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AMERICAN HEALTH CONSULTANTS

December 2004 • Volume 19, Number 12 • Pages 133-144

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Trying political times require new tactics to lobby for HIV/AIDS

Doctors are asked to step up to the plate

The ending to a highly charged political year that brought a few ups and many downs to AIDS funding and policy still leaves a major question unresolved: How can AIDS groups convince the public and legislators the domestic epidemic remains potent?

"That's the question all of us are struggling with," says **Ernest Hopkins**, director of federal affairs at the San Francisco AIDS Foundation.

AIDS advocates were reminded in October during the vice presidential debate that domestic AIDS plays second fiddle to the international pandemic when it comes to the attention span of politicians. And that was the only debate in which an AIDS question was even asked.

Moderator Gwen Ifill of PBS asked the vice presidential candidates to talk about AIDS in the United States where black women between the ages of 25 and 44 are 13 times more likely to die of the disease than their counterparts.

"We sunk to our knees when neither vice president candidate could respond appropriately and when the sitting vice president said, in a genuine way, he wasn't aware of the HIV statistics about black women at all," Hopkins says.

The lack of knowledge and interest on the part of vice presidential and congressional officeholders would be disturbing even if it weren't accompanied by flat funding for the past four years, AIDS advocates say.

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COMING IN FUTURE ISSUES

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- **What will happen with the Ryan White Care Act?** When the act comes up for reauthorization, will it meet with a receptive administration and Congress, or will other problems make reauthorization a challenge?
- **Working out problems of adding HIV RNA testing to routine HIV testing:** Investigators discuss how this can work well
- **CDC's increased HIV testing push:** Exactly how well is this program going, and is it resulting in increased ADAP waiting lists?
- **AIDS from Afghanistan to Zimbabwe:** How have war, famine, genocide impacted the international pandemic?

AIDS Alert® (ISSN 0887-0292), including **AIDS Guide for Health Care Workers**®, **AIDS Alert International**®**,** and **Common Sense About AIDS**®, is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **AIDS Alert**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421. Fax: (800) 284-3291. Hours of operation: 8:30 a.m-6 p.m. M-Th, 8:30-4:30 F EST. E-mail: customerservice@ahcpub.com. Web site: www.ahcpub.com.

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This CME program is intended for HIV/AIDS physicians. It is effective for 36 months from the date of publication.

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Editorial Questions

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"Over the last couple of years, we haven't seen sufficient increases in prevention funding and care funding," says **Mark Del Monte**, JD, director of policy and government affairs for the AIDS Alliance for Children, Youth & Families in Washington, DC.

Garnering more attention for the domestic AIDS program will become especially important in 2005 as AIDS groups work with Congress to reauthorize the Ryan White Care Act, AIDS advocates say.

"The really important emphasis placed on the global epidemic is something we all support and work on and care about, but we haven't found a good way to make the domestic epidemic stand up along side the global epidemic in a way that we can advocate for both efficiently," Del Monte says.

Meantime, AIDS organizations are faced with a fourth year of flat funding for care and prevention, he adds. As the epidemic's ranks increase and funding remains the same, there will growing waiting lists for HIV medications through the AIDS Drugs Assistance Program (ADAP) and for primary care treatment, Del Monte says.

Waiting lists growing

"We're seeing more and more waiting lists developing across the country," says **Gene Copello**, executive director of the AIDS Institute in Washington, DC, and one of the organizers of the Federal AIDS Policy Partnership, which is a coalition of AIDS advocacy groups formed over two years ago for the purpose of pooling advocacy resources.

"Although waiting lists typically are discussed in the context of ADAP, the reality is that there are waiting lists for all kinds of AIDS services across the country," he says. "There are increased waiting times for housing, increased waiting times for social services and nutritional counseling; and we're seeing this across the system."

If the numbers of HIV-infected individuals continues to rise — and everyone predicts it will, especially with the new push by the Centers for Disease Control and Prevention (CDC) to increase HIV testing — then waiting times and lists only will increase, Copello explains.

"The other issue is that increasingly more people are coming into the system from marginalized populations, including poor people and non-English speaking people," he says. "This means agencies will need resources for translation services and bilingual staff."

Despite the magnitude of the problems, there has been too little media and public policy attention on domestic AIDS, HIV/AIDS advocates say.

Various AIDS groups are banding together to increase lobbying power and resources, and they are seeking new ways to capture public and policy-maker attention.

