

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.

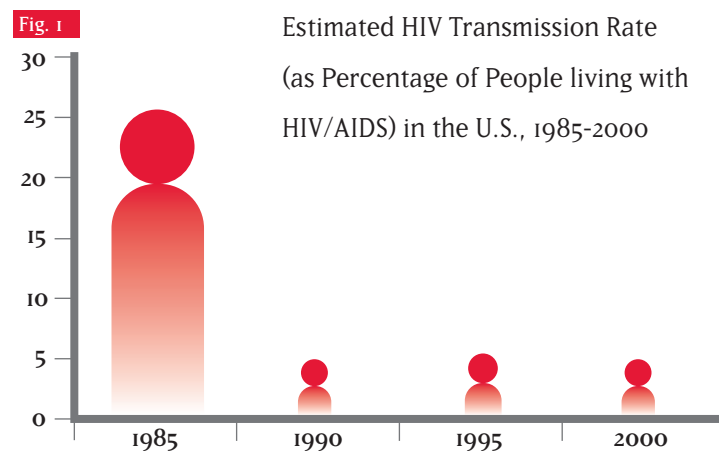
1. We must ensure CDC HIV prevention programs are adequately funded including core prevention, surveillance and public information that reaches all Americans with accurate information.
2. We must invest in programs that are working on the local level such as access to sterile injection equipment, prevention 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.

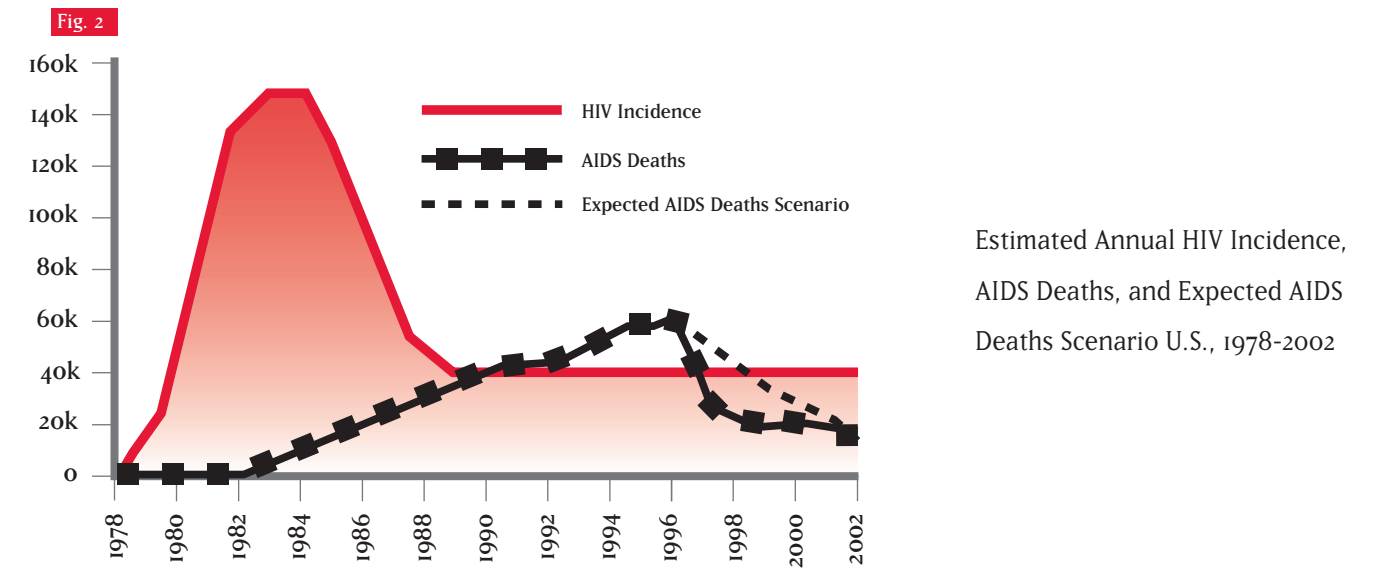
The Current State of HIV/AIDS in the U.S.

