Florida, now accounting for nearly half of Florida's 400,000 annual HIV tests. Reactive rapid tests are sent to the state laboratory for confirmatory testing. A small proportion of reactive specimens are indeterminate or negative by Western blot (discordant). Subsequent follow-up testing has shown that approximately one-third of these reactive results will eventually be confirmed positive; one-third will be confirmed negative; and one-third are lost to follow-up. Aggressive follow-up is needed to ensure resolution of discordant rapid test results. Clients with a reactive rapid test and negative/indeterminate confirmatory test may mistakenly believe they are not infected and pose a transmission risk to others. Many of these clients are recently infected and in the window period, a time of increased infectiousness.

Publicly funded rapid HIV test sites in Florida

In 2009, we noticed a disturbing trend; noticeable numbers of discordant rapid test results were unresolved months after the initial reactive rapid test. We implemented a proactive, aggressive approach involving intensive record
searches, followed by intervention by rapid test sites and STD field staffs to help locate these clients, deliver results, obtain confirmatory specimens, encourage retesting until resolution of HIV status, and perform partner services.

RESULTS: Between November 2009 and October 2010, 406,305 HIV tests were conducted at publicly funded sites; 197,609 (49%) were rapid and of those, 2,324 (1.2%) were reactive. All but 176 (7.6%) were confirmed positive by Western blot. Excluding 12 duplicates, a total of 164 clients had discordant test results. Many of these clients reported multiple sex or drug partners. All discordant results are record searched in STD and HIV databases in an attempt to resolve their status. Cases that remain unresolved are turned over to the rapid test sites and/or STD field staffs to resolve. Of these 164 discordant cases, 56 (34%) were resolved HIV positive (concordant); 30 (18%) were resolved as HIV negative (true discordant); 2 (1%) continue to be indeterminate; 5 (3%) were lost to follow up (anonymous or out of jurisdiction); and 71 (43%) are pending. By utilizing existing resources and incorporating this program into staff's routine job duties, this effective program was implemented at no additional cost.

LESSONS LEARNED: We believe it is a best practice for rapid HIV testing programs to aggressively locate clients to obtain definitive test results, and, if necessary, provide linkage and partner services. Closely monitoring rapid test results, searching for clients in other databases and prompting test sites to follow-up with unresolved discordant clients is now a routine part of our quality assurance plan. Many of these sites did not understand the importance of locating unresolved clients. Involving STD field services to locate these clients when needed has galvanized a partnership between HIV test sites and the STD program. As a result of this program, HIV-infected clients who otherwise would have believed they were not infected have learned their HIV status and been linked to care and support services.

Abstract 1760 - HIV Multiline Rapid Test (HIV-MRT): A One-stop HIV Serodiagnostic
Author(s): Bijon Kumar Sil; Elaine Te; Leng Min See

The diagnosis of HIV is a two-step process. The initial screening tests, including ELISA/ Rapid tests are highly sensitive and can detect very low concentrations of anti-HIV antibodies. However, these tests are less specific and can lead to false positive results. Thus, a positive screening test should always be validated with a confirmatory test. According to the CDC and other health organizations, ELISA/Rapid test combined with a confirmatory test such as the Western blot or immunofluorescent assay test is 99 percent accurate which requires extended hours and established laboratory settings with well-trained manpower. It, thus, necessitates the development of a diagnostic tool which could serve both screening and confirmation at all levels of healthcare settings. We have developed a reverse-flow based rapid test platform called HIV Multiline RT which detects antibodies against three HIV recombinant proteins: p-24, gp-41 and gp-120. The presence of these three antibodies in HIV patient blood is the requirement for diagnosis of true HIV infection by most of the international health organizations including CDC, USA.

Two HIV envelope proteins (gp-41 and gp-120) and one core protein (p-24) were incorporated to develop HIV-MRT using reverse-flow technique. Sensitivity and specificity of the HIV-MRT assay were determined against HIV positive (ELISA, PCR and Western Blot) and negative (ELISA and Western Blot) serum samples. A comparative analysis of HIV-MRT in terms of antibodies profiles against p-24, gp-41 and gp-120 proteins was also made with Western Blot. The relative sensitivity of HIV-MRT was evaluated using 5 HIV sero-converted panels. The applicability of the assay to detect HIV-1 and 2 was also assessed. The specificity of HIV-MRT was further evaluated using 51 HIV indeterminate and 100 sera obtained from patients infected with other infectious diseases.

HIV-MRT showed 100% [95% confidence interval (CI) 98.95-100.00] sensitivity against 233 HIV confirmed positive sera while 100% (95% CI98.95-100.00) specificity against 450 HIV ELISA and Western Blot negative sera obtained from apparently healthy persons. Of the HIV-MRT-positive samples, 96.57% (225/233) showed reactivity with p-24 while 100% (233/233) samples reacted against gp-41 and gp-120 proteins. The observed performance rated better than HIV-WB which showed 98.1% (230/233) reactivity with p-24, 85.83% (200/233) with gp-41 and 92.27% (215/233) with gp-120 proteins respectively. A similar pattern of reactivity of HIV-MRT was also observed with 5 HIV sero-conversion panels. The earliest antibody detected with HIV-MRT was found against gp-41 and gp-120 proteins. All 51 indeterminate serum samples reactive only with p-24 antigens were found negative against all three proteins of HIV-MRT. HIV-MRT also detected both serotypes of HIV collected worldwide.

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The newly-developed HIV-MRT has proven to be efficient in sero-diagnostic screening as well as confirmatory test, thus paving the way for time-saving, cheap, and reliable method to be applicable at all levels of healthcare settings.


Author(s): Jonathan Jay

In 2010, the iPrEX and CAPRISA 004 studies demonstrated that oral and topical antiretroviral interventions (PrEP and microbicides) may be safe and effective for preventing HIV transmission. For future clinical trials, however, these encouraging results raise a concern: if ARV prophylaxis is safe and effective, is there an ethical obligation for prevention researchers to provide it to study participants? The consensus current practice involves providing the full array of established prevention interventions to all participants in prevention research: male condoms, risk reduction counseling, and testing and treatment for sexually transmitted infections, among others. According to current practice, as well as UNAIDS/WHO guidance, a safe and effective ARV prophylactic intervention should be considered for inclusion on this list. Yet an ethical obligation to provide ARV prophylaxis to all participants in a prevention study could create major challenges for sponsors and investigators, including increased cost and duration, procurement issues, and potentially reduced relevance of study results.

Division of AIDS (NIAID/NIH) and meetings sponsored by the National Institutes of Health, YRG-CARE (Chennai, India) and Public Responsibility in Medicine and Research.

The author reviewed research ethics literature, U.S. and international guidelines relating to research ethics, human rights and health policy, and consulted experts in HIV prevention science, policy, advocacy and regulatory issues. The author analyzed information from these sources in order to generate recommendations relating to the ethical design of ongoing and future prevention studies. (This project was funded by the Henry Jackson Foundation, NIAID Contract No. HHSN272200800014C.)

Given the current available data, official research ethics guidelines do not require the inclusion of ARV prophylaxis in the standard prevention package provided by researchers. While the available data are encouraging, they do not prove the safety and effectiveness of ARV prophylaxis with sufficient strength to mandate its provision from an ethical standpoint. Moreover, there remain significant questions as to how widespread the use of these interventions may become, once regulatory approval is obtained. However, assuming the completion of confirmatory studies, regulatory approval, and public rollout of these interventions, there may develop an ethical presumption that researchers should provide ARV prophylaxis or at least allow access to it. In settings where participants could likely access the intervention outside the study, it would be considered ethically inappropriate for researchers to ask participants to abstain from accessing these potentially beneficial interventions. In lower-resource settings internationally, even if access remains limited, researchers would nonetheless be expected to provide a justification—grounded in the value to the community where the research was being conducted—for why ARV prophylaxis should be withheld.

Track B
B04 - Methods and Measures in HIV Surveillance
Room: Piedmont (Hyatt Regency Atlanta)


Author(s): M. Patricia Joyce; Andrew Mitsch; Jianmin Li; Tebitha Kajese; H. Irene Hall

Background: Revised surveillance case definitions for HIV infection were recommended by the CDC in 2008 and included an updated system to stage HIV disease. We determined differences in stage of disease at diagnosis and survival among persons diagnosed with HIV in the United States.

Methods: HIV surveillance data from 40 US states were examined to determine the stage at diagnosis among persons newly diagnosed in 2009, and 5-year survival among persons newly diagnosed in 2004. Stage at diagnosis
was based on reported CD4 levels and AIDS-defining conditions (ADC) within three months of HIV diagnosis. CD4 and viral load (VL) results within three months of diagnosis were used as surrogates of access to and quality of medical care available to persons with HIV. Survival was assessed with Kaplan-Meier estimates.

Results: Of 41,845 persons diagnosed in 2009, 2,902 (6.9%) were diagnosed with Stage 1 (CD4>500), 7,197 (17.2%) at Stage 2 (CD4 200-499), and 11,510 (27.5%) at Stage 3 (based on CD4 or ADC criteria); 20,237 cases (48.4%) did not have sufficient information reported (Stage Unknown). A higher percentage of younger aged persons were not staged, with 55.7% of persons < or equal to 34 years old not staged vs. 42.2% for those >34 years. Higher percentages of blacks/African Americans and Hispanics/Latinos were Stage Unknown (51.9% and 48.2% respectively) compared to whites (42.7%). Stage 3 was more common among older patients, 46.6% of persons greater or equal 65 years, compared with 12.1% in 15-24 year old persons. Lowest percentages of Stage 3 at time of HIV-diagnosis were in blacks (26.0%) and highest in multiple race persons (32.2%). Failure to have any laboratory testing reported within 3 months of HIV diagnosis was highest among the 15-24 year age group (51.1%), in heterosexual women (40.9%), and in blacks (43.4%).

Of 35,767 persons diagnosed with HIV in 2004, five-year survival was 0.94 for Stage 1; 0.94 for Stage 2; 0.77 for Stage 3; and 0.92 for Stage Unknown. Survival in Stage 3 cases based solely on CD4 criteria was 0.90 at 1 year and 0.82 at 5 years. For Stage 3 cases based on the presence of ADC, survival was 0.77 at 1 year and 0.67 at 5 years.

Conclusions: Initial HIV surveillance staging based on laboratory evaluation and reporting within three months of HIV diagnosis shows varying completeness. While technical problems in surveillance are factors, delays in initial medical evaluation may demonstrate inequity in access to and quality of health care. Surveillance staging within 3 months of HIV diagnosis has prognostic value.

Abstract 1372 - Racial Disparity Trends in Rates of AIDS Diagnosis in the United States, 2000-2009
Author(s): Qian An; Joseph Prejean; Irene H Hall

A goal of Healthy People 2010 is to eliminate health disparities in the United States population. In 2007, Keppel et. al identified the ten largest health disparities by race/ethnicity in the United States, among which the rate of new diagnoses of AIDS ranked fourth and the death rate due to HIV infection ranked fifth. Narrowing these AIDS-related racial/ethnic disparities is an important public health objective. Analysis of temporal trends in racial/ethnic disparities in AIDS diagnosis rates helps to monitor progress toward meeting targets of the Healthy People 2010 initiative.

We used diagnoses of AIDS among persons aged 13 years and older during 2000-2009 in the 50 states and District of Columbia reported to national HIV surveillance through June 2010, and census population data, to examine the trend in racial/ethnic disparities in rates of AIDS diagnoses. We calculated the rate difference (RD) and the rate ratio (RR) to assess between-group differences, and used three summary measures of disparity, between-group variance (BGV), Theil index (TI) and mean log deviation (MLD), to quantify overall disparities across all race/ethnicity subgroups.

In the United States, the overall racial/ethnic disparity, black-white disparity and Hispanic-white disparity in rates of AIDS diagnoses decreased significantly from 2000 to 2009 (p < 0.01). Among males, the racial/ethnic disparity in the rates of AIDS diagnoses decreased significantly (p <= 0.01). Among females, there was a decreasing trend in overall racial/ethnic disparity (p <= 0.02) and in Hispanic-white disparity (p < 0.01); the absolute black-white rate difference decreased significantly (p < 0.01) but not the black-white rate ratio (p=0.13). The overall racial/ethnic disparity, black-white disparity and Hispanic-white disparity decreased among age groups 25-44, 45-64 and 65+ except for young men aged 13-24, where the black-white disparity increased significantly from 2000 to 2009 (BGV: p < 0.01, black-white RD: p < 0.01 and Hispanic-white RD: p = 0.20).
Findings indicate overall decreases in racial/ethnic disparities in AIDS diagnoses in the United States except the increasing relative burden of AIDS in young men, particularly black young men aged 13-24. HIV testing, prevention, treatment and policymaking should be a priority for this group.

Abstract 1388 - Retention in Care of HIV-Infected Adults and Adolescents in 13 U.S. Areas

Author(s): H Irene Hall; Kristen C. Mahle; Tian Tang; Jianmin Li; Anna Satcher Johnson; Luke Shouse

The DHHS Panel on Antiretroviral Guidelines for Adults and Adolescents recommends regular monitoring of disease status and treatment response in HIV-1-infected patients with CD4 and viral load test (VL) results. However, little population-based information is available on whether HIV-infected persons receive the recommended check-ups every 3-6 months or are retained in care.

Using data from 13 areas with mandatory laboratory reporting of HIV-related tests and reporting to national HIV surveillance, we determined retention in care in persons >12 years old who were diagnosed with HIV through the end of 2008, residents of the 13 areas at time of diagnosis, and living with HIV at the end of 2009. Retention in care was defined as having had at least one CD4 or VL test result in the past year (i.e., in 2009). We assessed retention in care by demographic and risk characteristics and stage of disease, comparing groups with chi-square statistics. We also assessed whether evidence of relocation since diagnosis, as available in the surveillance system, affected our results.

Of 100,369 adolescents and adults diagnosed in the 13 areas through 2008 and living at the end of 2009, 59% had at least one testing event in 2009. Overall, 12% had one testing event and 47% had two or more tests; 45% had two or more tests at least 3 months apart. A lower percentage of blacks/African Americans (55%) and Hispanics/Latinos (49%) had ≥1 testing event compared with whites (64%, p<0.001 for both comparisons). Among males, having had ≥1 test was more common among men who have sex with men (63%, referent group) compared with injection-drug users (47%) and those exposed through heterosexual contact (58%) (p<0.001 for both comparisons). Among females, the percentages of having had ≥1 test was higher among those exposed through heterosexual contact (65%) compared with injection-drug users (57%, p<0.001). A higher percentage of persons who ever met the AIDS case definition had ≥1 test (62%) compared with those never classified as AIDS (54%, p<0.001). Results based on data excluding persons with evidence of residential relocation, i.e., persons reported in duplicate to the national surveillance system from different areas, were similar.

Based on surveillance data, about 40% of persons living with HIV did not have a recommended testing event in 2009. In addition, the results indicate disparities in receiving care among racial/ethnic and risk groups. Further assessments are needed to determine the barriers to accessing recommended care.

Abstract 1574 - Comparing Measures of Late HIV Diagnosis in Washington State

Author(s): Jason Carr, MPH; Laura Saganic, MPH; Tom Jaenicke, MPH, MBA, MES; Maria Courgen, MPH; Rosa Solorio, MD, MPH; Ann Duerr, MD, PhD, MPH

A growing number of U.S. HIV surveillance programs are routinely monitoring late HIV diagnosis, or the proportion of new HIV cases that are diagnosed late in the course of their HIV illness. Data on late HIV diagnosis provides a measure of HIV testing frequency and helps characterize HIV-positive people who are unaware of their HIV status. Yet, there is currently a lack of consensus regarding how to measure late HIV diagnosis. Most programs use a time-based approach in which cases defined as late are those diagnosed with AIDS within a short time period after diagnosis of HIV infection: usually 1, 6, or 12 months. However, this approach can require a lengthy follow-up period, and hinges on our somewhat limited ability to determine when a diagnosis first occurred. Also, the chosen time interval between diagnosis of HIV and AIDS often varies across jurisdictions, reducing comparability.

In this study, we use multivariate logistic regression and time trend analysis to compare a time-based measure of late HIV diagnosis to one based on laboratory test results. Using surveillance data from Washington State's HIV/AIDS Reporting System, we analyze adult cases diagnosed with HIV infection between 2000 and 2009. The time-based measure defines cases as late if diagnosed with AIDS within 12 months of HIV diagnosis. The lab-based measure
defines cases as late if initial CD4+ T-cell count is < 350 cells/mL. We exclude cases from our analysis if initial CD4+ result was collected within 90 days of HIV diagnosis. We use a cut-off of 350 cells/mL because current WHO guidelines recommend HIV treatment at or below this level. Covariates in the multivariate regression model include gender, age at HIV diagnosis, race and Hispanic ethnicity, mode of HIV exposure, and county of residence at HIV diagnosis.

Overall, a lower proportion of cases were diagnosed late using the time-based measure (37%) compared with the lab-based measure (56%). However, adjusted relative odds of late HIV diagnosis are similar regardless of measure used. Men are 1.5-1.8 times more likely to be diagnosed late than women. Cases ages 45 years or older at HIV diagnosis are 1.3-1.6 times more likely to be diagnosed late vs. those ages 25-34. Late diagnosis is 1.4-2.0 times more likely among members of a racial or ethnic minority. Compared to cases categorized as men who have sex with men, heterosexual cases are 2.0-3.0 times more likely to be diagnosed late. Both measures indicate that, statewide, the proportion of cases diagnosed late has decreased over the past decade.

These findings suggest the need to increase routine HIV screening in Washington among males, older adults, racial and ethnic minorities, and heterosexual people who are sexually active. They reaffirm the validity of a time-based definition of late HIV diagnosis, while at the same time demonstrating the potential value of a lab-based measure. Moreover, because it is subject to fewer potential limitations, the lab-based measure might be a better alternative in jurisdictions with comprehensive electronic laboratory reporting, especially those with access to health information exchanges.

Track B

B08 - Behavioral Surveillance in Special Settings
Room: Spring (Hyatt Regency Atlanta)

Abstract 1412 - Sexual Risk Behaviors and HIV Testing among Men Who Have Sex with Men, Guam 2007-2008

Author(s): Bernadette P. Schumann; Ester Mallada; Choi K. Wan; Drew Voetsch; Walter Chow; Vince Aguon; Elizabeth Adriatico; Jessica Cate

Guam is a small island and U.S. territory located in the western Pacific Ocean with a population of 180,000 persons. It is an international travel hub for Asia and the Pacific region. Although the HIV prevalence is low, 53% of the 221 HIV cases in Guam since 1985 have been men who have sex with men (MSM).

The Guam Department of Public Health & Social Services, in collaboration with the GUAHAN Project, conducted a survey of MSM in 2007-2008. Respondent-driven sampling was used for enrollment. Respondents were eligible if they were 16 years or older, and either male or transgender person (TG) who had sex with a man in the past 5 years. Surveys were conducted in-person. Participants were offered an HIV test following the survey.

There were 211 MSM surveyed, of whom 200 (89%) were men and 11 (5.5%) were TG. Most (74%) were born in Guam, 12% elsewhere in the U.S., 10% in the Philippines, and 4% in some other place. Eighteen (9%) had ever been married and 10 (5%) were currently married. The mean age at sexual debut was 15 years and 192 (91%) reported sexual contact with a man or transgender person in the past 6 months. Of these, 189 (98%) reported oral sex and 52 (27%) reported anal sex with male partners. Ninety-one (43%) of MSM reported ever having had vaginal or anal sex with a women, of whom 17 (19%) had sex with a women in the past 6 months. Overall, 80 (38%) reported two or more concurrent sex partners and 35 (17%) reported having had group sex in the past 12 months. There were 98 (48%) MSM who reported traveling from Guam in the past 12 months, of whom 57 (59%) reported having had sex with someone other than a sex partner from Guam. Outside of Guam, the median number of sex partners was two (range 1 - 20 sex partners); 53 (93%) MSM reported that the most recent sex partner outside Guam was male and 25 (44%) reported condoms were used with the most recent partner. Of the 208 who had ever heard of sexually transmitted diseases (STDs), 25 (12%) reported having ever been diagnosed with an STD, including 6 (3%) who had been diagnosed with HIV. Overall, 150 (71%) MSM reported having ever been tested for HIV and 82 (39%) reported having been tested for HIV in the past 12 months. Overall, 125 (59%) of MSM were offered an HIV test, of whom 37 (30%) accepted to be tested; all test results were negative.
Although no new infections were identified as part of this survey, the prevalence of HIV-associated risk behaviors is high among MSM in Guam. Further, 27% of MSM reported having had sex off island, which may increasing the opportunity for infection with HIV and other STDs and increase the risk for their sex partners in Guam. Prevention messages specifically for MSM in Guam and other nearby Asian and Pacific Island nations are needed.

**Abstract 1466 - Modest HCV Prevalence Despite Risky Injecting Practices among Injection Drug Users in San Diego, CA**

**Author(s):** Dr. Richard S Garfein; Amanda Rondinelli; Richard F. W. Barnes; Jazmine Cuevas-Mota; Mitcheal Metzner; Michele Velasquez; Meredith Reilly; Jian Xing; Eysau H. Teshale

Hepatitis C virus (HCV) infection prevalence up to 51% has been reported among young adult injection drug users (IDUs) in United States cities. San Diego, CA is adjacent to Tijuana, Mexico, a city in which 95% of IDUs are estimated to have HCV infection. Despite extensive traffic between the cities, little is known about the prevalence and risk factors for hepatitis C virus (HCV) infection among IDUs in San Diego.

In 2009-2010, 18-40 year-old IDUs residing in San Diego County were recruited for a cross-sectional study that included a risk assessment interview followed by serologic testing for HCV and HIV infection. Participants were recruited using respondent driven sampling (RDS), venue-based sampling via a syringe exchange program (SEP), and convenience sampling using street outreach and targeted advertising. Bivariate and multivariate logistic regression analyses were performed to identify correlates of HCV infection.

Of 566 IDUs enrolled, 542 (96%) had complete data on the variables of interest and were included for analysis. The overall prevalence of HCV infection was 25.6%. The IDUs recruited via RDS were more likely to be female and slightly younger than IDUs recruited via the other two methods, but HCV prevalence did not differ by recruitment method. Overall, median age was 28 years (interquartile range [IQR]: 24-33 years); 73% were male; 60% white and 29% Hispanic; 96% were born in the U.S.; 39% did not have stable housing; and 78% had a history of incarceration. The median duration of injecting was 6 years (IQR: 2-12 years); 43% injected daily; heroin was the most commonly injected drug (62%), followed by methamphetamine (36%) and cocaine (2%); 50% receptively shared syringes and 68% shared other injection paraphernalia; only 22% reported always using new syringes. Sixty-seven percent had traveled to Mexico, and 20% injected while there. In multivariate analysis controlling for years of injecting and other relevant variables, HCV infection was independently associated with sharing injection paraphernalia (AOR = 1.70, P = 0.04) and obtaining most syringes from an SEP (AOR = 1.92, P < 0.05) in the previous three months, and having a history of overdose (AOR = 2.21, P < 0.05).

The prevalence of HCV infection among young adult IDUs in San Diego is modest compared to other US cities and much lower than in nearby Tijuana, Mexico. However, given San Diego IDUs risky behavior and their frequent mixing with IDUs in Mexico, prevention efforts remain needed to prevent HCV and other viral infections in IDUs.

**Abstract 1838 - Acute HIV Infection among Black Men Who Have Sex with Men Attending Sociocultural Events**

**Author(s):** Peter E. Thomas; Pollyanna Chavez; Emeka Oraka; Steven Ethridge; Patrick Sullivan; Ruby Lewis-Hardy; Veronica Hartwell; Kyle Monroe Spencer; Lamont Scales; Pragna Patel; Laura Wesolowski; James Heffelfinger

According to CDC estimates, 21% of HIV-infected persons are unaware of their infection. Expansion of HIV testing is needed. Early HIV diagnosis is associated with a reduction in high-risk behaviors associated with transmission as well as better health outcomes for infected persons linked to care. During the early stages of infection when HIV antibody cannot be detected, a period termed acute HIV infection (AHI), persons are highly infectious. Nucleic acid amplification testing (NAAT) can detect HIV during AHI, but diagnosing AHI has largely been limited to clinical settings. We conducted HIV screening, including NAAT, at event-based venues attracting black men who have sex with men (MSM).

During August-September 2010, CDC's Behavioral Assessment and Rapid Testing (BART) project offered HIV counseling and screening (including NAAT) at 2 events attracting black MSM in Atlanta, Georgia, and Little Rock,
Arkansas. HIV screening was offered at six non-clinical venues at the two events. Rapid testing (RT) was performed using OraQuick on oral fluid in Arkansas and Unigold on whole blood in Georgia. Blood was collected from all participants and pooled NAAT was conducted at a private laboratory on RT-negative specimens. Participants received RT results and those with negative results were given an explanation about AHI and a toll-free number to call for NAAT results, beginning 10 days after the event. RT-positive specimens were sent to Arkansas or Georgia labs for Western blot testing. Persons with RT-negative but NAAT-positive results were classified as having AHI. Those with RT and Western blot-positive results were considered to have HIV infection but not AHI.

Of 476 people tested at the two events, 252 (53%) were black men. Of these men, 200 (79%) reported sex with a man in the preceding 12 months and 152 (60%) were aged 18-24 years. Overall, 45 (18%) of 252 black men had RT-positive results: 30 (67%) were aged 18-24 years, 41 (91%) reported sex with men, 29 (64%) reported sex without condoms and 8 (18%) had never been tested for HIV; 14 (31%) were already aware they were HIV-infected and 12 (27%) had confirmed new diagnoses. The number of 19 non-Georgia-residents that were newly diagnosed is pending. Two (1%) of the 207 men with RT-negative results were identified with AHI. Both men were >25 years old, reported sex with men, had 3 or more anonymous sex partners in the past 12 months, and reported having been previously tested for HIV. Assuming all 31 with RT-positive results are new positives, NAAT testing increased those newly diagnosed by 6.5%. The return of NAAT results to the two testing positive was 14 days later than expected due to logistical problems.

Conducting NAAT along with HIV screening among black men attending events attracting MSM is feasible, offers the opportunity to identify new and acute HIV infection among high-risk populations, and may prevent onward HIV transmission. However, operational barriers to prompt return of NAAT results must be addressed.

[Please add coauthors Veronica Hartwell (Fulton County Health and Wellness) and Pragna Patel (CDC) after coauthor #8 (Lamont Scales)]

**Abstract 2098 - High-risk Sexual and Non-sexual Behaviors among Rural HIV-infected Women**

**Author(s):** Daphne Greenawalt; Janice Powers; Patsi Albright; Ruth Lindsey; Tonya Crook; Cynthia Whitener; Neil Christensen; John Zurlo

As HIV-infected women live longer in the era of highly active antiretroviral therapy (HAART) in the US, they are more likely to experience adverse health outcomes due to immunosuppression and co-existing high-risk behaviors. However, previous studies focus on urban HIV-infected women, and limited research has been conducted to examine high-risk behaviors among HIV-infected women living in small cities and rural areas. Rural HIV-infected women may possess unique behavioral profiles because of different demographics, social environment, and provision of healthcare services. We want to better understand behavioral risk factors associated with adverse health outcomes among rural HIV-infected women.

We are conducting a cross-sectional behavioral survey among HIV-infected women living in Central Pennsylvania, which is a combination of large rural areas with population concentrations in small urbanized cities. HIV-infected women were recruited from 3 local HIV/AIDS outpatient clinics operated by Pennsylvania State University College of Medicine. Study participants answered a self-administered survey questionnaire including detailed demographics, socioeconomic status, general health habits, and sexual and non-sexual behaviors. HIV-related medical information including CD4 count and HIV viral load was abstracted from the electronic medical record and linked with the survey data.

A total of 50 HIV-infected women have been enrolled in this ongoing study. Those women were mainly older than 40 years (median age=46 years), non-Hispanic white (63%), in low socioeconomic status, and living in the area for more than 10 years (89%). Most of them acquired HIV via heterosexual contact (74%), followed by IDU (20%), and had been infected with HIV for 10 years or longer (71%). All of them were currently on HAART. Recent CD4 count and HIV viral load data indicated that 85% of them had a CD4>500/mm3 and 88% of them had a low HIV viral load (<48 copies/ml). High-risk behaviors were commonly reported: 36% had more than 10 sexual partners in lifetime, 67% reported a history anal intercourse, 20% had new sexual partner(s) in the past 12 months, and about 35% reported a travel history to meet sexual partner(s). Regarding high-risk non-sexual behaviors, 20% reported the use of street.
drugs in the past 12 months, 47% were current smokers, and 28% drank alcohol regularly. Younger age (<=40 years), minority race, and a shorter length of HIV infection (<10 years) were associated with lifetime number of sexual partners and anal sex history (P<0.10). Women with detectable HIV viral load or with a shorter length of HIV infection were more likely to report recent drug use.

High-risk sexual and non-sexual behaviors were common among HIV-infected women living in Central Pennsylvania. Tailored intervention programs targeting high-risk behaviors among rural HIV-infected women, especially those with detectable HIV viral load, need to be developed to prevent adverse health outcomes in the HAART era.

Track C
C03 - Developing an HIV Testing Campaign for Black MSM
Room: Singapore/Manila (Hyatt Regency Atlanta)

Abstract 1623 - Community Involvement, Formative Research and Creative Development for an HIV Testing Campaign for BMSM
Author(s): Jennie Johnston; Jen Uhrig, PhD

In the United States, MSM account for more than one half of all new HIV infections annually, and black men who have sex with men (BMSM) are disproportionately affected. CDC currently recommends that all MSM who have had unprotected sex be tested for HIV at least annually (CDC, 2006). Recently released epidemiological data indicated that more than 25% of BMSM are HIV positive, and 59% of BMSM who tested positive were unaware of their infection (CDC, 2010). These data suggest that HIV prevention and testing efforts among BMSM must be expanded.

CDC used an iterative approach to develop materials for a national HIV testing campaign for BMSM.

This panel highlights 4 stages of campaign development with four proposed presentations: 1) engagement of a community workgroup (CWG) to guide campaign development; 2) completion of exploratory research in five U.S. cities to identify key influences associated with testing; 3) development and testing of creative materials; and 4) development of full-scale implementation plan for a nationwide campaign.

Results: In 2008, CDC formed a CWG with the goal of obtaining community suggestions and feedback to help guide and inform the development of the campaign. To date, the CWG has participated in 4 meetings and 5 conference calls. CWG recommendations underscore the importance of examining and incorporating holistic health and community level influences. CDC designed and conducted qualitative (n=179) and quantitative (n=221) formative research with a sample of BMSM across 5 U.S. cities segmented by age, HIV risk and testing behavior to examine factors that influence HIV testing intentions and behavior. Results suggested focusing the campaign on two distinct audience segments: (1) BMSM who do not get an HIV test at least annually and report no intention to test and (2) BMSM who test annually, but should test more frequently given their reported risk behavior. While some overarching influences may need to be addressed across both groups (e.g., normative beliefs, framing HIV testing as a part of one's overall or sexual health, and education about the window period), our results suggest that there are also different influences that motivate testing for the two segments. Self-efficacy appeared to be an important influence on BMSM who did not test at least annually and report no intention to test and (2) BMSM who test annually, but should test more frequently given their reported risk behavior. While some overarching influences may need to be addressed across both groups (e.g., normative beliefs, framing HIV testing as a part of one's overall or sexual health, and education about the window period), our results suggest that there are also different influences that motivate testing for the two segments. Self-efficacy appeared to be an important influence on BMSM who did not test at least annually. For annual testers whose risk behavior suggests more frequent testing, our findings suggest a misalignment between perceived and actual risk that needs correction. The results of the exploratory research were used to develop campaign messages and materials that will be tested in Spring 2011. Results of the message and materials testing will be used to revise materials and refine channel selection that will ultimately constitute campaign implementation.

Lessons Learned: Campaign development is an iterative process involving the target audience and the community. Gathering input from all sources is essential to a successful creative development process. Overall, the results indicate that HIV testing messages and creative materials should have an uplifting tone. Lessons from the formative research indicate that attitudes, self-efficacy, and social norms all influence testing while underestimating one's risk may reduce testing frequency.
Abstract 1555 - Adapting Community PROMISE with Older MSM and Transgender Individuals of Color
Author(s): Luis Scaccabarrozzi; Hanna Tessema

The older HIV-positive and at-risk population tends to mirror its younger counterpart, and to face many of the same stigmas, but with the added burden of ageism. Today, more than half of new HIV diagnoses are among MSM. Older MSM face a unique set of challenges when it comes to HIV prevention. Having experienced stigma and discrimination in their youth, they now confront ageism as well as homophobia. Also, many gay men over 50 have lost lovers and friends to the HIV epidemic in the 1980s and 1990s. While some evidence suggests that this experience can motivate them to practice safer sex, current experience also suggests that this norm may be changing due to condom fatigue and treatment optimism. Our experience is, and independent studies show, that social isolation and depression are major threats to quality of life of seniors living with HIV is proportionately affecting LGBT seniors.

Targeted MSM and transgender of color, English and Spanish-speaking, in high-HIV-incidence areas in four boroughs in NYC (Manhattan, Queens, Brooklyn, and the Bronx).

A NYC Council- and NYC Department of Health and Mental Hygiene-funded demonstration project on HIV and Older Adults that includes a tailored version of Community PROMISE targeting older MSM and transgender individuals of color who are living with HIV and those at risk for HIV.

Over 12 Role Model Stories (RMSs) have been developed in English and Spanish targeting MSM and transgender individuals of color. Over 50 older MSM and transgender senior peer educators have been trained in 3 years, maintaining a consistent team. Over 3,500 older MSM and transgender individuals have been reached in NYC, with over 1,200 of them tested for HIV.

Lessons Learned:
- HIV-positive older MSM and transgender individuals are largely stigmatized by HIV-phobia, homophobia, transphobia, and ageism.
- Integrating HIV treatment and care into the RMSs has been essential in targeting older adults living with HIV.
- Social isolation and loneliness are important factors in sexual risk taking and need to be taken into account when developing RMSs targeting older MSM and transgender individuals.
- Important factors influencing behavior that need to be taken into account when developing RMSs for older adults include perceived susceptibility, self-efficacy, communication and negotiation, positive and negative moods, cultural norms about sexuality and gender roles, and social inequities.
- Current understanding of HIV prevention successes used with younger populations should be utilized, while considering important intervention principles gathered from work with older populations in other health areas.

Next Steps:
- More prevention strategies that include a strong evaluation and research targeting older adults HIV/STD primary and secondary prevention.
- More education to increase awareness and knowledge, skills training to help older adults negotiate risk-reduction behaviors, messages that are age appropriate and culturally sensitive.

Abstract 1659 - Adapting the Mpowerment Project to Serve to Hispanic MSM, Ages 18-29, in Orange County, CA
Author(s): Mario Casas
In Orange County, CA, 71.6% of people living with HIV are MSM, 31.4% are Hispanic and 19.7% are ages 20-29. MSM Hispanics are considered at high risk for HIV infection since this is the second group most affected by the disease in Orange County.

Orange County is an ethnically diverse, suburban region located 90 miles north of the U.S.-Mexico border. Santa Ana and Anaheim, the two largest cities, concentrate over 70% of Hispanic residents in the county.

The Mpowerment Project model has been adapted under the name SOMOS OC to meet the specific needs of young Spanish-speaking Hispanic MSM, ages 18-29. The model was adapted to integrate the cultural traditions and needs of both U.S.-born and recently immigrated Hispanic individuals. As a result, the group is composed of participants from different socioeconomic and educational backgrounds. The group has spearheaded the promotion of HIV/AIDS prevention and awareness in the community at large thought a variety of different HIV prevention and education community events. The latest event was the Mr. SOMOS OC pageant, where 11 contestants were judged by 5 local HIV prevention experts based on their personality, general HIV knowledge, attitude towards prevention and their production of a one-minute HIV educational video. Additionally, each spectator received a one-time special edition magazine, in Spanish, with various HIV education articles and testing resources. The winner was crowned Mr. SOMOS OC 2011 in front of over 250 attendees and his video is being used in a county-wide HIV prevention campaign.

Results: During 2009-2010 alone, SOMOS OC provided a space for HIV education and safer sex discussions, coordinated formal and informal outreach events to over 150 participants. More than 50% of core group members attended 5 meetings or more. The average meeting attendance was 12-15 participants. Approximately 90% of this cohort reported being tested at least once within a 12 months period after they attended the first SOMOS HIV educational M-Group. As a result of the pageant, SOMOS OC was recognized by the county's transgender community with the helping the community award for educating the general public about HIV transmission and prevention.

Lessons Learned:
The Mpowerment project model has been well received by the Hispanic Spanish-speaking MSM population. By keeping the original core elements and integrating language and cultural competence to all program activities and events, we were able to increase HIV testing, and decrease sexual risk behaviors to the target population. In addition, we were able to educate and reduce high risk behaviors to a group of 15 participants in a period of 2 months, 11 of them were able to educate a crowd of approximately 250 spectators on how to prevent HIV infection.

Abstract 1929 - YMYV: An HIV Intervention for Young Men of Color Who Have Sex with Men

Author(s): Mithcell J. Wharton, MS, RN, FNP; Damon L. Humes, MHS; Judith Bauman, MSW, MPH; Elizabeth Anson, MS

HIV/AIDS continues to disproportionately affect men of color in general with Black men having the highest case rates. A concerning trend is the resurgence of HIV infections among young men of color who have sex with men (YMCSM). In 2008 over half of the new HIV infections among MSM age 13 -24 occurred in young black MSM. This is more than any other racial or ethnic age group of young MSM. The number of new infections among young Black MSM was nearly twice that of young white MSM and more than twice that of young Hispanic/Latino MSM. Until there is a cure for HIV there will continue to be a need for behavioral interventions. Young Men Young Voices (YMYV) is a group level HIV/STD intervention that was adapted from the successful Many Men, Many Voices (3MV) intervention to more directly meet the needs of this highly at risk subpopulation of YMCSM. This adaptation was part of a HRSA funded multi site investigation known as Project YEAH (Youth Empowerment Around HIV).

Between February 2007 and February 2009 we recruited and enrolled 25 YMCSM in four waves of the Young Men Young Voices (YMYV) cohort study. The YMYV intervention consisted of 6-one hour group sessions delivered over a 6-week period. We Utilized a pre-test post-test model using a demographic form, knowledge attitude and behavior survey (KAAB), and a valid and reliable HIV knowledge questionnaire (HIV-KQ). Data was collected Pre-intervention (T1), Immediately Post-intervention (T2), and at 6-weeks (T3), and 3-months Post-intervention (T4). Frequencies
were run on demographic variables, t-test were conducted on the HIV-KQ and KAAB as well as qualitative analysis for some questions on the KAAB.

23 participants completed the pilot study with complete usable data. All were male (100%), mean age 18.08 (range 16 - 24, SD=2.080), single 92%, reported no religion (32%), African-American (60%), multiracial (36%), Latino (4%), Gay (80%), HIV negative (88%), still in high school (52%), unemployed (68%), incomes of less than $15,000/year (48%), sexually anal receptive bottoms (64%), initiated sex on average at age 13.75 (range 8 - 21, SD =3.040), reported an average of 3.80 male sexual partners in the past 12 months prior to enrolling in the study. Trends towards positive changes in knowledge, attitudes, and HIV risk behaviors were found over the course of the study. HIV-KQ knowledge scores increased from an average of 66% at T1 to 76% at T4. There was a decrease in the average number of sexual partners (T1=3.8; T4=2) over the course of the intervention, an increase in HIV testing (T1=4; T4=18), and an increase in readiness to use condoms with anal sex (T1=5; T4=20).

YMYV was able to positively influence HIV knowledge, attitudes, and behaviors of YMCSM that was sustained over time. Our data supports the further testing of this intervention with a larger more diverse subpopulation of young MSM of color. Research to develop effective interventions that are culturally and age appropriate for YMCSM is vitally important and must continue.

Abstract 1944 - Academic - Community Collaborative: Lessons from an Intervention for Behaviorally Bisexual Black Men

Author(s): Nina T. Harawa; John K. Williams

Community Based Participatory Research (CBPR) has been adopted as a strategy to ensure that research involves and responds to the communities that are being researched. The success of CBPR depends on effective partnerships and the extent of involvement of all partnering entities. We present our findings on partnership readiness and engagement in conducting a randomized clinical trial of a novel community based HIV risk reduction intervention targeting Black MSM.

The Men of African American Legacy Empowering Self (MAALES, pronounced males) Project is an academic-community collaborative that involved 2 universities and 4 community based agencies (CBO) in Los Angeles. Two of the 4 CBOs primarily served Black communities in Los Angeles. One agency specialized in substance abuse treatment and the other provided services to children and young adults. This collaborative was created to develop and test a unique, culturally based intervention for a group of under served and underrepresented community of Black MSMW.

MAALES is a culturally congruent HIV risk reduction intervention that includes Black men who have sex with men and women (MSMW), age 18 years and above and live in Los Angeles county. Other eligibility criteria include self-reporting high risk sexual activities with both s female and male partner in the prior 3 months. MAALES is guided by the Theory of Reasoned Action, the Empowerment Theory and the innovative Critical Thinking and Cultural Affirmation (CTCA) Model developed by a collaborating CBO. The MAALES project is implemented in small groups, by facilitator dyads that include a CBO and an academic representative. Since August 2007, the MAALES project has enrolled 427 Black MSMW into the randomized clinical trial and has conducted 36 intervention cohorts with 200 men.

The community-academic partnership of the MAALES project presented a variety of benefits and challenges. Benefits primarily included CBO representatives having a greater understanding of how, where and when to locate potential participants. Representives were able to provide critical insights about recruiting and retaining this unique population of Black MSMW. Some of the challenges included differences in prioritizing the research project, differing management expectations between researchers and heads of community agencies, barriers to supervising CBO representatives and academic employees while maintaining same standards of accountability and responsibility, understanding the ethics and rigor of research methods by CBO representative and continuing the research project in a CBO that is facing sustainability issues.

Lessons Learned: 1) Community based HIV prevention research requires additional effort and time from all partners to identify and set clear goals and objectives of the research being conducted, 2) CBOs partners require a research
boot camp to learn the main aspects of research activities, 3) Academic partners require an understanding that in some situations, the research project may not be a priority to a CBO, who have to respond to more proximal challenges about their sustainability.

Track C
C14 - Prevention Research for Better Understanding Interventions for Heterosexual Communities of Color
Room: Hong Kong (Hyatt Regency Atlanta)

Abstract 1245 - Perceived Risk for HIV as a Moderator of the Healthy Love EBI for Black Women
Author(s): Jerris L Raiford, PhD; Don Dixon Diallo, MPH; Lisa Diane White; Paulyne Ngalame, MPH, MIAD; Thomas M. Painter, PhD; Jeffrey H. Herbst, PhD

In response to the disproportionate rate of HIV infection among black women, SisterLove Inc., a community-based organization located in Atlanta, GA, developed the single-session Healthy Love HIV prevention intervention. Healthy Love was found to be efficacious in increasing condom use and HIV testing in a group randomized controlled trial (Diallo et al., 2010), and has been included in the CDC's 2010 Compendium of Evidence-Based HIV Prevention Interventions. The present analyses were conducted to identify potential moderators of intervention efficacy on behavioral outcomes that were not statistically significant in the original outcome study.

Women were eligible for the study if they self-identified as black, 18 years or older, and not pregnant or planning to become pregnant in the next 6 months. Eligible pre-existing groups of women (e.g., sororities, friends, church groups) were randomly assigned to receive either Healthy Love (15 groups, 161 women) or an HIV101 comparison intervention that focused on HIV/STD facts only (15 groups, 152 women). Assessments were conducted at baseline, immediate post-intervention, and at 3- and 6-month follow-ups. Logistic regression tested whether theory-based psychosocial measures (i.e., perceived risk for HIV infection, stage of change for condom use, and condom use self-efficacy) moderated intervention efficacy on sex behavior outcomes. Baseline levels of each outcome variable were controlled in all analyses.

In the original outcome study, no significant intervention effect was found for reducing unprotected vaginal sex with any male partner or with primary male partners. Among black women who perceive themselves to be at risk for HIV at baseline, a lower proportion of women in the Healthy Love condition (57%) reported engaging in unprotected vaginal sex with any male partner at 6-month follow-up than women in the HIV101 comparison condition (78%) [B=-1.91, OR=.15, p=.01]. However, there was no significant intervention effect for the same outcome among women who did not perceive themselves to be at risk for HIV risk at baseline.

The Healthy Love intervention has been traditionally delivered by SisterLove Inc. to pre-existing groups of black women regardless of their perceived risk of HIV infection. The findings of the present analyses suggest that women who perceive themselves to be at high risk for HIV infection may garner additional benefits from the Healthy Love intervention in terms of reducing unprotected vaginal sex with their male partners. These findings will be discussed in terms of targeting and tailoring the intervention for high-risk groups of black women.

Abstract 1752 - Adaptation of an Intervention to Prevent HIV/STD in Young Heterosexual Latino Couples
Author(s): David Perez-Jimenez

HIV transmission occurs primarily in the context of a relationship. Changing high-risk behaviors of both members of the dyad must be a prevention priority. Little prevention efforts have been designed and implemented to target both members of the relationship, particularly those targeting young populations. Adapting interventions that have proven to be effective in changing high-risk behaviors may facilitate the development of new effective interventions.

Institute for Psychological Research, Social Sciences College, University of Puerto Rico, Rio Piedras Campus.

We created Project MHUSS@, a study funded by the National Institute of Mental Health aimed at promoting the sexual health of young heterosexual couples. The study is conducted in two phases. In the first phase we adapted an
intervention designed for adult couples, using the "ADAPT-ITT" model. This model proposes a series of eight steps adapt HIV interventions. Some of these phases include the implementations of focus groups, implementing a novel methodological approach called theater testing and a pilot of the intervention. In the second phase the adapted intervention will be implemented with a group of 74 couples who will be randomized to the intervention group or waiting list. Couples will learn to use condoms in a fun and enjoyable way, and will acquire the necessary skills to manage conflict and improve their communication. This presentation consists of presenting the adaptation of the intervention.

We conducted three focus groups, one with six young men who were involved in a romantic relationship, one with eleven women also involved in a romantic relationship, and one with five couples. We also conducted the theater testing with seven couples, and a pilot of the intervention was implemented with eight couples. Some of the changes we made as result of the adaptation process included: (a) adding a video to address the information about HIV/STD; (b) teach how to put a condom with the mouth; (c) making the intervention more dynamic and participatory; (d) adding more audiovisual components such as music and videos; (e) making the atmosphere more sensual; and (f) giving condoms in all sessions.

The "ADAPT-ITT" model is a useful tool to tailor preventive interventions, because it takes in consideration the opinions and perspectives of the target population, and also of experts. It is essential that the adaptation process takes in consideration the opinions and recommendations of those members of the population to which the intervention is intended to serve and that the final product meets the needs of this population. The ADAPT-ITT model is a very useful tool to adapt preventive interventions.

Abstract 1922 - Methodology for Mapping Formative Research Onto HIV Prevention Intervention for Heterosexual Men of African Descent

Author(s): Michael Joseph, PhD; Brignel Camilien; Francis Agbetor; Kim Williams, PhD; Kirk D. Henny, PhD

Prevention programs typically utilize formative research to develop tailored and acceptable approaches to behavior change. Methods for applying formative data to interventions have not been well-articulated, and some approaches may introduce biases that the formative research is meant to circumvent. We describe a community-engaged approach to HIV prevention program development for adult, high-risk, heterosexual black men that seeks to ensure that themes identified in formative work are effectively translated into core components.

Investigators from an established community-academic partnership recruited and interviewed customers and personnel from four barbershops in Brooklyn, NY neighborhoods with high HIV/AIDS prevalence.

From 9/10-12/10, we conducted 105 audio computer-assisted structured interviews. Based on self-reported HIV risk, we selected 21 men for 3 focus groups and 14 in-depth interviews. An additional focus group with barbershop personnel explored the potential role of the barbershop in intervention delivery. Analysis and mapping of the data were approached through several activities, including adoption of a set of principles overriding all aspects of development, including a strength versus deficit-based perspective, sensitivity to issues of masculinity and gender roles, and commitment to exploring community advocacy as a key to sustainability. We also engaged in a process that ensured involvement of academic and community-based personnel at all stages. Public health investigators provided education on qualitative analysis, development of matrices of change, and utilization of theory in program development. Community partners provided key content based on their experience working and living within the community, their own knowledge acquired from their experiences in thematically analyzing and coding the formative research, and their development and participation in a study group focused on issues of masculinity, racism and discrimination, and other contextual influences on men's health. A community advisory group consisting of community stakeholders, including barbers, provided additional project input.

The process of intervention development took approximately one year; the team allocated maximum time and effort towards improving the quality and cultural relevance of intervention components so that the final product fits the needs of the target population. The combined effort resulted in a three-session intervention for high-risk men recruited from barbershops, coupled with barbershop-based health education. Key components focused on
knowledge, attitudes and skills regarding condom use and HIV testing, but also on the role of contextual variables on HIV disparities, and how men can utilize their own commitment, skills, and networks to improve community health. An iterative approach to intervention development produced a culturally appropriate intervention that is true to the formative data, and resulted in a strong, multi-disciplinary research team in which each member gained additional skills and commitment to continuing partnerships focusing on HIV prevention initiatives.

CCT1
CCT1-1 - Social Determinants of HIV Risk among Black Men
Room: Hanover C (Hyatt Regency Atlanta)

Abstract 1174 - Investigating the Effects of Racial Discrimination and Social Support on Black Heterosexual Men's Sexual Risk
Author(s): Lisa Bowleg; Michelle Teti; Gary Burkholder; Jenne Massie; David Malebranche; Jeanne Tschann

Although there is empirical evidence that documents the relationship between chronic exposure to racism and adverse health outcomes, research on the relationship between racial discrimination and HIV risk for Black populations is virtually nonexistent. Our study examined whether social support moderated the relationship between racial discrimination and sexual HIV risk among Black heterosexual men (BHM).

Using venue-time-based sampling methods, we recruited 578 BHM, age 18-45 (M=28.8 years) from venues (e.g., barber shops, corner stores) in randomly selected Census block groups in Philadelphia, PA. Participants completed a computer survey that included measures such as the Day to Day Unfair Treatment Scale (DTD, a measure of racial discriminations), the PHQ-9 measure of depressions, the Multidimensional Scale of Perceived Support, and questions related to condom use. We tested two models that hypothesized social support (from friends and significant others) serves as a moderator of DTD in predicting unprotected vaginal sex (UVS). A regression model was used to examine DTD, social support, and the DTD*social support interaction (controlling for demographics of age, marital status, employment status, and education level). The DV was a ratio of UVS (the sum of the number of occasions of reported UVS across all partners during the previous two months divided by the total number of occasions of vaginal sex).

