

The document was prepared and circulated by the Prevention Defense Working Group of the Federal AIDS Policy Partnership, of which GMHC is a founding member. For more information or to join the list of organizations endorsing this document, please email Gregg Gonsalves at: [greggg@gmhc.org](mailto:greggg@gmhc.org)

## HIV PREVENTION SAVES LIVES

December 2002

CDC's existing framework for providing HIV prevention services through state and local health departments and community-based organizations works. HIV prevention community planning groups work hard to identify priority populations and implement interventions in their local communities. CDC should maintain these existing structures, and resist the excessive external interference in program management that is being driven by political agendas, rather than scientific imperative. CDC should also work hard to ensure that front-line providers have the resources and tools they need to implement scientifically sound practices. HIV will not sit idly by while the nation's commitment to prevention is held hostage to politics.

CDC's HIV prevention programs are under heavy scrutiny by select Members of Congress and the Department of Health and Human Services. The AIDS community has always demanded the highest levels of accountability from its organizations. However, programmatic reviews and audit processes should not impede the delivery of life-saving education and services for persons at risk for, infected and affected by HIV/AIDS. If we allow political pressure to dictate public health strategies, more Americans, not fewer, will become infected with HIV.

- Locally developed and implemented HIV prevention programs offer the best hope for controlling the epidemic. Local communities know what's best in their areas. Community planning groups identify priority populations and interventions that are likely to reduce new infections. Federal agencies and Congress must not micro-manage front-line HIV prevention providers.
- Recent federal audits of prevention programs—which have uncovered very little fraud or impropriety despite multiple investigations—waste taxpayers' dollars by burying skilled public health workers under an avalanche of redundant paperwork and politically biased inquiries.
- This heightened scrutiny has had a chilling effect on how prevention organizations are able to reach those most at risk. We need more tools to work with, not fewer. Don't muzzle public health with a political agenda that will put our nation's future at risk.
- President Bush and his administration need to work *with* community-based AIDS groups, instead of stonewalling those whose HIV prevention philosophies do not match their political ideologies. AIDS is a public health crisis, not a political campaign.
- Prevention is still our best weapon against the HIV/AIDS epidemic. The estimated lifetime cost of care and treatment for just one HIV-infected person is approximately \$195,000.<sup>1</sup> In a recent cost benefit analysis of HIV prevention programs, researchers found that the enormous lifetime cost of caring for an HIV-infected individual is far greater than the funding needed to reach that individual with prevention messages and interventions.<sup>23</sup>

### WHAT DOES THE SCIENCE SAY ABOUT EFFECTIVE HIV PREVENTION PROGRAMS?

The Institute of Medicine (IOM)<sup>4</sup>, National Institutes of Health (NIH)<sup>5</sup>, Joint United Nations Program on HIV/AIDS (UNAIDS)<sup>6</sup> and CDC Prevention Research Synthesis Project (PRS)<sup>7</sup> have all completed scientific reviews of HIV prevention programs and all have come to the same conclusion: HIV prevention programs work. The evidence presented

in these reviews indicates that successful and effective prevention programs currently exist to meet the needs of a wide variety of populations including men who have sex with men (MSM), injection drug users (IDU), and heterosexuals. Furthermore, a recently published study by a leading HIV prevention researcher estimates HIV prevention efforts in the U.S. have saved up to 1.5 million lives.<sup>8</sup>

## WHICH HIV PREVENTION PROGRAMS WORK?

HIV prevention messages must be designed with the target population in mind. Different prevention programs work for different people. Numerous HIV prevention methods have been scientifically evaluated and found to be effective:

### ➤ **Promotion of Proper and Consistent Use of Condoms.**

For people who are sexually active, condoms have been the surest way to prevent the transmission of HIV and other sexually transmitted diseases. When used correctly and consistently, condoms provide an effective barrier, blocking the pathway of the HIV virus during sexual activities. A meta-analysis of several studies conducted by the National Institutes of Health found an 85% decrease in risk of HIV transmission among consistent condom-users.<sup>9</sup>

### ➤ **Comprehensive Sexuality Education Works, Not Abstinence-Only Education.**

Research has shown that the most effective sexual health programs are comprehensive ones that include a focus on delaying sexual behavior and provide information on how sexually active young people can protect themselves.<sup>10</sup> Research indicates that comprehensive HIV/STD education does not lead to an increase in or early initiation of sexual activity and that some studies show a positive association between early HIV/STD education and the delay of sexual activity.<sup>11</sup>