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.

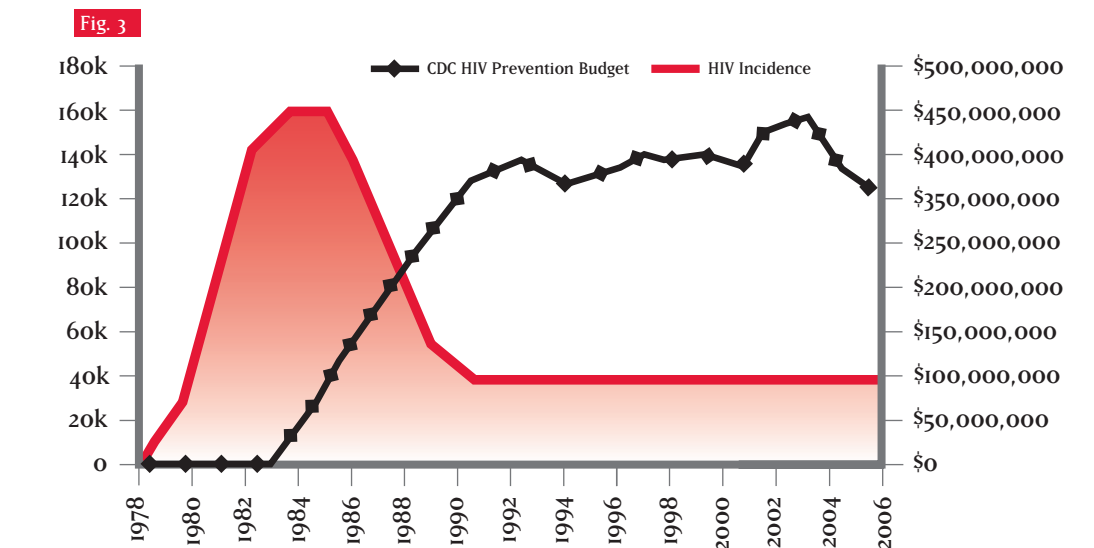
individuals capable of transmitting the virus in the U.S., totaling nearly 1.2 million persons as estimated by CDC.¹

In the domestic epidemic, African-Americans carry the burden of HIV/AIDS, representing nearly half of all cases in 2006² 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.³ 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 2006.⁴ 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.

