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**2007 National HIV Prevention Conference - Day 4  
Plenary: Synergy Between Science and Program  
CDC  
December 5, 2007**

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[START RECORDING]

**VICTORIA CARGILL-SWIREN, M.D., M.S.C.E.:** Good morning. That was really terrible. I know we're all tired but let's try that again. Good morning.

**AUDIENCE:** Good morning.

**VICTORIA CARGILL-SWIREN, M.D., M.S.C.E.:** That's it. That's it. We're on the move. This has been a different kind of conference, and I don't know about you but I feel very energized and I feel like we're on the move. Thank you. [Applause] It's a new day in prevention.

This is our closing session, I think one that will really help you and I hope help all of us bring it all together since we've talked about synergy, and this is Synergy Between Science and Program.

Our first speaker will be speaking about incarcerated populations, prevention and community linkages. And that will be given by Dr. Timothy Flanigan. Dr. Flanigan is a Professor of Medicine at Brown Medical School and Director of the Division of Infectious Diseases.

He joined Brown University in 1991 to work with Dr. Charles Carpenter. He has spearheaded an HIV primary care initiative to outreach among HIV positive women, substance abusers and prisoners. And something that's not on Tim's bio but will also help you know how old I am, is I was Tim's

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Internal Medicine Fellow at the University of Pennsylvania.

Tim Flanigan. [Applause]

**TIMOTHY FLANIGAN, M.D.:** Thank you Vicki. It's really a pleasure to be here and I want to thank the organizers for inviting me to talk. But most of all, I want to thank them for focusing on this very important topic.

Now I am an AIDS conference veteran for the last 20 years. But I have to tell you, I enjoy this conference the most because it's real people doing real work in the trenches, struggling day in and day out with HIV prevention and treatment, often with limited resources. So I take my hats off to you. [Applause]

I also have to say that when I went through the lobby last night around 12:30, everyone was having a very good time. So maybe those two things go together.

So, many people think of corrections as being a jail and a prison, behind a huge concrete wall which is out there. People that are incarcerated are not part of our community. We know that that is absolutely wrong. Those concrete walls are really more a semi-permeable membrane. As you can see from this slide, in the United States there are over 10 million inmates per year that are released to the community. So that individuals in jail and prison are going back and forth, and back and forth. And these different colored dots here represent the many infectious diseases; such as HIV, hepatitis

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B and C, STDs that are therefore both within the correctional setting and within the community.

So corrections are part of our community. If we are committed to prevention and care, we must be involved in the correctional setting and the data that I will talk about I think will support that.

Now this slide is from work by Ted Hammock going back to 1997. And what it shows is the-percent of individuals with different infectious diseases that pass through the correctional setting in that year. It's not the percentage that are in corrections but that go through, because corrections is really a revolving door. And he estimated that among individual with AIDS, it was 16-percent. With individuals with HIV it was 20 to 26-percent, chronic hepatitis B, over 12-percent, hepatitis C, about a third. And active TB disease, 38-percent. So the burden of infectious diseases in the correctional setting is enormous.

Now this disproportionate burden of HIV, along with incarceration and with substance abuse is disproportionately born by the minority community and particularly by the African-American community. African-American men bear the highest burden of incarceration and HIV. They have six times the HIV rates of white men and over 10 times the incarceration rates of white men. But incarceration can provide a public health opportunity to intervene.

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This slide is from the CDC data showing the increase in the proportion of AIDS cases among black individuals and you can see, as you all know, there's a rate approaching 50-percent.

So this epidemic of HIV incarceration and substance use is enormous and is very heavily born in the African-American community and really requires and mandates a very focused and effective response.

So, I'm going to speak a little bit today about opportunity for HIV testing, prevention, and linkage to care in the correctional setting. Now when I say correctional setting, I'm going to talk about prisons and jails. And just a little primer, prison is where you go when you have been sentenced for a crime. Most individuals in prison are there for a longer period of time. Over a year. Jails are where you go when you're picked up. They tend to be chaotic places, it's very transient. You're usually there just when you're charged. And I'll point out some of the differences as we go along.

Now, one of the big successes, which is extraordinary, which we need to celebrate, is that the AIDS related mortality has fallen dramatically in state prison facilities. So AIDS related deaths overall in state prisons has dropped by more than 80-percent since 1995 due to HARP.

In 1999 the AIDS related death rate was 20 per 100 thousand state prisoners, which was actually lower than it is

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CDC

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for comparable groups with AIDS in the general population. And routine HIV testing is offered in many systems, about 19 states now, and the community standard for treatment is accepted as the appropriate standard in corrections. This is very important. It means we still have a long way to go within the prison system, but the standard is out there and our goal and the goal of Public Health and Corrections working together is to try and achieve that.

This slide just shows the relative HIV sero-positivity rates among prison inmates from 1999 to 2005. The good news is that these rates have fallen. They've fallen slightly, but this is very significant.

If you look at the top line which is among women, the rate's fallen from three-percent to under 2.5-percent. And although the drop in the HIV sero-[inaudible] rates in men is relatively smaller, it's been consistent and it's very significant.

Now I want to tell you a little bit about Rhode Island and I'll go back and forth and talk about Rhode Island as well as other systems. This is our maximum security prison, which is in Cranston, and myself and one of my colleagues. We've been very lucky, because we have one centralized system, both a jail and a prison.

Back in 1989, routine HIV testing was initiated. And the first ten years of the epidemic, 26 to 32-percent of all

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the HIV positive tests in the state came from the correctional setting. It was by far and away the most important testing site. And then due to leadership, particularly by Dr. Carpenter and the state level and the correctional level, a committed HIV care program was instituted which included care within the state and within the community. And that linkage has proven to be enormously effective.

But, that's taken place in one system. I told you we've made progress in prisons. But the new frontier and the one where I think we have to focus as we move forward is HIV prevention and care within the jails.

There are 16 times the number of individuals that pass through jails than prison, but jails are really tough to work in. They're chaotic. They're in county and city jurisdictions. They're not centralized. It's hard to find the leadership. Often they operate with very poor funding. Inmates are transient. The median length of stay in most jails is less than three days. Security is a priority in jails, not public health and not health care. So it's hard to work there, but as I'm going to show you, I think we have to work there. There is no choice.

Now, one of the things that have made this possible is rapid testing, and this is obviously a side of OraQuick, there's also Unigold. But rapid testing programs has been shown to be very effective within jails and I'm going to show

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you data that's been presented at this conference. One of the reasons why I'm so passionate about it is that even though we've been able to do comprehensive testing in Rhode Island, and in other prison systems, the standard is often, quote, "No news is good news." Now this is going to be shocking to some of you. Not to those that work in corrections but to others.

In Rhode Island when you get your blood drawn, you're told it's for an HIV test, but in essence, there's no counseling the way we think of counseling, a consent is signed. But if you don't hear back, the assumption is your test is negative. And when we looked at project stark, unfortunately in most other systems with routine testing, the same thing. No news is good news.

This is a huge challenge. We're missing the opportunity for effective HIV prevention in one of our most vulnerable communities. One of the other reasons why rapid testing is so attractive is when your sitting there doing and developing your rapid test, it's a great opportunity to do counseling.

So my hope is that when we institute rapid testing, we'll be instituting client center counseling at the same time. So this is data from the rapid HIV test in jail project, funded by the CDC, four states and 25 jails, 2004 to 2006, 33,000 tests done. 1.3-percent was positive, and 269 individuals were newly identified with HIV, about half of these diagnoses were

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among persons with heterosexual or no reported risk, and this is so common in corrections that individuals with heterosexual risk do not perceive themselves to be at risk for HIV. The best news is that as a result of this study, rapid testing programs have been mainstreamed and actually expanded in Florida and New York and Louisiana and are continuing in Wisconsin.

Now, data presented at this conference here, and I'm really excited about all the correction work presented at this conference is from a very ambitious, effective HIV rapid-test program in the D.C. jail system. The D.C. jail has 18 thousand intakes per year. 88-percent are male. 89-percent black. HIV testing was done using OraQuick and HIV testing was quote, "automatic." That was a new term for me.

