

## In this issue:

National Alliance of State and Territorial AIDS Directors

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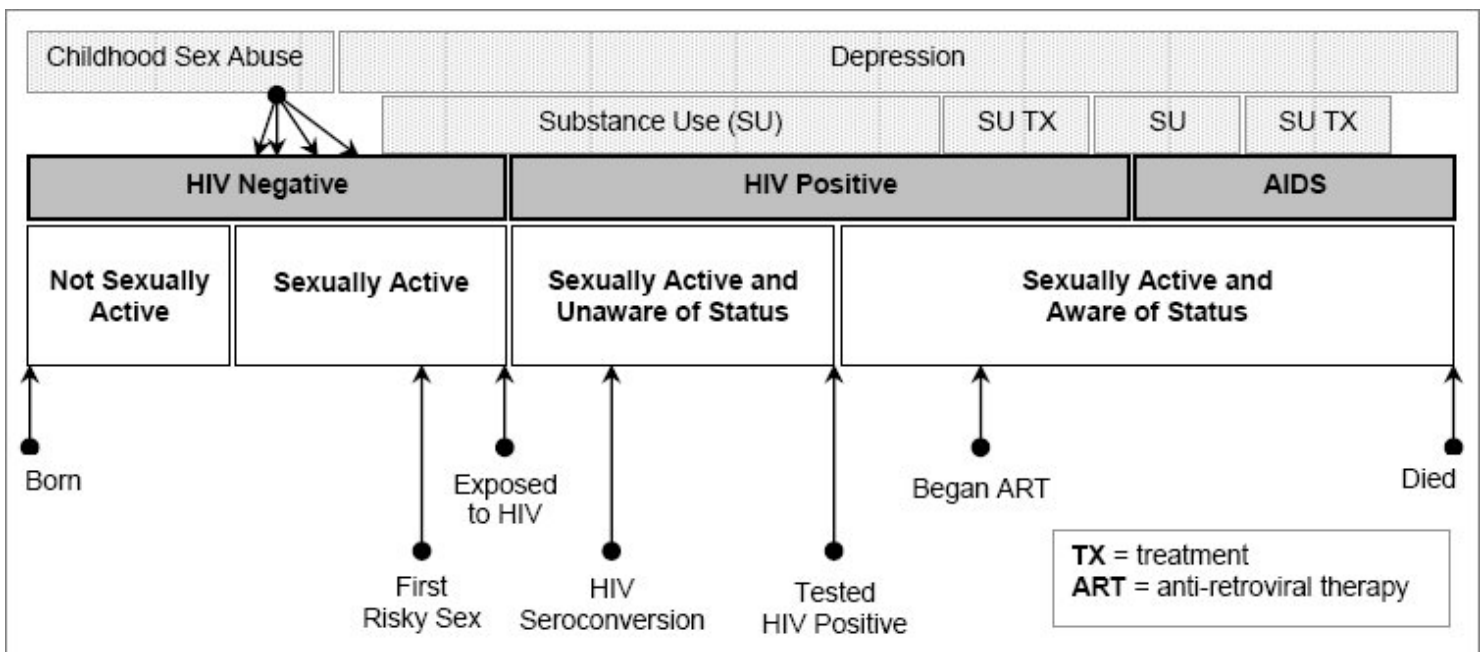
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### Understanding the Layers of Need

Public health prevention programs have long-identified the complex interactions between disease, behavior and social and economic disparity. While it is understood that these interactions influence the level of health and wellness in particular individuals, communities and populations, programs often struggle to operationalize comprehensive responses to holistically address these issues. How can these factors and the connections between them be better understood in order to prevent disease in individuals and to ultimately reduce disease disparity in populations at greatest risk?

HIV, viral hepatitis and STD prevention programs typically focus their efforts at the individual-level, constructing and implementing interventions that strive to prevent the spread of disease through methods like education, testing, treatment and vaccination. During these interactions, public health professionals often witness factors that contribute to the existence of, or potential for, these diseases. However, current categorical philosophies, structures, guidance and funding for disease prevention and control offer limited opportunity for little more than tacit acknowledgement of these contributing factors, the interconnections between them and their role in proliferation of disease. As an example, consider the following model that illustrates the life course of a hypothetical individual. The model demonstrates the existence of multiple health issues faced by the individual in life. Together, these health issues chart the course for this individual's health profile across the lifespan.

