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## IN THIS ISSUE




***In This Issue*** **continued on next page**


# The Internet's role as modern bathhouse is being scrubbed

*On-line hookups increasingly popular among MSM*

Nearly as quickly as 21st century technology is creating a new problem in the HIV/AIDS epidemic, the same technology offers a solution.

Some new epidemiological data, combined with anecdotal evidence and research, show that men who have sex with men (MSM) increasingly are meeting men in Internet chatrooms where they schedule what are called "real-time" sexual encounters or hookups. The relatively new venue for meeting sexual partners works nearly as fast as a meeting at a bar or bathhouse, according to researchers and prevention counselors.

The good news is that researchers and HIV prevention organizations already are developing programs that target MSM who look for sex via the Internet, and some of these have found efficient ways of reaching high-risk populations and providing interventions prior to their engaging in risky sexual behavior.

This trend of MSM meeting through the Internet has contributed to alarming increases in syphilis cases in California where the number of MSM with primary or secondary syphilis has increased from 162 reported cases in 2000 to 857 cases in 2002, says **Terrence Lo**, MPH, an epidemiologist with the


*(Continued on page 123)*

***In This Issue*** **continued from cover page**

**ADAPs enter the fall with waiting lists**

As if AIDS Drug Assistance Program directors weren't worried enough, they have a new potential problem to discuss: How would the states and ADAP programs handle a large influx of new HIV and AIDS patients if the Centers for Disease Control and Prevention succeeded in significantly increasing HIV testing rates? . . . . . 129

## ***FDA Notifications***

**NRTI Emtriva receives FDA approval**

The Food and Drug Administration has approved Emtriva (FTC, emtricitabine), a new nucleoside reverse transcriptase inhibitor to be used in combination with other antiretroviral agents for the treatment of patients with HIV infection . . . . . 131

## ***AIDS GUIDE For Health Care Workers***

**New language is needed to operate in the world of cybersex** . . . . . supplement

## COMING IN FUTURE ISSUES

- **Parents are from Mars:** What parents think their kids believe about sex and HIV often is quite different from what the kids say
- **Sex instruction for parents:** Intervention teaches adults how to talk to their children about HIV and sexual risk behavior
- **HIV continues to make its way across Eastern Europe and Asia:** Here's the latest on the epidemic's progress in areas where the epidemic still is toddling
- **Antiretroviral treatment edges forward:** Here's the best outlook for the future of HIV treatment as the epidemic presses forward
- **Promises broken and met:** AIDS organizations and officials offer assessment of domestic and international AIDS funding and programs



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Editor: **Melinda Young**, (864) 241-4449.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda. mooney@thomson.com).
Editorial Group Head: **Glen Harris**, (404) 262-5461, (glen.harris@thomson.com).
Managing Editor: **Robin Mason**, (404) 262-5517, (robin.mason@thomson.com).
Senior Production Editor: **Ann Duncan**.



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**Editorial Questions**

For questions or comments, call **Melinda Young** at (864) 241-4449.

California Department of Health Services in Berkeley.

The state's syphilis rate has increased from one case per 100,000 population in 2000 to three cases per 100,000 in 2002, he says.

Since California has had no changes in how syphilis is reported within that time frame, the increase suggests that more people, and particularly MSM, are engaging in unprotected sex and that the Internet has played a major role in this problem, Lo says. "We're definitely alarmed by this trend.

"HIV and syphilis are interrelated, and some of the risk factors such as unprotected sex are similar for HIV and syphilis," he explains. "Also, having syphilis has been shown to facilitate the transmission of HIV by three-to-five times; so yes, the current syphilis epidemic would most likely have an effect on the HIV epidemic as well."

State data also show that 66% of the MSM whose syphilis was reported in 2002 were HIV-positive, and this percentage also has increased in recent years, according to Lo. "In 2000, 53% of the MSM with primary or secondary syphilis were HIV-positive; and in 2001, 63% were HIV-positive."

## No return address?

The Internet's role in this also is apparent from the data. In the first half of 2001, 12% of the MSM with syphilis reported meeting their partners over the Internet; by the first half of 2003, this percentage increased to 40%, he points out.

Looking at the surveillance data more closely, health officials found that the percentage of MSM who reported the Internet was their only source of meeting sexual partners had increased from 4% in 2002 to 17% in the first half of 2003, Lo says.

"What we're finding is that people who meet partners off the Internet have a higher number of sex partners than those who said they didn't, and they have a higher number of nonlocatable partners, which is problematic for us," he adds. "We can't find them for testing and counseling."

Surveillance data confirm what researchers are finding when sampling MSM who use Internet chatrooms to meet sexual partners.

In a new study, investigators recruited MSM from Internet chatrooms and interviewed 91 people on-line, both with a research assistant asking questions and through having them fill out a survey. All participants were older than 18, sexually active, and using the Internet for sex purposes, says **Gregory Rebchook**, PhD, investigator for the Center for AIDS Prevention Studies at the University of California, San Francisco.

"Nearly everyone said they thought the Internet allowed them to increase their number of sexual partners and provided a convenient mechanism for finding sex quickly," he says.

About 58% of the men surveyed reported unprotected anal sex within the last two months, and 39% reported unprotected anal sex with partners they had met on-line, Rebchook adds. "Men in our study spent an average of 20 hours a week on-line for personal purposes."