And that meant it was done unless an inmate refused. And when the question was asked, 8-percent of inmates did refuse. So I think that's good and appropriate, but it's an opt out strategy. 11 thousand tests were performed, and when they analyzed the data, African-American men were significantly more likely to be tested in jail than in any other sites. 240, that's at the other sites throughout the city. 240 persons were identified to be HIV positive. Half of them were newly diagnosed and all were referred to care. We tend to look at this data and assess how many are newly diagnosed. But

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remember, a lot of the individuals in jail, they may know they're positive, but they're out of care.

They may not admit it and a repeat, routine testing program can help link them back to care. So there's a big value of testing somebody who already knew they were positive, because it can serve as a linkage to care. But there's also some not so good news.

This is a paper recently from CID and it showed the immune status, meaning the CD4 count at presentation to care has not improved among antiretroviral [inaudible] persons from 1990 to 2006 at the Johns Hopkins HIV Clinic, which is spectacular, in Baltimore, Maryland. Baltimore is one of the top 10-5 cities in terms of HIV and AIDS rates. We would think with all of this work going on, with all this testing, we'd be diagnosing people earlier and getting them to care. But we're not. The median presenting CD4 count was 371 back in 1990 to '94. It dropped to 276. And multi-viral analysis has shown that male sex, being a man, and being African-American meant you presented with lower CD4 counts.

Now what's going on? What the at risk community, particularly if you're a man and you're African-American, is just not being tested early in the disease, only later when CD4 counts have fallen. Part of the problem is with all this spectacular CDC and other initiatives on HIV testing and

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medical care, let's face it, the medical system focuses on woman early on. It does not focus on men.

So young men don't have routine primary care, particularly you are going to have less access if you're poor or if you're African-American, so men are not going to be reached necessarily through a lot of those initiatives. So we have to reach out and jail is one of those places.

And this slide is a little dramatic, but still, sometimes we're smoking while the house is on fire and the result is bad. So why is there not routine mainstream HIV testing, and what about syphilis testing? What about gonorrhea and Chlamydia testing in the Baltimore jail system? This is an example, not to pick on Baltimore. OK, HRSA has funded a SPNS, a Special Projects of National Significance. There are going to be ten sites with 16 jails, that are going to look at rapid testing and linkage to care, and hopefully this will make a difference. Now I want to talk a little bit about prevention.

This is data from a study in Rhode Island where we did rapid testing and risk assessment on 100 folks, and three quarters of the folks did not consider themselves to be at risk. So you can't just test people that think they're at risk, you've got to test everyone.

Multiple sexual partners were common. Condom use was rare. Self reported STDs were common. When we asked folks most people thought that testing within the round of Department

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of Corrections was a good idea, and most thought that partner notification would be helpful.

But we're not doing it. And that's another area we need to look at. Now, this slide is small but it shows the gonorrhea rates broken down by race. And you can see the incredible burden of gonorrhea in the African-American community. Well, I've just talked about HIV testing, what about STD testing?

And this slide shows a very important study on a urine based jail screening program for gonorrhea and Chlamydia in New York. In the first year in six jails, you can see the number of men reporting with Chlamydia increased by over 1,600-percent. And by this by far and away surpassed all the other testing sites, so the adult jail became the most important STD testing site. So, is there routine STD testing for GC and Chlamydia in Jackson, Mississippi? In Miami? In Atlanta?

Look at the southeast, where GC and Chlamydia exploding. What are we doing? And this is part of HIV prevention. Prevention within corrections is possible. The CDC funded project [inaudible], which we're very happy to learn, is going to be a DEBI, and it looked at 522 young men being released from prison.

It compared a single session client centered approach to a six session intervention. Two within corrections and four after. One on one, clients centered. And what it showed is six

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weeks after release, those individuals with the six sessions, had a significant reduction in unprotected vaginal and anal sex.

And the difference is relatively small, but very powerful. Now what about sex within jails or prison? It does occur. This is an MMWR talking about an HIV transmission which occurred in Georgia among 88 inmates. And a smaller study showed that where consensual sex is going on, people are trying are often trying to get protection. Ongoing risk taking behaviors occurs in jail and prison but much less than in the community.

As my friend Barry Zach said, most of the HIV positive people going into jail and prison and leaving jail and prison, came in infected. So most of transmission is occurring in the community, not within the setting behind the walls. But that doesn't mean we shouldn't be developing effective prevention behind the walls. We should, obviously. Now, last point, what happens after release? Linkage to care is critical, it's possible and it can be successful. It's usually done with case management paired with community outreach. And the key component is starting prior to release. So an excellent model is Hamden County Mass. where they've linked the correctional setting with the community. They've done it by looking at four Health Centers which they assign people based on zip code or by their history. They have dually based team members. This is a

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really important principle, individuals that are comfortable working both within the Health Center and within the corrections. This actually helps to transform the correctional setting. It also helps to transform the health care setting. So this dually based concept, if it's achievable, a lot of times it's hard because the geography really can work well.

So, the HIV patient show rate after release was 84 to 90-percent, really extraordinary. And there's a decrease in Emergency Room visits and hospitalizations before versus after jail. So it was very, very cost effective. Project Bridge is a similar project in Rhode Island. This is what south Providence looks like. It's not as bad as some of the other inner cities around. And we use a dropping center and a two person team with a social worker and an outreach worker which has been very, very effective. Initially there's daily contact, then weekly contact, then monthly contact.

95-percent of eligible folks have enrolled, 90-percent have a clinic visit in the first month, but many miss and appointment. You've got to be flexible. You can't be rigid. It's been associated with increases in CD4 count, decreases in viral load and good continuity. But most of our clients continue to use drugs. So we thought, gosh maybe this will mean-- will folks be abstinent? No. Ongoing substance use is the rule, not the exception.

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Now, just a few thoughts to try and encourage you or help you if you're thinking about working in a jail, at a prison, or you do work there. First is, unexpected things happen. And you've got to be very flexible. So get ready. The second thing is scaling those prison and jail walls in order to get inside can often be discouraging.

So you may feel like this poor fellow on this big, tall wall. Remember your priority, which is health and public health is not the priority of the correctional system. For them it's security. So you've got to be patient, you've got to be flexible. But why are you doing it? You're doing it because the inmates really need your help. And it can be very satisfying and it can be very, very rewarding and very interesting.

Partnership is absolutely key and this partnership with professionals and with the community. With professionals, I mean partnering with wardens where you can with correctional officers, with administrators that don't share your point of view. This is hard to do sometimes because we're obviously passionate and strongly believe in what we do. But it's the key to success within corrections. You've got to understand where they're coming from, which is not public health, but security.

So, I also say partnering with the community and you probably think I mean with a really good CBO and I definitely

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mean that. You've got to be working with your CBO. But it also means working with the community which is the inmates. And the poster here on the side is from an inmate who drew this poster as part of a behind the walls prevention project. And the point being, you've got to be working with that community which is the key community as well, so a lot of people to thank, including the CDC, NIH, or Center for AIDS Research. I also list a number of people who I work with here at Brown, and at the bottom I want to thank colleagues around the country who have been deeply involved in correctional HIV work, many for over 10 years.

And this is my backup team, keeps me sane. And this last slide is from a jail in Mysore in Southern India. I've only talked about HIV within corrections in the United States. But this is a much bigger global problem which also needs our care and attention and passion. Thanks very much. [Applause]

**VICTORIA CARGILL-SWIREN, M.D., M.S.C.E.:** Thank you so much Tim. Our next presenter is going to be Alice Gandelman and she is going to speak about Science to Program Translation for Community Based Organization. She is a Director of the California STD/HV Prevention Training Center and Chief of the Disease Prevention Section of the STD Control Branch for California Department of Public Health.

She has received her MPH in Community Health Education from San Jose State and has worked in HIV, STD and hepatitis

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programs for over 20 years in both community and public health settings. She oversees training and technical assistance activities for clinical behavioral intervention and partner service programs for California as well as many ATB training and prevention projects.

