COMMUNITY HIV/AIDS CHAMP MOBILIZATION PROJECT
HHS WATCH

SPECIAL FOCUS ON CONGRESS: Hoping for a Tidal Wave, Settling for the Tidal Drift

The new year brings in a new Congress, just at a critical time for US-backed HIV prevention efforts. Will the Democrats' ascension to majority status make a difference as the Bush administration increasingly embraces its abstinence-promoting allies? The president, after all, retains a veto on new legislation, and the new Senate majority is razor-thin.

Then too, many of the new Democrats are moderates who are replacing moderate Republicans. In two of the more clear-cut cases, Robert Casey defeated Rick Santorum and James Webb defeated George Allen. Two moderates replaced two extremely conservative senators.

Casey spent considerable time during his campaign defending his opposition to abortions. He emphasized his Catholic faith's support for social services aimed at improving children's lives. Webb, a former secretary of the Navy under Ronald Reagan, joined with the anti-abortion Family Foundation in a marriage of convenience to make trouble for his opponent. Allen owns stock in Barr Laboratories, the maker of emergency contraceptive Plan B. The campaign outcry occurred just as the long struggle to get FDA approval of over-the-counter Plan B was achieving partial success. Both candidates are far more sympathetic to gay rights than the essentially homophobic senators they succeed.

The new Congress may not mark a radical break with the past, but the atmosphere will be greatly relaxed. Rep. Mark Souder (R-IN), for example, will no longer be able to use his position as chair of the House's Drug Policy subcommittee to launch investigations of groups promoting harm reduction (see *HHSWatch*, June 2005). That subcommittee may be chaired instead by its current ranking minority member, Elijah Cummings of Baltimore. Cummings is co-chair of the House AIDS Working Group, as well as past chair of the Congressional Black Caucus.

On Drug Policy's parent committee, the House Committee on Government Reform, chair Tom Davis (R-VA) will make way for Henry Waxman (D-CA), who has been a consistent critic of the abstinence-based sexual education programs funded by HHS. Cummings and Waxman have worked together – and in opposition to Souder and Davis – to protest the US government's attempts to block syringe exchange programs around the world.

In December 2004, the Government Reform minority staff released, under Waxman's direction, a report criticizing the misinformation disseminated in federally funded abstinence curricula. Waxman may eventually steer his committee back to investigating how HHS-sponsored abstinence programs work, but fixing Medicare's new drug benefit is clearly his first priority. Reducing Medicare's drug expenses and extending the drug coverage is one of two consensus issues that Democrats promised to act on immediately if they took control of Congress. The other is promoting stem cell research. (Casey, though, supports the administration's current restrictions on creating new stem cell lines from surplus human embryos derived from in vitro fertilization.)

When it opens up shop in January, the new Congress will immediately face a major budgetary quandary. Congress this year has passed only 2 of 11 spending bills of fiscal

year 2007, which began in October. A brief lame-duck session in December will likely be able pass only a continuing resolution, allowing the government to function at 2006 levels.

The Health, Education and Labor budget are among those left in the lurch. That includes controversial funding for abstinence-until marriage programs as well as the CDC's HIV prevention budget. In the proposed budget stalled in the current Congress, abstinence education was flat-funded at $176 million despite the president's request to increase it to $204 million. HIV prevention was slated for $706 million, including a $55 million in new funding for the president's domestic HIV testing initiative (see *HHSWatch*, October 2006). Reauthorization of the Ryan White Care Act (also see *HHSWatch*, October 2006) is another unresolved issue.

The Democrats may be annoyed that they have to clean up the previous Congress's leftovers, but given their small majority and the president's veto power, fine-tuning the budget may be their point of greatest leverage. They could adjust program expenditures and also impose new spending strictures to better suit their social priorities. For example, the national AIDS Budget and Appropriations Coalition has called for a $387 million increase in the CDC's HIV prevention budget in an effort to reach all those at risk for HIV. That amount would save money over the long-run if it resulted in only moderate reductions in HIV transmission (12,000 fewer newer cases per year). With the present Republican majority relinquishing this year's budget to the new Congress, the 2007-2008 legislators will exceptionally have power over three expenditures, 2007 to 2009.

Condoms Slip Less Than Abstainers Do

Waiting in the wings are bills that would significantly alter the administration approach to HIV prevention and sex education in general. One important reform effort is the REAL Act (Responsible Education about Life). It is sponsored by Rep. Barbara Lee (D-CA) and Sen. Frank Lautenberg (D-NJ) and would allocate $206 million a year for the next five years to underwrite comprehensive, secular-based sex education in schools.

True to its intent to promote comprehensive sex ed, the REAL Act requires that programs are medically accurate and teach about the protective value of contraceptives and barrier methods. The most critical topic for sex ed – managing relationships – is currently buried as the sixth of the seven optional points that REAL-funded programs may cover, calling for educational activities to "promote self-esteem and positive interpersonal skills focusing on relationship dynamics, including, but not limited to, friendships, dating, romantic involvement, marriage and family interactions."

