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February 3, 2010

Jeffrey S. Crowley  
Director  
Office of National AIDS Policy  
and Senior Advisor on Disability Policy  
The White House  
1600 Pennsylvania Avenue  
Washington, DC 20500

Dear Jeff:

On behalf of the National Alliance of State and Territorial AIDS Directors (NASTAD), I am writing to submit comments for consideration during development of the National HIV/AIDS (NHAS) Strategy.

NASTAD is an alliance of the nation's chief state health agency staff (state AIDS directors) who have programmatic responsibility for administering HIV/AIDS and viral hepatitis health care, prevention education, and support services programs funded by the states and the federal government. NASTAD seeks to promote a more effective national, state, and local response to the HIV/AIDS and viral hepatitis epidemics. Our goal is to prevent HIV and viral hepatitis disease occurrence and to assure, for those infected, access to early treatment and support services to minimize the impact of these deadly epidemics. NASTAD's vision is a world free of HIV/AIDS and we believe this should be the ultimate goal of the NHAS for the United States.

NASTAD members administer state health department programs, including Ryan White Program Part B and AIDS Drug Assistance Programs (ADAP), by organizing systems of health care and supportive services for uninsured and underinsured individuals living with HIV. NASTAD members are also charged with responsibilities central to the goals of the Health Resources and Services Administration (HRSA): to improve access to quality health care for all HIV/AIDS infected individuals, eliminate health disparities, and improve the public health and health care systems in each state. NASTAD members also administer Centers for Disease Control and Prevention (CDC) and state funded HIV prevention, surveillance, and viral hepatitis programs and many also administer STD, TB, and reproductive health programs.

State public health agencies serve an essential and unique role in the delivery of HIV/AIDS prevention, care and treatment programs. The agencies are entrusted through U.S. law as the "central authorities of the nation's public health system"

and as such, bear the primary public sector responsibility for health. State public health agencies provide leadership, resources and technical assistance to local and community-based agencies and work in partnership with the federal government, other state and local agencies and community-based entities to meet the needs of all citizens within their borders. State and local health departments also have a primary responsibility to address health disparities among racial and ethnic minority populations, gay men and other men who have sex with men, people who inject drugs, and other populations where disparities in health occur.

The following are recommendations for consideration as the NHAS is developed:

### ***Increased Coordination and Flexibility***

One goal of the NHAS must be for meaningful coordination at the federal level. The current federal response is based on siloed funding resulting in artificial barriers separating prevention services from care and treatment. Federal agencies focus only on what fits in their purview and make policies without consultation with other agencies that will clearly be impacted. CDC's 2006 revised HIV Testing Guidelines are one example, where coordination and planning for care and reimbursement for tests with HRSA and CMS should have occurred prior to the release of the guidelines. Another example is the recent release of the revised HIV Treatment Guidelines where coordination and impact planning should occur among the agencies.

HIV/AIDS funding and programming must be coordinated on both the federal and state levels to ensure resources are being used in the most effective way possible. Federal agencies often do not coordinate with each other in delivery of HIV/AIDS programs, which provide a challenge for state health departments when parallel programs with different reporting requirements exist. For example, the Substance Abuse and Mental Health Services Administration's (SAMHSA) HIV testing initiative has not been coordinated with CDC's enhanced testing efforts. This makes it difficult for states to implement effective programs and ensure coordination of testing messages. Interagency collaboration must also include the Center for Medicare and Medicaid Services (CMS) which provides the bulk of medical care to individuals living with HIV, yet has been difficult to coordinate with on both state and federal levels.

Increased coordination on the federal level needs to be mirrored on the state and local level with the state HIV/AIDS program in the coordinating role. States currently develop state-wide prevention and care plans; however, this is challenging when trying to coordinate with other state agencies, including Medicaid programs, correctional institutions and mental health and substance abuse programs, as well as directly funded entities. States need the authority to coordinate all programs funded by grants provided to the state as well as those directed to city and local health departments, clinics, and community based organizations. This is exceedingly challenging when there are no federal requirements that these other entities coordinate with the state or in the case of the Ryan White Program's coordination requirements that are not enforced and therefore are essentially meaningless. Increased authority to coordinate funding streams and programs on a state-wide level will lead to better utilization of existing resources and a decrease in service duplication which will in turn increase efforts towards the goals laid out in the NHAS. Increased coordination could be as simple as informing the state HIV/AIDS program of all funded entities in the state, involving the state office when a federal agency has concern regarding a grantees' performance as many times the state has invested resources in the same grantee, and the inclusion of language allowing and encouraging flexibility in notices of grant awards.

States must also retain flexibility to address the epidemic as it occurs in their jurisdiction. There is no one size fits all approach to preventing HIV and linking newly-identified individuals to appropriate care and treatment in different care systems throughout the country. States must be able to adapt and tailor any recommendations from the NHAS to fit their epidemic and the prevention and care needs of their most affected populations.

Increased coordination and program and service integration is extremely important, but it is not the panacea for effective programs and funding shortfalls. Program and service integration, as currently promoted by CDC for their HIV, STD and viral hepatitis programs, comes with a price tag to truly integrate program activities. NASTAD is concerned that program integration is another way of asking the states to do more with less by providing additional services with no additional and currently inadequate funding. Program integration must also occur amongst all relevant agencies including CMS, SAMHSA, Department of Justice (DOJ), Department of Education (DOE), National Institutes of Health (NIH), Food and Drug Administration (FDA), the Veterans Administration (VA) and the Indian Health Service (IHS).

### *Increased Resources for HIV/AIDS Programs*

State HIV/AIDS programs are struggling to continue providing services in the face of staggering state general revenue budget cuts and limited increases from the federal government. A recent survey conducted by NASTAD found that 29 states experienced over \$170 million in state budget cuts during FY2009. States have begun to report additional cuts in FY2010. State HIV/AIDS programs are also experiencing staff shortages which make it extremely difficult to implement, administer and monitor programs. In FY2009, 66 staff positions were eliminated in states and programs collectively are faced with at least 195 unfilled positions. Exacerbating these staff shortages is the diversion of staff to other public health issues such as H1N1, bioterrorism activities, etc. The NHAS must contain recommendations to shore up the public health workforce, as well as frontline HIV/AIDS clinicians. It is critical that the NHAS not result in unfunded mandates to states, as states are currently struggling to provide services at the current level.

Federal support for HIV, hepatitis and STD programs has stagnated in the past decade. The NHAS must address this severe funding shortage and commit to working with Congress to provide adequate resources to HIV/AIDS programs. AIDS Drug Assistance Programs (ADAPs) are experiencing a dramatic number of clients being placed on waiting lists. As of January 7, 2010, nine states had waiting lists of 540 individuals. These waiting lists are in spite of increased contributions from pharmaceutical companies in the form of rebates, discounts and price freezes and an increased contribution from states in the past several years. The [ADAP Crisis Task Force](#), convened by NASTAD, negotiates reduced drug prices for all ADAPs. Since 2003 agreements with the Task Force have saved \$827 million. In addition to waiting lists for ADAPs, individuals in states are also experiencing long waits to receive other medical and support services.

HIV prevention programs are also severely underfunded, receiving only four percent of all federal funds dedicated to HIV/AIDS. Funds must be made available to states to continue to increase testing of targeted populations, as well as to provide a wide-range of prevention interventions. Increased resources must also be dedicated to shoring up state HIV surveillance systems. Surveillance data is key to understanding the epidemic and the appropriate targeting of resources.

The NHAS should also acknowledge that there must be an adequate level of funding to build and maintain sufficient capacity to provide prevention, care and treatment services, to collect data, and to monitor and evaluate programs in every state and territory regardless of the size of the epidemic.

### ***Program Simplification***

Federal funding to states is provided in silos with numerous different application, administrative, reporting and evaluation requirements throughout the year. Each agency uses different data systems that often do not utilize common definitions of terms. Many staff hours are lost in responding to these duplicative and burdensome requirements. NASTAD has developed a graphic representation of 71 separate federal reporting requirements for CDC's HIV prevention, surveillance, expanded testing initiative, viral hepatitis, and sexually transmitted diseases cooperative agreements, as well as HRSA's Ryan White Part B care and ADAP grants. The illustration is attached as an attachment. The NHAS should examine the various grant reporting and evaluation requirements and provide recommendations for simplification across federal programs.

### ***Use of Data***

Data is also a critical piece to the success of the NHAS. States and local health departments and community based organizations will require additional resources to comply with mandates for data collection and reporting, outcome evaluation and program accountability.

State HIV/AIDS programs currently provide an extraordinary amount of data to their funding agencies. NASTAD feels this data could be better utilized and used for educational purposes. In addition, data from other agencies is currently lacking or not accessible, such as tracking health care services and outcomes for individuals with HIV currently enrolled in Medicaid and Medicare. As we move towards a reformed health system, it is critical to understand the healthcare needs of this population in order to ensure that their needs continue to be met under a new system. State health departments are particularly concerned that with the expansion of Medicaid and the aging of the HIV positive population into Medicare, many people currently in their data systems will move into programs with cloistered systems that provide little information on this population, much less use the data to improve linkages into care and increase the quality of care.

