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Limitations of Counseling and Testing in CDC's HIV Prevention Efforts

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Letter to the Editor

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To the Editor: We were delighted to see that our colleagues at the Centers for Disease Control and Prevention (CDC) had read our article (Darrow *et al.,* 1998a) and responded (Wolitski and Doll, 1999). Their criticisms of our cross-sectional study of 51 HIV-infected men who have sex with men (MSM) and live in South Beach are welcomed and appreciated. In this brief reply, we continue the dialogue by addressing their concerns and recommending an appropriate course of action.

Their methodological concerns are twofold: (1) our analysis did not assess pre–post changes in risk behavior and (2) it did not compare risk practices of men who had previously received counseling and testing (CT) with those who had not. They continue by identifying three limitations of our findings and end with a rhetorical question, "Is this a reasonable standard for any single prevention program to be held to?" To which we answer, "Why not?"

Let us begin with their phrase, "single prevention program." Three books—all with the same title—have now been published which can be used to trace the evolution in social scientific thinking about "preventing AIDS" in the United States. Valdiserri (1989) clearly points out that CT has its roots in the paternalistic model of a medical provider conducting a "risk assessment," diagnosing a patient's "behavioral problem," and remedying "the problem" by telling the complacent patient what to do about "his or her problem." DiClemente and Peterson (1994) open up HIV prevention possibilities to a wide array of more promising, theoretically based intrapersonal, interpersonal, community-level, and societal interventions. Kalichman (1998) begins the process of rigorously examining the empirical evidence for the efficacy, effectiveness, and cost-effectiveness of these interventions in a variety of settings. One immediately apparent problem with "CDC's HIV prevention efforts" is its determination to promulgate and support with $253 million a year a "single prevention program" anchored in the medical model of Counseling and Testing, Referral, and Partner Notification (CTRPN). If CDC does not intend to prevent HIV transmission through behavioral changes prompted and maintained by CTRPN, then what is the purpose of this program?

Now let us turn to their argument that "CDC does not require state and local health departments to provide a specific level of support [for CTRPN]" and "local HIV community planning groups" have been responsible for allocating funds for prevention activities since 1994. From the outset, CDC (1993, p. 1) defined CTRPN as an "essential" component that must be included in every HIV prevention program. In program announcements published subsequently to 1994, CDC instructs state and local health departments to include funding for CTRPN "unless prohibited by State law or regulation" (Department of Health and Human Services, 1997, p. 7). In a paper recently published through CDC sponsorship, Valdiserri (1997, p. 11) maintains that—even in the absence of convincing evidence—"HIV CT will continue to be an essential component of a comprehensive national HIV prevention strategy."

To our knowledge, *no local community planning group is responsible for allocating funds for HIV prevention activities anywhere in the United States.* Planning groups are advisory. They make recommendations. They are allowed to express their "concurrence" with health department decisions about how to spend the money awarded to the health department through a cooperative agreement between the health department and CDC. Usually, they "concur" (Division of HIV/AIDS Prevention, 1996).

We were pleased to be able to conduct the South Beach Health Survey on behalf of the Florida Department of Health and the Miami-Dade County HIV Prevention Community Planning Group (DCPG), 1 of 17 community planning groups in the state that reports, through three representatives (one each from the local health department, Ryan White Title II consortia, and community, respectively), to the Florida HIV/AIDS Community Planning Group (FCPG). In turn, the 64-member FCPG reports to the Bureau of HIV/AIDS in Tallahassee (Florida Department of Health, 1998a). Of the $631 million

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awarded to CDC for HIV prevention in Fiscal Year 1996, about $12.3 million (1.9%) was distributed to the Florida Department of Health, and exactly $5,000 (0.0008%) trickled down to DCPG to support the South Beach Health Survey: An Instrument for [Local] Community Planning (Webster, 1997).

Finally, we use the limited space assigned to us by the Editor to address the following specific comments made by our HIV prevention partners at CDC: (1) "the single study . . . cited by Darrow and colleagues," (2) "these programs motivated individuals," and (3) "CDC has a long history." In our article we cited many studies and reviews of CT, and merely used the Otten *et al.* (1993) study, conducted in own backyard, as an example. Wolitski and Doll are well-trained and very capable psychologists who may be concerned with "motivations," but the major outcome of interest in our work is "unprotected insertive anal intercourse," a risky behavior. There is very limited evidence that any of the studies they cite demonstrate that a single pretest and posttest counseling session about an HIV-antibody test ever changed the sexual risk-taking behavior of any gay man in America, and Wolitski *et al.* (1997, pp. 54–56) agree with us on this point in their review article.

Kamb's (1996) randomized controlled "efficacy study" is a marvelous piece of scientific work, but has absolutely no bearing on the behavior of MSM in South Beach. The subjects in Project RESPECT were HIV-negative, heterosexual STD clinic patients in Baltimore, Denver, Long Beach, Newark, and San Francisco: *men with homosexual experiences or proclivities were excluded.* Recently published results support our critique of CTRPN by demonstrating that theoretically based and enhanced HIV prevention counseling sessions are more efficacious for heterosexual STD clinic patients than the standard CT that has been delivered to millions of Americans since March 1985 (Kamb *et al.,* 1998).

If CDC is going to conduct a "Seropositive Urban Men's Study" to find out why HIV-infected MSM are continuing to engage in unsafe sexual behaviors in spite of repeated exposures to CTRPN (Wolitski *et al.,* 1998), they must include Miami and other cities outside of New York and San Francisco if they are to receive any credibility with the scientific community, because of variabilities in gay culture (Gagnon and Nardi, 1997). In the social setting of South Beach, we were compelled to conclude that CT is ineffective because (1) every HIV-infected man had been exposed to this intervention at least once, (2) those who knew they were HIV-positive were *more likely* to report engaging in unprotected insertive anal intercourse than those who were told they were HIV-negative when last tested, and (3) there was *no* relationship between dose and response: men who were counseled and tested frequently were just as likely to report unsafe sex as those counseled and tested less often. As for "CDC's long history," we don't consider 5 years of experience with community planning to be sufficient to conclude anything when the bottom line in Florida is still $6,326,845.55 for CTRPN (Florida Department of Health, 1998b, p. 17).

We encourage CDC to adopt an evidence-based approach to social and behavioral interventions for primary HIV prevention that requires the careful scrutiny of adequate, unbiased data for establishing the safety and efficacy of proposed interventions before full-scale, nationwide implementation (Kegeles and Hart, 1998). The safety and efficacy of CTRPN as a public health intervention for MSM have not been established.

Our research is concerned with behavioral outcomes, empirical evidence of long-term impact, and external—as well as internal—validity (Holtgrave *et al.,* 1997). It assesses the cumulative effectiveness of multiple CT sessions on a representative sample of MSM living in households and suggests that if CT must be done, it must address two client-centered issues of concern to MSM in South Beach: primary relationships and the use of recreational drugs (Darrow *et al.,* 1998b). We are prepared to cooperate with CDC and other open-minded investigators in a randomized control trial of an empirically based alternative to traditional CT, but it must be one that has a chance of preventing HIV transmissions among MSM.

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