

Track B: Prevention Models in the Context of HIV Testing

ABSTRACT 50

Results from a Multimedia Testing and Counseling Program in a New York City Emergency Department

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OBJECTIVE: The US Centers for Disease Control recommends routine HIV screening in emergency departments (EDs). This study evaluates a novel approach to counseling and testing in a high-volume ED which utilizes an HIV counselor and a multimedia tool for conveying video HIV information and electronically collecting risk factor data. We evaluated this program to assess demographics and risk factor characteristics, patient-reported satisfaction and outcomes for positive patients.

METHODS: This prospective cross-sectional evaluation was conducted for 2 years at an inner-city, level 1 trauma municipal hospital. A convenience sample of stable patients were recruited by HIV counselors. Previously validated videos for HIV pre- and post-test counseling were used. Demographics, risk factors, and satisfaction information were collected using patient self-reporting on the touch screen computer. Chart reviews were conducted by the HIV-positive patients' medical provider. Data were analyzed using SPSS.

RESULTS: 28,995 patients were tested for HIV. Demographics were: 41.9% male, mean age 36.0 ± 14.2 years, 54.7% Hispanic, and 32.2% African-American. Risk factors were: 6.4% MSM, 31.0% had multiple sex partners in the past 3 months, 49.8% reported condom use as "never," 1.5% used injection drugs. Patient satisfaction was high: 88.8% reported learning a moderate-to-large amount of new information about HIV and 78.6% preferred the video-and-counselor format. 101 patients tested HIV positive and 86% were linked to medical care; mean days to first medical visit was 7. Positive patient outcomes: 85% of eligible patients began HAART, median days to HAART treatment was 35, 62% of patients on HAART had viral load less than 400 copies/mL.

CONCLUSIONS: A rapid HIV testing and counseling program which uses a multimedia tool and a counselor in

a busy ED can effectively test a large number of patients, provide consistent prevention messages to patients and link a large percentage HIV-positive individuals to comprehensive medical care.

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Outreach Isn't Just Handing Out Condoms: Making Referrals that Work

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OBJECTIVE: After Hurricanes Katrina and Rita and the upheaval across the state, people had multiple needs and limited services with no clear links. As a result, the Louisiana Office of Public Health HIV/AIDS Program (HAP) identified strategies to strengthen service integration and to build a holistic outreach program. Five main priorities were identified: 1) to connect people with needed services; 2) to remove barriers to reducing risk and making healthy decisions; 3) to increase awareness of resources; 4) to ensure people received the services they needed; and 5) to document the capacity of agencies to make successful referrals. Initially, staff from community-based organizations (CBOs) resisted this new approach with the following questions: "Is this another way to burden and judge us?", "Will we be penalized if this doesn't work?" "The clients won't give us all of this personal information". And "tracking" in reference to referral follow-up was a loaded term, since historically, "tracking" had negative connotations.

METHODS: A referral documentation and follow-up protocol was piloted across the state and finalized with input from CBOs. HAP's Regional HIV Coordinators provided close monitoring and a plethora of technical assistance. The HIV Regional Prevention Coordinators assisted CBOs to build referral networks, a coalition with the sole purpose of linking clients into necessary services. They assisted groups by working with existing local networks of service providers to address information sharing and HIPAA concerns. Additionally, the Coordinators aided the organizations by providing a clear plan to support relationship building with other state agencies.

RESULTS: After implementing the holistic outreach and referral program, CBOs learned that merely providing information regarding the location of a service resource did not constitute a referral. Instead, providing a referral meant that the client agreed to the referral and the CBO was expected to directly follow-up with the client or the service provider to ensure access. CBOs had to come to terms that the purpose of outreach is to identify and address barriers to individuals' behavior change and their reluctance to access/utilize available services.

CONCLUSIONS: As a result of the intensive technical assistance and support provided to the CBOs, there has been a marked increase in the number of referrals made and the number successfully accessed. CBOs have begun to embrace the holistic outreach and referral program. The community has also begun to recognize them as a valuable resource for assistance, enhancing the CBOs' ability to decrease barriers to behavior change.