### ***Reducing HIV Incidence***

In 2007, NASTAD issued *A New Blueprint for the Future: Ending the Epidemic through the Power of Prevention* and companion *Policy Agenda providing health department recommendations for HIV prevention* programs and policies. NASTAD's Prevention Blueprint and Policy are attached as attachments. The major tenet of these documents is that we must bring effective prevention strategies to scale if we are to be effective in significantly reducing the number of new infections in the U.S.

NASTAD believes a National Testing Goal may be necessary to keep all players focused on making a big impact on decreasing the number of new HIV infections. We must reduce the number of people who don't know their status as early in the disease progression as possible. This must also include a focus on providing expanded partner services and on ensuring linkage into care, rather than a simple focus on the number of tests performed.

However, a goal is only attainable when accompanied by the proper resources to implement targeted and effective programs to reach the goal. The NHAS should call for funding to increase a wide array of interventions aimed at reducing new HIV infections, including specific dollars to implement syringe exchange programs (SEPs) and other harm reduction efforts. It is critical for areas that currently have local restrictions on SEPs that the voice of the federal government is unified in supporting and encouraging the development of these programs in areas with existing epidemics driven by injection drug use. The NHAS should also recommend an enhanced mass marketing/ media campaign to draw attention to the HIV epidemic among a variety of populations and for the general public.

The NHAS must continue support for biomedical and evidence-based prevention research. The Strategy should call for increased resources for existing research areas and new dollars to increase research in specific areas such as behavioral interventions for black gay men and transgender individuals. Communities must also be given resources to develop, implement and evaluate homegrown, evidence-based behavioral interventions for specific local populations at risk for HIV.

NASTAD welcomes the end of discretionary abstinence-only education programs and the advent of the Teen Pregnancy Prevention Program. The NHAS should call for this program to be expanded to comprehensive sexuality education that explicitly includes programs aimed at reducing HIV and STD infections, as well as addressing homophobia, given the high rates of infection among young gay men.

Every year thousands of formerly incarcerated people return to their communities and partners. Many jails and state prisons across the country offer a variety of HIV prevention services. The federal prison system should do the same. The NHAS should include specific recommendations for providing increased prevention services in correctional settings. Additionally, sufficient resources and policy changes must be directed to the Bureau of Prisons to make HIV education, counseling, testing, treatment and condoms available in the varied correctional settings throughout the country.

#### ***Increasing Access to Care and Optimizing Health Outcomes:***

The system of care for individuals living with HIV/ AIDS is extremely complicated due to a combination of federal and state programs, arcane eligibility rules, inadequate funding and other factors. While much of this will presumably change under a reformed health system, the majority of those changes are years away and will still result in a complex patchwork system. The NHAS must provide recommendations that fully fund a health system for individuals living with HIV in the interim years. This includes full funding for the Ryan White Program, including the AIDS Drug Assistance Program. The NHAS must take into account the current economic downturn, the countercyclical nature of our safety net programs, and the increased focus on testing and linkages to care when examining funding for these programs. Focusing on increasing linkage to care is essential, however, promoting programs in states where there are long wait times for doctors visits, drugs and other services is counterintuitive and may drive people away from finding out their HIV status and accessing medical services. Retention in care must also be a focus of the NHAS, not only for the Ryan White Program but for Medicare, Medicaid, and private insurance.

Caring for the HIV population is becoming increasingly complicated as the population ages and HIV becomes a chronic condition. Co-morbid conditions such as cancer, heart disease, diabetes, liver disease, mental health, etc must be addressed alongside suppressing the HIV infection. (Please also see the [NHAS recommendations](#) of the Hepatitis C Appropriations Partnership related to HIV-hepatitis co-infection.) Comprehensive systems of care must be able to address the whole person and their health needs, not just HIV. State HIV/AIDS programs have worked in concert with medical providers and other providers in their jurisdictions over the past decades to build such systems of care. The NHAS should recognize the comprehensive systems of care that have been built to deliver HIV care and provide ongoing support for these programs. The importance of support services must also be recognized. Additional resources must also be made available for screening of co-morbid conditions for individuals with HIV already in care. The NHAS must also acknowledge the need to increase vaccinations for high-risk adults. There are very few resources available for this activity. Health departments currently receive some support from CDC to provide hepatitis A and B vaccine to those infected with HIV; these programs must be continued and expanded and infrastructure must be shored-up.

### ***Reducing HIV-related Health Disparities***

Health disparities are a symptom of larger social determinants such as poverty, stigma, discrimination, racism, homophobia, etc. The NHAS should include a plan to address these issues as they interact with HIV infection and the most affected populations, including gay men of all races, transgender individuals, and black and Latino women and men.

NASTAD has long addressed racial and ethnic health disparities as an overarching priority of its work. This goal sets the stage for technical assistance and the dissemination of effective program models to state and local health departments that seek to reduce health inequities among people of color in the U.S. NASTAD has created a number of policy and program documents for health departments that are listed and linked in an attached attachment.

Gay men and other men who have sex with men of all races and ethnicities carry a disproportionate burden of HIV disease. Between 2003 and 2006, HIV/AIDS cases increased among gay men and other men who have sex with men and represented nearly 50 percent of all HIV/AIDS cases and 67 percent of male HIV/AIDS cases in 2006. The NHAS should include an initiative to mobilize action to address the HIV prevention needs of gay men of all races. The initiative should include targets and adequate resources for reaching articulated goals. As part of this effort, the NHAS should support the removal of the prohibition on federal funds “to provide education or information designed to promote or encourage directly homosexual or heterosexual activity or intravenous drug abuse.” The language is often a barrier to addressing the sexual health needs of gay men and effective prevention efforts.

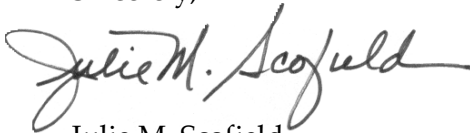
In addition, the NHAS should explicitly address efforts to prevent new infections among person who use injection drugs. In communities where syringe access programs have been locally supported, HIV infection rates have decreased dramatically among this population. Now that the federal funding ban has been lifted, syringe access programs and other harm reduction services should be ramped up.

States are increasingly working to combat stigma in their jurisdictions but are stymied by lack of resources to implement large social marketing campaigns. The NHAS should call for the development of social marketing campaigns to counteract HIV stigma. Increased support must also be provided to other programs that address co-morbidities such as substance use and mental health, as well as the housing needs of people living with HIV that is essential to maintaining persons in care and preventing new infections. The NHAS should call for full-funding for the HOPWA program and additional resources for SAMHSA to provide more targeted HIV and hepatitis programs.

State HIV/AIDS programs work to reduce health disparities by developing and implementing targeted prevention and other programs and should be supported to continue these efforts. Additional models of programs to reduce health inequities should be developed for adaptation by local jurisdictions. Additional resources are needed to improve health literacy in populations affected by HIV. Consumers need to be educated on treatment and health care options available to them so that they can advocate for the best care possible. In order to link individuals into care and ensure their retention, service delivery models that meet patient needs in their communities must be encouraged.

We applaud your leadership in addressing this preventable and costly disease through the development of a National HIV/AIDS Strategy, and welcome the opportunity to work with you as the development process moves forward, and particularly as partners in implementation. Please contact me at [jscofield@NASTAD.org](mailto:jscofield@NASTAD.org) if you require further information on any of our recommendations.

Sincerely,



Julie M. Scofield  
Executive Director

Attachments (4)



