PREVENTING HIV/AIDS & SEXUALLY TRANSMITTED DISEASES

Tool Kit

Healthy States
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Sexually transmitted diseases (STDs) refer to the more than 25 infectious organisms transmitted primarily through sexual activity. Despite the burdens, costs, complications and preventable nature of STDs, they remain a significant public health problem that is largely unrecognized by the public, policymakers and health care professionals in the United States. Many STDs are easily treated, but if left untreated they can cause harmful, often irreversible and costly clinical complications such as infertility, cancer and death.

The Centers for Disease Control and Prevention (CDC) estimates that each year 40,000 new HIV infections are diagnosed, and hundreds of thousands more people are diagnosed with other STDs. If left untreated, HIV/AIDS and syphilis can lead to death. Untreated gonorrhea and chlamydia in women can lead to pelvic inflammatory disease (PID), which can lead to ectopic pregnancy, chronic pelvic pain and infertility.

There are economic as well as health consequences. The federal government budgeted more than $21 billion in HIV/AIDS care for fiscal year 2006. CDC estimates the annual direct medical costs of all STDs (including HIV) are $13 billion (2003 dollars).

What Are HIV/AIDS and STDs? Their Causes andWhom Do They Affect?

HIV/AIDS

HIV (human immunodeficiency virus) and AIDS (acquired immunodeficiency syndrome) are terms used to describe the virus that causes infection (HIV) and the syndrome or set of symptoms that can develop as a result of infection (AIDS).

AIDS is the most severe manifestation of HIV infection. CDC has documented many opportunistic infections and cancers that determine if an HIV-infected person meets the definition for a diagnosis of AIDS. A patient’s white blood cell count, which signals the strength of a person’s immune system, also is used to diagnose AIDS.

Since 1996, the introduction of powerful anti-retroviral medications has dramatically slowed the progress of HIV infection into AIDS. Prior to 1996, 50 percent of those infected with HIV were expected to develop AIDS. A recent study of highly active anti-retroviral therapy (HAART) suggests that these drugs now reduce the risk of dying or developing AIDS by 86 percent compared to those receiving no treatment.

STDs

In addition to HIV, there are more than 25 other infections transmitted primarily through sexual activity. CDC estimates that there are 19 million new infections every year in the United States, almost half of them among young people ages 15 to 24. The three major nationally reportable STDs are chlamydia, gonorrhea and syphilis. These three are bacterial STDs that can be treated and cured.

Chlamydia and gonorrhea usually have few or no symptoms and, if left untreated in women, can lead to pelvic inflammatory disease (PID), which can lead to chronic pelvic pain, ectopic pregnancy and infertility.

Syphilis is easily cured in its early stages, but if left untreated can lead to serious long-term complications including nerve, cardiovascular and organ damage and even death. Congenital
syphilis (mother-to-child transmission) can cause stillbirth or death soon after birth and physical deformity and neurological complications in children who survive. In addition, infection with chlamydia, gonorrhea or syphilis increases the risk of becoming infected with HIV at least two- to fivefold.

Genital human papillomavirus (HPV) is the most common STD in the United States; at least 50 percent of sexually active people will have HPV sometime in their lives. There is no cure for genital HPV, but a healthy immune system can usually fight the virus off on its own. There are treatments for the health problems that genital HPV can cause, such as genital warts, cervical cell changes and cervical cancer.

In June 2006, the Food and Drug Administration licensed the first HPV vaccine. It protects against four types of HPV, including two that cause most cervical cancers (70 percent) and two that cause most genital warts (90 percent). Also in June 2006, the CDC’s Advisory Committee on Immunization Practices (ACIP) recommended the vaccine be routinely given to girls 11–12 years of age. The vaccine also is recommended for women 13 to 26 years of age who have not been vaccinated and may be used in girls as young as 9. The vaccine is delivered through a series of three injections over a six-month period.\(^5\)

**Causes**

The spread of HIV and other STDs is most commonly attributed to unprotected sex with an infected partner. However, HIV also can be contracted through risky behaviors such as sharing drug needles or syringes. Other ways HIV is spread include contact with infected blood (i.e. blood transfusions), and mother-to-child transmission during pregnancy, birth or breastfeeding.\(^6\)

**Who’s Affected**

It is estimated that 1 million Americans today are infected with HIV, one-quarter of whom are unaware of their infection. There are 40,000 new HIV cases and more than 45,000 new AIDS cases reported in the United States annually,\(^7\) with communities of color being most adversely affected. For STDs, including HIV/AIDS, African-Americans are the hardest hit with new infections. Other groups disproportionately affected include Hispanics, young women, and men who have sex with men (MSM).

According to data released by the CDC, although the estimated number of new HIV/AIDS cases decreased in the African-American community between 2001 and 2004, African-Americans still accounted for 50 percent of all new cases in 2004. During that same time period, the number of HIV/AIDS cases increased among MSM, accounting for 47 percent of all new infections.\(^8\) Other startling statistics include:
In 2002, HIV/AIDS was the third and fourth leading cause of death among African-American men and women (25–54 years) respectively. It was the leading cause of death for African-American women 25–34 years old during this time.9

African-Americans have the highest rates of HIV/AIDS infections of all racial categories in the United States. In 2004, there were an estimated 97 cases per 100,000 people. This compares to just 11 cases per 100,000 for whites.10

At the end of 2004, Hispanics had the second greatest number of people estimated to be infected with HIV/AIDS, with 39 cases per 100,000.11

In recent years, data from across the United States suggest that an increasing number of MSM are acquiring STDs, and that young people are at higher risk for acquiring STDs for a combination of behavioral, biological and cultural reasons. The following data from 2004 underscore these points:

In 2004, young African-American females aged 15–24 had the highest rates of chlamydia infections, followed by American Indian/Alaska Native females aged 15–24 and Hispanic females aged 15–24.

Gonorrhea rates were highest among women 15–24, followed by women 20–24. As with chlamydia, rates of reported gonorrhea were highest among African-American women aged 15–19.

CDC estimates that in 2004, MSM comprised 64 percent of new primary and secondary (P&S) syphilis cases, up from an estimated 5 percent in 1999.12

Young people (13 to 24 years old) are at particularly high risk of contracting HIV. In 2004, an estimated 5,000 young people received a new diagnosis of HIV/AIDS, representing 13 percent of the new positive diagnoses in that year.13 In 2001, the CDC reported that African-American youth were the largest group of young people affected by HIV; accounting for 56 percent of all HIV infections ever reported among the youth age group. Transmission in this age group is primarily due to heterosexual contact, where young minority women are at an increased risk due to biological vulnerability, lack of recognition of a partner’s risk factors and having sex with older men. For young MSM, risks are associated with those who do not disclose their sexual orientation and if infected, may transmit the virus to both women and men.14

The higher rate of STDs among adolescents reflects multiple barriers to quality STD prevention services, including lack of insurance or ability to pay, lack of transportation, discomfort with facilities and services designed for adults, and concerns about confidentiality.15

The Costs of Infections

Preventing and controlling the spread of HIV/AIDS and STDs is both a public health and an economic concern. The lifetime direct medical costs of HIV/AIDS and STDs are estimated at $13 billion annually. This total cost does not include lost wages and productivity, out-of-pocket expenses or the costs associated with transmission of diseases to infants.16

Federal and state governments are responsible for some of the costs of treating poor and elderly HIV/AIDS patients, and they also must deal with the loss of income and productivity that can result when HIV/AIDS patients are unable to continue working. To lower these costs, prevention is essential. However, the majority of federal funding goes to treatment. In the FY 2006 federal budget, $21 billion is allotted for HIV/AIDS. Of that, 60 percent is for care—which includes $6.3 billion for Medicaid and $3.2 billion for

What State Legislators Can Do: Advancing Prevention Efforts Through Legislation and Regulation

- Reduce barriers to screening for HIV that prevent people from getting tested, such as written consent requirements before testing and limitations on spousal/partner notification.
- Reduce barriers to STD prevention activities and support basic STD prevention in high-risk populations.
- Support HIV screening tests as part of routine medical care through policy support or legislation.
- Require insurance coverage for HIV and STD screening programs through Medicaid and state employee health benefits and consider requiring private insurers to offer coverage.
- Require changing to confidential name-based reporting of HIV cases if your state is not already doing so.
- Support expedited partner therapy treatment for selected STDs through adjustments to practices, regulations or legislation, depending on the barriers in your state.
- Support state education department tools for HIV/AIDS and STD prevention education through collaboration with school districts, parent organizations and community groups so youth are educated about preventing sexually transmitted diseases.
Medicare. Just 4 percent is earmarked for prevention, which is less than the amount designated for research, global AIDS programs and housing assistance. Also, while new drugs have increased the life span of individuals with AIDS, medications are expensive and more patients are seeking help to pay for them. The AIDS Drug Assistance Program (ADAP) provides financial help with medications for people who have no or limited prescription drug coverage. The main source of funding is the federal government, although state governments and drug companies also provide money.

Each year, ADAP provides help to 136,000 people—or approximately 30 percent of the total number of people with HIV/AIDS who are receiving medical care. Between 1996 and 2004, the number of people using ADAP increased by 217 percent in the 41 states reporting data during that period. The amount of money spent on medications rose during the same time, increasing 591 percent. The average cost per HIV/AIDS prescription in June 2004 was $257.

How Do States Monitor Infection Rates?

