CDC's New HIV Initiative
Advancing HIV Prevention: New Strategies for a Changing Epidemic United States

Questions & Answers

General Questions

1. **Why did the Centers for Disease Control and Prevention (CDC) develop this new initiative?**

   The basis for the *Advancing HIV Prevention (AHP) Initiative* is to address five aspects of the HIV/AIDS epidemic in the United States:

   - The first is the leveling of AIDS cases and AIDS deaths since 1998 following a decline in cases. From 1995 to 1998, the annual number of AIDS cases declined 38 percent and deaths from AIDS declined 63 percent. Recent preliminary 2002 data show a 2.2 percent increase in new AIDS diagnoses between 2001 and 2002. The annual numbers of AIDS cases and deaths have remained stable since 1998, with an estimated 40,000 AIDS cases and 16,000 AIDS deaths.
   - The second is that the annual estimated number of new HIV infections appears to have remained relatively stable for about a decade. CDC does not currently have national HIV incidence data. However, CDC will be funding 34 areas to conduct HIV incidence studies in 2004 and expects to have data available by the end of 2005. CDC is concerned that new HIV infections may be increasing, but does not have good measurement data. For example, HIV reporting data from 1999-2001, in the 25 states that had HIV reporting since 1994, indicate that the number of persons who had HIV infection newly diagnosed increased 14 percent among men having sex with men (MSM) and 10 percent among heterosexuals. In addition, recent syphilis outbreaks among HIV-positive MSM suggest that risk behaviors are increasing in MSM.
   - The third is inadequate HIV testing. An estimated 850,000 to 950,000 people are living with HIV in the United States. A quarter of these people (180,000 to 280,000) are unaware of their HIV status and may transmit HIV without knowing that they are putting partners at risk. The new initiative encourages access to testing and expanding testing.
   - The fourth is evidence that CDC has found that once people learn they are HIV-infected, most take steps to reduce transmission to partners.
   - The fifth is the availability of a new rapid HIV test, which the Food and Drug Administration (FDA) approved and to which it granted a waiver under the Clinical Laboratory Improvements Act (CLIA). This test provides a preliminary positive test result in approximately 20 minutes and can be done in non-clinical settings. Other testing methodologies require several days to get results; about 30 percent of persons who test positive for HIV in CDC-funded sites do not return for their test results. A simple, rapid test should increase the proportion of people who receive their test results.

   Although prevention programs may be slowing the epidemic, more needs to be done to reduce new infections. Refocusing some activities will result in more HIV-infected people learning their serostatus and should reduce new infections.

2. **Does this initiative have any implications for programs funded internationally through the Global AIDS Program?**

   No. The strategies in this initiative are geared toward reducing the number of HIV infections in the United States.

3. **Does this new initiative replace the *CDC HIV Prevention Strategic Plan* that was published in 2001? How will CDC achieve implementation of goal 1 of the strategic plan if the *Advancing HIV Prevention Initiative* changes the direction of prevention programs?**

   No, the initiative is consistent with the *CDC HIV Prevention Strategic Plan*. Focusing more on people living with HIV is consistent with Goal 1, Objective 1 of the strategic plan ("By 2005, decrease by at least 50 percent the number of persons in the United States at high risk for acquiring or transmitting HIV by delivering targeted, sustained and evidence-based HIV prevention interventions. Among people living with HIV, increase the proportion who consistently engage in behaviors that reduce risk for HIV transmission or acquisition").

   In addition, this initiative addresses the prevention needs of populations at high risk for transmitting HIV, such as men having sex with men, intravenous drug users, sexually active heterosexual men and women, and adolescents. This is also consistent with Goal 1 of the *Strategic Plan*. Counseling, testing and referral (CTR) activities funded under this initiative will focus on these high-risk groups. Prevention interventions will include those for individuals living with HIV, their sero-discordant partners as well any other sexual and injection drug using contacts, and sero-negative individuals at very high risk for HIV infection. In addition, CDC will continue to fund, through state and local health departments, primary prevention behavioral interventions as guided by community planning.

4. **Is CDC continuing to support primary prevention/behavioral risk reduction?**

   Yes, keeping people from becoming infected with HIV, whether through working with HIV-positive or HIV-negative persons, remains CDC's primary HIV prevention mission. CDC will continue to support primary prevention and behavioral risk-reduction programs, such as health education and risk reduction (HERR) for persons at high risk for acquiring HIV through programs funded through state and local health departments and our directly-funded CBO program. However, CDC is refocusing some of its prevention activities to better address the needs of people living with HIV.