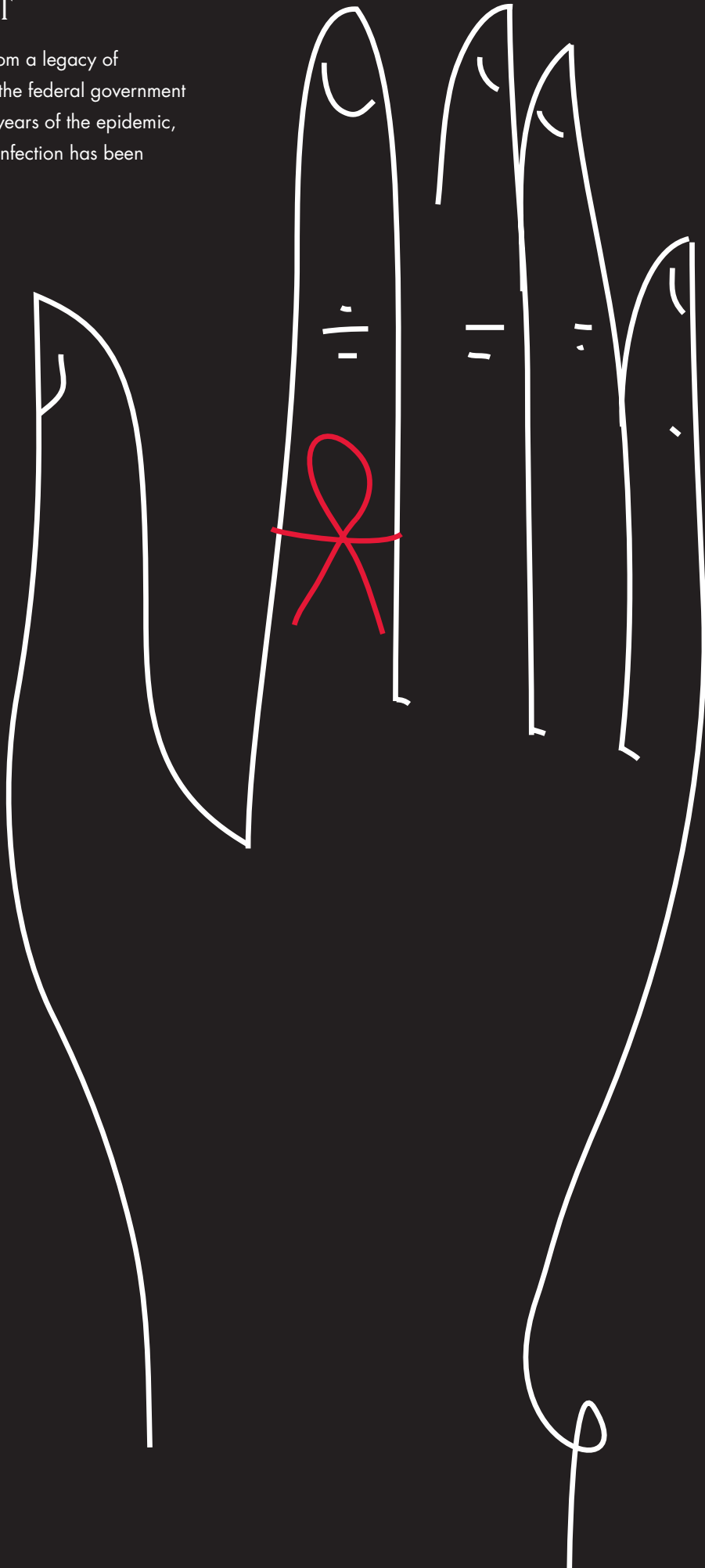
HIV Incidence and CDC's HIV Prevention Budget (in 1983 Dollars) U.S., 1978-2006



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.⁵ Between FY2002 and FY2007, experts estimate that CDC's prevention budget, when adjusted for inflation, actually decreased more than 19 percent.⁶ 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.

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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.⁷ 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 "siloes" 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.⁸ 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.⁹ 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.

