Housing Works: Housing Prevents AIDS. Housing Improves Health.

AIDS Issues Update: Features:

_Housing Works Response and Recommendations Regarding the National HIV/AIDS Strategy_

Housing Works welcomes the introduction of the National HIV/AIDS Strategy for the United States (NHAS). We have been part of a long line of advocates and activists who have been fighting since before the 2008 election for a plan that addresses ending the domestic epidemic and are glad to see the work of the Office of National AIDS Policy (ONAP), community advocates and activists come to fruition. However, we would be remiss if we did not frankly address the notable limitations of the NHAS and discuss our concerns with both the Obama administration and the AIDS community.

Read an editorial by Housing Works' CEO Charles King about why the organization is speaking out about the plan.

One of the most jarring aspects of the NHAS is that the stated ambitions far outstrip the actual plan. The first page of the document is a vision statement that calls for a United States where “new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high quality, life extending care, free from stigma and discriminations.”

Yet the NHAS sets a modest target of reducing new infections by 25% by 2015 (from 56,300 to 42,225). In the best of circumstances, we would still have more than 267,000 new infections in this country over the next 5 years—nobody's idea of “rare.” According to ONAP staff these targets were "developed in consultation with the Federal HIV Interagency Working Group and reflect our collective judgments about what is achievable. These targets were set based on a review of current epidemiological trends, informed by research and mathematical modeling about the likely course of the epidemic. ... For the HIV incidence target, this was set against a backdrop of potentially increasing incidence, and in light of minimal progress toward lowering annual incidence rates during past efforts where a goal was set to cut HIV incidence in half." How can we be confident in the aggressiveness of these targets? We know, for example, that women and youth are under-represented in HIV research—a point underscored by the fact that the NHAS itself does not call for research on either population.

The NHAS plan also does nothing to address an unprecedented AIDS Drug Assistance Program crisis that has left nearly 2,400 poor Americans with no access to treatment, let alone the “high-quality, life extending care” called for in the vision statement.

While there are many intelligent recommendations in the NHAS, these two high-profile examples are an unfortunate indicator of its overall lack of vision. The NHAS is a plan to manage the growth of the AIDS epidemic, not to end it. In particular, we believe that the strategy largely ignores one of the fundamental causes of the AIDS epidemic: poverty. The plan’s failure to embrace well-documented structural interventions to cut the link between poverty, and homelessness in particular, and AIDS is all the more disappointing given that both the Centers for Disease Control and Obama’s Federal Strategic Plan to Prevent and End Homelessness have recognized the critical importance of such interventions.

The NHAS is divided into four sections: 1) Reducing New HIV Infections; 2) Increasing Access to Care and Improving Health Outcomes for People Living with HIV; 3) Reducing HIV Related Disparities in Health Inequities; and 4) Achieving a More Coordinated National Response to the HIV Epidemic. Housing Works’ response to the NHAS addresses each of these sections in turn.

1) Reducing New HIV Infections
Less than a week after the release of the NHAS, the Centers for Disease Control and Prevention held a press conference at the International AIDS Conference to report on a first-of-its-kind analysis showing that 2.1 percent of heterosexuals living in high-poverty urban areas in the United States are infected with HIV. That astonishing statistic means that HIV is now a generalized epidemic in these poor communities and that all sexually active adults are at high risk of becoming infected. The analysis also shows that poverty is the single most important demographic factor associated with HIV infection among inner-city heterosexuals. Contrary to severe racial disparities that characterize the overall U.S. epidemic, researchers found no differences in HIV prevalence by race/ethnicity in this population. “These findings have significant implications for how we think about HIV prevention. We can’t look at HIV in isolation from the environment in which people live,” said Jonathan Mermin, M.D., director of CDC’s Division of HIV/AIDS Prevention, at the press conference. “We need to address larger environmental issues, such as poverty, homelessness and substance abuse, which are well beyond the traditional scope of HIV intervention. Addressing those is as essential to HIV prevention as providing condoms.”

