COMMUNITY HIV/AIDS CHAMP MOBILIZATION PROJECT
HHS WATCH

January 2007 -



## Plan? Did Somebody Say We Had a Plan?

Whatever happened to the CDC's HIV prevention planning process? In 2001, the agency issued a plan that set four targets for 2005. Chief among them was that the annual rate of new HIV cases would be reduced by half, from 40,000 to 20,000. Other goals involved expanding testing and counseling so that nearly all Americans with HIV were aware of their infection and had treatment available to them.

Six years later, little has been achieved toward meeting those goals. The CDC has launched a new initiative aimed at identifying and working with HIV-positive persons. A consequence of this initiative was the new CDC guidelines advocating mass HIV testing as part of routine medical care (see HHSWatch September and October 2006).

The number of new infections has not noticeably abated over the years. The exact figures remain a mystery: Only 33 states have had named HIV reporting since 2001, and these do not include California and several other large states. Among the 33 alone, close to 40,000 persons are newly diagnosed every year. It's likely that over all the entire US, many more than 40,000 acquire HIV annually. The CDC expects to release its 2006 HIV Surveillance Report by early spring.

The CDC is now working with its HIV advisory board to extend the current plan through 2010, with certain adjustments. (The board is known formerly as the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment, or CHAC, because it also works with the HHS's Health Resources and Service Bureau.) This low-key effort is in sharp distinction to the previous planning effort. Jean McGuire, CHAC's outgoing co-chair, recalled, "It was a two-year massive, thorough process looking for coherence of overall funding and priorities. There was a lot of public input. The effort aligned with other work going on at CDC."

Yet, McGuire noted, the 2001 goals proved flawed from the very beginning. She said, "The plan pertained only to the CDC though its objectives reached beyond that agency. There were inherent problems. On the one hand, we had a good vision; on the other, there was insufficient scope. And critically, the plan was underfunded by $350 million. There was insufficient data collection capacity. The numbers in the goals were just picked out of a hat because of pressure from the OMB [the White House's Office of Management and Budget] to come up with something measurable."

The lack of a unified, national HIV plan has become a common complaint. Last spring in a run-up to the United Nations' special session on HIV, the Open Society Institute produced a 76-page review of the US government's accomplishments as measured against the UN's 2001 "Declaration of Commitment on HIV/AIDS." OSI's number 1 recommendation for improving care and prevention in the United States was to establish "a national HIV/AIDS strategy that focuses on outcomes." The organization is currently producing a report that elaborates on how implementing such a plan would enhance the government's ability to reach its goals.

Such a plan would coordinate activities by the multifarious US agencies that provide care, prevention, social services and research. For example, when the CDC proposes broader HIV testing, it would

automatically be working with HRSA other offices in HHS to ensure effective treatment for additional patients with HIV. Similarly, research into medical prevention measures such as microbicides at the NIH would be coordinated with the CDC's behavioral prevention programs.

Rob Janssen, who heads the CDC's Division of HIV/AIDS Prevention, told HHS Watch that further coordination of government agencies faces bureaucratic hurdles. He commented, "I absolutely agree that cooperation with other federal agencies is needed. We've worked with HRSA for a very long time. But coordination is not easy: Our demonstration project with three agencies failed because there are legal constraints to commingling funds. At the local level, health departments can combine funding streams. We're working on how that can be done."

One of the CHAC's primary recommendations was that the CDC updated plan should "prioritize African Americans at the highest level." The lack of focus on African Americans is another area where the CDC has come under considerable recent criticism. In November, the National Minority AIDS Council issued a report decrying the failure of government HIV strategies in the African American community (see HHSWatch, November 2006). NMAC noted that blacks acquire HIV and progress to AIDS ten times more often than whites, with black women and men who have sex with men particularly affected. The CDC is expected to announce a new African-American HIV prevention strategy in early March.

NMAC pinpointed a number of "structural" interventions that were required to reduce HIV in the African American community. These included providing better housing for African Americans and expanding reentry programs for recently incarcerated persons. Another major issue was AIDS stigma and homophobia. (CHAMP is an endorser of the report and its recommendations.)

The need for structural reforms was reinforced by a study appearing this month in the American Journal of Public Health. The authors looked at 8,700 young adults aged 18 to 26. 6,300 were white and 2,400 black. They broke the population down into 12 categories of risk, based on sexual and drug use history, and compared HIV and STD rates. The study found an HIV rate of 0.5% in the young adult African Americans, but HIV was almost entirely absent among the whites.

