HIV Prevention in the U.S.: Where Are We Headed?

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HIV prevention efforts faces enormous political, economic, social, environmental, and scientific challenges.

In short, we are losing ground in efforts to slow HIV’s spread.
Why and how is HIV prevention off track?

and

What can we do about it?
**HIV PREVENTION OFF TRACK. WE ARE:**

**NOT meeting the 2001 goal to reduce annual infections to 20,000 by 2005**

The evidence suggests incidence is rising:

- More than 1.1 million living with HIV/AIDS in the U.S. (African Americans make up 47% of cases; by risk factor, gay and bisexual men make up 45%)
- According to Dr. Carlos del Rio of Emory University, annual infections could be as high as 60,000 -- **50% higher than previous estimates**
- In a five-city study, 46% of African-American MSMs tested HIV+ (67% did not know it)
- In 32 states, HIV/AIDS cases in MSM increased 11% from 2000 to 2003 (CDC, Dec. 2004)
- 35% of HIV cases reported in 29 states from 1999 to 2002 occurred heterosexually; 90% of new HIV cases among teens were due to heterosexual contact (CDC, Feb. 04)
HIV PREVENTION OFF TRACK. WE ARE:

**NOT endorsing** what works—condoms, sterile syringes, comprehensive sex-ed

The evidence suggests HIV prevention works

- Feds promoting condom “ineffectiveness” and abstinence-only
- Abstinence programs lie about condoms effectiveness
- Clinton-era ban on needle exchange funding continues
- Comprehensive sex education, which includes abstinence, is proven effective at delaying sexual debut and promoting condom use once sexually active
- Waxman report documents medical inaccuracies of abstinence only; Columbia found high STDs and risk taking among youth who make virginity pledges
- Abstinence-only programs are ineffective for sexually active youth and GLBT youth
HIV PREVENTION OFF TRACK. WE ARE:

**NOT adequately funding HIV prevention services**

In facts, Congress may approve deeper cuts

- HIV prevention is underfunded by at least $300 million annually
- Administration is requesting $4 million less for domestic prevention and $38 million more for abstinence-only in FY06
- Federal funding for HIV/AIDS prevention has declined from 9% of the total HIV/AIDS budget in 1995 to 5% in 2003, according to KFF
HIV PREVENTION OFF TRACK. WE ARE:

**NOT prioritizing primary prevention**

- Advancing HIV Prevention (AHP) shifted CDC’s focus from culturally competent services to case finding
- HIV testing is a poor substitute for behavioral and structural interventions
- Federal focus on testing and prevention-with-positives is reducing funds for primary prevention
- Focus on seropositives continues to send a message that prevention is not a shared responsibility between people who are positive AND people who are negative
HIV PREVENTION OFF TRACK. WE ARE:

**NOT sufficiently assisting high-risk negatives**

- Expanded testing may not be reaching the highest risk populations
- Few prevention services exist for high-risk individuals who test negative
- Negative test results should trigger as many referrals as positive test results
- Move to provide little or no counseling, does high-risk populations a disservice
HIV PREVENTION OFF TRACK. WE ARE:

**NOT reaching the highest risk positives**

- Research remains incomplete on Prevention With Positives (PWPs)
- Interventions targeting seropositives at medical and social services may likely be serving a majority of low or moderate transmission-risk individuals
- Reliance on medical providers to do prevention is unrealistic and impractical
- Those not in care (homeless, incarcerated, drug addicted, sex workers, runaway youth, mentally ill) are likely higher transmission-risks
- A spectrum of care services (peer support, mental health, substance abuse treatment, housing, healthcare) may in and of itself be effective PWP interventions
- CDC must ensure that PWP does not put positive people at higher risk of criminal prosecution—issues of self-incrimination; recording keeping; confidentiality have not been addressed by CDC
- More research is needed!
**HIV PREVENTION OFF TRACK. WE ARE:**

*NOT doing enough to address AIDS stigma, homophobia, and poverty as risk factors*

