

## NASTAD Prevention Bulletin

**When one is infected, all are affected.**



January 2008

## Table of Contents: NASTAD's Top Ten Issues to Watch in 2008

- [Introduction](#)
- [Revised HIV Incidence Estimate](#)
- [Prevention Funding in 2008](#)
- [Erosion of HIV/AIDS Surveillance Programs](#)
- [The Epidemic among Gay men and other Men who have Sex with Men](#)
- [Addressing Racial and Ethnic Health Disparities](#)
- [Expanding HIV Case Finding](#)
- [Broadening and Deepening our Research Base](#)
- [Program Collaboration and Service Integration](#)
- [New CDC Program Announcements](#)
- [Changing Leadership at All Levels](#)

## Introduction

2008 will be the Year of Prevention! With the release of NASTAD's [A New Blueprint for the Future: Ending the Epidemic through the Power of Prevention](#) and companion [Policy Agenda](#), health department HIV prevention programs, their community planning groups and community partners can now speak with a unified voice about what needs to be done to reduce new HIV infections in every jurisdiction in the U.S. Collectively, partners in the fight against HIV/AIDS can rally against a common set of barriers and challenges, working actively to acknowledge and address them. The time for collective and coordinated action is now.

As 2008 begins, several issues will influence HIV prevention efforts in the new year. Chief among these is the impending release of the revised national estimate of HIV incidence. More than ever, advocates for HIV prevention will need to coalesce around a common message: HIV prevention has been successful, even in the face of increasing HIV/AIDS prevalence, restrictive policy and the erosion of resources. Unfortunately, the outlook for funding in 2008 remains bleak. One of the greatest consequences of eroded funding will lie with our nation's HIV/AIDS surveillance programs. These essential programs provide the information necessary to accurately target prevention efforts and, as importantly, provide the data used to determine allocation of billions of dollars in HIV/AIDS care and treatment resources. Throughout 2008, the health of HIV/AIDS surveillance programs must be watched closely.

Since the beginning of the epidemic, HIV/AIDS has had the most devastating impact on gay men and other men who have sex with men of all races and ethnicities. 2008, unfortunately, will likely demonstrate that the successes we have seen in preventing new infections in this population are losing momentum.

- [Meeting and Planning](#)  
[Calendar](#)

Like gay men and other MSM, racial and ethnic minorities, particularly African Americans, remain disproportionately impacted by the epidemic and will continue to bear an unacceptable and growing burden in 2008.

Efforts to encourage individuals to know their HIV status will continue to be scaled up in the new year, in line with CDC's 2003 [Advancing HIV Prevention initiative](#). Through expanded testing programs, primarily in health care settings, and revised guidance for delivering partner services, prevention programs will enhance their efforts to identify the estimated 25 percent of individuals living with HIV/AIDS who are unaware of their status and work to ensure these individuals receive quality care and treatment services. Beyond case finding, the continued implementation of behavioral interventions will be extremely important in 2008, including interventions that have been rigorously evaluated and those home-grown to address the unique conditions in communities across the country. To further support delivery of HIV prevention services, the Centers for Disease Control and Prevention (CDC) National Center for HIV, Hepatitis, STD and TB Prevention (NCHHSTP) will continue to promote program collaboration and service integration in 2008.

Finally, in preparation for the reissue of several Funding Opportunity Announcements (FOAs) over the next few years, CDC will use 2008 to gather input from stakeholders across the country. As leadership within NCHHSTP and its Division of HIV/AIDS Prevention (DHAP) has changed over the past year, the partnership between CDC and their funded grantees, including health departments, promises to be more collegial in 2008. Leadership in the field, however, remains an ever-challenging issue, as veteran leaders in the movement begin to move on to other endeavors. In particular, the need to develop leadership in communities most impacted by the epidemic is essential. Throughout 2008, NASTAD will scale up its efforts to support health department leaders of color across the country.

As the NASTAD Blueprint clearly articulates, "The nation must lift its veil of indifference and commit itself to ending the HIV/AIDS epidemic through the power of prevention...We are confident the nation can be successful in its fight to reduce HIV infection in U.S. We must act now."

