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***"We still need to consider that we may be underestimating the burden and impact of this insidious global epidemic, and that perhaps silence does still equal death on the worldwide scene, and that denial and complacency are still the greatest enemies to progress."***

- Emory University's Jim Curran, in a [CDC/KFF Press Conference](#)

## Reflections on AIDS at 25

A flurry of media, publications and presentations accompanied the commemoration of the twenty-fifth year since the first publication on AIDS in the *Morbidity and Mortality Weekly Report* (MMWR) on [June 5, 1981](#). This important milestone prompted widespread reflections on where we have come with the epidemic, with an eye to what we should be doing to stem the tide in the future. [Last month](#), NASTAD profiled the plenary session the Centers for Disease Control and Prevention (CDC) presented at the HIV Prevention Leadership Summit (HPLS) in Dallas, TX. This month, the *HIV Prevention Bulletin* continues this focus by presenting reflections by NASTAD, health departments, and partners on the implications for HIV/AIDS programs, and also includes summaries and links to recent press and publications on "AIDS at 25."

## The State of Prevention

In January 2006, NASTAD convened AIDS directors and prevention directors from the 65 jurisdictions funded by CDC for HIV prevention programs in Atlanta for a meeting with CDC to discuss their successes and challenges in implementing HIV prevention programs. It was the first time in several years that health departments and CDC met to discuss administration of health department prevention programs, which represent about 60 percent of CDC's extramural domestic budget for HIV/AIDS. The following "status report" represents the collective thinking of health departments on the state of prevention 25 years into the epidemic.

### *Challenges Facing HIV Prevention Programs*

Today, there can be little doubt that HIV prevention works. Since the beginning of the epidemic, there have been key successes including reduced mother-to-child transmission and reduced transmission among injection drug users (IDUs). Blood supply screening has also been a major success with transfusion related infections now nearly non-existent. Today, however, HIV prevention and surveillance programs operate in a very different environment that endangers this success and threatens to derail current prevention efforts. If these challenges are not addressed our progress may be stymied and we may see a reversal in trends and rising rates of HIV infection.

- *Inadequate Resources.* In 2006, CDC cut health department cooperative agreements by nearly 3 percent. This includes not only the \$5 million cut in funds appropriated by Congress for prevention in FY2006 and the one percent federal budget rescission, but also cuts to meet other funding gaps as well. This comes on top of several years of budget cuts and rescissions that have eroded health department prevention and surveillance funding. As a result, health departments are being forced to eliminate key programs such as HIV rapid testing and programs to address the epidemic in impacted communities, particularly communities of color. Surveillance is also highly affected as the ability of health departments to conduct core surveillance deteriorates, resulting in fewer cases reported and therefore less funding for states in the future.

At the same time, costs to implement HIV prevention programs have increased.

Technologies such as acute HIV testing and rapid HIV testing provide new methods of reaching individuals that are infected but are unaware of their status. Yet despite their potential cost effectiveness, these technologies come with increased upfront costs related to training and quality assurance that do not exist with current testing technologies. These costs have placed a strain on health department prevention programs and prevented health departments from implementing these technologies to their full benefit. At the same time, until recently, health departments were told they were required to implement the Program Evaluation and Monitoring System (PEMS). PEMS is designed to monitor the effectiveness of programs, but the resources required including human capital and funding may negatively impact program quality.

- *Political Climate.* The current conservative political environment continues to impact the ability of health departments to conduct HIV prevention activities. Resistance to frank information about sexual transmission needed to reach some communities, including comprehensive sexual education for youth, as well as harm reduction information for injection drug users (IDUs) hinder programs from using the most effective interventions. A website sponsored by the Department of Health and Human Services, [www.4parents.gov](http://www.4parents.gov), required significant content revisions due to its presentation of inaccurate information. Also, the effectiveness of harm reduction continues to be questioned despite significant evidence in support of it.

Abstinence-only funding continues to be an example of ideology taking precedence over science. Despite strong evidence about the effectiveness of comprehensive sexual health programs for youth, <sup>1</sup> which include information on abstinence, funding for abstinence-only programs continues to increase dramatically. The President's FY2007 budget calls for an increase of \$27 million for abstinence education programs to \$204 million, with a goal of \$290 million by FY2009. Yet, there is currently no scientific evidence to support the effectiveness of abstinence-only programs, <sup>2, 3</sup> and many of these programs are exempt from the rigorous evaluation required of more comprehensive programs. Furthermore, the removal of the "C" component of the widely-touted "ABC" approach (**A**bstinence, **B**e faithful, and **U**se condoms) to global HIV prevention seriously undermines its effectiveness, which has also been rigorously evaluated and proven effective as a *comprehensive* approach.