For example, the American Academy of HIV Medicine in Los Angeles held a White Coat Day in May in which 20 HIV doctors took a day off their clinic work to lobby Capitol Hill in one concerted effort, says **Greg Smiley**, MPH, public policy director.

"The effort was successful," he says. "We targeted members of the House appropriations subcommittee who fund the AIDS programs."

The people working in the targeted congressional offices reported they thought the White Coat lobbying effort was great because they had never heard about HIV from a doctor's perspective, Smiley explains. "We held the White Coat Day as a stunt for taking pictures on Capitol Hill because most doctors don't wear white coats anymore. It was our way of saying, 'We're another voice telling you a lot of things you've probably already heard, but here's the immediacy of these needs.'"

More White Coats in 2005

The organization will hold another White Coat Day in 2005 with the goal of bringing 100 HIV medical providers to Washington, DC, he adds.

"It will be a much broader campaign next year because we need folks to reinvigorate the advocacy process," Smiley says. "Instead of always having the same people going on the Hill, we want to remind Congress that providers have a stake in this and a unique role and voice they can share."

Local and regional AIDS organizations also are looking for fresh ways to get public attention, but AIDS advocates admit they often fail to come up with new ideas.

"The problem is no one ever comes up with effective new strategies for discussing HIV/AIDS issues," says **Kevin Sullivan**, director of Ohio AIDS Coalition in Columbus.

"It appears to me that the general public isn't interested in domestic HIV/AIDS cases, and I don't know how to address that," he notes. "We are looking for guidance and community input of how we can make the public more aware of HIV/AIDS in Ohio, but we have to be realistic."

Besides HIV/AIDS, there are several emerging public health issues that have to be addressed, such as Hepatitis C, Sullivan adds.

"We need to figure out how HIV/AIDS issues fit in with those other issues and where we are on the radar screen," he explains.

The Ohio AIDS Coalition will continue to lobby Ohio legislators by bringing in HIV clients to meet with them. While often this elicits glassy-eyed looks and rude behavior, more often AIDS advocates are met with strong support, Sullivan continues. "We like to introduce legislators to people who are successfully on antiretroviral treatment because we think that sells itself. In a conservative state like Ohio, a congressman who sees a person in good health who is able to work and is a tax producer rather than a tax consumer thinks this is a good thing."

So far, California AIDS groups have had a relatively easier time lobbying their Democrat majority in the legislature, but they anticipate some rougher waters ahead as ADAP continues to need large infusions of cash to keep up with medication demands.

"This year is going to be tougher because ADAP will need $20 million to $25 million in additional funding; and in the past couple of years, we have had a surplus rebate revenue from the purchase of pharmaceuticals to cover nearly the amounts we have needed to increase the program's funding," says **Dana Van Gorder**, director of state and local affairs for the San Francisco AIDS Foundation, HIV Advocacy Network.

"Our job has been to persuade the governors not to take the money and apply it to other funding gaps, but this year we may not have that additional revenue," he notes. "That means at a time when there are further budget cuts, asking for additional general fund money could be very difficult, and we'll have to have a more effective community organizing strategy than we've had in the last few years."

Drawing attention

The San Francisco AIDS Foundation and other California groups have worked with providers and ADAP clients to gather at rallies, testify at hearings, and meet with legislators; and this has generally worked well, Van Gorder says.

Also, the groups have gained press coverage and usually can meet with newspaper editorial boards to ask them for an editorial position on a budgetary issue, he adds.

The American Academy of HIV Medicine has begun a new focus of bringing HIV physician leadership to local AIDS issues, as well as focusing on the national lobbying efforts, Smiley says.

For example, when some states are running into major problems with ADAP, the academy will send HIV doctors e-mail of a sample letter they could write to their local newspapers or legislators, Smiley explains.

"There are ways our members can get involved, and many do want to do what they can do," he says. "Every constituent carries weight, but medical providers carry more weight because people have this [concept] about doctors — and they do command respect."

Also, the academy has a public policy committee, consisting of 15 doctors and nurses, who look at ways to increase the academy's involvement in the political process, Smiley says.

"There are some things we should do, like providing comments on prescription drug benefits for Medicare and how it will impact people with HIV," he points out.

The committee will address both large and small issues, such as the Medicare law that requires hospitals to do a citizenship status check on patients, Smiley notes. "Members wanted to get involved, so we cosigned a letter about what was not a favorable part of the law and how we thought it should not be implemented."