5. **The *Advancing HIV Prevention Initiative* seems to focus on increased testing in medical settings. How is CDC going to reach those populations that do not access services in traditional medical settings?**

   The new initiative focuses on making HIV testing a routine part of medical care. CDC will strongly encourage all health care providers to include HIV testing, when indicated, as part of routine medical care and on the same voluntary basis as other diagnostic and screening tests. In addition, to reach persons infected with HIV who do not have access to traditional medical settings, CDC will implement new models for diagnosing HIV infections outside medical settings. CDC will create new program models to increase HIV testing in high-prevalence, non-medical settings by encouraging the use of HIV rapid tests. The agency will fund pilot projects aimed at identifying the most effective models

for HIV diagnosis and referral for medical and preventive care that CDC grantees can employ outside traditional medical settings. CDC will also continue to fund community-based organization outreach activities that target persons who do not access services in traditional medical settings (e.g., homeless youth).

6. **It appears that CDC is moving away from a focus on prevention for HIV-negative persons and focusing only on HIV-positive persons. Is that true?**

   No. CDC will continue to support activities--primarily health education/risk reduction activities--that focus on high-risk HIV-negative persons, both directly and through indirect funding provided to community-based organizations (CBOs) through state and local health departments. In the directly-funded CBO program announcement, increased emphasis will be placed on reaching HIV-infected persons and their partners, as well as other persons at very high risk of infection. CBOs will need to conduct targeted outreach, health education and risk reduction and testing with high-risk populations to identify HIV-positive persons. CDC will work with those identified as positive to help prevent the spread of HIV to others and will work with very high risk HIV-negative persons to help keep them from acquiring HIV infection.

   Compared with persons who learn that they are HIV-positive, persons who are unaware of their infection are 2-3 times more likely to engage in risky behaviors, resulting in increased exposure of others to the virus. Many studies have shown that receiving a positive HIV test result reduces risk behavior by 60-80 percent. In a 2002 study published in the journal *AIDS*, men recently infected with HIV showed a 70 percent reduction of risk behavior after 1 year of follow-up. In 2001, a study published in the *American Journal of Preventive Medicine* showed that, compared with an HIV-positive control group, persons with HIV undergoing a behavioral science-based risk-reduction intervention reported 82 percent fewer HIV risk behaviors at 6-month follow-up than the control group.

   In 1998, a study published in the *Journal of the American Medical Association* showed that, among uninfected persons, enhanced risk-reduction counseling resulted in 18 percent fewer sexually transmitted infections at 1 year compared with persons receiving standard counseling. (Sexually transmitted infections are transmitted through the same risk behaviors as HIV.)

   These studies suggest that by working with HIV-infected persons, we can achieve greater reductions in risk behaviors and HIV transmission than by working with uninfected persons. For example, one study showed that among persons testing positive for HIV, there was a 70% reduction in reported risk behavior at 1 year. However, CDC believes it is important to continue to work with both HIV-infected and uninfected persons, especially the partners of those already infected with HIV.

7. **Are there any activities within this new initiative that focus specifically on racial/ethnic minorities?**

   Yes, the *Advancing HIV Prevention Initiative* focuses on people at greatest risk for transmitting HIV and their partners; members of racial and ethnic minorities are disproportionately represented among these. CDC will continue to target services for racial and ethnic minorities, particularly African Americans, Latinos, American Indians, Asian Americans, and Pacific Islanders.

   CDC funds awarded through the Minority AIDS Initiative (MAI) will continue to be used for programs targeted to communities of color. CDC will also use funds to fulfill the intent of Congress and build capacity for HIV prevention within communities of color.

Specifically, CDC will provide $68.6 million in fiscal year 2004 to community-based organizations (CBO) and capacity building assistance (CBA) providers. A total of $48.7 million will be allocated in the new CBO Program Announcement, of which $34.8 million will be MAI funds that includes $5 million from HHS. A total of $19.9 million will be allocated in new CBA program announcement; $18.9 million of this allocation will be MAI funds.