HIV/AIDS, Viral Hepatitis, and STD Program Reporting Requirements

Reference	Month	Day	Program	Sub-program	Name
1	December	31	CDC	Viral Hepatitis	CY Annual Progress Report (APR)
2	February	1	CDC	Tuberculosis	CY Complete Report of Verified Case of Tuberculosis (RVCT)
3	February	15	CDC	Expanded Testing Initiative	Quarterly Summary Data Report
4	February	15	CDC	Medical Monitoring Project	CY Interim Progress Report (IPR)
5	February	28	CDC	HIV Prevention	CY APR
6	February	28	CDC	STD	CY APR
7	March	15	Ryan White	General	Ryan White Program Data Report (RDR)
8	March	31	CDC	Tuberculosis	CY APR
9	March	31	CDC	Tuberculosis	CY Financial Status Report (FSR)
10	April	15	HOPWA	General	Consolidated Annual Performance and Evaluation Report (CAPER)
11	May	15	CDC	Expanded Testing Initiative	Quarterly Summary Data Report
12	May	31	CDC	Expanded Testing Initiative	CY IPR
13	June	26	Ryan White	WICY	PY WICY Report due
14	June	29	Ryan White	Part B	PY Part B Final FSR and Carryover Request
15	June	30	Ryan White	Part B	CY Part B Revised Budget and Narrative
16	June	30	CDC	HIV Prevention	CY Performance Measure Data
17	June	30	HOPWA	General	IDIS Set-up
18	July	15	Ryan White	General	RSR Initial Grantee Report
19	July	31	Ryan White	ADAP	CY ADAP Quarterly Report
20	July	31	CDC	Viral Hepatitis	CY IPR
21	July	31	CDC	Viral Hepatitis	CY Grant Application
22	July	31	CDC	HIV Prevention	CY IPR
23	July	31	CDC	HIV Surveillance	CY IPR
24	July	31	CDC	HIV Surveillance	NY Grant Application
25	July	31	CDC	STD	CY IPR
26	July	31	CDC	STD	NY Grant Application
27	August	1	Ryan White	Part B	Part B Final Expenditure Table
28	August	15	HOPWA	General	CY One-year Action Plan
29	August	15	CDC	Expanded Testing Initiative	Quarterly Summary Data Report
30	August	15	CDC	Enhanced Perinatal Surveillance	CY IPR
31	August	15	CDC	National HIV Behavioral Surveillance	CY IPR
32	August	15	CDC	Medical Monitoring Project	CY APR
33	August	15	CDC	Tuberculosis	CY Aggregate Reports Program Evaluation (ARPE)
34	August	27	Ryan White	Part B	FY 2008 Part B Final Annual Progress Report
35	August	28	Ryan White	Part B	CY Part B Interim FSR Showing 75% obligation
36	August	31	CDC	HIV Prevention	CY Quarterly Data for HIV Testing and PEMS
37	August	31	CDC	Medical Monitoring Project	CY FSR
38	August	31	CDC	STD	CY Performance Measure Data
39	August	31	Ryan White	Part D	CY Allocations Funds Report
40	September	1	Ryan White	Part B	CY Part B Consolidated List of Contracts (CLC)
41	September	1	Ryan White	Part B	CY Part B Contract Review Certification (CRC)
42	September	1	Ryan White	General	RSR Provider Initial Report Due (first 6 months of year, January - June)
43	September	1	Ryan White	General	RSR Client Report (first 6 months of year, January - June)
44	September	8	Ryan White	General	RSR Provider Report Final Deadline
45	September	8	Ryan White	General	RSR Client Report Final Deadline
46	September	15	Ryan White	General	RSR Grantee Approval of Provider Reports
47	September	18	Ryan White	General	RSR Grantee Approval of Client Reports
48	September	30	Ryan White	Part B	PY Part B Final Expenditure Table
49	September	30	Ryan White	MAI	CY MAI Final Expenditure Table
50	September	30	Ryan White	MAI	CY MAI Revised Budget/Narrative
51	September	30	Ryan White	Part B	CY Part B Planned Allocation Table
52	September	30	Ryan White	MAI	CY MAI Planned Allocation Table
53	September	30	Ryan White	MAI	CY Revised MAI Implementation Plan
54	September	30	CDC	HIV Prevention	NY Grant Application and Comprehensive Plan
55	September	30	HOPWA	General	Five-year Consolidated Action Plan
56	September	30	HOPWA	General	IDIS Data
57	September	30	Ryan White	Part D	CY RSR
58	September	30	CDC	Tuberculosis	CY IPR
59	October	30	Ryan White	MAI	PY MAI Annual Report
60	October	30	Ryan White	Part B	CY Part B Mid-Year Program Progress Report
61	October	31	Ryan White	ADAP	CY ADAP Quarterly Report
62	October	31	Ryan White	Part B	Part B grant application preparation
63	October	31	Ryan White	MAI	CY MAI Final FSR
64	October	31	Ryan White	MAI	CY MAI Progress Report
65	October	31	Ryan White	Part D	PY FSR
66	November	15	CDC	Expanded Testing Initiative	Quarterly Summary Data Report
67	November	30	CDC	HIV Prevention	CY Quarterly Data for HIV Testing and PEMS
68	November	30	CDC	Expanded Testing Initiative	CY APR
69	November	30	CDC	Expanded Testing Initiative	CY FSR
70	December	15	CDC	Prevention Training Center	CY IPR
71	December	30	Ryan White	MAI	MAI Consolidated List of Contracts
72	December	30	Ryan White	MAI	MAI Contract Review Certification
73	December	31	Ryan White	General	RSR Grantee Report
74	January	31	Ryan White	ADAP	CY ADAP Quarterly Report
75	January	31	Ryan White	Part D	CY RSR
76	February	1	Ryan White	Part B	CY Part B Ryan White Program Services Report (RSR) Client Report
77	February	28	CDC	HIV Prevention	CY Quarterly Data for HIV Testing and PEMS
78	February	28	CDC	HIV Prevention	CY FSR
79	February	28	CDC	HIV Surveillance	CY APR
80	February	28	CDC	STD	CY Performance Measure Data
81	February	28	CDC	STD	CY FSR
82	March	15	Ryan White	Part B	CY Part B Ryan White Program Data Report (RDR)
83	March	15	CDC	Enhanced Perinatal Surveillance	CY APR
84	March	15	CDC	National HIV Behavioral Surveillance	CY APR
85	March	31	CDC	HIV Surveillance	CY FSR
86	March	31	CDC	Enhanced Perinatal Surveillance	CY FSR
87	March	31	CDC	National HIV Behavioral Surveillance	CY FSR
88	May	15	CDC	HIV Training through Prevention Training Center	CY IPR
89	May	31	CDC	HIV Prevention	CY Quarterly Data for HIV Testing and PEMS
90	June	15	CDC	Prevention Training Center	CY APR
91	June	30	CDC	Prevention Training Center	CY FSR
92	December	15	CDC	HIV Training through Prevention Training Center	CY APR
93	December	15	CDC	HIV Training through Prevention Training Center	CY FSR

Notes:

Represents three separate grant cycles:

- PY - previous fiscal year
- CY - current fiscal year
- NY - next fiscal year

HRSA Ryan White grant year is April 1 through March 31.

CDC HIV Prevention grant year is January 1 through December 31.

CDC Expanded Testing Initiative grant year is September 30 through September 29. Only 25 jurisdictions are currently funded under this initiative.

CDC core Surveillance grant year is January 1 through December 31.

CDC STD grant year is January 1 through December 31.

CDC Viral Hepatitis grant year is November 1 through October 31.

HOPWA grant year is July 1 through June 30.

# T H E   B L U E P R I N T

ENDING THE HIV/AIDS EPIDEMIC THROUGH  
THE POWER OF PREVENTION





## A VISION FOR SUCCESS

Like the long-term progression of the concerns that have brought us to this point, it will take time to correct our current course. To get where we need to be, we must have the financial, political and programmatic resources necessary to meaningfully scale up domestic HIV prevention efforts.

WHEN ONE IS INFECTED, ALL ARE AFFECTED.

## A BLUEPRINT FOR THE FUTURE: ENDING THE HIV/AIDS EPIDEMIC THROUGH THE POWER OF PREVENTION

In anticipation of the new estimate of national HIV incidence from the Centers for Disease Control and Prevention (CDC), we, America's health department HIV prevention programs, offer the nation *A New Blueprint for the Future*. By building on the successes of the nation's prevention programs, we are confident that America can turn the tide on the domestic HIV/AIDS epidemic.

Since the beginning of the epidemic, HIV prevention programs led by health departments have provided the skills and tools necessary to millions of Americans to reduce or eliminate the risks associated with HIV transmission. Today, transmission of HIV from mother to child has nearly been eliminated in the United States (U.S.) because of successful local responses. In jurisdictions where sterile injection equipment is widely available, infection rates in populations who use injection drugs have fallen dramatically. For many of those already infected, HIV counseling and testing programs have ensured a necessary linkage to life-saving care and treatment and prevention services.

While we are confident in the capability of the public health system, its potential has never been fully realized. Our programs have been constrained by external influences which have limited our ability to control the epidemic in our jurisdictions. At the same time, the continued growth of HIV/AIDS prevalence, particularly among gay men and other men who have sex with men and African-Americans, has led to increased demands on our already-overburdened system.

We must scale up America's response to the HIV/AIDS epidemic. Our programs must be given the support necessary to offer full coverage of services that we know work in order to have the greatest impact possible. The time to correct our course is now.

# INTRODUCTION

America can turn the tide on the domestic HIV/AIDS epidemic.

**"To realize the promise of available HIV prevention tools, they must be brought to scale...the appropriate mix of evidence-based HIV prevention strategies must achieve sufficient coverage, intensity, and duration to have optimal public health impact."**

Global HIV Prevention Working Group, 2007

With our combined wisdom, we assert that the nation must make the following commitments to move us closer to a world free of HIV/AIDS.

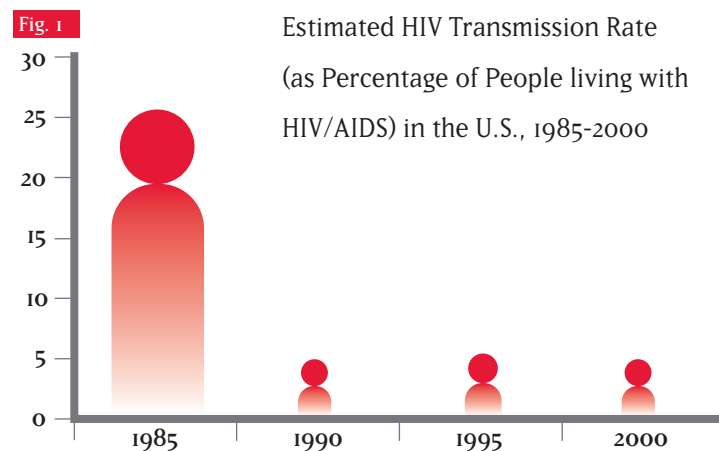
1. We must ensure CDC HIV prevention programs are adequately funded including core prevention, surveillance and public information that reaches all Americans with accurate information.
2. We must invest in programs that are working on the local level such as access to sterile injection equipment, prevention services in correctional settings and comprehensive sexuality education and support these programs with ongoing research.
3. We must invest in programs that expand the reach of core HIV prevention activities like sexually transmitted disease (STD) treatment, adult vaccination programs, microbicide development, substance abuse and mental health services and housing.
4. The federal government must provide coordination, funding and meaningful support for locally driven and developed HIV prevention programs.
5. State and local health departments must lead the nation's HIV prevention efforts to ensure effective and locally appropriate approaches are being implemented in every jurisdiction in the U.S.

