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CDC: 2003 HIV Prevention Conference
Challenges in HIV Prevention
July 30, 2003

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MALE VOICE: Good morning everyone. I said, good morning. Okay, good. I can see you, but I like to hear you as well. I wanted to make a special announcement, and I'm going to be very brief because we have an outstanding line-up of speakers this morning, and you are all here to hear from them, not me. But, I think probably most of you know that like many of the folks involved in this conference, I wear multiple hats, and I am co-chair of this conference along with Dr. M Valerie Mills, but I also happen to work at CDC and it's in that later capacity why I'm at the podium this morning. My colleagues from CDC at the highest levels of the organization have asked me to share with you what I think is a very important message. Throughout this meeting there have been a number of very important discussions related to CDC's new HIV/AIDS prevention initiative. There've been some formal sessions where it's been discussed. There have also been a number of community meetings where the issue has been raised, and many of us, myself included have been invited to meet individually with community leaders to hear your valid concerns about the initiative, and wanted to say first and foremost is that we are listening and we have heard your concerns, and we definitely intend to address them. So, I wanted just to make a couple of very brief comments about what we're hearing. This is not the end of the dialogue. It's the beginning, and then I really want to turn it over to the speakers we have this morning.

First of all, let me say loud and clear that CDC wants to keep people healthy and free of HIV infection. That is our primary

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goal. We see working with the sera positive communities as one element of this, but it clearly is not the only element. I also want to state in front of all of you on behalf of all my colleagues at CDC that we have no intention of abandoning the rich knowledge of behavioral science, and we will not stop talking about sexual risk reduction and other means to reduce the risk of HIV transmission.

Now, to that end, there's been a lot of concern raised by the community about the directly-funded community based organization program which is up for recompetition and we're currently working on it, and what I want to say to you is this that that program announcement will contain activities, funded activities directed at high risk sera negatives. It won't just be working with people who are already living with HIV and AIDS. Now, what I don't know is what that combination will be or how it will appear, but we definitely heard all of your feedback about the importance of having a comprehensive approach in that program. And, also I think it's so important to state for the record that we want to build, this is not about tearing down, this is about building up. We want to build on the exceptional work that community based organizations and grass roots, and state and local health departments have done to build a prevention infrastructure. We don't want to tear that down. We want to build that up, and we have no intention of shifting dollars away from racial and ethnic minority communities because that's where the epidemic is raging.

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One other point that I wanted to make was that we are very much concerned about the estimated 250,000 persons in the United States who are infected with HIV and don't know it. They can't, if they don't know it, they can't try to access medical care, and certainly we also know that they maybe unknowingly transmitting the virus. So, we're not backing away from that, but let me state loud and clear that the working with physicians and the medical sector is not – I repeat is not – the only way that we intend to address this program. We recognize that many of our most important population do not have access to medical care, and so I do want to go on record on behalf of all my CDC colleagues that we will be putting resources into developing models that don't rely on just rely on the standard medical model or assume that everyone who needs these services is going to come in a doctor's office because we know that that's not the case.

Finally, because it's clear that there are some important areas where we need to continue to receive input from our partners, it is our stated public intention to hold additional consultations with representatives from community, from health department, from grass roots organizations to address these issues. First and foremost, we have heard the very valid concerns about needing to get substantial inputs from communities of people who are living with HIV/AIDS. We do not intend to back away from the prime need to strengthen ongoing prevention for people living with HIV/AIDS, but the positive communities have reminded us as well they should, that

we need to get that input. We need to understand from the perspective of the communities how best to do that. So, we will definitely have that consultation, and again, this is not just me speaking. I'm speaking on behalf of a number of my colleagues at CDC. We want to also have further discussions specifically around issues of prevention needs for communities of color because it's very clear that we have not done – CDC has not done an effective job communicating what this about and what it's done, I think, has threatened the good working relationship we have with those communities. So, we want to hear more from you on that issue.

So, it's not the end of the dialogue. Obviously, there's still a lot of issues that need to be addressed, but on behalf of my colleagues again wearing my CDC hat, we thought that it was very important to relay that feedback to you. I want to thank the panelists for indulging me and giving me these few moments and I want to get on with the plenary session this morning. Thank you.

CARLOS VEGA-MATOS: Good morning. My name is Carlos Vega-Matos, deputy executive director for programs at AIDS Alliance for Children, Youth and Families. Our first speaker today is Mick Gardner, Director of Programs at Centerforce in California. He'll be talking to us about implementing successful prevention programs in correctional settings. Thanks.

MICK GARDNER: Good morning everyone. Good morning. My name's Mick Gardner and first of all I'd like to thank the organizers for inviting me to present about the success Centerforce has

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experienced with correctional programming in jails and prison. For those of us that work with the incarcerated communities, we are very pleased to have this dialogue around prisons and jails. As community service providers, researchers, policy makers, and ex-inmates, it's important to acknowledge that the rates of HIV, STDs, Hepatitis, etc, are greater in the incarcerated population then in the community.

Okay, I'll tell you. First a list of behaviors that inmates engage in, please note that these are consistent with routes of transmission on the outside. There are also reasons for disciplinary consequences to the incarcerated community on the outside. Showing another reason why it's so important to provide prevention and harm reduction messages on the inside.

This is a table by KF Hammit (misspelled?) that really blew me away. In the first row, you'll note that it stands at 17% of the country's entire AIDS cases in 1996 were released from custody that year. These numbers are sadly astonishing because it shows how important it is to work with this population.

Now, my presentation today is really a talk about success and what it takes to implement successes, but I thought it would be really neat to start out by talking about challenges that one faces when going inside, working inside a correctional setting. Some of the things that you experience going inside is lock down and lock outs, inability to access inmates and do services inside, conduct regular programming, confidentiality in meeting space is really important because inside a prison setting, meeting space is really at a

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minimum. So, in order to gain meeting space and space to effectively provide programming, that's a big deal, and then lack of community resources. Some more challenges is the inability for custody staff to be aware of HIV/AIDS. It's really important that custody has a buy-in in terms of the work that you do, the efforts that you do, so that you have like cohesion. (unintelligible) inmates with information regarding medical care and treatment, and then creating a harm reduction message on the inside. If you note, in one of my earlier slides I mentioned that – of all those risks that take place inside, and those are illegal inside, so if you're creating a harm reduction message, it's like sending a message that's contrary to what the administration wants you to provide.

Some of the factors associated with Centerforce to be effective and successful program is that first of all Centerforce is a prison and jail based community service provider. Our mission is to work with the incarcerated and their families during incarceration and to the community that supports them as they transition back. We have offices with the phone line which is huge plus. The phone line is a huge plus, because there you have the ability to make connections to the outside world on and for your clients. And, then we also have full-time staff based inside the institution. Plus, another plus is that our funding sources do not come from Department of Corrections. So, therefore, they look favorably upon our programs.

We incorporate institutional priorities in our program priorities. We know the mission of the Department of Corrections is

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custody, control, and safety. So, we have learned to work with this, always a challenge for us to choose to develop the trust and respect of the inmates, the family and the custody providers. We are very proud that staff at Centerforce reflects our constituency, and this is really important. The majority of our staff and board are people of color, have been exposed to the prison culture, and have a sincere passion to work with this population.