8. **What about programs that use interventions from the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*? Will there be programs that allow for other primary and behavioral prevention interventions?**

Directly-funded community-based organizations (CBOs) will be required to use CDC-developed protocols and procedures for targeted outreach, health education and risk reduction, voluntary counseling and testing services, partner counseling and referral services (PCRS), and prevention interventions for individuals living with HIV, their serodiscordant partners as well any other sexual and injection drug using contacts, and seronegative individuals at very high risk for HIV infection. CDC will provide guidance and procedures for customizing these interventions to various target populations, and for implementing and evaluating them. Presently, indirectly funded programs will be encouraged to use interventions from the *Compendium*. Programs need to target high-priority activities and interventions that are likely to have the greatest impact on reducing the epidemic.

9. **How will the new initiative affect programs that are currently receiving prevention funding from CDC?**

Directly-funded community-based organizations (CBOs), whose funding would have ended in 2003, will receive an extension of their awards through May 2004. While current grantees are not required to adopt the activities in the *AHP Initiative,* CDC will provide training to current grantees on the use of the simple, rapid HIV test and other interventions supporting the Initiative. A number of CBOs are already providing prevention services to HIV-positive persons and have experience in these interventions. For example, CDC directly funds some grantees to provide counseling, testing and referral services, and some organizations already provide prevention interventions for people living with HIV who have ongoing risk behavior that can transmit HIV.

In the new directly-funded CBO program announcement, CDC will require organizations to implement activities that support the Advancing *HIV Prevention (AHP) Initiative.* Organizations will be able to choose from a list of interventions that include targeted outreach and health education and risk reduction (HERR); targeted outreach and voluntary counseling and testing (VCT) services; prevention interventions for individuals living with HIV and their serodiscordant sex or injection drug using contacts, and seronegative individuals at very high risk for HIV infection; and partner counseling and referral services (PCRS).

The CDC AHP initiative is primarily reflected in the new CBA program announcement under Focus Area 2, Strengthening Interventions for HIV Prevention. Successful applicants will be required to provide ongoing CBA in the adaptation, tailoring, and implementation of HIV prevention interventions, partner counseling and referral services, counseling and testing, and prevention interventions for PLWA, their discordant partners and others at very high risk of HIV infection.

CDC will continue to fund state and local health departments for primary HIV prevention activities such as health education and risk reduction, especially with indirect funding provided to CBOs. CDC already requires all state and local health departments to carry out partner notification programs. CDC will encourage new models of partner notification through health departments, such as using peers to expand the reach of traditional partner notification models and to increase the number of people who learn they are infected. In the new health department program announcement, CDC will increase emphasis on counseling, testing, and referral (CTR) and partner counseling and referral services (PCRS). Consistent with *CDC's HIV Prevention Strategic Plan,* CDC will be asking community planning groups (CPGs) to make people living with HIV the highest priority population and to prioritize services for those who are at highest risk of transmitting the virus. CPGs also must target activities to those at highest risk for becoming infected. This does not mean that all resources will go for people living with HIV, but that their needs must be addressed first - - because of their potential to transmit HIV.

10. **What is the budget for the new initiative?**

    In FY 2003, CDC directed $35 million to this initiative. This includes the $8 million increase appropriated in FY 2003 for domestic HIV prevention, as well as funds that are becoming available as a result of projects reaching their natural end point. Nearly 90 percent of the $35 million will be directed to new activities related to the goals of the initiative that will be coordinated with State and local health departments and community-based organizations. Approximately $2 million of the $35 million was used for bulk purchase of rapid HIV test kits. In addition to the $35 million for special projects, $97 million provided to state health departments and $13 million provided to community-based organizations for HIV diagnosis and referral for medical and preventive care services supported activities related to the initiative. These funds constitute $145 million of NCHSTP's $699 in million domestic HIV funding for FY2003.

Community-Based Organizations

11. **In some jurisdictions, community-based organizations (CBOs) cannot, by law, do contact tracing and partner notification by going into the field to people's homes, etc. What provisions are being made to address this and other barriers that may prevent implementation of the *Advancing HIV Prevention Initiative*?**

    CDC already requires all state and local health departments to carry out partner notification programs. CDC will encourage new models of partner notification through health departments, such as using peers to expand the reach of traditional partner notification models and to increase the number of people who learn they are infected. CDC will identify and disseminate best practices identified from these model programs to state health departments and CBOs. In addition, CDC will assess state laws regarding partner counseling and referral services (PCRS) and will work with the National Conference of State Legislatures, National Black Caucus of State Legislators, and state health departments to identify options for overcoming barriers encountered during implementation.