### ➤ **Increase Knowledge of HIV Status Through Voluntary HIV Counseling and Testing and Linkage to Care.**

Voluntary HIV testing is an important element in preventing the transmission of HIV. Research has found HIV-positive youth, who were aware of their status, were six times more likely to have safer sex than HIV-positive youth who did not know they were infected.<sup>12</sup> In addition, the counseling that accompanies an HIV test affords a tremendous opportunity to reach HIV-negative individuals who may engage in activities that put them at increased risk for contracting HIV, and help these persons to reduce their risk.<sup>13</sup> Increasing the number of individuals who have knowledge of their sero-status, linking HIV infected individuals to care and providing comprehensive HIV prevention to HIV-positive individuals is now a cornerstone of CDC's HIV prevention activities.<sup>14</sup>

### ➤ **Reducing Perinatal Transmission of HIV Has Been Effective.**

Efforts to combat the transmission of HIV from mother to child have been incredibly successful. According to CDC, the number of U.S. infants who acquire AIDS through mother-to-child transmission declined by 83% from 1992 through 1999. The primary strategy to prevent perinatal HIV transmission is to maximize prenatal HIV testing of pregnant women. CDC recently reviewed mandatory and voluntary approaches used to promote HIV testing of pregnant women.<sup>15</sup> Results of the survey indicate voluntary testing approaches were able to achieve high rates of acceptance of testing similar to mandatory situations. States can promote prenatal HIV testing by implementing voluntary, routine approaches to counseling and informed consent, in lieu of mandatory testing.

### ➤ **Behavioral Interventions Are Effective.**

An extensive body of research exists on how to help individuals change their HIV-related risk behaviors.<sup>16,17</sup> Research has shown that aggressive promotion of safer sexual behavior, and prevention and treatment of substance abuse could avert tens of thousands of new HIV infections and potentially save millions of dollars in health care costs.<sup>18</sup> In the *CDC's Compendium of HIV Prevention Interventions with Evidence of Effectiveness*<sup>19</sup>, several program models are featured that have met scientifically rigorous criteria for effectiveness in reducing HIV risk behavior. Effective models include multiple, individual and small group sessions; client-centered, interactive education sessions; peer-led interventions; comprehensive health education; and structural and

environmental interventions. Scientific reviews of these types of behavioral interventions have identified the critical importance of adhering to the fundamental elements of effective HIV prevention programs when designing a program. Among these fundamentals, a program should be based on social or behavioral research science; the target audience and objectives should be clearly defined; and members of the target audience should be included in the development of the program. In addition, the specific messages of the HIV prevention program must be culturally and developmentally appropriate to the targeted audience. Finally, these programs must be sustained, reinforced and supported by sufficient resources.<sup>20</sup>

➤ **Needle Exchange Programs Reduce HIV Transmission.**

In March 2000, the U.S. Surgeon General prepared a review of all peer-reviewed, scientific studies of syringe exchange programs completed since 1998.<sup>21</sup> The review reaffirmed that there is "conclusive evidence that syringe exchange programs, as part of a comprehensive HIV prevention strategy, are an effective public health intervention that reduces transmission of HIV and does not encourage the illegal use of drugs."

### **WHY ARE THERE AN ESTIMATED 40,000 NEW INFECTIONS EACH YEAR?**

The decline in reported HIV cases throughout the 1980s and early 1990s proves that HIV/AIDS prevention programs do indeed work. Since the mid-1990s, the rate of new infections has leveled-off at about 40,000 new HIV cases per year. However, federal funding for prevention programs also remained constant, with adjustments for inflation outstanding, during this period while the population at risk grew significantly larger. While the level of infections may have remained steady at 40,000, the makeup of communities most affected by HIV has changed dramatically. There are still serious barriers to reaching communities of color with effective prevention. In addition, the success of anti-HIV medications has enabled more people with HIV to live longer, healthier lives. With about a million HIV-positive people in the U.S., there are more potential transmissions now than there were five or even ten years ago.<sup>22</sup> It should come as no surprise that given the lack of substantial new resources for domestic HIV prevention, the number of new cases has remained steady and not continued to decline.

### **WHAT MUST BE DONE TO ENSURE CDC IMPLEMENTS EFFECTIVE HIV PREVENTION?**

CDC has conducted HIV prevention by allowing science to guide policy. Radical departures from science-based decision-making are unwarranted. Indeed, the consequences will be disastrous if the world's premier public health organization is forced to make decisions based on politics and not scientific analysis.

➤ **Science Not Politics Should Guide HIV Prevention Policy.**

Recent actions by the Administration raise concerns that politics, not science, is driving federal HIV prevention policy. The recent movement toward censorship of science-based programs is problematic, particularly those programs targeting MSM. The Administration's focus on abstinence-only rather than comprehensive sexuality education is also cause for concern, since there is no scientific evidence to document the effectiveness of abstinence-only education. We are also concerned by the removal of information regarding condom effectiveness from CDC web-sites and the prohibition of federal funding for needle exchange programs. The apparent purging of CDC's HIV/STD Advisory Committee of individuals that cannot pass an ideological litmus test is further evidence of a tendency to favor politics over science. Finally, audits and heightened scrutiny seem to unfairly target programs reaching gay and bisexual men and people of color.