### Figure 1: Model of Health Profile over a Life Course

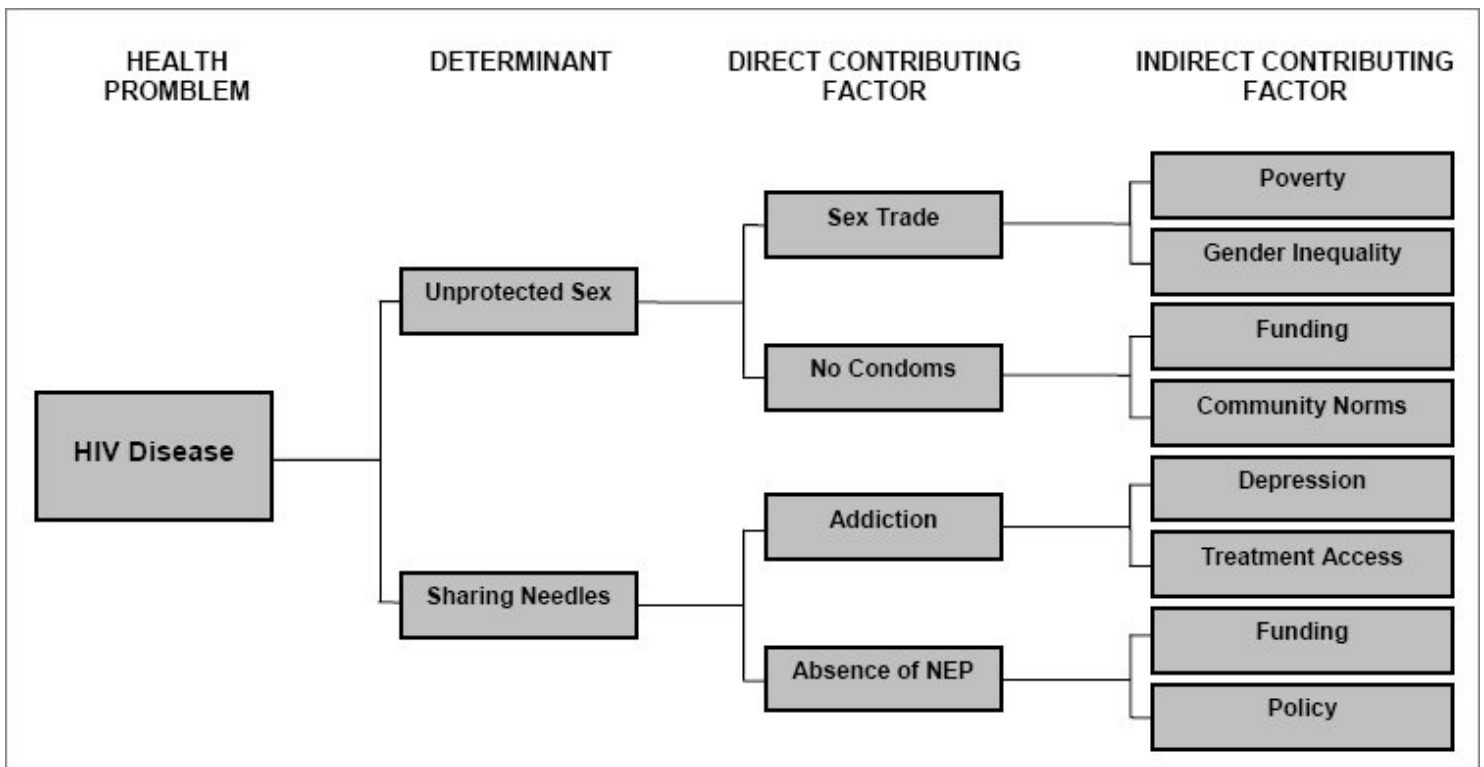


Adapted from the 2007-2009 Chicago Comprehensive HIV Prevention Plan

In this example, childhood sexual abuse, depression, substance use and risky sexual behavior act in tandem to influence the opportunity for exposure, infection, treatment and, ultimately, death associated with HIV. Our current programming efforts can offer targeted interventions to address the specific concerns faced by the individual in each of the identified areas. For example, there are numerous opportunities for HIV, viral hepatitis and STD prevention, as well as treatment for substance use and for HIV disease and therapeutic intervention for mental health concerns like depression and those stemming from childhood sexual abuse. However, because of categorical implementation of programs, the interventions and services that an individual would likely receive would not begin to address the reality of the whole-person or the interaction that exists between the co-occurring issues.

