NATIONAL HIV
PREVENTION INVENTORY

NHPI

# 2013 Funding Survey Report

NASTAD™
NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

# Table of Contents

# Executive Summary

In 2009, the National Alliance of State and Territorial AIDS Directors (NASTAD) and the Kaiser Family Foundation released the National HIV Prevention Inventory (NHPI), a first-ever in-depth analysis of health department-led HIV prevention programs in the United States. The NHPI provided a baseline understanding for how HIV prevention is organized and delivered across the country and provided detailed information on how services were funded.

Since the release of the first NHPI, several circumstances have redefined the focus of domestic HIV prevention efforts, specifically the release of the White House National HIV/AIDS Strategy (NHAS), ongoing implementation of the Affordable Care Act (ACA) and the updated priorities set by the Centers for Disease Control and Prevention Division of HIV/AIDS Prevention (CDC-DHAP). This updated report on HIV prevention funding builds on the 2009 NHPI report and explores funding changes experienced by health department HIV prevention programs over the last five years.

## Key Findings

- Funding, including the way it is allocated, is a major driver of changes experienced by health department HIV prevention programs over the last five years.
- State and local health departments continue to rely almost exclusively on governmental funding to support HIV prevention activities and services in their jurisdictions. The primary source of HIV prevention funding comes from the CDC.
- CDC implemented a new five-year cooperative agreement in January 2012 based on its landmark FOA, PS12-1201. When taking total CDC 12-1201 funding into account, 30 jurisdictions saw increases in funding. Twenty-nine (29) jurisdictions saw decreases.
- When considering core HIV prevention funding only (i.e., a jurisdiction's base award), only 20 jurisdictions saw increases in funding, ranging from $16,000 to $2.8 million. Thirty-nine saw decreases, ranging from $19,000 to $6.1 million.
- State funding accounted for one-third of total HIV prevention funds in both 2007 and 2012. The total number of jurisdictions that did not provide state/ local funding for HIV prevention increased from 14 to 23 from 2007 to 2012. Eight health departments lost all state funding. Only five health departments saw an increase in state HIV prevention funding between 2007 and 2012.
- Implementation of the NHAS has had a clear impact on the distribution of federal funding to state and local health departments, as well as an impact on the way health departments allocate their own resources. Ninety-six percent of health departments reported that the NHAS was the primary factor in funding allocation decisions.

- Since 2007, dramatic shifts in the way health departments allocate funding locally have occurred. In 2007, 34% of funding was allocated to evidence-based behavioral interventions. In 2012, only 11% of funding went towards these activities.
- Treatment as prevention accounted for the bulk of HIV prevention activities and services funded by state and local health departments in 2012, an increase from 26% to 50% of total funds allocated to these services.
- Three-quarters of health departments reported scaling up programming for persons living with HIV. Half of respondents scaled up programming for Black gay and bisexual men, and 40% scaled up services for White and Hispanic gay and bisexual men.
- Funding decreases have driven health departments to make tough choices around cutting programs for low prevalence populations, such as rural communities. More than a third of prevention programs reported providing less funding for population-based community programs in 2012.

## Conclusion

Recent federal FOAs[1] provide a glimpse into future federal funding priorities for HIV prevention. In the short term, federal funding for categorical HIV prevention programs will likely remain flat, at best. The resources that are available will continue to be directed to jurisdictions with high disease burden and to activities and services that support treatment as prevention activities. For all health departments, but in particular for those receiving few resources, cross-program collaboration and the development of new partnerships will be important. As an AIDS Director from a low incidence jurisdiction put it, "We will never have enough resources. We have to work well with others."

In the longer term, ongoing implementation of the ACA will result in escalating investments in the health care delivery system, including institutions and payers that will take more responsibility for the provision of preventive services, including HIV prevention. As financing for and service delivery within these systems increases, the role of public health agencies in the broader health care continuum will change. Moving forward, health department HIV prevention programs must position themselves to identify gaps in the health care system and implement activities, services and policy change initiatives to fill these gaps. As a health department leader from the Midwest summarized, "The HIV

[1]Other recent federal FOAs include CDC's Enhanced Comprehensive HIV Prevention Planning (ECHPP) and Care and Prevention in the United States (CAPUS), and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Minority AIDS Initiative Targeted Capacity Expansion (MAI TCE).These funding opportunities targeted jurisdictions with a high number of cases and disproportionate burdens of HIV. Funding from these FOAs is not included in this report. For more information about these FOAs, please visit www.cdc.gov and www.samhsa.gov. The 2009 Ryan White HIV/AIDS Treatment Extension Act Legislation administered by the Health Resources and Services Administration (HRSA) includes some activities traditionally associated with prevention programs, the funding of which is also not included here.

response must come from all of us (all public and private health care agencies). It's not just about HIV anymore."

## Introduction

In 2009, the National Alliance of State and Territorial AIDS Directors (NASTAD) and the Kaiser Family Foundation released the National HIV Prevention Inventory (NHPI), a first-ever in-depth analysis of health department-led HIV prevention programs in the United States. The NHPI provided a baseline understanding for how HIV prevention is organized and delivered across the country and provided detailed information on how services were funded. Information from this report was used by policymakers, public health officials, community organizations and other stakeholders to better understand domestic HIV prevention efforts and the role played by health departments in their delivery.

Since the release of the first NHPI, several circumstances have redefined the focus of domestic HIV prevention efforts, specifically the release of the White House National HIV/AIDS Strategy (NHAS), ongoing implementation of the Affordable Care Act (ACA) and the updated priorities set by the Centers for Disease Control and Prevention Division of HIV/AIDS Prevention (CDC-DHAP). The national recession and ongoing economic concerns in many states and localities have influenced health departments' ability to provide and lead HIV prevention efforts. Additionally, the availability of new strategies, such as treatment as prevention, and technologies, such as electronic health records, continue to change the prevention landscape.

This updated report on HIV prevention funding builds on the 2009 NHPI report and explores funding changes experienced by health department HIV prevention programs over the last five years. Specifically, it provides a comparison of funding in 2007 and 2012, describes current resource allocation criteria and details challenges and unmet needs resulting from funding decreases and efforts to scale up or scale back activities and services given funding shifts.

## Methodology

All state and local jurisdictions and U.S. territories that receive direct federal funding from CDC-DHAP for HIV prevention were surveyed by NASTAD in late 2012. This includes all 50 states, the District of Columbia, Puerto Rico, U.S. Virgin Islands and the eight directly-funded localities (See Appendix One). The survey was developed by NASTAD in consultation with NASTAD's Prevention Advisory Committee (PAC), which consists of representatives from health departments around the country. The survey was designed to obtain an inventory of HIV prevention funding and other relevant information. The survey instrument consisted of eleven, close-ended multiple-choice questions (see Appendix Four). After the survey field period, follow up was conducted with non-responders. A total

of 47 health departments responded to the survey including 40 states, six directly-funded jurisdictions and one territory. All data were reviewed for completeness and accuracy. Data are from FY2012, unless otherwise noted. All data are reported in aggregate.

To capture the nuances of HIV prevention funding decisions, NASTAD conducted eight qualitative interviews with HIV prevention leadership at state and local health departments. The participants came from high, moderate and low incidence states and localities. Qualitative interview questions were open-ended, allowing participants to tell the story of their funding processes, their challenges and their successes with implementing HIV prevention. Qualitative responses are included in the narrative of this report.

## The Domestic HIV Prevention Landscape

In the United States, an estimated 50,000 people become infected with HIV each year[2]. Certain populations bear the brunt of the impact, particularly gay and bisexual men of all races/ethnicities and Black Americans. Similarly, certain areas of the U.S. are disproportionately impacted by HIV, including urban centers and the Southeastern U.S.

These trends underscore the continuing importance of HIV prevention. While the CDC plays the central, federal role in the nation's HIV prevention response, much of what is considered "HIV prevention" is decentralized to and carried out by state and local health departments, who have primary responsibility for coordinating and delivering HIV prevention services, as they do for public health activities more generally in the U.S.

Since the 2009 NHPI report, several circumstances have redefined the focus of domestic HIV prevention efforts. Taken collectively, these influences have served to shift the distribution of resources and implementation of HIV prevention in the U.S.

- ***The National HIV/AIDS Strategy (NHAS)*** – The NHAS changed HIV prevention activities and services by calling for resources to be targeted to communities where HIV is most heavily concentrated. The NHAS shifted the federal government's response by charging specific federal agencies with developing operational plans that promote increased collaboration across these agencies and a more coordinated national response to the HIV epidemic.

- ***The Affordable Care Act*** **(ACA)** – The ACA significantly changes health care in the U.S. through increasing access to health insurance coverage for Americans. The ACA requires coverage of preventive services, including certain HIV prevention

[2] Centers for Disease Control and Prevention. HIV Surveillance Report, 2011; Vol. 23. http://www.cdc.gov/hiv/topics/surveillance/resources/reports/ Published February 2013. Accessed on March 4, 2013.

services, such as HIV testing and HIV/STD counseling and screening for women. The ACA established the Prevention and Public Health Fund that allocates billions of dollars to prevention initiatives and programs each year. The ACA also invests heavily in community health centers, which provide primary health care to tens of millions of Americans.

- ***CDC's New Funding Strategies and High Impact Prevention*** – The 2011 PS12-1201 funding opportunity announcement (FOA) and accompanying High Impact Prevention (HIP) strategy calls for a focus on four core program activities for health departments: HIV testing and linkage to care, prevention with positives, condom distribution and policy initiatives. Funding provided through the FOA expands the availability of HIV testing and innovative prevention projects and re-directs funds away from health education/risk reduction activities for HIV-negative persons. Additional funding announcements also align with the NHAS to redistribute resources to activities that are most likely to reduce HIV incidence in the U.S.

- ***The Great Recession*** – HIV prevention funding has not escaped the economic recession. Systematic cuts to health department programs from federal and state budgets, federal sequestration and internal hiring and wage freezes have occurred consistently across the U.S. While the country as a whole is beginning to recover, the state and local governmental workforce has seen significant contraction since 2009.

- ***Advancements in Science*** – Treatment advances continue to improve treatment outcomes for persons living with HIV. In 2011, researchers announced that HIV treatment also protects HIV-negative partners of persons living with HIV disease, reducing transmission by 96 %[3]. "Treatment as prevention" offers HIV prevention programs an important new tool to use in their efforts to reduce HIV incidence.

- ***The HIV Treatment Cascade***[4] – In 2011, the HIV Treatment Cascade was put forth as a useful tool to monitor population-level HIV prevention and treatment outcomes and progress towards achieving NHAS goals. Federal agencies have reacted to the Treatment Cascade by issuing funding opportunities or developing policies to better support HIV programming that impacts HIV prevention, such as Early Identification of Individuals with HIV/AIDS (EIIHA) requirements from the HHS Health Resources and Services Administration (HRSA) and the Minority AIDS Initiative-Targeted Capacity Expansion (MAI-TCE) grants from the HHS Substance Abuse and Mental Health Services Administration (SAMHSA).