### **Revised HIV Incidence Estimate**

During NASTAD's 2007 Annual Meeting in May, Dr. Kevin Fenton, Director of the CDC NCHHSTP indicated that CDC would be releasing a new estimate of the number of new HIV infections in a year, by the end of the year. AIDS directors recognized the significance of this announcement and the potential for new incidence estimates - depending on the numbers - to bring greater attention and scrutiny to HIV prevention programs across the country. The HIV/AIDS field has been relying on the previous estimate of 40,000 new infections per year since the 1990s even though many in the field questioned the ongoing accuracy of this

estimate.

Unfortunately, the year ended without the release of the new estimates and CDC once again found the agency in the hot seat with stakeholders, advocates, programs and politicians asking tough questions about when the data would be released and what it would say about the state of the epidemic in the U.S.

By way of background, CDC has developed a new technology called STARHS (Serological Testing Algorithm for Recent HIV Seroconversion) that can distinguish recent from long-standing HIV infections. Using this technology, CDC developed a system to provide more accurate and timely HIV incidence estimates and has been working in recent years to evaluate this system. To ensure the accuracy of both the new methodology and the resulting estimates, CDC decided to seek publication of this information in a scientific journal so that it would have to stand the test of a rigorous process of peer review. In a December 2, 2007 statement, CDC indicated, “presuming that the methods are found to be sound, we anticipate releasing the new estimates in early 2008.”

While some may question CDC decisions and communications about the forthcoming release of incidence estimates, there can be no doubt of the importance of subjecting the methodology and the estimates to the intense analysis and validation that are part of a peer-review process. For those of us in the HIV/AIDS field, this IS rocket science and we must get it right, or as close to right as we can, because it is important to the programs we run and the people we serve. The data that are ultimately released will paint a timely picture of the HIV epidemic in the U.S. and influence the direction of HIV policy and programs in 2008 and beyond.

## **Prevention Funding in 2008**

In 2008, states and cities will be tightening their belts related to HIV prevention funding. Despite the impending release of the revised estimate of HIV incidence, HIV prevention programs will once again be denied sufficient resources to maintain or ramp up prevention programs. In addition, the only new funding being provided for prevention is for HIV testing. Other elements of the prevention portfolio, particularly interventions targeted toward individuals at high-risk for HIV infection and the development of targeted behavioral interventions for high-risk populations are not receiving dedicated new resources from Congress. This continues to be a troubling trend for HIV prevention advocates who are coalescing to raise the profile of prevention issues in 2008.

The FY2008 Omnibus Appropriation bill includes a \$3.6 million cut for CDC’s HIV prevention program for a total of \$692 million. In addition, Congress has directed CDC to increase its domestic HIV/AIDS Testing Initiative by \$9 million for a total of \$53.3 million. It is highly likely that the additional funding for the Testing Initiative increase will be taken from the state and local HIV/AIDS cooperative agreements. State and local cooperative agreements have been cut

by \$26 million since FY2003 and could potentially face an additional \$12 million in cuts.

The Testing Initiative funds that go to 18 states and five cities will also be tapped to pay for the implementation of the Early Diagnosis Grant program in FY2008. \$30 million will be made available to make grants to states eligible as of December 31, 2007. Awards to states will be capped at \$1 million and will be distributed based on a state's epidemiological profile. CDC is required to redistribute any remaining funds after May 31, 2008. The grants will be made to states that have enacted voluntary opt-out testing of pregnant women and universal, or mandatory, testing of newborns and to states that have enacted voluntary opt-out testing of clients at STD clinics and voluntary opt-out testing of clients at substance abuse treatment centers. Funds can be used for HIV/AIDS testing, included rapid testing, prevention counseling, treatment of newborns exposed to HIV/AIDS, treatment of mothers infected with HIV/AIDS and costs associated with linking those diagnosed to care and treatment for HIV/AIDS. It is unknown at this time how much of the \$30 million available will be needed to fulfill these grants.