The political climate has created an environment where prevention programs continue to receive an inordinate amount of scrutiny. A recent harm reduction conference received intense political criticism due to the titles of a couple of sessions, although the conference was overall scientifically sound. As a result, the CDC and state health departments were forced to spend valuable time responding to information requests regarding the conference even though the planners had followed the necessary procedures and ensured everyone was fully informed about the conference in advance.

### *Impact on HIV Prevention Programs*

- *Deterioration of public health infrastructure.* The impact of reduced funding across all public health programs coupled with rising health care costs results in the deterioration of public health infrastructure. Positions within health departments remain unfilled, impacting their ability to implement and evaluate prevention and surveillance programs. New technologies such as HIV rapid testing are not deployed to their fullest benefit because of lack of capacity, and the additional training and evaluation costs not associated with current technologies. As a result, programs are forced to do more with less. While this may lead to a focus on only the most effective programs, it also creates a situation where program quality will eventually decline. At the same time, community based organizations (CBOs)

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-serving highly impacted communities, particularly communities of color, find themselves losing staff and cutting back on services in an effort to keep their doors open.

Cuts to programs supporting related health conditions also have an impact on many HIV programs. Sexually transmitted disease (STD) programs and hepatitis programs serve the same clients. Interventions such as partner counseling and referral services (PCRS) are often shared responsibilities between programs. When viral hepatitis or sexually transmitted disease (STD) programs are cut, the impact is felt in HIV programs as well. In addition, cuts to mental health services and substance abuse treatment create service gaps that prevent treatment of the underlying causes of these epidemics.

- *Prevention interventions guided by ideology.* The focus on ideology over science limits the ability of prevention programs to use the most effective tools available. As noted above, the focus on abstinence-only, despite no evidence of effectiveness over comprehensive sexual education programs, places youth at higher risk. Interventions with proven effectiveness cannot be supported by CDC due to sexually frank content and are kept from the [Compendium of Effective Interventions](#) and the Diffusion of Effective Behavioral Interventions (DEBI) project. Continued barriers to providing sexually explicit information needed in some communities denies the reality of individuals' lives. And by limiting the use of effective interventions, we continue to place individuals at risk for HIV infection.
- *Competing approaches to prevention.* Without resources to implement a full continuum of prevention programs, health departments are forced to make difficult choices on what interventions will best impact the epidemic within their jurisdiction. Resources can be spread across a continuum of activities, without funding any one fully, or can be concentrated in specific areas, leaving clear gaps. Health departments are forced to make difficult choices between interventions that should be complementary but are now seen as competitive, including routine versus targeted testing; biomedical versus behavioral approaches; and interventions for positive persons versus interventions for high risk negatives.

The current, heavy focus on HIV testing is one example of tensions arising from conflicting approaches. Testing remains the cornerstone of many prevention programs given the important care and prevention outcomes linked to knowledge of serostatus. Individuals that learn they are HIV positive take clear steps to protect their partners and experience better health outcomes from early linkage to care. However, over-emphasis on testing can be problematic as it only focuses on individuals already HIV positive. Behavioral and other interventions are still vital in addressing the needs of negative individuals at high risk for infection. CDC emphasizes the continued importance of addressing the needs of high risk negatives, but without critical resources the trend has shifted to testing over other prevention strategies.

- *Prevention increasingly prescribed at the national level.* As prevention programs have come under increased scrutiny, there have been growing efforts to dictate HIV prevention at the national level, including what interventions must be used and what populations should be targeted. While national leadership is critical, these efforts have become more about prescribing prevention at the local level rather than offering needed guidance. While the CDC *Compendium of Effective Interventions* and the DEBI project are important, focusing too narrowly on a small set of interventions does not meet local needs. More interventions are needed to fight the epidemic within key communities, particularly communities of color. The development of such interventions will come from supporting the use of "homegrown" interventions with adequate resources to build and evaluate these interventions.

Prevention requires national guidance, but it should be developed and implemented at the local level. Community input is valuable in setting the prevention direction. However, in a more prescriptive environment, the value of one approach to planning comes into question. New models of community input are needed to provide the local input and direction necessary for successful prevention programs.

- *Focus on accountability to the exclusion of program quality.* With increased scrutiny come calls for increased accountability of programs. Accountability is vital to prevention programs to demonstrate their effectiveness and identify when programs must be changed or phased out. However, accountability cannot come at the cost of program quality. PEMS has raised concerns that data collection will take precedent over serving clients. The data burden associated with PEMS is not compatible with sound public health practice given the time and intensity of data collection. As a result, health departments must divert resources and manpower toward data collection and programs are at risk of losing clients due to potentially invasive questions. Data collection is already being done by many health departments in a manner that assures both accountability and program quality. PEMS, however, must be significantly streamlined and scaled-back in order to be effective.