The current state of HIV/AIDS in America is unacceptable to us. If energy continues to be drained away from programs that work to prevent new infections, we run the risk of losing the momentum generated by years of success. We cannot allow this to happen. A meaningful investment in state and local public health is the very best opportunity for correcting the course and will allow our programs to meet the needs of those most affected by HIV/AIDS in the U.S.

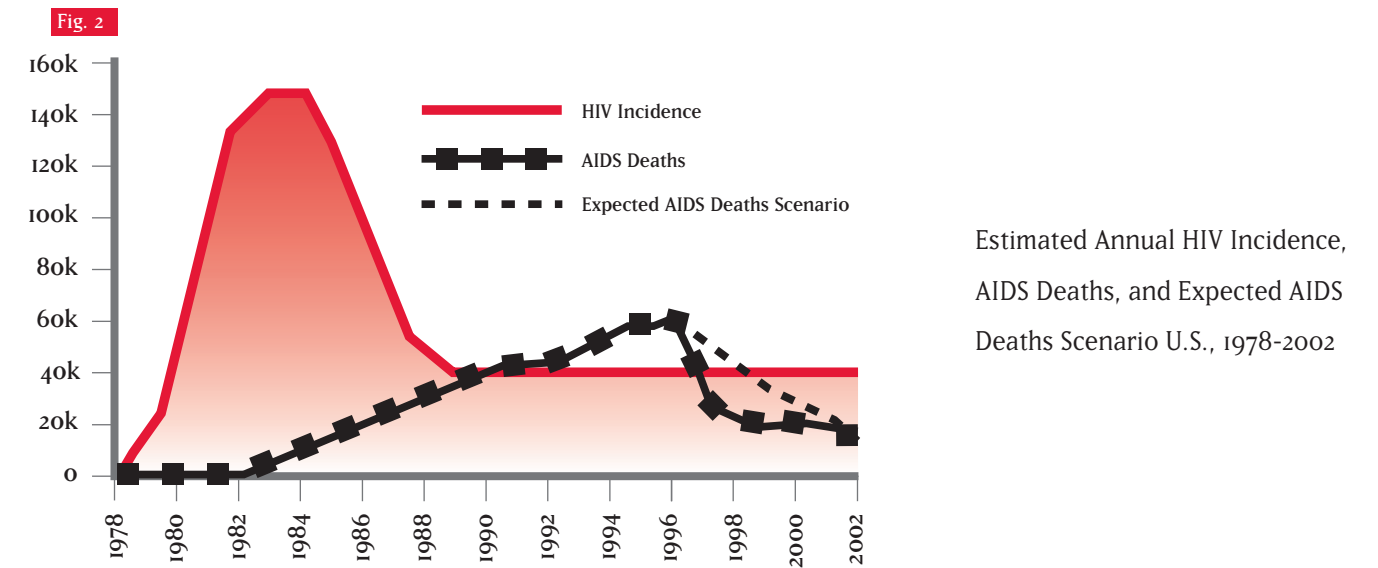
## The Current State of HIV/AIDS in the U.S.

### Where Are We Now?

Over the years, America's HIV prevention programs have had an important impact on the HIV/AIDS epidemic. As figure 1 illustrates, HIV transmission in the U.S. fell dramatically in the early years of the epidemic and has remained relatively stable ever since. In the mid-1990s, AIDS mortality began to decrease due to life-saving advancements in care and treatment for persons living with HIV/AIDS. Coupled with a relatively stable number of new HIV infections each year, these influences have led to a steady increase in the number of persons living with HIV/AIDS, as illustrated in figure 2. This has resulted in a continuing increase in the number of



Holtgrave, DR. Journal of Acquired Immunodeficiency Syndromes. 2004; 35(1): 89-92.



Holtgrave, DR, et al. International Journal of STD & AIDS. 2004; 15(12): 789-92.

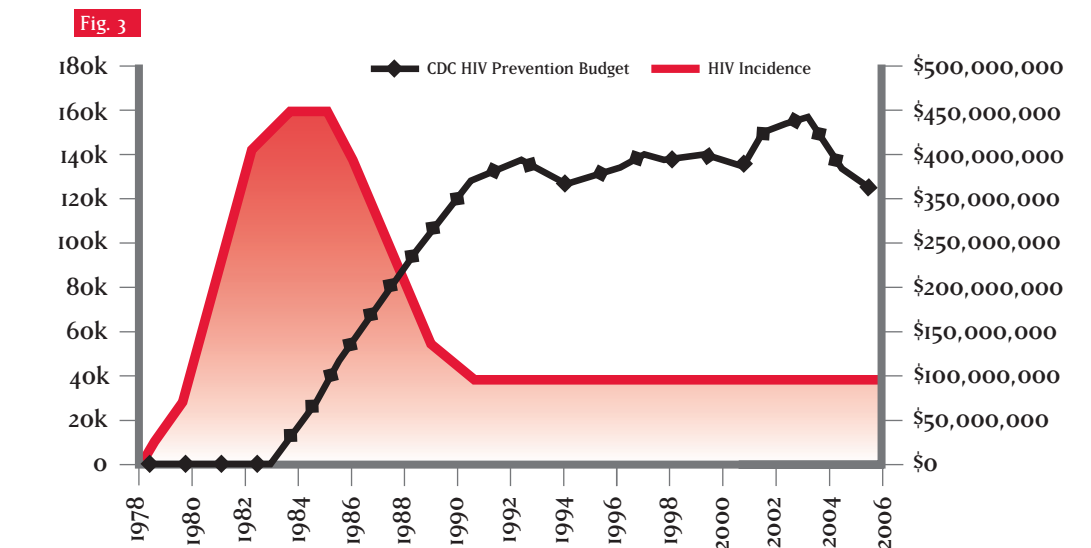
individuals capable of transmitting the virus in the U.S., totaling nearly 1.2 million persons as estimated by CDC.<sup>1</sup>

In the domestic epidemic, African-Americans carry the burden of HIV/AIDS, representing nearly half of all cases in 2006<sup>2</sup> in the 33 states and five U.S. dependent areas with confidential name-based HIV infection reporting, while representing only 13 percent of the U.S. population.<sup>3</sup> Gay men and other men who have sex with men of all races and ethnicities also carry a disproportionate burden. Between 2003 and 2006, HIV/AIDS cases increased among gay men and other men who have sex with men and represented nearly 50 percent of all HIV/AIDS cases and 67 percent of male HIV/AIDS cases in 2006.<sup>4</sup> Despite the successes we have seen, our efforts must be scaled up if we are ever to meet the actual prevention needs of these and other high-risk populations.

### Why Are We Here?

In simplest terms, we are here because of the imbalance between the number of persons in need of prevention services and the funding and support available to provide these services. While HIV prevention programs strive for the broadest reach possible, our programs cannot, in the current environment, provide the coverage necessary to reach all individuals capable of transmitting HIV and their partners.