CDC, through the National Center for HIV/AIDS, STD and TB Prevention (NCHSTP) is the primary federal agency that provides support to states for HIV/AIDS and STD surveillance and prevention programs. CDC’s STD surveillance consists of national notifiable disease reporting, sentinel surveillance, special surveys and prevalence monitoring:

- **National notifiable disease reporting**: This system collects case reports of chlamydia, gonorrhea, syphilis and chancreoid infections reported from all jurisdictions.
- **Sentinel Surveillance**: Sentinel surveillance systems collect data from a limited number of participating facilities that perform specific, and sometimes nonroutine, STD testing among a particular population. One such system is the Gonococcal Isolate Surveillance Project (GISP), which monitors the antimicrobial drug resistance of strains of gonorrhea.
- **Special surveys**: Special surveys use population-based samples and provide the only means by which an accurate national estimate of disease prevalence can be obtained. The National Health and Nutrition Examination Survey (NHANES) examines about 5,000 people each year from across the country to focus on a variety of health and nutritional measurements to meet emerging needs.
- **Prevalence monitoring**: Prevalence monitoring provides data on prevalence trends in disease among defined populations over time. Prevalence monitoring focuses on populations, such as MSM or adolescents, or takes place in particular settings, such as correctional facilities and family planning clinics.
- **STD Surveillance Network**: This is a network of local enhanced STD surveillance systems to improve the capacity of national, state and local STD programs to detect, monitor and respond to trends.

These surveillance systems are critical for understanding and describing the burden of STDs on the health of Americans, particularly young Americans; for monitoring national disease trends and health disparities; and for evaluating the impact of important national programs, such as the Infertility Prevention Program and the Syphilis Elimination Effort. The data are also used to help target resources for specific populations and health jurisdictions and for specific disease control activities, such as partner notification and screening. National recommendations for the treatment of gonorrhea continue to rely on information from GISP, and surveillance data have triggered CDC investigations, often resulting in increased targeted public health efforts in local areas.

CDC uses other surveillance systems to monitor behaviors related to HIV/AIDS transmission and services provided to HIV-infected patients. Those systems include:

- **Morbidity Monitoring Project (MMP)**: This is a new surveillance system designed to collect information from HIV/AIDS patients who received care from randomly selected HIV care providers. MMP collects information about access to and use of HIV care, treatment, prevention services and prevalence of behaviors that can result in HIV transmission and affect disease outcomes (like adherence to therapy).
- **National HIV Behavioral Surveillance System (NHBS)**: Surveys are conducted in cities with high levels of HIV/AIDS among high-risk populations (such as injection drug users) to determine their risk behavior, testing behavior and use of prevention services.

CDC also continues to adapt surveillance systems to match changes in the epidemics. In the
early years of the HIV/AIDS epidemic in the 1980s, the CDC requested states and local health departments to report AIDS cases to the CDC. Since 1996, due to the increased life span of those infected with HIV, reporting AIDS cases proved to be insufficient to track the scope of the epidemic.

In July 2005, CDC formally recommended that all states and territories adopt a confidential name-based surveillance system to report HIV infections. Name-based HIV reporting provides a more accurate and reliable reporting of the epidemic. As of June 2006, 44 states and the U.S. territories were using confidential name-based reporting of HIV infection. The remaining state health departments use other reporting methods.

The 2000 Ryan White Comprehensive AIDS Resources Emergency Act (RWCA)—which helps meet the care needs of those living with HIV/AIDS—requires that funding be determined by the number of HIV cases (not AIDS cases) reported to the CDC by no later than 2007. CDC only accepts name-based HIV reporting. Thus, states stand to lose funding under RWCA if they have not adopted a name-based HIV surveillance system.

What Are the Federal and State Prevention Programs for HIV/AIDS and STDs?

**Federal Programs**

The federal government plays a key role in the prevention and treatment of HIV/AIDS and STDs. Federal health agencies recommend policies, set screening and treatment guidelines based on scientific evidence, provide funds for research, finance health services and provide technical assistance. The U.S. Department of Health and Human Services (DHHS) has the lead role in public health programs to address HIV/AIDS and STDs, including research on prevention and treatment of HIV and financing treatment services.

For HIV/AIDS, the vast majority of money is spent on medical treatment, which comes mainly from the Health Resources and Services Administration through the RWCA. Since 1990, the RWCA has provided for the needs of individuals and families living with HIV or AIDS, and directed federal funding to areas disproportionately affected by the epidemic. Its main focus is to provide primary care, treatment and support services.

The Centers for Medicare and Medicaid Services (CMS) also spends a significant amount of money on HIV/AIDS care. Medicaid is the largest source of federal funding for HIV/AIDS treatment in the country. CMS estimates that in FY 2005, Medicaid spent $5.7 billion on HIV/AIDS treatment. For FY 2006, that number is expected to increase to $6.3 billion.

CDC, through the National Center for HIV/AIDS, STD and TB Prevention, provides the majority of funding to states for HIV/AIDS and STD prevention and surveillance - more than $600 million in FY 2005.

CDC provides funding and technical assistance to 65 state and local health departments to conduct HIV/AIDS case surveillance to track the epidemic and identify those groups most at risk of contracting the virus and to develop programs and interventions to control the spread of the disease. Funding also is provided to community- and faith-based organizations, which tailor prevention, counseling and testing programs to match local needs.

CDC also has an active role in STD prevention efforts. It provides leadership through research, surveillance, policy development and financial and personnel assistance to states, territories and local health departments. Two major STD program areas are preventing infertility in women and eliminating syphilis.

The Infertility Prevention Program—which funds chlamydia screening and treatment services for low-income, sexually active women attending family planning, STD and other women’s health care clinics—has proven that routine screening of women can reduce the prevalence of chlamydia and PID.

The National Plan to Eliminate Syphilis, launched in 1999 and updated in 2006, improves access to high-quality, community-based preventive and care services; provides education about the prevention of syphilis and other STDs to affected communities; and strengthens outbreak response and preparedness.

STD surveillance and prevention are two of the ways state health departments fulfill their responsibilities of preventing disease and injury, promoting healthy behaviors and ensuring access to health care services. State-by-state profiles of HIV and STD prevention activities can be accessed at: www.cdc.gov/nchstp/od/stateprofiles/usmap.htm.
State Programs

State health departments also receive funding through state budgets, user fees and fines, and special funds such as tobacco settlement funding. Each state receives some funding from a variety of grants and organizations, though this also varies from state to state and year to year.

Prevention programs created by states vary based on their local political, social and demographic context; however they should be based on sound scientific principles. Specific recommendations for state HIV/AIDS programs include:

- HIV prevention programs must be science-based and use messages, techniques and interventions that have been scientifically demonstrated to effectively reduce HIV transmission.
- Funding must be flexible and sufficient to allow creative, unique and innovative HIV prevention programs, using a variety of methods to reach high-risk groups.
- Prevention programs should be culturally competent and address the unique needs of the targeted population.
- Partner counseling and referral services to prevent further infection should be an integral part of comprehensive HIV prevention programs.23

What Can State Legislators Do to Promote HIV/AIDS and STD Prevention Efforts?

State legislators across the country have been introducing, debating and passing legislation aimed at preventing HIV/AIDS and STDs. Many states have recently passed legislation establishing HPV and cervical cancer task forces. Many are considering requiring Medicaid and state employee health benefit coverage for HIV/AIDS and STD screenings. Some are targeting efforts at particular populations to eliminate health disparities.

Individual state legislators looking for ways to further advance prevention efforts in their own states can choose from a number of roles—from supporting legislative and regulatory changes to serving as a community leader on the issue. On the legislative and regulatory front, for example, state lawmakers can advance prevention efforts by reviewing state laws and regulations for barriers that prevent people from getting tested for HIV. Legislation also can address expanding Medicaid, private and state employee health benefit coverage to include chlamydia screening and HIV screening or support confidential name-based reporting of HIV to ensure the accurate tracking of HIV-infected populations.

In addition to legislative and regulatory efforts, state legislators can play a community leadership role in keeping HIV/AIDS and STD prevention at the forefront of public awareness. State legislators can call for committee hearings on prevention efforts and hold town hall meetings. By speaking publicly about the importance of HIV/AIDS and STD prevention, they can help advance awareness of and support for prevention efforts. Lawmakers may also provide leadership to help neighborhoods and communities mobilize resources in a coalition to support local prevention efforts.
Endnotes


9 Ibid.


11 Ibid.


HIV/AIDS and sexually transmitted diseases (STDs) continue to pose a major problem in the United States. More than 20 years after the first diagnosed case of AIDS, the Centers for Disease Control and Prevention (CDC) estimates that 40,000 people are infected with HIV every year, and hundreds of thousands more are diagnosed with an STD. With today’s prevention efforts and treatment options, many of these infections can be averted.

In this section, you will find the basics about HIV/AIDS and the most common STDs, the populations most affected, the impact of these diseases on minority communities and the costs of these infections.

What is HIV/AIDS?

HIV (human immunodeficiency virus) is the virus that causes AIDS (acquired immunodeficiency syndrome). HIV is commonly spread by sexual contact or by sharing needles and syringes, primarily for drug injection, with someone who is infected. HIV is less commonly transmitted through transfusions of infected blood or blood clotting factors. Also, babies born to HIV-infected women can become infected before or during birth, or through breast-feeding following birth.\(^1\)

AIDS stands for Acquired Immunodeficiency Syndrome. Acquired means that the disease is not hereditary, but develops after birth from contact with a disease-causing agent, in this case, HIV. Immunodeficiency means that the disease is characterized by a weakening of the immune system, and syndrome refers to a group of symptoms that collectively indicate or characterize a disease.

In the case of AIDS, this can include the development of certain infections and cancers, as well as a decrease in the number of disease-fighting cells in a person’s immune system. CDC lists numerous opportunistic infections and cancers that can help determine if an HIV-infected person has AIDS. Those living with AIDS often have infections of the lungs, brain, eyes and other organs, and frequently suffer debilitating weight loss, diarrhea and a type of cancer called Kaposi’s sarcoma.\(^2\)

What are STDs?

