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Special Report: HIV Prevention at 25 Years

HIV prevention over past 25 years had early successes, now treads water

Progress made fast and early on

When money and time are put into HIV prevention efforts, they can have a dramatic impact, and the United States is a good example of this. But the reverse also is true, HIV prevention experts say.

Prevention programs dropped new infections from 160,000 a year in the mid-1980s to 40,000 a year since 1990, says **David Holtgrave**, PhD, a professor and chair in the department of health, behavior and society in the Bloomberg School of Public Health at Johns Hopkins University in Baltimore.

A study Holtgrave co-authored estimated that without HIV prevention investments totaling more than $10.1 billion from the early 1980s to 2000, there would have been an additional 204,000 to 1.585 million HIV infections in the United States.[1] **(See story on new report about HIV prevention, p. 79.)**

That's the good news. The flip side of the coin is that the prevention work and research funded by the CDC and state and local prevention spending have not resulted in any further reduction in HIV infections nationwide in 16 years. This is despite the CDC's well-publicized prevention goal of 2001 to cut new HIV infections in half to 20,000 a year by 2005.

The nation's prevention strategy problems were highlighted last year when the U.S. failed to make progress toward the CDC's 2005 goal, says **David Satcher**, MD, PhD, former U.S. Surgeon General and interim president of Morehouse School of Medicine in Atlanta. Satcher spoke at a news teleconference about the state of HIV in America, held by the Open Society Institute of New York, NY. "The CDC's prevention budget has been cut since the goal was promoted in 2001," Satcher said.

"We invest not enough, but a significant amount of money to HIV in the U.S., but the outcomes are hugely disappointing," says **Chris Collins**, a Philadelphia consultant to the Open Society Institute. Collins authored a report called "HIV/AIDS Policy in the United States,"

produced by Public Health Watch and the Open Society Institute. **(See story about Open Society report, p. 76.)**

"Half of people needing treatment are not getting it, and the HIV infection rate is locked at 40,000, year-in, year-out," Collins says. "Our country has failed to hold itself accountable."

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The CDC's failure to meet its 2005 goals and the stagnant new infection rate is a matter of dollars and cents, Holtgrave says.

"When we look at the HIV prevention budget at the CDC, adjusted for inflation, it's a mirror image of an HIV incidence curve," Holtgrave says. "As we spent more money we saw a drop in infections; when the investment leveled off, we saw a drop-off of reduction as well."

To further make a significant dent in the estimated 40,000 new infections each year, the CDC's prevention budget would need to be increased by $300 million annually, Holtgrave says.

In recent years, the CDC has shifted its focus to prevention efforts aimed at persons living with HIV infection and to identifying more people who are infected.

The CDC's Serostatus Approach to Fighting the HIV Epidemic was introduced in 2001; and in 2003, the CDC implemented the Advancing HIV Prevention (AHP) initiative.[2]

It's still too early to know if the CDC's increased push for HIV testing has had any impact on reducing the number of people who are unaware that they are HIV positive, says **Richard Wolitski**, PhD, chief of the prevention research branch of the CDC.

"Within our demonstration project that was supported through AHP, we've been looking at a variety of different strategies for improving the effectiveness and ability of HIV testing programs to identify undiagnosed HIV positives," he says.

For example, one project funded under AHP was the social network demonstration project in which the strategy was to recruit HIV positives in the community to refer the people they know who they think may be HIV positive and to bring them in for testing, Wolitski explains. "Under AHP, we funded a nine-site demonstration project that evaluated this strategy," he says.

Preliminary data published last year showed that of 814 people tested during that project, 5.7% were newly-identified HIV positive, he says. "That's a rate that is about six times higher than what we see in a regular HIV testing and counseling program," Wolitski says. "We'll present updated data this summer at the International AIDS Conference."

CDC officials are working on translating AHP knowledge into HIV prevention programs, creating materials and programs that will help health departments and community-based organizations (CBOs) implement the approach, Wolitski says.

"I think that CDC believes in and the data support the need for a three-pronged approach to HIV prevention that includes HIV counseling and testing, prevention for people who are living with HIV, and prevention for persons who are at high risk for contracting HIV," Wolitski says. "We can't leave any of those three major activities out of the equation."

However, critics say the CDC is emphasizing HIV testing and prevention for positives over traditional prevention programs designed for high risk groups, and they claim that this is contributing to the new infection rate remaining high.

Better spending would yield better results

If federal funding was used more efficiently, it could have a far greater impact, says **Judy Auerbach**, PhD, vice president for public policy with the American Foundation for AIDS Research (amfAR) of New York, NY. Auerbach also spoke at the Open Society Institute's teleconference on AIDS in America.

"A 2005 RAND study, for example, reviewed the cost effectiveness of various HIV prevention interventions and determined that the approximately $415 million dollars that CDC was providing in 2004 for HIV prevention activities could cut HIV infections in half, or by about 20,000 per year, if the funding were used for a mix of targeted and generalized interventions,"[3] Auerbach says.

These interventions might include community mobilization for men who have sex with men, needle exchange programs in high drug use and HIV prevalence areas, notification, expanded condom availability, and mass media campaigns, she says.

"But these are not the things our government is supporting," Auerbach says. "Rather, the CDC's current prevention program emphasizes HIV testing, which, in fact, has not been shown to actually reduce HIV risk behaviors or HIV infections."

The CDC also continues to emphasize prevention of perinatal transmission, although this has practically disappeared in the United States, Auerbach says.

Prevention for positives is an important strategy, Wolitski says. "First of all, people who don't know they are HIV positive are at greatest risk of transmitting the virus to others. Those who test positive reduce risk behaviors following the diagnosis, and they are less likely to engage in risky behaviors that put other people at risk for contracting the virus."

Plus, it's incredibly important that people with an undiagnosed infection get diagnosed and treated for their infection, Wolitski adds.

"We have to be concerned about both the transmission to others and the health and well-being of people living with HIV and AIDS," Wolitski says. "We know that late diagnosis of HIV disease is a critical factor in the ongoing problem with AIDS morbidity and mortality."