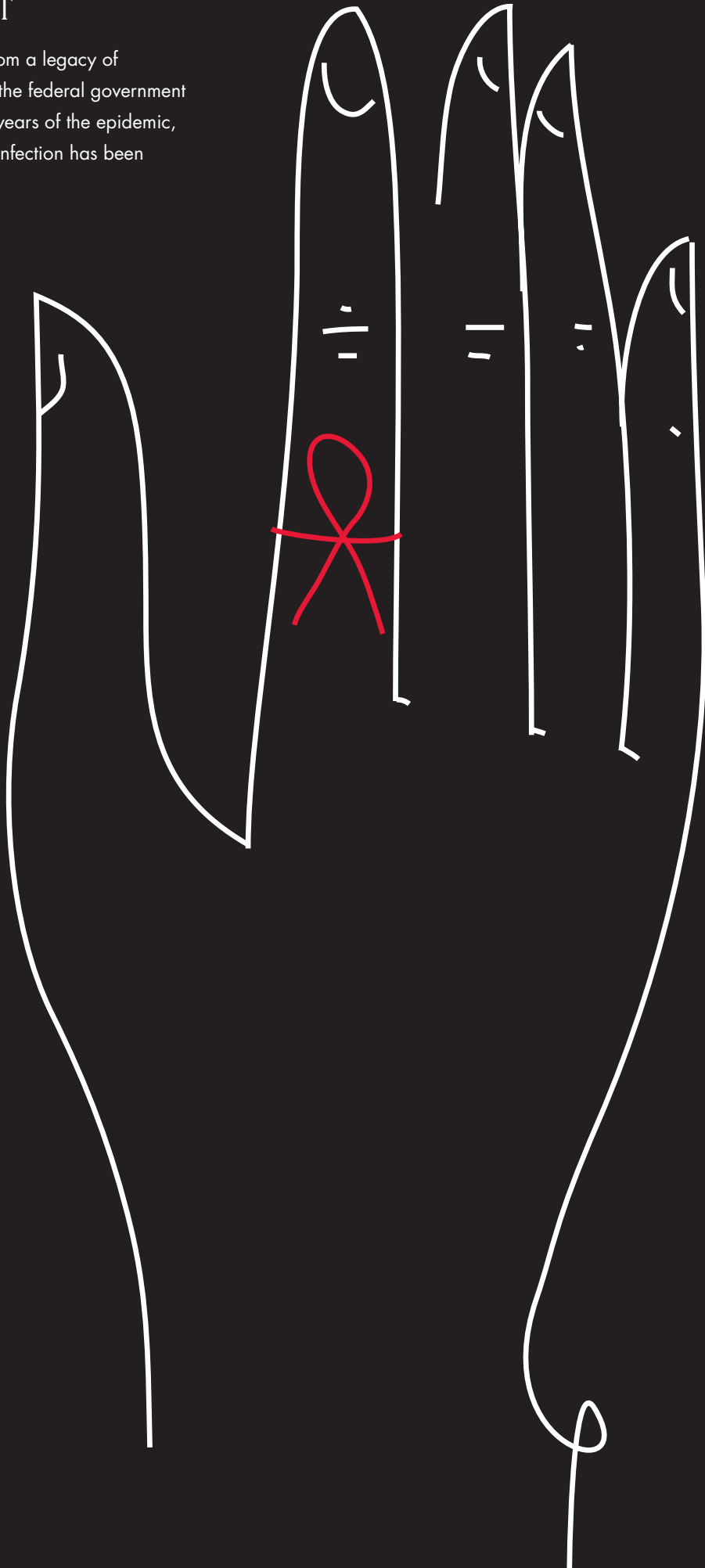
HIV Incidence and CDC's HIV Prevention Budget (in 1983 Dollars) U.S., 1978-2006



Holtgrave, DR. Untitled. 2006. Retrieved November 19, 2007, from <www.kaisernetwork.org/health\_cast/uploaded\_files/David\_Holtgrave.pdf>

## DON'T FORGET OUR PAST

America's prevention response suffers from a legacy of indifference. From the beginning, when the federal government remained silent during the crucial early years of the epidemic, America's investment in preventing HIV infection has been woefully inadequate.



As illustrated in figure 3, experts have identified a relationship between the investment in and the success of the nation's prevention response. As CDC's HIV prevention budget grew between the late 1980s and the early 1990s, the number of new HIV cases decreased nearly 75 percent. When CDC's budget flattened, the number of new HIV infections stabilized.<sup>5</sup> Between FY2002 and FY2007, experts estimate that CDC's prevention budget, when adjusted for inflation, actually decreased more than 19 percent.<sup>6</sup> Even more disheartening, funding for domestic HIV prevention makes up only three percent of domestic federal HIV/AIDS spending. If the nation is truly committed to reducing HIV incidence, the imbalance between actual needs and funding to provide for these needs must be corrected.

Beyond this simple explanation, other factors impact the ability of our programs to prevent new infections. Some of these factors are difficult, if not impossible, to address within the context of our programs alone. Nevertheless, as leaders in the nation's fight against HIV/AIDS, we feel it is our obligation to name these issues in order to recognize and address them in our efforts to move the nation forward.

**America's prevention response suffers from a legacy of indifference.** From the beginning, when the federal government remained silent during the crucial early years of the epidemic, America's investment in preventing HIV infection has been woefully inadequate.

**While America's support for our work is broad, it is very shallow.** Most Americans, while sympathetic, perceive HIV/AIDS as a problem faced by "other" people. Consequently, they are not immediately willing to compromise their own interests to promote the wellbeing of others.

**Oppression and stigma are at the root of America's social problems, including HIV/AIDS.** Poverty and discrimination, especially racism, homophobia and sexism, undermine every attempt we make to keep people healthy.

**The nation's response to HIV/AIDS is fragmented.** America's response to HIV/AIDS has been a shifting patchwork of strategies and approaches that often thwarts the success of our programs through ongoing change in emphasis and imposition of unfunded mandates.

**Scientific fact does little to confront ideological concerns.** Ideological concerns are often a significant barrier to the implementation of evidence-based HIV prevention interventions. HIV prevention advocates must creatively reframe our positions in a way that brings broadly acceptable value and meaning to the essential strategies in our arsenal.

Each of these issues, in some way, has led to the current state of HIV/AIDS in America. For some of these concerns, progress can be made sooner rather than later if the nation commits to making change happen. Others will take generations to resolve. Nevertheless, we must own the reality of these circumstances as we move America's HIV prevention response forward.

**"We must regroup and recommit ourselves to developing an HIV vaccine and other new prevention weapons while providing proven HIV prevention tools to those who need them."**

Anthony S. Fauci, M.D., Director, National Institute of Allergy and Infectious Diseases, National Institutes of Health, 2007

# The Future of HIV Prevention in the U.S.

## Where Do We Need To Be?

As the institutions that hold leadership over HIV/AIDS prevention efforts in every state, city and territory in the U.S. and as the stewards of more than half of CDC's 692 million dollar domestic HIV prevention budget, we remind the nation: HIV disease is preventable.

We are at a point in the epidemic where we must scale up primary HIV prevention efforts, support services that address the factors associated with the transmission of HIV and actively fight to remove obstacles that impede our progress. To be successful in reducing the number of new HIV infections, America's prevention response must do the following.

**Provide full coverage of services and tools that prevent infections.** HIV prevention is not only cost-effective, it is cost-saving.<sup>7</sup> Basic prevention tools that directly prevent HIV infection must be made readily available to anyone who chooses to use them: condoms, clean needles and syringes, treatment for STDs and efforts to prevent mother-to-child transmission. These tools must be balanced with other prevention strategies like HIV counseling and testing; partner services; behavioral interventions, including individual counseling and small group, community-level and peer-opinion leader interventions; treatment adherence; and comprehensive sexuality education. Given the unique circumstances we encounter in each of our jurisdictions, we must have the flexibility to use the best combinations of behavioral and biomedical interventions that science has to offer. Alone, neither behavioral nor biomedical intervention will be sufficient.

**Ever expand the HIV prevention arsenal.** Research translated into practice is essential to ending this epidemic. New behavioral interventions must be developed and interventions that are shown to be effective must be made widely available as quickly as possible. We must also invest in strategies deemed effective but not widely practiced such as non-occupational post-exposure prophylaxis. There must also be a commitment to, and investment in, research efforts that gauge the effectiveness and appropriateness of approaches validated in other areas of the world, notably circumcision. Finally, despite controversy and set-backs, further research into the development of not-yet-realized options such as microbicides, vaccines and pre-exposure prophylaxis using antiretroviral drugs, must be scaled up.

**Encourage all people living with HIV/AIDS to know their status.** We must continue to thoughtfully scale up both targeted HIV counseling and testing and HIV screening efforts, though the costs and consequences of each approach must be measured against the circumstances we face in each of our jurisdictions. While we support the appropriate scale-up of early diagnosis efforts in all forms, we must remind the nation that these services can never supplant a full scale-up of interventions and services that have the potential to prevent new infections. Moreover, since HIV testing efforts are largely a diagnostic endeavor, financing must be appropriately portioned out to all possible payers, most notably the public and private insurance systems in America.

**Link people living with HIV/AIDS to quality care and treatment.** We must guarantee that individuals living with HIV/AIDS are linked to and actually receive care and treatment services, along with ongoing prevention services. In addition to their improved health status, individuals adhering to a treatment regimen lower the probability they will transmit the virus to others, particularly utilizing ever-improving regimens. The nation must make certain that these services are available to every American living with HIV/AIDS regardless of the status of his or her health care coverage. Systems like Medicare and Medicaid, the AIDS Drug Assistance Program, as well as all other parts of the Ryan White Program, particularly those that support primary care services, must be funded accordingly and have appropriate policies in place to ensure access to care and treatment.

**Work to eliminate disparities based on race, ethnicity, gender, sexual identity and class.** Wherever possible, HIV/AIDS prevention efforts must acknowledge and strive to eliminate the disparities that exist between those with power and privilege in our society and those who are marginalized, including African-Americans, Latinos/as, Asians, Pacific Islanders, Native Hawaiians, American Indians and Alaskan Natives. Further, HIV prevention efforts must be initiated and/or scaled up to meet the needs of those who bear the greatest HIV/AIDS burden in the U.S.—gay men and other men who have sex with men and African-Americans—in order to provide the coverage of services necessary to reduce behaviors associated with HIV and other disease transmission, particularly STDs and viral hepatitis.

**Address the complexity of individuals' lives.** The nation's HIV prevention response must operationalize programming that recognizes other real-life issues facing those being infected with HIV such as other STDs, viral hepatitis, tuberculosis, reproductive health issues, homelessness and unstable housing, substance use/abuse and mental health concerns. Health departments are leading the way in efforts to integrate services at the client-level but need increased flexibility to scale up these efforts. We must continue to deconstruct the barriers that exist between distinct health concerns, like competing prevention and treatment philosophies, restrictive funding and guidance and "siloeed" organizational and staffing structures. To be effective in reducing new HIV infections, as well as STD and viral hepatitis infections, we must be able to easily leverage all necessary resources and services to offer a holistic response to the individuals we serve.

