Review of the Obama Administration's 2010-2015 National HIV/AIDS Strategy

Maia Gibbons

PURPOSE

The following is a review of the Obama Administration's National HIV/AIDS Strategy (NHAS) released in July of 2010. Each of the four sections of the NHAS are outlined in detail followed by a critical analysis, rooted in public health theory, of the effectiveness of each section and the likelihood of achieving section benchmarks by the year 2015. The report will focus specifically on how well the Obama Administration plans to address co-risk factors such as homelessness, low incomes, and low education levels in populations that are at high risk for HIV. The conclusion provides a summary of suggested additions or revisions to the strategy as well as a list of best practices that could lead the country to further success in the fight against HIV/AIDS.

INTRODUCTION

The NHAS is the United States' first domestic policy to address the HIV/AIDS crisis. The policy is divided into four parts: 1) minimizing new HIV infections, 2) improving access to care for people already living with HIV, 3) reducing HIV related health disparities, and 4) structuring a more coordinated national response to the crisis (United States *National HIV/AIDS Strategy for* vii-x). The vision for the strategy, written by the Office of National AIDS Policy (ONAP) is as follows:

"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" (United States *National HIV/AIDS Strategy for* vii).

The NHAS is a five-year plan (2010-2015), and its success will be measured by the following benchmarks for the year 2015. The benchmarks are divided amongst the first three sections of the NHAS:

1) **Minimizing new HIV infections:**
- Lower the annual number of infections by 25% (from 56,300 to 42,225)
- Reduce annual transmission rate by 30%.
- Increase from 79% to 90% the percentage of people who know their serostatus (from 948,000 to 1,080,00). (United States executive summary).

2) **Improving access to care:**
- Increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65% to 85% (from 26,824 to 35,078 people).
- Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months, at least 3 months apart) from 73 percent to 80 percent (or 237,924 people in continuous care to 260,739 people in continuous care).
- By 2015 increase the number of Ryan White clients with permanent housing from 82% to 86% (from 434,000 to 455,800 people) (United States executive summary).

3) **Reduce HIV related health disparities:**
- Increase proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20%.
- Increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20%.
- Increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20%

The strategy is accompanied by the NHAS Federal Implementation Plan (July 2010), which outlines the roles and responsibilities of various federal departments in achieving the 2015 benchmarks. In addition to the federal government, the strategy stresses the collaborative roles of

"State, tribal and local governments, businesses, faith communities, philanthropy, the scientific and medical communities, educational institutions, people living with HIV, and others" (United States *National HIV/AIDS Strategy for* ix). The Department of Health and Human Services, Office of the Secretary (HHS OS) is responsible for coordinating HIV/AIDS programs across federal departments and reporting on efforts to implement the strategy at the State level. State governments are responsible for creating an entity that will report to the HHS on the progress of programs at a local level (Federal Implementation Strategy (United States *National HIV/AIDS Strategy for* 4-5). The Office of National AIDS policy (ONAP), which released the strategy, developed an interagency working group that brings together representatives from departments such as Housing and Urban Development (HUD), Justice, Veterans Affairs (VA), Defense, the Center for Disease Control (CDC), and the centers for Medicare and Medicaid, in order to collaborate on important NHAS actions. In addition to an annual report by ONAP, the President's Advisory council on HIV/AIDS (PACHA) will provide feedback and revisions for the implementation efforts on an ongoing basis (United States *National HIV/AIDS Strategy: Federal* 3-5).

Although the implementation strategy emphasizes the importance of community level stakeholders such as businesses, philanthropy, medical communities, and faith communities, there are no reporting or monitoring mechanism for these entities. State level reporting to the HHS has the potential to reflect a number of these stakeholders but it will vary from State to State (United States *National HIV/AIDS Strategy: Federal* 5).

A key component to the NHAS is the Obama administration's cornerstone of healthcare reform, the Affordable Care Act (ACA), signed into effect on March 23, 2010 and put into effect the beginning of January 2014 ("The Affordable Care Act"). It is currently estimated that 30% of

people living with HIV do not have health insurance. Under the ACA all Americans are required to have health insurance and those who previously could not afford insurance are eligible for tax subsidies to cover the cost. Significant changes made by the ACA which greatly impact the HIV/AIDS community include the prohibition of insurance companies to deny coverage based on pre-existing conditions, and the elimination of lifetime coverage caps. Additionally, the ACA increases funding for healthcare clinics and professionals in low-income communities, many of which are most impacted by the HIV/AIDS virus ("The Affordable Care Act"). Prior to the ACA, Medicaid and Medicare covered the majority of costs for HIV/AIDS treatment in the country (Barr 7). Under the ACA. eligibility for Medicaid will be expanded and more funding will be added to the program ("The Affordable Care Act").