Also, the men reported having had an average of seven sexual partners within the last two months, and 11% of the men surveyed said they were HIV-positive, while the HIV status of 15% of the participants was unknown, he says.

"The reasons why risk behavior and HIV incidence are going up are multifaceted; and so the Internet may be part of that, but it's not the only part," Rebchook explains. "I think the context in which HIV risk behavior happens now is different from what it was five years ago."

Besides the new Internet trend, other changes that have played a role in the current epidemic include treatment optimism due to the antiretroviral drugs, the increase in party drug use, and the greater number of people living with HIV infection, he says.

Data and studies such as these suggest that more interventions should focus on Internet sex-seekers, using the same technology in outreach projects. "By providing anonymity, the Internet allows counselors to discuss issues some men might be reluctant to discuss in other settings." Rebchook points out. "Our study underscores the need for using the Internet for prevention."

A number of community-based organizations and other groups have started these types of prevention projects, sometimes on shoestring budgets:

PowerOn in the Seattle area and SexEd4U in Ferndale, MI, are two good examples of interventions that reach MSM in chatrooms at the precise moments when they may be making a decision to have anonymous sex. **(See story about Internet HIV-prevention programs, p. 124.)**

Another new intervention is the Internet Sexuality Information Services Inc. (ISIS), which provides syphilis elimination services to MSM in San Francisco through a contract with the city and county. Also, ISIS collaborates with the California Department of Public Health to coordinate an on-line Syphilis Action Coalition in the Bay Area. ■

# Interventions can ease dangers of cybersex

*Counselors educate while in chatrooms*

Successful Internet prevention programs need to reach the population most at risk for HIV and which uses the Internet as a major avenue for meeting anonymous sexual partners. Several regional programs have found ways to do this, including at least one that operates on a shoestring budget.

Although some will say the outreach intervention essentially is the same as what has been used for years in bars and bathhouses, the methods are very different and require counselors to receive unique training.

For instance, both PowerON of Seattle and SexEd4U of Ferndale, MI, provide counselors with training in how to deflect sexual propositions and with information about Internet abbreviations commonly used in chatrooms. **(For more Internet HIV intervention information, see *AIDS GUIDE For Health Care Workers*, inserted in this issue.)**

While the traditional outreach for gay bars and bathhouses might involve having counselors visit these locations and dispense condoms and information to patrons, the on-line HIV prevention counselors sign into chatrooms where men who have sex with men (MSM) make appointments with other men for anonymous sex.

Men will say in these chatrooms that they're looking for RT (or real-time sex), meaning they want to hook up with someone within an hour, says **Jeffrey Neil Weldon**, program director of the Friend-to-Friend Project and PowerON of the HIV/AIDS Project Development and Evaluation Unit of the School of Social Work at the University of Washington in Seattle,

Here's a brief look at how PowerON and SexEd4U programs work:

- **SexEd4U**

The Midwest AIDS Prevention Project of Ferndale, MI, expanded its prevention services into the area of Internet interventions after **Michael Odom**, SexEd4U project director, read about similar programs operating on the West and East Coasts.

"I thought this was a great way to create a program as an outreach to a community, so we came up with the premise and were going to jump in with guns blazing," he says.

SexEd4U counselors are certified by the state of Michigan as HIV counselors, and the outreach project's mission can be described by the acronym BEEF:

— **Becoming** a resource
— **Effective** communication
— **Establishing** trust/rapport
— **Facilitating** referrals

"We searched for resources in the community, including HIV social support, housing, emergency financial assistance, HIV testing sites in each county; and we compiled a list that could be easily transferred to the Internet," Odom says.

The goal was to find out as much as possible about Michigan resources for MSM so that HIV counselors could quickly answer any questions that arise as they have discussions with men in the Internet sex chatrooms.

For example, the Internet counselors often are contacted by teenage boys who have never had sex, but identify themselves as gay or bisexual. "We refer them to the Lesbian, Gay, Bisexual, Transgender (LGBT) teen center, which also is on-line but is an actual community center in metro Detroit," he says. "It's a safe haven for people of their own age to relate to and come to terms with their sexuality."

SexEd4U counselors sign into MSM chatrooms, using SexEd4U as their pseudonym. One of the challenges in the initial stages of the intervention was to advertise to MSM what SexEd4U was about, so that the chatroom participants would be familiar with it and would know that the information they received came from a certified HIV counselor.

"We sent out press releases to gay publications and newspapers to announce that SexEd4U was legitimate and sponsored by the Midwest AIDS Prevention Project," Odom explains. "We had to establish that trust and rapport."

Whenever HIV counselors found that some of the same questions came up time and again, they decided to create a topic-of-the-month feature in which one topic is fully researched with files ready to send to anyone who has questions about it. Chatroom users are told about the topic of the month and encouraged to ask questions about it.

For instance, in January there was the topic of HIV and oral sex; in February, the topic was rimming. In March and April — at the request of the state health department — the topic was syphilis, Odom says.

The Internet counselors are trained to understand the chatroom terminology and get answers

promptly because about 80% of the people using these MSM sex chatrooms are looking for casual and anonymous sex partners and won't waste much time with other agendas, Odom says.

"Sometimes, people will even tell you, 'Hey, you're taking the space of some hot guy in here,'" he continues. "So what we do is — we want our counselors to be personable."