I think the most important thing to me that Alice has mentioned is how she's committed and I think you will see when you listen to her, to integrating community, provider, funder and research agendas to improve the quality of life services delivered in practice settings. Alice. [Applause]

**ALICE GANDELMAN:** Thank you Vicki. I'm very happy to be here and thanks for inviting me to speak about these important topics.

When I was asked to speak about science to program translation for community based organizations, I realized that if I was to genuinely speak about this topic, I really needed to address it from additional perspectives.

So I decided to change the title just slightly to reflect the broader perspective, and would like to talk about science to program and program to science translation for community based organizations, health departments, researchers and funders. What we all need to know.

Because we're all involved in this effort together and we must work very closely and research translation activities

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if we want to have success. So during my discussion I'll be speaking from a program, or practice perspective.

Here we go. I was asked to speak about five general areas. The importance of translation of research into practice, challenges of translating research into programs and practice settings, examples of successful translations, lessons learned to date, and recommendations to expedite the process. So a lot to talk about in 20 minutes.

I'd like to begin by addressing research and evidence based approaches. Evidence based interventions are those that have been tested using methodologically rigorous designs and evaluated using behavioral or health outcomes by utilizing comparison or control groups.

Research studies determine whether an intervention is efficacious. In other words, does it work? And are the effects due to the intervention and not something else? Understandably, efficacy is a central focus and the early stages of research translation focus primarily on how to transfer efficacious or evidence based studies to community or program settings.

Technology transfer was a very popular term which was widely used and still is today although to a lesser extent as a way to disseminate evidence based interventions and programs. Although technology transfer was the popular approach used for many years, during the early phases of the diffusion process,

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the term has had implications for community based organizations and other HIV prevention providers.

Technology transfer is viewed by many programs as a one way street from funders and researchers down to programs. And while the science or research view was emphasized, and was the basis of the technology transfer, it did not include other factors or viewpoints necessary for successful translation.

The term technology exchange has been used more recently to describe the multi-directional technology and information exchange that incorporates the experiences and expertise of value partners with often years of experience working in HIV prevention in their respective communities. It's not to say that technology transfer is wrong and technology exchange is right, it's just that each has a different emphasis and we need both.

We need to be focused on efficacy issues and how science based programs get disseminated because we want to deliver efficacious programs. But we also need to emphasize technology exchange because this too is critical for DEBI diffusion.

Technology exchange in fact is critical for effectiveness research and research translation. While efficacy is concerned with whether and intervention does more good than harm when delivered under controlled circumstances, effectiveness research has been defined as whether a program

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does more good than harm when delivered under real world conditions.

Effectiveness research looks at implementation and practice settings and identifies what factors act as benefits or barriers to successful implementation. I'll talk about some of these factors in just a few minutes.

The reality is, most of our previous efforts have focused on technology transfer and we are only more recently understanding the importance of technology exchange and its role in effectiveness research.

The diffusion of effective behavioral interventions or DEBI program that we're all so familiar with has furthered our understanding of how complex the application of research into practice or real world settings can be and the importance of partner dialog.

Given these complexities, I'd now like to describe some of the challenges of translating research into practice. One challenge that is often overlooked is the sheer number of partners that are involved in the research translation and DEBI diffusion processes.

In addition to persons living with and those increase risks for HIV and effected community, other partners include: funders, researchers, community and faith based organizations, state and local health departments, which may also include one or more of the above entities.

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Our CDC partners including center, division and branch representatives from multiple programs. National, state and local training and technical assistance partners. And there are probably some that I have forgotten that belong on this list.

The point is, with so many people involved in the diffusion process, communication is extremely important. Including who we communicate with, what gets communicated, how that communication occurs, and when certain things get communicated. Research translation and the current national diffusion efforts via DEBI is a relatively new and evolving process. And as a result, updates, revisions and changes occur frequently.

So who hears what from who and when they hear it is important in this evolving field. Particularly as it relates to definitions, program requirements and how DEBIs can and cannot be implemented, which brings me to the next slide.

The accurate or correct implementation of DEBIs has been another challenge many CBOs and other funded agencies have experienced. Particularly as it relates to fidelity or adhering to core elements based on the internal logic of a particular intervention.

By way of implementation in a real world or practice setting we know that some level of adaptation is bound to occur. While adaptation continues to be better articulated and

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defined as repressed, it is at the same time becoming less clear cut as we travel further down the DEBI diffusion road.

We are fairly clear about what constitutes fidelity and fairly clear about what constitutes reinvention, but at what point on the line does adaptation become reinvention? Does adding a session, addressing different behavioral determinants for the same target population equal reinvention?

Does taking a session away constitute reinvention if it does not alter intervention outcomes? I think we still have much to learn regarding where the boundary lines are for adaptation and we'll hopefully be learning that in the next several years.

And finally, determining the extent to which DEBI implementation has been successful whether adaptation has occurred or not is also challenging as there are also currently not sufficient resources for agencies to conduct meaningful evaluations. I'll speak more about this in a bit.

Another important lesson we are learning is that effective research translation requires sufficient workforce capacity. Although some CBOs and health departments are highly skilled, others are inadequately prepared.

Successful DEBI implementation requires prerequisite foundational skills that are not usually covered in DEBIs specific trainings. These skills are critical and have become more apparent throughout the DEBI diffusion process.

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Foundation skills have not historically been an issue during intervention studies because research staff tends to be fully trained according to intervention protocols to ensure fidelity throughout the study.

In general, the greater the intervention complexity, the greater the capacity needed to implement with fidelity which is an important consideration in the DEBI selection process.

Basic foundation skills are necessary for the successful implementation of individual, group or community level DEBIs and without going into great detail, at a minimum, providers should either be representative of or have a thorough understanding of the communities they are serving.

If conducting a DEBI that's an individual level intervention, they should be competent in client centered counseling including in risk assessment and risk reduction counseling.

For group level interventions, group process and facilitation skills including conflict management and for community level interventions, street outreach skills such as ethnography and field safety.

What we are learning is that we can not simply choose a DEBI or an intervention without simultaneously considering the risk behaviors and characteristics of the population prioritized for services, the intervention requirements and

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feasibility of conducting that intervention in a given community and the capacity of staff in a given agency to effectively carry it out. All of these factors must be looked at together because each is an important piece that will affect implementation and outcomes. Despite the challenges, there have also been many successful translations or creative approaches used to implementation evidence based on interventions in the field. And I'd like to highlight what a few agencies have done in this regard to best meet their needs.

Many currently available DEBIs are not good matches for smaller states with low HIV morbidity. This was the case for the Idaho State Health Department. So they decided to integrate respect into their statewide counseling and referral strategy.

For them, the majority of prevention opportunities occur when clients interact with providers during individual counseling in clinic appointments. As a result, all state and local prevention providers now receive a day of basic HIV prevention counseling followed by the two day respect training.

Although this is not really an adaptation, by combining these two approaches, Idaho was able to utilize an evidence based intervention in their counseling and testing programs to best meet their needs.

Centerforce is an organization that provides services for prisoners and family members and adapted healthy

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relationships for incarcerated men and women in two different prisons in the Bay Area and central California.

The intervention sessions did not vary significant but as we heard from our last speaker, implementation planning became a major focus for the agency as they had to obtain buy in and approval throughout the prison system and leadership at each of the institutions, which required several months of advanced planning. Recruitment strategies also had to be altered within these closed systems to maintain and protect client confidentiality.

The Broadway Youth Center at Howard Brown Health Center in Chicago adapted, or reinvented SISTA for transgender communities and renamed it TWISTA. This involved changing the intervention sessions to more closely relate to issues that are central for transgender communities, particularly around cultural and gender pride. They have also added an additional session to focus on transgender specific roles related to risk taking behaviors related to them and their sexual partners as well as safer needle use for hormone and other injections.

Gay Men's Health Crisis in New York has enhanced their implementation of community promise by using the internet as a way of recruiting for the intervention and displaying some role model stories to motivate potential program participants.