A recent study in the *American Journal of Public Health* found evidence that federal HIV prevention spending correlates with increased HIV testing rates and awareness of mother to child transmission[4], Wolitski notes.

The Open Society report also criticizes the increasing funds spent on abstinence-only education. In the past 10 years the federal government has spent nearly $1 billion on abstinence-only programs, and an estimated 35% of school districts that have a sex education program teach only abstinence until marriage and prohibit discussions of condoms for disease or pregnancy protection.[3]

"This approach to teaching about sexuality and HIV persists even though a wealth of studies and program evaluations have failed to find abstinence-only programs to be effective," the report says.[3]

While it's important to talk about abstinence with young people, it's neglectful to withhold information from them about what will help them prevent pregnancies and sexually transmitted diseases in the event they fail to abstain from sexual contact, Satcher says. "And certainly, everybody's not going to agree in terms of the values that we hold, but withholding information from people who need to be responsible to themselves and others is certainly not appropriate," Satcher says.

Likewise, the federal government has prohibited the use of federal funds for needle exchange programs despite the overwhelming scientific evidence that such programs greatly reduce HIV transmission.[4]

Nationally, the injection drug use (IDU) transmission rate continues to be substantial, but there has been a decrease in incidence of infections associated with IDU, Wolitski says.

"There has been a decline from 10% to 14% to less than 2% during the 1990s in HIV incidence among IDUs," Wolitski says.

The CDC has established a prevention effectiveness team to look at how CDC prevention money is spent and to assess what would be the

optimal allocation for resources to different types of prevention programs, Wolitski says. ■

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1. Holtgrave DR, Curran JW. What works, and what remains to be done, in HIV prevention in the United States. *Annu Rev Pub Health*. 2006;27:261-75.
2. Evolution of HIV/AIDS prevention programs—United States, 1981-2006. *MMWR Morb Mortal Wkly Rep.* 2006;55(21): 597-603.
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Special Report: HIV Prevention at 25 Years

Open Society Institute criticizes US progress

U.S. didn't come close to its own goals

A new report about the state of HIV/AIDS in America finds fault with how 25 years of presidents and Congresses have handled the AIDS epidemic domestically, which the report says has exploited longstanding inequities in American society.[1]

"The country has failed to come to grips with an interwoven set of social factors—including economic inequality, racial and gender disparities, racial discrimination, and homophobia—that create vulnerabilities to HIV infection and lead to poorer outcomes from health care services,"[1] states the Public Health Watch/Open Society International report. The report, titled "HIV/AIDS Policy in the United States," was issued May 23, 2006.

The biggest problems with the United States' response to the AIDS epidemic has been the reliance on a multi-tiered health system in which the best medical care and outcomes go to the people who have access to private health insurance coverage and the growing disconnect between prevention programs with scientific validity and what is funded by federal dollars, the report says.[1]

"U.S.-funded AIDS research has led to lifesaving scientific breakthroughs. Hundreds of thousands of infections have been prevented, and many lives have been saved through publicly funded treatment and care programs," says **Chris Collins**, author of the report and a Public Health Watch consultant. Collins spoke at a teleconference about the report. "But it is also true that needless mortality, inadequate access to care, persistent levels of new infection, and sharp inequalities define AIDS in America today," Collins adds.

About half of the people in the U.S. who have HIV receive regular HIV-related medical care, and only about half of the people who meet government criteria for antiretroviral drugs receive antiretroviral treatment, Collins says.

The other problem is that HIV prevention funding is limited, it has not been allocated in the most cost-effective manner, and it's often at odds with evidence-based prevention knowledge, Collins says.

Evidence-based strategies ignored

The Open Society report illustrates the disconnect between public health consensus on effectiveness of evidence-based HIV prevention and current U.S. policies that undermine it, says **Judy Auerbach**, PhD, vice president for public policy with the American Foundation for AIDS Research (amfAR) of New York, NY.

Funding for abstinence-only until marriage education has grown from $80 million in 2001 to $178 million in 2006, Auerbach says.

"At the same time, the U.S. currently denigrates condom effectiveness in its public health material," Auerbach says. "Then it prohibits programs that receive this abstinence-only funding from even mentioning that condoms are proven to be 80% to 95% effective in preventing HIV transmission, when used correctly and consistently."

HIV prevention research, itself, has been under attack, and this contributes to the problem, Auerbach says. **(See brief Q&A with Auerbach, p. 77.)**

The Open Society report points out the glaring racial disparities in the HIV epidemic with African Americans accounting for 40% of AIDS diagnoses through 2004, despite their 13% share of the U.S. population.[1] Likewise, Latinos represented 20% of new AIDS diagnoses in 2004, although they represent 14% of the U.S. population.[1] "Survival after AIDS diagnosis was lower for African Americans and Latinos than for whites and Asians," the report says.

"The U.S. is failing in efforts to reduce the racial and economic disparities that are the hallmark of HIV/AIDS epidemic in America," says **Phill Wilson**, executive director of the Black AIDS Institute of Los Angeles.

amfAR expert: There's a political assault on prevention scientists

[Editor's note: At a recent teleconference, sponsored by the Open Society Institute, a Soros Foundations Network, of New York, NY, ***Judy Auerbach****, vice president for public policy at the American Foundation for AIDS Research (amfAR) of New York, NY, spoke about the disconnect between science and the current Congress and presidential administration's handling of HIV prevention and research. Here is a brief question-and-answer exchange between Auerbach and* AIDS Alert.*]*

AIDS Alert: I have spoken with HIV prevention scientists who have talked about a chilling effect on the research from this administration and Congress in recent years. They say they believe the research will not be funded if it targets certain populations or uses certain words. I'd like to know how significant you believe this problem is and if it contributes to the overall effectiveness of evidence-based intervention?

Auerbach: That's a very common perception among HIV and AIDS researchers, particularly prevention scientists, and it comes from some very specific actions that have occurred recently, including attacks on particular researchers and their research projects based on the contents of those projects and the populations they have addressed, specifically around sexual health and HIV prevention and vulnerable groups: men who have sex with men or gay men, sex workers, and injecting drug users.

