HIV PREVENTION PRACTICES AND NON-FEDERAL FUNDING AMONG U.S. STATES AND NON-STATE REGIONS: A Survey of HIV/AIDS Directors

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Abstract and Conclusions provided here, including recommendations for CDC and HRSA:

ABSTRACT

We surveyed U.S. HIV/AIDS Directors or designees in states and non-state regions, regarding factors influencing HIV viral suppression: 1) non-federal prevention funding; 2) contacting newly-reported patients and providers, for care linkage and partner services; 3)

follow-up of non-received viral load reports, to identify untreated patients; and 4) genotype/phenotype surveillance, to monitor drug resistance. The survey was conducted April-July 2015; 50 (87.7%) participated. Of jurisdictions, 80% contacted all newly-reported patients; 60% contacted all providers. HIV resistance tests were reportable in 38%; 66% contacted providers and/or patients about missed viral loads. Non-federal funding was significantly associated with annual diagnoses (p=0.0001) and population (p=0.0002), but not with other factors studied. Many jurisdictions lacked non-federal funding (28%), or experienced unrestored reductions since 2008 (33%). Jurisdictions' funding and preventive practices varied greatly**. HIV viral suppression could be enhanced by restoring (or establishing) non-federal prevention funding, and by more standardized surveillance/outreach practices.**

CONCLUSIONS AND RECOMMENDATIONS

(ENDORSED BY BOARD OF DIRECTORS, BEYOND AIDS FOUNDATION)

After several years of economic recovery, restoration of recession funding cutbacks for HIV prevention was overdue at jurisdictional and local levels. Federal matching of non-federal funds could incentivize this. **Restored (or newly established) non-federal funding could help monitor and facilitate progression through the HCC, especially if used in part for outreach to patients and their providers after new diagnoses or if viral load results were not received for a year, and for collection and forwarding of viral resistance data to CDC.** However, such services, which were not yet specifically funded routinely by CDC, showed no statistical association with non-federal funding,.

Public health practices relating to follow-up of newly reported HIV diagnoses and missed viral load results, and reporting of genotypes and phenotypes, varied widely among states and NSRs. **CDC could revise guidelines to encourage a more uniform system of HIV surveillance and monitoring, based on HCC stages and goals.**

Linkage to care and partner services were already endorsed by CDC, but inconsistently applied. **They could become a required use of CDC prevention funding, with specifications regarding the types of outreach expected.**

Public health tracking of non-received viral load results (an indicator of infected persons who may not be in treatment), with outreach to providers and patients, may facilitate two more stages of the HCC: retention in care and antiretroviral treatment. Despite lack of specific funding by CDC, a majority of jurisdictions already claimed engagement in this activity. **Patient progression through the HCC could be facilitated by making it a required use for CDC and/or HRSA funding. To make this a universal surveillance activity, jurisdictions that do not have mandatory laboratory reporting of all viral loads, regardless of result, would need to institute such reporting.**

CDC considered genotype surveillance optional, did not collect phenotypes, and neither was reportable in most jurisdictions. **Uniform reporting, with submission to CDC for nationwide analysis, could produce a more complete database for monitoring antiretroviral resistance.**

CDC could require grant application objectives to address jurisdiction-specific shortfalls in these areas, and opportunities for improvement.

Surveys like this may prove valuable in increasing awareness among public health advocates about funding gaps and potentials for expanded surveillance and outreach within their jurisdictions. Such awareness could stimulate discussions about policy and any necessary political action.