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## **Katrina Diaspora: Implications for People with HIV**

As this issue of HHSWatch went to press, Hurricane Katrina bore down with all its fury on New Orleans and surrounding coastal areas. Vulnerable populations, the sick, the poor or both, were unable to leave the area ahead of the storm and faced the subsequent flooding almost unaided. Persons with lower immunity due to HIV are particularly sensitive to diseases that arise under these deprived, contaminated conditions. With nearly everyone now evacuated from the hardest-hit areas, special attention needs to be given to those who have run out of HIV medicines. They will experience rebounding HIV over the next several weeks. The many people with unrecognized and untreated HIV will face the threat of sudden declines in immunity coupled with exposure to additional diseases in crowded emergency habitations. Doctors need to be on the look out for the classic opportunistic infections, especially Pneumocystis Pneumonia, (PCP) which starts as an innocuous dry cough and then suddenly becomes life-threatening. Active cases of tuberculosis are also a danger.

A major hurdle is qualifying for services by establishing HIV status. Most people will have no medical records with them. They may not even know what drugs they were taking. A first step is to expand the availability of rapid HIV testing. Although there are concerns about "routine" HIV testing (see below under Ryan White Reauthorization), the present emergency justifies exceptional measures. A further important aspect of testing is that it makes people conscious of the possibility

that they can spread HIV to others. Most persons aware of their HIV-positive status will act to protect others from infection. Such individual moves are particularly important now, when the usual reproductive health services, including condoms and post-exposure prophylaxis are hard to come by. Indeed, a vital measure is condom distribution among evacuees.

An important but overlooked area is the condition of IV drug users. No systematic measures have been taken to ensure the availability of sterile syringes, and their shortage could result in a wave of new HIV cases. Indeed, the illicit drugs themselves are in short supply, creating withdrawal symptoms and potentially desperate behavior. A humane, rational move by local authorities would be the provision of methadone and other treatments that control the symptoms of drug withdrawal.

So far, the national Department of Health and Human Services has had no substantive response to HIV concerns in the affected areas. State and local health programs have been left to cobble together aid with available Ryan White CARE Act and Medicaid money as well as local funds. For example, the Texas AIDS Drug Assistance Program (ADAP) is providing drugs to evacuees in that state through a streamlined application system.

The New Orleans region is in the center of the too-weak Southern response to HIV, characterized by high rates of transmission, poor local services and disproportionately low local, state and federal spending. One way the federal government can help immediately is to loosen Medicare and Ryan

White restrictions to ensure that the immediate needs of persons with HIV – and other serious diseases – are met in an appropriate and timely fashion.

In the meantime, several local organizations critically need funds to continue their work. One is Acadiana C.A.R.E.S, Attn: Claude Martin, PO Box 3865, Lafayette, LA 70502, see also [www.acadianacares.com](http://www.acadianacares.com)). In Houston, the well-known Montrose Clinic is working with evacuees at the Astrodome and other centers. Contributions can be sent to Montrose Clinic, Attn: Sonna Alton, PO Box 66308, Houston, TX 77266 (or online at <http://www.montroseclinic.org/>). Two national organizations that are providing strong support to local AIDS groups are: The National AIDS Fund (National AIDS Fund – Saving Lives, 1030 15th Street, NW, Suite 860, Washington, DC 20005 or [www.aidsfund.org](http://www.aidsfund.org)) and the AIDS Alliance for Children, Youth and Families (AIDS Alliance/Katrina Fund, 1600 K Street NW, Suite 200 Washington DC 20006 or [www.aids-alliance.org](http://www.aids-alliance.org)).

Updates on care provisions can be found at the American Academy of HIV Medicine at [www.ahivm.org](http://www.ahivm.org). In addition, CHAMP has established an email list for providers of HIV/AIDS care and supportive services for people with HIV and their families, who are located in areas affected by Hurricane Katrina and/or are in areas where Katrina survivors are relocating. To subscribe, send a blank e-mail to: [KatrinaAIDSCare-subscribe@yahoogroups.com](mailto:KatrinaAIDSCare-subscribe@yahoogroups.com).

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### **Ryan White Reauthorization Brings More Worry, Less CARE**

On July 27, Health and Human Services Secretary Mike Leavitt announced a set of principles under which the administration would support Congressional reauthorization of the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act for another five years.

The Ryan White CARE Act provides critical treatment and care services for needy persons living with HIV. In addition to ambulatory medical care and drugs, its funds go to paying for such support services as case management that optimizes care delivery, mental health and substance abuse treatment, and food, financial and housing assistance. A distinguishing feature of the act is the exceptional local control it affords community planning boards and the large disbursement of funds to local nongovernmental organizations. Since 2000, the Ryan White Act has also covered early identification of people with HIV through testing and counseling, but it has never formally sponsored HIV prevention efforts.