Successful programs may develop into strong ties in keeping all inmates informed, and so developing relationship in California with Sacramento headquarters is very key as far as ongoing success. We also meet with the wardens bi-annually to inform of the progress of our programs, and we meet with other administrative staff for ongoing program support. We provide in-services for the medical and especially the custody staff, again, I said that it’s really important that you get a buy-in from the custody staff in relationship to the work that you do and the efforts that you do, and the programming that you’re doing on the inside. And, then our inmates are very, very key, and I really want to drive that point home. The inmate peer advisors are very critical to the success of program implementation as they are the ears, the eyes of what we do. So, in many cases when we are in a hiring process, part of our interviewing process is to bring the candidate inside the prison and meet with our peer advisors and let them interview, and they tell us whether this person is appropriate or will be effective working inside the setting. When we develop education material, we always run

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that material by our peer advisors just to get some type of feedback whether this information is going to be appropriate, whether it's going to be prison friendly. In addition to that, when we bring other people in as far as programming or different services, then we always get some advice from the inmates as far as the effectiveness of that program. As a matter of fact, I have a meeting like this Saturday.

Also, our inmates are very effective as far as promoting and increasing general HIV/AIDS education within the correctional setting. Our regional (unintelligible) curriculum was developed by Centerforce, and is the inmate education training model that has been used to implement peer education programs in many states. The program empowers inmates to educate and reach out to other inmates about health issues as well to educate population on harm reduction techniques, and then as the end results it increases our voluntary testing rates.

Through previous studies, we have documented the effectiveness of these programs. Inmates that were offered health education inside were more likely to use a condom at first intercourse after release.

Almost ten years ago, Centerforce in collaboration with UCSF developed and evaluated prevention with positives program for HIV positive inmates. Another successful program intervention is exposing the population to many community service providers to connect with them the local providers. Centerforce finds out which county the inmate will be released to, finds an appropriate community

provider in that community, facilitates the security clearance which is really important, and escorts, and then brings these providers into the prison health fairs to meet with the paroling population. That's really key because we're in effect doing a continuum of services on the inside and starts from the time a person arrives until the time until they're preparing to leave.

Through our participation with the seven state CDC personal correctional demonstration project, these are some successful components for the prevention case management intervention. We believe that enrollment is really important sixty days before release in order to develop a relationship with the paroling person. We believe that meeting with that person once a week to develop a sense of trust and confidence in the case manager both ways actually. We do a client center risk assessment and a release plan, and we utilize the harm reduction strategies as our model for intervention. Then again, that confidentiality space is a true plus because again in terms of connecting with services in the community, you have the phone line right there. You can make the call to the program on the outside while the inmates right there in the room, a huge plus.

We also believe that parole is a true ally. When we first this demonstration project, we were on the belief that we didn't want to be looked at as cops, because again we work inside a correctional setting. We didn't want to be associated with cops. We later found that actually using parole is a true plus, and for any of you who have worked with this population, I would certainly suggest it

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because what happens is that if a person does not report to their parole office within the first 24-48 hours, they're considered a violator, which means they automatically go back. So, what we did initially was to go out and meet with the parole agent, provide them with an overview of the services, told them that we would be accompanying the parolee to the meetings, and that was really, really effective. We had gotten tremendous response from paroling community in reference to that as well as belonging to different police and corrections programs that are in the California Bay area.

So, what are our next challenges? Well, new CDC guidance will have a profound affect on the incarcerated population with the emphasis on counseling and testing in increased rates inside prisons and jails, we have new challenges. How will we facilitate partner notification when one partner is incarcerated? How will we coordinate communications when someone goes from getting care and treatment in the community to jail and prison? And, what will the impact of testing in a prison reception center? These are real questions that need to be answered before we implement new policies in the prison setting.

So, what do we leave here with? Hopefully a lot in these last three days, but the point that I want to bring to home is that this is a HIV conference and one clear lesson that we have learned is that it's dangerous and limiting to be disease specific. The prisons and jail settings is a unique and amazing opportunity for public health interventions. When we do HIV education, we have to include

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Hepatitis, STDs, Tuberculosis, and other health concerns identified by the population.

Okay, so, now that I have my collective audience out there and you've heard me, I just like to just once again thank the organizers and also I would like to personally you to our yearly gathering in California. This brings together public health, corrections, medicals, providers, community and family service providers in one setting, October 20th to the 22nd in beautiful San Francisco Bay area, and for more information about Centerforce programs visit our website. Thank you very much.

CARLOS VEGAS-MATOS: One of the challenges mentioned by Mick Gardner was the need for interrelating messages about HIV and other infections, and that's precisely the topic of our next speaker, Dr. Gail Bolan the Chief of the STD Control branch at the California Department of Health Services, and also a member of the CDC Advisory Committee on HIV and STD prevention, Dr. Bolan.

DR. GAIL BOLAN: Thank you, Carlos, and good morning. Again, I would like to extend my thanks to the planning committee especially Dr. Ron Valdecera (misspelled?). We had many discussions about the challenge of integration of HIV STD and Hepatitis, and I'm pleased to be able to discuss this topic with you today. First of all, as with all processes, there's been a number of discussions about integration and I would like to acknowledge that there's been members of NCSTD, the National Coalition of STD Directors, the advisory committee for HIV and STD prevention had integration

workgroup. Certainly, in the state of California working with the Office of AIDS and working with local AIDS Directors as well as within the STD control branch, and STD Controllers locally has been very helpful to sort of frame this discussion. So, I really would like to say that this has been a group effort for the information that I would like to share with you today.

What I'd like to discuss with you is basically the history as always, it's important to review history and learn from it, regarding integrating approaches to HIV, STDs and Hepatitis, what some of the underlying issues are or have been, sort of the rational, I think people are thinking about now in terms of integration, we'd like to share some programmatic approaches. I notice there's been a number of integrative sessions at this conference, and also currently in the Ottawa at the International STD HIV Research Meetings where I think a lot of people are trying new things and then, lastly, I'd like to discuss some of the challenges and directions I think we're moving towards.

So, first of all, some of you may remember that in 1998 there was an MMWR published titled "HIV Prevention Through Early Diagnosis and Treatment of Other STDS", and I think at that time for many of us, the emerging co-morbidity of STDs and HIV especially among gay and other MSM were not occurring in many areas of the country, and for that reason, I think this MMWR did not receive a lot of priority and ended up mainly on library shelves. There was also in 1998, an MMWR recommendation for prevention and control of

hepatitis C virus, but certainly this in the state of California where there were almost no funds for implementing this recommendations, little were done.

More recently, in the 2002 STD treatment guidelines, MSM has actually been listed as a special population in need of STD screening and hepatitis C was added to hepatitis A and B session for providers, and this is a very important documents that providers use, or at least health care providers use as standards of clinical management in health care settings.