Counselors have a rare opportunity to provide just the right HIV-prevention advice needed before two MSM engage in risky sex. Counselors are trained to ask the users only the questions necessary to provide them with the most accurate answer and to not become embroiled in a sexual pick-up type of conversation by bringing the conversation back to HIV and safe sex education. And when users have direct questions, a prompt, practical answer is the key.

For instance, a chatroom user asks a counselor: "What lubricants can I use with latex condoms?"

The counselor answers: "You can use water or silicon-based lubricants with all latex condoms. Stay away from petroleum jellies, hand lotions, baby oils, Vaseline, and any type of product that has oil in it because it breaks down the condom itself and can cause it to rip or tear."

About 15 minutes after the counselor sends the answer, the chatroom user might be answering his door to man he hooked up with, and when that man pulls out a condom with Vaseline, the chatroom user can say that he had just learned that Vaseline doesn't work, Odom explains.

## Timely information

"The prevention message is at the time the on-line person needs it most because they're making their arrangements right then and there, and they may be hooking up on-line in the next 15 minutes," he says.

Interactive on-line interventions such as SexEd4U can be replicated in other parts of the country, and if they are staffed by paid employees of a community-based organization or health clinic, they could operate on a small budget, Odom suggests.

SexEd4U receives no grants or extra funding. It's fueled by a core group of committed HIV counselors who are willing to devote some of their weekday and even weekend time to going on-line to visit these chatrooms and offer educational services to men who may be hooking up with an anonymous sexual partner within that hour, he explains.

The project started by targeting weekday chatroom users, but now is expanding to include night and weekend chatroom users, Odom says.

"We're in the process of starting a marketing campaign to talk about SexEd4U to promote the program, and we've created an electronic postcard for it," he says.

The postcard is sent by volunteers to 10 of their friends, who also forward it to more people, he says. SexEd4U, in the past year, has averaged three MSM interventions during each one-hour on-line discussion, and the program has made referrals to local agencies for HIV testing, treatment, and other services, Odom adds.

- **PowerON**

PowerON, developed by staff at the HIV/AIDS Project Development and Evaluation Unit in the School of Social Work at the University of Washington in Seattle, was created to target the highest risk category of Internet sex seekers, Weldon says.

"We realized that those individuals had high-speed modems, and we needed to compete with existing porn sites that have that same level of activity," he says. "So what we decided was to go with a flash site, which is more interactive and has moving elements."

While more traditional HIV prevention sites lack frills and look as though they were designed by government agencies, the PowerON project was aiming for something more enticing, Weldon explains. "We knew that saying it was about HIV prevention wouldn't interest people, so we marketed it as a gay health site," he says.

The five pages most accessed out of the web site's more than 7,000 pages include the HIV self-assessment that gives health statistics on a person's risk for HIV infection based on responses to various questions, Weldon says.

"If you said you slept with 15 to 20 guys in six months, it gives you a gauge of your risk level, according to race and demographics," he explains. "We found that this was the No. 1 accessed page on the whole site, so we found that individuals really are very interested in basic HIV prevention information."

The second top-rated page is one on negotiating sexual safety, and the third is about sexually transmitted diseases. The fourth most visited page shows men how to put on a condom, and the fifth has information about drugs and sex, he says.

PowerON was designed as a way to improve referrals to HIV and other agencies. Its $150,000, two-year budget pays for the referral site research

and web site design, as well as for the collection of prevention material, according to Weldon.

"Costwise, the first year is much more costly because of start-up costs; but this year, we're proposing a much bigger budget because we're involving four collaborative partners, all that deal with communities of color and populations using crystal methamphetamine," he says.

Each agency involved will allocate four hours a week in outreach to specific communities that can be accessed through on-line counseling, Weldon adds. The idea is to have counselors visit on-line MSM web sites, and notifying web site users of their presence through a screen icon that says "Outreach worker available," he explains. The user could click on the icon and have an instant virtual conversation with the outreach worker, who could direct the person to the web site or to additional information.

PowerON's basic web site design, which took about eight months to launch, could be duplicated inexpensively by other community and health care organizations, Weldon points out.

"What we've done is design the site so it can be duplicated from different city to different city, and we propose that it be a regional or national thing, like having a PowerON Los Angeles," he says. "We've collected information from all different web sites around the world, and it could be tailored and replicated."

For example, PowerON's very efficient and thorough referral service might require the greatest amount of start-up manpower, but maintaining it would be fairly simple. The traditional system of self-referring often is inefficient and can lead to frustration as people seeking information are turned away from a particular agency because they don't fit that agency's target population.

Through PowerON's web site referral service, people are sent directly to the agency and even the very staff member who can best help them with whatever it is they need, Weldon explains.

PowerON staff had collected information and direct names and phone numbers of counselors for every type of agency that might offer services to the targeted HIV and MSM population. It's updated monthly, so users easily may find the very person who can help them with a particular problem or issue, he says.

About one-third of the people who visit the PowerON web site will visit the referral section, which was a surprising affirmation that the project's goals were being met, Weldon says.

The web site received more than 55,000 hits in the first two months in a county where the target population numbers 50,000, he notes. "Individuals were returning to the site consistently, and that was an important thing to know."

Another feature of the PowerON web site is its role model postcard in which volunteers send out 10 a month to friends. They can send information from the web site that they think will interest their friends, Weldon says.

"We recruited three steady role models who represent the gay, bisexual, and transgender communities, and they shared their personal testimonies about how the web site helped them," he says. The role models do not work in the on-line chatrooms, as do the outreach workers, but their stories help to draw more people to the web site, Weldon adds.

