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NASTAD HIV PREVENTION BULLETIN
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National Alliance of State and Territorial AIDS Directors

In this issue:

Table of Contents:

- Defining and Measuring Success
- A Program Evaluation Perspective: Thoughts from Janet Myers and Steve Morin of the University of San Francisco Center for AIDS Prevention Studies (UCFS-CAPS)
- Maryland's *Pharaoh* Program
- Implementing the L.I.F.E. Program® in Missouri
- Wisconsin's Use of Social Networks Strategy for HIV Testing
- The Institute for HIV Prevention Leadership: Successfully Developing the Workforce
- Conclusion
- Meeting and Planning Calendar

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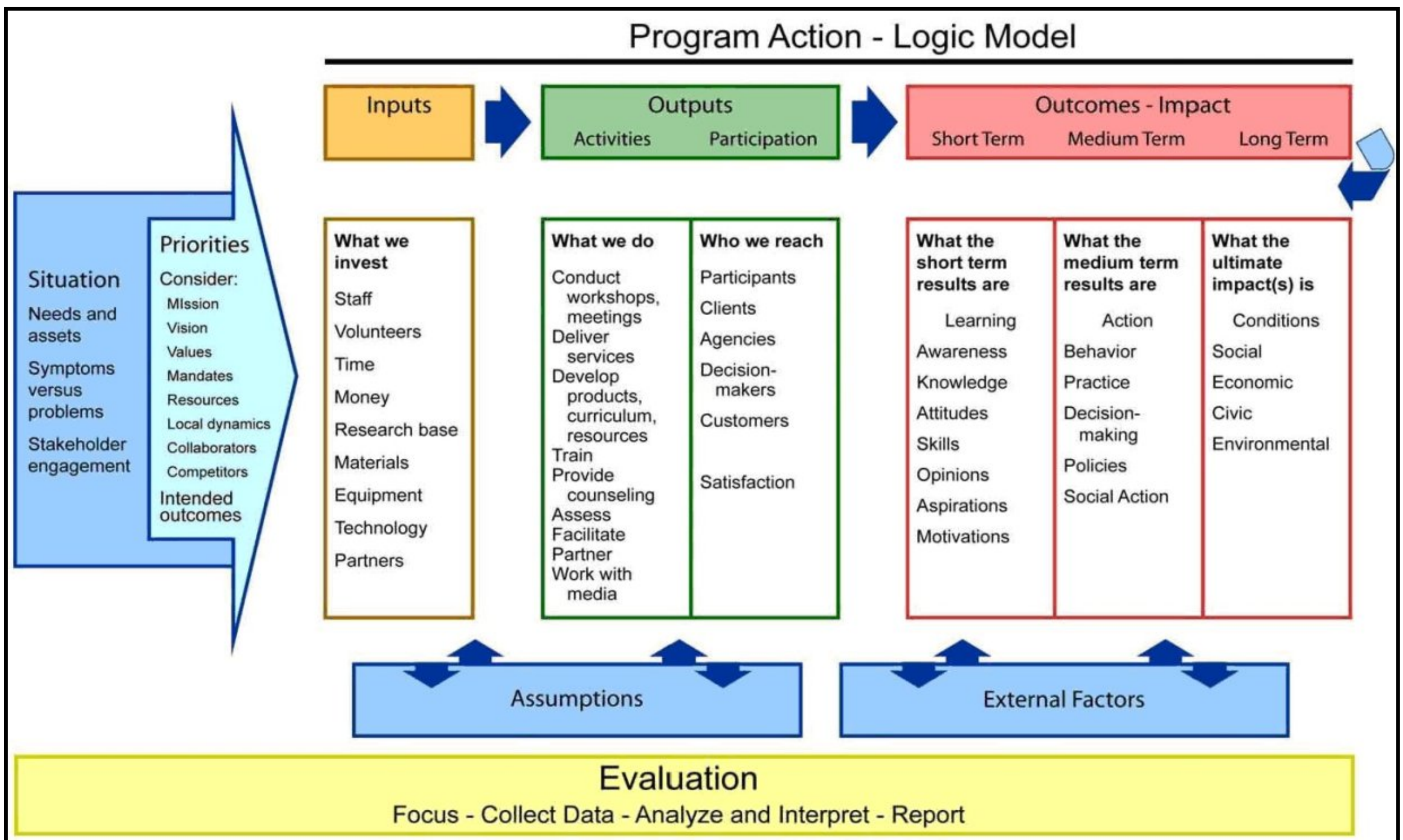
Defining and Measuring Success