In terms of other important prevention programs serving people at risk of HIV, viral hepatitis prevention was flat funded at \$17.6 million, STD prevention was cut \$2.8 million for a total of \$152 million and TB prevention received an increase of \$5.7 million for a total of \$140.4 million. The Title X Family Planning Program received \$300 million, an increase of \$16.8 million.

On a positive note, the flow of new funds for unproven abstinence-only-until-marriage sex education programs has been stemmed. Congress flat-funded the Community-Based Abstinence Education Program at \$113.4 million. Additionally, there are now 15 states that have rejected the Title V abstinence-only-until-marriage education grants, totaling more than \$15 million of the total \$50 million in funding. Comprehensive sexuality education advocates are not expecting this programming to go away, rather they are working to ensure that the programs receive no new funding and that in the case of Title V, the program is altered to allow states the flexibility to use the funds for comprehensive sexuality education.

Another abstinence-related fight is brewing for 2008 as part of the consideration of legislation to reauthorize the President's Emergency Plan for AIDS Relief (PEPFAR). Many global advocates would like to see a removal of the current Congressional mandate that thirty-three percent of prevention funding be set-aside for abstinence-until-marriage programs. This will be a significant challenge given support for the abstinence earmark by the Administration and a number of Republican members of Congress.

In 2008, there will also be the election of a new President, the entire House of Representatives and one-third of the Senate. The outcome of these races could have a big impact on the direction of HIV prevention, particularly in the U.S. Some Presidential candidates have already released positions that include HIV prevention policy recommendations. They range from support for removing the

federal funding ban on syringe exchange, increasing funding for HIV/AIDS research at NIH and increasing funding for comprehensive sexuality education to increasing funding for support services including housing through Ryan White and HOPWA.

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### **Erosion of HIV/AIDS Surveillance Funding**

“For those of us in the trenches, addressing the under-funding of surveillance is paramount” says Andre Rawls, Chief of the HIV/AIDS Section at the Illinois Department of Public Health and NASTAD Chair.

While those in the trenches know that the chronic under-funding of surveillance programs has been a concern for a number of years, this alarm was heightened last summer with the release of CDC’s FOA PS08-802. The projected award amounts in this FOA indicated a \$3 million (or six percent) reduction from the previous year. Moreover, the FOA detailed the reduction of the number of jurisdictions funded for incidence surveillance and Variant, Atypical and Resistant HIV Surveillance (VARHS), two of the special surveillance studies for which a limited number of jurisdictions have been eligible to receive funding over the past several years. The impact of such funding decisions is two-fold. First, lower morbidity states, that have not historically been eligible for special

studies funding, will be negatively affected, widening the gap between high and low resource surveillance areas. Second, jurisdictions that were not refunded but had followed the CDC's directive to integrate special studies into core surveillance programs will have even fewer resources to support essential core surveillance.

"The bottom line is [surveillance programs] can't continue to do the work that we have been asked to do with the resources available," says Nanette Benbow, Surveillance, Epidemiology and Research Director for the STD/HIV/AIDS Division at the Chicago Department of Public Health and Chair of the Council of State and Territorial Epidemiologists (CSTE) HIV surveillance coordinators work group.

"The funding cuts are a problem but level funding over multiple years is a part of the problem too. This is something that has been discussed for awhile now - in multiple venues for several years. It is now at the point where not having sufficient resources is going to have a negative impact on a critical national data set."

In November 2007, CSTE and NASTAD wrote a [letter](#) to CDC Director, Dr. Julie Gerberding, detailing these concerns. Additionally, it noted that demands placed upon HIV/AIDS surveillance programs over the past several years have increased. With the requirement of name-based HIV reporting, states are required to go through resource intensive de-duplication activities with other states. Furthermore, the implementation of new systems and activities requested by CDC to improve the quality of surveillance data (e.g., Evaluation HIV/AIDS Reporting System (e-HARS), electronic laboratory reporting, document based surveillance and evaluation) require more resources, not fewer.