**Use structural-level interventions to effect change.** To have a more global impact on the epidemic in America, structural-level impediments must be removed and structural-level assets must be leveraged. We must do everything in our power to rid our jurisdictions and the nation of policies and systems that restrict our ability to prevent new infections and promote health, such as those that prevent or restrict access to sterile injection equipment, buprenorphine and naloxone for people who use injection drugs; prevent or restrict access to accurate science-based information for youth; and those that promote, overtly or covertly, stigma and discrimination. We must also engage systems and institutions, including state and local governments, the Internet and faith communities, to leverage their support for our HIV prevention efforts.

**Continuously educate the mass public.** By elevating HIV/AIDS in the public's view, we can reinforce accurate, evidence-based information and begin to reduce the stigma associated with the disease. To help the public internalize the true impact of the epidemic, we must educate them about the economic, social and health consequences HIV/AIDS is having on our society. Primary and secondary schools, as well as colleges and universities, must incorporate comprehensive HIV education into their curricula to ensure that upcoming generations are aware and have the

**"We must increase the level of understanding of AIDS as a crisis that affects many groups of people and our entire health care system. To do this we must act together."**

**Dr. Nicholas A. Rango (1944-1993), Director of  
New York State AIDS Institute, 1988-1993**



## HIV/AIDS AND AFRICAN-AMERICANS

In the domestic epidemic, African-Americans carry the burden of HIV/AIDS, representing nearly half of all cases in 2005 while only representing 13 percent of the U.S. population.

information they need to protect themselves. We must invest in a sustained national media presence that brings knowledge and information to all corners of the nation.

### How Do We Get There?

Similar to the long-term progression of the concerns that have brought us to this point, it will take time to correct our current course. To get where we need to be, we must have the financial, political and programmatic resources necessary to meaningfully scale up domestic HIV prevention efforts. However, this investment must never come at the cost of efforts to provide care and treatment to those living with HIV/AIDS or our efforts to fight HIV/AIDS globally.

To achieve our vision of a world free of HIV/AIDS, the nation must commit to the following.

#### **We must ensure CDC HIV prevention programs are adequately funded.\***

1. Invest more in core HIV prevention. The current investment in HIV prevention is inadequate. If health departments are given sufficient resources to scale up HIV prevention programs that include all tools in the prevention arsenal, it will have a substantial impact on the epidemic.
2. Invest more in HIV/AIDS surveillance. Core HIV/AIDS surveillance funding and infrastructure has eroded over the last decade, while the importance of understanding the epidemic is even more critical to targeting effective prevention programs and allocating resources for care and treatment. Additionally, national HIV behavioral surveillance and other special surveillance studies provide essential information to the field and must be enhanced.
3. Support a national education campaign. CDC must be provided with sufficient funding to conduct a national campaign to educate the public that HIV remains a significant public health concern.

#### **We must invest in programs that are working on the local level.**

1. Lift the ban on federal funding for syringe exchange. In communities where syringe access programs have been locally supported, HIV infection rates have decreased dramatically among people who use injection drugs. If Congress is serious about reducing new infections, this one action will have a significant impact on the epidemic.
2. Invest in behavioral research to provide diverse populations with diverse interventions. Current investments in behavioral research are not producing enough evidence-based interventions to reach the variety of high-risk populations. CDC and its national partners, such as the National Institutes of Health, must work together to develop

**"HIV prevention needs long-term investment and sustained engagement in order to have maximum impact. There are no easy solutions or 'quick fixes' to promoting and sustaining safer forms of sexual and drug-related behaviour over time or to changing contextual factors that drive the HIV epidemic."**

UNAIDS Policy Position Paper, Intensifying HIV Prevention, 2005

\* For more information on the recommendations in this section, please see the Blueprint's companion *The Policy Agenda: An Action Plan to Support the HIV Prevention Blueprint*.

a research action plan to increase the number of behavioral interventions in the prevention arsenal. Communities must also be given resources to develop, implement and evaluate homegrown, evidence-based behavioral interventions for specific local populations at risk for HIV.

3. Invest in HIV prevention programs in correctional settings. Every year thousands of formerly incarcerated people return to their communities and partners. Sufficient resources and policy changes must be directed to make HIV education, counseling, testing and treatment and condoms available in the varied correctional settings throughout the country.
4. Invest in comprehensive sexuality education. Age-appropriate HIV education needs to take place before young people engage in sexual behaviors that put them at risk for HIV infection and other STDs. We must abandon abstinence-only-until-marriage programs and dedicate funding for comprehensive sexuality education that includes an abstinence-first message.

### **We must invest in programs that expand the reach of core HIV prevention activities.**

1. Invest in substance abuse prevention and treatment and mental health services. Preventing and treating substance abuse and providing mental health services can help prevent the transmission of HIV, viral hepatitis and STDs. Injection drug use, other substance use and untreated mental illness are major contributing factors for HIV, STD and viral hepatitis infection.
2. Invest in the Housing Opportunities for Persons with AIDS (HOPWA) and other housing programs. People living with HIV who have stable housing can receive the health care they need as well as essential prevention services. Persons who maintain their treatment regimen can significantly decrease their viral load and their potential to infect others.
3. Invest in CDC's STD prevention program. In the nation, one in four teenage girls is infected with at least one sexually transmitted disease.<sup>8</sup> Additionally, in 2007, the rate of syphilis infection increased for the seventh year in a row, reflecting continuing increases among gay men and other men who have sex with men.<sup>9</sup> While evidence suggests that untreated STDs contribute to the continued spread of HIV, diagnosis and treatment of STDs lag far behind the need.
4. Invest in new biomedical interventions including vaccines and microbicides. Research into the development of not-yet-realized options like microbicides, an HIV vaccine and pre-exposure prophylaxis must be scaled up. They could have a monumental impact on the epidemic.

### **The federal government must provide coordination, funding and meaningful support for locally driven HIV prevention programs.**

1. Make a national commitment. It is our responsibility, as a nation, to protect the basic rights of our citizenry, including their right to life. We can ensure these rights are provided by actualizing a national, multi-sectoral commitment to ending the HIV/AIDS epidemic in America and by building in measures of accountability for the federal government to ensure meaningful progress is made. Through the commitment of Congress and the Administration, we can ensure the nation's public health infrastructure has both the resources and the flexibility to mount the responses necessary to fight this war against disease in every state, territory and directly-funded city in the nation. To support this, the federal government must ensure national efforts are coordinated across governmental agencies, including the Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, National Institutes of Health, Department of Justice, Department of Education and others, to maximize the effect of the nation's prevention resources.
2. Put cooperation back into health department cooperative agreements. CDC must actively partner with health department HIV prevention programs in both the development of strategic initiatives and the implementation and evaluation of programs. CDC must accept that we are the experts in responding to the specific and unique needs of our constituents and are implicitly expected to provide leadership and guidance for public health services in our jurisdictions, including other prevention settings such as directly-funded community-based organizations and unaligned health care institutions, including emergency departments.

**Our Commitment:** State and local health departments will lead the nation's HIV prevention efforts to ensure effective and appropriate approaches are being implemented in every jurisdiction in the U.S.

Like politics, all public health is local. Since the birth of our nation, states have been responsible for protecting and guaranteeing the health of the individuals living within our boundaries. Our constituents expect certain guarantees from our programs, and we, in turn, must have the support necessary to meet these expectations. If we do not, we ultimately face the consequences.

