

Composed of more than fifty organizations, the Caucus for Evidence-Based Prevention will monitor the use of evidence in HIV prevention programs and policies at the IAC, report on HIV prevention-related conference proceedings to a wide audience, and alert the community when ideology, prejudice, or opinion interfere with evidence-based approaches to reducing the further spread of HIV/AIDS.

## Promoting HIV Prevention Supported by Sound Science

### Presentations to Watch for Monday:

State of the AIDS Epidemic Plenary  
Session Room 1  
9:00-10:30

Vaccines and Microbicides: Where Do We Go From Here?  
Session Room 1  
11:00-13:00

HIV and Health System Reform  
Session Room 1  
13:15 - 14:15

Male and Transgender Sex Workers:  
Session Room 4  
16:30 - 18:00

Prevention Works: What's the Evidence?  
Session Room 5  
14:15 - 15:45

# Caucus for Evidence-Based Prevention

Founded by SIECUS, PAI, and amfAR

AUGUST 4, 2008 Issue 9

## Welcome to the XVII International AIDS Conference

Welcome to Mexico City. The newsletter in your hand—or the one you just summoned to your computer screen—was produced by the Caucus for Evidence-Based Prevention, a collaborative of more than 50 U.S. public health organizations which advocates for the primacy of scientific evidence in executing, evaluating and funding HIV prevention. Because the XVII International AIDS Conference is the largest forum ever to explore the frontiers of HIV prevention, the Caucus is eager to serve delegates and a growing electronic audience following Conference proceedings from Bangalore to Boston.

Founded a year before the Toronto International AIDS Conference in 2006, the Caucus was a response to the ideological chill felt by many in the HIV prevention community. Over a period of months, reports of political influence surfaced among researchers dealing with vulnerable and stigmatized groups, including men who have sex with men, commercial sex workers, and people of color. Government funding was scrutinized, federal researchers' participation in conferences was curtailed, and the merits of scientifically proven prevention methods, such as latex condoms, syringe exchange, and comprehensive sexuality education were interrogated by ideologues who prioritized personal belief over scientific fact. Further frustrating the prevention climate was Federal support of abstinence-only education—still a significant line item in domestic and global AIDS budgets despite the lack of evidence that it reduces HIV infection.

As we prepare for Mexico City, the prevention landscape has become even more volatile: the reauthorization of the President's Emergency Plan for AIDS Relief (PEPFAR) after months of contentious debate, the National Institutes of Health (NIH) decision to halt the Partnership for AIDS Vaccine Evaluation (PAVE) vaccine study, and the Center for Disease for Control and Prevention's (CDC) anticipated revision of the U.S. annual infection rate feeds a swirl of prevention news likely to take center stage this week. Throughout the meeting, the Caucus newsletter will help delegates navigate a conference at once stimulating and overwhelming. Volunteers will distribute the newsletter at the end of each day's opening plenary, providing a guide to that

day's menu of prevention research and a review of the prior day's sessions.

We welcome your feedback by contacting [sonia.kandathil@yahoo.com](mailto:sonia.kandathil@yahoo.com) and offer our thanks for sharing our commitment to eradicating HIV infection.

Peter Taback  
San Francisco AIDS Foundation

### In this issue:

- ◆ Jamila Taylor and Vanessa Brocato Give Us the 411 on PEPFAR Reauthorization  
Page 2
- ◆ Kelly Castagnaro Complains, Where's the Evidence-Based Prevention in PEPFAR?  
Page 2
- ◆ Abbey Marr Says PEPFAR Fails Youth  
Page 3
- ◆ Elisha Dunn-Georgiou on PEPFAR's Unconscionable Conscience Clause  
Page 3
- ◆ Walt Senterfit Asks if We Can "Treat" Our Way Out of the HIV/AIDS Epidemic  
Page 3
- ◆ Mitchell Warren on the False Dichotomy Between Treatment and Prevention  
Page 4
- ◆ Check Out **What's New** With Caucus Members  
Page 4



## PEPFAR II Fails Youth, Again

By Abbey Marr, International Youth Leadership Conference, Advocates for Youth

Last year in Kenya, I met a remarkable woman named Susan. She had abstained from sex until she married her husband, who discovered he was HIV positive only after he'd passed the virus on to her.

Susan now works with other young women who face the same risk, educating them about the realities of HIV, how to protect themselves, and how to confront stigma. Her efforts are important because women comprise 61 percent of new HIV infections in sub-Saharan Africa, even though 80 percent of them, like Susan, remain faithful to their husbands and partners.

Nonetheless, PEPFAR requires the Office of the Global AIDS Coordinator to report to Congress if any country with a generalized epidemic fails to spend at least 50 percent of its sexual transmission prevention funds on programs that promote abstinence and fidelity, even though evidence has consistently shown these programs to be ineffective in preventing HIV.