### Chatroom training

Outreach workers visit MSM chatrooms to discuss HIV prevention and suggest that people visit the web site, explaining what it is and what the organization is trying to do with it, Weldon says. Since outreach workers are entering a highly charged sexual atmosphere in which other chatroom users may try to recruit them for sexual acts, PowerON has a three-hour training session for workers. Also, there is a software system that tracks conversations between outreach workers and chatroom users, he says.

"So our volunteers know that happens, and we give them training on how to de-escalate sexual situations and how to turn that person's interest around and direct the person to the web site," Weldon says. "They're not to turn the user away with a hard and cold approach."

Internet HIV prevention interventions have two main advantages over traditional interventions: The first is that they reach people at a time when they are seeking an anonymous sexual partner. The second advantage is that they give people anonymity for their questions and problems, he notes.

Often, the people who contact PowerON wouldn't have sought the same information in a traditional environment because they wouldn't have wanted to be identified as an MSM or they wouldn't have wanted to look stupid to the outreach worker they meet face to face, Weldon says.

"They couldn't access it in the traditional environments because it might expose something about their character, so the anonymity meant no one knew who they were, as opposed to having a

one-on-one conversation with an outreach person they might see on the street or in a bar," he explains. "Then there is the marginalization of some of the subpopulations, so this was a venue in which they felt comfortable."

*(For more information, contact:*

- ***PowerON:** HIV/AIDS Project Development and Evaluation Unit of the School of Social Work at the University of Washington, Seattle. Web site: http://depts.washington.edu/poweron.*
- ***The Midwest AIDS Prevention Project**, Ferndale, MI. Web site: www.aidsprevention.org/index.htm.)* ■

# Rapid HIV test yields counseling, referrals

*Clients report satisfaction with rapid test*

Recent studies of the rapid HIV test's use among at-risk populations show that the test can be a valuable tool when combined with counseling in intervention programs because the percentage of people who stay to receive their test results is very high.

The test also has increased demand for HIV testing and counseling outreach programs in communities that otherwise may be difficult to reach or that are at greater risk for the AIDS epidemic.

For example, the AIDS Research Consortium of Atlanta has developed a program called the Metro Atlanta Women of Color Initiative that targets African-American women for HIV testing and counseling at both the consortium's clinic and at community sites, says **Melanie Thompson**, MD, principle investigator.

"In Georgia in 2002, 86% of the women diagnosed with AIDS were African-American, and 28% of AIDS cases overall were women," she says. "And within the African-American community and particularly among women, there is a significant stigma against testing."

The program resulted in nearly all participants staying to receive their HIV test results, and greater than 99% said they preferred receiving their HIV test with the rapid testing, Thompson says. "One hundred percent said they'd do it again with the rapid test, and 100% said they'd refer friends for the rapid testing," she adds.

Another recent study evaluating OraQuick rapid HIV testing in high-risk settings also found that the test results reach a high percentage of people being tested. University of Minnesota investigators tested 739 people in Minneapolis for HIV, and all but one person received the test results. The targeted population included people found in chemical dependency programs, homeless shelters, halfway houses, and youth centers.[1]

The AIDS Research Consortium's ability to take state-certified counseling and testing staff to local churches, community centers, YMCAs, and other venues to provide HIV prevention counseling before and after results are given from a rapid HIV test has struck a positive cord within the African-American community.

"The response from the community has been overwhelmingly positive," Thompson says. "In fact, we haven't been able to meet all the demand from community groups that want us to come out and work with them."

Although the program has targeted African-American women, it also has reached at-risk men, who accounted for 29% of the first 300 clients who were tested, she explains.

"What we find is men also want to avail themselves of testing an sometimes will bring their partners with them," Thompson says.

Of the first 300 clients, 80% were African-American; 53% were ages 20 to 29; the annual income was less than $15,000 for 44% of the clients, and 67% had been tested and found negative previously, she adds.

"But 25% had never been tested before, and 20 clients or 7% had been tested previously, but didn't return for test results," Thompson says. "And when you look at that group of 20 a little more closely, they were all African-American, and two of them tested positive in our program."

This was affirmation that the program was picking up the at-risk people who otherwise might not learn of their HIV status.

Nationally, the Centers for Disease Control and Prevention (CDC) estimates that the percentage of Americans who have been tested for HIV is 45.6%, which includes women who are tested during pregnancy and people who are tested involuntarily due to military service, insurance application, employment, immigration, and other reasons.[2]

Out of the entire group of 300 included in the study analysis, there were 11 positives (3.7%), Thompson says. Breaking this down by gender, the seroprevalence for the men was 10.3%; and for

the women, it was 0.9%. "About 20% of our HIV-positive clients came to be tested because of recent risky behavior," she points out.

The program is designed to do far more than provide HIV testing. Counselors meet with clients during the 20 minutes it takes to process the OraQuick rapid HIV fingerstick test, which is what has been used in the program since March 2003, she says.

"We are still counseling with clients at the time the test comes back." This service all but guarantees a high rate of clients learning their test results, and there was, in fact, only one person who left before the results could be revealed, Thompson adds.

"The first prevention message was that people got their test results, and their knowledge of their serostatus is important in implementing interventions. The second intervention was in the counseling," she adds.

Counselors discussed with clients, as they waited for their results, about HIV, how it's transmitted, about their own risk behaviors, and how to develop a personal risk-reduction plan.