### *Recommendations*

- *Support increased funding to health department HIV prevention programs and programs impacting related health conditions.* To address the growing needs of HIV programs and co-morbidities such as STDs and viral hepatitis, funding needs to be increased. While it may be important to link some funding to particular initiatives, jurisdictions should be given the flexibility to use increased funding to strengthen public health infrastructure and the overall quality of programs across the entire prevention portfolio.
- *Support science as the basis for HIV prevention programs.* Science should determine the best strategies to fight the epidemic regardless of ideology. Frank, explicit interventions should be used as required, and harm reduction embraced as an effective prevention strategy.
- *Support local determination of HIV prevention needs and programs in conjunction with national guidance.* Determination of prevention needs and programs should be kept at the state and local level. National leadership is critical, but program decisions should not be made at the national level.
- *Support the use of multiple prevention strategies within programs.* Prevention programs should be encouraged to adopt a wide spectrum of interventions as appropriate to the needs of the communities that they serve and be provided with the necessary funding to support them. However, without additional funding, health departments should be given the flexibility to determine the best mix of strategies for their jurisdiction. Jurisdictions should not be forced to focus on a narrow set of interventions or settings if that does not meet their local need.
- *Support accountability measures in line with sound public health practice.* Accountability is a necessary part of any program, but that accountability cannot come at the expense of good public health practice. Data collection should be reasonable and not overly burdensome to clients and providers. Data collected should only be what is necessary to monitor the program and ensure it achieves its goals.

Health departments continue in their efforts to ensure that HIV prevention works. Program

standards remain high and jurisdictions have focused on critical prevention elements essential to success. Health departments continue to respond to emerging issues such as the rise in syphilis among men who have sex with men and the growing connection between HIV and methamphetamines. However, in the face of current challenges, it is becoming unclear how long health departments can maintain success. Health department need to be supported with resources and sound public health policy to develop and implement the best programs possible.

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***“Prevention programs must engage civil society and be evidence-based (not moralistic), locally planned, and linked to efforts to reduce stigma and elevate the status of women.”***

- [Mike Merson](#), Director of the Yale Center for Interdisciplinary Research on AIDS and former director of the World Health Organization’s HIV/AIDS program

## CDC Commemorates 25 Years Since First AIDS Publication

In addition to HPLS, CDC conducted several activities to commemorate the twenty-fifth year since the first publication on HIV/AIDS. On May 5, 2006, CDC and the Kaiser Family Foundation hosted a press conference, [25 Years of AIDS: Current and Former CDC HIV/AIDS Leaders to Discuss State of U.S Epidemic](#), featuring Kevin Fenton, current director of the National Center for HIV, STD and TB Prevention, and other HIV/AIDS leaders at CDC, as well as Jim Curran, Dean of the Rollins School of Public Health at Emory University and former Director of the Division of HIV/AIDS Prevention at CDC. From his perspective as a CDC researcher at the time AIDS first emerged, Curran highlighted three lessons of the past 25 years, including the importance of surveillance, the role of innovative science in addressing HIV, and the fact that HIV prevention works. Fenton’s remarks largely reflect the content of the [June 5, 2006 MMWR](#) commemoration, noting several key prevention successes:

- Reducing mother-to-child (perinatal) HIV transmission;
- Reducing the number of annual HIV infections, from an estimated 150,000 new infections in the 1980’s to approximately 40,000 new diagnoses per year;
- The steady decline of HIV/AIDS diagnosis among injection drug users (IDU);
- Improvements in blood donor screening and testing technologies; and
- Advancements in screening technologies that have enhanced the widespread uptake of HIV testing.

Some of the key challenges include having more than one million Americans living with HIV/AIDS while approximately a quarter of those infected are unaware of their HIV status. Another critical challenge is addressing the populations that remain at increased risk for HIV infection, including

men who have sex with men (MSM) and racial and ethnic minority communities. Changing the public's perception of what an HIV infection means is also a central challenge. During the press conference, Fenton noted that "during the last decade, major advances in treatment for HIV/AIDS have prolonged and improved the lives of many, but as they will be the first to say, living with HIV infection is not easy."

Key opportunities for addressing the epidemic include increased access to voluntary HIV testing, developing prevention messages focused on both HIV positive and HIV negative persons, integrating HIV prevention programs with care and treatment and other programs or diseases, developing new prevention technologies, and improving the monitoring of new HIV infections.

For more information, visit [CDC's commemorative activities and publications website](#).