Similar models can be constructed to examine factors that contribute to disease morbidity and mortality. In his book, *Public Health: What It Is and How It Works*, Bernard J. Turnock, offers the following model to characterize the way in which factors determine and contribute to actual disease.

Figure 2: Model of Health Determinants



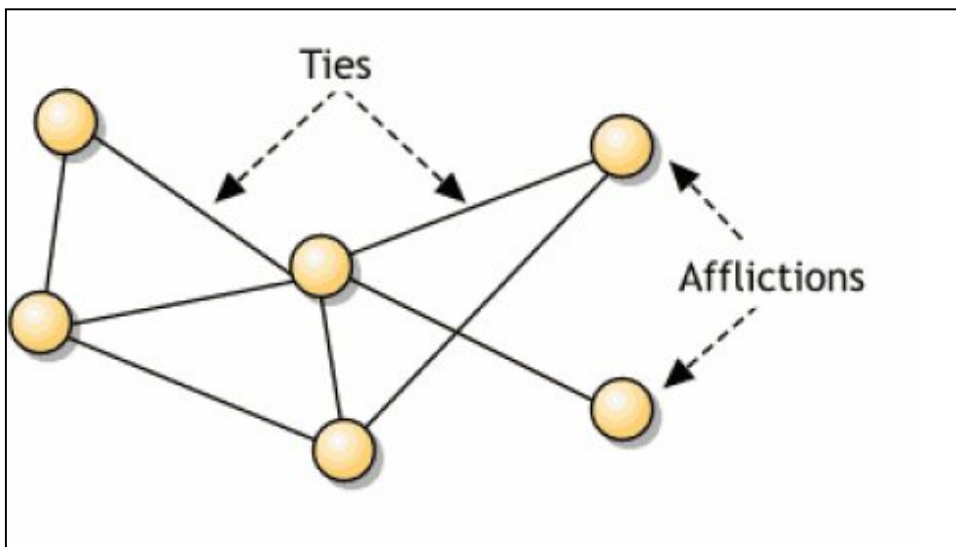
## Adapted from CDC Public Health Practice Program Office Health Problem Analysis Worksheet

In this model, greater attention is paid to the connections between life circumstances, risk behaviors and disease, yet the model does not explicitly double-back to investigate the connections between the direct and indirect contributing factors that lead to the health determinants that actually cause disease. However, the model does begin to offer a consideration of these factors as influences that promote disease transmission in broader categories of individuals with similar life circumstances. This examination allows us to consider, collectively, the particular influences that increase the likelihood a community or population will be disproportionately impacted by disease. How, then, can the actual connections between multiple diseases and between their contributing factors, be better leveraged to create programs that address the whole individual in the context of the broader population?

### What is a Syndemic?

Attempting to explain the links between substance abuse, violence and AIDS in populations of urban women in the U.S., anthropologist [Merrill Singer](#) first published the term "syndemics" in 1992. Syndemics is defined as "two or more afflictions, interacting synergistically, contributing to excess burden of disease in a population."<sup>1</sup>

Figure 3: Model of a Syndemic<sup>2</sup>



A syndemic orientation emphasizes examination of the ties, or connections, between health concerns. Rather than focusing on a specific disease, a syndemic orientation looks first at a particular community to understand the causes of disease burden and to identify what is needed to promote the community's overall health.<sup>3</sup> According to the CDC, a syndemic orientation follows a specific line of questioning:

- Who is sick (with which diseases)?
- Why those people?
- Why those diseases?
- What can be done to create (or restore) the conditions for optimal health?
- Under what circumstances do interventions contribute to improvements in health status and health equity?<sup>4</sup>

CDC goes on to note that, "...diseases in human populations do not occur randomly. In virtually all societies, the heaviest burden of disease falls upon those who are socially marginalized, disenfranchised, or oppressed."<sup>5</sup> With this explicit acknowledgement, a syndemic orientation maintains, first and foremost, that diseases and other health conditions are tied together within certain populations. This idea offers another frame within which programs can begin to address the collective needs of a population. If successful, programs can hope to begin to alter the cycle of disease and disparity within marginalized population groups.

