

In this issue:

HAPPY NEW YEAR!

Focus on Ten Things to Watch in 2006

- Top Ten Things to Watch in 2006
- Community Perspectives: Julie Davids' (CHAMP) Six Things to Watch and Four Things to Try in 2006

Capacity Building Calendar

Meeting and Planning Calendar

[VISIT NASTAD.ORG](http://www.nastad.org) →

*****2006 National Black HIV/AIDS Awareness Day*****

February 7, 2006 marks the 6th annual National Black HIV/AIDS Awareness Day (NBHAAD). NBHAAD is a national mobilization effort whose primary goal is to encourage African Americans to “get tested, get educated, get involved, and get treated.” The campaign is designed to build the capacity of community-based organizations (CBOs), health departments, and community stakeholders to increase awareness of HIV/AIDS among African Americans, prevent the spread of the disease, and secure treatment for those in need. Numerous organizations and health departments are planning events and activities to address HIV/AIDS in their communities on this day.

NBHAAD was co-founded by five national organizations: Concerned Black Men, Inc. of Philadelphia; Jackson State University – Mississippi Urban Research Center; Health Watch Information and Promotion Service; National Black Alcoholism & Addiction Council; and the National Black Leadership Commission on AIDS. This group is commonly referred to as the Community Capacity Building Coalition (CCBC), funded by the Centers for Disease Control and Prevention (CDC).

For more information, visit the [NBHAAD website](#).

Focus on Top Ten Things to Watch in 2006

As in years past, the January *HIV Prevention Bulletin* focuses on the “Top Ten Things to Watch” in the new year. These are issues NASTAD staff and members have identified as likely to have a significant impact on HIV/AIDS programs, commanding attention and resources at the federal, state, local, and community levels throughout 2006. Given their critical nature, some of these issues have consistently been included in NASTAD’s “Top Ten,” yet some, such as the disproportionate impact of HIV/AIDS on African Americans, have moved to the top of the list in light of alarming new prevalence data. This historic 25th year in the life of the HIV/AIDS epidemic brings several new developments that pose both challenges and opportunities for HIV/AIDS programs nationwide.

Top Ten Things to Watch in 2006

1. HIV/AIDS Among African Americans

At the start of 2006, African Americans stand at the crossroads of the domestic HIV epidemic. HIV/AIDS is taking a particularly devastating toll on Black men who have sex with men (MSM) and Black women. In 2004, African Americans accounted for 50 percent of estimated new AIDS diagnoses.¹ That year, African American women accounted for 67 percent of estimated new AIDS diagnoses among women.² HIV was the number one cause of death for black women ages 24-34 in 2002.³ In addition, a recent study of MSM conducted from June 2004 through April 2005 in five urban areas (Baltimore, Los Angeles, Miami, New York City, and San Francisco) showed that of the black MSM who were tested for HIV, nearly half (46 percent) were HIV-positive. Moreover, 67 percent of the HIV-positive Black MSM in the survey were unaware of their HIV status.⁴

In response to the alarming data on MSM, CDC convened a consultation of health care providers, policymakers, scientists, researchers, and community leaders in August 2005 to discuss current HIV prevention programs and research activities targeting black MSM. Recommendations from this consultation, as well as those developed by the National Black Gay and Same Gender Loving Men's Health Coalition, are expected to assist CDC and other HHS agencies in crafting a comprehensive response to drastically reduce rates of HIV/AIDS among black MSM.

As part of NASTAD's overall strategy to address this crisis, NASTAD recently began working with the National Black Gay and Same Gender Loving Men's Health Coalition to develop a health department assessment tool to evaluate health departments' responses to the HIV/AIDS epidemic among black MSM. In addition, in November 2005, NASTAD released a Call to Action entitled [A Turning Point: Confronting HIV/AIDS Among African Americans](#) that urges state health departments, federal agencies, national organizations, and community leaders to act decisively to reduce the spread of HIV in the Black community.

In 2006, look for the results of NASTAD's assessment, which will assist NASTAD in prioritizing technical assistance, policy analysis, and mobilization efforts in response to Black MSM-focused HIV/AIDS programs at the local, state, and national levels. NASTAD and CDC will work closely together as final recommendations from the health department assessment are released. In addition, NASTAD's Call to Action and its African American Advisory Committee will help guide NASTAD's Black MSM work and its development of a detailed strategy to address the issue of HIV/AIDS among Black women.

