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National Alliance of State and Territorial AIDS Directors

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Provoking Thought About the State of HIV Prevention

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Provoking Thought about the State of HIV Prevention

NASTAD's [December 2006 HIV Prevention Bulletin](#) looked back at important issues in 2006, the 25th year of the domestic HIV/AIDS epidemic. These stories set a tone for meaningful discussion about current U.S. HIV prevention efforts. January's *Bulletin* builds upon this discussion, but uses a more introspective lens. In keeping with NASTAD's tradition of profiling "things to watch in the coming year," this month's *Bulletin* is meant to provoke critical thinking about the current state of U.S. prevention efforts by reflecting on what we have done well and what we still need to do.

Several individuals were asked to offer their personal perspectives on prevention efforts in the U.S. While the methodology for gathering this information was not meant to be scientific, individuals were intentionally selected from different backgrounds to provide a variety of viewpoints. To offer comparison to the points of view shared by those who work in the HIV/AIDS field, "consumers" of prevention services were also asked to respond. Simple questions guided the development of responses.

- Is prevention working? Why?
- Assuming resources are not an issue, name a couple things that need to happen in order to prevent as many new infections as possible?
- What is your role in making these things happen?

Though straightforward, the questions uncovered many similarities in opinion as well as some blatant differences. Notably, those working in the field shared the opinion that prevention works overall and each person articulated similar evidence to back this assertion. Further, they identified many of the same ideas for preventing new infections, an indication that certain strategies are ripe for national consideration, and, possibly, diffusion. The consumers of prevention services, however, expressed a different reality. Though the themes in their responses often matched those working in HIV/AIDS programs, they also illuminated some critical considerations for future prevention efforts.

Yet key themes emerged from all the responses. A call to enhance and re-energize the current prevention arsenal was sounded. Traditional interventions and activities like needle exchange, HIV case finding (including testing and partner counseling and referral services), perinatal prevention efforts, targeted, effective behavioral interventions and evaluation were identified as essential components in the arsenal. To supplement these, respondents encouraged exploration of new or not widely considered approaches like testing for acute HIV infection, structural level interventions, strategies to address trauma, social networks and the internet. Acknowledging that HIV does not exist in isolation, respondents clearly articulated the need to integrate HIV/AIDS programming with other co-occurring epidemics, like substance abuse, mental health and sexually transmitted diseases. Responses also signaled a need to continue shifting our paradigm to more overtly address issues like racial and ethnic health disparities, the acute difference between epidemics in the U.S. and a holistic orientation to better honor the whole person and the reality of his or her life circumstances.

NASTAD's 2007 *HIV Prevention Bulletin* series will explore many of these key themes. Each month's *Bulletin* will focus on a particular topic, offering more in-depth exploration and illustrative examples of how specific strategies are being successfully implemented around the U.S.

As we move beyond the first twenty-five years of this epidemic, we are ever-challenged to ask difficult questions about the ways in which we do our work and how we interpret our success. How do we ensure our HIV prevention efforts reach beyond implementation of programs to consider whether or not they are making the difference we need them to? To some, 40,000 new domestic HIV infections each year is a testament to our public health system's ability to manage a decreasing AIDS death rate and an increasing HIV/AIDS prevalence rate. To others, it's abject failure. It is our collective responsibility to define our success and to be able to measure it and defend it through many, and, at times, highly unsympathetic, lenses.

Question 1: Is prevention working? Why?

Since 1983, James Vergeront, M.D., has been a physician and medical epidemiologist for the state of Wisconsin Division of Public Health, Bureau of Communicable Disease and Director of the [Wisconsin AIDS/HIV Program](#).

Vergeront: There have been a lot of successes. As [David Holtgrave](#) has written about, if we look back at the history of the epidemic, there have been declines in new infections and these successes cross most risk behaviors. Needle and syringe exchange has been one of the significant successes we've seen in prevention – where there's access to clean needles and syringes, we've seen decreases in HIV transmission and drug use. I think a lot of these successes have been driven by the community-based decision making we have in HIV prevention programs. In the early 1990's, community planning was very successful in assisting health departments, community based organizations and AIDS service organizations assure that resources and funds were directed to target populations rather than the broader public. While the original role of these planning groups may have changed, the need for community input has not diminished.