It would seem that individual changes in behavior did not appreciably reduce young African Americans' chances of contracting HIV or AIDS. Blacks were more concentrated in the lower risk strata but they had many fold higher combined STD/HIV rates at every level of risk. In distinction to whites, blacks' rates also varied little as risk increased. The STD/HIV risk was five times greater among black men who have sex with men (34% for vs. 7% for whites). This difference was similar to that found for heterosexuals with few sex partners and little drug use (20% vs. 3%).

Speculating on the reasons for these results, the study's lead author, Denise Hallfors, said, "There's a lot of crossing over between high-risk males and low-risk females. We think at bottom is the relationship between incarceration and STDs. One in three black men is imprisoned at some point. Men have little to loose and very risky behaviors after they get out. Also, black men are underrepresented in colleges and in the workforce. Black women tend to have sex only with black men, and there's a shortage of males due to incarceration and mortality."

The high rate of STDs among available sex partners means that even persons who are monogamous or mostly use condoms have a high probability of exposure to infection. One necessary structural intervention would be to greatly expand STD testing and treatment. Hallfors said, "We need to take the prevalence down in African Americans – get everyone tested and treated. But this kind of

broad program would be a waste of money for whites."

Other necessary interventions involve better education and employment opportunities and, particularly, alternatives to the current drug laws. These broader policy areas are beyond the CDC's focus. Janssen said, "Structural interventions are a real challenge. We struggle with this area the most. We need to move in this direction, and mobilize mainstream African Americans to confront HIV. The big question is: are we getting to the right people? We're now doing a study with HUD [the Department of Housing and Urban Development] on providing housing to persons with HIV – its impact on health, risk behavior, medication adherence."

"Getting to the right people" is always a central issue in HIV, but you also have to get to them with right activities. Any plan, if it hopes to be successful, will have to look at the different groups within in the US population, their different characteristics and their different risks. It will have to consider targeted interventions for each group, from the individual, behavioral level to the population-based, structural level. And to choose between each strategy, there will have to be a careful analysis of their costs, where the money is coming from and what benefit will accrue.

## Needle Exchange: The Ban Plays On

Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

That simple, unqualified statement has been present in every HHS appropriations bill approved by Congress since 1998. For the decade before that, there had been a built-in way to override the ban: The HHS Secretary could certify that distribution of clean syringes – as in needle exchange programs – reduced the spread of HIV while not encouraging addition use of illegal drugs. But when Secretary Donna Shalala tried to invoke these provisions in 1998, President Clinton overruled her at the last minute at the urging of drug czar Brian McCaffrey. Shalala could admit that "A meticulous scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs." But the government still refused to release any funds to support such programs, and Congress soon made the appropriations ban ironclad.

A decade later the government remains hamstrung. In a recent review of prevention interventions, CDC HIV/AIDS researchers merely noted, "Because substance-abuse treatment and needle-exchange programs are not supported by CDC HIV-prevention funds… those programs were not included [in our review]. These strategies were shown to be effective in previous reviews and, thus, should be considered in comprehensive prevention programs."

The political climate might become more supportive as the new Democratic majority settles into Congress. It might now be possible to simply drop the ban's language from next year's health appropriations bill. Such an omission would be practically veto-proof. The Bush administration would have to reject the entire bill, which includes funding for the Departments of Labor and Education as well as all of HHS.

Alan Clear, executive director of the Harm Reduction Coalition, observed, "There's been a big change in atmosphere since the 1990s. Needle exchanges are now more widely and thoroughly instituted. Minority support has increased because people saw benefits when needle exchanges were established in their communities. CDC and NIDA [National Institute of Drug Abuse] scientists say it is effective, too."

Indeed, the New Jersey legislature in December approved the establishment of a needle exchange demonstration project for that state. That state was the last in the nation to legalize needle exchanges in some form or other. "Quite simply, this bill will save lives,'' said Governor Jon Corzine as he signed the measure.

The New Jersey legislature appropriated $10 million for the initial program in six municipalities. In contrast, ending the federal ban would provide no new funds. It would merely allow local governments and organizations to apply for funding through existing programs, and applicants would probably receive a harsh reception. Still, the lifting the ban would encourage needle exchanges as part of the effort to halt HIV, both here and abroad. "It would be a first step," said Clear. "Then we'd have to find out what support there is in Congress for specific appropriations."

*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.*

**COMMUNITY HIV/AIDS MOBILIZATION PROJECT (CHAMP)**
32 Broadway, Suite 1801 New York, NY 10004
tel. (212) 937-7955 x 10
www.champnetwork.org