In the first model that included social support from friends, the overall model was statistically significant, R²=.07, F5,484=5.83, P< .0001. The interaction term was statistically significant after controlling for demographic variables and main effect terms, B = -.06, p < .05, indicating that those with less perceived support from friends and higher racial discrimination experiences reported more UVS. In the second model that included social support from significant others, the overall model was statistically significant, R²=.095, F5,484=7.84, P< .0001. The interaction term was statistically significant after controlling for demographic variables and main effect terms, B = -.07, p < .05, indicating that those with less perceived support from significant others and higher racial discrimination experiences reported more UVS.

Interventions that increase social support may be effective in decreasing the link between racial discriminations and sexual risk for BHM.

Abstract 1802 - Utilizing Cultural Programming to Engage Young Black Sexual Minority Men Around Sexual Health Promotion
Author(s): Osamudiane Uzzi; Kevin Hachter; Denise Stokes; Chase Andrews; Craig Washington; Neena Smith-Bankhead; Charles Stephens; Shannon Walker; Rosalie Davis; Chirag Patel

Young black sexual minority men (YBSMM) are disproportionately impacted by HIV in Atlanta. However, many YBSMM are reticent to uptake HIV related interventions due to HIV stigma and the lack of innovative and dynamic sexual health programming for this population. Many YBSMM find music, visual arts, literature, and dance entertaining, and these forms of cultural expression can impact the way this population views sex, sexuality and sexual health.
The Evolution Center is the only community center in Atlanta, GA specifically tailored to address the sexual health, social and emotional needs of young black sexual minority men aged 18-28.

The Evolution Center introduced cultural programming into its schedule with the aim to extend the reach and mode in which participants were engaging with the center and a range of topics relevant to sex, sexual health, sexuality, ethnicity and gender. Cultural programs implemented include the Evolution Film Institute (where participants screen cultural and social relevant films); The Evolution Salon, (a monthly literary club), Write OUT loud (a monthly workshop where participants develop and share written and spoken word pieces), a monthly CD listening party and the Rustin-Lourde breakfast (an annual commemorative event honoring leadership and cultural excellence within Atlanta's black LGBT community).

Preliminary data suggest that there is an increase in the number of young black sexual minority men entering and participating in center activities as a result of the cultural programming. Moreover, many participants who were initially exposed to the center through cultural programming attended other center activities and were linked to other relevant services as required by need. Cultural programming enhanced the ability of participants to explore highly stigmatized or complex issues related to sex, sexuality and sexual health in creative ways. In addition, the programming allowed for participants to engage in highly informed and dynamic discussions, and also allowed for participants to produce creative works. This has improved participants overall experience in the center, and enhanced the center in general in relation to HIV and sexual health promotion among young black sexual minority men.

LESSONS LEARNED: Introducing cultural programming into HIV/sexual health centers can improve program recruitment and retention and linkage to other services for marginalized populations. This type of programming can assist in de-stigmatizing and enhancing discussion of highly sensitive topics related to HIV and sexual health. Using creative programming within HIV interventions has implications for evaluation as adaptation of traditional evaluation techniques and utilization of creative evaluation methods and tools is needed to best encapsulate participants experience and behavior change related to the program.

Abstract 1948 - Socioeconomic Status, Sexual Orientation, and Racism among Black MSMW: Associations with Mental Health and Self-Concept

Author(s): John K. Williams, MD

Qualitative data show that Black men who have sex with men and women (MSMW) frequently experience challenges related to low socioeconomic status (SES) and racism. Many choose sexual orientation labels other than gay or homosexual and many do not disclose to others their sexual activity with other men. In order to understand the potential influences of these phenomena on mental and self-concept, we assessed the associations of SES, self-defined sexual orientation, secrecy regarding same-sex behaviors and experiences of racism with psychological distress, self esteem, internalized bi/homophobia, and racial pride Black MSMW from Los Angeles.

Using baseline data from 422 men who participated in an HIV prevention intervention for African American MSMW, we looked at the following potential predictors: highest level of education completed, current housing status, self-identified sexual orientation, secrecy regarding sex with other men, and Harrell's Racism and Life Experiences Scale (RaLES). We used Proc GLM in SAS to adjust means scores for group differences in age group, HIV status, education, and housing status and to examine the associations of each potential predictor with the outcomes of interest: the Global Symptom Inventory (from the Brief Symptom Inventory-53), the Rosenberg Self-Esteem Scale, an Internalized Bi/Homophobia Scale (adapted from Herek), and Racial Pride (adapted from Lukwago).

The mean age of study participants was 42.7 years. Overall income levels were quite low, but 26% had completed an AA degree or more. Nearly half (48%) reported having tested HIV-antibody positive. The largest group self-identified as bisexual (64%); 16% self-identified as gay or homosexual and 14% self-identified as heterosexual/straight. The remainder identified with a range of other labels or no label at all. Higher levels of education were associated with increased self esteem (p<0.0001). Trends were observed between both lower levels of education (p=0.061) and lacking a regular place to live (0.066) and increased psychological distress. High levels of secrecy regarding same-sex behavior but not self identification as heterosexual or down Low were associated with increased distress (p<0.0001) and decreased self esteem (p=0.0002). Both secrecy and self-identification as other
than gay/homosexual were associated with increased internalized bi/homophobia ($p<0.0001$). Strong, positive dose-response associations were observed for recent experiences of racism ($p<0.0001$) with distress symptoms ($p<0.0001$), internalized homophobia ($p<0.0001$) and reduced self esteem ($p=0.0002$). No significant associations were observed between the predictors of interest and racial pride.

Racism and socioeconomics do have important associations with mental and psychosocial health in sexual minority Black men. The associations of racism with internalized homophobia may indicate that, for sexual minorities, other types of oppression may compound the experience of coming to terms with one's sexual orientation. Given that increased psychological distress has been associated with HIV risk taking, prevention interventions that address socioeconomic disparities and racism may result in reduced HIV transmission in this highly impacted subgroup. Given that many race- or ethnic-specific interventions seek to bolster racial/ethnic pride, the stability of racial pride scores in this subpopulation warrants further research.

**CCT2**

**CCT2-1 - Compounding stigmas: Systems that can help or hurt**

**Room: Dunwoody (Hyatt Regency Atlanta)**

**Abstract 1165 - The Use of HIV Surveillance Technologies to Enforce Michigan's HIV Disclosure Law**

**Author(s):** Trevor Hoppe

In the state of Michigan, people infected with HIV are required by law to disclose their HIV-positive status to their sexual partners. Failure to do so is a felony and subject to prosecution, sentencing for which varies widely but has included jail time. As part of their HIV surveillance efforts, local health departments are tasked with identifying individuals who may be breaking the law and dealing with what they term health threat to others cases. But not all cases are identified, nor are all cases pursued for prosecution. Indeed, although no state agency keeps centralized records of such prosecutions, local reports suggest a small minority of such cases are pursued criminally.

Although over thirty states now have some form of HIV disclosure law, little is known about the role that health departments play in their enforcement. This study addresses that question through qualitative, in-depth interviews with local health officials in Michigan.

In coordination with Michigan Department of Community Health staff, two local health department organization roles were identified whose responsibilities are most closely tied to responding to and managing health threat to others cases: the HIV/AIDS Services Coordinator and the Disease Intervention Specialist (DIS). The coordinator is responsible for overseeing their jurisdiction's programs and services that are related to HIV/AIDS, while the DIS is charged with making site visits and organizing and implementing interventions developed to deal with health threat cases.

I conducted interviews with twenty-three health department staff at thirteen of the seventeen local health jurisdictions. I obtained human subjects approval from both the University of Michigan's Health Sciences and Behavioral Sciences Institutional Review Board and the Michigan Department of Community Health's Institutional Review Board.

Interviews reveal that local health officials in a majority of local jurisdictions actively employ technologies developed for HIV epidemiological surveillance for law enforcement purposes. In particular, health officials report actively cross-referencing two sources of data developed to help monitor new HIV infections: the state's "Mandated Names Reporting" database (which includes the name of everyone in the state who is known to be HIV-positive) and "Partner Services" referrals (which includes the names of individuals that newly-diagnosed individuals report to the state as previous sexual partners). Thus, in jurisdictions actively using these surveillance technologies to enforce the HIV disclosure law, individuals who are already known to the state as being HIV-positive and who are then named as sexual partners by newly-diagnosed individuals are in some counties automatically investigated for potential non-disclosure.
This study reveals that HIV surveillance technologies are actively being employed for criminal surveillance purposes. Debates over mandated names reporting systems in the 1980s and 90s centered on privacy concerns, and it appears that these concerns were warranted. As over thirty states currently have some form of HIV disclosure law, the ethical dimensions of the use of public health tools for law enforcement ends should be examined.

Abstract 1604 - Knowing Your Rights as a Strategy to Overcome AIDS Stigma and Discrimination
Author(s): Souhail M. Malave PhD; Blanca Ortiz-Torres, PhD, JD; Nelson Varas-Diaz, PhD; Jose Toro-Alfonso,

As the HIV/AIDS epidemic continues to affect many people around the world, so do the stigma and discrimination related to it. In 2000, the Puerto Rican government passed a law to protect people with HIV/AIDS (PWHA) from discrimination and to ensure their civil and constitutional rights. However, PWHA in Puerto Rico still experience discrimination. The HIV/AIDS literature has indicated the need of using a human rights approach to reduce AIDS stigma. Still, the rights of many PWHA are violated because they lack knowledge about their rights (UNAIDS, 2006). The main objective of this study was to explore the knowledge of their legal rights and their handling of discriminatory events among PWHA in Puerto Rico.

A mixed methods approach was used. We administered 103 questionnaires and carried out 10 in-depth interviews with PWHA. Descriptive statistics were conducted for the analysis of quantitative data. Qualitative interviews were transcribed and submitted to a content analysis using the software QSR NUDIST N-VIVO.

Quantitative results indicate that 67% (n=69) of participants reported having some knowledge of the law that protects their rights. However, only 47% (n=48) of participants could recognize at least 75% of their legal rights when presented in the questionnaire. Although 65% (n=67) reported having experienced at least one discriminating event, 84% (n=56) of them had never complained or reported a discriminating event to the authorities. Qualitative findings showed that PWHA are frequently faced with violation of their rights, but most of them do not take legal actions, either because they are not familiar with the legal system or because they are afraid of the consequences if they were to disclose their status in court.

The results of this study show that the establishment of laws does not ensure the protection of human rights for PWHA. Interventions to promote knowledge of legal knowledge and steps that PWHA can take if their rights are violated are needed in order to reduce stigma and discrimination.

Abstract 1825 - Stigma among Clinical Providers: Effects on HIV Screening and Care in 3 low Resource Settings
Author(s): Michael Reyes, MD, MPH; Mona Bernstein, MPH; Nancy Warren, MPH

Under-served, low resource, low prevalence communities in Federal Region 9 have long been challenged to provide HIV treatment and screening. Clinical providers in these communities have not embraced HIV screening and treatment, despite promotion of HIV testing and the existence of high risk behaviors in these communities.

The Pacific AIDS Education and Training Center (PAETC) is a regional network of 15 local sites in a 4 state region (AZ, CA, NV, HI) including the U.S. Pacific Jurisdictions. With Ryan White funding, PAETC provides training, education, capacity development and clinical support activities to HIV clinical providers and other clinicians who manage high-risk populations including the needs of providers in rural under-served areas.

PAETC conducted focus groups with clinicians (both HIV and non-HIV) working in 3 diverse low resource settings (the California/Arizona border region with Mexico, California’s Central Valley (the “vertical border”), and the U.S. Pacific Jurisdiction) to explore more deeply their challenges in providing HIV screening and treatment in rural areas that are predominantly Latino or Pacific Islander.

We were surprised to identify cross-cutting themes from 3 very different settings. Such themes included the pervasive stigma focus group participants identified both within themselves and their fellow clinical providers regarding HIV-infected and potentially HIV-infected patients. These providers reported high levels of stigma against people based on socio-demographics such as sexual orientation and substance use, attributed, at least in part to the low profile of
HIV in their communities, with PLWHAs seeking clinical services in large cities where anonymity is assured, or not seeking care at all. However, these providers also reported a new stigma resulting from clinicians' perception that HIV-infected patients will drain their already thin resources resulting in provider reluctance to HIV testing, related to provider desire to avoid offering HIV care, or even linkage to care. Focus group participants also described the devastating impact of budget cuts on patient care and emphasized how language, cultural, and geographic barriers affected patient access. Participants speculated that HIV trainings, especially distance learning attached to a live provider who could provide ongoing mentorship, could aid providers to move past the perceived stigma(s).

Lessons learned
These focus groups revealed not only that traditional stigma is alive and well among clinical providers but that severe budget cuts are driving providers to the new stigma seeing HIV screening and treatment as a resource drain to be avoided at all costs. Discussions of test, Link and Treat should consider how to deal with the seemingly intractable stigma among some providers, especially those in areas where other HIV clinical resources are not available and patients are unable to obtain screening or treatment locally. The dearth of resources includes lack of provider access to HIV education and training opportunities. As Ryan White is the payer of last resort for many PLWHAs, PAETC is also the trainer of only resort for providers in under-served low-resource settings in our region, and is crucial in providing capacity development and education to these communities.

Abstract 1919 - HIV Related Stigma among Patients in Two South-Los Angeles Clinics Implementing Routine HIV Testing

Author(s): Anish P. Mahajan, MD, MS, MPH; Jacqueline Rurangirwa, MPH; Janni Kinsler, PHD; Rishi Manchanda, MD, MPH; Lakshmi Makam, MD; Jennifer N. Sayles, MD, MPH

Over the last decade, CDC recommendations for HIV testing evolved from risk-assessment based testing to routine opt-out testing that may normalize HIV screening in all health care settings. Despite these changes in policy, low HIV screening rates persist with only 38% to 44% of all adults in the U.S. having ever been tested. Patient-level barriers include low-self perceived risk, anxiety about results, and fear of social stigmatization. In support of the 2006 CDC Revised Recommendations for HIV Testing, the Office of AIDS Programs and Policy (OAPP) in collaboration with UCLA, Hubert Humphrey Comprehensive Health Center, and St. John's Well Child and Family Center implemented a routine HIV testing demonstration project at two adult medicine clinics in South Los Angeles. In this report we examine how HIV-related stigma among patients at the clinics may vary by demographics, and influence HIV testing behavior.

Between October of 2009 and July of 2010, routine, rapid HIV testing was implemented in four phases: risk-based screening, physician initiated opt-out screening, nurse initiated opt-out screening and nurse initiated opt-in screening at two clinics that serve predominantly African-American and Latino patients. During each of these phases, patients were surveyed to collect information regarding the manner in which the HIV test was offered, attitudes toward testing, socio-demographic information, patient acceptability, test history, and HIV-related stigma. The purpose of this analysis was to examine HIV-related stigma among patients presenting at both clinics and to determine whether stigma would vary among patients based on demographics, test acceptance and whether participants had tested previously.

A total of 695 patients were randomly approached and asked to participate in the 30-minute survey. Of those approached, 590 agreed to participate. HIV related stigma was measured using a 9-item scale. Out of a possible 100 points, the mean stigma score for the sample was 44.4. When looking at average stigma score and ethnicity, it was found that African-Americans had significantly higher stigma than did Latinos, (45.2 vs. 39.2, p<.0001). Average stigma was also found to be higher among males than females, (44.6 vs. 39.5, p<.0001) and was higher in participants that accepted HIV testing on the day of the interview, compared to those that declined (51 vs. 41.2, p<.0001). Additionally, uninsured participants had a higher average stigma score than insured participants, (46.8 vs. 36.5, p<.0001), and older participants had higher average stigma scores than younger participants (p<.05). There was no significant difference in reported HIV stigma according to relationship status, marital status, educational level, and whether participants had tested for HIV prior to the date of the interview.
Several significant differences in HIV related stigma were found according to demographics and HIV testing behaviors in our sample of primary care patients in South Los Angeles. These findings suggest that stigma of HIV may have a negative impact on the acceptance of HIV testing in the healthcare setting, and should inform future development and implementation of routine HIV testing strategies.

**Track D**

**D11 - Systems-level Evaluation of a Large-scale Combination HIV Prevention Initiative in 12 U.S. Cities**  
Room: Hanover F/G (Hyatt Regency Atlanta)

**Abstract 1210 - Systems-level Evaluation of a Large-scale Combination HIV Prevention Initiative in 12 U.S. Cities**  
**Author(s):** Holly H. Fisher; Tamika Hoyte; Dale Stratford; Gary Uhl

The Enhanced Comprehensive HIV Prevention Planning (ECHPP) project is a CDC initiative that supports the development and implementation of combination HIV prevention programs in U.S. cities that are hardest hit by the HIV/AIDS epidemic. ECHPP-funded cities will implement an optimal mix of biomedical, behavioral, and structural interventions to have maximum impact on HIV transmission within their respective communities. A combination HIV prevention approach has not been attempted previously at the national level in the U.S., although it has been used successfully internationally. ECHPP will be monitored and evaluated using a systems-level, population-based approach whereby key HIV indicators will be tracked over time to determine the impact of ECHPP in these communities at the individual, community, and structural levels. Evaluation results will be used to determine the extent to which ECHPP is associated with positive HIV-related outcomes for high-risk HIV-negative and HIV-positive individuals across metropolitan statistical areas (MSAs).

ECHPP funding has been provided to health department-funded programs in the 12 MSAs with the highest AIDS prevalence in the U.S. ECHPP implementation will occur over a three-year period (Phase 1= October 2010 to September 2011; Phase 2= October 2011 to September 2013). Evaluation data from a variety of sources will be collected from 2009 (two years prior to ECHPP implementation) to 2015 (two years after ECHPP implementation ends). Process data will be collected regarding program implementation on a routine basis throughout the implementation period. Outcome and impact data will be collected from existing, national-level CDC surveillance systems [e.g., Medical Monitoring Project (MMP); National HIV Behavioral Surveillance System (NHBS); MSM Web Surveillance System; HIV Case, Incidence, and Perinatal Surveillance Systems]. Survey data will be collected from high-risk, HIV-negative and HIV-positive subpopulations in six of the 12 MSAs to supplement surveillance data; survey data will be collected at the beginning and end of ECHPP implementation. The Program Evaluation Branch (PEB) within CDC's Division of HIV/AIDS Prevention will lead the ECHPP evaluation and collaborate with staff from other CDC branches, the contractor SciMetrika, and external federal agencies. In this roundtable discussion, PEB staff will provide an overview of the evaluation design, data collection activities, the statistical analysis plan, and how results will be used to improve program performance.

ECHPP is a cross-branch effort within CDC's Division of HIV/AIDS Prevention. This initiative represents the first time that the Division will synthesize data from a variety of internal sources, such as MMP and NHBS, and from other federal partners, such as HRSA and SAMSHA, to more fully describe the HIV epidemic and the public health response at the community level in high AIDS prevalence areas.

**Track D**

**D14 - Bringing HIV Prevention Programs to College-Age Minority Students: The Minority-Serving Institutions HIV Prevention Sustainability Demonstration**  
Room: Hanover D (Hyatt Regency Atlanta)

**Abstract 1556 - Bringing HIV Prevention Programs to College-Age Minority Students: The Minority-Serving Institutions HIV Prevention Sustainability Demonstration**  
**Author(s):** Liza Solomon; Crystal Gust; Kimberly Coleman; Timothy Harrison
Young people in the United States are at increased risk for HIV infection. A significant percentage of college students report engaging in risky sexual behaviors including using drugs or alcohol prior to or during sexual activity, having sex with multiple partners, and infrequent use of condoms during vaginal and anal intercourse. Disturbingly, an estimated 5,259 young people aged 13-24 were diagnosed with HIV/AIDS in 2006, representing almost 14% of the persons diagnosed that year. This initiative address two critical components of the National HIV/AIDS Strategy, intensified HIV prevention efforts in communities where HIV is most concentrated, including racial and ethnic minority communities; and use of effective, evidence-based approaches to HIV prevention.

Seven Minority Serving Institutions (MSI), representing four Historically Black Colleges or Universities (HBCU), one Hispanic Serving Institution (HSI), and two Tribal Colleges or Universities (TCU) received funding to conduct comprehensive HIV prevention initiatives on their campuses.

After assessing the need on campus, schools selected interventions that were culturally and programmatically appropriate for their school environment. Interventions included use of peer educators, utilization of DEBs, social marketing campaigns, and expanded HIV testing programs conducted both on and off campus.

An overview of the first year of the MSI Initiative will be presented; this includes stakeholder involvement, selection of the MSIs and a description of the overall evaluation plan. This will be followed by three presentations, each focusing on the unique challenges and programs of the distinct types of MSIs; HBCUs, HSI, and TCUs. Each presentation will provide an overview of their HIV Prevention Program: the HBCU presentation will describe their use of DEBs including SIHLE, SISTA, NIA, and the Popular Opinion Leader and their adaptations to respond to a college environment; the HSI will present data on their adaptation of the SENORITAs program; and the TCU will describe the development of their HIV prevention programs and their inclusion of community elders to ensure that the tribal culture and values are incorporated into all program activities. All schools will discuss their use of peer educators and their role in the campus program, as well as activities to increase HIV testing.

Minority serving institutions offer a unique opportunity to reach young college age minority students. These institutions are eager to participate in HIV prevention activities and offer the opportunity to reach a critical group of students with prevention programs. In order to be successful, programs must be culturally appropriate in order to address the complex HIV prevention needs of a highly diverse student minority population. Approaches to HIV prevention activities must be flexible to allow schools the ability to define and guide the most appropriate prevention modalities.

**Track D**

D17 - Results from a Multi-City Campaign to Promote the Updated Female Condom (FC2) Among High Risk Women

Room: Hanover E (Hyatt Regency Atlanta)

**Abstract 1740 - Community Mobilization to Improve Acceptance of Female Condoms**

**Author(s):** Jennifer D. Medina Matsuki, MPH, CHES; Haven Battles, PhD; Hanna Hjord, MPH; Tracey Packer, MPH

In 2008, heterosexual intercourse accounted for 84% of HIV diagnoses in women while male-to-male sexual contact accounted for 72% of HIV diagnoses in men. Promoting effective HIV prevention strategies for these populations is critical. The female condom (FC) is the only receptive partner-initiated, physical barrier method available that protects against HIV and STIs. However, awareness, acceptance, and access are extremely limited among communities at risk and the health and human services providers who serve them.

During 2010-2011, five large cities: San Francisco, Chicago, Washington DC, New York City, and Buffalo, NY developed new or enhanced existing community-based FC projects to provide increased knowledge of and access to FCs via social media (i.e., Facebook, Twitter, social marketing campaigns, dedicated FC web sites); traditional locations such as health care settings, community-based organizations, and schools; and non-traditional venues such as nail and hair salons, restaurants, and bars.
These five FC projects mobilized consumers and providers in high-risk communities to better understand the benefits of the FC and to increase FC availability with the goal of improving promotion and increasing use of the FC as another prevention option against HIV, STIs, and unintended pregnancy. Each jurisdiction worked independently, but all five projects included the following components: (1) extensive provider training at both traditional and non-traditional venues; (2) social media presence to increase public awareness about the FC; and (3) increased FC availability via one or more of the following: stocking FCs at pharmacies in the family planning section, distributing FCs though non-traditional venues, and increasing free FC distribution at traditional locations through government-sponsored FC supply programs or pooled purchasing programs for those organizations unable to obtain free condoms from their city jurisdictions.

Collaborative training and promotional efforts resulted in large numbers of health and human services providers and their community partners who were better able to promote the FC (e.g., Washington DC and Chicago each trained almost 300 people in one year to be FC educators); increased client knowledge and awareness of the FC (e.g., Washington DC reported a 34% increase in knowledge after training, NYC’s Condom Facebook page has over 15,000 fans, and Chicago’s FC Facebook page has 805 fans); substantially increased distribution and access to the FC (e.g., NYC distributed over one million FCs in 2010 and local pharmacy chains in Washington DC and Buffalo have agreed to stock FCs), increased level of FC purchases (e.g., 20% of surveyed FC training participants in Chicago increased purchasing of FCs), and increased community support of FC promotional activities (e.g., over 3,000 agencies participate in NYC’s condom distribution program and San Francisco has partnered with local schools and the teacher Bus).

Providing comprehensive FC education and skills building to providers, increasing FC promotion to the public via social media, and making the FC readily available to the public are essential components to increasing acceptance of the FC among high-risk populations and the providers who serve them.

**Track E**
**E04 - Biomedical PrEP and PEP**
**Room: Cairo (Hyatt Regency Atlanta)**

**Abstract 1404 - A Post-Exposure Prophylaxis Pilot Program Implemented in Public Health Settings in Los Angeles**
**Author(s):** Robert K. Bolan, MD; Wilbert C. Jordan, MD, MPH; Raphael J. Landovitz, MD, MSc

Post-exposure prophylaxis (PEP) has been demonstrated to be safe and feasible in rigorous clinical trial settings. The real world concerns regarding wider implementation of PEP include feasibility of implementation, operational integration within non-research settings, and sustainability. The iPrEx findings demonstrating efficacy of pre-exposure prophylaxis (PrEP) for men who have sex with men, underscore the need to address implementation and sustainability issues prior to expanding use of such biomedical prevention tools. We report on a community-based HIV prevention pilot program including PEP as part of comprehensive HIV prevention services.

Two publicly funded community-based HIV clinics in Los Angeles.

Between March 2010 and March 2011, PEP was targeted to individuals with high-risk sexual exposures presenting within 72 hours of exposure to the two clinics. The services were part of an Institutional Review Board approved pilot, non-randomized study. Agency staff received training in screening and conduct of a structured protocol, which was developed by a clinical advisory team. Each clinic integrated PEP with existing HIV prevention risk reduction counseling. Ongoing monitoring from pre-implementation through maintenance was conducted by public health staff. PEP consisted of 28-days of antiretroviral medication with either a standard 2-drug regimen for high-risk exposures or an expanded 3-drug regimen for the highest-risk exposures. Feasibility was conceptualized in terms of accrual of eligible participants and completion of PEP with risk reduction. Operational integration was indicated in terms of trained staff, quality assurance, and augmentation of service contracts. Sustainability was defined as progress toward transitioning the pilot into ongoing HIV prevention services.
Two hundred participants who reported a high-risk sexual exposure to HIV and treated with PEP were enrolled within twelve months of operations. Enrollments are ongoing and the pilot will conclude in March 2011. Preliminary analyses indicated that PEP in these clinical settings is feasible to implement, e.g., PEP can be targeted to individuals at high-risk and the combination of PEP and risk reduction is acceptable to participants. Staff trained with the PEP protocol included medical providers, counselors, and HIV prevention staff. Ninety-percent of participants (N/200) completed the 28-day regimen. Three participants seroconverted (1.5%). Baseline characteristics of the initial (N/115) participants were: mean age 32.76 (SD 10.83); 70% uninsured; 54% Caucasian/White, 9% African-American, and 29% Latino/Hispanic; annual income 65% less than $30,000; index exposure 59% receptive anal intercourse and 44% insertive anal intercourse; and mean number of sex partners in the last month 3.1 (SD 3.5). The PEP pilot is being transitioned into ongoing HIV prevention services to be managed by public health staff. The pilot cost $281,000 with donated medications. The lessons learned are: PEP is best coupled with HIV risk reduction counseling; clear implementation protocols and quality assurance can be integrated into existing contracting mechanisms; and feasibility data are essential to ensuring key executive buy-in for sustainability. PEP is an effective complement to the public health HIV prevention toolbox, and augurs well for community-based chemoprophylaxis programs in general to compliment more conventional HIV risk reduction programming.

Abstract 1686 - Patient-Provider Communication around Sexual Behaviors: Potential Barriers to PrEP among MSM Engaged in On-line Networking

Author(s): Rosenberger, JG; Novak, DS; Mimiaga, MJ; Mitty, JA; Mayer, KH

Identification of men who have sex with men (MSM) who may benefit from pre-exposure prophylaxis (PrEP) may be limited by gaps in patient-provider communication around HIV risk behaviors and HIV prevention methods. We surveyed MSM to assess levels of communication with healthcare providers about high-risk sexual behaviors and HIV prevention methods.

In January 2011, we surveyed HIV-uninfected MSM in the US who were members of an on-line sexual networking site about 3 elements of communication with their primary care providers (PCPs): their comfort level in discussing that they have sex with men; if they had discussed having anal sex with men without condoms; and if they had discussed ways to protect themselves against HIV infection. We also assessed demographics, HIV risk behaviors, engagement in healthcare, and interest in PrEP use. We performed logistic regression analyses to identify associations of whether MSM had discussed having anal sex with men without condoms.

4,325 MSM participated in the survey. Mean age was 39 (SD=12.8); 84% were Caucasian, and 86% had completed at least high school. Over the prior 3 months, 45% reported anal sex without condoms with at least 2 male partners, 13% reported anal sex without condoms with at least 1 male partner who was HIV-infected, and 10% reported anal sex without condoms with at least 5 male partners.

Respondents were actively engaged in healthcare, as 89% of MSM had seen a provider in the past 12 months; 82% of MSM identified a PCP, and 88% visited PCPs who practice in a private office setting. A substantial proportion (25%) of MSM reported they were uncomfortable/extremely uncomfortable discussing same-sex behaviors with their PCP, and the majority (66%) had not discussed having anal sex without condoms; 48% had ever discussed ways to protect themselves against HIV. Approximately half (51%) of the MSM would be likely/extremely likely to use oral PrEP, and most (63%) would prefer to obtain PrEP from either their PCP or another healthcare provider. MSM who reported high versus low self-perception of HIV risk (OR = 1.1, CI 1.03-1.11) or reported anal sex without condoms with at least 5 male partners in the prior 3 months versus fewer than 5 male partners in the prior 3 months (OR = 1.1, CI 1.01-1.06) were more likely to have discussed anal sex with their PCP, whereas MSM who self-reported bisexual versus homosexual orientation (OR = 0.2, CI 0.06-0.5) were less likely to have discussed anal sex with their PCP.

MSM who participate in on-line sexual networking show interest in using PrEP, but nearly two-thirds have not discussed high-risk sexual behaviors with their healthcare providers. Though their active engagement in healthcare could facilitate access to PrEP medications, suboptimal communication between patients and providers, particularly among MSM who self-identify as bisexual and who may not perceive themselves to be at high-risk of HIV acquisition, could limit identification of individuals who are most likely to benefit from PrEP. To maximize PrEP use among at-risk
MSM, prevention programs should address ways to enhance patient-provider communication around high-risk behaviors.

**Abstract 1972 - Sex Frequency and Planning Behaviors among MSM Engaged in On-line Networking: Implications for PrEP Dosing**

**Author(s):** Rosenberger, JG; Novak, DS; Mitty, JA

Event-driven dosing of PrEP, whereby chemoprophylaxis is only administered around the time of potential HIV exposure, could offer benefits compared to daily dosing, including decreased pill burden, cost, and side effects. However, if individuals engage in either high-risk behaviors on a frequent basis or unplanned sexual activity that precludes timely administration of PrEP before exposures, daily PrEP may be more appropriate. We assessed sex frequency and planning behaviors among North American MSM engaged in on-line sexual networking to identify PrEP dosing regimens that may be appropriate in this population.

In January 2011, we invited HIV-uninfected MSM in the US and Canada who were members of a large on-line sexual networking website to complete a survey about sex frequency and planning behaviors. Unprotected sex was defined as anal sex with a man without a condom, and planned sex was defined as an intentional arrangement to have sex with a man, such as making an appointment to have sex, or going out to a sex party, bar or club to have sex. We also assessed social and demographic factors, high-risk sexual behaviors (unprotected sex with at least 1 HIV-infected partner or at least 5 partners of any HIV-serostatus over the prior 3 months), and interest in event-driven and daily PrEP use.

4,858 MSM participated in the survey. The mean age was 38.5 (SD = 12.8) years, and 84% were Caucasian. Nineteen percent engaged in high-risk sexual behaviors in the prior 3 months. Among high-risk MSM, 19% reported unprotected sex at least several times per week, and 3% reported daily unprotected sex. In the prior 7 days, 28% of high-risk MSM reported unprotected sex on 1 day, 15% on 2 days, and 18% on 3 or more days; 37% indicated at least 1 unplanned sexual event during that time. For high-risk MSM who reported no sex during the prior 7 days, the most recent sex act was unplanned in 37%. Sex was planned sometimes in 57% of high-risk MSM and never in 13%. Most (76%) high-risk MSM surveyed would take PrEP if they had to take a pill right before and shortly after sex, and 58% would take daily PrEP.

Among high-risk North American MSM who participate in on-line sexual networking and may benefit from PrEP, most reported patterns of sexual frequency and planning behaviors that would support event-driven dosing. However, a substantial subset reported high-frequency sex or unplanned sex behaviors that may require daily dosing. Interest in daily PrEP was high, though a larger percentage of high-risk MSM reported interest in event-driven PrEP. Our results support the rationale for continued studies assessing the efficacy and implementation of intermittent PrEP dosing strategies.

**Track E**

**E08 - Now That a HIV Vaccine Candidate Has Proven Partially Effective, What Next?**

**Room: A701 (Atlanta Marriott Marquis)**

**Abstract 1208 - Now That a HIV Vaccine Candidate Has Proven Partially Effective, What's Next?**

**Author(s):** Katharine Kripke PhD; Prince Bahati Ngongo; Mitchell Warren; Robert T. Chen; Merlin Robb

The HIV vaccine field has been reenergized with the Thai RV144 trial results which showed a prime-boost combination of ALVAC HIV and AIDSVAX B/E lowered the rate of HIV infection by 31% compared with placebo after 2.5 years (declining from ~60% after one year). The HIV prevention field has also been bolstered by recent clinical trials showing efficacy with male circumcision, microbicide, and pre-exposure prophylaxis (PrEP). What are the next steps to bring a HIV vaccine to fruition in this new milieu?

Presenters will present and discuss with the group what their organizations are doing to facilitate the eventual licensure, availability, and implementation of an HIV vaccine. These activities include: 1) basic/applied science (e.g.,
search for a laboratory correlate of protection and broadly neutralizing antibodies); 2) follow up clinical trials (e.g.,
administration of boosters to RV144 vaccinees to see if the duration of protection can be increased and planning
large licensure trials with newer HIV vaccines in Thailand and South Africa); 3) thinking about possible role of partially
effective vaccine in a combination HIV prevention package. At least 30 minutes of the session will be devoted to
discussion with the audience on their perspective, building on the 2002 Advisory Committee on Immunization
Practices HIV Vaccine Working Group recommendations in anticipation of the results of the Phase III trials of the first
HIV vaccine candidate (Vaxgen gp120 AIDSVAX).

The concept that it is possible to make a vaccine that partially protects against HIV has been proven. Several
challenges remain in adding a HIV vaccine to the HIV prevention toolbox. This session will highlight the next steps to
clearing these hurdles.

Track F
F02 - HIV Prevention in the Era of Health Reform
Room: Courtland (Hyatt Regency Atlanta)

Abstract 1652 - HIV Prevention in the Era of Health Reform
Author(s): Peter H Kilmarx

The 2010 Patient Protection and Affordable Care Act includes a wide range of provisions taking effect over the next
four years.

In this seminar, health policy experts will provide an overview of the key elements of health reform and the many
opportunities and challenges relevant to people at risk for or living with HIV infection, community-based
organizations, health care providers, and state and local health departments. There will also be presentations on
scaling up HIV testing in the health reform era and on experience with HIV prevention and health reform in
Massachusetts.

Key elements of health reform include coverage of preventive benefits with no cost sharing; expanding coverage
through Medicaid expansion, health insurance exchanges, and subsidies; new payment and service delivery models,
including health homes; development of a National Prevention and Health Promotion Strategy; establishment of a
Prevention and Public Health Fund; and availability of Community Transformation Grants.

Key issues in HIV prevention and health reform in Massachusetts include the value of covered preventive services in
primary care, the potential for freeing up discretionary HIV/AIDS funding, the challenge of adequate primary care
availability, and the ongoing need for specialized outreach and prevention efforts, as well as dedicated clinical care
systems.

Track G
G06 - Integrating HIV Prevention in Substance Abuse Treatment
Room: Inman (Hyatt Regency Atlanta)

Abstract 1337 - Implementation of an Electronic Information System to Enhance Practice at an Opioid Treatment
Program
Author(s): Melissa Chu, MS; Roberto Zavala, MD; Lawrence S. Brown, Jr., MD, MPH

The Addiction Research and Treatment Corporation, an outpatient opioid treatment program that also provides
primary medical care, including HIV/AIDS care for approximately 3,000 predominantly minority adults in New York
City implemented an electronic health information system integrating counseling, social services, medical services,
case management, HIV services, dispensing, and administrative/fiscal data. We combined our in-house dispensing
and social services program with eClinicalWorks, which became available through a grant obtained by the NYC
Department of Health and Mental Hygiene. System performance was studied.
Four domains (Quality, Satisfaction, Productivity, and Financial Performance) were evaluated utilizing a pre and post-implementation research design to assess the effect of the electronic health record. A fifth domain, Risk, was dropped from the analysis due to insufficient numbers for valid statistical comparison. For Quality, orders for hepatitis C (HCV) viral load in patients testing positive for HCV antibody were evaluated, as well as timeliness of annual medical and periodic multidisciplinary assessments. Patient and clinical/managerial personnel Satisfaction were assessed via surveys. Productivity was reported in three areas: number of addiction related counseling services, number of HIV counseling services, and the number of primary medical care services. Financial Performance was assessed by cost per patient visit and revenue per capita staff derived from the corporation’s financial department.

Pre-implementation data for the four specific aims have been collected and analyzed. For Quality, HCV viral load was appropriately performed in 92% of cases; annual medical assessments were timely for 82% of cases; and multidisciplinary assessments were timely at 30 days, 90 days, and annually for 72%, 46%, and 70% of cases, respectively. For Satisfaction, 74% of patients were satisfied or very satisfied with their care, while 33% of clinicians and managers were satisfied or very satisfied with the pre-implementation record system. For Productivity, the number of addiction related counseling services was 64,345, the number of HIV counseling services was 2,680, and the number of primary medical care services was 5,221. For Financial Performance, cost per patient visit was $31.45 and $31.34 for fiscal years 2006 and 2007, respectively, while revenue per capita staff was $75,814 and $66,900 for fiscal years 2006 and 2007, respectively. Post-implementation data has been compiled in the domains of Quality and Satisfaction. For Quality, HCV viral load was appropriately performed in 81% of cases post-implementation, representing a slight decrease from the pre-implementation data cited above. For timeliness of annual medical and annual multidisciplinary assessments the post-implementation performance was 92% and 93%, respectively, a highly statistically significant improvement. For Satisfaction, 73% of patients were satisfied or very satisfied with their care, which represented no change.

The pre-post comparisons compiled thus far indicate a mixed result. Once all data has been compiled, intensive review will be done to make changes to areas where performance fell short, while maintaining areas where performance improved.

Abstract 1557 - Availability of Special Programs for PLWHA in Substance-Abuse Treatment Facilities in the United States, 2002-2008
Author(s): Dionne Godette

Substance abuse is prevalent among a significant proportion of people living with HIV/AIDS (PLWHA). Substance abuse compromises secondary prevention by facilitating the transmission of HIV through sharing contaminated injection drug use equipments and increasing risky sexual behaviors. Substance abuse also contributes to HIV disease progression by suppressing immune response and compromising access and adherence to medical treatments. Substance-abuse treatment programs designed to address the unique needs of PLWHA are central to improving HIV prevention, effectiveness of medical treatments, and quality of life. Data on the availability of substance-abuse treatment programs specifically designed for PLWHA are limited. This study examines trends and determinants of the availability of specialized programs for PLWHA among facilities that provide substance abuse treatment across the United States.

We used seven years of data (2002-2008) from the National Survey of Substance Abuse Treatment Services an annual survey designed to track the characteristics and composition of substance-abuse treatment services in the United States. An average of 13,610 facilities participated in each year’s survey. Facilities indicated whether or not they offered special substance-abuse treatment programs for PLWHA and provided information about their organizational characteristics. We used generalized estimating equations with a logit function to examine trends and determinants of the availability of special programs for PLWHA in these facilities. Time trends were examined with dummy-coded year. Potential determinants examined were organizational characteristics including service settings, ownership, licensure, insurance, and aggregate client characteristics.
Abstract 1594 - Assessing Immediate Outcomes of Early Intervention HIV Training

Author(s): Stephanie Beane; Marie Sutton; Shenee Reid

In the effort to identify new positives and reduce HIV transmission among high risk populations, the Centers for Disease Control and Prevention (CDC) recommends integration of substance abuse treatment and HIV testing and prevention. Between July 2009 and June 2010 nurses and counselors working under Georgia's Department of Behavioral Health (GDBH) in HIV Early Intervention Services (EIS) programs tested 8,850 individuals in substance abuse treatment centers across Georgia; 95% of whom received results. To help prepare EIS substance abuse workers for HIV testing and counseling the GDBH's Division of Addictive Diseases, Imagine Hope, and the Southeast AIDS Training and Education Center (SEATEC) collaborated to provide ongoing training. Trainees included EIS counselors, nurses, and social workers who have the opportunity to identify new positives and link clients to HIV care. Two two-day workshops, led by a licensed psychologist, taught client-centered prevention counseling approaches defined by CDC, pre- and post-test counseling strategies, harm reduction techniques, and OraSure testing technology. Training modalities included didactic presentation, role play, skills building activities, including OraSure testing demonstration by each participant. To determine trainee change in knowledge and skills, pre and post-training evaluation data were examined.

During 2 2-day workshops pre and post-test data were collected from 35 training participants using a 22 item instrument. Items represented 3 constructs: client centered counseling, HIV transmission routes and prevention, and HIV testing and result interpretation. Audience response system (ARS) technology was used to administer assessments and facilitated learning by encouraging interactive engagement (Moredich & Moore, 2007).

There was an average 18% increase of questions answered correctly from pre (67%) to post-test (85%). A paired samples t-test was conducted to evaluate the difference in raw score means from pre to post-test. The results indicated that post-test scores (M=18.8, SD=.259) were significantly higher than pre-test scores (M=14.8, SD=.388), t(34) = 10.461, p<.01. The standardized effect size index, d=1.53, was calculated to determine the magnitude of difference between pre and post-training scores. By common standards an effect size of .8 is large, indicating the difference between pre and post-training scores is practically significant.

The results of pre and post-test data indicate EIS workers that participated in training gained necessary knowledge and skills to provide prevention counseling and testing for substance abuse populations. Preparing those working with high risk populations is a precursor to meeting the CDC's call for advancing HIV prevention by testing individuals unaware of their status in untraditional settings. Further data collection scheduled for March of 2011 will include a follow up survey to gauge the extent to which knowledge and skill gain are transferred into practice in the care setting.


Abstract 1915 - HIV/AIDS Risk Reduction and Decreased Substance Use among African-American Women in Metropolitan Atlanta


African-American women continue to be disproportionately impacted by sexually transmitted infections (STIs). Increased STI prevention knowledge, coupled with culturally sensitive intervention strategies, hold promise for reducing risk behaviors that can lead to contracting HIV/AIDS and Hepatitis among special populations, including individuals who were previously incarcerated or those living in transitional living facilities. The Wholistic Stress Control Institute, Incorporated and Morehouse School of Medicine Prevention Research Center partnered to assess the Health, Enlightenment, Awareness, and Living Program (HEAL) approaches and outcomes.

The HEAL Program served African-American re-entry and non-re-entry women ages 18 to 55 at Atlanta Union Mission, Dismas House and other facilities in Fulton and DeKalb counties in Metropolitan Atlanta.

HEAL was implemented among 355 predominately African-American (77%) women from 2005-2010, with 29.6% re-entering the community following incarceration and 32.0% of participants self-reporting being homeless or currently living in a shelter. The intervention delivered an eight-week substance abuse, HIV/AIDS, and Hepatitis prevention program, for a total of 16 prevention sessions and referral recommendation services. Paired-sample t-test and McNemar tests analyses compared pre-test and post-test results. Focus groups provided participants the opportunity to discuss their thoughts regarding key program elements.

Statistically significant increases in Hepatitis (p=.000) and HIV/AIDS (p=.008) knowledge were observed. Decreases in self-reported use of alcohol (p=.011), marijuana (p=.011), illegal drugs (p=.002), cocaine/crack (p=.003), and being very drunk (p=.007), were also statistically significant. There was a significant decrease in the number of adult participants who had sex while under the influence of drugs or alcohol (14%) (McNemar test p = 0.000), had unprotected sex in exchange for money, drugs or shelter (6.1%) (McNemar test p = 0.008), and had unprotected sex with a partner suspected of having a STD (3.6%) (McNemar test p = 0.039), from pre- to post-test survey. In addition, there were also increases seen for self-reported condom use. Participants identified Hepatitis and STI knowledge as salient topics, with instructors compassion, positive energy, and willingness to share personal experiences as positively central to their HEAL experience. When discussing the ability to avoid risky behaviors in the future, many participants discussed recalling knowledge or information gleaned from HEAL sessions. Participants also cited social support, such as that received from participation in meetings and/or discussions with other program participants.

The community-campus partnership forged by Wholistic Stress Control Institute, Incorporated and Morehouse School of Medicine Prevention Research Center to assess HEAL identified a model that integrates HIV/AIDS, substance abuse, and Hepatitis knowledge with discussion of consequential outcomes. These traditional approaches were coupled with supportive learning environments and relationship building, toward prevention strategy development. Results hold implications for the design of community-based interventions and the community-campus partnerships to assess them.
Tuesday, August 16, 2011
Concurrent Sessions
1:30PM-3:00PM

Track A
A07 - Condoms from the Commissary: Lessons Learned about HIV Prevention in the Big House
Room: Baker (Hyatt Regency Atlanta)

Abstract 1487 - HIV Testing Focus Groups in New York City Jails: A Model for Prevention and Intervention
Author(s): Ariel Ludwig; Homer Venters, MD

Rapid testing rates for HIV have significantly increased on intake to New York City jails from less than 5% five years ago to a current 30%, with a positivity rate of under 0.4%. However, a 2006 serosurvey found that 6.5% of men and 14% of women in New York City jails are living with HIV/AIDS. Approximately 2.5% of men and 7.3% of women self-disclose their HIV+ status on intake, potentially leaving around 1,838 individuals annually who are positive but who may not know their status, and therefore do not receive necessary treatment or discharge planning. Since all inmates are routinely offered a rapid HIV test upon entry into jail as well as at subsequent encounters, further investigation into reasons for refusal was warranted.

New York City has one of the largest jail systems in the United States with around 95,385 admissions annually across 11 facilities, and an average length of stay of 49 days.

The objective of these focus groups was to identify patient experiences, beliefs, attitudes and perceptions surrounding HIV testing in New York City jails in order to improve testing practices. Focus group participants were inmates who declined HIV testing and included male and female young adults, unsentenced adults and sentenced adults. Transcriptions were made from audio-recordings and were analyzed using Atlas.ti.6.

Between August and October, 2010, 13 focus groups were conducted across 4 facilities with 134 participants. The most common reasons expressed for refusing testing were: lack of confidentiality (75), fear of results (44), mistrust of jail medical services (27), and recent testing in the community (25). Despite this, 95% of participants thought it was good that HIV testing is offered in jail.

Participants were also asked to rate their perceived risk of HIV exposure. Of the responses, 55% percent believed they were at high risk, 32% believed they were at low risk and 13% believed they were not at risk. When assessing knowledge of HIV transmission, the most commonly discussed modes were blood-to-blood contact (42), unprotected sex (42), fighting and human bites (13), and mother-to-child transmission (12). While the groups generally had knowledge about HIV/AIDS, some common conspiracy theories and misconceptions persisted, including beliefs that: there is a cure only available to the wealthy (15), it is a man-made disease created for population control/genocide (14), and that the virus can hide in the body, undetectable, for years(10).

At the end of each focus group, moderators had the opportunity to answer questions and address misconceptions that arose during the session. An unexpected outcome was that 74% of focus group participants reoffered testing accepted.

These focus groups lent insight into both the barriers to HIV testing in jails as well as the utility of focus groups as a method to increase testing acceptance. While focus groups are rarely used in correctional settings, they provide a cost-effective tool for both data collection and health behavior intervention.

Abstract 1698 - Condom Distribution in Jail to Prevent HIV Infection
Author(s): Nina Harawa; Mary Sylla; Christopher Hallstrom; Peter R. Kerndt

Prisons and jails have been implicated as places where HIV and syphilis transmission occurs among male inmates. Interventions to reduce HIV transmission among inmates are critically important because the number of men (particularly African-American men) incarcerated in the US has quadrupled since 1980. Jail units that house self-
identified men who have sex with other men (MSM) separately from other inmates may experience particularly high rates of HIV transmission due to the high rate of prevalent HIV and other STIs. This paper examines the cost effectiveness of a condom distribution program in such units, using data from the MSM unit of the Los Angeles County Sheriff’s Department.

The analysis contrasts the net societal costs and numbers of HIV infections among jail inmates in segregated MSM units who have access to condom distribution and those who do not. Data on sexual activity among inmates are derived from surveys in the MSM unit before and after implementation of the condom distribution program. Costs of distributing condoms in the MSM unit were collected for a recent representative month. Mathematical modeling estimated numbers of HIV transmissions in the presence or absence of the condom distribution program. The discounted cost of treating a person with HIV was multiplied by the estimated numbers of HIV infections averted by condom distribution to determine treatment costs averted.

The monthly cost of the condom distribution program in the MSM unit was modest, $961 per month. In the base case, condom distribution was predicted to avert 0.34 HIV infections per month in a population of 320 inmates, resulting in discounted societal cost savings of $102,490 over the next 32 years. Sensitivity analyses show that condom distribution can be cost saving; that is, the savings to society from averting HIV infections exceed the cost of the program. We found that the number of HIV infections averted was sensitive to the percentage of anal sex acts for which a condom was used.

Condom distribution in jail units devoted to MSM yields a high rate of return on investment. For each dollar spent on the program, societal savings exceed $10. Therefore, we recommend expanding condom distribution to other such segregated MSM units and exploring the applicability of condom distribution programs to general populations of jail and prison inmates. We found that the effectiveness and cost-saving of the jail-based condom distribution program depended on how much risk behavior is reduced (i.e. how many sex acts are not protected by condoms). Therefore policies that provide limited access to condoms (like the policy in the Los Angeles jails of distributing only one condom per week) may decrease the cost effectiveness of such programs.

**Abstract 1916 - A Transitional Case Management Intervention among HIV-positive Inmates in Los Angeles County: Lessons Learned**

**Author(s):** Trista A. Bingham; Mary Sylla; Angela Boger

Incarcerated individuals living with HIV/AIDS experience many barriers to HIV medical care when released back into the community, including: substance use, homelessness, and mental health issues. Without continuity of HIV treatment, released inmates may put sexual partners at increased risk for HIV infection and risk the deterioration of their own health. While transitional case management (TCM) is a common method used to assist HIV-positive inmates with their transition back into the community and into healthcare, little information has been published to demonstrate the most effective TCM models for linking inmates to HIV care upon release.