Rob Johnston is the HIV Prevention Coordinator with the HIV/AIDS/Hepatitis Program at the [Wyoming Department of Health](#).

Johnston: Wyoming is a very low incidence state with about 10 new HIV/AIDS cases in 2006. As such, most residents assume they are not at risk for HIV infection. Over the past three years, our prevention intervention efforts have been provided by four substance abuse treatment facilities and one local community based organization serving the gay, lesbian and transgender community. All of these programs focused their prevention efforts not only on the clients or patients receiving direct services but also on creating community coalitions to help address HIV and hepatitis issues in their community. Our HIV Counseling and Testing Services system also conducted over 5000 HIV tests in 2006.

Ricardo Mendiola is the HIV Prevention Manager in the Prevention Services Branch at the [Georgia Department of Human Resources Division of Public Health](#).

Mendiola: HIV prevention works but has to be targeted to the needs of those most at risk. Comprehensive

programs have been shown to reduce infections among men who have sex with men (MSM), injection drug users (IDU), and women when utilizing well-built community-level interventions and flexible risk reduction and behavioral approaches. My definitions of comprehensive programs include social marketing to street outreach while incorporating community input. I believe one of the reasons HIV prevention has been effective is the combination of comprehensive prevention along with community mobilization working together to utilize different approaches focusing on the person's ability to make healthy choices and sustaining those decisions and behaviors.

Barry D. Walston, MSW is the Director of the Community Coordination and Planning Section at the [New York State Department of Health AIDS Institute/Division of HIV Prevention](#).

Walston: Yes, HIV prevention has worked and continues to work. This has been demonstrated in high incidence states within the U.S. like California and New York, where new infections have decreased significantly since the beginning of the epidemic. Health departments continue to mount strong and vigorous efforts toward increasing counseling and testing initiatives for high risk communities and individuals. We have programs that reach high risk populations such as IDUs (i.e., successful needle exchange programs and expanded syringe access programs). We continue to build on linkages to treatment for those newly diagnosed. We are aware that treating sexually transmitted diseases (STDs) is a way to prevent HIV infection across the U.S. The significant decrease of perinatal transmission of HIV due to the voluntary testing of pregnant women is more evidence of success. Without any prevention efforts, we would have lost many more lives to date.

Monique Tula is the Director of Prevention and Education at [Cambridge Cares About AIDS](#), an AIDS services organization (ASO) in Cambridge, Massachusetts.

Tula: I think, in the states, overall, yes [prevention works]. When you look at new HIV/AIDS cases from, say, 1993 -2004, you see the decline in numbers, so, sure, it's working. It depends on who you are talking about. But generally, yes, if you are motivated and have access to programs, then prevention is working for you.

It's the same things we have been talking about for a long time – it's about access and the socio-economic differences that determine health disparities. I don't think HIV is different than any other health issues. And it is time that HIV treatment and prevention go "mainstream." I mean, there are always the competing priorities in the economic, cultural, spiritual and familial [realms]. One thing that I think can cut across this is "my doctor told me I had to do this."

Jeff Baily was the Community Co-Chair of the Los Angeles County HIV Prevention Planning Committee from 2001 to 2005 and is currently a member of the [Urban Coalition for HIV/AIDS Prevention Services \(UCHAPS\)](#).

Baily: We have made significant progress in averting new HIV infections through a number of biomedical and behavioral prevention strategies. Perhaps the most apparent success story lies within reducing mother-to-child transmission through administering anti-HIV medications. Another area of promise is syringe exchange programs which, despite the U.S. government's lack of funding support for such programs, demonstrate success with averting new HIV infections without an increase in drug use. More recent programs focusing on men who have sex with men who use crystal meth demonstrate that substance use treatment programs not only reduce substance use but also reduce sexual risk-taking behaviors.