The disproportionate impact of HIV/AIDS on African Americans will continue to receive great attention in 2006. NASTAD expects that the recently appointed Director of the National Center for HIV, STD, and TB Prevention (NCHSTP), Dr. Kevin Fenton, will continue the emphasis at the Center on confronting the epidemic among African Americans. CDC will also host a consultation on African Americans and HIV/AIDS in early 2006.

It is critical that federal, state, and local leadership are clearly informed about the devastating impact of HIV/AIDS on Black MSM and women and on communities of color in general. In 2006, educating key policy actors and re-energizing the efforts of African American leaders and community advocates will be key priorities.

1. CDC, HIV/AIDS Surveillance Report, Vol. 16, 2005.

2. CDC, HIV/AIDS Surveillance Report, Vol. 16, 2005.

3. NCHS, "Deaths: Leading Causes for 2002," NVSR, Vol. 53, No. 17, March 7, 2005.

4. CDC, MMWR, Vol. 54, No. 24, June 24, 2005.

2. Reauthorization of the Ryan White CARE Act

Reauthorization of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act should shift into high gear in early 2006. There appears to be continuing support for a bicameral, bipartisan process for reauthorizing the CARE Act, however no clear positions have emerged from Congress. NASTAD continues to believe that in the current political and fiscal environment, and with a commitment to a broadly supported process, the Ryan White CARE Act will be reauthorized with its current title structure. Within the structure, however, significant changes may occur based on Bush Administration priorities and other community and

lawmakers' interests.

The themes of medicalization (core services), flexibility to shift resources, accountability, coordination of programs, and integration of prevention activities have continued to emerge in both Department of Health and Human Services (DHHS) and Health Resources and Services Administration (HRSA) discussions since the President's principles for reauthorization were released. Most of these ideas have not yet been publicly operationalized, including the Severe Need Core Services Index (SNCSI), which was proposed by the President as a way to shift resources to jurisdictions with severe need.

Given the likelihood that no new federal funds will be provided to the CARE Act outside of the AIDS Drug Assistance Program (ADAP), and given existing disparities in both services and funds, NASTAD expects that some formula changes may be proposed for Titles I and II. HIV cases will almost certainly be added into formulas in FY2007, and NASTAD anticipates significant discussion about hold harmless language in Titles I and II.

Since FY2003, ADAP is the only component of the CARE Act that has received any increases in appropriations. This fact, coupled with the President's \$20 million "one-time emergency" funds last year to purchase medications for individuals on ADAP waiting lists, indicates support for finding a solution to the ADAP crisis among policymakers and the Administration. NASTAD anticipates that reauthorization will revise the methodology used to distribute ADAP supplemental funds. NASTAD also expects to see language introduced that gives the Administration flexibility to direct unobligated funds to areas of "severe need" without a formal grant process. To date, no criteria have been put forth that more clearly define "severe need" or how it will be evaluated. Both core services and core formulary discussions will likely increase the CARE Act's focus on medical services.

To stay abreast of reauthorization developments, visit [NASTAD's website](#).

3. "Doing More with Less": The Impact of Funding Cuts on HIV/AIDS Programs

Shifting national priorities will continue to result in federal funding cuts for HIV/AIDS programs in 2006. Both prevention and care will receive a one percent across-the-board cut in FY2006, as will all discretionary spending except Veterans Affairs. The one percent overall reduction in HIV prevention funding is on top of a \$5 million decrease for these programs. This decline in the federal commitment to the domestic AIDS epidemic comes at a time when more people are living with HIV/AIDS than ever before, and when this devastating disease has created a veritable crisis in minority communities. This decline in the federal commitment to the domestic AIDS epidemic comes at a time when more people are living with HIV/AIDS than ever before, and when this devastating disease is a crisis in minority communities.

Decreased federal funding for HIV/AIDS programs will have significant consequences for state and local efforts to care for people living with HIV/AIDS. Cuts to the Ryan White CARE Act will lead to longer wait times for services and more waiting lists for programs such as ADAP, which are already resorting to a variety of cost-containment measures that limit access to medications for people in need. One state is even considering removing individuals from their ADAP rolls who have not paid their co-pays for an extended period of time. As the payer of last resort, the CARE Act will likely be forced to absorb individuals unable to access care through Medicaid due to cuts to that program and so-called Medicaid "reforms" taking place in states throughout the country. Decreased funding will also require greater collaboration between CARE Act titles and other primary health service providers such as community health centers.