Reducing ADAP disparities

The group also has a subcommittee studying the problem of ADAP inequities and working on suggestions for reducing disparities across states, such as many Southeastern states that receive less than needed Ryan White and ADAP funds, says Smiley.

"One of the larger goals of the ADAP subcommittee is to look at ways medical providers can do their bit in keeping costs down through cost-conscious prescribing practices and educating other providers about ADAP," he adds.

Whenever possible, the academy will work to raise public awareness about HIV/AIDS and is working on a plan to train willing medical providers to speak with the media, Smiley says.

"So if a reporter calls from Kentucky and says, 'ADAP has a waiting list in Kentucky; do you have anyone we can talk to about it in Kentucky?' then we can say, 'Yes, we have these providers who can speak with you about this,'" he explains. "I hope we can develop a series of one-pagers

with one on Medicaid, one on ADAP, one on hepatitis C funding and advocacy, that providers can use — but we haven't done it yet."

The AIDS Institute also has been working on developing material that members can use in speaking with the media, including sample letters to write to editorial pages and strategies for obtaining meetings with editorial boards, Copello says.

For example, in Arkansas, AIDS advocates have been successful in bringing attention to ADAP problems through the use of local media, he explains.

Advocates worked with local reporters, gave them information, and followed up when stories were written by writing letters to editors, Copello says.

"One issue that some of us are thinking about is how we can make sure the reporting around HIV and the challenges the HIV community faces are accurate," he notes. "And part of this is informing local reporters what the statistics are and what the challenges are for the community and what the resources are." ■

Navy condom strategies work — in foreign ports

Study highlights intervention strategies

Researchers studying condom use among men enlisted in the U.S. Navy found that strategies promoting condom use in foreign parts appear to be working effectively, although more intervention efforts are needed in home ports.[1]

Condom use with steady partners varied from 7% to 13%; condom use with casual partners at home varied from 39% to 46%; and condom use with casual partners in a foreign port varied from 52% to 69%.[1]

"There's a sense that when [Navy men] are on deployment, they're on guard, which facilitates condom use," says **Anne E. Norris**, PhD, APRN, BC, FAAN, associate professor at Boston College, William F. Connell School of Nursing in Chestnut Hill, MA.

"Also, the Navy has done smart things," she adds.

As soon as a ship pulls into a foreign port, the TV system, broadcasting throughout living areas, including the mess hall, lounges, and rooms, has a slide presentation about STD rates, HIV rates, and risk, Norris says.

"It identifies areas in the city where you shouldn't go in terms of not being safe from a physical and sexual health safety standpoint," she explains.

Also, some medical departments on ships make condoms available. For these reasons, investigators found a low incidence of STD symptoms and diagnosis in the naval population, Norris says.

"The data are fairly consistent with other data the Navy has and are even consistent with some civilian data with men," she says.

Researchers interviewed subjects at the end of their deployment, as they were on their way back to the United States, Norris says. "We didn't ask about prostitutes — we just asked about sex with partners they didn't know very well."

Other questions explored their confidence in using condoms consistently and whether they thought they could stop and put on a condom if they'd been drinking, she says.

"One thing that was interesting was that alcohol use had an impact on condom use for the whites in the sample, but not for the other groups," Norris points out. "Alcohol intake actually enhanced condom use for that group."

Since there's a strong mental association among some people between drinking and risky sex, it's possible that men who are drinking may make an automatic mental connection to using a condom, she continues.

"When you're drinking your brain goes on autopilot, so you're more prone to engage in behaviors where you have strong associations," Norris explains.

"Another interesting thing was we had a ship effect, but only for certain ethic groups," she says. "This was only for whites and biracial people, who may have less strong cultural identity so they may be more influenced by being on deployment."

The effect was that white men who were returning from Iraq were less likely to use condoms consistently than those on the carrier that saw the initial action in Afghanistan, Norris adds. "Biracial men were using condoms more."

Reference

1. Norris AE, Phillips RE, Statton MA, Pearson TA. Condom use and sexual behavior of U.S. male enlisted personnel with multiple partners in home and foreign ports. Presented at the XV International AIDS Conference. Bangkok, Thailand; July 2004. Abstract: TuPeC4913. ■

IDSA Report: Coverage of 2004 IDSA Meeting

Condom use inconsistent for high-risk heterosexuals

Survey conducted in 10 states

Researchers at the Centers for Disease Control and Prevention (CDC) have concluded that safe sex messages continue to be ignored by many high-risk individuals.

