



Changing How We Think: HIV Prevention Policy in the U.S.

Executive Summary

HIV prevention in the United States has been enormously successful and cost efficient despite the public scrutiny and criticism it continues to receive. Such HIV prevention efforts have resulted in the drop in HIV incidence from its peak of 161,000 infections in 1984. Moreover, the gross cost per HIV infection prevented is well below the estimated lifetime cost of treatment for one person living with AIDS.

Several effective HIV prevention programs, largely behavior modification interventions, have been developed over the first two decades of the HIV/AIDS epidemic. Recent reviews of these interventions have demonstrated that across studies, reductions in HIV risk behavior and improvements in knowledge, attitudes and beliefs about HIV/AIDS were greater for the target populations who received the risk reduction intervention compared with those who did not.

In addition, overall reductions in the proportion of individuals engaging in sex without the use of condoms as a result of receiving an HIV prevention intervention range from 26% for men who have sex with men to 29% for heterosexual adults. These rates are comparable to the 30% efficacy rate established as the minimum acceptability standard when testing potential vaccine products.

But if HIV prevention works, why have HIV incidence rates not continued to drop and why is sexual risk taking among certain groups on the rise? This paper presents a series of recommendations that build on the success of HIV prevention over the last 20 years. In our view, the key to further reducing HIV incidence in the U.S. lies in how we think about HIV prevention.

Presently, HIV prevention in the U.S. lacks the comprehensiveness it needs to drive down HIV incidence rates even further. The new CDC HIV prevention initiative, entitled “Advancing HIV Prevention,” places renewed emphasis on HIV testing (case finding) in medical settings, including routine HIV testing of all pregnant women and partner notification. It further

prioritizes prevention services for people living with HIV/AIDS, singling out prevention case management as the intervention of choice.

While HIV testing is important, prioritizing testing and prevention case management for people living with HIV/AIDS narrows even further an already sparse continuum of prevention strategies. HIV prevention requires varied, multi-level approaches that are well funded and sustained over many years.

Specifically, in building an advocacy agenda for continued and expanded support of a more comprehensive HIV prevention approach in the U.S., we must:

- ❑ Work to eliminate disparities in health access;
- ❑ Promote intensified support for vaccine and microbicide research;
- ❑ Make the medicalization of addiction central to a more comprehensive national HIV prevention plan;
- ❑ Target our HIV prevention efforts to those most at risk for HIV exposure;
- ❑ Ensure that priority be given to social science and intervention research with gay and bisexual men of color;
- ❑ Concern ourselves with both HIV/AIDS survivors who may still be at high risk for HIV infection and younger generations of people with whom we must now be concerned;
- ❑ Gain support for sustained and creative prevention strategies that address both risk behavior and the social and interpersonal contexts within which risk behavior occurs;
- ❑ Continue to support and explore community-sensitive, ethical structural interventions to complement behavior modification programs;
- ❑ Question the policy of promoting pre-packaged science-based HIV

prevention interventions over supporting and researching more localized, indigenous and collaborative HIV prevention strategies;

- ❑ Promote HIV prevention programs that build upon individual and community resiliencies; and
- ❑ Honor local knowledge by protecting local control over how HIV prevention strategies are developed and prioritized.

Driving down HIV incidence even further is an attainable goal that will require that we think differently about HIV prevention. Although it is easy to get defensive about HIV prevention given the great scrutiny that our work continues to receive, it is critical that we re-direct our attention and energies towards building a more comprehensive HIV prevention agenda. We must challenge ourselves to imagine new possibilities for HIV prevention work by remaining creative and open to innovative ideas and collaborative approaches to ending the HIV/AIDS epidemic.

Keeping An Eye on the Big Picture

During fiscally and politically conservative climates, proponents of government supported social programs such as HIV prevention are scrutinized more intensely than usual. HIV prevention advocates are asked to justify, explain, and defend the need for and importance of our work, work that experience, public health wisdom, and science have told us for years is effective and efficient. HIV prevention is and will continue to be intensely contested and scrutinized. Even with the added scrutiny, we must always hold ourselves accountable using only the highest standards available. We remain committed and must be supported to systematize our evaluation and quality improvement efforts to ensure efficiency, effectiveness, accessibility, cultural competence, and consumer satisfaction. However, being on the defensive about the effectiveness and efficiency of HIV prevention does not serve us - people affected by HIV/AIDS, service providers, advocates, public health officials, and researchers alike. Spending time mounting defensive advocacy strategies distracts us from the work at hand, which is to prevent new HIV infections from occurring and to ensure access to health care and treatment for those already infected with HIV or living with AIDS. Moreover, it distracts us from the big picture by compromising our capacity to proactively imagine new possibilities for HIV prevention work.