[3] Cohen MS, Chen YQ, McCauley M, Gamble T, Hosseinipour MC, Kumarasamy N, Hakim J, Kumwenda J, Grinsztejn B, Pilotto JH, Godbole SV, Mehendale S, Chariyalertsak S, Santos BR, Mayer KH, Hoffman IF, Eshleman SH, Piwowar-Manning E, Wang L, Makhema J, et al. Prevention of HIV-1 infection with early antiretroviral therapy. *NEJM.*2011, 365: 493-505.
[4] Gardner EM, McLees MP, Steiner JF, del Rio C, Burman WJ. The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection. Clinical Infectious Diseases. 2011, 52 (6): 793-800.

Persistent challenges to HIV prevention exist. HIV stigma and discrimination associated with certain behaviors, gender, race/ethnicity and sexual identity continue to impede the success of HIV prevention efforts. The reinstatement of the federal ban on funding for syringe exchange exemplifies just one policy roadblock to delivering proven, effective HIV prevention programs.

# Findings

## *PREVENTION FUNDING*

Health departments receive most funding for HIV prevention from local, state and federal coffers. While the federal government is the primary funding source for HIV prevention, state and local resources continue to make up a significant share, nearly one-third of total funding. As in 2007, state/local funding far exceeds federal allocation in some jurisdictions.

The CDC's funding opportunity announcement (FOA) PS12-1201 and associated cooperative agreements reallocated federal domestic HIV prevention funding to better match resources with epidemic burden. States and localities where the HIV epidemic is most heavily concentrated, particularly large urban centers and in the South, saw increased funding allocations. Low prevalence health department HIV prevention programs received significantly less funding than five years ago.

Given the priorities identified by the NHAS, prevention leaders across the U.S. anticipated the CDC's funding changes and generally support the new direction, with a few caveats. The timing and size of funding cuts have created a unique set of challenges for states receiving less funding. States gaining funding also face challenges related to scaling up service delivery and creating necessary infrastructure and capacity to implement successful programs.

## FY2012 CDC HIV Prevention Funding (PS12-1201)[5]

CDC implemented a new five-year cooperative agreement funding cycle in January 2012. New health department cooperative agreements were based on requirements detailed in CDC's FOA, PS12-1201, which made funding available in three categories. Category A provided funding for core health department HIV prevention programs. All health departments received Category A funding. Category B provided funding for expanded HIV testing initiatives targeting disproportionately affected population groups. Eligibility for Category B funding was limited to jurisdictions with at least 3,000 prevalent HIV cases

[5] Quantitative findings include only CDC PS12-1201 (Categories A, B and C) and state / local funding. Because data are incomplete, low cost extension, carry forward, special federal funding (CAPUS, ECHPP, PCSI, SAMHSA, HRSA) funding could not be included.

among Blacks and Hispanics as of year-end 2008; 34 jurisdictions received Category B funding. Category C provided funding for demonstration projects to implement and evaluate innovative high-impact prevention strategies. Category C funding was competitive; 30 jurisdictions received Category C funding. Two additional jurisdictions were funded by CDC through PS12-1201.

Thirty jurisdictions saw increases in CDC cooperative agreement funding between 2007 and 2012[6]. Of jurisdictions seeing an increase, twelve were in the South, seven in the West, six in the Midwest and five in the Northeast. Seven were directly funded local health departments. Stratifying jurisdictions by HIV prevalence, nine were high-prevalence states, seven were high-to-moderate prevalence, one was moderate prevalence and six were low prevalence. (See Appendix One for a description of geographic regions and prevalence categories.)

Twenty-nine (29) jurisdictions saw decreases in their CDC cooperative agreement funding between 2007 and 2012. Of those seeing a decrease, eight were in the South, eight in the West, seven in the Midwest and six in the Northeast. Stratifying jurisdictions by HIV prevalence, one was a directly-funded local health department, five were high prevalence, three were high-to-moderate prevalence, eight were moderate prevalence and twelve were low prevalence.

Figure one provides a summary of funding increases/decreases by geographic region between 2007 and 2012. Figure two provides a summary of funding increases/decreases by prevalence category between 2007 and 2012.

[6] Analysis compares CDC PS 12-1201 Comprehensive HIV Prevention Programs for Health Departments, all categories, with CDC PS 04-012 Core HIV Prevention Projects and CDC PS07-768 Expanded and Integrated HIV Testing for Populations Disproportionately Impacted.

**Figure 1.**

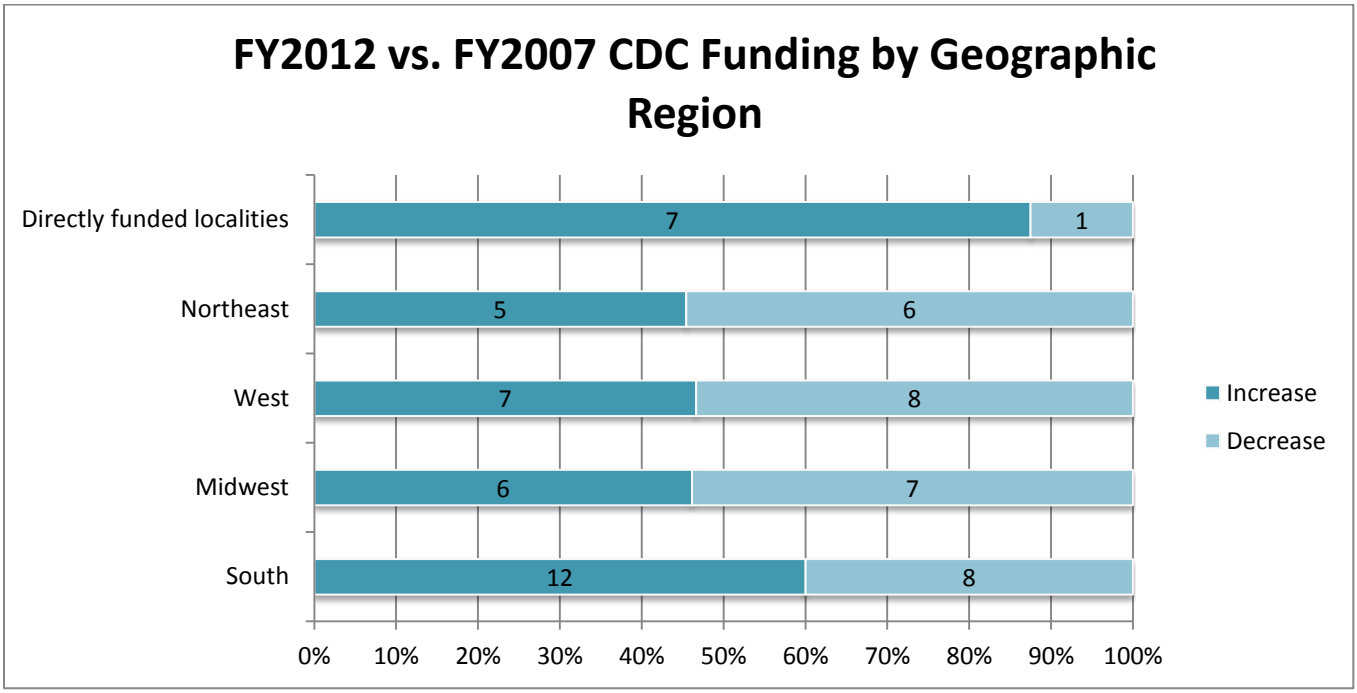
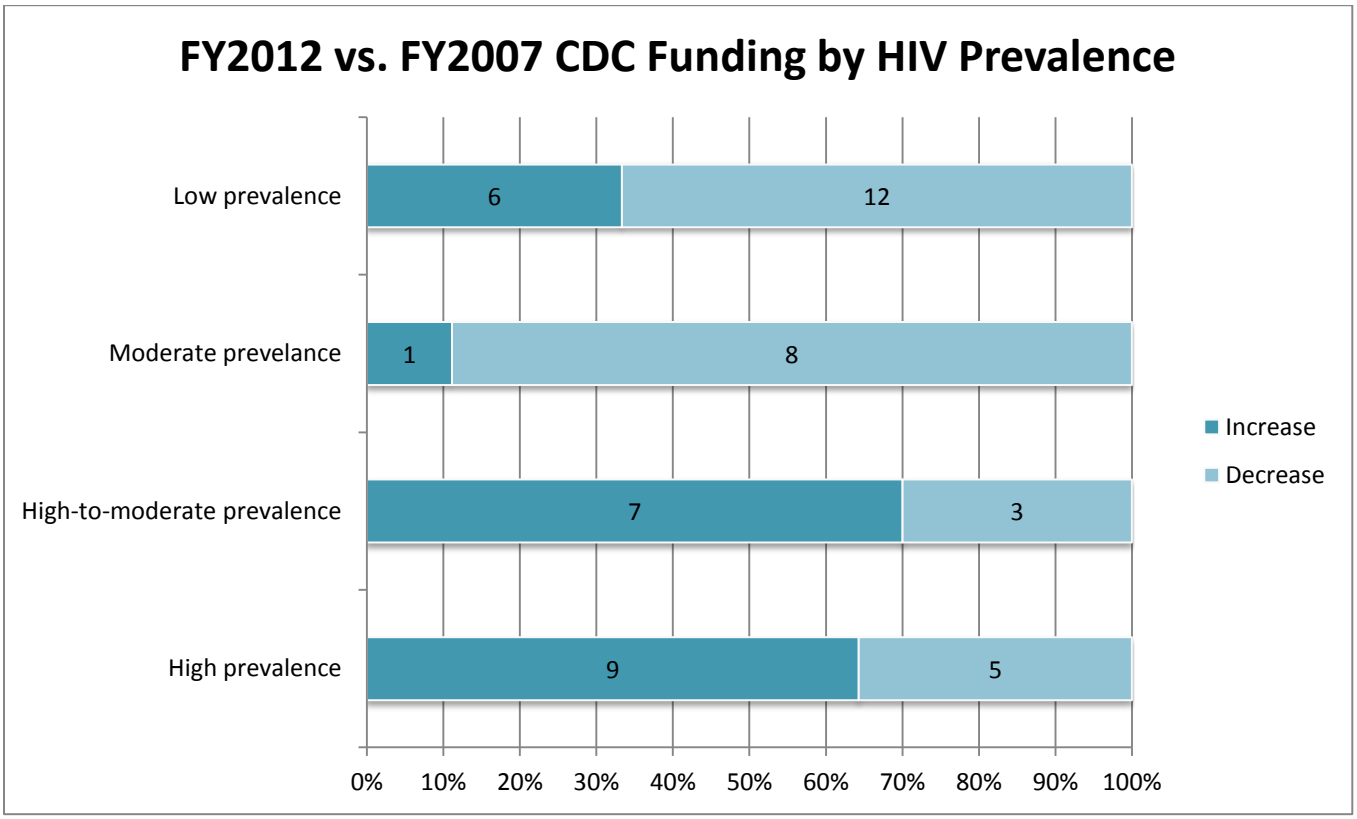