BACKGROUND

Global Pandemic and the Public Health Response

After cases of what became known as the Human Immunodeficiency Virus were first reported to public health officials in 1981, the virus spread rapidly and became one of the most challenging public health crises of all time ("Timeline: 25 years"). HIV is a retrovirus that attacks the body's immune systems and regenerates itself by using the genetic material found in the body's CD4 cells. High levels of the virus in the body lead to the final stage of the disease known as Acquired Immunodeficiency Syndrome (AIDS) (Stine). As of today there is no cure for the disease, however medicine has developed treatments, which allow HIV positive people who are treated effectively to no longer die of the disease. Slowing the spread of the disease poses a particular challenge to public health officials because it is characterized by a latency period of up to two years in which infected individuals continue infecting others, not knowing that they carry the disease. HIV is spread through bodily fluids including blood, semen, pre-

ejaculatory fluid, vaginal fluid, and breast milk (Stine). As a sexually transmitted disease HIV carries a heavy burden of stigma within society. Over the past thirty years the stigma surrounding the disease and therefore the public's unwillingness to talk about the disease has been a major barrier to public health officials. While both effective treatments and prevention methods are well established at this point in the epidemic, the third challenge that public health officials face is how to access the millions of people affected worldwide. Drug treatments are particularly costly and although the disease is present in all regions of the world it is disproportionately concentrated in countries of lower economic status and limited resources, particularly in Sub-Saharan Africa ("The Global HIV/AIDS Epidemic"). Even within more affluent countries, such as the United States where treatment is more widely accessible, the disease disproportionately affects pockets of lower-income, resource poor communities, thus mirroring the larger global trends of health inequality ("The HIV/AIDS Epidemic in the United States").

Epidemic in the United States

In the United States it is estimated that about 1.2 million people are currently living with HIV and that every nine and a half minutes a new person is infected with the virus ("The HIV/AIDS Epidemic in the United States"). Although infection rates have plateaued thanks to the introduction of Anti-Retroviral Therapy (ART) in 1995, about 50,000 people have been infected each year from the mid-1990s onward ("Healthy People 2020"). Public health categorizes the likelihood of a person or a group of persons becoming infected with a disease based on indicators of susceptibility and vulnerability. Susceptibility is defined as the likelihood of being exposed or at risk for the disease (Bess). HIV is transmitted through bodily fluids: blood, semen, vaginal fluid, breast milk, and pre-ejaculate fluid, so susceptibility is classified by certain risk factors based off of behaviors that make transmission of the virus through these

fluids, most likely (Bess). The most common categories of susceptibility are men who have sex with men (MSM), heterosexuals, injection drug users, male injection drug users who have sex with men (MSM-IDU), and sex workers ("CDC Fact Sheet: New"). Men who have sex with men make up the largest population of individuals affected by HIV in the United States; In 2010 an estimated 63% of new HIV infections were amongst men who have sex with men, even though it is estimated that MSM only make up about 2% of the entire U.S population ("CDC Fact Sheet: New"). Heterosexual women are the second most susceptible group and account for two thirds of the 25% of new HIV infections that were transmitted through heterosexual sex in 2010 ("CDC Fact Sheet: New"). Vulnerability refers to the impact that the disease has on those infected (Bess). Factors that determine vulnerability are access to care and drugs, age, ethnicity, and overall health prior to HIV infection. In the United States certain racial groups are disproportionately affected by the disease over others. Black Americans have accounted for the majority of HIV/AIDS infections in the United States as early as 1986. As of 2010, Black Americans accounted for 44% of new infections, but they are only 12% of the entire population. Latinos accounted for 21% of new infections but are only 16% of the population ("The HIV/AIDS Epidemic in the United States"). It is important to note that historically, in the United States, race is heavily tied to socioeconomic status that accounts for the increased vulnerability amongst these two racial groups. The disproportionality of the disease along racial lines is an indicator that perhaps actions to prevent, treat, and reduce infections have been influenced by violent social structures.

Past U.S Political Interventions

HIV/AIDS was publically announced by the CDC in 1982, however the political community was extremely slow to respond to the rapidly growing crisis ("Timeline: 25"). The first significant legislative act taken by the federal government in response to HIV/AIDS was the Ryan White CARE Act signed by President Bush senior in 1990 ("Timeline: 25"). The CARE Act allocated $4.4 billion over the course of five years to be used for health care costs of low-income level HIV patients living in the cities most effected by HIV: Atlanta, Boston, Chicago, Dallas, Fort Lauderdale, Houston, Jersey City, Los Angeles, Miami, Newark, New York, Philadelphia, San Diego, San Francisco, and Washington D.C ("Timeline: 30"). The CARE act has since been renewed and is in effect as of today. During the Clinton administration $156 million dollars were allocated specifically towards education campaigns targeting African Americans and Latinos because as early as 1986, the racial inequity in HIV/AIDS distribution was glaringly obvious ("Timeline: 30"). Unfortunately in 1998 the Clinton Administration failed to lift a ban on the use of federal funding for safe needle exchange programs ("Timeline:30"). During the Bush administration in 2003 President Bush created the President's Emergency Plan for AIDS Relief (PEPFAR), a campaign aimed at ending the HIV/AIDS epidemic abroad. PEPFAR has since become known as one of the largest political efforts to prevent HIV/AIDS globally, thus far (Isbel). The plan allocated $15 billion dollars to be used over the course of five years to fund HIV prevention programs in 15 low income countries, mainly in Sub-Saharan Africa and Latin America (Isbel). The U.S plays an incredibly large role in HIV/AIDS prevention in low and middle-income countries. In 2012 the U.S alone funded 64% of the total international aid efforts for HIV/AIDS ("Fact sheet: Shared Responsibility").