The Center for Health Justice and the Los Angeles County Department of Public Health conducted a randomized control trial (RCT) of HIV-positive inmates in the Los Angeles County Jail. Eligible participants included those who were newly diagnosed or who had not had a medical visit in the 12 months prior to their current incarceration. After obtaining informed consent, we administered a baseline assessment (using 3-month recall period prior to incarceration), and randomized participants to either the intervention or standard care condition. Participants randomized to the standard care condition received the existing TCM services. Participants randomized to the intervention received the existing TCM services while incarcerated and received a strengths-based case management model (ARTAS) upon their release. We collected follow-up data at 3 months post release from jail. For this analysis, we examined the prevalence of high-risk behaviors at baseline and our ability to implement ARTAS upon release from jail.

Forty-three participants were enrolled in the RCT between November 2009 and October 2010. Of the 43 participants, 37% reported being newly diagnosed and 23% had an AIDS diagnosis. Fifty-one percent reported being homeless prior to arrest, and 42% reported ever being seen by a mental health provider. Non-injection drug use in the past 3
months was reported by 77% and injection drug use in the past 12 months was reported by 40%. The average number of sexual partners in the past 3 months was 4.7 and 49% reported unprotected sex in the past 3 months. When asked how many times they had been incarcerated, 37% reported more than 10 times. Preliminary data show that of the 22 intervention participants, 45% received the ARTAS intervention upon release, 27% were transferred to prison prior to release, 23% could not be located after release, and 5% had not yet been released. Sixteen of the 43 RCT participants have successfully completed the follow-up assessment, however, 56% completed these follow-up assessments in jail after being reincarcerated.

Although TCM services were available to intervention participants both inside and outside the jail, less than half were able to access these services. In spite of monetary incentives and attempts by the ARTAS case manager to build rapport with the participants while still incarcerated, challenges such as homelessness and substance use likely reduced our ability to reach participants once they were released. Our findings suggest that additional methods are needed to link newly released HIV-positive inmates to HIV care.

Abstract 1956 - Condom Distribution Program in the Los Angeles Men's Central Jail: Sheriff Deputy's Attitudes and Opinions
Author(s): Nina T. Harawa

As part of a condom distribution program in the K6G unit of Los Angeles Men's Central Jail (MCJ), condoms are distributed to inmates, one condom per week. The K6G unit is comprised of males who have sex with males (MSM), whether gay, bisexual or transgender. Few data are available on the safety and effectiveness of in-custody condom distribution programs and on how such programs are received by jail staff. The current study was conducted to better understand how acceptable the program is to staff and to describe their experiences and opinions, specifically in regard to the program's safety, orderliness, and effectiveness.

Between April and October 2009, 10 interviews (mean length = 35 minutes) were conducted with the unit's line staff (n= 8) and administrative staff (n=2). 9 were male and 1 was female. The average length of experience working in the Los Angeles Sheriff's Department was 14.8 years and 1.7 years working within the K6G unit. The semi-structured interviews were completed one-on-one by a male ethnographer in a private area of the jail and were recorded and transcribed for coding.

Staff described the overall experience of working with the population inside the unit as shocking at first and having to get used to. One emerging theme prevalent during interviews is the mixed message sent to inmates by the condom program's implementation, there is a sign over the unit that states having sex in a jail facility is a felony and directly beneath the sign is a disposal unit for used condoms. However, the majority of staff acknowledged that sex would occur with or without the program and that the program did not cause an increase in sexual behavior. All of the participants interviewed felt the program did not significantly affect unit operations and that it was conducted in a very orderly manner. There were very few safety hazards recalled. Commonly reported condom-related incidents included there being used as balloons and hair ties. Deputies reported that only on rare occasions did they find used condoms that had not been disposed of properly. All but one of the interviewees felt the program should continue even if the program conflicted with their personal moral beliefs. The most common reason given for supporting the program was reducing the spread of HIV and other STDs. Finally, 6 of the 10 jail staff felt that more than one condom per week should be provided.

Los Angeles County is one of just 5 jail systems to make condoms available to its inmates. These summary findings suggest that condom distribution to inmates causes few operational and safety concerns and that jail staff feel it is worthwhile for inmates that do engage in sexual activity. Staff generally agreed that the program should continue to occur in the K6G unit, nevertheless, none of the interviewees felt the program should be expanded to the general population. The existence of a dedicated unit for MSM seems to be a key to the condom programs acceptance by staff.
Abstract 1227.3 - Racial Disparities in Antiretroviral Therapy among HIV-infected Men who Have Sex with Men

Author(s): Linda Beer; Alexa M. Oster; Christine L. Mattson; John Wen; Mark S. Freedman; Eduardo Valverde

Recent U.S. HIV prevention strategies identify reduction of disproportionate rates of HIV acquisition among black men who have sex with men (BMSM) as a primary goal. However, reasons for these disproportionate rates are not well understood. Studies indicate that HIV-infected persons with higher HIV viral loads are more likely to transmit HIV. Compared with whites, HIV-infected blacks have lower prevalence of antiretroviral therapy (ART) use, lower adherence to ART, and poorer health status. Because research shows that BMSM are more likely to choose other BMSM as sexual partners, lower ART use and adherence and resulting higher viral loads may account for some of the racial disparity in new HIV infections. Understanding the factors that produce these disparities will contribute to efforts to decrease HIV infection in this population.

We conducted a cross-sectional analysis using interview data collected from 6/2007 to 9/2008 from the Medical Monitoring Project, a supplemental surveillance system that monitors behavioral and clinical information on HIV-infected adults receiving care in 19 states and one U.S. territory. We compared HIV viral loads, ART use, and ART adherence between BMSM and white men who have sex with men (WMSM). Additionally, multivariate logistic regression models were built to assess factors associated with self-reported ART use and 100% adherence to ART.

Among 273 BMSM and 685 WMSM, BMSM were more likely to report recent detectable viral load test results (odds ratio [OR]=1.7, 95% confidence interval [CI]=1.1-2.5). WMSM reported higher levels of ART use (OR=1.7, CI=1.0-2.8) and adherence to ART (OR=2.0, CI=1.1-3.4). On multivariate analysis, factors associated with ART use were self-reported nadir CD4<200 (adjusted OR[aOR]=16.7, CI=7.2-38.5) and 200-349 (aOR=5.5, CI=2.7-11.2) compared to >500  cells/mL, age 35-44 (aOR=2.3, CI=1.2-4.6), 45-54 (aOR=2.6, CI=1.3-5.4), and >55 (aOR=6.3, CI=2.1-18.7) compared to 18-34 years, and having continuous health care coverage for the previous 12 months (aOR=1.9, CI=1.1-3.4). Race was not significantly associated with ART use in the final model. Among those on ART, factors associated with adherence to ART in the past 48 hours were a per-unit decrease in number of daily medication doses (aOR=0.7, CI=0.6-0.8), attainment of a Bachelor's degree or higher (aOR=3.0, CI=1.6-5.6), no binge drinking in the past 30 days (aOR=2.5, CI=1.3-4.6), continuous health care coverage in the previous 12 months (aOR=2.3, CI=1.2-4.5), and HIV care visit in the previous 6 months (aOR=4.3, CI=1.3-13.9). Race was not significantly associated with adherence after adjusting for these factors.

Although HIV-infected BMSM reported higher viral load test results and lower ART use and adherence compared to WMSM, these differences did not persist on multivariable analysis and may be attributable to sociodemographic and clinical factors. Improvements in health care coverage and utilization and lower-dose ART regimens may increase use of and adherence to ART among MSM. Continued efforts to understand the roles of HIV viral load and ART in disparities in HIV transmission may help inform efforts to reduce HIV transmission among BMSM.

Abstract 1227.4 - Representing the Population of U.S. HIV-infected Adults in Care: Findings from the Medical Monitoring Project

Author(s): Linda Beer; Janet M. Blair; Emma L. Frazier

The objective of the Medical Monitoring Project (MMP) is to collect data from a nationally representative probability sample of adults receiving care for HIV infection, patients who comprise only a small part of the general population. Compared to health surveys of the general population, special challenges arise with respect to creating a sample frame, identifying and locating members of the population, and tailoring survey procedures. We describe the methodology for this complex, multi-stage sample, assess how effective MMP methods were in obtaining data about
and from persons in care for HIV, and evaluate whether the survey produced estimates that generalize to the larger population of HIV-infected adults receiving care in the U.S.

The survey employs a multi-stage sample of states, facilities providing HIV care, and their patients in care. States were sampled with probability proportional to size, with the number of people living with AIDS in 2003 as the measure of size; facilities are sampled with probability proportional to their caseloads of HIV-infected patients; and then patients are sampled from participating facilities. Sampled patients are contacted for interview and their medical records are abstracted.

Basic demographic information is obtained for all sampled patients from state surveillance databases or other sources. This "minimum dataset" (MDS) is an adjunct to the patient interview and medical record abstraction components of the study, but is itself a probability sample containing valuable and novel information about adults in care for HIV/AIDS. We use MDS information and facility characteristics to adjust for nonresponse at the patient and facility levels, creating weights that allow survey results to be generalized to the population level.

Facility response rates were in general high, ranging from 44% to 100% across project areas with a median response of 82%. Patient interview response rates were lower, ranging from 25% to 71%, with a median response of 56%. Taking account of both patient and facility sampling fractions, we succeeded in obtaining in-person interviews from subjects representing more than 42% of the target population and abstracted medical records data from subjects representing more than 50% of the population. Examining the characteristics of those sampled, we found that men and younger patients were significantly less likely to participate. We incorporated these factors in weighting adjustments to reduce nonresponse bias.

It proved feasible to obtain the data needed to implement a multistage design for sampling HIV-infected persons under medical care with known probabilities. The experience that CDC and project areas gained in implementing MMP may inform other surveillance projects and studies focused on small populations. MMP results provide valuable population-based information not previously available from existing data sources on the characteristics and experiences of HIV-infected adults.


Author(s): Sean Schafer; Haiou He

According to HIV public health surveillance reports, approximately 5,000 Oregonians are aware of their HIV infection and receiving treatment. Most of these are men. Among this group, the number and characteristics of those that currently engage in high-risk sex behaviors has not been described in Oregon.

Data were collected through interviews with HIV-infected patients seen for ambulatory HIV care in Oregon facilities during 2007 and 2008 cycles as part of the Medical Monitoring Project, a supplemental HIV surveillance project funded by the Centers for Disease Control and Prevention that assesses the clinical and behavioral outcomes of HIV-infected persons receiving care in the U.S. For this analysis, we defined risky sex as any anal intercourse without a condom with a partner whose HIV status was negative or unknown to the patient. Analyses consisted of weighted frequencies with 95% confidence intervals, unadjusted relative prevalence estimates with Chi-square tests of significance, and comparison of group means with analysis of variance.

Of the 541 respondents, 89% were male; 60% identified as homosexual, 10% as bisexual, the remainder as heterosexual; 76% were white. Thirty-eight percent of male patients reported no sex partners and 30% only one sex partner during the previous year. Only 8% of male patients reported having risky sex. Being younger than 35 years of age (relative prevalence [RP] = 4.1), receiving HIV care in an Portland metro-area facility (vs. rural and other urban areas) (RP=1.4), and having never had an opportunistic infection (RP=2.1) were all significantly (p<0.05) associated with having engaged in risky sex. Men who engaged in risky sex had been infected an average of 9 years compared to 13 years for those who denied risky sex (p<0.05). Better overall health (RP 1.5) and receiving most of one's income from salary (RP=1.8) were not significantly associated with risk sex.
A small minority of HIV-infected men in treatment in Oregon participated in high-risk sex. Future efforts to prevent HIV transmission from those aware of their infection should focus on patients who are younger, employed, and more recently infected.

**Abstract 1461.4** - Barriers and Unmet Need for Supportive Services for HIV Patients in Care in Los Angeles County, California

**Author(s):** Amy Rock Wohl, PhD; Judith Tejero, MPH; Juli-Ann Carlos, MPH; Rhodri Dierst-Davies, MPH; Eric S. Daar, MD; Homayoon Khanlou, MD; Joseph J. Cadden, MD; William Towner, MD; Douglas Frye, MD

HIV-infected patients face multiple psychosocial challenges including depression, drug use, inadequate housing, lack of transportation and unemployment. These issues can be associated with missed HIV primary care visits, suboptimal medication adherence and poor quality of life. While supportive services are often available in the U.S. through the Ryan White Care Act and other sources to help HIV patients manage their competing needs, it is important to understand gaps in services.

As part of the CDC-funded Medical Monitoring Project(MMP), supportive service needs and unmet need was characterized for 333 HIV-infected patients from a representative sample of primary HIV care clinics(n=37) in Los Angeles County(LAC) in 2007 and 2008. Participants were asked about their need for a variety of supportive services including but not limited to case management, mental health or drug and alcohol treatment, dental and shelter/housing services. Unmet need was defined as a need for a service in the previous 12 months that was not received. Low socioeconomic status(SES) was defined as receiving public assistance, reporting an income <$10,000, being unemployed or homeless. Socio-demographic factors associated with any need or unmet need for services was examined using logistic regression and differences in the need for specific services by race/ethnicity were analyzed using chi-square analyses.

Among this sample of HIV-infected patients(n=333), 71% reported a need for at least one supportive service(n=236) and 35%(n=117) reported at least one unmet need for services in the previous 12 months. African Americans were more likely than whites and Latinos to need case management(p<.0001), homemaker services(p=.005), shelter/housing(p=.01), and transportation services (p<.001). Latinos were more likely than African Americans and whites to need meals/food services(p=.04). In a logistic regression analysis that included all participants, those with a low SES (OR=2.5; 95% CI:1.4-4.5) were more likely to report at least one service need. Among Latinos, those who completed the study survey in Spanish were more likely to report at least one service need (OR=3.5, 95% CI:1.2-9.6). Among whites, those with a low SES (OR=3.8, 95% CI: 1.5, 9.3) and those without health insurance (OR=9.3, 95% CI:2.8, 31.5) were more likely to have at least one service need. The main factor associated with at least one unmet need for a service was gay or bisexual sexual orientation (OR=2.8; 95% CI:1.3-6.0). Although the study response rate was low (40%), demographic comparisons of MMP participants to local surveillance data and non-participants were similar with the exception of an under-representation of African Americans and youth (ages 18-29) and an over-representation of Latinos and those with an AIDS diagnosis in MMP.

There is a substantial need for supportive services for HIV patients in LAC with more than a third of patients with an unmet need for services in the preceding 12 months. Disparities were observed for a need for supportive services with respect to race/ethnicity and socio-economic status. These data can be used to guide the expenditure of shrinking resources for supportive services for HIV-infected patients in care in LAC.

**Track C**

C04 - Community Mobilization Models for HIV Prevention for MSM of Color

**Room:** Singapore/Manila (Hyatt Regency Atlanta)

**Abstract 1957** - HIV Prevention for MSM of Color- 3 Community Mobilization Models

**Author(s):** (ADD Adolph St. Arromand as a presenter) Rodney McCoy, Jr.; Mia Humphreys; Adolph St. Arromand

**ISSUE:** MSM continue to represent the largest proportion of people living with HIV/AIDS at 56% of the US epidemic. In addition, annual incidence among MSM has increased in each of the last 3 years. (CDC, 2008). Men of Color
consistently comprise the majority of HIV/AIDS cases among MSM. Yet mobilizing communities around HIV prevention for MSMs of Color has been a challenge for years. With funding from the CDC MSM Supplemental Grant, NAPWA, CHLA and MBK implemented such community mobilization initiatives.

All three Projects targeted at-risk MSM of Color in the Washington, DC, Atlanta GA, and San Diego via newly-formed coalitions.

1) NAPWA's Bayard Rustin Project creates a coalition of community-based Coalition Partners and African-American, HIV-positive gay men who serve as HIV Testing Advocates. The project conducts a concentrated HIV testing initiative for high-risk African-American MSM (AA MSM). 2) MBK's Atlanta project incorporates coalition building, and strategic planning into a framework to address the needs of AA MSM. 3) CHLA, in collaboration with the National Youth Advocacy Coalition, addressed the HIV prevention needs of African American and Latino young gay, bisexual, and other young men who have sex with men (YMSM) in San Diego through a coalition of service providers, health department representatives, and community stakeholders that identify and strategically implement structural change objectives.

RESULTS: 1) From September 2010 through March 2011, The Bayard Rustin Project provided webinar trainings, facilitated conference calls, and awarded mini-grants of $1000 for the Coalition Partners to help them develop and produce their testing events. In addition, HIV Testing Advocates conduct targeted street outreach for AA MSM, and tell their stories of living with HIV to encourage at-risk AA MSM to access HIV testing and/or care services.

2) Through coalition building, the sharing of information and resources, and strategic planning, organizations were successful in mobilizing the Atlanta community to train emerging leaders in HIV prevention. As a result, the community has begun planning to create a center for LGBT people of color.

3) For a six-month period in 2010/2011, CHLA provided training and technical assistance with a newly-formed coalition in San Diego to guide a strategic process for creating structural change. Through supplemental funding, CHLA provided seed grant money to the coalition members to implement structural change objective projects to support African American and Latino young gay, bisexual and other YMSM in San Diego.

LESSONS LEARNED: The presentation will highlight best practices and challenges faced by all the projects by discussing each project's Community Mobilization model. Participants will learn how to use a multi-pronged approach in order to successfully mobilize their communities to enhance HIV prevention efforts among AA MSM, as well as to implement structural change. Presenters will form a panel for Q&A.

Track C
C09 - MSM, risk, and interventions
Room: Vancouver/Montreal (Hyatt Regency Atlanta)

Abstract 1323 - Reduction in Unprotected Sex among Methamphetamine-Using MSM: Meta-analysis of Pilot Tests of Four Interventions
Author(s): Wayne D. Johnson; Gordon Mansergh; Mahnaz R. Charania; Elwin Wu; Richard S. Garfein; William A. Zule

Methamphetamine use is strongly associated with increased risk for HIV transmission among men who have sex with men (MSM). We pilot tested four different interventions using common outcome measures of HIV risk reduction among methamphetamine-using MSM. Here we report a meta-analytical summary of change in unprotected sex following the interventions.

Site A tested a 2-week text-messaging intervention in a large city on the US West Coast (N=48 participants with follow-up data). Site B tested a couples-based intervention for black MSM in a large city in the Northeast (N=29). Site C tested a 1-session Motivational Interviewing intervention in smaller cities the Southern US (N=31). Site D tested a client-centered toolbox intervention in Southern California (N=65). We measured change across time from baseline to
follow-up in number of episodes of unprotected anal sex in the prior 2 months. Meta-analysis was used to summarize change across sites. Separate results are also presented by sexual position (insertive versus receptive anal sex) and by HIV status (positive versus negative or unknown). Number of episodes with main and non-main partners was combined in all analyses. Unweighted estimates of the total number of unprotected episodes are provided for baseline and follow-up.

Mean age of participants was 40 years (interquartile range 33-44). 42% were non-Latino black, 31% were non-Latino white, and 18% were Latino. 62% were HIV-positive. Unprotected sex decreased from an unweighted total of 13 episodes to 4 episodes; the meta-analytically weighted decrease was 7.9 episodes (95% CI, 5.8-10.1). Unprotected insertive sex decreased by 4.1 episodes (CI, 2.9-5.3). Unprotected receptive sex decreased by 4.0 episodes (CI, 2.5-5.5). Among HIV-positive men, unprotected sex decreased by 7.1 (CI, 4.6-9.5) episodes. Among men whose HIV status was negative or unknown, the decrease was 7.8 (CI, 4.4-11.3). In analyses by site (not shown here), all summary changes were in the favorable direction; most effects were statistically homogeneous across sites.

Although no control groups were available for this pilot test, pre/post-test results preliminarily indicate that a range of behavioral interventions can assist methamphetamine-using MSM in reducing risk for acquiring or transmitting HIV. These interventions warrant further research to determine efficacy compared to control groups.

Abstract 1359 - Sex Party Attendance and HIV Risk among MSM in Massachusetts: Results from Project PARTY screening
Author(s): Blake Rowley; Matthew Mimiaga; Jackie White; Sari L. Reisner; Kenneth H. Mayer

Recent studies of men who have sex with men (MSM) in urban communities have shown that engaging in group sex is becoming increasingly more common and presents a high level of risk. Many MSM report having attended a private sex party in the prior 12 months and prior research has found meeting sexual partners at private sex parties to be associated with increased numbers of sexual partners, unprotected anal sex, and HIV infection among this group.

Between April- November 2010, 93 MSM were screened for Project PARTY, a randomized controlled pilot study examining the feasibility and acceptability of a new HIV prevention intervention designed for HIV-uninfected MSM who attend sex parties and engage in HIV risk behavior. We used logistic regression procedures to examine factors associated with engaging unprotected anal sex (UAS) at the most recent sex party attended by MSM who screened for eligibility into this study.

Men who were screened had a mean age of 40.3 (SD=9.8); 11% were HIV-infected, and 39% reported currently having a female partner. In the prior 12 months, among those who screened, 87% reported attending at least one private sex party, with an average of 5.8 (SD=7.3) private sex parties attended. Only 48% self-reported attending a safer sex party where condoms were enforced in the past 12 months. Twenty one percent reported engaging in UAS at the most recent sex party they attended. In a multivariable, age-adjusted model, UAS with a casual male (outside of the sex party context) in the past 12 months (AOR= 6.45; p= 0.01) and sex with both men and women (AOR= 5.13; p=0.01) were associated with an increased odds of engaging in UAS at the most recent sex party attended.

Among this sample of MSM reporting sex party attendance in the past year, men who reported sex with both men and women, and those reporting UAS outside of parties, were most likely to engage in UAS at the most recent sex party they attended. Interventions, like Project PARTY, are urgently needed to address HIV sexual risk taking behavior in the context of private sex parties.

Abstract 1463 - Social Network Analysis of Methamphetamine-Using Men Who Have Sex with Men in San Francisco
Author(s): Glenn-Milo Santos; Moupali Das; Deirdre McDermott Santos; Priscilla Lee Chu; Grant Nash Colfax

Men who have sex with men (MSM) have disproportionately high rates of HIV infection and methamphetamine use compared to the general population. Substance use patterns, sexual risks, and potential for HIV exposure are influenced not solely by individual behavior, but also by the peers within an individual's networks. We collected
network-level data to describe the composition, connectedness, level of interaction, and risk engagement of methamphetamine-using MSM with their respective methamphetamine and sexual-networks.

We conducted egocentric interviews among 89 MSM who reported sexual activity and methamphetamine use within the past six months. Each participant was asked to identify 1) the three people that they used methamphetamine with most frequently (i.e., their methamphetamine-network); and 2) the three people they had sex with most frequently (i.e., their sexual-network). We asked participants about their perceived emotional closeness (0-10 scale; 0 being least close, 10 being closest), length of acquaintance, frequency of interactions, and their sexual activities with each network member. We constructed sociogram visualizations of participant's networks to identify disparate attributes and compared data between the network types (methamphetamine-network versus sexual-network) using Fisher's exact test for proportions and Wilcoxon rank-sum test for means. Primary partners were excluded in this analysis.

Participants identified 212 unique non-primary-partner network members (165 in methamphetamine-network, 47 in sexual-network). The mean overall network size was 3.18 (SD = 3.1) members; methamphetamine-network mean was 2.13 (SD = 0.87) and sexual-network mean was 0.58 (SD = 1.06; p<0.001). Participants perceived greater emotional closeness (p=0.02) toward their methamphetamine-network (mean 3.44; SD 3.18) than their sexual-network (mean = 2.28; SD = 2.6). Methamphetamine-network members were seen more regularly by participants (p<0.001); participants saw 54.6% of their methamphetamine-network at least once a month and saw 6.4% of their sexual-network with the same frequency. Participants also had longer relationships with their methamphetamine-network (p<0.001); they have known 50% of their methamphetamine-network for at least one year and have been acquainted with 13% of their sexual-network for the same period length. Participants had more HIV-serodiscordant anal sex partners in their sexual-network than their methamphetamine-network (27.7% versus 11.5%; p=0.01); among these partners, participants had similarly high proportions of unprotected anal sex within their two networks (sexual-network 54% versus methamphetamine-network 77% versus; p=0.26).

In this sample of sexually-active methamphetamine-using MSM, participants maintained more extensive methamphetamine-networks than sexual-networks. Moreover, participants perceived deeper emotional closeness and reported more established relationships with their methamphetamine-network than their sexual-network; thus, methamphetamine-network members may exert greater social influence than their sexual-network counterparts. It is possible that our MSM sample's social circles predominantly revolve around methamphetamine use; they may be using methamphetamine to enhance and facilitate social connections with other users these explanations have been documented in qualitative data among this population. The high frequencies of unsafe sexual behaviors between participants and their HIV-serodiscordant network members indicate heightened potential for HIV transmission via different sources. Our data highlights the need for network-level interventions that engage and mobilize pre-existing social ties to disseminate risk reduction strategies, and enhance disease control efforts.

**Abstract 1879 - Integrated Sexual Risk/Trauma Symptom Reduction in MSM with Childhood Sexual Abuse: Pilot Randomized Trial Outcomes**

**Author(s):** onall O'Cleirigh; Ellen Hendriksen; Jillian C. Shipherd; Brett M Goshe; S. Wade Taylor; Kenneth H Mayer; Steven A Safren

MSM represent the single largest group of new HIV infections and the largest group of people living with HIV domestically. MSM with childhood sexual abuse (CSA) histories have higher rates of HIV sexual risk behavior and HIV infection. CSA in MSM have been estimated as high as 47% making it one of the most prevalent syndemic conditions negatively impacting the sexual, physical, and mental health of MSM. Further, emerging evidence suggests that HIV prevention interventions are less effective in MSM with CSA. Accordingly, the aim of this study was to test, in a randomized controlled trial, the impact of a 10-session integrated cognitive-behavioral therapy (CBT) intervention on sexual risk for HIV and trauma symptom severity among MSM with CSA.

HIV-uninfected, MSM with histories of childhood sexual abuse (n = 45) reporting unprotected anal/vaginal intercourse were randomly assigned to receive either HIV testing and counseling and the integrated 10 session CBT intervention or HIV testing and counseling alone. At study entry and post treatment (3 months post baseline) participants completed comprehensive sexual behavior and psychosocial assessment and underwent assessment of...
posttraumatic symptoms by an independent assessor blind to treatment assignment condition. At baseline, participants also completed a rapid HIV test and an interview assessing the presence and severity childhood sexual abuse.

The average age of the sample was 39 years, with 60% identifying as Caucasian, 28% as African American, and 7% as Hispanic/Latino. One quarter of the sample had a college degree or higher and 53% reported an annual income of $20,000 or less. Employing logistic and multiple regression models controlling for baseline, utilizing completer analysis \((n=38)\) the integrated treatment was associated with a statistically significant reduction in the proportion of those reporting sexual risk with serodiscordant partners \((Wald = 5.39: OR = .13 95\% CI: .02 - .73)\). At post treatment 61% of the control group and only 35% of the treatment group reported episodes of unprotected insertive or receptive anal intercourse in the previous 3 months with HIV-infected or unknown status partners. The intervention was also associated with a significant reduction in trauma symptom severity \((t (36) = -2.71, p = .01)\).

The results of this pilot RCT provide encouraging preliminary evidence of the ability of an integrated cognitive behavioral intervention, that addresses co-occurring CSA, to produce large changes in sexual risk behavior post treatment among MSM. These findings suggest that addressing co-occurring mental health issues (e.g., trauma symptom severity) may represent an important innovation to increase the efficacy of HIV prevention programs among MSM. The effect of this intervention on long term follow-up (6 and 9 month) will inform a complete interpretation of these results. However, the smaller sample size requires that these results be interpreted with caution. The next programmatic step is to test the efficacy of this intervention in a full scale trial, with a time matched control, and evaluate the maintenance of treatment effects over time.

This study is supported by an R34 grant from the NIMH (1R34MH081760) awarded to PI: Dr. O'Releigh.

Track C
C16 - Reaching and Intervening with Various Populations
Room: Hong Kong (Hyatt Regency Atlanta)

Abstract 20110 - Barriers and Facilitators Associated with HIV Testing among Latino MSM
Author(s): M. Rosa Solorio, MD MPH; Jane Simoni, PhD; Beti Thompson, PhD; India Ornelas, PhD

Latino men who have sex with men in the U.S. are disproportionately affected by HIV and are at high risk for late HIV detection. Late HIV detection has negative implications for individual morbidity and mortality due to delayed treatment and for HIV prevention in the community due to individuals transmitting HIV to others unknowingly.

Using a community-based participatory research approach, the University of WA principal investigator partnered with a local AIDS service organization, to design an intervention to increase HIV testing among Latino men who have sex with men (MSM). Sixty semi-structured in-depth interviews were conducted to assess barriers and facilitators associated with HIV testing. The interview assessed the following domains: individual factors, health system factors, and counseling and testing factors.

The major barriers to HIV testing included fear of testing positive, confidentiality concerns, denial of HIV risk, HIV-related stigma, lack of knowledge about the benefits of timely HIV detection and lack of information about health care resources. Many men perceived that testing HIV positive was the equivalent of a death sentence and few reported knowing the benefits of timely HIV detection. Due to confidentiality concerns due to tight-knit Latino communities, many MSM indicated a preference for HIV testing sites that do not have Latino staff. Because of their fatalistic outlook on the possibility of testing positive, many MSM contemplate HIV testing for years before actually receiving testing; close to 50% of our sample had never been tested. The factors which facilitated HIV testing included having peer support and having access to HIV testing in a non-medical setting.

The findings indicate a need for the development of an intervention to decrease the time from contemplation of HIV testing to actual testing. Further, it is necessary to promote the benefits from timely HIV detection and instill in
participants accurate perceptions of HIV susceptibility and knowledge about HIV infection. In addition, future interventions will need to reduce fear and stigma from HIV testing.

Abstract 2034 - Feasibility of recruiting African-American and Latino MSM for a Peer-based HIV Intervention on Facebook

Author(s): Thomas Coates

Little research exists as to whether online social network platforms can be used to deliver HIV prevention interventions. This study tests whether participants at high-risk for HIV (primarily African American and Latino men who have sex with men (MSM)) can be recruited online to participate in a longitudinal, randomized controlled trial (RCT) to increase HIV testing using an online social network.

Participants were recruited online for HOPE-UCLA, a longitudinal peer-based HIV prevention RCT that takes place entirely online (intervention carried out on Facebook, baseline and follow-up surveys on Survey Monkey). Participants (primarily African-American and Latino MSM) were recruited through posts and banner ads on social media sites (Facebook, Craigslist, Myspace, etc) and from referrals from existing participants.

One-hundred and twenty-three culturally and racially diverse MSM participants (58.5% Latino, 27.6% African American, 10.6% White, 3.3% other; average age 32 years old) were recruited for the study. Thirty-four percent of the sample completed high school or less education, 21.9% completed an associates degree, 26.9% a bachelors degree, 5.4% a GED, and 11.8% graduate school. A participant validation algorithm found that 5 participants were repeat-participants.

A study that is 100% online (including the recruitment and intervention) allowed for recruitment of a unique sample of participants at high-risk for HIV. Anecdotal reports confirmed that many of the participants had never participated in an HIV prevention study and did not want to disclose their MSM status (i.e., they wanted to remain discreet). User analytic software is helpful to understand sources of participant traffic to the study. Results suggest that African American and Latino MSM can be recruited to participate in culturally and racially diverse HIV prevention interventions using Facebook and other social media sites as platforms to deliver the intervention.

Abstract 2041 - Developing an Intervention to Prevent HIV/STI in Heterosexual Women through Art

Author(s): Jacqueline Cruz Rodriguez; Patricia Noboa; Alana Feldman Soler

The incidence of women infected with HIV through unprotected heterosexual intercourse in the 7 municipalities of the northeastern coast of Puerto Rico exceeds the state 61% rate of infection among women. Since 1989, unprotected heterosexual contact has consistently been the leading cause of HIV infection in women of all ages in Puerto Rico. Young people, especially, are at a high risk when over 71% of sexually active youth in Puerto Rico report engaging in unprotected sex with an average of 2 to 4 sexual partners.

Arte con Salud (AcS) implemented focus groups and pilot sessions in Lola and Carolina, Puerto Rico.

AcS is a 7 session prevention project funded by the AIDS United Foundation whose main goal is to provide safe sex knowledge and negotiation skills and increase inter generational communication among women in communities with limited resources. Expected outcomes are to: 1) increase knowledge about HIV and STIs transmission and prevention, 2) increase risk perception of becoming infected with STIs and HIV, 3) increase knowledge on the proper way to use a condom, 4) increase frequency of condom use in vaginal and anal intercourse, and 5) increase communication between participants and female youth. The team is composed by educational, art, and psychological facilitators. Sessions are: 1: Presentation, 2: Who am I (self-esteem, body), 3: My History (self esteem, image), 4: I (Anatomy, STIs/HVI and vaginal self exam), 5: My Protected Body. (Sexual negotiation), 6: HIV Testing and 7: Me, from now on (Closure).
Art is a technique used to engage participants and to create comfortable spaces to explore women's body, health and sex topics. The creation and artistic transformation of the participants drawn silhouette offers continuity to all sessions.

AcS was conducted in 2 phases. The formative phase conducted 2 focal groups to receive input on curriculum format and content. The pilot phase implemented 2 group cycles to test and modify the interventions.

The formative and pilot phases were useful tools to develop a more assertive curriculum that better responds to local women's prevention needs.

Focus group results redefined the intergenerational communication concept and requirements; confirmed that art was a useful tool for women to talk comfortably about issues of sexuality; strengthened the psychologist's role during interventions; and established that HIV/STI interventions were too scientific. AcS staff modified the curriculum accordingly.

Results from the pilot phase demonstrated that AcS's basic premises were accurate and effective as a prevention and education strategies. Adult women incorporated younger women and sexual partners into HIV testing activities; created a comfortable space for personal discussions on gender, sexuality and prevention; and in evaluations, recognized that eroticizing condom use was a necessary and useful strategy for women's sexual negotiation.

An Implementation phase initiated in February 2011.

**Abstract 2075** - Integrating Condom Skills in Family-Centered Prevention: Efficacy of the Strong African American Families Teen Program

**Author(s):** Steven Kogan; Gene H. Brody, PhD

The Strong African American Families-Teen (SAAF-T) program, a family-centered preventive intervention designed to deter adolescent problem behavior among rural African American adolescents, was evaluated to determine whether it prevented unprotected intercourse and increased condom use efficacy.

African American 16-year-olds (N = 502) and their primary caregivers were randomly assigned to SAF-T (n = 252) or an attention control (n = 250) intervention. SAF-T families participated in a 5-week family skills training program that included an optional condom skills unit after session 4. All families completed in-home pretest, posttest, and long-term follow-up interviews during which adolescents reported on their sexual behavior, condom use, and condom use efficacy. Because condom use was addressed only in an optional unit that required parental permission, we analyzed efficacy using Complier Average Causal Effect analyses which provided unbiased estimates of efficacy for SAF-T youth who participated in the condom skills unit.

Attendance in both SAF-T and the attention control averaged 4 out of 5 sessions; 70% of the youth assigned to SAF-T attended the condom skills unit. CACE models indicated that SAF was efficacious in reducing the frequency of unprotected intercourse and increasing condom use efficacy among rural African American high school students. Parent-youth relationship quality and parents support for educational activities was associated with receiving a full dose of SAF-T.

Results suggest that brief condom skills educational modules in the context of a family-centered program are feasible and reduce risk for sexually transmitted infections and unplanned pregnancies.

**CCT3**

**CCT3-1 - Innovative Approaches and Diverse Perspectives in Community Mobilization**

**Room:** Dunwoody (Hyatt Regency Atlanta)

**Abstract 1267** - Mobilizing Black Communities: Does it Work?

**Author(s):** Spencer Lieb, MPH; Marlene LaLota, MPH; Leisha McKinley-Beach, MS
More blacks in Florida are living with HIV or are already dead from AIDS than any other racial or ethnic group. In Florida, approximately 1 in 44 non-Hispanic black males and 1 in 68 non-Hispanic black females were living with a diagnosed case of HIV/AIDS. This compares with approximately 1 in 209 non-Hispanic white males, 1 in 1,281 non-Hispanic white females, 1 in 117 Hispanic males, and 1 in 472 Hispanic females. There are HIV/AIDS gaps between blacks and whites and gaps between Hispanics and whites, but the black-white gap is the widest by far.

This is a statewide initiative. Community mobilization meetings were conducted in every county in the State of Florida to inform the community about the problem; build trust, credibility, and a sense of ownership with the community; and invite community participation.

The State of Florida has created four community mobilization reports using Persons Living with HIV/AIDS (PLWHAs) data to help mobilize Florida's black communities. The reports are Silence is Death: The Crisis of HIV/AIDS in Florida's black Communities; Out in the Open: The Continuing Crisis of HIV/AIDS among Florida's Men who have Sex with Men (MSM); Organizing to Survive: The HIV/AIDS Crisis among Florida's Women; and Man Up: The Crisis of HIV/AIDS among Florida's Men. These reports have resulted in blacks getting tested for HIV, local governments getting involved, black communities mobilizing to stop the spread of HIV, black churches becoming HIV test sites and reduced stigma.

Racial/ethnic disparities are evident in each county in the State of Florida. The black-white gap is the widest by far. Numerous communities have formed coalitions to strategically work with local county health departments in reducing HIV/AIDS cases and deaths. As a result of the department's mobilization initiative, the St. Lucie County School Board has changed its policy from abstinence only to abstinence plus. The SOS initiative has resulted in thousands of black women getting tested for HIV and taking to pledge to encourage other black women to get tested for HIV. Over the past two years, the State of Florida has witnessed an increase in HIV testing among black/Latino MSM, black/Latina women, and blacks overall. We have observed increased involvement in HIV/AIDS awareness by fraternities, sororities, historical black colleges and universities, the black church and lay people.

Brief reports combining understandable data and a call to action at the individual and community level can result in the mobilization of minority communities and local health departments to reduce HIV/AIDS racial/ethnic disparities. Florida's analytic model may be adopted by other states seeking an enhanced county-level response to the epidemic.

**Abstract 1301 - Philadelphia's Citywide Interfaith HIV/AIDS Prevention Campaign: Results and Lessons Learned**

**Author(s):** Nunn, Handy, Waller, Miles, Thomas, Friend, Cornwall, Chute, Sanders, Mayer

African Americans are disproportionately infected and affected with HIV/AIDS. Philadelphia has the 6th largest epidemic in the nation and wide racial disparities in HIV infection; nearly 70% of new infections are among African Americans and 2% of African Americans in Philadelphia are HIV positive. Philadelphia's faith-based community can potentially play an important role in addressing racial disparities in HIV infection.

In June 2010, we conducted focus groups with African American faith leaders about how to enhance the faith-based response to Philadelphia's AIDS epidemic. These focus groups yielded important information about how to conduct HIV prevention programs in faith-based settings and culminated in a citywide, interfaith HIV prevention campaign. The Interfaith Health Action Alliance of Philadelphia (IHAAP), formed as a result of focus groups, is an interdisciplinary coalition of Pastors, Imams, public servants and researchers committed to reducing racial disparities in health outcomes, particularly HIV infections.

IHAAP conducted a citywide HIV awareness, testing and education campaign in over 50 churches and mosques across greater Philadelphia during November 2010. The campaign's three primary objectives included: cultivating local faith-based leadership in the fight against HIV/AIDS; fighting HIV/AIDS stigma and raising broader awareness about HIV/AIDS, particularly in high incidence zones in Philadelphia; and expanding HIV/AIDS education and testing programs in local churches and mosques.
With support from Clear Channel and Philadelphia’s AIDS Activities Coordinating Office, we posted five billboards in Philadelphia’s highest incidence zip codes featuring prominent Pastors and Imams encouraging individuals to get tested for HIV; these billboards received several million views over eight weeks. With support of Kaiser Family Foundation's Greater than AIDS campaign, we blanketed the city with media messages by strategically engaging the radio, advertising, print media and online media outlets. Media coverage was far reaching; IHAAP leaders participated in dozens of interviews and public service announcements. Additionally, 50 faith-based institutions participated by hosting HIV testing programs, education campaigns, or preaching about HIV/AIDS from the pulpit; we estimate we reached at least 10,000 congregants with HIV/AIDS prevention messages during November 2010. We disseminated locally tailored HIV prevention information in church and mosque bulletins, along with HIV prevention information from the Greater than AIDS campaign.

Lessons Learned: Leadership of pastors and Imams was critical to this successful city-wide HIV prevention campaign. Community-based participatory research that includes cross-sectoral partners provides opportunities for greatly enhancing HIV prevention messages and can be an important catalyst for fighting racial disparities in HIV infection. Engaging a variety of different media outlets is critical for fighting HIV/AIDS stigma, encouraging individuals to get tested, and enhancing HIV/AIDS prevention. Churches and mosques whose leaders preached about HIV/AIDS had much higher participation in testing programs than those in which Pastors and Imams did not. Future programs should should cultivate leaders and encourage Pastors and Imams to discuss or preach about testing and education in advance of programs. The campaign would be enhanced by a rigorous pre and post monitoring and evaluation program.


Author(s): Lovette Ajayi; Karyn Watkins

Social media is becoming an increasingly popular form of media for Americans, specifically women. Over 42 million women participate in social media activity 2-3 times per week on a weekly basis, with 23 million women reading, posting to, and/or publishing blogs. These statistics set the stage for a great opportunity to bring the message of HIV/AIDS awareness and prevention into this arena. While men account for most HIV/AIDS cases, the impact on women is growing with over 280,000 American women (approximately 25% of those living with HIV/AIDS) currently living with this disease. According to the 2005 census, Black and Latina women represent 24% of all US women combined, but account for 82% of the estimated total of AIDS diagnoses for women in 2005.

The rock the Red Pump campaign existed in the virtual space targeting women in the digital space.

With the goal of leveraging the influence of women bloggers, The Red Pump Project was launched in 2009 to mobilize women, particularly women of color, around National Women and Girls HIV/AIDS Awareness Day. Using the image of a red shoe wrapped in the iconic red AIDS awareness ribbon, Red Pump developed a badge for bloggers to display on their sites and encouraged women to share statistics in the days leading up to March 10, 2009 as part of the initial rock the Red Pump online campaign. Red Pump continued its online outreach work by hosting Twitter townhalls, live-blogging HIV conferences, and utilizing social networks such as Facebook to encourage open dialogue about the effect of HIV/AIDS on women.

Since the initial campaign in 2009, the rock the Red Pump campaign has seen much success in building and mobilizing a community of women, particularly women of color. In 2009, 125 websites signed up as participants and supporters. In 2010, the number of participating sites doubled to 256. The 2011 rock the Red Pump campaign is proving to be the largest campaign yet. Over 650 blogs are featuring the widget with less than 30 days left before March 10, 2011. Originally planned to be an online execution only, The Red Pump Project is now a national nonprofit supported on the ground by ambassadors across the country who plan educational events and fundraisers for local HIV/AIDS agencies.

Under the awareness is Always in Style platform, Red Pump encourages women to take a bold approach to HIV awareness prevention. The campaign has received the support of online communities like BlogHer, Blogging While
Brown, and Blogalicious, an annual conference for women bloggers of color. The work of The Red Pump Project has been applauded by organizations such as the U.S. Department of Health & Human Service, the U.S. House of Representatives, and the Congressional Black Caucus.

**Abstract 1928 - Strengthening Community Advocacy in HIV Prevention Research: AVAC's PxROAR Program (Prevention Research, Outreach, Advocacy, Representation)**

**Author(s):** Matthew Rose; Nichole Little; Hadiyah Charles; Venton Jones; Mudia Uzzi; Ebony Johnson; Lisa Diane White

The biomedical HIV prevention research field has had a number of positive research results over the past 18 months. With these results and ongoing/planned vaccine, microbicide and PrEP trials, it is increasingly crucial to ensure that communities are involved in setting the prevention research agenda and that advocacy is rooted in local priorities. Yet, there are limited resources to support local advocates and grassroots networks. Since 2009, AVAC has led a program, PxROAR (Prevention Research Outreach, Advocacy and Representation), which nurtures community advocates. The program's goal is to build the capacity of civil society advocates and organizations--especially in affected communities across the US to monitor, inform and advocate around HIV prevention research; and to increase the cadre of skilled advocates who can contribute to setting the prevention research agenda.

ROAR representatives work in areas with some of the highest HIV prevalence rates in the US: Atlanta, Oakland, New York and DC. Members represent communities highly affected by the epidemic and to whom new prevention options will first be targeted youth, people of color and LGBT.

Program members are trained in biomedical prevention research, advocacy, and communications and, in turn, educate members of their own constituencies in the language and challenges of research. In addition to updating communities they document community responses, acting as essential bridges across the community, policy makers and researchers.

Results: The mentoring and training of advocates results in ongoing mobilization in communities most affected by the HIV epidemic in the US. Well informed and connected communities are able to add to the national debate and shape the prevention research and implementation agendas.

Lessons Learned: There are talented, motivated advocates interested in leadership positions in communities where the results of prevention research are most relevant. ROAR members report that research skepticism and lack of understanding and familiarity with language are serious barriers to community buy-in, but once relationships are forged and people learn more, they become open to the process of getting involved in advocacy, research and/or voicing their needs. Given the challenges of implementing new scientific prevention interventions in these very populations, the advocates work and the mobilization it spawns are imperative for potential acceptance, or rejection, of new interventions by a highly informed constituency.

**CCT3**

**CCT3-3 - The 12 Cities Initiative: What is the Role of Community**

**Room: Regency Ballroom VI (Hyatt Regency Atlanta)**

**Abstract 1846 - The 12 Cities Initiative: Leading a More Coordinated Effort to Accomplish National HIV/AIDS Strategy Goals**

**Author(s):** A. Toni Young; Chris Collins; Anna Ford

The National HIV/AIDS Strategy (NHAS) released by the Obama Administration in July 2010 set ambitious targets in HIV incidence, care access and HIV-related health disparities. In August 2010, the CDC released a funding announcement for a new initiative called Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS (ECHPP). ECHPP provides funding for the jurisdictions to plan more coordinated, targeted and scaled HIV prevention approaches. HHS quickly announced full agency participation in the project as part of NHAS implementation. The 12 Cities concept has the potential to develop
models for HIV programming that effectively integrate HIV testing, prevention and treatment, and expand the research of these services to those most in need. As such, ECHPP can lead NHAS efforts to bring needed systems reforms to US response to HIV/AIDS.

The jurisdictions eligible for the initiative are the 12 Metropolitan Statistical Areas (MSAs) that had the highest estimated AIDS prevalence at the end of 2007. These are: New York City, Los Angeles County, Washington, D.C., Chicago, Atlanta, Miami Philadelphia, Houston, San Francisco, Baltimore, Dallas and Puerto Rico. These jurisdictions represent 44% of the estimated number of people living with AIDS in the US as of 2007.

Looking at ECHPP as a means to drive more strategic, innovative, coordinated, targeted, and scaled prevention efforts in the major epicenters in this country, the presenters have inventoried each jurisdiction's ECHPP plans and planning processes. We have surveyed leaders at the local, state, and national levels on the current challenges in HIV prevention, care, and treatment integration. We monitored HHS oversight of the 12 Cities Initiative, assessed collaboration across federal agencies, and identified the necessary resources to make ECHPP a successful model of systems change.

We have developed an issue brief that includes an assessment of 12 Cities implementation to date and key policy recommendations to advance the ECHPP Initiative. The following are among the policy priorities critical to 12 Cities Initiative success: Adequate and sustainable funding to carry out the project, enhanced cross-HHS and cross-federal Department engagement and visible federal leadership, and identification of resource needs and (where appropriate) resource reallocation. We also find the use of innovative methods to integrate community based organizations and government partnerships, expanded research with a focus on bringing interventions to scale in the most heavily impacted local areas, development and testing of models to reach communities of color, and technical support for innovative activities such as database integration and economic modeling are necessary for optimal allocation of resources.

**Track D**

**D13 - Outcomes and Lessons Learned: Six Studies Evaluating Behavioral Interventions for Latino and African American MSM**

**Room: Hanover F/G (Hyatt Regency Atlanta)**

**Abstract 1266 - Outcomes and Lessons Learned: Six Studies Evaluating Behavioral Interventions for Latino and African American MSM**

**Author(s):** Jocelyn Patterson; Pilgrim Spikes; Heather Joseph; Lydia O'Donnell; Ann Stueve; Nicole Martin; David Fingerhut; David Seal; Gary Hollander; Beryl Koblin; Sebastian Bonner; Maria Fernandez; Nilda Hernandez; Karin Tobin

Latino and African American men who have sex with men (MSM) are disproportionately impacted by HIV/AIDS. According to NHBS (2008), HIV prevalence was 28% among African American MSM and 18% among Latino MSM. When we began the current project (2006), only one behavioral HIV prevention intervention with demonstrated efficacy existed for African American MSM and none existed for Latino MSM. Under this project CDC funded six sites to conduct small-scale randomized control trials to determine the preliminary efficacy of six unique interventions to reduce high-risk sexual behavior for MSM. Four interventions were specifically designed for African American men and two were designed for Latino men.

Six study sites in five US cities developed their own theory-based, group-level HIV prevention interventions ranging from 1-8 sessions. High-risk Latino and African American MSM were recruited and randomized to receive either the experimental HIV prevention intervention or control condition. Across the sites, the control condition consisted of both HIV risk-reduction counseling and testing or only risk-reduction counseling for HIV-positive participants. Sites enrolling African American men did not include HIV status as an eligibility criterion. Latino sites included only those self-reporting HIV-negative or unknown status. Surveys assessing demographics, sexual behaviors, and possible intervention mediators were conducted at baseline and three months after the last intervention/control session. While outcomes varied by site, all sites focused on unprotected sex as a key indicator of intervention efficacy.
Between 2008 and 2009, 1,495 men were randomized with each site enrolling between 170 and 370 men. The mean age was 37 years among African American men and 35 years among Latino men. African American participants reported low annual income (60% less than or equal to $10,000 a year). The annual income for Latino men was higher, 45% made less than or equal to $10,000. At 3 months follow up, retention across sites was between 66% and 92%.

In preliminary analysis, two interventions for African American MSM showed efficacy (p<0.05) in one or more of the following sex outcomes: increase in condom use, decrease in number of sex partners, and decrease in sex while under the influence of drugs. One intervention for Latino men showed significant effects (p<0.05) among men 40 years of age and under in reducing unprotected sex at last intercourse, increasing condom usage with last 2 partners, and increasing in uptake of HIV testing. Three of the interventions were unable to demonstrate any intervention efficacy.

We have developed and evaluated 6 unique HIV prevention interventions for high-risk African American and Latino MSM, 3 of which showed preliminary efficacy. In this forum, we will briefly describe the interventions, present the evaluation results, explore potential core elements of those found to be efficacious, and discuss possible explanations for interventions with null results. We will also reflect on lessons learned from conducting this type of small-scale efficacy project as well as the implications for future intervention development and evaluation. Finally, we will discuss considerations for developing the next generation of behavioral interventions for African American and Latino MSM.