This requirement limits programmers' choices on the basis of politics, not evidence. And in Susan's case, it forces her to choose between doing what she knows is most effective or possibly shutting down her program, altogether. What an absurd choice for her to face!

Abstinence and fidelity programs will not help young women like Susan. Clearly, PEPFAR's inflexibility will hinder them and all of us from getting closer to our goal of ending the AIDS pandemic.

## President's Emergency Plan for AIDS Relief (PEPFAR): An Update

By Jamila Taylor, Center for Health and Gender Equity & Vanessa Brocato, Gay Men's Health Crisis

Too late for the G8 but in time for the International AIDS Conference, the U.S. Congress passed the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (SB2731 or PEPFAR II), sending PEPFAR II to President Bush to sign into law.

Several victories were achieved in the PEPFAR reauthorization. The authorized funding level is the largest single commitment by any government to combat HIV/AIDS. Additionally, the bill lifts the travel ban on HIV-positive people entering the United States. Consequently, the Department of Health and Human Services (HHS) will regain the authority to remove HIV from the list of medical conditions barring visitors and immigrants.

PEPFAR II also calls for prevention interventions designed for men who have sex with men (MSM), as well as research to better understand HIV among MSM in the global epidemic. This is especially important in Africa and the Caribbean, where homosexuality is largely underground and little epidemiological research exists.

However, the Senate faced an uphill battle to bring the PEPFAR reauthorization bill to the floor for a vote. In March, seven Senators, led by Senator Tom Coburn (R-OK), blocked PEPFAR II. The senators opposed an array of issues in the proposed legislation, including its price tag of \$50 billion and lack of a treatment funding directive.

To move the bill, Senate Majority Leader Reid and Senate Minority Leader McConnell worked out a com-

promise. In exchange for conservative representatives removing their block, restrictions on prevention activities were added, including a new requirement that "more than half" of PEPFAR funds be allocated for treatment and care and the extension of a "conscience clause" that enables PEPFAR grantees to exclude people and critical interventions from their services based on moral and religious grounds.

The legislation also includes a "balanced funding requirement," which stipulates that if less than half of all funding for the prevention of sexual transmission activities is spent on abstinence and be faithful activities, the Global AIDS Coordinator is required to report to Congress its justification within thirty days of making such a decision.

Serra Sippel, Executive Director of the Center for Health and Gender Equity said, "Balanced prevention theoretically provides individuals with the necessary tools and information to make informed decisions and choices about their sexual and reproductive health, but this requirement makes it difficult for organizations to promote and support comprehensive prevention interventions that are grounded in sound science, rather than ideology."

Additionally, the bill fails to acknowledge the critical need to strengthen the linkages between family planning and reproductive health services and HIV prevention efforts. The bill was signed into law, Thursday, July 31.

Advocates are preparing for next steps in both implementation and correcting the many missed opportunities.

## Evidence, Schmevidence: Prevention Loses Out to Politics in PEPFAR II

By Kelly Castagnaro, International Women's Health Coalition

PEPFAR fell short exactly where more was needed: full and flexible prevention funding that would improve the health and save the lives of countless women, youth and families.

The PEPFAR reauthorization process provided policymakers with a golden opportunity to both set and correct global HIV/AIDS policies based on evidence gathered and lessons learned after five years and nearly \$20 billion. Congressionally-sanctioned analyses by independent agencies, international health guidelines and operational research from a range of programs should have shaped the next five years of prevention programming. But, talking about sex is apparently too difficult when it comes to U.S. foreign policy – so lawmakers stuck their heads in the sand, sacrificing the integration of family planning services and real improvements in the prevention provisions in exchange for greater funding levels.

The ones failed most by political cowardice are women and young people, both increasingly vulnerable to infection in nearly every region of the world. They are most likely to use family planning and reproductive health services, and would benefit from the integration of HIV prevention and treatment with family planning services. However, the legislation fails to call for, or even acknowledge, linking health and HIV prevention services, a strategy identified by the World Health Organization as a best practice.

HIV is a reproductive and sexual issue and sexual transmission is the single greatest cause (80 percent) of new infections. A sustainable response to the pandemic requires investments that meet the real-life needs of women and their families and prioritize evidence over ideology. A missed opportunity? You bet — with long-term and harmful impacts

## PEPFAR's Unconscionable Conscience Clause

By Elisha Dunn-Georgiou, Population Action International

The passage of the PEPFAR Reauthorization Act is bittersweet as it not only fails to redress the ideological policies of the previous legislation, but in many cases has even expanded their impact. One of these ideological policies is the so-called "conscience clause," which allows organizations who have a moral or religious objection to opt-out of providing services to which they may object. In the 2003 Act, the clause was limited to objections over HIV prevention or treatment programs, thereby allowing faith-based and other organizations to promote the A (abstinence) and B (be-faithful) of ABC, without fear of retribution or loss of funds for not providing the comprehensive information needed to prevent sexual transmission of HIV.