### Why is Syndemic Orientation Important to Prevention?

For several reasons, a syndemic orientation lends itself well to prevention of HIV, viral hepatitis and STD. First,

HIV, viral hepatitis, and STD are often transmitted in the same ways: unprotected sexual activity with an infected person; sharing of unclean needles, syringes and other paraphernalia with an infected person; and during birth. Accordingly, the strategies to prevent or control these diseases are often the same. Second, these diseases most often impact the same high-risk communities. Third, the presence of one of these diseases has the potential to facilitate the transmission or acquisition of a second or third disease. Fourth, the diseases share many of the same direct and indirect contributing factors, like gender inequality and poverty. Fifth, other "afflictions" that impact communities where HIV, viral hepatitis and STD disease burden is high are, for the most part, the same: substance use, mental health concerns, incarceration, violence, etc. And, finally, the institutions that take leadership over addressing the concerns associated with these diseases are becoming more and more integrated in their structures and philosophies.

On its website, CDC states:

*The medical model of disease specialization, once praised for its utility and versatility, is proving inadequate for confronting such contemporary public health challenges as eliminating health disparities. Although conventional prevention programs have had strong effects, for the most part the categorical approach has failed to assure the conditions for overall community health, and it has done little to spread successes equitably among subgroups in society.<sup>6</sup>*

Given the HIV, viral hepatitis, and STD disease burden in certain populations in the U.S., specifically African-Americans, white and Latino men who have sex with men (MSM) and injection drug users, programs must strive to identify comprehensive solutions to address the multiple concerns of these marginalized populations.

### **An Interview with Ronald Stall**

*To better understand how a syndemic orientation can help inform public health programs' desires to address the broader concerns of a community's health and wellness, NASTAD interviewed Ronald Stall, Professor and Assistant Dean at the University of Pittsburgh's Graduate School of Public Health.*

**NASTAD:** Describe syndemic orientation.

**Stall:** It would be useful to start with a definition of what a syndemic is. To use the medical definition, it refers to a cluster of epidemics that act additively to predict other epidemics. Other phrases that have been used to convey the same idea include "intersecting epidemics" and "twin epidemics," among other phrases. In HIV research, we often see interconnections between HIV and substance use, HIV and violence, HIV and depression, HIV and childhood sexual abuse, among other problems. These intersection epidemics can all be described as "syndemics."

**NASTAD:** Describe what your research has shown about syndemics.

**Stall:** One of the striking findings regarding MSM in the context of AIDS has been the high prevalence rates of other dangerous health conditions found even in population-based samples of gay men when compared to other samples of men. That is, rates of depression, drug use, violence victimization, childhood sexual abuse, tobacco use and other health problems are generally higher among MSM than among other populations of men. We were struck by this consistent finding and decided to take a closer look at the interconnections of these epidemics among gay male populations. More specifically, we took a look at the interconnections between substance use, partner violence, childhood sexual abuse and depression and found that that these four epidemics function to reinforce each other among gay male populations, and together also function to raise both levels of current sexual risk-taking as well as HIV infection itself. The interconnections between substance use, childhood sexual abuse, depression and partner violence operate as a complex syndemic that drives HIV risk among gay men.

**NASTAD:** How do the findings supports consideration of syndemics in increasing community health and reducing disease burden and health disparities?

**Stall:** The phenomenon raises an interesting question: If there are four high prevalence psychosocial epidemics that work to raise levels of risk for HIV infection among gay men, why does HIV prevention work focus primarily on sexual risk-taking among gay men and generally ignore co-occurring psychosocial problems? Put another way, we now have a set of meta-analyses to show that model HIV prevention programs work to lower risk by about a third. Could we increase the effect of HIV prevention work even further if our interventions took into account the co-existing conditions that may keep men from responding more fully to prevention messages? Putting the question in the broadest frame, could we increase the effectiveness of HIV prevention work among gay men by partnering with violence prevention, substance abuse treatment and mental health efforts within gay communities?

**NASTAD:** How can syndemic orientation be operationalized within categorical public health programs?

**Stall:** We need to identify ways via funding streams to increase cross-agency collaborations and to encourage "cross-epidemic" thinking when providing services. As one example, if a young gay man seeks shelter from a violence prevention agency because his partner is beating him, providers should automatically screen for substance abuse, HIV and depression while also trying to find him safe housing.

Looking ahead, I'd like to see some, or a cluster, of funding agencies attempt a demonstration project where funding streams could be mingled to deal with syndemic situations, with careful process and uncontrolled outcome data to measure the effects of this new way of providing front line public health services.

### **Operationalizing Syndemics Orientation: Examples from the Field**

Having defined syndemics and set the context for syndemic orientation, we now look to models that have successfully operationalized this concept. First, we profile the work of the National Stakeholders Collaborative, of which NASTAD is a partner, to spotlight a national effort to build cross-program capacity within state education and health department programs. Next, the Chicago Department of Public Health is profiled to demonstrate how a local health department has been able to incorporate a syndemic orientation into program planning and implementation.