**Figure 2.**



PS12-1201 Category B and C awards made a significant difference in total CDC funding received by jurisdictions. Without accounting for Category C funding, only 21 jurisdictions saw increases in their CDC cooperative agreement funding between 2007 and 2012; 38 saw funding decreases.[7]

Without accounting for Categories B and C funding, only 20 jurisdictions saw increases in their CDC cooperative agreement funding between 2007 and 2012; 39 saw decreases.[8] Of jurisdictions seeing an increase in core HIV prevention funding, 12 were in the South, four were in the Midwest, two were in the Northeast and two were in the West. Five of the jurisdictions seeing an increase in core CDC cooperative agreement funding were directly-funded local health departments. Stratifying these jurisdictions by HIV prevalence, six were high prevalence, seven were high-to-moderate prevalence and two were low-prevalence jurisdictions. Increases in core CDC funding ranged from $16,000 to $2.8 million. Decreases in core CDC funding ranged from $19,000 to $6.1 million. Table one provides a summary of percentage change in CDC funding between 2007 and 2012.

**Table 1. Comparison of 2007 to 2012 CDC Funding Totals**

| Percentage Change in CDC Funding, 2007 vs. 2012 | Number of Jurisdictions (PS12-1201 Parts A, B and C)[4] (n = 59) | Number of Jurisdictions (PS12-1201 Parts A and B only)[5] (n = 59) | Number of Jurisdictions (PS12-1201 Part A only)[6] (n = 59) |
|---|---|---|---|
| **Greater than 25% increase** | 6 | 3 | 3 |
| **11% to 25% increase** | 12 | 9 | 5 |
| **0% to 10% increase** | 12 | 9 | 12 |
| **1% to 10% decrease** | 14 | 11 | 9 |
| **11% to 25% decrease** | 8 | 15 | 19 |
| **Greater than 25% decrease** | 7 | 12 | 11 |

Key informant interviews shed light on the contrasting contexts in which health departments found themselves based on increases and decreases in CDC funding. Health

[7] Analysis compares CDC PS 12-1201 Comprehensive HIV Prevention Programs for Health Departments, Categories A and B only, with CDC PS 04-012 Core HIV Prevention Projects and CDC PS07-768 Expanded and Integrated HIV Testing for Populations Disproportionately Impacted.
[8] Analysis compares CDC PS 12-1201 Comprehensive HIV Prevention Programs for Health Departments, Category A only, with CDC PS 04-012 Core HIV Prevention Projects.

department leaders in jurisdictions that lost funds feared the elimination of basic HIV prevention services for vast geographic areas. "It has been very challenging for us when we look at how to provide a very basic service such as HIV testing to people who need it," commented a health department official from low-prevalence rural state. Leaders in these states also noted that they lack staff to meet existing requirements due to contract cuts and constraints on hiring. Because of challenges associated with CDC's reallocation of resources under PS12-1201, these leaders were concerned they would not be able to fully implement CDC's High Impact Prevention due to insufficient funding.

In contrast, health departments that gained resources through PS12-1201 experienced a significant expansion of administrative requirements. Some of these health departments were struggling with existing capacity and infrastructure and found it difficult to develop an appropriate work force.

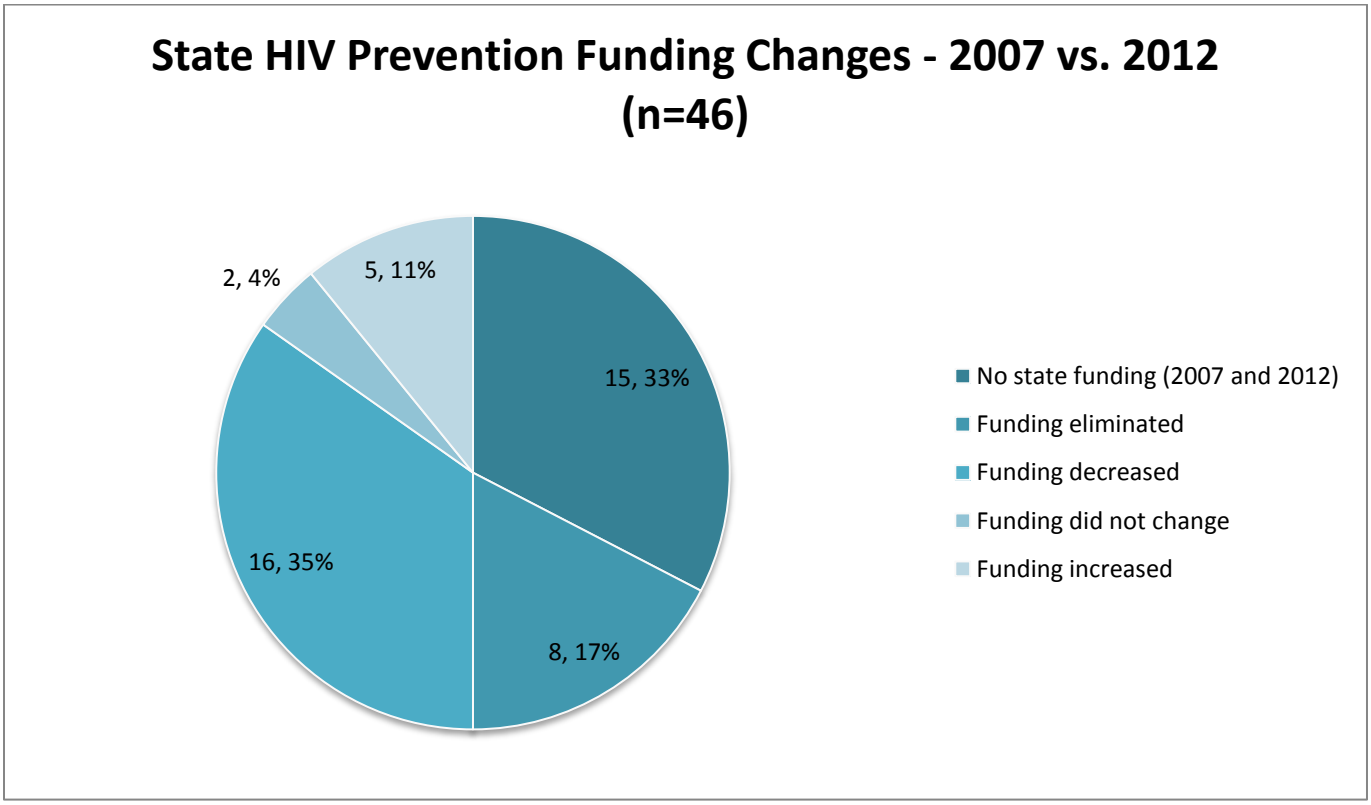
## FY2012 State Funding

State HIV prevention funding often provides health department HIV prevention programs more freedom to implement strategic local responses to the HIV epidemic, deploying resources according to state-identified needs. While still a significant share of total health department HIV prevention funding, the number of states contributing funding to HIV prevention programs decreased between 2007 and 2012.

In 2007, 14 states provided no funding to health departments for HIV prevention. In 2012, 23 states provided no funding (n=46). Eight health departments lost all state funding between 2007 and 2012; four of these were directly-funded localities. State contributions to HIV prevention programs decreased in an additional 16 jurisdictions, ranging from losses of $2,000 to $10 million (mean $2 million, median $700,000), between 2007 and 2012. Fifteen of the 24 jurisdictions seeing state funding reductions were high-to-moderate prevalence, high prevalence or directly-funded cities, jurisdictions with the greatest epidemic burden.

Five health departments saw an increase in state HIV prevention funding between 2007 and 2012, ranging from $55,000 to $15 million (mean $4 million, median $1 million); three of these were high-prevalence states. Two health departments saw no change in state funding contributions. Figure three provides a summary of state-allocated HIV prevention funding between 2007 and 2012.

**Figure 3.**




While the number of states that contribute funding to health department HIV prevention programs decreased in the last five years, state funds remained an important part of HIV prevention budgets in 2012. As in 2007, state funding contributions in 2012 represented nearly one-third of total HIV prevention funding in U.S. health department HIV prevention programs.

Across all funding sources, health departments relied almost exclusively on governmental funding (including federal, state and local resources) to support HIV prevention programs. Little evidence suggested health departments have made funding diversification a priority.

## Other Federal Funding Sources

FOAs released by federal agencies other than CDC have added a layer of complexity to the prevention landscape, shifting resources to innovative activities and projects of particular relevance to specific federal partners. The new funding streams have helped some health departments navigate through challenging economic times. With this funding, some health departments have created new HIV prevention initiatives to strengthen HIV case finding, linkage to care and retention in care activities; to address HIV-related co-morbidities, such as substance use and mental health counseling; and to lead transition planning for local community-based partners.

While new funding opportunities have increased the availability of resources for HIV prevention programs, health departments reported some challenges with the new funding streams, including overlapping activities and oversight, increased requirements and reporting burden and inconsistent performance indicators. For example, health department cooperative agreements through the HRSA Ryan White Program include *Early Identification of Individuals with HIV/AIDS*, a set of activities nearly identical to activities required by CDC HIV prevention cooperative agreements. Funded jurisdictions were required to report data to both federal funders on nearly identical activities.

## *FUNDING ALLOCATION*

Health departments used a range of criteria to allocate HIV prevention resources within their jurisdictions. More than three-quarters of health departments considered the NHAS, CDC grant requirements (including PS12-1201), recommendations from the jurisdiction's HIV planning group and trends in new HIV cases when making funding decisions. Few jurisdictions were guided by bureaucratic, administrative and/or legislative directives for resource allocation; less than a quarter of health departments reported these as criteria for allocation decisions (n=47). About one-third of jurisdictions considered historic funding patterns in their allocation methodologies. Table two provides a summary of resource allocation criteria used by health departments in 2012.