Written in the shadow of the crusade for abstinence-only in a Republican-controlled Congress, the REAL Act currently states third among its nine program requirements that abstinence is the only "sure" way to avoid pregnancy and STDs. In real life, people who rely on abstinence to defend them against pregnancy and STDs frequently have unplanned, unprotected sex. Such episodes may be considered "abstinence failure," analogous to "condom failure." In its position paper on abstinence-only education, the Society of Adolescent Medicine states, "Although it has been suggested that abstinence-only education is 100% effective, [the cited] studies suggest that, in actual practice, efficacy may approach zero."

Although abstinence-only funding first became a growth industry under the Democratic Clinton administration, the new Congress may be able to consider a REAL Act that moves now-optional points up the ladder to become mandates. Abstinence, on the other hand, should move to a rank more in keeping with its practical flaws.

"Safe Sex is No Sex"? The GAO Looks Askance

Helping to bring the abstinence debate to the fore is a new analysis released after the elections by Congress's nonpartisan Government Accountability Office (GAO). The GAO did not pass judgment on the programs' quality. Rather, it examined the process by which HHS evaluated these programs. The answer is hardly at all.

There are three major federal funding streams supporting abstinence education in schools and community centers. Two originate in the HHS Administration for Children and Families. These include the *Community Based Abstinence Education* program, which distributes grants directly to local nongovernmental organizations. The program started with a $20 million appropriation in 2001 and grew to $113 million in 2006. A second program distributes $50 million a year to states, who have to match every $4 they receive in federal money with $3 of their own. The states may distribute this pot of money to local abstinence-promoting organizations or administer abstinence education programs on their own.

The oldest federal abstinence funding comes from the *American Family Life Program* in the HHS Office of Population Affairs (OPA). The OPA program began in 1982 and currently sends about $14 million annually on abstinence-until-marriage "demonstration" grants. The ACF, it turns out, does not review grantees' educational materials for scientific accuracy, nor does it require the grantees themselves to do so. The OPA, on the other hand, has a staff medical education specialist who reviews all materials – many of the curricula are the same as used in the ACF-funded programs.

The OPA review seems more pedantic than profound. The GAO describes how the staff specialist once objected to a sentence that read, "The only 100% effective way of avoiding STDs or unwanted pregnancies is to not have sexual intercourse." The specialist had the offending sentence altered to state, "The only 100% effective way of avoiding STDs or unwanted pregnancies is to not have sexual intercourse and engage in other risky behaviors."

Efforts to evaluate abstinence program effectiveness also came up short in the GAO's opinion. The agency concluded that overall, the HHS evaluation methods did not meet established scientific standards. ACF requires programs funded through the state grants merely to report on changes in such parameters as the rates of sexual intercourse, pregnancy and STDs among their state's total adolescent population. The community grant recipients have to report on program output, such as the number of youths taught or adults trained, as well as the achievement of program goals. Such goals can consist merely of increased knowledge of abstinence or changes in expressed attitudes. OPA, once again, is more methodical. In addition to knowledge and expressed intent, it does look for some indications of changes in behavior compared with the community-at-large.

The NIH, CDC and other organizations are conducting long-term studies of abstinence programs effectiveness. In the meantime, the fogginess about what abstinence programs accomplish has not stopped ACF from this year extending its abstinence focus through age 29 and more rigorously enforcing its eight-point guidelines about what grantees need to teach. Their used to be some wiggle room, but no more. From now on, there is no way under the program to avoid teaching that abstinence is the only certain way to avoid STDs, pregnancy, and the "harmful psychological and physical effects" of extramarital sex.

The stiffer rigid rules prompted New Jersey this October to reject the state grants as incompatible with its comprehensive sex ed curriculum. Three other states, California, Pennsylvania and Maine, have previously

rejected the grants for similar reasons. The community-based grants announcement defines sexual activity as "any type of genital contact or sexual stimulation between two persons, including, but not limited to, sexual intercourse." That might seem as an aggressively broad definition, but it turns out that the ACF expects abstinence programs only to educate youth; not trigger behavior change. While rigidly enforcing the rules for program content, the agency has become fuzzier about program goals. Grant announcements now speak only of providing education to "support decisions to abstain from sexual activity" until marriage. With such a loose standard, evaluating program effectiveness is not so critical after all.

The Fox in Charge of the Hen House

The administration has not backed off from its abstinence agenda in the light of the change in Congress. Rather it has courted confrontation by appointing Boston anti-abortion activist Dr. Eric Keroack as deputy assistant HHS secretary in charge of OPA. Amid widespread protest and press coverage Waxman and six other representatives issued a letter to HHS demanding retraction of the appointment. Another missive to HHS came from 14 senators including Kennedy and Kerry from Keroack's home state.

OPA has a budget of $313 million. Most of the funding goes to its Office of Family Planning, which was set up in 1970. OFP supports the activities of health clinics that provide contraceptive information and supplies, gynecological and STD exams, and pregnancy counseling. For poor women, OFP-funded clinics can be the only source of such care.