NASTAD's 2007 *Prevention Bulletin* series began by highlighting a range of perspectives about the state of HIV prevention by asking the provocative questions, "*Is prevention working?*" and "*Why?*" The next several issues offered a great deal of foundational information on the scope of the diverse epidemics in the U.S. and interventions that seek to prevent new HIV infections— both those that are tried and true as well as those on the horizon. In more recent months, the *Bulletin* delved into overarching structural issues and social constructs, examining how they each impact and, arguably, drive the epidemic. Throughout the series, a range of perspectives has been shared by leaders in health departments, the Centers for Disease Control and Prevention (CDC) and from the community.

Given this wealth of information, the November *Bulletin* now explores how we both define and measure the success of our prevention efforts. As we heard in January, those working in the field share the opinion that prevention efforts are working. However, a few questions remain:

- *Do our efforts actually reduce as many new infections as possible given the resources we have?*
- *Should this be the sole metric of our success?*
- *If not, how do we then best measure the successes of our efforts?*

Without uniform data collection and inconsistent access to evaluation and evaluators, we struggle to assess the long-term impact as described in the following schematic.



Source: http://www.uwex.edu/ces/pdande/

For the majority of our prevention programs, our measurements are limited to accomplishments in the process of providing an intervention, like monitoring the number of outreach contacts made or the number of individuals that show up for a group session. This tells us very little about the actual impact of our efforts. In some circumstances, through pre/post assessment, some programs are able to demonstrate an intervention's effect on short term learning such as increased knowledge or changed attitudes or beliefs. Unfortunately, few programs have adequate resources and staffing capacity to document actual sustained behavior change or action.

Despite the difficulty in defining and measuring success, there have been some significant HIV prevention successes in the U.S. to date. In the 1980s, the rate of HIV infection in the U.S was at an all-time high. The steep decline culminating in a stable number of new infections each year in the 1990s is attributed to the power of HIV prevention efforts. David Holtgrave, PhD, contends that even though the estimated rate of new infections has remained relatively constant for many years, the rates of HIV infection in the U.S. would have mirrored those in the developing world without the nation's sustained HIV prevention response.[1]

Perinatal HIV transmission decreased from 1650 in the 1990s to less than 200 in 2005,[2] blood screening has nearly eradicated the possibility of HIV transmission through transfusion and, because of programs offering access to sterile injection equipment, HIV/AIDS cases among IDU markedly declined in the U.S. between 2001-2004.[3] Additionally, the availability and affordability of highly active antiretroviral therapy (HAART) has had a substantial impact on the decline of AIDS-related deaths and has likely had a meaningful impact on the transmission of HIV because of the lower viral loads of treatment-adherent individuals.

Even so, the inherent nature of measuring the prevention of disease is challenging, as it is most often described by the absence of disease transmission. We are often limited by not knowing the number of individuals in a given population (e.g., the number of injection drug users (IDU) in a given jurisdiction) and, more critically, the number of individuals in a population who are actually high risk (e.g., the number of IDU in a jurisdiction who share needles). Still more challenging, we cannot easily assess the frequency of positive behavior change among the identified high risk individuals, (e.g., all times an IDU used a clean needle). In lieu of these data, we paradoxically measure the impact of prevention programs by their failures (i.e., rates of new HIV infection or number of AIDS deaths). As the nation prepares for the release of a new methodology for estimating incidence, along with new estimates, is it time to reframe and broaden how we evaluate the success of our prevention efforts?