In order to market the program to the House and Ball community with community input, they re-branded community

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promise as For Real [misspelled?]. Role models Educating All Labels. Members of the House and Ball community often use the internet to stay connected, network, socialize and plan future events.

In addition to maintaining fidelity of the community promise intervention, they added an innovative approach to reach youth by creating a web page on Myspace, where role model stories and other prevention materials are provided. The webpage was an effective way to expose youth to the role model stories. Youth have the opportunity to comment and exchange views about the stories and by keeping track of the frequency of site visits, staff can gauge the popularity of the webpage.

I'd now like to offer several recommendations to continue moving translation efforts forward, and the first one is to increase emphasis on workforce capacity by offering courses such as introductory behavioral science, prevention counseling, group facilitation, ethnography and field safety, and perhaps recruitment and retention trainings.

Equally important are the basic program planning courses such as community assessment, objective writing, logic models and program evaluation. Many community based organization and health department staff have invaluable skills and expertise within their community settings, but they may not have backgrounds in the above areas.

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Having a stronger foundation in these areas will go a long way to increase capacity for successful implementation whether it is a DEBI, a best practice, or a home grown intervention, because all of these courses build critical thinking skills, which greatly contribute to excellent programs.

Which brings me to my next recommendation; perhaps it's time to consider HIV prevention special certification programs. These programs are not uncommon and have been in use for other professions as well, such as for disease intervention specialists. The Institute for HIV Prevention Leadership is one good example of such a program for HIV prevention staff for CBOs and I understand that there's consideration for a similar program for health department staff.

The National Coalition of STD Directors is also considering a leadership program for STD Program Managers. While these are excellent programs, the number of persons who could ultimately benefit far outweighs the actual numbers who are able to take advantage of these opportunities. Larger programs should they be developed would require significant resources, prioritization of desired skills and program outcomes.

I believe that with current national HIV diffusion efforts via DEBIs, we are at the perfect time to put more emphasis on effectiveness studies or programs that focus on

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outcomes of evidence based interventions conducted in practice as opposed to research settings and utilize participatory research approaches that actively involve clients, affected communities, researchers, funders, providers, and technical assistance partners, because all of these people, i.e. all of us are involved in the diffusion process. Some of these things are already happening, which is good, but not enough of them. There are some effectiveness frameworks that may be relevant for us, one of which is called REEAIM [misspelled?] by Russell Glasgow and colleagues.

Glasgow's REEAIM model is a framework that examines issues relevant to program adoption, implementation, and sustainability. And attempts to close gaps between research and practice by looking at reach efficacy, effectiveness, adoption, implementation and maintenance.

There's so much to say about this model, but due to time constraints I'd like to refer interested folks to his website where he discusses the framework in greater detail, as well as additional applications for it in effectiveness studies. And it's on the screen here, [www.reeaim.org](http://www.reeaim.org).  
[misspelled?]

If we are not yet at the point where we can conduct more effectiveness studies, in the interim we should place more emphasis on evaluation as DEBI implementation evolves. Many of us are familiar with process monitoring, but less of us

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regularly conduct process evaluation which tells us if the intervention has been conducted as intended.

And both outcome monitoring and evaluation are becoming increasingly important as adaptations continue to occur. Too often we see evaluation as punitive and agencies have certainly been given messages that DEBIs must be implemented with fidelity. But there are probably good reasons why they aren't and it would benefit us to know what those barriers are in practice settings.

My last recommendation is really a question and that is do we need a translation model to support agencies to effectively implement evidence based approaches? We have efficacy models via DEBIs and there are some effectiveness models such as REEAIM that may prove to be beneficial in measuring what happens in the field after interventions are rolled out.

Perhaps we need a translational model that guides agencies to support both efficacy and effectiveness. There are actually a few research translation resources that are now available.

The behavioral intervention training center is part of the national network of prevention training centers have developed and standardized a national course called Selecting Evidence Based Interventions, which is available for health

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departments and CBOs and other agencies implementing EBEEES [misspelled?].

This course is based on a model developed by the Adapt and Science Application Teams and other partners of the Division of HIV/AIDS Prevention and is relevant for agencies who are making decisions about which EBEE [misspelled?] to choose as well as those who have chosen an intervention and are seeking guidance on how to adapt. Information about this course is available through the NNPTC website.

In closing, I'd like to end with a few messages for CBOs, researchers, and funders and I'm not leaving health departments out because you know you may be represented in one if not all of the above categories. So these messages are for you too.

If you or a CBO representative engages in a healthy dialog with your research colleagues and funders, I know it can sometimes be a precarious relationship, but if you know something won't work, say so.

But don't stop there, say why it doesn't work but don't stop there. Say what you think will work better, because funders and researchers do want to know these things and you may be your community's best representative. Many of you are already doing this.

If you are a researcher, to the extent possible, think from an effectiveness perspective, while being mindful of

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efficacy issues, because we realize that this is important in your priority.

Imagine a much less controlled setting where you're intervention will be conducted and consider the degree to which it can be developed within a flexible framework, regarding core elements and other components.

Talk to a CBO or health department employee and get their perspective on study design, methodology, feasibility and logistics of your intervention in your setting. As well as staff training, and other capacity needs from a practice based perspective. Again, many of you may already be doing this, but the more the better.

And if you are a funder, to the extent possible, invest in capacity building from a foundational perspective. What are the basic capacity needs required of HIV prevention providers to successful implementation evidence based interventions.

What other challenges do you anticipate agencies will experience? And how can you address and support them in these barriers? How can training and technical assistance are better coordinated to improve workforce capacity in HIV prevention?

And I know many of these activities may already be occurring, which is a good thing, but more needs to happen. We are all committed to the same goal but tend to see things from our own perspective.

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Research translation requires all partners to see things from multiple perspectives. I believe we're moving in that direction, but if we all do just a little bit more of this, I think we can truly make a difference in the epidemic. Thank you very much. [Applause]

**VICTORIA CARGILL-SWIREN, M.D., M.S.C.E.:** Thank you so much Alice. I think you gave us a great deal to think about in a very cogent talk. Articulating I think what many of us has talked about in the corridors and since we've come to this meeting, and before.

Our next speaker's going to be Dr. Jeffrey Kelly. He's going to speak to us about Technology Transfer, New Ways to Disseminate Information. Dr. Kelly is Professor and Senior Vice-Chair of the Department of Psychiatry and Behavioral Medicine at the Medical College of Wisconsin. He directs the Center for AIDS Intervention and Research, known as CAIR, a research center funded since 1994 by the National Institute of Mental Health.

Dr. Kelly is an author of over 300 publications exclusively in the HIV/AIDS fields since the mid 1980s and his research has focused on the conceptualization, conduct and rigorous evaluation of HIV primary and secondary prevention interventions both in the United States and in other areas of the world.

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Much of his current work has addressed the problem of HIV/AIDS in countries of the former Soviet Union. And something that Jeff hasn't put on his bio that each of you should know here and I told Jeff I will say this until the day I die. He took a wet-behind-the-ears African-American minority junior investigator who could not find a mentor and took her under his wing and mentored her so that that person can stand before you today. I bring you Jeff Kelly. [Applause]

**JEFFREY KELLY, PH.D.:** Thank you so much Vicki. A few years ago, I was at a conference, it might have been this one, and I was presenting outcomes of an HIV prevention intervention that we had recently done, and that was positive. The results were good. And after the presentation, someone came up to me and said, isn't it great that your research stops HIV, stops people from contracting HIV. And not being one to dodge a compliment I said thank you. But then I realized later, that's not true. That's not true. Research in HIV prevention approaches can only contribute to the public health goal of stopping the disease when interventions are translated and transferred to providers, when they can be used by providers, when they're adapted to meet local needs, when they're owned by provider agencies and when they produce positive outcomes in the community.

This morning I'm going to be using the words 'we' pretty often and when I say 'we' or 'our', I'm referring to my

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colleagues at the Center for AIDS Intervention Research, CAIR. And also my colleagues at the community based organizations in the country, in the world, with whom we've collaborated in this work.