Despite being a global leader in the fight against HIV/AIDS, ,the domestic crisis in the United States continues to be very serious. It is estimated that if Black America were a country in

and of itself, it would rank 16th in the world for most serious AIDS epidemics and it would qualify for PEPFAR funding. In fact it would qualify as a more serious epidemic than 7 out of the 15 countries that currently receive PEPFAR funding (*Endgame*). Seven years since the introduction of PEPFAR and thirty years since the beginning of the HIV/AIDS epidemic, the United States has finally released a policy aimed at the domestic crisis.

THE NATIONAL HIV/AIDS STRATEGY

Section 1: Reducing New Infections

Section one of the NHAS focuses on reducing new HIV infections. At the peak of the HIV epidemic in 1995 about 130,000 people were infected each year ("Timeline: 25"). Over time practices such as HIV testing, effective screening of the blood donor supply, screening and treating effected mothers during pregnancy, minimizing infection from injection drug use, and new advances in HIV therapy, have brought the yearly infection rate down to about 50,000 new infections per year, where it has remained since about 1995 (United States *National HIV/AIDS Strategy for* 5). According to the NHAS the following challenges are reasons why HIV transmission has not gone down in many years: "many people living with HIV are unaware of their status, access to HIV prevention and care is too limited, and public awareness of the epidemic has gone down since the initial hype in the eighties and early nineties". (United States *National HIV/AIDS Strategy for* 6). In order to counter these challenges the strategy follows three steps, which are outlined in detail below.

Step 1: Intensify HIV prevention efforts in the communities where HIV is most heavily concentrated:

According the NHAS, the social groups most affected by HIV are gay and bisexual men, African Americans, Latinos, and substance abusers. Geographically the heaviest concentration of HIV/AIDs is in the south and northeast regions of the country. According to ONAP, 50% of HIV infections are concentrated within only 5 states, but those states only receive 48% of CDC funding for prevention services. In order to better place services where they are needed, the strategy suggests that federal funding be reallocated to directly match proportions (United States *National HIV/AIDS Strategy for 5-8*). It also suggests that congress and state legislatures pass new laws and policies that acknowledge the disproportionate burden that the virus has on certain communities, such as the African American community (United States *National HIV/AIDS Strategy for 5*). .

The challenge of intensifying prevention efforts in the communities most affected by HIV is that these are often the same communities plagued by other obstacles such as poverty, homelessness, lack of resources, and overall stigmatization. A week after the NHAS was released, the CDC published a study showing that 2.1% of heterosexuals living in high poverty urban areas are infected by HIV. According to officials at the CDC, this is a serious indicator that HIV has become a generalized epidemic regardless of specific racial communities (King). While race is of course heavily linked to socio-economic status, the strategy does not make this association. The director of the CDC's division of HIV/AIDS prevention stated at a press conference, "We need to address larger environmental issues, such as poverty, homelessness and substance abuse, which are well beyond the traditional scope of HIV intervention. Addressing those is as essential to HIV prevention as providing condoms" (cited by King). The report suggests that by failing to create strong co-strategies surrounding these other issues, the NHAS

will only be mildly effective in targeting the high-risk communities that are named in the policy (King).

Step 2: Expand efforts to prevent HIV infection using a combination of effective evidence based approaches.

The effective and evidence based approaches for preventing HIV infection as defined by the strategy are the following: abstinence from sex and drug use, HIV testing, condom use, access to sterile needles and syringes, and anti-retro viral therapy. In public health there are two forms of HIV interventions: behavioral and treatment based. Abstinence, condom use, and safe needle exchanges are examples of behavioral interventions because they promote changes in actions and behaviors. Treatment tends to be about biological change and often involves drugs (United States *National HIV/AIDS Strategy for* 15-19*).* Anti-retroviral therapy is the most commonly known form of treatment for HIV-positive individuals.

Since the publication of the NHAS in 2010, a number of new preventative treatments have been proven to be highly effective for HIV negative individuals who are at high risk for contracting the disease ("Revitalizing" 20). These treatments include Pre-exposure Prophylaxis (PrEP) therapy, vaginal/anal microbicides and Opiod Substitution therapy. PrEP puts people who do not have HIV but are at high risk for becoming infected on small doses of anti-retroviral therapy in order to prevent acquisition of the virus ("Pre-Exposure"). Vaginal/anal microbicides also prevent acquisition of the virus but are localized creams or gels used to kill the virus during sexual intercourse ("Resources for"). Opioid substitution therapy, unlike the prior treatments, is not directly related to the HIV virus, although it is used to treat IUDs who are at great risk for contracting it. The therapy works by blocking opiate receptors in the brain and eliminating the patient's desire to use injection drugs (Kermode). Although not referenced in the strategy itself,

all three of these methods of prevention treatment became part of the updated implementation strategy in 2012.

Despite the fact that behavioral practices such as condom use and safe needle use are acknowledged by the strategy, there is no mention of these practices in the implementation strategy. Historically U.S policy has strayed away from funding both safe needle exchange programs and condom distribution. Due to the heavy involvement of the conservative religious community in the funding and implementation of PEPFAR, two of every three dollars goes to abstinence-only programs, which essentially eliminates condoms from all programs because the rest of the money is used for structural program necessities (Isbel). Due to similar conservative politics, the United States is currently the only country in the world to ban federal funding for safe needle exchange programs (*Endgame*). In 2009 the Obama Administration lifted the ban, but in 2011 Republican congressmen lobbied to have it put back in place and through budget compromising it was re-established ("Federal Funding Ban").