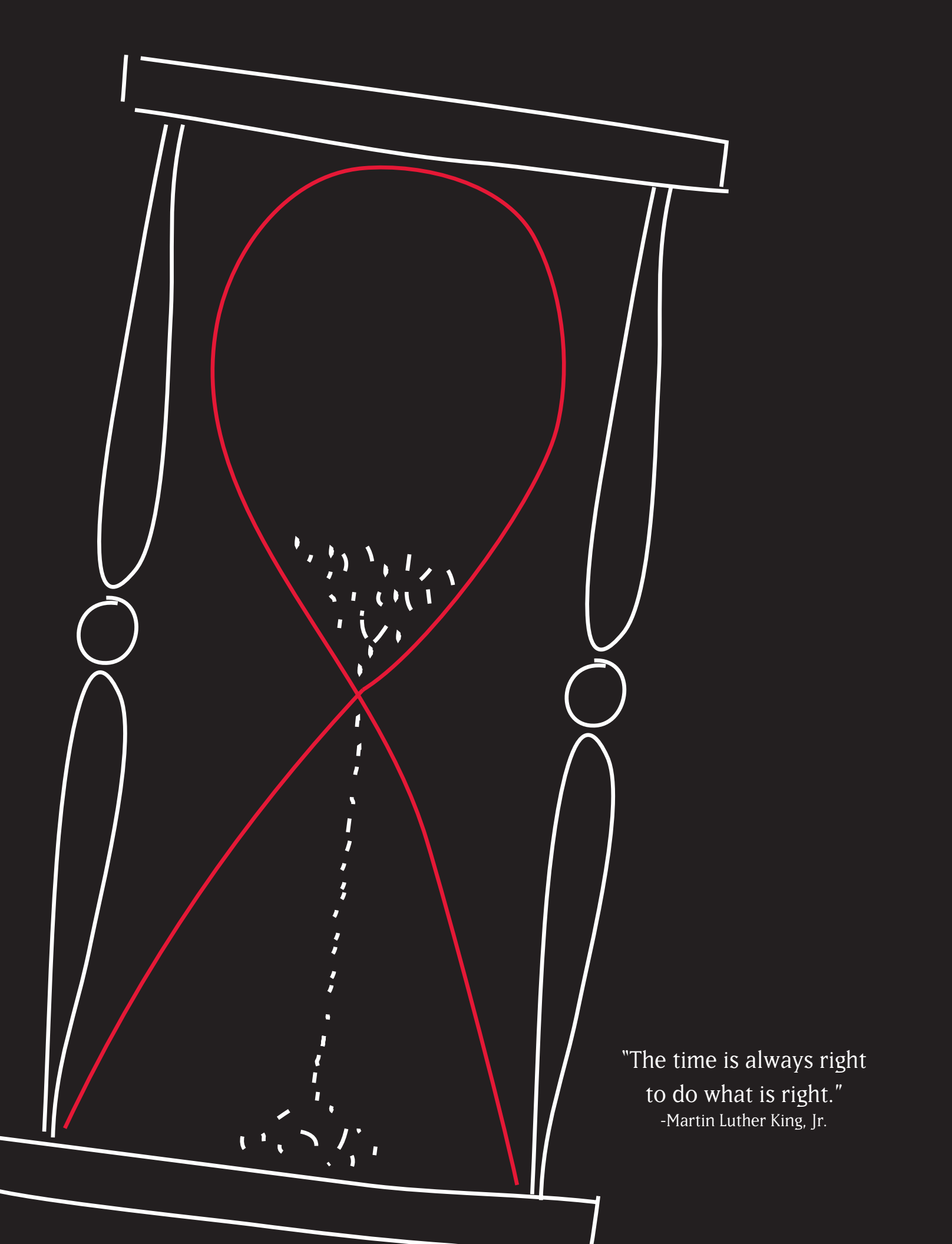
Because of our dependence on federal resources to support our programs, we have ceded certain control over the course of our local HIV prevention responses. To maximize our potential to prevent new infections, we must correct the balance of power in the nation's efforts to end the epidemic by allocating 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.

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¹ Glynn M, Rhodes P. Estimated HIV prevalence in the United States at the end of 2003. National HIV Prevention Conference; June 2005; Atlanta. Abstract 595.

² Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2006. Volume 18. Retrieved April 11, 2008 from <<http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2006report/table1.htm>>

³ Population Estimates. September 11, 2007. The Census Bureau. Retrieved November 19, 2007 from <<http://www.census.gov/popest/national/asrh/NC-EST2006-srh.html>>

⁴ Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2006. Volume 18. Retrieved April 11, 2008 from <<http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2006report/table1.htm>>

⁵ Holtgrave, DR, Kates, J. HIV incidence and CDC's HIV prevention budget: an exploratory correlational analysis. American Journal of Preventive Medicine. 2007; 32: 63-73.

⁶ Holtgrave, DR. When "Heightened" Means "Lessened": The Case of HIV Prevention Resources in the United States. Journal of Urban Health: Bulletin of the New York Academy of Medicine. 2007

⁷ Holtgrave DR. Estimating the effectiveness and efficiency of U.S. HIV prevention efforts using scenario and cost-effectiveness analysis. AIDS. 2002;16(17):2347-9.

⁸ Forhan, S, Gottlieb, S, Sternberg, M, Xu, F, Datta, S, Berman, S, Markowitz, L. Female Adolescents in the United States: Data from the National Health and Nutritional Examination Survey (NHANES) 2003-2004. National STD Prevention Conference; March 2008; Chicago, Abstract D4a.

⁹ Weinstock, H. Syphilis in the United States: Epidemiology and Emerging Issues. National STD Prevention Conference; March 2008; Chicago. Abstract A6b.

This is not
the epidemic
we faced 20
years ago.



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