"We know that correct and consistent use of condoms can prevent HIV and sexually transmitted diseases (STDs), and there are a lot of people who are not getting that message or who are choosing not to use that information," says **Kathleen M. Gallagher**, DSC, MPH, CDC epidemiologist. The study was presented at the recent 2004 annual meeting of the Infectious Diseases Society of America, held Sept. 30 to Oct. 3, 2004, in Boston.

And the people who are not consistently engaging in safe sex include those who visit STD clinics, where the message should be readily available, she says.

CDC investigators analyzed 2002 data from the HIV Testing Survey, an anonymous, cross-sectional study in 10 different states of three different at-risk populations: injection drug users, men who have sex with men (MSM), and high-risk heterosexuals, Gallagher explains.

"For this study, we focused on high-risk heterosexuals, who were recruited at STD clinics," she says. "Then we collected patient information about sexual and drug-use behaviors that could ultimately result in HIV transmission."

In all, 1,225 heterosexuals were included in the study, and of this population, 54% were male, 61% were black, 12% were white, and 17% were Hispanic. Also, 61% were between the ages of 18 and 24, although the age ranged up to 50, adds Gallagher.

"We looked at the respondents and saw how many had sex with their primary partner and how many with nonprimary partners," she says.

About 61% reported sex with primary partners within the past 12 months, and most of these people reported inconsistent condom use with those partners. Another 51% reported having sex with a nonprimary partner during the same 12 months prior to the interview, and 64% of those patients reported inconsistent condom use, Gallagher points out.

"So the message is there's a lot of inconsistent condom use, and this obviously could increase the risk for HIV transmission, especially among heterosexuals," she says.

"Some of the data are consistent with other studies," Gallagher adds. "For example, other studies have shown that people are usually better at using condoms with nonprimary partners, and these findings were consistent with that."

Investigators did not ask about the HIV status of partners or their knowledge of HIV status, and this information might offer an explanation for the finding of inconsistent condom use among primary partners, she notes.

"If they're negative and their partner is negative, maybe they don't feel it's necessary," she says.

"This has come up in many other studies." However, the study found that 35% of respondents reported having sex both with a primary partner and with a nonprimary partner, adds Gallagher.

"These are people who are having more than one sex partner during a 12 month period, and we don't know if they are serial partners," she explains. "At least for some of those people, it's likely they have both a primary and a nonprimary partner at the same time, but we haven't been able to quantify that."

More consistent use with younger people

Another interesting finding was that people who were younger tended to use condoms more consistently, Gallagher notes. "We saw a statistically significant increase in inconsistent condom use with age."

Investigators did include questions about HIV prevention messages, but haven't analyzed those data, she adds.

"I think we realize that this is a significant population for prevention messages for a couple of reasons," Gallagher says. "One is that if you look at HIV and AIDS statistics that the CDC publishes annually, you'll see over time there's been a steady increase in cases attributed to heterosexual transmission, and this particularly is true of female cases."

CDC scientists know that trend is something that needs to be followed and the CDC has given out funding to community-based organizations (CBOs) to target heterosexuals at risk for HIV, she says.

"Of the 141 directly funded CBOs, 63 receive money for targeting heterosexuals, so there are prevention programs out there," Gallagher adds. ■

Opportunistic infections remain a key problem

Comorbid conditions growing in importance

Although the most common reasons for hospitalization among HIV patients in six hospitals nationwide are for comorbidities, there remains a significant rate of hospitalization for opportunistic illnesses, a new study says.

Investigators analyzed hospitalization rates for more than 10,000 patients, with a median age of 41, at six hospitals across the country, where there were large samples of HIV-positive patients who were part of the HIV Research Network, says **Kelly Gebo**, MD, MPH, assistant professor of medicine at Johns Hopkins University, School of Medicine in Baltimore. The study was presented at the recent 2004 annual meeting of the Infectious Diseases Society of America, held Sept. 30 to Oct. 3, 2004, in Boston.

In 2001, 17% of the cohort had one or more hospitalizations, and 23% of all hospitalizations were for AIDS-defining illnesses, she says.

The same data showed that 10% were for gastrointestinal problems, 9% for mental health problems, and 7% for circulatory disease, Gebo adds.

"Hospitalizations for opportunistic infections were higher than we anticipated. And these rates were higher in women and Hispanics. The next most common reasons for hospitalization were gastrointestinal disease, mental health problems including substance use, and circulatory disease, including cardiovascular disease," she says.

"Women had higher rates for gastrointestinal and mental health disease, but lower rates for circulatory problems," Gebo adds.

