Contextualizing the WRI: Key Science & Policy Issues

Judith Auerbach, Ph.D.
Women’s Research Initiative on HIV/AIDS
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Contextualizing the WRI

Key Science Issues
✓ HIV/AIDS and Aging
✓ Combination HIV Prevention

Key Policy Issues
✓ National HIV/AIDS Strategy
✓ Health Care Reform (ACA)
✓ Budget Cuts
“In my work at WORLD, as a peer advocate working with women who are over 50 and HIV positive, I have seen challenges, but I also see resilience. . . I have seen peer advocacy change the lives of positive women.” Sylvia Young, WORLD
Increased Proportion of New HIV Infections in Older US Women

Increased Risk of HIV Acquisition in Older Women

- Elevated percentages of CCR5+CD4+ T cells in cervix may increase the risk for HIV acquisition in pre- and post-menopausal women.
- Correlation between age and cervical expression of CCR5 may be due to age- or hormone-related effect on CCR5 expression.

Amie Meditz, prospective cohort study presented at CROI 2011
Post-menopausal compared to pre-menopausal women:
- Higher tenofovir blood plasma trough concentration → risk of renal toxicity
- Increased tenofovir exposure in the genital tract → systemic concordance
- Emtricitabine → persistently increased exposure in the genital tract

Kristine Patterson, PK study presented at CROI 2011
“Why did I get healthy if I’m trapped in an income level that I can’t live on?”

“I think all we really need to do is focus on the very simple fact that everybody needs to use protection when they’re having sex.” Loren Jones, PWN
“The strategic, simultaneous use of different classes of prevention activities (biomedical, behavioral, social/structural) that operate on multiple levels (individual, relationship, community, societal), to respond to the specific needs of particular audiences and modes of HIV transmission, and to make efficient use of resources through prioritizing, partnership and engagement of affected communities”
**Behavioural intervention strategies:**
- Behaviour change communication
- School-based HIV education;
- Peer-led advocacy and persuasion
- Counseling
- Influence cost of access to services
- Etc.

**Biomedical intervention strategies:**
- Improved STI services; Appropriate & accessible clinical services;
- Opioid substitution therapy, detox;
- Male circumcision
- PMTCT services – ARV prophylaxis
- ART for prevention
- Etc.

**Social and cultural intervention strategies:**
- Community dialog and mobilization
- Advocacy and coalition building for social justice
- Media and interpersonal communication to clarify values, change harmful social norms;
- Education curriculum reform, expansion and quality control
- Etc.

**Intervention strategies addressing physical environment:**
- Housing policy and standards
- Access to land; subsistence;
- Infrastructure development – transportation, communications, etc.

**Political and economic intervention strategies:**
- Human rights programming;
- Prevention diplomacy with leaders at all levels;
- Community
- Microfinance/microcredit
- Training/advocacy with police, judges;
- Engaging leaders
- Stakeholder analysis & alliance building;
- Strategic advocacy;
- Regulation/deregulation;
- Etc.;
Combination Prevention: Multiple disciplines and approaches; Mermin, CROI 2011
Highly Active HIV Prevention

Cited by CoCates et al., 2008
Prevention Packages
NIH “Methods for Prevention Packages (MP3)” RFA

Description:
This project will support collaborations between behavioral and biomedical clinical scientists, epidemiologists, and clinical trial design specialists to:
(1) devise optimal HIV “prevention packages” (combination interventions) for specific populations
(2) design clinical studies to rigorously examine the safety and efficacy of these “packages” in the target population
(3) demonstrate that the proposed prevention package is acceptable to the target population and the study design is appropriate and feasible.
Combination Prevention for Young Women

Pettifor, CROI 2011

Individual Behavior + PREP + CCT + CM with Men = HIV Risk

9/29/2014
High-Impact Prevention (CDC)
Mermin, CROI, 2011

• Key Components
  • Effectiveness and Cost
  • Feasibility of full-scale implementation
  • Coverage of targeted population
  • Interaction and targeting
  • Prioritizing

• Mathematical models, research, and programs should incorporate these factors
Why We Need More
Mermin, CROI 2011

✓ Combining interventions is not enough
✓ All interventions are not effective and all effective interventions are not equal
✓ Limited resources are available and we need to prioritize
✓ Applying the science of implementation to maximizing impact
National HIV/AIDS Strategy

Dear President Obama,

Thank you for President-elect Obama’s leadership on health reform and, specifically, in calling for a National AIDS Strategy for the United States.

In his AIDS platform, then candidate Barack Obama pledged that “...in the first year of his presidency, he will develop and begin to implement a comprehensive national HIV/AIDS strategy that includes all federal agencies. The strategy will be designed to reduce HIV infections, increase access to care, and reduce HIV-related health disparities. The strategy will be coordinated by White House staff and will be led by a task force comprised of representatives from all federal agencies.”