HIV Prevention Is Key To Keeping Incidence Down

We need not be defensive. HIV prevention efforts in the U.S. have, in fact, resulted in the drop in HIV incidence from its peak in 1984 at 161,000 infections and a significant overall cost savings.¹ We know this because:

- The pattern of HIV infections from 1978 to 2001 in the U.S. does not follow what scientists have observed to be the natural history of the disease in the absence of nationally funded prevention efforts;

- Funding for prevention activities and HIV incidence are highly correlated; and
- Many studies now show that a variety of HIV prevention interventions are effective and cost efficient across a variety of populations particularly vulnerable to the risk for HIV infection.

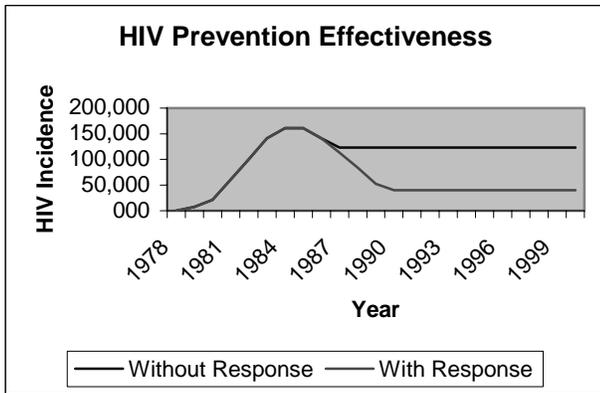
A goal of HIV prevention is to reduce the number of new HIV infections (incidence) from occurring over time. To estimate the effectiveness of U.S. HIV prevention efforts, one would have to compare actual HIV incidence with HIV incidence that would have occurred had there been no HIV prevention activities. The difference between the two represents the number of HIV infections prevented – one measure of HIV prevention effectiveness. Obviously, the challenge in developing good estimates of effectiveness is that it is impossible to know the number of new HIV infections had prevention activities not occurred. We can, however, estimate the number of infections prevented under a variety of plausible scenarios.

Without a national HIV prevention program in place, the course of the epidemic would be determined by the natural history of the disease, perhaps following a pattern seen more often in developing countries where little or no resources are directed towards preventing new infections, and where HIV incidence continues to rise for years before leveling off. Instead, HIV incidence in the U.S. declined 12.4 percent after the first year past the peak of 161,000 infections and continued to decline until incidence flattened at 40,000 new infections per year. The figure below illustrates a plausible hypothetical incidence scenario in which HIV infections reached a plateau of 123,000 infections a year after peaking at 161,000. Comparing actual HIV incidence with incidence proposed in this scenario, an estimated 82,860 HIV infections were averted each year for 10 years since 1990.

Researchers have used these modeling approaches in conducting cost effectiveness analyses to estimate the efficiency of HIV

¹ Holtgrave, D.R. Defining and measuring HIV prevention effectiveness. Keynote address. August 2003.

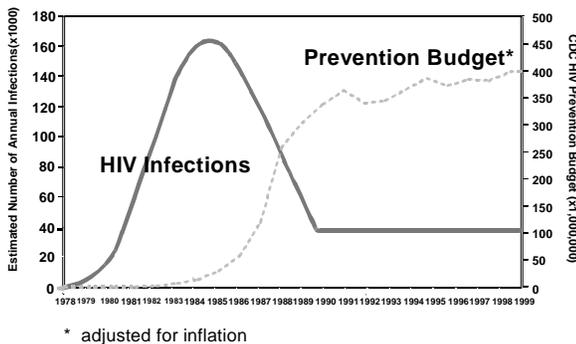
prevention activities in the U.S. and have



concluded that prevention activities averted a total of between 204,000 and 1,585,000 infections since the start of the epidemic at a cost of between \$6,400 and \$49,700 per infection prevented. *The gross cost per HIV infection prevented is well below the estimated lifetime cost of treatment for one person living with AIDS (estimated at between \$154,000-\$195,000 since the availability of highly active anti-retroviral therapies).*²

Funding and HIV incidence appear to be highly related. HIV incidence began to decline after peaking at 161,000 new infections in 1984 as national funding for HIV prevention began to rise. When funding levels began to plateau, so did new infection rates. The figure below³ clearly illustrates this point.

National Investment in HIV Prevention & Number of New Infections Annually



² Holtgrave, D.R. Estimating the effectiveness and efficiency of U.S. HIV prevention efforts using scenario and cost-effectiveness analysis. *AIDS*, 2002, Vol. 16, No. 17, 2346-2349.

³ Emory University Center for AIDS Research.