Much of the Leavitt's proposal involves redistributing current Ryan White funds so that states receive a more even amount per case of HIV/AIDS. There is also a provision for establishing a still undefined "severity of needs index" that will take account of other resources available to each state. There is, however, no promise of additional funding to support a system that is overburdened even in the best endowed states. One much feared result is a struggle over pieces of the pie between Southern states, whose smaller cities have high HIV rates but relatively little support from any level of government, and the West Coast and Northeastern states, which contain three-fourths of the HIV population and have large, long-established AIDS programs.

Beyond the threat to the unity of community care and treatment programs, the reauthorization "principles" significantly impinge on HIV prevention. Leavitt's statement raised the following issues that threaten prevention efforts:

- **Treatment and prevention are integrally connected.** One of Leavitt's new requirements is that that 75% of Ryan White funding be dedicated to "core medical services." This measure will further shrink the current network of case management,

mental health and financial assistance services that integrate persons with HIV into a comprehensive care system. When support services ensure access to medical services, members of high-risk populations have a greater stake in their future and in their communities. Whether HIV-positive or -negative, they are more likely to come forward for sexual health care, HIV testing, and safe sex counseling. "We don't feel there should be a 75% set-aside for core medical services if they are strictly defined," said Diana Bruce of the AIDS Alliance for Children, Youth & Families. "At the community level, they know best how to structure care for their constituencies."

• **Testing is not prevention.** The only section in the Bush administration's Ryan White "principles" that deals with prevention explicitly (entitled "Increase Prevention Efforts") focuses solely on promoting states' use of traditional public health measures – testing and contact tracing. It also asks states' help in carrying out the CDC's Advancing HIV Prevention initiative (AHP). AHP urges greater "prevention with positives" efforts, in which people with HIV are recognized as having a special responsibility for HIV prevention. The initiative relies heavily on routine HIV testing in medical facilities and includes a call to curtail pre- and post-test counseling. Now in its fifth year, AHP has made no visible progress toward its goal of halving HIV transmission rates, estimated at 40,000 annually.

• **Weakening community control.** The administration's reauthorization "principles" shift many decisions out of the hands of local communities, first by demanding that medical services receive most of the funds. Another of the "principles" strikes a blow at local control by allowing mayors to claim authority over the local planning councils that set priorities for city-based grants. Leavitt's move follows a CDC proposal to put local health officials in charge of approving federally funded prevention materials produced by community organizations. Taken together, the trend is to hamstring the

local agencies that have provided a bulwark against the spread of HIV in the hardest-hit locales.

Congress is just getting back to business after its August recess. With the next fiscal year's budget and a Supreme Court nomination on its hands, there is no sign that it will focus on Ryan White any time soon. The reauthorization bill is not even written yet, though funding is included in an appropriations bill already passed by the House of Representatives. "The money can be appropriated as discretionary funds," explained Bruce. "Congress may not take up reauthorization until 2006, but that's an election year and all sorts of funny things might end up in the bill. Still, indefinite delay will send a signal that HIV has been deprioritized and the whole structure of Ryan White funding could be lost." Already, total appropriations under Ryan White have decreased in each of the last three years.

Last minute note: Of course now that Hurricane Katrina has hit, disaster relief and climate protection issues will also consume Congressional attention. At the same time, the storm provides an opportunity to further review the equity and strength of the Ryan White structure, as well as those of the many other social safety nets subject to increasing government neglect in recent years. The future of the Ryan White CARE Act could be uncertain for a considerable length of time.

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### **CDC efforts deemed too little, too weak**

Just before Secretary Leavitt released his Ryan White "reauthorization principles" boosting the CDC's prevention strategies, researchers at the RAND think tank issued a cost-effectiveness analysis predicting that the CDC's HIV prevention programs could never achieve its goals. The report, published in the July/August issue of the prestigious policy journal *Health Affairs*, considered the likely outcome of the CDC-sponsored local prevention programs, on which the agency spends about \$400 million annually. Using a

mathematical model, the researchers estimated that the strategies advocated by the CDC's Advancing HIV Prevention initiative could only decrease new HIV infections by at most 7,300 cases a year. The slowly declining budget for local prevention programs (now merely 7% of total federal HIV spending) would have to quadruple, to \$1.7 billion per year, if the CDC has any hope of reaching its goal of stopping 20,000 new cases through AHP.

That would come to a price of about \$85,000 per case of HIV prevented. The CDC's mass counseling and testing strategy, which now is enshrined in the Bush administration Ryan White Act reauthorization "principles," came out very expensive in the RAND analysis. In optimized form, it would cost an estimated \$110,000 per avoided case of HIV. Counseling and testing is relatively expensive on a per person basis. Also, it prevents few new cases of HIV because it includes many individuals with low risk. It cripples the agency's prevention strategy by sucking up enormous budgetary resources with only a modest return.