In addition to HIV, there are more than 25 other infections transmitted primarily through sexual activity. CDC estimates that there are 19 million new infections every year in the United States, almost half of them among young people ages 15 to 24. The three major nationally reportable STDs are chlamydia, gonorrhea and syphilis.

Chlamydia is caused by bacteria and can damage a woman’s reproductive organs. It has been called a “silent” disease, because about three-quarters of infected women and half of infected men have no symptoms. Although any sexually active woman is at risk of contracting chlamydia, teenage girls and young women are particularly susceptible because the cervix has not fully matured.\(^3\)

If left untreated, the infection can spread into the uterus or fallopian tubes and cause pelvic inflammatory disease (PID). The damage can lead to chronic pelvic pain, infertility and a potentially fatal ectopic pregnancy. In pregnant women, there is some evidence that untreated infections can lead to premature delivery. Women infected with chlamydia are also up to five times more likely to become infected with HIV if exposed.\(^4\)
What is syphilis?

Syphilis, a genital ulcerative disease, is highly infectious, but easily curable in its early primary and secondary stages. If untreated, it can lead to serious long-term complications, including nerve, cardiovascular and organ damage, and even death. Congenital syphilis, which is passed along by a mother to a fetus, can cause stillbirth or death soon after birth, and death. Untreated babies may die or have developmental delays or seizures.

If left untreated, syphilis can cause damage to internal organs, such as the brain, nerves, eyes, heart, blood vessels, liver, bones and joints. A pregnant woman with syphilis may transmit the disease to her unborn child, which greatly increases the risk of a stillbirth or the baby dying shortly after birth. Untreated babies may die or have developmental delays or seizures.

Human Papillomavirus (HPV) is caused by a virus that includes more than 100 different strains. Although most people infected with HPV won’t show any signs and will recover from it on their own, some of the viruses may cause abnormal Pap tests and may lead to cervical cancer. HPV, although it is not a nationally notifiable disease, is the most common STD in the U.S. At least 50 percent of sexually active people will have it sometime in their lives. There is no cure for genital HPV, but a healthy immune system can usually fight off the virus on its own. There are treatments for the health problems that genital HPV can cause, such as genital warts, cervical cell changes and cervical cancer.

In June 2006, the Food and Drug Administration licensed the first HPV vaccine. It protects against four types of HPV, including two that cause most (70 percent) cervical cancers and two that cause most (90 percent) genital warts. Also in June 2006, the CDC’s Advisory Committee on Immunization Practices (ACIP) recommended the vaccine be routinely given to girls 11–12 years of age. The vaccine is also recommended for women 13 to 26 years of age who have not been vaccinated and may be used in girls as young as 9. The vaccine is delivered through a series of three injections over a six-month period.

Who is Affected by HIV/AIDS?

HIV/AIDS affects a large segment of the U.S. population, with almost 1 million Americans now infected with HIV. Of these 1 million Americans, it is estimated that one-quarter are unaware of their infection. There were an estimated 40,000 new HIV cases and almost 45,000 new AIDS cases reported in the United States in 2004.
Nationally those who were living with HIV/AIDS in 2004 were:

- 34 percent white, 48 percent African-American and 17 percent Hispanic
- 73 percent males and 27 percent females.

Since 1996, the introduction of powerful anti-retroviral medications has dramatically slowed the progression of HIV infection into AIDS and has led to significant decreases in AIDS deaths. The number of AIDS deaths decreased 8 percent from 2000 through 2004, and an estimated 415,000 people at the end of 2004 were living with AIDS. A long-term study looking at the effectiveness of highly active antiretroviral therapy (HAART) determined that the drugs given to HIV patients reduces the risk of dying or developing AIDS by 86 percent compared to those receiving no treatment.

Who is Affected by STDs?

Although there have been advances in reducing the rates of some STDs, there still is cause for concern—especially among minorities, young women and men who have sex with men.

In 2004, the number of cases of chlamydia reported to the CDC increased 6 percent from the previous year, to 319.6 cases per 100,000 population. Rates of reported chlamydia infections—the most commonly reported STD—have been increasing annually since the late 1980s, when public programs for screening and treatment of women were established to prevent PID and its complications. Part of the increase in the number of diagnosed infections may be due to increased testing and the use of more sensitive tests.

The highest rate of infection in 2004 was among women 15 to 24 years old. Overall, women are three times more likely to be diagnosed with chlamydia than men, likely because of the greater number of women screened for this infection in accordance with CDC guidelines for annual chlamydia screening for sexually-active women under age 26.

Gonorrhea, the second most commonly reported STD in the U.S., has declined dramatically in recent years. From 1975 through 1997, the national gonorrhea rate declined 74 percent; and it dropped an additional 12 percent from 2000 to 2004. With an infection rate of 113.5 cases per 100,000 people in 2004, it reached the lowest level ever reported.
In 2004, gonorrhea rates were slightly higher in women than in men. Adolescents and young adults were most at risk, with the highest rates recorded among 15- to 24-year-old women. Among men, the highest rates were recorded in 20- to 24-year-olds.18

Although the gonorrhea infection rate has decreased, antibiotic resistance has increased. The Gonococcal Isolate Surveillance Project (GISP), established in 1996, monitors antibiotic-resistant strains reported in STD clinics in 28 cities. In 2004, 16 percent of cases recorded by GISP were resistant to penicillin or tetracycline, two commonly prescribed antibiotics. The antibiotic resistance is increasing particularly among men who have sex with men (MSM). Strains resistant to the more powerful ciprofloxacin increased from 15 percent in 2003 to 24 percent in 2004, which led the CDC to recommend that it no longer be used to treat gonorrhea among MSM.19

The rates of primary and secondary syphilis, declined during the 1990s and in 2000 by 89 percent to its lowest level since reporting began in 1941. Since 2001, however, infection rates have increased each year, mainly among men. In 2004, overall infections increased by 11 percent. Because the number of men being infected has risen more rapidly than women, it is believed that more of the cases are being transmitted by men who have sex with men.20

Congenital syphilis cases have decreased. Between 2003 and 2004, the overall rate of congenital syphilis decreased 18 percent, from 10.7 cases to 8.8 per 100,000 live births. The overall yearly average has continued to fall—a 92 percent decrease since 1991—likely due to the substantial decrease in infection rates in women.21

Controlling syphilis infections also may have an impact on the rate of HIV infections. Some STDs make it easier for a person to contract HIV if exposed. One study showed that a person infected with syphilis was far more likely to contract HIV than a person infected with chlamydia, gonorrhea or genital herpes.22

Since the incidence of HPV is not part of the state-federal reporting system, CDC is conducting sentinel surveillance for HPV at 29 clinics in six cities in an effort to estimate prevalence and help guide prevention efforts. In the sentinel surveillance cities in 2003–04, those most likely to be infected were young people ages 14 to 29 years old. Combined, those two age groups accounted for 64 percent of HPV diagnoses.23

Health Disparities

The rate of HIV/AIDS and STDs is of particular concern for racial and ethnic minority communities. In 2004, HIV/AIDS cases reported in the 35 states and territories with confidential name-based reporting showed that African-Americans accounted for 50 percent of all the new HIV/AIDS cases.24 By the end of 2004, more than 200,000 African-Americans had died from AIDS.25

The most common sources of HIV infection among African-Americans in 2004 were male-to-male sexual contact, heterosexual contact with infected persons and injection drug use. Women and youth in the African-American community also are being infected at an alarming rate. In 2002, HIV/AIDS was the number one cause of death for African-American women aged 25–34.26 In 2001, African-Ameri-
can youth were the largest group of young people affected by HIV, accounting for 56 percent of all HIV infections ever reported among the youth age group. To control the spread of the epidemic, education, prevention, screening and treatment must become more available in the African-American community.27

Among Hispanic men living with HIV/AIDS in 2004, male-to-male sexual contact was the greatest source of infection, accounting for 54 percent of all male cases. Injection drug use was second, which was linked to 26 percent of male infections. Among Latinas, the most common sources of infection were heterosexual sex (68 percent) and injection drug use (30 percent).28

African-Americans are also at the highest risk of contracting an STD, as shown in Figure 6. In 2004, the rate of chlamydia among African-American women was 7.5 times higher than the rate among white women. For African-American men, the rate was 11 times higher than white men. The rate of primary and secondary syphilis infections among African-Americans was six times greater than that of whites.29

For gonorrhea, the rate of infection has decreased among African-Americans, although it remains substantially higher than for whites. From 2000 to 2004, African-American infection rates dropped 19 percent, but the rate of gonorrhea is still 19 times higher than the rate among whites.30

In addition to racial and ethnic minority communities, young people (13 to 24 years old) also are at high risk for HIV/AIDS. In 2004:

- An estimated 5,000 young people received a new diagnosis of HIV/AIDS, representing 13 percent of the new diagnoses in that year.
- An estimated 2,200 young people were diagnosed with AIDS; accounting for 5 percent of total estimated AIDS diagnoses.
- An estimated 10,000 young people with AIDS have died; accounting for 2 percent of total deaths of people with AIDS.31

Between the ages of 13 and 24, transmission of the disease was linked to factors such as heterosexual contact, men having sex with men, substance abuse and lack of awareness about HIV. Young minority women are at risk due to biological vulnerability, lack of recognition of partners’ risk factors, and sexual activity with older men, while young MSM are at high risk often due to failure to disclose their sexual orientation. MSM who fail to disclose are often involved in relationships with males and females, increasing the likelihood of transmitting the disease to both women and men, if infected.32

The Costs of Infections

Preventing and controlling the spread of HIV/AIDS and STDs is both a public health and an economic concern. The lifetime direct medical costs of HIV/AIDS and STDs are estimated at $13 billion annually. This total cost does not include lost wages and productivity, out-of-pocket expenses or the costs associated with transmission of diseases to infants.33

To reduce these costs, prevention is essential. However, the majority of available funding, for HIV/AIDS specifically, is allocated to treatment. In the Fiscal Year 2006 federal budget, $21 billion is allotted for HIV/AIDS. Of that amount, 60 percent is for medical care—which includes $6.3 billion for Medicaid and $3.2 billion for Medicare. Just 4 percent is earmarked for prevention, which is less than amounts designated for research, global AIDS programs and housing assistance.34

While new drugs have increased the life expectancy of HIV-infected persons, medications are expensive and consequently, more patients are seeking help to pay for treatment. The AIDS Drug Assistance Program (ADAP) provides financial help for medications for people who have no or limited prescription drug coverage through the federal Ryan White Comprehensive AIDS Resources Emergency Act (RWCA). Funding for HIV/AIDS treatment primarily comes from federal resources and state governments, with a smaller funding role from pharmaceutical companies.