We believe it is time to consider "other" successes that result from our programs' efforts and recognize their value

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in the broader scheme of HIV prevention, successes like treatment for substance abuse and mental health concerns, leaving an abusive relationship, attaining a GED and finding stable housing. Because prevention programs are most often required to assess measures related only to process and are measured against disease transmission and death, these positive outcomes are not readily captured beyond anecdotal acknowledgement. As described in the last several issues of the *Bulletin*, the influence of social, economic and structural factors on the lives of the populations we serve may actually make these "other" successes the most critical in supporting a decrease in HIV/AIDS case rates.

This month's *Bulletin* features stories and interviews from public health and research experts who share their experiences and thoughts about defining and measuring the success of HIV prevention programs. First, Janet Myers and Steve Morin from the Center for AIDS Prevention Studies at the University of California at San Francisco share their thoughts about program evaluation. Next, Maryland, Missouri and Wisconsin—jurisdictions with diverse epidemics—share their successes with targeted HIV prevention interventions in their communities. The *Bulletin* closes with a story about CDC's Institute for HIV Prevention Leadership (IHPL). The program's proficiency in supporting a comprehensive curriculum that equips community based organization (CBO) staff to respond to the complexity of HIV prevention offers a framework for how alternate forms of success can be recognized in our prevention efforts.

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1. Holtgrave, David. Estimating the effectiveness and efficiency of US HIV prevention efforts using scenario and cost-effectiveness analysis. *AIDS*. Volume 16(17)22 November 2002 pp 247-2349.
2. http://www.cdc.gov/hiv/topics/perinatal/resources/factsheets/pdf/perinatal.pdf
3. www.cdc.gov/mmwe/preview/mmwrhtml/mm5521.htm

A Program Evaluation Perspective: Thoughts from Janet Myers and Steve Morin of University of San Francisco Center for AIDS Prevention Studies (UCSF-CAPS)

Stephen F. Morin, PhD is a professor of medicine and chief of the Division of Prevention Science in the Department of Medicine at UCSF. He is director of the Center for AIDS Prevention Studies (CAPS) and the AIDS Policy Research Center. He is also associate director of the UCSF-GIVI Center for AIDS Research. Janet Myers, PhD, MPH, is assistant professor of medicine and co-director of the AIDS Policy Research Center (APRC), a program of the AIDS Research Institute at UCSF. She currently serves as principal investigator and director of the AIDS Education and Training Centers National Evaluation Center, which is working to provide leadership in identifying, documenting, and disseminating effective models to assess the outcomes of HIV clinical training activities.

NASTAD*: How would you define an HIV prevention program as successful? Briefly describe an example if you would like.*

Morin and Myers: Understanding the success or effectiveness of any HIV prevention program really depends on the audience. For example, in the case of the Mpowerment project,[1] the program—or "intervention" as such programs are typically called in this context—was initially proven successful (safe and efficacious) in a randomized, controlled trial. Such trials are considered the "gold standard" for scientists and for audiences interested in interventions proven to work using these methods, such as scientific journals or the CDC. However, Susan Kegeles and her colleagues have also demonstrated that Mpowerment can be successfully replicated (i.e., effective when adapted in communities). For example, the intervention can be adapted for use with young African-American men, who were not the target of the original intervention. Although evaluations aiming to understand the success of these replication projects did not use the same research design as the original study, they were conducted using rigorous methods and the results are useful for program planners and public health providers seeking information on how to translate the core components and processes of Mpowerment in their communities. The process is parallel to the monitoring of drugs after they have received marketing approval. Finally, investigators at CAPS have recently conducted a general survey of the methods that community-based agencies are using to evaluate Mpowerment projects underway across the country, funded by special federal initiatives, by state AIDS offices and by local public health jurisdictions, among others. In these cases, measures of success have included everything from staff perceptions of community-level change to cross-sectional community-based brief behavioral surveys administered by volunteer data collectors. Access to resources such as skilled evaluators, data collectors, and analysis support often influences project staff decisions on how best to measure "success." Still, programs are deciding at the grassroots how to prioritize the information collected, what measures to focus on, and how to use the results—tailored to the needs of their programs, including continued funding and quality assurance.