## **Twenty-Five Years of Servanthood**

*by Jesse Milan, Jr., JD*

Twenty-five years is a significant slice of human history. It is certainly for me. I became infected just one year after the HIV virus was identified in 1981. Over the past 25 years, I have had a front row seat as a policy and program volunteer and professional to the many milestones in HIV/AIDS – from the creation of new community-based organizations, to the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, AIDS Drug Assistance Programs (ADAP), Housing Opportunities for People With AIDS (HOPWA), highly active anti-retroviral therapies (HAART), and now fixed dose regimes and the President's Emergency Plan For AIDS Relief (PEPFAR). And, as an African American and gay man, I have stood at bedsides and sat in memorial services too numerous and painful to recall.

I am hardly alone in having these experiences. The calluses from building HIV/AIDS community-based infrastructure, the scars of serving on planning councils and community planning groups, the pains of serving in government programs on AIDS; and the memories of tears shed for friends and lovers are ones that I share with thousands and thousands of others who have dedicated portions of their lives to this disease.

Yet through all the hard, sad, and difficult experiences of the past 25 years, the joys of working in HIV/AIDS outweigh them all.

Joys from working in HIV/AIDS? Am I crazy? Has dementia finally set in? I don't think so, for the joys of working in HIV/AIDS are those that we share, but rarely name. They are the joys derived from serving others.

Servant leadership is often not acknowledged or well understood. It is based on hearing at the deepest personal level a call to serve others, and it is lived out through efforts made with no expectation of reward. Twenty-five years of HIV/AIDS is a 25-year history of servant leadership on a scale and dimension the likes of which our country and the world has never experienced. The array of people who have responded to HIV/AIDS as servants over the past 25 years is amazingly diverse and includes hardcore advocates who acted up and demanded policies and programs that saved lives; financial wizards who figured out how to make payroll when nothing was there; program developers who crafted new ideas and never slept until their grant applications were finished; and queens who gave fabulous fundraisers befitting royalty. Though we wore different hats and titles, and had different roles and outcomes, we all shared the common joys of servanthood: The joy of trying our hardest in often messy, exhausting, and dangerous circumstances. The joy of persevering against funding, political, and social odds. The privileged joy of being with men, women and children who were traveling their last days on

Earth. The undocumented joy of helping someone avoid infection, dispel stigma, attain treatment, or remain hopeful. The special joy of bridging gaps across races, ages, cultures, genders, transgenders, and sexual orientations.

Have we been completely successful? No. Is there more we could have done? Definitely. Has it been worth it? Hell, yes. Is there more left to do? Sadly, yes. HIV/AIDS is relentless in its demands. But, for this past quarter century, people like the members of NASTAD have responded in ways that define servant leadership – heroic and often unheralded efforts achieved in large and small ways, day after day.

As one who has been living with HIV for literally the entirety of the epidemic, I want to say thank you. I may not be empowered to thank you on behalf of the thousands of Americans who have died, or on behalf of the more than a million in the U.S. living today with HIV/AIDS, but I can thank you on behalf of myself – a man with a personal stake in this epidemic who witnessed the landscape of HIV/AIDS programs and policies, and of HIV/AIDS care and compassion be changed and sustained because of servant leaders like you.

*Jesse Milan, Jr., JD is Vice President for Global Health Convergence at the Constella Group, LLC. He is co-chair of the CDC/HRSA Advisory Committee on HIV and STD Prevention, Treatment and Care (CHAC), current board chair of the Black AIDS Institute, and former director of the AIDS Office for the City of Philadelphia Department of Public Health.*

***“Coming in from the outside to hang up posters doesn’t work. You have to convince people that they have rights worth fighting for, and that progress is feasible.”***

- UNAIDS director Peter Piot in [Newsweek](#)

## **AIDS at 25: Addressing Communities of Color**

After 25 years, HIV/AIDS is now considered a “health crisis” for many communities of color. Although collectively African Americans and Latinos comprise roughly 27 percent of the U.S. population, these communities account for 68 percent (African Americans – 50 percent and Latinos – 18 percent) of the estimated number of persons diagnosed with HIV/AIDS in 2004. <sup>1</sup> An epidemic once associated primarily with white gay men, has been, and continues to be, an epidemic that disproportionately impacts communities of color. Twenty-five years into the epidemic, the early challenges of addressing HIV/AIDS within the often complex cultural, racial and socioeconomic contexts impacting these communities still remain difficult to solve.