As in past years, HIV prevention will continue to sustain considerable reductions in funding despite indications of a surge in the epidemic among certain at-risk populations. Surveillance and other monitoring activities will face mounting pressures to meet demands for greater accountability and additional data despite receiving fewer resources. Health departments and community based-organizations will be forced to prioritize their activities, eliminating programs that are viewed as less essential or whose effectiveness has not been sufficiently documented. In addition, increasing pressures for accountability will also likely result in fewer direct services.

Overall, FY2006 funding cuts threaten to further destabilize an already precarious fiscal environment for AIDS programs. Decreased federal funding for domestic HIV/AIDS prevention and care places significant

financial pressure on already strained states. In addition, these reductions could have potentially devastating consequences for small community-based organizations that rely on federal and state funding to operate. Sadly, many of these entities provide services that are specifically tailored to meet the needs of hard-to-reach, at-risk individuals, many of whom are racial/ethnic minorities. Without a strong and sustained federal investment in HIV/AIDS programs, state and local entities face the daunting task of "doing more with less" for much of the foreseeable future.

4. Advances in HIV Testing

New guidelines and advances in technology will bring important developments in HIV testing in the coming months. As early as spring 2006, CDC is expected to issue recommendations for testing in healthcare settings for adults, adolescents, and pregnant women. These recommendations will encourage an increase in routine screening of patients in clinical settings with a high HIV prevalence or where patients are at high risk, including acute care settings such as emergency rooms. The recommendations will also contain guidance on reducing barriers to testing by streamlining consent, targeting the use of prevention counseling, and normalizing HIV testing. At the same time, the guidelines will emphasize the need for patients to be fully informed regarding HIV testing and for HIV-positive individuals to receive appropriate counseling and referrals. The recommendations for pregnant women will be similar to past guidance and will include voluntary testing during pregnancy and at delivery when serostatus is unknown. Work is also expected to begin next year on new guidelines for testing in general.

Meanwhile, HIV testing technology continues to evolve. Movement toward an over-the-counter (OTC) HIV rapid screening test will likely occur in 2006. Although it will take time for such a test to reach the market, expect discussions throughout the year about how to ensure that such tests are used properly, that clients receive appropriate counseling, and that HIV-positive individuals receive confirmation testing and are linked to medical care. The results of these discussions will surely guide programmatic responses to the availability of an OTC HIV rapid screening test.

Declining resources will pose a key challenge to testing efforts in 2006. While CDC's Advancing HIV Prevention (AHP) initiative emphasizes the use of rapid testing as a tool to expand testing, many programs continue to struggle to simply maintain current efforts as resources decline. In addition, increased focus on routine testing will elevate discourse regarding the role of public health programs in HIV testing campaigns. Research indicates that increased testing of the general public is cost-effective and can identify individuals who might not otherwise learn their status. However, most public health programs have emphasized more targeted efforts and cannot pay for testing to individuals generally considered to be low-risk. Finally, programs will continue to weigh the costs and benefits of acute testing technology, which can identify individuals in the earliest stage of infection. Acute testing creates important opportunities for "real time" intervention to prevent the spread of HIV. Look for these and other new developments in HIV testing to significantly impact HIV/AIDS programs as the year 2006 unfolds.

5. Care and Treatment in Flux

The upcoming year will likely bring substantial change regarding the way in which people with HIV/AIDS access health care. The launch of the Medicare Part D drug benefit, potential federal and state cuts to Medicaid, the expiration of the President's ADAP Initiative (PAI), and the continued absence of sufficient ADAP funding will pose new challenges for patient access to care.