NASTAD*: Certainly there are some inherent challenges to measuring HIV prevention activities (i.e., we tend to use HIV incidence—instances where HIV transmission has not been prevented as the measurement). Are there certain criteria that you have found to be the more useful for measuring a program's success?*

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Morin and Myers: In most cases, HIV prevention activities have a target. For example, while Mpowerment is a community-level intervention, aiming to change the norms among young men who have sex with men (measured, in this case, by rates of self-reported unprotected intercourse). Other interventions such as Healthy Living[2] seek to influence individual risk behavior by changing the stress and coping capacity among participants seen in one-on-one counseling sessions (in this case, working with HIV-infected individuals with an intended outcome of self-reported unprotected intercourse with negative or unknown status partners). Understanding a program's "success" requires understanding its aims—creating change at the individual, family, or community level. At the broadest level, policy or structural interventions are best understood with broad measures of population impact, such as the new HIV infections or trends in HIV risk behavior. A key challenge to measuring and demonstrating success is to clearly understand the aims or objectives of the program and to collect and interpret measures based on these aims.

Another challenge to measuring success is finding the resources to do it. Without specific time and money set aside, understanding the results of HIV prevention programs can get lost in the crisis-oriented world of client services. To make sure that their activities can demonstrate results, agencies can and should encourage an atmosphere of learning along side service provision. For example, agencies can include structured evaluation tasks into job descriptions and allow time for staff to read and discuss what they've learned in regular meetings. Funders can prioritize, require, and cover evaluation. Often-overlooked costs include staff time and training, travel to conferences and workshops, printing, and postage for dissemination.

NASTAD*: Do you think it is important and/or feasible for HIV prevention programs to begin to incorporate other meaningful metrics, like impact on community development, into the evaluation of HIV prevention efforts? Why or why not? If so, how?*

Morin and Myers: Even though some programs target individuals or small groups, it is also important for policy makers, in particular, to understand how programs contribute to community-level changes, such as community empowerment or development. It's not always appropriate to consider the success of a distinct program this way because there are many factors contributing to community-level change that happen between an individual case management session, for example, and HIV incidence in a community. In addition to the support provided through the case management, an individual's support networks, the social and sexual norms among a group, or condom availability may influence HIV incidence. Still, it is feasible to incorporate indicators such as community empowerment into the evaluation of HIV prevention efforts, especially if they are considered in light of the connectedness between all prevention efforts occurring in the community where incidence is measured.

There is evidence linking measures of community development to health indicators, especially internationally.[3,4] These projects demonstrate the importance of community-wide efforts for stemming new HIV infections. Among HIV prevention scientists, new methods for understanding these influences are being developed as an alternative to random controlled trials.[5] In the near future, these methods will help HIV prevention program developers and implementers understand the influence that programs at all levels —individual, small group, and community—may have on reducing risk and infections and improving health outcomes for people living with HIV.

Finally, we can learn from other fields of public health, and, in particular, injury prevention and tobacco control, which have used policy as an integral part of the strategy to achieve results. As Wohlfeiler and Ellen (2007) note:

> "These fields, with more years of experience than HIV's quarter-century, have achieved greater success at developing economic, policy, environmental, and technological strategies that allow their prevention efforts to be more self-sustaining and less reliant on a constant infusion of public health resources, whether these are staff or financial support. This requires public health professionals to be facilitators of change in addition to service providers."[6]

NASTAD*: In your opinion, are successes in prevention programs easily replicated—with other populations, in other geographic regions and/or from year to year? Why or why not?*

Morin and Myers: Examples such as Mpowerment demonstrate that successful prevention programs can be implemented and replicated. New evidence from the field of translation research increasingly guides these efforts. While replication may not be easy, approaching it systematically with attention to core elements and processes can go a long way to ensuring its success. Principles developed as part of community-based participatory research, particularly involving stakeholders in the adaptation process. seem to be essential to the success and sustainability of prevention programs.[7]

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2. Gore-Felton C, Rotheram-Borus MJ, Weinhardt LS et al. (2005). The Healthy Living Project: an individually tailored, multidimensional intervention for HIV-infected persons. *AIDS Educ Prev* 17 (Suppl A):21-39.
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Maryland's *Pharaoh* Program

NASTAD interviewed Claudia Gray, RN, Acting Chief in the Center for Prevention, AIDS Administration at the Maryland Department of Health and Mental Hygiene.