Step 3: Educate all Americans about the threat of HIV and how to prevent it.

In order to educate Americans about the threat of HIV and how to prevent it, the NHAS suggests utilizing evidence-based social marketing and education campaigns to counter misperceptions about HIV and educate the public on how it is transmitted (United States *National HIV/AIDS Strategy for* 19-21). As part of the implementation strategy the CDC launched a number of media/ marketing campaigns targeting specific high-risk communities such as African American MSM. Promoting national campaigns such as AIDS Day (December 1st) and National HIV Testing Day (June 27th) is also a key focus of the strategy (United States *National HIV/AIDS Strategy: Federal* 16).

Although the NHAS suggests that efforts be made to promote age-appropriate HIV and STI prevention education for all Americans in all educational environments, there is very little implementation towards sex-education in public schools. In the United States 25% of all new HIV infections are in the youth population, aged 13-24. ("Fact Sheet: Shared"). For this reason it seems particularly urgent that comprehensive HIV/AIDS education be incorporated into public school education; however, in many school districts HIV/AIDS is only mentioned one day out of the year and is presented with highly outdated materials (*Endgame*).

Section 1 Benchmarks:

The following are the benchmarks that will mark the success of this first section of the NHAS if accomplished by 2015:

- Lower the annual number of new infections by 25 percent (from 56,300 to 42,225).
- Reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30 percent (from 5 persons infected each year per 100 people with HIV to 3.5 persons infected each year per 100 people with HIV).
- Increase from 79 percent to 90 percent the percentage of people living with HIV who know their serostatus (from 948,000 to 1,080,000 people).

Treatment Action Group (TAG), an independent AIDS research and policy think tank, published a report in 2012 stating the Obama administration was not on track towards reaching their benchmarks. The report suggests that the main reason why the campaign was not on target was a lack of federal funding needed to appropriately implement the goals of the strategy. As stated explicitly in the NHAS, it is not a budget document, rather the $19 billion per year that the U.S has allocated for HIV prevention efforts will be re-allocated to more efficiently meet needs in high-risk areas. However, despite more efficient spending of the budget, TAG estimates that an additional $15.2 billion would be needed to successfully cover all costs of the strategy (Barr

4). The report argues that further investment in prevention will ultimately save over $18 billion in medical costs.

Housing Works, a non-profit organization dedicated to fighting homelessness, further criticizes the strategy by suggesting that even if benchmarks are met by 2015 they will not make a significant dent in the HIV/AIDS crisis. According to Housing Works a 25% decrease in infection rates by the year 2015 will still leave around 42,000 people newly infected in that year, and if infections continue to only drop by 25% every 5 years, it won't be until around 2055 that infections per year are down to 5,000, which is still a significant number (King).

The U.S currently has the sixty-second highest prevalence rate of HIV in the world, ranking higher than many developing nations. If the 2015 benchmarks are met the U.S will still remain within the top half of the world for high prevalence rate ("Country Comparision").

Section 2: Increasing Access to Care and Increasing Health Outcomes for People Living with HIV

The second section of the NHAS is focused on increasing access to care and health outcomes for people already living with HIV. The following is an analysis of the steps set forth to achieve that outcome.

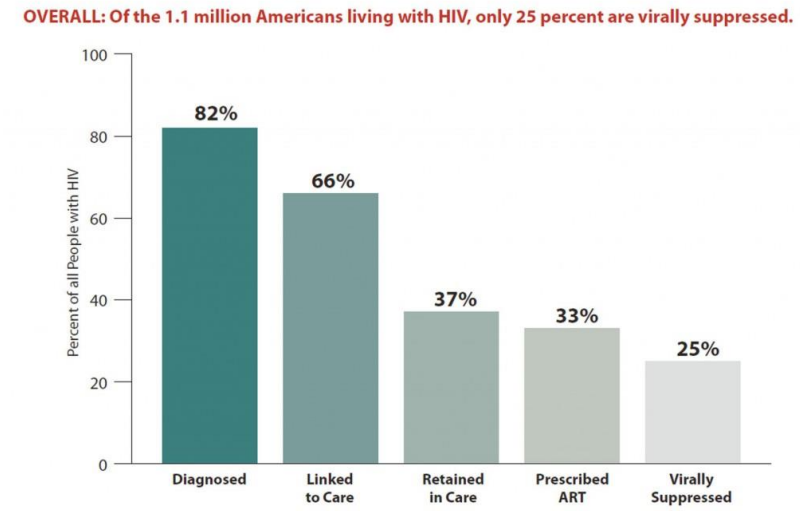
Step 1: Establish a seamless system to immediately link people to continuous and coordinated quality care when they are diagnosed with HIV.

Care of HIV positive patients is often categorized in five main stages: testing and diagnosis, linkage to care for those who test positive, retention in care over time, provision of antiretroviral therapy, and achieving "viral suppression" to reduce the risk of transmission to others. These five stages are incorporated into what is known as the Treatment Cascade, a model used for public health officials to assess where current gaps in treatment and prevention lie.