The RAND experts argued that the wisest strategy is to save expensive measures involving personal contact for targeted high-prevalence populations. Cheap mass media materials such as educational videos are more suitable for reaching the general US public.

The report proposed an alternative set of interventions that would stay within the current \$400 million spending level but were likely to achieve the desired annual 20,000 HIV transmission reduction (a cost of about \$20,000 per avoided case). Three of the CDC-supported measures – STD treatment at HIV clinics, partner notification, and expanded testing and counseling – were among the nine advocated strategies, with counseling and testing greatly scaled back. The most important prevention effort was grassroots organizing among young men who have sex with men, which had a calculated cost of \$12,000 per prevented HIV case. Two of the other top prevention

strategies were needle exchanges and expanding condom availability. The data on HIV prevention by mobilizing young gay men came from a study of a CDC-endorsed prototype known as "Mpowerment." Condom distribution, however, has become politically controversial, and Congress has banned federal funding for needle exchanges since 1988.

Cost-effectiveness analysis is becoming more popular, and the mathematical model used here has some unsettling implications for the government's current direction in HIV prevention. Deborah Cohen, the report's lead author, told HHSWatch, "We are not taking advantage of all the scientific evidence of what works in HIV prevention. We are neglecting the cheaper, more cost-efficient things that could greatly reduce the number of people infected."

The model is open to criticism based on the assumptions it makes concerning each strategy's ability to reach a given population and prevent HIV transmission. Known as "Maximizing the Benefit," the model is available on the Internet in an Excel spreadsheet form at [http://www.rand.org/health/tools/hiv\\_prevention.html](http://www.rand.org/health/tools/hiv_prevention.html). The site also contains an explanatory manual. The spreadsheet takes advantage of Excel's automatic recalculation features, allowing users to tinker with its assumptions and see the effect on cost per prevented HIV case.

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### **From ABC to CCC? Triple Combination Therapy for HIV Prevention Holds Promise**

One prevention strategy that dropped out of the RAND model is circumcision. Like mass testing and counseling, it is a relatively expensive one-on-one intervention that prevents only a small number of new HIV infections in a low prevalence area like the United States. The RAND researchers considered it not cost effective -- but that evaluation could change in a high-prevalence population. Also, there are new data indicating that circumcision has a

greater effect than previously thought. Loose observational studies have previously suggested that circumcision reduces men's HIV risk by around 40%.

A randomized trial conducted in a shantytown near Johannesburg, South Africa may greatly increase that estimate. The study, presented at the International AIDS Society's July conference in Rio de Janeiro, enrolled 3,128 young HIV-negative men. Besides repeated testing for HIV, they all received safe-sex counseling and treatment for sexually transmitted diseases. Half were circumcised immediately and the other half only when the trial was over. The difference in HIV transmission was very sharp: After an average of 18 months follow-up, new HIV occurred at a rate of 0.77 per 100 person-years in the circumcised men and 2.2 per 100 person-years in the uncircumcised men.

This protection effect was 65% to 75%, depending on how you interpret the numbers. This dramatic benefit has induced several observers, including lead investigator Bertran Auvert, to deem circumcision equivalent to an effective vaccine. Circumcision is undoubtedly strongly protective, but it is not a magic bullet of this nature. Recall that in this trial, all the men also received two other interventions: counseling and STD treatment. Doing all three probably has a synergistic effect, achieving greater protection than the sum of the individual benefits. Picture HIV entering the body through three large doors. If you

close only two, you will still get a lot of HIV transmission. When you close the third, suddenly there aren't any new HIV cases, but that doesn't mean that closing the third door did the whole job by itself.

Auvert insists on the power of circumcision. He told HHSWatch by e-mail, "What we know is that when estimating HIV incidence from HIV prevalence by age among local men [outside the trial], we found an HIV incidence about 20% higher than what we observed in the [deferred circumcision] group. But such calculations are not precise. I am convinced that our other interventions (counseling, STD treatment) had some impact on the HIV incidence but not a very high impact."

Ongoing large circumcision studies in Kenya and Uganda will further define the level of HIV protection that circumcision affords. However you evaluate the South African trial, the bottom line is that the three interventions together achieved a remarkable reduction in HIV transmission. With little data behind it, the Bush administration advocates HIV prevention through "ABC" (abstinence, be faithful, or use condoms), but here, a rival strategy that might be dubbed "CCC" (Circumcision, Safe-sex Counseling, and STD Care) has proven effective in a carefully recorded scientific study.

This issue of 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](mailto:champ@champnetwork.org).



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