In June of 2002, NCDC and NCSD actually published a policy paper on HIV and STD prevention integration. If you have not read that, I think it's a very good resource that's available on NCDC website, and also the advisory committee on HIV and STD prevention, the work group on STD and HIV integration finally had one meeting in October of 2002, and then lastly CDC has published information on their assessment of syphilis among MSM in eight cities. So, that's sort of the chronological order of things that have been happening more on the national level, and I will say that in NCDC and NCSD's policy document, there was a policy statement that I quote said, "The lack of integration between STD and HIV", and I'll insert and "hepatitis" "prevention services is one of the barriers to more effective programs. Integration is essential for many reasons." The HIV STD integration work group of the advisory committee agreed that integration was important. One of the challenges of integration has been the definition. I think a lot of times when people hear about

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STD, HIV integration they think about organizational structures and merging of programs, and I think what everyone would like to talk about is integration at the client level and allow organizational systems to define the structure that will best achieve this goal. So, the advisory committee work group recommended that integration must happen at the client level first, and it was also acknowledge to many of them there is a lot of recognition that is integration is important, but the challenges have been the questions regarding how should we implement, what are the best practices to use in our local programs?

So, with that, I have a few questions I would like to pose to the audience, we're not going to get answers today. I'm not having audience feedback, but I think it's important to ask yourself these questions because I think if you move forward thinking about integrations you really need to know what perspective you're coming from, and the first question is when the phrase "Integration of HIV STD and hepatitis" is used, what does that mean to you? You think it's important, and if you do, why? And if you don't, why not? Think about successful examples of integrated services in your area, and what barriers have you encountered and did you address them or were you able to address them, and how? And, then I think one of the more challenges questions is how can one prioritize multiple morbidities in the context of our current funding situations and current unmet HIV needs? So, I think this are some very important challenges. Now, in terms of trying to bring diverse groups together, I think we all

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recognize that there have been for a long time different organizational and professional cultures especially between STD and HIV and I kind of put hepatitis on this table in the middle because hepatitis is challenging. Some forms of hepatitis are transmitted through sexual transmission, others through blood borne transmission, and so part of hepatitis relates more to HIV prevention, organizational and professional cultures, and other parts of hepatitis relate more to STD types of organizational and professional cultures.

So, the differences that I think we are all well aware of is that HIV is a chronic infection compared to the STDs that we focus on in our control programs which are the bacterial STDs which are curable infections. Then the other that I want to remind everyone was that hepatitis is our only sexually transmitted disease that we actually have vaccines that we can use to prevent them, but obviously there's been challenges in implementing comprehensive vaccination programs for individuals in need in our country.

HIV has also been focused on more a behavioral and community level, intervention approach. We look at this as sort of primary prevention where the STD model has been more of biomedical case finding approach where the focus was more on secondary prevention, trying to identify infected individuals, insure timely treatment, and implement appropriate management of exposed partners.

Again, HIV's emphasis has been prevention and care, and STD has been more screening and the word control. We all know the

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challenges of the mortality and the stigma of HIV – it's regular confidentiality concerns that have been paramount then we see in STD although I don't want to minimize the confidentiality concerns that many individuals with other STDs also have, but it certainly has led to anonymous testing approaches in HIV that have not been used in STDs programs, and then clearly one of the greatest strengths of HIV has been the ability to have community advocacy and community involvement in planning activity which has not been something that has been easy for STD programs to include.

So, I want to focus a little bit because sometimes there's been a lot of confusion as to why should we care about these other STDS? And, why is STD diagnosis and treatment something that you might want to consider in your tool box of HIV prevention strategies? Clearly, from a biological standpoint, I think in general, studies have suggested that the presence of STDs can increase either HIV acquisition if you're not yet infected or HIV transmission if you're HIV infected - somewhere depending on the STD between two to five times more then if you were having unprotected sex without these STDs being present. Certainly from the standpoint of susceptibility, it makes sense, and I have my little clinical slide to bring here just to sort of reinforce the message that if you have breakdown of normal skin, (unintelligible) with genital ulcers that you're going to be more likely to acquire HIV if exposed. Also if you're HIV infected, you're more likely to shed virus from the ulcers. You're more likely to shed virus in the semen and in genital secretions. So, there are a

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lot of biological reasons why STDs facilitate HIV transmission and deserve some attention in HIV prevention priorities.

Now, the rationale, I think that people are using, for integration services is sort of multi-fold. First of all, I think there's clear recognition that the behaviors that cause STDS and hepatitis also cause HIV and vice versa. So, the transmission risks overlap and many of us are working with risk populations that are in common, and I don't think that it's very helpful from a client perspective if we've got one program showing up at the door one day and a different program from the same department showing up at the door on a different day. So, clearly a much more client centered approach is needed, and I think that some of our highest risk client highlight the need for this integration because their multiple needs. I think we're not only talking, we're mainly focusing on the disease aspects today of HIV, STDs and hepatitis, but it's important to recognize that there's also substance abuse issues, mental health issues, as well as reproductive health needs of the clients that we're serving and certainly from a client's perspective it would be better if services were more comprehensive.

It's also another rationale for integrated services is that the approaches that we use in many of our programs are very similar be it health education and outreach, be it risk and harm reduction, be it testing and treatment, and be it partner management. So, there's a lot of commonalities that we actually have that are another reason to consider integrating services and then lastly especially

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speaking from California, our fiscal imperatives are becoming more paramount or fiscal resources are becoming more paramount for us to identify the most cost effective and cost efficient services to provide in our local areas and to maximize the use of existing resources.

So, the question is why now? Why not in 1998? Why not in 1980?, and I think that for many of us, we recognize there's a lot of overlapping comorbidity in patients that we're serving these days. I think we also recognize that some of the traditional tools that we've used especially in STD control are not as effective and are not working and we need some innovative strategies, and then also the fiscal realities are making us relook at how we are implementing our programs.

I would like to just briefly share with you sort of the intersection of comorbidity of STDs in California for those of you who weren't able to attend some of these sessions, what you're seeing here is the rates of primary and secondary syphilis by gender in California from 1992-2001. We seen a substantial increase among men, and we've analyzed the data. This increase is predominately among gay and other men who have sex with men. We also collect self-report information about HIV status in our syphilis cases only because those are the cases that we prioritize for case management and partner follow-up, and we've seen a significant increase of the number of syphilis with infectious primary and secondary syphilis in the past few years that are co-infected with HIV. In the year 2002, by the end

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of 2002, about 60% of our primary and secondary syphilis cases were co-infected with HIV. We also recognize that patients are being seen in a variety of settings, and it's not the STD clinic anymore. It's probably because STD clinic are being consumed by managed care, at least on the West Coast. So, when we look at the data in California, only 15% of our primary and secondary syphilis cases were actually seen in the categorical STD clinic. So, if you're going to sit in your STD clinic and wait for the patients to show up, you're going to miss the vast majority of syphilis cases that are in need of intervention.

We also looked at reasons why patients with primary and secondary syphilis were presenting to their provider, not surprisingly, because this is the symptomatic form of syphilis that about 72% presented with symptoms, but it's also important to recognize the department of health, DIS intervention reaction was able to bring in 7% of these symptomatic cases, and we also recognize that partners can be informed by the index clients that they need to go in and get evaluated for syphilis. So, about 3% of these symptomatic cases came in for care because their partner had told them that they had been exposed to syphilis and they needed to come in for evaluation.