Track D
D18 - CDC Turning Research into Practice: Video Opportunities for Innovative Condom Education and Safer Sex (VOICES/VOCES)
Room: Hanover D (Hyatt Regency Atlanta)

Abstract 1851 - CDC Turning Research into Practice: Video Opportunities for Innovative Condom Education and Safer Sex (VOICES/VOCES)
Author(s): Mary Neumann; Camilla Harshbarger; April Bankston; Alpa Patel-Larson

Over the last two decades, many behavioral interventions conducted in research settings have shown efficacy in changing HIV-related risk behaviors. However, there has been limited information about the experiences of service providers and the outcomes of clients receiving HIV prevention activities by community-based organizations in real-world settings.

VOICES/VOCES is an efficacious behavioral intervention (EBI) developed in the early 1990s for clients at high risk for STD/HIV. It is packaged as a 45-minute single session for groups of 8-12 same-gender/ethnicity participants. A 20-minute culturally-appropriate video is shown followed by a discussion of condom negotiation, demonstration of correct condom use, and distribution of condoms. Multiple agencies in various communities throughout the U.S. have delivered VOICES/VOCES to thousands of clients. Any service provider who delivers or plans to deliver VOICES/VOCES or similar EBIs may benefit from this session.

This presentation shows how VOICES/VOCES has cycled through the CDC Division of HIV/AIDS Prevention (DHAP) research to practice model: Starting with Research -> Research Synthesis -> Packaging and Translation -> Dissemination and Training -> Program Support and Ongoing Technical Assistance -> Monitoring and Evaluation -> Impact Assessment -> and circling back to further research. Different Branches within DHAP are responsible for the results from each step that will directly contribute to public health advances in the research and practice of HIV prevention and move EBIs from evaluation by researchers into implementation by service providers.

Each presenter will discuss steps for moving VOICES/VOCES from research into practice and the experiences, outcomes, and implications of the various projects in the sequence. The Prevention Research Branch conducted the original efficacy research of VOICES/VOCES, packaged and beta-tested it with 6 agencies for dissemination, and
studied its effectiveness in 2 practice settings. The Capacity Building Branch prepared VOICES/VOCES training curricula, trained trainers and over 1800 facilitators, has provided technical assistance to over 800 agencies, and assesses agencies implementation fidelity. The Prevention Program Branch directly funds and monitors the implementation of VOICES/VOCES at 12 community-based organizations delivering the intervention to clients at high-risk for HIV infection. The Program Evaluation Branch conducted a sexual behavior outcome monitoring project of VOICES/VOCES from 2006-2008, including the experiences of 4 community-based organizations delivering and monitoring VOICES/VOCES. Overall, the sexual risk behaviors of clients (e.g. number of partners, number of unprotected anal or vaginal sexual events) significantly declined after participation in the intervention.

The results of each step in the research to practice model show that VOICES/VOCES and other EBIs can be utilized in the field, even with limited resources, and can lead to continual improvement of agency services and positive changes in client behaviors. As more EBIs are evaluated in the field, communicating findings to behavioral interventions researchers, implementers and technical assistance providers can improve HIV prevention services and further reduce HIV/AIDS morbidity.

Track D
D20 - A PLACE--A Community Assessment Tool to Measure Syringe Access Readiness
Room: Hanover C (Hyatt Regency Atlanta)

Abstract 1942 - A PLACE--A Community Assessment Tool to Measure Syringe Access Readiness
Author(s): Katie Burk; Narelle Ellendon

Extensive research has demonstrated that Syringe Access Services (SAS) are effective in preventing HIV and hepatitis C (HCV) transmission among injection drug user (IDUs). While many communities or programs hoping to implement SAS focus solely on the legality of syringe access in their respective jurisdictions as either an enabling factor or barrier, the Harm Reduction Coalition (HRC) has identified several factors influencing the establishment and expansion of SAS.

HRC's Capacity Building Assistants (CBA) for SAS team has utilized the A PLACE framework for needs assessments in New Jersey, Colorado, Arizona, and Nevada.

HRC's CBA for SAS community mobilization team developed A PLACE, an assessment tool to assist agencies and alliances in identifying barriers to and opportunities for SAS in their communities and developing proactive strategies around SAS efforts. A PLACE assesses six crucial components for successful SAS: Awareness, Policy/Practice, Leadership, Alliances, Cultural Competency, and Establishment/Expansion. This framework guides health departments, non-profits, and syringe access advocates through a series of questions measuring their community’s readiness for SAS establishment or expansion. A PLACE can be administered through key informant interviews or surveys and used to guide strategic planning efforts and support coalition-building. Qualitative feedback from the A PLACE interviews guides decisions about what types of capacity building assistance HRC offers to jurisdictions.

In NJ, HRC CBA for SAS staff conducted six key informant interviews with representatives of the five pilot syringe access programs in the state, transcribed the interviews, and analyzed them using a Strengths Weaknesses Opportunities Threats (SWOT) analysis. This analysis was compiled into a needs assessment report and made available to members of the syringe access providers alliance and used to steer their strategic planning process.

In CO, feedback from A PLACE-guided interviews pointed to a need for coalition development and cultural competency trainings for agencies working with IDUs. HRC’s CBA for SAS staff arranged to meet these needs in March 2011 by administering trainings and congregating syringe access stakeholders. In Tucson, AZ, the A PLACE assessment revealed a focus on syringe access service expansion, so CBA for SAS staff offered training to the new syringe access program. In NV, the A PLACE assessment highlighted the need for community awareness and understanding about syringe access services. The CBA for SAS team responded by providing trainings on HCV and syringe access models.
A PLACE is a versatile tool that is adaptable to diverse communities, geographic locations, and institutions. By utilizing A PLACE for community assessment, providers and stakeholders can better understand how to leverage their community's strengths and resources in order to reduce barriers to SAS. This process supports the building of community capacity to integrate successful SAS into HIV and HCV prevention efforts.

**Track D**

**D25 - Mobilizing Youth: Lessons learned from the US and abroad**

**Room: Hanover E (Hyatt Regency Atlanta)**

**Abstract 1292 - Practice Makes Perfect? Training Facilitators for Delivery of an Evidence-based Parenting Program in Sub-Saharan Africa**

**Author(s):** Drewallyn Riley; Kim Miller; Melissa Poulsen

Facilitator-led Evidence-Based Interventions (EBIs) represent a large sub-set of HIV prevention programs globally. While most EBIs conduct trainings for their facilitators, few provide further post-training support prior to the implementation of the EBI.

The Families Matter’s Program (FMP) is a pre-risk HIV prevention EBI that promotes positive parenting and effective parent-child communication about sexuality and sexual risk reduction among parents and caretakers of children aged 9-12 years. Adapted from Parents Matter’s, a US evidence-based intervention, FMP was developed in response to a lack of parent-child communication about sexuality identified by Kenyan youth. FMP is currently being implemented by more than 40 non-governmental organizations, faith-based organizations and Ministries of Health in 5 sub-Saharan African countries. These organizations have certified over 400 facilitators, reaching over 100,000 families.

One male and one female work together to facilitate this complex, multi-session EBI. Facilitator candidates attend a 5-day FMP Training of Facilitators and only those candidates who demonstrate strong facilitation skills, understanding of the program content, and fidelity to the curriculum are certified. Certified facilitators are then guided through a practice week.

During the practice week facilitators deliver the 15 hour curriculum to community participants, allowing them to practice and to become more familiar and at ease with the EBI content. Observers consisting of the Program Manager and a technical assistance specialist utilize a standardized tool to provide feedback on specific facilitation skills they may need to improve upon and clarification on activity objectives. Special attention is paid to the facilitator's fidelity to the program curriculum and time management strategies.

FMP has included the practice week in Tanzania, Zambia and South Africa. Facilitators reported that conducting the practice week with community participants led to greater familiarity and comfort with the curriculum content and increased self-confidence in their ability to deliver the intervention to an audience. Compared to previous FMP countries and the Parents Matter’s Program in the U.S. who did not receive a practice week, process monitoring of the pilot tests showed fewer problems with fidelity to the curriculum and an improved understanding by the facilitators of the objective of each session activity.

The inclusion of a guided practice week provides important one-on-one feedback for facilitators on how to improve their facilitation skills and better deliver the program content. Provision of a practice week for US-based EBIs relying on facilitator delivery of program content may improve facilitator retention and fidelity to the EBI curriculum.

**Abstract 1366 - Developing and Sustaining HIV Prevention Capacity for an Evidence-based Intervention: Lessons Learned from Sub-Saharan Africa**

**Author(s):** Kim Miller; Drewallyn Riley; Melissa Poulsen

Evidence-based interventions (EBIs) are an important component of HIV sexual risk prevention among youth in the U.S. and globally. Implementing EBIs with integrity and fidelity is often difficult in real world settings. Having the proper tools to develop and sustain HIV prevention capacity is critical.
The Families Matte's Program (FMP) is a pre-risk HIV prevention EBI that promotes positive parenting and effective parent-child communication among caretakers of children aged 9-12 years. One male and one female co-facilitate the five 3-hour intervention sessions. Adapted from Parents Matter’s, a US-based EBI, FMP was rigorously adapted, and evaluation data were collected from 375 parents and their children at baseline and one year post-intervention. Evaluation results showed the adapted evidence-based parenting program retained its effectiveness, successfully increasing parenting skills and parent-child communication about sexuality and sexual risk reduction. To retain FMP’s effectiveness as an EBI program, developing and sustaining the HIV prevention capacity of implementing organizations is essential.

To assist organizations in the successful implementation of the EBI, we offer a five-step capacity-building plan: 1) a community needs assessment to ensure that community participants want and need the EBI offered; 2) guided program adaptation workshops to ensure that EBIs are adapted in a culturally appropriate way, and to increase community buy-in and participation; 3) support for recruiting, training, certifying and hiring qualified facilitators; 4) guidance to conduct pilot testing and monitoring activities; and 5) provision of process and outcome evaluation tools for the specific EBI.

More than 40 non-governmental organizations (NGOs), faith-based organizations (FBOs) and Ministries of Health have used this 5-step process, with over 400 facilitators currently delivering FMP. Over 100,000 families have been reached in 5 sub-Saharan African countries. Across countries, 89-97% of FMP participants that start the EBI complete it.

A systematic process such as the one presented here is important for building organizational capacity of NGOs, FBOs and Public Health departments to implement sustainable EBIs in the United States.

**Abstract 1489 - Challenges AA Female Adolescents and Young Adults Face: Contributing Factors for HIV Infections in Mississippi**

**Author(s):** Shemeka Hamlin-Palmer

Women living in Mississippi have seen a significant increase in their infection rate since 2005. A preponderance of these cases is among the African American (AA) population. The number of reported cases of HIV within Mississippi was 9,214 in 2009 with 6,687 reported cases among the AA population. Furthermore, 579 of the reported cases were among AA females between the ages 13 to 24 (Mississippi State Department of Health, 2010). Statistics reveals that HIV infections and transmission problems exist among the adolescent and young adult AA female population in Mississippi.

My Brother's Keeper, Inc. (MBK) implemented three focus groups with AA females between the ages of 14 to 18 who reside in Copiah, Hinds, Madison, Rankin and Simpson counties in Mississippi. Each focus group was held at MBK Wellness Center located in Jackson, Mississippi.

Best Friends Forever (BFF) Project is a five year intervention designed to empower African American females ages 14-18 around topics such as HIV, healthy relationships, self-pride and partner communication skills. Prior to implementing the SIHLE intervention, BFF staff held three (3) focus groups to better understand factors teens consider when making decisions regarding sex and condom use. Also, services they would like to see available within their communities that may help decrease HIV transmission and lastly, how they felt the SIHLE intervention would impact AA female peers.

RESULTS: From September 2010 through October 2010, BFF staff recruited a total of 30 AA females to participate in three focus groups throughout the month of November 2010. Results show most heard of HIV but still did not have a clear understanding how HIV is transmitted, besides that, misconceptions and myths still exist concerning condom use. Participants recommended less abstinence only classes, more HIV/sex education classes in schools and female health symposiums on HIV/STD education. Most importantly, they stressed the need for near aged adults available to counsel on issues dealing with sex, self esteem, violence displayed from partner and teen pregnancy. As well as,
face-to-face with female peers living with HIV to share their story of how they became infected and how living with HIV has impacted their life. In final analysis, most felt they did not have a voice, therefore, issues they were dealing with stayed concealed and questions continued to go unanswered which makes them vulnerable to HIV infections.

LESSONS LEARNED: Based on the focus groups, implementing the SIHLE intervention will provide HIV education in a safe environment and allow AA females to express themselves openly and freely with peers and near age facilitators on issues they face. The expected outcome is to clear up myths and misconceptions which are major contributing factors for HIV infections and transmission among this population and finally, to educate on safer sex practices and reinforce self pride and self worth.

Abstract 1756 - Discussing Abstinence Only Versus Comprehensive Sex Education by Implementing the Focus on Youth EBI
Author(s): Dwayne Morrow

The city of Houston is the 4th largest city in the nation, with a population of over 2 million residents. Houston, along with the rest of Texas, has adopted an abstinence only sex education approach in public schools. Advocates of abstinence-only programs contend that this type of sex education is effective because it instills morals and values at a young age. However, the Guttmacher Institute reports that teenagers living in Texas between the age of 15 and 19 have the second highest number of pregnancies in the nation. African American and Hispanic teens disproportionately become pregnant at a higher rate than other races. Also, in the Houston area alone, 76% of all gonorrhea and Chlamydia infections are among 15-24 year olds. The CDC attributes early age sex initiation and lack of awareness to the rising rates of teen pregnancy and sexually transmitted infections. The objective was to provide students with comprehensive sex education and risk reduction strategies. This was accomplished through values recognition, role playing, risk identification, and the SODA decision making model.

Focus on Youth with ImPACT EBI was taught in various community based venues throughout the city of Houston. These venues included churches, community centers, and juvenile justice probation offices.

The Focus on Youth with ImPACT EBI was the first sex education class for most of our students. 76% of students reported that they had not received any sort of safe sex education class in school. Only 61% of them felt like they knew where they could go to find good information on HIV. By the end of the class, 94% of the students felt like they knew where to go to get good information about HIV transmission and infection. We were able to address common HIV transmission myths. 57% of the students believed that you could get HIV from mosquitoes initially. This number decreased to 30%. Students also showed increased confidence in correct use of barriers. At the beginning of the program 71% of students believed that correct condom use could protect them from HIV. By the end of the program, this number increased to 94%.

Implementing the Focus on Youth with ImPACT EBI an effective method to reach youth. Providing the youth with comprehensive safer sex education is a good way to reduce teen pregnancy and STI rates.

Track E
E05 - CDC’s Expanded HIV Testing Program: Successes, Best Practices and Lessons Learned
Room: Cairo (Hyatt Regency Atlanta)

Abstract 1416 - CDC’s Expanded HIV Testing Program: Successes, Best Practices and Lessons Learned
Author(s): Samuel Dooley; Erica Dunbar; Benny Ferro; Priya Jakhmola; Kimberly Thomas; Christopher Brown

In the United States, African Americans continue to be disproportionately affected by HIV/AIDS. Representing only 12% of the U.S. population, African Americans account for almost half (46%) of the more than one million people estimated to be living with HIV/AIDS in the United States and almost half (45%) of newly reported HIV infections. In 2008, the Centers for Disease Control and Prevention (CDC) estimated that 21% of persons living with HIV in the United States did not realize they were infected. HIV-infected persons who are undiagnosed miss opportunities to
seek care and to protect their partners from infection. HIV testing provides a critical pathway to prevention, care, and
treatment services that may lead to improved health outcomes and reduction of HIV transmission.

Expanded HIV Testing Program (ETP) activities were implemented across the United States in healthcare and non-
healthcare settings.

In 2007, CDC funded a three-year Expanded HIV Testing Program: PS07-768 Expanded and Integrated Human
Immunodeficiency Virus (HIV) Testing for Populations Disproportionately Affected by HIV, Primarily African
Americans to 1) increase HIV testing among populations most affected by HIV and 2) identify HIV-infected persons
who were previously unaware of their infection. Health departments in jurisdictions with an estimated 140 or more
AIDS cases among blacks diagnosed in 2005 were eligible for funding.

To accomplish the goals, grantees implemented a number of activities, including the establishment of routine opt-out
HIV testing programs in accordance with CDC’s 2006 Revised Recommendations for HIV Testing of Adults,
Adolescents, and Pregnant Women in Health Care Settings, as well as activities covering monitoring and evaluation,
data collecting, reporting, management and staffing, capacity building, quality assurance, and accountability.

Twenty-five health departments (20 states and five cities) were funded to expand their HIV testing efforts and identify
more persons with previously undiagnosed HIV infection. During the first 2 years, grantees conducted more than 1.4
million HIV tests and identified more than 10,500 new HIV-positive clients. The majority of tests were conducted
among African Americans (62%), followed by whites (18%) and Hispanics (15%). Seventy percent of newly
diagnosed positive tests were among African Americans, 14% among whites, and 11% among Hispanics. Among
persons with newly diagnosed HIV infection, 86% received their test results, 75% were linked to medical care, and
78% were referred for partner services. Major barriers to program implementation included legislative, start-up,
financial, operational and staffing issues. The objectives of this presentation are to 1) describe from a national
perspective the key components, achievements, and lessons learned of the three-year program and 2) describe
experiences, achievements, and lessons learned from the health department perspective.

Implementing routine HIV testing locally requires substantial resources and time. Comprehensive strategic planning,
flexibility, creativity, and leadership are needed to overcome resistance to change and increase program success.
While program implementation was initially beset with startup challenges and unanticipated barriers, during years two
and three grantees addressed most of these challenges and markedly improved their performance.

Track F
F03 - Community Mobilization Targeting African American and Latino young gay:Lessons learned from San Diego
Room: Courtland (Hyatt Regency Atlanta)

Abstract 1797 - Community Mobilization Targeting African American and Latino Young Gay Men: Lessons Learned from San Diego
Author(s): Mia Humphreys; Eugene Beronilla; Catrina Flores; Lori Jones; Nicholas Lagunas; Antonio Munoz

The Centers for Disease Control and Prevention (CDC) has named the San Diego Metropolitan Statistical Area
(MSA) as one of the top 20 MSAs in the United States that comprise 75% of the cumulative number of AIDS cases
among African American and Latino gay, bisexual and other men who have sex with men (MSM). In 2010, CDC
released one-time supplemental funding for Capacity Building Assistance (CBA) providers to address the HIV
prevention needs of this population through targeted community mobilization projects that support HIV testing,
linkages to HIV prevention, treatment and care services, reduction of stigma and efforts to address the social
determinants of HIV-related health disparities. Children’s Hospital Los Angeles, in collaboration with the National
Youth Advocacy Coalition and San Diego community partners, was funded to address the HIV prevention needs of
African American and Latino young gay, bisexual, and other young men who have sex with men (YMSM).
CBA services were provided to a newly formed coalition of service providers, health department representatives, and community stakeholders to address the HIV prevention needs of African American and Latino young gay, bisexual and other YMSM in San Diego.

Over a six-month period, Children's Hospital Los Angeles and the National Youth Advocacy Coalition provided seven trainings and on-going technical assistance to a coalition of service providers and community stakeholders in San Diego related to two community mobilization models. Children's Hospital Los Angeles 'Connections for Youth' model guided the coalition through a framework for identifying and implementing structural change objectives in their community, with additional trainings focused on coalition building and sustainability. Seed grant money was provided to the coalition to fund the implementation of structural change objectives. The National Youth Advocacy Coalition provided training and technical assistance surrounding the 'We Know Different/Sabemos que no es asi' social marketing campaign, aiming to increase HIV testing for Latino YMSM.

Presenters will share outcomes of the coalition-building process, including membership recruitment and retention, decision making processes, and other key milestones. Updates will also be provided on the seed grant projects determined through the Connections for Youth strategic planning process to create structural changes in the community to support African American and Latino young gay, bisexual and other YMSM in San Diego. Presenters will also discuss the We Know Different campaign run in San Diego, including marketing strategies, outreach efforts, and evaluation data on testing numbers for Latino YMSM. Presenters will highlight the lessons learned from the six-month project and offer tips for CBA providers and recipients embarking on community mobilization efforts. This session will provide a unique opportunity to hear CBA provider, health department and community-based organization perspectives on the collaborative process, capacity building, coalition engagement and the sustainability of efforts.

**Track F**
**F04 - Mathematical Modeling and Economic Analysis to improve Local HIV Prevention and Care Planning**

**Room: Spring (Hyatt Regency Atlanta)**

**Abstract 1823 - Mathematical Modeling and Economic Analysis to Improve Local HIV Prevention and Care Planning**


In recent years, there has been a consistent call for HIV prevention to include an optimal mix of biomedical, behavioral, and structural interventions that can be adequately funded and tailored, so that levels of services are appropriate to personal and community-level risk of acquiring or transmitting HIV. Mathematical modeling and economic analyses may be useful tools for health departments in determining the optimal combination of prevention activities and for decision-making related to resource allocation.

Baltimore-Towson, Maryland and New York, New York

Enhanced Comprehensive HIV Prevention Planning (ECHPP) is a one-year CDC/DHAP demonstration project that supports the implementation of the National HIV/AIDS Strategy (NHAS) by maximizing the impact of HIV prevention in the 12 U.S. Metropolitan Statistical Areas (MSA) with the highest AIDS prevalence. During the ECHPP planning period (October 2010-March 2011) each health department grantee developed an enhanced HIV prevention plan by conducting situational analyses, identifying goals and objectives, and determining the optimal combination of HIV prevention approaches for their jurisdiction. To facilitate evidence-based decision-making and resource allocation, two ECHPP health department grantees, Maryland and New York City, partnered with local university researchers to conduct mathematical modeling and economic analyses designed to generate quantitative estimates of the cost per HIV infection averted for various interventions and public health strategies. Needs assessments were also conducted to estimate the resources needed to achieve the NHAS goals for reducing new HIV infections and increasing the percentage of persons living with HIV aware of their serostatus.
As a part of ECHPP, health departments successfully partnered with local university researchers in Maryland and New York City to develop mathematical models and conduct economic analyses designed to inform evidence-based comprehensive HIV prevention plans. In Maryland, modeling recommended significant changes to the allocation of HIV prevention funds for HIV testing and behavioral interventions with persons living with HIV in the Baltimore-Towson MSA and provided quantitative estimates of unmet prevention needs. The process also highlighted opportunities to improve program outcomes by modeling the impact of increased program targeting. In New York City, modeling highlighted the cost-effectiveness of condom distribution and the importance of a test, link-to-care plus treat approach for the prevention of HIV, in terms of potential infections averted.

Public/academic partnership may be a useful investment for health departments considering the use of modeling for local HIV prevention and care planning. Mathematical modeling and economic analyses are important tools for examining the relative costs and anticipated outcomes of various HIV prevention and care interventions in order to maximize the impact of current HIV prevention resources.

Track G
G07 - Technology as a Tool for Service Integration
Room: Inman (Hyatt Regency Atlanta)

Abstract 1390 - Social Network Testing Project (SNTP): An Effective Method to Diagnose HIV Infection among Young MSM
Author(s): Pamela Ogata; Candice Rivas; John Mesta

Approximately 21% of people infected with HIV (48% among adolescents and young adults) are unaware of their infection and account for 54-70% of all incident transmissions. Racial disparities in HIV infection continue to persist with African-Americans (AA) estimated to have higher rates of undiagnosed HIV compared to Whites or Latinos. Despite numerous studies reporting that AA men who have sex with men (MSM) exhibit lower levels of risk behaviors compared to other races, this population continues to be disproportionately impacted by HIV/AIDS. Effective testing strategies that reduce rates of undiagnosed infection must be evaluated to reduce HIV transmission and ensure affected individuals receive proper HIV care.

In 2009, social network testing was implemented at three Los Angeles County (LAC) agencies funded by the Office of AIDS Programs and Policy to provide HIV testing services. Young MSM at high-risk were identified and trained as recruiters to refer members of their social and sexual networks to test for HIV at these agencies. Utilizing snowball sampling methodology, subsequent recruiters were identified and trained from the previous pool of network associates that tested.

Significance tests and multivariate regression analyses were performed on demographic characteristics, risk behaviors, and social/sexual network factors of both project recruiters and testers. SNTP testers were further stratified by race in order to test hypotheses that may help explain the contradiction between the presence of low risk behaviors and high HIV prevalence rates among AA MSM.

A total of 39 recruiters referred 238 network associates (network index = 6.1) who tested for HIV at one of five testing sites, yielding a new HIV positivity rate of 7.1%. Compared to individuals who tested at the same project venues, SNTP testers were significantly more likely to report being first time testers (26% vs. 9%), AA (63% vs. 17%), bisexual (36% vs. 9%), and homeless (49% vs. 4%). Project recruiters who were HIV-positive, AA, bisexual, and employed were more successful in bringing in network associates with undiagnosed infection.

HIV prevalence rates for AA (9.5%) were two and three times higher than Latinos (4.7%) and Whites (3.0%), even though their relative risk levels were not significantly different. Among project testers, AA and Latinos were more likely than Whites (AOR = 2.87/1.79, CI: 2.12-3.89/1.33-2.42), homeless testers were more likely than those with stable housing (AOR = 3.25, CI: 2.07-5.09), and those who engaged in sex trade were more likely than those that didnt (AOR = 2.36, CI: 1.55-3.62) to test positive for HIV.
Social network testing in LAC has produced a HIV positivity rate almost five times greater than the rate (1.4%) found at OAPP-funded testing agencies in 2008. This testing strategy has proven successful in reducing the rates of undiagnosed infection in other regions of the U.S. Further investigation into the feasibility of implementation and generalizability to other high-risk populations must be assessed before this testing strategy becomes an essential modality within the array of standard prevention services.

Abstract 1437 - Building a Mobile, Location-Based Search Mash-up for AIDS.gov Open Government and Geolocation

Author(s): Lance Roggendorff; Jennie Anderson

Federal HIV/AIDS programs are split among agencies across the Federal government. People seeking tiers of services, including testing, housing, mental health, substance abuse and general health care often lack a centralized online application capable of displaying the locations of nearby services available to the general public.

AIDS.gov, a project of the U.S. Department of Health and Human Services, Office of HIV/AIDS Policy, serves as the Federal gateway website for HIV/AIDS services that include the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), Housing and Urban Development (HUD), and the Office of Population Affairs (OPA).

Create an online locator mash-up that combines the various services provided by CDC, HRSA, SAMSHA, HUD, OPA, and others as an application that displays these locations on a mapping interface such as Google Maps. Provide options for users to search by ZIP code or city/state and adjust search radius according to the number of results displayed. In coordination with the above agencies, provide a single website to access all of these resources (locator.aids.gov), and release a widget that can be shared across multiple domains but pulls from a single application source.

RESULTS: The HIV/AIDS Prevention and Service Locator is a first-of-its-kind inter-agency web product, the result of collaboration across five Federal agencies and multiple data sources. In addition to the AIDS.gov website, over 70 websites have installed the widget, and over 1,500 unique searches are performed each month. A mobile interface has been built and geolocation has been enabled to allow mobile users to pinpoint their location without the need for a ZIP code entry.

LESSONS LEARNED: Developing interagency tools provides an important opportunity for collaboration, but may also bring with it some challenges. In the case of the locator, the team had to address challenges working with systems that are different and require distinct technical protocols, data that does not match, and the existence of single locations on a map that could have multiple entries across five different databases. However, the team overcame these barriers with strong technical leadership, a concrete mission and goals, and a collaborative approach by all parties involved.

Abstract 1567 - Building Meaningful Collaborative Relationships for HIV Prevention through Social Media

Author(s): F.E. Harrison, Rupal Mehta, Melissa Beaupierre, Cynthia Newcomer

Throughout the United States, HIV prevention professionals seek out information on program design, new research, prevention strategies, and events and often within an isolated framework. By staying disconnected from national partners and relying on individual research to build HIV prevention programs, institutions and individuals have been unable to access existing programs, make collaborative contacts, obtain lessons learned from successful campaigns, and share innovative techniques in HIV prevention programs.

Building online collaborative relationships between NGOs, CBOs, non-profits, state and local health departments, grantees, activists, federal agencies, and public health employees across the United States through social media.

CDC NPIN's social media outreach promotes conversations around conferences, meetings, awareness days, new research, important publications, and other major milestones in prevention. Through the use of new media
technologies, those with the common interest in HIV prevention have their choice of new media outlets to share their own insights on developments and challenges in HIV prevention. Organizations of all levels and sizes can now create visible and responsive HIV campaigns, and they are able to share their successes and strategies with colleagues from around the world. By creating unique forums for discussion and information sharing, CDC NPIN has built practical collaborations and been able to provide new resources to organizations through blogs, microblogs, social networking sites, online conversations, town halls, real-time interviews, and personalized forums.

In a time of declining budgets for travel and conferences, the opportunity to network and share insights with colleagues has diminished. But by using social networking, blogging, location-based networking, personalized web communities, and other tools, CDC NPIN has created virtual networks of prevention professionals, partners, grantees, activists, and organizations that can share their experiences.

By making multiple new media forums available and marketing to the appropriate outlets, social media users utilized the CDC NPIN and partner forums to collaborate, network, and develop more innovative web prevention tools. Using social media as a mechanism to unite prevention partners is an efficient way to exchange information and build collaborative relationships and networks. These methods of communication provided a simple outlet for collaboration, but these sites need to be cultivated and promoted to ensure successful and efficient use. Even though the use of most of these tools is free, the maintenance may be time consuming.


Author(s): Angelique Griffin, MS

Retention in care and loss to follow up have been challenges for HIV prevention and care/treatment services. This study was to assess an innovative approach in improving the engagement and retention in care for persons diagnosed and living with HIV/AIDS who have dropped out of care services in Washington DC eligible metropolitan areas.

Recapture-blitz was designed to identify individuals who have dropped out of care, and recruit them to return to care. HIV/AIDS care service providers in DC developed this model by reviewing clinical records and determining those individuals that had discontinued receiving primary care services without explanation or transfer. Trained staff were deployed by HIV/AIDS care providers to contact former clients who dropped out from their care service and to determine whether the individual was receiving health care from any other provider or receiving no care (lost follow up). Follow-ups were deployed to encourage clients to make a return appointment through multiple phone contacts. Approximately 15 to 20 phone contacts were required for each client returning to care. Case records from investigated care providers were matched with the Enhanced HIV/AIDS Reporting System (eHARS) data and laboratory report data received by the DC Health Department. This method further confirmed the status of care for dropped cases.

In September, 2009, the HIV/AIDS Administration of Washington DC Health Department implemented recapture-blitz among 5 care providers over a period of 2 months. Examination of the 5 providers medical records showed that a total of 1375 individual cases had discontinued receiving primary care services without explanation or transfer. After matching with eHARS and laboratory report data, 74% (1018) of these discontinued cases were found receiving health care from other providers, 23.9% (328) received no care or lost follow up, and 2.1% deceased. Within the 2-month recapture-blitz initiative, attempts were made to contact 982 individuals. 404 cases were contacted mainly focusing on the cases receiving no care or lost follow-up. Among these 404 contacted cases, 56.9% (230) were in care with other providers and 43.1% (174) were identified as not in care. Through data matching and follow-up, all of these cases who were not in care were successfully recaptured and returned to care.

Recapture-blitz showed promise not only in improving the quality of surveillance data and strengthening the case report surveillance system. It also resulted in marked improvements in eliminating potential loss follow up and retention in care of persons diagnosed and living with HIV/AIDS who dropped out of care services. This study highlighted the recapture-blitz as an important addition to routine surveillance activities.
Abstract 1639 - Matching HIV Registry to Partner Services Data: Identifying New Infections among Partners HIV-Negative at Notification

Author(s): Dipal Shah; Sarah Braunstein; Arpi Terzian; Chi-Chi Udeagu; Colin Shepard

Through the provision of HIV partner services (PS), the New York City (NYC) Department of Health and Mental Hygiene (DOHMH) identifies reported sex partners of HIV-infected clients, informs them of their potential exposure to HIV, and assists them in obtaining an HIV test, including the offer of a field test at notification. Because some sexual relationships identified through PS will endure following notification and testing, and will include unprotected sex, partners testing HIV-negative at notification are at high risk for acquiring HIV. However, the rate of HIV acquisition among HIV-negative partners in the months following receipt of PS is not known.

The NYC HIV Surveillance Registry (HARS) is a population-based registry of all persons diagnosed with HIV infection in NYC since 2000 and AIDS since 1981. The NYC PS database includes all partners of HIV-infected New Yorkers reported to DOHMH, and outcomes of PS activities conducted by DOHMH and non-DOHMH staff, including HIV testing at notification. In 2008, all HIV PS partners reported to the DOHMH from September 1, 2006 to September 30, 2007 with non-missing first name, last name, and date of birth or age, were matched to HARS. Matching was performed using a standard algorithm combining an automated screening match and manual reviews of ambiguous results by surveillance staff. All partners who matched to HARS were considered HIV-infected. HARS-matched case-patients reported initially as partners who tested HIV-negative at the time of notification were identified, and their proportion among all partners confirmed to be HIV-negative at notification during the same time period was calculated.

Of 1,996 partners reported to the DOHMH during the specified timeframe, 1,270 (64%) had sufficient data for matching, and 386 (30%) of these partners matched to HARS. Of the 238 partners who tested HIV-negative at the time of notification, 5 (2%) matched to HARS one year later and were thus recently HIV-infected, and diagnosed soon after notification. Of the 5 newly-infected and diagnosed partners, 3 (60%) were male. One (20%) reported MSM transmission risk, 2 (40%) heterosexual risk, and 2 (40%) unknown risk. The intervals between the dates of initial notification and HIV diagnosis ranged from 6-17 months.

At least 2% of sex partners of HIV-infected PS clients in NYC testing HIV-negative at notification were diagnosed with HIV infection in the months following notification. This proportion suggests an HIV seroconversion rate in this group that is comparable to that observed previously among uninfected members of HIV serodiscordant heterosexual couples in which the infected partner never initiated antiretroviral therapy. The 2% with known seroconversion can be considered the minimum estimate of partners newly-infected with HIV following notification, because other HIV-negative partners of NYC HIV PS clients may have been diagnosed outside of NYC, or did not test for HIV in the months following notification. HIV-negative partners of HIV PS clients are at very high risk of HIV, and prevention efforts focused on these individuals should be considered. Data linkage activities involving HIV partner services data and jurisdictional HIV registries should be performed routinely.

Abstract 1663 - Strategies to Enhance Names-based HIV Reporting of Non-AIDS Cases in California

Author(s): Phil Curtis; Kevin Farrell

California began names-based reporting of non-AIDS cases in 2006. There is concern that some cases previously reported by code are not in the names-based Registry, but the numbers are not known. A complete registry is needed to enhance California's response to HIV and to assure California of its fair share of Ryan White funding.
State of California Surveillance activities are of interest to state, county, and national policy makers as well as researchers, advocates and program administrators.

Benefits of adding cases to California's registry were estimated from Ryan White funding formulas. Costs reflect the Los Angeles experience. To assess successful surveillance strategies, interviews were conducted with the California Office of AIDS and with 12 California county health departments. Representatives of 3 other states that recently adopted names-based reporting were interviewed.

There are 2800 to 20,000 individuals who are aware of their HIV status, but who are not listed in California's registry. Ryan White funding formulas indicate that California gains approximately $1700 in Ryan White funding for each new case registered. The cost of adding a case ($992) is about half of the revenue gain. Thus, additional outreach would be cost-saving.

Active case follow-up at the local level has helped California close the gap between code based reports (41,155) and names-based reports (40,590). However, Counties reported a number of continuing challenges:

- Insufficient staffing for active outreach
- Costly re-classification of persons with non-AIDS HIV at time of AIDS diagnosis
- Lack of coordination between publicly funded services and the Registry, e.g., some current ADAP clients are not listed in the Registry
- Lack of centralized statewide reporting structure, such as exists in smaller states, which could reduce duplication of County efforts
- If the confirmatory positive test is not delivered to the client, the case does not result in a full names report
- Migration from state of first diagnosis means some individuals receiving services in California are not registered

A number of policy recommendations flow from these findings:
- Expand outreach efforts, which cost/benefit analysis shows is cost-saving
- Reward agencies with high rates of return for confirmatory results or that successfully link HIV-positive clients to care
- Erase the reporting distinction between HIV and AIDS status to redeploy resources used for case reclassification
- File registry reports for all new and re-certifying ADAP enrollees
- Provide local health jurisdictions limited access to the state HIV case registry to reduce duplication of efforts
- Collect more extensive information at the time of a preliminary positive HIV test
- Publish the number of a state's reported HIV cases that were previously reported in another state
- Modify CDC reporting to separately list state of origin for HIV cases and for diagnosed AIDS cases, if the distinction between HIV and AIDS persists
- Maintain data on persons who have received an HIV or AIDS diagnosis in California and are currently receiving care in the state but who are listed in another state's registry

Author(s): Lynne A. Sampson; Janet G. Alexander; William E. Jones; Jason A. Maxwell; Jacquelyn M. Clymore; Peter R. Moore

Patients receiving HIV testing through the North Carolina counseling, testing and referral (CTR) program are interviewed at the time of testing to determine current HIV status and HIV testing history. Inaccurate responses could indicate one of several problems: (1) the patient truly does not understand whether or not they have been tested for HIV, (2) the patient does not understand (or did not receive) their HIV test results, or (3) the patient purposefully supplies incorrect information in order to receive incentives and/or avoid identification. All of these scenarios can be improved through changes to HIV testing programs. Understanding the degree and distribution of these inaccurate reports will point to areas for program improvement.
From January to June, 2010, we matched HIV CTR interview data from samples processed by the NC State Laboratory of Public Health to surveillance records to establish the status of patients with HIV positive tests (previous positive test on record vs. new HIV diagnosis). We then compared HIV case status to the self-report data. This analysis includes 103,656 tests (of a total of 113,572 tests performed) for which HIV testing history information was available.

Over half of the positive HIV tests (255 of 498) were from persons with a previous HIV positive test on record. Among these previous positives, 53.3% (n=136) correctly identified themselves as previously positive at the time of testing. The remaining 119 previous positives indicated that they had never had a previous test or that they had a negative, indeterminate or unknown previous test. Previously positive African-Americans (OR 2.2, 95% CI 1.3-4.0) and persons over 30 years of age (OR 1.7, 95% CI 0.96-3.0) were more likely to report their status incorrectly. A disproportionate number with incorrectly reported status came from Drug Treatment (4.2% vs. 2.4% of all previous positives) and Outreach settings (24.4% vs 15.6%). Among 266 patients reporting a previous positive HIV test, only 136 actually had one on record (PPV=57.6%). Seven had positive test results but all records indicate that the infections were newly identified, not previous as indicated by the patients. The remaining 123 patients tested HIV negative despite having reported a previous HIV positive test. Among HIV negatives, those incorrectly reporting previous HIV positive status were more likely to be female (OR 1.6, 95%CI 1.1-2.5).

Previously HIV-positive individuals who fail to correctly report their status were more likely than other previous positives to come from Drug Treatment and Outreach settings. Fear of disclosure or desire for incentives may play a role and should be considered in program design. More research is needed to fully understand why persons over 30 and African-Americans are less likely to report their HIV-positive status and why women are more likely to report that they are positive when they are not. Implications for HIV testing policy remain as CDC recommendations move away from extensive pre-test counseling to more routine screening approaches. Streamlined testing policies need to include detailed information for patients regarding HIV tests performed and how results will be delivered.

Abstract 1881 - Syphilis Co-infection among Persons Living with HIV Infection in Shelby County, Tennessee

Author(s): Kristen Morrell, MPH; Rebecca Yvonne Konnor, MPH, PhDc; Jennifer Kmet, MPH; Theresa Chapple-McGruder, MPH, PhD

Recent studies indicate that rising syphilis rates are correlated with increasing incidence of HIV. Syphilis raises the susceptibility of transmitting or acquiring HIV, while relapse of a syphilis infection is more likely in an HIV positive patient. This study aims to identify the number of persons recently diagnosed with syphilis/HIV co-infection, to describe the timing of diagnoses, and to identify populations at an increased risk for co-infection in Shelby County.

All individuals reported to be currently living with HIV infection as of December 31, 2009 in Shelby County were identified through the Tennessee HIV/AIDS Registry System (HARS). Persons diagnosed with syphilis between 2006 and 2009 were also identified through Tennessee's Sexually Transmitted Disease Management Information System (STDMIS). Only current residents of Shelby County who had been diagnosed with HIV or syphilis over the age of 13 years were included. Datasets were linked to evaluate the number of persons co-infected and describe the timing of each diagnosis. Multivariate logistic regression was used to examine predictors for increased risk of co-infection, such as race, sex, age at HIV diagnosis, HIV transmission risk category, residence (Memphis vs. not Memphis), and facility at HIV diagnosis.

A total of 6,232 persons living with HIV as of December 31, 2009 were identified through HARS, while 2,680 persons were diagnosed with syphilis infection between 2006 and 2009; a total of 377 syphilis records (14.1%) were linked. Of the 377 co-infections, 35.8% (135) were diagnosed between a 3 month time period, while 57.8% (218) were diagnosed with HIV followed by syphilis at least three months later and 6.4% (24) were diagnosed with syphilis followed by HIV at least three months later. This indicates that 64.2% of persons had unprotected sex three months after initial HIV or syphilis diagnosis. Logistic regression analyses indicate that males (OR=2.5, p<.0001), Black persons (OR=5.6, p<.0001), and men who have sex with men (MSM) (OR=2.2, <.0001) are at an increased risk for co-infection. Persons diagnosed with HIV in correctional (OR=3.9, p<.0001) and public facilities (OR=1.9, p=.0005)
also demonstrated a significant increased risk for contracting co-morbid syphilis. Risk for co-infection significantly increased as age at initial HIV diagnosis decreased.

Although certain populations demonstrate an increased risk for syphilis co-infection, initial evaluation of all HIV-positive patients should include screening for syphilis; anyone seeking screening for syphilis should be tested for HIV. Over 60% of the co-infections did not occur within a three month time period; this indicates the increased need for patient education and targeted risk-reduction programs to prevent subsequent co-infections.

Track G
G10 - A Public Health Approach to Improve Sexual Health in the U.S.: Implications for HIV Prevention
Room: A701 (Atlanta Marriott Marquis)

Abstract 1275 - A Public Health Approach to Improve Sexual Health in the U.S.: Implications for HIV Prevention
Author(s): John Douglas

The first formal U.S. government recognition of the importance of a sexual health framework for enhancing STD/HIV prevention—The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior has published ten years ago. In the intervening years, many measures of adverse health outcomes of unhealthy sexual behaviors have improved only minimally or worsened, including HIV, STD, and teen and unplanned pregnancy. Core public health disease control and prevention efforts in the U.S. need to be enhanced by a renewed effort to mobilize all levels of society to address issues of sexual health and responsible sexual behavior as an intrinsic part of human health. CDC is committed to enhancing program impact for HIV prevention and other programs by complementing traditional disease control and prevention-focused efforts with a health promotion framework that more comprehensively addresses the broader issue of sexual health. The use of such a health-focused framework has the potential for providing messages that may be more effective at reaching the public and providers, enhancing the efficiency and effectiveness of services, and facilitating societal dialogue around sexuality, a topic that is socially sensitive but vital to human health and well-being.

Sexual health is an issue for the whole population, not just those in groups at risk for specific adverse outcomes such as HIV infection. In addition, since sexuality is an intrinsic component of human physical, emotional, mental, and social well-being, sexual health is important across the lifespan. Sexual health is relevant to settings across all of society, including our families, communities, schools, faith-based organizations, and media, and the sexual health framework has increasingly been recognized as a useful unifying concept by many nations and international organizations.

This group oral session will address four topics relevant to sexual health:
1. Advancing a public health approach to improve sexual health: a framework for national efforts (John Douglas, CDC)
2. International perspectives on advancing sexual health (Meg Ivankovich, CDC)
3. Advancing a sexual health framework in the US: Impact on national HIV prevention (Rich Wolitski, CDC)
4. Sexual health and HIV prevention programs: Opportunities and challenges (Julie Scofield, NASTAD)

Results:
Presentations will be followed by a panel discussion moderated by John Douglas and Kevin Fenton, CDC, allowing the audience to address how such an approach could complement core HIV prevention activities and raise perspectives of relevance for both other audience members and panel experts.
Lessons learned:
The presentations and panel discussion will allow participants to understand national efforts in the U.S. to advance a public health approach to improve sexual health, comparative efforts in other countries, and potential opportunities and challenges for HIV control and prevention that can be provided by a complementary framework that addresses sexual health.
Abstract 2012 - Prevention with People Living with HIV: New Research and Guidance

Author(s): Peter H. Kilmarx

People living with HIV infection are a high-priority population for HIV prevention activities. CDC and partner organizations are updating recommendations for prevention with people living with HIV (PWP).

PWP focuses on the prevention of HIV transmission to uninfected partners through interventions to reduce HIV transmission risk behavior and reduce infectiousness. PWP interventions also improve the health of the individual and reduce the risk of acquisition of sexually transmitted diseases and HIV superinfection. Currently, there are substantial gaps in realizing the potential benefits of the full continuum of PWP interventions and strategies that include awareness of HIV infection status, linkage to and retention in care, risk assessment and appropriate use of risk-reduction interventions, appropriate use of anti-retroviral treatment (ART), adherence to ART, and suppression of viral load. This group oral presentation will provide an update on new research and guidance on PWP, including risk screening and risk-reduction interventions, use of ART for HIV prevention, and interventions to increase adherence to antiretroviral medication.

Risk reduction: All persons with a diagnosis of HIV infection should regularly receive counseling or prevention messages that provide tailored and up-to-date information on behaviors and prevention methods that best protect their health and the health of their partners. For HIV-diagnosed persons who engage in behaviors that put themselves at risk for STDs and their partners at risk for HIV infection and other STIs, more intensive and ongoing prevention interventions should be offered.

ART for prevention: Available evidence indicates that ART substantially reduces the risk of HIV transmission. Recent U.S. HIV treatment guidelines support initiation of ART at any CD4 lymphocyte count and the use of ART for prevention. HIV-infected persons should be made aware of individual health benefits and risks of ART and potential benefit of ART in reducing the risk of HIV transmission. HIV-infected persons initiating or continuing ART should be made aware of the need to continue other prevention measures while on ART and the important of adherence.

Adherence: Consistent, near-perfect adherence is necessary for sustained viral suppression and optimal health outcomes. Actual adherence levels, however, are often low and tend to decrease over time. Adherence interventions are efficacious in improving adherence behaviors and should focus on educating and motivating patients, building patients skills and providing tools for better medication management, simplifying treatment regimens and tailoring them to individual lifestyles, preparing for and managing side effects, providing ongoing support, and addressing concrete issues, such as substance use or mental illness, that may act as barriers to adherence.

Abstract 1178 - The Updated CDC's Compendium of Evidence-based Behavioral Interventions: HIV Risk Behaviors and HIV Medication Adherence

Author(s): Mahnaz Charania; Linda Kay; Nicole Crepaz; Cynthia Lyles; Darigg Brown; Renyea Colvin; Darrel Higa; Sima Rama; Maria Tungol; Waverly Vosburgh

The National HIV/AIDS Strategy (NHAS) outlines several goals for ending the domestic HIV epidemic including use evidence-based prevention strategies to reduce HIV transmission, increase access to care, and optimize health outcomes for people living with HIV (PLWH). Since 1996, the Centers for Disease Control and Prevention's (CDC)
HIV/AIDS Prevention Research Synthesis (PRS) team has been conducting on-going systematic reviews to identify evidence-based behavioral interventions (EBIs) for preventing HIV acquisition or transmission in the U.S. These risk-reduction (RR) interventions focus on reducing sex or drug risk behaviors and HIV/STD incidence in various high-risk groups. In 2008, PRS expanded its scope to include HIV medication adherence (MA) interventions to increase PLWH's medication adherence behaviors. Helping PLWH adhere to their HIV medication regimen optimizes individual health outcomes and possibly reduces population-level viral load, which may lead to a lower HIV transmission risk. This presentation will (1) describe RR EBIs published or in press between July 2009 and December 2009 and (2) describe MA EBIs published or in press between January 1996 and December 2009.

The comprehensive PRS database of HIV behavioral intervention research was used for both RR and MA systematic reviews. The database is updated using annual systematic searches of 4 bibliographic databases and quarterly manual searches. Each RR and MA intervention was evaluated against standardized criteria that assess quality of study design, implementation, analytic methods, and strength of evidence of efficacy. The newly developed MA efficacy criteria were the result of multiple consultations with internal and external partners and partnership with the National Institutes of Health (NIH), the Health Resources and Services Administration (HRSA), and the National Institute on Drug Abuse (NIDA).

Four RR EBIs were identified: 3 group-level interventions and 1 community-level intervention. Two targeted heterosexual women, 1 targeted heterosexual men, and 1 focused on high-risk youth. All 4 RR EBIs either targeted, or were tested with, majority of, persons of color. Eight MA EBIs were identified: 5 individual-level interventions and 3 group-level interventions. All 8 MA EBIs either targeted, or were tested with, majority of, persons of color. Four MA EBIs targeted both treatment (tx)-na e and tx-experienced patients, 3 targeted tx-experienced patients only, and 1 targeted tx-na e patients. Five MA EBIs were conducted in a healthcare setting.

The compendium of EBIs identified through PRS systematic reviews provides up-to-date information about scientific evidence of intervention efficacy useful for program planners and prevention providers to guide their activities in accordance with the NHAS. There is still a gap between the emerging HIV epidemic and available EBIs, as none of the new RR EBIs were specifically developed for PLWH or MSM, particularly MSM of color. Currently, CDC has a technical transfer system for developing intervention packages and providing training and technical assistance to help prevention providers implement RR EBIs in their community. A system for disseminating and supporting the implementation of MA EBIs in healthcare and non-healthcare settings has not yet been established and requires further investigation and collaboration among key partners.

Abstract 1283 - A Systematic Review of HIV Interventions for People Living with HIV (PLH): 1988 - 2010
Author(s): Maria L. Tungol; Sima Rama; Darrel Higa; Yuko Mizuno; Khiya Marshall; Linda S. Kay; Cynthia M. Lyles; David Purcell

People living with HIV (PLH) are key partners for reducing the number of new HIV infections. Many PLH reduce risk behaviors after learning about their HIV-seropositive status; however, adopting and maintaining safer behaviors can be challenging for some. Identifying evidence-based behavioral interventions (EBIs) to help PLH protect themselves from other sexually transmitted infections (STIs) and prevent HIV transmission to uninfected individuals is critical for the national HIV prevention effort. This systematic review examines the body of evidence of intervention efficacy and describes the challenges associated with identifying efficacious interventions for PLH.