**Table 2. Factors Health Departments Considered in Funding Allocations**

| Funding Allocation Criteria | Percent of all Jurisdictions Using Allocation Criteria (n=47) |
|---|---|
| **National HIV/AIDS Strategy priorities** | 96% |
| **Grant requirements** | 85% |
| **Recommendations from jurisdiction's HIV planning group** | 83% |
| **Trends in new HIV cases (e.g., increases/decreases between 2006 and 2010)** | 81% |
| **Number of new HIV cases for a specified multi-year time period (e.g., 2006-2010)** | 72% |
| **Number of prevalent HIV cases** | 66% |
| **Other relevant epidemiological data (e.g., STD, hepatitis or other health indicators)** | 60% |
| **Number of new HIV cases for a specified one-year time period (e.g., 2010)** | 40% |
| **Historical funding patterns** | 30% |
| **Directives from health officials** | 23% |
| **Statute and/or regulation** | 15% |
| **State and/or local appropriations language** | 13% |
| **Executive orders** | 6% |

CDC FOAs, the primary source of HIV prevention funding for a majority of health departments, were increasingly directive about the activities and services that could be funded. Further, CDC exercised more control over how specific activities and services were organized and delivered. Under PS12-1201, CDC emphasized activities and services that identify persons who are unaware of their HIV infection and link and retain HIV-positive persons in care and treatment (i.e., "treatment as prevention"). CDC also emphasized condom distribution and policy change initiatives. CDC de-emphasized behavioral interventions and other activities and services that cannot be brought to sufficient scale at a reasonable cost.

In 2012, health departments allocated the greatest share of their HIV prevention budgets to direct services, more than 70%. The remaining 30% of HIV prevention budgets were allocated to program administration, HIV prevention planning and mobilization and other support activities (n=43).

Of the direct services, almost 50% of reported funding was allocated to "treatment as prevention" services, including targeted HIV testing, routine HIV screening, partner services and prevention with positive activities. Allocation to treatment as prevention has increased significantly from 2007, when only 26% of resources were allocated to these services (n=43). Health departments reduced their investments in health education/risk reduction activities, including behavioral interventions. In 2007, 34% of funding was allocated to these services, while only 11% was allocated to behavioral interventions in 2012. Health departments reported allocating less than one percent of funding to post-exposure prophylaxis and no funding to pre-exposure prophylaxis in 2012. Table 3 provides a summary of health department funding allocation for specific activities and services.

**Table 3. Funding Allocations for HIV Prevention Services and Activities**

| HIV Prevention Services and Activities | Percent of all Reported Resources Allocated to Specific Services and Activities (n=43) | Percent of all Jurisdictions Allocating Resources to Specific Services and Activities (n=43) |
|---|---|---|
| **Targeted HIV testing** | 18% | 100% |
| **Prevention with positives** | 13% | 98% |
| **Behavioral interventions** | 11% | 81% |
| **Program administration** | 10% | 93% |
| **Routine HIV testing** | 10% | 77% |
| **Partner services** | 6% | 84% |
| **Capacity building assistance, technical assistance and training** | 4% | 84% |
| **Condom distribution** | 3% | 98% |
| **Evaluation and quality assurance** | 3% | 84% |
| **Public information, social marketing and media** | 3% | 74% |
| **Syringe services programs** | 3% | 30% |
| **HIV laboratory support** | 2% | 70% |
| **STD services** | 2% | 33% |
| **HIV surveillance** | 2% | 30% |
| **Community planning** | 1% | 91% |
| **Policy initiatives** | 1% | 42% |
| **Community mobilization** | 1% | 37% |
| **Viral hepatitis services** | 1% | 30% |
| **Prevention of mother-to-child transmission** | 1% | 23% |
| **Post-exposure prophylaxis** | <1% | 9% |
| **Pre-exposure prophylaxis** | 0% | 0% |

A vast majority of health departments strived to meet the ambitious goals of the NHAS. Many had already started implementing core components of the NHAS prior to the release of CDC's 12-1201. Health departments generally anticipated the shift in federal funding away from behavioral interventions and toward "treatment as prevention." Health departments reported having initiated conversations with community partners about the need to better target resources to the most heavily impacted populations. Health departments also initiated communication processes with community partners to signal the impending shifts in federal funding, specifically, the decreased emphasis on behavioral interventions and increased emphasis on treatment as prevention.

When asked about the decision-making process around the CDC's re-allocation of funding, HIV prevention leaders noted the challenge such a dramatic shift posed. "It is a tough balancing act. This is a new direction, and it is kind of uncomfortable. The nation is going in this direction – we will too – and yet [our communities] are on the ground doing the work." Key informants in jurisdictions with decreasing funds were challenged to prioritize

which prevention structures in their jurisdiction would remain and which would be cut. According to informants, treatment as prevention services, such as HIV testing, linkage to care and partner services, remained while many other services were cut.

Key informants in jurisdictions with increasing resources also cut services that were outside high-impact prevention. A health department leader from a southern jurisdiction that received a federal funding increase reported, "We have been honing in on the contracts that were most efficient and had demonstrated the best outcomes." Said another health department leader, "We are putting ourselves in a position, because we are receiving other resources, to be in somewhat good alignment [with the NHAS]."

## *CHALLENGES EXPERIENCED BY HEALTH DEPARTMENTS*

Health departments reported many challenges in implementing their HIV prevention programs. More than half of health departments (55%) reported decreases in funding as a primary challenge. More than one-third (36%) identified reporting requirements as a challenge. Health departments also reported challenges associated with program implementation and workforce. Table 4 provides a summary of challenges faced by health departments in 2012.

**Table 4. Current Health Department Challenges**

| Challenges | Number of Health Departments Identifying this Challenge (n=47) |
|---|---|
| **Decreased funding** | 26 |
| **Data collection and reporting requirements** | 17 |
| **Scaling back programs** | 16 |
| **Shortage of health department staff** | 15 |
| **Lack of community-based providers serving disproportionately impacted populations** | 13 |
| **Scaling up programs** | 9 |
| **Provider resistance to implementing HIV prevention services** | 8 |
| **Lack of skill/expertise in the health department workforce** | 7 |
| **Lack of skill/expertise in the community-based workforce** | 7 |

Decreased funding was paramount among the challenges faced by health department HIV prevention programs. Health department staff in one low prevalence jurisdiction commented that, "Continued cuts to funding will decimate our ability to provide HIV prevention services." Another prevention staff commented, "We worry about what is going to happen when prevention structures leave. Outreach to testing, that kind of stuff is going to go away."

Reporting requirements to federal funders challenged health departments regardless of funding increases and decreases. Despite sizable differences in cooperative agreement budgets, reporting requirements are the same for all CDC HIV prevention grantees. Key

informants across the map suggested that state hiring freezes and wage freezes constrained their ability to meet increasing grant reporting demands from federal funders. For health departments with smaller prevention budgets, reporting requirements were particularly daunting, given that available HIV prevention staff are often shared across programs areas. One health department noted, "We all…wear multiple hats."

Providing leadership for community-based partners to help re-orient them to new federal priorities posed an additional challenge to sustaining effective HIV prevention programs. While health departments continued to play a central role in organizing systems of HIV prevention in their jurisdictions, e.g., by keeping track of existing services and issuing new Requests for Proposals (RFPs) based on the changing context, key informants suggested that more work needs to be done to re-orient community-based providers. A health department leader noted that, "[The RFP] was new and different. [Partners] had to read the language and interpret it for it to work. There were a fair amount of (RFP) responses trying to place old activities into a new framework. We still have work to do to move [partners] along."

As treatment as prevention becomes central to effective HIV prevention, HIV prevention programs were challenged to clearly distinguish between HIV prevention and care programming. Most health departments understood the importance of aligning care and prevention funding. However, in many jurisdictions, HIV prevention and care programs have been separated. Movement toward creating a seamless system of services from diagnosis to sustained treatment will require enhanced collaboration across these programs.

## *CONSEQUENCES EXPERIENCED BY HEALTH DEPARTMENTS*

Health departments faced a number of consequences related to the challenges they experienced. More than half of health departments (53%) reported redirecting funds to meet new requirements, such as requirements included in CDC PS12-1201. More than a third of prevention programs reported providing less funding for population-based community programs, including funding fewer organizations and reducing the size of community-based awards. Many health departments ended programming for certain groups, including low risk communities, rural communities and HIV-negative populations. Several jurisdictions reported internal consequences, including the elimination of and/or the inability to fill health department HIV prevention positions. Table 5 provides a summary of consequences experienced by health departments in 2012.

**Table 5. Consequences Experienced by Health Departments since 2007**

| Consequences | Number of Health Departments Identifying this Consequence (n=47) |
|---|---|
| **Redirected funding to meet other requirements** | 25 |
| **Funded fewer community-based providers** | 20 |
| **Reduced the size of awards to community-based providers** | 19 |
| **Stopped funding programs for some populations** | 18 |
| **Health department positions eliminated** | 18 |
| **Health department positions remained vacant** | 15 |

Jurisdictions were leading their community partners through these dramatic changes by providing more capacity building activities, being transparent about overall funding amounts and leveraging resources to continue services. As the traditional structures for health department and community relationships have been de-emphasized (i.e., behavioral interventions, community planning), health departments were seeking new meaningful ways to engage community. A health department leader in the South commented that "Evidence-based (behavioral) interventions (EBIs) are still very valued in the community. I worry about disconnecting us from our community providers. This work still needs to be done."

New partners in HIV prevention are emerging in addition to traditional community partners. Health department HIV prevention programs have begun to forge relationships with clinical partners with varying degrees of success. For example, in a low prevalence jurisdiction, key informants discussed a "…big disconnect between the community-model and the clinical-model. There is little incentive for medical providers to engage." While challenging, another health department colleague noted the importance of looking for new partners to better address the epidemic, "Housing is an issue for HIV prevention and care. Youth development is an issue…So how do we connect to something larger?"

## *SCALE UP AND SCALE BACK OF HIV PREVENTION ACTIVITIES AND SERVICES*

Health departments reported scaling up a range of HIV prevention strategies. More than three-quarters of health departments reported scaling up linkage to care services (79%) and condom distribution (79%). Nearly two-thirds reported scaling up prevention with positives activities (62%). The most cited reasons for scaling up these services were to support the NHAS, to implement requirements in CDC PS 12-1201 and because of funding increases.

Activities and services considered to be part of "treatment as prevention" were scaled up more than others, with a third or more of respondents reporting scale up of these services. Figure four provides a summary of activities and services for which programming was scaled up in 2012.

Health departments reported scaling back certain HIV prevention activities and services. More than three-quarters reported scaling back health education/risk reduction interventions for HIV-negative populations. A third of respondents reported scaling back public information/media campaigns, planning and targeted HIV testing in community-based settings. Funding decreases were the most cited reason for scaling back these activities and services.

With the exception of condom distribution, few health departments reported scaling up primary prevention efforts, including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (nPEP) and syringe exchange programming. Figure five provides a summary of activities and services for which programming was scaled back in 2012. See Appendix Two for more information about scaling up/scaling back of activities and services.