#### ***National Stakeholders Collaborative: Incorporating Syndemics into Prevention for Youth***

Since 2003, NASTAD has been involved in the National Stakeholders Collaborative (NSC), a partnership of four national organizations – the Society of State Directors of Health, Physical Education and Recreation (SSDHPER), NASTAD, the National Coalition of STD Directors (NCSDD), and the Association of Maternal and Child Health Programs (AMCHP). The NSC was created with the main goal of increasing the capacity of health and education agencies to collaborate more effectively around the integration of HIV, STD and unintended and teen pregnancy prevention programs for youth. To achieve this outcome, the NSC conducts [National Stakeholders Meetings \(NSM\)](#), two-day meetings of state teams comprised of state health and education agency representatives working on these issues to brainstorm about the challenges and facilitators to integrating HIV, STD and unintended and teen pregnancy prevention programs and to develop action plans with collaborative strategies and approaches. The NSC also conducts comprehensive technical assistance and follow-up with state team participants, providing them with such opportunities as on-site technical assistance, mini grants and access to tools and resources.

The rationale for the NSM is twofold. On a programmatic level, the national partners provide state health and education agencies targeting the same populations the opportunity to assess programmatic gaps, share knowledge and information and decrease duplication of efforts and resources. More importantly, however, collaboration between health and education agencies to integrate HIV, STD and unintended and teen pregnancy prevention ensures that consistent messages are provided to young people. It enables programs to approach prevention more holistically and, ultimately, elevates the importance of youth as a priority issue. According to a participant describing her experience at an NSM:

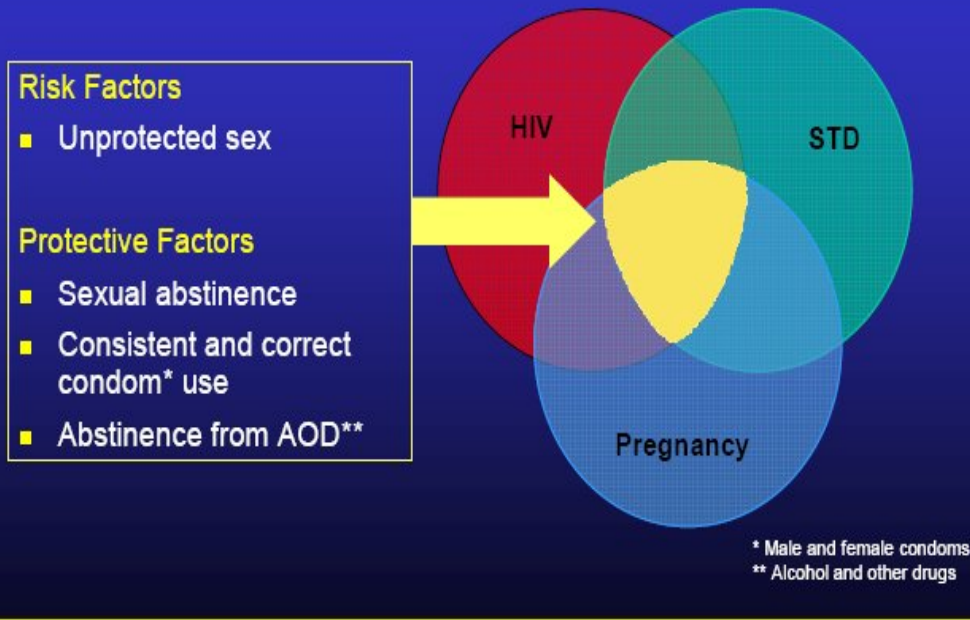
*"We didn't just talk about STDs, we talked about 'sexual reproductive health,' including HIV, unintended pregnancy and STDs. We started to make some changes by redefining how we described our problems, focusing on the commonalities as opposed to the differences."*

The triangulation of the current epidemiological data for HIV, STD and unintended and teen pregnancy paints a startling picture of the sexual reproductive health of young people. In 2004, among the 35 areas with confidential name-based HIV reporting, an estimated 4,883 young people, ages 13-24, received a diagnosis of HIV infection or AIDS, representing about 13 percent of the persons given a diagnosis during that year.<sup>7</sup> While the rates of HIV infection among youth remain relatively low, the rates of STD infection among youth are alarming. In 2000, approximately 18.9 million new STD infections occurred, of which approximately 9.1 million cases were among persons aged 15-24 (48 percent of the total cases).<sup>8</sup> The total estimated burden of the 9.1 million new cases of STDs in 15-24 year olds in 2000 was \$6.5 billion.<sup>9</sup> Lastly, in 2000, approximately 822,000 pregnancies occurred in 15-19 year olds and 19,640 pregnancies occurred among those 14 years and under.<sup>10</sup>

The common risk and protective factors for HIV, STD and unintended and teen pregnancy clearly overlap, which strengthens the case for providing youth with consistent and concise messages on how to protect themselves from all of the possible outcomes of risky sexual behavior.