➤ **Remove Political and Ideological Obstacles to Effective HIV Prevention.**

Appointments to scientific panels and personnel positions must be made based on scientific-expertise. CDC should work in collaboration with NIH and leadership in the Department to ensure continued implementation of scientifically sound HIV prevention programs and research into scientifically sound behavioral, biomedical and social prevention methods.

➤ **Full Funding of CDC HIV Prevention Activities is Critical.**

Full funding of CDC for HIV prevention activities is necessary to achieve the agency's goal of cutting new infections in half. Scientists estimate that providing appropriate HIV prevention interventions to all those at risk of sexual transmission of HIV and providing services to all those at risk from injection-drug related HIV infection in the United States would cost an estimated \$1.423 billion annually.<sup>23</sup>

➤ **Achieve NORA Recommended Funding Levels.**

The National Organizations Responding to AIDS (NORA) FY 2003 funding request is for an additional \$300 million, for a total appropriation of \$1 billion for the Division of HIV/AIDS Prevention. President Bush's FY 2003 budget included no new resources for funded CDC HIV prevention programs, with DHAP's funding level currently at \$696,900,000.<sup>24</sup> Pending the outcome of the final FY 2003 final budget negotiations, NORA will ask for an increase in DHAP's funding to \$1 billion in FY 2004.

➤ **HHS Department-Wide Leadership on HIV Prevention is Woefully Overdue.**

HHS needs to provide greater leadership on domestic HIV prevention issues. This means including HIV prevention in general health promotion messages; facilitating implementation of new HIV testing technologies; and including more HIV/AIDS reporting in *Healthy People 2010*. CDC should be tapped to help shape enhanced leadership on HIV prevention throughout HHS. CDC should implement routine meetings with community stakeholders and individuals infected and affected by HIV.

### NEW DIRECTIONS FOR HIV PREVENTION LEADERSHIP

Bold new leadership from CDC is needed now more than ever. The following recommendations should move governmental policy makers and stakeholders to think outside of the box while supporting CDC in meeting new challenges in national HIV prevention efforts.

➤ **Build Strong Prevention Partnerships for HIV/STD Prevention Throughout the Health Care System.**

CDC should work with the Agency for Healthcare Research and Quality and the Center for Medicare & Medicaid Services to develop reasonable reimbursement mechanisms for risk assessments and counseling for HIV and STDs. Such reimbursement would increase opportunities for intervening around HIV/STD prevention and treatment with patients while they are in their health care providers' offices. Partnerships should be developed with managed care organizations and provider groups so that patients in both the private and public sectors receive adequate STD and HIV prevention and treatment.

➤ **Mobilize the Private Sector.**

HIV prevention cannot succeed if it remains the sole responsibility of government and community-based organizations. The private sector has an important role to play. Businesses which facilitate partners meeting each other – in particular, bars, internet providers, and sex club owners – should be invited to contribute their expertise and resources to HIV and STD prevention. CDC should fund operations research to discover best practices of mobilizing these stakeholders to maximize prevention opportunities and minimize STD and HIV transmission.

➤ **Improve Implementation of Community-based HIV Prevention Strategies.**

Working through HIV Prevention community planning groups, health departments and CBOs have partnered to play a crucial role in developing innovative interventions run by and for community members. However, several important challenges hamper implementation of effective interventions in impacted communities. Salaries are low, which discourages staff retention and makes it difficult for any organization to retain a high level of expertise. The scale of prevention efforts is often insufficient to create the dose-response needed to alter the course of the epidemic. Those implementing interventions also need assistance in strategically selecting the best type of intervention (individual, group, community or structural). CDC must work with NIH and other HIV researchers to address issues of salaries, scale, and strategic selection of interventions, replication and sustainability of evidence-based interventions in community settings.