12. **Will CDC continue to fund community-based organizations directly with funding received through the Minority AIDS Initiative?**

    Yes. CDC will continue to directly fund community-based organizations (CBOs) through the Minority AIDS Initiative (MAI) dollars to provide prevention services for people of color. CBOs are the backbone of CDC's MAI activities and will play a central role in

implementing this new initiative. This initiative includes an expanded role for CBOs in HIV testing, outreach and prevention intervention.

13. **Are community-based organizations eligible to apply for funding only through the Minority AIDS Initiative?**

    No. CDC funds community-based organizations (CBOs) directly with both Minority AIDS Initiative (MAI) and base HIV prevention dollars. In 2004, approximately $35 million of the $49 million awarded under the new CBO program (PA 04064) will be MAI funds. In addition, CBOs can apply for funding through state and local health departments.

14. **How can CBOs strengthen their linkages with health departments and clinics to ensure treatment options for clients with positive test results?**

    CDC recommends that CBOs strengthen linkages with health departments and clinics through direct involvement in HIV/AIDS prevention activities, such as community planning and surveillance efforts. In addition, in the new CBO announcement, CDC will encourage CBOs to develop coalitions with health departments, medical care providers, and other CBOs to provide access to an array of HIV prevention and care services.

15. **Is social marketing a component of the new initiative?**

    Yes, in 2003 CDC allocated $2 million for social marketing activities (including $1 million of HHS funds) which included campaigns to raise awareness of the Initiative. These social marketing activities are also an effort to increase demand for testing and prevention services by persons at risk for or living with HIV. In addition, CDC plans to expand the “Know Now” campaign to two or three additional cities. This campaign encourages targeted populations to get tested and learn their serostatus. Messages and promotions are developed locally, in collaboration with affected communities and health departments.

16. **Will CDC require funded grantees to conduct counseling and testing activities using the new rapid HIV test? If so, when?**

    CDC will encourage grantees to use the new rapid HIV test, but it will not be mandatory. CDC wants organizations to use the most effective methods to get people into testing, provide them their test results, and as appropriate, refer them to care and treatment services. CDC will begin training and technical assistance on rapid testing methodologies this fall.

17. **What interventions will CDC fund through the new community-based organization announcement?**

    In 2004, the directly-funded community-based organization (CBO) program announcement will include activities in support of the *Advancing HIV Prevention Initiative*. CDC will require organizations to choose from a list of protocol-based interventions which include targeted outreach and health education and risk reduction (HERR); targeted outreach and voluntary counseling and testing (VCT) services; prevention interventions for individuals living with HIV and their sex or injection drug using contacts, and seronegative individuals at very high risk for HIV infection; and partner counseling and referral services (PCRS). CDC is creating technical guidance that will provide procedures and protocols for prospective grantees to follow.

CDC directly-funded CBOs will focus on outreach to high-risk populations for counseling and testing and prevention interventions for people living with HIV, their partners, and seronegative individuals at very high risk for HIV infection. In addition, CDC will continue to indirectly fund CBOs through state and local health departments to conduct health education and risk reduction activities and other community-based interventions for HIV-negative persons at high risk of acquiring HIV.

18. **How can CBOs in states with regulations that restrict the use of rapid tests use this new technology?**

    Health departments have "limited public health use" authority that allows organizations to perform testing outside of medical care and public health settings, under the supervision of the health department. In some states, health departments are able to contract with organizations that essentially become part of the health department through a contractual arrangement and are allowed by state and local laws to provide those services. Each state is likely to be different and CDC will be reviewing relevant laws, rules and regulations. Some states have laws or regulations that are very restrictive concerning who can perform testing, who can offer testing, how much counseling is needed, etc. There also may be limitations regarding partner counseling and referral services as well. CDC plans to work with the National Conference of State Legislatures, the National Black Caucus of State Legislators, and state health departments to identify options to address barriers encountered during implementation.

19. **Will the MAI monies in the *AHP initiative* stay in minority communities?**

    Yes. CDC will continue to use specific language in its program announcements (PAs) to ensure that the Minority AIDS Initiative (MAI) dollars benefit minority communities that are disproportionately affected by the HIV/AIDS epidemic. CDC is currently using specific eligibility criteria to ensure that MAI funding stay in minority communities. For example, under Category A of the CBO program announcement organizations must have current tax-exempt status; be located in the area(s) where services will be provided or have a history of 3 years or more providing services in the area; and have proof that 85 percent of the persons the CBO has served in each of the last 3 years were of racial/ethnic minority populations, and have provided HIV prevention services in each of the last 3 years to the proposed high-risk population. The Capacity Building Assistance (CBA) PA (04019) requires an applicant to have current tax exempt status, have a 3-year track record of providing CBA in the focus area for which they are applying, and have a 3-year track record for providing CBA to organizations that serve one or more of the four major racial and ethnic populations (Black/African-American, Hispanic/Latino, Asian /Pacific Islanders, and American Indian/Alaska Natives) or a record of providing direct HIV prevention services to a major racial and ethnic minority population as documented by annual agency reports, a board resolution or other documentation.