Data from no other disease surveillance system provide the basis for allocating \$2 billion of care resources. HIV/AIDS surveillance program staff and the data they provide are heavily relied upon for prevention programming as well (e.g., through their efforts to develop epidemiological profiles and their involvement with community planning groups). With the increased level of interest in HIV/AIDS surveillance data as the nation anticipates the release of new HIV incidence estimates, it is more critical than ever to adequately fund HIV/AIDS surveillance programs. Having heard the outcry from AIDS directors and surveillance coordinators, federal partners clearly understand that steps must be taken to rectify this crisis now. Look for more information about HIV surveillance funding in 2008.

## **The Epidemic among Gay Men and other Men who have Sex with Men**

As the HIV/AIDS epidemic continues to evolve, gay men and other men who have sex with men (MSM) remain the population most impacted by HIV disease. At the end of December 2005, in the 33 states with confidential HIV reporting, 68 percent of the living HIV and AIDS cases were among MSM, seven percent of

whom also reported injecting drugs.<sup>1</sup> Incidence reports among the same states point to similar statistics, with new infections among MSM (including those that also inject drugs) in 2005 at 53 percent of the cases reported during the same time period. Most individual state epidemiological reports also indicate similar trends, and many show that an increasing percentage of new infections are among MSM.<sup>2</sup> Clearly, the epidemic in the U.S. remains rooted among gay men and other MSM.

While the nation awaits the new estimates of HIV incidence from CDC, many fear that the HIV/AIDS epidemic among gay men and other MSM is again increasing at a faster pace than among other populations. Most agree there must be a heightened response to addressing the prevention needs of these populations. One size does not fit all in serving gay men and other MSM, particularly when examining the impact on certain racial and ethnic populations, as well as those who engage in certain risk-priming behaviors, like substance use.

In 2008, we must refocus our prevention efforts and tailor programs and interventions that address the needs of gay men and other MSM who are most impacted by HIV/AIDS. This includes gay men and other MSM of all races. Prevention efforts serving these men must recognize and address the social determinants and sometimes subtle nuances in different populations that contribute to HIV transmission. While evidence-based interventions targeting specific populations of MSM must remain a focus of scientific research, forward-thinking and home-grown interventions and other proven strategies, like post-exposure prophylaxis, must have a place at the table. Effective structural level interventions, including those addressing the Internet and social networks, public sex venues, stigma and discrimination and the intersection of substance use and HIV risk, must be given greater focus in HIV prevention programs. In 2008, HIV prevention efforts serving gay men and other MSM must be scaled up if we are ever to reduce new infections in this most-impacted population.

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#### References:

1. Centers for Disease Control and Prevention. Cases of HIV infection and AIDS in the United States and Dependent Areas, 2005. HIV/AIDS Surveillance Report, Volume 17, Revised Edition, June 2007. Accessed on December 21, 2007 at <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report/table9.htm>.
2. Centers for Disease Control and Prevention. Cases of HIV infection and AIDS in the United States and Dependent Areas, 2005. HIV/AIDS Surveillance Report, Volume 17, Revised Edition, June 2007. Accessed on December 21, 2007 at <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report/table1.htm>.

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## **Addressing Racial and Ethnic Health Disparities**

As we embark on 2008, racial and ethnic minority communities stand at the epicenter of the domestic HIV epidemic. Moreover, HIV/AIDS is taking a particularly devastating toll on gay men and other MSM of color. Consistent with NASTAD's strategic map and its overarching priority of addressing racial and ethnic health disparities, an ever-changing political landscape and the advent of new technologies, NASTAD continues to work closely with CDC and other Department of Health and Human Services agencies, state and local health departments, national organizations and within various coalitions to mount an aggressive response to the unacceptable rates of HIV infection in racial and ethnic minority communities.