NASTAD: *Please provide a brief background about a successful program or intervention.*

Gray: African-American men are disproportionately affected by HIV/AIDS. Based on the 2000 U.S. Census, African Americans represent 28 percent of Maryland's population despite representing 80 percent of the state's AIDS cases. Heterosexual transmission is the leading mode of HIV transmission in Maryland and represents an ever-increasing proportion of new cases of HIV. In response, the Maryland AIDS Administration responded to this urgent need by developing the intervention program Pharaoh for heterosexual African American men with a history of incarceration. Maryland is currently delivering *Pharaoh* in correctional, transitional housing, and in-patient drug treatment settings. *Pharaoh* consists of five two-hour sessions (groups of eight to 12 men) covering ethnic/gender pride, responsibility and empowerment, HIV prevention education, condom skills and self-efficacy, and transitioning into the community. In the first three years of the program, 3,592 participants were reached through the implementation of Pharaoh.

NASTAD: *What made the program/intervention successful? How did you define success?*

Gray: Initial outcome evaluation indicates partial success in addressing factors that impact risk behaviors among incarcerated heterosexual men. Pharaoh participants showed significantly greater intentions to use condoms during both vaginal and anal sex, reported feeling significantly less likely to trade drugs for sex with a woman after release from incarceration, indicated feeling a greater obligation to live a healthy lifestyle, indicated greater self-efficacy in dealing with stress and pressure to use drugs after release, and showed a decreased tolerance for risk. Knowledge of HIV transmission methods and risks significantly increased as well. However, perceived risk of contracting HIV remained unchanged after the program. The results also provide evidence of dosage effects, in that those with at least eight hours of intervention showed more success in achieving the stated objectives than those who received fewer than eight hours of intervention. This finding indicates the importance of ensuring that as many participants as possible are able to complete the full intervention.

Local agencies embraced *Pharaoh* to address a considerable range of unmet programmatic needs and adapted the curriculum to specific venues and to subpopulations of heterosexual men. The state health department closely observed the early implementation of the intervention and has successfully drafted a subsequent iteration of the curriculum that is adaptive to a variety of settings.

NASTAD: *How did you measure success? What mechanism/tools were used?*

Gray: To assess outcome measures, *Pharaoh* participants completed both a pre-test survey during the first program session and an identical post-test survey at the last program session. Pre- and post-test responses were compared to assess intentions, attitudes, and knowledge pertaining to program objectives. Future plans to continue evaluation of *Pharaoh* include obtaining funding and other support to conduct a more rigorous evaluation, including randomized control groups and follow-up assessment with participants three to six months after completing the intervention.

NASTAD: *Would you describe the impact as a short, medium, or long term outcome?*

Gray: At this point Maryland has been able to determine a positive improvement in short-term outcomes. Support for further evaluation should allow us to demonstrate positive medium-term impact on participants.

NASTAD: *Do you think that this program could be replicated in other jurisdictions? What are the essential elements? What are your "lessons learned?"*

Gray: Based on our experience in implementing and evaluating *Pharaoh*, we believe that the intervention can be replicated in other jurisdictions. However, there are a few challenges including establishing and maintaining curricular fidelity, retention of incarcerated participants for all five sessions of the intervention because of the unpredictability of the incarcerated setting, inmates' release dates, and, finally, sessions may be abruptly terminated or canceled due to lock downs and other events in these venues.

To be successful with *Pharaoh*, a jurisdiction needs buy-in from the local facilities housing African-American men, approval to have frank discussions about sexuality and HIV prevention, and, finally, African American male leaders with counseling and group facilitation skills/training skills.