"We do role-playing with clients about what would happen if they got a positive test," she continues. "We ask them very specific questions like, 'Who would you call today? What would happen if you told your sexual partner that you are positive? Are you afraid you would be subjected to violence?'"

The role-playing is important because once the test results come back, it's very difficult for people to think through these scenarios, Thompson says. "We counsel people to come to grips with getting a positive test."

Also, the role-playing serves as an additional prevention message because it's often the first time that a person has seriously considered what would happen if the HIV test came back positive, she says. "It's not unusual to see a client cry and experience strong emotions when asked these questions."

The program is fairly unique in that it also includes providing a free CD4 cell count for the people who test positive. "That allows us to triage the emergency of getting someone into care," Thompson says.

Clients who have low CD4 cell counts are referred to services where they could receive antiretroviral treatment and, if necessary, prophylaxis for opportunistic infections.

Six of the 11 people who tested positive in the first group had CD4 counts of less than 350, indicating that they were candidates for antiretroviral treatment, she notes.

The other aspect of the program links clients to care and is part of the clinical trials consortium, which includes private doctors and health clinics and referrals to the proper health insurance or safety net, Thompson adds.

Also, since the CDC has announced it will focus more intently on providing prevention messages to HIV-positive populations, the program includes counseling for positives to help people with risk reduction, she explains.

This opportunity arrives when the patient is seen at a follow-up session a week after the rapid test. At this meeting, the client is told of the results of a second HIV test that is taken for confirmation purposes.

"Most of the time, they're willing to give us their name and contact information or to take our name and our counselor's name and then call that person back," Thompson says.

"We try to keep in contact with that newly diagnosed person over the course of that week, so they have someone to talk to, or so they can call us and we can send them to whatever referral services they might need, including psychiatric care or drug-abuse treatment," she explains.

Thompson says that the rapid test is better from the client's perspective because the week-long wait often is difficult, leaving people with a lot of anxiety and fear.

Many studies of HIV testing show a low response rate of people returning for their test results, and the rapid test will capture nearly all of these testing dropouts. Also, HIV counselors have the option of not providing a rapid test's results to a client immediately if the counselor determines that the client is not in the best frame of mind to hear about a bad result, Thompson explains.

For instance, if rapid testing is offered in a bar, counselors could set an appointment to contact the people the next day when they are sober, she says. "You do have the option of waiting to give the results. Just because it's a rapid test doesn't mean the results have to be given back rapidly."

## References

1. Keenan P. HIV outreach in the African-American community using OraQuick rapid testing. Presented at the 2003 National HIV Prevention Conference. Atlanta; July 2003 Presentation #T2-1502.

2. HIV Testing — United States, 2001. *MMWR* 2003; 52 (23):540-545. ■

# Study: Condoms in school do not promote sex

*Very few high schools offer condoms, however*

A recent study of student behavior in high schools where condoms are available suggests that the mere fact of having condoms in schools does not increase sexual behavior among students.[1]

Researchers found that in schools where condoms are available, condom use was significantly higher among sexually active students, with 72% of those students reporting using condoms during their most recent sexual encounter. Among sexually active students who attended schools without condoms available, 56% reported having used condoms during their most recent sexual encounter, says **Susan Blake**, PhD, associate research professor at the School of Public Health and Health Services of George Washington University in Washington, DC.

The study also found no evidence of increased risk of sexual activity in schools where condoms were available; and in fact, the opposite proved to be true, she adds.

"In schools with condoms available, 42% of all kids reported ever having sexual intercourse," Blake says. "In schools where condoms were not available, 49% reported ever having sexual intercourse, and that difference was significant."

In 1991, the Massachusetts state board of education established a policy that encouraged local school districts to consider making condoms available in high schools, according to some policy recommendations, she says.

The policy suggested that local school districts bring up this topic for public discussion, Blake points out. "They were to encourage a public dialogue between board members, superintendents, school administrators, faculty, parents, and others."

Researchers looked into the program to see how many school districts had adopted the program, how the public discussions had been conducted, and how the program was implemented. The second part of the research involved assessing student behavior in both schools with condoms and those without condoms, and this was done through the Youth Risk Behavior Survey (YRBS), she says.

"So we segmented the YRBS data from high schools with and without condoms, as opposed to doing a separate study," Blake explains.

Nationwide, condom availability in high schools is rare. Various studies estimate between a fraction of 1% to about 8% of high schools make condoms available, and 42% of the school districts that made condoms available were in Massachusetts, she says.

Under the Massachusetts program, 10% of the school districts approved having condoms available in high schools, and 65% of the school districts held at least one public meeting to discuss the issue, Blake says.

About 45% held discussions with the school board, as suggested by state policy, and 28% of the districts developed explicit policies related to condom availability, she adds.

"There's a message here in terms of when you open up a sensitive issue to public discussion, and when more constituencies are involved, the probability of parents and policy-makers approving programs for sexually active teenagers increases," Blake says.

When a state makes such a policy to open discussion on a controversial topic, such as condoms in schools, that gives local school boards and administrators the freedom to hold public discussions on topics they might otherwise be afraid to address on their own, she explains.

"When you have a state policy that encourages discussion of sensitive issues, you open the door to public dialogue that otherwise might not be addressed," Blake adds. "And given a choice or voice in these matters, many parents will support programs that protect their children from harm, including condom availability programs."