**Figure 4.**

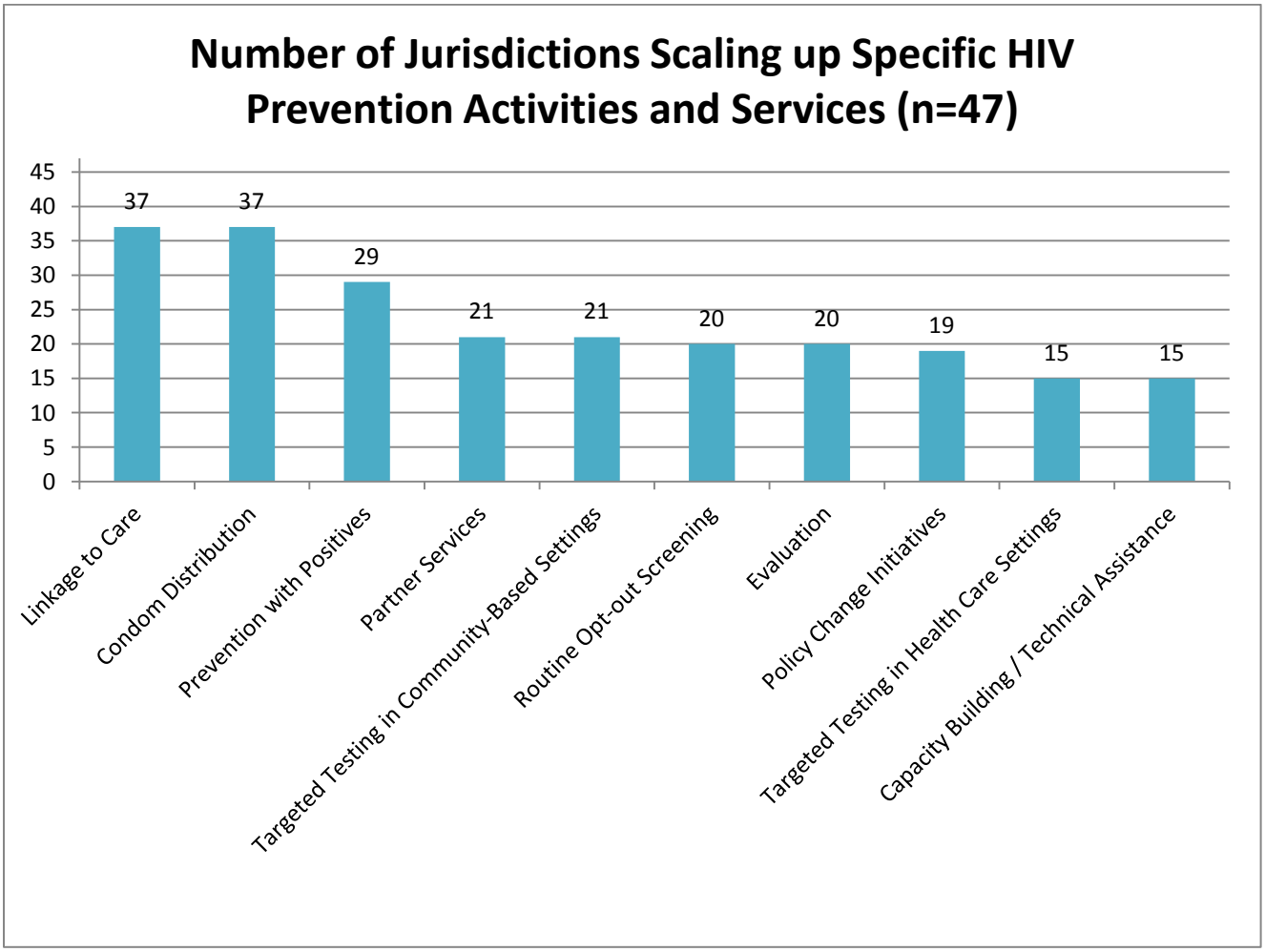
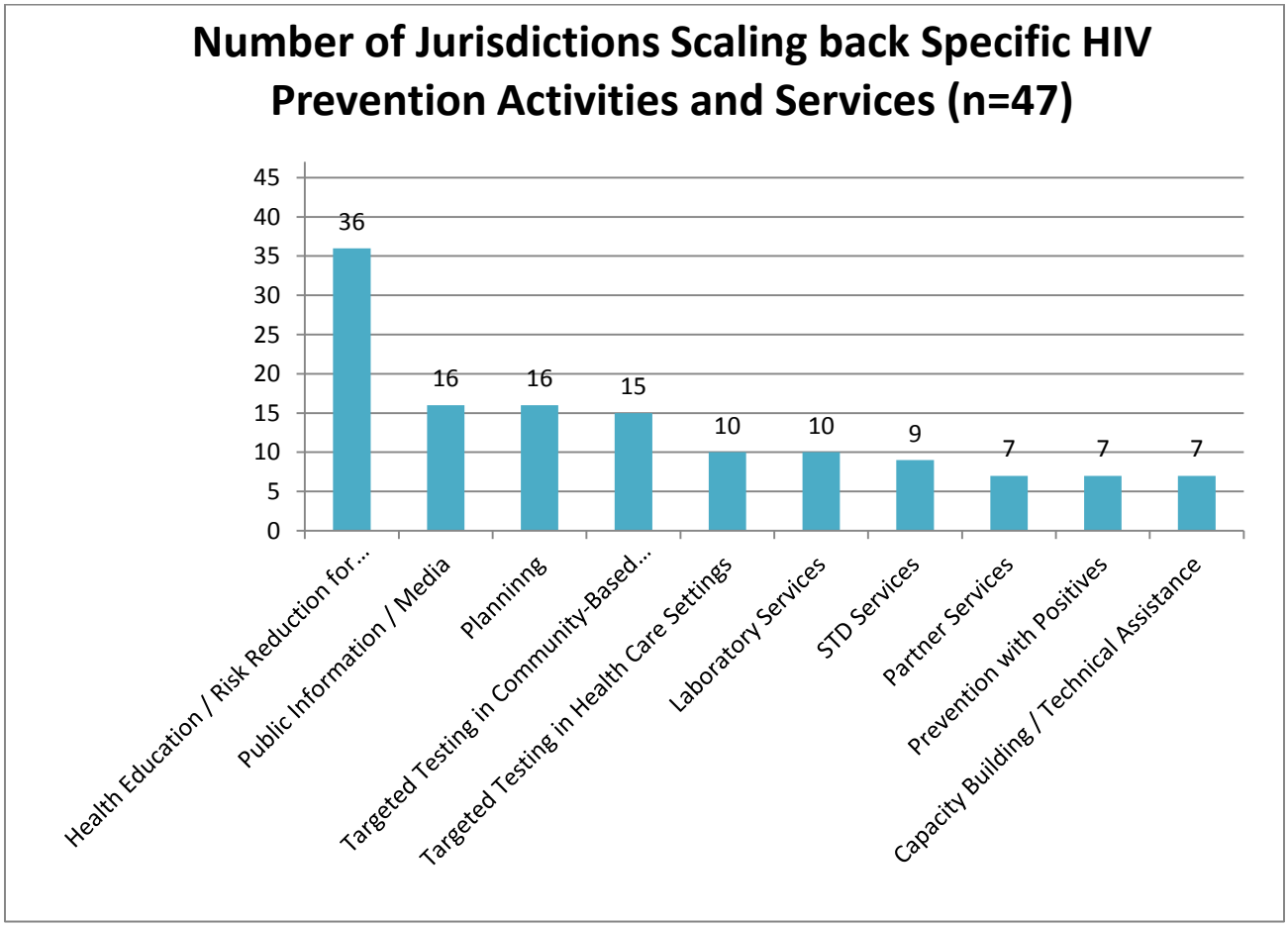


**Figure 5.**



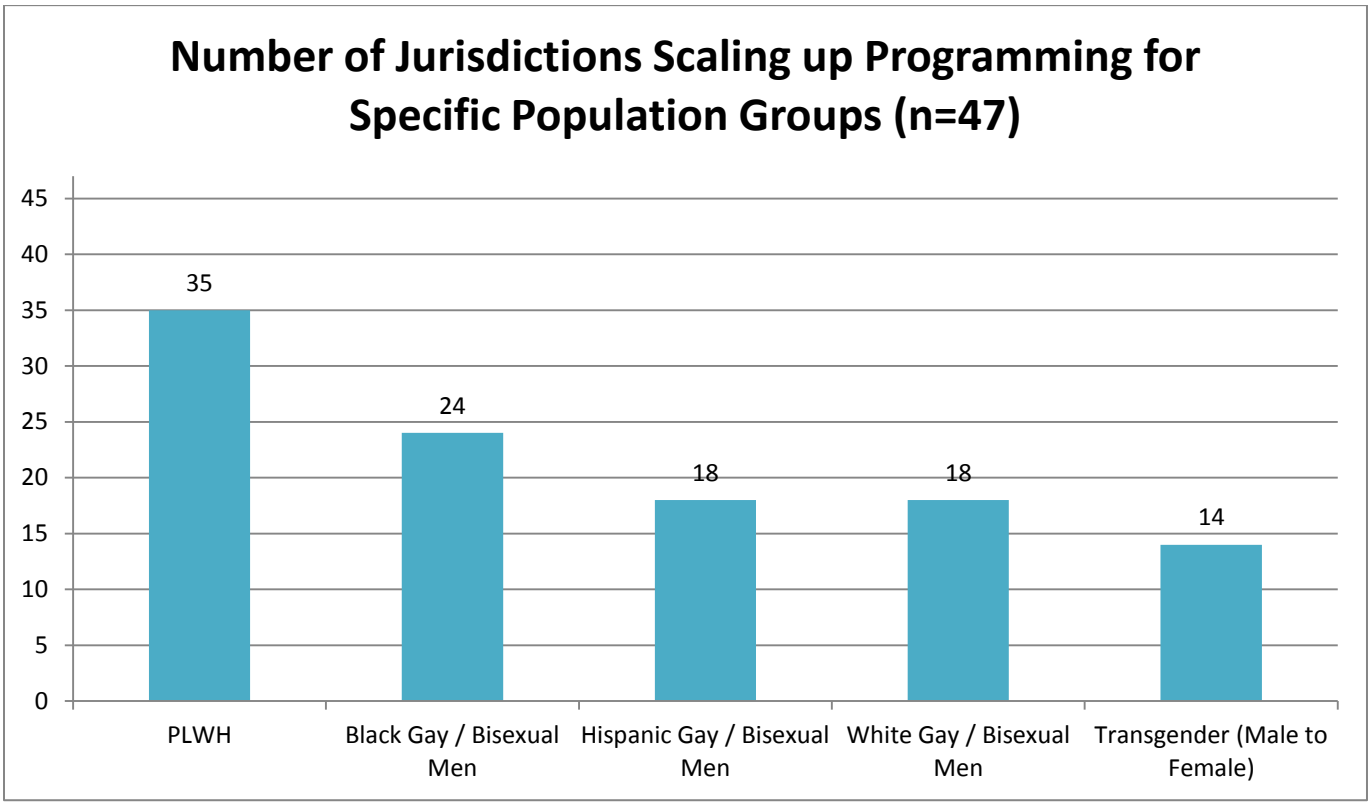

Key informants discussed what programming they could implement in order to maintain an effective HIV prevention program, given the amount of resources available. Health department prevention staff in a moderate-high incidence jurisdiction stated that "Given the resources we have, we have done a really good job at keeping a critical level of services available in those core areas. We have scaled back on educational activities and educational materials. We have scaled back social marketing. There are activities that we have simply been unable to afford at this point, such as pre-exposure prophylaxis."