Below is a graph produced by the CDC showing the current state of the care continuum in the U.S. (“CDC Fact Sheet: HIV”)

Figure 1

CDC Treatment Cascade



Source:

“CDC Fact Sheet: New HIV Infections in the United States. National Center forHIV/AIDS Prevention.” *Centers for Disease Control and Prevention*. CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Dec. 2012. Web. 15 Dec. 201

As evidenced by the graph, a significant portion of patients is lost at each stage of care. Viral suppression is the ideal health outcome in today’s HIV treatment practices, as there is currently no cure. With maintained viral suppression a patient will live a normal lifespan, and the likelihood that they will spread the virus decreases by 96% (Wilson 7). The ideal goal towards ending the HIV/AIDS crisis is to maintain as close to 100% of patients throughout the continuum, therefore severely decreasing further spread of the virus.

The main mechanism that the NHAS proposes for accomplishing the following two steps under the second phase of the strategy is the Affordable Care Act.

Step 2: Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV.

Step 3: Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV.

The Affordable Care Act includes an expansion of "initiatives to strengthen cultural competency training for all health care providers and ensure all populations are treated equitably." ("The Affordable Care Act"). The ACA also allocates funding for loans and scholarships to be distributed by the National Health Services Corps, which has allowed the Corp to triple in number since 2008. The National Health Services Corps now reaches about 10.4 million patients throughout the country ("The Affordable Care Act").

Until the Affordable Care Act, insurance companies could deny coverage to people with pre-existing medical conditions including HIV/AIDS. Medicare, Medicaid, and the Ryan White HIV/AIDS program, which have been the main coverage mechanisms for the HIV/AIDS population in the United States. As part of the Affordable Care Act, more HIV patients will have all their needs met by normal health plans, therefore relieving a portion of the financial burden that has been placed on Medicare, Medicaid, and Ryan White. These funds will continue to be available to HIV/AIDS patients and eligibility for Medicaid will be expanded under the ACA ("The Affordable Care Act").

In the 2012 report reviewing the progress of the NHAS, TAG cautions that although the ACA will greatly increase HIV patients access to care and therefore minimize the Treatment

Cascade gap, it will also change the way that HIV services have been administered over the years. Both patients and medical professionals will need a great deal of information to allow them to navigate the changes smoothly (Barr 2). TAG suggests that the implementation strategy for the NHAS focus more efforts on education programming to ensure that the provisions of the ACA are accessible to all, particularly high-risk, low-resource communities (Barr 2-7).

Section 2 Benchmarks

1. Increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65 percent to 85 percent (from 26,824 to 35,079 people).
2. Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73 percent to 80 percent (or 237,924 people in continuous care to 260,739 people in continuous care)
3. Increase the percentage of Ryan White HIV/AIDS Program clients with permanent housing from 82 percent to 86 percent (from 434,000 to 455,800 people).

Similarly to the first set of benchmarks, the Treatment Action Committee states that the NHAS is not on track towards achieving these benchmarks for 2015. The reason these benchmarks will not be achieved is that the main mechanism for achieving them, the Affordable Care Act, does not come into effect until 2014, one year before the end of the strategy. Even once the Affordable Care Act is implemented it will take some time for providers and patients to adjust to the new system (Barr 2).

A major drawback of the ACA for those living with HIV is that insurance companies approved by the act are only required to cover one type of each class of drugs ("Assessing the Impact"). HIV patients rely on a cocktail of drugs to make up their treatment and often change drugs throughout the course of their lives because of the high likelihood that they will develop drug resistances (Stine). Even with the ACA many people will still be reliant on the Ryan White

CARE Act to cover the full cost of HIV care. In order to truly give universal access to quality care, the NHAS would have to include certain mechanisms for lowering the cost of HIV treatment in general. The majority of HIV care spending in the United States is spent on anti-retroviral drugs, which cost more in the United States than anywhere else in the world due to drug patenting laws ("Assessing the Impact"). Overall only 3% of U.S expenditures of HIV/AIDs related care goes towards preventative measures (Barr 8).

As mentioned in section one of this analysis, the co-risk factors keeping people out of care such as environmental factors, poverty, and homelessness cannot be ignored. Although the ACA provides tax subsidies, which will allow persons of low income to afford care, there are no provisions meant to alleviate other environmental factors that affect health, such as housing ("The Affordable Care Act"). According to Housing Works, the NHAS severely undersells the rate of HIV infection amongst the homeless population; it is sixteen times higher than that of the general population. According to a different Obama strategy, the *Federal Strategic Plan to Prevent and End Homelessness,* housing is shown to be one of the most practical and cost effective HIV interventions out there. While the *Federal Strategic Plan to Prevent and End Homelessness* is mentioned in the Executive Summary of the NHAS, it is only referenced as a "blueprint" strategy (King). Housing Works is highly critical of the NHAS's attempt to better coordinate national efforts because there is a clear disconnect between the facts presented on HIV in each strategy.

Section 3: Reduce HIV Related Health Disparities and Health Inequities

The third section of the NHAS focuses on better servicing populations that are disproportionately affected by HIV, specifically gay and bisexual men, Blacks, and Latinos. The following is an analysis of the steps/goals for this section.