Each year, ADAP provides medication assistance to 136,000 people—or approximately 30 percent of the total population of people living with HIV/AIDS. Between 1996 and 2004, the number of people using ADAP increased by 217 percent in the 41 states reporting data during that period. The amount of money spent on medications grew during the same time period, in-
creasing 591 percent. The average cost per prescription for HIV/AIDS treatment in June 2004 was $257 per month.35

Conclusion

Despite advances in prevention and treatment, HIV/AIDS and other STDs remain an important health concern, particularly the disproportionate impact of the epidemics on racial and ethnic minority populations. Increased focus on HIV and STD prevention efforts is necessary to control the spread of the diseases and reduce the economic and health costs.

The costs of drugs used to treat HIV/AIDS have increased and the number of people seeking federal assistance to offset costs has followed. The direct medical costs of HIV/AIDS and other STDs are estimated at $13 billion annually (2003 dollars).36, 37

To encourage the development of effective prevention messages and better targeted efforts, legislators should be aware of local populations most affected. Chlamydia is most often diagnosed in young women, and gonorrhea rates are slightly higher in women than men. Syphilis rates, however, have been increasing among men and the majority of those living with HIV/AIDS are men. Prevention messages must address the specific concerns of African-Americans, Hispanics, young women and MSM.

Legislators should also be aware of how HIV/AIDS data are collected in their state. States that have not yet adopted confidential name-based surveillance systems for reporting HIV infections could potentially face major reductions in funding for treatment through RWCA resources.

HIV/AIDS and other STDs are preventable. Legislators who are aware of the epidemics and informed of their local impact can be champions for prevention, testing and educational efforts focused on these diseases.

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<tr>
<th>Race/Ethnicity</th>
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Endnotes

2 Ibid.
4 Ibid.
6 Ibid.
8 Ibid.
13 Ibid.
15 Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance, 2004. Atlanta, GA: U.S. Department of Health and Human Services, September 2005. This report also is available by Internet via the CDC home page at: www.cdc.gov/std/stats/
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34 Kaiser Family Foundation, “The President’s FY 2006 Budget Proposal: Overview and Briefing
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al-Overview-and-Briefing-Charts.pdf
To prevent the spread of HIV/AIDS and other sexually transmitted diseases (STDs), state and federal governments work in partnership with community-based providers and organizations. Because these infections are sexually transmitted, privacy issues, fears of embarrassment or exposure and morality concerns have created obstacles to instituting proven prevention efforts, such as making testing a part of routine medical care.

Prevention programs in African-American and Hispanic communities face particular challenges, including a lack of proven interventions that are culturally sensitive and specifically designed to reach these populations. For Hispanics, the diversity of the Latino population in the United States further complicates outreach efforts because regional and cultural differences, socioeconomic status and behavioral risk all impact HIV/AIDS status. Distrust of government health departments, fear of deportation, language barriers and lack of representation in planning processes further complicate effective STD and HIV/AIDS prevention. Culturally competent prevention programs should take all these factors into account.

Government policy seeks to prevent further spread of the diseases by:

- Encouraging individuals to be tested so they know if they have a sexually transmitted disease;
- Counseling and educating those who are infected regarding their role in preventing the spread of the disease;
- Generating support for prevention and treatment efforts among health care providers and other community-based partners such as schools and faith-based organizations;
- Understanding the populations most affected by the diseases, including how the diseases are transmitted and how well treatments are working; and
- Using data to help develop more targeted prevention and treatment efforts.

The following sections will describe how the federal government works with state and local governments and community agencies to implement programs that reinforce these prevention strategies.

What Role Does the Federal Government Play in Prevention and Treatment of HIV/AIDS and STDs?

The federal government plays a key role in the prevention and treatment of HIV/AIDS and STDs. Federal health agencies recommend policies, set screening and treatment guidelines based on scientific evidence, provide funds for research, finance health services and provide technical assistance. The Department of Health and Human Services has the lead role in overseeing public health programs that address HIV/AIDS and STDs, including research on prevention and treatment of HIV and financing treatment services.

CDC provides funding to state and local health departments for STD control and prevention through its Comprehensive STD Prevention Systems cooperative agreements, which includes funding for the Infertility Prevention Program and Syphilis Elimination Effort. These federal funds are used in local communities for STD clinical and prevention services. CDC also provides direct personnel and technical assistance to state health departments. In addition to providing human and financial resources to states, the CDC monitors disease trends through sur-
Effective clinical management of patients with treatable sexually transmitted diseases (STDs) requires treatment of the patients’ current sex partners to prevent reinfection and stop further transmission.

The standard approach to partner treatment has included clinical evaluation in a health care setting, with partner notification accomplished by the patient, the provider or an agent of the provider, or a combination of these methods.

Provider-assisted referral is considered the optimal strategy for partner treatment, but is not available to most patients with gonorrhea or chlamydial infection because of resource limitations. The usual alternative is to advise patients to refer their partners for treatment.

In recent years, research supported by CDC evaluated expedited partner therapy (EPT), an approach where partners are treated without an intervening clinical assessment. EPT typically is accomplished by patients delivering either medications or prescriptions to their partners.

Based on evidence from randomized control studies and surveys of practice, CDC has concluded that EPT is a useful option to facilitate partner management, particularly for treatment of male partners of women with chlamydial infection or gonorrhea. EPT is permissible in only five states, though it may be possible in as many as 33 additional states with some regulatory or administrative action.

Since 2005, the CDC has strongly encouraged local and state health departments and policymakers interested in STD prevention to work together to resolve the outstanding legal issues and find ways to implement this proven prevention strategy. EPT is a promising practice for treating infected sexual partners of those diagnosed with chlamydia, but implementation likely requires policy or legislative action in most states. Some states, such as California, have passed legislation to permit EPT; other states, such as Tennessee, have implemented regulations to permit the practice.


For HIV/AIDS, most federal funding is spent on medical treatment, which comes mainly from the Health Resources and Services Administration through the Ryan White Comprehensive AIDS Resources Emergency Act (RWCA). Since 1990, the RWCA has provided for the needs of individuals and families living with HIV/AIDS and directed federal funding to areas disproportionately affected by the epidemic. Its main focus is to provide primary care, treatment and support services. More than 2,700 providers who receive RWCA funding reach more than 500,000 people each year—which is about half of all of those estimated to be living with HIV/AIDS in the United States.

The Centers for Medicare and Medicaid Services (CMS) also spends a significant amount of money on HIV/AIDS care. Medicaid is the largest source of federal funding for HIV/AIDS treatment in the country. CMS estimates that in Fiscal Year (FY) 2005, Medicaid spent $5.7 billion on HIV/AIDS treatment. For FY 2006, that number is expected to increase to $6.3 billion.

CDC provides most of the funds spent on HIV prevention by state and local health departments and community-based organizations. CDC provides HIV prevention funding to 65 state and local jurisdictions. Each state contributes some local funding to both prevention and treatment, although the amount varies from year to year and from state to state.

**Federal Surveillance Systems**

CDC, through the National Center for HIV/AIDS, STD and TB Prevention (NCHSTP) is the primary federal agency that provides support to states for HIV/AIDS and STD surveillance and prevention programs. CDC’s STD surveillance consists of national notifiable disease reporting, sentinel surveillance, special surveys, and prevalence monitoring:

- **National notifiable disease reporting**: This system collects case reports of chlamydia, gonorrhea, syphilis and chancroid infections reported from all jurisdictions.
- **Sentinel surveillance**: Sentinel surveillance systems collect data from a limited number of participating facilities that perform specific, and sometimes nonroutine, STD testing among a particular population. One such system is the Gonococcal Isolate Surveillance Project (GISP), which monitors the antimicrobial drug resistance of strains of gonorrhea.
- **Special surveys**: Special surveys use population-based samples and provide the only means by which an accurate national estimate of disease prevalence can be obtained. The National Health and Nutrition Examination Survey (NHANES) examines about 5,000 people each year from across the country to focus on a variety of health and nutritional measurements to meet emerging needs.
- **Prevalence monitoring**: Prevalence monitoring provides data on prevalence trends in disease prevalence among defined populations over time. Prevalence monitoring focuses on a variety of populations, such as men who have sex with men (MSM) or adolescents, or takes place in particular settings, such as correctional facilities and family planning clinics.
- **STD Surveillance Network**: This is a network of local enhanced STD surveillance systems to improve the capacity of national, state and local STD programs to detect, monitor and respond to trends.