## *SCALE UP AND SCALE BACK OF HIV PREVENTION PROGRAMMING FOR SPECIFIC POPULATION GROUPS*

Health departments reported scaling up programming for specific population groups. Three-quarters of health departments reported scaling up programming for persons living with HIV, citing the NHAS and CDC PS12-1201 as primary reasons.

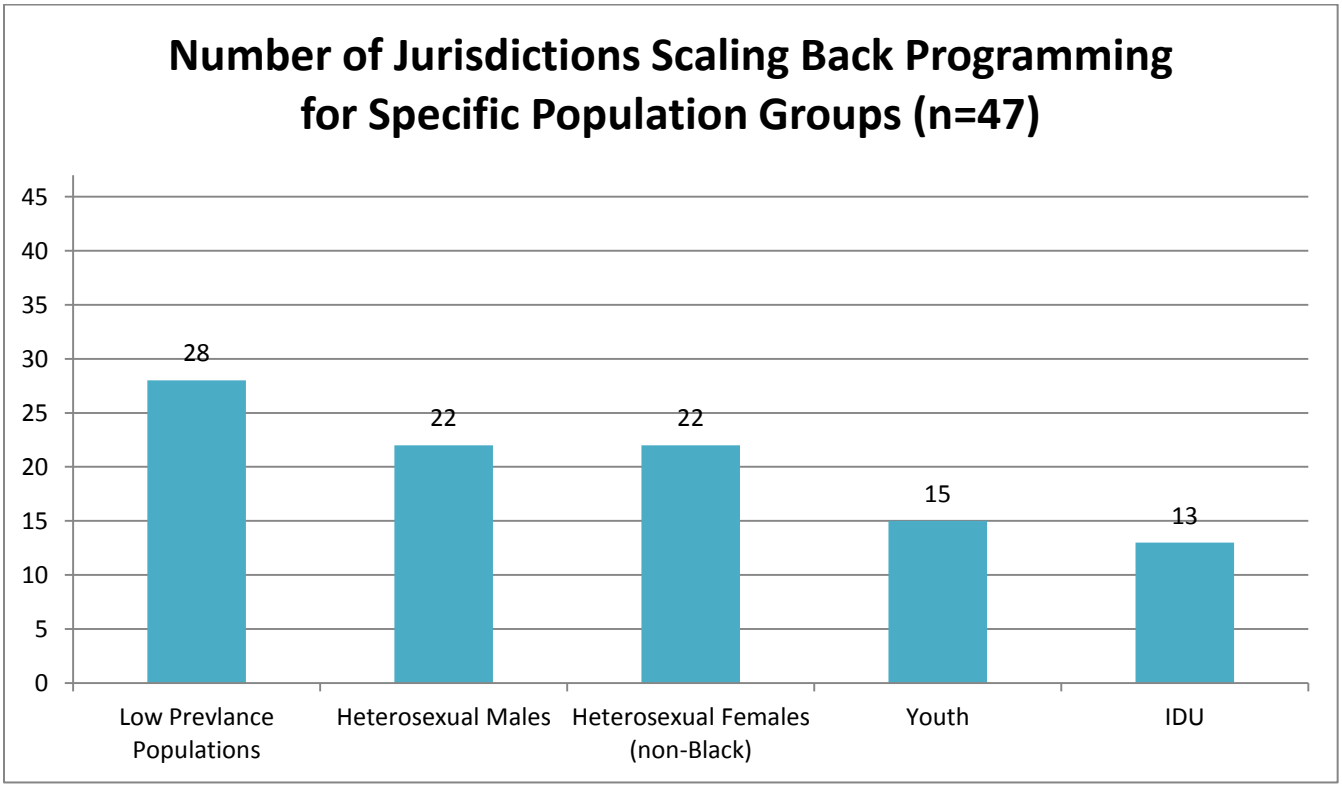
Half of respondents scaled up programming for Black gay and bisexual men. While the NHAS was the most cited reason, nearly as many health departments cited local surveillance data as cause for scaling up efforts for this population. Forty percent of health departments also scaled up services for White and Hispanic gay and bisexual men. Figure six provides a summary of populations groups for which programming was scaled up in 2012

**Figure 6.**




Sixty percent of health departments reported scaling back programming for low prevalence populations. Nearly equal numbers of respondents cited funding decreases, the NHAS and CDC PS12-1201 as reasons. Nearly 50% of health departments reported scaling back services for heterosexual males and non-Black heterosexual females. Funding decreases were the primary reason. Figure seven provides a summary of populations groups for which programming was scaled back.

**Figure 7.**




Even though many respondents reported scaling up work with gay and bisexual men, health department informants expressed both successes and challenges in making HIV prevention relevant to this group, in particular Black gay and bisexual men. Key informants noted challenges on multiple levels, including the lack of agencies available to serve these communities and, when available, the organizational capacity of existing agencies to be fiscally sound and/or relevant to gay and bisexual men. A health department staff from the South commented, "We need more work with specific [men who have sex with men (MSM)] interventions. MSM could benefit from different services. It is a recruitment issue with MSM." Another respondent from the South added, "It has been such a struggle to orient [providers] to gay men in general."

## Discussion

Findings from the updated NHPI indicate a variety of changes in HIV prevention programs since the release of the 2009 NHPI report. Funding, including the way it is allocated, is a major driver of the changes experienced over the last five years. Two primary funding scenarios are emerging. In the first, jurisdictions with greater epidemic burden are receiving more resources to implement HIV prevention activities and services. Increased funding comes with the challenge of scaling up programs, including building sufficient capacity and infrastructure to support effective service delivery. In the second scenario, jurisdictions with lower epidemic burden are receiving fewer resources, sometimes

significantly fewer, and are making decisions about where and what services to cut. Decreasing funding comes with the challenge of scaling back activities and services in a manner that preserves sufficient capacity to fulfill core public health functions. Each scenario results in unique consequences.

In 2012, as in 2007, state and local health departments relied almost exclusively on governmental funding to support HIV prevention activities and services in their jurisdictions. The primary source of HIV prevention funding comes from the CDC. Since 2007, CDC core HIV prevention funding to health departments has decreased, with 39 jurisdictions receiving less funding through CDC PS12-1201 Category A in 2012 than they received through CDC PS04-014 in 2007. This loss of funds comes after years of no growth in the total amount of CDC funding for HIV prevention, as described by the 2009 NHPI report. CDC PS12-1201 Categories B and C offset some of the 2012 funding losses, though these funding streams are linked to narrowly defined CDC priorities. Because every health department relies on CDC funding to support HIV prevention programs, some exclusively, there has been a noticeable loss of local control and health department autonomy over how HIV prevention is coordinated and delivered since 2007.

In 2012, as in 2007, state funding accounted for one-third of total HIV prevention funds. However, the total number of jurisdictions that did not provide state/local funding for HIV prevention increased from 14 to 23 from 2007 to 2012. As HIV prevention funding increasingly comes solely from the federal government, local determination of the use of HIV prevention funds continues to be impacted.

Likely due to the changes in the HIV prevention landscape, in particular the NHAS and the new CDC PS12-1201, a dramatic shift in funding allocation occurred since 2007. Then, 34% of funding was allocated to evidence-based behavioral interventions. In 2012, only 11% of funding went towards these activities. Treatment as prevention accounted for the bulk of HIV prevention activities and services funded by state and local health departments in 2012, an increase from 26% to 50% of total funds allocated to these services. In contrast, biomedical interventions, such as PrEP and nPEP, which are also promoted as CDC priorities, received less than one percent of health department funding. This contrast is likely due to the recent emergence of these strategies, ongoing research on effective implementation and restrictions on the use of CDC funding to purchase of anti-retroviral drugs.

As described throughout this report, implementation of the NHAS has had a clear impact on the distribution of federal funding to state and local health departments, as well as an impact on the way health departments allocate their own resources. Ninety-six percent of health departments reported that the NHAS was the primary factor in funding allocation decisions. The NHAS strongly advocates that funding for HIV services be directed towards communities with the greatest need, in particular gay and bisexual men of all race and ethnicities. More than half of health departments reported scaling up services for Black

gay and bisexual men and many others reported scaling up services for White and Hispanic gay and bisexual men.

While federal resources have become more targeted, HIV prevention programs are still being implemented in every state in the country and in some localities. Funding decreases have driven health departments to make tough choices around cutting programs for low prevalence populations, such as rural communities and heterosexual men and non-Black heterosexual women.

## Closing

Recent federal FOAs[9] provide a glimpse into future federal funding priorities for HIV prevention. In the short term, federal funding for categorical HIV prevention programs will likely remain flat, at best. The resources that are available will continue to be directed to jurisdictions with high disease burden and to activities and services that support treatment as prevention activities. For all health departments, but in particular for those receiving few resources, cross-program collaboration and the development of new partnerships will be important. As an AIDS Director from a low incidence jurisdiction put it, "We will never have enough resources. We have to work well with others."

In the longer term, ongoing implementation of the ACA will result in escalating investments in the health care delivery system, including institutions and payers that will take more responsibility for the provision of preventive services. As financing for and service delivery within these systems increases, the role of public health agencies in the broader health care continuum will change. Moving forward, public health agencies must actively develop and maintain relationships with provider and payer systems, including federally qualified health centers and state insurance and Medicare/Medicaid agencies. Some health departments may opt to explore opportunities to integrate core public health services, such as disease case investigation and partner services, into health care institutions. Some may choose to take a more active role in developing new business models that support delivery of preventive services within health care settings, such as providing resources to update electronic health record systems to prompt providers to screen for disease and public and private partnerships that leverage governmental and non-governmental funds to support expanded service delivery. Whichever route individual health departments take, they will continue to hold primary responsibility for identifying gaps in existing systems in order to implement activities, services and policy change

[9]Other recent federal FOAs include CDC's Enhanced Comprehensive HIV Prevention Planning (ECHPP) and Care and Prevention in the United States (CAPUS), and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Minority AIDS Initiative Targeted Capacity Expansion (MAI TCE).These funding opportunities targeted jurisdictions with a high number of cases and disproportionate burdens of HIV. Funding from these FOAs is not included in this report. For more information about these FOAs, please visit www.cdc.gov and www.samhsa.gov. The 2009 Ryan White HIV/AIDS Treatment Extension Act Legislation administered by the Health Resources and Services Administration (HRSA) includes some activities traditionally associated with prevention programs, the funding of which is also not included here.

initiatives to fill these gaps. As a health department leader from the Midwest summarized, “The HIV response must come from all of us. It’s not just about HIV anymore.”