Step 1: Reduce HIV-related mortality in communities at high risk for HIV infection

The NHAS proposes to reduce HIV-related mortality in communities at high risk for HIV infection by implementing strategies for keeping high-risk communities from falling off the Treatment Cascade. The earlier on in the Cascade that a patient slips away, the more likely they are to die of AIDS ("CDC Fact Sheet: HIV"). The NHAS states that high-risk groups must have regular access to viral load and CD4 tests in order to monitor risk for complications. The action for implementing this step is to create a research group consisting of multiple federal agencies that will collect data from various providers on the viral loads and CD4 counts of infected individuals that are categorized as "high-risk," meaning gay and bisexual men, Blacks, and Latinos. The data will be used to monitor community level mortality rates and determine best practices (United States *National HIV/AIDS Strategy: Federal* 17-19) .

Step 2: Adopt community-level approaches to reduce HIV infection in high-risk communities.

This section of the strategy emphasizes promoting a holistic approach to health services that focus not just on HIV prevention but also prevention of all STDs and other co-morbidities associated with HIV. According to the NHAS implementation strategy, HHS OS will implement various pilot programs in at-risk communities including a braided funding program in conjunction with HUD to work on housing issues in select communities (specific communities are not named in the strategy). Additionally, the CDC will use up-to-date technology to collect data on community level viral load in order to assess the effectiveness of the pilot program (United States *National HIV/AIDS Strategy: Federal* 19-21).

Step 3: Reduce stigma and discrimination against people living with HIV.

As stated in the implementation strategy, "addressing ongoing stigma and discrimination is perhaps the biggest challenge we face, as this is not about what government does as much as it is about changing hearts and minds among members of the public" (United States *National HIV/AIDS Strategy: Federal* 2). However on the governmental side the strategy focuses on reviewing and reforming civil rights laws to protect people with HIV when disclosing their HIV status. The NHAS has tasked the Department of Labor and HUD with investigating and working to eliminate incidences of discrimination related to HIV status. Additionally it has tasked the Department of Justice with investigating HIV criminalization laws, laws that penalize persons from not disclosing their HIV status to partners. The goal behind the investigation is to understand what public health practices best promote safe, non-discriminatory disclosure on HIV status (United States *National HIV/AIDS Strategy: Federal* 21-23).

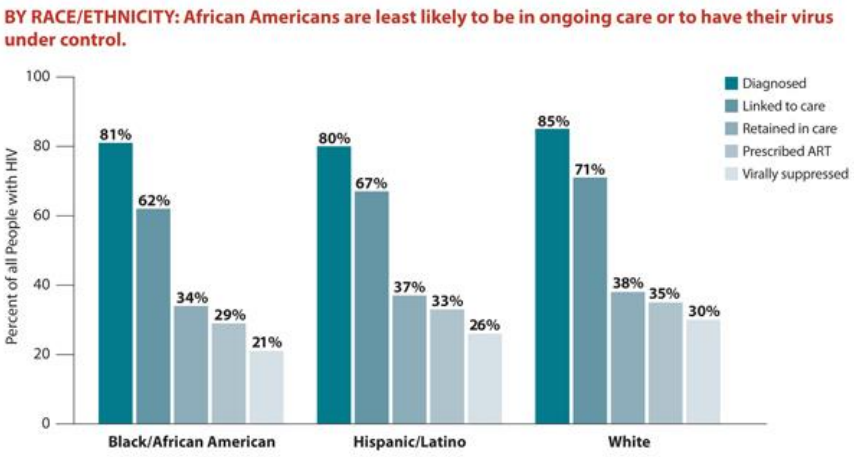
Section 3 Benchmarks:

1. Increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20 percent.
2. Increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20 percent.
3. Increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20 percent.

In order to best interpret the 2015 benchmarks, below is the CDC's Treatment Cascade based on racial groups:

Figure 2

CDC Treatment Cascade By Race



Source:

"CDC Fact Sheet: New HIV Infections in the United States. National Center forHIV/AIDS Prevention." *Centers for Disease Control and Prevention*. CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Dec. 2012. Web. 15 Dec. 2013

Currently the proportion of Black Americans with undetectable viral load is 21% and for Latinos it is 26%. This means that if increased by 20% in five years, still under half of all HIV positive members of those groups will not reach viral suppression. This is incredibly significant considering that Black Americans and Latinos already account for a disproportionately high percentage of overall HIV infections. A report entitled *Light at the end of the tunnel: Ending AIDS in Black America* published by the Black AIDS institute in 2012 suggests that it is possible for 80% of the Black American HIV population to achieve viral suppression by the year 2017 (8). The report focuses on community level approaches and distribution of relevant information to these communities. Similarly to the TAG report, it suggests that communities will need specific training and education on how to best access programs through the Affordable Care Act (4-7).

While the benchmarks in this section are unambitious in terms of lowering percentages for three at-risk groups, they also leave out specific at-risk sub groups ,which must be acknowledged in order to impact the HIV/AIDS crisis in the United States. Although the unique

risk that HIV plays on women and transgendered people is mentioned in the NHAS, there are no strategies, steps, or benchmarks set out to target these populations specifically. Furthermore, there is not a single mention of sex workers anywhere in either the NHAS or the implementation plan, despite the fact that they are an incredibly high-risk group.

