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Implications for HIV prevention programs of the 11 September 2001 terrorist attacks on the United States

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Abstract

The tragic 11 September 2001 terrorist attacks on the United States have had enormous individual, public health, and fiscal consequences. Several key areas of HIV prevention that seem to have changed as a result of the events are discussed here, namely: (a) resource availability for HIV prevention efforts, (b) interpersonal communication among HIV prevention workers, (c) expansion of social services provided by or linked to HIV prevention service settings, and (d) policies surrounding blood donation and deferral. In each area, potential action steps are identified.

Background

The tragic 11 September 2001 terrorist attacks on the United States resulted in the loss of more than 3000 lives and affected the nation in countless other ways (*1*, *42*). The purpose of this paper is to discuss some implications of the assault and the following deepening of the economic slowdown on HIV prevention efforts in the United States. The strike against the United States impacted the lives of a number of people involved in HIV prevention efforts. There are also other, perhaps less obvious, potential effects of the attacks. Here, we identify several of these potential impacts and discuss possible responses.

Impacts on HIV prevention efforts

1. Resources

In its strategic plan for HIV prevention efforts through 2005, the U.S. Centers for Disease Control and Prevention (CDC) identified the following as an overarching national goal: "Reduce the number of new HIV infections in the United States from an estimated 40,000 to 20,000 per year by the year 2005, focusing particularly on eliminating racial and ethnic disparities in new HIV infections" (*2*). However, it has been noted clearly that to achieve this goal, additional HIV prevention resources on the order of $300 million per year for fiscal years 2002 through 2005 are needed (*2*-*4*).

Given the following factors, it seems less likely than ever before that new funding will be allocated to provide the necessary resources to achieve this national HIV prevention goal: (a) President George W. Bush's proposed fiscal year 2002 budget included an increase of only $11 million for domestic HIV prevention efforts before the terrorist attacks (5); (b) Congress has increased HIV prevention funding in fiscal year 2002 for CDC-administered HIV prevention efforts by about $39 million (6); (c) the significant fiscal implications of the recent terrorist acts for the country's economy (and federal expenditures in particular); (d) the impact of the costs of the attacks on New York City's budget, necessitating broad cuts in funding for city agencies (7); (e) the increased costs of providing AIDS-related services in New York City given service disruptions and more complex client needs (8); and (f) the redirection, at least in part, of private philanthropy away from HIV/AIDS causes to those related to the events of 11 September (9-12).

Given these HIV prevention resource issues, it therefore seems that a policy choice must be made between either giving up on the critical, national HIV prevention goal of reducing new HIV infections by half or redirecting resources. Assuming that the former is unacceptable, we are left with the latter. This may mean that we face difficult decisions such as whether to redirect some HIV prevention research resources into prevention program efforts. At a minimum, all existing HIV prevention efforts must be examined carefully and questioned as to whether the resources would be better spent providing services needed to achieve the national goal of reducing new HIV infections by half in the next 4 fiscal years.

2. Expansion of services

When new treatments for HIV disease became available in the mid-1990s, HIV prevention interventions changed dramatically. HIV counseling and testing, which some had considered to be a cruel hoax, became a potential gateway to promising and effective therapies. People had key questions about what these new treatments meant for them, their partners, and the community in general. Behavioral HIV prevention programs then in place had to adapt and address these news issues. If interventions are perceived as irrelevant, they are not likely to be effective.

The recent terrorist strikes and subsequent worsening of the economic recession may have similar effects on HIV prevention. Clients will need to deal with additional life challenges, such as heightened unemployment rates in some industries, and deployment into military service (of themselves or loved ones or both). Additionally, numerous mental health issues have been triggered or exacerbated by the attacks (13-21). Mental health needs must be met to reduce suffering and to hinder possible increases in HIV-related risk behaviors caused by unmet mental health needs (22). Also, an extended military campaign could shorten the cognitive time horizon clients consider when making sexual risk behavior choices (23-25). *The Washington Post* reported in December that post-11 September, the number of clients requesting free HIV counseling and testing at the Washington, D.C.-area Whitman-Walker Clinic dropped by 27%, a remarkable, measurable relationship between the terrorist attacks and subsequent lessening demand for public health services in HIV/AIDS (26).

Therefore, HIV prevention service providers will be challenged to expand or at least strengthen the array of services they provide or to which they can successfully refer clients. Social services (especially those related to employment, housing, and mental health counseling) will be vitally important. Also, HIV prevention service providers will be challenged by some clients to make their HIV prevention messages seem important in light of the recent attacks and subsequent military (and other) responses. When interacting with skeptical clients, it may be important for HIV prevention service

providers to encourage these clients to take HIV prevention messages to others in their family and community out of a sense of camaraderie. Indeed, the appeal to altruistic motives has been a theme of at least some HIV prevention research and programs throughout the epidemic.