We also know from our syphilis case management interviews that a number of risk factors are merging in our syphilis populations. We know the vast majority of syphilis cases right now have anonymous partners. Now, again, I think we've had to redefine

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what we mean by anonymous, in STD that used to mean that you needed name, locating information, telephone, or whatever. Some clients actually know their partners, know that they'll be at a certain venue on a certain day, but may not know their name or may not know where they live. So, from the standpoint of the client being able to follow the partner, that is a strategy we need to look at. The ability to of the health department actually to find that partner is compromised.

We also have seen the Internet as an emerging venue where people are meeting partners as well as commercial sex venues. At least in California methamphetamine is the most common substance abuse that's associated with syphilis, and we're also hearing a lot of anecdotal reports in addition to seeing a lot of Viagra wrappers in commercial sex venues that there's an association of methamphetamine use and recreational use of Viagra. Again, we've just begun to get a better handle on how common this problem is.

So, as a result of these emerging risk factors among MSM with primary and secondary syphilis, some of our traditional control efforts have certainly been challenged, and I bring my little cartoon to share with you and I want to highlight that if you can't tell your mom or your partner who your partners certainly trying to look at partner notification as a strategy for informing people of the need of treatment and testing is not going to happen.

We are now starting to look at some innovative ways of using the Internet, of using commercial sex venues as venues where we can offer opportunity for intervention. I also want to say because

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we don't have information on our Chlamydia and gonorrhea cases. We don't interview gonorrhea and Chlamydia cases. We have a case base reporting system that gives us very limited demographic information. We don't know how much comorbidity exists among gay and other MSM for those STDs. I will say that based on problems that we've had with clinical resistance in California where we actually followed up on resistance cases, we're seeing similar profiles that we're seeing with MSM of our 24 resistant cases had occurred from July to December of 2001, 16 were men who had sex with men. Of those, six were HIV positive, most had many anonymous partners, and many had not traveled to endemic areas implying that the problem among the gay and other MSM community was already endemic.

So, encourage people when you talk about STDS and you talk about hepatitis not to focus on one STD, not just to focus on syphilis, but to look at all sexually transmitted diseases or infections when you're integrating your programs.

So, now let me turn to sort of program components that you might want to think about in terms of integration, areas we might want to consider in integrating. Certainly, there's surveillance system and data systems that can be looked at to have better integration information that can be used for program planning and evaluation, risks assessment, prevention messages, prevention interventions, screening and testing, treatment and care, partner counseling and referral, outreach and venue based activities,

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vaccination and then program planning, school risk curriculum and guidelines.

So, let me just highlight some examples of types of intervention that people are considering or actually have implemented around the country that you might want to consider, but first I'd also like to say that this is not just a public sector problem, and again we really need to embrace a collaborative public and private partnership to look at these opportunities for integration. So, I encourage local health departments to look at STD clinics, CIP clinics, family planning clinics, counseling and testing sites, mobile vans and other outreach sites to look at what could you do in terms of integrating STDS, HIV and hepatitis. Community-based organizations and non-governmental organizations need to look where they have opportunities for integration. Drug treatment facilities, we just heard about the excellent work that Centerforce is doing in correctional settings. Primary care providers especially those providing HIV care need to look at opportunities as well as commercial sex venues and Internet providers.

So, that gives us sort of some examples of program integration. In surveillance I think we need a better understanding of the characteristics of newly identified HIV positive persons and those unaware of their status. It's probably more important to focus on current risks rather then how they may have acquired their HIV ten years ago, and we can do this by expanding our data elements that are collected on case reports forms. There's also prevalence monitoring

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programs and population based behavioral and social surveys that I think need to be considered.

In the interest of time, I'm going to go quickly through the next opportunities. In terms of risk assessments, I think it's important to incorporate comprehensive sexual history taking and risk assessments and healthcare settings which may be surprising to some of you, but is not commonly occurring especially in the private sector, think about the last time you visited your physician and was a comprehensive sexual history obtained, but it's important that we provide the providers with tools and training to be able to do this. We also need to have risk assessments and drug treatment programs. It's important that many drug users are sexually active and that many infections are actually transmitted through sexual exposure and not through needle sharing. And, it's important that STD screening be conducted as part of your HIV risk assessment because if you identify an individual with STDS, that is a marker of someone who is at risk for potentially transmitting HIV.

In terms of prevention messages, we need to incorporate our STD prevention messages into HIV prevention messages into prevention and care programs. It's important to emphasis the roles of STDS in facilitating HIV transmission, what the symptoms are, the need for coming in for testing, if you're considered about exposure, and partner management, and it's also important to incorporate HIV prevention messages and STD and hepatitis programs and to integrate these messages into school curriculum and other guidelines.

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I'd like to highlight some areas where people can consider screening and testing. I think it's important that when you're offering STD screening, be comprehensive to include syphilis, gonorrhea, Chlamydia and possibly herpes, unless you find low prevalence, and that the yield is not very low then you can discontinue comprehensive screening. There's opportunity to link with rapid HIV testing programs now, and also I think it's important to think any time you're doing outreach, is there the possibility to add comprehensive screening programs to your work in the community, in sex venues, or other outreach settings.

I would also like to say that partner counseling and referral services I think could be better integrated. They provide an important bridge between prevention and care services. I think it's important that all STD patients receive partner referral and counseling services as well as HIV infected individuals, and again we need to identify the best staff to offer these services. It may be the health department. It may be a community-based organization, and we need to provide them the appropriate training and technical assistance. And, again in terms of moving on to program planning, I think it's important to integrate your goals and objectives, your policies and procedures, and assure timely distribution of information to communities, to partners in need, and to identify areas of common concern. So, with that I've run out of time and let me stop with my concluding statement where I would like to conclude that the integration of HIV, STD, hepatitis services may increase

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comprehensive services for clients, provide an important link between prevention and care, and identify HIV infections and help reduce HIV transmission. Thank you very much for your time.

CARLOS VEGAS-MATOS: One of the key issues facing us today is how to decide to invest the limited dollars that we have, and for many of us working with community based organizations how we limited resources in effective and evident ways HIV prevention programs. For that purpose, Dr. David Holtgrave Professor of Behavioral Science at Emory University here in Atlanta Georgia will help us answer some of these questions. Thank you.

DR. DAVID HOLTGRAVE: Nelson Mandela, the former president of South Africa defines a hero not as someone who's a head of state or a celebrity, but rather someone who works everyday to improve social justice and better the lives of other persons. I think that work that each of you do meets that definition, and so it's a great honor to be able to address a room so filled with heroes today.

With my time, I'd like to address three major issues. The first is to look to the past and ask the question "what have our HIV prevention efforts so far in the US gained us at the national level?" Secondly, to look at CDC's national goal of reducing new infections by half by 2005 and ask about the consequences of meeting or failing to meet that national goal, and third to discuss the effectiveness and to assess the different programs, resources and policies that may be necessary to reach this national goal.