Section 4: Achieving a more coordinated national response to the crisis

Step 1. Increase the coordination of HIV programs across the federal government and between federal agencies and state, territorial, local, and tribal governments.

In order to increase coordination of HIV programs across the federal government and between federal agencies and state, territorial, local, and tribal governments, the NHAS has tasked the HHS OS with coordinating joint-program planning meetings with a number of federal agencies including HUD, VA, DOL, SSA and DOJ. The departments will collaborate to write regular reports documenting individual progress towards NHAS benchmarks and goals. Under this section of the strategy the federal government has also tasked itself with re-allocating resources in the most equitable way. Specific re-allocation of HUD resources will allow Housing Opportunities for Persons with AIDS (HOPWA) grants to better reflect the needs of the HIV positive population (United States *National HIV/AIDS Strategy: Federal* 27-29).

Step 2. Develop improved mechanisms to monitor, evaluate, and report on progress toward achieving national goals.

The NHAS will re-allocate funding to programs that are proven to be must effective for preventing and treating HIV. The following criteria will be used to assess the effectiveness of a program:

1) Scientifically proven to reduce HIV infection, increase access to care, or reduce HIV-related disparities. 2) Able to demonstrate sustained and long lasting (>1 year) outcomes toward achieving any of these goals 3) Scalable to produce desired outcomes at the community-level, and 4) cost efficient. Although there are no legal obligations, states are encouraged to report on prevention programs in order to receive better funding. (United States *National HIV/AIDS Strategy: Federal* 29)

There are no benchmarks for section 4

CONCLUSION

The NHAS is currently in the fourth year out of five and it seems unlikely that the majority of benchmarks will be met. The main reason why the strategy is not on track is that it relies too heavily on the Affordable Care Act as the driving mechanism for accomplishing the goals, yet the ACA only recently took effect and it is unlikely the public will see the impact of the program for many months to come. Had the federal government been able to allocate additional funding for HIV/AIDS treatment and funding over the course of the three years leading up the ACA, they may have been more successful in reaching their goals.

As the first ever domestic policy focused on ending the HIV/AIDS crisis in the United States, the NHAS is on the right track by acknowledging that HIV disproportionately effects individuals based on social factors such as age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance (works referenced). However, many reports indicate that the goals of the NHAS, even if successful, will not make a significant dent in the overall domestic crisis. Despite a significant push to re-allocating funding to at-risk communities, the NHAS will not be successful in closing the inequity gap in HIV/AIDS if it does not take more significant actions to alleviate the burden of co-risk factors such as housing, poverty, and lack of resources that devastate the same communities devastated by HIV/AIDS.

The following are a list of best practices that the author of this report believes would best complement the Obama Strategy were it to be renewed for another five years. The practices draw from a number of sources both cited and referenced by the author.

1. Invest in HIV and increase funding for preventative services
2. Put pressure on drug companies to decrease the cost of ART
3. Lift the ban on federal funding of safe needle exchange programs
4. Create mechanisms to incorporate the work of non-profits and NGOs into the federal strategy and better reflect non-political perspectives
5. Re-write the strategy to better reflect information in co-strategies such as the *Federal Strategic Plan to Prevent and End Homelessness*
6. Acknowledge sex workers as an at-risk population and work to de-stigmatize this population as much as the other.
7. Implement programming to educate communities about accessing provisions of the Affordable Care Act
8. Write a mandate at the federal level to include HIV/AIDS awareness curriculum in all public schools

Works Cited

"The Affordable Care Act Helps People Living With HIV/AIDS". *AIDS.gov*. AIDS.gov, 1 Dec. 2012. Web. 16 Dec. 2013

"Assessing the Impact of the Affordable Care Act on Health Insurance Coverage of People with HIV." *The Kaiser Foundation: The HIV/AIDS Epidemic in the United States.* The Henry J. Kaiser Family Foundation, 22 Mar. 2013. Web. 24 Jan. 2014

Barr, David and Jeff Hoover. *Revitalizing the National HIV/AIDS Strategy: Action Plan. Treatment Action Group*. Treatment Action Group, n.d. Web. 16 Dec. 2013.

Bess, Jennifer. Class Lecture. Goucher College, Baltimore. 9 Sept. 2013. Lecture.

Beyrer, Chris and H.F Pizer ed. *Public Health and Human Rights: Evidence Based Approaches.* The Johns Hopkins University Press: Baltimore, 2007. Print

"CDC Fact Sheet: HIV in the United States: The Stages of Care. National Center for HIV/AIDS Prevention." *Centers for Disease Control and Prevention*. U.S Department of Health and Human Services, July 2012. Web. 15 Dec. 2013

"CDC Fact Sheet: New HIV Infections in the United States. National Center for HIV/AIDS prevention." *Centers for Disease Control and Prevention*. CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Dec. 2012. Web. 15 Dec. 2013

"Country Comparison: HIV/AIDS Adult Prevalence Rate." *The World Factbook.* Central Intelligence Agency, 2009. Web. 24 Jan. 2014.

Endgame: Aids in Black America. Frontline, 2012. Documentary.