Another researcher who participated in the study, Dr. Kevin Fenton, director of the CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, observed that, “There is also a growing recognition that to significantly reduce new HIV infection in the United States, we need to address the larger environmental and structural risk factors that fuel HIV, such as poverty, homelessness and substance abuse.”

By far the most disappointing gap in the NHAS is the failure to acknowledge housing as an evidence-based prevention intervention. There is only one small reference to housing in the prevention section of the strategy.

Homelessness and unstable housing are linked to greater HIV risk, inadequate care, poor health outcomes and early mortality for people living with HIV/AIDS. The conditions of homelessness and extreme poverty—the pressures of daily survival needs, the inability to maintain intimate relationships, and substance use as a response to stress and/or mental health problems—leave homeless and unstably housed persons extremely vulnerable to HIV infection. It is projected that at least one-half of homeless persons in any community fall into one or more of the highest-risk categories. Moreover, proven HIV risk-reduction interventions are less effective among persons who are homeless or unstably housed.

The unique vulnerability to HIV infection of black women, persons of transgender experience, and formerly incarcerated persons (all mentioned in the NHAS), as well as street-involved youth (not mentioned in the NHAS) has been linked to housing instability, violence and other structural factors. We know that the rate of new infections among homeless persons has been found to be as much as 16 times the rate in the general population.

The Obama administration’s own United States Interagency Council on Homelessness report Opening Doors: Federal Strategic Plan to Prevent and End Homelessness recognizes housing as an evidence-based, cost-effective HIV prevention intervention. According to Opening Doors, “Housing status has been identified as a key structural factor affecting access to treatment and health behaviors among people living with HIV/AIDS. Research shows that housing assistance is associated over time with reduced HIV risk behaviors and improved health care outcomes, controlling for a wide range of individual characteristics (poverty, race/ethnicity, substance abuse, mental illness) and service use (primary care, case management, substance abuse, and mental health treatment) variables. Housing assistance coupled with health care has been shown to decrease overall public expense and make better use of limited public resources, such as use of emergency rooms and hospitals.” (Citing: Auerbach, J. 2009. Transforming social structures and environments to help in HIV prevention, Health Affairs, 28(6): 1655-1665.)

Likewise, the Opening Doors plan recognizes the high cost, in lives and money, of heightened HIV risk among homeless youth: “More needs to be known about the cost associated with youth homelessness. But we know that high rates of medical and behavioral health issues and incarceration are costly. These costs compound over a lifetime, as today’s homeless youth become tomorrow’s homeless adults, or when risky behaviors or sexual exploitation result in HIV infection.”

However, the NHAS “recommended actions” for HIV prevention fail to acknowledge housing as an HIV prevention strategy. The plan simply recommends that, "Government agencies should fund and evaluate
demonstration projects to test which combinations of effective interventions are cost-efficient, produce sustainable outcomes, and have the greatest impact on preventing HIV in specific communities.” Structural factors such as housing are barely mentioned in the NHAS discussion of gaps in prevention knowledge and directions for future research. The U.S. Department of Housing and Urban Development is not even included as a participating federal agency.

Therefore, the NHAS should:

- identify homeless/unstably housed persons as a high risk group, and instruct federal agencies to direct resources to focused prevention efforts, including housing assistance.
- set the goal of ending homelessness among persons living with HIV as a key prevention strategy.
- adopt an evidence-based, public health approach that identifies and limits policy and other barriers to housing assistance for persons living with and at heightened risk of HIV.
- mandate further study of the impact and cost effectiveness of housing assistance as a prevention intervention, including collection and analysis of data on housing status as a key structural determinant of HIV infection.
- include HUD as a collaborating agency in recommendations regarding expanding evidence-based interventions (sections 2.1, 2.3, 2.4) as well as recommendations refocusing existing prevention (section 1.4).
- address a key prevention strategy recommended by the National AIDS Strategy Coalition (NASC): reimbursed and voluntary HIV testing and mandating the offering of HIV tests in clinical settings. There are only two action steps in the recommendations that refer to testing and screening, with the first year spent exploring best combinations of behavioral and biomedical prevention activities that would include testing and reviewing fourth-generation HIV diagnostic tests. Piloting is scheduled for 2011—no scaling up of efforts is scheduled.