Several HIV prevention programs, largely behavior modification interventions, have been developed over the first two decades of the HIV/AIDS epidemic. Methods for collecting and summarizing information about the effectiveness of available HIV prevention interventions include systematic reviews and meta-analyses. In recent years, these methods have demonstrated that across studies, reductions in HIV risk behavior and improvements in knowledge, attitudes and beliefs about HIV/AIDS were greater for the target populations who received the risk reduction intervention compared with those who did not. This is true for men who have sex with men (MSM)⁴, heterosexual adults⁵, adolescents⁶, and individuals receiving HIV prevention intervention delivered within drug treatment programs.⁷ For example, *overall reductions in the proportion of individuals engaging in sex without the use of condoms as a result of receiving an HIV prevention intervention range from 26% for men who have sex with men to 29% for heterosexual adults. These rates are comparable to the 30% efficacy rate established as the minimum acceptability standard when testing potential vaccine products.*^{8 9}

⁴ Johnson, W.D., Hedges, L.V., et al. HIV prevention research for men who have sex with men: a systematic review and meta-analysis. *Journal of Acquired Immune Deficiency Syndromes*. 2002, 30:S118 - S129.

⁵ Neumann, M.S., Johnson, W.D., et al. Review and meta-analysis of HIV prevention intervention research for heterosexual adult population in the U.S. *Journal of Acquired Immune Deficiency Syndromes*. 2002, 30:S106 - S117.

⁶ Johnson, B.T., et al. Interventions to reduce sexual risk for human immunodeficiency virus in adolescents, 1985-2000: a research synthesis. *Archives of Pediatric Adolescent Medicine*. 2003, Vol. 157, 381 - 388.

⁷ Prendergast, M.L., Urada, D., & Podus, D. Meta-analysis of HIV risk reduction interventions within drug abuse treatment programs. *Journal of Consulting and Clinical Psychology*. 2001, Vol. 69, No. 3, 389 - 405.

⁸ Bogard, E. et al. The impact of a partially effective HIV vaccine on a population of intravenous drug users in Bangkok, Thailand: A dynamic model. *Journal of AIDS*, 2002; 29:132.

⁹ Stover, J. et al. The epidemiological impact of an HIV/AIDS vaccine in developing countries. 2002. Working Paper #281 from the World Bank Development Research Group available at: <http://www.policyproject.com/pubs/countryreports/>

Among adolescents, HIV prevention interventions have been shown to significantly enhance sexual communication about risk, condom use skills, and condom use. Interventions designed to achieve condom use among sexually active adolescents were most successful when condoms were provided and information and skills training about their use was offered. *Moreover, behavioral interventions reduce the risk for HIV specifically because they increase knowledge about sexual health, skill acquisition, sexual communication, and condom use, and they decrease the onset of sexual intercourse or the number of sexual partners.*^{10 11}

Where National HIV Prevention Policy Is Headed Today

Cost effectiveness analyses and systematic reviews of HIV prevention literatures provide clear evidence that HIV prevention is key to keeping incidence down. *But if HIV prevention works, why have HIV incidence rates not continued to drop and why is sexual risk taking among certain groups on the rise?*^{12 13 14} These are two of the thorny questions that continue to frustrate even the most patient and persistent prevention advocates. Our collective desire to address these questions and the urgency that we feel to do so quickly open the doors for defensiveness and simplistic, overly medicalized and inadequately researched public health responses. This is the case with the new HIV prevention strategy being advanced by the Department of Health and Human Services' (DHHS) Centers for Disease Control and Prevention's (CDC).

The new CDC HIV prevention initiative, entitled "Advancing HIV Prevention,"¹⁵ places renewed emphasis on HIV testing (case finding) in medical settings, including routine HIV testing of all pregnant women and partner notification. It further prioritizes prevention services for people living with HIV/AIDS, singling out prevention case management as the intervention of choice. The emphasis on testing and prevention case management significantly narrows the continuum of possible prevention strategies.

There is no disputing the potential personal benefits of HIV testing. However, HIV-infected persons draw the greatest benefits from the latest available treatment when they can receive treatments early. The personal benefits of knowing one's HIV status early are lost on those who must overcome the significant barriers to care and treatment. Nearly 40% of HIV-infected persons learn of their infection within a year of receiving an AIDS diagnosis.¹⁶ For Latinos and African Americans, this number can be much higher.¹⁷ *¹⁸ The CDC's prevention initiative does not address persistent disparities in access to care and treatment and the social stigma associated with acquiring or having HIV/AIDS. Nor does the initiative identify funding sources for providing care and treatment services to all persons newly diagnosed with HIV.*

It is also true that when people know they are infected with HIV, they are significantly more likely to protect their partners from infection than when they are unaware of their infection.¹⁹

¹⁰ Johnson, B.T. et al. 2003.