The most common reasons for hospitalization among those who had opportunistic infections were *Pneumocystis carinii* pneumonia (PCP) and bacterial pneumonia, she explains.

Pneumonia diagnoses were higher than researchers had expected, and this indicated a shift in HIV disease progression, Gebo notes.

"People are getting immune benefit from highly active antiretroviral treatment (HAART), but they're still showing bacterial infections," she says. "They're getting fewer traditional opportunistic illnesses, but the most common new OI is bacterial pneumonia."

Recurrent bacterial pneumonia was the most common of AIDS defining illnesses, with a hospitalization rate of 3.86 per 100 patient years; PCP, by contrast, had a hospitalization rate of 1.63 per 100 patient years, Gebo says.

"I think recurrent bacterial pneumonia is more common in older people, and this reflects that our patients are getting older," she notes.

When data were adjusted for CD4 cell counts and viral load counts, it was found that patients with lower CD4 cell counts and higher viral loads were more likely to have AIDS-defining illnesses, just as might be expected, Gebo points out.

"And those on antiretrovirals were less likely to get AIDS-defining illnesses than those not on them," she adds. "Also, people who had more visits to their doctor were more likely to have AIDS-defining illnesses."

Other findings included these:

- Hispanics had higher rates of hospitalization for AIDS defining illnesses than did whites or African Americans.
- African Americans were more likely to be hospitalized for a mental health condition than were whites or Hispanics.
- Older patients were more likely to be hospitalized for a circulatory disorder and for gastrointestinal disorders but not for AIDS-defining illnesses or for mental health conditions.

The hospitalization rates for substance-use disorders also were surprisingly high, Gebo says.

"I think a lot of our patients are actively using illicit drugs, causing toxicity, and needing hospitalization," she says.

Substance use had a hospitalization rate of 1.42 per 100 patient years, which was the highest rate among non-AIDS defining illnesses, Gebo adds.

"I think there are two messages in these findings," she says. "One is that patients are suffering from traditional OIs less than they were before, and bacterial pneumonia is now the most common AIDS-defining illness, and, two, patients are hospitalized for multiple comorbidities, with mental health, circulatory, and GI the most common."

As HIV patients age, clinicians should expect to see more general comorbidities, including heart attacks, strokes, hepatitis-related complications, and substance-abuse disorders, Gebo says.

"They need to be aware of the fact that HIV patients will have general health problems that could be a result of therapy or the normal processes of aging, but we'll be seeing more and more of these things," she adds. ■

What you can learn from Internet sex study

CDC official discusses alarming new trend

[Editor's note: AIDS Alert *asked* ***Sevgi O. Aral****, PhD, associate director for science in the Division of STD (Sexually Transmitted Disease) Prevention at the Centers for Disease Control and Prevention to discuss a recent study presented at the 2004 annual meeting of the Infectious Diseases Society of America. Her study, poster 841, investigated predictors of sexual risk taking on the Internet. Aral discusses the findings and the public health implications in this Q&A interview.]*

AIDS Alert: Would you please explain the chief findings of your study on the Internet and sexual risk-taking predictors.

Aral: The main conclusion is that people who recruit their sex partners through the Internet and have same sex partners, people with those two characteristics, tend to have large numbers of sex partners. And therefore, we concluded that Internet-based, sex partner recruitment and having same sex partners are important predictors of high-risk behaviors.

If you want some specifics, we found that those who had sex with partners they found on the Internet had a larger number of partners compared with other groups. There was an average of 42 lifetime partners and 11.3 partners in the past 12 months. That's high.

AIDS Alert: What does that tell a scientist, such as yourself?

Aral: That tells me that people who are into many, many partners have a higher probability of using the Internet for sex partner recruitment. And we have a dose response relationship: Those who had sex with Internet partners had 42 lifetime partners, for example. But when we looked at those who searched the Internet for partners, we saw that they had 17 lifetime partners and two partners within the last year. Also, those who met Internet sex partners but didn't have sex with them had 19 lifetime partners and nearly two partners in the last year.

These things become particularly meaningful when you look at men who have sex with men and Internet-based partner recruitment. With Internet use, we saw a very similar pattern in terms of sexual orientation: People who had opposite sex partners, on average, had nearly 11 lifetime partners; for people who had opposite and same sex partners, their average was 26 lifetime partners; and those who reported only same sex partners had about 41 lifetime partners.