- Persistent stigma keeps people from accessing testing, prevention, and care—stigma is a significant barrier for women, rural residents, MSMs, and IDUs.
- Homophobia and internalized homophobia are likely contributors to resurgence of high-risk behavior.
- Social norms—more than individual behavior—construct risk for many people. Example: In rural NC, poverty, unemployment, segregation/discrimination, concurrent sexual partners (and fewer eligible males) are fueling the epidemic among Black women.
HIV PREVENTION OFF TRACK. WE ARE:

**NOT adequately reaching high risk groups**

CDC needs to add more culturally competent interventions

Current strategies are failing to adequately reach:

- MSMs of color
- Young MSMs and older (over 30) MSMs
- Girls with older male sex partners
- Women
- Homeless
- Substance users
- Incarcerated and formerly incarcerated
- Mentally ill
- People with other STDs
- Sexually active over 50
HIV PREVENTION OFF TRACK. WE ARE:

**NOT engaging stakeholders**

- Communities are not being asked what they need in HIV prevention
- Community planning is stagnating--its full potential is not being realized
- Volunteerism in HIV prevention is nearly gone
- There are few advocates for HIV prevention
- Federal decision makers consult community members infrequently on prevention policy
- Communities are not being encouraged to be innovative/expansive in search of new solutions
- At risk groups have unaddressed concerns about federal prevention policy: confidentiality under Program Evaluation Monitoring System (PEMS) and PWP
- AHP was implemented without community input
NOT supporting CBOs or fostering careers in HIV prevention

- With less funding overall, and more funding going to medical sites, longstanding prevention CBOs are folding
- Culturally competent prevention providers are disappearing; staff attrition is high
- Bush administration’s principles for CARE Act reauthorization, if enacted, would drive many ASOs out of business
- People at risk are being left without “cultural homes” i.e. places to gather, hang out, find peer support
- Agencies increasingly cannot afford prev work--grants do not cover all costs
- Complexity of applying and providing prevention services, such as Diffusion of Effective Behavioral Interventions (DEBIs) and PEMS, is making it harder for CBOs to stay in prevention
- Agencies are not encouraged or funded to innovate
HIV PREVENTION OFF TRACK. WE ARE:

NOT supporting research where it is needed the most

More research is needed on:
- Effective interventions for high risk groups: add more culturally competent interventions to DEBIs
- Rectal and vaginal microbicides
- Effective ways to reach and help high-risk seronegatives and seropositives, including interventions on relationships, disclosure, and resistance
- Effective crystal meth and internet interventions
- Prevention with positives strategies
- More research is needed on ways to affect social norms and social networks
HIV PREVENTION OFF TRACK. WE ARE:

**NOT building capacity and confidence in public health**

- Despite preparedness funding, public health nationwide is still 20 to 30 years behind the times (equipment; facilities; knowledge; skills; adequate staffing)
- Public health is responding too slowly to STDs among teens, hepatitis,
- Public confidence in CDC is low; staff morale is low
- Emerging diseases--like West Nile and Avian Flu--could overwhelm public health and severely affect people with and at-risk for HIV
- Catastrophes (i.e., Hurricane Katrina, Tsunami) escalate HIV risk
NOT outraged by the decline in HIV prevention

- HIV transmissions can be prevented if we provide adequate support for strategies that work
- HIV/AIDS complacency is accompanying the epidemic’s rapid growth in communities of color: we should be outraged.
- HIV prevention needs allies and advocates!
Meanwhile, our government is exporting our ineffective policies

- U.S. pressures UN Commission on Narcotic Drugs to not support harm reduction and syringe exchange
- President’s Emergency Plan for AIDS Relief requires 1/3 prevention funding for abstinence
- In October 2004, the U.S. did not join 85 countries that signed a statement reaffirming commitment to reproductive health- and HIV/AIDS-related goals agreed to at the 1994 International Conference on Population and Development in Cairo
- U.S. is withholding international funding for groups that do not sign pledge against prostitution and human trafficking, essential cutting off funds for groups that work with sex workers
- U.S. successfully pressured Uganda to DECREASE distribution of condoms--essentially cutting back on “C” and expanding “A, B”
CDC’s Scientific Integrity Is in Jeopardy