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I'd like to start on the first point by looking at this slide which in pink shows the HIV incidence curve in the US since the beginning of the epidemic. So, that curve plots the number of new HIV infections a year, and we peaked at about 160,000 new infections a year in about 1985, and dropped down to about 40,000 infections a year throughout the 1990s. Of course, there's considerable uncertainty about that 40,000 a year and what it is precisely. Nevertheless, there was a significant drop in the number of new infections, but that alone doesn't tell us how many HIV infections we've prevented in the US, rather we have to look at what would have happened had these programs not been in place, and you can see the other curve here looked at what might have happened if the epidemic had dropped down from it's peak but then stayed flat at say 125,000 infections a year. Well, we looked at four different very conservative scenarios about how the epidemic might have unfolded, and we estimate that somewhere between 204 and 1.5 million HIV infections have been averted in the US due to the efforts that have taken place in the parts of governmental efforts, state and local health departments, community based efforts and voluntary and private sector efforts. And, even though over ten billion dollars has been spent so far since the beginning of the epidemic on HIV prevention we can see that the cost for infection diverted is between 6,000 and 50,000 dollars. When we compare that to the medical care costs of HIV and AIDs, we see that these efforts have actually been cost saving to

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society. So, not only have we averted enough infections to fill a good size US city, we've actually done so in a cost saving way.

Now, have the prevention programs caused this change, or is it just the natural history of the disease? I think it's the programs because the pattern of HIV incidents without interventions that we've seen perhaps in other countries, has not unfolded as seen in the US. And, also I say this as a scientific and budgetary reason, on the slide you can see the HIV incidents curve again plotted in red, and over top of it I plotted the CDC's HIV prevention budget simply adjusted for inflation, and what we see is our investment as a nation went up, the number of new infections went down, and we stopped investing more and more into prevention efforts so to did the number of new infections stall out. I call this slide the "you get what you pay for" slide.

When we look at the science also, which tells us whether or not interventions make a difference, we can see that there's very good evidence of effectiveness of a specific HIV prevention interventions. From the world's best medical and public health journals, from NIH's Consensus Development Conference, to the CDC's prevention research synthesis project and I'll come back to the compendium issue later on and a variety of other documents. What do these documents tell us? Well, they actually say, and this is a paper from Bernard Shwartlander (misspelled?) it says, "A number of interventions have very good science to support them. For instance, teacher training or peer education, male or female condoms, condom

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promotion and social marketing, treatment of SDIs, counseling and testing, workplace programs, transfusion screening, prevention to mother to child transmission, mass media campaigns, harm reduction programs and peer counseling." And, even more recently there's been a paper by Dr. Albert Ferry (misspelled?) at CDC and colleagues published in Nature Medicine, which examines the science of all the interventions you see here on this slide, and I think it's important to note that for instance, with sexual transmission this paper reports that the science is good around small group and community levels and other kinds of interventions as well.

Not only are these kinds of interventions effective, but we can also look at the economic evaluation literature and find that these efforts are also cost saving, and on this slide you see here for men who have sex with men, men who have sex with men and/or women, at risk women, injection drug users and STD clinic clients, a number of different kinds of interventions that are actually cost saving to society and when we compare the HIV prevention effort to a number of other kinds of medical interventions such as kidney dialysis, mammography, different treatments for coronary artery disease and so, we see that HIV prevention especially targeted HIV prevention, extremely favorably in terms of cost per year of lives saved.

Another way to look effectiveness is on this slide. Instead of looking at incidents, I've plotted here the estimated HIV transmission rate. Well, what's that? It's the number of new HIV

infections per year divided by the number of persons living with HIV in a given year, and what we see is that it's sprout from about 25% in the mid 1980s to now it's about 4.2%, and what does that mean. It means that over 96% of persons living with HIV in a given year, do not transmit HIV to someone else. So, very important research is for us to ask when the remaining transmissions do occur what societal conditions have led to that? Is it homelessness, substance abuse, poverty and other conditions? And, we need to intervene on the person living with HIV and the sera negative partner to address this in a comprehensive way.

Now, that's talking about the past, what about the future when we look at our national goal? The national goal has been talked about very much this week and you see it on this slide, perhaps not enough attention this week has been focused on the second part in blue, focusing particularly on eliminating racial and ethnic disparities in new HIV infections.

Now, we can see on the next slide simply a graphic version of the national goal that shows us that time is running out. The goal was set in 2001, we're halfway through 2003 on our way through 2005 and we're still at about 40,000 new infections a year. So, this is an extremely urgent issue.

On this slide, we recently did this study at Emory where we looked at from the years 2001 through 2010, what if we continue our current pace of roughly 40,000 infections a year, and how would that compare to if we actually met the national goal and reduced new

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infections to 20,000 by 2005? And, we'd simply compare this two scenarios, the planned infections versus actually meeting the new goal, or meeting the goal, and we found that if we don't meet the national goal throughout the rest of the decade an extra excess 130,000 people will become infected by HIV by 2010. That's roughly enough people to fill three baseball stadiums and this will incur at an additional cost of care and treatment of eighteen billion dollars, and that's roughly enough to fully support the global AIDS fund for two years. So, the human and fiscal consequences of failing to meet the national goal are incredibly substantial, and when we here epidemiological information at the recent retrovirus conference and also newer, updated information that's been reported this week from 25 states that report HIV diagnosis, one of the things that we actually see is that new cases from 1999-2001 in those states was up by about 8%, more up in men who have sex with men, and probably down actually just a bit in injection drug users. Well, what this tells us is the epidemic is probably not going down in terms of numbers of new infections a year. Whether it's staying the same or going up, a little hard to tell, but it's probably not going down. We should be moving up toward the national goal.

So, given that, what do we need to do to try and move toward our national goal of reducing new infections by half by 2005? I think we need a truly comprehensive program that has several pieces to it. We need the surveillance including incident studies, program, capacity building, evaluation, research, and policy and planning, all

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of which are incredibly important, and I think we can look perhaps not to the announcement of the recent initiative by CDC, but a little bit further back to the paper called “The Safe Initiative” that was published by CDC a couple of years ago. The sero status approach to fitting the epidemic, and in that paper, it noted that when we talk about HIV prevention services, we always must customize them to the needs of the clients considering their sexual orientation, substance use history, race, ethnicity, geography, and quite a number of other factors including the factor of the HIV sero status, and that paper pointed out four different kinds of populations – persons who are unaware of the sero status, persons who test negative that are at no apparent behavioral risks, and on a slide I’ll show in a minute, persons who test negative but are high risk for infections and persons who test positive. Well, what kinds of services are appropriate for each of these four different kinds of populations? I want to just throw out some ideas. I know each of you working in this field would have other ideas as well. For persons who are unaware of their sero status, we need to provide current, essential HIV information and we need to encourage HIV counseling and testing utilizing the best available methods, and I say counseling and testing because I think the literature shows that those two together are very strong prevention service, and too often this week we’ve heard the word testing and counseling disappearing off of slides and out of discussions. I think that medical system in the US is too busy

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for counseling, we need to address then and fix the medical system instead of throwing away counseling.