### Reference

1. Blake SM, Ledsky R, Goodenow C, et al. Condom availability programs in Massachusetts high schools: relationships with condom use and sexual behavior. *Am J Pub Health* 2003; 93(6):955-962. ■

# Rapid tests could mean trouble for ADAPS

*Increased HIV testing could flood system*

As if AIDS Drug Assistance Program (ADAP) directors and other people monitoring the costs of providing HIV drugs to the uninsured weren't worried enough, they have a new

potential problem to discuss: How would t he states and ADAP programs handle a large influx of new HIV and AIDS patients if the Centers for Disease Control and Prevention (CDC) succeeds in significantly increasing HIV testing rates?

With estimates of some 200,000 to 300,000 people in the United States who are HIV-positive and don't know it, a big increase in HIV testing could put a whole lot more HIV-infected people into the ADAP and Medicaid care systems, says **Murray Penner**, director of the HIV Treatment Program of the National Alliance of State and Territorial AIDS Directors of Washington, DC.

"It's going to be a huge strain on the program, and we're already experiencing waiting lists, so it absolutely is a big concern," he says.

## Push could add thousands of clients

The new push for HIV testing and outreach using the rapid HIV test could result in 5,000 to 15,000 new AIDS clients being added to the ADAP rolls, says **Bill Arnold**, director of the ADAP Working Group in Washington, DC.

It's a safe bet that most of the HIV-positive people discovered through increased testing and counseling outreach programs will not be people who have adequate health insurance to cover their antiretroviral medications, he says.

"The outreach vans are going into areas where nobody goes to see a doctor unless their health is so bad that they have to go to the emergency room," Arnold adds.

"We had in Washington, DC, a grandmother who was so busy taking care of her kids and grandkids that by the time she ended up in an emergency room, she had full-blown AIDS; and at the age of 61, she died of PCP [*Pneumocystis carinii* pneumonia]," he adds.

These are the kinds of cases that rapid testing might uncover. And while that is a positive public health direction, the big question is whether ADAPs and other safety nets will be able to handle an influx of such new clients.

The key will be how quickly and in what regions these new cases show up, Arnold contends. "If they all come out in 60 days — then we're screwed."

Likewise, if a disproportionate number of these new cases appear in states that have struggled all year with ADAP funding, including Texas, North Carolina, and Alabama, then those ADAPs likely will have serious problems meeting the increased need, he says. "We're trying to figure out what we should be preparing for."

By late summer, the number of people on ADAP waiting lists had grown to more than 600, and 16 states had limited access to antiretrovirals.

New York and California seemed to be handling their ADAP and Medicaid clients with HIV, but a budget and political crisis in California could threaten that stability; and no one could say whether these states could handle a large influx of new HIV cases discovered through rapid testing and outreach programs, Arnold points out.

Throw on top of this the ubiquitous state fiscal problems and Medicaid cuts that are throwing more people onto the ADAP rolls, and there is serious cause for concern, Penner explains.

"And this doesn't look any better with Fiscal Year 2004 funding, which is actually less [of an increase] than what it was last year," he points out.

## Congress to the rescue?

Penner and Arnold held out hope that Congress would come through with emergency funding or at least increase the amount promised for next year's ADAP budget and that Congress would pass the Early Treatment for HIV Act, which was introduced last June.

"There has to be long-term solutions, including having expanded Medicaid coverage like the Early Treatment for HIV Act," Penner says. "This would allow people to get on Medicaid much sooner in their disease process and allow them to receive antiretrovirals, which would take some strain off of ADAP."

Also, there were two pieces of good news this year for ADAP, and these will help a little with the crisis, Arnold says.

The first is that all of the major antiretroviral manufacturers agreed to stabilizing prices of HIV drugs through voluntary rebates and other price-cutting concessions to last through the next 1½ years, he says.

The other good news is that the ADAPs which included the new infusion therapy in their formularies have not had the expected influx of clients needing this expensive new treatment, Arnold says.

"The take-up rate with ADAPs has been much slower than people thought," he says. "So that's good news, but how long that will go on, we don't know." ■

# FDA Notifications

## NRTI Emtriva receives FDA approval

The Food and Drug Administration has approved Emtriva (FTC, emtricitabine), a new nucleoside reverse transcriptase inhibitor (NRTI) to be used in combination with other antiretroviral agents.

Emtriva is indicated for adults 18 and older. Safety and effectiveness in pediatric patients have not been established. In antiretroviral-treatment-experienced patients, Emtriva may be considered for adults with HIV strains that are expected to be susceptible to Emtriva as assessed by genotypic or phenotypic testing.

The recommended dose of Emtriva is one 200 mg capsule daily, with or without food.

The FDA based its approval on data from two 48 week clinical trials. The first trial was a double-blind, active-controlled multicenter study comparing Emtriva (200 mg once daily) administered in combination with didanosine and efavirenz vs. stavudine, didanosine, and efavirenz in 571 antiretroviral patients.

The proportion of patients who achieved and maintained confirmed HIV RNA < 400 copies/mL (< 50 copies/mL) through week 48 was 81% (78%) for the Emtriva, didanosine, and efavirenz group vs. 61% (59%) for the stavudine, didanosine, and efavirenz group, respectively.

The mean increase from baseline in CD4 cell count was 168 cells/mm3 for the Emtriva arm compared to 134 cells/mm3 for the control arm.