Research undertaken over the past 20 years has convincingly demonstrated that many interventions can reduce sexual risk behaviors in many vulnerable populations. Individual level interventions, couples counseling, small group programs, social network interventions, community level interventions and structural change approaches.

Although these different interventions have been cast from differing theoretical frameworks and they've often been given different names, different brands or identities, effective interventions share much more in common with one another than they have differences.

Always we find attention to a core set of social behavior change constructs including correct risk understanding, positive attitudes, beliefs, motivations and intentions, stress behavior change. And also the practice of cognitive and behavioral skills needed to bring about change.

Effective interventions regardless of their theory, regardless of their name, always involve attention to helping people handle real life personal situations that might otherwise trigger risk behavior. If the interventions are

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meant to promote maintenance of change, and hopefully they are, then development of normative and social and partnership works.

Effective interventions no matter what their theory, no matter what their brand are delivered by charismatic agents that believe in them and that understand clients and community culture. Relationships and circumstances and there's enough of an intervention to make a difference.

The traditional products of HIV prevention research are articles that appear primarily in scientific journals read by other scientists. However, the most important users, the most important audience of HIV Prevention Research are public health care service providers nationally and internationally.

Service providers often lack access to the journals in which HIV prevention research is published. Or in the international arena, don't speak the languages the journals are published in. Providers couldn't possibly be successful in implementing an intervention from which usually present in a journal article.

You know, about that much space describing the program and pages describing the statistical methods. Providers have to guess how to tailor interventions to meet their needs while maintaining attention to critical core elements.

Although researchers have extensively studied the effects of HIV prevention interventions there's been very

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little study of how best to move evidence based models from the research arena to service providers.

Most investigators want to see their interventions used and most make manuals or outlines available. CDC is [inaudible] efforts to identify efficacious models and offer training to providers in them through the replication projects, DEBI and other mechanisms.

However the field has lacked systematic comparative research on how best to translate evidence based interventions to providers on a wide scale, and how to assist providers and using those interventions.

In our experience, providers understand community needs, want to know about program relevant research, but also want to tailor and adapt evidence based interventions to meet local needs.

Service provider agencies understand much better than researchers. Key issues, needs, priorities and perspectives of the communities they serve and the constituencies they represent.

Experience provider agencies are not passively sitting around waiting for researchers and funders to tell them what to do, as much as researchers and funders would hope otherwise. Evidence based models have to be tailored to meet the needs of the provider agency and the community while maintaining critical core elements responsible for the interventions input.

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Bridging the gap between the science and the service of HIV prevention is by no means a unique question in the HIV prevention arena. There's been a large literature on the effects of continuing medical education, CME, and it illustrates the challenges faced in technology exchange efforts.

CME research conducted for 30 years has shown that information or one shot training in a new medical procedure, the new way to do tonsillectomies for example, can increase provider knowledge but does not necessarily influence provider practices.

New adoption of programs by providers is greatest when providers are themselves dissatisfied with currently available techniques perceive a new approach is more effective than existing methods.

When providers are high in openness to innovation and have enough resources and money for new program adoption, when providers receive adequate training, practice based training in the new model, when high status peer are known to have already adapted the innovation and been successful with it.

When access provided to ongoing implementation assistance in problem solving and when providers can reinvent a model and can feel true ownership of it. CAIR investigators began a line of studies to scientifically study approaches for

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transferring evidence based HIV prevention intervention to service providers.

These studies were randomized trials, not randomized trials of the risk reduction intervention, but rather trials of approaches that can be used to assist providers in using interventions that are being disseminated.

The objective of our research was to determine what dissemination services most often result in providers adapting the intervention in using it as a part of their service program repertoire. We also sought to learn how providers tailored and adapted interventions to meet their local needs.

Our first dissemination project was carried out in a collaboration with 74 service organizations representing most states in the country. All of the ASOs carries out HIV prevention programs for men who have sex with men and for women.

The intervention being disseminated in the study was based on a small group of cognitive behavioral risk reduction program, the kind of model that's been highly studied in the research field and is probably familiar with everyone here.

In person interviews with ASO directors measured the organizations baseline use of the intervention that included all of the core elements of the intervention being disseminated. Few of the organizations had offered the intervention at baseline.

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Agencies were then randomized to one of three dissemination conditions. A third of agencies received detailed assistance manuals, detailed facilitation manuals, intervention materials and guides.

Another third of the organizations received the same manuals, but also two day, onsite training that was undertaken and involved our staff with CAIR meeting with the organizations frontline staff and spending two days in training and discussion about the model and how it could be used and tailored.

The third group of AIDS organizations received manuals the two day training, but also ongoing telephone consultation, which were calls generally be-weekly in which a consultant discussed with the organization its goals, its problems, its successes implementing the intervention, advances toward implementation, tailoring the model to meet community needs, the organizations priorities and resource constraints, and review of the interventions core elements.

Six and twelve month following the dissemination activities, onsite interviewer's interviews with AIDS organizations were repeated. An adaptation was considered to occur when the organization offered a client service program that incorporated the key core elements of the model that had been disseminated.

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We found that manuals only produced a modest increase in the percentage of organizations that offered the intervention. Manuals and training a greater increase, and I'm sorry there's an error in the last slide. What it should be showing is that the manuals initial-- the AIDS organizations did not initially offer the intervention but 75-percent, not 59 but 75-percent did at final follow up.

The implications of the study were that successful uptake of the disseminated intervention took place when providers had implementation guides, received intensive interactive face to face training in the method, and also received individualized consultation concerning implementation efforts.

A key component of the project was ongoing opportunities for bi-directional dialog between providers and researchers. That seemed to be the key ingredient. Yet, while the outcomes were promising, this training model was time and cost intensive. There are after all, thousands, heck, many tens of thousands of community based providers doing HIV prevention work in the world.

CAIR research has shown the traditional technical assistance models carry considerable limitations for service providers. In an interview study with directors of 77 AIDS organizations from throughout the U.S., we found that organizations predominant current programs for MSM were

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distributing AIDS education materials, giving AIDS 101 talks and one on one educational outreach.

Those were the majority of programs. Most programs offered to women were the same. When we talked with AIDS organization directors, they said we'd like to be able to offer more targeted, more intensive, individual group community level programs of the kind that are studied in the research arena but we have barriers.

The main barriers were very high staff turn over. The majority of frontline staff held their job for less than one year in these organizations, lack of technical assistance and limited budgets.

Advanced communication technologies have the potential to link service providers nationally and globally with training, consultation and experience sharing, and new programs. The internet is available nearly worldwide and can serve as a distance learning vehicle for providing interactive, practice based training of service providers in new HIV prevention models.

Distance based training could be made available on demand whenever needed and as often as desired for new agency staff training or retraining, very relevant when there's high turnover in one's staff. Apart from training curricula, distance models can link service providers and research

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consultants and also link agencies with one another for experience sharing.

CAIR undertook a project that was supported by NIMH to test whether distance communication technology could be used as a dissemination vehicle for international AIDS service providers. The project was called the Global AIDS Intervention Network, or GAIN project.

We identified 86 leading AIDS prevention NGOs in the capital or large cities of 78 countries in Africa, Eastern Europe, Central Asia, Latin America and the Caribbean. We met with the directors of all the organizations and solicited their input in the kind of prevention programs needed and they arrived at the consensus that community level approaches would make most sense.

We selected for dissemination in this project the Popular Opinion Leader, the POL intervention because it appeared to cross culturally adaptable and suitable with multiple populations and multiple countries. Also, we know the intervention well.

Each NGO director was interviewed at baseline to establish any use of the POL intervention or programs that included its core elements. The POL intervention includes eight core elements and the presence or absence of each element was measured in all of the community level programs carried out by each NGO in the past six months.

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The 86 NGOs were then randomized within each world region to a distance training condition or to a lab controlled condition. All NGOs received a computer, subsidized internet access, information about the POL intervention, and fact sheets about HIV prevention topics that were of interest to them.

Directors and staff of experimental program NGOs received a distance disseminated program with three main components. Those were an electronic POL training curriculum, individual distance cultural consultation and the encouragement of networking with other NGOs in the same condition. I'll talk more about each in just a minute.