These surveillance systems are critical for understanding and describing the burden of STDs on the health of Americans, particularly, young Americans; for monitoring national disease trends and health dispari-
ties; and for evaluating the impact of important national programs, such as the Infertility Prevention Program and the Syphilis Elimination Effort. The data are also used to help target resources for specific populations and health jurisdictions and for specific disease control activities, such as partner notification and screening. National recommendations for the treatment of gonorrhea continue to rely on information from GISP, and surveillance data have triggered CDC investigations, often resulting in increased targeted public health efforts in local areas.

CDC uses additional surveillance systems to monitor behaviors related to HIV/AIDS infections and the services provided to those patients. Those systems include:

- **Morbidity Monitoring Project (MMP):** Information is collected from HIV/AIDS patients receiving care from randomly selected providers about access to and use of HIV treatment and prevention services, as well as their behaviors that can result in HIV transmission and affect disease outcomes (like adherence to therapy).
- **National HIV Behavioral Surveillance System (NHBS):** Surveys are conducted in cities with high levels of HIV/AIDS among high-risk populations (such as injection drug users) to determine their risk behavior, testing behavior and use of prevention services.¹

### Federal HIV/AIDS Prevention Initiatives

CDC provides grants to all 50 state health departments for prevention and reporting of HIV/AIDS cases and targeted funding for special surveillance activities for priority populations or behavioral interventions in 29 states.

CDC funding supports state efforts to strengthen organizational infrastructure, improve and evaluate interventions that prevent HIV, especially in high-risk populations, and work with community representatives from high-risk ethnic and racial minority groups to improve community access and use of HIV prevention and risk-reduction activities.

**Advancing HIV Prevention (AHP):** In April 2003, CDC, in partnership with other U.S. Department of Health and Human Services (HHS) agencies and other governmental agencies, launched their new initiative, “Advancing HIV Prevention: New Strategies for a Changing Epidemic.” The initiative was begun because the annual new HIV infection rate had remained relatively stable for about a decade
and about a quarter of the estimated 1 million HIV-infected people had not been tested. Also, making people aware that they were carrying the virus became a priority because CDC research demonstrated that once a person learns of their infection they tend to take steps to reduce transmission to partners. AHP focuses on four proven strategies:

- Making voluntary HIV testing a routine part of medical care;
- Implementing new models for diagnosing HIV infections outside medical settings;
- Preventing new infections by working with HIV-infected persons and their partners; and
- Further decreasing perinatal HIV transmission.6

AHP also focuses on encouraging facilities to conduct rapid HIV testing, which provides results in 20 minutes and can be done in a non-clinical setting. Non-rapid HIV tests can take several days and research has shown that about 30 percent of the people who test positive in CDC-funded sites do not return to get their results.7 Between 2003 and 2005, the CDC purchased and distributed more than 500,000 rapid HIV testing kits for state and local use and conducted training sessions on how to properly use them.8

The AHP initiative promotes including HIV testing as part of routine medical care in clinical settings such as hospitals and emergency rooms. The purpose of this strategy is to increase the proportion of people who know their HIV status and to eliminate barriers to voluntary testing such as pre-test counseling requirements.

However, many physicians are concerned about routinely testing their patients for HIV, preferring to test only those who have a traditional risk factor.9 Researchers are evaluating the cost benefit of widespread population screening programs. One study estimated that in high-risk populations where more than 40 percent have a lifetime risk of becoming infected with HIV, each HIV-positive person identified cost $32,000, but further transmission to 300 others was averted.10

Minority AIDS Initiative (MAI): Since 1999, HHS agencies, including the CDC, have received resources from the Minority AIDS Initiative (MAI) to enhance prevention of HIV infections in racial and ethnic minority communities, particularly in African-American and Hispanic/Latino populations.
MAI resources are appropriated annually by Congress. The initiative supports community-based HIV prevention programs and targeted education efforts. Using these funds, CDC conducts additional surveillance to define the magnitude of the problem in racial and ethnic communities, and to research, develop and refine culturally relevant interventions and programs.\textsuperscript{11}

\textbf{Federal STD Prevention Initiatives}

CDC’s \textit{Comprehensive STD Prevention Systems (CSPS)} provides support to 65 project areas in 50 states, six cities, seven territories, the District of Columbia and Puerto Rico to design, implement and evaluate high quality, comprehensive state and local STD prevention and treatment programs that integrate HIV services. Examples of collaborative activities include encouraging medical providers to provide HIV, hepatitis and STD screening in high-prevalence settings; supporting the development and expansion of HIV counseling, testing, referral and partner services; and integrating HIV, hepatitis and STD prevention messages into educational materials.

Four important CDC STD prevention programs are:

\textbf{Infertility Prevention Program}. Chlamydia and gonorrhea are the most important preventable causes of infertility and potentially fatal tubal pregnancy. If not adequately treated, up to 40 percent of women infected with either disease will develop pelvic inflammatory disease (PID), the critical link to infertility. Because most infected women and at least half of infected men have no symptoms, many infections go undetected and are not reported or counted.

CDC, in collaboration with the Office of Population Affairs, supports a national Infertility Prevention Program that funds chlamydia screening and treatment services for low-income, sexually-active women attending family planning, STD and other women’s health care clinics. The program was authorized by Congress in 1993 and has demonstrated that routine screening of women can reduce chlamydia prevalence and PID incidence in women.

\textbf{Syphilis Elimination Effort (SEE)}. When CDC launched the National Plan to Eliminate Syphilis in 1999, the epidemic of infectious syphilis was at an historic low and was contained in limited geographical areas, making the elimination goal of 1,000 or fewer cases feasible. At the time of the launch, syphilis was mainly found in disadvantaged and underserved African-American communities where poverty and access to health care were key factors allowing it to persist. In 1998, the primary and secondary syphilis (P&S syphilis) rate for African-Americans was 34 times greater than the rate for whites.

As a supplement to the CSPS grants, 39 SEE projects in 31 states, seven cities and Puerto Rico were funded in 2005 in areas with high syphilis morbidity. The SEE program improves access to high-quality, community-based preventive and care services, provides education about prevention of syphilis and other STDs to affected communities and strengthens outbreak response preparedness. The program also builds and strengthens partnerships with public health organizations, the private medical community and other public and private partners in STD and HIV prevention.

SEE allows the CDC and states to target resources and programs in areas with the highest rates of disease. Such targeting has resulted in significant declines in syphilis among key populations at risk. For example, between 1999 and 2004, P&S syphilis rates among African-Americans decreased 37 percent; the black-white disparity in syphilis rates fell from 28.6:1 to 5.6:1; syphilis rates among women decreased 60 percent; and congenital syphilis (transmission from mother to child) rates declined 39 percent.\textsuperscript{12} Overall, there has been a 92 percent decrease in cases of congenital syphilis since 1991.\textsuperscript{13}

The national plan was updated in 2006 to address the increasing rates of syphilis among men who have sex with men. More than 60 percent of new infections now are diagnosed among MSM. The effort will include enhancing surveillance, including asking for the gender of sexual partners, advocating routine syphilis screening among MSM by HIV care providers, developing Internet-based interventions and increasing funding to community-based organizations in high-prevalence areas to more effectively target at-risk populations.\textsuperscript{14}

\textbf{STD/HIV prevention training}. The National Network of STD/HIV Prevention Training Centers is a group of 18 CDC-funded regional centers. Ten provide clinical and lab training, four provide behavioral interventions training and four provide partner services training. They were created in partnership with health departments and universities that provide state-of-the-art education for health professionals in the areas of sexual and reproductive health.

Supporting screenings as part of routine medical care. It is a national health priority to diagnose and treat individuals as soon after infection as possible. But because some of the STDs
have few or no symptoms, the CDC recommends regular screenings become a part of routine patient care. CDC and other professional health care organizations recommend annual chlamydia screening of sexually active women 25 years old or younger in order to avert PID, which can lead to infertility, ectopic pregnancy and chronic pain. Because syphilis can have devastating effects on unborn children, CDC and other professional health care organizations recommend prenatal screening of all pregnant women for syphilis. And as with HIV/AIDS, counseling also is recommended to prevent new infections or transmission of the disease to partners.

How Do State and Local Health Departments Work to Prevent HIV/AIDS and STDs?

State health departments

State health departments are responsible for protecting the health of their state’s population. Their primary roles include preventing diseases and injuries, protecting against environmental hazards, responding to disasters, promoting healthy behaviors and ensuring access to health care services. The activities of health departments integrate these priorities with the requirements of federal and other grant funding. State-by-state profiles of HIV and STD prevention activities can be accessed at www.cdc.gov/nchstp/od/stateprofiles/usmap.htm.

In FY 2005, CDC provided more than $600 million in grants to states for HIV/AIDS and STD surveillance and prevention. State health departments also receive funding through state budgets, user fees, fines and special funds, such as tobacco settlement funding.

Each state health department determines its own approach to meeting the requirements of the CDC funding to monitor the number of patients diagnosed with HIV, AIDS and STDs as well as to implement initiatives to meet their own priorities. Some state health departments also fund the activities of the local health departments.

States report cases of HIV/AIDS and STDs to the CDC. National surveillance data are used to help policymakers decide what actions to take to address the areas of their state or segments of their population most at-risk of contracting HIV or an STD.