In 1998, NASTAD identified “Addressing HIV/AIDS Health Disparities among Racial and Ethnic Minority Communities” as a top priority. In 2001, NASTAD further refined and strengthened this priority by identifying “Primary HIV Prevention and Access to Care for Communities of Color” as a top policy priority. In order to raise awareness around the myriad issues impacting HIV prevention and care for these communities, NASTAD has dedicated many issues of the HIV Prevention Bulletin to various communities of color and NASTAD has released several publications, including: [HIV/AIDS: African American Perspectives and Recommendations for State and Local Health Departments](#) (November 2001), [A Turning Point, Confronting HIV/AIDS in African American Communities](#) (November 2005), [Addressing HIV/AIDS, Latino Perspectives and Policy Recommendations](#) (2002), a [Native American report](#) (November 2004), a [Black MSM issue brief](#) (February 2006) and a forthcoming report on Asian and Pacific Islander (API) communities.

A tremendous amount of work has been done by NASTAD and many other national organizations, community-based organizations, federal agencies and other partners to address the disproportionate impact of HIV/AIDS in communities of color. But the rate of new HIV infections among specific populations including African American men who have sex with men (MSM), African American women, and Latinos, as well as certain Native American and API communities, reveal that the HIV/AIDS crisis in communities of color is far from over.

So what are some of the challenges that lie ahead in addressing the HIV prevention needs for communities of color, particularly for some of the hardest hit communities? Although the bulk of the global HIV/AIDS pandemic among women falls on other parts of the world, the impact of HIV/AIDS on African American women in the U.S. cannot be ignored. While the proportion of estimated AIDS cases being diagnosed among women has tripled since 1985, the most dramatic increases have been experienced by African American women.<sup>2</sup> Women of color accounted for 80 percent of all women estimated to be living with AIDS in 2004 and African American women accounted for 64 percent of these cases. <sup>2</sup>

Poverty is an issue that continues to plague many communities of color and creates conditions that may lead to risky behavior. African American women at high risk for HIV are often caught at the intersection of poverty and other factors that may place women at a disproportionate risk for HIV including imbalances of power, discrimination and even the scarcity of female-controlled HIV prevention methods. Meeting the HIV prevention needs of African American women will require broader dialogue surrounding the complex set of factors that place these women at risk, and further commitment from a variety of stakeholders. There must also be further support for research into microbicides and other HIV prevention methods that place the power of prevention in the hands of women.

Just as African American women are experiencing a disproportionate burden of the HIV/AIDS epidemic, the tremendous impact of HIV/AIDS on African American MSM in the U.S. is also well documented. Much attention was raised over data released at the 2005 National HIV Prevention Conference showing that 46 percent of the Black MSM tested in a study involving five urban cities, were found to be HIV positive. More alarming, 67 percent of these HIV positive men were unaware of their status. Addressing the needs of African American MSM will require that further attention be placed on specific populations including gay or same gender loving men, young gay men, and non-gay identified men who have sex with men and women. Effective strategies for reaching these men to encourage HIV testing, regular condom use and other risk reduction behaviors can differ. Additionally, strategies to prevent HIV transmission and urge African American MSM to access care should consider the social, cultural, sexual, racial and socioeconomic issues that define the realities for these men.

Latinos, like African Americans, face many complex cultural, social, socioeconomic and other issues that place them at a disproportionate risk for HIV. While male-to-male sexual contact is the most common mode of HIV transmission among these men, Latinas are at greatest risk of contracting HIV through heterosexual contact. Given that approximately forty percent of Latinos residing in the U.S. are foreign-born, <sup>3</sup> prevention efforts must accurately reflect the language and culture of Latinos, keeping in mind that a "one-size fits all" approach is not adequate to engage Latinos. It is also critical to understand that seemingly unrelated issues and concerns such as the recent national debate on immigration may also serve to socially isolate individuals from seeking timely HIV testing, treatment and prevention.

Addressing HIV/AIDS among communities of color requires a thoughtful examination of the successes and lessons learned from the past 25 years of this epidemic, as well as an acknowledgement that the needs, concerns and realities within communities of color are becoming increasingly more complex and HIV prevention strategies for the future must take these factors

into account.

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***“Reducing the toll among African-American [men who have sex with men], and African Americans overall, will require a comprehensive and sustained response. There is really no simple solution. There are many complex factors that we have to deal with: stigma, racism, denial, poverty. This really requires a comprehensive approach where we have to have sustained partnerships between the government, community, community leaders, community-based organizations, health care providers and families.”***

- CDC behavioral scientist Greg Millett, as reported in “What’s Gone Wrong?” by Benjamin Ryan in the July 2006 *HIV Plus* magazine

## AIDS at 25: Care and Treatment

Over the past 25 years, we have truly witnessed evolutionary progress in the diagnosis and treatment of HIV disease. Once relegated to treating this terminal illness with palliative care, the model of care has evolved to a chronic infectious disease approach. Twenty-five years ago, there were few resources for medical care, little case management, and no HIV-specific medications; today, there is an infrastructure designed to provide medical care, HIV treatment medications, and psychosocial support for people living with HIV. The advent and development of antiretroviral medications and the establishment of HIV care and treatment services delivery systems in states and urban areas are the overwhelming successes in the U.S. Despite this progress, two significant challenges remain: 1) ensuring access and adherence to HIV medical care; and 2) maintaining linkages between HIV prevention and care and treatment.