¹¹ Kirby, D., Short, L., Collins J. 1994. 'School-based Programs to Reduce Sexual Risk Behaviors: A Review of Effectiveness.' Public Health Reports. 109:339-360.

¹² Elford, J. & Hart G. If HIV prevention works, why are rates of high-risk sexual behavior increasing among MSM? AIDS Education and Prevention, 2003;15(4): 294-308.

¹³ CDC. Primary and secondary syphilis among MSM – NYC, 2001. MMWR, 2002;51:853-856.

¹⁴ CDC. Outbreak of syphilis among men who have sex with men – Southern California, 2000. MMWR. 2001, 50:117-120.

¹⁵ DHHS/CDC Advancing HIV prevention: New strategies for a changing epidemic – U.S. MMWR. 2003; Vol.52 No.15

¹⁶ Neal, J.J., et al. Frequency and predictors of late HIV diagnosis in the U.S., 1994 through 1999 [Abstract 474M]. 9th Conference on Retroviruses and Opportunistic Infections, Seattle, February 24-28, 2002.

¹⁷ Turner, et al. Delayed medical care after diagnosis of persons infected with HIV. Archives of Internal Medicine. 2001;Vol.16.

¹⁸ Supplemental HIV Surveillance Study Project. L.A. County, Department of Health Services, January 2000.

¹⁹ Hays, R.B., et al. Actual versus perceived HIV status, sexual behaviors and predictors of unprotected sex among young gay and bisexual men who identify as

²⁰ Research also tells us that behavior change that occurs as a result of HIV testing is sustainable for up to 18 months at best, making HIV testing as effective as other stand-alone behavioral interventions. Knowledge alone, in this instance knowledge about one's HIV status, is not enough to sustain and support behavior change over time.^{21 22}

Prevention case management for people newly diagnosed with HIV can serve to enhance and reinforce behavioral changes that occur as a consequence of testing. However, the core elements of prevention case management have not been clearly or consistently defined and as such have not yet been systematically evaluated for efficacy in preventing HIV transmission.

Although people make changes to their behavior when they learn they are living with HIV, testing must be complemented by a variety of prevention approaches at the individual, group, community and structural levels that are sustained over long periods of time. Even if we are to understand the new CDC HIV prevention initiative to be a sub-component of a larger national HIV prevention portfolio, there is no scientific evidence to suggest that an emphasis on HIV testing and prevention case management targeted at people living with HIV/AIDS will adequately reduce HIV incidence and risk behavior at the population level.

Driving Down HIV Incidence in the U.S.: We Must Change How We Think

The key to further reducing HIV incidence in the U.S. lies in how we think about HIV prevention. In other health fields with much

longer histories, prevention has a more sophisticated shape. For example, we all recognize that preventing cancers associated with smoking requires using biological, behavioral and social science research on nicotine addiction and epidemiologic data to target and tailor smoking cessation efforts. A reduction in smoking rates in the general population is difficult and requires that our prevention strategies be varied, adequately funded, and sustained literally over decades. Smoking cessation programs combine pharmacological interventions, behavior modification, social persuasion techniques (including the use of social marketing to influence community norms), and structural change (like policy reform and legislative initiatives) designed to discourage nicotine use.

Obviously, nicotine addiction and HIV infection and the behaviors leading to each are different and we must exercise caution in comparing the two. But the point of the comparison is compelling because in contrast to smoking cessation efforts, HIV prevention is not treated with the same comprehensiveness. This becomes apparent when we consider the following:

- ❑ Pharmacological interventions of HIV disease including highly active anti-retroviral treatment do not cure HIV, are not effective for some, and are not accessible or available to everyone who is HIV infected;
- ❑ Addiction to substances other than nicotine including alcohol dependence is highly stigmatized and in most cases criminalized rather than medicalized in the U.S.;
- ❑ Non-medical HIV prevention programs are not always targeted and sustained over long periods of time;
- ❑ Available HIV prevention interventions were primarily tested for efficacy in the late eighties and early nineties on groups heavily affected by HIV/AIDS at that time;

HIV-negative, HIV-positive and untested. *AIDS*. 1997;11:1495-1502.

²⁰ Colfax, G.N., Buchbinder, S.P., Cornelisse, P.G.A., et al. Sexual risk behaviors and implications for secondary HIV transmission during and after HIV seroconversion. *AIDS*. 2002;16:1529-1535.

²¹ Helweg-Larsen, M., Collins, B.E. A social psychological perspective on the role of knowledge about AIDS in AIDS prevention. *Curr Psychol Sci* 1997;6:23-53.

²² Fisher J.D, Fisher W.A. Theoretical approaches to individual-level change in HIV risk behavior. In Peterson & DiClemente (Eds.) *Handbook of HIV Prevention*. 2000. Kluwer Academic/Plenum Publishers.

