



HIV PJA Statement
CDC Funding Opportunity Announcement
(FOA) PS12-1201:
Comprehensive HIV Prevention Programs
for Health Departments

CDC's new Funding Opportunity Announcement for health departments (CDC's single largest investment in HIV prevention) includes dramatic changes in the geographical allocation of funding, planning requirements, and the mix of federally funded programs and services. CDC states that these changes are necessary to implement "high impact prevention," and says it is essential to achieve the National HIV/AIDS Strategy's HIV prevention goals.

The changes embodied in this FOA are not only significant in terms of HIV prevention efforts but as a harbinger of potential shifts in the entire domestic HIV/AIDS effort. According to CDC, the FOA responds to new directions described in the National HIV/AIDS Strategy (NHAS), new data on treatment as prevention, alignment with the Affordable Care Act and other factors.

As currently planned, this FOA will *shift* funds:

- from low-prevalence to high-prevalence areas (and in most cases, from states to cities),
- from regions with lower disease burden to those with higher (the former include those who have likely reduced transmission through comprehensive and/or innovative programming),
- from primary prevention efforts targeted to those who are HIV-negative to "prevention with positives," and
- from community-based efforts to those centered around clinical and public health settings.

CDC has stated that this new approach "features better geographic targeting of resources and a stronger focus on supporting the highest-impact prevention strategies. This approach embodies CDC's commitment to high-impact prevention using scalable, cost-effective interventions with demonstrated potential to reduce new infections to yield a major impact on the HIV epidemic."

The HIV Prevention Justice Alliance (HIV PJA) strongly supports the CDC's goal of more closely aligning funding with the epidemic. However, as with any change involving shifting funding and/or focus, there is great concern about areas of the FOA. The HIV PJA will continue to work with our members and constituents to inform the nation's approach to this FOA, but wishes to express several immediate concerns and recommendations:

August 16, 2011

The Political and Economic Climate

Economic justice is rarely seen in our nation today. Health department, AIDS service organizations and community-based organizations, as well as the constituencies we serve, are under great strain in the economic downturn, with no end in sight. The FOA would add additional changes to the funding climate in many jurisdictions, potentially destabilizing long-standing as well as new or innovative efforts.

CDC must restore the additional \$20 million for Category A activities, while continuing to fund the new Category C at anticipated levels to allow for greater innovation through competitive funding. As recommended in the External Peer Review of DHAP, broad change in CDC programming requires distinct shifts in funds, and it is imperative to be vigilant about scrutinizing CDC for any potential shifts from a range of smaller, antiquated and/or less essential areas to allow for innovation as well as retention of core programming in this challenging economic climate.

The awarding of Category C (for innovative activities and pilot projects) would best reach the category's goals *after* CDC awards Category A and B. Any innovation must be built on a platform of core HIV prevention services and expanded HIV testing initiatives. With these federal funding streams current up for competition, and likely to shift dramatically, local and state jurisdictions cannot make informed decisions about what additional innovative projects to propose. *The HIV PJA strongly supports Category C as an important supplemental source fostering innovative HIV prevention activities but strongly urges CDC to postpone the Category C competition until a time after Category A and B grants have been awarded.*

In the August 12 MMWR on high rates of HIV among urban residents living in poverty, CDC reminds us that “Structural interventions, which address adverse social, economic, policy, and environmental conditions within communities, have been shown to be effective public health interventions,” and states that “The association between HIV prevalence and low socio-economic status in the NHBS survey suggests that improvements in educational and employment opportunities in low-income communities, along with concomitant reductions in poverty, could reduce new HIV infections.” *CDC should require grantees to explain how they will develop, implement and maintain structural interventions that increase economic justice in all jurisdictions.*

In an era in which over 10,000 people living with HIV will soon be on waiting lists for antiretroviral therapy, **the escalating ADAP crisis counters the vision and implementation of broad-based support for test and treat models and other forms of treatment as prevention.**

An Urgent Need for HIV Treatment Justice:

The HIV PJA urges all HIV prevention and other stakeholders to call out and campaign for **HIV treatment justice**, including **drastic and lasting reductions in the price of antiretroviral therapy from drug companies** to addressing the ADAP crisis, as well as engagement in sustained and amplified efforts to obtain more funding for treatment.

August 16, 2011

High Impact Prevention

There is no biomedical intervention that does not involve human behavior. A range of public and community organizations and entities have developed significant expertise in behavioral and social interventions that reach hard-hit populations that have been traditionally overlooked or marginalized in the clinical setting. Although one of the goals of the FOA is to increase health equity, CDC must clarify how the program will assure that the right mix of behavioral, biomedical and structural efforts (in our challenging economic climate) will ensure the integration of these approaches in a healthy mix of providers and settings to increase equity.