And that's a case where the assaults have come as much from Congress as they have from the administration. In fact, their allies in think tanks or non-governmental organizations have identified by name certain studies and researchers, and, in some cases, proposed amendments to funding legislation, saying these grants that already have been peer reviewed and approved for funding, and in many cases, are already in process as studied, [they say] their funding should be cut.

So there have been really very specific and deliberate attacks on grants, peer-reviewed studies, and the researchers. And the implication is that the populations that they're interested in studying aren't worth studying. They're not as deserving of our public health support as some other groups, I suppose. Or they don't like the contents of the research because it's around sexuality or drug use. So this, in fact, has put a chilling effect on the researchers.

Some of that concern gets translated to the folks who manage the grant programs out of the federal agencies that fund research, where they're trying to protect the research and make sure that it happens. But they're also cautioning researchers to be mindful of these kinds of assaults. So what you see is folks, you know, either not getting into this line of work at all or moderating the approaches to appease political concerns. And it could in the end mean that we don't have the kind of research being undertaken that should be.

We also have the fear that the whole peer review system that the entire world really celebrates about the U.S.—we have a model system for assessing what's appropriate science to fund with public dollars—that that's under assault itself. And that's a pretty fundamental concern for science and for the quality and validity of the kinds of science we do support. ■

"Twenty-five years into this epidemic, its burden falls more heavily than ever on people of color, especially African Americans, men who have sex with men [MSM], women, the young, and the poor," Wilson says. "In 2006, AIDS in America has become virtually a black disease."

CDC data show that half of the black MSM in some cities are HIV positive, and two-thirds of these men don't know that they're infected, Wilson says.

"Reducing the HIV burden in poor and disenfranchised communities in the U.S. will require a real effort on the part of our government to reach out into black and other communities of color with programs that are developed for and targeted to, rather than just simply adapted for those communities," Wilson adds.

AIDS is the number one cause of death among African American women, ages 24 to 34, says **Pernessa Seele**, founder and chief executive officer of The Balm in Gilead of New York, NY.

"AIDS diagnosis among women rose from 8% of total diagnoses in 1985 to 27% in 2004," Seele says. "Among women diagnosed with AIDS in 2004, 64% were African American, and 18% were Latino."

One of the problems is that non-governmental organizations (NGOs), such as The Balm in Gilead, have not been invited to participate in the process of evaluating the U.S. government's response to the epidemic to make certain it's efficient and effective, Seele says.

"In recent years, there has been growing concern about perceived federal harassment of NGOs providing AIDS services that may not reflect the ideology or power positions of the government," Seele says. "For example, in October, 2003, Representative Henry Waxman noted that HHS may be inappropriately using its authority to penalize groups that promote comprehensive sex education."

The report provides suggestions for improving the state of HIV/AIDS in the U.S., and these include accountability, addressing racial disparities, and focusing on effective interventions.

"First, America should hold itself accountable for steadily improved results on HIV prevention and care," Collins says. "We should use concrete targets as part of an ongoing effort to systematically assess programming and policy."

Secondly, racial disparities need to be addressed in a much more intensive way, Collins says.

"The government should launch a vigorous, federally managed effort to test, refine, and deliver innovative programming that improves outcomes for communities of color," Collins says. "We have to better understand how to deliver services to those who are often not reached in the current healthcare system."

And, third, the U.S. should dedicate more resources to proven effective interventions, Collins says.

"On HIV prevention, the CDC and other agencies should tie programming much more closely to evidence of what works," he says. "This includes needle exchange, condom availability and abstinence-plus education."

In the CDC's recent report about HIV prevention after 25 years, there's a table listing some of the CDC's prevention interventions from the CDC Diffusion of Effective Behavioral Interventions (DEBI) project.[2] The DEBI list represents scientifically-proven intervention methods, and states and community-based organizations are encouraged to use and adapt one of these methods for their own prevention work.

Critics say the DEBI list, which so far has less than 20 interventions included, is too limited and does not address all of the populations at high risk for HIV infection.

Part of the problem is that most of the CDC's approved evidence-based interventions were not designed by or for African Americans, Wilson says.

"They're not programs that have credibility in black America," Wilson says. "So, as a result, while these programs may have evidence that they work in some communities, there is not evidence that they are culturally appropriate in black America."

While there are some interventions on the DEBI list that were designed for African American women, there are none that were specifically designed, tested, and found to be effective for African American men who have sex with men, says **Richard Wolitski**, PhD, chief of the prevention research branch at the CDC.

"So one of the challenges now is how to take these effective interventions and culturally tailor and adapt them so they can be effective for African American MSM, while at the same time developing new interventions for this population," Wolitski says.

At present, the CDC is working with the North Carolina Department of Public Health to implement and test an adaptation of the popular opinion leader intervention on the DEBI list to be used for African American MSM, Wolitski says.

The intervention initially was designed and tested on a primarily white, at-risk MSM population.

The adapted model has been implemented at three sites in North Carolina, and the preliminary evaluation data from the project are very promising, Wolitski says. "And we'll present results of that evaluation as part of an oral presentation at the International AIDS Conference this summer."

"There has been a significant reduction in risky sexual practices among MSM who were sampled in community venues over a one-year period of time," Wolitski says.

Once an adaptation is proven effective then the CDC will provide training and technical assistance to organizations that wish to use it, Wolitski adds.

"This project suggests at least in one case taking an effective intervention and adapting it for another population has promise," Wolitski says. ■

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1. HIV/AIDS policy in the United States. Monitoring the UNGASS Declaration of Commitment on HIV/AIDS. Public Health Watch/Open Society Institute. May, 2006:1-76.

2. Evolution of HIV/AIDS prevention programs—United States, 1981-2006. *MMWR Morb Mortal Wkly Rep.* 2006;55(21): 597-603.

Prevention costs much less than treatment

Prevention programs needed to reduce infections

Each new HIV infection may reach more than $200,000 in medical costs and result in the loss of nearly 24 quality-adjusted life years, according to a new study.[1]

The cost of prevention efforts, by contrast, are estimated to range from $6,400 to $49,700 per HIV infection prevented.[1]

This is why more money directed at HIV prevention in the United States is a cost-effective strategy for dealing with the epidemic, says **David Holtgrave**, PhD, professor and chair of the department of health, behavior and society at the Bloomberg School of Public Health at Johns Hopkins University in Baltimore.