We searched CDC's HIV/AIDS Prevention Research Synthesis (PRS) project's database for intervention evaluations published between January 1988 and December 2010. The comprehensive, cumulative PRS database is updated annually using systematic searches of 4 bibliographic databases and manual search procedures. Inclusion criteria for this review are: (1) U.S.-based HIV/STI interventions specifically targeting PLH; (2) controlled trials with a comparison group; and (3) evaluation of HIV risk behaviors (e.g., unprotected sex, condom use, number of sex partners, needle sharing) or biologic outcomes (i.e., new STI). Each eligible intervention was evaluated against standardized PRS efficacy criteria that assess quality of study design, implementation, analytic approaches, and strength of evidence of efficacy.
Thirty-six studies were identified: 10 (28%) met PRS evidence-based efficacy criteria, 23 (64%) did not meet at least one efficacy criterion (i.e., non-EBIs), and 3 (8%) had insufficient information to complete the efficacy review at this time. EBIs were more likely to be conducted in clinics than non-EBIs (40% vs. 9%). A larger proportion of non-EBIs than EBIs (65% vs. 20%) were specifically designed for PLH at high risk of transmitting HIV, including PLH who reported unprotected sex with HIV-negative or serostatus unknown partners at study entry, injection drug users, men who have sex with men, or a combination of these risks. Of the 23 non-EBIs, 15 did not find any significant positive intervention effects, and 11 of the 15 also did not meet other criteria (primarily due to small sample size, low retention, and short follow-up). Of the 8 non-EBIs that found at least one significant positive intervention effect, the most common reasons for not meeting the overall efficacy criteria included small sample size (6 studies) and low retention rate (4 studies).

The body of evidence suggests that HIV clinics may be ideal settings for conducting and testing behavioral interventions to PLH. Designing efficacious interventions for PLH at high risk of transmitting HIV is challenging and needs more research attention. Given that the majority of non-EBIs did not have significant positive effects, it is plausible that these interventions did not adequately address critical behavioral determinants or contextual factors or that control conditions were too strong to detect a significant difference between study arms. Examining these potential explanations will inform the design of efficacious interventions for PLH. More resources are also needed to improve research design and implementation, especially for recruiting and retaining a larger number of study participants, and conducting longer-term intervention evaluations.

**Abstract 1457 - Improvement in Adherence to HAART: Best Practices in Adherence Education By Three Model Programs**

**Author(s):** Susan Rogers; Caitlin Corcoran

Individuals served by AIDS Services Organizations (ASOs) in community settings face a number of challenges which can act as barriers to adherence to highly active antiretroviral therapy (HAART). Adherence education can be an effective way to address these barriers to increase adherence, which is necessary to obtain maximum benefit and minimize the development of antiviral resistance. A recent public-private partnership (ConnectHIV) between the Pfizer Foundation and the community provided funding to ASOs to implement adherence education, among other integrative HIV care and treatment programs. Among the ASOs served by this initiative, three organizations provided adherence education programs. A cross site evaluation of these model programs was conducted to identify best practices associated with positive client outcomes and to share lessons learned.

A longitudinally designed study included one-on-one interviews conducted with approximately 400 clients at intervention baseline, post and follow-up which included 4 measures representing a common set of indicators developed collaboratively by grantees and the evaluators. All grantees with adherence education and supportive linkage service programs for HIV positive persons were included in the analysis. Grantee data was considered by type of intervention and common service characteristics. Generalized Estimated Equations (GEE) models were built to determine clients change over time while controlling for client level confounders of basic demographic variables. Qualitative data on program best practices and factors that may have accounted for differences between grantee client outcomes were analyzed using E-Z text software.

In general ConnectHIV implementation of adherence education and support interventions was associated with significant favorable results (p<.05) from either baseline to post and/or baseline to follow-up across most client outcomes (knowledge of HIV disease management, adherence to HIV medications; viral load; actual CD4 counts; and perceived health score). More specifically, there was significant (p<0.001) increase in HIV medication adherence over time after controlling for confounders of age and gender (N=373). Some differences by gender and age were observed males tended to take medication more consistently than females and had higher perceived health scores; older clients had lower viral loads than younger clients.

Providing adherence education with persons living with HIV and AIDS can improve adherence, clinical outcomes, and overall perceived quality of life. Strategies developed by grantee ASOs, involving peer-led interventions and the
integration of technology, were designed to overcome client barriers to adherence. These strategies can serve as models for other organizations planning or enhancing adherence education efforts.

**Abstract 1669 - Site Migration in Seeking Care Services among People Living with HIV/AIDS in Washington, DC**

**Author(s):** Yujiang Jia; Charles Wu; Jenevieve Opoku; Rowena Samala; Angelique Griffin; Tiffany West; Gregory Pappas

To assess site migration in seeking care services among people living with HIV/AIDS in Washington DC.

Study subjects included HIV/AIDS cases diagnosed in 2007 and reported to DC’s Enhanced HIV/AIDS Reporting System (eHARS) with at least 2 laboratory tests of CD4 cell counts and/or viral load measurements from 2007 to August 2010. Site migration referred to patients who had CD4 and/or viral load labs ordered by different health care providers during the time period. Non-migration referred to patients whose labs were all ordered by the same health care provider.

Of the 780 HIV/AIDS cases analyzed, 71.5% were male; 77.4% aged from 20 to 49 years; 78.2% were Black; 17.6% had most recent CD4 cell counts at <200 cells/mm3 and 36.4% had most recent viral load at <70 copies/ml. Nearly a third (32.3%) had their first positive HIV testing within 12 months of AIDS diagnosis (termed late testers); 72.4% were receiving or referred for HIV-related medical services; 58.6% ever received ART; and nearly one-third (31.2%) ever had site migration in the past two years. Site migration in seeking HIV/AIDS care services occurred significantly more frequent among injecting drug users (39.8%), those with non-identified risk factors (40.4% vs. 27.2% among those had male-to-male sexual contacts), those with CD4 cell counts at <200 cells/mm3 (47.4% vs. 27.8% CD4 cell counts at ≥200 cells/mm3), and those with an AIDS diagnoses (late tester 34.1% and non-late 46.6% vs. 25.7% among non-AIDS cases). Site migration occurred less frequently among those were receiving or referred for HIV-related medical services (28.7% vs. 37.7% among those were not receiving or referred to medical services) and patients on ART (28.0% vs. 35.6% not on ART). Multivariable logistic regression analyses found that site migration among care providers was independently associated with CD4 cell counts (AOR=2.37, <200 vs. ≥200 cells/mm3, 95%CI: 1.6-3.5) and ART (AOR=1.5, not on ART vs. on ART, 95%CI: 1.1-2.0).

This study demonstrated that site migration in seeking HIV/AIDS care services was prevalent and independently associated with CD4 cell counts and ART. Site migration might potentially limit effective delivery of HIV/AIDS care services and capability of research outcome evaluation, particularly in a highly populous metropolitan area where there are more facilities to choose for treatment. Further research programs are needed to examine the impact of site migration on HIV/AIDS care service delivery.

**Track C**

**C17 - Health Department and Practitioner Perspectives on HIV Prevention**

**Room: Hong Kong (Hyatt Regency Atlanta)**


**Author(s):** Dr. Wilbert C. Jordan; Valerie E. Stone; Lori L. Delaitsch; Eric Y. Wong; David J. Malebranche; Rebecca A. Abravanel; Bryan P. Baugh

In 2006, CDC recommended routine HIV testing for all sexually-active adults. No study to date has evaluated the perceptions and practices of Black physicians related to HIV testing. This survey-based research evaluated HIV testing attitudes, behaviors, barriers, and drivers among Black frontline physicians. We present overall findings according to socioeconomic status (SES) of the physicians’ patient base.

A 15-minute online survey was administered to physician attendees at the 2010 National Medical Association’s (NMA) Annual Convention; other eligible physicians were contacted via email and online panels. Respondents were practicing (>1 year) Black primary and emergency/urgent care physicians who treat adults and whose patient base was at least 20% Black.
Demographics of 502 respondents: 47% male; 73% ≥40 years old; 59% based in southern US; 50% office-based practices; 64% NMA members; 31% with a high proportion (>45%) of low-SES patients. Specialties: Internal Medicine (37%); Obstetrics/Gynecology (26%); Family Practice (24%); Emergency/Urgent Care (13%). Demographics of patient base: 56% Black; 33% men; 24% on Medicaid. Physicians with lower SES patients were more likely to be younger, be an NMA member, and have more Black, Medicaid, and HIV-positive patients than physicians with higher SES patients (<10% low-SES patients in practice).

Overall, 34% of patients were tested for HIV in the past year. Physicians with the highest testing rates (average, 52%) were more likely to be: <40 years old; female; Obstetricians/Gynecologists; comfortable discussing HIV and testing for HIV routinely in all sexually-active patients. High testers also had significantly more low-SES, Black, and Medicaid patients. Physicians with lower SES patients tested more frequently (40% vs 31%) than physicians with higher SES patients.

Multiple sex partners (89% of physicians), injection drug use (85%), sexual assault (83%), suspected prostitution or homosexuality (77%), and previous incarceration (70%) were more common reasons for recommending HIV testing than routine testing (55%), regardless of patients’ SES.

The overall top 5 factors limiting physicians from recommending testing were: 1) patient may perceive recommendation as accusatory or judgmental (57%); 2) patient would not want to be identified as HIV-positive (48%); 3) competing priorities (45%); 4) insufficient time with patient (45%); and 5) patient may get offended due to stigma associated with HIV (43%). Physicians with lower SES patients ranked stigma and competing priorities as less, and insufficient time as more, of a barrier than physicians with higher SES patients. Physicians generally believe educational office materials, greater media attention, more training, and government mandates may encourage more routine testing. Physicians with lower SES patients were more likely to place importance on “having a script to raise the issue.”

Among Black frontline physicians, HIV testing rates were below 50%, and physicians with lower SES patients tested more frequently than those with higher SES patients. Routine testing was less common than testing of patients with risk factors. Educational and health policy efforts should focus on lessening the discomfort associated with the physician-patient interaction and addressing disease stigma to encourage early and routinized HIV testing practices among Black and other physicians caring for Black patients.

Abstract 2096 - Ongoing Evaluation of a Community-Embedded Disease Investigator Specialist Model

Author(s): Ellen Rudy; John Cross; Getahun Aynalem; Frank Ramirez

In 2008 the Sexually Transmitted Disease Program (STDP) of Los Angeles County initiated the Community-Embedded Disease Investigator Specialist (CEDIS) model at a sexually transmitted disease clinic that serves the MSM community as a comprehensive strategy to provide enhanced partner services for newly-diagnosed early syphilis (ES) and HIV/syphilis co-infected cases. The program is in its third year of operation. The objective of this analysis is to evaluate the ongoing effectiveness of the CEDIS program in identifying new early syphilis cases.

We evaluated the CEDIS model outcomes for 2010 with the traditional PHI model outcomes for 2007 (before initiation of the CEDIS model) with six performance measures. Performance measures include total number of cases interviewed, time to interview, the number of partners elicited per cases interviewed and the number of new early syphilis cases identified through the program. Data were extracted from the STD*CASEWATCH Surveillance database system. We present the performance measures and the percentage change in performance measures between the CEDIS model and the traditional PHI model and provide a summary of key strategies attributable to the success of the CEDIS program.

We observed a 20-fold increase in ES cases interviewed within 7 days of diagnosis for the CEDIS compared with the traditional PHI. We observed a 72% increase in the number of ES cases interviewed (186 in 2010 vs. 108 in 2007) and a 3-fold increase in the number of partners elicited (222 partners in 2010 versus 61 in 2007). Of the number of partners located and notified about possible syphilis exposure there was an 8-fold increase in the number of new early syphilis cases identified in 2010 compared with 2007 (83 partners identified with early syphilis in 2010 compared with 10 partners in 2007).
The 2010 evaluation of the CEDIS program demonstrates ongoing success and sustainability of this innovative program. Key elements to a successful partner notification program such as the CEDIS program include strong community and health department collaboration and community trust.

**Abstract 2104 - Using the Geographic Information System to Scale up Needle Exchange Programs in Washington, DC**

**Author(s):** Jenevieve Opoku; Michael Khafre; Rowena Samala; Angelique Griffin; Tiffany West; Nnemdi Kamanu-Elias

At the end of 2008, 16,513 residents were diagnosed and living with HIV/AIDS, which accounts for approximately 3.2% of the District's adult and adolescent population with 37.3% of cases attributed to MSM, 27.0% attributed to Heterosexual contact and 17.4% of cases attributed to injection drug use. This generalized epidemic has reached the entire city, with nearly 5% of Black residents, 2.1% of Hispanic residents and 1.8% of White residents living with HIV disease. By Ward, all Wards, with the exception of Ward 3, have prevalence rates above 1%. These proportions show that there is an inherent need to expand prevention programs, including needle exchange. The purpose of this study is to use ArcGIS in order to examine ways to expand the needle exchange programs in Washington DC.

This project was conducted in Washington DC using drug arrest data

Surveillance data from the enhanced HIV/AIDS Reporting System (eHARS) was analyzed for cases through 2008 to locate areas of high HIV/AIDS prevalence. Censustract information was assigned to cases using ArcGIS 9.3 and was geocoded. An overlay of 2008 drug arrest data (heroin and crack arrests) added to identify areas of condensed drug traffic. A final overlay of current Needle exchange programs were added to the map.

At the end of 2008, there were 3,965 drug arrests in Washington DC. Geocoding results identified areas injecting drug trafficking as well as tracts to which current programs were established. Nearly a a quarter (14.3%) of the geocoded arrests were located in censustracts where there were no previous needle exchange programs.

This project provides insight into ways to use ArcGIS for the expansion of prevention programs. Using mapping techniques in locating areas and establishments for prevention programs, such as needle exchange, health departments are able to evaluate areas of high disease, risk behaviors and target specific areas to which programs are lacking. Future projects will include updated surveillance data, continued expansion of exchange sites, and mapping of sites by number of needles exchanged to the public.

**Track D**

**D09 - Launching WILLOW: The CDCs First Intervention Specifically for HIV Positive Women: Pilot Lessons Learned**

**Room:** Hanover C (Hyatt Regency Atlanta)

**Abstract 1203 - Launching WILLOW: The CDCs First Intervention Specifically for HIV Positive Women: Pilot Lessons Learned**

**Author(s):**

Globally, HIV/AIDS is the leading cause of death for women of reproductive age. It is estimated that out of the over 33 million adults worldwide living with HIV and AIDS, more than half are women. The AIDS epidemic has had a unique impact on women, which has been exacerbated by their role within society and their biological vulnerability to HIV infection. Also, women are living longer with the disease due to better and more expansive treatment regimes. As such, interventions designed specifically for this group of women are greatly needed.

WILLOW is designed for heterosexual women 18 to 50 years of age living with HIV/AIDS of any race or ethnicity. It is designed to be implemented in community-based settings that target and/or offer services to women living with HIV/AIDS.
WILLOW: Women Involved in Life Learning from Other Women is the first intervention of the CDC designed specifically for women living with HIV/AIDS. The small group, peer-led, educational and social skills building intervention addresses issues of gender pride, social support, healthy and unhealthy relationships, condom use and negotiation, and coping skills, all from the perspective of women living with HIV/AIDS.

Between 2008 and 2010, the CDC conducted six pilot trainings of the WILLOW intervention in five cities with approximately 110 staff from community-based organizations and local health departments. About one half of the participants in the trainings were women living with HIV/AIDS, who were to serve as Peer Facilitators for the intervention. A combination of training, materials and implementation issues emerged during the pilots that indicated the need for significant changes in the intervention to support and enhance national diffusion. Some of these included: extending the training from four to five days; altering the sequence of selected sections of the intervention for a more positive effect on the target audience; expanding the scripting, instructions and activities of both the Implementation and Trainer's Manuals to meet literacy and experience needs of facilitators; and expanding implementation recommendations to enhance recruitment and retention to and participation in the intervention by women living with HIV/AIDS. The six pilots of the WILLOW intervention revealed the need for major changes in the intervention's sequence, materials and implementation strategies to be most appropriate for women living with HIV/AIDS. The methods employed in the development, revision and initial diffusion of this intervention serve as a model for the refinement and diffusion of an evidenced-based intervention from research to practice.

Track D
D19 - Results from a Comprehensive Counseling, Testing, Referral, and Partner Notification Initiative in Baltimore, MD
Room: Hanover D (Hyatt Regency Atlanta)

Abstract 1905.1 - Community Screening: Effective Method of Providing HIV Testing to High Risk Populations in Non-traditional Settings
Author(s): P. Burnett; T. Myers; C. Serio-Chapman; N. Fields

Baltimore is disproportionately affected by HIV disease with an overall case rate of 2065.4 per 100,000 in calendar year 2009. Fifty five percent of those cases were AIDS defined. Community based testing and referral to care for HIV positive clients provides an intervention strategy to prevent HIV transmission and provide healthier outcomes for those infected.

In September 2004 an aggressive outreach screening was initiated through Baltimore City Health Department mobile vans deployed to neighborhoods with documented high incidence of HIV infection and to areas identified by interviews with HIV positive and early syphilis clients as having high risk behavior occurring. Clients were screened for HIV and syphilis. Additional HIV screening was funded with Community Based Organizations and Hospital emergency rooms. Risk and demographic data was entered in STD*MIS. Modifications to STD*MIS allowed the program to meet reporting requirements, access each positive client's status and provide appropriate follow-up and provide real time direction to outreach site selection.

: From September 2009 through November 2010 the program tested 52,587 clients for HIV. Some clients tested multiple times resulting in 83,329 tests being performed. The testing yielded 4817 positives on 2804 clients. The demographic breakdowns for clients tested were 57% male, 43% female, 76% African American, 14% White and 10% all others. Those testing positive were 67% male, 33% female, 91% African American, 6.5% White and 2.5% all others. MSM risk accounted for 4.4% of those tested but they accounted for 10% of positives. IVDU risk accounted for 15.8% of those tested and 34% of those positives. Ten percent of clients were involved in commercial sex work and accounted for 15% of positives. Substance abuse other than IVDU was a risk factor for 32% of those tested and those positive. Based on 2000 census data of the adult population of Baltimore ages 15 - 64, approximately 12% of the city's adult population has been tested through this effort

: Community based screening driven by tracking current syphilis and HIV morbiditystatistical and social network data is an effective method of identifying HIV positive individuals. Clients will continue to test after learning of their positive
status and outreach strategies are necessary to assure these clients are enrolled in care and receiving appropriate support to maintain care status. Maintaining comprehensive data on clients tested is important to analyze screening efforts and redirect activities as needed. Data systems should be structured to allow for modifications as needed.

Abstract 1905.2 - Reaching HIV-positive MSM Youth Through the Underground Ballroom Scene
Author(s): K. Holt; S.M. Johnson; P. Burnett; G. Olthoff

Baltimore City comprises almost one-tenth of the population of Maryland, but contributes nearly half the HIV cases in the state. Of the prevalent HIV cases, 580 are between the ages of 18 and 24. Many MSM and transgender individuals under the age of 25 may be unaware of their HIV status and are often unaware of primary medical care and case management services available to people infected with HIV.

The House Ball community is a largely an underground community comprised predominately of gay, lesbian, bisexual, and transgender people. This community is built around competition for trophies and prizes at events known as balls, and multiple balls are held each month in Baltimore and cities across the United States. This project was a collaboration with leaders of the House Ball Coalition in Baltimore City to expand STD/HIV testing and linkage-to-care services.

The Baltimore City Health Department and the House Ball Coalition sponsored Now Your Status Ball Conference, which took place on Saturday, November 20, 2010, at the Sheraton Inner Harbor. This event provided the youth, especially African American gay males, an opportunity to take advantage of health-related services such as: STD/HIV counseling, testing, HIV care linkage, housing assistance, dental, health insurance, and other services.

The Baltimore City Health Department tested 113 people, of whom 73 (65%) were age 24 or under, 51 (45%) were youth MSM, and 16 (14%) tested HIV-positive, which included 6 youth (5%). Those vendors who reported their conference data encountered 608 people, 396 received literature, and 68 people had more specific inquiries about available services.

Testing at such an event can be highly productive in identifying HIV. The relationships developed will help the Health Department to continue to provide services to this community. The Program and the Ballroom Coalition will continue collaborating to bring STD/HIV counseling, testing, and care linkage services to more MSM youth. Employing a community member as the youth outreach coordinator is an effective method of engaging hard to reach high risk MSM.

Abstract 1905.3 - Challenge: Reducing the Number of HIV+ persons Who Test Repeatedly Without Disclosing Their Positive Status
Author(s): M. Johnson; P. Burnett; G. Olthoff; R. Miazad, MD; C. Nganga-Good

The Baltimore City Health Department STD/HIV Prevention Program provides 12,000 to 14,000 HIV tests per year in field outreach settings and achieves an HIV positivity rate of 6%. Despite the Program’s success, some of the clients, who tested HIV-positive previously, are tested again for HIV without disclosing their positive status. Outreach workers may not recognize repeaters if several months have passed since the last encounter or a different worker might counsel the client. This has caused lost opportunities to assess the clients care status immediately, as well as incurring unnecessary costs through the completion of unnecessary Western Blot tests.

The Program offers STD/HIV testing via its outreach testing van in numerous neighborhoods and fixed site locations through its street outreach services. When HIV positive persons are identified through these efforts, the Program provides partner services and assesses their primary care status.

Since April 2010, the Program has used a Do Not Test List as a means of avoiding unnecessary HIV testing and helping HIV-positive people, who we find in very high-risk settings, access primary care. An outreach worker will check the list before clients are tested, and counsel those clients appearing on the list to determine their HIV care
status. If clients are not in care or have dropped out of care for longer than 6 months, they are linked to care, immediately.

From April through December 2010, 9103 clients were tested, 393 tested positive (4.3%). During the same period in 2009, 8379 tested positive, 536 tested positive (6.3%). From April 2010 through November, the Program, through the do Not Test List approach, documented 212 people already in care, 19 linked to care, and 37 clients found from previous care linkage field records closed as unable to locate.

As a confirmatory measure, we call our clients providers to verify that they have kept their appointments over the last six months. Finally, the Program saved more than $12,000 in laboratory costs by not running Western Blot tests.

Knowing the HIV status of clients before testing provides an opportunity to immediately assess the care status of those who are positive, and provide care linkage to clients who are not in care or have dropped out of care. Addressing these issues in a street outreach setting, while having your clients present, is critical since you might not see them again. Avoiding unnecessary repeat testing also saves a significant amount of funding annually.

Abstract 1905.4 - Increased Partner Services Referrals of HIV cases by Private Providers in Baltimore City
Author(s): Ravikiran Muvva; Carolyn Nganga-Good; Rafiq Miazad; Phyllis Burnett; Glen Olthoff; Marcia Pearl

Objectives: To show the effect of changed reporting requirements and increased provider outreach on the number of partner services referrals of HIV positives by private providers in Baltimore City.

In 2007, the State of Maryland changed its HIV reporting requirements from code-based reporting to name-based reporting of HIV cases. In 2008, the Infectious Disease and Environmental Health Administration (IDEHA), the recipient of the cooperative agreement for CDC funding, mass mailed to all Maryland medical providers, notifying them of the new requirements on HIV reporting and partner services referrals. Subsequently, IDEHA provided numerous update presentations and trainings to medical providers across the State. As a result, Baltimore City Health Department (BCHD), Bureau of STD/HIV Prevention received more referrals for partner services.

The Interview and laboratory report data were extracted from STD-MIS database and analyzed. The provider-type was sorted into 3 broad categories, public (outreach, BCHD clinics), IDEHA-funded (testing sites funded by IDEHA) and private (hospitals, clinics, private physicians). A descriptive analysis was done to assess the frequency of partner services referrals.

The HIV partner services referrals in the private category increased from 15 cases in CY 2007 to 34 cases in CY 2008 (44% increase), and 105 cases in CY 2009, representing an increase of 200% from 2008 cases. In the IDEHA-funded category, referrals increased from 10 cases in CY 2007 to 71 cases and 129 cases in CY 2008 and CY 2009, respectively. This 82% increase from 2008 to 2009 is possibly due to new grant funded projects that included routine HIV testing in the Emergency Departments. In the public category, referrals increased from 118 cases in CY 2007 to 120 cases in CY 2008, and then 148 cases in CY 2009, a 23% increase from 2008 to 2009. This may be explained by the fact that providers in the public category were already making these referrals as mandated by the BCHD internal policies.

Partner services referrals have generally increased across all the categories. The increase in the private category was significantly higher than other categories due to the change in the HIV reporting requirement and targeted presentations emphasizing the requirements on making partner services referrals. Providers in the IDEHA funded and public categories were already aware of these reporting requirements and had mostly been compliant.
Abstract 1231 - The Influence of the Rural Closet on Sexual Risk Communication and Behaviors among MSM
Author(s): Amee Schwitter

Since the beginning of the HIV epidemic, vast amounts of resources and literature have been dedicated to understanding sociocultural factors, including determinants of risky sexual behavior influencing the epidemic among urban gay men. Yet, few studies have explored behaviors and risks specific to rural men who have sex with men, despite known differences in social and cultural environments. Men who have sex with men (MSM) living in rural areas experience a whole range of challenges unlike the majority of their counterparts in urban settings including living in a hidden subculture, difficulties accessing health care, health education, counseling, and a lack of confidentiality. According to the CDC, in the United States, MSM account for approximately half (48%) of all new HIV infections each year. In 2009 in Montana, MSM accounted for 71% of all persons newly diagnosed with HIV. This session will: 1) Review the results of in-depth qualitative interviews focusing on rural closeted MSM sexual risk behaviors and HIV prevention needs; 2) Identify barriers to accessing HIV prevention materials and services among MSM in Montana; and (3) Delineate lessons learned and implications for ongoing HIV prevention measures targeting rural closeted MSM.

During 2010, in-depth qualitative interviews were conducted with 28 self-identified closeted MSM living in Montana. The interviews were audio-recorded, transcribed, and analyzed to elicit overall themes influencing men's sexual behaviors and prevention needs. In addition to the interviews, demographic data were collected and Mohr and Fassinger's (2000) Outness Inventory (OI) was administered to determine each man's perceived level of outness to their family, the world, and the religious community.

Among the overall themes that emerged from this study included a feeling of social isolation that influenced the ability to access support systems. This isolation leads to feelings of depression and increased risky behaviors, including drug and alcohol abuse and anonymous unprotected sex. A decreased sense of HIV risk was correlated to living in rural areas and a sense that HIV is an urban problem. This was cited as a reason for decreased condom usage and testing frequency, despite many men reporting the need to travel to urban centers to engage in sexual activities. Homophobia was cited as reason for remaining closeted, decreased testing frequency, and overall ability to engage in sexual risk communication with partners and testing providers. As a result, the Internet is often used as an alternative to face-to-face contact when questions regarding sexual behaviors and HIV symptoms arise.

Qualitative research provides the opportunity to produce detailed descriptions about behaviors among small sample populations. With the difficulty reaching closeted MSM, this research offers insight into the HIV prevention needs of rural MSM. The research demonstrated a need for accurate increased Internet HIV prevention programs and increased local testing by providers who are able to provide these services in discrete locations while protecting men's anonymity. Remaining closeted about one's sexuality and living in a rural area with demonstrated stigma towards MSM influences the overall well being of an individual while increasing susceptibility to high-risk sexual behaviors and HIV.

Abstract 1415 - Effectiveness of Motivational Interviewing on HIV Risk Behaviors among MSM: A Systematic Review
Author(s): Rigmor C Berg; Michael W Ross; Ronny Tikkanen

In most areas of the world, despite the small size of their community, men who have sex with men (MSM) continue to be the population most affected by HIV. Among this group, the principal risk practice for HIV infection is unprotected anal intercourse (UAI), often engaged in under the influence of alcohol and other substances. Both behaviors are targeted through Motivational Interviewing (MI), a harm reduction approach that has been used to prevent HIV risk behaviors among this group for more than a decade, without its effectiveness having been systematically studied.

We conducted a systematic review (SR) according to the Cochrane Handbook for Systematic Reviews of Interventions investigating the effectiveness of MI on HIV risk behaviors for MSM. We searched 9 electronic databases, Google scholar, databases of websites and newsletters relevant to MI, literature lists of 22 relevant reviews, and contacted experts. Two reviewers independently appraised records and full-text papers for inclusion.
They extracted data using a pre-designed data recording form, performed risk of bias assessment using Cochrane’s risk of bias tool, and used the instrument Grading of Recommendations Assessment, Development and Evaluation (GRADE) with GRADE-Profiler to assess the extent to which we could have confidence in the estimate of effect. Finally, Mantel-Haenszel random effects meta-analyses for dichotomous outcomes and inverse-variance random effects meta-analyses for continuous outcomes were used to pool results.

The searches yielded 255 unique records, of which 10 randomized controlled trials were included. Risk of bias was generally moderate or low. With the exception of one study from the Netherlands, all were from the U.S. In total, they included 6,051 participants at baseline. Nine outcomes were sufficiently similar to compute meta-analyses. The quality of these outcomes was judged as moderate (GRADE). There was no significant difference between the group receiving MI and the control group for seven sexual behavior outcomes: unprotected anal intercourse (UAI) with nonprimary partner (RR=1.06, 95%CI= -4.71, 6.84), UAI with primary partner (RR=1.02, 95%CI= -6.43, 8.48), number of sexual partners (MD=0.34, 95%CI= -0.91, 1.58), UAI at short term follow up (MD=0.13, 95%CI= -0.15, 0.40), UAI at medium term follow up (MD=0.09, 95%CI= -0.49, 0.31), UAI at long term follow up (MD=0.08, 95%CI= -0.33, 0.17), condom use (MD=0.06, 95%CI= -0.32, 0.20). The meta-analysis for drinks per day at short term follow up was significant (MD=-1.24, 95%CI= -2.04, -0.43), but failed to reach significance at long term follow up (MD=-0.29, 95%CI= -0.74, 0.16). None of the meta-analyses showed statistically significant heterogeneity (max I² = 36%).

The effectiveness of MI as a prevention strategy for unsafe sexual and substance use behaviors among MSM does not appear promising. To dismiss MI as an intervention for all HIV risk behaviors among all groups of MSM, however, is premature. The results of this SR demonstrates that crafting suitable HIV prevention programming for MSM remains a challenge for today’s health promotion community.

**Abstract 1430 - Adapting HIV Interventions for Targeting Online Populations**

**Author(s):** Joshua Fegley; Jean Redmann

There is a need to adapt HIV prevention to changing technologies. At-risk populations can now often most effectively be reached through online venues. Many interventions, including EBIs, are not designed to reach these populations.

Online venues that target MSM (Men who have Sex with Men), specifically venues with geographical proximity to New Orleans/Louisiana.

NO/AIDS Task Force (NATF) has adapted 3 different intervention, street outreach, Popular Opinion Leader (POL), and RESPECT for use online to reach MSM populations. NATF started by adapting street outreach for online outreach in 2000. This intervention was successful with staff spending several hours each week in online chat rooms. Building on this success NATF decided to adapt an EBI for online use and in 2004 chose POL for this project. Despite the interruption of Katrina in 2005, with the grant award 04064 and supplemental ADAPT funding NATF successfully translated the core elements and key characteristics of POL into an online intervention. Subsequently, the changing environment prompted NATF to change from POL to RESPECT, an individual level intervention as opposed to a community level intervention (CLI) like POL.

**RESULTS:** For online outreach, staff were successful in conducting 20-30 conversations per week that touched on HIV prevention and risk reduction. From 2000 - 2004, approximately 100 people per year came in to NATF for HIV testing after contact with an NATF online outreach worker. Initially, POL was able to recruit and train online Opinion Leaders for the targeted online chat rooms. A total of 10 Opinion Leaders were trained in the initial year of implementation. In 2008, Gustav caused another evacuation of the region. This displacement, while much shorter than that caused by Katrina, and a major change in the chat room platform the project targeted caused many users in the New Orleans/LA region to abandon that venue. Subsequently, NATF recognized the need to find an intervention that could be used over multiple online venues rather than a venue that could only work for a CLI. NATF recognized that RESPECT could be adapted for use online and would be appropriate for multiple types of online venues.
LESSONS LEARNED: Interventions need to be able to easily adapt or shift to follow at risk populations, including to online venues. Interventions can be adapted successfully for online use by familiarity and knowledge of online culture and using that to translate the interventions into versions that can be effective online.

Abstract 2042 - An Examination of Communication about HIV Prevention within Social Networks of African American MSM

Author(s): Brian Weir; James Griffin; Pilgrim Spikes; Jocelyn Patterson; Carl Latkin

Promoting HIV testing and counseling is a key component of the National HIV/AIDS Strategy for reducing racial disparities in HIV among men who have sex with men (MSM). Peers are important sources of influence on HIV risk behaviors through social processes such as role-modeling and communication. Peer-based interventions focused on training individuals to promote HIV risk reduction within personal networks has shown efficacy in reducing risk behaviors, but less attention has been paid to HIV prevention related communication patterns. The purpose of this study was to 1) examine attitudes on talking with peers about HIV prevention, 2) examine topics of communication between African American MSM (AA MSM), their social networks and sexual partners and 3) identify factors associated with talking to social networks specifically about HIV testing.

As part of a CDC funded cooperative agreement, AA MSM were recruited who were at least 18 years of age, self-reported two or more sex partners and at least one male sex partner in the prior 90 days; reported unprotected sex and were willing to take an HIV test. Participants completed a social network inventory and survey on topics and frequency of HIV prevention communication with members of their social networks and sex partners. Of 188 participants, 49% were HIV seropositive, 27% were aged <30 years old, 57% identified as gay and 72% were not working full or part-time.

Many participants reported favorable attitudes around HIV Prevention communication. A majority of the sample agreed that it was important to talk with their male friends about HIV prevention (85%) and that they were comfortable talking with their friends about their sexual behavior (84%). However, recent communication within social networks was less common. In the prior 3 months, half talked to any network member about general HIV prevention topics (50%), less than half talked to a network member about HIV testing (47%) and a substantial minority reported talking with social network members about using condoms (n=7%). Adjusting for HIV status, older age was associated with decreased odds of having talked with a social network member about testing in the prior 90 days (AOR=0.48; 95%CI=0.24-0.93).

With sex partners, most participants reported talking about their HIV status (n=80%). Nearly half talked with sexual partner about getting tested together (40%), using condoms with others outside of the relationship (47%) or about being monogamous in the relationship (45%). Adjusting for HIV status, older age was associated with decreased odds of talking with a sex partner about monogamy in the relationship (AOR=0.25, 95%CI=0.12-0.50).

Despite attitudes that communication was important, levels of HIV prevention related communication was low. Results from the current study show key differences by age in communication with social network members and sexual partners. Tailoring interventions to include communication skills and practice is warranted, particularly for older AA MSM.

Track D
D28 - Correcting the Corrections Gap: New HIV Prevention Approaches with Incarcerated and Adjudicated Populations
Room: Hanover E (Hyatt Regency Atlanta)

Author(s): Monique Carry; Deborah Gelaude; Amy Fasula; Juarlyn Gaiter
Women released from correction facilities in the U.S. South carry the second highest regional burden for HIV. Despite the disease burden, there are few evidence-based behavioral interventions (EBIs) designed specifically to address the unique HIV prevention needs of this population.

In 2007, the CDC funded the University of North Carolina Chapel Hill to adapt an evidence-based HIV prevention intervention for incarcerated women in the rural U.S. South. Project S.A.F.E, a 3-session small group HIV/STD prevention intervention for Mexican American and African American women diagnosed with gonorrhea, Chlamydia, syphilis, or trichomoniasis, was chosen as a relevant intervention to adapt. The intervention significantly reduced new STD infections and sexual risk behaviors.

We illustrate the use of CDC's systematic approach, Map of the Adaptation Process (M.A.P) (McKleroy 2006), to adapt Project S.A.F.E. to meet the HIV prevention needs of incarcerated women in the rural US South and delivery in a long-term correctional facility. We describe findings from the formative research phase of the adaptation process, and the specific adaptations made to the intervention content, materials, and delivery.

Following the MAP, formative research activities were conducted to explore the HIV prevention related issues and needs of women prisoners. Six key activities were conducted: 1) an extensive literature review, 2) in-depth individual interviews with former (n=25) and current (n=27) women prisoners, 3) a focus group with former women prisoners (n=4), 4) in-depth interviews with prison staff and administrators (n=10), 5) forging partnerships with community stakeholders, and 6) the development of a Community Advisory Board (CAB). Women prisoner participants ranged in age from 18 - 45 and were 52% Caucasian (n=27), 46% African-American (n=24), and 2% Hispanic (n=1). Interviews were conducted by trained interviewers and analyzed using QSR NVivo 8.

Individual interviews identified issues that former and currently incarcerated women commonly face and barriers to positive behavior change. Focus group discussions gathered information on how to successfully deliver interventions within prison settings, and obtained feedback on the intervention. CAB recommendations included providing multiple birth control methods; opportunities for testing; and follow-up and support for women after release as essential components of Project P.O.W.E.R.

Findings were used to adapt the content of the Project S.A.F.E. intervention for incarcerated women, including information and activities specific to women prisoners (such as sessions on re-entry in to the community and HIV risk), updating intervention media (adding videos that address issues of incarceration), and tailoring the intervention for the prison setting (more sessions shorter in length to accommodate prison schedules). Core elements of the original intervention were not altered.

Formative research activities indicated that HIV risk is intricately intertwined with the individual and social circumstances surrounding incarceration. While the long-term correctional setting poses challenges to implementing HIV prevention programming, working with facility staff throughout the adaptation process can help address these challenges. Lastly, the CDC's MAP provides useful guidance for adapting EBIs to address the specific HIV prevention needs of different populations, and for adapting EBIs for new settings.


**Author(s):** Justiniano, B; Tesoriero, J; Kramer, K; Zack, B

Many individuals released from correctional settings engage in sexual and drug use behaviors that put them at risk to acquire or transmit HIV/STDs and hepatitis C (HCV). These behaviors are often the result of multiple determinants, including: low perception of risk; lack of risk reduction knowledge; lack of risk reduction skills; and the inability to prioritize HIV/STD/HCV prevention until other life issues such as mental health, substance abuse, housing and employment have been addressed.
Project START intervention services to incarcerated individuals began inside targeted New York State (NYS) Department of Correctional Services (DOCS) facilities (Orleans Re-entry, Queensboro Correctional Facility, and Sing Sing Correctional Facility) and continued after release in community settings.

Staff conducted program recruitment for incarcerated individuals who were then screened for eligibility, given an intake assessment and then enrolled into this individual-level, multi-session intervention. Two pre-release sessions were conducted with every enrolled client, assessing their HIV/STD/HCV risk, their Transitional Needs and developing an Immediate Release Plan, Risk Reduction Plan and Goal Setting worksheet. Four post-release sessions were conducted in the community updating the clients assessments, plans and goals as well as providing them with community resources, condoms, HIV/STD testing referrals and skills building techniques.

From April 2009 through July 2010, the Project START pilot program screened potential participants for eligibility and provided HIV/STD/HCV prevention education to over 300 incarcerated individuals. (Note: Pilot Program is on-going with an end date of February 2011.) As of July 2010, 98 individuals (29% of those screened) were enrolled in the program, with 74 individuals enrolling early enough to close out by the time of this study. Among closed cases, a total of 390 out of a possible 444 total sessions were completed. A total of 65 individuals (87.8%) completed all 6 sessions, and received HIV/STD testing referrals, condoms and individualized risk reduction plans. The positive outcomes of this pilot program has resulted in NYSDOH's continuing funding for this intervention program and an expansion of its service provision to include DOCS Bayview Re-Entry (a women's correctional facility) and DOCS Hudson Re-entry in upstate New York. LESSONS LEARNED: The Project START intervention translated well to New York's real world prison settings. Project START was implemented with fidelity to its core elements and to its key characteristics, although maintaining fidelity did limit the intervention's generalizability in NYS. In order to provide effective HIV/STD/HCV intervention programs, the primary needs of clients like housing, employment, mental health issues and family reintegration should be addressed. The NYS DOCS reentry unit structure facilitated the successful implementation of the Project START intervention, alleviating several challenges associated with providing services inside NYS prisons. The high rate of client retention can be attributed to utilizing the same staff person working with program participants for all 6 (pre/post) sessions and the inclusion of tailored client incentives for all post-release sessions. Results from the real world implementation of the Project START intervention matched the results obtained in the research setting, and confirms the importance of strict adherence to the core elements of the intervention.

Abstract 1314 - HIV Prevention to Care Continuum in a Jail Setting: Targeted Services for High Risk Inmates.

Author(s): Ann K. Avery, MD; Rhoderick N. Machekano, PhD, MPH; Rachel W. Ciomcia, MSSA, LISW-S

Among incarcerated inmates, there is a known higher prevalence of HIV infection than in the general community. An estimated 14% of the population of PLWHA passes through the corrections setting annually, making the corrections setting an ideal place to focus on engagement in care. Additionally, HIV + inmates often have significant medical and social issues that result in a more marginalized position. There is a significant gap in targeted prevention and care services for incarcerated individuals and this gap significantly impacts disease awareness as well as health and social outcomes.

The ATLAS Program (Assess, Test, Link: Achieve Success) provides prevention and care services in the Cuyahoga County Corrections Center, located in downtown Cleveland, Ohio.

The ATLAS Program offers voluntary rapid HIV testing to inmates upon incarceration at intake and throughout the general population. Health Education sessions are offered to all inmates throughout the jail stay to provide additional disease awareness and support to prevention efforts. For inmates diagnosed through the testing program or for those who self-disclose an HIV diagnosis upon incarceration, linkage case management services are provided to identify medical and social needs and create linkages to community based providers for continuity of care upon release. The program is funded through a Special Project of National Significance grant from HRSA and is part of a national multi-site evaluation project, focusing on the effectiveness of jail based services and health outcomes of program participants six months post release.
Results: From 2008 to 2010, the ATLAS Program tested nearly 8,000 inmates (7,000 unique inmates) with 27 positive tests, resulting in a 0.33% positivity rate. Of those tested, nearly 70% were African American and 90% male. Of those testing positive, 75% were male and 55% identified their sexual orientation as heterosexual. Health education classes were attended by 878 inmates. More than 380 HIV+ inmates were incarcerated in 28 months and more than 2/3 remained 7 days of more. 122 inmates participated in the linkage case management program and had a mean jail stay of 50 days. 61% of participants reported using illicit drugs in the last 30 days and 82% reported recent mental health concerns. 88% reported having an HIV care provider yet only 33% had standard monitoring of T cells and viral load in the 6 months prior to incarceration. All inmates in the program were linked to a medical provider during the jail stay. Lessons Learned: Providing HIV prevention and supportive care services within a jail setting is highly encouraged as it reaches a high risk and primarily out of care population. Targeted HIV services in a jail are often an unmet need but are valuable to both the clients and the system. Jail stays are long enough that services can be meaningful and effective and the inmates present with disproportionately high risk factors and social issues. Jail based services encourages successful re-entry into the community which translates into better health and prevention outcomes.

Abstract 1801.1 - NHVREI Evaluation
Author(s): Daniel Eckstein, MA; Caroline C. McLeod, PhD

The National Institute of Allergy and Infectious Diseases HIV Vaccine Research Education Initiative (NHVREI) is a large-scale community engagement and education program designed to increase knowledge and understanding of HIV vaccine research efforts within the populations most affected by the AIDS epidemic—African Americans, Hispanics, and Men-Who-Have-Sex-With-Men (MSMs). The initiative employs a combination of approaches to reach key influencers within each of these subpopulations with pro-HIV vaccine research education. Expectations are that these messages will be taken up by key influencers and spread within their social networks.

A mixed-method evaluation methodology was employed that included a variety of process and outcome evaluations using both quantitative and qualitative techniques. Process evaluations included reviews of Initiative outputs, stakeholder interviews, and key influencer focus groups. Outcome evaluation was measured using a survey of key influencers and focus groups with key influencers.

Process evaluations uncovered a wealth of data relevant to the implementation of the Initiative including issues related to the difficulty of gathering and assessing data from a large network of key influencers in a manner that was timely and confidential. Outcome data from a survey on key influencers that concluded in December 2010 is currently being analyzed and will be shared at the NHPC.

Obtaining quality process data on a complex communications initiative can be challenging but is achievable. Outcome data related to effects within the target audience are equally difficult to obtain. Our programmatic evaluation indicates that a key influencer model can be used to achieve positive results toward changing understanding of biomedical prevention research aimed at reducing the health impact of HIV. This is true within each of the target populations evaluated.

Abstract 1801.2 - Knowledge and Awareness of HIV Vaccine Research: Findings from Qualitative Research
Author(s): A. Cornelius Baker; Elyse Levine, PhD; Carol Schechter, MA, MPH; Bonny Bloodgood, MA

The National Institute of Allergy and Infectious Diseases (NIAID) HIV Vaccine Research Education Initiative (NHVREI) is committed to building knowledge and awareness of HIV vaccine research among U.S. populations most affected by HIV/AIDS. NHVREI conducted formative research to ensure future outreach strategies complement the educational needs and interests of these populations.
Participants across vulnerable populations had mixed perceptions of the urgency for HIV vaccine research; while many expressed the need for a vaccine, others perceived that a vaccine is not a high priority given that HIV is isolated to specific groups, and other means of prevention are available. Most had little knowledge of the concept of preventive HIV vaccines and frequently confused it with a cure for HIV/AIDS. Altruism and hopes of a vaccine ending HIV/AIDS were cited as facilitators of support, while safety concerns (e.g., side effects, vaccine contents), research costs, lack of knowledge, stigma, concerns about access to a future HIV vaccine, and distrust of government and researchers, were cited as barriers to support HIV vaccine research. There was a general lack of understanding of the research process; including methodology (e.g., Who are the participants? How do you know if it is effective?) and safety protocols (e.g., What are the short- and long-term effects of participation? How do you know it is safe?). Concern was also voiced about the that ifs related to research (e.g., What if I get sick? What if I become HIV-positive?). Many voiced a lack of information about research successes.

NHVREI can enhance outreach to its priority populations by focusing messaging on altruism, specifically for future generations and one's community. Findings suggest the need to strategically consider ways to increase knowledge of HIV vaccine and other health research. Basic health research information is needed to reduce misinformation and increase knowledge. Messages should include ongoing updates, including the potential for success. Issues of distrust of researchers and research organizations and safety concerns should be met with targeted communication and environmental changes related to health care delivery and research processes. Audiences should also see and hear a diversity of individuals reinforcing the concept that HIV/AIDS affects all communities and therefore HIV prevention research must reflect all communities.

Abstract 1801.3 - NIAID HIV Vaccine Research Education Initiative (NHVREI) Partnership Program: Partnership with Community for Broader Community

Author(s): Stacey E. Little, PhD, MPH, MSW; Joy Mbajah, MA; Russell Brewer, DrPH, CHES

Issues: The development of a safe and effective vaccine that could prevent HIV would help tremendously in the fight against AIDS and save millions of lives. Vaccines have been essential in the reduction and/or elimination of other infectious diseases such as smallpox, polio, and measles. Misunderstandings about HIV vaccine research are still common, and the success of HIV vaccine studies depends on the understanding, trust, support, and participation of all communities. The Partnership Program of the NIAID HIV Vaccine Research Education Initiative (NHVREI) builds the capacity of organizations at professional and senior staff levels to better understand the science of HIV vaccine research and enhance their ability to provide accurate, timely, and culturally appropriate information about HIV vaccine research within their communities and among their constituents. The NHVREI Partnership Program is comprised of three types of Partners, which include 16 local Community Based Organizations (CBOs), 5 national ASOs, and 24 Network Partners that are located and/or have constituents in cities with an HIV Vaccine Trial Unit (HVTU). These Partners are trusted sources with far-reaching significance and influence among the initiative's target populations.

Description: The NHVREI is sponsored by the Division of AIDS at the National Institutes of Allergy and Infectious Diseases (NIAID) from 2007-2011 and implemented by AED and GYMR. The overall goal of the NHVREI is to increase awareness and understanding of HIV vaccine research among populations most affected and infected by HIV/AIDS, specifically Blacks, Latinos, and men who have sex with men (MSM) of all racial/ethnic groups. The Partnership Program is an important component of this larger initiative.
Results: Over the five years of the project, NHVREI Partners have developed significant knowledge about HIV vaccine research and other biomedical HIV prevention research and have shared this information within their communities and among their constituents in innovative ways such as integrating HIV vaccine research within their current programs and services, using social media (e.g., Facebook and Twitter), and discovering additional venues to distribute information about HIV vaccine research among the intended audience. In addition, Partners have utilized a variety of tools and materials to address misconceptions and misunderstandings about HIV vaccine research within their communities and among their constituents. These include using an HIV vaccine quiz to assess baseline HIV vaccine knowledge and attitudes and developing eye catching materials that lead to questions and discussion about HIV vaccine research.

Conclusions: As a result of the NHVREI Partnership Program, communities across the country have received specific culturally relevant information and messages about HIV vaccine research and studies occurring in their communities. Qualitative information gathered from the Partners indicate strong levels of confidence in the subject matter of HIV clinical research and comfort in imparting this information to communities most affected by HIV.

Abstract 1801.4 - The National Institute of Allergy and Infectious Diseases HIV Vaccine Research Education Initiative Framework
Author(s): A. Cornelius Baker; Carol Schechter, MA, MPH; Katharine Kripke

Issue: The first National Institutes of Health (NIH)-sponsored HIV vaccine clinical trial began in 1987. Since then, National Institute of Allergy and Infectious Diseases (NIAID, a part of the NIH)-supported investigators have enrolled more than 28,000 volunteers in over 100 trials across the world, testing more than 75 HIV vaccine candidates. In the future, large trials requiring thousands of volunteers will be conducted. There is a continuing need for the U.S. populations most heavily affected by HIV/AIDS to learn about HIV vaccine research, so that they can make informed decisions about trial participation.

Setting: The NIAID HIV Vaccine Research Education Initiative (NHVREI) is based in the United States and partners with national and other organizations that reach U.S. populations most heavily affected by HIV/AIDS (in particular, Blacks/African Americans, Hispanics/Latinos, men who have sex with men).

Project: NHVREI aims to engage national, regional and local organizations to increase knowledge and understanding of HIV vaccine research among U.S. populations most heavily affected by HIV/AIDS. NHVREI activities, including materials and message development and dissemination, partnership development and outreach, media activities, and issues and crisis communications were guided by strategic planning, research, and consultation with stakeholders.

Results: An evidence-based rationale for NHVREI program activities was developed based on a literature review of recruitment to HIV clinical trials and of the theoretical basis of behavioral and social change. The literature review of recruitment to HIV clinical trials documented the facilitators and barriers to HIV clinical trial recruitment amongst the NHVREI audiences and strategies used to increase individual willingness to participate in HIV clinical trials. The review of behavioral and social change literature aimed to delineate strategies and lessons learned from broad scale social change programs. Five key theories that describe human behavior (Health Belief Model, Social Cognitive Theory, Theory of Reasoned Action, Theory of Self-Regulation and Self-Control, and Theory of Subjective Culture and Interpersonal Relationships) and eight key variables that affect behavior (intention, environmental constraints, skills, positive attitude, social norms, self image, emotional reaction, self-efficacy) were reviewed. The initiative is grounded in the Social Ecological Model. The initiative acknowledges that multiple factors influence health behaviors and multilevel interventions are most effective. The Diffusion of Innovation theory was also incorporated to focus on the role of opinion leaders as early adopters of desired behaviors and the role of community networks in facilitating diffusion. The NHVREI logic model resulting from the analysis will be shared.