We look forward to working with you to help your Administration develop and implement a National AIDS Strategy that can bring needed coordination, accountability, and re-orientation to our national response to the epidemic.

The attached Framework document discusses the need for a Strategy, provides guiding principles to make a Strategy effective, and suggests a process for establishing a Strategy. Consistent with this document, we very much hope the new Administration will act, within its first 100 days, to appoint a National AIDS Strategy panel and establish a White House level office and coordinator to provide leadership in developing and implementing the Strategy.

We are ready to help you consider how to begin the National AIDS Strategy process. Please feel free to contact us through Chris Colley of the Coalition for a National AIDS Strategy at ChrisC@aidstid.com or by phone at 860.561.0858.

Sincerely,

Ronda Aldape, CARE International
Judy Hilliard, San Francisco AIDS Foundation
Sallie Bingham Center for Women’s History and Culture
Chris Colley, Coalition for a National AIDS Strategy
John Everard, Communities HIV/AIDS Mobilization Project (CHAMP)
Rebecca Vieg, AIDS Action
Reena Khanal, Wraam
Tracy Ford, The National Association of State AIDS Directors
Fernando Saade, The Birth to Eight, Washington, D.C.
Dana Van Boeckel, Project Respect
Karen Ellis, The Institute for AIDS
A. Yvonne Young, Community Education Group

Framework for Developing an Effective National AIDS Strategy for the United States

JULY 2010
Vision:

“The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.”
National HIV/AIDS Strategy Goals

1. Reduce HIV Incidence
2. Increase access to care and improve health outcomes of PLWHAs
3. Reduce HIV-related health disparities
4. Improve cross-agency coordination and collaboration
Goal 1. Reducing HIV Incidence

By 2015

- Lower annual number of new infections by 25%
- Reduce HIV transmission rate by 30%
- Increase percentage of PLWHAs with knowledge of their status from 79% to 90% (reduce to 10% undiagnosed)
Goal 2. Increasing access to care and improving health outcomes for PLWHA

By 2015:

- Increase proportion of newly diagnosed patients linked to care within 3 months of diagnosis from 65% to 85%
- Increase Ryan White program clients in continuous care from 73% to 80%
- Increase Ryan White clients with permanent housing from 82% to 86%

By 2015:

- Increase proportion of HIV-dx gay and bisexual men with undetectable viral load by 20%
- Increase proportion of HIV-dx Blacks with undetectable viral load by 20%
- Increase proportion of HIV-dx Latinos with undetectable viral load by 20%
Goal 4. Increasing cross-agency coordination

- Cross-department planning
- Equitable resource allocation - shift from AIDS to HIV case reports
- Data collection - streamlined, standardized
- Reporting & Evaluation on progress toward goals
Key Areas To Be Assessed

- Law and Policy Review
  - Discriminatory laws & actions
- Data Collection & Risk Assessment
  - Unique aspects for women; disaggregation of data
- Meaningful Involvement of HIV+ Women
  - In federal, regional, local decision-making bodies
- Women Centered Service Delivery
  - Preventive interventions, care programs, services
- Resource Equity
  - Geographic disparities
- Research
  - Social & structural vulnerabilities, biomedical & operational
Patient Protection and Affordable Care Act of 2010

Key Benefits for PLWHA & Women

- Public health insurance (Medicaid/Medicare) improvements
  - Eliminates disability requirement & Part D “donut hole”
- Private health insurance improvements
  - Prohibits pre-existing condition exclusions & lifetime limits on coverage
  - Increases scope of coverage w/ mandatory benefits package
  - Subsidizes people w/income <400% of FPL
- Increases access to OB-GYN & midwifery care
- Preventive care & access to community health centers
Key Losses/Concerns for PLWHA & Women
- Continues age rating and some gender-rating
- Lack of coverage for immigrants & undocumented
- Elimination of abortion care and assisted reproductive services in private insurance market/ Pre-existing Condition Insurance Plans
- High premium costs for PCIPs
Federal deficit ~ $1.3 trillion for FY 2010
5 year freeze on federal discretionary spending
State budget shortfalls in FY 2010: > $190 billion
Reductions in HIV prevention by health departments:
  > 50% reported budget cuts--$170 million* in FY 09
  Staff furloughs, hiring freezes, pay cuts
• Many community organizations closed or struggling
• ADAP waiting lists

*total includes HIV and viral hepatitis programs, but much of funds cut were from HIV
Rolling Back Funding to FY 2008 Levels: Impact on the Domestic and Global AIDS Epidemic

Federal Funding for HIV/AIDS Programs

$ Billions

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Conclusion

Prioritize, Prioritize, Prioritize!
Acknowledgements

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