Behavioral strategies promoting risk reduction strategies have reduced the number of sex partners among MSM, increased condom use and also resulted in community-driven risk reduction strategies known as sero-sorting, resulting in a reported decrease in new HIV infections among MSM in San Francisco.

In an effort to understand what the consumers of prevention services feel about HIV prevention work, NASTAD staff interviewed individuals who do not work in the HIV/AIDS field. Their responses to the question, "Is HIV prevention working?" follow.

Consumer 1: If the question is meant to refer to the last couple years and currently, then my answer has

to be no [prevention is not working]. When prevention works, I know it when I hear guys from all over the place repeating the same phrase or information: "Don't use oil-based lube" and "N-9 is an irritant" are examples of phrases or knowledge that I used to hear all the time when they were getting infused and still new, and they had successfully made it to the level of common knowledge. Lately, I feel like the prevention community has not been able to infuse [messages into] the community, i.e., those at risk for infection, with such "infectious" information. I do not believe the reason for that lies in a lack of information to tell. I believe that if the goal is to get people to change their behavior, then everyone needs to be on the same page about how we should be changing our behavior.

Consumer 2: As a gay man, I don't care anything about HIV prevention messages. They don't apply to me, and, at the risk of sounding callous, I'm not concerned about transmission of the virus. I'm concerned about trying to stay sober so I can keep my life afloat. When I'm using, the last thing in the world I think about is possibly transmitting the virus. I already have HIV. When I'm using, I worry about making sure I can get my next "bump" and that I can get as much sex as possible when I'm using. When I'm not using, I worry about trying to stay clean.

Question 2: Assuming resources are not an issue, name a couple things that need to happen in order to prevent as many new infections as possible?

Vergeront: I think the major theme that needs to be addressed, both in Wisconsin and collectively, is the whole issue of late entry of individuals into care. This ties in to program integration and earlier case finding and access to care. That's a direction that is critical. In Wisconsin, we will be focusing on the Center for Disease Control's (CDC) routine opt-out testing recommendations and how that might be implemented. Also, the Partner Counseling and Referral Services (PCRS) guidance currently under revision by CDC is largely directed at case finding and earlier identification of infected individuals. We will also focus on increased utilization of social networks, beyond traditional counseling and testing sites, to use social networking in a more organized manner.

I'm a strong believer that anti-retroviral treatment is a significant prevention strategy. This means linking individuals once they're found into treatment, and also making sure they're adherent, possibly including directly observed therapy (DOT) in some cases, and ensuring that we've gotten them into a system of care and that there's been follow through.

We need to do a better job of identifying cases we do know about with PCRS services and monitoring adherence by looking at the bio markers of high viral load, repeat STDs, pregnancy, etc., and prioritizing the linkages of these services. And although it might not be that cost effective in lower prevalence areas, increased capacity to identify acute infection could make a significant impact. I also think the internet can be a tool for reaching folks and their partners and looking at ways to use that as a prevention tool, such as the [inSPOT](#) intervention.

Continuing to press forward with needle and syringe exchange is critical. This requires us to focus on policy changes, particularly the federal prohibition on needle exchange. This wouldn't take new resources, but does require a change of will at the federal level.

Better targeting of resources to racial and ethnic minority populations – African Americans, Latinos and, in my state, Native Americans – should certainly be an underpinning of what we are doing.

Finally, a central tenet, from a societal standpoint, is dealing with the underpinnings of the epidemic, social inequities such as poverty, discrimination and stigma. We all need to be addressing those.

Johnston: [The first thing that needs to happen is] an increase in access to testing in medical clinics and other settings. In December 2006, the HIV/AIDS/Hepatitis Program in conjunction with the Wyoming AIDS Education and Training Center conducted two HIV counseling and testing training sessions with medical staff from sites around the state. These training sessions were a pilot training approach to condensing the "old" HIV prevention counseling training into a one-day course with an additional half-day on rapid testing.