20. **Will CBOs currently receiving funding from CDC be able to successfully recompete for funds under the *AHP initiative*?**

    As in the past, currently funded CBOs must compete with other eligible CBOs for this funding. In past recompetitions, CDC experienced a high turnover of organizations—over 60 percent. Some CBOs are currently conducting counseling, testing and referral activities, and prevention services for people living with HIV. These organizations will be in a good position to compete for funding. To help other organizations compete, CDC provided technical assistance to its current grantees on the implementation of rapid HIV testing. CDC also hosted pre-application workshops to help CBOs better respond to these PAs and contract solicitations.

21. **Will a comparable number of CBOs be funded?**

    CDC anticipates reducing the number of awards but increasing the size of each award. CDC believes that organizations will require increased funding to implement the activities related to the new initiative and to conduct evaluation activities. Since CDC has a finite amount of funding available to directly fund organizations, the number of awards will be reduced and the size of the awards will increase. In addition, since the bulk of CDC HIV prevention funds are awarded to state and local health departments, funding will continue to be available to CBOs through health departments (i.e., indirect funding).

22. **The stigmatization of HIV-infected persons continues to be of concern to some folks. How will CDC address this concern?**

    The new initiative focuses on making HIV testing a routine part of medical care. CDC will strongly encourage all health care providers to include HIV testing, when indicated, as a part of routine medical care and on the same voluntary basis as other diagnostic and screening tests. In addition, CDC is currently examining ways to address stigma related to HIV testing and disease. CDC, in partnership with the Health Resources and Services Administration (HRSA) convened a consultation on HIV stigma in November 2003.

    There were several action items from this meeting that are being implemented by CDC and HRSA. HRSA will include discussion of stigma as an agenda item during the Ryan White grantee meeting to be held this summer 2004. CDC project officers also plan to contact CDC-funded grantees to discuss HIV-associated stigma and highlight issues associated with HIV and stigma in an upcoming satellite broadcast. CDC will conduct a technical assistance call on integrating prevention and care that highlights the role of stigma and actions to reduce it; and conduct workshops and present at plenary sessions at the 2004 HIV Prevention Leadership Summit (June), and United States Conference on AIDS (September). CDC and HRSA will also convene a meeting with a small group of the earlier consultants from the November 2003 stigma consultation to discuss the potential interventions identified at the meeting.

Community Planning

23. **How does this *AHP Initiative* impact the community planning process, since people living with HIV are to be considered the "highest priority?"**

    Consistent with *CDC's HIV Prevention Strategic Plan*, CDC will be asking community planning groups (CPGs) to make people living with HIV the highest priority population and to prioritize services for those who are at highest risk of transmitting the virus. CPGs also must target activities to those at highest risk for becoming infected. This does not mean that all resources will go for people living with HIV, but that their needs must be addressed first - - because of their great potential to transmit HIV.

    Recent studies suggest that by working with HIV-infected persons, where we can achieve intervention efficacy of 60-80 percent, we will see greater reductions in risk behaviors and HIV transmission than we see in our current work with uninfected persons. Still, because we see intervention efficacy of 20-30 percent in uninfected persons, CDC believes it is important to continue to work with both HIV-infected and uninfected persons, especially the partners of those already infected with HIV.

    CDC needs to ensure that available resources are targeted as effectively and efficiently as possible by prioritizing services to the highest risk populations and to interventions that are likely to have the greatest impact on reducing the epidemic.

24. **Can you define "prevention case management?" How does CDC's definition tie into HRSA's definition? CDC's definition is based on "risk behavior" while HRSA's definition is based on "care and treatment."**

    CDC focuses on providing HIV-infected persons with prevention services to prevent further transmission while HRSA focuses on providing HIV-infected persons with care and treatment services to forestall disease progression.