So you have a dose response that starts with 10.7 goes up to 26.4 and up to 40.7 when you look at people who report only same sex partners. And when you look at the two together, we find that people who have same sex partners and have sex with partners they meet through the Internet have the greatest proportions of high-risk behaviors.

So what does that mean? That means we need to better target people who have same sex partners and people who recruit their partners through the Internet.

For example, health departments can work on partner notification, getting to sex partners who have been exposed to a sexually transmitted disease through Internet recruitment, and some health departments have been doing this in San Francisco and Los Angeles.

Prevention efforts may increase partnering with Internet service providers; we may use web sites to provide users with easily accessible and reliable information on HIV and STDs and on testing and treatment for these conditions. We may be able to provide support group chat rooms through the Internet; we could use chat rooms as support groups and put out prevention messages through those chat rooms on the Internet.

Also, in terms of a risk factor, when a person comes into the clinic, we usually try to focus on a few items of information that will tell us whether this person is a high-risk person or not. We need to add the Internet question to our battery of questions to identify high-risk patients and to use as a risk marker. If we ask the question in the clinic situation, we can identify high-risk clinic attendees and differentiate between them and lower-risk clinic attendees.

AIDS Alert: What are some details about the study and its sample size?

Aral: This study was conducted in Seattle in 2004. The respondents were 919 sexually active people. We excluded anyone who wasn't sexually active, and the age group was 18-39.

It's interesting; most people do not use the Internet to recruit sex partners. Seventy-five percent of our respondents said they do not use the Internet, so the Internet is a very good risk marker because immediately it [distinguishes] between the majority of sexually active people who at least don't have very many partners and

the minority — the 25% who use the Internet for sex partner recruitment and who also have high-risk behaviors.

AIDS Alert: Were women included in the cohort of people who had sex with same sex partners?

Aral: There were fewer women who reported having same sex partners when compared to men; we excluded women because there were so few of them.

AIDS Alert: What kind of intervention strategies should be used for people who use the Internet for sex partner recruitments?

Aral: That means you need to take a bit longer for that person and ask in a bit more detail about their risk behaviors, particularly receptive unprotected anal intercourse and whether they try to find out about the infection status of partners and whether they use condoms. I think you need to spend a little bit more time counseling them about the importance of the number of partners, unprotected intercourse, whether they have receptive or insertive sex, the importance of anal intercourse which is associated with higher acquisition risk, and the importance of prevention in general and protection.

AIDS Alert: Does the CDC have plans to do any more studies like this?

Aral: The Internet has attracted our attention in a big way, and our division has studies going on about Internet use and the Division of HIV Prevention has studies going on about Internet use. And we're actively working with Internet providers to see what preventions can be launched through the Internet.

We are talking to them about the role they could potentially play in providing users with easily accessible and reliable information on HIV and STDs and on testing and treatment for HIV and STDs where they could go to receive care information, risk assessment, and testing.

AIDS Alert: Does the Internet promote high risk sex, or is it just convenient for those who are doing it anyway?

Aral: I don't think the research has been done that would answer that at the individual level. We don't know whether the Internet increases risk behaviors. I have heard anecdotes about people who are spending every night on the Internet; I don't know of any research that shows causal link, but at the population level, we do know that the Internet does collapse time and space thereby making the spread of infections throughout a population much faster and more efficient.

So the same behaviors could go across long distances, and they could happen in much shorter time frames — that's what I mean by saying the Internet collapses time and space. Whereas time and space are very good barriers to spread of infection in populations, you can find somebody in the city you're traveling to, whereas before the Internet that was very pretty difficult.

We know people use the Internet before they have a meeting in some other city, or before they go on a pleasure trip to another city, they'll line up partners. And even if someone only is going to spend 24 hours in another city, it's possible for him to line up partners through the Internet so he can connect with them sexually even in such a short time.

AIDS Alert: Is this a frightening trend to someone working in public health?

Aral: Yes. I'd say, yes. ■

IDSA Report: Coverage of 2004 IDSA Meeting

HIV affects STD rates, Kenya research shows

Study looked at women in Kenya

Research often has looked at the way sexually transmitted diseases (STDs) increase the risk of people acquiring HIV, but few have examined the reverse: whether HIV infection increases the risk of acquiring STD.

A recent study took that perspective and found that infection with HIV-1 was associated with a higher incidence of genital ulcer disease, gonorrhea, and vulvovaginal candidiasis, after adjusting for potential confounding factors, says **R. Scott McClelland**, MD, MPH, an assistant professor of medicine and epidemiology at the University of Washington in Seattle. The study was presented at the 2004 annual meeting of the Infectious Diseases Society of America, held Sept. 30 to Oct. 3, 2004, in Boston.