[The second thing is] targeting interventions more effectively. For example, in 2007, only two grant awards have been designated for HIV prevention services. Those two grants will focus on the implementation and

delivery of the [Real AIDS Prevention Project](#) model; six programs around the state were awarded mini-grants for special one-time events in their communities for services supporting everything from counseling and testing events to [crystal] meth awareness initiatives; and four programs have been funded to provide rapid testing to inmates, homeless populations and MSM.

Mendiola: We know that HIV is preventable and we know what works. I believe that if we get back to a comprehensive community level approach, where we learn from the community and tailor HIV prevention to that community while utilizing evidenced-based programs and being flexible enough to adapt our responses, then we can reduce infections.

Walston: I believe that we have to continue to approach HIV prevention in a holistic manner. We have to address the whole person and understand that some "dated" models of prevention need to be updated, reframed or thrown out. We should begin to contextualize HIV prevention for indigenous populations and communities.

We know that needle programs have reduced infections for the IDU population and [and other interventions] with other highly impacted populations such as gay men/MSM. We need to develop interventions that address mental health, trauma, unemployment and housing as it relates to provisions of prevention and treatment within medical care settings.

[We need to] begin to explore HIV prevention through the lens of structural barriers or interventions. It is imperative that the integration of the impact of poverty, sexism, racism, discrimination and stigma as it relates to HIV/AIDS [be addressed].

Tula: We need to develop better systems to gather the information that we need; we could hire top notch researchers who understand HIV prevention and harm reduction; we need to build stronger organizational infrastructure; and staff need better and more consistent training. Unfortunately, in most cases, community-based organizations (CBO) and ASOs don't have these resources.

Take for example, resources like the multi-year SAMSHA grant that we were recently awarded. Almost half of the budget over five years goes to evaluation and technical assistance. We've been able to be matched up with an incredibly strong evaluator who understands harm reduction for HIV, substance abuse and hepatitis.

And then, of course, it comes down to behavior change. All the resources can not with full accuracy predict when someone is ready and motivated to change.

For example, the 13-24 year olds who participate in [Cambridge Care's] [Youth on Fire](#) are very knowledgeable and savvy. There is nothing new we can tell them about HIV; they have heard it all before. Life circumstances prioritize what they are willing to focus on and when. Until their basic needs are met, HIV prevention is pretty far down on their list of priorities.

Another thing we have to take into consideration is the impact of trauma (violence, multiple losses to HIV/AIDS, overdoses, etc.) on people's lives. We need to develop programs that focus these issues. This means staff have to be equipped with a very sophisticated set of skills. Health education staff need to have a sound grounding in psycho-social dynamics, and adapting, tailoring and implementing evidence-based interventions also dictates that staff must have advanced training [in program design and delivery]. According to the literature, these interventions must be applied with rigor if they are going to have any impact. ASOs require significant resources in order to do this and do it well. In order to be proactive and adapt them in culturally appropriate ways they have to have a solid understanding of concepts like harm reduction and behavioral science models.

We need to consider different means of client recruitment. For example, let's focus our efforts on exploring social networks instead of pouring all of our resources into traditional outreach. In some circles, traditional outreach is kind of played out. And CBOs need to be able to offer as many services as possible – these are the things people want. I know I certainly don't want to be approached by somebody I don't know asking me if I want condoms when I'm trying to get my dance on and my swerve on. I would however, be more

likely to pay attention to my friends and what they're doing. They're also much easier to find than the occasional outreach worker who may or may not be at the club the night I manage to find a hook up and need a condom. My friends are the ones I might be more willing to listen to when I've had enough to drink or whatever I'm doing. Yes, "social networks" is kind of the buzz word nowadays, but I think it's for a good reason. We should be exploring how to use them instead of micromanaging outreach workers who are doing a job that is ineffective and outdated. This is 2007, not 1997 – we need a new approach.