If the U.S. fails to put money and effort behind further reducing new HIV infections, then the public health cost will be considerable, with more than 100,000 persons becoming HIV infected by 2010, resulting in medical costs of about $18 billion.

The CDC has focused in recent years on expanding HIV testing and prevention for positives, and these strategies make sense because studies show that 96% of people who know their status and live with HIV are not transmitting the disease to anyone, Holtgrave says.

Scientists define the HIV transmission rate as the number of new HIV infections in a year divided by the total number of persons living with HIV/AIDS in that year.[1]

In 1983, the HIV transmission rate was estimated to be 43%, but has fallen to about 4% in recent years.[1]

For those who are unaware of their HIV infection, the transmission rate is nine to 11%, Holtgrave says. And for HIV positive people who are aware of their status, but who are continuing to engage in risky behaviors, the transmission rate is 1.7% to 2.5%, he adds.

"So it's very important for people to receive counseling and testing and to be aware of their HIV status," Holtgrave says. It's also important to continue to provide risk reduction interventions to people who are at risk for HIV infection, but are seronegative, Holtgrave notes. "We need to make sure we're targeting services to African American metro-sex males, addressing their health disparities, and making sure we're studying the kind of interventions that are needed," Holtgrave says.

Other prevention interventions could be aimed at the general population as both a public health prevention strategy and also a way to improve HIV education and reduce the disease's stigma, he suggests.

"You might think it's obvious that people in the U.S. know how to protect themselves, and years ago, that might have been the case," Holtgrave says.

Former Surgeon General C. Everett Koop, who was appointed by President Reagan in 1982 and served in that role until 1989, had sent out a public health service brochure, called "Understanding AIDS," to all 107 million U.S. households in 1988.

Koop's public brochure and treatment of AIDS as a public health issue helped to educate the public about the disease and its transmission, Holtgrave says.

The public's knowledge about HIV/AIDS has deteriorated since then.

In a recent survey by the Kaiser Foundation, 43% of Americans answered at least one basic question wrong about how HIV is transmitted, Holtgrave says.

Also, nearly 45% of people surveyed didn't know there were medicines available that pregnant women could take to avoid transmitting HIV to their infants, Holtgrave says.

"The idea that there's that much misinformation in the United States is not widely discussed," he says.

If the U.S. fails to put money and effort behind further reducing new HIV infections then the public health cost will be considerable, with more than 100,000 persons becoming HIV infected by 2010, resulting in medical costs of about $18 billion.[1]

"This year, I have to say, I saw a ray of hope in the president's budget proposal to Congress," Holtgrave says. "There was an inclusion of $93 million in new dollars for domestic HIV prevention at the CDC, and that would reverse the trend of flat funding."

The proposed $93 million was targeted toward rapid testing and counseling services, especially

for incarcerated populations, and it's debatable whether that would be the most efficient use of the additional funding, Holtgrave notes.

"But nevertheless, seeing that figure was hopeful," he says. "The overall level of resources is tremendously important. If you need to apply X number of tests or interventions, it costs so much per client to do so, and we need to get that $300 to $350 million more."

It's also important to use the prevention money for science-based strategies, he says.

Needle exchange programs and condom use to prevent HIV transmission have a good body of scientific evidence showing their efficacy, so it's disheartening to see political concerns pushing these strategies to the back shelf, Holtgrave says.

"There's a federal ban on needle exchange, and condoms information was removed from the CDC web site for a time," he says. "It's like we have a shelf in which one is putting interventions that we know will work, but we can't use them, and, unfortunately, that shelf is getting a little crowded."

Holtgrave says he's also dismayed that the CDC has decided to no longer recommend HIV counseling for everyone who is offered HIV testing.

"I'm in favor of making HIV testing more routinely available, but I'm concerned about tossing counseling away because it's perceived that clinicians are too busy to provide it," Holtgrave says. "There's good evidence to show the positive effect of providing HIV counseling and basic information to people." ■

Reference:

1. Holtgrave DR, Curran JW. What works, and what remains to be done, in HIV prevention in the United States. *Annu Rev Pub Health*. 2006;27:261-75.

Computerized intervention increases condom use

Intervention is translatable to other clinics

Researchers have developed a computerized condom use intervention that significantly improved consistent condom use among participants randomly selected at a sexually transmitted disease (STD) clinic.[1]

The one-time intervention was tailored according to the stages of change behavioral theory, says **Diane M. Grimley**, PhD, an associate professor and chair of the department of health behavior at the University of Alabama at Birmingham (AL) School of Public Health.

For purposes of the study, the STD clinic patients were referred from the waiting room to a computer where they were randomly selected to go into a treatment/intervention group or a comparison group, Grimley explains.

"The people in the intervention group were given an assessment on the computer, and based on their own responses, they would get behavioral change feedback, and this is done continuously throughout the program," Grimley says.

The comparison group completed a multiple health risk assessment that covered STD/HIV risk behaviors, as well as smoking and violence, she notes.

"They kept giving answers, but never got any feedback," Grimley says.

At the end of the initial recruitment, the computer again randomized participants to be in the follow-up sample of more than 600 people, and they were told to come back in six months, she says.

"If they did come back, they did a paper and pencil, self-assessment on condom use and were also tested for chlamydia and gonorrhea, using one urine sample," Grimley says. "We found there was a significant increase in condom use at the six-month follow-up for the intervention group," Grimley says. "Actually, the intervention group's condom use went up 6.5%, and the comparison group's condom use went down 6.5%, which was interesting and significant."

At baseline, the intervention group had a higher proportion of STDs with a 28% STD rate in the intervention group and a 24% STD rate in the comparison group, Grimley says.

"After six months, 11.7% of the intervention group had STDs and 14.4% of the comparison group," she says. "Also, 78% of the people in the intervention group came back at six months, compared to 58% of the people in the comparison group who came back."

The intervention provided a clinical approach to risk assessment without having a health care worker there with the patient, Grimley notes.

A one-shot intervention might work best for the STD clinic population because the evaluation visit often is the only opportunity the clinic staff have to educate these patients, she says.