The Ryan White CARE Act, including the establishment of state AIDS Drug Assistance Programs (ADAP), has advanced access to HIV related medications, medical care, and other psychosocial support greatly over the past 15 years. In addition, the development of resistance testing technology, the availability of guidelines for antiretroviral regimens and opportunistic infection treatment/prophylaxis, and the continual advancement of clinical and psychosocial models of care and service delivery are testaments of how extensively HIV care and treatment has developed. However, ensuring access to care and treatment resources remains difficult due to:

- inconsistent or reduced federal funding for medications through ADAP, for HIV health care, and for the care system infrastructure;
- geographic or regional availability of resources; and
- service delivery system gaps.

These challenges are compounded by socioeconomic and cultural barriers experienced by communities impacted by HIV, especially communities of color which have historically been disenfranchised from quality health care.

Despite the increasing arsenal of HIV treatment options, side effects, pill burden, and resistance to available medications or regimens are disincentives for individuals to stay engaged in their HIV care and treatment. Combined with comorbidity with substance abuse, other sexually transmitted diseases, viral hepatitis and acute/chronic mental health conditions, these are the main reasons for lapses in treatment adherence. Lapses in treatment adherence result in medication resistance in both newly diagnosed and treatment experienced individuals, making it still more difficult to maintain a manageable health regimen. Engaging people living with HIV in care and treatment through models that incorporate psychosocial support with medical care can promote adherence and provide an opportunity to deliver prevention information in the clinical setting.

Focusing prevention efforts on HIV-positive people through a variety of care and treatment settings provides additional opportunities for prevention education. Integrating prevention and care should be facilitated through communication at the state, local and community levels about integration strategies; through the co-location of prevention and care in clinical and other service provider settings; through creative resource distribution that allows both prevention and care to be provided collaboratively; through a community planning process that considers the prevention and care needs of the state population; and most importantly, through the development of strong linkages between counseling and testing initiatives and care and treatment resources. State HIV programs are the key facilitators in these processes.

The continual development of medications to treat HIV in simple, effective regimens remains a top priority in HIV care and treatment; however, medication development is only part of the future of HIV care and treatment. Establishing stable access to care and treatment resources in states and urban areas is critical to adherence. As funding resources continue to place constraints on the HIV prevention and care infrastructure, collaborative integration with other health care and psychosocial support systems will be required to maintain access to care for people living with HIV. Encouraging HIV testing as a routine part of health care may increase HIV diagnoses prior to advanced disease progression. Implementing a process for linking an individual from HIV testing and counseling services to care and treatment services increases the likelihood of engaging in HIV health care and treatment adherence. Policymakers and practitioners alike should recognize and respond to these lessons learned. The future of HIV care depends on establishing HIV prevention as a priority in care and treatment initiatives.

## **AIDS at 25: Integrating Viral Hepatitis Services**

Twenty-five years ago, there was little public awareness of the impact of viral hepatitis. However, over the course of the last 25 years, the importance of viral hepatitis has emerged as a central challenge for HIV/AIDS programs and, coupled with the increasing need for public health integration in an era of shrinking resources, has made it imperative that we address viral hepatitis in many of the settings and for many of the communities receiving HIV/AIDS services.

HIV/AIDS prevention programs have identified large numbers of people at risk for hepatitis A virus (HAV), hepatitis B virus (HBV) and hepatitis C virus (HCV) infection, which are the most common types of viral hepatitis in the U.S. These viruses impact many of the same populations who are at-risk of, or infected with, HIV; at least one-quarter of persons living with HIV are co-infected with HCV, and up to 10 percent of persons infected with HIV are also infected with HBV.

Behaviors that put people at risk for HIV may also be exposing them to viral hepatitis. To comprehensively serve the needs of individuals served through HIV programs, planners can offer

viral hepatitis prevention for very little cost. Including recommendations for hepatitis services in community planning documents, providing brochures in waiting rooms and incorporating hepatitis messages into counseling and evidence based interventions are a few steps toward integration of viral hepatitis programs into HIV/AIDS programs.