The disproportionate impact of HIV/AIDS on racial and ethnic minority populations will continue to receive great attention during 2008. During the recent 2007 National HIV Prevention Conference, CDC leadership held several listening sessions with racial and ethnic minority communities, providing an opportunity for them to strategize around the future of prevention efforts targeting their populations. NASTAD expects that NCHHSTP Director, Kevin Fenton, will continue his strong emphasis at the Center on confronting health disparities among racial and ethnic minority populations. In particular, CDC is poised to increase its efforts around Latino communities through an internal work group and planned consultation in 2008.

As part of NASTAD's overall strategy to address this crisis, NASTAD will continue its focus on addressing racial and ethnic health disparities, particularly among African Americans and Latinos, with targeted technical assistance efforts focusing on Black and Latino gay men and other MSM as well as African American women. Additionally, NASTAD will begin to examine the impact of HIV/AIDS on immigrant and indigenous populations. These efforts will focus on surveillance activities to help inform the nature of the epidemic in specific jurisdictions and how jurisdictions should respond to the unique cultural experiences each population brings.

The various challenges to addressing racial and ethnic health disparities require an examination and confrontation of multiple societal-level influences, including racism, power and privilege, gender disparity, homophobia and socio-economic status. While not easily addressed through prevention programs, these factors must be considered when designing programs, as should a variety of other subtle and not-so-subtle nuances that require a hybrid approach to addressing varying populations. Efforts must address the prevention needs of racial and ethnic minorities in general, while at the same time recognizing the various factors that contribute to HIV transmission. Finally, educating key policymakers and re-energizing the efforts of leaders and community advocates in various racial and

ethnic minority populations must be key priorities.

## **Expanding HIV Case Finding**

In response to the release of CDC's [\*Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings\*](#) in September 2006, state and directly-funded city health departments spent 2007 assessing the extent to which the revised recommendations were feasible and necessary in the context of current HIV testing programs. Although the recommendations indicated that written informed consent and pre-test counseling were barriers to HIV testing in health care settings, NASTAD reported, in its June 2007 [\*Report on Findings from an Assessment of Health Department Efforts to Implement HIV Screening in Health Care Settings\*](#), most jurisdictions were already implementing HIV testing in health care settings within the parameters of these requirements. Moreover, the most significant concern and barrier to implementation of the recommendations reported by health departments was funding. This very concern was echoed by many stakeholders, including CDC, over the course of 2007.

In 2008, state health departments will likely face continued pressure from external entities in support of changing existing state testing laws. Health departments and their allies will need to continue their assessment of the recommendations to determine what makes the most sense within their programs, including, if appropriate, policy change. The need to educate external stakeholders will remain necessary to ensure state and city HIV testing programs are best positioned to meet the needs of their jurisdiction's environment and epidemic. Also in 2008, stakeholders will need to continue to battle the issue of funding for HIV screening programs in order to leverage resources from all possible payers, particularly public and private insurance companies.

With the expansion of testing in health care settings funded under FOA PS07-768, *Expanded and Integrated Human Immunodeficiency Virus (HIV) Testing for Populations Disproportionately Affected by HIV, Primarily African Americans*, the 18 state and five city health departments funded under the announcement will continue to scale up efforts to provide HIV testing in 2008. In addition to increased testing, PS07-768 will lead to greater integration of viral hepatitis, STD and TB prevention into HIV testing programs, further supporting the efforts of the CDC NCHHSTP to advance program collaboration and service integration. To support PS07-768 programs, CDC will enhance efforts in 2008 to provide training, technical assistance and capacity building to HIV testing programs. NASTAD will also continue to provide high-quality technical assistance through peer-to-peer exchange and through publications like [\*HIV Testing in Emergency Departments: A Primer on Issues and Strategies for Health Departments\*](#).

Given the availability of multiple rapid HIV testing products in 2008, the competitive market place will likely benefit health department HIV testing programs. In 2007, NASTAD successfully negotiated a lower price for two rapid HIV testing products currently on the market from industry partners Inverness Medical and Trinity Biotech. As competition and demand continue to expand, prices for rapid HIV tests will likely continue to drop.