For persons who test negative but are at no apparent behavioral risk, what a great opportunity in time to equip those persons to be carriers of HIV prevention messages to family, friends, children and partners and that goes hand in hand with the other point earlier in the slide, that we need across the board to address stigma of HIV disease and stigma associated with simply receiving HIV related services or going to a clinic in which the HIV or AIDS simply appears in the title of that clinic.

Now, for persons who test HIV negative, but are at high continued risk for infection, we need HIV counseling and testing customized for persons who are testing repeatedly. If someone's a continued behavioral risk, they may and should probably be tested again over time, but that needs to be part of the counseling. Also, time including in the CDC's compendium of effective intervention that intensive, individual, small group and community level interventions can really make difference for changing HIV related risk behaviors, and we also need linkages to STD, substance abuse, mental health, hepatitis, and social services as needed as well as prevention case management and structural interventions such as providing the scientifically sound and cost effective service of access to sterile syringes and needles.

For persons who test HIV positive and are living with HIV, first and foremost the services need to be informed by communities of

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persons living with HIV, and we also need to keep in mind that about two thirds of persons who test positive upon receiving counseling and testing and their test results change their behavior to the point of not transmitting HIV. In addition, that says we need to especially focus on providing intensive prevention services for persons who are for whatever reason, for homelessness or other reasons aren't able to change their risk behavior at that particular time and before this conference there was a two day meeting sponsored by NIH, CDC, and (unintelligible) in which they went over the science of a large number of studies that are now under way about how to best to provide prevention services for persons living with HIV. I think that the studies are showing that in some cases their interventions have a favorable effect, in other cases a mixed effect, in some cases they weren't successful and a lot of studies don't have data yet. So, I think it's hard right now to come up with very good best practices for this area. It's an area that we need to watch carefully, and it needs to be informed not only by scientific studies, but public health practice from the front lines and we need a lot more consultations and discussions about best practice in this area.

We also need to provide partner counseling and referral services, linkage to medical care and treatment, STD, hepatitis, mental health, substance abuse treatment, housing and social services as appropriate, prevention case management, structural interventions to avoid discrimination, and I would like to also note that in the case of perinatal transmission which is part of CDC's initiative, we

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need to get from that 300 new cases a year down to zero, but that's not going to get us very close to our national goal of reducing new infections by half. I think what we might be better off doing is looking to the public health literature on disease elimination and eradication such as has been done in polio and small pox and other areas where to get down to a zero with a particular kind of disease or a particular kind of transmission, we set aside a very special program and allocate special funds for that. So, I don't want to say that we need to deemphasize this, but it's not going to get us to our national goal of reducing new infections by a half. We need to make this a special program and devote special resources, I think.

So, I wanted to emphasize again, we need a comprehensive program that goes across all of the types of services that I've mentioned here. Also we need prevention and treatment and as Dr. Del Rio said earlier in this week, although there's theoretical reasons to suggest that HIV treatment might lead to decreased transmission, at the community level that may not necessarily be so, and we covered that point earlier. So, I will simply emphasize the need for HIV treatment and prevention.

I believe that we also need to look at structural factors, and at Emory, we've been looking at poverty, income and equality, and social capital as predictors of several types of STDS, AIDS cases and also TB, and we find that at the state level, we can predict very large amount of the variance by looking at social capital or social

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connectiveness and also variables of income and equality and poverty and these need to be addressed as well.

Now, I have just about four minutes remaining, and what I'd like to do in that time is talk just a bit about the resources that we need to fund these kinds of programs and also the policy environment that would be necessary as well. How much CDC's prevention budget at least as of fiscal year ago or so was about seven hundred million dollars give or take. Well, I think that we need about an increase of another three hundred million dollars, and let me say why. This is based on some cost analysis that I've been involved in. When we look at CDC's plan itself, it says that adequate resources to address all the unmet gaps and needs are not available and that these activities would require an additional public investment of three hundred million dollars. That's from the Safe Initiative paper that I mentioned earlier. Now, there's really two studies in the literature that come to very similar figure of roughly three hundred million dollars a y ear more being necessary. One is the safe paper, and the other is the paper I did with Mike Murcin (misspelled?) I did at Yale, and Steve Pinkerton in Wisconsin, and what we did in that paper was look at the number of persons at risk of HIV infection in the US, and a very cautious estimate is it is about five million people. Now, that's probably a very, very low estimate and probably an underestimate but based on the literature nonetheless. And, we looked at what it would cost to provide science based HIV prevention services to everyone who may need them in the

US, and what we found is that the figure is between eight hundred million to 1.8 billion, but that's if you did it all at one time, all in one chunk. If you took the midpoint of that estimate and divided it over four years, you're back in a figure of roughly over three hundred million dollars a year. So, when I say that this amount is necessary, I say it based on some very careful two peer reviewed cost analysis that have been done trying to address unmet needs.

Now, in my last three slides, I wanted to mention some prevention barriers or policy barriers that I think also need to be addressed to create the environment for these kinds of services and programs (unintelligible). We, of course, have inadequate resources in the US to serve all at risk of infection. We have the needle and syringe exchange ban. We have misinterpretation, I think, of a recent NIH condom report. We have scientific information being removed from federal websites for long periods of time. We had a recent CDC sponsored conference in December of last year. We heard from some external consultants some specifically significantly and very negative attitudes expressed towards gay youth and men who have sex with men. We have prevention burnout still in the US, and we need to address the ongoing issues of racial and ethnic discrimination and HIV related stigma. Also, I think that we have value that are sometimes crowding out science, and I want to emphasize a couple of points very briefly. One is that we need to use the science that's available. For instance in the HIV Prevention Compendium, and whether you're directly funded or indirectly funded shouldn't make a

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difference whether or not you can use a lifesaving intervention. I also think that we consider some of the comments recently heard about gay men and gay youth that we have to look to the American Public Health Associations code of ethics in global declarations of human rights which demand for everyone respect and access to necessary medical and public health services without discrimination, and I would submit that value statements outside of the bounds of these ethical systems should be disregarded by public health agencies.

Finally, I only have thirty seconds to go, but I want to show one last slide, which is I think we can ask the question when we end or reduce new infections by half in the US, is that matter of national skill or will? I think as a nation, we know basically what needs to be done, we know basically what it will cost, but we've not yet made manifest our desire to do that, and you can see here a quote from the Reverend Martin Luther King that the ultimate measure of a person is not where in stands in moments of comfort, but where he stands in times of challenge and controversy, and I think that recently in Georgia, we saw passing of some key civil rights figures, former mayors Ivan Allen and Maynard Jackson and former governor Lester Maddox, and all were civil rights figures for better or for worse in some cases, but when all of them were remembered recently and eulogized the first thing that people remembered is what they do when faced with social injustice? I would argue that failure to use effective, science based HIV prevention interventions at a level of investment necessary to meet the really needs of persons at risk of

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infection or transmission or living with HIV, it's public health malpractice, public health malpractice is social injustice, and so too we will be judged in the future by how we respond to this particular situation. Thank you for your work, and thank you for your time.