25. **What is the status of the request for applications (RFA) for the HIV Prevention Program?**

    The RFA for health department HIV prevention funding was published on July 10, 2003. The new project period will begin January 1, 2004.

Counseling, Testing, and Referral

26. **Can you clarify what CDC now recommends compared to previously published counseling and testing guidelines, particularly in regards to eligibility for pre- and post-test counseling?**

    Previously, CDC recommended that patients be routinely offered HIV testing in high HIV-prevalence acute care hospitals and in clinical settings serving populations at increased risk for HIV infection. The *AHP initiative* adds to those recommendations to include offering testing to all patients in all high HIV-prevalence clinical settings and to those with risks for HIV in low-prevalence clinical settings. Because prevention counseling should not be a barrier to testing, CDC will promote adoption of simplified HIV-testing procedures in medical settings that do not require prevention counseling before testing. Where pre-test counseling is not a barrier to testing, it may be conducted.

27. **Have there been studies about the effect of eliminating pre-test counseling in a medical setting on individual's willingness to take the HIV antibody test?**

    Yes. One recent study showed that replacing verbal pre-test counseling with an information leaflet increased the proportion of patients undergoing HIV testing. This was due, in part, to the physicians' being more likely to offer the test because time constraints of pre-test counseling were removed.

28. **Is there a difference between the likelihood that an individual will return for confirmatory test results from a rapid test versus standard testing (EIA and Western Blot)?**

    In the mid-1990s, CDC conducted studies that examined rapid HIV tests and the impact on persons receiving their preliminary HIV test results. The studies found that people who received a preliminary positive test result were very likely (around 97 percent) to return to get their positive test results. At present, approximately one-third of the people who test positive with EIA in publicly funded sites do not come back for their Western Blot test results. Therefore, there is a significant difference in return rates between our standard testing (EIA and Western Blot) and rapid testing.

29. **What is CDC's recommendation for treatment of indigent persons, including indigent pregnant women who test positive in states and communities that do not have Ryan White Title IV funded programs?**

Many federal agencies are involved in providing services to persons infected with HIV. CDC will work with the Health Resources and Services Administration and the Center for Medicare and Medicaid Services to link HIV-positive persons, including pregnant women, to services through existing programs. Indigent pregnant women are eligible for care through the Medicaid program. CDC will also work with CBOs and health departments to ensure that persons who are diagnosed with HIV or AIDS are linked to ongoing prevention services.

30. **Will anonymous testing still be allowed and funded?**

Yes, CDC will continue to fund anonymous testing in those states that allow for anonymous HIV testing.

31. **Is CDC supplanting funds for existing comprehensive programs with this new initiative?**

No, supplanting refers the practice of using federal funds to replace non-federal funds which would have otherwise been made available for this purpose. As CDC has done in the past, we are refocusing efforts to assure that the prevention dollars are most efficiently targeted to achieve the greatest benefit. To this end, CDC is refocusing some of its prevention activities, with a greater emphasis on HIV prevention among HIV-positive persons. However, keeping people from getting infected with HIV, whether through working with HIV-positive or high-risk HIV-negative persons, remains CDC's primary HIV prevention mission. The new initiative is consistent with *CDC's HIV Prevention Strategic Plan*, which was published in January 2001. In the strategic plan, highest priority was placed on reducing risk behaviors among persons living with HIV.

32. **Isn't the impetus for this initiative political?**

No. The impetus for this initiative is to reduce the number of new HIV infections in the United States. The discussion and exploration of strategies in the new initiative actually started as early as 1996 through consultations with a variety of groups, including HIV prevention advocates and other constituents. Thus, the basis for the initiative came from those discussions. The *Advancing HIV Prevention Initiative* represents science-based public health principles and practices, not a political agenda.

As part of its mission of reducing HIV infection, CDC has for years sought to identify HIV-infected individuals in order to be able to refer them to prevention and treatment services. Today CDC estimates that 850,000 to 950,000 people are living with HIV infection in the United States; nearly one half are untested, untreated, or both. This initiative describes a logical approach to identify the estimated 180,000- 280,000 people who are not aware of their status and connect them to care, treatment and prevention.

Studies indicate that after learning their HIV status, infected individuals are more likely to take steps to protect their partners. Making testing more widely available also increases opportunities to provide prevention information to both infected individuals and HIV-negative people at risk. For these reasons, CDC will increase the emphasis on prevention services for people living with HIV. Efforts to prevent HIV infection in at-risk persons who are HIV negative will also continue.