

National HIV Prevention Survey

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Introduction

Recent data from the Centers for Disease Control and Prevention (CDC) indicate that the HIV/AIDS epidemic in the United States (U.S.) is far from over. An estimated 56,300 people become infected with HIV each year, 40 percent higher than previously estimated. In addition, infections have remained at this level for more than a decade and certain populations bear the brunt of the impact, particularly black Americans and gay and bisexual men of all races/ethnicities. These trends underscore the continuing importance of HIV prevention in the U.S. While the CDC plays the central, federal role in the nation's HIV prevention response, much of what is considered "HIV prevention" is actually 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.

NASTAD and the Henry J. Kaiser Family Foundation partnered together to produce this report that offers a baseline picture of how HIV prevention is delivered across the country. It provides policymakers, public health officials, community organizations, and others a more in-depth understanding of HIV prevention and the role played by health departments in its delivery. The report is based on a survey of 65 health departments, including all state and territorial jurisdictions and six CDC directly funded U.S. cities and provides a comprehensive inventory of HIV prevention efforts at state and local levels.

Key Findings

Funding for HIV Prevention Has Been Relatively Flat in Recent Years; While Funding from CDC Represents Just Over Half the Nation's Prevention Budget, States Provide Key Share

Funding for HIV prevention was \$581 million in FY2007, ranging from less than one million dollars in four smaller states (Idaho, North Dakota, South Dakota, and Wyoming), to more than \$20 million in six large states which account for significant shares of the nation's HIV/AIDS prevalence and have longer-standing epidemics (California, Florida, Massachusetts, New Jersey, New York, and Texas). Just over half of prevention funding (58 percent, or \$337 million) was provided by CDC. More than a third (35 percent or \$205 million) was provided by 38 state and local governments, in some cases acting to supplement CDC support and in others providing the bulk of funding for their HIV prevention response. Since FY2004, funding has been relatively flat, with the exception of an increase in FY2007 of \$35 million in federal funding for a CDC initiative to expand HIV testing; 22 of the 30 jurisdictions with increases in the last year received expanded HIV testing grants.

Jurisdictions with Greater Numbers of People Living with HIV/AIDS Have the Largest Prevention Budgets, but do not Rank at the Top in Funding Per Person with HIV/AIDS

The investment in HIV prevention varies across the country, reflecting differences in population size, epidemic burden, state and local contributions, local capacity, and other factors. In general, those states with the greatest numbers of people living with HIV/AIDS also have the largest HIV prevention budgets. However, when analyzed per person living with HIV/AIDS, low prevalence states as a group received the highest HIV prevention funding per case (\$1,617), followed by high prevalence states, who received about half as much (\$826), moderate prevalence states (\$811) and high-to-moderate prevalence states (\$652), a pattern largely driven by CDC funding; by contrast, state funding per person with HIV/AIDS was proportionate to prevalence. There were also regional variations in the HIV prevention investment, which largely tracked HIV prevalence.

An Array of HIV Prevention Services is Provided Across the Country, Including Health Education and Risk Reduction Activities, Partner Services, and HIV Testing

Health departments provide an array HIV prevention services, primarily a core set that consists of health education and risk reduction (HE/RR) activities, HIV testing and screening, and partner services. Other activities and services include HIV laboratory support, prevention community planning, and public education and media campaigns. Some jurisdictions also offer post exposure prophylaxis, needle and syringe access, and drug substitution services. In general, jurisdictions with lower prevalence spent a greater share of their budgets on program administration, laboratory support, and community planning compared to those with higher prevalence, who in turn allocated greater shares to direct prevention services (HE/RR, testing, partner services). This likely reflects the need for a jurisdiction to have at least a minimum amount of funding in place to support operation of a prevention program, and the economies of scale that are generally more achievable in higher prevalence jurisdictions, which also face greater demand for services.

Health Departments Are Increasingly Moving to Routine Population-Based HIV Screening, While Continuing More Targeted Efforts to Reach Those at Higher Risk

All states use targeted HIV testing strategies, which are designed to reach populations at highest risk. An increasing share is moving to implement routine HIV screening, recommended by CDC for all adults/adolescents (ages 13-64), all pregnant women, and newborns, although this varies by population group: 42 jurisdictions report conducting routine HIV screening for pregnant women, 17 for newborns, and six for adults/adolescents.

Health Departments Face Numerous Challenges, Primarily Due to Funding Shortages, Which Affect Their Prevention Capacity and Have Resulted in Some Scaling Back

Health departments reported facing several challenges in delivering HIV prevention programs, most often citing: funding (52 jurisdictions); training and capacity building for local partners (45); capacity of local partners to provide needed services (43); and data collection and reporting requirements (43). These challenges affected their prevention capacity in several areas including the ability to deliver prevention services to high-risk populations, recruit clients into programs, and retain clients

once there. Challenges also led to some scaling back of prevention services, particularly community-level HE/RR programs (29 jurisdictions); individual/group level HE/RR (24), public information/media campaigns (26), and community planning (25). Given these challenges, states were asked what they would choose to scale-back, if they had the flexibility to do so (e.g., if not required under grant agreements), and to scale-up, if resource constraints were not a factor. Two main areas were identified for scaling-back: community planning (29) and abstinence-only-until-marriage education programs (22). If scale-up were possible, the top areas identified by states were partner services (17), HIV screening in health care settings (17), structural level interventions (16), and evaluation activities (15).

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Conclusion

The ability of state and local jurisdictions to address challenges and meet HIV prevention needs in their communities going forward remains uncertain. The limitations cited above were identified at the early stages of the current economic downturn, a situation which has significantly worsened since that time. In a recent budget survey conducted by NASTAD, twenty-two jurisdictions reported state revenue reductions in FY 2009, including 12 with existing or expected cuts to HIV prevention specifically, with more cuts anticipated for FY2010. In addition, federal HIV prevention funding has been flat between FY2007 and FY2009, including funding provided by CDC to states for HIV prevention activities.

At the same time, the Obama Administration has signaled a strong interest in reinvigorating the domestic HIV prevention response, including through the development of a National HIV/AIDS Strategy for the country. In addition, the President's FY2010 budget request includes a \$53 million increase for domestic HIV prevention efforts, although funding levels will not be finalized by Congress until later this year. These developments, as well as the larger fiscal health of the nation, will need to be closely monitored to assess their continued effects on HIV prevention in the United States.