The NASC recommends the development of goals to end the epidemic among injection drug users (IDUs). The NHAS does target IDUs as a priority population and includes access to sterile needles and syringes. Increasing the percentage of PLWHA who know their serostatus to 90% is the type of ambitious goal we would liked to have seen more of throughout the NHAS.

2) Increasing Access to Care and Improving Health Outcomes for People Living with HIV/AIDS.

In marked contrast to the NHAS’ prevention goals, the access-to-care goals are ambitious. We applaud the call to increase the percentage of people living with HIV/AIDS (PLWHAs) who are linked to care to 85% and increase the percentage of people in continuous care to 80%. However, we are concerned that the marker for continuous care is Ryan White Program clients. Ryan White covers only about 18% of those receiving HIV/AIDS services and is not representative of the entire HIV/AIDS client population.

The NHAS does recognize that housing has been assessed and included as a key component of treatment for PLWHAs. We believe that the goal of 86% of Ryan White HIV Program clients in permanent housing is appropriate for this part of the population. However, calling for an increase of 21,800 people in permanent housing for Ryan White recipients falls far short of our evidence-based estimate of 142,000 PLWHA with a current unmet housing need. Federal agencies responsible for implementing the NHAS and Opening Doors must have a goal of ending homelessness among persons living with HIV, and every health care program serving PLWHA must monitor housing status as a key component of health care.

We are also struck by the lack of attention to supportive housing for those who need it. Again, the NHAS contrasts sharply with Opening Doors, which encourages partnerships between housing providers and health and behavior providers.

We agree with the NHAS that “implementation of health insurance reform presents the Nation with an opportunity to re-think what will be needed from the Ryan White HIV/AIDS Program in order to bring people with HIV into care and retain them in care once more people have insurance coverage.”

We are deeply troubled by the fact that the NHAS includes no mention of low-threshold, harm reduction health care or housing services, despite their wide acceptance as public health best practice. Federal leadership is essential here, especially in the South and other areas where stigma and lack of understanding bar PLWHA from...
mainstream services and hinder the development of HIV-specific services.

The NHAS should:

- require that individual housing need be assessed and reported by all grantees of targeted HIV funding and that data on housing needs be compiled nationally.
- make housing assistance a core health care activity under all health care delivery systems including Ryan White.
- impose requirements and/or offer incentives for local communities to commit housing resources to evidence-based, low-threshold housing models with few or no housing-readiness requirements and to develop programs that meet the unique needs of underserved groups such as transgendered persons, active drug users, and sex workers.
- include clear and consistent measures for evaluating need and outcomes, which assess not only biological markers but also progress in addressing social determinants of health such as housing status and food security.
- include this type of data collection and reporting as a stated goal. Evaluation of all federally-funded HIV programs must include assessment of structural/contextual factors in order to give a clear picture of what works and for whom.
- make recommendations for increased financial resources as well as improved interagency federal coordination.

3) Reducing HIV-Related Disparities and Health Inequities

The NHAS goals around reducing HIV-related health disparities are quite limited. Youth, women, poverty level and geography are not expressly mentioned as key topics. (Overlooking women in this section is particularly troubling, since women are included as a targeted population in the prevention section). Again, we need strong presidential leadership to promote structural interventions that address contextual, community-level factors such as housing affordability and adequacy that drive the U.S. crisis.

In the NHAS discussion of adopting a community-level approach to reduce HIV infection in high-risk communities, the goals, action steps and implementation plan lack specificity. Elsewhere in the strategy, ONAP has been able to make very specific goals in addressing conditions among gay and bisexual men, Blacks and Latinos.

We applaud the call for states to eliminate laws that criminalize HIV. However, the NHAS fails to call for change in federal programs and requirements that bar access to public housing based on histories of incarceration or drug use.