An example of HIV surveillance data providing the impetus for policy action occurred in Alabama, where the data showed that while only 26 percent of the state’s population is African-American, more than 70 percent of newly reported HIV infections occurred in African-Americans. This information led to a multi-year initiative, including declaration by the governor of an African-American HIV/AIDS Awareness Day, which was paid for through additional federal funding. The initiative sought to encourage African-Americans to be tested for HIV and supplied funding to faith-based and minority organizations to build community coalitions to confront the problem.15

Complete and accurate state data are essential to developing effective actions on the federal, state and local level to combat HIV and STDs. For example, case reports in Western states identified methamphetamine use as a contributor to unsafe sexual practices and increased transmission of STDs, particularly among MSM. Additional reporting and analysis alerted the public health agencies to the problem as the use of methamphetamine spread to the Eastern states. East Coast states now are using the experiences of Western states as a framework for formulating their own programs to address the issue.16

Local health departments

Organization and funding of local health departments varies. Some serve cities, counties or townships. In some states, they are independent from the state health departments but are required to conform to state regulations. In other states, funding may be completely or partially state provided. State regulations grant authority to the local health departments to quarantine, investigate disease outbreaks and regulate facilities, and to require supportive actions from medical care providers such as reporting individuals infected with HIV/AIDS and certain STDs.17

Using the guidance of broad federal initiatives, state and local programs target their activities according to those local populations most affected by the epidemics. Some examples are:

- Based upon surveillance data, the Wyoming Rural AIDS Prevention Project (WRAPP) is finding new ways to target prevention efforts for MSM in the largely rural state. Because
there is little gay-identified culture in Wyoming, WRAPP is looking for new ways to use the Internet to get its prevention message across to MSM.18

- In San Francisco, patients now can order syphilis tests and get the results online, eliminating the need for waiting at clinics and encouraging more people to be tested. In addition, the health department also hosts a Web site that allows patients to send e-cards to partners to let them know that they may have been exposed to an STD and they need to be tested. Follow-up research has shown that the Web site helped health officials detect 20 cases of syphilis that probably otherwise would not have been diagnosed. San Francisco’s initial investment to set up the Web site was $20,000 and monthly maintenance costs $40.19

- The William F. Ryan Community Health Center in New York City conducts targeted street and community outreach for African-Americans and Latinos to reduce their risk of becoming infected with HIV. One-on-one and group sessions offer educational materials and counseling. Client surveys are used to assist in planning future activities.20

- During 2004, the Illinois Department of Public Health STD Program, in collaboration with the Chicago Department of Public Health, helped fund routine chlamydia and gonorrhea screening at the Cook County Jail. All female detainees were offered chlamydia and gonorrhea testing at the time of booking. A total of 12,447 women were tested for chlamydia, resulting in the identification and treatment of 1,297 infected women. A total of 12,479 females were tested for gonorrhea, which resulted in 1,046 women being identified and treated. Because of the success of the program, routine testing began in 2005 for males at increased risk of infection.21

What Other Local Programs and Resources Work On HIV/AIDS and STD Prevention?

Health care providers

Private and public health care, mental health and substance abuse providers, emergency rooms and hospitals offer information about HIV/AIDS and STDs, and provide screening tests and referrals to
treatment and counseling services. Free or reduced-cost educational and testing/counseling programs are offered to communities, particularly minority and underserved populations, to address these epidemics. Local community medical clinics funded by state or federal initiatives provide opportunities for community members to receive testing and counseling services for HIV and other STDs.

School and youth-based programs

Local school boards and schools make decisions on how to incorporate health and sex education, including prevention of HIV/AIDS and other STDs, into school curricula. School boards are faced with balancing local preferences for education on sexual risk behaviors and the desire to protect the health of their students, with parents’ rights to control information presented to their children. Many approaches have been implemented across the states to deal with these local issues.

CDC’s Division of Adolescent and School Health provides funding to state departments of education to implement HIV/AIDS prevention education programs. These programs primarily emphasize abstinence from sexual intercourse to protect teens from HIV, other STDs and unintended pregnancy. Since a 2005 study reported that 47 percent of high school students have had sexual intercourse and only 63 percent of them used a condom during their most recent intercourse, there is a continuing cause for concern about education and prevention for teens. In some states, the state departments of education have curricula related to HIV and STD prevention, which is used by schools at the discretion of the school board and with parental involvement in the approval of school-based programs.

In Michigan, a 2004 state law gives a broad outline of what schools should teach in a comprehensive sex education course, but it also allows for a great deal of local control so it can be modified to fit community standards. Under the regulations, sex education cannot be taught unless a community sex education advisory board is established. At least half of the board’s members must be parents who have children that attend a school in the district. The advisory board decides what is taught within the
confines of the law, which regulates that all information should be age-appropriate and medically accurate. Parents are allowed to exclude their children from the classes.

While abstinence is the only 100 percent effective way to prevent HIV, other STDs and unintended pregnancy, the Michigan State Board of Education requires students to be educated about other ways to reduce the risk of infection. The state also has developed model curricula for use by local school boards for elementary, middle school and high school students. For more information about Michigan’s law, see the archive of a Web conference hosted by The Council of State Governments titled, “Protecting America’s Youth: Schools and Communities Tackle Youth Sexual Risk Behaviors,” available at www.healthstates.csg.org/Events+and+Conferences/Web+Conferences/Teen+Sexual+Risk+Behavior+Web+Conference.htm.

A school district’s impact can go beyond education. To deal with a growing number of teens diagnosed with chlamydia and gonorrhea, the School District of Philadelphia partnered with the local health department to offer optional urine screenings for students. In 1995, the Philadelphia Department of Health recorded 7,946 cases of chlamydia for all ages throughout the city. This number doubled to 14,605 by 2002, and the case rate for 15- to 19-year-old girls was 8,251.8 per 100,000. These infection rates indicated a growing chlamydia epidemic disproportional to other large cities. The Commissioner of Health suggested establishing a first annual school system-wide STD screening program in high schools in high morbidity areas. The chief executive officer of the Philadelphia School District directed all high schools to participate to avoid stigmatizing any group of schools. In 2003, CDC provided funding for the screening program.

During the first year, the health department presented educational sessions to students in 53 of the city’s 54 public high schools. Voluntary urine-based screening was offered immediately following each presentation and treatment was provided in each school approximately 7-to-10 days after the screening. During the 2004–05 school year, the third year of the program, 16,378 students were tested; of those, 680 or 4.2 percent were positive for chlamydia, gonorrhea or both, a decrease of 21 percent from the 5.3 percent who tested positive in 2002–03.

**Faith- and Community-Based Initiatives**

Faith-based efforts have been a successful approach to reaching minority communities—particularly African-American communities. Local churches bring a level of comfort when they address the rising epidemic that is disproportionately affecting minorities.

Community-based organizations, like faith-based organizations, can provide highly tailored programs to meet the specific needs of the community. Some examples include:

- **Institute for Public Health Faith Collaboration/Interfaith Health Program (IHP)** builds and develops broad networks for learning within and across health and faith systems locally, nationally and globally. Interdisciplinary academic working groups link government, religious organizations, academic institutions, foundations and community partners to confront issues such as teen pregnancy, HIV, elder issues and cancer.

- **The Balm in Gilead** is a nonprofit, nongovernmental organization that brings together more than 17 major church denominations, caucuses, coalitions and independent churches to respond to the AIDS crisis in the African-American community. It has established and continues to develop educational and training programs to meet the needs of African-American churches that strive to become centers for AIDS ministry, education and compassion.

- **The National Latina Health Network** began in 1989 as a group of Latina professionals in public health who wanted a way to involve Latina leaders in HIV prevention. There are currently six regional offices and more than 1,500 members, including health professionals, educators and the media. Several of the programs to promote HIV/AIDS awareness involve peer educators and storytelling—a tradition in Hispanic communities—to spread awareness. A youth advisory group made up of young women ages 16–24 help ensure all materials are age appropriate.

- **The Healing Lodge** is a faith-based ecumenical organization located in Robeson County, N.C., that receives SEE support for syphilis screening. It has been instrumental in providing risk-reduction counseling and drug rehabilitation services for women engaged in high-risk sexual activities. As a result, the rate of infectious syphilis in 2004 in the county was 12.7 per 100,000 people, down from 47 per 100,000 in 2000.
Conclusion

Legislators can join with other groups to address local HIV and STD prevention efforts targeting populations most at risk in their states or communities. While there are many proven HIV and STD prevention strategies, there are also challenges to implementing them, including stigma, privacy concerns and state laws restricting some efforts such as partner notification. Legislators should be aware of STD trends among populations in their communities and the obstacles to people getting prevention and treatment services.

While the federal and state governments play a major role in prevention and treatment efforts, there are many other groups who can play a role. Local health departments, physicians, schools and faith-based organizations can be invited to the table to help plan and implement prevention programs. Legislators can serve as facilitators of these coordinated efforts.
Endnotes


18 Ibid.


HIV/AIDS and STD Prevention Efforts: How Legislators Can Act

State legislators can advance efforts to prevent and control HIV/AIDS and other sexually transmitted diseases (STDs) in a number of ways—from supporting legislative changes to becoming an advocate for the constituents affected by or involved in prevention efforts. Here are eight ways legislators can make a difference in HIV/AIDS and STD prevention.

The Prevention Checklist for State Health Policymakers

Become Informed About State Policies Affecting HIV and STD Prevention

Every state public health department has a state AIDS director and a state director for STD Prevention who is knowledgeable about the laws, regulations and practices that influence how HIV/AIDS and STD cases are reported and how prevention activities are carried out in their state. Centers for Disease Control (CDC) summaries of state-by-state prevention activities and contacts can be obtained at: www.cdc.gov/nchstp/od/stateprofiles/usmap.htm.

One notable activity being implemented in every state is the “Advancing HIV Prevention: New Strategies for a Changing Epidemic” Initiative. In April 2003, CDC, in partnership with other federal agencies, launched this initiative consisting of four keys strategies:

- Make voluntary HIV testing a routine part of medical care.
- Implement new models for diagnosing HIV infections outside medical settings.
- Prevent new infections by working with persons diagnosed with HIV and their partners.
- Further decrease perinatal HIV transmission.