Medicaid, the largest federal payer of HIV/AIDS care in the U.S., has come under increased scrutiny as spending on the program continues to increase. Unfortunately, in a misguided effort to curb this spending, Congress recently passed budget legislation that will substantially limit patient access. Currently, Medicaid law requires that any state-offered service be available to all populations, both mandatory and optional. Congress' FY2006 budget savings legislation, in contrast, enables states to offer a much more limited set of services to a subset of Medicaid beneficiaries. It also allows states to charge higher co-pays for medical services and prescriptions. In addition, the new budget waives a nominal provision that currently prevents Medicaid programs from charging more than \$3 per prescription and that entitles individuals who cannot pay to still receive their medications. The new legislation allows states to charge much higher co-pays and enables pharmacies to deny prescriptions to individuals for failure to pay.

States also continue to explore options to limit growth in their Medicaid programs. In 2005, thirteen states sought waivers from the federal government to institute various "reforms." These reforms included limiting the number of allowable prescriptions per month, offering fewer services to certain populations, increasing cost-sharing, and/or "privatizing" elements of state Medicaid programs. Look for these waiver efforts to continue throughout 2006.

The year 2006 also marks the launch of the Medicare Part D prescription drug benefit. For the 80,000 to 100,000 individuals living with HIV/AIDS who are enrolled in Medicare, this benefit represents a new challenge to piecing together a comprehensive system of care. The majority of individuals living with HIV/AIDS are dually enrolled in Medicaid and Medicare, and will be automatically switched into a Medicare drug plan beginning January 1, 2006. The new benefit has caused substantial confusion among Medicare enrollees due to its highly individualized nature. Medicare enrollees generally have over 40 plans from which to choose, each with different formularies, network pharmacies, and levels of cost-sharing. The new benefit establishes completely different benefit structures for beneficiaries depending on their income level. Furthermore, the start of the Medicare Part D benefit also has important implications for ADAPs, which continue to struggle to understand the new benefit and determine how their programs will coordinate with it.

Several ADAPs will face an additional challenge in 2006 with the expiration of the PAI. President Bush established this initiative on June 23, 2004, by announcing the immediate availability of \$20 million in one-time funding outside of ADAP to provide medications to individuals on ADAP waiting lists in 10 states. As of November 17, 2005, 932 individuals were still receiving access to medications through the PAI. However, PAI funding is expected to run out in early January 2006. States that have been able to secure additional funding from their legislatures are currently working to transfer individuals from this program into their traditional ADAP. States are also partnering with pharmaceutical manufacturers to enroll individuals into Patient Assistance Programs (PAPs), although this is not a permanent solution to the funding crisis in these states, nor a comprehensive long-term method to provide clients access to medications.

The Administration has given no indication that they will continue funding for the PAI or increase ADAP funding for FY2007. While the FY2006 proposed budget includes a \$10 million increase for ADAPs, the across-the-board cut of one percent will erode that amount to a mere \$2 million increase, far less than what is required to meet anticipated needs.

6. HIV/AIDS in Correctional Settings

The September 2005 release of new data on HIV/AIDS in correctional settings will likely bring increasing attention to this issue in 2006. According to a report by the U.S. Department of Justice (DOJ) Bureau of Justice Statistics, two percent of state prison inmates and about one percent of federal prison inmates were known to be HIV-positive by the end of 2003. In 2003, 268 state prisoners died from AIDS-related causes and, in cases for which demographic information is available, about 96 percent of prisoners were male and slightly more than 69 percent were African American. The confirmed AIDS rate in state and federal prisons is 51 in 10,000, more than three times greater than the U.S. general population rate of 15 in 10,000 (demographic breakdowns by race/ethnicity were not available).¹

Given these statistics, the epidemiology of HIV/AIDS in correctional settings continues to be of great interest to health departments, CDC, DOJ, and other federal and state agencies working to address HIV/AIDS. The role of health departments in delivering HIV/AIDS programs to incarcerated populations varies from state to state. Some states offer HIV counseling and testing to inmates upon request; other states have implemented mandatory HIV testing programs. Several jurisdictions provide case management services to HIV positive inmates prior to and immediately following release from a correctional facility, while others have implemented primary HIV prevention programs. Often, prevention and education programs are geared towards inmates. However, the educational needs of the staff in correctional settings must not be overlooked. Educating correctional facility staff and administrators about the importance of HIV prevention, counseling, testing, and care and treatment for inmates, as well as demonstrating the value of these programs to the facility, are typically first steps in implementing these programs within correctional settings.