- ❑ Most HIV prevention interventions are designed to modify behavior at the individual level (i.e., perceived personal vulnerability, self efficacy, intention, assertiveness and communication skills, condom use, reduction in the number of sex partners) with little regard for the interpersonal, social and cultural contexts in which risk behavior occurs;
- ❑ Many HIV prevention interventions are difficult for community-based HIV prevention providers to adapt and therefore adopt because they were tested under research conditions that are different from real life settings; and
- ❑ When addressing the risk for HIV infection, behavior modification seeks to redress personal deficits. They must be reconfigured to promote individual and collective competencies.

Prevention of both nicotine addiction and the behaviors that heighten the risk for HIV infection is similar in that each requires varied, multi-level approaches that are sustained over many years in order to change behaviorally based phenomena.

Sadly, we are still years away from a vaccine that prevents HIV infection, though HIV treatment and other biomedical interventions including the advancement of microbicide research hold enormous prevention potential. From a prevention perspective, medical management of HIV disease lowers viral load, thereby reducing infectiousness.²³ This makes treatment and adherence important components of our overall HIV prevention strategy. In addition, current HIV treatment technologies have prolonged and improved the quality of life for many.²⁴ Unfortunately, treatment is neither accessible nor viable for all. For example, African Americans and

Latinos are over-represented among those living at or below poverty level, and without health insurance.^{25 26} *We must continue to call for the eradication of disparities in health access and promote intensified support for vaccine and microbicide research as part of our HIV prevention advocacy agenda.*

Similarly, we must make the medicalization of addiction central to a more comprehensive HIV prevention advocacy plan. In HIV prevention research, one of the most powerful behavioral predictors of HIV risk behavior is drug and/or alcohol use.^{27 28} Prevention providers have known this anecdotally for years. And yet substance abuse prevention and treatment programs are few in number, under-funded, and in some instances, nothing more than court mandated 12-step programs, the quality of which vary from meeting to meeting. *Substance abuse treatment and prevention remains a poorly funded, poorly integrated and poorly understood component of our HIV prevention approaches. This too must change.*

HIV prevention efforts should be targeted to those most at risk for HIV exposure. One way to monitor the extent to which prevention efforts are targeted is to track national funding trends. In an analysis of HIV prevention funding comparing fiscal year 1997 to 1999 budget projections with AIDS prevalence by race/ethnicity, researchers found consistent improvement over time in the targeting of health education and risk reduction activities as well as counseling, testing, referral and partner notification services²⁹ (see the figures below). In terms of targeting services by race and ethnicity, nationally and in general, funding has followed trends in the HIV/AIDS epidemic through 1999.

²⁵ United States Census Bureau, July 2001.

²⁶ Brodie, M. et al. The 2002 National Survey of Latinos. Pew Hispanic Center/Kaiser Family Foundation, December 2002.

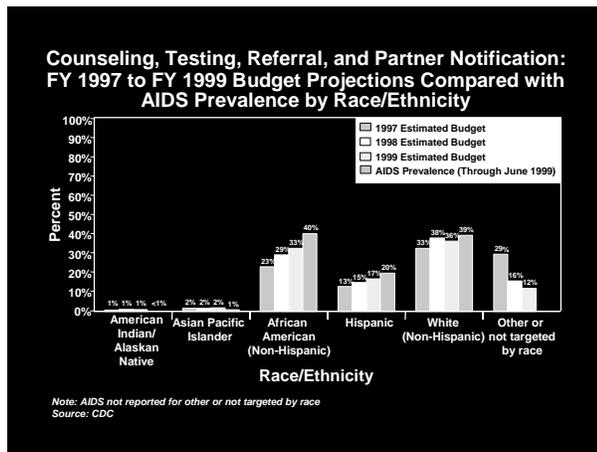
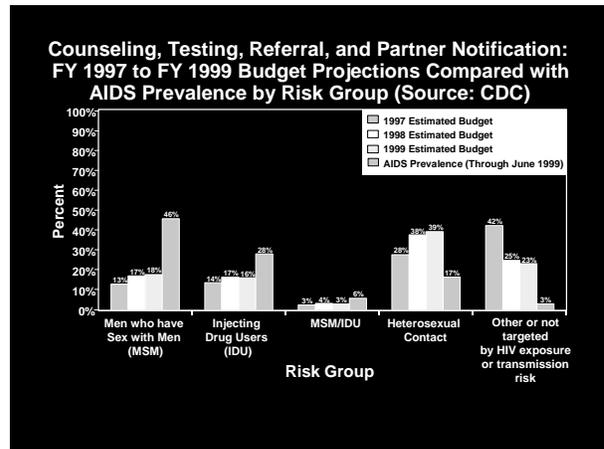
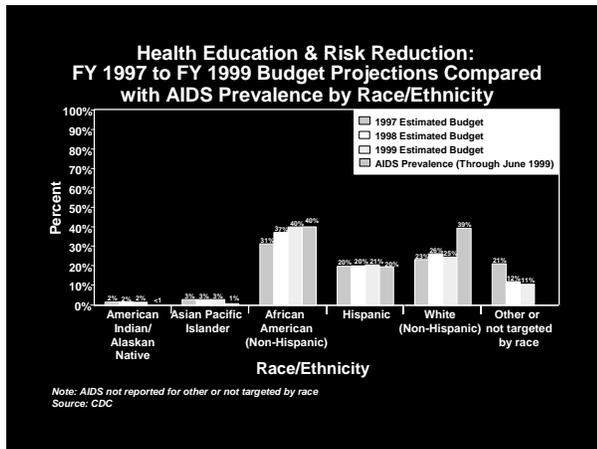
²⁷ Parsons, J.T. Correlates of sexual HIV transmission risk behaviors among HIV+ MSM. National HIV Prevention Conference. 1999. Abstract No. 181.