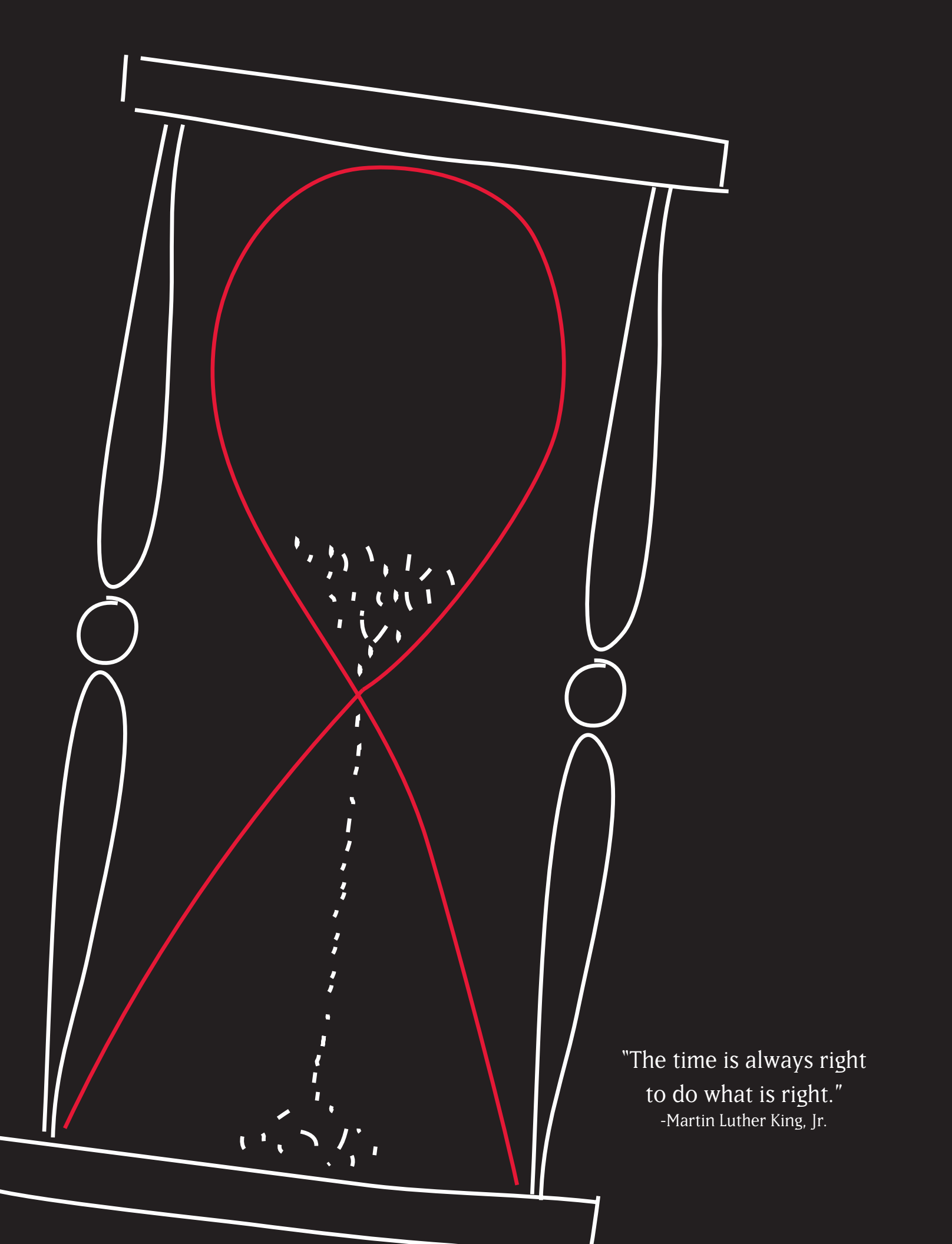
Because of our dependence on federal resources to support our programs, we have ceded certain control over the course of our local HIV prevention responses. To maximize our potential to prevent new infections, we must correct the balance of power in the nation's efforts to end the epidemic by allocating our share of the 692 million dollar domestic HIV prevention budget in the manner most appropriate to the conditions we face. With this in mind, we commit to doing the following.

1. Provide vision and strategic direction for our local responses to HIV/AIDS.
2. Judiciously manage our system level inputs including human and fiscal resources.
3. Coordinate HIV prevention efforts in our jurisdictions to ensure they fit together in a logical and effective way.
4. Build and sustain meaningful internal and external partnerships to support the integration of services at the client level and maximize the health benefits to our constituents.
5. Consistently and thoroughly assess the current status of the epidemic through traditional core surveillance and special surveillance studies.
6. Use evidence-based decision-making processes to drive program planning, funding, implementation and evaluation.
7. Leverage non-traditional resources like business, civic organizations, media and other institutions in our communities.
8. Diagnose disease and ensure linkages to quality care and treatment services.
9. Provide capacity development and technical assistance to community-based organizations and other providers to strengthen their potential for success.
10. Support CDC's efforts to educate the general public about HIV/AIDS.
11. Provide tools proven effective at preventing HIV transmission to all who need them like condoms, clean needles and syringes, STD treatment and efforts to prevent mother-to-child transmission to ensure individuals who are uninfected stay uninfected.
12. Mobilize communities, including community planning groups, to foster community ownership over the local fight against HIV/AIDS.
13. Develop, advocate and enforce public health policy that supports our ability to offer meaningful public health services, including engagement of our own state and local governments.
14. Evaluate internal and external processes to ensure our programs have the greatest impact possible.
15. Conduct public health research to promote innovation and to strengthen current and future HIV prevention efforts.

Because of the unique circumstances in each jurisdiction, only state and local health department programs can act as the primary architects for our own prevention responses. There is no single methodology for meeting the demands placed before us.

## **Closing**

The nation must lift its veil of indifference and commit itself to ending the HIV/AIDS epidemic through the power of prevention. If we do not, HIV/AIDS is poised to become the most preventable problem our nation has faced in the twenty-first century. Through meaningful investment in state and local health department led HIV prevention programs and the removal of barriers that slow our progress, our programs can be scaled up to meet the current demands of the epidemic. We are confident the nation can be successful in its fight to reduce HIV infection in U.S. We must act now.



"The time is always right  
to do what is right."  
-Martin Luther King, Jr.

## Acknowledgements

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This is not  
the epidemic  
we faced 20  
years ago.



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# THE POLICY AGENDA

AN ACTION PLAN TO SUPPORT  
THE HIV PREVENTION BLUEPRINT

# WHEN ONE IS INFECTED, ALL ARE AFFECTED.

## THE POLICY AGENDA: AN ACTION PLAN TO SUPPORT THE HIV PREVENTION BLUEPRINT

### NEED FOR ACTION

Prevention efforts in the U.S. have been very successful, but with the significant strides in treatment and radical decreases in mortality, the number of people living with the disease still continues to climb. Therefore, the population in need of prevention services grows as well. With the decline in federal prevention funding since its peak in FY2003 through FY2008, state and local prevention programs have been running in place at best. Prevention funding makes up only three percent of domestic federal HIV/AIDS spending. In the U.S., gay men and other men who have sex with men continue to bear the greatest burden, representing nearly half of all HIV/AIDS cases. Minority communities are also disproportionately impacted and devastatingly so in some subgroups such as young gay Black and Latino men. Persons between the ages of 13-24 represented 14 percent of new HIV/AIDS infections in 2006, and within that population, African Americans represented 69 percent of cases in ages 13-19 and 68 percent of cases in ages 20-24. HIV/AIDS is the third leading cause of death for African-American women ages 25-34 in 2004. If our nation's leaders are serious about further reducing new infections, there are actions they must take to support health departments in scaling up programs that will further control the U.S. epidemic.

### VISION

Public health, encompassing federal, state, local and community partners, has made great strides in preventing HIV infection since the beginning of the epidemic 27 years ago. While much emphasis is placed on the number of new infections occurring annually, research has shown that prevention programs have averted between 204,000 and 1,585,500 HIV infections between 1978 and 2000. In addition, the annual HIV transmission rate has dropped from a high of 43 percent in 1983 to roughly four percent since 1990. When health departments are given sufficient resources and not hindered by political or legal impediments, successes are achieved. For example, perinatally acquired AIDS cases have dropped by 95 percent to less than 40 cases in 2006 from the peak of 954 cases in 1992. In communities that fund and support access to sterile injection equipment, transmission of HIV in persons who use injection drugs has declined as a proportion of all cases by mode of transmission. For example, in New York, a state with 17 needle exchange programs, annual AIDS cases among IDU have dramatically decreased from a peak of over 7,000 in 1992 to fewer than 837 in 2004. Another success is the decrease in HIV/AIDS mortality due to testing and treatment. By investing in HIV prevention and programs that expand the reach of prevention, we can improve the health of all Americans, hold the line on rising health care costs and maintain a healthy and productive national workforce.

As public health experts in the field of HIV/AIDS and in anticipation of CDC's revised estimate of national HIV incidence, we make the following recommendations to reverse the course of the domestic HIV/AIDS epidemic. If these recommendations are realized, we are confident the following goals can be achieved:

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"...have a significant impact on the epidemic."

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- A reduction in annual incidence,
- Fewer new cases in racial and ethnic minorities,
- An increased number of people who are diagnosed earlier in the progression of disease and a subsequent slowing in

the progression from HIV to AIDS for individuals who access treatment earlier,

- Lower infection rates in persons who use injection drugs, gay men and other men who have sex with men and youth,
- A reduction in the already low prevalence of perinatally acquired HIV/AIDS cases,
- A reduction in stigma and discrimination, and
- An increase in public awareness of HIV and the knowledge to prevent new infections.

### RECOMMENDATIONS FOR SUCCESS

#### **Adequately Fund CDC HIV Prevention Programs.**

**Invest \$600 million more or a total of \$1.3 billion in core HIV prevention.** As the saying goes, an ounce of prevention is worth a pound of cure. Preventing HIV is cheaper than treating HIV/AIDS. If state and local health departments are given sufficient resources to scale up HIV prevention programs, it will have a substantial impact on the epidemic. With this additional funding, health departments will strengthen and expand outreach and HIV testing efforts targeting high-risk populations, including gay men and other men who have sex with men, racial and ethnic minority communities, substance users, women and youth. But, testing alone can never end the epidemic. CDC and Congress must support all the tools in the prevention arsenal. Resources must also be directed to build capacity and provide technical assistance to enable community-based organizations and health care providers to implement evidence-based behavior change interventions, ensure fiscal responsibility and refer partners of HIV-positive individuals to counseling and testing services.

**Invest \$35 million more in HIV/AIDS surveillance.** Core HIV surveillance funding and infrastructure has eroded over the last decade, while the importance of understanding the epidemic – old and new – has become even more critical to targeting effective prevention programs. Demands on surveillance programs are increasing as greater investments are made in HIV testing, not to mention that federal funding decisions are based primarily on this data. Additionally, national HIV behavioral surveillance and other special studies provide essential information to the field and must be enhanced.