This project was technically complex because all communication, materials, curricula, consultation and assessment measures were provided in the NGOs preferred language. So everything was conducted in parallel in English, French, Russian and Spanish, which can reach a lot of the world.

The POL electronic training condition, the curriculum was used by NGO directors, managers and frontline staff, either individually or in small groups at each agency. The curriculum was grouped into three modules: planning, carrying out, and evaluating and maintaining the intervention. Each module had many half hour segments so people wouldn't be stuck by a computer for a long time.

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The modules made use of instructional text and narration, video segments modeling critical intervention techniques, interactive problem solving, printable materials and manuals and self evaluation guides.

NGO staff progressed at their own pace, could use either the curriculum on the computer or could print out the materials. Not everybody wants to spend all their time at a computer screen.

The second component of the project was distance cultural consultation. Each NGO was linked throughout the project with a cultural consultant who was a CAIR affiliated behavioral scientist experienced in implementing the intervention.

An individual fluent in the NGOs language, importantly an individual from the NGOs region or familiar with its cultures, and the consultants initiated and offered bi-weekly contact to the NGO by telephone, by email or other modalities.

The consultation focused on core elements of the POL model, tailoring, adapting the intervention to meet local needs, handling implementation problems, reinforcing the NGOs efforts and assisting the NGO in anyway possible. Organizations were very different points.

The consultation was client centered. Some NGOs wanted to immediately implement the intervention and we assisted them

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in doing it. Others were considering it and weighing it relative to other interventions and we assisted them as well.

Others sought our assistance in planning program funding applications to gain the money to be able to offer the intervention. The third components were NGO networking channels.

Talking with researchers is not enough. NGOs in the distance condition were encouraged to share experiences, implementation issues, problems, solutions with one another through direct contact and by a project website communications.

The dialog involved-- a lot involved locating funding sources and NGOs shared approaches with target populations that included, depending on the NGO and the region, men who have sex with men, drug users, youth, students, factory workers, sex workers, unions of workers and other groups.

NGO use of the distance training program we found that the curriculum was used by an average of 12 staff at each NGO. They viewed it for an average of about seven hours, viewing 70-percent of its content. 93-percent of NGOs also printed out the materials and spent an average of 16 hours reading them. The mean number of consultations provided was six per NGO with a range of up to 17. 72-percent of NGO directors rated the electronic curriculum as very useful. As did 88-percent for the printed materials and 67-percent for consultation. 88-percent of NGOs held staff meetings about the intervention, 81-

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percent selected a target population in their community, and 57-percent wrote program funding applications.

At 15 month follow-up, NGO directors in both the distance training and controlled conditions were re-interviewed concerning their community level prevention programs carried out in the past six months. At follow-up, 43-percent of distance trained NGOs but only 17-percent of controls had developed a new program based on the model. 64-percent of distance training NGOs had either developed a new program or often modified an existing program. Organizations in the training group more often incorporated core elements of the intervention in various of their programs. And we're heartened that 55-percent of organizations networked with other NGOs in their countries by sharing the electronic materials or conducting training for them themselves.

Our conclusions were that advanced communication technology can bring on-demand training and consultation to service providers in a cost effective manner. The number of agencies that can be reached is almost limitless.

The distance methods that we use permit bi-directional communication and dialog between researchers and service providers as well as between service providers and others. And these approaches permit training access, even to small agencies in regions far removed from other training.

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They create a more level playing field for access to training. There's a bigger picture. Traditional face to face methods are limited in their potential scale, scope and number of people who can be reached.

By contrast, we can envision virtual training centers that use advanced communication technologies to link AIDS service providers anywhere with flexible, on demand, and whenever needed training and new program models. And we can envision this reaching literally around the world.

This model was more than placing intervention manuals on a website. Whenever new interventions are shown efficacious and represent models that are sought by providers, interactive distance curricula can be developed. We can foresee an array of self-paced intervention curricula available to providers who can then pick the ones that most meet their needs.

By doing this in multiple languages one can reach the world. Our studies show that individualized cultural and behavioral science consultations are critical as are opportunities for provider networking. Even with distance methods, the human touch is essential.

I'd like to close this with several observations. We know a great deal about the effects of HIV prevention interventions when studied in highly controlled efficacious studies. As our last speaker pointed out, we need to learn much more about the effects of the same intervention when

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they're offered by providers in real world settings, to real world clients in community populations.

Interventions that are transferred from the research arena to service providers must be the kind of interventions that are wanted by service providers. Much greater provider input is needed in the development of a research agenda in HIV prevention interventions.

The means of providing training and technical assistance in carrying out evidence based interventions must be accompanied by sufficient funding of providers to be able to implement them. And although we know a lot about the effects of many prevention interventions there's a lot we don't know.

Among our greatest priorities are interventions that can reach young ethnic minority men who have sex with men, reach persons with sexual and substance use intertwined risk, interventions for women with high risk partners, interventions that promote long term maintenance of change, not just initial enactment.

And interventions oriented for persons with acute or primary HIV infection. The development of a repertoire of effective HIV risk reduction interventions is one of the greatest public health research achievements in the past 25 years.

But these achievements can only contribute to the mission of stopping HIV and AIDS when interventions are placed

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in the hands of service providers, can be successfully used by providers and bring about positive outcomes in the community.

Thank you. [Applause]

**VICTORIA CARGILL-SWIREN, M.D., M.S.C.E.:** Thank you so much Jeff. Our last speaker is going to be Greg Millett. He's going to be speaking about HIV prevention, what works for the young MSM of color. Greg Millett is known to many of you. He's a behavioral scientist at the division of the HIV/AIDS prevention or DHAP at the U.S. Centers for Disease Control and Prevention. He is the lead scientist for Brothers Y Hermanos, a large multi-site study investigating social and cultural factors associated with the high rates of HIV infection among Latino MSM and black MSM.

Mr. Millett is also lead scientist on exploratory study that employs respondent driven sampling to target black bisexual men. You've certainly seen Greg's work, I know as he's published extensively, certainly in the American Journal of Public Health, The American Journal of Preventive Medicine, AIDS, sexually transmitted diseases and many others. It is my pleasure to bring you Greg Millett. [Applause]

**GREG MILLETT, M.P.H.:** Good morning. I'd like to thank the conference organizers for the opportunity to speak this morning and I also wanted to express how much of a genuine pleasure it is to share the stage with such esteemed colleagues, as well as a pleasure it is to see as many people

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who are here today for the last presentation, during the last plenary. [Applause]

I'm going to be discussing HIV prevention among MSM of color. What works? And briefly, just to give you an outline of my presentation, I'm going to talk about the impact of the epidemic among young MSM of color. Some of the factors that are associated with disproportionate infection rates among young MSM of color, HIV prevention behavioral interventions, important issues for existing and future interventions, and then I'm going to give some conclusions and some of the next steps.

So why focus on young MSM of color? Well it's clear from the epidemiological data that why MSM are at greater risk for HIV infection. As much as 81-percent of new HIV/AIDS cases among male adolescents between 2001 and 2005 among MSM-- it was among MSM relative to other members of other risk groups.

And moreover, when you look at HIV/AIDS cases among adolescents and young adults in 2005 by race ethnicity, we find that young MSM of color and particularly black MSM are a clear plurality of these cases despite representing a minority of the U.S. population.

The disproportionate burden of HIV/AIDS diagnoses among young MSM of color generally and especially black MSM is also evident when we look at HIV/AIDS diagnoses by race ethnicity and age from 2001 through 2005. We see clearly again here that

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young black MSM, ages 13 to 24 are disproportionately represented among HIV/AIDS diagnosis.

Now some jurisdictions have reported an increase in diagnosis among young MSM. Just a few months ago the New York City Department of Mental Health and Hygiene reported that new HIV diagnosis increase substantially among young MSM in New York City while new HIV diagnosis decline 22-percent among older MSM. In fact, young MSM now in New York City account for 44-percent of new HIV diagnosis.