CARLOS VEGA-MATOS: Thank you, Dr. Holtgrave, David. In my years of working on HIV prevention and services, it's hard to come across a behavioral science that can articulate in very simple lay succinct terms how to address this ineffectiveness of our programs, and articulate the cost effectiveness of the programs that we currently are working. Speaking of challenges and ways of responding, or the ways in which many communities have responded to the HIV epidemic, we'll have Harry Simpson, Director of Substance Abuse Services for the Community Health Awareness Group of Detroit, Michigan. He will talk to us about HIV prevention among injection drug users, and effective strategies for prevention.

HARRY SIMPSON: Thank you, good morning. Good morning! My name is Harry. I'm from Detroit, Michigan, and I'm sure that all of you will agree with me of course that Michigan is the greatest state in the country. Some of you know me, and some of you don't, so I think it's important that I share a couple of things with you that not only will you know a little bit more about me, but you'll also would know what perspective I bring to this discussion this morning.

I begin using drugs during the summer of 1968 as an 18 year old tank crewman in the Republic of Vietnam. When I returned from

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that country a year later, I had a purple heart for wounds received in battle, an army commendation medal for valor under fire, and a heroine addiction that controlled my life for the next 14 years. Every hour, every minute, every second of every day I was consumed with an overpowering need to feed the monkey that was on my back. It was not a matter of getting high for me. It was a matter of survival. I thought I would die if I didn't get that next fix. I shot dope each and every day, several times a day. Most of those days, I would cop and then go to the shooting gallery to inject. The needles and syringes they had there were never new. They sat in a glass of pink blood-tainted water in the middle of the table. I never carried needle or syringes with me because you could go to jail for possession of paraphernalia if you got caught with them. So, I got my works from wherever I can get them. I got them from other users. I got them from street sellers, wherever. Most of the time, the works that I used to inject were used with someone else, or they had been used by someone else. I knew this was dangerous. I had heard about hepatitis and abscesses and all kinds of danger, later on about HIV and AIDS, but those were not things that were high on my list of things to worry about. Anyway, after several failed attempts at recovery, I entered treatment for the final time September of 1984, and in a few months, I will be celebrating my 19th continuous year of sobriety.

I'm telling you this story so that you can put a face on all the suffering users who are not here today to speak for

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themselves. Users whose lives are in grave danger because they are injecting with used, possibly contaminated syringes. I have been asked to speak this morning about a subject that I have spoken about many times in many different places, sometimes with anger, sometimes with frustration, and sometimes with a sense of accomplishment. I'm sure that some of you, many of you, most of you, have had similar feelings as you too have had to try to deal with the dual epidemic of HIV and hepatitis C among persons who inject drugs, and that brings me to the subject of my comments this morning and that is the good and the bad news about HIV and hepatitis C prevention for injection drug users.

First, some of the good news, between 1994 and 1999 there was a significant decrease in HIV diagnosis among injection drug users. According to a recent article published in the MMWR, which we've heard a lot about, that looked at HIV surveillance in 25 states that have case reporting, HIV diagnosis among injection drug users declined by about 42% overall, and this was consistent with findings from others who saw similar decreases in prevalent in incidents in New York City, New Jersey, Chicago and other parts of the country, and though there are surely a number of reasons for these declines including advances in retro therapy and reductions in HIV risk behaviors, it is also certain to me anyway, that effective prevention programs were and are an important factor. That's the good news, really good news because it means that you're prevention efforts have not been in vain.

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The bad news is that after several years of decline there was an 8% increase in HIV diagnosis in those same 25 states in the year 2000 and 2001. Although this does not necessarily indicate that we're headed for more increases, it does suggest at least to me, that we may be in fact experiencing a comeback. There could be, again, a number of reasons for this resurgence. I've heard that it may be kind of a rebound effect similar to what was seen in gay men when after the HIV related deaths declined, some returned to risky sexual practice such as barebacking, and some would say as a result of that, there was increases in sexual transmitted infections especially syphilis. Or, it may be that the increased HIV cases are related to drug changing drug use trends. New Jersey for example saw between 1992 and 1999 an increase in the number of people who reported injection drug use as their usual mode of using drugs. The greatest increases as you see here were reported among individuals between 18-25 years old. New Jersey also increases in heroine use by injection by youth in their suburb and rural areas. Now, this is especially troubling to me because suburban injections exhibit very high levels of injection risk behavior. One study that was published by Forbe (misspelled?) and colleagues in 2001 showed that 63% of the suburban injectors in the study had shared needles in the previous six months, that's the highest level that was observed during the 1990s. Now, these suburban youth may well be the next wave of HIV and hepatitis cases, and I think that's bad news because we may not be ready for that. But, there is still more good news.

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Because there is now still increased legal access to syringes in many parts of this country – New York, Rhode Island and Illinois, for example, now have legal access to syringes. There has also been in this country and important recognition that access to sterile injection equipment is a much broader issue then just needle exchange alone. We're seeing changes in laws, local ordinances, and also in policy guidelines. That's good news because more access to legal syringes will reduce sharing behaviors and prevent more disease and death. I can't think of a better example of that then New York City. New York has you will recall, had the highest number of HIV and AIDS case among injecting drug users in the world and a prevalence rate of 50-60% from 1980-1990. Through 2001, New York has experienced an 80% drop in new HIV infection cases among injectors presenting at Beth Israel, 80%. I don't know of any other intervention that can make that claim. The authors of the study including Don Dayjerle (misspelled?) who provided me with the slides attribute this reduction to legal access to syringes, increased funding, and expansion of syringe exchange and an increase in voluntary HIV testing. In fact, when you compare the number of syringes exchanged in New York from 1990-2002, which you see on the top slide, to the decrease in HIV incidents and prevalence during the same period which you see on the bottom slide, it becomes obvious that the two are related. That's good news. An 80% reduction in HIV incidents and prevalence among injectors as a result of legal syringe exchange. The bad news is that there is no access to syringes in most

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areas of this country, partly because of funding, partly because of apathy, partly because of fear, and partly because of ignorance. Even today, in spite of exhaustive scientific evidence showing the effectiveness of syringe exchange for preventing disease transmission, federal funding of needle exchange is still prohibited. As a result, these lifesaving prevention programsw even when they are available are underfunded and totally dependent upon their ability to acquire private and local funds. They are forced to raise these funds in an environment where private funders have decreased their giving and the budget crisis in state and local budgets across the US have caused a dramatic reduction in public funding of all prevention programs including those targeting drug users. Now, I'm not going to belabor this point, but I've said it before and I think it's important enough to say here again. We need federal funding of syringe access programs in this country. We needed it yesterday. We need it today, and we will need it tomorrow. It will not go away just because you refuse to talk about it.

There has also been, I think, a tendency for communities to hang their IDU prevention hats on needle exchange. The going sentiment seems to be that if we have needle exchange, then we have this IDU thing covered, and if we don't have needle exchange, then we've failed. Neither is correct. There are, in fact, many other ways to help injectors reduce their risk including drug abuse treatment. Drug treatment is effective HIV and hepatitis C prevention, and it needs to be available on demand whenever and wherever it's needed.