Viral hepatitis services can be included in HIV services by providing HCV testing and HAV and HBV vaccination to at-risk individuals. In addition, treatment for hepatitis B and C can be provided through AIDS Drug Assistance Programs (ADAP) or other HIV treatment programs. While lack of funding may be a barrier for HIV programs to include these viral hepatitis services, it is much more cost-efficient to integrate these services into existing infrastructure rather than attempting to build new services for co-infected individuals. Serving mono-infected individuals living with hepatitis also remains a challenge in this limited funding environment where viral hepatitis services have not received the attention or priority necessary among public health policymakers and lawmakers to effectively combat the epidemic.

State health departments can demonstrate their continuing commitment to public health by focusing attention to the growing viral hepatitis epidemic and take steps toward integration. Integration of viral hepatitis programs into existing services has become a major goal of many HIV/AIDS/STD programs. To support this goal, NASTAD produced "[Viral Hepatitis and HIV/AIDS Integration: A Resource Guide for HIV/AIDS Programs](#)".

*For more information on integrating hepatitis into HIV programs, contact [Chris Taylor](#). For information on hepatitis recommendations and services, contact your state's [Hepatitis C Coordinator](#) and/or [Hepatitis B Coordinator](#).*

## **MTV/Kaiser Family Foundation's think HIV and Youth Vlogging Competition**

[think HIV](#) is a new website about HIV/AIDS, developed by [MTV](#) and [Kaiser Family Foundation](#) for adolescents and young adults in the U.S. Since the first AIDS case was documented 25 years ago, a generation of young people has grown up never knowing a time without the disease. This project is designed for this first generation of Americans who have lived their entire lives during the AIDS epidemic.

The site will go live during the International AIDS Conference (AIDS 2006) in August as an engaging, interactive, safe space for young people to share their personal stories through videos, photos, "blogs" (web logs), and text about HIV/AIDS. The user-friendly site will also provide easy access to information and resources about HIV/AIDS including prevention and testing, and access to health information, developed by Kaiser and NASTAD.

The kick-off to the site is an "essay contest" called the [Alive at 25 HIV Vlogging Competition](#). In June, young people ages 13-25 from around the country were encouraged to submit essays of 250 words or less to MTV on why they should be selected as the exclusive think HIV "vlogger" (video blogger) for their state. One winner will be selected from each state by Kaiser, MTV and NASTAD, and will be given a video camera to create an on-going video diary about what HIV/AIDS means from their unique perspective. Vlogs will appear live on the think HIV website on August 18. One vlogger will be awarded a grand prize VIP trip to the MTV studios in New York, and earn the opportunity to showcase the winning vlog on MTV.

*For more information, contact [Kellye McKenzie](#).*

***“We can only hope that the years ahead will be characterized not just by better drugs, new vaccines and improved prevention methods, but also by the adoption of the humility necessary to control a disease that is transmitted through sexual activity and drug use – two of proper society’s least favorite topics.”***

- Memorial Sloan-Kettering Cancer Center specialist [Kent Sepkowitz](#)

## Resources and Links

### ***CDC Resources:***

- CDC’s press and publications in commemoration of “AIDS at 25” can be accessed at: <http://www.cdc.gov/hiv/spotlight.htm>.
- A timeline is accessible at: <http://www.cdc.gov/hiv/resources/other/PDF/TimeLine%202006.pdf>

### ***Kaiser Family Foundation AIDS at 25 Resources:***

- The Kaiser Family Foundation, a leader in on-line HIV/AIDS resources: <http://www.kff.org/hivaids/aidsat25.cfm>
- Chartpack Overview of Major Trends in the U. S. Epidemic: <http://www.kff.org/hivaids/upload/7525.pdf>
- Overview of Media Campaigns: <http://www.kff.org/entpartnerships/upload/7515.pdf>
- Survey of Americans on HIV/AIDS, which found that the American people do not suffer from AIDS fatigue and want to see an investment in HIV/AIDS: <http://www.kff.org/kaiserpolls/pomr050806pkg.cfm>

### ***Other Resources and Links:***

- National Institutes of Health’s Page and Statement by Director Zerhouni: <http://www.25yearsofaids.oar.nih.gov/>
- The Body – a web-based source for HIV/AIDS information. Summarizes and provides links to AIDS at 25 coverage at: <http://www.thebody.com/whatis/25years.html>
- Keith Boykin’s coverage of the impact of HIV/AIDS on African Americans: [http://www.keithboykin.com/arch/2006/06/06/aids\\_at\\_25\\_the](http://www.keithboykin.com/arch/2006/06/06/aids_at_25_the)
- *Newsweek*’s coverage:
  - o <http://www.msnbc.msn.com/id/12663345/site/newsweek/>
  - o <http://www.msnbc.msn.com/id/3034456/>