"If we were to increase the number of intervention sessions to maybe three, then maybe we'd see more positive change," Grimley says.

The intervention was designed with a National Institutes of Health (NIH) grant, and it's sustainable, developed so that it can be done with thousands of people, Grimley says.

"It's very cost-effective," she says.

It could be used at STD clinics in this way, she suggests:

- When patients register at the front desk, the receptionist could note whether they are new patients.
- If they are new patients, they could be told to come into a room to sit at the computer for an assessment, which would take less than 10 minutes. Plus they won't lose their place in line.
- They answer questions on the computer, and based on their gender and their answers, they are given information about prevention and behavior change.

For instance, if a person says they have a main sexual partner, then they are assessed for condom use based on the stages of change model, Grimley says.

"So if they say they are thinking about using condoms, which is the contemplation stage, then the computer grabs that file based on gender and orientation and puts it on the screen," Grimley says.

"It's an audio program too, and you can wear headsets for privacy," Grimley says.

The software was intentionally built into a regular office computer so that it could be disseminated to any STD clinic that has computers, she notes.

"It's a combination of a clinical approach and a public health/population approach, and we have back and forth interaction and can reach hundreds and hundreds of people," Grimley says. ■

[Editor's note: For more information about the condom-use intervention or to purchase the CD software copy for $5 plus shipping and handling, contact Diane Grimley at dgrimley@uab.edu *or by writing to her at the UAB School of Public Health, RPHB 227, 1530 Third Ave. South, Birmingham, AL 35294-0022.]*

Reference:

1. Grimley DM, Annang L. Efficacy of a "one-shot" computerized, individualized intervention to increase consistent condom use and decrease STDs among STD clinic patients. Presented at the 2006 National STD Prevention Conference, held May 8-11, 2006, in Jacksonville, FL. Abstract: 235.

Low transmission rate among Georgia inmates

Tattooing could be mode of transmission

Public health officials have relied on sparse data about HIV transmission in prisons, even while knowing that HIV infection rates among prisoners typically are higher than in the general population.

So the CDC studied HIV transmission among male inmates in the Georgia prison system with the goal of learning enough to make recommendations, says **Patrick Sullivan**, DVM, PhD, chief of the behavioral and clinical surveillance branch of the CDC.

The state of Georgia invited the CDC to conduct an epidemiological investigation as a way to understand the factors associated with HIV infection and to make recommendations for preventing transmission, Sullivan says.

Investigators reviewed data showing that from July, 1988, to February, 2005, 88 male inmates had both a negative HIV test when they entered prison and a positive HIV test while they were incarcerated.[1]

"We wanted to shed light on the subject and have a snapshot of the specific circumstances of 88 men who became infected in a prison system," Sullivan says. "The study fills in some gaps and challenges a popular misconception about prison."

A control group of inmates had a negative HIV result on their most recent HIV tested during 1997 and 2005.[1]

Inmates who participated in the study were given audio, computer-assisted self-interviews and no personally identifying information was collected. The interview asked about risk behaviors, including sex, drug use, and tattooing during the six months before incarceration and during the incarceration period.[1]

The investigation had some interesting findings, including the possibility that some inmates were infected with HIV while receiving tattoos while in prison.[1]

"We're going back to the inmates who reported tattooing and doing an in-person interview because our experience is that sometimes you need repeated contact in interviews to build a relationship before you can ascertain all of the risk factors," Sullivan says.

"We want to be scientific about observing whether this is a mode of transmission," Sullivan

explains. "We'll ask them who did their tattoo and what kind of equipment was used, and whether they saw someone else get a tattoo right after them."

It would be unusual to find that tattooing is indeed a mode of transmission for HIV, but in prisons where there is no access to sterile needles for tattooing it would make the possibility more likely, Sullivan adds.

Through DNA analysis and viral "fingerprinting," investigators will determine whether there is a relationship between the viruses of men who reported tattooing as their only risk factor and those who reported sex as a risk factor, as well, Sullivan says.

"The goal is to reach the best conclusion about whether this relationship is causal," he says.

One common belief that was punctured by the study is the idea that most sex is non-consensual, Sullivan says.

Most of the men who had sex in prison characterized it as consensual, and rape was the least reported among the types of sexual encounters, Sullivan says.

Among the men who were infected with HIV while in prison, 29% reported no sexual encounters, 46% reported consensual sex only, 16% reported sex in exchange for food, drugs, or cigarettes, and 9% reported having been victims of rape.[1]

The study also shows that most of the inmates who are HIV positive had entered the prison system while infected, Sullivan says.

The Georgia Department of Corrections had 44,990 male inmates in 73 facilities in October, 2005, and 856 of these inmates were known to be HIV-positive. Of these 856 inmates, 780 had been infected before incarceration and 732 were black.[1]

"In October, 2005, when we looked at the whole group of infected inmates in the state prison system, we saw that 91% came into the prison system with HIV, and 9% of all HIV-infected individuals had acquired it in prison," Sullivan says. "That doesn't minimize the importance of prisons in the HIV epidemic because we know from other sources of data that the prevalence of HIV among inmates is four times what it is in the general population."

What the study does show is that the prison population is a population of men who engage in high-risk behaviors within their communities, and they have some risk of acquiring HIV while in prison, Sullivan says.

This population is a hard one to reach while they're in the community, and 97% of them will return to their communities, so providing HIV prevention services to them while they're in prison is critical, Sullivan adds.

"We'd like to think those released back into the community will go back with the knowledge, tools, and skills to protect themselves, their partners, and the community," he says.

Characteristics of HIV-positive Georgia inmates who seroconverted in prison

The CDC investigated the seroconversion of 88 Georgia inmates and reported findings, including these characteristics / behaviors, in the April 21, 2006, *MMWR*.

Here is a partial list of the demographics of the 68 inmates who had become HIV positive while in prison:

Characteristic/Behavior	Number	Percentage
Age		
≤26	10	15
>26	58	85
Race		
Black	45	66
White	23	34
Non-Hispanic	63	93
Hispanic	4	6
Had sex in prison		
No	20	29
Yes	48	71
Nature of sexual encounter		
No sex	20	29
Consensual sex only	31	46
Exchange sex* (no rape)	11	16
Any rape as victim	6	9
Received tattoo in prison		
No	28	41
Yes	40	59

*Sex that was bartered in exchange for items (e.g., food, drugs, or cigarettes), money, or social reasons (e.g. protection or gang initiation).