**This document has been endorsed by the following organizations (as of December 12, 2002):**

1. ACT UP/Atlanta, Atlanta, GA
2. ACT UP/New York, New York, NY
3. ACT UP/Philadelphia, Philadelphia, PA
4. Advocates for Youth, Washington, DC
5. African Services Committee, New York, NY
6. AIDS Action Baltimore, Baltimore, MD
7. AIDS Action Council, Washington, DC
8. AIDS Alliance for Children, Youth and Families, Washington, DC
9. AIDS Foundation of Chicago, Chicago, IL
10. AIDS Housing Association of Tacoma, Tacoma, WA
11. AIDS Project Los Angeles, Los Angeles, CA
12. AIDS Services Foundation Orange County, Irvine, CA
13. AIDS Services of Austin, Inc., Austin, Texas
14. AIDS Survival Project, Atlanta, GA
15. AIDS Treatment Data Network, New York
16. AIDS Treatment News, Philadelphia, PA
17. Asian and Pacific Islander American Health Forum, San Francisco, CA
18. Asian & Pacific Islander Coalition on HIV/AIDS, New York, NY
19. American Foundation for AIDS Research, New York, NY
20. Black Gay Network of New York State, New York, NY
21. Boulder County AIDS Project, Boulder, CO
22. Bronx AIDS Services, Bronx, NY
23. Brooklyn AIDS Task Force, Brooklyn, NY
24. Brown University AIDS Program, Providence, RI
25. Center for Health and Gender Equity (CHANGE), Takoma Park, MD
26. Central City AIDS Network, Macon, GA
27. Desert AIDS Project, Palm Springs, CA
28. Fenway Community Health Center Research Department, Boston, MA
29. Florida AIDS Action, Tampa, FL
30. The Foundation for Integrative AIDS Research, Brooklyn, NY.
31. Gay and Lesbian Medical Association, San Francisco, CA
32. Gay City Health Project, Seattle, WA
33. Gay Men of African Descent, New York, NY
34. Gay Men's Health Crisis, New York, NY
35. Global Campaign for Microbicides, Washington, DC
36. Health 2000, Portland, ME
37. HIV and Hepatitis.com, San Francisco, CA
38. HIV Medicine Association, Alexandria, VA
39. Housing Works, New York, NY
40. Howard Brown Health Center, Chicago, Illinois
41. Human Rights Campaign, Washington, DC
42. Infectious Diseases Society of America, Alexandria, VA
43. International Harm Reduction Development Program, New York, NY
44. Johns Hopkins Urban Health Institute, Baltimore, MD
45. Kaula'i AIDS Project, Lihu'e, HI
46. Latino Commission on AIDS, New York, NY
47. Lifelong AIDS Alliance, Seattle, WA
48. LLEGO -- The National Latina/o Lesbian, Gay, Bisexual, and Transgender Organization, Washington, DC
49. Los Angeles Gay & Lesbian Center, Los Angeles, CA
50. The Magic Johnson Foundation, Inc. , Beverly Hills, CA
51. Mano a Mano, New York, NY
52. Michigan Persons Living with AIDS Task Force, Lansing, MI
53. Mojaevans, Inc., Decatur, GA
54. Montrose Clinic, Houston, TX
55. Nashville CARES, Nashville, TN
56. National Association of People with AIDS, Washington, DC

57. National Alliance of State and Territorial AIDS Directors, Washington, DC
58. National Coalition for LGBT Health, Washington, DC
59. National Family Planning and Reproductive Health Association, Washington, DC
60. National Minority AIDS Council, Washington, DC
61. National Network for Youth, Washington, DC
62. National Youth Advocacy Coalition, Washington, DC
63. Native American AIDS Project, San Francisco, CA
64. New York AIDS Coalition, New York
65. New York City AIDS Housing Network, New York, NY
66. North Central Texas HIV Prevention Planning Group, Dallas, TX
67. OMEGA Project, Inc., Providence, RI
68. Pierce County AIDS Foundation, Tacoma, WA
69. Project Achieve, New York, NY
70. Project Inform, San Francisco, CA
71. Resource Center of Dallas, Dallas, TX
72. San Francisco AIDS Foundation, San Francisco, CA
73. San Francisco Department of Public Health, STD Prevention and Control Services, San Francisco, CA
74. Seattle Treatment Education Project, Seattle, WA
75. Sexuality Information and Education Council of the United States (SIECUS), Washington, DC
76. Stop AIDS Project, San Francisco, CA
77. Tacoma Urban League, Tacoma, WA
78. Test Positive Aware Network, Chicago, IL
79. Title II Community AIDS National Network, Washington, DC
80. Treatment Action Group, New York, NY
81. United Communities AIDS Network, Olympia, WA
82. Unity Fellowship Church, Inc., Brooklyn, NY
83. Unity Fellowship Breaking Ground, Inc., Brooklyn, NY
84. Vermont Department of Health, Middlebury, VT
85. Vermont People with AIDS Coalition, Montpelier, VT
86. Whitman-Walker Clinic, Washington, DC

## NOTES

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<sup>2</sup> Holtgrave, D, et al. Estimating the Cost of Unmet HIV-Prevention Needs in the United States. *American Journal of Preventive Medicine* 2002; 23: 7-12.

<sup>3</sup> Holtgrave D. Estimating the Effectiveness and Efficiency of US HIV Prevention Efforts Using Scenario and Cost-effectiveness Analysis. *AIDS*. November 22, 2002; 16(17): 2347-8.

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<sup>6</sup> Joint United Nations Programme on HIV/AIDS. *HIV Prevention Needs and Successes: A Tale of Three Countries*. Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS; 2001.

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