Finally, a deeper understanding of the modes of HIV transmission and the characteristics of those at greatest risk for HIV in correctional settings is imperative to adequately serving individuals in need. Such information is currently being used in the development of programs designed to reach this population. Greater collaboration among the various entities that serve incarcerated and formerly incarcerated

populations is necessary to ensure that these programs are effective. In 2006, look for re-energized efforts to confront the spread of HIV in correctional settings from a variety of institutions and organizations.

1. U.S. Department of Justice, Bureau of Justice Statistics. Criminal Offenders Statistics, www.ojp.usdoj.gov/bjs/crimoff.htm Accessed December 8, 2005.

7. The Future of Prevention

June 2006 will mark 25 years since the first reported AIDS case. This milestone represents an important opportunity to reassess current HIV prevention efforts. While much progress has been made with regard to promoting awareness of the epidemic and decreasing risky behaviors, significant challenges in HIV prevention remain.

As reflected in CDC's Advancing HIV Prevention (AHP) initiative, an emphasis on serostatus knowledge will continue to drive much of HIV prevention in the coming year. Promoting awareness of one's HIV serostatus is essential to ensure that HIV-positive individuals receive appropriate medical services and to give these individuals the opportunity to protect their partners and reduce the risk of transmission. With this emphasis, prevention efforts such as testing, partner counseling and referral services, and targeted outreach (including using social networks to identify high risk individuals) will remain important strategies in 2006.

The upcoming year will also bring continued focus on ensuring that risk reduction efforts are effective and a persistent push for more research on and evaluation of behavioral interventions. A central theme of these efforts will be strengthening programs to monitor and evaluate their efforts. The Program Evaluation and Monitoring System (PEMS) is scheduled to begin operation in 2006. Its goal is to assist agencies in monitoring their programs. However, states remain concerned that the complexity of PEMS and its associated costs will drain already limited prevention resources, both human and financial. The impact of such a dramatic increase in the collection of detailed behavioral information from clients on outreach efforts remains unknown as well.

NASTAD anticipates that prevention efforts will face several key challenges over the next year. Declining resources will continue to present a major barrier, and programs will struggle to determine the best mix of interventions to address priorities given the resources available. Insufficient resources will also likely impact infrastructure as some agencies fight to remain open. Programs will also work diligently to determine appropriate prevention messages to stem the rising rates of HIV infection in certain communities. The HIV/AIDS crisis in communities of color, particularly among African American women and men who have sex with men, will challenge programs to develop new and innovate ways to limit the spread of HIV and reduce stigma surrounding the disease in these communities.

Despite significant progress in HIV prevention since the emergence of HIV/AIDS, look in 2006 for a renewed focus on maximizing program effectiveness to build upon the important accomplishments of the past 25 years.

8. Lessons From the Global Front

The year 2005 brought a significant increase in the level of attention paid to global public health issues in the popular U.S. media. With ongoing coverage of a potential flu pandemic, increasing awareness of the global impact of HIV/AIDS, and a major collaborative media effort in November focusing on global public health (Rx for Survival), the general U.S. population is beginning to understand, as never before, that infectious diseases are oblivious to political boundaries. Americans are discovering that, while these diseases may emerge in countries on the other side of the world, without strong local public health systems to contain them, they spread globally. Indeed, the public has begun to recognize that the distinction between "domestic" and "global" public health is increasingly a false one. Government officials have come to the same conclusions. In November, Surgeon General Richard Carmona remarked in an interview with Public Radio International (PRI) that his role "truly is a global position" and he anticipates presenting the "first-ever Surgeon General's call to action on global health" in 2006. This document will emphasize the

relevance of global health and emerging infections domestically.

Part of the impetus for this renewed attention to global public health has been the devastating impact of HIV/AIDS worldwide. The global impact of HIV/AIDS "encircles" the U.S. and its "ramifications are rippling," according to Carmona. He has also noted the stake that the average U.S. resident has in preventing HIV/AIDS worldwide, given that "civilizations are wiped out, futures are lost, economic catastrophe ensues [and] whole continents are devastated" as the virus spreads.

Increased media and government attention to global public health presents important opportunities for state public health systems, particularly state AIDS programs. In 2006, it may be important to build upon the focus on public health infrastructure by advocating for resources for comprehensive statewide health systems rather than piecemeal efforts to address individual disease threats. Improved public health laboratories, disease diagnosis and reporting systems, and health education programs can all directly benefit HIV program efforts.