## CE/CME *directions*

To complete the post-test for *AIDS Alert*, study the questions and determine the appropriate answers. After you have completed the exam, check the answers **on p. 132**. If any of your answers are incorrect re-read the article to verify the correct answer. At the end of the semester in December, you will receive an evaluation form to complete and return to receive your credits.

## CE/CME *questions*

13. Which of the following is the fast-growing venue for where men who have sex with men (MSM) meet anonymous sexual partners, according to recent information about the spread of syphilis in California?
    A. bathhouses
    B. gay, bisexual, and transgender bars
    C. internet sex chatrooms
    D. none of the above

14. Prevention programs targeting MSM who seek sexual partners through Internet chatrooms may provide which type of intervention?
    A. HIV counselors visit the MSM chatrooms and strike up conversations with users and answer their questions about HIV and risky behavior.
    B. Internet chatroom users are encouraged through electronic postcards and other marketing tools to visit a web site with HIV prevention information.
    C. On-line HIV counselors refer chatroom users to an HIV and MSM referral network that can be accessed on-line.
    D. all of the above

15. Typical HIV testing offered to marginalized, at-risk populations have lower rates of individuals returning to learn their HIV test results. The new rapid HIV test, when used by organizations targeting the same populations, has been shown in some studies to have HIV test return rates of what percentage?
    A. 79%
    B. 87%
    C. 95%
    D. 99%

16. According to a recent study, Massachusetts schools that provide access to condoms in the high schools have what types of results, when compared with schools that did not provide condoms?
    A. The schools without condoms had lower rates of sexual activity and lower condom use among those who engaged in sex.
    B. The schools that had condoms showed no evidence of an increased risk of sexual activity among students, and they had higher rates of condom use among those who engaged in sex.
    C. Schools without condoms had a higher rate of sexual abstinence.
    D. none of the above

The second trial was an open-label, active-controlled multicenter study comparing Emtriva to lamivudine, in combination with stavudine or zidovudine and a protease inhibitor or NNRTI in 440 treatment experienced patients who were on lamivudine-containing triple-antiretroviral drug regimen for at least 12 weeks prior to study entry, and had HIV-1 RNA * 400 copies/mL.

The proportion of patients who achieved confirmed HIV RNA < 400 copies/mL (< 50 copies/mL) through week 48 was 77% (67%) for the Emtriva group vs. 82% (72%) for the lamivudine group. The mean increase from baseline in CD4 cell count was 29 cells/mm3 for the Emtriva arm compared to 61 cells/mm3 for the lamivudine arm.

The most common adverse events that occurred in patients receiving Emtriva with other antiretroviral agents in clinical trials were headache, diarrhea, nausea, and rash, which generally were of mild to moderate severity.

Approximately 1% of patients discontinued participation in the clinical studies due to these events. With the exception of skin discoloration, which was reported with higher frequency in the Emtriva-treated group, all other adverse events were reported with similar frequency in Emtriva and control treatment groups.

Skin discoloration, manifested by hyperpigmentation (excess pigmentation) on the palms and/or soles, was predominantly observed in non-Caucasian patients. The mechanism and clinical significance are unknown.

It is recommended that all patients with HIV be tested for the presence of chronic hepatitis B virus (HBV) before initiating antiretroviral therapy.

Emtriva is not indicated for the treatment of chronic HBV infection, and the safety and efficacy of Emtriva have not been established in patients co-infected with HBV and HIV. "Flare-ups" of hepatitis B, where the illness can return in a worse way than before, have been reported in patients after the discontinuation of Emtriva. Patients co-infected with HIV and HBV should be closely monitored with both clinical and laboratory follow-up for at least several months after stopping treatment.

As with other NRTIs, Emtriva may cause lactic acidosis (buildup of an acid in the blood), serious liver problems called hepatotoxicity, with liver enlargement (hepatomegaly), and fat in the liver (steatosis).

Emtriva is a product of Gilead Sciences in Foster City, CA. ■



## CE objectives

After reading this issue of *AIDS Alert*, CE participants should be able to:

- identify the particular clinical, legal, or scientific issues related to AIDS patient care;
- describe how those issues affect nurses, physicians, hospitals, clinics, or the health care industry in general;
- cite practical solutions to the problems associated with those issues, based on overall expert guidelines from the Centers for Disease Control and Prevention or other authorities and/or based on independent recommendations from specific clinicians at individual institutions. ■

## CE/CME *answers*

| | |
|---|---|
| **13. C** | **15. D** |
| **14. D** | **16. B** |

AIDS GUIDE
For
Health Care
Workers®

# New skills required to operate in the world of cybersex

*Research suggests Internet increases risk*

Research and data presented at the 2003 National HIV Prevention Conference, held July 27-30, 2003, in Atlanta suggest that community-based organizations (CBOs); health care, treatment, and prevention clinics; and other public health organizations might need to consider initiating outreach programs to reach men who have sex with men (MSM) who use the Internet as a venue for meeting anonymous sexual partners.

The California Department of Health Services has collected surveillance data that show an increasing trend of MSM using the Internet to meet sexual partners and then engaging in high-risk sexual activities.