Implementing the L.I.F.E. Program® in Missouri

NASTAD interviewed Sandra Hentges, Prevention HIV Prevention Planner for the Missouri Department of Health and Senior Services.

NASTAD: *Please provide a brief background about a successful program or intervention.*

Hentges: A really successful program in our state is a prevention intervention for positives called the L.I.F.E. Program® which stands for Learning Immune Functioning Enhancement. The intervention consists of structured, topic-driven group counseling interventions that include 16 weekly meetings utilizing a very structured health education and counseling curriculum that focuses holistically on the prevention and care needs of the clients. Each meeting features discussion, skills building exercises, and reflection on different psycho-social issues that influence risk behavior, immune system functioning, and overall physical health, including: relationships with medical providers, adherence to health routines (including medication protocols), self-assertiveness, sustained survival stress, life purpose and goals, crisis coping skills, social support, self-disclosure, beliefs about disease progression, grief and depression, altruism and spirituality, and others. These thirteen issues are collectively called co-factors. The L.I.F.E. Program® design also includes individual health and risk-reduction counseling sessions with clients if they request.

NASTAD: *What made the program/intervention successful? How did you define success?*

Hentges: The intensity of this program—sixteen weekly sessions that focus on holistic client needs—coupled with incentives and careful evaluation of programmatic activities that are a part of this intervention has made it successful. We have had many clients come to providers who facilitate this intervention and state how much of an impact this intervention has made in their lives.

NASTAD: *How did you measure success? What mechanism/tools were used?*

Hentges: Weekly evaluations were conducted at the program sites. These evaluations were turned in and analyzed through the SHANTI program (the creator of the L.I.F.E. Program®). We used client surveys to collect the information.

NASTAD: *Would you describe the impact as a short, medium, or long term outcome (as depicted in the schematic in the lead story)?*

Hentges: At this point we would describe the intervention as a medium outcome.

NASTAD: *Do you think that this program could be replicated in other jurisdictions? What are the essential elements? What are your "lessons learned"?*

Hentges: Yes, it can be replicated in other jurisdictions. The essential elements focus on psychosocial co-factors that are addressed within each of the sixteen weekly sessions. We have learned that it is expensive to purchase, but worth every penny. Additionally, it takes agencies with the capacity and infrastructure to effectively implement this intensive intervention. Also, it is best to have sessions for only one priority population at a time. Mixing populations is very difficult to do and still develop the trust and understanding needed between group members.

Wisconsin's Use of Social Networks Strategy for HIV Testing

NASTAD interviewed Tim Pilcher, HIV Prevention Supervisor, with the Wisconsin Department of Health and Family Services.

***NASTAD**: Please provide a brief background about a successful program or intervention.*

***Pilcher**:* After the release of the CDC's *Interim Guide* for use of a "social networks" testing strategy, we decided to use principles outlined in the guide to pilot a social networks testing strategy at two HIV counselling, testing, and referral (CTR) sites in the City of Milwaukee. The estimated HIV/AIDS prevalence rate for Milwaukee County is 180.2 per 100,000, and more than one-half of all persons living with HIV /AIDS in Wisconsin reside in this area. Our objectives include increasing the percent of tests among clients at high risk for HIV infection, increasing the percent of tests among men who have sex with men (MSM), particularly MSM of color, and increasing the percent of tests among at risk sex partners (defined as opposite sex partners of persons with HIV disease, opposite sex partners of persons with injection drug risk, and women with male sex partners who have had sex with other men). More than 90 percent of all HIV cases reported in Wisconsin are among persons at high risk and reported HIV cases in Wisconsin among MSM have increased more than 50 percent in recent years. MSM of color in Wisconsin have the highest rates of HIV infection.

***NASTAD**: What made the program/intervention successful? How did you define success?*

***Pilcher**:* The project had the following outcomes as evidenced by analysis of the site's HIV CTR data:

- High risk testing increased from an average of 28 percent of all tests the previous three years to 56 percent in the 15 month period;
- Testing among MSM increased from an average of six percent of all tests the previous three years to 13 percent in the 15 month period;
- Testing among at risk sex partners increased from an average of ten percent of all tests to the previous three years to 22 percent during the 15 month period;
- Seroprevalence of tests increased from 0.5 percent to one percent; and
- The total number of positives identified doubled from an average of three per year for a five year period to six per year.