States can also loudly publicize what domestic public health programs have to offer to the global arena. Much of what is needed to improve public health systems globally is already in place in the U.S. and is being implemented by states and state HIV programs. State health departments have years of hands-on experience developing effective surveillance and partner notification systems, and of managing infectious disease prevention and care programs. AIDS programs in particular can also contribute their knowledge of how to mobilize and engage communities to reduce the spread of stigmatized infectious diseases.

Furthermore, state public health programs can capitalize on the focus on global public health by learning from the experiences of other countries. Efforts in Sub-Saharan Africa to address HIV drug-resistance, for example, or research on developing an HIV vaccine or female-controlled microbicides in countries with high HIV prevalence, can significantly benefit the U.S. and other industrialized nations. Similarly, growing global pressure to access cheap, generic drugs for the treatment of HIV and other diseases will help domestic efforts to contain the cost of HIV treatment. By focusing on the common public health need, and by remaining open to sharing resources and experiences, state HIV programs stand to benefit from a continued emphasis on global public health in 2006.

Click [here](#) for NASTAD's *Top Global HIV/AIDS Issues for 2006*.

9. The Integration of Viral Hepatitis into HIV and STD Programs

The recent reorganization of the Centers for Disease Control and Prevention (CDC) will place new emphasis in 2006 on the importance of integrating viral hepatitis prevention services (e.g., hepatitis B and C testing, hepatitis A and B vaccine) into HIV and STD programs. The Division of Viral Hepatitis will soon be co-located with HIV/AIDS and STD prevention when CDC completes this reorganization, creating the National Center for HIV, Hepatitis, STD and TB Prevention (NCHHSTP), which will help increase coordination, planning, and communication across these four program areas at the federal level. Future efforts to integrate hepatitis into such CDC initiatives as HIV/STD counseling and testing guidelines, behavioral surveillance studies, and evaluation and monitoring systems, would better reflect the work of health departments and more accurately capture disease co-morbidities.

In addition, CDC's new Hepatitis B Immunization Recommendations for Adults, which encourages the implementation of hepatitis B vaccine in all settings reaching high risk adults (e.g., HIV counseling and testing sites, STD clinics, correctional settings), will provide needed guidance to providers who have not yet adopted adult hepatitis vaccine recommendations. Furthermore, the Substance Abuse and Mental Health Services Administration (SAMHSA) will begin an adult hepatitis vaccine demonstration project in January 2006, which will provide combined hepatitis A and hepatitis B vaccine to select drug treatment/prevention sites across the country. Finally, the increased emphasis by Congress and the Administration on Avian Flu, vaccine development and vaccine programs targeting adults may help public health bolster its efforts to purchase and provide both hepatitis vaccines and the vaccine to prevent human papilloma virus (HPV).

Unfortunately, continued cuts to federal discretionary health programs may limit the potential of health departments to provide comprehensive HIV, STD and hepatitis prevention services. Moreover, the lack of a strong federal response to address hepatitis B and C mono-infection and co-infection with HIV continues to hinder broader implementation of hepatitis care services. As more effective antiretroviral therapies are

developed for chronic hepatitis B and C, expect greater interest by Congress on access to these therapies for persons living with hepatitis in 2006.

10. Politicization of Prevention

Issues related to HIV prevention continue to be a hot button with Congress and the Bush Administration. In 2005, controversy swirled around the issues of federally funded meetings, abstinence, an anti-sex workers pledge for American not-for-profits receiving federal dollars for global work, harm reduction, and condom efficacy. Below is a quick look back at several of the controversies of 2005. NASTAD expects this level of scrutiny and controversy to continue in 2006.

Last February, the Substance Abuse and Mental Health Services Administration (SAMHSA) asked that the title of a workshop examining suicide risk among lesbian, gay, bisexual, and transgendered (LGBT) individuals be changed to more general language about "sexual orientation," and avoid using the term "gender identity." After the researchers' protest garnered attention from Rep. Barney Frank (D-MA) and major news outlets, government officials agreed to support the original workshop title.