PEPFAR II expands this provision to include "care" as an activity that an organization may refuse to provide based on a moral or religious objection. This will allow organizations who receive U.S. funds to deny services to those whose behavior, identity,

religion, or other attributes may be deemed objectionable. In essence, it codifies discrimination in U.S. law and perpetuates stigma against people living with HIV/AIDS.

Money is sorely needed to fight the pandemic — but our experiences with PEPFAR over the past five years have shown us that money alone is not enough. This is particularly true when funding is restricted by ideological policies and by provisions that have the potential to erase three decades of efforts to eliminate the stigma and discrimination faced by people living with HIV/AIDS. Without addressing these problems, we have fallen short in our moral and fiscal responsibility to use PEPFAR funding to prevent as many infections as possible. The United States must use its leadership to support effective (evidence-based) HIV/AIDS services and prevention that will both save lives and, one day, end this pandemic.

## Treatment as Prevention: What is the Evidence.....and the Skepticism?

By Walt Senterfit, CHAMP

Since anti-retroviral therapy (ART) for HIV can extend life by 50+ years, providing ART to all who need it worldwide is an ethical imperative. But is treatment also an effective prevention strategy as well? Can we "treat our way out of the epidemic" as some at the highest levels of government and science argue?

The efficiency of HIV transmission depends primarily on the concentration of the virus in an HIV positive person. Effective ART substantially reduces the viral burden and thus would be expected to correspondingly reduce infectiousness.

Observational studies in several places, beginning with the famous Rakai study in Uganda, have shown that in sero-discordant heterosexual couples the likelihood of the negative partner's becoming infected is very low when the positive person's viral load is very low. However, preliminary conclusions from observational studies do not always prove true in more rigorous study designs or in real world experience. This underscores the importance of a large, multi-site clinical trial (HPTN Protocol 052, Dr. Myron Cohen, Protocol Chair) of 1,750 heterosexual sero-discordant couples in six countries to see whether or not early vs. later initiation of ART will reduce transmission of HIV to the uninfected partners. Results of the study, conducted by the NIAID HIV Prevention Trials Network, will likely not be available until sometime after 2013.

**Is the treatment effect significant at a population or public health level?**

**Can we "treat our way out of the epidemic" as some at the highest levels of government and science argue?**

It would be wise to remain skeptical. As many as 50 percent of new HIV infections come from individuals who are in the acute or very early stage of HIV infection, when they are likely to be highly infectious and unlikely to know of their infection. Drug resistant strains of HIV emerge and may be transmitted. Many individuals have difficulty tolerating ART indefinitely and others have problems in adherence for a variety of reasons.

The strongest argument for skepticism is the experience of much of the United States and parts of Western Europe, where treatment is relatively widely available and yet HIV incidence remains stubbornly high and even rising. At the very least, the relationship of treatment to prevention is not simple or automatic, even under the best current conditions.

If this is the case in the wealthiest countries, how much farther away then are we from being able to "treat our way out of the epidemic" in developing nations, home to the majority of people living with HIV and those at highest risk of contracting it? For each person started on HAART in 2006, there were three new infections of HIV.

Treatment is a basic human right. It may also contribute to lessening transmission and thus be an important part of effective prevention strategies. Nonetheless, no universally effective prevention strategy exists, and none is likely for the foreseeable future. Meanwhile, less than one in five persons at substantial risk of HIV infection has access to even basic prevention services, let alone a broad evidenced-based package of prevention tools.

We have work to do.

## Promoting HIV Prevention Supported by Sound Science

### Caucus Members

Academy for Educational Development  
Adventist Development and Relief Agency  
Advocates for Youth  
AIDS Action  
AIDS Alliance for Children, Youth, and Families  
AIDS Foundation of Chicago  
The AIDS Institute  
AIDS Vaccine Advocacy Coalition  
Alliance for Microbicide Development  
American Academy of HIV Medicine  
American Jewish World Service  
amfAR, the Foundation for AIDS Research  
California Microbicides Initiative  
CARE USA  
Catholics for Choice  
Center for Health and Gender Equity  
Community Education Group  
Community HIV/AIDS Mobilization Project (CHAMP)  
CONRAD  
Constella Group  
Elizabeth Glaser Pediatric AIDS Foundation  
EngenderHealth  
Family Care International  
Family Health International  
The Female Health Foundation  
Futures Group  
Gay Men's Health Crisis  
Global AIDS Alliance  
Global Campaign for Microbicides  
Global Health Council  
Global Youth Coalition on HIV/AIDS  
Gutmacher Institute  
Harm Reduction Coalition  
HIV Medicine Association  
Ibis Reproductive Health  
International AIDS Vaccine Initiative  
International Partnership for Microbicides  
International Planned Parenthood Federation/ Western Hemisphere  
International Women's Health Coalition  
Ipas  
Management Sciences for Health  
Minnesota AIDS Project  
National Association of People With AIDS  
National Minority AIDS Council  
Planned Parenthood-Golden Gate  
Planned Parenthood Federation of America  
Population Action International  
Population Council  
Population Services International  
San Francisco AIDS Foundation  
SIECUS, the Sexuality Information and Education Council of the United States  
The Female Health Foundation  
Treatment Action Group