***NASTAD**: How did you measure success? What mechanism/tools were used?*

***Pilcher**:* There was analysis of the data collected at the HIV CTR sites.

***NASTAD**: Would you describe the impact as a short, medium, or long term outcome?*

***Pilcher**:* It is difficult to determine whether the project has had short, medium, or long term outcomes based on the definitions provided in the logic model schematic. However, we feel safe stating that any increase in the number of persons with knowledge of their serostatus has short and long term benefits for the individual and long term benefits for the community.

***NASTAD**: Do you think that this program could be replicated in other jurisdictions? What are the essential elements? What are your "lessons learned"?*

***Pilcher**:* The program could be replicated in other jurisdictions. Two Wisconsin HIV/AIDS program staff attended the training-of-trainers social networks training conducted by the CDC in July 2007. The essential elements included getting buy-in from the HIV/AIDS program director and the HIV/AIDS CARE case management staff. With careful planning, even a partially-implemented "packaged" behavioral intervention or pilot can have impact on the success of a program. In addition, implementing a pilot project using some of the key elements of an intervention may, in some circumstances, serve as a good trial to determine if the intervention would be effective if implemented in its entirety. The pilot CTR site described in this interview, along with six other Wisconsin CTR sites, recently participated in formal social networks training. We will continue to analyze outcomes as the sites implement a more "formal" social networks strategy.

The Institute for HIV Prevention Leadership: Successfully Developing the Workforce

The Institute for HIV Prevention Leadership (IHPL) is an intensive capacity-building program designed for HIV prevention program managers working in community-based organizations (CBOs). It was established in 2000 and has graduated more than 230 participants. The IHPL is funded by the CDC through a cooperative agreement with the Association of Schools of Public Health (ASPH) and administered by the University of South Carolina.

The Institute utilizes a dual-track curriculum that integrates principles of effective public health practice with strategic planning and management. The curriculum is offered over a nine month period, including four weeks of on-site instruction. The Institute's on-site weeks occur approximately once per quarter. All of the

participants (referred to as "scholars") are flown to a single national location with their travel and accommodation paid for by the Institute.

During each week of the Institute, scholars are engaged in classroom-style presentations as well as small group activities, case studies, role play, and group facilitation exercises. The presenters and faculty include a wide variety of experts on community assessment, ethics and values, strategic planning and management, behavioral theory, and evaluation. Additionally, the IHPL staff is primarily comprised of public health practitioners and researchers who also act as mentors to each of the participants (referred to as "advisors").

Advisors play a vital role with the Integrative Learning Experience (ILE), a series of assignments completed by participants between the on-site sessions. The ILE provides participants with the opportunity to practically apply Institute-gained knowledge and skills to actual situations at their CBOs. The on-site instruction and the activities of the ILE are supplemented by distance learning support via the Internet.

When participants complete the nine month Institute program, they continue to be engaged in ongoing learning via advanced seminars. These seminars cover a variety of topics including HIV policy analysis, emergent strategies in effective behavioral interventions (such as facilitation and motivational interviewing), qualitative data collection and analysis, and others. As with the nine month program, travel and accommodation costs are covered by the Institute.

The Institute has a comprehensive mixed-methods evaluation process which includes a battery of surveys, discussion guides, and onsite visits to select CBOs. Each year, the evaluation data have revealed significant changes in individual and organizational capacity to provide effective HIV prevention programming and engage in strategic planning and management activities that strengthen organizations.

Expanding upon the successes of the Institute, the University of South Carolina is interested in engaging health department HIV prevention managers in a series of assessments and meetings regarding the possibility of developing a national training model for HIV prevention program managers working in health departments. The goal of this national training model will be to increase the capacity of local and state health departments to provide effective and efficient HIV prevention interventions to populations most at risk of HIV infection.