"The focus on everything has to be abstinence," said a long-time CDC scientist, who asked not to be identified. "The language has to be very scrutinized and approved at 3,000 levels. The general sense is that propaganda has taken precedence over science." -- Toronto Globe and Mail
What this means on the ground

Prevention with positives:

- A prevention case manager may identify an individual’s needs/concerns (resistance education; disclosure; relationship support) for which there are no local referral services
- PCM overlaps with CARE Act case management--do we need two systems?
- Medical providers are too busy and too poorly reimbursed to do meaningful prevention
- Detailed sex and drug use histories, included in the national PEMS database, can put clients at risk for criminal transmission charges
Rapid testing:

- Helping seropositives know their status is critically important.
- Because testing is a bridge between prevention and care, the responsibility should be shared with HRSA.
- Prevention dollars are too scarce to do it alone.
- Testing is not case-finding--we still lose people to care who are in denial, afraid, avoiding.
- We need better support services to offer newly tested positives and negatives.
What this means on the ground

MSMs

- Our inability to acknowledge that sex and sexuality are healthy, natural, and normal is having an impact on prevention, especially the psyche of MSMs.
- Tired of the messages, some MSMs are happy to forgo condom use.
- Our counseling on condoms is not reinforced by government or even commercial messages making our work nearly impossible.
- Men who have sex with men and women are hard to reach at all.
- Resurgence of high risk behaviors point to a deeper crisis.
- More research, interventions are needed.
What this means on the ground
Youth at continued risk for HIV & STDs

MOST YOUNG PEOPLE ARE SEXUALLY ACTIVE

- **1 in 3** 15-year-olds report having ever had sex (2002)
- **2 in 3** 19-year-olds report having had sex (2002)

TEENS TURNING TO ORAL SEX

- Nearly 1 in 4 teen virgins has engaged in oral sex, seemingly from abstinence-only ed about contraception failures
- In terms of HIV, oral sex is safer; STDs remain a concern.
- Oral sex often accompanies vaginal and/or anal sex. Teens may not receive proper education on condoms to protect themselves.

 Teens define sex in new ways

By Sharon Jayson, USA TODAY

The generational divide between baby-boomer parents and their teenage offspring over oral sex is well-documented. More than half of 15- to 19-year-olds are doing it, according to a groundbreaking Preventer report.

"The researchers did not ask about the circumstances in which oral sex occurred, says Dr. Martha Bechtold, director of the National Campaign to Prevent Teen Pregnancy.

"What we're learning here is that adolescents are redefining what is intimate."
What this means on the ground
High rates of incarceration fueling HIV

- The prevalence of HIV/AIDS is believed to be 14 times higher among inmates than the general population.
- Illinois reported 471 prisoners with HIV in 2002; the actual number could be as high as 900.
- Number of male inmates engaging in sex could be as high as 65%; 28% of inmates report sexual assault.
- Contraband of syringes and drugs also a risk factor.
- Prisons in jails in only 7 U.S. jurisdictions provide condoms.
- Federal prisons in Canada have allowed condoms for more than 10 years without incident.
- No U.S. correctional system distributes sterile syringes.
- With an estimated 2 million people locked up, and 650,000 released annually, the health and service needs of inmates affect the entire community.
- Prisons and jails must expand peer-based prevention; voluntary testing and care; and re-entry services.
What can we do about it?

We must **mobilize** support for science-based prevention—and communicate **ideas and urgency** to elected officials.
According to a cost-effectiveness analysis, CDC’s current strategies would need $1.7 billion to prevent 20,000 cases annually. At current funding, only 7,300 cases can be prevented.

CDC could prevent 20,000 cases (at a cost of $400 million) if it directed funds to a combination of the most cost effective methods to reach both high-risk and low-risk groups of people.
Cost-Effectiveness Recommends:

- **Community mobilization**—targeting men who have sex with men—was predicted to prevent nearly 9,000 HIV infections per year.