When appointed, Keroack was the medical director for a Boston-based chain of Christian "crisis pregnancy centers" known as A Women's Concern. He is known as a pioneer in using ultrasound images of women's fetuses to dissuade them from having abortions. One of his unique assertions is that multiple sex partners alter brain chemistry so that men and women are unable to form stable marital relationships, an assertion disputed by the researchers he has cited in his presentations. A Women's Concern also refuses to advise patients about contraceptives regardless of their age or marital status.

Several years ago, A Women's Concern founded an abstinence education unit called Healthy Futures, which now receives federal abstinence money through Massachusetts' ACF grant. Keroack himself is on the expert advisory panel for ACF's community-based grants.

In their letter to Leavitt, the senators concluded, "This appointment is another example of the Administration allowing ideology to trump science, and it could jeopardize vital services on which large numbers of women and families depend. Given Dr. Keroack's ideological record on Title X [family planning] services, we urge you to withdraw this appointment and select a Deputy Assistant Secretary who will vigorously administer Title X as intended by Congress under current law."

Beyond Condoms to Social Justice

There's more to HIV prevention than sex and condoms. To remind us of the social aspects of prevention, the National Minority AIDS Council on November 16 published a report entitled *African Americans, Health Disparities and HIV/AIDS: Recommendations for Confronting the Epidemic in Black America*. The report was written by Robert Fullilove who is Assistant Dean for Community and Minority Affairs at Columbia University's Mailman School of Public Health.

"Simply put," the report states, "the epidemic is rapidly outpacing our efforts to control it using standard public health, infection-control procedures." Blacks acquire HIV and progress to AIDS ten times often than whites, with black women and men who have sex with men particularly affected by

the epidemic.

Health disparities abound between blacks and whites. In New York City, for example, the areas of high HIV and high diabetes prevalence overlap in the same African American neighborhoods. The Fullilove report argues that these disparities are due to the socioeconomic factors that undermine African American communities and break up interpersonal relationships. It advises, "[Public health] policies must effectively deal not only with unstable housing and incarceration, but also with the poverty and social disadvantages of poor African-American neighborhoods. Policies that address the role that homophobia plays in driving new HIV infections among black MSM must also be adopted so that programs mitigating that impact can be implemented."

The report urges a five-point plan for rectifying the situation. The first point is to provide more affordable housing, which *Health Disparities and HIV/AIDS* calls one of the best ways to reduce HIV mortality and morbidity. Excessive housing expenses can set up the conditions for poor education and health access. The second point addresses incarceration as a driver of the HIV epidemic among black men. Fullilove advocates voluntary testing of prisoners upon entry and release; making syringes, condoms and prevention HIV information available in prisons; and improving post-release programs (including HIV prevention, substance abuse and mental health services) to help prisoners succeed in mainstream society.

A major point is to work to ameliorate stigma and marginalization experienced by black men who have sex with men: "Sustained investment must be made to build the capacity of organizations developed to serve black MSM in order to effectively change social networks, behavior and conditions contributing to HIV infections in this population." The report passionately protests the lack of research on effective HIV prevention aimed at black MSM. It further recommends routine HIV testing and early linkage to care. Finally, the number of HIV infections in African Americans can be reduced by expanding drug addiction preventi•on and treatment services. It also strongly advocates providing clean syringes for injection drug users outside of treatment.

What happens now? Is anybody willing to move these recommendations forward? The point about connecting HIV testing to care requires immediate action as the CDC moves to make HIV testing part of standard healthcare (see *HHSWatch*, September and October 2006). Fullilove observed at a press conference, "If people get the sense that there's no point in getting tested because there's nothing that can be done for you, then I think we're in real trouble."

Generally speaking, the report's recommendations have been repeated many times before with little action. Fullilove argues that the approach is different this time, and that lawmakers in the new Congress and in state houses will feel more compelled to address the issues. He said, "I tried to take many of the agenda items that we were pushing during the civil rights movement around housing, around examining issues of poverty and racism, and to advance the way in which we speak about them by looking at … the fact that these are problems that live with us today…. They have become all the more intense because they're now affecting the health and welfare of a significant portion of the American population."

Confronted by a cautious Congress and a rigid administration, it's hard to see where the needed tidal wave will come from. Fullilove evoked a glorious epoch when community activism broke through a similar period of social conservatism. Sometimes you do want to repeat history – precisely because you remember it.

This HHS Watch was written by David Gilden

HHSWatch, a watchdog newsletter from CHAMP, monitors and reports on activities related to HIV prevention at Health and Human Services agencies, including CDC, NIH, HRSA and SAMHSA.

HHSWatch is a resource for community members, policy advocates, researchers and anyone interested in more fully understanding and tracking the committees, panels and administrators whose recommendations and decisions affect our work.

HHSWatch is committed to providing an outlet for those concerned about infringements upon science-based HIV prevention and treatment, and will respect your wishes for confidentiality. If you are interested in contributing information or suggesting a story, please contact champ@champnetwork.org.

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