CDC will finalize its revised guidelines for partner services in mid-2008. The revised guidelines combines HIV partner counseling and referral services and STD partner services. CDC plans to release preliminary information of the new guidelines at the [2008 National STD Conference](#) in March; at NASTAD's 2008 Annual Meeting (and the annual meetings of other national partners); and via teleconference or web conference to key HIV/AIDS/STD program staff. Official release is scheduled for the [2008 HIV Prevention Leadership Summit](#) in June.

## **Broadening and Deepening our Research Base**

The recent release of the [Updated Compendium of Evidence-Based HIV Prevention Interventions \(Updated Compendium\)](#) is the most recent effort by CDC to share HIV prevention interventions with evidence of effectiveness. While the interventions in the *Updated Compendium*, "address a broader array of risk groups and communities"<sup>1</sup> than the previous compendium, jurisdictions and communities need to continue to explore adaptation of effective interventions throughout 2008. Additionally, the creation of locally-developed or homegrown interventions needs to be enhanced. Based in theory or logic models, homegrown interventions can be effective in meeting the needs of a specific community by taking into account the local environment and culture. In many cases these interventions, when implemented with fidelity, can be as effective in delivering HIV prevention messages as those detailed in the *Updated Compendium* or the Diffusion of Effective Behavioral Interventions (DEBI) project, though they often lack the scientific and rigorous evaluation of outcomes necessary to be included in either of these projects.

Implementing, adapting, developing and evaluating interventions require money. In these days of eroding HIV prevention funding, funding HIV prevention activities, behavioral interventions in particular, can be a challenge. In some instances, jurisdictions have been able to identify resources beyond those of CDC. Some organizations have identified funding from other federal agencies like the National Institutes of Health and the Substance Abuse and Mental Health Services Administration. Non-traditional sources of funding can also lead to program collaboration with non-traditional organizations and agencies which can result in integrated HIV prevention services into other services like viral hepatitis, STD and TB prevention; substance abuse prevention and treatment; reproductive health services; and mental health services. To ensure messages reach as many individuals as possible, it is important to consider program collaboration in 2008.

It is through effective behavioral interventions, which serve people living with HIV/AIDS and individuals at high-risk for becoming infected, that individuals learn, in a culturally-appropriate way, how to protect themselves and others. Even with increased interest in and emphasis on HIV testing, these interventions must remain a critical component of truly effective HIV prevention programs.

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#### References:

1. Janssen, RS. December 14, 2007. "CDC Releases Updated HIV Compendium" Electronic mail correspondence.
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### **Program Collaboration and Service Integration**

In 2007, there was much discussion about program collaboration and service integration (PCSI) led by the CDC NCHHSTP. As the public health community continues to work with NCHHSTP in 2008 to further define how PCSI takes shape, health department HIV/AIDS, viral hepatitis, STD and TB programs must continue to provide leadership to ensure comprehensive and seamless services are provided to the populations they serve. As the pioneers of PCSI, health departments have led by example in working collaboratively across programs and categorical funding streams to meet the complex and real prevention needs of their communities. With the release of the NCHHSTP white paper on PCSI in early 2008, the year promises to provide even more opportunities for creative and forward-thinking integrated prevention programming.

Health departments have long recognized that the prevention needs of communities are not limited to HIV/AIDS, viral hepatitis, STD and TB, but also include other compounding life and social factors. As a result, they have collaborated with a host of programs across the human services spectrum, working internally with their counterparts in substance abuse, mental and reproductive health and communicable disease, as well as with external partners in departments of corrections, CBOs, the faith community and human rights organizations. It is through these important networks of collaboration and integration that communities at risk have access to the comprehensive services they need.

While there have been many successes, many communities still do not have access to comprehensive prevention services. In 2008, HIV prevention programs must strive to increase the level of collaboration and integration of services, including seeking additional sources of funding to strengthen the public health safety net and supporting the maintenance and growth of complimentary programs. Until all needed services can be provided to every individual who

walks through a program's door, the work of collaboration and integration is not done. Throughout 2008 and beyond, NCHHSTP's efforts must be supported through ongoing and evolving program collaboration and service integration on the local level.