Lessons Learned: The development of a multi-component initiative is best informed by a comprehensive analysis of the environment, literature, and theory.

Track F
F01 - Creating Systems Change in the South by Building Policy/Advocacy Capacity: Results, Insights, and Lessons
Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 1265 - Creating Systems Change in the South by Building Policy/Advocacy Capacity: Results, Insights and Lessons
Author(s): Maya Wyche, Jessica Terlikowski

The South has the highest proportion of new AIDS diagnoses, constituting 46% of cases in 2007 and the highest prevalence of persons living with HIV/AIDS 40% of all U.S. cases. The South is the only U.S. region where the estimated number of HIV/AIDS-related deaths has increased since 2001. Despite being an epicenter of a growing epidemic, the South continues to be disproportionately impacted by inequitable funding and availability of prevention/care services. These factors, coupled with the myriad social determinants that increase the risk for HIV infection in the South and predispose those living with HIV/AIDS to higher morbidity rates, all support the need for larger systemic changes in the region.

Strategic policy advocacy activities supported in 9 Southern states: Alabama, Arkansas, Northern Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina and Tennessee.

In 2007, AIDS United joined with the Ford Foundation to create Southern REACH (Regional Expansion of Access and Capacity to Address HIV/AIDS). The goal of Southern REACH is to support strategic policy advocacy activities led by CBOs, ASOs, advocacy coalitions, and other allies with public policy and advocacy experience. Since 2007, the initiative has supported almost 120 projects with $5.5 million in direct grants plus technical assistance (TA) to build organizations capacity to develop and implement advocacy plans. Instrumental in the TA process is the administration of a comprehensive organizational assessment to provide the direction for the strategic advocacy plans. Providing a framework within which organizational leadership and general advocacy capacity can be established or enhanced is vital to the provision of TA. Assessments conducted at the end of the project provide an indication of the impact of TA on organizational capacity.

The baseline organizational assessments revealed a significant lack of experience with policy advocacy. Instead, the majority of the organizations were more focused on programmatic support and expansion. As a result, TA to these organizations largely consisted of strategic planning activities, building evaluation systems, board development and general organizational development. At the conclusion of the funded project, we found that the TA resulted in more effective advocacy strategies, skills and knowledge and overall strengthening of the infrastructure that lends to greater advocacy effectiveness. Additionally, organizations were more consistently utilizing strategic plans to develop and implement programs at the end of each grant cycle.

In order to effectively advocate for needed funds and services, Southern organizations need to strengthen existing systems, including leadership and skill sets among advocates, for seamless integration and implementation of an advocacy component. However, there remains a significant lack of policy advocacy capacity among Southern organizations among organizational leadership and persons living with, affected by and/or advocating on behalf of HIV/AIDS. The need for advocacy and messaging trainings and basic elements of a policy advocacy tool kit are essential for local areas to affect systems changes. Supporting advocacy efforts through the strategic provision of TA provides the organizational infrastructure needed to execute successful policy advocacy efforts that many of the community-based organizations with access to the most high-risk populations may not have.

Track F
F05 - What Makes a Comprehensive HIV Prevention Program in Low to Medium Incidence States Relevant?
Abstract 1580 - What Makes a Comprehensive HIV Prevention Program in Low to Medium Incidence States Relevant?

Author(s): Ann Daehling-Gardner; Tim Pilcher; Benny Ferro; April Bankston; Deborah Reardon-Maynard; Erica Dunbar; Sam Van Leeuwen

The National HIV/AIDS Strategy (NHAS) in a coordinated effort is to reduce new HIV infections, increase access to care and prevention services, and decrease HIV-related health disparities. This strategy will intensify HIV prevention efforts in communities where HIV is most heavily concentrated. It also will create a redistribution of federal dollars to health department jurisdictions beginning in 2012. Given these issues, how will low to medium incidence states develop the best comprehensive HIV prevention program plan to accomplish the intent of the NHAS?

In order to reduce new HIV infections, the NHAS calls for: 1) intensified HIV prevention efforts in areas most heavily impacted by HIV/AIDS; 2) expanding targeted efforts to prevent HIV infection using effective evidence-based approaches and non-traditional innovations such as biomedical interventions; 3) use of the Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS (ECHPP) as a planning model; and 4) educate Americans about how to prevent it by continuing condom distribution and awareness. NHAS recommends that government agencies ensure that HIV prevention funding is allocated consistent with the latest epidemiological data and is targeted to the highest prevalence populations and communities.

Factors and considerations that will influence the structure and requirements of future programs include the National HIV/AIDS and DHAP strategy plans, new evidence-based interventions, increased accountability, enhanced testing and linkage to care and treatment, development or release of new guidance documents (i.e., Community Planning, Testing in Non-Clinical Settings) integration of STD, Hepatitis, and TB, new technologies such as internet prevention services and testing technologies, and the influence of the ECHPP planning model. The presentation will demonstrate how current low to medium incidence states develop and implement a comprehensive HIV prevention program that is relevant to the current influences of the epidemic.

A comprehensive HIV prevention program results in an increased emphasis on accountability and performance monitoring, including utilization of program data and evaluation to inform and direct efforts locally and nationally for program improvements. New guidelines such as Community Planning and Testing at Non-Clinical Settings, and new testing technologies and testing strategies to improve early detection of HIV/AIDS and linkage to care will improve the program planning process. Other examples of influences not yet mentioned are the American National Heightened Response, Hispanic/Latino Executive Committee Initiative, the 12-city MSA (ECHPP), PCSI Demonstration Project, and Expanded Testing Initiatives in both clinical and non-clinical settings. Currently, several activities are under way that will be critical in supporting the structure of, and policies governing, future comprehensive HIV prevention programs. Providing an overview of these activities and highlighting lessons learned from CDC’s recent Rural Health Department Consultation will provide the federal perspective. The health department perspective will demonstrate the essential activities such as Partner Services, Program Collaboration and Service Integration, prioritizing Prevention with Positives, and Counseling and Testing initiatives. Successful examples will be provided by Arizona and Wisconsin departments of health. These changes and influences are important in planning for a new comprehensive HIV prevention program.
**Abstract 1302 - Using Systematic Public Health Law Research to Assess HIV Prevention Policy Environments**  
**Author(s):** J. Stan Lehman; M. Chris Cagle

**ISSUE:** State laws and regulations greatly affect the ability to develop and implement effective HIV prevention policies at both the state and local levels. However, there has been little systematic public health law research across the 50 states regarding important HIV policy domains. In response, CDC is developing the capacity to assess policy environments and characterize and promote effective policy environments.

**SETTING:** Each legal assessment surveys all 50 states and the District of Columbia.  
**PROJECT:** In 2010, the Division of HIV/AIDS Prevention (DHAP) at the Centers for Disease Control and Prevention (CDC) implemented a Legal Assessment Project (Project) to assess state-level HIV-related policies (laws and regulations) and assess model policies for effective HIV prevention policy environments. These laws and regulations are fluid and vary by state, presenting challenges to the utility and timeliness of public health law research. In response, the Project uses traditional public health law research methods to systematically assess state laws and regulations across a variety of key legal and policy domains and routinely update the research. For most domains, at least some previous research has been conducted. The Project seeks to establish standardized approaches across the different domains and to keep previous research updated.

**RESULTS:** As of January 2011, the Project focuses on five legal domains: criminalization of HIV exposure; syringe service programs (SSPs); laboratory reporting of CD4 and viral load data; state Medicaid reimbursement for HIV screening; and state HIV testing laws. The assessments revealed that 32 jurisdictions have HIV-specific criminal laws; further, all states have general criminal laws (such as assault and battery) that can be used to prosecute potential exposure of HIV. The SSP assessment revealed that 17 jurisdictions expressly authorize the operation of SSPs in some form. Regarding laboratory reporting, 21 jurisdictions have laws or regulations requiring the reporting of all CD4 and viral load results (both detectable and undetectable results). The research showed that Medicaid programs in 18 jurisdictions reimburse for HIV screening in all settings and populations, while the Medicaid programs in 18 jurisdictions do not reimburse for HIV screening at all. Lastly, 45 jurisdictions’ HIV testing laws were consistent with CDC’s recommendations.

**LESSONS LEARNED:** Conducting systematic legal assessments across key HIV policy domains presents an effective tool in the development of HIV prevention policies. Collaboration with subject matter experts is very important to the success of the assessments, which are quickly outdated and require methods to keep them current. Lastly, developing methods for coding the assessments allows for better inclusion in analyses and promotion of effective policy environments.

**Abstract 1921 - HIV and Related Co-Infections: Canada's Policy Framework for Prevention**  
**Author(s):** Beausoleil, K

The Public Health Agency of Canada has developed a pan-Canadian HIV and Co-Infections Prevention Policy Framework to support a more effective and comprehensive prevention response to HIV/AIDS and its related co-infections (i.e., other sexually transmitted and blood-borne infections and tuberculosis). The framework also aims to improve the strategic use of policy and resources to address issues common to these infections.

**Canada**

The Public Health Agency of Canada (PHAC) consulted with stakeholders to develop the elements, principles and qualities essential to a pan-Canadian HIV and co-infections prevention policy framework. The consultation, international and domestic developments in prevention, and specific input from an expert working group informed the development of the framework.

The framework includes guiding principles for effective prevention interventions, inspired by HIV prevention principles endorsed by UNAIDS (2005). The principles ask that prevention interventions be holistic, address vulnerable
populations and the social determinants of health, adhere to principles of social justice and human rights, encourage the use of sound evidence, and foster collaboration across sectors and with those living with/affected by HIV/AIDS.

PHAC has developed a conceptual model to be used by public health practitioners, policy-makers and planners as a tool for developing prevention interventions. The model is based on best-evidence in prevention and integrates various public health models for prevention, including a categories/levels of prevention approach, a population-specific approach, and a determinants of health approach.

Intended as a policy tool to help re-invigorate HIV prevention policy and programming across Canada, the framework will guide policy-makers and planners as they develop comprehensive and robust interventions for populations most vulnerable to HIV/AIDS and related co-infections. The framework will also inform strategic use of policy and resources to address HIV/AIDS and related co-infections.

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**Track G**

**G01 - Enhancing HIV Prevention by Promoting a Public Health Approach to Improved Sexual Health: International Perspectives**

**Room:** Baker (Hyatt Regency Atlanta)

**Abstract 1356** - Enhancing HIV Prevention by Promoting a Public Health Approach to Improve Sexual Health: International Perspectives

**Author(s):** John Douglas

In the United States, there are continued concerns about the public health impact of poor sexual health, including the continued high incidence and prevalence of HIV/STDs, viral hepatitis, teenage pregnancy, sexual violence and abuse, and the intersection with other syndemics of drug and alcohol abuse. These conditions account for substantial morbidity and tremendous economic and social costs. They are also a major cause of health disparities with a disproportionate burden on our young people, MSM, ethnic minority communities. Specific to HIV prevention, HIV disproportionately affects certain populations MSM, African Americans, and Hispanics/Latinos.

To avoid these adverse health and social outcomes, and at the same time allow individuals to maximize positive outcomes, other high resource, Western industrialized countries are emphasizing a comprehensive approach to sexual health. A sexual health approach provides opportunities to address behaviors and contexts driving these syndemics, and to engage individuals and communities in a broader dialogue on prevention and wellness rather than simply disease incidence or avoidance.

Sexual health is an issue for the whole population across the lifespan. Over the past decade, a variety of nations and international organizations have recognized the importance of sexual health as a useful unifying concept that addresses an important aspect of overall health and well-being, calling for enhancements in public policy, education, and research. To stimulate discussion and promote capacity building, CDC and the Public Health Agency of Canada are bringing together public health officials from the U.S., Canada, Europe, and the Pan American Health Organization (PAHO) to describe their efforts to date in advancing a public health approach to improve sexual health. This session will be the fourth in a series of policy discussions by public health officials from high resource, Western industrialized countries. These discussions were initiated at the International AIDS Conference in Mexico City in 2008.

This group oral session will address four international perspectives on advancing sexual health:

1. Advancing a public health approach to improve sexual health in the US (John Douglas, CDC)
2. Advancing a public health approach to improve sexual health outcomes in Canada (Public Health Agency of Canada)
3. Advancing a sexual health framework in Europe (Marita van de Laar, European Centre for Disease Prevention and Control [ECDC])
4. Sexual health and HIV prevention programs in the Americas: Opportunities and challenges (Rafael Mazin, PAHO)
The presenters will give an overview of efforts toward advancing sexual health in their country or region, with a focus on impact on HIV prevention efforts. Presentations will be followed by a panel discussion moderated by Kevin Fenton, CDC, allowing panel experts and audience members to address how international policy approaches linking sexual health and HIV prevention efforts can be shared and present ideas for future collaboration.

The presentations and panel discussion will allow participants to understand international efforts to strengthen HIV control and prevention efforts by using a complementary framework that addresses sexual health.

**Track G**

**G08 - Synergistic Epidemics of STIs and HIV**

**Room: Inman (Hyatt Regency Atlanta)**

**Abstract 1559 - HIV and syndemics in San Francisco**

**Author(s):** Priscilla Lee Chu; Israel Nieves; Tomas Aragon; L. Masae Kawamura; Susan Philip; Susan Scheer; Susan Fernyak; Grant Colfax

Syndemics are linked epidemics, where one epidemic is synergistically linked to increase transmission and/or worsen outcomes of either or all diseases. Separate disease surveillance systems Tuberculosis (TB), Viral Hepatitis (VH), Sexually Transmitted Diseases (STD), and HIV in San Francisco (SF) are not linked electronically. Thus, while SF has been a traditional HIV epicenter, the extent of syndemics or HIV co-infections are not fully known. In 2010, the SF Department of Public Health became a CDC Program Collaboration and Systems Integration (PCSI) funded site. The PCSI goal is to systematically evaluate, link, and coordinate these surveillance systems to examine syndemics at the community and individual levels. The results of the preliminary match of HIV registry against the TB, VH, and STD registries are described here.

Distinct case inclusion criteria appropriate to each disease registry were developed to generate cases for matching. HIV registry included cases living as of December 31, 2009. VH included all cases; TB included all living active and latent cases. STD included cases with an STD in 2009. Cases were matched by name and date of birth. HIV co-infections were characterized by: active and latent TB (ATB, LTB), Hepatitis B and C (HBV, HCV), syphilis, gonorrhea, and chlamydia. Logistic regression determined the demographic factors (age, sex, behavioral risk for HIV, homeless status at HIV diagnosis, race/ethnicity) associated with having co-infections.

HIV prevalence in SF was 2,039 per 100,000 in 2009. TB incidence was 115 per 100,000. Prevalence and incidence for Hepatitis B (HBV) and Hepatitis C (HCV) could not be calculated. STD 2009 incidence per 100,000 was 66.8 for early syphilis, 537 for chlamydia, and 233 for gonorrhea. The HIV database had 16,786 living cases as of the end of 2009. Overall, 11.5% (N=1,935) of HIV cases had a co-infection, resulting in an HIV population prevalence rate of 11,527 per 100,000. Specifically, rates for every 100,000 HIV infected persons were 774 who had ever had ATB (N=130), 1,960 (N=329) with LTB, 1,537 (N=258) with HBV, and 3,872 (N=650) with HCV. In 2009, co-infection incidence rates per 100,000 for syphilis, chlamydia and gonorrhea were 1,340 (N=225), 2,139 (N=359), and 1,894 (N=318), respectively. There were 131 per 100,000 (N=22) HIV cases diagnosed with both HBV and HCV, and 1,036 per 100,000 (N=174) HIV cases with two or more STDs. In logistic regression, African-American (Adjusted Odds Ratio [AOR]=1.27, 95% Confidence Interval [CI]=1.08-1.50, Referent [REF]=Latino), younger age at time of HIV diagnosis (20-29 years, AOR=2.60, CI=1.36-4.99; 30-39 years, AOR=2.36, CI=1.23-4.51; 40-49 years, AOR=2.42, CI=1.26-4.63; 50-59 years, AOR=1.98, CI=1.01-3.90, REF=60+ years), intravenous drug users (IDU) and men who have sex with men intravenous drug users (MSM-IDU) (AOR=3.06, CI=2.54-3.67; AOR=2.81, CI=2.48-3.18, respectively, REF=MSM) were more likely to have co-morbidities. White were more likely to have no co-infections (AOR=1.25, CI=1.13-1.48, REF=Latino).

Populations with higher rates of HIV infection are also at higher risk for co-infection with other transmittable diseases. Integrated efforts to expand comprehensive screening, access to medical care, and substance use treatment among such populations are needed to decrease these syndemics.
Abstract 1755 - Urethral and Rectal Chlamydia and Gonorrhoeae Infection in Black and White MSM

Author(s): Shauni L Williams; Colleen F Kelley; Eli S Rosenberg; Angie Caliendo; Jessica Ingersoll; Deborah Abdul-Ali; Patrick S. Sullivan

The incidence of HIV infection in black men who have sex with men (MSM) in the US is 2-3 fold higher than white MSM, and differences in individual-level risk behavior do not explain this disparity. Black MSM have a higher incidence of sexually transmitted infections (STI), a known risk factor for HIV acquisition. Therefore, comprehensive evaluation of the influence of various STI, including urethral and rectal STI, on HIV acquisition by race is crucial. We report preliminary data on the prevalence of STI and HIV in a cohort of black and white MSM in Atlanta, GA.

The InvolveMENt Study is a currently enrolling longitudinal cohort of 1083 MSM (approximately 25% enrolled) aged 18-39 years in Atlanta, GA designed to examine individual, dyadic, and community level factors that contribute to the disparity in HIV and STI prevalence and incidence among black MSM. Participants are recruited from community-based venues in the Atlanta area and tested at each study visit for HIV antibody by OraQuick Advanced and for STI including urethral Chlamydia trachomatis (CT) and Neisseria gonorrhoeae (GC) by urine nucleic acid amplification testing (NAAT). Testing for rectal GC and CT with participant-collected rectal swabs by NAAT began at the 3 month follow-up visit. We analyzed the prevalence of urethral CT and GC at study entry and the prevalence of rectal CT and GC at the 3 month follow-up visit and assessed differences in black and white MSM.

Of 213 MSM enrolled thus far into the cohort, 127 (60%) self-identified as black and 86 (40%) as white with mean ages of 28 and 31 years, respectively. Twenty-eight percent (59/213) had prevalent HIV infection at the baseline study visit: 36% (46/127) in black MSM and 15% (13/86) in white MSM (p=0.002). Prevalence of urethral CT and GC were not significantly different among black and white MSM (2.4% (3/127) vs. 4.7% (4/86) for urethral CT; 3.2% (4/127) vs. 0% (0/86) for urethral GC; p=NS for both comparisons). At the 3 month visit, prevalence of rectal CT and GC infection did not differ significantly between black and white HIV negative MSM (12.8% (5/39) vs. 24.0% (6/25) for rectal CT and 5.1% (2/39) vs. 4.0% (1/25) for rectal GC).

Our data supports recommendations for routine testing for rectal CT and GC in high risk MSM as prevalence is high in our cohort. Although preliminary, our data do not suggest that disparities in urethral or rectal CT or GC may be a major driver of disparities in HIV incidence between black and white MSM. Future analyses will delineate these relationships more clearly.

Abstract 1818 - HCV and HIV Co-Infection among Adolescents and Young Adults in Massachusetts: Implications for Prevention

Author(s): Daniel Church; Shauna Onofrey; Betsey John; Kerri Barton; Alfred DeMaria, Jr.

A re-emergence of hepatitis C virus (HCV) infection among young injection drug users (IDU) in Massachusetts was first detected by the Massachusetts Department of Public Health (MDPH) in 2007. Since that time, there have been approximately 1,000 reported cases of HCV infection (confirmed and probable) annually among people between the ages of 15 and 24 years. The most common risk factor reported is injection drug use. The number of new cases of reported HIV infection among IDU has been declining in recent years.

In January, 2011, MDPH HIV/AIDS surveillance staff matched 4,916 cases of HCV infection among people ages 15 to 24 years and 4,381 cases among people ages 25 to 29 years reported to MDPH between 2005-2010 to 29,399 cases of individuals ever reported with HIV/AIDS. Analyses were conducted with a resulting deidentified matched dataset.

A total of 27 15-24 year olds and 38 25-29 year olds were identified as having been reported with both HIV and HCV infection. Among those in the younger age group, 56% were male; in the older group, 63% were male. Among all co-infected persons in both age groups, eleven cases were residents of the City of Worcester, in central Massachusetts, six were from Boston, eleven cases had no address information, and the remaining 37 cases resided in separate towns in three Massachusetts counties (Essex, Hampden, and Middlesex).
Co-infection with HIV and HCV has numerous serious implications, including increased risk of disease progression and mortality. While the number of co-infected individuals in this routine surveillance-derived population is small compared to the overall numbers of HCV infected, HIV co-infection is evident in probable social networks, particularly in urban areas. These data suggest that the re-emergence of HCV infection among young people in Massachusetts, as it continues, may become associated with an HCV/HIV syndemic. Increased and enhanced efforts at HCV and HIV prevention among young IDU is imperative to reduce further HCV transmission and a re-emergence of HIV transmission in this population.

Abstract 1874 - Epidemiology of Co-Infection with HIV and Syphilis in 34 States, United States, 2009
Author(s): John R. Su; Hillard S. Weinstock

Background: During the early 2000s, reports of the re-emergence of syphilis in a few cities described high prevalences of co-infection with human immunodeficiency virus (HIV). However, the prevalence of co-infection with HIV and syphilis on a national level has remained unknown. Until 2008, HIV co-infection status was not available as part of syphilis case report data at the national level. Here, we present the first description of HIV co-infection among persons with syphilis across multiple states during 2009.

Methods: We reviewed data reported to CDC from states that reported HIV co-infection status at least 70% of cases of primary and secondary (P&S) syphilis during 2009. These data originated from P&S syphilis patient interviews and included census region, sex, sex of sex partner, race and ethnicity, age, and HIV infection status. Prevalence of co-infection was calculated using co-infected patients as the numerator, and all P&S syphilis patients who were asked about their HIV status as the denominator.

Results: 34 states and Washington D.C. met inclusion criteria, accounting for 82% of P&S syphilis in the U.S. during 2009 and 79% of estimated AIDS diagnoses during 2008. Of 11,499 patients with P&S syphilis, 11,043 (96%) were asked about HIV status. Of these 11,043 patients, 36% were co-infected with HIV, 49% were not co-infected, 1% refused to disclose their status, and 15% did not know their status. Prevalence of co-infection among patients with P&S syphilis varied with sex of sex partners: 53% of 6,346 men who had sex with men in the past 12 months (MSM), 9% of 2,021 men who had sex with women only (MSW), and 5% of 1,599 women were co-infected. Prevalence of co-infection among MSM with P&S syphilis was significantly higher among black MSM than MSM of other races and ethnicities (59% of 2,405 black MSM, 49% of 1,262 Hispanic MSM, 50% of 2,348 white MSM) (PR = 1.3, P < 0.001).

High prevalences of HIV co-infection existed among 15 9 year-old MSM with P&S syphilis (black MSM: 35%, Hispanic MSM: 11%, white MSM: 22%). Prevalence of co-infection among MSM with P&S syphilis remained high regardless of region: 52 3% by region among black MSM, 45 7% by region among Hispanic MSM, and 44 3% by region among white MSM. Most reports of co-infection among MSW and women with P&S syphilis occurred among blacks (68% of 176 reports among MSW, and 72% of 72 reports among women).

Conclusion: Regardless of race, ethnicity, or region, high prevalences of HIV co-infection occurred among MSM with P&S syphilis. Interventions to more effectively prevent HIV and syphilis among younger MSM, especially younger black MSM, are urgently needed.

Abstract 2029 - Enhancing Comprehensive HIV Prevention Planning: A Syndemic Spatial Analysis of HIV and STD Burden
Author(s): Hu, YW; Cheng, K; Frye, D; Kermdt, PR; Sayles, JN

The use of geographic information systems (GIS) and spatial statistical analysis provide an effective tool in identifying smaller-area disease trends. Los Angeles County (LAC) is the most populous County in the nation at 9.8 million, with a size of 4,083 square miles. Historically, HIV prevention planning has been focused on prioritizing services within 8 Service Planning Areas (SPAs) within LAC; however, disease burden is not evenly distributed within these SPAs. In order for LAC to begin to align with the National HIV/AIDS strategy and effectively target prevention efforts in communities where HIV is most heavily concentrated a different disease mapping approach is needed. Through the CDC-funded Enhanced Comprehensive HIV Prevention Planning (ECHPP) project, as part of LAC’s HIV situational
analysis, a syndemic spatial analysis was conducted to assess areas (clusters) where the co-occurring epidemics of HIV, Syphilis, and Gonorrhea are concentrated.

HIV, Syphilis and Gonorrhea surveillance data from 2009 were examined and included residence address, demographics and HIV status. A total of 2,036 new HIV cases from 2009 surveillance data were used for the analysis. Of the 1,858 HIV cases for which a residence address was provided, 1,731 could be geocoded (93.2%). In addition, 2,641 new cases of Syphilis and 7,918 new cases of Gonorrhea from STD surveillance data were used. Average Nearest Neighbor statistic (ANN) was calculated for each disease to determine the spatial variability of cases. ANN statistics were calculated using the Euclidean distance method. The Nearest Neighbor Hierarchical Clustering (NNh) method was used to analyze HIV cases, Syphilis with HIV co-infection, Syphilis without HIV co-infection, and Gonorrhea cases. Clusters were identified using the single-level NNh method and the minimum case count criteria for clusters was 1% of total cases. The four sets of clusters were overlaid to examine spatial relationships. Overlapping cluster areas were identified as syndemic clusters.

ANN statistics revealed that each of the three sets of geocoded cases were statistically clustered (HIV, p<.001; Syphilis, p<.001; and Gonorrhea, p<.001). NNh statistics identified 8 clusters areas of HIV cases, 9 cluster areas for Syphilis with HIV co-infection, 11 for Syphilis without HIV, and 10 for Gonorrhea. Further spatial analysis identified five syndemic cluster areas within the County. The five cluster areas represent 83.9% of new HIV cases, 81.9% of Syphilis with HIV co-infection, 78.9% of Syphilis without HIV, and 79.0% of Gonorrhea cases diagnosed in 2009.

The use of spatial analysis and GIS have demonstrated that HIV and STD cases are not dispersed evenly but rather clustered in smaller areas within the County. The identification of 5 syndemic clusters representing the vast majority of new HIV and STD disease burden within 34.5% of the total area of the County provides both the health department and community planning bodies a clearer view of the epicenters of disease burden with Los Angeles County. These maps will be crucial in the next steps of community and program planning in addressing the most impacted areas within LAC as well as better align LAC in meeting the National HIV/AIDS Strategy goals.
Tuesday, August 16, 2011
Roundtable Sessions
5:15PM-6:00PM

Track A
AR03 - The Paradigm Shift: Embracing New Scientific Paradigms for Effective HIV Prevention among Black MSM.
Room: A703 (Atlanta Marriott Marquis)

Abstract 1894 - The Paradigm Shift: Embracing New Scientific Paradigms for Effective HIV Prevention among Black MSM
Author(s): Ron Simmons, PhD; Jamaal Clue, MA

Current HIV prevention research and practice with Black MSM is dominated by a scientific paradigm focused on behavioral determinants. Numerous recent studies challenge the traditional long held hypothesis that reductions in HIV risk behavior will lead to significant reductions in HIV incidence among Black MSM. Compared to white and Latino gay men, Black MSM report less risky sexual behavior, greater condom use, and fewer sexual partners yet still bear a disproportionate burden of new HIV infections.

A 2010 behavioral surveillance study of 500 MSM in the District of Columbia found that 32% of Black MSM over the age of 30 and 12% of Black MSM under 30 were HIV-infected. In comparison, 8% of the white MSM over age 30 and none of the white MSM under 30 were HIV-infected. Yet, Black MSM reported using condoms 50% more and having fewer sex partners than white or Latino MSM. The Centers for Disease Control's (CDC) 2005 five-city behavioral study of MSM, and a recent surveillance study in Chicago, found a similar discrepancy between sexual risk behavior and HIV prevalence among Black MSM. It is clear that Black MSM realize the importance of protection and HIV prevention as evident by their higher rates of condom usage compared to other MSM. However, the increased use of condoms is only one piece of the larger puzzle. At the 2011 National Black MSM Leadership Conference on HIV/AIDS and Other Health Disparities in Brooklyn, NY, Black MSM researchers and community members proposed and endorsed alternative areas that warrant scientific investigation to determine their contribution to the disproportionate impact of HIV on Black MSM communities. The facilitators will summarize current research on disparities in HIV infection in Black MSM and recommendations from the researchers and community members, and lead a discussion on new strategies and paradigms for effective HIV prevention among Black MSM, including community-level, biomedical, and structural interventions.

The scientific community can no longer evade the anomalies in behavioral surveillance reports which continue to subvert current behavioral prevention research paradigms and by extension, prevention practice efforts. As evidence continues to mount regarding the limits of the behavioral HIV prevention paradigm for Black MSM, the research and practice communities must commit to exploring new avenues that consider social, structural, community/network, biomedical, and intersectional determinants of HIV infection. Engaging Black MSM in critical analysis, discourse, and scientific leadership is imperative. Such explorations open the way for unconventional yet promising interventions that may reduce HIV infection among Black MSM in the United States.

Track D
DR13 - Specialized CBA support and innovative approaches to HIV prevention for transgender individuals
Room: Hanover C (Hyatt Regency Atlanta)

Abstract 1410 - Specialized CBA Support and Innovative Approaches to HIV Prevention for Transgender Individuals
Author(s): KN McCurtis; AJ King

Though HIV/AIDS prevalence among transgender individuals can only be estimated due to typically insufficient gender-reporting options, some studies have found that as many as 30% of transgender individuals are HIV positive. The inherent challenges of living with or being at high-risk for HIV, in conjunction with myriad structural barriers that
transgender women face, calls for innovative approaches to HIV prevention and specialized capacity among HIV prevention providers.

Though various different CBOs have adapted existing evidence based interventions (EBIs) and/or developed home grown interventions for transgender individuals, many CBOs serving the transgender community still lack adequate capacity and are challenged by having to choose among interventions that were not researched or developed for transgender individuals. In response to this need, Capacity Building Assistance (CBA) providers have developed technical and capacity building assistance models to assist CBOs serving transgender women in adapting and modifying (EBIs) to fit their communities. They have also provided technical consultation and training to build providers’ cultural competence in working with trans populations.

This roundtable will highlight successful strategies for HIV prevention in the transgender community, including essential areas of agency capacity. Key points of the roundtable include: 1) lessons learned from adaptations of existing EBIs for transgender persons 2) gaps in the current portfolio of EBIs for HIV positive transgender women and, 3) greatest CBA needs among CBOs serving the transgender community. Authors will ensure that subject matter experts and members of the trans community are present during this roundtable discussion.

The National HIV/AIDS Strategy recommends refocusing prevention efforts by targeting high-risk populations like transgender individuals. The unmet HIV prevention needs in the transgender community suggest these and other approaches should be part of future strategies: development of new interventions specifically researched and developed for transgender individuals; selection of EBIs (for adaptation) that take into account the needs of HIV positive transgender women and address structural barriers to prevention common among the transgender community; and, specialized CBA support for CBOs serving the transgender community. Behavioral interventions, even when adapted for transgender women, do not provide much opportunity to address structural barriers to HIV prevention that many transgender women face. New interventions may be able to better address these issues. Given the estimated HIV prevalence rate among transgender persons, adaptations of existing EBIs and development of new interventions for the transgender community will need to focus on prevention for positives and address structural barriers to HIV prevention unique to transgender individuals.

Track D
DR14 - The Importance and Challenges of African American Women Advocating for Sexual Health
Room: Hanover D (Hyatt Regency Atlanta)

Abstract 1644 - Importance of African American Women Advocating for Sexual Health
Author(s): Breanna Washington; Shemeka Palmer; Dorlisa Hutton

Men who self identify as heterosexual are dating and marrying women while also having unprotected sex with men. In the most recent years a term to describe these men has surfaced, down low. The down low term has been mostly associated with African American men but is evident across various ethnic groups. The result is African American heterosexual female partners are being infected with HIV/AIDS and other STIs at alarming rates. Therefore African American women have to take responsibility for their own sexual health and protect their selves from HIV.

This roundtable will discuss how to empower African American women to advocate for their own sexual health through HIV/AIDS and other STI education and empower them to discuss safer sex options with their sexual partners. The roundtable discussion will also examine the importance of understanding the mental and emotional impact sexual relationships have had on African American women before providing HIV/AIDS prevention services.

Providing African American women with the skills they need to advocate for safer sex practices will empower them to take responsibility for their own sexual health. This roundtable will be an open and participatory discussion and participants will be able to ask questions and discuss concerns.
Track D
DR15 - The Importance of Providing HIV/AIDS Prevention to Young African American Females in the Deep South
Room: Hanover E (Hyatt Regency Atlanta)

Abstract 1816 - Importance of Providing HIV/AIDS Prevention to Young African American Females in the Deep South
Author(s): Breanna Washington; Shameka Palmer; Dorlisa Hutton; Audrey Sawyer

Young African American females ages 14-18 who reside in the Deep South have a lack of knowledge when referring to the anatomy of the female body and in reference to HIV/AIDS and other STI prevention facts. Consistent and correct utilization of protective barriers is also an issue among young African American females. In the Deep South, HIV/AIDS and STI prevention facts are often misunderstood or not mentioned at all due to the belief that education will promote sexual relationships. However controversial the issue, it is important to discuss HIV/AIDS and other STI prevention facts. The result of not communicating prevention facts with young African Americans females in the Deep South is evident due to generation after generation of females with undeveloped self efficacy or insufficient self-worth coupled with increasing HIV/AIDs and other STI rates.

This roundtable will examine and discuss risk factors associated with young African American females in the Deep South. Topics to be discussed will include (1) lower socioeconomic status; (2) low risk perception; (3) unprotected oral, anal and vaginal sex early dating behavior; (4) lack of involvement in/from school, family, or community activities and (5) early childbearing is viewed as the norm.

Providing accurate HIV/AIDS and other STI information to young African American females ages (14-18) in the Deep South, will develop self efficacy and sufficient self worth to counter the HIV/AIDs and other STI rates. This roundtable will be an open and participatory discussion and participants will be able to ask questions and discuss concerns.

Track D
DR16 - How are HIV-positive persons identified for Partner Services?
Room: Hanover F/G (Hyatt Regency Atlanta)

Abstract 1342 - How are HIV-Positive Persons Identified for Partner Services?
Author(s): Elin B. Begley; R. Luke Shouse; Samuel W Dooley; Michele Rorie; Ann Gardner; Romni Neiman; Rebecca Jordan; Patricia Young

The Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection suggest offering partner services to all newly identified HIV-positive persons. On January 1, 2011, the Division of HIV/AIDS Prevention (DHAP) began requiring grantees to collect and report to CDC standardized client-level data for HIV partner services activities for the purpose of monitoring and evaluating (M&E) these activities at the national level. As part of these requirements, grantees must report on the number of index patients (HIV-positive clients) that are reported to HIV surveillance. Health department jurisdictions approach the identification of index patients in different ways, including working with HIV surveillance units, receiving reports of HIV-positive test results directly from funded counseling and testing programs, identifying lab results from HIV-positive persons and receiving requests from providers to offer partner services. The method of identifying index patients impacts the grantees ability to offer partner services to all newly identified HIV-positive persons, as well as their ability to respond to DHAP M&E requirements.

State health department roundtable representatives will discuss how index patients are identified in their jurisdiction and discuss the barriers and facilitators to offering partner services to all newly identified HIV-positive index patients. The session will address ways to improve access to HIV partner services by discussing: 1) ways in which partner services and HIV surveillance programs can share data to improve identification of all HIV-positive persons; 2) how the grantees plan to meet the DHAP M&E requirements if they do not have close working relationships with HIV surveillance; and 3) the impact of reporting delays to HIV surveillance on the timely identification of index patients.
All newly identified HIV-positive persons should have access to partner services. In order for this to happen, State and local health departments must find ways to offer partner services to all newly identified HIV-positive persons and their partners. Sharing of data between partner services and HIV Surveillance offers benefits to both programs and has the potential to increase the identification of newly identified cases of HIV infection. Peer-to-peer idea sharing in this roundtable will generate ways to overcome barriers to and maximize the facilitators for offering partner services to all newly identified HIV-positive index patients that may be broadly disseminated.

Track D
DR22 - Successful Coalition Development Strategies to Increase HIV Testing in African American Communities through the Community Guide Model
Room: Hong Kong (Hyatt Regency Atlanta)

Abstract 1471 - Successful Coalition Development Strategies to Increase HIV Testing in AA Communities through Community Guide Model
Author(s): Antwan L. Nicholson, MA; Joseph Lindsey, MS; Mark Colomb, PhD

Public health professionals attend numerous meetings and sometimes assume that they understand everything it takes to address the issues facing HIV/AIDS in the African-American community. But the issues related to HIV/AIDS are as complex and diverse as the disease itself. To avoid this type of experience, people and organizations need to sharpen the skills that are necessary to build and maintain coalitions. This roundtable will facilitate this process by offering an eight-step guide to building effective coalitions through the Community Guide Model and will be helpful to an organization considering initiating and leading a coalition, or in strengthening an existing coalition.

Facilitators will present and discuss community focused group strategies to linking the social environments to gain access to and utilization of HIV prevention and risk reduction services. Through the use of a structural, population-based behavior change model, this roundtable will discuss how successful HIV/AIDS prevention coalitions are developed and implemented by linking health determinants and the capacity building assistance services of the Community REACH Project to specific health outcomes to strengthen access to and utilization of HIV Prevention Services.

Providing community health organizations with a systematic approach to planning organizing, and implementing coalitions has implications for targeting prevention efforts, service integration, and non-duplication of services. With access to training and technical assistance in Coalition Development, community health organizations can successfully identify the steps to building an effective coalition, discuss the barriers related to HIV testing and counseling, discuss techniques used in forming a coalition that addresses the barriers related to HIV testing and counseling. This is highly beneficial to organizations that seek to build effective coalitions and will be helpful to an organization considering initiating and leading a coalition or in strengthening existing ones to provide quality HIV prevention services.

Track D
DR23 - Coalition Development Strategies for African American MSM: Assessing a Structural Population-Based Capacity Building Assistance Course
Room: Singapore/Manila (Hyatt Regency Atlanta)

Abstract 1475 - Coalition Development Strategies for AAMSM: Assessing a Structural Population Based Capacity Building Assistance Course
Author(s): Joseph Lindsey, MS; Antwan L. Nicholson, MA; Mark Colomb, PhD

Access to and utilization of HIV prevention and risk reduction services is a major health disparity in the African American Men Who Have Sex with Men (MSM) community. Through the use of a structural, population-based behavior change model, participants will discuss how successful HIV/AIDS prevention coalitions are developed and
implemented by linking health determinants and the capacity building assistance services to specific health outcomes to strengthen access to and utilization of HIV Prevention Services in the African American MSM Communities. This roundtable will facilitate this process by offering an eight-step guide to building effective coalitions and will be helpful to an organization considering initiating and leading a coalition or in strengthening existing ones.

This roundtable will facilitate coalition development strategies that are designed to assist community health organizations in the development and maintenance of coalitions that address the HIV testing and counseling needs of African American MSM communities utilizing a variety of focus strategies that are designed to support CBO’s in implementing and maintaining effective and efficient HIV testing services to their target population.

With access to training and technical assistance in coalition development strategies, organizations can gain a clear understanding of the advantages of collaborating to increase testing and counseling services for the African-American MSM community by strengthening community access to and utilization of HIV prevention services. This roundtable will provide strategies for combating barriers related to African American MSM accessing services for HIV/AIDS.

**Track D**

**DR24 - Effectiveness of POL and D-Up Interventions among African American MSM in the Rural South on Community Norms**

**Room: Vancouver/Montreal (Hyatt Regency Atlanta)**

**Abstract 1429 - Effectiveness of POL and D-Up Interventions among AAMSM in the Rural South on Community Norms**

**Author(s):** Gibson, G, MA; Hutton, D, MPH; Colomb, M, PhD

African American Men who have Sex with Men (AAMSM) between the ages of 18-30 are testing positive for HIV at disturbing rates. Due to this crisis within the AAMSM community, interventions that address the needs of the AAMSM community are critical to combating HIV. Popular Opinion Leader (POL) and D-Up have proven to be effective in targeting the influential person in social groups to help change community norms around risky sexual behavior. These interventions give the person the necessary skills, tools, and self-efficacy to motivate friends and acquaintances to change risky sexual behavior.

Facilitators will present and discuss lessons learned and best practices experienced as a result of adapting POL and D-Up as effective interventions for AAMSM; 1) discuss lessons learned from implementing POL and D-Up in a rural settings; 2) discuss issues related to rural, social, and individual determinants of health; and, 3) discuss how negative social and cultural factors impact AAMSM sexual risk behavior and ways to promote positive self-worth to change this behavior.

When implementing POL and D-up for AAMSM you have to focus on looking at the geographical, accessibility, and ultimately retention issues that are common for this community in a rural setting. This is highly beneficial when the interventions need to be adapted and tailored to meet the needs of the population to be served.

**Track D**

**DR25 - Latinas United Against AIDS**

**Room: Inman (Hyatt Regency Atlanta)**

**Abstract 1843 - Latinas United Against AIDS**

**Author(s):** April Hogan; Sandra Estevez; Ronald Henderson; Marlene Lalota; Thomas Liberti

Gender norms and roles within Latino communities present unique challenges and opportunities for addressing HIV/AIDS among Latina women. The term marianismo refers to the cultural expectation that the ideal Latina woman should be modest, dependent, weak, vulnerable, abstinent until marriage, and then upon marriage subordinate and
obedient to her spouse. This view of what a Latina woman should be creates obstacles for delivering effective HIV prevention messages for Latina women, because of the stigma associated with not meeting the cultural expectations associated with marianismo. However, there are opportunities to utilize the role of women as caregivers and nurturers in Latino communities to deliver effective HIV prevention messages. For many Latinas, the family is the center of their lives. The health and well being of their families often takes priority over their own health needs and concerns. In recognizing the importance of family and the role of Latina women within families, the Florida Department of Health, Bureau of HIV/AIDS and the Florida Latino women’s Advisory Group, created the Latinas Unidos Contra el Sida or Latinas United Against AIDS (L.U.C.E.S.) community mobilization initiative to increase the capacity of Latina women to respond to HIV/AIDS.

A six-series DVD set was created to serve as a mobilization tool to support L.U.C.E.S. mobilization activities. HIV/AIDS prevention messages and resources are presented through four main characters: Wise Light) The Grandmother; Bright Light) The Mother; Radiant Light) The Daughter; and Brief Light) The Granddaughter. Through these four characters HIV prevention messages are presented to Latina women in a culturally relevant manner. This poster presentation will provide an overview of the L.U.C.E.S. DVD and provide details related to each character.

Understanding gender roles within Latino communities is essential when developing HIV prevention messages for Latina women. The culture and values within Latino communities must be considered when designing interventions targeting Latinas. Incorporating positive elements of the Latino culture in HIV prevention activities increases the capacity of Latina women to effectively respond to the HIV/AIDS epidemic in their community.

Track D
DR26 - Housing The Greatest Un-Met Need to HIV Prevention and Health Care
Room: Spring (Hyatt Regency Atlanta)

Abstract 1873 - Housing The Greatest Un-Met Need to HIV Prevention and Health Care
Author(s): Michael A. Myers; Daiquiri Y. Robinson

Research and the voices of those living with HIV/AIDS make it apparent that there is an un-met need when it comes to access to adequate affordable housing. Studies also show that this lack of housing also affects the health of Americans, especially marginalized populations who are at risk for contracting HIV/AIDS. The CDC estimates that there are approximately 1.2 million people living with HIV/AIDS in the U.S., and over 56,000 persons become newly infected each year. Housing experts estimate that over 500,000 of all PLWHA will need some type of housing assistance during the course of their illness. Affordable accessible housing is a critical element to HIV prevention and HIV health care.

Based on Family Services of Montgomery County’s, Project HOPE’s three Housing Programs, Housing Opportunities for People With AIDS (HOPWA), Supportive Housing Program (SHP), and the HOME Investment Partnership Program (HOME), which we have served persons living with HIV/AIDS for over ten years, we will discuss the advantages of stable, accessible, and affordable subsidized housing to the persons we serve living with HIV/AIDS. Homelessness/unstable housing are linked to greater HIV risk, poor health outcomes, and much of the time an early death. Family Services Project HOPE has approximately 175 individuals who receive case management services; 99% are low to very low income and could benefit from subsidized housing. Many receive Supplemental Security income and it is a struggle from month to month to meet financial obligations. Currently we have 35 available housing slots which are all filled; a waiting list for others who qualify for subsidized housing and are in need. Our findings are based on those 35 individuals, some with families for which to care. 1) We will discuss the impact that housing has had on the reduction of HIV/AIDS risk behaviors. 2) Accessing medical care, treatment adherence and improved/stable health. 3) The rationale of decreased drug and alcohol use/addiction. 4) The solidity of Psychosocial/mental health stability, follow up treatment and supports.

This discussion will guide the principle that housing is the greatest unmet need of persons living with HIV/AIDS. It will create a platform to advocate to our community organizations and our government entities to understand that housing
is a top prevention priority, a critical element to HIV health care and a basic human right. Additionally, housing has proven to be a cost-saving and cost-effective HIV prevention intervention based on HUD and CDC findings.

**Track D**

**DR27 - Promoting HIV Prevention for Latino Youth, Older Adults, and Farmworkers in non-HIV Organizations**

**Room: Piedmont (Hyatt Regency Atlanta)**

**Abstract 1789 - Promoting HIV Prevention for Latino Youth, Older Adults, and Farmworkers in non-HIV Organizations**

**Author(s):** Kattrina Merlo; Hilda Crespo; Maria Eugenia Hernandez-Lane

It is well known that Latinos are disproportionately impacted by the HIV/AIDS epidemic, and the fast spread of HIV among Latino men and women in the United States is a crisis that requires immediate and creative interventions. Health departments and HIV-focused community-based organizations are doing a lot to prevent HIV in the Latino population, but it is also important to reach out to other sectors of society not currently involved in the fight against HIV. There are many organizations that currently work with Latino youth, older adults, and farmworkers that are not knowledgeable of and involved in HIV prevention but could be key players in the fight against HIV. There are many organizations that work with the Latino populations in areas outside of health and it's important to mobilize them in HIV prevention efforts.

Representatives from three of the nation's preeminent Latino-serving organizations will facilitate an interactive and dynamic round-table discussion on best practices for working with different Latino populations along with current efforts to include other non-HIV sectors of society in HIV prevention. Specific key points to be discussed will be a) best practices in working with Latino youth, older adults, and farmworkers; b) approaches to involving non-HIV organizations in the fight against HIV, and; c) building partnerships among HIV and non-HIV organizations in the same community in order to reach more of the population.

With the proper tools, technique, and assistance, organizations that are not currently working on HIV can successfully integrate basic HIV prevention efforts within their current mission. By providing information on current best practices while also linking HIV and non-HIV organizations together we can create strong cross-sector partnerships and allow for a more holistic approach to HIV prevention. Involving an entire community in HIV prevention will only benefit the community as a whole and work towards decreasing the rate of HIV.

**Track F**

**FR12 - From Why? To How? Root causes, Structural Changes, and Advocacy for At-Risk Youth**

**Room: Baker (Hyatt Regency Atlanta)**

**Abstract 1519 - From Why? To How? Root causes, Structural Changes, and Advocacy for at Risk Youth**

**Author(s):** Julia C. Dudek, MPH; Miguel Martinez, MSW, MPH

Providers who work with populations of at-risk youth understand that there are multiple causes for high HIV rates among these populations beyond individual risk behaviors, i.e., social determinants of health. However, in their day-to-day work, providers may lack the opportunity to address these larger issues. Nevertheless, social determinants of health, as well as structural-level changes, are increasingly being discussed as a strategy to address the HIV epidemic. Providers are positioned at a powerful place to advocate for structural-level changes that address the social determinants of health for at-risk youth populations.

Facilitators will discuss the importance of addressing social determinants of health and working , or at the structural level, to prevent HIV among at-risk youth. They will demystify the meaning of structural, explaining how changing practices, programs, or policies can constitute structural-level changes that can impact large numbers of youth. Emphasis will be on practice changes that are feasible to attain. During the majority of the session, facilitators will break participants into two groups and lead each group through a Root Cause/Structural Solution activity. During
the activity, participants will: (1) identify a problem (e.g., low numbers of youth getting tested for HIV), (2) discuss the context of why the problem exists and drill down to root causes, (3) brainstorm structural-level changes that respond to identified root causes, (4) identify a structural-level change (i.e., change in practice) that they can enact or champion within their agency or community to address the problem.

With a working definition of structural change, providers will tap into creative and tangible ways to advocate for at-risk youth. By thinking through root causes, including social determinants of health, providers will propose solutions that are meaningful in the context of at-risk youth's lives. They will leave with one idea for a practice change to share with their agency and to act upon to impact youth.

Track G
GR05 - Pathologies of Oppression: A Harm Reduction Leadership Development Model for YBMSM
Room: Courtland (Hyatt Regency Atlanta)

Abstract 1447 - Pathologies of Oppression: A Harm Reduction leadership Development Model for YBMSM
Author(s): Michael T. Everett

The rates of HIV infection among men who have sex with men (MSM), particularly young Black MSM (YBMSM), has remained the same or increased in recent years. Despite the decline in HIV transmission seen in other populations and the interventions designed to address behavioral determinants, effective prevention efforts geared towards Black MSM prove to be a difficult feat. The traumas Gay and Same Gender Loving (SGL) men experience over the course of their lives along with the absence of a positive rites of passage coupled with the loss of a generation of Black gay men in the 1980s and 1990s due to AIDS has decreased protective factors against HIV/AIDS risk. In addition, heterosexism, sexual abuse, and a lack of family support have all contributed to the trauma many YBMSM experience throughout their lives.

Facilitators will present the launching of a national effort by capacity building assistance providers in developing and diffusing a harm reduction leadership development model for YBMSM. Facilitators will then discuss leadership development priorities of agencies and other stakeholders who have access to YBMSM. The discussion will address the following points: 1) what is working well with CBOs targeting YBMSM? 2) How should the following common themes among YBMSM be addressed?
A). Healthy Relationships
B). Boundaries
C). Evidence-based Intervention
D. Culturally responsive leadership
and 3) How can a harm reduction youth development model for YBMSM support some of the challenges occurring with organizations serving YBMSM?

With access to training and technical assistance tools, HIV/AIDS programs serving YBMSM can successfully prioritize leadership and increase leadership skills in order to appropriately address the unique challenges that serve as barriers to effective HIV/AIDS prevention for YBMSM. In addition, the conversation will help to inform technical assistance providers on packaging and diffusing leadership development initiatives to strengthen service providers and the clients that they serve.