²⁸ Strathdee et al. Determinants of sexual risk taking among young HIV- gay and bisexual men, Journal of AIDS Human Retrovirology. 1998;19:61-66.

²⁹ This analysis excludes other CDC funding, state and local funding, and private funding.

²³ Quinn, T.C., Wawer, M.J., Sewankambo, N., et al. Viral load and heterosexual transmission of HIV-type 1. New England Journal of Medicine, 2000;342:921-929.

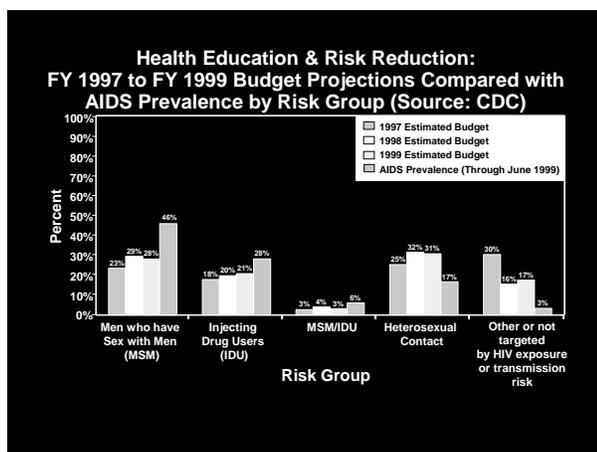
²⁴ The CASCADE Collaboration. Survival after introduction of HAART in people with known duration of HIV-1 infection. Lancet. 2000;355:1158-59.



especially MSM and injecting drug users.³⁰

Taken together, these analyses suggest that although HIV prevention funds started to reach communities of color at levels commensurate with trends in the epidemic as of 1999, once there, funding was poorly targeted to those *most* at risk. This is troubling given the disproportionate number of African American and Latino MSM affected by HIV/AIDS. In many places around the country, MSM, and specifically MSM of color, continue to drive the AIDS epidemic. For example, in jurisdictions like New York City and Los Angeles County, where seroprevalence among African American and Latino MSM can be as high as 32%, the need for effective HIV prevention programs specifically geared to these two groups is especially urgent.^{31 32} *Nearly five years after this analysis was completed, our advocacy efforts must ask whether funding is reaching communities most at risk at both the national and local levels and specifically insist that the CDC take a stronger leadership role in ensuring that prevention funding is targeted within communities of color to MSM and injection drug users.*

However, as illustrated by the following figures, when budget projections for the same period and for the same services were compared with AIDS prevalence by exposure category, there were significant discrepancies suggesting inadequate targeting of prevention programs to groups at highest risk for HIV infection,



³⁰ Holtgrave, D. Trends in HIV Prevention Policy. Presentation given at the University California, Los Angeles' Center for HIV Identification, Prevention and Treatment Services, September 2001.

³¹ Valleroy et al. HIV prevalence and associated risks in young MSM. JAMA. 2000;284:198-204.

³² Diaz, R. Ayala, G. Social discrimination and health: The case of Latino gay men and HIV risk. 2001. Commissioned Monograph. National Gay and Lesbian Task Force.

HIV prevention efforts must also be sustained and expanded over time. Trends in the HIV/AIDS epidemic continue to change. With our successes in HIV prevention, there are large cohorts of high-risk HIV negative individuals who have remained uninfected for over two decades of the epidemic. Their prevention needs may be quite different from newer cohorts of individuals, mostly young MSM of color, who are at great risk for HIV infection. Nevertheless, they continue to require our collective attention.