Investigators collected data from a prospective cohort of female sex workers in Mombasa, Kenya, between 1993 and 2003. HIV-seronegative women were tested monthly for HIV and STDs. Altogether, 238 out of 1,215 women seroconverted to HIV-1 during follow-ups. HIV-positive and -negative women's incidence of genital tract infections were compared.[1]

The study concluded that increased incidence

of genital tract infections among HIV-1 positive women could promote the spread of HIV and other STDs.[1]

The study's focus was intentionally different from most of the literature that examines co-infected individuals, he explains.

"While there are many studies that have looked at the impact of genital tract infections on the risk for acquiring HIV, there are far fewer studies that have examined the effect of HIV on the risk for acquiring genital tract infections," McClelland says. "Both components of this bi-directional interaction could contribute to the spread of HIV and other sexually transmitted diseases."

The study's findings are particularly applicable to programs and policies regarding screening and treatment for STDs in high-risk populations as a component of HIV prevention, he says.

"For individual patients, there does appear to be a modest increase in the risk of genital ulcer, vaginitis, and gonorrhea," McClelland notes. "But the study wasn't designed to make recommendations about whether individual patients should be screened."

Screening would be challenging in resource-limited settings where the health care dollars are earmarked, he says.

"The question arises as to what interventions may be the most important for decreasing the spread of HIV, and one intervention in place is for programs aimed at diagnosis and treatment of sexually transmitted diseases," McClelland explains.

"A greater focus recently has been on antiretroviral therapy, and while that's important for patients with more advanced disease, many who are HIV-positive will not qualify for that," he says. "So continuing to maintain the programs aimed at prevention of HIV as we scale up treatment programs will be critically important for continuing to prevent the more rapid spread of HIV."

It comes down to money

It comes down to the limited money available and how it best can be spent, he says.

"We're facing the same issues in our own clinic where we were introducing antiretroviral therapy in the last year, and in the context of doing that we're trying to step up and maintain efforts to control prevention services as well," McClelland continues. "I think, in some settings, that can be lost."

In a clinic that has served as a prevention research cohort for 11 years, as is the case with the clinic in Mombasa, Kenya, it's not very difficult to maintain prevention efforts, he notes.

"However, prevention is something that can be lost in a clinic that begins to focus more on finding patients with the most advanced disease and puts all resources on treatment," McClelland says.

The study's other main message is that it's important to continue to screen for STD infections among HIV-positive individuals, he says.

"We continue to stress STD screening as an important intervention for preventing HIV transmission," McClelland adds.

Reference

1. McClelland RS, Lavreys L, Katingima C, et al. Contribution of HIV-1 infection to STD acquisition: A ten-year prospective study. Presented at the 2004 annual meeting of the IDSA. Boston; October 2004. Poster: 797. ■

HIV prevalence declined among high-risk group

Serosurveillance at STD clinics has value

Investigators analyzing data obtained from at-risk populations in the Western United States found a decline in HIV infection between 1989 and 1999, a new study shows.

"We saw declines over time in all of the behavioral lists, including injection-drug users (IDUs), heterosexuals, and men who have sex with men (MSM)," says **Nina Harawa**, MPH, PHD, an epidemiologist at the Los Angeles County Department of Health Services — Public Health in Los Angeles.

The study used data from leftover blood samples that were obtained for routine syphilis testing from 256,819 patient visits to sexually transmitted disease (STD) clinics in Denver, Los Angeles, San Francisco, and Seattle.[1]

Among men who have sex with men (MSM), HIV prevalence, from the 1989-1990 period and compared to 1998-1999, declined at least 50% in all of the counties included in the study, and among women, HIV prevalence declined at least 30% in all but one county.[1]

There were HIV-prevalence declines among IDUs and minorities, but the declines among African Americans were the least dramatic, the study showed.

"What we see in Los Angeles, for example, is that African American women, in particular, continue to become a larger and larger proportion of new cases," Harawa explains. "But it's not that their absolute numbers of new infections are increasing."

However, the declines observed in HIV prevalence among African American women was less pronounced than the declines observed among heterosexual men, she adds.

Investigators linked HIV status to basic information collected during the STD clinic visit, including sexual behavior information, such as the gender of the sexual partner, and how the respondent identified his or her sexual orientation.