**No Easy Answers:  
Debunking the False  
Dichotomies of the Global  
AIDS Response**  
By Mitchell Warren, AIDS Vaccine  
Advocacy Coalition

The history of the global response to the AIDS pandemic is littered with false hopes, expectations and promises. More recently, and perhaps even worse, we now face false dichotomies as well: prevention or treatment; vaccines or microbicides; vertical AIDS funding or health systems strengthening; abstinence and be faithful programs or condom use (A and B or C).

But these aren't mutually exclusive or even real choices, and debating them only prevents us from moving forward. There are over four million new infections every year. For every person who starts antiretroviral medications, another three are newly-diagnosed with HIV.

These are mind-numbing, tragic figures. And they serve as a constant reminder that there is only one viable answer to the question, Which of the many strategies before us do we pursue? The answer is clear: *We undertake them all even more aggressively.*

We must not only continue, but also expand proven prevention strategies — including male and female condoms, clean needles, prevention of mother-to-child transmission, risk-reduction counseling and culturally appropriate male circumcision.

We must also do more to bring comprehensive

care, treatment and support to people already living with HIV worldwide. Global targets have been set and missed and are in danger of being missed again.

In addition, we must continue to search for expanded treatment options and new biomedical HIV prevention strategies, including vaccines, microbicides and oral pre-exposure prophylaxis.

To pit proven prevention against treatment or against research is a false and dangerous dichotomy. The range of prevention and treatment options that we have at our disposal today is not reaching every person at risk. But even if it did, it is not enough. Women and men, adolescents, boys and girls and infants all still need more choices.

We must do everything possible to provide every person at risk with the options available to protect him or herself from HIV, and we must also recognize that the best approach to prevention is one that provides the most options. Since there is no magic bullet — be it a condom or a clean needle today or a microbicide or vaccine tomorrow — there is only the ethical and moral imperative to develop a multi-faceted response that is a match for the multiple drivers of the epidemic itself.

We will not treat our way out of this epidemic, we will not prevent our way out, and we won't research our way out either. We will end this epidemic only when we harness all three components as the three essential pillars of a truly comprehensive, integrated, sustainable and evidence-based response.

### Spotlight on Members of the Caucus for Evidence-Based Prevention:

- ◆ **IPAS** will be presenting, **“I was walking crooked and now I’m walking straight,”** a capacity-building session for African women living with HIV to address gender bias, violence and reproductive rights in and with their communities. It will take place today from 12:30-14:30, Hall D
- ◆ **Population Council** will be presenting, **“Is it a risk to talk about risks only?”** The session will discuss negotiating U.S. Global AIDS policy for young people, policy gaps, limitations, etc. It will take place today at from 18:30-20:00 in Skills Building Room 7, Conference Hall
- ◆ **AIDS Vaccine Advocacy Coalition, Center for Health and Gender Equity, Global Campaign for Microbicides, Ibis Reproductive Health, International AIDS Vaccine Initiative, International Partnership for Microbicides, and International Women’s Health Coalition** will be presenting, **“No Simple Solutions: Investing in HIV Prevention Research for Women and Girls,”** to discuss the work needed to develop and test a range of interventions addressing the complex gender inequality challenges that continue to exacerbate a feminized HIV/AIDS epidemic worldwide. Stephen Lewis, Co-Director of AIDS-Free World will moderate. It will take place from 16:30—18:30 in Session Room 6.

#### General Caucus Inquiries

Sonia M. Kandathil  
Cell: 425-577-3412  
Sonia.kandathil@yahoo.com

Activities of the Caucus for Evidence-Based Prevention are made possible by generous donations from The UN Foundation, Population Services International, The AIDS Institute, San Francisco AIDS Foundation, CHAMP, Advocates for Youth, International Women's Health Coalition, and the HIV Medicine Association

#### Media Inquiries

Tyler LePard:  
Cell: 202-468-3635  
tlepard@popact.org  
Dave Ellison  
dellison@sfa.org  
Cell: 510-493-3531