And when you look at it by race and ethnicity, we found that young black MSM had an increase of about 38-percent in HIV diagnosis over that time period. While older black MSM had a 23-percent decline. And you found the same thing among Latinos, the same pattern that young Latinos had a 29-percent increase of HIV diagnosis over that time period and older Latinos has had about a 20-percent decline.

And these data are data which I'm sure for everyone in the room is readily acquainted with. This is from the Young Men's survey, which found a greater HIV prevalence among black MSM, Latino MSM and American Indian, Native American MSM compared with white MSM, and comparable HIV prevalence between API MSM and white MSM.

And another reason why it's so important to focus on young MSM is that when you take a look at the data by age cohort for black MSM you see that HIV prevalence actually

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triples from the ages 15 to 22 to a median age of 32, where African-American MSM are the hardest hit population in the black community where the HIV rates are just as bad as what you find in Sub-Saharan Africa.

Now it is important that we understand what factors are and are not contributing to the disproportionate HIV rates among young MSM of color because it has implications for HIV prevention interventions.

We tend to define risk at the individual level, substance abuse, unprotected anal intercourse, number of sex partners. But we also need to consider interpersonal and social factors beyond the individual that influences HIV risk among young MSM of color. And the data bear this out.

These are data from the Young Men's Survey comparing substance use among black MSM, Latino MSM and white MSM. And you found here that young black and Latino MSM are not engaging in greater risk behaviors compared with young white MSM.

Consistently young black MSM are engaging in greater prevalence for substance abuse compared with Latino MSM or white MSM. And Latino MSM are engaging in less substance use risk compared with white MSM.

And you find the same pattern when you take a look at sexual risk among young MSM as well. You get a clearer picture here between black MSM and white MSM compared with Latino MSM and white MSM. But even though black MSM were less likely to

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engage in sexual risk behavior compared with white MSM, they were still nine times more likely in YMS data set to be HIV positive.

And Latino MSM, even though they engage in less substance use behavior as well as some sexual risk compared with white MSM, they were still twice as likely to be HIV positive. And we don't only see this dynamic just in the YMS data. We find these paradoxical findings across studies from the very beginning of the epidemic.

And in fact my colleagues and I published in Med Analysis earlier this year, where we compared HIV risk behaviors between black and white MSM across studies, and found that young black MSM were 34-percent less likely than young white MSM to report engaging in any unprotected anal intercourse.

And young black MSM were also 75-percent less likely than young white MSM to report any substance abuse. We also find these paradoxical data when we compare API MSM with white MSM. This figure shows a-percent of unprotected anal intercourse with two or more partners of unknown HIV sero-status among API MSM and white MSM in San Francisco between 1999 and 2002.

And you see a steep increase in high risk sex among API MSM whereas risk increases and then decreases among white MSM. So perhaps looking at these data, one might expect and increase

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in HIV diagnosis among API MSM in successive years. Instead we find that the number of HIV diagnosis among API MSM decrease slightly from 2002-2006 in San Francisco.

Now these paradoxical data can partially be explained by sexual networks and characteristics of sexual partners. The literature is replete with many articles that have looked at sex between older and younger adults and found of course that those younger adults who have sex with older partners are more likely to become infected with HIV.

And we know also from the literature that black MSM are more likely to have sex with older partners compared with other groups of MSM. And Kung Hee Choy [misspelled?] has done some research where she found that API MSM were less likely to have sex with partners outside of their generation compared with other MSM.

Another thing that we know is an interracial sexual mixing influences HIV exposure. And even though black MSM and API MSM are more likely to report partners of the same race, because of background, HIV prevalence is higher in black communities. Black MSM are at greater risk for infection than API MSM.

There are also additional factors that influence HIV rates among MSM of color. Chief among them is unrecognized HIV infection. Again looking at the YMS data, everybody in this room already knew that among those individuals that are HIV

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positive and African-American, 91-percent did not realize that they are HIV positive.

And among Latino who were HIV positive in the YMS data, 69-percent did not realize that they were HIV positive. And this is important information because data shows that those individuals with unrecognized infection are the ones who are likely driving the epidemic in the United States.

Another issue that's likely driving the high infection rates among MSM of color is HART use and adherence. We know from several different cities that young MSM of color are less likely to have access to HART.

We don't have enough data on HART adherence, but just knowing that they have less access to HART we realize that those men are likely to have a higher viral load and if they have a higher viral load, they're more likely to transmit the virus to partners per active unprotected anal intercourse.

We also know from the data too that young MSM of color across the board have higher rates of STIs. And if you have a higher rate of STI in your community you're more likely to become infected with HIV if you're negative and have an STI. And for those individuals who have an STI and they're HIV positive, they're more likely to have a higher viral load and to transmit HIV to their sexual partners.

So what can we do? The good news is that behavioral interventions actually work. Recently published analysis of

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HIV prevention behavioral interventions found that U.S. based intervention for MSM reduce sexual risk by 35-percent.

Moreover, individual, group and community intervention targeting MSM all reduce HIV risk, with individual level reducing risk by 43-percent, group level intervention reducing risk by 27-percent and community level interventions reducing risk by 35-percent.

Moreover, interventions for young MSM reduce sexual risk by 29-percent in the Med Analysis. In addition, we have effective behavioral interventions for MSM of color. There's one behavioral intervention that only targeted MSM of color that we have in the compendium, it's a brief group counseling behavioral intervention for API MSM.

There are also behavioral interventions that include substantive samples of MSM of color, like healthy relationships which included a large sample of HIV positive black and Latino MSM as well as the Empowerment Project that was undertaken with Latino MSM as well as white MSM in several cities.

And we also have successfully adapted interventions for young MSM of color. A recent and exciting successful adaptation of an existing effective intervention was undertaken by Kenneth Jones and his team at CDC.

Jones and his colleagues adapted the Popular Opinion Leader model for young black MSM. The adapted intervention is called DUP and the investigators measured intervention exposure

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in successive assessment ways and saw that intervention exposure grew from 20-percent at the beginning of the project, to slightly less than two-thirds of the surveyed individuals by the projects end-- to slightly more than two-thirds of the individuals at the projects end.

And looking at the outcome for the DUP intervention the authors found a substantial decrease in the rates of unprotected anal intercourse from the beginning of the project to the end. The intervention is currently being packaged by CDC and being prepared for dissemination.

There are also other behavioral intervention research studies that are underway across HHS agencies. There are HIV prevention studies for MSM of color like the Empowerment Project which is being adapted for black MSM again being handled by Kenneth Jones at CDC.

CDC has also funded several projects in the last year called LAMB [misspelled?], where they are developing new interventions for black MSM as well as Latino MSM. There're four sites for black MSM and two sites for Latino MSM.

And one of the most exciting things that CDC is doing is an evaluation of Many Men, Many Voices. And why this is exciting is this is one of the few interventions that came from the community that is rigorously being evaluated by CDC.

There are also interventions that target HIV positive MSM of color. As was mentioned in an earlier presentation,

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there is the adapt intervention where the goal is to reduce HIV risk behavior and its being undertaken in three communities using different models, popular Opinion Leader model, community response and healthy relationships.

And [inaudible] also has funded the Special Projects of National Significance Project, where they funded nine sites across the country to look at outreach, care and prevention for young HIV positive MSM of color with the goals to increase care access and to reduce risk.

So given all of that there are still other important issues for existing and future interventions for young MSM of color. A recent paper reported findings of men who were grouped according to their ages when they first reported participating in particular milestones in the development of their gay identity.

These milestones were when you first realized that you were attracted to a male, when you first had sex with a male, when you decided that you were gay, and when you told another person that you were gay. And the authors, after they categorized these individuals according to those who reported early, middle and late gay related development found some very interesting results.

Men who reported early gay related development were more likely to report harassment for being gay during childhood

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and adolescence and were more likely to experience sexual abuse during childhood and adolescence.

Moreover the authors found that these patterns of risk continued into adulthood. Men who reported early gay related development were more likely to report victimization as an adult for gay related violence. More likely to be depressed as an adult, and more likely to be HIV positive as an adult compared to the other men.