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Tenderloin Health's (TLH) Street Fair-based Counseling, Testing and Linkages (CTL) Program: Mobile Allies for Sexual Health (MASH)



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OBJECTIVE: The purpose of this project is to reach San Francisco Department of Public Health's (SFDPH) directed behavioral risk populations (BRPs) for contracting and/or transmitting HIV/AIDS. BRPs are ranked in order from 1-8 in relation to the acuity of their risk factors/behaviors. The program was specifically launched in order to target and reach as many of BRP #1 and #3 groups as possible, including: Men who have Sex with Men (MSM), MSM/F; and MSM-Injection Drug Users (IDU), MSM/F-IDU, respectively.

METHODS: The provision of CTL services are set in SF street fairs frequented by said BRPs, including SF Pride, Folsom Street Fair, Up Your Alley and SF AIDS Walk,

among others. To address agency's historical barrier to engaging MSMs, the department utilized a theme based around TV show MASH, including camouflage tent, battle dress uniforms and associated regalia. Theme was envisioned to accent attraction some modern gay males have with strength and empowerment and convey a sense of organized protection, compassion and brotherhood, in addition to aesthetically setting agency apart from other mobile testing units. Staffing model includes Health Promotions Manager, CTL Coordinator and team of certified interns. Generally, an SFDPH/AIDS Office evaluation representative has also been present. Participants are also offered linkages to prevention case management for both HIV+ and -; syringe exchange, case management, medical and other services as appropriate.

RESULTS: Prior to MASH, the department's overall HIV positivity rate was 1%; only 60 days into MASH, the positivity rate skyrocketed to 3.5%. The most recent fair-based positivity rate is 2.4% and includes: 2009 Pride (14 tests – 1 positive); 2009 Up Your Alley (58 tests, 1 positive); 2009 Folsom Street Fair (83 tests, 5 positives); 2010 Pride (101 tests, 1 positive); 2010 AIDS Walk (18 tests, 1 positive); and 2010 Up Your Alley (94 tests, 0 positives). Through said targeted fairs, TLH administered 368 OraQuick Rapid Antibody Tests, reaching 289 BRPs, with three (3) declining disclosure. If a test was reactive, Rapid Test Algorithms (RTA) technology was employed to obtain a sample that was subsequently taken to SFDPH's lab for confirmatory screening.

CONCLUSIONS: The rise in positivity rates before and after implementation of MASH underscores the premise that the right persons were not being reached before utilization of theme and large-scale effort to provide CTL services at BRP-attended fairs. Additionally, the increase demonstrates a pattern for the efficacy of this form of outreach and engagement particular to the targeted populations.

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Resiliency and Stigma in the Midlands: HIV Risk and Testing for LGBT Nebraskans



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OBJECTIVE: Stigma is a well documented phenomenon that impacts HIV testing efforts in the lesbian, gay, bisexual, and transgender (LGBT) community. However, less is understood about the power of resiliency behaviors in supporting HIV testing. This study, part of a larger needs assessment, looked to explore the impact of several indicators of stigma including perceived and experienced discrimination and depression as well as resiliency factors such as self acceptance and “outness” on HIV testing behavior and perceived risk for HIV.

METHODS: A community-based participatory research approach was utilized to develop a 30-minute, online anonymous survey. Participants (N = 335) were recruited via advertisements in local media, fliers at LGBT-friendly venues and events, and snowball sampling techniques via e-mail. Participants could choose to receive a \$5 gift card for their participation. Chi-square, t-tests, and ANOVA were run in PASW 18.0.

RESULTS: The majority of the sample identified as male (n = 200, 59.7%), homosexual (n = 247, 73.7%), and Caucasian (n = 300, 89.6%). Mean age was 35.83 (range 19 – 70, sd = 15.4). Latinos comprised 5.7% of the sample (n = 19) and 48 participants (14.3%) identified as transgender. All stigma- and resiliency-related scales had acceptable to high reliability. Individuals with a higher acceptance of themselves as LGBT were more likely to perceive themselves as at risk for HIV, $F(2,301) = 5.755, p < 0.01$. No other scales were differentiated by perceived risk. Individuals indicating being “out” to more social circles were more likely to have ever had an HIV test, $t(301) = 3.256, p < 0.01$. However, those indicating more perceived discrimination were also more likely to have ever had an HIV test, $t(323) = 2.688, p < 0.01$, though overall levels of perceived discrimination based on

sexual orientation were low. No other relationships between the remaining scales and testing behavior were found.