Source: CDC. HIV transmission among male inmates in a state prison system — Georgia, 1992-2005. *MMWR Morb Mortal Wkly Rep.* 2006;55(15):421-426.

The study's final analysis found four things associated with being infected with HIV among inmates, and these included male-to-male sex and having received a tattoo while in prison, Sullivan says.

"Both were independently associated with being HIV infected," he says. "The other factors were demographics, including being black and having a [lower] body mass index (BMI) which was in the lowest quartile of inmates we talked to."

The demographic factors aren't related to risk biologically, but probably are markers for other aspects of behavior or HIV prevalence, Sullivan notes. **(See table of HIV-positive inmate demographics, p. 82.)** For instance, HIV prevalence is higher among African American men than it is among Caucasian men, so although the percentage of black men who said they had engaged in male-to-male sex was similar to the percentage of white men who said the same, the black men may have encountered more partners at risk for having HIV infection, Sullivan says.

"One hypothesis is if there are race-specific sexual or injecting networks in the prison, then that would suggest the black inmates were preferentially picking partners of a higher prevalence pool," he explains.

Another hypothesis, which is about the BMI findings, is that men of slight build are more likely to be receptive partners when anal intercourse occurs, Sullivan says.

"Because the number of reported rape incidences was low, we weren't able to statistically say that men of slighter build were more likely to be rape victims," he says. "We're still in the process of looking at data to see whether they were more likely to be receptive partners in consensual sexual relationships."

Other characteristics associated with HIV seroconversion in prison were being older than 26 years at the time of interview and having served five years or more of the current sentence.[1] ■

Reference:

1. HIV transmission among male inmates in a state prison system—Georgia, 1992-2005. *MMWR Morb Mortal Wkly Rep.* 2006;55(15):421-426.

FDA notifications

Update: Accessing CCR5 meeting Webcast

The Forum for Collaborative HIV Research and the FDA's Division of Antiviral Products hosted an open public meeting on May 31, 2006, to discuss issues regarding the development of CCR5 co-receptor antagonists for the treatment of HIV infection. Those who were unable to attend the meeting, may view it via a Webcast until June 2007.

Specific issues discussed were mechanisms for long-term follow-up to monitor safety of patients enrolled in CCR5 antagonist clinical trials, potential consequences of viral tropism changes, and characterization of resistance to these investigational agents.

Here are instructions for accessing the free Webcast:

1. Go to www.hivforum.org/CCR5/webcast.html.
2. Scroll down to the bottom of the page and log in or become a member.
3. Once you log in or become a member of FDALive.com, go to the home page where you will see Upcoming Webcast.
4. Click on Upcoming Webcast. Under Upcoming Webcast you will see the meeting of interest on the same line. Click Order Webcast.
5. Put a Check in the Webcast order for $0.00 and Add Items to Cart Above.
6. Click on Checkout.
7. Scroll down to bottom of page and purchase meeting on account number: 053106, then continue. On next page scroll down to bottom and click Process Order. Once your order goes through, on the next page you will continue to My Account.

You will find the link to the meeting on the homepage or in My Account Area.

For questions about the May 31 meeting, please contact Becky Griesse at blg@gwu.edu or at (202) 416-0494. ■

COMING IN FUTURE MONTHS

- What new HIV testing guidelines say
- Rwanda makes progress in reducing mother-to-child HIV transmission
- Computerized intervention improves condom use
- One pill, once-a-day may keep AIDS away

CE/CME objectives

The CE/CME objectives for *AIDS Alert*, are to help physicians and nurses be able to:
• Identify the particular clinical, legal, or scientific issues related to AIDS patient care;
• Describe how those issues affect nurses, physicians, hospitals, and clinics;
• Cite practical solutions to the problems associated with those issues.

Physicians and nurses participate in this medical education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any question answered incorrectly, please consult the source material.

After competing this activity at the end of each semester, you must complete the evaluation form provided and return it in the reply envelope provided to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

CE/CME *questions*

1. The CDC estimates that new HIV infections numbered about 160,000 a year in the mid-1980s in the U.S., but by 1990, prevention programs had helped reduce that number to 40,000 per year. What does the CDC estimate is the 2005 new infection number?
A. 20,000
B. 26,000
C. 34,000
D. 40,000

2. According to a new study about what works in HIV prevention, the medical costs of each new HIV infection may reach more than $200,000. By contrast, the cost of prevention efforts per HIV infection averted ranges from $6,400 to what amount?
A. $23,400
B. $35,900
C. $49,700
D. $58,200

3. A study of a condom use intervention delivered by computer at an STD clinic found a significant increase in condom use at the six-month follow-up for the intervention group, but not for the comparison group. What were the results?
A. The intervention group's condom use increased 6.5%; the comparison group's condom use decreased 6.5%.
B. The intervention group's condom use increased 16%; the comparison group's condom use increased 7%.
C. The intervention group's condom use increased 7%; the comparison group's condom use remained flat.
D. The intervention group's condom use increased 9%; the comparison group's condom use dropped 2%.

4. Which of the following was not associated with being HIV infected among Georgia state inmates who seroconverted while in prison, according to a recent CDC study?
A. Being black and male-to-male sex
B. Having a tattoo while in prison
C. Having a body mass index (BMI) that was in the lowest quartile of inmates surveyed
D. All of the above were associated with being HIV infected

Answers: 1. D; 2. C; 3. A; 4. D

AIDS ALERT®
INTERNATIONAL

U.S. officials continue to weaken UN political declaration about HIV/AIDS

The United States wielded its power at the United Nations' high-level review meeting on HIV/AIDS in early June and weakened a political declaration by opposing the setting of clear targets and time frames for stopping the epidemic, critics say.