### ***Global Impact:***

- Link to the *Frontline* series, “The Age of AIDS”: <http://www.pbs.org/wgbh/pages/frontline/aids/view/>
- Mike Merson, Director of the Yale Center for Interdisciplinary Research on AIDS and former director of the World Health Organization’s HIV/AIDS program: NEJM Commentary
- Commentary in *Newsweek* by Peter Piot, director of the United Nations’ Joint Program on HIV/AIDS (UNAIDS):
  - o <http://www.msnbc.msn.com/id/12665066/site/newsweek/>

- o <http://www.msnbc.msn.com/id/12665678/site/newsweek/>
- National Public Radio's *News and Notes* with Ed Gordon, focused on women: <http://www.npr.org/templates/story/story.php?storyId=5548540>

***Is [progress in reducing HIV transmission] a lack of "skill or will"?***

- [David Holtgrave](#), chair of the Department of Health, Behavior and Society in the Bloomberg School of Public Health at Johns Hopkins University and former director of the CDC Division of HIV/AIDS Prevention

**Meeting and Planning Calendar**

August 13-18, 2006

XVI International AIDS Conference, Toronto, Canada. For more information, visit the [conference website](#).

August 23-24, 2006

Indian Health Service, Division of Behavioral Health, 2006 HIV/AIDS Collaborative Regional Training, Oklahoma City, OK. Sponsored by the Indian Health Service Office of Urban Indian Health Programs, SAMHSA, NIMH, HRSA, and the National Minority AIDS Education And Training Center. For more information, visit the [training website](#) or contact [Victor Paternoster](#) (509) 747-4994.

August 23-25, 2006

"Share the Vision" Association of Nutrition Services Agencies (ANSA) conference, San Francisco, CA. For more information, visit the [association website](#).

August 28-31, 2006

The Ryan White CARE Act Grantee Conference and the 9th Annual Clinical Conference Update, Washington, D.C. Workshop and poster presentations will be grouped under six tracks: 1) access to care; 2) quality; 3) program development; 4) coordination and linkages; 5) administration (fiscal and program management); and 6) data evaluation and outcomes. For more information, visit the [conference website](#).

September 12-14, 2006

CDC's 2006 National Health Promotion Conference: Innovations in Health Promotion: New Avenues for Collaboration, Atlanta, GA. For more information, visit the [conference website](#).

September 24-26, 2006

United States Conference on AIDS (USCA), Hollywood, FL. For more information, visit the [conference website](#).

September 25-26, 2006

"Decade of HAART: Historical Perspectives and Future Directions," San Francisco, CA. Sponsored by International Association of Physicians in AIDS Care (IAPAC) and the University of Medicine and Dentistry of New Jersey, Center for Continuing and Outreach Education (UMDNJ-CCOE). For more information, visit the [conference website](#).

October 15, 2006

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

November 4-8, 2006

"Public Health and Human Rights," American Public Health Association's 134th Annual Meeting, Boston, MA. For more information, visit the [conference website](#).

November 9–12, 2006

Sixth National Harm Reduction Conference, Oakland, CA. For more information, visit the [conference website](#).

December 1, 2006

World AIDS Day. For more information, visit the [event website](#).

December 6-10, 2006

The 2006 Staying Alive Conference: "Access Matters," New Orleans, LA. For more information, visit the [conference website](#).

February 1-3, 2007

"Science and Response 2007" The 2nd National Conference on Methamphetamine, HIV and Hepatitis, Salt Lake City, UT. For more information, visit the [conference website](#).

February 17-19, 2007

Ryan White National Youth Conference, Oakland, CA. Sponsored by NAPWA. For more information, visit the [organization's website](#).

March 21, 2007

American Indian HIV/AIDS Awareness Day. Designated at the "[Embracing Our Traditions](#)" [Conference](#) in Anchorage, AK.

April 5-7, 2007

"HIV/STD Prevention in Rural Communities: Sharing Successful Strategies V," the Rural Center for AIDS/STD Prevention national conference, Indiana University, Bloomington, IN. A call for papers will be issued in fall 2006. For more information, visit the [RCAP website](#).

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## Credits, Feedback, and Input

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.

If you have an idea or program relative to any of these topics that you would like to include in the *Bulletin*, please contact [Lynne Greabell](#) (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.

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](mailto:NASTAD@NASTAD.org).

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

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prevention and care projects.

444 North Capitol Street, NW • Suite 339  
Washington D.C. 20001 • [nastad@nastad.org](mailto:nastad@nastad.org)

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