In March, the Department of Health and Human Services (HHS) unveiled a website – www.4parents.gov – to provide parents with tools to talk with their children about sexual health. HIV/AIDS and family planning advocates heavily criticized the content as biased and inaccurate. They also complained that the website did not address the needs of many youth, including sexually active youth, youth who have been or are being sexually abused, and lesbian, gay, bisexual, transgender and questioning youth.

In June, the Administration officially notified U.S. organizations providing HIV/AIDS services overseas that in order to be considered for federal funding, they would be required to sign a pledge that opposes commercial sex work and trafficking. When the President's Emergency Plan for AIDS Relief (PEPFAR) was first authorized in 2003, only foreign organizations receiving U.S. funds were required to have policies that prohibited sex trafficking and prostitution; U.S. based organizations were exempt from this requirement through a Justice Department decision. DKT International, a charity providing prevention services to sex workers, has filed suit against the U.S. Agency for International Development (USAID) for rejecting the group's grant applications because it refused to sign the anti-prostitution pledge. The American Civil Liberties Union (ACLU) filed an amicus brief in the case and was joined by a large number of HIV/AIDS organizations.

In August, the first national conference on methamphetamine and its link to HIV and hepatitis was held in Salt Lake City, Utah. The federal government's sponsorship of the conference was sharply criticized by long-standing harm reduction opponent Representative Mark Souder (R-IN) as well as six Senators led by Chuck Grassley (R-IA). HHS responded to Congressional inquiries by stating that the department was "incorrectly" listed as a conference sponsor and was working with conference organizers to remove its name from conference materials.

In September, Maine Governor John Baldacci (D) declined \$161,000 in federal funds for an abstinence-only sex education program, in part because new federal guidelines prohibit use of funds to teach "safe-sex" practices. Federally-funded abstinence programs continue to receive significant funding increases by Congress (including an increase of \$11 million in FY2006, for a total of \$115 million), while domestic HIV prevention funds are expected to be cut by as much as \$7 million.

On November 14, the Federal Drug Administration (FDA) released its draft guidance for condom labeling. New labeling was a requirement of legislation passed in 2000 authored by then Rep. Tom Coburn (R-OK) that directed FDA to provide more detailed information about the risks associated with certain sexually transmitted diseases (STDs), particularly human papilloma virus (HPV). Despite intense pressure, FDA crafted a careful message that provides more information about risks associated with specific STDs while continuing to promote the benefits condoms provide, including greatly reduced risks of pregnancy and HIV infection. Now a U.S. Senator, Coburn has opined that the FDA condom regulations have not gone far enough by making inconclusive, exaggerated claims about condom effectiveness.

Community Perspectives: Six Things to Watch and Four Things to Try in 2006

By Julie Davids, Community HIV/AIDS Mobilization Project

It's not going to be much fun to watch things in the coming year, so I've tempered this list by including a few things to try as we reconceptualize what we can do in a time of drastic underfunding and blatant health disparities that still have not managed to shock a world into effective action. (Please click [here](#) for an expanded version of this story.)

Things to Watch

- 1. Less, Increasingly, Will Mean Less.** Will 2006 bring the straw that breaks the back of our strained infrastructure? We simply cannot continue to do more and more with less and less.
- 2. Further Expansion of Abstinence-Only Programming.** "Abstinence-only" as a federal funding stream and service framework in the United States and around the world is focused on behavior change but agnostic about public health outcomes.
- 3. PEMS May Emerge from its Holding Pattern, But Still Won't Give Us the Answers We Need.** CDC's Program Evaluation and Monitoring System (PEMS) is supposed to track who is doing what with prevention funds, and evaluate the efforts as well. Before we end up with a mess of burned-out prevention workers and unreliable data, it's time to radically re-think PEMS by separating out the E from the M.
- 4. Learning whether Prevention Works Will Take More than Program Evaluation.** If we really want to ask "does prevention work," perhaps we need to start by asking another question: If we were to learn that an infusion of resources for prevention research, the scale up of innovative programs and the stabilization of core programs would be the answer, would we have the funding to do it?
- 5. They Get AIDS from Needles, Don't They?** We've never devoted enough inquiry to the federal funding ban on needle exchange. With the reality that African American and Latino injection drug users are up to 20 times as likely as white injection drug users to be HIV positive, we have a responsibility to move forward on effective structural interventions to increase access to needle exchange as a component of addressing racial disparities in HIV.
- 6. Prisons are at the Core of HIV but at the Margin of our Efforts.** With at least 20% of people with HIV locked up, prisons are at the core of our epidemic and bringing prison issues to the core of our organizations will not be easy. We need to invest in training, support, and some carrots and sticks to build local, state and national capacity.