"Since the declaration is primarily a political document to promote accountability and government progress in fighting the AIDS epidemic, it's difficult to see how that can effectively be achieved if there are no clear targets or outcomes set," says **Rachel Guglielmo**, project director for the Public Health Watch of the Open Society Institute in New York, NY.

"The document failed to target the specific groups that we know 25 years into the epidemic are most vulnerable to the disease," Guglielmo adds. **(See excerpt from UN declaration, p. 2.)**

These groups include sex workers and injection drug users, who continue to be driving forces for the transmission of HIV in many different parts of the world, she adds.

The document also doesn't mention vulnerable groups, including African Americans in the United States, Guglielmo says.

"The U.S. is a global leader in financing a response to HIV and has very special responsibility in making sure the global response is on track," says **Chris Collins**, consultant with Open Society Institute in Philadelphia. Guglielmo and Collins attended the review meeting from May 31, 2006 to June 2, 2006. "So it's terribly disappointing to see my own country not leading efforts in assisting vulnerable populations and insisting those are on the document," Collins says.

While the United States sets the tone for international action on the epidemic, it also ensures that little will be done by developing nations without the largest donor's approval.

"In many countries, the domestic resources are minimal," Guglielmo says. "Some receive 90% of their AIDS budget from donors, so donor policies have a disproportionate impact."

So if the President's Emergency Plan for AIDS Relief (PEPFAR) requires a significant portion of funding to be spent on abstinence-only-until-marriage education, then these types of programs will be what crop up, regardless of whether they are a particular country's preference, Guglielmo says. **(See story on GAO report about PEPFAR, p. 3.)**

The problem is the abstinence-only approach has not been shown to prevent HIV or sexually-transmitted diseases (STDs), Collins notes. So even if a developing nation believes the scientific literature would suggest a more comprehensive HIV prevention approach would be better, there's a limit to how much that nation can follow that approach, he says.

Funding restrictions tie hands

Another disconnect with how the U.S. funds other nation's prevention work occurs when the epidemic has spread through injection drug using (IDU) groups, Guglielmo says.

In Vietnam, for example, IDU is a major mode of HIV transmission, and the nation's own policy promotes harm reduction interventions, such as needle exchange, Guglielmo says. "But you can't use PEPFAR money to meet their goals," she adds.

To be successful, HIV prevention efforts should teach women how to negotiate condom use, make condoms available, make clean needles available to IDUs, and encourage abstinence, delaying sexual activity, and reducing number of sexual partners, Collins says.

The UN meeting's weakened action parallels the United States' own failure to set and meet goals and outcomes, Guglielmo notes.

AIDS meeting declaration excerpt

The draft Political Declaration on HIV/AIDS resolution submitted by the president of the United Nations' general assembly during the 2006 high-level meeting on AIDS at the United Nations in New York, NY, reads, in part:

1. We, Heads of State and Government and representatives of States and Governments...

2. Note with alarm that we are facing an unprecedented human catastrophe; that a quarter of a century into the pandemic, AIDS has inflicted immense suffering on countries and communities throughout the world; and that more than 65 million people have been infected with HIV, more than 25 million people have died of AIDS, 15 million children have been orphaned by AIDS and millions more made vulnerable, and 40 million people are currently living with HIV, more than 95 percent of whom live in developing countries;

3. Recognize that HIV/AIDS constitutes a global emergency and...requires an exceptional and comprehensive global response;

4. Acknowledge that national and international efforts have resulted in important progress since 2001 in the areas of funding, expanding access to HIV prevention, treatment, care and support and in mitigating the impact of AIDS, and in reducing HIV prevalence in a small but growing number of countries, and also acknowledge that many targets contained in the Declaration of Commitment on HIV/AIDS have not yet been met…

Therefore, we:

20. Commit ourselves to pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards achieving the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010;

22. Reaffirm that the prevention of HIV infection must be the mainstay of national, regional and international responses to the pandemic, and therefore commit ourselves to intensifying efforts to ensure that a wide range of prevention programmes that take account of local circumstances, ethics and cultural values is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviours and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmitted infections…

25. Pledge to promote, at the international, regional, national and local levels, access to HIV/AIDS education, information, voluntary counselling and testing and related services, with full protection of confidentiality and informed consent, and to promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status;

30. Pledge to eliminate gender inequalities, gender-based abuse and violence; increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, and the provision of full access to comprehensive information and education; ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence; take all necessary measures to create an enabling environment for the empowerment of women and strengthen their economic independence; and in this context, reiterate the importance of the role of men and boys in achieving gender equality…

38. Pledge to provide the highest level of commitment to ensuring that costed, inclusive, sustainable, credible and evidence-based national HIV/AIDS plans are funded and implemented with transparency, accountability and effectiveness, in line with national priorities…■

"We haven't done enough to target vulnerable groups in this country, and that's worrisome," she says. "If we're dedicating funding overseas in support of policies that have not been proven effective here in the United States, then we have something to answer for when those policies are not effective internationally."

There also is a disconnect between some of the requirements put on how international HIV money is spent and what is constitutional in the United States, Guglielmo says.

For example, a recent federal court ruling said that it is unconstitutional for the federal government to require groups receiving federal funds to

take a pledge opposing prostitution, but the same requirement can be made of international groups receiving U.S. funds, she says.

"The international groups don't have a constitutional basis for protesting the pledge," Guglielmo adds.

The anti-prostitution pledge ties the hands of prevention groups that intend to promote risk reduction measures with sex workers.

At the same time, the positive news is that the United States has greatly increased PEPFAR prevention funding in recent years, from $207 million to $322 million between 2004 and 2006.[1]

And there are some success stories in prevention work in developing nations, Collins says.

"Incidences appear to be falling in several countries that have constituted comprehensive intervention, while the epidemic is accelerating elsewhere," Collins says.

Reference:
1. Global Health, spending requirement presents challenges for allocating prevention funding under the president's emergency plan for AIDS relief. United States Government Accountability Office Report to Congressional Committees. April 2006:1-47.