Through your state health department, you can determine how this comprehensive initiative is being implemented in your state.

Reduce Barriers to Screening for HIV Through Legislative or Regulatory Change

Barriers that prevent people from getting tested for HIV, such as written consent requirements before testing and limitations on partner notification, may be modified through regulatory or legislative change. For example:

- Florida SB186 (enacted 2005) allowed rapid testing, testing without written consent of pregnant women and the reporting of HIV-exposed infants after birth.

Make HIV Testing A Routine Part of Medical Care

State health policymakers can support efforts to make HIV testing a part of routine medical care by:

- Working closely with and educating health care providers about the importance of incorporating HIV testing into current services, particularly providers treating patients at high risk of HIV infection;
- Conducting educational and anti-stigma programs to encourage the public to be tested for HIV infection and know their HIV status; and
Working with state correctional facilities to test for and treat HIV infections among inmates. Legislators also can help make screening tests a part of routine medical care through support for policies or legislation that targets special or high-risk populations. For example:

- **New Jersey** HB 164 (proposed 2005) supported insurance coverage for counseling services for pregnant women who test positive for HIV, allowing for follow-up care after testing.
- **California** AB 1142 (enacted in 2005) established a statewide initiative to address the disproportionate impact of HIV/AIDS on the health of African-Americans through coordinated prevention and service provider networks in the state, and to increase the capacity of these service providers.
- To encourage screening of high-risk populations, **Minnesota** HB 1373 (introduced 2005) sought to create and fund an AIDS prevention initiative for African-born Minnesotans, and **Ohio** HB 44 (introduced 2005) proposed creating a minority HIV/AIDS task force to develop a prevention program targeting at-risk groups.

**Require Insurance Coverage for HIV and STD Screening Programs**

Consider expanding Medicaid and state employee health benefit coverage to include screenings and consider requiring private insurers to provide coverage to support CDC’s recommendations for:

- HIV testing for all at-risk populations in the state;
- Prenatal screening of all pregnant women for syphilis, which can have devastating effects on unborn children; and
- Annual chlamydia screening for all sexually active women age 25 and younger to avert pelvic inflammatory disease, which can lead to infertility, ectopic pregnancy and chronic pain. Currently, only three states require coverage—Georgia, Maryland and Tennessee.

**Require Use of Confidential Name-based HIV Reporting If Your State Does Not Have This System**

After a positive HIV diagnosis is made, state and national surveillance systems rely on accurate reporting of positive cases. To enable accurate tracking of affected populations, CDC recommends a confidential name-based surveillance system to report HIV infections. As of June 2006, 44 states and the U.S. territories were using confidential name-based reporting of HIV infection. The remaining state health departments use other methods of reporting.

The Ryan White Comprehensive AIDS Resources Emergency Act (RWCA)—federal legislation which helps meet the needs of those living with HIV/AIDS—requires that by no later than 2007, funding will be determined by the number of HIV cases (not AIDS cases) reported to the CDC. As a result, several states are now considering changing from code-based to name-based HIV case reporting. Name-based HIV reporting provides a more accurate and reliable picture of the epidemic. Because CDC only accepts name-based HIV reporting, states stand to lose funding under RWCA if they fail to adopt these systems.

**Florida** added to its HIV case reporting requirements through 2005 legislation that requires reporting lab results that indicate how far the disease has progressed toward AIDS. It also allows the state to report HIV exposure in newborns. This enables policymakers to have more specific information on who is affected by HIV in their states and to plan appropriate action.

**Remove Legislative and Regulatory Barriers To Expedited Partner Therapy for Treatment of Partners of Patients Diagnosed With Some STDs**

Effective clinical management of patients with treatable STDs requires treatment of the patients’ current sex partners to prevent reinfection and stop further transmission. The standard approach to partner treatment has included clinical evaluation in a health care setting, with either the patient or health care provider alerting partners of their potential exposure. The usual alternative is to advise patients to refer their partners for treatment.

In recent years, research supported by the CDC has evaluated expedited partner therapy (EPT), an approach where partners are treated without an intervening clinical assessment. EPT typically is accomplished by patients delivering either medications or prescriptions to their partners. EPT is permissible in only five states, though it may be possible in as many as 33 additional states with some regulatory or administrative action.
Since 2005, the CDC has strongly encouraged local and state health departments and policymakers interested in STD prevention to work together to resolve the outstanding legal issues and find ways to implement this proven prevention strategy. Some states, such as California, have passed legislation to permit EPT; other states, such as Tennessee, have implemented regulations to permit the practice.

**Assure That Youth Are Educated About HIV/AIDS and STD Prevention**

School districts can authorize schools to provide age-appropriate and medically accurate HIV and STD prevention education as part of comprehensive health education. Districts also can be encouraged to collaborate with parent groups and community organizations on determining the scope and content of curricula. State education departments provide leadership for these efforts by supporting interagency partnerships and curriculum development, and requiring accountability for learning outcomes.

At the local level, legislators can provide leadership for these collaborations, which may include parent organizations, health departments, hospitals, medical providers, community and faith-based organizations, businesses and educational organizations. Some state legislatures have taken specific action to support these efforts:

- In 2004, Michigan strengthened the role of parents in overseeing sexuality education in their children’s schools through parent advisory boards. The Michigan Department of Education developed a parents’ survey for school districts to use to assess opinions. It also provides model curricula for different grade levels and requires the districts to set goals and objectives for student knowledge and skills.4
- In 2004, Washington directed the Departments of Education and Health to develop voluntary guidelines for school districts on sexual health information and disease prevention. Completed in 2005, the guidelines were developed to assure that medically accurate information was included in the curriculum.

**Work Locally To Keep HIV/AIDS and STD Prevention On Your State’s Public Health Agenda**

In addition to legislative and regulatory efforts, state legislators also can take important leadership roles in keeping HIV/AIDS and STD prevention issues on their state’s public health agenda. For example, legislators can:

- **Use their power to convene.** As elected public officials, state legislators are positioned to call on government, business and community leaders to work together to bring attention to an issue and to search for common solutions. State legislators can call for committee hearings on prevention efforts and hold town hall meetings on the issue. By speaking publicly about the importance of HIV/AIDS and STD prevention, they can help advance awareness of and support for prevention efforts.
- **Help neighborhoods and communities mobilize resources.** In any local community, state legislators can help to build a coalition of community support for prevention efforts by bringing together neighborhood leaders, health care providers, educators, faith-based organizations and public officials.7

Working with individuals who have been infected with HIV or other STDs is important when planning community-based programs to meet their needs and when enlisting their cooperation in prevention efforts. Programs need to be culturally appropriate for those groups disproportionately affected.

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**Key People to Include in a Coalition to Support Prevention**

When working with community Organizations, it is important to include all the relevant organizations, keep the discussion progressing toward a specific outcome and have a timetable to complete the work and determine next steps.

Key participants in a prevention coalition include:

- Local health department staff and state health department program experts who will know the number of affected individuals in the community and the populations at high risk for contracting and transmitting the diseases.
- Representatives from community-based HIV and STD prevention programs, which provide educational and testing/counseling services, or those that are directed to particular segments of the community, such as parents of African-American youth.
- Private health care providers, such as family physicians and obstetrician-gynecologists, psychotherapists and counselors, dentists and social workers who identify and report cases of HIV or STD infection.
- Representatives of local drug treatment centers, who have experience reaching out to drug users.
- Instructors or administrators of school and youth-based programs who are sensitive to local concerns about sexual risk behaviors among youth.
- Faith-based leaders, who are effective in reaching minority communities in prevention efforts and can bring a level of comfort to those unaccustomed to addressing the rising epidemic that disproportionately affects minority communities.
Summary

Legislators can have a positive impact in the prevention and control of HIV/AIDS and other STDs. They can educate others about the current issues surrounding HIV and STDs, help form task forces or committees to identify solutions and draft legislation to address the issues. Although the problems presented by these diseases are serious, approaches such as expedited partner therapy, routine screening and basic STD prevention programs can help. Legislators must simply make an effort to help raise awareness, focus scarce resources and lead local and state community partnerships.

Endnotes

2 Ibid.
Talking Points: HIV/AIDS and STD Prevention

Hundreds of thousands of Americans are diagnosed each year with an STD.

- Chlamydia infections reported to the Centers for Disease Control and Prevention (CDC) rose to more than 929,000 cases in 2004. This was an almost 6 percent increase from 2003.
- The number of primary and secondary syphilis infections has increased yearly since 2000, with almost 8,000 cases reported in 2004, an increase of 11 percent from 2003. Early treatment of these cases can save lives.
- The number of reported cases of gonorrhea dropped in 2004 to its lowest level ever—about 330,000 cases.

Although sustained treatment efforts over the past 20 years have reduced the number of AIDS cases and deaths, HIV and AIDS are still major problems in the United States.

- CDC estimates that currently 1 to 1.2 million people in the U.S. are infected with HIV, the virus that causes AIDS.
- Although the number of people dying from AIDS has decreased due to new drug therapies, the number of people being infected yearly with HIV—an estimated 40,000—has remained stable for more than a decade despite ongoing prevention efforts.

Communities of color are the hardest hit by HIV/AIDS and other STDs.

- African-Americans accounted for 50 percent of all new HIV/AIDS diagnoses in 2004, with African-American women and youth increasingly at risk of infection.
- In 2002, HIV/AIDS was the number one cause of death for African-American women age 25–34 years.
- In 2001, African-American youth were the largest group of young people affected by HIV, accounting for 56 percent of all HIV infections ever reported among the youth age group.
- In 2004, compared to whites, African-Americans were: six times more likely to have primary or secondary syphilis; eight times more likely to have chlamydia; 16 times more likely to have congenital syphilis; and 19 times more likely to have gonorrhea.
- In 2004, compared to whites, Hispanics were: twice as likely to have primary or secondary syphilis; twice as likely to have contracted gonorrhea; three times more likely to have chlamydia; and nine times more likely to have congenital syphilis.