Study's main findings

Some of the study's main findings were as follows:

- HIV prevalences among MSM were 15 to 60 times that of heterosexual men and women.[1]
- Of all HIV-positive tests, MSM comprised 73%.[1]
- The 30 to 39 year age group was the least likely to be infected.[1]
- The Western cities' HIV infection levels among MSM in 1998/99 were lower than the range observed in the Northeast and Southern regions of the United States in 1997.[1]

Since the study was completed and funding from the Centers for Disease Control and Prevention (CDC) ended, the serosurveillance method mostly has ended, Harawa says.

"It was done as a national effort," she notes. "Now the CDC has been putting more effort into other areas like HIV and AIDS reporting and developing systems to test people who have recently reported HIV cases to identify whether they are recent infections."

However, the serosurveillance effort had some positive aspects that may be lost in the cities that no longer test blood for HIV after it already has been collected for syphilis testing.

For example, Seattle, which has continued the serosurveillance at its STD clinics using local funding, has found that there is a resurgence of new infections among MSM, Harawa says.

"They found in the later years, 2000 through 2001, a reversal in trends," she explains. "Where we saw a decline among MSM of HIV infection, they started to see it going up."

If all of the cities had continued their HIV serosurveillance efforts, it's possible the trend might

CE/CME *questions*

21. A recent study of HIV patients who were hospitalized in 2001 found that the reasons for hospitalization had changed from earlier years to which of the following diagnoses?
    A. gastrointestinal problems
    B. mental health problems
    C. *Pneumocystis carinii* pneumonia and bacterial pneumonia
    D. all of the above

22. In a recent study of how people use the Internet with regard to dating and recruiting sex partners, investigators concluded which of the following:
    A. Heterosexuals who recruit sex partners through the Internet are at greatest risk of engaging in risky behavior.
    B. Men who have sex with men who recruit sex partners though the Internet are most likely to have a large number of sex partners and are at high risk for HIV infection.
    C. A large percentage of the general public (35%) meet potential sex partners via the Internet.
    D. all of the above.

23. Researchers who studied people attending STD clinics found that most reported what type of risk behavior with both primary and nonprimary partners?
    A. inconsistent condom use
    B. anal receptive intercourse
    C. Injection drug use
    D. none of the above

24. In a study of HIV prevalence at STD clinics in four Western areas, investigators found that HIV prevalences among men who have sex with men were how many times greater than that of heterosexual men and women?
    A. 10 to 20
    B. 15 to 60
    C. 30 to 50
    D. 22 to 38

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. 144**. If any of your answers are incorrect, re-read the article to verify the correct answer. **This concludes the six-month semester. An evaluation form has been enclosed. Complete and return to receive your credits.**

have been identified across the Western region, Harawa says. If HIV testing sites and STD clinics only identify HIV infection among the people who volunteer for HIV testing, they likely will miss these sorts of trends among high risk populations, she notes.

"We have general populations of people with HIV, and in the absence of sentinel surveillance, we're missing out on information from high-risk people who may not accept testing. An STD clinic is a particularly high-risk setting, and there's the potential that other STD epidemics could portend a rise in HIV," Harawa points out.

Syphilis is a good example of this potential because there have been a number of syphilis outbreaks in recent years, Harawa adds.

"The benefit of serosurveillance in these cities is that most people who are tested at public STD clinics are routinely tested for syphilis because it's a blood test and leftover serum could be used for HIV testing," she says.

"It lets us get a good snapshot of the STD clinic population and who has refused testing," adds Harawa. "This way we have a group of high-risk people who are there not because of HIV but because of symptoms of another disease."

For all of these reasons, HIV surveillance in STD clinics offers a unique perspective that is worth reinstating, she says.

The study also highlights the need for increased HIV prevention counseling in STD clinics, as well as more sensitive efforts at identifying a person's risk behaviors.

"The concern is that some STD clinics or private providers may not ask questions in a way that is sensitive enough to learn about behavior," Harawa adds. "It's their behavior that's important and it doesn't matter whether they call it 'straight' or 'gay.'"

Reference

1. Harawa NT, Douglas J, McFarland W, et al. Trends in HIV prevalence among public sexually transmitted disease clinic attendees in the Western region of the United States (1989-1999). *J AIDS* 2004; 37(1):1,206-1,215. ■

CE/CME *answers*

Here are the correct answers to this month's CME/CE questions.

21. D **22. B** **23. A** **24. B**

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. ■

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