# Acknowledgements

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# Appendix One: Geographical Regions and Prevalence Categories

## Geographic Regions

Midwest (13): Chicago, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio South Dakota and Wisconsin

Northeast (11): Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York City, New York State, Pennsylvania, Philadelphia, Rhode Island and Vermont.

South (20): Alabama, Arkansas, Baltimore, Delaware, District of Columbia, Florida, Fulton County (Atlanta), Georgia, Houston, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia.

West (15): Alaska, Arizona, California, Colorado, Hawaii, Idaho, Los Angeles County, Montana, Nevada, New Mexico, Oregon, San Francisco, Utah, Washington and Wyoming.

## Prevalence Categories[10]

Directly funded localities (8): Baltimore, Chicago, Fulton County (Atlanta), Houston, Los Angeles County, New York City, Philadelphia and San Francisco.

High prevalence (14): California, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, New Jersey, New York State, North Carolina, Ohio and Pennsylvania, Texas and Virginia.

High-to-moderate prevalence (10): Alabama, Arizona, District of Columbia, Indiana, Michigan, Mississippi, Missouri, South Carolina, Tennessee and Washington.

Moderate prevalence (9): Arkansas, Colorado, Connecticut, Kentucky, Minnesota, Nevada, Oklahoma, Oregon and Wisconsin.

Low prevalence (18): Alaska, Delaware, Hawaii, Idaho, Iowa, Kansas, Maine, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Rhode Island, South Dakota, Utah, Vermont, West Virginia and Wyoming.

[10] Prevalence categories are based on the estimated total of new HIV infections in 2011. Centers for Disease Control and Prevention. HIV Surveillance Report, 2011; Vol. 23. http://www.cdc.gov/hiv/topics/surveillance/resources/reports/ Published February 2013. Accessed on February 23, 2013.

# Appendix Two: Scale up and Scale Back of HIV Prevention Services and Activities

| Activity/Service | Scale Up | Scale Back | No Change | Not Applicable |
|---|---|---|---|---|
| **Targeted Testing in Community-based Settings** | 21 | 15 | 9 | 2 |
| **Targeted Testing in Health Care Settings** | 15 | 10 | 17 | 5 |
| **Routine Opt-out Screening in Health Care Settings** | 20 | 4 | 11 | 12 |
| **Partner Services** | 21 | 7 | 17 | 2 |
| **Linkage to Care** | 37 | 1 | 7 | 2 |
| **Prevention with Positives** | 29 | 7 | 10 | 1 |
| **Condom Distribution** | 37 | 2 | 7 | 1 |
| **Syringe Services Programs** | 5 | 5 | 27 | 10 |
| **PrEP** | 5 | 0 | 36 | 6 |
| **nPEP** | 5 | 1 | 32 | 9 |
| **Health Education/ Risk Reduction Interventions** | 0 | 36 | 8 | 3 |
| **Public Information/ Social Marketing/ Media** | 11 | 16 | 16 | 4 |
| **Community Mobilization** | 9 | 5 | 19 | 14 |
| **Policy Initiatives** | 19 | 2 | 20 | 6 |
| **Planning** | 10 | 16 | 20 | 1 |
| **Program Administration** | | | | |

| | | | | |
|---|---|---|---|---|
| **Capacity Building/ Technical Assistance** | 15 | 7 | 24 | 1 |
| **Evaluation** | 20 | 4 | 22 | 1 |
| **Prevention of Mother to Child Transmission** | 1 | 6 | 23 | 17 |
| **STD Services** | 8 | 9 | 18 | 12 |
| **Adult Viral Hepatitis Services** | 11 | 2 | 12 | 22 |
| **Surveillance** | 11 | 2 | 13 | 21 |
| **Laboratory Services** | 7 | 10 | 19 | 11 |

# Appendix Three: Scale Up and Scale Back of Programs and Activities for Target Populations

| Population | Scale Up | Scale Back | No Change | Not Applicable |
|---|---|---|---|---|
| **Persons living with HIV** | 35 | 3 | 8 | 1 |
| **Black gay/bisexual men** | 24 | 5 | 12 | 6 |
| **Hispanic gay/bisexual men** | 18 | 3 | 21 | 5 |
| **White gay/bisexual men** | 18 | 8 | 19 | 2 |
| **Persons who use injection drugs** | 9 | 13 | 20 | 5 |
| **Black heterosexual females** | 6 | 12 | 23 | 6 |
| **Non-Black heterosexual females** | 1 | 22 | 20 | 4 |
| **Heterosexual males** | 0 | 22 | 21 | 4 |
| **Transgender** | 14 | 2 | 21 | 10 |
| **Youth** | 10 | 15 | 16 | 6 |
| **Persons involved in the sex trade** | 3 | 5 | 21 | 18 |
| **Perinatal** | 2 | 4 | 27 | 14 |
| **Immigrants** | 7 | 6 | 21 | 13 |
| **Low prevalence populations** | 1 | 28 | 13 | 5 |
| **Blacks** | 16 | 8 | 17 | 6 |
| **American Indian/ Alaskan Native** | 1 | 4 | 22 | 20 |
| **Asian** | 1 | 4 | 22 | 20 |
| **Hispanic** | 12 | 6 | 22 | 7 |
| **Non-Hispanic Pacific Islander** | 0 | 2 | 18 | 27 |
| **White** | 5 | 13 | 25 | 4 |

# Appendix Four: Survey Instrument

**National HIV Prevention Inventory Module 2: HIV Prevention Funding**

***JURISDICTION INFORMATION***
Jurisdiction's name
Name of jurisdiction's contact person for this survey
Phone number
Email address

1. Which of the following programs fall under the purview (i.e., fiscal and administrative responsibility) of your jurisdiction's NASTAD member? Please check all that apply.

☐ HIV prevention (prevention programming, such as evidence-based interventions, excluding HIV testing)
☐ HIV testing
☐ HIV partner services
☐ HIV care (excluding the AIDS Drug Assistance Program (ADAP))
☐ ADAP
☐ CDC Division of Adolescent and School Health (HIV, STD and teen pregnancy prevention programming)
☐ Perinatal HIV prevention activities
☐ HIV/AIDS surveillance
☐ Viral hepatitis services (i.e., the Viral Hepatitis Prevention Coordinator)
☐ Perinatal hepatitis B services
☐ Acute viral hepatitis surveillance
☐ Chronic viral hepatitis surveillance
☐ STD services (excluding STD partner services)
☐ STD partner services
☐ STD surveillance
☐ TB services
☐ TB surveillance
☐ Immunization
☐ Refugee health
☐ Reproductive health
☐ Maternal and child health
☐ Minority health
☐ Housing Opportunities for People with HIV/AIDS (HOPWA)
☐ Lesbian, gay, bisexual and transgender health
☐ Other (please describe: )

1a. If your jurisdiction's HIV/AIDS director is different than your NASTAD member, which of the following programs fall under the purview (i.e., fiscal and administrative responsibility) of your HIV/AIDS director? Please check all that apply.
☐ Jurisdiction's HIV/AIDS director and NASTAD member are the same person
☐ HIV prevention (prevention programming, such as evidence-based interventions, excluding HIV testing)
☐ HIV testing
☐ HIV partner services
☐ HIV care (excluding the AIDS Drug Assistance Program (ADAP))
☐ ADAP
☐ CDC Division of Adolescent and School Health (HIV, STD and teen pregnancy prevention programming)

☐ Perinatal HIV prevention activities
☐ HIV/AIDS surveillance
☐ Viral hepatitis services (i.e., the Viral Hepatitis Prevention Coordinator)
☐ Perinatal hepatitis B services
☐ Acute viral hepatitis surveillance
☐ Chronic viral hepatitis surveillance
☐ STD services (excluding STD partner services)
☐ STD partner services
☐ STD surveillance
☐ TB services
☐ TB surveillance
☐ Immunization
☐ Refugee health
☐ Reproductive health
☐ Maternal and child health
☐ Minority health
☐ Housing Opportunities for People with HIV/AIDS (HOPWA)
☐ Lesbian, gay, bisexual and transgender health
☐ Other (please describe: )

***HIV PREVENTION FUNDING AND RESOURCE ALLOCATION***

*Questions in this section address funding and allocation of resources for HIV prevention activities. Please report data for the 2012 calendar year (CY2012).*

2. For this assessment, NASTAD will obtain some CY2012 federal funding data from existing sources. For each federal funding source in the table below, please review the funding amount provided on DHAP's webpage. If the funding amount is accurate, please check "YES." If the funding amount is not accurate, please provide the correct funding amount in the space provided.

| Funding source | Funding (CY2012) accurate on webpage? | Corrected funding amount (CY2012) |
|---|---|---|
| CDC / DHAP 12-1201 Part A | ☐ Yes<br>☐ No | $ |
| CDC / DHAP 12-1201 Part B | ☐ Yes<br>☐ No | $ |
| CDC / DHAP 12-1201 Part C | ☐ Yes<br>☐ No | $ |

3. For each funding source requested below, please provide the funding amount allocated to HIV prevention activities for CY2012. If you receive no funding from a designated source, please enter "0" for the funding amount.

| Funding source | Did you receive funding from this source? | Funding amount (CY2012) |
|---|---|---|
| CDC / DHAP 04-012 Low Cost Extension | ☐ Yes<br>☐ Don't know<br>☐ N/A | $ |
| CDC / DHAP 10-10138 Low Cost Extension | ☐ Yes<br>☐ Don't know<br>☐ N/A | $ |
| CDC / DHAP ECHPP (11-1117) | ☐ Yes<br>☐ No | $ |

| | | |
|---|---|---|
| | ☐ N/A | |
| CDC / NCHHSTP PCSI (10-10175) | ☐ Yes<br>☐ No<br>☐ N/A | $ |
| CDC / CAPUS (12-1210) | ☐ Yes<br>☐ No<br>☐ N/A | $ |
| CDC / other (list all that apply: ) | ☐ Yes<br>☐ Don't know<br>☐ N/A | $ |
| SAMHSA HIV prevention funding | ☐ Yes<br>☐ No<br>☐ N/A | $ |
| HRSA / HAB Ryan White support for HIV prevention activities (e.g., early intervention services, harm reduction) | ☐ Yes<br>☐ Don't know<br>☐ N/A | $ |
| Minority AIDS Initiative funding | ☐ Yes<br>☐ Don't know<br>☐ N/A | $ |
| Other federal agency support for HIV prevention (list all that apply: ) | ☐ Yes<br>☐ Don't know<br>☐ N/A | $ |
| State funding | ☐ Yes<br>☐ Don't know<br>☐ N/A | $ |
| Local funding | ☐ Yes<br>☐ Don't know<br>☐ N/A | $ |
| Funding from industry, private sector, foundations and / or other (list all that apply: ) | ☐ Yes<br>☐ Don't know<br>☐ N/A | $ |

4. Across ALL funding sources, what is the total CY2012 funding amount allocated to HIV prevention? Your response should equal the sum of all funding sources in questions 2 and 3.