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Let's turn our attention to hepatitis C for a minute. The good news is there were only 30,000 new hepatitis C in the year 2000. In fact, that was a dramatic drop, there was a dramatic drop in the US, incidents of hepatitis C from an estimated 240,000 per year during the 1980s to only 30,000 new infections estimated in 2000, and 60% of these infections occurred among persons who inject drugs.

Now, again, the reasons for the decline aren't well understood, but I believe that it is a result of intensive sustained prevention efforts, and that those efforts play an important role in the decrease, and again, that's good news.

The bad news is though there were 17,000 new hepatitis C infections among drug users in the year 2000 and that is 17,000 cases too many given that hepatitis C is preventable. Still more bad news, the sero estimate rates continue to be very high. There is still uncertainty about exactly how to prevent transmission of hepatitis C and there is low use of existing hepatitis A and hepatitis B vaccines for injectors, and that's bad news.

But, some more good news. Dr. Richard Garfein (misspelled?) reported earlier this week that the prevalence of hepatitis C among 18-30 year old injection drug users in seven US cities was lower at 36% overall then what was seen in earlier studies, while the prevalence of HIV in that same population was much lower at 3.7%. People who had been injecting for about four years, which indicates that there is a longer window between and viral infection then was originally thought. That's good news again because it means that a

large number of young injectors can be accessed before they are infected with hepatitis.

A little bit more bad news. Dr. Garfein (misspelled?) also reported that these same people had multiple risks for hepatitis and HIV. Half are sharing syringes, 72% are sharing cookers, cottons or rinse water, and nearly all are injecting with other people, while only 40% use needle exchange programs. So, not only are more young people starting to inject in New Jersey, they may also be adding increased risk of HIV and hepatitis C because of the increased risky behaviors.

And, the final piece of bad news, IDU's as we've heard are at very high risk of co-infection with HIV and hepatitis C. That means that there may be some faster progression and more severe hepatitis C related liver disease, faster progression to AIDS, a lower response to therapy, and a great risk of heart related, liver toxicity especially if they have genotype one. That's bad news.

What's the good news this time? Well, for one thing, improvements (unintelligible) hepatitis C including the possibility of a cure. There are now three FDAs approved therapies for treating hepatitis C in adults. There has also been in this country an increased recognition that drug injectors can and should receive anti-hepatitis C treatment. The bad news is that hepatitis C treatment is not available to everyone. It is only effective less than half the time. It often causes severe side effects, and it's very, very expensive. Now tell me, how is a person whose life is

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severely impacted by years of drug use going to pay $18,000 plus a year for treatment? How would you pay for it? If you have that little plastic card in your purse or your wallet, and how would you feel if there was a life saving treatment out there that could save or improve your life and you couldn't get it because you didn't have insurance? Would that be okay with you? It wouldn't and it wouldn't be okay with me either, yet that is exactly what we're telling people all over this country everyday, and that's bad news. It has to change and it has change now. We need to get people access to treatment for hepatitis C.

Some more good news, we have a new prevention strategy that seeks to increase the effectiveness of prevention programs. That's good news and I know you'll agree with me about that because we all want to do a better job of preventing disease transmission. The bad news is we have a new prevention program that seeks to increase the effectiveness of prevention programs, but we don't yet know what it's impact will be on existing prevention programs. We don't know what or how much money will shift from primary prevention, and we don't what will happen to the interventions that were funded with these transplanted funds. Now, we heard Dr. Valdesary express publicly CDCs commitment to make sure that the infrastructure, the prevention infrastructure is not dismantled and we expect CDC to stand up to that commitment.

Of course, it's important that we focus more efforts on our brothers and sisters who are living with HIV, but our efforts need to

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be focused more on how we can help them stay healthy and alive then looking at them as vectors as disease. That's enough news for now. Let's talk about how we can do to prevent further threat of HIV and hepatitis C among injection drug users. First of all, our efforts must be comprehensive, and I'm going to go through these pretty quickly because we've heard all of this before. It must be comprehensive, and they must be integrated, and they must use multiple strategies to reach drug users. They must also be better collaboration among the different worlds of substance abuse, mental health, and HIV prevention and treatment programs. The comprehensive approach to HIV and hepatitis C prevention must include all of the things that you see here including prevention of drug treatment and access to drug treatment, more services in jails and prisons, and more services for persons who are co-infected with HIV and hep C. A comprehensive approach alone is not enough. As we heard previously in this panel, our services also must be integrated. That means that pulling HIV, AIDS, STDS and substance abuse programs into a seamless delivery system that reaches drug users whenever and wherever they present for services. To borrow our quote from our friends at the National Alliance for State and Territorial AIDS Prevention, it would be a huge disservice to clients who may have multiple risk and/or morbidities to focus on a single disease rather then to view clients as whole human beings.

Let me make two final points before I close. First, these are not just drug users we're talking about. We're talking about our

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brothers, our fathers, ours sisters, our mothers, our friends, and our loved ones. They are people just like you and me, and just like you and I they have to right to effective treatment regardless of their willingness or ability to abstain from drugs, and their ability or inability to pay for that treatment. Secondly, we can, we will and we must do a better job of disease prevention among drug users, but we need more resources to do it. My message to those who have the money is that we need more money. I think – did you all hear that? We need more money! And, for those of you from community, I think that the real problem is that we have done so much with so little for so long until now we're expected to do the impossible with nothing.

Let me close with a message a personal message from me to all of you who are working in prevention. There are those who suggest that are HIV prevention efforts have failed because there are still 40,000 infections in this country each year, and that's bad, but I think the larger question is how many new infections in this country would there be if our HIV prevention efforts did not work?

I started this talk expressing the anger and frustration that many of us often feel as we deal with the dual epidemics of HIV and hepatitis C. It has been for many of us, and it still is a frustrating time. Sometimes you've got to do your work with little or no funding, sometimes you've had to do it while looking over your shoulder for the police or the big bad boogeyman that requires you to give abstinence only messages rather then lifesaving messages about safer sex and injection practices, and sometimes you've had to do it

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against the seemingly insurmountable obstacle of public policies that have everything to do with politics and nothing to do with public health, but in spite of the anger, in spite of the frustration, and in spite of the lack of funding, you have successful delivered effective HIV prevention programs in this country, and I celebrate with you those successes. You have made a difference in the lives of people all over this country, but we must also recognize that the work is not yet finished, and that there is still much to be done. We can not afford to rest on our successes because people are still dying, people are still shooting drugs, and people are still at risk of getting or transmitting HIV and hepatitis C. So, as we celebrate our successes, we must also honestly assess where we have been, where we are now, where we are going, and how we are going to get there, and for me, that means that we must be open to new ideas and even to new strategies, even when they are contradictory to what we believe. We don’t have accept them, but we should be open to them. Again, I would like to thank the organizers of the conference for inviting me, and most importantly though, I would like to thank each of you for caring enough to keep fighting for drug users even when they were unwilling or unable to fight for themselves. Thank you.

CARLOS VEGAS-MATOS: Thank you to all the speakers.

[END OF PRESENTATION]

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