With changing trends in the epidemic, decreased visibility of targeted HIV prevention messages and gaps in services for MSM may have reduced the salience of HIV prevention programs among gay men in some communities.³³ Outdated and over-simplistic prevention messages for MSM may be behind what is often referred to as “HIV prevention fatigue” or “HIV/AIDS burnout.”³⁴ *It is important that HIV prevention advocates not get seduced into forgetting that HIV prevention needs not only evolve, they must also expand.* This is because in addition to HIV/AIDS survivors, there are newer generations of people with whom we must now also concern ourselves. Therefore our efforts must be increasingly sustained and creative.

HIV prevention interventions were developed and tested for efficacy with populations that are demographically different than populations currently most at risk. For example, there are relatively few HIV prevention interventions specifically designed and tested to meet the needs of Latinos, African Americans, Asian or Pacific Islanders, and Native Americans. In a review of the HIV prevention literature, investigators at University of California, San Francisco’s Center for AIDS Prevention Studies (CAPS) found 137 studies of ethnic minority participants. Using the highest standards for methodological quality including having a large enough number of people of

color participating in the research study, investigators were able to identify only 52 studies that were geared toward African Americans. The vast majority of the 52 studies identified researched populations whose primary risk for HIV transmission involved heterosexual sex. There was only one intervention specifically designed for African American MSM. Literature searches of the HIV prevention intervention research targeted towards Latinos yielded even more troubling results. Only 15 studies were identified to be methodologically sound. Four of the fifteen interventions focused on Latino injection drug users, five focused on heterosexual women, and six focused on youth. Researchers were unable to identify interventions geared for Latino MSM.³⁵

There have been only two published studies of interventions designed for men of color who have sex with men and tested using randomized, controlled conditions (the highest standard for methodological quality), one targeting African American MSM³⁶ and the other targeting Asian Pacific Islander MSM.³⁷ Although this issue is beginning to receive much needed attention at the policy level, it remains a serious gap. *Prevention advocates must track research dollars and insist that priority be given to social science and intervention research with gay and bisexual men of color.*

The risk for HIV infection is often understood as being connected to some individual trait, characteristic, or deficit. Another way to understand the risk for HIV infection is as a function of interpersonal and socio-cultural contexts. In other words, risk behavior does not happen in a social vacuum. At present, interventions that are endorsed by public

³⁵ Darbes, L.A., et al.
<<http://hivinsite.ucsf.edu/InSite.jsp?page=home-00-00&doc=kb-07-04-11>>

³⁶ Peterson, J.L., Coates, T.J., Catania, J.A. et al. (1996). Evaluation of an HIV risk education intervention among African American homosexual and bisexual men. *AIDS*, 10, 319-325.

³⁷ Choi, K.H., Lew, S., Vittinghoff, E., et al. (1996). The efficacy of brief group counseling in HIV risk reduction among homosexual Asian and Pacific Islander men. *AIDS*, 10, 81-87.

³³ Aral, S. Elimination and reintroduction of sexually transmitted disease: lessons to be learned? *American Journal of Public Health*. 1999; 89: 995-997.

³⁴ Odets W. AIDS education and harm reduction approaches for the 21st century. *AIDS Public Policy Journal*. 1994;9:1-15.

health institutions in the U.S. largely focus on modifying individual risk behavior without taking into account the situational, interpersonal, social or cultural contexts in which risk occurs. For example, of the studies including African American participants reviewed by the CAPS group discussed above, the majority tested one or more interventions that targeted individual behavior only; six tested one or more interventions that included an explicit attempt to change peer or social norms; and two studies tested an intervention aimed at changing individual behavior through the introduction of a policy or administrative decision. Of the 15 studies including Latino participants, all 15 tested interventions that targeted individual behavior only, two of these were community-level interventions. It is important that our interventions address changing risk environments and their effects on individual behavior. *HIV prevention advocates must work to gain support for prevention strategies that address both risk behavior and the contexts that heighten the risk for HIV exposure.*

At the structural level, laws and policies that result in a lack of immigrant rights, lack of family housing at migrant labor worksites, unregulated commercial sex, criminalization of possession of hypothermic equipment like syringes and lack of financial support for medical, educational, prevention, and social services can be changed through demonstrations, boycotts, constitutional and legal reform, civil and human rights activism, legislative lobbying, etc. For example, in 1992, New York State enacted a change in the public health law (Public Health Law 80.135) that carves out an exemption to the Penal Code regarding criminal possession of hypodermic instruments. The change in law gives the New York State Commissioner of Health the authority to grant waivers to community-based organizations and government entities to collect and furnish syringes. New York State supports a multi-component syringe exchange program that is informed by harm reduction principles, which is credited for a 50% reduction in HIV transmission among injection drug users, a 75% decrease in the buying or renting of syringes, and a 63% decrease in

syringe sharing behaviors.³⁸ Similar reductions in HIV incidence rates among injection drug users in New York are well documented.³⁹ Structural-level changes buttress gains in behavior change made through individually geared prevention interventions. This is one of the biggest lessons learned from our efforts to prevent smoking, and one that we are just beginning to learn in the HIV/AIDS field. *We must continue to support and explore community-sensitive structural interventions to complement behavior modification programs as part of a larger, more comprehensive national HIV prevention program.*