Track G
GR06 - Service Integration: Meeting the Many Needs of Urban Adolescents
Room: Dunwoody (Hyatt Regency Atlanta)

Abstract 1985 - Service Integration: Meeting the Many Needs of Urban Adolescents
Author(s): Callender, Traci; Camacho, Melinda; Cauthen, Brad
HIV Prevention programs designed for youth in urban settings are faced with a myriad of issues in addition to HIV incidence rates. These include poverty, crime, teenage pregnancy, substance abuse, physical abuse, a lack of educational supports and untreated mental health issues. In the face of dwindling resources, service providers will increasingly have to find ways to integrate services in order to continue providing holistic services to urban youth.

The facilitators will describe their experience in developing a continuum of services under one umbrella, BAS. Go Girl! program, that brings together substance abuse and HIV prevention, mental health treatment, theatre, CTR services and Peer Leadership. Attendees will be presented with (and encouraged to share their own) ideas on how to build a complete program from various funding sources without duplication of services to meet the needs of urban youth. Increasing the self esteem of youth has a great impact on their ability to make sound decisions. By accessing public (federal, state, local) and private (local and national foundations) funding sources, agencies must find a way to meet the multiple needs of their clients.

By integrating service components, community-based organizations will have the flexibility to provide their clients with services from basic risk reduction and personal health information to more advanced ideas related to community health and activism, while developing a cadre of Peer Leaders who will assist in disseminating these messages. Having peers involved in an intervention increases knowledge, self-efficacy, and the ability to see oneself as an agent of change within the larger community. Engaging youth in long term, multi-faceted programming as opposed to a brief sexual health intervention, will likely lead to greater and longer lasting outcomes.
Abstract 1321 - Evaluation of Using Dried Fluid Spots for HIV-1 Drug Resistance Genotyping in the United States
Author(s): Danuta Pieniazek; Rebecca Ziebell; Richard Kline; Joseph Prejean; H Irene Hall

There are limitations associated with the availability of patient remnant diagnostic specimens for additional public health testing for HIV surveillance. The small fluid volume (~65 µL, range 30-100 µL) used for dried fluid spots (DFS) may be sufficient for HIV-1 antiretroviral drug resistance and subtypes testing. CDC assessed the feasibility and the efficiency of HIV-1 group M genotyping using DFS by testing specimens from ongoing drug resistance surveillance activities among newly diagnosed, drug-naive persons in the United States during 2005-2009.

558 specimens including 125 plasma, 71 serum, and 362 whole blood, were deposited on filter papers (DPS, DSS, and DBS, respectively) at four surveillance sites. Specimen collection and processing, RT-PCR amplification of a 940-nucleotide protease-reverse transcriptase region of the HIV-1 genome, and sequencing were performed according to local procedures. PCR amplification rates, transmitted drug resistance-associated mutations, and subtypes were compared for DFS and parallel liquid plasma or serum specimens.

The PCR amplification rate of total DFS (53%) and liquid (88%) specimens differed significantly (p<0.0001, X. The amplification rate of DPS (78%) was significantly higher than DBS (42%; p=0.0001, X, but not significantly higher than DSS (68%; p=0.123, X. DPS amplification rate was lower than liquid plasma (93%; p=0.002, X, but did not differ significantly from liquid serum (83%, p=0.0984). In contrast, DSS rate was significantly lower than liquid serum (p=0.0008, X. The rates improved about 25% in 20 randomly selected PCR-negative DFS specimens by increasing the concentration of viral RNA or separate amplification of protease and reverse transcriptase genes. There was concordance on mutations associated with drug resistance and subtype data from paired DFS and parallel liquid plasma or serum specimens.

The routine DFS genotyping approach for identification of transmitted HIV drug resistance and subtypes used in this study did not reach the effectiveness usually obtained with liquid specimens. The combination of insufficient concentration of viral RNA and decreased quality of RNA in DFS specimens were factors leading to a low PCR amplification rate. DPS had the highest amplification rate of 78%, which was similar to liquid serum. Thus, DPS could be sufficient for HIV-1 group M genotyping for surveillance purposes in the United States based on the CDC requirement of comparable efficiency of PCR amplification rates between DFS and liquid specimens.

Abstract 1360 - Phylogenetic Surveillance of HIV-1 non-B Subtypes among HIV-1 New Diagnoses, United States, 2006-2008
Author(s): Danuta Pieniazek; Rebecca Ziebell; Cheryl Banez Ocfemia; Neeraja Saduvala; Richard Kline; Joseph Prejean; David Kim; H. Irene Hall

Although the HIV-1 subtype B epidemic in the United States has been characterized, little is known about infections caused by viruses of non-B subtypes. Information on subtypes is important in understanding factors related to their transmission for epidemiologic and prevention program purposes. Variant, Atypical, and Resistant HIV Surveillance (VARHS) collects viral resistance and subtype data on individuals newly diagnosed with HIV infection.

HIV-1 pol sequences from drug-naïve persons newly diagnosed with HIV-1 infection in 15 states and one county from 2006 to 2008 and reported to national HIV surveillance through June 2010, were phylogenetically assigned to subtypes and intersubtype recombinants including circulating recombinant forms (CRFs) and unique recombinants (URs). We evaluated the prevalence, phylogenetic diversity, and distribution of non-B subtype viruses and used chi-square (X) test to assess demographic and exposure category differences between individuals with non-B and B infections.
From the 69,912 individuals diagnosed in this period, 11,952 (17.1%) sequences were available for analysis; 574 (4.8%) were from non-B subtype infections. Individuals with non-B infections were more likely (p<0.0001) to be females, persons aged 30-39 years at diagnosis, black/African-American or Asian, men with heterosexual contact as the mode of transmission, residents in large areas (>2.5 million), or persons diagnosed in hospital settings than their counterparts. Six non-B subtypes (A, C, D, F, G, H) accounted for 47% non-B infections; the rest contained intersubtype recombinants, including 14 different CRFs. The most common non-B viral clades were subtype C (1.4%), CRF02 (1.4%), subtype A (0.6%), CRF01 (0.4%), and URs (0.3%). Among 485 non-B-infected persons reported with countries of birth, 71.3% were foreign-born (excluding U.S. dependencies), predominantly in Africa (74%), and 28.2% were U.S.-born. In contrast, 1490 (16.5%) of 9024 subtype B-infected persons were foreign-born, mostly in Mexico (34%), the Caribbean (22%) and Central and South America (22%).

The first major population-based surveillance report of non-B subtype HIV-1 infections in the United States revealed a broad genetic diversity of non-B viruses. A slight majority of non-B infections were due to recombinant viruses of mainly African and Asian origins. Though a number is small, almost one third of persons infected with HIV-1 non-B subtypes were U.S.-born, suggesting spread of non-B subtypes into U.S.-born populations. Differences in demography between non-B and B infections may be useful in developing public health strategies for diagnosis, treatment, and prevention services for people at risk for or living with non-B infection. Continued surveillance of viral sequences is needed to monitor trends in transmission of non-B subtypes and diversification of the HIV-1 epidemic in the U.S.

**Abstract 1731 - Public Health Applications of Molecular Epidemiology: Use of HIV-1 Sequences to Identify Transmission Networks**

**Author(s):** Jacqueline Rurangirwa, MPH; Jeanette Aldous, MD; Sergei Kosakovsky Pond, PhD; Jan King, MD, MPH; David Smith, MD

Molecular epidemiology can identify HIV transmission networks within a population, and is emerging as an important tool for public health efforts to target HIV screening and prevention activities. Here, we examined demographic, geographic, and clinical factors associated with identified transmission networks or clusters within Los Angeles County (LAC), which is one of the largest and most diverse jurisdictions in the country and the second largest epicenter of the US HIV epidemic.

Unique HIV pol sequences generated from HIV-infected individuals receiving clinical care in the LAC Ryan White program (n=3201, 2001-2008) were used, and the cohort represented both individuals on failing therapy and newly diagnosed patients entering care. A phylogenetic cluster analysis was conducted (HKY model in the HyPhy package), and clustering was conservatively defined at a genetic distance of less than 1%. Identified clusters were then examined by gender, race/ethnicity, age, most recent CD4 count, most recent viral load, and residence zip code in one of eight service planning areas (SPAs) within LAC.

One hundred and sixty-five unique clusters were identified, which represented 12% of patients (n=413) that clustered into highly related HIV subpopulations (1% genetic distance). Most clusters had less than 5 sequences (137 clusters had 2 sequences, 13 had 3, and 10 had 4). The clusters with 5 or more sequences had the following characteristics: CLUSTER A was the largest (n=34) and most diverse cluster: 97.1% male, 41% White, 12% African American, 41% Latino, 3% Asian Pacific Islander, 3% unknown; mean age 40.6 years (range 25-57); median most recent CD4 224.5 cells/ul (range 2-775); mean most recent HIV-1 viral load (VL) 84,276 copies/ul (range 1085-750,000 copies/ul); 12% residence in SPA 2, 9% in SPA 3, 53% in SPA 4, 15% in SPA 5, 6% in SPA 8. CLUSTER B (n=11) was 100% male; 9% White, 91% Latino; mean age 37.2 years (range 25-49); median most recent CD4 277 (range 53-782); mean most recent VL 74,669 (range 2445-240,000); 18% residence in SPA 2, 9% in SPA 3, 27% in SPA 4, 18% SPA 6, 18% SPA 7, 9% SPA 8. CLUSTER C (n=5) 100% male; 100% African American; mean age 25.6 years (range 16-47); median most recent CD4 174 (range 67-498); mean most recent VL 264,062 (range 51,731 - 750,000); 80% SPA 6, 20% SPA 8. CLUSTER D (n=5) 100% male; 20% White, 60% Latino, 20% unknown; mean age 44.4 years (range 35-60); median most recent CD4 365 (range 287-780), mean most recent VL 101,043 (range 10,420-201,921); 60% SPA 4, 20% SPA 5, 20% SPA 8. CLUSTER E (n=5) 100% male, 80% White, 20% Latino; mean age
31.2 years (range 25-37); median most recent CD4 318 (142-578); mean most recent VL 231,483 (77,205-750,000); 20% SPA 2, 60% SPA 5, 20% unknown.

Molecular epidemiology can be used to identify HIV transmission networks in LAC. Larger clusters were overwhelmingly comprised of men, and each cluster contained a unique combination of dominant race/ethnicity, age range, and geographic location. The findings inform public health interventions to deliver targeted HIV testing and prevention services.

**Track B**

**B11 - Tracking HIV Across the Age Spectrum**

**Room:** Piedmont (Hyatt Regency Atlanta)


**Author(s):** Laurie Linley; Qian An; Joseph Prejean

HIV-infected persons aged 50 and older (50+) have a high percentage of late HIV diagnosis compared to younger persons. It is essential to identify persons early in infection to delay disease progression to AIDS and to reduce HIV transmission. Data on HIV testing history from national HIV incidence surveillance offer insight into testing behavior in older compared to younger persons diagnosed with HIV infection.

Data were analyzed for adult/adolescents (age ≥ 13 years) with HIV diagnosed during 2006-2008 and reported to CDC through June 2009 from 16 states and 2 cities to determine testing history. We compared the percentage of new testers (those whose first HIV test was positive) aged 50+ with those of younger persons (13-24 and 25-49 years) by gender, race/ethnicity, transmission category, and AIDS diagnosis within 6 months of HIV diagnosis. Among persons with a previous HIV-negative test we compared the median time interval between the last negative test and the date of HIV diagnosis.

From 2006-2008, 14,309 cases of HIV infection were diagnosed among persons aged 13-24, 59,795 among persons aged 25-49, and 14,990 among persons aged 50+. Overall, 43% of cases were reported with HIV testing history data: 56% among persons aged 13-24, 42% among persons aged 25-49, and 33% among persons aged 50+. Of those with HIV testing history information, persons aged 50+ were most likely to be new testers, 57% compared with 36% of persons aged 13-24 (p<0.001) and 39% of persons aged 25-49 (p<0.001). Among persons diagnosed with AIDS within 6 months of HIV diagnosis, the percentage of new testers was higher—69% for 50+ vs. 48% for 13-24 (p<0.001) and 52% for 25-49 (p<0.001). Blacks and Hispanics were more likely to be new testers compared to whites; with greater disparity among persons age 50+ (61% [p<0.001] for blacks and 60% [p<0.001] for Hispanics vs. 50% for whites) compared to younger age groups (13-24: 39% for blacks [p<0.001] and 35% for Hispanics [p<0.005] vs. 30% for whites; 25-49: 42% [p<0.001] and 41% [p<0.001] vs. 33%). A higher percentage of heterosexuals compared to MSM were new testers (50+: 62% vs. 44%, p<0.001; 25-49: 45% vs. 31%, p<0.001; 13-24: 40% vs. 33%, p<0.001). Among HIV-diagnosed persons with a previous negative HIV test, the median number of months from the last negative test to the HIV diagnosis was 24 months for persons aged 50+, 19 months for persons aged 25-49, and 12 months for persons aged 13-24.

There is a great disparity in HIV testing behavior in older compared to younger persons. Older persons are less likely to have previously sought HIV testing and test less frequently, which puts them at greater risk for late diagnosis. Disparity in HIV testing experience for whites compared to non-whites indicates missed opportunities for encouraging testing among those at greater risk for HIV infection. Public health organizations should stress adherence to CDC recommendations for HIV screening for all persons in health care settings and all persons at high risk for HIV infection.

**Abstract 1386 - Health Risk Behaviors Among Sexual Minority Students, Selected U.S. Sites, 2001-2009**
Small surveys conducted among convenience samples and anecdotal evidence indicate that sexual minority youth demonstrate disproportionate rates of health-risk behaviors and selected health outcomes compared to non-sexual minority youth. However, little population-based data are available, particularly at the state and local level, to substantiate the relationship between sexual minority status and health risk behaviors among youth. The objective of this presentation is to summarize results from Youth Risk Behavior Surveys conducted from 2001-2009 in 7 states and 6 large urban school districts that measured sexual identity, sex of sexual contacts, or both among representative samples of high school students.

T-tests were used to identify differences in prevalence estimates of health risk behaviors and obesity and overweight among subgroups of students defined by sexual identity (i.e., heterosexual, homosexual, bisexual, or unsure) and sex of sexual contacts contact (i.e., opposite-only students, same-sex only students, and both-sex students) across states and large urban school districts.

Results document the disproportionate rates at which sexual minority students defined by sexual identity practice many health-risk behaviors. This is most apparent among students who identify themselves as homosexual or bisexual. Across the 9 sites combined that assessed sexual identity, homosexual students were at greater risk than heterosexual students for 63.8% of all the risk-behaviors measured and bisexual students were at greater risk than heterosexual students for 76.0% of all the risk behaviors measured. Homosexual students and bisexual students were at less risk than heterosexual students for only 1.4% and 1.3% of the risk behaviors measured, respectively.

This same pattern of disproportionate risk is evident among both-sex students. Across the 12 sites combined that assessed sex of sexual contacts, both-sex students were at greater risk than opposite-sex only students for 71.1% of all the risk-behaviors measured. Both-sex students were at less risk than opposite-sex only students for only 1.4% of the risk behaviors measured. However, same-sex only students were at greater risk than opposite-sex only students for 29.7% of all the risk behaviors measured. This relative lack of difference between same-sex only and opposite-sex only students across the other risk behavior categories may be more a function of the small numbers of same-sex only students than the lack of real differences between these subgroups of students.

The Youth Risk Behavior Surveillance System is the only public health surveillance system in the United States monitoring among states and large urban school districts the prevalence of health-risk behaviors and selected health outcomes among population-based samples of sexual minority youth. The results of this report indicate a need to routinely include questions on sexual identity and sex of sexual contacts when monitoring health-risk behaviors among high school students in states and large urban school districts using large, population-based samples. Results from these surveys will help monitor and ensure the effectiveness of public health and school health policies and practices designed to address the health-risk behaviors and selected health outcomes of sexual minority students.

**Abstract 1778 - Differences in Risk Behaviors and Sexual Partner Characteristics of Perinatally versus Heterosexually HIV-Infected Youth, NYC**

**Author(s):** Adey Tsega; Angelica Bocour; Samuel M Jenness; Chi-Chi Udeagu; Colin W. Shepard

Despite advances in prevention of mother-to-child transmission, in 2009 perinatally-infected persons comprised 43% of 4388 persons aged 15-24 living with HIV in NYC. Many perinatally-infected youth engage in sexual risk behavior, but it is unclear how those behaviors compare to similarly-aged youth who acquired HIV sexually.

Perinatally-infected youth aged 15-24 years were referred to the NYC health department for partner services (PS) if they were sexually active, had an STI, were pregnant, or had an un-notified partner. Sexually-infected youth were referred for the same reasons or because they tested HIV-positive, either as a diagnostic or repeat test. Since perinatally-infected youth were overwhelmingly heterosexual (50/52), we compared them to two groups of heterosexually-infected youth who were either previously diagnosed (prevalent meaning interviewed >12 months...
from diagnosis) or newly diagnosed (interviewed <1 months from diagnosis). Risk behaviors were measured for the 12 months preceding PS interview. We used chi-square tests and t-tests to compare youth’s sexual risk behaviors, partner demographics, and PS outcomes.

Two hundred and nineteen heterosexually-active youth (50 perinatal, 69 prevalent, 100 newly-diagnosed) were interviewed for PS between July 2007 and June 2010. Perinatally-infected youth were slightly younger than sexually-infected youth (median age 19 vs 22 vs 21, p<0.0001 for both prevalent and newly-diagnosed youth). All three groups of youth were overwhelmingly female (64% vs. 83%, p=0.02 vs. 72%), had approximately 2 partners in the past 12 months, (mean 2 vs. 2.6 vs 2.1), and high STI rates (26% vs. 25% vs. 16%). Perinatally infected youth and prevalent youth were more likely to report condom use than newly diagnosed youth (30% vs. 22 % vs. 6%, p<0.0001). Approximately 27% of male youth had children. Fewer perinatally-infected than sexually-infected females had children (19% vs. 47% prevalent, p=0.008 vs. 36% newly-diagnosed p=0.08). Youth from all groups named mostly partners who were HIV negative or of unknown status (90% vs 86% vs 84%). However, none of the partners of perinatally-infected youth, and 8% (3/36 tested, p=0.54) of partners of prevalent youth tested HIV-positive as a result of PS, whereas 23% (9/39 tested, p=0.04) of partners of newly-diagnosed youth tested HIV-positive.

Heterosexual youth continue to report high risk behaviors and biological susceptibility for ongoing transmission as exhibited by high STI rates. The absence of partners named by perinatally-infected youth who were newly-diagnosed with HIV following partner services and their higher rates of condom-use suggest that heterosexually-infected youth, especially those who were newly diagnosed, may exhibit a higher potential for secondary transmission. However, further risk assessment and risk reduction counseling for both perinatally and sexually-infected youth are indicated.

Track C
C06 - PrEP & PEP for MSM
Room: Singapore/Manila (Hyatt Regency Atlanta)

Abstract 1611 - Minimum Required Effectiveness to Use Pre-exposure Prophylaxis During Sex Without Condoms among Risky HIV-negative MSM
Author(s): Gordon Mansergh; Beryl A. Koblin; Victoria Frye; Hong Van Tieu; Donald R. Hoover; Sebastian Bonner; Stephen A. Flores; Sharon M. Hudson; Grant N. Colfax

To better understand minimal required PrEP effectiveness among high- risk, HIV-negative MSM in order to forego condom use during receptive anal sex. Recently, the iPrEx PrEP efficacy trial among 3000 MSM found that daily oral tenofovir and emtricitabine reduced the risk of HIV infection by 44% overall and 73% among men who had high levels of adherence.

A convenience sample of MSM who use substances during sex was recruited in Chicago, Los Angeles, New York City, and San Francisco in 2006-07 for a behavioral intervention trial. Among HIV-negative MSM, three groups were defined based on their perception of minimal HIV transmission prevention effectiveness level for PrEP to forego condom use during receptive anal sex. Recently, the iPrEx PrEP efficacy trial among 3000 MSM found that daily oral tenofovir and emtricitabine reduced the risk of HIV infection by 44% overall and 73% among men who had high levels of adherence.

Among n=630 HIV-negative men who had never used PrEP, 73% reported needing a high level of PrEP effectiveness, 15% needed mid-range, and 11% required only low effectiveness to forego condoms during receptive anal sex. In multivariate analysis, black (OR=3.4, 95% CI=1.8-6.3) and Latino (OR=2.0, CI=1.5-5.4) men were more likely than white men to need only a mid-range (versus high) level of effectiveness to forego condom use during receptive anal sex, however there were no differences by age, education, income, gay identification, or other factors. There were no race/ethnicity or other demographic differences for needing only a low (versus mid-range) level of effectiveness to forego condoms during receptive anal sex. Difficulty communicating about safer sex while using
substances was associated with needing only a mid-range (versus high) level of effectiveness (OR=1.5, CI=1.2-1.9) to forego condoms during unprotected receptive anal sex.

These analyses assist in better understanding how condom use may be adjusted among high-risk MSM given an environment where an effective PrEP medication exists. Relevant prevention messages should be developed to better inform potential PrEP administration for prevention of HIV infection during receptive anal sex among high-risk, HIV-negative MSM who use substances during sex, and to encourage reducing substance use during sex. Minority MSM, particularly black MSM, could especially benefit from targeted messages warning about increased risk for HIV infection when using moderately effective PrEP medications instead of condoms, which are highly effective. More research is needed and underway to better prepare for implementation of this emerging biomedical intervention.

Abstract 1757 - An iPad-Based Risk Assessment Tool for PrEP Administration: Opinions of MSM
Author(s): Jeb Jones; Patrick S Sullivan; Rob Stephenson; Jennifer A Taussig

Preexposure prophylaxis (PrEP) is a new biomedical HIV prevention intervention that has demonstrated efficacy in preventing HIV infection among MSM. Since PrEP is an expensive treatment, there is a need to identify patients who may be at high risk of infection and who would be appropriate candidates for clinicians to recommend PrEP. We developed an iPad application that incorporates a short risk-screening tool to collect information that can guide providers about appropriate HIV prevention recommendations for their patients. We engaged MSM in a qualitative study to assess the feasibility, usability and acceptability of self-administering this iPad application in their health care provider's office.

Two focus group discussions (FGD) were conducted in Atlanta, GA 1 with white MSM and 1 with black MSM. A range of 5-10 individuals participated in each discussion. Participants were asked about past experiences discussing risk behaviors with their health care providers. Participants each had a chance to review and enter dummy data into the iPad application and were then engaged in a discussion about the feasibility, usability and acceptability of completing the assessment while at a health care provider encounter. Suggestions for how the assessment tool both content and its administration could be improved were solicited from participants.

Overall, FGD participants were receptive to the idea of using the iPad-based risk assessment screener during healthcare visits, although there were some differences in issues/concerns raised between black and white participants. For example, black, but not white, participants reported that they would not want to feel like they were being singled out as MSM when asked to complete the risk assessment. Most FGD participants suggested additional questions to add to the current risk-assessment to better identify high-risk behavior for HIV infection. Participants also indicated that they would like individually tailored HIV prevention information shared with them at the end of the screener so that they can discuss it with their provider and potentially receive a written copy at the end of their visit or via email.

Based on the results of the FGDs, the iPad-based risk assessment is a promising method for identifying patients at highest risk for HIV transmission. Given the high cost of PrEP, identification of the highest risk patients will be of paramount importance for healthcare providers who serve MSM. Use of the iPad-based application can potentially reduce the burden on healthcare providers who may not have time to administer the screening tool verbally, or who do not typically discuss HIV risk behaviors with their MSM patients, by providing them with straightforward guidance about appropriate interventions to recommend to their MSM patients. The iPad application was well received and endorsed by MSM in our FGDs and should be given strong consideration for incorporation into clinical encounters. Future studies will explore health care providers receptivity to the iPad application including their attitudes about its feasibility, usability and acceptability.

Abstract 1978 - Awareness of and Intention to Use PrEP: A Post-iPrEx Survey of U.S. MSM
Author(s): P Sullivan; A Liu; J Fuchs; R Irby; R Tarver; S Buchbinder

On Nov. 23, 2010, news reports of partial efficacy of PrEP for preventing HIV acquisition in MSM reached an estimated 1.2 billion persons; pilot and feasibility programs will soon evaluate PrEP in practice. It is important to
know the extent to which MSM are aware of recent PrEP results, their intentions to use PrEP in light of these results, and associated factors.

From November 30 to December 14, 2010, we administered an online survey to US MSM recruited from Facebook and Black Gay Chat. Topics included awareness of and intentions to use PrEP. We report, descriptively, the proportion of men who had heard news of the iPrEx trial results, and who reported being likely to use PrEP when explained the results. We used ordinal logistic regression to describe factors associated with higher intent to use PrEP.

We had complete survey results from 1,397 HIV-negative MSM. Median age was 28; 71% were white, 8% African-American, 13% Hispanic; 36% completed at least college, and 22% reported unprotected anal intercourse (UAI) at last sex. Overall, 399 (29%) reported having heard about the iPrEx results, most from the internet (240, 60%) or from a newspaper or magazine (106, 27%). 665 respondents (47%) reported being extremely likely or very likely to use PrEP after being told the iPrEx results; 240 (17%) reported being not likely at all to use PrEP. Expressing higher intent for PrEP use was positively associated with black race (aOR 1.9; 95% CI 1.3-2.7) and Hispanic ethnicity (aOR 1.5, CI: 1.1-2.0; both versus white) and negatively associated with having completed at least college (aOR 0.7, CI 0.6-0.9). Age, recent UAI, and census region were not associated with expressing higher intent for PrEP use. When presented with alternative explanations of trial results, approximately 1/2 believed PrEP would drop their individual risk, rather than decreasing HIV risk at a population level; 17% were unsure of what the study results meant.

In the 3 weeks after the announcement of the iPrEx results, most internet-using MSM in our survey were unaware of the study results, and most did not correctly interpret the results. However, nearly half reported being very likely to use PrEP. MSM of color may hold more intention to use PrEP, and more educated men may hold less intention. Additional outreach and education to MSM communities about PrEP will be important in the early phases of PrEP implementation in the United States.

Track C
C13 - Cost of Prevention
Room: Vancouver/Montreal (Hyatt Regency Atlanta)

Abstract 1152 - Cost-effectiveness of a Fourth-Generation Combination Immunoassay for Detection of HIV Infections in the United States
Author(s): Lael Cragin, MPH; Feng Pan, PhD; Siyang Peng, MS; Julia R. Green, BS; Cynthia A. Doucet, MS, MSCI; Donald B. Chalfin, MD, MS

In 2010, the U.S. Food and Drug Administration approved the first 4th generation HIV test, ARCHITECT HIV Ag/Ab Combo, for the simultaneous qualitative detection of HIV p24 antigen and antibodies to HIV type 1 (Group M and O) and/or type 2 in human serum or plasma. Unlike currently available 3rd generation HIV tests, the combo assay detects HIV p24 antigen in addition to antibodies, and can be used to detect HIV in the acute stage of infection (i.e., before antibodies are detectable), a period when viral replication and shedding peak. This study evaluated the cost-effectiveness of the 4th generation assay versus a representative 3rd generation HIV test (i.e., GS HIV-1/HIV-2 PLUS O EIA) in screening for HIV infections in the United States.

A decision-analytic individual patient time-to-event microsimulation model was developed. The model follows 1.5 million hypothetical individuals with unique characteristics (e.g., age, gender, HIV infection status, disease awareness, treatment status) and simulates the natural history of HIV/AIDS, treatment with highly active anti-retroviral therapy (HAART), and transmissions. Two perspectives, a U.S. third-party payer and a public health perspective, were adopted. Model outcomes included HIV cases detected, HIV cases receiving test results, total costs, incremental cost per quality-adjusted life year (QALY) gained, and HIV transmissions avoided. The base case analysis assumed: 1% prevalence of undetected HIV of which 3.8% were acute infections; 80% of true test positive patients received their test results; delayed diagnosis of 5 years, on average, for false negative patients; reimbursement of $30 for the 4th generation assay; and CD4 count threshold of 350/mm3 for initiating HAART.
Scenario analyses were conducted to evaluate the robustness of the model results to changes in key input parameters.

In the base case analysis, screening 1.5 million individuals with the 4th versus 3rd generation assay resulted in: the detection of 266 additional HIV cases at an incremental cost per additional HIV case detected of $63,763; an additional 428 life years and 171 QALYs; and 39.1 HIV transmissions prevented. Although lifetime costs were increased by $16.8 million, the incremental cost per QALY gained was $98,560, within the range generally considered cost-effective. As expected, scenario analyses demonstrated that the model was sensitive to the prevalence of undetected HIV, time to delayed diagnosis, proportion of true test positive patients receiving test results, 4th generation assay reimbursement, and CD4 count threshold for initiating HAART. Notably, the 4th generation test was highly cost-effective in higher prevalence settings; the cost per QALY decreased to less than $50,000 when the prevalence of undetected HIV increased to 2%.

Based on the results of this model, HIV screening using the 4th generation assay is a cost-effective method for the detection of HIV infection in the United States. It results in increased case identification, fewer transmissions, extended life, and increased quality of life. This 4th generation test may provide a suitable alternative to currently available 3rd generation tests, fulfilling an unmet need for early and accurate detection at a reasonable cost.

Abstract 1355 - Estimating the Cost of HIV Prevention Interventions with Demonstrated Effectiveness in Reducing Risky Behaviors

Author(s): Ram K. Shrestha, PhD; Stephanie L. Sansom, PhD, MPP, MPH; Paul G. Farnham, PhD; Arielle Lasry, PhD

The Division of HIV/AIDS Prevention (DHAP), Centers for Disease Control and Prevention, identified evidence-based behavioral interventions that can be adopted by health care providers to reduce risky behaviors in specific populations. The 2009 Compendium of Evidence-based HIV Prevention Interventions included 23 individual- and 42 small group-level (4-12 persons) interventions. While these interventions are recommended for adoption, published studies on their efficacy rarely include complete data on their implementation costs. We estimated the cost of implementing 4 of the interventions for which DHAP most frequently provides implementation training to local health departments and community-based organizations.

We identified 2 individual-level and 2 small group-level behavioral interventions that delivered risk-reduction counseling, education, and skill-building exercises, usually over several sessions. The individual-level interventions were the RESPECT-brief intervention (462 agencies trained), for heterosexual, HIV-negative, STD clinic patients, and the Modelo de Intervencion Psicomedica (MIP, 31 agencies trained), for Hispanic injection drug users. The group-level interventions were the Women Involved in Life Learning from Other Women (WiLLOW, 46 agencies trained), for women living with HIV, and the Sistering, Informing, Healing, Living, and Empowering (SiHLE, 30 agencies trained), for sexually experienced African American adolescent girls.

We estimated the total program costs (variable and fixed) required to deliver each intervention. We estimated variable costs based on hours of labor required to deliver each intervention as described in published reports, and additional information provided by investigators. To estimate the fixed cost of the interventions, we reviewed 4 published papers, not included in our analysis, that provided details on both the variable and fixed costs of similar HIV prevention interventions. We estimated that fixed costs were 80% of the total costs on average, and we applied this proportion to the interventions included in our analysis. The fixed costs included administrative staff time, training, travel, facility overhead, and office supplies.

The number of persons served under RESPECT and MIP was 1,447 and 258, and the providers who delivered the interventions spent on average 0.67 hours and 6.00 hours, respectively, per person served. We estimated the total intervention cost of these individual-level interventions at $139,578 and $247,420, and the cost per person served at $96 and $868. In group-level interventions, the number of persons on average in a group was 9 and 11 in WiLLOW and SiHLE, respectively. The provider's time spent per group was 32 hours (3.56 hours/person) and 48 hours (4.36
hours/person). We estimated the per-group intervention cost to be $4,630 and $6,945 and the cost per person served to be $514 and $631.

We estimated the total and the per-person costs of effective behavioral interventions based on limited information provided in the literature. However, more published data based on the costs of actual program implementation would be useful. Our analysis provides cost estimates to HIV prevention planners and providers, who must determine the resources required to implement these interventions in their communities.

Abstract 1464 - Enhancing the Effectiveness of Needle Exchange Programs (NEPs)
Author(s): Jim Hales; David Wilson

Needle Exchange Programs (NEPs) have been demonstrated to be an effective community-based strategy for reducing transmission of HIV and other blood-borne viruses (BBVs) among injecting drug users (IDUs). The ability of these programs to deliver a return on investment has also been demonstrated. Despite the proven success of NEPs in increasing access to sterile injecting equipment, many IDUs continue to reuse and share non-sterile injecting equipment. CDC data indicates 32% of IDUs continue to share syringes. Consequently, HIV prevalence among IDUs is estimated at 16%, while HCV prevalence is 70+. BBV transmission rates could be further reduced via single-use syringes that prevent reuse and sharing.

NEP access is expected to increase under new U.S Federal guidelines. It is appropriate that new technologies be assessed to maximize the effectiveness of NEPs in preventing BBV transmission and protecting those at risk from unsafe disposal.

This project explores preventative health opportunities arising from further enhancement of NEPs by adopting technologies that restrict IDU sharing. We examine the potential for single-use syringes to reduce BBV transmission, and demonstrate a projected return on investment for governments by delivering preventative health outcomes. A model is presented taking into account current IDU sharing practices and the potential for further reductions through provision of single-use syringes. The impact of this initiative on the HIV and HCV incidence is then explored. An economic model is presented to examine costs associated with technology adoption and avoidance of downstream healthcare costs for treating IDUs with BBV-related illnesses.

RESULTS: Estimated annual U.S NEP costs for providing standard syringes is $8.5 million. Taking into account rates of sharing and reuse, additional annual costs to transition to single-use syringes to meet current demand is approximately $86 million. This investment is projected to result in the avoidance of nearly 78,000 cases of HIV, and 3.5 million cases of HCV over ten years, and about 247,000 cases of HIV and over 11 million cases of HCV over 25 years. The total cost of treatment avoided for HIV is $1.4 billion over ten years, equating to net savings of $454 million. Over 25 years, HIV treatment costs avoided rise to $32 billion, with net savings of $28.9 billion. When HCV is taken into account over 25 years, total treatment costs avoided (HIV and HCV combined) are $163 billion, with net savings (allowing for additional single-use syringe costs) of nearly $160 billion.

The Net Present Value (NPV) of an investment in single-use syringes over a ten-year period for HIV alone is $177 million, increasing to $11.1 billion over 25 years. When both HIV and HCV are taken into account, the NPV over 25 years rises to $62 billion.

LESSONS LEARNED: Single-use syringes can have a significant impact on reducing BBV transmission among IDUs, and further enhance NEP effectiveness. Additional costs of single-use syringes can be economically justified by avoiding costs associated with treating BBV infections. Government investment in single-use syringes may significantly enhance NEP effectiveness, complement preventative health strategies and deliver a favourable return on investment.

Abstract 1677 - Financial Return on Investment of CDC’s Expanded HIV Testing Initiative
Author(s): Angela Hutchinson; Paul Farnham; Nadia Duffy; Stephanie Sansom; Rich Wolitski; Sam Dooley; Janet Cleveland; Jonathan Mermin
The Centers for Disease Control and Prevention’s (CDC) Expanded HIV Testing Initiative significantly increased funding to state and local health departments serving populations disproportionally affected by HIV for the purpose of expanding HIV testing services to new clinical venues and increasing awareness of serostatus among infected persons. Cost-effectiveness analyses have found that routine HIV testing is cost-effective in the United States. However, policy makers are also interested in the financial return on investment (ROI) of large scale testing. Such analyses are helpful to government agencies that must optimize public health given a set budget.

We conducted an ROI analysis of the initiative based on expenditure and outcome data from the program (October 2007-September 2010). We calculated return on the health system investment, calculated as program benefits divided by all program expenditures regardless of source, including the medical costs of treating newly diagnosed index patients. We also calculated the return on investment by CDC and partners, such as state and local governments, as program benefits (the medical costs associated with HIV transmissions averted) divided by CDC and partner’s expenditures on the program. Our analysis incorporated benefits attributable to reduced HIV transmission of persons diagnosed and notified of their infection through the initiative compared to when, on average, those persons would have been diagnosed without the screening program (3 years later in the base case). We used a published mathematical model of HIV transmission to estimate transmissions averted. In sensitivity analysis, we tested the effect of diagnosis occurring 1 and 5 years later. The benefit of HIV transmissions averted was valued using published estimated lifetime HIV treatment costs.

Over the three years of the program CDC’s initiative tested over 2.7 million persons for HIV, resulting in 18,432 new HIV diagnoses. Estimated HIV transmissions averted due to the initiative varied by assumed alternative screening interval: 3,381 (base case), assuming persons would have been otherwise diagnosed 3 years later, and 1,127 and 5,634 for the 1- and 5-year alternative screening intervals, respectively. For every dollar of health system investment in the program, there was a return of $1.95 (base case) and $1.46 and $2.01 for the 1- and 5-year alternative screening intervals, respectively. Return on investment by CDC and partners was $9.26 (base case) and $3.27 and $14.54 for the 1- and 5-year alternative screening intervals, respectively for every dollar invested.

CDC’s Expanded Testing Initiative yielded positive returns (ROI >$1) on investment due to reductions in transmissions from persons newly diagnosed with HIV infection. Our analysis supports large-scale HIV testing programs as beneficial from public health and economic standpoints. We did not value benefits to the index case of enhanced life expectancy due to earlier linkage to care, or the effect of re-linkage to care among those who had been previously diagnosed with HIV. Both would be expected to add a greater return on investment.

**Track D**

**D02 - Training the Trainers: An Update on Recent CDC and Local Health Department Capacity Building Initiatives**

**Room: Hanover C (Hyatt Regency Atlanta)**

**Abstract 1320 - Enhanced CBA for CBOs and Communities Serving African American and Latino Gay/Bisexual Men, and MSM**

**Author(s):** Maria E. Alvarez; Vel S. McKleroy; Rashad Burgess; Partnerships Team; PS09-906 MSM Supplement Grantees

To address the significant and disproportionate impact of HIV/AIDS on AALMSM.

Nine PS09-906 grantees were awarded one-time supplemental funds to provide CBA to CBOs and Communities Serving AALMSM in major metropolitan cities in the U.S. and Puerto Rico from 08/02/2010 through 03/31/2011.

The purpose of this supplemental funding opportunity is to boost current provision of CBA to CBOs and communities serving AALMSM by focusing on (1) developing and maintaining strong organizational management and infrastructure, (2) acquiring the skills to deliver culturally appropriate evidence-based behavioral interventions, (3) ensuring program collaboration and service integration at the client level, and (4) mobilizing communities to develop...
coalitions to support HIV antibody testing; linkages to HIV prevention, treatment, and care services; reduction of stigma; and efforts to address the social determinants of HIV-related health disparities.

Nine CBA providers implemented unique programs in one of three enhanced components: (1) Strengthening organizational infrastructure & program sustainability (OIPS) of CBOs serving AALMSM; (2) Strengthening implementation of EBIs by CBOs serving AALMSM; and (3) Strengthening community mobilization to increase access to and utilization of HIV prevention services by AALMSM. To date, some of the highlights include but are not limited to:

Program development, implementation, & evaluation. CBA was provided regarding the strategic use of research to develop new or adapt existing DEBIs; and make programs strengths-based, culturally relevant, and more participatory.

Leadership development. Leadership institutes were conducted to promote program sustainability, leadership development, workforce development, program collaboration, and service integration.

Organizational management. CBA included skills-building trainings on budget management; grant writing; and managing external pressures like politics, funding, inter-agency tensions, and working in unwelcoming communities.

Summits and bootcamps. Two 2-day summits supported continued development of mastery on d-up!, MMMV, Mpowerment, and POL. EBI-specific boot camps were conducted with agencies implementing 3MV and POL with AALMSM.

Community mobilization. Structural change skills-building trainings were held with young AALMSM-serving agencies on conducting a community assessment; and on coalition development regarding shared leadership, diverse participation, management, & sustainability. Networks of AAMSM community leaders participated in skills-building sessions and town halls; shared personal stories with newly created coalitions; and advocated for HIV testing. Although the approach taken by each of the 9 CBA providers was different, these cross-cutting themes emerged.

1. It is important to conduct needs assessment to identify narrow focus of objectives & activities. AALMSM have multiple needs in addition to HIV risk prevention (i.e., social determinants of health).
2. It is important to build on existing relationships with partners/stakeholders to assist with the formative process. It is important to use local stakeholders whenever possible to deliver/negotiate services.
3. It is important to include target population input for social marketing campaigns/materials.
4. Timelines should be realistic, established early, and include lead time to allow for delays.

Abstract 1528 - CBA's Impact on HIV Prevention Services

Author(s): A. Zaverl; M. Chion

It is difficult to determine the impact of Capacity Building Assistance (CBA) services for HIV prevention programs due to the complexity of prevention programs: type of intervention, diversity of the prevention staff, the variability of services that are currently provided, and other contextual factors (e.g. stigma, limited funding resources, accessibility, etc.). Shared Action and Shared ActionHD, the capacity building programs at AIDS Project Los Angeles (APLA), conceived their evaluation of CBA programs guided by the principal: Capacity=Competence x Practice. This formula uses practice or "sability as one of the main factors. Shared Action created and implemented a comprehensive model for evaluating CBA programs that not only addresses client satisfaction and Quality Assurance (QA) issues, but it also investigates how participants are using the assistance provided.

APLA has been providing capacity building services for more than 10 years. Since 2004, through its CBA programs Shared Action and Shared ActionHD, APLA has been providing CBA services to both community based organizations (CBOs) and health departments implementing Effective HIV prevention programs.

APLA's Shared Action developed a CBA evaluation model with "sability as the purpose guiding the framework. APLA's CBA programs have been serving CBOs and health departments to increase their capacity adopting, adapting, increasing core competencies and evaluating their HIV prevention programs. Therefore, "ese is the indicator for capacity in the context of implementing HIV prevention interventions. The evaluation model includes 3 and 6 month follow up interviews that track indicators including: what elements from the CBA services have been implemented, what impact the services have had, self-efficacy of the participants, among others.
During the presentation Shared Action will present both quantitative and qualitative data from formative evaluation results from the past two years of service delivery. The data is gathered from over 70 3-month phone interviews and over 50 6-month phone interviews from both trainings and technical assistance services. Preliminary results indicate:
- Over 80% of CBA recipients have included at least one element learned from the services into their current work.
- These changes made due to Shared Actions services impact their work by
  a) participants feeling more effective,
  b) increased number of clients served
  c) more work done more efficiently
- Even at 6 month follow-up, participants report high levels of self-efficacy (90%) to implement knowledge learned

LESSONS LEARNED: Follow-up interviews focused on how information provided by services from Shared Action is used have provided an effective manner for evaluating CBA services. Shared Action has learned that a majority of recipients of services are indeed using or practicing what they were trained in. This demonstration of practice along with the competency of the material indicate that in fact Shared Action is increasing CBO's and HDs capacity.

Abstract 1648 - Utilization of an Intervention to Improve Capacity to Implement/Adapt an Evidence-Based HIV Prevention Intervention

Author(s): Gregory M. Rebchook, PhD; David M. Huebner, PhD, MPH; Scott Tebbetts

The Mpowerment Project (MP) is a community- and multi-level, cost-effective, evidence-based HIV prevention intervention designed to reduce sexual risk behavior and increase HIV testing among young men who have sex with men. Implemented in over 150 community-based organizations (CBOs), the MP is consistent with the National HIV/AIDS Strategy. This study discusses the utilization over time of an intervention to build CBO's capacity to implement and adapt the MP successfully.

With input from CBOs, we developed the Mpowerment Project Technology Exchange System (MPTES), which includes written manuals, training, online resources, and proactively-delivered, client-centered technical assistance (TA). We provided the MPTES to 72 CBOs. This presentation focuses on 49 CBOs followed for 2 years. Surveys were administered by phone, and CBO staff reported MPTES utilization at baseline, 6-, 12-, and 24-months (N=532 interviews with N=329 individuals). Agency-level utilization scores were computed, and repeated measures negative binomial regression analyses were conducted.

The Program Manual was used more frequently than other MPTES components, and its use did not significantly decline over time. Utilization varied, with some CBOs reporting rare use (at 6-months, three CBOs never used it), and others reporting frequent use (at 6-months, two CBOs had used it 100+ times). Utilization of other materials declined over time (p's<.01). In contrast, TA increased from baseline to 6-months (p<.001), and did not decline over time. CBOs increased their requests for TA after baseline (p<.001) and continued requesting it over time. Proactively delivering TA to many CBOs was challenging: some staff were receptive to it, whereas others avoided TA calls. TA topics were also tracked and included discussions about core elements as well as other implementation issues. Topics addressed during TA changed significantly over time. At every assessment an average of 20% of MP staff had attended a training. Qualitative data showed that participants found the MPTES to be very helpful, but wanted more: 1) adaptation information, especially for communities of color; 2) diversity depicted and discussed; and 3) information about other CBOs real implementations. The CBOs experienced high staff turnover: only 8% of CBOs retained the same coordinators and 49% had replaced more than one coordinator during the two years.

The MPTES was used, but the level of use may be insufficient to help ensure fidelity for some CBOs. Once TA was proactively provided, CBOs increasingly requested it. Increased use of technology exchange services could be a way of coping with rapid staff turnover. Technology exchange efforts should address the spectrum of issues that CBOs face in implementation (not only core elements), and aim materials at specific CBO staff as well as the entire system (frontline staff, management, and funders). Adaptation issues frequently arose; some CBOs wanted detailed instructions about the adaptation process, whereas others wanted advice on specific program modifications for their populations and settings. CBOs vary in their capacity to conduct adaptation work, and many desire more direction.
than we provided. An enhanced MPTES that addresses issues identified in this research has now been developed and will be discussed.

**Abstract 1784 - Project Stronger Together: Working Towards a Model for Capacity Building among Emerging HIV/AIDS Services Organizations**  
**Author(s):** Quinn Gentry; Romero Stokes; Ria Garner

Despite years of programmatic and service delivery development, HIV/AIDS organizations remain in need of capacity building and technical assistance in key areas of operation. New organizations, in particular, are struggling to provide much-needed services in resource-poor communities where the HIV/AIDS epidemic continues to manifest as a social and health problem. The purpose of this presentation is to describe how Georgia-based collaborative partners identified and addressed organizational barriers in an effort to adequately address the continued spread of HIV/AIDS in communities of color. The theory of organizational change that guides the work posits that if organizations serving communities of color experiencing disproportionately higher risks for HIV/AIDS receive technical assistance to enhance their organizational and program service capacity in several key areas, then there will be an overall improvement of the continuum of HIV/AIDS care and prevention services in a way that ultimately reduces the disproportionate rates of HIV/AIDS in communities of color.

Project Stronger Together (PST) is implemented in organizations serving communities of color located in the 20 county metro-Atlanta area, as well as proximate cities such as Macon, LaGrange, Athens, and Gainesville.

PST is a collaboration among the Georgia Department of Community Health (Division of Public Health, Office of Health Equity), AID Atlanta, Wholistic Stress Control Institute, and Mary Hall Freedom House. Collectively, these agencies serve as a strong network of successful organizations charged with developing comprehensive capacity building and technical assistance strategies. These strategies enhance emerging organizations to better serve individuals who are HIV positive, men who have sex with men (MSM), injection drug users, other substance abusers, transgender, the incarcerated and newly released, gay men, lesbians, and sex workers within minority populations in the described geographic area.

For year two of this three-year initiative, process indicators revealed that the intended organizational changes are underway. Select results included: 37 agencies were selected to receive intense technical assistance uniquely designed to address core areas of needs; 19 agencies received intense technical assistance in areas they identified as part of a comprehensive needs assessment; 31 capacity-building workshops sponsored by lead TA providers; 60 individuals participated in collaborative capacity-building workshops; 31 subject matter experts engaged to facilitate capacity-building and technical assistance; 19 agencies matched or linked with other agencies for customized assistance; 10 agencies selected for technical assistance that focus on substance abuse and mental health needs. In the end, agencies provided evidence that capacity was built in 11 core categories.

Year 2 lessons learned included: (1) agencies need a comprehensive and rigorous assessment to engage them effectively in identifying the underlying dynamics of their organizational needs; (2) agencies at different stages of organizational development need appropriate TA directly related to their level of readiness to receive and apply capacity building resources; and (3) the need for customized technical assistance is paramount in assisting organizations with concrete strategies for applying knowledge gained from the PST Initiative.

**Track D**

**D23 - Results from Recent Formative Research with Women**  
**Room: Hanover F/G (Hyatt Regency Atlanta)**

**Abstract 1468 - Black Women and HIV/AIDS: Findings and Implications from Regional Focus Groups**  
**Author(s):** Michelle Batchelor, MA; Joy Mbajah, MA; Lynn Shaull, MA; Jacqueline Coleman, MEd, MSM; Niasha Brown, MA
Recent national data illustrates that Black women represent a disproportionate number (65 percent) of the total number of women currently living with HIV/AIDS. According to the Centers for Disease Control and Prevention (CDC), as of 2007 most reported AIDS cases among female adults and adolescents were among those who reside in the South and the Northeast and the majority were among Black/African-American females.

Since 2007, the National Alliance of State and Territorial AIDS Directors (NASTAD) hosted over 24 jurisdictions in a regional forum series entitled, black Women and HIV/AIDS: Confronting the Crisis and Planning for Action. Following the 2008 and 2009 Black Women’s Regional Forums, focus groups were conducted with 15 Midwest, Northeast and Southeast city and state jurisdictions.

In response to the epidemic, NASTAD, with support from the CDC, launched its regional forum series, where state teams examined opportunities to strengthen partnerships and collaborate more effectively to implement programs specifically targeting Black women.

In March 2010, NASTAD released Black Women Issue Brief No. 2: Black Women and HIV/AIDS: Findings from Southeast Regional Consumer and Provider Focus Group Interviews. The issue brief highlights the voices of women living with and affected by HIV/AIDS to provide a clear and fresh perspective on issues and suggestions for health departments and additional stakeholders to consider when designing, targeting and implementing culturally relevant programs or interventions for Black women. NASTAD also created state summaries based on city or state specific focus group outcomes.

The focus group data results provide a picture of the range of issues faced by Black women in the respective regions. Issues for consideration, as identified from consumer and provider focus groups include: holistic and varied support groups, affordable housing, transportation, prevention messages, media and social marketing, comprehensive sex education for all women, clinician education and sensitivity, interventions specific to Black women, advocacy, community collaborations and partnerships and HIV-positive Black women involved in decision-making. Various programs and activities specific to Black women were initiated as a result of the regional forums, and the subsequent technical assistance provided by NASTAD following these forums.

**Abstract 1505 - Reinforcing Cultural Strengths and Values in a HIV/STI Prevention Intervention among Young American Indian Women**

**Author(s):** Whitefoot, P; Wynn, W; Jones, ML; Cassels, S; Morrison, DM; Simoni, JM; Walters KL

Although great diversity exists among American Indian (AI) women, as a group they are at potentially high risk for HIV and other sexual transmitted infections (HIV/STIs) due to historical trauma, adverse socio-demographic conditions, and relatively high rates of substance use and lifetime trauma. Many health services available to AI women fail to address these important community-level factors. Individually tailored interventions address cognitive-behavior factors such as knowledge and skills. Interventions tailored from a cultural perspective captures health behavior within the social and physical environments. Culturally responsive interventions are needed to address health behaviors in a cultural and social context.