So the bottom line, men who experienced discrimination and abuse related to their sexuality in childhood, may be at greater risk for adverse consequences as adults. And how does this apply to young MSM of color?

There are several studies that have been done with Latino MSM, black MSM, as well as API MSM which found the effects of discrimination certainly affects sexual risk in these populations. Two studies have been done with Latino MSM. The first one with HIV positive MSM and they found that the experience with discrimination was associated with greater rates of sexual risk. And of course most people in the room are acquainted with Raphael Diaz' work where they found that homophobia, racism, poverty, psychological distress all explained 20-percent of the variance in sexual risk in their multi-varied models.

And with black MSM there's a recent publication that history of discrimination was associated with greater sexual

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risk in black MSM. And among API MSM there's a paper by Yoshi Kawa [misspelled?] that found that anti-immigrant discrimination experiences by API MSM was associated with increased risk of unprotected anal intercourse.

I'd like to talk briefly about the gay identity. Young men of color are less likely to identify as gay. And this is particularly black and Latino gay men compared to other men of color. And non-gay identity we all know from the literature is associated with sex with women, exchange sex, drug use, but it's also associated with a lower likelihood of being tested for HIV.

As important as it is to focus on men who are non-gay identified, when you still take a look at samples across studies, you find that most samples, even in gay men of color communities, most of these men still identify as gay. Usually anywhere from 60 to 70-percent of the sample or more in gay men of color communities actually identify as gay.

Now why I'm harping on this point is that in the '80s and the '90s gay identified men were less likely to engage in sex. However that is really turned around. It's done a 180 over the last several years, and today gay identified men are more likely to engage in sexual risk behavior in terms of number of sex partners, unprotected anal intercourse, and more likely to be HIV positive compared with non-gay identified men.

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And I have to admit that one of the most dismaying things that I've noticed over the last several years is as a community, a public health community we put as much focus onto non-gay identified men, when we still haven't finished our commitment to gay identified men where the locusts of infections are. [Applause]

We need to recommit our efforts to target gay identified men. Also one thing that we need to keep in mind as well is that there are differences among MSM of color. These communities are not homogenous and there's research that also supports this.

Among black MSM in YMS they found that those black MSM who are of mixed race engaged in greater risk behaviors compared with black MSM who reported that they did not have mixed parentage.

We also know that in studies of black MSM that geography plays a role in terms of substance use. That black MSM on the west coast engage in different patterns of substance use compared to black MSM on the east coast. You also find these same patterns among API MSM.

There are differences that are found in the literature in unprotected anal intercourse with South Asian MSM engaging in greater risk compared to East Asian MSM. And similarly to some of the data that I described a little earlier, mixed race

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Asian MSM also engaged in greater rates of unprotected anal intercourse in one paper compared to East Asian MSM.

Among Latino MSM there is one study that I found in the literature that found no differences among MSM in New York City between Colombian, Dominicans, Puerto Ricans and Mexicans. However, we do know that there are differences in HIV diagnosis among Latino MSM depending upon the country of birth.

When this is a recent data from an MMWR showing obviously very different rates of diagnosis for MSM who are from Central America, from Cuba, from Mexico and from Puerto Rico, as well as those Latino MSM who are born in the United States.

And we also note too from the literature a fairly clear pattern that emerges among black MSM, Latino and API MSM is that those MSM who are born in the United States engage in greater rates of UAI than those MSM who don't. You find that pattern irrespective of race and ethnicity.

So conclusions and next steps. First, behavioral intervention does work and existing behavioral intervention can be adapted for MSM of color. Moreover MSM of color are not a homogenous group and we must tailor interventions to local needs and to culturally specific needs.

There are also new interventions for MSM of color under way and community members and CBOs are meaningful partners in

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behavioral intervention research. The research cannot be unidirectional.

We need to listen to our CBO partners and the community and able to come up with relevant as well as effective interventions for those communities. In terms of next steps, we need more research with API and Native American communities. I can't stand up here today and talk about YMSM of color, but the implication in most of the slides and the data that I showed you are primarily Latino MSM and black MSM.

We need a clear focus with Native American MSM and we also need a focus among API MSM. [Applause] In addition, we need a mix of intervention strategies to impact the epidemic. Dr. Fenton and others have said several times during the meeting that when you take a look at the MHBS data that only 20-percent of MSM reported ever being exposed to an intervention and that just speaks to the fact that we need multiple types of interventions.

We need network based interventions, we need community based interventions, group level interventions as well as individual interventions. Not one strategy is going to buy us exactly the reduction in HIV prevalence that we need. We need to use all of them in tandem.

We also need to use some of the traditional tools that we have in HIV prevention such as HIV and STI testing and screening, especially given the large rate of unrecognized

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infection in these communities as well as high rates of STI, as well as access to care for each of these communities.

And last, we need more penetration from our interventions and we need to put a clear focus on community level interventions, network based interventions as well as structural interventions for each of these communities.

And last I wanted to acknowledge several colleagues who were instrumental in helping me design the presentation as well as giving me some data for the presentation. Thank you.

[Applause]

**VICTORIA CARGILL-SWIREN, M.D., M.S.C.E.:** Please join me in thanking all of our panelist one last time. [Applause] Now I'm going to be joined by my co-chairs Dr. Kevin Fenton and Dr. Tim Mastro. While they're coming up to the stage and we're getting ready to say goodbye, I want to at least be able to express my thoughts which I hope will echo yours on this meeting.

I share Tim Flanigan's comments and many others in that I've been to a lot of these, but this is the first time in a long time I have felt like I can hitch up my boots and get out there and do it again. And I hope you feel the same way.

[Applause]

It's been wonderfully refreshing to see so many people. I have truly enjoyed talking to so many of you. My only regret

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is I could not talk to each of you, because I have learned so much from each of you.

I spent every night sending two and three page emails back to the NIH about what we need to do, how we need to partner, because how different this meeting is from others where finally the lights have gone off for those of us who have been in the community and those of you who have been slogging forever in the community to say, you realize you need a partner in this. There is no one hero in this epidemic.

And so with that, I'm going to close and say thank you and just say that you know, Jesse has had that song going around in my head since he sang it on the plenary. But it must be catching, whatever little spirit whispered in his ear.

And as a person who is partially Native American, I'm hoping that perhaps my great-grandfather's spirit whispered in my ear, because I woke up at 3:00 this morning and the song that I had in my head was, ain't no stopping us now, we are on the move. And I hope that's true for all of us. [Applause]

**MALE SPEAKER:** Well Vicki thanks very much. I have about 50 slides, but I think I can get through this in the next 40 minutes. But, just to scare you a little bit. Seriously, it's-- thank you all for coming. I guess maybe the reflection is why do we have conferences like this? Why do we bring 3,000 people to Atlanta, Georgia for four days to talk about HIV prevention?

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And this last year I was discussing with an old friend and colleague that is not involved with public health, what I do for a living, and why we have a meeting and he goes, well why do you have such a big conference on HIV prevention. It's not rocket science.

And indeed it's not and it's actually extraordinarily more complicated than rocket science. Rocket science is fairly straight forward. [Applause] This simple virus with nine genes that manages to get transmitted through sexual activity, substance abuse, sharing of blood products has confounded us over the last 26 years and we simply haven't quite figured it out.

I think a conference like this helps us figure it out. We've realized over the last four days with 420 oral presentations, 250 posters, dozens of roundtables, thousands if not millions of conversations is we're still figuring it out.

And since it is more complicated than rocket science, it's going to take all of us. So it takes epidemiologists to characterize the epidemic, researchers to refine what we do know and identify new ways to prevent transmission. All of you in the trenches at CBOs, NGOs, local health departments, state health departments, not yet, the Federal level that we all really need to pull together in this.

We need policy, we need advocacy. It was great to see activism at this conference because we need to keep doing all

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this. I'm as energized as Vicki is. I think this conference will help move us forward. I'm ready to get on for work tomorrow and going forward. So thank you all. We all need to work together on this. And thanks for coming to Atlanta.

[Applause]

[END RECORDING]