HIV Health Care Access Working Group

February 21, 2013

Dr. Robert Cosby
c/o U.S. Preventative Services Task Force
540 Gaither Road
Rockville, MD 20850

Re: Draft Research Plan on Behavioral Counseling to Prevent Sexually Transmitted Infection

On behalf of the HIV Health Care Access Working Group (HHCAWG), we appreciate the opportunity to comment on the U.S. Preventative Services Task Force’s (USPSTF) draft research plan on the topic of behavioral counseling to prevent sexually transmitted infections (STIs). HHCAWG is a coalition of more than 100 national and community-based HIV service organizations providing critical HIV-related health care and support services and representing HIV medical providers, advocates, and people living with HIV. The Working Group is actively engaged in efforts to improve HIV and STI prevention through screening, education, and behavioral counseling. Our comments address populations, interventions, and outcomes that should be included in your research approach.

Populations Studied

The research plan should include studies on HIV-positive populations.

We applaud the USPSTF draft research plan for appropriately including studies of patients with STIs, but strongly urge USPSTF to also include studies of HIV-positive populations. Behavioral counseling that targets HIV-positive individuals has a significant impact on overall public health. Reducing risky behavior among this population is especially pressing, as these individuals are at increased risk of transmitting HIV and have increased susceptibility to other STIs. Moreover, there is empirical evidence that behavioral counseling improves outcomes among HIV-positive populations,¹ ² and CDC clinical guidelines recommend offering prevention counseling to both HIV-positive and HIV-negative patients.³ In making recommendations about when to offer counseling, the USPSTF should take this research into account.

Additionally, many counseling interventions are applicable to both HIV-positive and HIV-negative patients, and in some cases the same intervention is more effective in reducing risk among HIV-positive individuals.⁴ The effectiveness of these interventions

should be measured by their total impact, not only their impact on HIV-negative patients. Excluding HIV-positive populations from the research plan may misrepresent the overall effect of behavioral counseling programs. Furthermore, including studies of HIV-positive populations could significantly expand the number of studies available for USPSTF review. HIV-positive individuals are the focus of many behavioral counseling programs, and many of these programs have been studied in detail. Therefore, we suggest that the USPSTF should investigate the effect of behavioral counseling on STI transmission among HIV-positive populations as well as high-risk and low-risk HIV-negative (or untested) populations.

Ultimately, the USPSTF recommendations should aim to assist providers in prioritizing behavioral counseling among HIV-positive individuals and other high- or low-risk HIV-negative patients. The 2008 recommendation on STI counseling applies uniformly to all patients, whether HIV-positive or not; a research plan that excludes HIV-positive populations is inconsistent with that recommendation. Currently, the USPSTF does not have a separate research plan for behavioral counseling for HIV-positive patients. Unless the USPSTF plans to initiate such a study, it would be best to include HIV-positive populations in the current research plan.

**Interventions Studied**

**The research plan should include interventions delivered by health-related community-based organizations.**

Community-based organizations (CBOs) are increasingly common sources of preventative counseling, including counseling to prevent the spread of STIs. Recent studies show that behavioral counseling delivered by CBOs can improve protective behaviors (e.g., condom use). Some CBO interventions can be recreated in clinical settings, especially clinics with a large support staff. For example, the successful “Be Proud! Be Responsible!” CBO intervention consists of six 50-minute interventions, similar to the “RESPECT” clinical intervention consisting of four 20-60 minute sessions. Even when CBO interventions cannot be replicated in primary care settings, they often serve as referral sources for physicians. CBOs that focus on STI prevention can conduct high-intensity interventions, which are often the most effective, making CBOs an important source for time-constrained providers. Moreover, the Patient Protection and Affordable Care Act (ACA) significantly increases CBO funding; the connection between community-based and clinical care is likely to grow.

It is unclear whether studies of CBO-based interventions will be included under the current draft research plan. On one hand, the research plan includes all interventions that are primary care conducted, feasible, or referable; many CBO interventions fall in the

---


latter two categories. Yet the list of intervention settings does not appear to allow for studies of CBO-delivered behavioral counseling, even if such counseling is primary care feasible or referable. Instead, CBOs seem to be categorically excluded as “community/university research laboratories or other nonmedical centers.” If it was not the USPSTF’s intention to exclude all CBOs from the study, we recommend clarifying this in the final research plan. If the draft plan purposely excludes CBOs, we ask that the USPSTF reconsider this restriction. Given that CBOs are an increasingly important source of preventative care, the USPSTF should explore the efficacy of CBO-delivered interventions and make recommendations regarding primary care referrals to CBO counseling services and vice-versa.

The research plan should include interventions that have an indirect impact on sexual behaviors.

The current draft research plan excludes two interventions with an indirect impact on STI-related sexual behavior: (1) promoting contraceptive use; and (2) promoting HIV/STI testing. First, increased use of barrier protection for contraceptive purposes decreases STI transmission. We ask the USPSTF to clarify that behavioral counseling promoting the use of barrier protection will be included in the final research plan, regardless of whether the counseling is directed at STI prevention, contraception, or both. Second, knowledge of STI status is linked with a increase in protective sexual behaviors, especially when combined with counseling to promote disclosure to sexual partners. Periodic testing and self-disclosure are themselves protective sexual behaviors. As such, behavioral counseling designed to promote testing and self-disclosure should be included in the USPSTF research plan as interventions that prevent or reduce STI incidence.

Outcomes Studied

The research plan should include behavioral outcomes that are relevant to individuals who are not sexually active.

The USPSTF draft research plan includes studies of individuals who are not sexually active. However, most of the included outcomes, such as changes in health and sexual behavior, are only measurable for individuals who are sexually active or become sexually active during the course of a study. While some studies of non-sexually-active populations include data about subsequent sexual behavior, others report data about self-efficacy, knowledge, skill, and intention to use protection upon commencement of sexual activity. The current draft research plan would inappropriately exclude the latter studies. Self-efficacy is a proven predictor of protective sexual behaviors in some populations, and intention to use a condom is a strong predictor of actual condom use. While data

---

on actual sexual behavior is ideal, data on predictors of sexual behavior may be used where direct data is unavailable.

The USPSTF recommendations on STI counseling will influence whether providers offer counseling to non-sexually-active individuals. It is essential that the benefits of counseling non-sexually-active individuals are not overlooked simply because the benefits are one step removed from positive sexual behavior and health outcomes. Thus, the draft research plan should include measures of self-efficacy, knowledge, skill, and intention to use protection as a proxy for future protective behaviors in non-sexually-active populations.

Conclusion

Thank you for the opportunity to comment on this regulation. We appreciate the commitment USPSTF has shown to promoting evidence-based behavioral counseling for STI prevention.

Please contact Amy Killelea with the National Alliance of State & Territorial AIDS Directors (akillelea@nastad.org), Andrea Weddle with the HIV Medicine Association (aweddle@hivma.org), or Robert Greenwald with the Treatment Access Expansion Project (rgreenwa@law.harvard.edu) if we can be of assistance.

Respectfully Submitted by the Steering Committee of the HIV Health Care Access Working Group,