In a tribally based participatory approach, a 12 member steering committee (service providers, elders, and consumers) and academic partners are designing a culturally relevant health and wellness intervention for young AI women (ages 15-24 years) that reflects the cultural values and beliefs of a northwest rural AI community.

The steering committee identified individual and cultural elements in the development of qualitative interview guides and a survey instrument. Social cognitive, indigenous stress-coping and social ecological theoretical models provided a framework to map HIV/STI strength-based measurements and program components. Key-leader (n = 15) and focus group (n = 30) interviews begin in spring 2011.

Community members and academic partners mapped measurements and program components into three distinct areas using a theoretical-structured framework: (1) Individual behavior (knowledge, attitude/ motivation, risk perception, self-efficacy, skills); (2) Social environment (norms, networks, culture, support, the role of men and the
role of family working toward family healing); (3) Physical environment (access, venues, community factors/environment). HIV/STI risk factors identified were trauma (historical, lifetime, and current); sexual activity; inconsistent condom use; lack of testing for HIV/STI; as well as alcohol and substance abuse. Areas were then translated into indigenous ways of knowing. Traditional story-telling was identified as a mean to communicate strengths and knowledge and exhibit skills and self-efficacy. Traditional and community practices were identified to support discussions, healing, and support systems. Findings from the qualitative interviews and will further inform the survey and intervention design.

LESSONS LEARNED: Intervention development at the community level with services providers and consumers will likely produce a culturally responsive HIV/STI program with high community commitment and excitement.

**Abstract 1685 - SIHLE: An Engaging HIV Prevention Intervention for African American Girls Ages 14-18**

**Author(s):** Rachel Stanley; De’Jah Wright; Cherri Gardner, MA; Jacqueline Coleman, MSM, Med

HIV prevention programming for African American (AA)youth has evolved over the past 2 decades. Notably, AA girls are disproportionately at risk for HIV. SIHLE (Sisters Informing, Healing Living and Empowering), a Peer-Led Program to Prevent HIV Infection among AA Teenage Females, was developed by Gina M. Wingood, ScD, MPH, and Ralph J. DiClemente, PhD to address this issue. A Training of Facilitators was developed to train CBO and Health Department staff in SIHLE implementation.

SIHLE was first implemented and evaluated in an AA community in Birmingham, AL, and later replicated with a similar group of participants in Atlanta, GA where 522 sexually active heterosexual African American females, aged 14-18 years, participated in either a control group or the SIHLE sessions. A Training of Facilitators was developed and SIHLE has since been disseminated into communities nationwide.

SIHLE provides gender-specific, culturally relevant sessions which include ethnic and gender pride, HIV risk-reduction information, assertiveness skills, behavioral self-management, and coping skills. SIHLE activities are based on 2 social science theories: Social Cognitive Theory (SCT) and Theory of Gender and Power (TGP). SIHLE teens ages 14-18 attend four 3-hour sessions to experience adult and near-peer facilitated group discussions, role-play, and behavioral skills-building activities.

As a peer-led intervention, the majority of the activities are facilitated by near-peer facilitators (18-22 years old) who are considered near-peers of the SIHLE participants. SIHLE core elements, key characteristics and supporting theories will be presented. Two SIHLE near-peer facilitators (18-22 years old) will present on the critical use of near-peer facilitators in SIHLE. Attendees will observe 1 - 2 peer-led activities from the SIHLE curriculum. The presentation will conclude with SIHLE training opportunities available through www.effectiveinterventions.org as well as Capacity Building Services available to support the successful planning, implementation, evaluation and monitoring of SIHLE within community settings.

Results: Compared to the control group, the teens that completed the SIHLE intervention were more likely to report:

- Consistent condom use
- Increased HIV/AIDS knowledge
- Enhanced self-efficacy
- Reduced STDs

Study results indicated that a near-peer-led social skills intervention delivered in a community setting can positively affect condom use. SIHLE therefore focuses on the use of near-peer facilitators, close in age and similar in cultural experience to members of the target population to communicate its HIV prevention message as a means of replicating these results.

Lessons Learned: Near-peer facilitator qualifications are the exact qualities of college-bound students. It is important to recruit from High School or CBO HIV prevention peer education programs because peer leaders in these settings have leadership skills and HIV prevention experience required for SIHLE. In order to preserve the longevity of the near-peer facilitators, stipends and recruitment near the 18 year old age is important. Once near-peer facilitators
reach 23, they can cross over and become adult facilitators. The use of near-peer facilitators to recruit SIHLE participants is extremely important. The success of the SIHLE intervention is grounded in an investment of the entire team completing the CDC SIHLE training.

Track D
D24 - Bringing HIV Prevention to the Campus: Recent Interventions for and by College Students
Room: Hanover D (Hyatt Regency Atlanta)

Author(s): Tyler Spencer

Washington DC has a significantly higher rate of AIDS cases compared to all other American cities. Specifically, this rate is 12 times the national average. Currently 1 of every 20 adults in our nation’s capital is HIV positive. The risk for HIV/AIDS is heightened for young people, and the number of new HIV infections among youth increased by 50% from 2001 to 2005, compared to the previous five years. Now, 10 percent of all new HIV infections in Washington DC are among individuals aged 13 to 24. These statistics are staggering and speak to the need for programs and services targeted toward this population that address HIV prevention and education. The Grassroot Soccer curriculum is an evidence-based program that has educated 300,000 young people across Sub-Saharan Africa, and it has potential to be successfully adapted for urban youth in Washington DC.

Sports-based HIV prevention education facilitated by college athletes in Washington DC middle schools and community centers.

College athletes undergo a 4-day training of trainers course to facilitate The Grassroot Project Curriculum (adapted from Grassroot Soccer in Sub-Saharan Africa). After the training, college athletes facilitate 8-week HIV prevention programs targeting 12-14 year old youth in schools and community centers. Upon completion of the program, youth come together for a graduation event, where they share what they have learned with each other and with a community audience.

From January 2009 through January 2011, The Grassroot Project programs have trained over 200 college athletes and graduated over 1,000 youth. Statistical analysis of participant pre/post tests suggest that The Grassroot Project is effective in improving knowledge, attitudes, and beliefs about HIV/AIDS. Interventions facilitated by non-traditional HIV educators such as college athletes offer a unique opportunity to reach at-risk youth with critical information and life skills. Organizationally- as a program run completely by young people under the age of 25- we have also learned that partnerships and capacity building assistance have been essential in scaling up our interventions.

Abstract 1562 - Expanding Workforce Capacity in HIV: Educating and Mentoring Diverse Undergraduate Nursing Students as Peer Educators
Author(s): Sande Gracia Jones, PhD, ARNP, ACRN; Carol A. (Pat) Patsdaughter, PhD, RN, CNE, ACRN; Mariela Gabaroni, MS, CHES

The U.S. Department of Health and Human Services released a document in April 2010 describing forces contributing to a workforce shortage in HIV healthcare. While the incidence of HIV cases is stable, the number has not declined. Additionally persons with HIV/AIDS are living longer, contributing to more complex cases. The current workforce is aging and expected to retire over the next 10-15 years, financial reimbursements are declining, and the population is expected to increase and be more diverse. Seventy percent of new AIDS cases in 2006 were among ethnic and racial minorities, highlighting the need for multilingual providers and culturally competent care. Preparing a culturally diverse workforce in HIV/AIDS care is critical.

Hispanic Serving University in South Florida.
Describes the development and integration of culturally diverse undergraduate nursing students as peer educators in HIV. Selected junior and senior nursing students were trained as certified student peer educators. Students received health focused leadership training using the Bacchus Network curriculum and topic education on HIV/AIDS, sexually transmitted diseases, and substance abuse. In a joint effort, the peer educators were connected with University Health Services on campus to deliver a one hour presentation on the above mentioned topics to incoming freshman. The development and refinement of the nursing student peer education program was supported by grants from the Office of Women's Health, the Substance Abuse and Mental Health Services Administration, and the Office of HIV/AIDS Policy.

The Student Peer Educators presented 52 classes to incoming freshman at the university. Students evaluating the peer-led education program rated the presentation very good to excellent, with 97% indicating that they learned something new. In addition, peer educators reported that they recognized knowledge deficits and at risk sexual behaviors among the students. The experience of being a peer educator has engaged students to expand their knowledge and understanding of HIV, understand their own knowledge deficits and biases, and gain understanding of working with a culturally and ethnic diverse student population. Engagement and development of undergraduate nursing students as campus leaders in HIV education can lead to culturally competent professionals in HIV healthcare.

Abstract 1738 - Lessons Learned from Delivering a Culture-Specific College Based HIV Risk Reduction Intervention among Black Women

Author(s): Katharine Stewart; Holly Felix; Zoran Bursac; Michelle Smith

Black women have been disproportionately affected by HIV since the beginning of the epidemic. Few evidence-based HIV interventions target young black college students, yet this group could benefit from such interventions. We adapted an existing evidenced-based HIV intervention (SISTA) to target young black women on college campuses. We assessed the effect of the intervention, using a mixed methods approach, and report here on the results of the qualitative evaluation.

In 2009, female students (n=48) at three historically black colleges and universities were recruited to participate in SISTERS, adapted from SISTA, a DEBI program. SISTERS added a sororal ambiance, HIV testing, and community awareness to the core elements of the original intervention. We conducted a qualitative post-intervention evaluation via two semi-structured focus groups with 20 participants. Questions addressed dating norms, self-efficacy, and facilitators and barriers related to practicing safe sex behaviors, effectiveness of the intervention, and recommendations for improvement. Recordings of the focus groups were transcribed and thematic framework developed. The transcripts were then coded by two reviewers using constant comparison techniques.

Focus group participants attended all SISTERS sessions. Findings related to key themes of relationship dynamics, power dynamics, condom use/negotiation, HIV risk perceptions, HIV testing, and intervention affects. Overall participants felt empowered by the intervention, recognizing its benefit for increasing knowledge, and changing attitudes and behavior to reduce HIV risk. Participants' favorite aspect of the intervention was the role-play activity but the length of the program was an area for improvement. The participants reported increased self esteem and self efficacy, skills to discuss safe sex with their partner and negotiate condom use, awareness of HIV & STD risk, willingness to get tested, willingness to ask their partners to get tested, and ability to encourage others to practice safe sex and get tested as a result of completing the SISTERS program.

SISTERS, an HIV intervention targeting black women on college campuses, was well received by the target group. Qualitative findings identified key positive aspects of the intervention that should be retained as well as a few aspects that warrant modification in future study of the intervention. Furthermore, our findings provide insight to program planners and researchers in the development of innovative culturally specific HIV prevention strategies specific to black female college students.

Abstract 2033 - Exploring Sexual Identity Development of African American Male College Students at a HBCU

Author(s): Schenita Randolph; Carol Golin; Mimi Kim; Derrick Matthews
Among the estimated 56,000 new yearly infections of HIV in the United States, 51% are among African Americans. This demonstrates a disproportionate burden of HIV infection as African Americans make up approximately 12% of the population. One group warranting attention in North Carolina has been African American male college students. Between 2000 and 2003, 11% of new HIV infections among men ages 18-30 were enrolled in college at the time of their diagnosis, with 87% of those college students being African American. Another examination of HIV transmission among men ages 18-30 in North Carolina revealed that 15% of the men reported sexual contact with both men and women in the year prior to their diagnosis, and that these individuals were more likely than men who exclusively have sex with men to be African American and enrolled in college.

Sexual identity is a complex and multidimensional construct, many factors of which have yet to be sufficiently explored in the context of the sexual transmission in the HIV epidemic. This is particularly true for heterosexual men and men who have sex with both men and women, as the work that has concerned sexual identity has often ignored these two groups. This neglect may stem from the fact that sexual identity development has often been inappropriately conflated to claiming a minority sexual orientation.

As a part of an attempt to more fully understand the role that sexual identity may play in the lives of African American men, we interviewed African American male college students within a historically Black college and university (HBCU) in North Carolina. Our aim was to address a gap in the literature by exploring what shapes sexual identity and its development among African American men.

Interviews were used to assess experiences, attitudes, and beliefs about sexual identity development and sexual activity held by African American male college students. A total of 31 African American male students took part in this investigation that occurred at a HBCU in the central Piedmont region of North Carolina, located in one of the largest cities within the state. Researchers developed interview questions based on The Measure of Sexual Identity Exploration and commitment (MoSIEC) survey instrument.

Results from this qualitative exploratory study revealed that the ideas and beliefs about sexuality and sexual identity for African American college males are heavily impacted by their peers and their environment. Males that had positive influence from an older sibling, cousin, or father about sex reported less sexual partners. Majority of the males reported that it is more acceptable for men to have multiple sex partners, but it is unacceptable for a woman to do the same. Many males related number of sex partners and being engaged in certain sexual activities with being classified as a man.

This research could lead to future research that could explain sexual behavior within the context of the HIV epidemic for this population.

**Track D**  
**D29 - Using Data to Develop and Evaluate HIV Prevention Social Marketing Campaigns: Lessons from the Field**  
**Room: Hanover E (Hyatt Regency Atlanta)**

**Abstract 1288 - Meth Makes You Ugly: An HIV Prevention Campaign Developed by Young MSM for Young MSM.**  
**Author(s): Danny Gladden**

In 2009, Missouri led the nation in the number of meth lab seizures with 1,774. In the fall of 2009, a St. Louis City Health Department behavioral surveillance reported a 10% increase in newly diagnosed HIV infections at a local club targeting MSM aged 18-24. In 2010, 84 individuals participated in HIV counseling and testing over a three-month period at the same local club. 29.76% of the tested individuals disclosed trying or knowing someone who has tried meth and/or being sexually active or knowing someone who has been sexually active while using meth. While Missouri is a leading manufacturer of methamphetamines, we are nearly two decades behind targeted prevention interventions in larger cities. Finally, a growing body of research supports the relationship between meth use by MSM populations and an increase in risk behaviors that can make the user vulnerable to HIV infection.

Targeted outreach for MSM aged 18-24 who attend the only 18+ club for young MSM.
Following the mission of Mpowerment one ongoing for mal outreach activity of our intervention is Boys N Brews; a biweekly gathering of MSM who gather to discuss topics around HIV risk reduction such as condom negotiation and skills, healthy relationships, and substance (ab)use. In January 2010, the Boys N Brews topic was "Meth Use in the Gay Community." Nineteen individuals attended the Boys N Brews discussion sharing very personal stories about current or prior use of meth by them and their friends, revealing risky sexual behavior. The pressure to try meth for the first time both in the bar scene and at after parties was substantial. The young people identified that every Friday night, a young person would try meth for the first time.

From January 2010 to June 2010 young MSM were determined to reverse the trend of meth use among their peers thus reducing the number of new HIV infections. Over a six-month period they worked hundreds of hours to prepare an effective meth/HIV prevention campaign that spoke specifically to their peers. The result of their hard work was Meth Makes You Ugly, a publicity campaign that includes four posters that were designed by young men from the community and utilized population specific language and images communicating harm reduction and prevention messages connecting meth use and HIV. The four unique posters were released weekly during the month of June culminating with a final release of all four posters at the St. Louis Pride Festival. Overall, four unique messages were disseminated throughout four bars reaching the intended population. In addition to the prevention campaign, current users were provided harm reduction tools and resources.

It is critical to have both ears open to the consumers we are serving. While Missouri was a leader in meth production, it was not until we heard from our consumers regarding rampant meth use and analyzed the data from behavioral surveillance that we recognized young MSM in our community were not only exposed to meth, but as a result were at greater risk for HIV infection.

**Abstract 1467 - Racial and Ethnic Identity: Reaching and Mobilizing Latino Communities through an Awareness Day**

**Author(s):** Miriam Vega

HIV/AIDS continues to devastate Latinos across the United States, Puerto Rico and the U.S. Virgin Islands. Latinos are the fastest growing population and pronounced health disparities are evident in the impact of the HIV/AIDS epidemic on Latinos in the United States and its territories. There are few effective prevention interventions that reflect the reality of Latino/Hispanic cultural, socio-economic and linguistic needs. The National Latino AIDS Awareness Day (NLAAD) is a national social marketing campaign that is implemented every October 15 to encourage awareness and testing of HIV/AIDS in the Latino community. To be effective, we encourage local awareness campaigns address the local epidemic and target audience with culturally appropriate messages. In order to determine awareness and reach of the campaign along with potential moderators of that awareness, an evaluation of the campaign with the general Latino population has been conducted since 2007.

Street intercept interviews were conducted since 2007 across ten cities in the United States. The ten cities were selected because they where long-standing Latino communities (NYC, El Paso, Santa Fe & San Antonio) or they were emerging Latino communities (DC, Atlanta, Houston, North Charleston, Rock Hill & Charlotte). The interviews were conducted a week before NLAAD and a week after NLAAD by staff of local community based organizations and health departments. The interviewers were trained beforehand and used a standardized survey. The survey inquired as to awareness, any action taken (HIV testing, attend local event, talk to others about HIV), source of awareness, and demographics (race, ethnicity, age, sexual orientation).

A total of 1589 street intercept interviews were conducted across the cities from 2007 through 2010. Thirty-two percent of all respondents indicated they were aware of NLAAD. 85% of respondents indicated they were Latino or Hispanic. In terms of specific nationalities/regions: 44% self-identified as Mexican, 175 as Central American, 15% as Dominican, 6% as Puerto Rican. Racial identification data was recoded into 4 groups: Caucasian (35%), Black (13%), API (3%), and other (53%). The fact that a majority of the Hispanic respondents self-identified as other mirrors national trends seen in past census data (year 2000). Self-identification differed by city ($\chi^2= .53, \ df =1080 \ p=.000$) with over 90% of Hispanic respondents in Charlotte, North Carolina identifying as other while 0% did in San Antonio. In San Antonio, over 70% identified as Caucasian. Lastly, there were significant differences in reported
NLAAD awareness by racial self-identification with those identified as Caucasian reporting higher awareness than others (p=.000).

The NLAAD evaluation demonstrates that social marketing can be an effective tool for addressing HIV/AIDS awareness in and mobilizing Latino communities. Street intercepts can be done cheaply and can also further the reach of the program. By doing the street intercepts, we also engaged the Latino community and were able to provide them with HIV testing information. In creating local campaigns that center around specific ethnic groups we have to take into account nuances in racial and ethnic identification in order to mobilize and engage.

Abstract 1615 - Increasing HIV Rapid Testing African American Younger MSM Using Localized Social Marketing

Author(s): Gary Paul Wright; E.S. Saunders; A. Dey

Younger AAMSM have among the highest incidence of HIV infection in the nation. The majority of those infected are unaware of their HIV status and must initiate test seeking behavior on their own within an environment with little community-level support. A partnership created a health communication social marketing campaign using images of Newark AAMSM and images of the city. The goal of the campaign was to increase HIV test seeking behavior among Newark AAMSM. Funding from the CDC and the NJHSS, DHSTS for this project was awarded to AAOGC, the largest community-based organization in New Jersey dedicated to meeting the needs of AAMSM.

A locally identifiable, large-scale social marketing campaign for AAMSM has been implemented in Newark, New Jersey since December 2009.

Focus groups were used to conduct an initial assessment of Newark area AAMSM HIV prevention needs and preferences. Group responses were used to develop branding, image selection, content messages and venues for a social marketing campaign. Branded as status Is Everything (SIE), the social marketing campaign was announced to the public on December 1, 2009 from Newark City Hall. Based upon recommendations from the focus groups, marketing strategies included use of Twitter, Facebook, an SIE website, text messaging (providing the location of the closest testing site to their residential zip code), YouTube videos and print media (using local AAMSM who auditioned for the campaign). The campaign promoted three local Newark HIV testing sites, identified by focus group members as most likely to be used by AAMSM, based on their reputations in the community for effectively working with AAMSM. Individuals who are determined to be HIV positive are immediately linked to care and treatment services. They are also offered partner services, and the opportunity to utilize additional existing local HIV prevention services.

During the first year of the campaign, 506 AAMSM were tested for HIV in the three testing sites and were referred into care and prevention services. Nearly 50% of those tested were between the ages of 16-24 followed by 25% between 25-34. Seventy-eight percent tested reported their risk for HIV as unsafe sex with men and and 18% reported having unsafe sex with both male and female partners. In addition, the campaign generated 64,092 hits to the SIE website from 2,854 unique visitors; 1104 viewings of SIE YouTube videos (using members of the AAMSM community telling the importance of knowing their HIV status), 772 Facebook Fans and 5,567 Twitter followers.

A health communication social marketing campaign using both traditional and social media can increase HIV test seeking behavior among younger AAMSM. At the end of the campaign's first year, follow-up focus group data indicated that the success of the campaign was due to its highly localized content, incorporation of social media, and that it was developed using information provided by the target population. Use of recognizable AAMSM community leaders in Newark and use the city of Newark as a backdrop for the media images increased the ability of the target population to respond to the campaign's message.

Track D
D31 - Beyond Syringe Exchange Programs: Case-finding among Drug Users
Room: Hong Kong (Hyatt Regency Atlanta)

Abstract 1576 - Predictors of In-Pharmacy HIV Testing among Drug Users: Preliminary Findings from the PHARM-link HIV Study
HIV burden is high among black and Hispanic injection drug users (IDUs). Since 2001, the Expanded Syringe Access Program (ESAP) has allowed New York State pharmacies to sell sterile syringes without a prescription to IDUs to help prevent transmission of HIV and other blood borne pathogens. ESAP has provided an opportunity for pharmacists and pharmacy staff to develop a rapport with IDUs which can help facilitate delivery of risk reduction and prevention services. Recent data suggests that the expansion of HIV services, such as HIV testing targeted to IDUs, is feasible and can be implemented within the pharmacy setting. We examined preliminary data from the Pharmacies as Resources Making Links to HIV Testing (PHARM-Link HIV) study to determine individual factors associated with willingness to undergo in-pharmacy HIV testing among drug users.

PHARM-Link HIV is a pilot study that utilizes 2 ESAP-registered pharmacies (selected from ethnographically mapped areas of high drug activity in Harlem, New York City) to test the feasibility of offering pharmacy customers in-pharmacy HIV testing. Participants completed a 30-minute survey about attitudes regarding expanded ESAP pharmacy services and in-pharmacy HIV testing. In-pharmacy HIV testing was offered to all participants. Significant bivariate associations determined by chi-square statistics were performed.

A total of 92 participants were mostly non-IDUs (69.6%), male (59.8%), older (mean age= 51.3, range 30-79), Black (77.5%), US born (97.8%), unmarried (85.9%), and high school graduates (68.5%). Twenty-three (27.1%) knew they were HIV positive and did not agree to be tested at the pharmacy. Among the 69 remaining participants, 36 (52.2%) of them underwent in-pharmacy HIV testing: 62 of these participants had tested negative for HIV in the past and 32 (51.6%) of them agreed to testing at the pharmacy. The remaining 7 (7.6%) participants reported never having an HIV test in the past, and 4 (57.1%) of them agreed to be tested at the pharmacy. Among those who declined HIV testing in the pharmacy, the main reasons were having an HIV test done in the last 6 months (58.9%) and being HIV positive (27.1%). Bivariate analysis shows that those who reported homelessness during the past 3 months, and those who earned income from paid work in the past 3 months were more likely to agree to testing in the pharmacy (p=0.0553 and 0.0014, respectively). Among lifetime injectors, those who injected in the past three months were more likely to be tested in the pharmacy (p=0.0043) compared to those who had not injected during the past three months.

To date, this is the first report on offering HIV testing to drug users in pharmacies. The relatively large proportion of study participants in this pilot study (both injection and non-injection drug users) who agreed to HIV testing in the pharmacy may suggest that pharmacies could be considered a convenient and trusted HIV testing venue. More research is needed to confirm these early findings, and to determine if pharmacies are able to reach those unable to access HIV testing services in other standard testing venues, and is currently underway.

**Abstract 2085 - Psychological Symptomatology Differences Between Clients Who Received/Did Not Receive HIV Testing in Outpatient Drug Treatment**

**Author(s):** Reynolds, G.L.; Napper, L.E.; Fisher, D.G.; Meyers, S.A.; Hodgens, S.A.

Determine baseline differences in mental health and psychological symptomatology between clients who did and did not participate in HIV testing who were enrolled in an outpatient drug treatment program using the Matrix Model of treatment. The Minorities Overcoming Risk (MOR) program is a SAMHSA funded drug treatment program focused on providing culturally appropriate drug treatment to minority drug users in an outpatient setting. Clients are routinely encouraged to get tested for HIV.

Three hundred ninety three outpatient drug treatment clients completed the Government Performance and Results Act (GPRA) measure; a subset of these (n = 184) also completed the Addiction Severity Index (ASI) and the Symptom Checklist-90R (SCL90-R) at baseline. Testing outcomes were available for 310 clients and 255 (82%) had received an HIV test. Differences between clients who did and did not follow through on HIV testing were determined using t-tests.
One hundred twenty (65.2%) of clients were male, with a mean age of 37.36 years (SD = 10.13). The ethnic breakdown of clients was Latino (59%), Black (35%) and White (6%). Latinos were divided into whether they were of Mexican American, Puerto Rican or Cuban family background. Individuals who followed through on HIV testing scored higher on several SCL-90R subscales of psychological distress. HIV tested clients had higher mean scores on: the paranoid subscale (M=5.2, SD=4.15) compared to those who did not follow through on testing (M=2.9, SD=1.09), t(136)=2.10, p = .04; the Positive Symptom Total Indices (M=31.3, SD=26.76) compared to non testers (M=21.3, SD=14.69), t(137) = 2.09, p = .04); the phobic subscale (M = 3.2, SD = 2.24) compared to non testers (M=1.2, SD=0.20), t(136)=2.03, p = .04); and the obsessive-compulsive subscale (M=10.3, SD=8.45) compared to non testers (M=6.5, SD=3.80), t(135) = 1.99, p = .05. There were no significant differences between testers and non testers with respect to scores on the psychotismic, hostility, anxiety, depression, sensitivity, somatization subscales, or the Positive Symptom Distress Index; however, testers had higher mean scores on all of the subscales.

Significant differences in psychological symptomatology were found between testers and non testers for HIV and may indicate different motivations for following through on HIV testing. Drug treatment counselors should prepare clients for the HIV testing experience within the context of clients' existing mental health status.

**Track E**
**D38 - Stay within that nine? Unprotected sex with concurrent partners among high-risk heterosexuals in NYC**
**Room: A703 (Atlanta Marriott Marquis)**

**Abstract 1179 - Stay within that nine? Unprotected sex with concurrent partners among high-risk heterosexuals in NYC**
**Author(s): Paul Kobrak**

In New York City, 22% of HIV diagnoses in 2009 were attributed to heterosexual transmission. Of those diagnosed, 60% were African-American; 32% Latino; 75% women; 54% over 40; and cases were concentrated in certain high poverty neighborhoods. Previous research has established the role of high-risk sexual networks in geographically-concentrated heterosexual HIV transmission. Furthermore, concurrent partnerships have been identified as an efficient means for spreading HIV. To inform the design of a targeted HIV prevention initiative, the NYC Department of Health and Mental Hygiene undertook an in-depth qualitative study of high-risk heterosexuals that explored both sexual practices and perceptions of HIV risk.

Open-ended interviews were conducted with 45 heterosexually-active adults living in high-poverty NYC neighborhoods with a high prevalence of heterosexual HIV infection. Participants were referred from the 2010 National HIV Behavioral Surveillance study of high-risk heterosexuals. The qualitative questionnaire encouraged participants to discuss their sex lives within the broad context of their personal history, including social and economic considerations. Interviews were recorded and transcribed and formed the basis of detailed fieldnotes.

Participants were 28 men and 17 women, predominately African-American (91%) and between 40 and 60 years old (73%); 15% were employed full-time while 27% received disability benefits; 7% (3 women) acknowledged having HIV; 35% reported unprotected sex with 3 or more partners in the past year; additionally, many currently monogamous participants spoke of previously having concurrent partnerships. The majority of participants - both men and women - expressed a strong preference for sex without condoms. Unprotected vaginal and anal sex occurred in all types of partnerships, but was less common in casual relationships and sex for money exchanges, and predominated in the context of on-going partnerships. Contrary to the idea of reserving unprotected sex for main partners, 10 participants mentioned currently forgoing condoms in concurrent "outside" partnerships as well. Long-standing partners were often viewed as less likely to transmit HIV, whether or not they had been tested for HIV. Participants perceived the following benefits of concurrent partnerships: sexual pleasure and variety; self-esteem and social prestige; economic security from multiple partners providing financial support; housing security as outside partners could offer a place to live if the main partnership ends; and emotional security, so "you won't be so hurt when one of them leaves you." Multiple stable partnerships were also viewed as a kind of risk reduction strategy, versus having "sex in the street." One unemployed man, 51, referred to his 9 concurrent unprotected partners as "My safe haven. I stay within that nine."
Concurrent unprotected partnerships have been shown to facilitate heterosexual HIV transmission, particularly in neighborhoods and sexual networks with a high background prevalence of HIV. Study participants often preferred being selective about partners over consistent condom use, but may use risk reduction criteria that provide limited protection against HIV. Prevention efforts in high-risk areas should not only promote condom use but should additionally include messaging about the risk of having untested partners and multiple partners, particularly in the context of concurrent partnerships.

**Track E**  
**E07 - TLC-Plus: Design and Implementation of a Community-focused HIV Prevention Study in the U.S.**  
Room: Cairo (Hyatt Regency Atlanta)

**Abstract 1900** - TLC-Plus: Design and Implementation of a Community-focused HIV Prevention Study in the U.S  
**Author(s):** Georgette King; Wafaa El-Sadr; Bernard Branson; Deborah Donnell; H Hall

Mathematical models suggest the test and Treat approach can substantially reduce a community’s HIV incidence. However, the success of such a community-wide HIV prevention intervention depends on a cascade of critical real-world factors: expanded testing to identify persons with unrecognized HIV infection, successful linkage of these patients to care, and appropriate initiation of HIV treatment (antiretroviral therapy [ART]) resulting in the achievement and maintenance of viral suppression. The Test and Link to Care Plus Treat study (TLC-Plus, HPTN 065), is investigating the feasibility of each of these components and the effectiveness of novel methods to optimize linkage to care and adherence to ART.

Two intervention communities (Washington, D.C. and the Bronx, NY) and 4 non-intervention communities (Chicago, Illinois; Houston, Texas; Miami, Florida; and Philadelphia, Pennsylvania) are participating in this study.

The study includes 5 components: (1) expanded HIV testing; (2) site randomized evaluations of financial incentives to facilitate linkage to care, and (3) achievement and maintenance of viral suppression; (4) efficacy of an ACASI-based prevention intervention for HIV-positive patients in care; and (5) surveys of provider and patient knowledge and attitudes about early ART initiation and the use of financial incentives. Surveillance data will be used to assess study outcomes. The study represents a unique collaboration between NIH, CDC, health departments, and communities affected by HIV.

A total of 77 HIV test and care sites in Washington, D.C. and the Bronx are participating in the study. The expanded HIV testing activities began in November 2010 and will continue for three years. The linkage-to-care and viral suppression study components will begin at all participating HIV test and care sites between February 1 and May 1, 2011. The prevention for positives component is anticipated to begin by August 2011 and will enroll a total of 1,320 HIV-positive patients. The session will include five presenters who will describe: 1) overall study design, 2) successes and challenges with expanding HIV testing, 3) design considerations for conducting HIV prevention intervention trials in the US, 4) the novel use of surveillance data for assessing study outcomes, and 5) community engagement during the design, promotion, and conduct of the study.

**Track F**  
**F06 - Mobilizing Communities for Change**  
Room: Courtland (Hyatt Regency Atlanta)

**Abstract 1690** - Crafting Messages so Lawmakers Listen: Advancing HIV Prevention Federal and State Advocacy  
**Author(s):** Donna Crews; Anna Ford; David Munar
An estimated 56,300 new infections occur each year in the United States. The National HIV/AIDS Strategy sets out ambitious targets for HIV prevention: Reducing national incidence by 25%, reducing national transmission rates by 30%, and increasing those aware of their HIV positive status from 79% to 90%. Reaching these goals will require re-energized public, private, and personal commitments; but success also hinges on political will, leadership, and increased public resources. Today, only 3% of the national investment in HIV/AIDS goes towards prevention.

Members of Congress, state and local legislators are tasked with appropriating funding and setting policies for HIV prevention programs at the federal, state, and local levels. It is critical that they understand how HIV prevention programs work and the importance of investing in prevention. In an environment where it is much easier to quantify needs and measure success in HIV treatment, legislators need to grasp the inextricable link between prevention and treatment and a gain a better understanding of meaningful success in the HIV prevention arena and the resources and policies needed to reduce the number of new infections in the United States.

Facilitators will present and discuss with the group key messages about HIV prevention that legislators need to know including: the success of HIV prevention, prevention investment cost-savings, and the resources and policies necessary to achieve the goals of the National HIV/AIDS Strategy. Facilitators will give a brief overview of the legislative process, current political landscape and rules of organizational advocacy, and share tactics and best practices for interacting with elected officials at the state, local, and national level.

During this time of national budget crisis and limited resources, it is critically important for HIV prevention providers, researchers, program administrators, and advocates to build the skills necessary to effectively communicate with elected officials and legislators about the importance of HIV prevention. Ensuring a better understanding of and increased support for HIV prevention from legislators will greatly benefit efforts to implement the National HIV/AIDS Strategy and increase the funding commitment for HIV prevention programs.

Abstract 1908 - Utilizing Community Readiness Model for HIV Prevention
Author(s): Barbara Plested, PhD; Pamela Thurman

This workshop will focus on implementing the Community Readiness Model (CRM) in Native communities that are addressing HIV/AIDS prevention and testing. The workshop will provide an overview of the model, identify types of interventions that have been successfully utilized in Native communities as a result of the CRM. The interactive presentation will focus on the how to build strengths and resources that already exist within Native communities to identify unique and community specific interventions aimed at educating people and encouraging HIV testing. A complete manual for using the CRM will be provided to all participants.

Community Readiness is a very user friendly and practical tool that has been used to develop culturally specific and tribally specific strategies that work in Native communities! Success stories from communities who have used the Community Readiness Model will be offered. It is a nine stage, multi-dimensional model developed to facilitate community change, is community-specific, issue specific and was designed to build cooperation among systems and individuals. The model has been used in Native communities throughout the United States and Canada for intervention and prevention efforts and has been named as one of the ten Best Practices in Indian Country by the First Nations Behavioral Health Association and also identified as a Best Practice by the Indian Health Service Suicide Prevention Initiative. Although the CRM was developed over 15 years ago at Colorado State University, its true success lies in the fact that many communities have taken it, modified it and made it the success it has become.

CRM utilizes a series of interviews that are scored. The scores then place the community at a stage of readiness across six dimensions. Once the dimension readiness is established, the community participates in a CRM workshop where strategies appropriate for their stages of readiness and the culture of their community are developed. The Readiness Action Plan is a clear and practical step by step process outlining who will do what, how they will do it and when it will be accomplished.

CA7AE: (Commitment to Action for 7th Generation Awareness and Education)Colorado State University
Fort Collins, CO 80523-1790
To date CRM has been used in over 2,500 communities throughout the U.S. for research, evaluation and grass roots efforts. It has also been the focus of over 35 published articles in this country and abroad. The CRM manual is available in English, Chinese and Spanish and has been used both nationally as well as internationally. It has been established as a very effective tool for HIV prevention in our Native communities. Currently the World Health Organization (WHO) recently funded 5 countries to decrease/eliminate child neglect using the concepts of the Community Readiness model.

Abstract 1954 - Engaging Traditional Black Institutions in HIV Prevention: Training Model to Transform Community Norms
Author(s): R. Abdus-Samad; C. Baran

In response to the widespread reluctance to engage in HIV prevention and education services as typified by traditional sectors of Black society in the United States, the Black AIDS Institute has developed and implemented a community mobilization training and practicum program to advance HIV/AIDS awareness, reduce stigma, and increase access to and utilization of HIV prevention services among Black communities. The fellowship training program uses a Community Mobilization Model based on Social Norms Theory to engage traditional Black institutions that are influential and omnipresent in their respective communities. Participants will learn the constructs of the mobilization model and the design of the training program, findings of the qualitative and quantitative evaluation of the program, and recommendations for replication in diverse communities of color.

The model is designed for implementation in African American communities in the United States, with an emphasis on urban environments.

The African American HIV University Community Mobilization College (AAHU CMC) is a capacity building and training program for community-based and AIDS-service organizations designed to develop a national cadre of social change agents with the knowledge and skills to engage and mobilize sectors of Black civil society. The AAHU Community Mobilization Model is delivered through an 11-month fellowship that includes four training modules and three 90-day practicum's where participants apply training modules to their community. AAHU CMC Fellows are recruited from CBOs and ASOs serving Black populations nationwide. Given that Blacks account for a disproportionate number of HIV and AIDS cases in the U.S., the program seeks to empower key stakeholders within the HIV/AIDS sector to engage and mobilize some of the most influential institutions in Black communities.

Preliminary evaluation demonstrated that program completion by Fellows influenced the capacity of their respective organizations to plan and carry out a plethora of HIV prevention mobilization projects. Eighteen innovative community mobilization campaigns were delivered throughout the United States as a direct result of participation in the program. Selected findings of needs assessments, lessons learned in coalition-building and strategic action plans developed by program participants will be presented. Presenters will also discuss key process outcomes and the findings of the complete program evaluation.

The primary objective of the training program is for participating agencies to increase access to and utilization of HIV prevention services in their local Black communities. Findings suggest this was accomplished by teaching Fellows effective strategies to engage, educate, and mobilize traditional Black institutions and community leaders which influenced Black social norms and set community priorities in areas where HIV was not among a priority issue with their constituents.

Author(s): Dr. Rhonda Waller, PhD; Ms. Wanike Shakespeare; Mr. Mandrell Brown; Ms. Karla Scipio, RN

Most Historically Black Colleges & Universities (HBCU's) are located in communities in which residents are disproportionately affected by HIV. Likewise, many of those that attend HBCU's are in an age group that is greatly affected by STI's from unprotected sex's risk factor for HIV. In fact, 9 of the 12 cities that are a focus of the HHS 2-
Cities Plan are home to 16 HBCU's. While it seems natural that HBCU's would lead this call to action, we know that campus/community partnerships can be challenging. Even for those campuses that have successfully forged partnerships in other service areas, the overarching stigma of HIV/AIDS continues to be a barrier to ensuring residents both on and off campus have access to testing and care.

Historically Black Colleges and Universities (urban/rural) and surrounding communities.

As a key initiative of the 11th Annual National Black HIV/AIDS Awareness Day, the organizers piloted the Communities Tested initiative. The year-long project was launched on February 3rd, 2011, and provided opportunities for HBCU's to publicize their events, receive testing incentives, and free NBHAAD 2011 supplies and materials. The goal is to increase the awareness of the impact of HIV on the Black community as well as provide access to testing and care.

We are extremely proud that 19 HBCU's answered the call to engage their campuses and communities in HIV testing and education events. This year, we were also pleased to welcome our first corporate sponsor of the initiative, Sodexo, who provided meal cards as testing incentives. Students and faculty at HBCU's from all over the country came together to provide free HIV and STI testing, host prayer services, view movies, facilitate discussions, and sponsor unique educational and outreach activities to raise the awareness of the impact of HIV/AIDS on our community. Thanks to their efforts, 652 people were tested, 3366 people participated in various outreach and educational events, and more than 3524 brochures, fact sheets, and safer sex kits were distributed. Of the 19 schools in the initiative, nine held special testing and/or outreach events. Other schools did a combination of holding information sessions or connecting students and community members to testing and other reproductive health services. Many schools were able to work with their local or state health department or local community based organizations for testing and supportive services.

With support for increased awareness, education, and linkages to care, HBCU's can better advocate for the needs of those infected and affected by HIV and STIs in the Black community. Participation in the Communities Tested Initiative will provide students, staff and community members with a sustainable framework in which to train students and community members to become peer educators and community organizers. The initiative also supports access to care for both students and communities members through community collaborations and mobilization efforts with churches, local health departments and both traditional and nontraditional social services. Plans for subsequent years include increased technical assistance around peer education, creating sustainable programs and events, and enabling productive mobilization efforts.

**Track F**

**F07 - Prevention in the Criminal Justice System**

**Room: Dunwoody (Hyatt Regency Atlanta)**

**Abstract 1943 - There's a Need and a Way; Where's the Will? Rapid HIV Testing for Jail Entrants**

**Author(s):** Jessica Cook; Chava Bowden; Rose Wanjala; Jonathan Schultz; Shalonda Freeman; Joy Church

Despite CDC guidance for offering opt-out HIV testing to all persons entering correctional facilities, most jails do not screen detainees routinely. Since the typical stay in jails is only 48-72 hours, rapid testing may be the most feasible way to screen jail inmates.

We sought to demonstrate the need to offer HIV testing of jail inmates in Atlanta GA and the feasibility of rapid testing by mucosal swab. Emory's Rollins School of Public Health (RSPH) conducted an HIV seroprevalence study of all entrants to Fulton County Jail (FCJ), beginning in 7/2010. In the fall of 2010, rapid HIV testing by mucosal swab was implemented at FCJ.

**Seroprevalence Study**

Prior to 2010, FCJ switched from opt-in to opt-out HIV testing at intake. Starting in 7/2010, nurses were instructed to record, for all entrants who underwent nursing evaluation, whether the person consented to testing and the reason...
why testing was missed in some (unable to draw, refused, including those who already knew they were positive and did not want retesting, etc.) ELISA and Western Blot HIV test results were received by FCJ health services to notify detainees of their status. Deidentified results were sent to the RSPH study team, who could then calculate the lower bound of an estimate of HIV seroprevalence in the jail population. Extrapolating seroprevalence data by birth year and gender from tested to untested detainees provides an upper estimate of seroprevalence.

Demonstrating Feasibility of Rapid Testing
Nurses were trained in rapid HIV testing by mucosal swab beginning in 11/2010. Routine, rapid opt-out HIV testing began in December 2010 for all FCJ entrants.

RESULTS: Of the 6733 admissions from 7-9/2010, 5218 (77.5%) were offered serum testing at entrance and 43.2% (n=2253) accepted. An additional 73 persons did not undergo HIV testing because of known positive status, which indicates that at least 114 of 5218 entrants (2.18%) were likely HIV positive. Forty-one of 2175 ELISA tests performed were positive, yielding a 1.89% seroprevalence among those tested. By multiplying the number of persons who were offered testing but declined by the seroprevalence for the birth year and gender, we estimate that an additional 51 cases of HIV could potentially have been found if untested detainees were tested. Adding these potential cases, the upper limit estimate of the population seroprevalence is 3.16%.

Of the 2152 admissions between 12/29/10-1/31/11, 1494 (69.4%) were evaluated and offered mucosal swab testing if not previously known positive. Of those offered needle-less testing, 988 (66.1%) accepted, a significantly higher rate than with venopuncture (Chi²=245, p<.0001). Four tests returned preliminarily positive.

LESSONS LEARNED: HIV seroprevalence at FCJ is likely at least 2.18% and may be as high as 3.16%,--higher than the seroprevalence in the Georgia prison system (1.8%). Opt-out rapid mucosal swab testing had significantly higher acceptance than conventional opt-out serum testing. Among persons passing through correctional facilities, 95% only go through jails, but more HIV testing resources have been directed to prisons. We have been missing an opportunity for undiagnosed HIV infected persons to learn their status.

Abstract 1973 - Latina Transgender Attitude and Perception towards Law Enforcement
Author(s): Alejandrina Jurado; Mohsen Bazargan, PhD; Lori Mizuno

A report released by Amnesty International (2005) provides evidence that LGBT (Lesbian, Gay, Bisexual, Transgender) individuals continue to be targeted for human rights abuse by law enforcement based on their real or perceived sexual orientation or gender identity. In particular, the transgender population, people of color, youth, immigrants, the homeless and sex workers within the LBGT community are at higher risk to experience police abuse or misconduct. In Los Angeles, the Los Angeles Police Department has a policy in place requiring officers to refer to a transgender as they present, but it has been reported that officers frequently, refer to transgender women as sir or I have to call you by your legal name? In addition, the negative interactions with police has created a reluctance to report among Transgender, because of fear to reveal their sexual orientation or gender identity and transphobic treatment by the responding officers. Other factors or barriers for reporting are treatment based on race, ethnicity, age, immigration status, socioeconomic status, language, cultural barriers and fear of being arrested. (Amnesty International, p.68, 2006). The focus of the study is on male to female transgenders and their interactions with the Los Angeles Police Department and other local municipalities. The study also examines everyday discrimination against male to female transgender Latinas and their response to discrimination and victimization.

Analyzing 39 out of the 220 hundred participants who will potentially be recruited in Los Angeles County identify as Latina/Hispanic male to female transgender ages 18 to 64. Among the 29 reporting participants 95% were born in Mexico, with 51.3% of the participants reported being undocumented. In addition, 75% reported having a 12th grade education and below, with 54% reporting making below 10,000 a year and 87% reported exchanging sex for money at one point in their lives. Results were analyzed using a chi-square to determine significance between specific demographics, discrimination, victimization and maltreatment.

Preliminary results from 39 Latina male to female transgenders interviewed demonstrate that Latina female to male transgranders are significantly more likely to be rejected by family members74.1%, friends 74.1%, to be victims of
crime by others 80.8% and 60% were victimized by police. In addition, Latina transgenders are also significantly more likely to be victims of crimes, with 65% reporting being victims of crime and significantly more likely to be victims of domestic violence (54%) and sexual assaults (60%) by their partners or casual partners.

These preliminary results show trends of rejection, stigma, and victimization and maltreated from childhood into adulthood within the Latina transgender community in Los Angeles County. Law enforcement further victimizes this community, putting them greater at risk and isolation. As a response to victimization and abuse they have encountered increased the likelihood of engaging in risky behaviors, thus increasing the likelihood for Latina Transgenders to become HIV infected and/or contract other sexually transmitted diseases. Further research is needed to develop programs that will address trauma, victimization and discrimination within the Latina Transgender community.

Abstract 2051 - Health Justice Test Link:

Author(s): Mary Sylla

HIV testing in Los Angeles has failed to meaningfully reduce the estimated 12,900 of people living with HIV who are unaware that they are HIV+. In a time of diminished prevention resources, “targeted” testing -- that is testing that focuses on groups known already to have a high prevalence -- have been encouraged. However recent targeted testing in Los Angeles County has produced a seropositivity rate of only 1.2%. Our program, Health Justice Test Link, coordinates mobile testing vans to visit meetings of parolees ten times a month to provide testing following an education session conducted by a recent parolee and staff member of the Center for Health Justice. Since the program's inception 6 months ago we have tested 504 individuals and have a seropositivity rate of 2.2%.

Los Angeles County was the locus of the first HIV diagnosis is a high incidence and high prevalence population today. It also is the County of return of 33% of the state's prison population: 30,000 people parole from state prison to L.A. County and given the known HIV prevalence of the prison population, at least 240 of those are positive. However, because there are many disincentives to testing for HIV during incarceration and there is no consistent routine screening for HIV, many individuals coming out of prison do not know their HIV status, and both by virtue of being incarcerated belong to a group at high risk for HIV.

Health Justice Test Link coordinates and provides access to HIV testing services targeting men and women recently released from California prisons to Los Angeles County. Through Health Justice Test Link, our peer staff individuals who are HIV+ with a history of incarceration encourage HIV testing among PACT Meeting attendees by emphasizing the importance of knowing one's status for the purpose of prevention, early diagnosis and treatment.

At six months, Test Link has provided linkage to tested 504 individuals and found a prevalence of 2.2%. This rate is more than double what Los Angeles County's funded testing programs found in 2009 (.89%) and substantially higher than even the targeted testing programs combined rate of 1.2%.

We surveyed 191 participants: 87% male, 13% female. The median age of respondents was 36.9 years (range: 19-73). 55% identified as African American; 27% Latino; 12% white and 4% Asian/Pacific Islander; 90% of the respondents reported they were heterosexual, 2.5% were gay, and 7.6% were bisexual.

49% of respondents had tested for HIV in the past year, 31% had tested over a year ago and 18% had never tested. 1.6% of respondents reported a previous positive test for HIV. Respondents acceptance of HIV testing increased following the Test Link educational session (18.8% to 45%, p<.0001).

Respondents also increased their HIV/AIDS knowledge score by 8% at post-intervention (p<.0001). Increases in HIV/AIDS knowledge scores were not associated with increased acceptance of free HIV testing at post-intervention. HIV stigma scores were also not associated with the decision to accept a free HIV test at pre- or post-intervention.
Abstract 1238 - Enhanced Comprehensive HIV Prevention Planning (ECHPP): Lessons Learned from Implementing the National HIV/AIDS Strategy

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About one person in the United States is newly infected with HIV every nine-and-a-half minutes resulting in approximately 56,000 new HIV infections every year. Released in July 2010, the National HIV/AIDS Strategy aims to maximize the impact of HIV program planning and implementation. The main goals of the strategy are to reduce new infections, strengthen links to care and treatment for people living with HIV, reduce HIV-related health disparities and achieve a more coordinated national response to the HIV epidemic.

Health Departments in the 12 jurisdictions that account for the top 44% of AIDS cases in the United States.

ECHPP is a high-profile demonstration project (Phase 1 is October 2010 through September 2011; Phase 2 is October 2011 through September 2013) which supports the implementation of the National HIV/AIDS Strategy and aims to maximize the impact of HIV program planning and implementation in these jurisdictions. Emphasis is placed on achieving an optimal combination of prevention, care and treatment activities that include biological, behavioral and structural/policy intervention strategies. Planning is intended to result in resources being targeted to best address the specific driving forces of the local epidemic.

RESULTS: The implementation phase of the ECHPP demonstration project (beginning March 2011), following a rigorous planning process to enhance jurisdiction-specific, comprehensive HIV prevention plans to maximize the impact of local HIV prevention, care and treatment activities. ECHPP grantees produced situational analysis reports for each jurisdiction which further informed the planning process. Jurisdictions developed enhanced plans incorporating key prevention interventions and strategies in optimal combination and scale, in order to maximize prevention, care and treatment. Within many jurisdictions, the planning process resulted in new partnerships with both traditional and non-traditional partners, as well as with federal partners. Organizational changes were made in order to support planning and implementation across prevention, care and treatment. Challenges were identified and addressed during planning and implementation.

LESSONS LEARNED: Presenters will discuss planning associated with implementing the National HIV/AIDS Strategy. Discussion will include topics such as the necessity of increased collaboration and coordination at many levels in order to maximize available resources and strategies applied in a very short timeline to achieve this scale of planning and implementation. Lessons learned will be discussed including topics such as the following: successful strategies for collaborating with prevention, care and treatment units within the health department structure; engaging stakeholders in the planning process; communicating with communities about the National HIV/AIDS Strategy; incorporating several types of data (e.g., efficacy, cost, local epidemiologic) into decision making; leveraging resources to maximize impact and collaborating with federal partners in new and more efficient ways.