## **New CDC Program Announcements**

Federal domestic HIV prevention activities funded by CDC are guided by FOAs and guidance that dictate how funding can be used and detail the requirements for implementing comprehensive HIV prevention programs. Several CDC-funded prevention activities will be entering the final year of funding over the next few years. Given this, CDC will be reaching out to stakeholders for input on proposed changes before new FOAs are written.

Through program announcement 04-019, 31 Capacity Building Assistance Providers (CBA) are currently funded by CDC through March 31, 2009 to provide CBA services to directly-funded CBOs, health departments and indirectly-funded CBOs (i.e., those CBOs funded by health departments) in four focus areas: 1) to improve the capacity of CBOs to strengthen and sustain organizational infrastructure; 2) to improve the capacity of CBOs and health departments to design, develop, implement and evaluate effective HIV prevention interventions; 3) to improve the capacity of CDC-funded CBOs and other stakeholders to implement strategies that increase access to and utilization of HIV prevention and risk reduction and avoidance services; and 4) to increase the capacity of community planning groups and health departments to effectively involve HIV infected and affected racial/ethnic minority individuals in the community planning group process and to increase parity, inclusion and representation on these groups. Together, these providers comprise one of CDC's chief mechanisms for skills-building and dissemination of prevention strategies and approaches, with a particular focus on increasing the ability of the agencies to address the HIV/AIDS epidemic in communities of color. CDC also contracts with other providers to further support dissemination and adoption of effective behavioral interventions, primarily through their DEBI project, as well as training and capacity building on testing, health education and professional development.

CDC is in the process of gathering stakeholder input on the current CBA portfolio and will likely issue an FOA in 2008 to re-compete the program. If past experience holds true, this funding will be competitive and there will likely be some turnover of funded providers. It is also common for CDC to modify what they require these funded providers to do in order to provide CBA in response to new guidance or recommendations. What impact the changes to the CBA program may have is anyone's guess, but this will be important to track in 2008.

On the programmatic side, the 65 state and directly-funded city health departments funded by CDC will be entering the final year of their current five-year funding cycle in 2008 under 04-012. These cooperative agreements with

health departments fund, in whole or in part, the HIV prevention services administered by the state and directly-funded city health departments. To date, CDC has successfully negotiated a 12-month extension to the current funding cycle, extending health department funding under 04-012 through 2009. CDC is currently in negotiations for a second 12-month extension with hopes of extending the current grant period through 2010. CDC is taking these steps to stagger the release of HIV prevention FOAs in order to better orient and support grantees. As CDC prepares to develop the new FOA for health department HIV prevention funding, the agency will seek public comment on any proposed changes to the program guidance of the FOA. Given the uncertainty of the second 12-month extension, this process may begin in 2008.

Aligned with the development of the health department FOA, CDC will also be seeking input into the development of the guidance for HIV prevention community planning. One likely area of focus is the different models and approaches to planning, including more explicit support for integrated prevention and care planning. Increasing local flexibility to determine the steps and processes to achieve the goals for planning is another likely area for input. As the epidemic has progressed, and as programs have matured and changed in response to the local circumstances of the epidemic, so have the roles for planning groups and goals for planning as a whole. With more planning experience and experts at the local level, jurisdictions can implement planning at a different level of intensity, and many planning groups are seeking ways to increase efficiency and build in more locally-relevant roles and goals for their work. NASTAD has produced a number of documents supporting flexible approaches to planning, available on its [website](#). Given the extension on 04-012, the current community planning guidance will remain in effect through at least 2009.

## **Changing Leadership at All Levels**

The past several years have seen unparalleled challenges and changes in leadership in the domestic HIV prevention arena. As the epidemic has matured, many early leaders in the field have now retired, moved on to other challenges in the global HIV/AIDS fight or have been tapped to apply their expertise in other areas of public health, such as bioterrorism and pandemic influenza. It is not overstating it to say that the field of HIV prevention is currently facing a significant burden on its infrastructure in this country, for some of these very reasons.

