What the Numbers Mean to Your Agency: Are You Ready?

June 15, 2011 By Paul Kawata

In the June 3, 2011 Morbidity and Mortality Weekly Report (MMWR), the Centers For Disease Control and Prevention (CDC) estimated that at the end of 2008 there were 1,178,350 Americans living with HIV. This number includes approximately 236,400 people who do **not** know they are HIV positive. The CDC also estimated that 350,000 HIV infections were averted due to HIV prevention efforts. Research has shown that avoiding these infections saved over $125 billon in medical costs.

Unfortunately, CDC also estimates that **more than 56,000 Americans are infected with HIV every year**. More than half of the new infections are among gay men and/or men who have sex with men (MSM) and half are African Americans.

What do these numbers mean to your agency? ***Are you ready?***

Treatment as Prevention

This could be the **game changer**. Like combination therapy in 1996 changed the lifespan for People with AIDS (PWAs), **treatment as prevention** may change the entire HIV prevention paradigm.

In the June 3rd MMWR, there is an editorial note about a recent study of 3,400 sero-discordant heterosexual couples in Africa, Brazil and India that found the use of **antiretroviral treatment** (ART) reduced HIV transmission risk by **92%**.

Individuals in this study were given ART as soon as they tested positive for HIV, even if they did not show symptoms of a compromised immune system. The study also showed that starting ART early had a statistically significant reduction in the risk of extrapulmonary tuberculosis; however, there was no significant difference in death rates.

Additional research is necessary to look at 1) the impact, if any, of starting ART with asymptomatic HIV positive people; 2) would the results be different for individuals with multiple sex partners; 3) is long term compliance possible for individuals who are asymptomatic; and 4) how much do we need to reduce the “community viral load” in order to see a reduction in the transmission of HIV?

This structural intervention could be a game changer; however, there is a challenge.

The CDC estimates that 235,400 Americans don't know they are HIV positive. Even if we could identify all or even most of these positive folks, do we have the money to provide antiretroviral treatment for all these newly diagnosed individuals? The cost of ART runs between $10,000 to $15,000 per year. At the lower figure, we are talking about an **additional** $2.35 billion per year just to cover the cost for medications. One possible solution might be the Affordable Care Act (ACA). Full implementation does not happen until 2014; in the meantime we can test more people and review the standard for HIV/AIDS care and when to start antiretroviral therapy.

At the very least, this finding provides another significant additional reason why we need to solve our ADAP (AIDS Drug Assistance Program) crisis. Meanwhile, we still need wide distribution of condoms (male and female), needle exchange, evidence based prevention programs, HIV testing, and other documented methods to prevent HIV transmission.

What this study means to your agency:

1. HIV testing needs to be a core component of your HIV prevention program;
2. Treatment education will be essential for newly diagnosed individuals; and
3. Access to care or referral for all the new clients.

Funding to Follow the Numbers

The National HIV/AIDS Strategy (NHAS) makes a recommendation to "intensify HIV prevention efforts in communities where HIV is most heavily concentrated."

It has been suggested that federal funding be proportional to the populations most impacted by HIV/AIDS, and to the cities and states with the most cases of HIV. According to this MMWR, 75% of the people living with HIV are male, 65.7% of those men are gay men/men who have sex with men (MSM).

If the federal government follows their own recommendations, this would mean a significant change in how they spend their resources. If you assume CDC's HIV prevention budget is approximately $700 million, it would mean that $525 million would be for programs that address HIV prevention for men. Of the $525 million, $345 million should go to programs specific to gay men/MSM. Remember, these are national estimates - the numbers in your city or state may differ.

As you dig deeper, the MMWR also says that younger people are less likely to know they are living with HIV than their older counterparts. Young people ages 13-24 account for 58.9% of all undiagnosed cases, versus 13.8% for people 45 to 54 years old. However, 45 to 54 year old Americans make up the largest number of HIV cases (385,400). There are also a greater percentage of undiagnosed cases among Asian/Pacific Islanders (26%) and Native Americans (25%) than among African Americans (21.4%), White (18.5%) or Latino (18.9%).

Is the HIV/AIDS community ready for a potentially significant reallocation of resources? What do these numbers mean to your agency?

Regardless of location or target populations, community based organizations (CBOs) must make the case for why they should be funded. For African American-serving CBOs, the case is clear. Unfortunately, the majority of PWAs are African American women and gay men/MSM. Until we effectively address HIV in the African American community, we will never be able to stop this epidemic. The same case can be made for CBOs serving Latinos and gay men/MSM.

For CBOs in low incidence cities or states, a reasonable case can be made that the loss of funding will put highly impacted populations like gay men/MSM and African American women at higher risk for HIV. Given the small amount of money going to these regions, any shifts in funding away from these cities/states will not provide enough resources to stem the epidemic. CBOs from these regions need to make the case that a certain baseline of funding is necessary for all regions of the country. Gay men/MSM and African Americans reside in more than just high incidence regions.

For NMAC, funding priorities should be as follows:

1. High incidence areas that target highly impacted populations (gay men/MSM and African Americans/Latinos)
2. Low incidence areas that target highly impacted populations (gay men/MSM and African American/Latinos)
3. High incidence areas that target low impacted populations
4. Low incidence areas that target low impacted populations

The lion's share of the money should go to the first priority; however, a reasonable case can be made for number two (2).

Over the last few months, I've asked "Are You Ready?" My musings are written to support CBOs through expected or unexpected transitions resulting from initiatives like:

1. Affordable Care Act (ACA)
2. National HIV/AIDS Strategy (NHAS)
3. 12 Cities Project
4. Enhanced Comprehensive HIV Prevention Plans (ECHPP)
5. Update of Funding Formula for Housing Opportunities For Persons With AIDS (HOPWA)
6. Ryan White Reauthorization (RWCA)
7. HHS Action Plan for the Prevention and Treatment of Viral Hepatitis
8. HHS Action Plan to Reduce Racial and Ethnic Health Disparities

I need to add a ninth transition: **Treatment as Prevention**

To get ready for Treatment as Prevention, your agency needs a comprehensive HIV testing program, a comprehensive treatment education program, and a health clinic (or referral service)

to provide HIV care. We will be discussing these issues at this year's United States Conference on AIDS (USCA) in Chicago. Please join us. **Are you ready?**

Yours in the struggle,

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