CDC must *prioritize syringe exchange*, as an intervention for which there is copious evidence of high impact. The federal funding ban has been lifted and there is long-awaited CDC guidance in clearance. However, it is not explicitly listed as a mandated or recommended requirement. In addition, the FOA shifts a greater proportion of funding to regions that have not offered syringe services in the past. Where capacity, legal or regulatory issues remain, *CDC should ensure appropriate technical assistance to expand the feasibility of syringe programs.*

CDC must *better explain what is the anticipated benefit of high impact prevention for high-risk negatives (HRN).* Programs must have support to develop and maintain effective models for identifying and serving HRN, including women.

Recent data further proves the growing impact of the epidemic among young Black gay and bisexual men. In addition to ensuring prioritized efforts for these populations in Category A and B, CDC could use the deferred Category C to more explicitly encourage jurisdictions to develop and propose structural interventions to address societal, faith-based, and family-centered stigmatizing attitudes and belief that elevate risk for gay and bisexual men and other MSM, particularly young gay and bisexual men and transgender people of color. CDC must *encourage efforts in distinct communities of young gay and bisexual men of color (as well as transgender people, and other men and women at high risk) that go beyond promotion of testing, as well as structural interventions to reduce external and internalized homophobia, trans-phobia and gender bias.*

After years of emphasizing DEBIs, CDC must *clearly state the rationale for the downgrading of DEBIs* in the FOA to provide community and government leaders with a greater understanding of how the shift to high impact prevention may better reach the goals of the NHAS. CDC must also provide support for retaining appropriate DEBIs, EBIs and new approaches for behavioral interventions to ensure that all targeted populations benefit from high impact prevention. CDC should *encourage innovation around mobilization, health community and social marketing, and with homegrown behavioral interventions developed at the community level*

Community Involvement and Local Control

The FOA includes a shift from “community planning” to “jurisdictional planning.” There is an urgent need for clarity on what this means, and the role of people with HIV and other community members. CDC must state *what are the desirable elements to retain from*

August 16, 2011

community planning and what will no longer be maintained, how the new structure will bring voice to those who are at disproportionate risk of infection, and how participants will be supported to engage in planning on structural interventions and policy efforts.

Currently, Category B mandates a 70% clinical / 30% non-clinical funding mix. However, not all communities will be best served by this formula. *CDC should allow jurisdictional waivers to this mandate in Category B if localities can provide data showing that such a funding mix is unlikely to reach the most affected elevated-risk communities, including young Black gay and bisexual men, drug users, high risk women and men, and transgender people of all races and ethnicities.*

Managing and Monitoring Transition and Change

Although the FOA is intentionally designed to shift the profile of services significantly, CDC must help *monitor and manage the transition of funds from levels of government and between types of providers*, showing there is continuity of service in key areas.

CDC must release a plan to *retain decades of expertise in prevention that may be lost due to funding shifts*. CDC must also do a better and clearer job of explaining how they intend to *mitigate the risk of punishing success*, as jurisdictions that have succeed or will succeed in reducing incidence have and will lose funding under this structure. Jurisdictions must show how they will retain or improve cultural and linguistic access to services.

CDC must empower jurisdictional planners to *monitor and evaluate the transitions of funding and programs under the FOA*, but also should contract with an independent entity to conduct an assessment of each year of the program by evaluating 10-15 representative jurisdictions that embody the different kinds of transitions (newly directly funded; net gain city/states; net loss city/states; high-incidence; lower-incidence, etc). In addition, *the mix of funding and programs at the national and jurisdictional level must collect data to allow for the monitoring and evaluation of proportionality of resources* towards groups with highest rates of infection, including gay and bisexual men and transgender people of all ethnicities and races, people in poverty or of low socio-economic status, women of color and/or drug users.

There is an elevated need for *effective and transparent collaboration between CDC and HRSA* under this new structure. Both entities should clearly state how this will occur, and how reporting and monitoring requirements will be streamlined to lower the burden on grantees.

CDC should clearly state *the modeling or other rationale for the amounts chosen for low-incidence and territorial jurisdictions*, and why these levels of funding would be expected to reach the goals of the NHAS.

The HIV Prevention Justice Alliance (HIV PJA) is a coalition of more than 80 organizations and a network of 13,000 individuals working at the intersection of HIV/AIDS, human rights, and struggles for social, racial, gender, and economic justice. Since 2007, our network of thousands of activists, researchers, service providers, and change-makers is mobilizing in the fight for human rights and HIV prevention justice.

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August 16, 2011