HIV/AIDS and other STDs have taken a heavy toll on those who are infected and state governments, which are bearing part of the costs for treatment.

- More than 500,000 people have died from AIDS through 2004.
- If left untreated in pregnant women, syphilis results in the death of the fetus in up to 40 percent of cases.
- The direct medical costs of HIV/AIDS and STDs are estimated at $13 billion annually. This total does not include lost wages and productivity, out-of-pocket expenses or the costs associated with transmission of diseases to infants.
What State Legislators Can Do:

**Advance Prevention Efforts Through Legislation and Regulation**

- Reduce barriers to screening for HIV, such as written consent requirements before testing and limitations on partner notification stipulated by state laws and regulations.
- Support STD prevention activities, such as annual chlamydia screening for sexually active women under age 26.
- Support HIV testing as part of routine medical care through policy or legislation.
- Provide insurance coverage for HIV and STD screening through Medicaid and state employee health benefits, and consider requiring private insurers to offer coverage.
- Explore changing to confidential name-based reporting of HIV cases if your state is not already doing so. Although this is recommended by the CDC, only 44 states were using this system as of June 2006. States could potentially receive reduced funding in Ryan White CARE resources in 2007 if they are not using an integrated name-based HIV/AIDS reporting system.
- Support expedited partner therapy for STD treatment as recommended by CDC through adjustments to practices, regulations or laws, depending on the specific barriers present in your state.
- Support state education department tools for HIV/AIDS and STD prevention education through collaboration with school districts, parent organizations and community groups.

**Take On Community Leadership Roles to Support Prevention**

- **Use the power to convene.** State legislators are positioned to call on government, business and community leaders to work together to bring attention to an issue and search for common solutions. State legislators can call for committee hearings on prevention efforts and hold town hall meetings. By speaking publicly about the importance of HIV/AIDS and STD prevention, they can help advance awareness of and support for prevention efforts.
- **Help neighborhoods and communities by mobilizing resources.** In any local community, state legislators can help to build a coalition of community support for prevention efforts by bringing together neighborhood leaders, health care providers, educators, faith-based organizations and public officials.
Resource List

Centers for Disease Control and Prevention Resources

National Center for HIV, STD and TB Prevention (NCHSTP), Centers for Disease Control and Prevention
www.cdc.gov/nchstp/od/nchstp.html

The mission of the Division of HIV/AIDS Prevention at the Centers for Disease Control and Prevention is to prevent HIV infection and reduce the incidence of HIV-related illness and death, in collaboration with community, state and national partners. The Division of STD Prevention provides national leadership through research, policy development and support of effective services to prevent sexually transmitted diseases and their complications.

- **State profiles:** To view a profile of your state, which includes the number of STD and AIDS cases, how your state ranks when compared to the rest of the country, programs funded by the CDC and who to contact for more information, visit: www.cdc.gov/nchstp/od/stateprofiles/usmap.htm.

National Network of STD/HIV Prevention Training Centers
http://depts.washington.edu/nnptc/

The National Network of STD/HIV Prevention Training Centers (PTCs) is a CDC-funded group of regional centers created in partnership with health departments and universities. The PTCs are dedicated to increasing the knowledge and skills of health professionals in the areas of sexual and reproductive health.

National Prevention Information Network (NPIN)
www.cdcnpin.org/scripts/index.asp

The National Prevention Information Network (NPIN) is a service of the CDC and serves as the nation’s largest collection of information and resources on HIV, STD and TB prevention.

Other Health and Human Services Resources

Health Resources and Services Administration (HRSA)
www.hrsa.gov

The HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA) was formed in August 1997 to consolidate all programs funded under the Ryan White Comprehensive AIDS Resources Emergency Act. This program funds treatment services for HIV/AIDS patients in the states. Information on state agencies benefiting from funding, examples of funding opportunities and more is available at: www.hab.hrsa.gov/tools/progressreport/ and www.hrsa.gov/grants/preview.
The Leadership Campaign on AIDS
www.osophs.dhhs.gov/aids/tlcapage1.html

In 1999, the Office of HIV/AIDS Policy in the U.S. Department of Health and Human Services launched The Leadership Campaign on AIDS (TLCA), which works with both private sector partners and federal agencies to support the fight against HIV/AIDS in communities of color.

National Institutes of Health-National Institutes of Allergy and Infectious Diseases (NIAID)
www.niaid.nih.gov

NIAID supports comprehensive clinical research to evaluate treatment and prevention strategies for HIV/AIDS and its associated complications and co-infections such as STDs.

Office on Minority Health Resource Center (OMHRC)
www.omhrc.gov

The mission of the Office of Minority Health is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that eliminate health disparities. It advises the secretary of the U.S. Department of Health and Human Services and the Office of Public Health and Science on activities affecting American Indians and Alaska Natives, Asian Americans, Blacks/African-Americans, Hispanics/Latinos, Native Hawaiians and other Pacific Islanders.

Substance Abuse & Mental Health Services Administration (SAMHSA)
www.samhsa.gov

SAMHSA’s mission is to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness. SAMHSA addresses increased access to health care through SAMHSA’s Rapid HIV Testing Initiative (RHTI); the Mental Health HIV Service Collaborative (MHHSC) Program; and targeted capacity expansion initiatives for Substance Abuse Prevention (SAP) and HIV prevention in minority communities.
National Professional Organizations

American Social Health Association (ASHA)
www.ashastd.org

Since 1914, the American Social Health Association has dedicated itself to improving the health of individuals, families and communities, with a focus on preventing sexually transmitted diseases and infections and their harmful consequences.

Association of State and Territorial Health Officials (ASTHO)
www.astho.org

The Association of State and Territorial Health Officials (ASTHO) is the national nonprofit organization representing state and territorial public health agencies of the United States, U.S. territories and the District of Columbia. ASTHO is dedicated to formulating and influencing sound public health policy and assuring excellence in state-based public health practice.

National Coalition of STD Directors
www.ncsddc.org

The National Coalition of STD Directors, based in Washington, D.C., represents the 65 directors of public health sexually transmitted disease prevention programs in states, large cities/ counties and territories of the United States. The group’s goal is to make STD programs stronger by advocating effective policies, strategies and sufficient resources and by increasing awareness of their medical and social impact.

National Alliance of State and Territorial AIDS Directors (NASTAD)
www.nastad.org

NASTAD is a nonprofit national association of state health department HIV/AIDS program directors based in Washington, D.C., that provides HIV/AIDS health care, prevention, education and support services programs. It is funded by state and federal governments.

National Association of County and City Health Officials (NACCHO)
www.naccho.org

NACCHO is the national organization based in Washington, D.C., that represents local public health agencies. It works to support efforts that protect and improve the health of all people and all communities. It offers a Model Practice Database, which is a searchable collection of practices across public health areas, allows professionals to learn what works and to ensure that resources are used wisely on effective programs.

Other Organizations

The Ark of Refuge: HIV/AIDS Ministry
www.arkofrefuge.org

The Ark of Refuge, based in California, is a program targeting high-risk groups designed for promoting AIDS education in the African-American community. An endeavor of the City of Refuge Community Church, United Church of Christ, it was developed as an AIDS service organization that recognizes the role of spirituality in the African-American community and the necessity of sustaining hope for everyone affected by the HIV epidemic. Its goal is to reduce the incidence of HIV infection among African-Americans by empowering church leaders to meet the HIV/AIDS prevention needs of their members.
The Balm In Gilead
www.balminglead.org/home.asp

The Balm In Gilead is a nonprofit, nongovernmental organization based in New York that brings together more than 17 major church denominations, caucuses, coalitions and independent churches to respond to the AIDS crisis in the black community. It has established and continues to develop educational and training programs to meet the needs of black churches that strive to become compassionate centers for AIDS ministry and education.

Black AIDS Institute
www.blackaids.org

The Black AIDS Institute, based in California, is the first black HIV/AIDS policy center dedicated to reducing HIV/AIDS health disparities by mobilizing black institutions and individuals in efforts to confront the epidemic in their communities.

Institute for Youth Development
www.youthdevelopment.org

The Institute for Youth Development (IYD) is a nonpartisan, nonprofit organization based in Washington, D.C., dedicated to ensuring the best possible future for America’s children by promoting positive choices and behaviors. IYD was awarded a grant from the federal U.S. Department of Health and Human Services under the Compassion Capital Fund to assist faith-based and community organizations in competing for federal grants.

Kaiser Family Foundation
www.kff.org

The Henry J. Kaiser Family Foundation, based in Washington, D.C., is a nonprofit, privately operated foundation focusing on the major health care issues facing the nation. The foundation sponsors publications and programs on issues such as HIV Policy Program, the Race/Ethnicity and Health Care Program and the National AIDS Drug Assistance Program Monitoring.

National Minorities AIDS Council (NMAC)
www.nmac.org

The National Minority AIDS Council is a national organization based in Washington, D.C., that is dedicated to developing leadership within the communities of color to address the challenges of HIV/AIDS.
CSG’s Healthy States Initiative

The Council of State Governments’ (CSG) Healthy States Initiative is designed to help state leaders make informed decisions on public issues. The enterprise brings together state legislators, officials from the Centers for Disease Control and Prevention, state health department officials, and public health experts to share information, analyze trends, identify innovative responses, and provide expert advice on public health issues. CSG’s partners in the initiative are the National Black Caucus of State Legislators and the National Hispanic Caucus of State Legislators.

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