#### **Figure 4: Risk and Protective Factors for HIV, STD and Unintended Teen Pregnancy<sup>11</sup>**

## Risk and Protective Factors for HIV, STD, and Unintended Teen Pregnancy



Since 2003, 29 states have participated in the NSM process. According to evaluation results from the 2003 and 2005 NSM, nearly all participants (94 percent) reported their state team had taken steps to improve state health and education agency collaboration. Furthermore, seven of nine domains included in the survey instrument to measure improvement in collaboration show a statistically significant improvement ( $p < 0.01 - 0.05$ , two-tailed test). These data suggested that the greatest improvements occurred in the area of developing trust between state health and education agencies, prioritizing collaboration and sharing data about HIV, STD and unintended and teen pregnancy prevention for school-age youth.

In 2006, NASTAD and the three NSC partners received funding from the CDC Division of Adolescent and School Health (DASH) to engage 15 new state teams in the NSM process, as well as to reconvene previous NSM participants to: 1.) provide state health and education agency participants a platform to discuss and enhance their ongoing efforts around integrated HIV, STD and unintended and teen pregnancy prevention programs for school-age youth; 2.) provide in-depth technical assistance around topical content areas and strategies to address the common barriers identified through previous [NSM evaluations](#); and 3.) provide a platform to examine challenges and share strategies and lessons learned across jurisdictions.

A syndemic orientation—one focusing at the community level to understand the causes of disease burden and identify what is needed to promote the overall health of that community—is an efficient and powerful method to address the sexual reproductive health needs of youth. With ever decreasing resources, this approach allows health and education agencies to capitalize on the often limited opportunities to strategically transfer knowledge and information to youth. This approach further ensures that the messages being received by youth are comprehensive, consistent and concise, ultimately empowering them to decrease the negative sexual health outcomes which they face.

For more information about the NSC, contact [Kellye McKenzie](#).

### **Chicago Department of Public Health: Incorporating Syndemics into Local Public Health Programming**

One of the most daunting feats for health department prevention programs is determining what an appropriate portfolio of interventions and activities should be in order to prevent as many new infections as possible with the resources available. The jurisdiction's geography, disease morbidity and identified priority populations must be taken into account as must the menu of available interventions and activities. Concepts like syndemics, while interesting and important, are often overlooked because programs struggle to identify ways in which to operationalize them. If a given priority population is known to engage in behavior that increases risk for disease transmission and is known to use alcohol and other non-injection drugs, like crystal methamphetamine or crack cocaine, and is disproportionately represented among the

jurisdiction's incarcerated population, what would need to be done to begin to address these multiple layers of concern?

Health departments are beginning to identify answers to questions like this. To help describe how a health department can translate an understanding of syndemics into actual programming, NASTAD talked with Fikirte Wagaw, Director of Community Services, and Linda Lesondak, Director of Evaluation, at the Chicago Department of Public Health, Division of STD/HIV/AIDS.

In January 2005, the Chicago Department of Public Health (CDPH), in partnership with the Chicago HIV Prevention Planning Group (HPPG), embarked on a year-long process of setting HIV prevention priorities for the City of Chicago. As in previous cycles, committees were identified to tackle the various aspects of priority setting. Throughout the process, CDPH and HPPG used HIV case data to demonstrate areas and populations in greatest need of HIV prevention services. Simultaneously, the groups recognized that factors other than HIV case data were essential in gaining an understanding of what was actually happening in specific high-risk areas and populations in the city.

Following a detailed analysis of social barriers related to HIV infection—STD and AIDS cases, substance abuse, health care access, poverty, crime and violence, mental health, disability, stigma, racism and homophobia, and undocumented immigration status—the HPPG Needs Assessment Committee was able to visually illustrate, using maps created with geo-mapping software (see the [June 2007 NASTAD HIV Prevention Bulletin](#) for a discussion of geo-mapping), the burden of these co-occurring issues on specific community areas in the city. This process offered the planning group insight into the ways in which social determinants may influence access to and uptake of HIV prevention services. From the analysis, the committee recommended that the full planning group consider a syndemic orientation as they set forth to identify HIV prevention priorities.