"Fact Sheet: Shared Responsibility to Strengthen Results for the AIDS-Free Generation." *Whitehouse.gov*. Office of the Press Secretary, 2 Dec. 2013.Web. 16 Dec. 2013.

"Federal Funding Ban on Needle Exchange Programs." *Whitehouse.gov.* Office of National Drug Control Policy, 5 Jan. 2012. Web. 24 Jan. 2014.

"Healthy People 2020 Leading Health Indicators". *Centers for Disease Control and Prevention*.National Center for HIV/AIDS Prevention. Jun. 2012. Web. 16, Dec.2013.

"The Global HIV/AIDS Epidemic."*The Kaiser Foundation: The HIV/AIDS Epidemic in the United States.* The Henry J. Kaiser Family Foundation, 10 Oct. 2013.Web. 16, Dec. 2013

Gowing, Linda R., Matthew Hickman, and Louisa Degenhardt. *Mitigating the Risk of HIV Infection with Opioid Substitution Treatment. WHO*. World Health Organization, 24 Sept.2012. Web. 18 Dec. 2013.

"The HIV/AIDS Epidemic in the United States." *The Kaiser Foundation: The HIV/AIDS Epidemic in the United States.* The Henry J. Kaiser Family Foundation,22 Mar. 2013. Web. 16, Dec. 2013

Isbel, Mike. *The Money Trail: Financing the Global AIDS Response*. *PBS*. Public Broadcasting Station, 30 May 2006. Web. 18 Dec. 2013.

King, Charles. "Why I Interrupted President Obama's Speech on the National HIV/AIDS Strategy." *Housing Works Blog*. Housing Works, 10 Aug. 2010. Web. 18 Dec. 2013.

Kermode, Michelle, Nick Crofts, M Suresh Kumar and Jimmy Dorabjee. "Opiod Substitution Therapy in Resource Poor Settings." *Bulletin of the World Health Organisation.* The World Health Organisation. 2011. Web 24 Jan. 2014

"Pre-Exposure Prophylaxis (PrEP*)." Centers for Disease Control and Prevention*. Centers for Disease Control and Prevention, 19 Aug. 2013. Web. 16 Dec. 2013.

"Resources for Entertainment Education Content Developers: HIV/AIDS & Microbicides." *Centers for Disease Control and Prevention*. Centers for Disease Control and Prevention, 11 Feb. 2011. Web. 24 Jan. 2013.

"Resources for Entertainment Education Content Developers: HIV/AIDS & Microbicides." *Centers for Disease Control and Prevention*. Centers for Disease Control and Prevention, 11 Feb. 2011. Web. 24 Jan. 2013.

"Response and Recommendations Regarding the National HIV/AIDS Strategy." *Housing Works Blog*. Housing Works, 10 Aug. 2010. Web. 18 Dec. 2013.

Revitalizing the National HIV/AIDS Strategy: Meeting Report. Treatment Action Group. Treatment Action Group, n.d. Web. 16 Dec. 2013.

Stine, Rachel. "HIV Biology 2013." Goucher College, Baltimore. 9 Sept. 2013. Lecture

"Timeline: 25 Years of AIDS." *Frontline the Age of Aids*. Public Broadcasting Station, 10 uly 2012. Web. 18 Dec. 2013.

"Timeline: 30 Years of AIDS in Black America." *Frontline*. Public Broadcasting Station, 10 July 2012. Web. 18 Dec. 2013.

United States. Office of National AIDS Policy. *National HIV/AIDS Strategy for the United States.* Washington: Government Printing Office, July 2010. *AIDS.gov*, Web. 16 Dec. 2013.

United States. Office of National AIDS Policy. *National HIV/AIDS Strategy: Federal Implementation Plan.* Washington: Government Printing Office, July 2010. *AIDS.gov*, Web. 16 Dec. 2013.

Wilson, Phil. *Light at the End of the Tunnel: Ending AIDS in Black America, 2013. BlackAIDS.org*. California: Black AIDS Institute, n.d. Web. 16 Dec. 2013.

Works Referenced

And the Band Played On. Dir. Roger Spottiswoode. Perf. Mathew Modine, Alan Aida, Patrick Bauchau, and Nathalie Baye. HBO, 1993. Film.

Barnett, Tony and Alan Whiteside. *AIDS in the Twenty-First Century: Disease and Globalisation.* 2nd ed. New York: Palgrave Macmillan, 2006. Print.

Marieb, Elaine N and Katja Hoehn. *Human Anatomy and Physiology*. 8th ed. San Fransisco: Benjamin Cummings, 2010. Print.

"Obamacare &You: What the Affordable Care Act Means for People Living with HIV." *Greater Than AIDS.* Greater Than AIDS, 2013. Web. 18 Dec. 2013.

Siplon, Patricia D. "Washington's Response to the AIDS Epidemic: The Ryan White CARE Act." Policy Studies Journal 27.4 (1999):796-808.

Ward, Darrell E. *The AMFAR AIDS Handbook*. New York: Norton, 1999. Print.

United States. Office of National AIDS Policy. *National HIV/AIDS Strategy: Update of 2011 2012 Federal Efforts to Implement the National HIV/AIDS strategy.* Washington: Government Printing Office, July 2010.*AIDS.gov*, Web. 24 Jan. 2013.