Neither the NHAS or the implementation plan directly address a coordinated financing mechanism that accounts for savings across silos—although the NHAS does refer to increased effectiveness in the use of resources causing cost savings throughout the system. Without defined action plans on how this will happen, it is unlikely that these cross-silo cost-savings will be accounted for appropriately. Again, HUD, the Veteran’s Administration and other Federal agencies that provide housing assistance should be responsible/collaborating agencies in all aspects of the implementation plan, including Section 2.3.

HIV-positive leadership is expressed as an intervention in addressing HIV-related disparities. It is recommended at the community level but not integral to the NHAS implementation process.

The NHAS should:

- remove eligibility requirements that exclude vulnerable persons from housing assistance (such as the HUD definition of homelessness, which excludes persons leaving institutions, and criteria that deny Veterans Administration housing assistance to veterans with other than honorary discharges from the military).
- lift public housing exclusions based on status, such as a history of incarceration or active drug use.
- include a defined goal and action steps for cross-silo, cost saving, financing mechanisms.

4) Achieving a more Coordinated National Response to the HIV Epidemic in the US

The NHAS should have a specific goal addressing the investment in housing as part of achieving a coordinated
response. We believe that this level of community development is not adequately focused on throughout the strategy.

Coordination of effort needs to include OMB, so that “savings” from housing and other structural interventions can be offset against their cost, in order to clearly understand the fiscal impact. We also see the streamlining of data collection and grantee reporting as a positive step that will streamline grant administration, but see no real collaboration in the delivery of funds.

Moving from AIDS cases to HIV infections case reporting as a base for formula grants is a step in the right direction but we remain concerned that access to all services is still thought about in terms of grant funding rather than moving towards people being eligible for services based on diagnosis and need.

We appreciate the outline that the NHAS provides but we are concerned on how coordination will be implemented at the state and local level. There does not appear to be any accountability on the state level to participate in the NHAS. We believe that many states will willingly participate but that others will opt out without a strong mandate for participation.

The NHAS should:

- have a stronger emphasis on how the Federal HIV Interagency Workgroup and the NHAS work together to end the dual crises of homelessness and HIV/AIDS.
- Promote the development of evaluation metrics that cut across cost centers and take into account the fact that much of the public “savings” attributable to housing investments occur in systems responsible for public health and medical spending.
- Require that all services be made available based on eligibility and not funding levels.
- Mandate and incentivize state and local participation in the NHAS implementation.

Summary

There are several strong elements in the NHAS. The fact that we now have a National HIV/AIDS Strategy is important and the focus on gay and bisexual men, Blacks, Latinos and substance users is laudable. We are, however, concerned that the goals throughout the NHAS are not ambitious, inspiring or end the domestic epidemic; lack an emphasis on the structural and contextual causes of HIV/AIDS and interventions that would end the epidemic; and reflect a nearly-invisibility status of youth throughout the strategy.

We acknowledge that many parts of the National AIDS Strategy Coalition Criteria have been met--such as a detailed social marketing campaign; an anti-stigma/discrimination initiative; a call for critical health care system reforms including Medicaid expansion and reform; scale up strategic programming for African Americans, gay men and other MSM; and a detailed implementation plan with a calendar.

However, there are no legislative changes recommended, such as a domestic PEPFAR; no short-term protections for programs such as the AIDS Drug Assistance Program and the utilization of Ryan White through the transition of full implementation of the Affordable Care Act; and no recommendations for increased resources depending on improved use of current resources to address the domestic epidemic. We acknowledge that this is not a budget document but believe that for the NHAS to be effective and fully implemented it will take more than review of current spending practices and more effective use of current resources.

Housing Works is fully committed to being an active partner with PLWHA, the federal government and the community at large in working towards ending AIDS. We believe that we need a bold vision, a strong ambitious plan and active participation from all to make it happen. We envision a day when we can say that we have ended AIDS.

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D. Davis 3 months ago

This is wonderful additional information and it really seems that this should be an integral part of the next phase of the NHAS. Let’s first give something that has never been recognize it’s space to make a difference; cause you know the government only understands pen to paper. D Davis Bklyn

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