CONCLUSIONS: Resiliency factors had significant bearing on HIV testing and perceived risk. Being out may increase perceived discrimination for an LGBT person. However, the resiliency of being “out” was related to being tested for HIV and being more accepting of one’s orientation/identity allowed for a more realistic perception of risk. Interventions designed to improve HIV testing in the LGBT community may consider focusing on a broader campaign aimed at increasing resiliency through addressing sexual orientation stigma to create an environment more conducive to being “out” and self-accepting of one’s sexual orientation.

ABSTRACT 54

Adapting HIV Testing Strategies to Address the Needs of Distinct Populations in San Francisco



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OBJECTIVE: SFAF launched several initiatives to increase the effectiveness of HIV testing strategies among those at highest risk of HIV acquisition in San Francisco.

METHODS: Staff conducted a review of the public health literature on the behavioral risk populations with the highest HIV incidence and prevalence in SF, and a review of STI, substance use, HCV rates, and other cofactors. A cross-analysis of these data with the geographic distribution of HIV prevalence was conducted to identify and prioritize populations and neighborhoods where services were to be offered: 1) gay identified men living or frequenting the Castro; 2) low-income African American and Latino gay and other MSM located in the Tenderloin; 3) street-based IDUs who utilize SFAFs syringe distribution site located South of Market; and 4) the sexual and substance using partners of persons known to be HIV positive.

RESULTS: HIV testing services for gay-identified men in the Castro were integrated with screening and treatment for syphilis, gonorrhea, and Chlamydia; as well as hepatitis A and B vaccinations. Uptake of services has been higher than anticipated with HIV testing numbers exceeding 4,000 tests annually with an HIV incidence of 1.5% - 2.0%. Among low-income African American and Latino men, weekly testing was launched at SFAFs drop-in site. Demand for testing has been lower than anticipated and attempts to recruit members of the targeted population have been moderately successful. Staff are refocusing efforts to offer venue-based testing at specific events. HCV testing was integrated into services at the SFAF syringe access program. Rates of HCV antibody positives are high (42.8%). New cases of HIV infection have been detected, and point of care HIV testing well received; however, coordinating linkages to care for HCV reactive clients has been challenging. Uptake of testing among the sexual and substance using partners of persons with known HIV infection has been slow. Staff are devising new strategies to enroll sexual/social networks for testing, as well as working with clients to better understand the risk reduction strategies and other cofactors utilized by HIV+ persons to prevent onward transmission to their sexual and substance using partners.

CONCLUSIONS: Behavioral and geographic data can lead to a better understanding of distinct populations at risk of HIV acquisition and development of culturally competent interventions that meet their needs. Strategies may need periodic refinement to maximize their effectiveness.

ABSTRACT 55

Differences in Self-reported HIV Risk Behaviors Across Gender: A 25 Month Analysis of the Howard University Hospital Routine HIV Screening Program

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OBJECTIVE: By the close of 2008, there were 16,513 (3.2%) District of Columbia (DC) residents living with

HIV/AIDS. In response to the high prevalence of HIV/AIDS in DC, Howard University Hospital (HUH) implemented the nation's first hospital-wide routine HIV screening program (RHSP). Screening was conducted utilizing the opt-out methodology in three key sectors: the outpatient, inpatient, and the Emergency Department (ED) settings. In the outpatient setting, screening was conducted anonymously while in the ED and inpatient areas confirmed demographic and personal information was obtained. In examining the data collected, HUH seeks to identify if there is an association between gender and risk factor reporting.