For example, both syphilis cases and the incidence of HIV have risen in just the past two years among the population of MSM who cruise the Internet for sexual partners. The data show that 23% of the California MSM who had secondary or primary syphilis in 2002 met their sexual partners via the Internet, vs. 21% who met their partners in bathhouses, and 9% who met partners in sex clubs.[1]

An on-line study, conducted by investigators with the Center for AIDS Prevention Studies at the University of California, San Francisco, shows that three out of four MSM reported having recent sex, including unprotected sex, with someone they met on-line within the previous two months, and 11% of these MSM said they were infected with HIV. Unprotected anal intercourse was reported by 39% of the respondents.[2]

Other recent research demonstrates that CBOs and others can reach the high-risk MSM population through on-line interventions and virtual outreach.

Several Internet HIV prevention programs have succeeded in reaching this population through sending trained outreach workers into MSM chatrooms, such as the Gay.com chatroom, where men meet men and often schedule sexual encounters.

In a study conducted by the Internet Sexuality Information Services Inc. (ISIS) of San Francisco, outreach counselors, who also were the study's investigators, were able to answer an average of 15 questions per hour while logging into the Gay.com chatroom. Furthermore, by posting a banner ad campaign on-line, ISIS brought 32,370 links between people seeking information and the San Francisco Department of Health Web site. Also, there were 212 exchanges of prevention information during the 57 hours of Internet outreach on three other sites, and there were 35 coupons redeemed among those distributed on-line for free syphilis testing. Investigators concluded that one-on-one outreach in chatrooms was more effective than larger, on-line presentations.[3]

The PowerON web site of Seattle also has reported success in reaching high-risk MSM.

| | | | |
|---|---|---|---|
| **: )** = smile | **{ }** = a hug | **AFK** = away from keyboard | **BTW** = by the way |
| **:>)** = big smile | **:(** = a frown | **BAK** = back at keyboard | **IMHO** = in my humble opinion |
| **:D** = smile/laughing/ big grin | **:'(** = crying | **BRB** = be right back | **WTG** = way to go |
| **:•** = kiss | **0: )** = angel | **TTFN** = ta-ta for now | **42O** = pot |
| **;)** = wink | **}:>** = devil | **WB** = welcome back | **PNP** = party & play |
| **:X** = my lips are sealed | **LOL** = laughing out loud | **GMTA** = great minds think alike | **R/T** = real-time hookup |
| **:P** = sticking out tongue | **ROTF** = rolling on the floor (laughing) | | **d/d** = drug & disease-free |

Called Prevention Organizations With Empowerment Resources On the Net, PowerON also has outreach counselors visit MSM chatrooms to provide HIV information and to direct men to the PowerON web site for access to more than 7,000 pages of health care and HIV prevention information. In a survey of 36 men, four out of five of whom used the Internet to find sexual partners and all of whom visited the PowerON web site, respondents said they found the site useful and would recommend it to their friends.[4]

Another successful pilot Internet intervention program, called SexEd4U, targets MSM in on-line chatrooms, using certified HIV prevention counselors to visit chatrooms and answer questions, make referrals, and send additional prevention information to chatroom participants. The project, started by the Midwest AIDS Prevention Project of Ferndale, MI, reached an average of three MSM during each one-hour on-line discussion.

According to the creators of PowerON and SexEd4U, one of the most important aspects of designing an Internet HIV prevention intervention is to make certain that outreach counselors are trained in both HIV prevention and Internet use, particularly how to use chatrooms.

As such, PowerON has provided its volunteers and counselors with this guide to what chatroom shorthand, symbols, and abbreviations mean. Reprinted with permission from **Jeffrey Neil Weldon**, program director of the Friend-to-Friend Project and Power ON, of the HIV / AIDS Project Development and Evaluation Unit of the School of Social Work at the University of Washington in Seattle, here is a summary of the guide to Internet MSM chatroom talk: **The Meaning of All Those Symbols and Shorthands Revealed!**

If you're new to chat, you may find this summary of on-line etiquette and shorthands useful. When you first enter a chatroom, most members give a brief greeting, or wave (::waving:☺ and grin (:D), or just a simple "hi." You may want to just hang around and listen without talking. Get the feel of the room. This is called "lurking" and is perfectly acceptable.

Typing in all caps is considered shouting, so please spare everyone's ears and your vocal chords. Vulgarity is unacceptable anywhere, anytime. 'Nuff said. Because on-line chat usually is a text-only medium, it makes the conveyance of emotion somewhat difficult. People use shorthands in this "faceless" medium to express feelings and show actions or "body language." You'll find shorthands used in chat, on message boards, in electronic mail — everywhere! Tilting your head to the left or turning your screen on its side will help you see most of the shorthands : ) < —- See? Two eyes and a mouth! **(For a list of some of the most popular symbols and abbreviations, see box, above.)**

## *References*


1. Lo T. Venues for infection: Trends in places where California MSM syphilis cases meet sex partners. Oral presentation at the 2003 National HIV Prevention Conference. Atlanta; July 2003. Presentation #T3-B0604.

2. Rebchook G. Exploring the sexual behavior and Internet use of chatroom-using men who have sex with men (MSM) through on-line qualitative and quantitative research. Oral presentation at the 2003 National HIV Prevention Conference. Atlanta; July 2003. Presentation #M1-A0202.

3. Levine D. Internet-based interventions for syphilis prevention among gay and bisexual men. Presented at the 2003 National HIV Prevention Conference. Atlanta; July 2003. Presentation #MP-066.

4. Weldon J. The Internet as a tool for delivering a comprehensive prevention intervention for MSM Internet sex seekers. Presented at the 2003 National HIV Prevention Conference. Atlanta; July 2003. Abstract #WO-C1104. ■