**Support a national education campaign.** CDC must be provided sufficient funding to conduct a national campaign to educate the public that HIV remains a significant public health concern. The campaign should seek to reduce stigma and misinformation that continue to be barriers to addressing HIV.

#### **Invest in Programs That Are Working on the Local Level.**

**Lift the ban on federal funding for syringe exchange.** There is overwhelming evidence that syringe exchange programs work: they prevent the transmission of HIV and viral hepatitis and do not promote substance use. In communities where syringe exchanges and other syringe access programs have been locally supported, HIV infection rates have decreased dramatically among injecting drug users. Additionally, policies and systems that restrict our ability to promote the health of persons who inject drugs through the use of buprenorphine and naloxone, as well as other harm reduction strategies, must be changed.

**Invest in behavioral research to provide diverse populations with diverse interventions.** Current investments in behavioral research are not producing enough evidence-based interventions to reach the variety of high-risk populations. In particular, new targeted interventions are needed to address highly impacted gay men and other men who have sex with men of all races and ethnicities. CDC and its national partners, such as the National Institutes of Health, must work together to develop a research action plan to increase the number of interventions in the prevention arsenal. Communities must also be given resources to develop, implement and evaluate homegrown, evidence-based behavioral interventions for specific local populations at risk for HIV.

**Invest in HIV prevention programs in correctional settings.** In 2004, 1.8 percent of male and 2.6 percent of female state prison inmates were HIV-positive, more than four times the estimated rate in the general population. Every year thousands of formerly incarcerated people return to their communities and partners. Many jails and state prisons across the country offer a variety of HIV prevention services. The federal prison system should do the same. To that end, legislation such as HR 178 (Rep. Barbara Lee) and HR 1943 (Rep. Maxine Waters) should be supported. Additionally, sufficient resources and policy changes must be directed to the Bureau of Prisons to make HIV education, counseling, testing, treatment and condoms available in the varied correctional settings throughout the country.

**Invest in comprehensive sexuality education by passing the Responsible Education About Life (REAL) Act (S 972/HR 1653).**

Forty-seven percent of high school students have had sexual intercourse, and 7.4 percent of them reported first sexual intercourse before age 13. Age-appropriate HIV education needs to take place before young people engage in sexual behaviors that put them at risk for HIV infection. Abstinence-only-until-marriage programs have not proven effective. We must abandon these programs and dedicate funding for comprehensive sex education that includes an abstinence-first message.

**Invest in Programs That Expand the Reach of Core HIV Prevention Activities.**

**Invest in substance abuse prevention and treatment and mental health services.** Preventing and treating substance abuse and providing mental health services can help prevent the transmission of HIV. Injection drug use, other substance use and untreated mental illness are major contributing factors for HIV, STD and viral hepatitis infection. Co-occurring HIV, substance use and mental illness require special focus and expanded service delivery.

**Invest in the Housing Opportunities for Persons with AIDS (HOPWA) and other housing programs.** Studies have shown that more than one-half of people living with HIV/AIDS are likely to need housing assistance at some point in their illness. People living with HIV who have stable housing can receive the health care they need as well as essential prevention services. Persons who maintain their treatment regimen can significantly decrease their viral load and their potential to infect others.

**Invest in CDC's STD prevention program.** In the nation, one in four teenage girls is infected with at least one STD. Additionally, in 2007, the rate of syphilis infection increased for the seventh year in a row, reflecting continuing increases among gay men and other men who have sex with men. While evidence suggests that untreated STDs contribute to the continued spread of HIV, diagnosis and treatment of STDs lag far behind the need. Funding for CDC's STD prevention program has been eroded over the years as the number of persons infected has continued to climb.

**Invest in new biomedical interventions including vaccines and microbicides.** Effective vaccines to prevent hepatitis A and B infection have been available for years, yet not even one-half of at-risk adults have been vaccinated. Because there is no federal funding earmarked to ensure these vaccines are available to adults, the nation has missed millions of opportunities to provide a relatively simple and cost-effective prevention intervention. Congress should act to adequately fund adult vaccine programs and to ensure that necessary systems are in place when HIV and hepatitis C vaccines become available. Additionally, research into the development of not-yet-realized options, such as microbicides, an HIV vaccine and pre-exposure prophylaxis, must be scaled up.



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# Racial and Ethnic Health Disparities (REHD): Overview

The National Alliance of State and Territorial AIDS Directors (NASTAD) has long prioritized reducing racial and ethnic health disparities as an overarching priority of its work. This goal sets the stage for technical assistance and the dissemination of promising program models to state and local health departments that seek to reduce health inequities among people of color in the United States.



The National Alliance of State and Territorial AIDS Directors (NASTAD) represents the nation's chief state health agency staff who have programmatic responsibility to administer HIV/AIDS and viral hepatitis health care, prevention, education, and supportive service programs funded by state and federal governments. NASTAD represents HIV/AIDS and viral hepatitis program directors in all 50 states, the District of Columbia, Puerto Rico, U.S. Virgin Islands and additional U.S. territories and affiliated jurisdictions. Programs administered by NASTAD members serve every population affected by and infected with HIV/AIDS and viral hepatitis in the U.S.

NASTAD recognizes that expanded programming to address the changing and complex demographics of the HIV and viral hepatitis epidemics must build opportunities for leadership while deconstructing social barriers that erode our best efforts to affect change. General objectives of NASTAD's Racial and Ethnic Health Disparities (REHD) program include:

- Increase leadership and develop the programmatic skills of minority staff in state and local health departments;
- Develop policy and program recommendations that enhance state and local health departments' response to racial and ethnic minority communities;
- Encourage state and local health departments to enhance synergy with community stakeholders in order to share ideas and lessons-learned;
- Examine challenges and barriers that health departments and communities face as they develop and administer effective programs targeting racial and ethnic minority communities;
- Reduce stigma and create more culturally appropriate approaches to HIV/AIDS, viral hepatitis and STD prevention, care and treatment activities through jurisdiction program examination.

NASTAD utilizes work groups and committees (comprised of health department prevention, care and treatment, and viral hepatitis program staff), networking groups (comprised of HIV/AIDS community stakeholders) and a variety of listservs to advance REHD priorities.

# Racial and Ethnic Health Disparities

## African American Communities

In 1998, NASTAD developed a monograph focused on supporting, improving and expanding health department activities in African American communities. Revised in 2007, the monograph, entitled [\*Why We Can't Wait: The Tipping Point for HIV/AIDS in African American Communities\*](#), encourages state and local AIDS directors to continue enhancing their work. In 2006 - 2008, NASTAD released a Black MSM Issue Brief series to underscore the disproportionate impact of HIV among black gay men/MSM in the United States. In 2007 - 2009, NASTAD hosted regional forums in the Midwest, Northeast and Southeast to address HIV among black women, by providing a platform to share program information, priorities and resources, and identify the facilitators and barriers to effective programming targeting black women. Staff Lead: [Michelle Batchelor](#)

## Latino Communities

NASTAD released [\*Addressing HIV/AIDS: Latino Perspectives and Policy Recommendations\*](#) in 2003 to assist health departments in strengthening their responses to and understanding of Latino communities. Building on the policy document, in 2008, NASTAD released a Call to Action, entitled [\*¡Adelante!\*](#), which urges health departments, national organizations, federal partners and key community-based organizations and leaders to scale up efforts to fight the HIV/AIDS and viral hepatitis epidemics in Latino communities. Staff Lead: [Francisco Ruiz](#)

## Native American Communities

NASTAD continues to enhance its efforts to support HIV/AIDS and viral hepatitis services for Native American communities. NASTAD's report, [\*Native Americans and HIV/AIDS: Key Issues and Recommendations for Health Departments\*](#), was created to facilitate a national dialogue between representatives from health departments and Native American agencies and communities about ways to build trust and capacity in Native American communities. Staff Lead: [Gary Jenkins](#)

## Asian American, Native Hawaiian and Pacific Islander Communities

In 2007, NASTAD, in collaboration with the [\*Asian and Pacific Islander American Health Forum \(APIAHF\)\*](#), released the policy document [\*Breaking Through the Silence: Key Issues and Recommendations to Address HIV/AIDS Among Asian Americans, Native Hawaiians and Pacific Islanders in the United States\*](#). One of the key issues discussed in the document is the need for health departments to consistently collect and report data disaggregated by Asian American, Native Hawaiian and Pacific Islander racial and ethnic subgroups. NASTAD continues to work with APIAHF and the [\*Council for State and Territorial Epidemiologists \(CSTE\)\*](#) to support data collection and reporting issues. Staff Lead: [Natalie Cramer](#)

## Youth of Color

Spotlighting the needs of young people, NASTAD recently launched an issue brief series to raise awareness of the HIV/STD epidemics among youth of color, particularly young men who have sex with men (YMSM). [\*HIV/AIDS: Crisis among Young Black and Latino Gay Men and Other Men Who Have Sex with Men \(MSM\)\*](#) explores current epidemiological data on young black and Latino gay men, social determinants of health and structural barriers in an effort to help health departments and their community partners understand how to better reach these populations. Staff Lead: [Gary Jenkins](#)

A complete listing of NASTAD publications is available on our website [www.NASTAD.org](http://www.NASTAD.org).

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