METHODS: Free, oral HIV screening was conducted at HUH on consenting individuals at least 18 years of age using the OraSure OraQuick Advance® Rapid HIV-1/2 Antibody Test. Participants were queried about risk factors for HIV infection within the last year as well as health insurance status and demographic information among others. Data for a 25 month period were reported.

RESULTS: Of the 27,272 participants screened during this period, 15,174 (56%) were women and 12,098 (44%) were men. 7,983 (29%) reported HIV-related risk behaviors; 4,508 (56%) were women and 3,475 (44%) were men. Women were more likely to report HIV-related risk behaviors than men. The most common risk factor reported by men and women was sex without a condom (96% and 97%, respectively). Specifically, over the last twelve months 246 women (5.5%) and men 158 (5%) reported contracting a Sexually Transmitted Infection (STI). However, injection drug use (IDU) 42 (1%) and men who have sex with men 96 (3%) were reported more frequently among men. Based on chi square analysis, there is a statistical difference in self-reported HIV risk behaviors across gender ($\chi^2 = 15979.5$, $p < 0.05$).

CONCLUSIONS: The data suggests that women are more likely to report self identified risk behaviors for HIV infection. Additionally, unprotected sex was the most commonly reported risk factor for both genders. Given that the association is based on self reported risk factors that are unverified, additional controlled studies should be performed to determine the actual differences in risk behaviors among gender. However, based on our data, there is an increased need for gender-specific, HIV-related risk behavior education.

ABSTRACT 56

HIV Testing, Condoms, STD Prevention and Substance Abuse Treatment in the District of Columbia Department of Corrections: A Community-oriented Correctional Healthcare Model



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OBJECTIVE: The Community-Oriented Correctional Health Care(COCHC)model includes a comprehensive initiative for routine, opt-out HIV rapid testing, condom distribution, STD screening/treatment, Hepatitis screening/vaccination, and residential substance abuse treatment and opioid treatment, targeted among minorities who comprise over 95% of the DCDOC population.

METHODS: Routine HIV oral rapid testing is integrated into the health services intake process, daily sick call and discharge, as well as screening of all inmates for syphilis and tuberculosis, and on high-risk inmates for GC/Chlamydia and Hepatitis B/C. The condom distribution program for males and females began in 1993 and includes access at intake and daily sick call, as well as being part of every discharge package or transfer to halfway houses.Substance abuse treatment includes Opioid Treatment(methadone and suboxone), begun more than 25 years ago, and certified in the District and accredited by the National Commission on Correctional Health Care. The Residential Substance Abuse Treatment (RSAT) unit--Progress Towards Empowerment--is certified in the District and provides a 90-day Modified Therapeutic Community for 72 males and 20 females.

RESULTS: The singular achievement of the HIV testing program is our designation as the single largest HIV/AIDS testing site in the District of Columbia. Over its 4-year history, more than 42,000 inmates or 87% of the offender population have been tested while incarcerated, and more

than 33% of those tested learning their HIV status for the first time. DCDOC data confirm an HIV positive prevalence rate of 6% with about 50% receiving HIV medications based upon clinical status, and all HIV positives released to the community receive a 30 day supply of medications. The D.C. Appleseed Center awarded the DCDOC its third consecutive 'A' on the annual Report Card evaluating HIV services in the District. The ACA conferred its 2010 Exemplary Offender Program Award to DCDOC for the HIV Program. To assess the condom distribution program, DCDOC conducted a survey of inmates and correctional officers published as a journal article ('Acceptability of Condom Availability in a U.S. Jail,' 2002). The results demonstrated the safety and acceptability to staff/inmates, confirmed no major security problems occurred, and gave no indication that the frequency of sex had increased. The RSAT program has provided services to over 300 inmates and completed over 100 bed-to-bed placements to community treatment providers.

CONCLUSIONS: The COCHC model of assessment/treatment/prevention/discharge planning/continuity of care has demonstrated the nexus of public safety and public health and the preeminent role of corrections in this relationship.