Things to Try

- 1 and 2: Get Out and Organize, and Give the Reins to a New Generation.** As a new generation of young people living with HIV and their peers enter the stage, we need to make way by giving them training and tools, and allowing them to think big and strong even if we are demoralized.
- 3. Create Opportunities for Inspiration and Innovation.** Let's try more collaboration between community organizations and researchers, giving frontline workers the chance to help find out if their programs are working.
- 4. The Whole World will be Watching: U.S. AIDS Disparities Laid Bare on Global Stage.** As our nation stands as the largest contributor to the international AIDS fight, it is vital to clarify to people around the world that we have not always had the most appropriate response to HIV within our own borders. Like our civil rights predecessors, we may see that a change in international perceptions may help bring changes here at home. This summer's International AIDS Conference will be an opportunity to highlight this information.

Julie Davids is the Executive Director of the Community HIV/AIDS Mobilization Project (CHAMP) and co-chair of the Federal AIDS Policy Partnership (FAPP).

Capacity Building Calendar

Information on CDC-sponsored Capacity Building Assistance trainings for [January-March](#) is now available.

Note: At press time, the following calendar item had changed:

The January 25-27, 2006 training in Atlanta, GA entitled "Institute on Strengthening HIV Prevention" has been changed to January 31-Feb. 2, 2006. David Alter is also the contact for this training.

Meeting and Planning Calendar

February 7, 2006

National Black HIV/AIDS Awareness Day. For more information, visit the [event website](#).

February 17-20, 2006

[Ryan White National Youth Conference](#), Philadelphia, PA. Presented by NAPWA. For more information, contact Catina Perkins or call (240) 247-1015.

May 2-6, 2006

"Embracing Our Traditions, Values and Teaching: Native People of North America HIV/AIDS Conference," Anchorage, AK. Presented by Inter-Tribal Council of Michigan, Inc. Currently accepting abstracts on Research, Mental Health, Prevention, Special Populations and Stigma, Spiritual Issues and Leadership, and Treatment, Care and Support. For more information, visit the [conference website](#).

May 8-11, 2006

National STD Prevention Conference, Jacksonville, FL. "Beyond The Hidden Epidemic: Evolution or Revolution?" For more information, visit the [conference website](#).

May 19, 2006

National Asian and Pacific Islander HIV/AIDS Awareness Day. For more information, visit the [event website](#).

May 25-28, 2006

"HIV/AIDS 2006: The Social Work Response." Eighteenth Annual National Conference on Social Work and HIV/AIDS, Miami, FL. Sponsored by the Boston College Graduate School of Social Work. For more information, contact [Vincent Lynch](#) (617) 552-4038.

June 4-7, 2006

HIV Prevention Leadership Summit (HPLS), Dallas, TX. For more information, visit the [conference website](#).

June 27, 2006

National HIV Testing Day. Sponsored by the National Association of People With AIDS. For more information, visit the [event website](#).

August 13-18, 2006

XVI International AIDS Conference, Toronto, Canada. Abstract submissions due February 22, 2006. For more information, visit the [conference website](#).

If you have an idea or program relative to any of these topics that you would like to include in the *Bulletin*, please contact [Nyedra Booker](#) (202/434-8090). The NASTAD *HIV Prevention Bulletin* is written and edited by NASTAD staff and participants of community planning and prevention efforts around the country.

NASTAD's production of the *Bulletin* is made possible through funding provided by CDC's Division of HIV/

AIDS Prevention (DHAP) in the National Center for HIV, STD, and TB Prevention.

LET US KNOW WHAT YOU THINK! NASTAD welcomes feedback to issues presented in our newsletter. To submit commentary, please e-mail us at NASTAD@NASTAD.org.

Visit our Webpage! Electronic versions of the *Bulletin* are posted along with other information on both NASTAD's prevention and care projects.

444 North Capitol Street, NW • Suite 339
Washington D.C. 20001 • nastad@nastad.org



Click [here](#) to unsubscribe

444 N. Capitol Street, NW, Washington, DC 20001