NOTE*: In the coming weeks, a series of conference calls will be announced for NASTAD and the National Association of City and County Health Officials (NACCHO) for interested health departments to join and provide their feedback. To receive an announcement of this and other events, contact Dr. Chris LaRose (803) 734-2518. For more information about the Institute for HIV Prevention Leadership, please visit their web site.*

Conclusion

Each of the perspectives on defining and measuring the success of HIV prevention programs shared in this month's *Bulletin* demonstrate the importance of targeted programs. Additionally, the involvement of the members of the target population in the design and evaluation of the intervention is critically important. Each profile also highlighted the need for financial capacity to support and sustain the intervention. Finally, each of these successful programs in some addressed, in a holistic manner, both HIV prevention needs as well as other pressing life circumstances of individuals.

While the often-cited harm reduction adage of "any positive change" can be challenging for programs to measure on the individual level, it is useful to think about the ways that these "positive changes" can impact greater community-level change. Behavior change is supported by increased awareness and access to prevention tools but also policies and programs that reinforce their availability and accessibility. As has been demonstrated through social marketing and structural strategies (e.g., seat belt use or anti-littering campaigns), the fortification of messages across multiple sectors of society is crucial in persuading an individual to modify her/his actions.

Finally, as programs such as the Institute for HIV Prevention Leadership demonstrate, it is important to continue to think broadly about the ways in which we define the impact of HIV prevention programs. Surely, we must uphold the successes we have seen in reducing new infections in the epidemic, but we cannot be bound by this simple measure alone. We must consider other success like community mobilization and workforce development. Doing so will help our programs create a broader framework with which to measure our impact. If we do not broaden our frame, we run the risk of being measured myopically as part of a system that has failed to reduce new HIV infections in the U.S., rather than the drivers of the meaningful successes the nation has seen over the past 25 years.

Meeting and Planning Calendar

Capacity Building Opportunities: For a searchable database of CDC-supported capacity building trainings and events, visit the Capacity Building Branch's Group Events Management System site.

November 3-7, 2007
American Public Health Association Conference, Washington, D.C.

November 7-10, 2007
United States Conference on AIDS, Palm Springs, CA.

December 1, 2007
World AIDS Day.

December 2-5, 2007
2007 National HIV Prevention Conference, Atlanta, GA.

December 4, 2007
Michigan Hepatitis C Conference, Plymouth, MI

February 3-7, 2008
15th Conference on Retroviruses and Opportunistic Infections, Boston, MA.

February 7, 2008
National Black HIV/AIDS Awareness Day

February 25-26, 2008
2008 National Conference on African Americans and AIDS, Philadelphia, PA. Sponsored by Minority Healthcare Communications, Inc.

March 3-7, 2007
National Housing and HIV/AIDS Research Summit III: Examining the Evidence: The Impact of Housing on HIV Prevention and Care. Sponsored by the National AIDS Housing Coalition (NAHC).

March 10, 2008
National Women and Girls AIDS Awareness Day

March 20, 2008
National Native HIV/AIDS Awareness Day

March 28-29, 2008
17th Annual HIV Conference, Orlando, FL. Sponsored by the Florida/Caribbean AETC.

May 19, 2008
National Asian and Pacific Islander AIDS Awareness Day

May 22-25, 2008
20th Annual National Conference on Social Work and HIV/AIDS, Washington, D.C.

June 11-14, 2008
HIV Prevention Leadership Summit (HPLS), Detroit, MI. The Call for Abstracts will be issued in November, with abstracts due on January 10, 2008. Conference information and the Call for Abstracts should be available at: www.NMAC.org by the end of November.

July 28-29, 2008
2008 National Conference on Latinos and HIV/AIDS, Miami, FL.

August 3-8, 2008
XVIII International AIDS Conference, Mexico City, Mexico.

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If you have an idea or program relative to any of these topics that you would like to include in the *Bulletin*, please contact Dave Kern or Lynne Greabell (202) 434-8090. NASTAD's *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. Submit your commentary to: NASTAD@NASTAD.org.

Visit our Webpage! Electronic versions of the *Prevention 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

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