Access [to prevention materials] is so important though. For example, our [needle exchange program](#) has been steadily enrolling new participants each month. In September, the guidelines were released regarding pharmacy sales and we enrolled 92 participants. In October we enrolled 49 and in November, 24. Sure, our staff is kind of freaking out a bit, but it's an opportunity to enhance our other HIV, STD, and viral hepatitis prevention efforts for IDUs, e.g., the use of Narcan ®* and case management.

**(Narcan ®, or Naloxone, is a pharmaceutical that completely or partially reverses the effects of narcotics. It may also be used to diagnose a narcotics overdose.)*

Baily: For many years, HIV programs linked to government funding have survived in isolation from other public health approaches and sources of funding opportunities, primarily incorporating traditional one-on-one and group level intervention strategies. As HIV prevention resources continue to be reduced as a result of challenges to the efficacy and cost effectiveness of such programs, HIV prevention must look beyond the island of HIV funding and traditional intervention strategies in order to demonstrate a greater impact.

Historically, HIV prevention programs have focused on those behaviors that place an individual at risk for HIV infection, and, more recently, on promoting risk reduction behaviors among persons living with HIV, with specific emphasis upon condom use. This myopic approach often negates [the exploration of] structural and environment approaches that address the context of an individual's life within his or her community. Encouraging persons to adopt health seeking behaviors is a lofty endeavor when their primary concern may be seeking employment, obtaining an education, dealing with both external and internalized homophobia or challenges with substance use. Programs designed to reduce HIV transmission behaviors would therefore have a greater impact in reducing new HIV infections by integrating efforts with other health and social programs.

Consumer 1: Taglines need be a driver of prevention. First it was "use condoms," then it was "but don't use oil-based lube," and, recently, I've been hearing a revived discussion on "circumcision helps prevent HIV in heterosexual men." There is no lack of opportunities for taglines. [Testing and identifying partners] are both very important for preventing HIV and the community is not completely on board with either yet. The community should play a role in driving those programs forward. Once I start hearing my friends bringing up these issues, or other equally important issues, then I'll know prevention is working. This need not be done through a social marketing campaign, though those are important. Social networks must be tapped. There must be a double-feedback loop so that everyone is learning and teaching at the same time, and HIV testers and counselors need to be reinforcing the messages at every encounter. The systems for this are all in place. What is lacking is a clear, coherent message about the current state of HIV in this country and how to better prevent oneself from becoming infected.

Consumer 2: HIV prevention messages need to be incorporated into the larger messages and work being done around life issues – for me that means not a stand-alone message of "prevent HIV" but rather help me beat my crystal meth addiction and weave the HIV prevention message into that. Many of us have much larger issues than HIV and, in the gay community, crystal meth is one of those larger issues. It's really, really bad, particularly in the online community.

Online prevention work, if I can even call it that, is a farce – someone needs to figure out how to more effectively message sexual health issues. [An adult gay website that facilitates connections between men] is trying, but I think it's missing the mark. What would work for me is more candid individual profiles about drug use and HIV status. But that's up to the individual and until the larger issues are addressed, guys like me will not feel confident enough to be honest. It's a self-esteem issue as much as anything.

Question 3: What is your role in making these things happen?

Vergeront: I have a talented staff, so I see my role as providing leadership and vision for the directions we should be taking to advocate on behalf of the program and the communities for adequate funding for prevention or care services. So, one of my chief roles is to advocate for funding. I also have a role in assuring the accountability of the resources we do receive and that they are prioritized correctly.

In addition, I see my role as promoting program integration of staff efforts across prevention and care and treatment. Specifically for my staff, this also includes reducing the administrative barriers that sometimes stand in the way of good services and creating opportunities for staff to implement effective programs and help staff grow professionally.

Johnston: As the HIV Prevention Coordinator for the state, I facilitate all of the HIV prevention activities funded by the CDC for health education/risk reduction and counseling and testing services in the state. I also work closely with the Department of Education to coordinate the delivery of HIV prevention messages to local school districts as requested.