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Novel Anti-stigma Pilot Campaign Targeting College Students



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OBJECTIVE: The stigma associated with HIV prevents the very success of effective HIV prevention and care programs. Experiences with HIV discrimination have been linked to increased unsafe sex practices. Individuals who are not tested for HIV exhibit significantly greater stigmatizing attitudes towards individuals with HIV/AIDS. In addition, HIV stigma prevents individuals from disclosing their status to their family and prevents individuals from

getting tested. Opinion Leader interventions have proven successful in educating populations about HIV. An Opinion Leader Intervention is one in which innovations and trends are diffused throughout a population through Opinion Leaders. College students not only have significant opportunities for Opinion Leader interventions, but also are in the demographic which have a greater percentage of HIV incidence than any other age group in the United States. The Opinion Leader model, however, has not yet been researched in the context of reducing HIV stigma. This abstract will reveal novel concepts in approaching college-aged students with Opinion Leader interventions in order to reduce HIV stigma and, as a result, possibly reduce HIV incidence in college-aged populations.

METHODS: A pilot program targeting college students at the University of Houston was performed March 2009. It consisted of: (1) a month long viral HIV and stigma education marketing campaign in the student newspaper; (2) peer discussions held with each of the university sororities and fraternities; and (3) Anti-Stigma Day event at the University of Houston, as proclaimed by the Mayor of the City of Houston. The event utilized an HIV stigma symposium panel that included students, student volunteers who actively encouraged their peers to learn more about HIV and to get tested on-site, and a consortium of 12 partnering CBOs that provided students with HIV education materials and available services.

RESULTS: In this pilot program, it was shown that college-aged students can be effectively educated about HIV stigma. Thousands of individuals were educated through both viral marketing and numerous discussions with various student groups. On Anti-Stigma Day, over one hundred students attended the symposium and sixty-four students, who had not previously considered HIV testing, were tested in four hours.

CONCLUSIONS: By creating a peer-based safe environment and supported by several CBOs, the Opinion Leader model is an effective HIV anti-stigma intervention strategy with college-aged students. A larger program is being designed that will include outcome measures on changes in stigma scores in the short and long term.

ABSTRACT 58

The Relationship of Stigmas Associated with Sexuality and HIV in MSM



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OBJECTIVE: Previous studies have implied the need to address the stigma related to homosexuality in order to reduce the stigma related to HIV. A survey of gay men was performed in Houston to determine if this inference is in fact true.

METHODS: A survey was provided to 131 gay men attending a Sunday fundraising event in Houston in March of 2010. Of these men, 16 (12.2%) indicated they were HIV seropositive, 5 (3.8%) did not know their HIV status, and the remainder reported themselves HIV negative. Men were asked 9 questions on their expectations and experience of gay-related and HIV-related stigma, scored on a 6-point Likert scale from 1 (experienced or anticipated no stigma) to 6 (suffered a lot of stigma).

RESULTS: Survey results showed surprising data indicating that HIV stigma and anti-gay stigma were separate judgments in this small sample of gay men, with low ($r=0.33$, $R^2=11\%$) intercorrelations. Factor analysis of the stigma-related items (Principal components analysis followed by Direct Oblimin rotation, of two factors since a Scree Test indicated that a two-factor solution had the best fit) revealed two separate dimensions: gay-related stigma, and HIV-related stigma. These data indicate that conceptualizing gay and HIV-related stigma occurs on two separate dimensions, and are thus two largely unrelated sets of judgments. The correlation between factors was 0.33, suggesting that they hold only about 11% of their variance in common. Interestingly, the correlation between the proportion of people one was "out" to as gay, and actual or anticipated stigma was not significant ($r=0.15$, $p=.09$). Taken together, these data indicate that gay-related stigma and HIV-related stigma in gay men involve largely separate processes, and that HIV-related stigma in the gay

community may not be different than is seen as anti-HIV stigma in the general community.

CONCLUSIONS: These data indicate that: (1) HIV stigma and stigma against gay men are exclusive of each other; (2) there is still considerable stigma in the gay community with regard to HIV seropositive status; and (3) anticipated HIV stigma in the gay community is not significantly different from that present in the general community. Such stigma may both discourage HIV testing, and disclosure of HIV status to sexual partners. More investigation to this finding is warranted.