At the same time, the HPPG Special Projects Committee (charged with identifying non-traditional projects that could significantly reduce HIV transmission in specific populations and settings) discussed several factors impacting specific population groups that naturally linked to the idea of a syndemic orientation. In their consideration, the committee identified co-occurring issues that, they believed, had a meaningful impact on an individual's risk for being infected with HIV. These special initiatives considered conditions like the presence of STD, incarceration, substance use, gender inequality and role of the Internet in disease proliferation.

The inclusion of syndemics in Chicago's planning process came organically. The members of the HPPG and staff from CDPH had long discussed the potential impact of life circumstances and other diseases on the HIV risk of the city's highest-risk populations. However, when these concerns were explicitly included in the planning discussion, it became obvious that there was merit in including these factors in the actual priority recommendations. CDPH and HPPG ultimately identified four Special Projects of Innovative Significance (SPInS) in the city's comprehensive HIV prevention plan.

Upon receipt of the completed comprehensive plan, CDPH staff began the process of translating the recommendations into a request for proposals (RFP) that would operationalize SPInS at the community level. CDPH recognized that its traditional mechanism for funding community-based programs was not robust enough to support these new and more complex projects. To address this concern, CDPH crafted a separate RFP to fund SPInS which clearly articulated that projects must be innovative in the ways in which they explored the links between HIV risk and the identified co-occurring issues. The RFP also asked projects to explore the links between healthy decision-making and community assets that increase the likelihood of reducing HIV transmission in specific target populations, i.e., asset mapping.

The RFP set forth rigorous expectations for applicants. First, CDPH required that applicants ground the design, implementation and evaluation of the model program in scientific or empirical evidence and/or scientific theory. Since they did not want mere replication of already-developed interventions, CDPH allowed applicants to consider the following bases for their proposed projects:

- cutting-edge HIV prevention research findings (i.e., findings that are not yet widely practiced);
- science-based interventions that have been proven effective but have not yet been implemented with the target populations identified in SPInS RFP; and/or
- empirically successful 'locally-grown' HIV prevention strategies that have not yet been scientifically proven effective.<sup>12</sup>

In addition, CDPH prescribed three specific project phases—design, implementation and continuous quality improvement—and a timeline for completing the objectives within each phase. CDPH understood that their traditional three-year funding cycle would not offer projects adequate time to successfully complete the three phases, particularly because the first year of funding dedicated to planning efforts without service provision. To this end, the projects were funded for five years. Finally, all projects were required to include HIV testing and hepatitis prevention activities within their programs.

On January 1, 2007, CDPH began funding four SPInS:

- *Corrections*—a program to reduce new HIV infections among incarcerated MSM who engage in high-risk behavior and who use of crack and other substances.
- *Female Empowerment*—a program to reduce new HIV infections among incarcerated women who engage in high-risk behavior and who experience gender inequality and associated vulnerabilities.
- *Prevention of Crystal Methamphetamine Use as a Means of Preventing HIV Infection/Transmission*—a program to prevent onset of crystal methamphetamine use in order to reduce new HIV infections among MSM who use the Internet to facilitate engagement in high-risk sexual behavior.
- *STD Clinic Waiting Room*—a program to enhance the delivery of HIV prevention interventions to clients of CDPH STD clinics in order to reduce new HIV infections among high-risk STD clients.

To support the implementation of SPInS, the CDPH holds quarterly grantee meetings with program and fiscal staff, as well as each project's external evaluator. The meetings are intended to clarify expectations and to share resources supporting the design phase of SPInS, e.g., the Health Resources and Services Administration [Needs Assessment Guide - 2003 Version](#), the University of Kansas' [Community Tool Box](#), National Association of County and City Health Officials' [Mobilizing for Action through Planning and Partnerships \(MAPP\)](#) and resources from Northwestern University Institute for Policy Research's [Asset-Based Community Development Institute \(ABCD\)](#).