Mendiola: As an administrator and a Latino MSM, my role and responsibilities converge to be a voice for underserved and underrepresented populations, while ensuring that our programs work together to develop an effective and comprehensive approach by guiding the planning, the implementation and evaluation of HIV prevention in Georgia.

Walston: I see myself as social agent in combating this pandemic and working in the capacity as a public health agent within the New York State Department of Health to continue to support HIV prevention resources for all New York State residents. I currently serve as the Chair of the Prevention Planning Group which works collaboratively with the AIDS Institute to develop New York State's Comprehensive Plan. I realize that as a social agent for this change process, I must be a voice for the voiceless and that I must continue to be a public servant and make efforts to improve the quality of life for individuals who are in harms way of HIV/AIDS.

Tula: I like to use the movie analogy. I'm the producer. I hire the talent – the directors (program managers) and actors (front-line staff). And it's my role to assure that they have all the resources they need to influence the project's intended outcome. I have to keep the big picture in mind.

I need to hire and develop staff to be really excellent program managers. They have to be able to take the vision of the organization from the senior managers and the board of directors and put it into action. They have to have strong supervisory skills and not be frightened or turned off by business models.

Baily: As the former co-chair of the Los Angeles County HIV Prevention Planning Committee and a member of UCHAPS, my role in community planning is to ensure that linkages are developed with a variety of community partners to ensure that HIV prevention messages are diffused in settings that traditionally have not addressed HIV.

Consumer 1: [My role can be] doing my part to spread the word about new prevention tools and how they can best be used to help individuals. This might include reading articles and sharing them with my friends, or it might include helping to raise money for a social marketing campaign at my local clinic. Who knows what the future will bring, but all will depend on how much time and / or money I will have to spare in the future.

Consumer 2: I don't believe I have a role in this unless I'm sober. When I'm sober and think about the implications of my behavior and the consequences it has on me, I start to realize that I do have a role. When I feel good about myself, I think about things like not transmitting HIV to others. But I don't feel good about myself when I worry if I'm going to get online and try to find sex so I can also find some "tina." The larger issues have to be addressed first. My role is to overcome my addiction so I can feel good about me and help you all help others stay HIV-negative. But you have to tell me that in a non-judgmental way. I won't get it if you tell me to have safe sex because it's the right thing to do.

To share your own perspective on any or all of these questions or topic areas, contact NASTAD's

Prevention Programs Director [Dave Kern](#) (202) 434-8090.

Meeting and Planning Calendar

January 25-28, 2007

National African American MSM Leadership Conference on AIDS, Charlotte, NC. Presented by the National AIDS Education and Services for Minorities, Inc. (NAESM). For more information, visit the [conference website](#).

February 1-2, 2007

"HIV Care in Arkansas: Expanding the Circle of Compassion," Third Regional HIV/AIDS Conference organized by the Jefferson Comprehensive Care System, Inc. and geared for Arkansas, Louisiana, Mississippi, and Tennessee. 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 7, 2007

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

February 17-19, 2007

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

March 4-7, 2007

Annual Black Church Week of Prayer for the Healing of HIV/AIDS. Sponsored by The Balm in Gilead. For more information, visit the [event website](#).

March 21, 2007

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

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. For more information, visit [RCAP's website](#).

May 19, 2007

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

May 20-23, 2007

HIV Prevention Leadership Summit (HPLS), New Orleans, LA. For more information, visit the [conference website](#).

June 27, 2007

National HIV Testing Day. Sponsored by NAPWA. For more information, visit [NAPWA's website](#).

October 15, 2007

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

November 7-10, 2007

United States Conference on AIDS, Palm Springs, CA. For more information, visit the [conference website](#).

December 1, 2007

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

December 2-5, 2007

2007 National HIV Prevention Conference, Atlanta, GA. Sponsored by CDC and other governmental and non-governmental partners. Additional information forthcoming.

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. Submit your commentary to: NASTAD@NASTAD.org.

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