ABSTRACT 59

Towards Understanding and Managing the Impact of Inconsistency in Self Reported Risks for HIV



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OBJECTIVE: Accurate HIV risk-assessment is important for surveillance, targeted screening, and effective prevention counseling. Yet, patient reports of stigmatizing risk behaviors in response to different question formats can be inconsistent, due to the effects of labeling. In the context of emergency department (ED) prevention counseling, we demonstrate 1) frequency of inconsistent reports, 2) patient and provider factors associated with inconsistencies, and 3) conversational antecedents and outcomes when inconsistencies occur.

METHODS: Our ED-based HIV testing program provides formal prevention counseling by trained counselors using a structured risk-assessment. Questions ask about activities (such as being a man who has sex with men, MSM) and also identification with a label (such as homosexual). Responses to these questions were extracted from the electronic medical record and assessed for inconsistencies. We determined whether patient and counselor characteristics affected the odds of inconsistency using logistic regression. Transcriptions of representative interviews were reviewed

to identify conversational development and management of inconsistency.

RESULTS: There were 4292 interviews abstracted. Mean age was 31 years, 52% were male, 68% were black, 5% were MSM, and 9% used injection drugs (IDU). There were 36 counselors; mean age 28 years, 47% were male, and 28% were black. Inconsistent reports occurred for sexual activity (13%), sexual orientation (3%), condom use (48%), and alcohol use (29%). Combinations of race, and gender of counselor and patient, as well as patients' risk characteristics, were predictive of inconsistent reporting. For example, female patients had higher odds than males of inconsistency in reporting condom use (OR 1.9, CI95 1.6-2.1); black counselors had lower odds of obtaining inconsistent reports about intoxication than non-black counselors (OR 1.9, CI95 1.6-2.1); and when patient and counselor race were both black, there was an increased odds of inconsistent reporting on sexual orientation (OR 2.8, CI95 1.2-6.3). Transcriptions of 16 interviews showed both acknowledged and ignored inconsistencies. Strategies to manage inconsistency included reframing questions, terminology clarification, humor, patient narratives, and patient-initiated "off the record" response clarification.

CONCLUSIONS: Potentially stigmatizing risk behaviors involving sex and substance use are inconsistently reported with sufficient frequency to affect the accuracy of risk-assessment. This has broad implications ranging from the quality of behavioral surveillance data to how patients are targeted for screening and prevention counseling. At-risk patients are more likely to be inconsistent, and provider characteristics add to inconsistency. Training providers to anticipate, recognize, and manage inconsistencies may be significantly beneficial for any situation in which HIV risk information is collected.

ABSTRACT 60

AIDSVu: Mapping HIV Surveillance Data and Promoting HIV Testing



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OBJECTIVE: AIDSVu is a website that seeks to make HIV prevalence data widely accessible 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 website functionality that promotes HIV prevention behaviors such as locating HIV testing sites.

METHODS: AIDSVu is developed by a cross disciplinary team of epidemiologists, public relations and marketing experts, and creative website 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 the Centers for Disease Control and Prevention's national HIV surveillance database. A primary feature of AIDSVu is a map overlay that allows website users to locate HIV testing centers in their community. Encouragement to get HIV tested and "know your status" - and to de-stigmatize the act - is promoted on the website through action-oriented content about "what you can do in your community to address HIV/AIDS."

RESULTS: AIDSVu seeks to draw internet users, who are not typical consumers of HIV surveillance reports, to the website to get a visual picture of how HIV is impacting their communities and to pair this content with action-oriented messages about what individuals can do in their community to address HIV. Website metrics such as number of "hits" to the site, number of users locating HIV testing sites, and time spent on the site will be collected to help evaluate the reach of the website and patterns of use. A brief, voluntary survey to capture information about website users -- such as referral sources to the website, previous exposure to HIV

surveillance data, and user type (e.g., researcher, policy maker, student, others) -- will assist with measuring and characterizing website users.

CONCLUSIONS: Mapping HIV prevalence data and displaying it on a website is a powerful tool to make HIV data more accessible, locally relevant and actionable to a wide range of viewers. 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.