Six months into the funding cycle, CDPH acknowledges that grantees are feeling challenged by the rigorous expectations of the SPInS. Particularly, grantees are struggling to dedicate a full year to planning efforts without providing direct services. CDPH admits that this strategy is a radical departure from traditional projects but is committed to seeing the design phase to completion. Also, CDPH has noticed that the concept of community assets is a difficult one for grantees to fully conceptualize. They suspect this is because HIV prevention programming has tended to be individualized and problem-focused as opposed to community-level and asset-focused. Additionally, CDPH feels the constraints of categorical funding as it unable to financially support proven public health prevention interventions, like vaccination for hepatitis A and B.

CDPH notes that grantees are beginning to value the concept of syndemics as they consider multi-disciplinary approaches to addressing the complex issues faced by the populations they are funded to serve. Further, CDPH has found that grantees and external evaluators, three of whom are university researchers, are benefiting from one another's points of view. Grantees are learning to appreciate scientific rigor, and the researchers are grasping the realities of HIV prevention work on the community level. CDPH also notes that grantees are beginning to understand the importance of systems and structural level change in order to impact the issues faced by the populations they serve.

While CDPH acknowledges there has been a steep learning curve in the operationalization of the SPInS, they appreciate the new energy that has been infused into the city's HIV prevention portfolio.

*For more information about Chicago's community planning process, see the [2007-2009 Chicago Comprehensive HIV Prevention Plan](#). For more information, contact [Fikirte Wagaw](#) or [Linda Lesondak](#).*

## Conclusion

A syndemic orientation offers public health programs a context within which to conceptualize comprehensive responses to the myriad health concerns affecting the populations they serve. As Ron Stall suggests in his interview, addressing issues like substance use and depression that co-occur within the context of HIV risk might increase the effectiveness of HIV prevention efforts. Further, as evidenced by the National Stakeholders Collaborative, non-traditional partners, like state health and education agencies, can work collectively to address the health concerns faced by a population such as school-aged youth. Finally, while the concept of syndemics may seem overwhelming, programs like the Chicago Department of Public Health's Special Projects of Innovative Significance demonstrate that a syndemic orientation can be operationalized on the programmatic level. As we continue to refine our efforts to prevent new HIV infections, a syndemic orientation, if successfully operationalized, holds great promise.

*"The conceptualization of a syndemic is significant because it expands the boundaries of public health science and action. The prospect of organizing resources around a syndemic orientation joins the science of epidemiology with the action agenda of community leaders, yielding a framework that can guide initiatives of greater size and complexity than ever before."<sup>13</sup>*

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## References:

1. <http://www.cdc.gov/syndemics/>
2. <http://www.cdc.gov/syndemics/overview-definition.htm>
3. <http://www.cdc.gov/syndemics/overview-principles.htm>

4. *ibid*
  5. *ibid*
  6. <http://www.cdc.gov/syndemics/overview-uses.htm>
  7. CDC Fact Sheet. HIV Among Young People. June 2006. <http://www.cdc.gov/hiv/resources/factsheets/PDF/youth.pdf>
  8. Weinstock, H, Berman, S, Cates, W, Jr. Sexually Transmitted Diseases among American Youth: Incidence and Prevalence Estimates, 2000. *Perspectives on Sexual and Reproductive Health*, 2004: 36(1):6-10
  9. Weinstock, H, Berman, S, Cates, W, Jr. Sexually Transmitted Diseases among American Youth: Incidence and Prevalence Estimates, 2000. *Perspectives on Sexual and Reproductive Health*, 2004: 36(1):6-10
  10. Teenage Pregnancy Statistics, Alan Guttmacher Institute, 2004
  11. Ventura SJ, Abma JC, Mosher WD (2004). *Estimated pregnancy rates for the US, 1990-2000: An Update*. National Vital Statistics Reports, 52 (23), June 15.
  12. Kirby, D., Lepore, G., and Ryan, J. (2005). Sexual Risk and Protective Factors, Factors Affecting Teen Sexual Behavior, Pregnancy, Childbearing, and Sexually Transmitted Diseases: Which are Important? Which can Change? ETR Associates.
  13. Chicago Department of Public Health Request for Proposals 06-03 <http://www.cdc.gov/syndemics/overview-definition.htm>
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## 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 website](#).

August 23-26, 2007

[Staying Alive 2007](#), Cleveland, OH. National conference by and for people living with HIV/AIDS sponsored by the National Association of People With AIDS (NAPWA)

October 15, 2007

[National Latino AIDS Awareness Day](#).

November 2-6, 2007

[American Association for the Study of Liver Diseases Conference](#), Boston, MA

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

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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 *HIV Prevention Bulletin* is written and edited by NASTAD staff and participants of community planning and prevention efforts around the country.

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