3. Blood donation

Blood donations are virtually always needed in the United States to keep supplies up to necessary levels, but after 11 September there was a perceived need for large numbers of blood donations, and some spokespersons called for continued blood donations for some time after the attacks (*27*). However, because the mortality of the 11 September events so overwhelmed the morbidity, others felt that there was a diminished need for blood donations (*27*). This led to mixed messages to the community about what was truly needed (*27*). Nevertheless, many U.S. residents responded admirably to blood donation drives.

This has heightened awareness of two major policy issues: (a) deferral of donated blood from persons at risk of HIV and other infectious diseases; and (b) notification of persons who donate blood that tests positive for various infections. The risk assessment questions asked of potential donors rule out a number of people who truly want to donate out of a sense of patriotic duty. The gay and general press have carried stories of the frustration of men who have sex with men (MSM) who wished to donate but were ruled out by the risk assessment questions (*28*, *29*). At least one advocate has admitted to lying on the questionnaire about his sexual behavior so as to be able to donate blood (*28*). These questions were controversial even before the attacks, and if blood supplies run low in the future they could be of potentially even greater significance. Although the goal of protecting the blood supply has not changed, the potential size of the blood demand and the context in which blood donations occur appears to have changed. Perhaps the risk assessment, testing, and self-deferral strategies in place should be reviewed more frequently now than they have in the past, as should alternative ways for persons who are not allowed to donate blood to contribute to these efforts in other truly meaningful ways. Besides MSM since 1987, there are approximately three dozen other factors that might lead a person's blood donation to be denied or deferred (*29*). There will be no easy, uncontroversial answers in this area (*30*). However, these policy issues must receive ongoing and increased attention.

A second policy issue is also critical. The high-volume response to the 11 September attacks brought out a large number of blood donors, about 65% of them first-time donors (*31*-*33*). Although the percentages of donations now testing positive for HIV, hepatitis B, hepatitis C, or other infections is about the same as usual, the large volume of donors has led to an unusually high number of persons learning that they have one or more infectious diseases via the donation testing process (*31*-*33*). Especially for first-time donors who might not have realized that they were at risk, the news that they are living with a serious disease may come as quite a shock (suggesting a possible need for reviewing predonation counseling) (*31*-*33*). After learning of their seropositive test results, these clients may then themselves need critical counseling services, increasing the human services demand on an already heavily burdened system (*31*-*33*).

4. Global impacts

In addition to these effects on HIV prevention efforts in the United States, there are critical global implications of the 11 September attacks on the United States and military responses in Afghanistan. Sweat and colleagues have noted the disruption that war can cause to HIV-related services and the direct or indirect impact of war on individual

risk-taking behavior (34).

It has also been reported that after the United States initiated retaliatory strikes in Afghanistan, heroin prices in Pakistan began to rise; this occurred subsequent to a drop in price right after 11 September due to the unloading of opium stock from Afghanistan (35). The price increase could be important for HIV prevention efforts because as prices rise, users may inject heroin rather than inhaling it, thereby increasing the risk of HIV transmission (35).

Piot has noted that the 11 September events shattered notions of personal safety and forced a rethinking of national security; this reevaluation of national security must include a renewed emphasis on AIDS as a national and international security issue (36).

Further, the issue of global investment in HIV/AIDS programs post-11 September has been the subject of much recent discussion; after the attacks, contributions to global funds tended to drop, but more recently, support for increasing those resources has rebounded (37-41).

5. Communication

Air travel in the United States and abroad is likely to be more difficult, time-consuming, and expensive (after an initial period of customer-inducing discounts) in the weeks and months ahead. This will limit the amount of face-to-face contact and in-person interchange HIV prevention workers have with their colleagues in other locales. One potential consequence could be less exchange of ideas and solutions to real world problems that arise in HIV prevention activities.

Therefore, cheap, reliable, and practical alternatives to air travel for HIV prevention meetings must be sought. Before the attacks, numerous organizations were beginning to rely on telephone conference calling and videoconferencing technology, as well as Web-based electronic communications, for interactions with distant colleagues. In the wake of the attacks, it seems useful for HIV prevention organizations to invest some resources in strengthening their electronic communications capabilities, especially in the area of videoconferencing. Because many community-based organizations are on extremely limited budgets, funding agencies may wish to consider spending the resources necessary to provide videoconferencing infrastructure for all grantees and financially support the costs of Web and telephone access necessary for the use of the videoconferencing hardware. Many other communication alternatives such as regional conferences within easy driving distance should be encouraged. The main point is not to let these attacks significantly disrupt the critical interactions of HIV prevention workers across the country.

Conclusion

The tragic 11 September 2001 terrorist attacks on the United States have changed many aspects of our lives for some time to come. These changes likely include some modifications to the way HIV prevention efforts are conducted. Several of these possible changes are discussed here; this paper is meant to stimulate open, timely dialogue. Behind the tragedy, there could be one positive, unintended benefit. HIV prevention efforts have often been inhibited by fractional disagreements over local, state, and federal funding, development of prevention messages, and a variety of other policy issues. It is hoped that the recent challenges to the United States will cause the nation to pull together more closely than ever before, set aside specific differences, and focus collectively on the critical public health goal of reducing new HIV infections and improving the quality of life for those infected and otherwise affected by this disease.

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