- **Needle exchange programs**—most cost-effective when used for injection drug users in areas with a high HIV prevalence—were estimated to prevent close to 2,300 new cases of HIV infection.

- **Mass-media campaigns** containing messages to reduce risky sexual behavior and programs to distribute free condoms could prevent an estimated 1,100 and 1,900 new infections, respectively, among lower-prevalence populations.

- HIV counseling and testing—one of the four CDC prevention methods—was found to be one of the least cost-effective prevention approaches, costing $74 per person reached and $110,000 per infection prevented. The investigative model predicted 700 HIV infections could be prevented using this method by limiting the number of people tested and counseled to 1 million annually.
Other Federal Recommendations

CDC Should:

- Respond to concerns about PEMS and DEBIs
- Revoke draft content review guidelines
- Develop a national research plan for HIV prevention
- Promote--instead of diminish--counseling
- Increase transparency for CDC’s estimates (number infected annually; number who do not know their status; percent of new infections under age 25) to increase CDC credibility and assist jurisdictions in devising their own estimates
More CDC Recommendations

**CDC must address criminal law concerns of PWP and PEMS**

- Communities, agencies, and clients must be fully informed of risks
- CDC must recommend strategies to states to close confidentiality loopholes and protect clients in services from self-incrimination
- CDC should do more to promote the HIV prevention benefits of providing HIV treatments to all who need them
Self-Incrimination, Partner Notification, and the Criminal Law: Negatives for the CDC’s “Prevention for Positives” Initiative

Excellent article by David W. Webber, JD

www.aidsandthelaw.com
Other Critical Issues

- CDC should set a new national goal to reduce annual HIV cases to 15,000 by 2008, and measure progress annually (Holtgrave)

- Congress should include provisions in CARE Act legislation to protect CARE Act funding for code-to-name states

- Increased federal funding for prevention, care, and housing is paramount
State Recommendations

- Bring together various state agencies, from Board of Education to Child Welfare and Department on Aging, to respond to HIV prevention needs
- Update prevalence estimates
- Convene community consultations on the future of HIV prevention. Community perspectives should help shape:
  - BASUAH (Brothers and Sisters United Against HIV/AIDS)
  - Priority setting of state and federal funds
  - Corrections interventions
  - Responses to the epidemic among Latinos, MSMs, and youth
Recommendations

Community:

- Build an active, grassroots constituency for HIV prevention
- Outreach to people involved in HIV and those outside our sector
- Develop local plans for slowing the epidemic
- Share what you know with elected officials
Join the Advocacy Network

www.aidschicago.org

International AIDS Expert Kicks Off 20-Year Speaker Series

Dr. Mark Kline of the Bayview International Pediatric AIDS Initiative will discuss the global impact of HIV/AIDS on children. A panel of leading pediatric HIV/AIDS experts will join Dr. Kline for a question-and-answer session following his remarks.

This session is part of a series of events commemorating the AIDS Foundation of Chicago’s 20 years of service to the community.

upcoming events

- *Not Just Song and Dance* - 5/7/05: Join us for an evening of food, music, and dancing at the fifteenth annual gala.

message board

- View the most recent topics of discussion:
  - National Black Church Week Of Prayer - March 6-12
  - Research study!!!
  - The State of AIDS in Black America
Ending (or Reducing) HIV Transmission: A Matter of Skill or Will?

As a nation, basically we know what needs to be done (be we don’t do it). As a nation, basically we know what it will cost to substantially reduce new infections (but we don’t make the investment).

--David Holtgrave, PhD
“Someday, the AIDS crisis will be over. Remember that. And when that day comes—when that day has come and gone, there’ll be people alive on this earth—gay people and straight people, men and women, black and white, who will hear the story that once there was a terrible disease in this country and all over the world, and that a brave group of people stood up and fought and, in some cases, gave their lives, so that other people might live and be free.”

VITO RUSSO, 1988, WHY WE FIGHT