HIV prevention interventions currently being promoted by the CDC or the so-called “out-of-the-box,” “evidence-based” interventions “scaled-up” for mass distribution are not easy to use and therefore not likely to be adopted by the end-users of the interventions who are community-based health educators and outreach staff. This is because these interventions were developed and tested within research conditions that do not mimic real-life conditions and are consequently prescriptive. These interventions sometimes require unrealistic time commitments from clients and specialized training for staff implementing them. Staff must feel a sense of ownership over interventions being adopted and therefore should be given the freedom to make ongoing adaptations as needed to an intervention. This includes the ability to introduce innovations developed using insights gained from experience working with clients who are the consumers of their services. The challenge lies in collaboratively (researchers, service providers, clients) formulating effective HIV prevention interventions that are flexible enough to permit creative modifications and withstand organizational change typical for non-profit agencies.^{40 41} *HIV prevention*

³⁸ New York State Department of Health, AIDS Institute. Presentation by Alma R. Candelas, March 2003.

³⁹ Des Jarlais, D.C. et al. HIV incidence among injection drug users in New York City, 1992-1997: evidence for a declining epidemic. *American Journal of Public Health*, March 2000, Vol. 90, No.3.

⁴⁰ Kalichman, S.C. et al. When briefer can be better: Single session approaches to HIV risk reduction interventions. *Interamerican Journal of Psychology*. 2001;Vol.35, No.2:41-58.

advocates must therefore question the policy of promoting pre-packaged science-based HIV prevention interventions over supporting and researching more localized, indigenous and collaborative HIV prevention strategies.

With few exceptions, HIV prevention interventions are problem oriented. They seek to remedy personal deficits rather than to promote individual and collective competencies or resiliencies. Individual and collective resiliencies to HIV risk are poorly understood and relatively overlooked as a resource by the HIV/AIDS establishment. There is prevention potential in honoring, engaging and mobilizing an individual's or community's capacity to know what is best for them when given opportunities for self-reflection, social involvement and connectedness like volunteerism and activism.⁴² *Whenever possible, HIV prevention advocates must work to promote HIV prevention programs that build upon individual and community resiliencies.*

Finally, it is important that HIV prevention advocates honor local knowledge by protecting local control over how HIV prevention strategies are developed and prioritized. This will ensure that HIV prevention efforts remain responsive, varied, dynamic and innovative. Available HIV prevention and epidemiological science should be used to guide local efforts, not dictate them. *The role of government should therefore be to ensure that the people setting priorities and designing HIV prevention programs at the local level have access to the best available information and the ability to evaluate their efforts.* Technical assistance and capacity building should be made available when and if requested, and should be tailored to the specific needs of those requesting assistance.

Conclusion

Although HIV prevention interventions have been shown to be effective, HIV prevention efforts in general have not had the funding needed to make them more comprehensive and widespread. HIV prevention messages are not ubiquitous or sustained, and may not be reaching those at highest risk for infection. This may in part explain the leveling off of incidence at 40,000 new infections each year. Driving down HIV incidence even further will require that we think differently about HIV prevention. We must also expand our capacity to imagine new possibilities for HIV prevention work by challenging ourselves to remain creative and open to collaborative approaches in our efforts to end the HIV/AIDS epidemic.

⁴¹ Miller, R. Innovation in HIV prevention: Organizational and intervention characteristics affecting program adoption. *American Journal of Community Psychology*. 2001; Vol.29, No.4.

⁴² Zimmerman, M.A, Ramirez-Valles, J. et al. An HIV/AIDS prevention project for Mexican homosexual men: An empowerment approach. *Health Education and Behavior*. 1997; 24(2):177-190.

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Changing How We Think: HIV Prevention in the U.S.

A HIV Prevention Policy Publication

Principal Author: George Ayala, Psy.D., Director of Education
Co-authors: Craig E. Thompson, Executive Director
Lee Klosinski, Ph.D., Director of Programs
Patrick "Pato" Hebert, M.F.A., Associate Director of Education/Prevention
Matt G. Mutchler, Ph.D., Manager of Research and Evaluation

APLA
3550 Wilshire Boulevard, Suite 300
Los Angeles, California 90010
213.201.1600
www.apla.org