$

5. To better understand funding trends over time, please provide the total dollar amount of your health's department HIV prevention budget <u>from all funding sources</u> for the following years.

$ CY2008
$ CY2009
$ CY2010
$ CY2011

6. Using the total CY2012 HIV prevention funding amount from question 4, estimate the dollar amount <u>from all sources</u> currently allocated to each of the following HIV prevention activities in your jurisdiction. Include funding that is allocated internally (remains within your health department) and externally (is granted or contracted out to external entities to complete work on behalf of your health department, e.g., local health departments, community based organizations).

| Prevention activities | Estimated funding amount (CY2012) |
|---|---|
| Program administration (excluding policy initiatives, | $ ☐N/A |

| | |
|---|---|
| community planning, capacity building / technical assistance / training and evaluation / quality assurance) | |
| HIV testing activities (targeted testing in community-based and clinical settings for disproportionately impacted populations, including linkage to care activities) | $ ☐N/A |
| HIV testing activities (routine testing in clinical settings, including linkage to care) | $ ☐N/A |
| Partner services | $ ☐N/A |
| Prevention with positives activities (e.g., behavioral interventions, risk screening, etc.) | $ ☐N/A |
| Condom distribution | $ ☐N/A |
| Syringe services programs | $ ☐N/A |
| Pre-exposure prophylaxis | $ ☐N/A |
| Non-occupational post-exposure prophylaxis | $ ☐N/A |
| Behavioral interventions for HIV-negative persons | $ ☐N/A |
| Public information / social marketing / media | $ ☐N/A |
| Community mobilization | $ ☐N/A |
| Policy initiatives | $ ☐N/A |
| Community planning | $ ☐N/A |
| Capacity building / training / technical assistance | $ ☐N/A |
| Evaluation / quality assurance | $ ☐N/A |
| Prevention of mother-to-child transmission | $ ☐N/A |
| STD services | $ ☐N/A |
| Viral hepatitis services | $ ☐N/A |
| HIV surveillance | $ ☐N/A |
| HIV laboratory support | $ ☐N/A |
| Other (please describe: ) | $ ☐N/A |
| **Total CY2012 HIV prevention funding (This amount should match the total in question 4.)** | $ |

7. In your jurisdiction, what factors are considered when deciding how to allocate funding? Please check all that apply.

☐ New HIV cases for a specified one-year time period (e.g., 2010)
☐ New HIV cases for a specified multi-year time period (e.g., 2006-2010)
☐ Trends in new HIV cases (e.g., increases / decreases between 2006 and 2010)
☐ Prevalent HIV cases
☐ Other relevant epidemiological data (e.g., STD, HCV or other health indicator data)
☐ Recommendations from your jurisdiction's HIV planning group
☐ Statute and / or regulation
☐ State and / or local appropriations language
☐ Executive orders
☐ Directives from health officials
☐ Historical funding patterns
☐ Grant requirements
☐ National HIV/AIDS Strategy priorities
☐ Other (please describe: )

***CHALLENGES FACING HIV PREVENTION PROGRAMS***

*Questions in this section address the challenges faced by HIV prevention programs and the impact of these on delivery of HIV prevention services, including the scaling up and / or back of HIV prevention program areas.*

8. Please select the **top three (3)** challenges you currently face in implementing your HIV prevention program.

☐ Health department workforce – shortage of staff (including shortages due to hiring freezes and other cost-containment measures)
☐ Health department workforce – lack of skilled / adequately qualified staff within in the existing workforce
☐ Community-based workforce – shortage of staff (including shortages due to hiring freezes and other cost-containment measures)
☐ Community-based workforce – lack of skilled / adequately qualified staff within the existing workforce
☐ Clinical workforce – shortage of staff (including shortages due to hiring freezes and other cost-containment measures)
☐ Clinical workforce – lack of skilled / adequately qualified staff within the existing workforce
☐ Lack of community-based providers serving disproportionately impacted populations (e.g., gay/bisexual men, Blacks / African Americans, Hispanics, IDU)
☐ Lack of clinical providers serving disproportionately impacted populations (e.g., gay/bisexual men, Blacks / African Americans, Hispanics, IDU)
☐ Lack of training and capacity building resources for community-based providers
☐ Lack of training and capacity building resources for clinical providers
☐ Provider resistance to implementing specific HIV prevention activities or services
☐ Funding decreases
☐ Funding increases
☐ Challenges scaling back programming
☐ Challenges scaling up programming
☐ Data collection and reporting requirements
☐ Decentralization of the jurisdiction's health care delivery system
☐ Policies (i.e., the presence or absence of a policy) (Describe: )
☐ Legal, legislative or other political resistance (Describe: )
☐ Other (please describe: )

9. Which of the following have you experienced since the 2007 National HIV Prevention Inventory survey?

| Consequences |
|---|
| ☐ We stopped funding HIV prevention programming for some populations.<br>If yes, please describe: |
| ☐ We were unable to implement planned prevention programming.<br>If yes, please describe the programming that your health department was unable to implement: |
| ☐ We funded fewer community-based providers.<br>If yes, please describe whether these community-based providers delivered services to disproportionately impacted populations (e.g., gay/bisexual men, Blacks / African Americans, Hispanics, IDU): |
| ☐ We funded fewer clinical providers. |
| ☐ We reduced the size of awards made to community based providers.<br>If yes, please describe whether these community-based providers delivered services to disproportionately impacted populations (e.g., gay/bisexual men, Blacks / African Americans, Hispanics, IDU): |
| ☐ We reduced the size of awards made to clinical providers. |

| |
|---|
| ☐ We redirected resources from direct services to meet internal administrative costs. |
| ☐ We redirected funds to meet the needs of other requirements (e.g., new CDC requirements, new state / local policies). |
| ☐ Health department prevention positions remained vacant due to lack of funding. |
| ☐ Health department prevention positions remained vacant due to lack of qualified technical expertise. |
| ☐ Health department prevention positions remained vacant due to hiring freezes or other administrative policies. |
| ☐ Health department prevention positions were eliminated. |
| ☐ Health department prevention staff were unable to access professional development and training. |
| ☐ Other (please describe: ) |

10. For each of the prevention activities listed below please indicate how your program has changed in the past 24 months. If you have scaled up or scaled back efforts, please indicate the primary reason for the change.

*Scale back is defined as reducing resources, human and / or financial, to decrease emphasis on a particular strategy, service, or activity*. *Scale up is defined as increasing resources, human and / or financial, to enhance emphasis on a particular strategy, service, or activity***.**

| Prevention activities | Scaled up or back? (Please check **one**.) | Primary Reason (Please check **one**.) |
|---|---|---|
| Program administration | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Targeted HIV testing in community based settings | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Targeted HIV testing in health care settings | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Routine testing in health care settings | ☐ Scaled up<br>☐ Scaled back | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC) |

| | | |
|---|---|---|
| | ☐ No change<br>☐ Not applicable | ☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Partner services | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Linkage to HIV care | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Prevention with positives activities (behavioral interventions, risk screening, etc.) | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Condom distribution | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement |

| | | |
|---|---|---|
| | | ☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Syringe services programs | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Pre-exposure prophylaxis | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Non-occupational post-exposure prophylaxis | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Health education / risk reduction for HIV-negative persons | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Public information / social marketing / media | ☐ Scaled up<br>☐ Scaled back | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC) |

| | | |
|---|---|---|
| | ☐ No change<br>☐ Not applicable | ☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Community mobilization | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Policy initiatives | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| HIV planning | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Capacity building / training / technical assistance | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement |

| | | |
|---|---|---|
| | | ☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Evaluation / quality assurance | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Prevention of mother-to-child transmission | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| STD services | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Viral hepatitis services | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| HIV surveillance | ☐ Scaled up<br>☐ Scaled back | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC) |

| | | |
|---|---|---|
| | ☐ No change<br>☐ Not applicable | ☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| HIV laboratory | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Other (please describe: ) | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |

11. For each of the populations listed below please indicate how your program has changed in the last 24 months. If you have scaled up or scaled back efforts, indicate the primary reason for the change. Please note, the categories asked about in this question are not mutually exclusive, e.g., the survey asks for information about Black / African American gay and bisexual men AND Blacks / African Americans.

| Population Group | Scaled up or back? (Please check **one**) | Primary Reason (Please check **one**) |
|---|---|---|
| Persons living with HIV | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy |

| | | |
|---|---|---|
| | | ☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Black / African American gay and bisexual men | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Hispanic gay and bisexual men | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| White gay and bisexual men | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Persons struggling with drug addiction / chemical dependency (including persons who use injection drugs) | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Black / African American heterosexual | ☐ Scaled up | ☐ Funding increase (CDC) |

| | | |
|---|---|---|
| females | ☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Other heterosexual females | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Heterosexual males | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Transgender females who have sex with males | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Youth | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy |

| | | |
|---|---|---|
| | | ☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Persons involved in the sex trade | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Perinatal | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Persons living in low prevalence areas | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Blacks / African-Americans | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| American Indians / Native Alaskans | ☐ Scaled up | ☐ Funding increase (CDC) |

| | | |
|---|---|---|
| | ☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Asians | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Hispanics | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Native Hawaiians / Other Pacific Islanders | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Whites | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy |

| | | |
|---|---|---|
| | | ☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Immigrants / migrant workers | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |
| Other (please describe: ) | ☐ Scaled up<br>☐ Scaled back<br>☐ No change<br>☐ Not applicable | ☐ Funding increase (CDC)<br>☐ Funding decrease (CDC)<br>☐ Funding increase (state / local)<br>☐ Funding decrease (state / local)<br>☐ National HIV / AIDS Strategy<br>☐ CDC funding opportunity announcement requirement<br>☐ Policy change (state / local)<br>☐ Other (please describe: ) |