GAO report finds problems with PEPFAR's int'l rules

No funds for teaching youths about condoms

The President's Emergency Plan for AIDS Relief (PEPFAR) basic requirements have created confusion and problems for many countries receiving the funds, according to a recent report by the U.S. Government Accountability Office (GAO).[1]

The Office of the U.S. Global AIDS Coordinator (OGAC) adopted the ABC (abstinence, be faithful, use condoms) model as an effective method for preventing HIV/AIDS in its PEPFAR sexual transmission prevention strategy. So the PEPFAR strategy contains the ABC model as one of its three elements, and combines this with the Leadership Act's abstinence-until-marriage (AB) spending requirement, and local prevention needs in the PEPFAR countries.[1]

The Leadership Act requires that beginning in fiscal year 2006 at least 33% of prevention funds be appropriated to abstinence-until-marriage programs.

The GAO report found that ABC guidance lacks clarity and creates problems for a majority of focus country teams.

Ten of the 15 focus country teams cited instances where elements of the guidance were ambiguous and confusing, the report says.

"For example, although the guidance restricts activities promoting condom use, it does not clearly delineate the difference between condom education and condom promotion, causing uncertainty over whether certain condom-related activities are permissible," the report states.

Also, most countries find it challenging to satisfy the Leadership Act's AB spending requirement because it can undermine the integration of prevention programs and it can impede their ability to respond to local epidemiology and cultural and social norms, the report says.

Ten of the 17 teams requested exemptions from the spending requirement, which meant the remaining seven teams had to spend more than 33% of prevention funds on AB activities in order for the entire program to meet the requirement.[1]

The GAO report recommended that Congress review and consider information provided by OGAC regarding the spending requirement's effect on country teams' efforts to prevent the sexual transmission of HIV.

The OGAC's guidance for using PEPFAR funds for ABC programs is as follows, according to the GAO report:

- Any PEPFAR-funded program that provides information about condoms must also provide information about abstinence and faithfulness.[1]
- PEPFAR funds may not be used to physically distribute or provide condoms in school settings.[1]
- PEPFAR funds may not be used in schools for marketing efforts to promote condoms to youths.[1]
- PEPFAR funds may not be used in any setting for marketing campaigns that target youths and encourage condom use as the primary intervention for HIV prevention.[1]
- PEPFAR funds may be used to target at-risk populations with specific outreach, services, comprehensive prevention messages, and condom information and provision. The guidance defines at-risk groups as:

— commercial sex workers and their clients;
— sexually active discordant couples or couples with unknown HIV status;
— substance abusers;
— mobile male populations;

— men who have sex with men;
— people living with HIV/AIDS, and
— those who have sex with an HIV-positive partner or one whose status is unknown.

Reference:
1. Global Health, spending requirement presents challenges for allocating prevention funding under the president's emergency plan for AIDS relief. United States Government Accountability Office Report to Congressional Committees. April 2006:1-47.

Sub-Saharan Africa: Two reports criticize strategies

Epidemic problems show progress and problems

Two new international reports highlight the world's continuing failure to rein in the AIDS epidemic in sub-Saharan Africa and in other economically-challenged regions. While there has been significant improvement in international funding and some declines of HIV prevalence among youths, there also are indications that any progress noted now will be short-lived.[1,2]

International AIDS funding has increased from $1.6 billion in 2001 to $8.3 billion in 2005, but the *2006 Report on the global AIDS epidemic* estimates that international funding needs to be $20 billion annually to stop the epidemic from continuing its wide and devastating swath through sub-Saharan Africa and other poor regions of the world.

Six of 11 African countries reported declines of 25% or more in HIV prevalence among 15 to 24-year-olds in capital cities, and sex among youths declined in nine of 14 sub-Saharan nations, while condom use with non-regular partners increased in eight out of 11 countries, the report says.[1]

However, overall condom use is below 50%, and less than half of young people demonstrated comprehensive knowledge about HIV prevention, according to surveys. Also, only 9% of pregnant women have access to antiretroviral treatment to prevent mother-to-child transmission of HIV.[1]

HIV treatment has expanded from 240,000 people in 2001 to 1.3 million people in low- and middle-income countries in 2005, and drug prices have dropped significantly with greater generic availability, however access to treatment varies greatly. In Botswana, 85% of the people who are HIV infected have access to antiretroviral drugs, while in the Central African Republic, which has 20,000 fewer people infected with HIV than Botswana, only 3% of the people have access.[1]

Comprehensive prevention services have not been fully implemented in some countries, including in Senegal, where HIV/AIDS programming and project implementation tend to be fragmented.[2]

Authorities have made little attempt to integrate HIV and TB policies and services, although research data suggest the HIV prevalence rate among TB patients in at least one city was greater than 15%.[1,2]

In Zambia, where the HIV prevalence rate among adults 15 to 49 is 17%, prevention programs are heavily dependent on donor funding and subject to donor influence and rules. Such influence has led to a significant emphasis on sexual abstinence-only programs even though these run counter to some of the nation's sociocultural beliefs.[1]

Senegal's estimated HIV prevalence among adults ages 15 to 49 is among Africa's lowest at 0.9% in 2005. However, female sex workers in Senegal have a skyrocketing HIV prevalence rate, which was estimated to be 13% in 2000 and 27.1% in 2005. Likewise, the HIV prevalence rate among men who have sex with men (MSM) in Senegal was an estimated 21.5% in 2005.[1]

Despite the nation's low general population prevalence and very high prevalence among certain vulnerable groups, the AIDS programs are focused on the general population.[2]

"This lack of programmatic focus has persisted despite the fact that the HIV/AIDS epidemic in Senegal is still concentrated, so a more targeted response is warranted to reduce infection rates and to ensure enhanced access to prevention, treatment, and care services among these high-risk groups," states the Public Health Watch and Open Society Institute report, "HIV/AIDS Policy in the United States," issued in May, 2006.

Likewise, the national AIDS policy in Zambia does not mention injection drug users or MSM and does not prioritize prevention services for women and girls who are especially vulnerable to HIV infection in that nation, the report says.[2]

References:
1. 2006 Report on the global AIDS epidemic. UNAIDS report. May, 2006. Web site: www.unaids.org.
2. HIV/AIDS policy in the United States. Monitoring the UNGASS Declaration of Commitment on HIV/AIDS. Public Health Watch/Open Society Institute. May, 2006:1-76.