At the same time, recently appointed leaders at the federal, state and local levels have been inspirational with their fresh, open perspectives. At the helm of the CDC NCHHSTP, Kevin Fenton has met with countless community and public health advocates across the country and has promoted a vision for integration, both within NCHHSTP and with other federal agencies that work on HIV/AIDS. His leadership has greatly inspired HIV prevention providers and

restored confidence in CDC as a supportive partner in the fight against HIV/AIDS in this country.

There are many new and emerging leaders at the state and local level as well. As the nation is now under a heightened national response to addressing the HIV/AIDS epidemic among African Americans, African American leaders like AIDS directors Andre Rawls (IL), NASTAD Chair, and Veda Latin (OR), NASTAD Secretary-Treasurer, as well as the growing ranks of leadership of color in senior positions in state and local health departments have been instrumental in building programs to address the HIV/AIDS epidemic in communities of color.

Yet, further supporting and enhancing public health leadership that is reflective of the epidemic remains a central challenge for the domestic HIV/AIDS movement. As part of NASTAD's organizational priority to address racial and ethnic health disparities in the HIV/AIDS and viral hepatitis epidemics, increasing leadership opportunities for minority health department staff is the focus of NASTAD's Leadership Development Initiative, which in 2008 will focus on a comprehensive assessment of health department leadership skills building needs and will provide opportunities for skills-building throughout the year.

Supporting new leadership in domestic HIV/AIDS also requires consideration of new partners and thinking about the epidemic in new and innovative ways. At the 2007 National HIV Prevention Conference, a plenary session focused on communities of color spoke clearly of the need for HIV prevention to tackle the social structures that create the conditions in which HIV risk takes place, structures like power, privilege and oppression. Linking to leaders from different types of scientific disciplines, renewing connections with business leaders and learning from public health leaders across a much broader spectrum of public health are all required. To address the structures that create risk, a social justice orientation also mandates learning from the experiences of the civil rights, women's and gay rights movements.

Leadership is critical to maintaining momentum and focus in reducing HIV and AIDS in this country. It is equally important to recognize that building leadership is also important to ensure that when current leaders move on, as they necessarily do, there is a long line of emerging leaders ready and able to replace them to lead and inspire all who are working to prevent the spread of HIV/AIDS in this country.

## **Meeting and Planning Calendar**

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

February 3-7, 2008

15th Conference on Retroviruses and Opportunistic Infections, Boston, MA. For

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

February 7, 2008

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

February 25-26, 2008

2008 National Conference on African Americans and AIDS, Philadelphia, PA. Sponsored by Minority Healthcare Communications, Inc. For more information, visit the [conference website](#).

March 10, 2008

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

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

March 20, 2008

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

March 28-29, 2008

17th Annual HIV Conference, Orlando, FL. Sponsored by the Florida/Caribbean AETC. For more information, visit the [conference website](#).

May, 2008

Viral Hepatitis Awareness Month.

May 19, 2008

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

May 22-25, 2008

20th Annual National Conference on Social Work and HIV/AIDS, Washington, D. C. For more information, visit the [conference website](#).

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 from [NMAC](#) by the end

of January.

June 27, 2008

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

July 28-29, 2008

2008 National Conference on Latinos and HIV/AIDS, Miami, FL. For more information, visit the [conference website](#).

August 3-8, 2008

XVIII International AIDS Conference, Mexico City, Mexico. For more information, visit the [conference website](#).

### **Credits, Feedback and Input**

The *NASTAD Prevention Bulletin* is edited by NASTAD staff and is written by staff and prevention experts from around the country. NASTAD's production of the Bulletin is made possible through funding provided by CDC's Division of HIV/AIDS Prevention (DHAP) in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.

If you have an idea or program that you would like to include in the Bulletin, please contact [Dave Kern](#) or [Lynne Greabell](#) (202/434-8090). NASTAD welcomes feedback to issues presented in Bulletin. To submit commentary, please [e-mail us](#). Electronic versions of the *Bulletin* are available on our webpage.

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