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IN THIS ISSUE

In This Issue **continued on next page**

Special Report on Prevention Initiatives

Epidemic continues to stabilize except for black females, MSMs

New testing, prevention efforts being tried

The latest surveillance data from the Centers for Disease Control and Prevention (CDC) continue to show a stabilization of the HIV epidemic in the United States. However, data also show there are increases among men who have sex with men (MSM) — and black women are being disproportionately affected.

HIV diagnoses among MSM rose 10.8% between 2000 and 2003, while the overall HIV diagnosis increase among men was 4.9%.[1]

"We saw the biggest increase [in 2003] in Latino MSM," says **Robert Janssen**, MD, director of the

(Continued on page 15)

CDC's success stories

Too often, the battle against HIV and AIDS seems futile. But from Harlem to San Francisco there are success stories that everyone can learn from. This issue of *AIDS Alert* highlights some of successes from the Center's for Disease Control and Prevention's efforts to increase HIV testing among the populations most likely to be infected and to target prevention interventions. ■

In This Issue **continued from cover page**

AIDS Alert International

COMING IN FUTURE ISSUES

- **What's the future of nevirapine use?** Latest reports shake up trust in federal AIDS officials
- **Sexual commerce fuels Asian epidemic:** Strong prevention efforts appear to work
- **Future of teen services:** New laws and restrictions in states such as Texas make it more difficult for HIV prevention services to reach teens
- **Joint venture will produce once-daily regimen:** Emtricitabine, tenofovir, and efavirenz will be combined into once-daily pill
- **ADAP programs beginning to slash client rolls:** Disaster predicted for years is taking shape

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CDC's divisions of HIV/AIDS prevention — surveillance and epidemiology support.

The report also notes African American women are 19 times more likely to be HIV-positive than white women, a trend that has continued since the epidemic's beginnings, he says.

"When you look at the HIV rates, the rates were higher among minorities since the beginning, but the numbers [of women becoming infected] didn't catch up until the mid-1990s, and since then, it's predominantly been a racial minority epidemic," Janssen adds.

"Looking at women and African American women historically, most cases were among women and injection drug users, and now the majority are the result of heterosexual sex," he points out.

African American men and women accounted for 25% of all AIDS cases in 2003, an increase from the 20% in 2001.

More than half of new HIV diagnoses are among African Americans, although they represent 12% of the United States population. African American women represent 72% of the new HIV diagnoses among U.S. women.[2]

Socioeconomic factors play a part

The racial disparity of HIV infection among women pertains particularly to low-income women of color who often are coping with various other issues, including socioeconomic factors and lack of access to health care and preventive services, says **Allan Rosenfield**, MD, dean of the Mailman School of Public Health at Columbia University in New York City.

Prevention programs developed for African American women should include easier access to the health care system, needle exchange programs, and better educational efforts, he explains.

Domestic and world health officials also point to the need for effective microbicides that women could use without their partners' knowledge and the need for prevention programs that address the socioeconomic problems, including domestic violence, sexual abuse, lack of adequate housing, and lack of financial resources.

Although some trends can be seen in the most recent data, there are several limitations to the CDC's current surveillance data, Janssen notes.

For one thing, the data continue to be drawn from only a portion of the states, since the CDC relies on the 32 states with confidential, name-based reporting of HIV infection for its data.

Some of the states with the highest numbers of HIV-infected individuals are not included in the data, such as California, New York, Illinois, Maryland, Massachusetts, and Pennsylvania.

Other problems with analyzing the data involve public health trends, which can impact the number of people being tested and diagnosed, Janssen says.

Part of the problem is that HIV diagnoses is a result of HIV incidence and HIV testing, so an increase in one but not the other could show an increase in HIV reporting, he continues. "You could see more HIV reports among Latino MSM, but that doesn't mean there are increases in new infections occurring in that group."

The CDC doesn't have enough information to discern whether the increases are related to changes in testing, new infections, or both, adds Janssen.

In about a year, CDC officials expect to roll out the first nationwide incidence surveillance system, which will give real-time data about who is becoming infected and whether new infection rates are increasing overall or within specific populations, he says.

Nonetheless, CDC officials say they are concerned about the increase in HIV diagnoses among MSM because of other reports that indicate MSM increasingly are engaging in high-risk sex because of the success of antiretroviral treatment and the reduced threat of death from AIDS, Janssen says.

"We hope when we see new incidence, that should give us a much better sense of what's going on," he points out.

Better-targeted testing programs

HIV diagnoses should show an increase next year due to the CDC's new testing and prevention program that has put considerable effort into increasing HIV awareness and testing, Janssen says. "I'm hopeful we'll see increases as a result of . . . better-targeted testing than what we have now," he says.

For instance, the CDC has provided grants to community-based organizations (CBOs) and state and local health departments to implement demonstration projects of targeted HIV testing. That includes using the Oraquick rapid test, testing in nontraditional sites, and the use of social networks and peer recruiters.

One of the demonstration sites, the Harlem United Community AIDS Center in New York

City, had concentrated its prevention efforts on keeping HIV-negative people negative. But it changed its focus to a prevention for positives emphasis in response to the CDC's targeting the positives population, says **Tata Traore**, program director.

"We create self-awareness and have clients understand their responsibility toward their community, and we also try to identify a risk factor that they're engaging in and try to work on it," she explains

"We are seeing slow progress," Traore says. "When the program was funded, they wanted it to have a three-month cycle; and we extended it to six months because we didn't think significant change could be noticed in under six months."

In Chicago, the Night Ministry has used rapid HIV testing with Oraquick since October 2003, as part of a pilot program that evolved into a CDC-funded demonstration project, says **Jenny Tsang**, MPH, rapid HIV testing coordinator.

Increase in % of clients who wait for results

So far, the testing initiative has found a 2% HIV-positive rate among those tested, and the rate of people who are tested and receive their test results has grown from 50% to nearly 100%, she says. Only two people out of 750 people tested did not stay for their results, Tsang adds.

"Our population really likes the rapid test," she says.

"We've had people come from the suburbs to get rapid tests from us, and we're one of 10 to 15 sites that can do rapid testing."

The positive response largely is because of the convenience of the rapid test and the fact that it's emotionally difficult to wait for HIV test results, Tsang notes.

Although no official data have been analyzed from the demonstration projects, some of the CBO officials in charge of the projects contend certain strategies are not well-suited for all populations.

For example, it has been difficult for the Southwest Louisiana Area Health Education Center in Lafayette to enlist the services of social network recruiters because of confidentiality issues in a small, rural community, says **Robin Boyles**, director of health education.

"We're the only demonstration project that serves rural communities, and that makes us a little different," she says. "We've had challenges related to confidentiality that are a little greater than in larger communities because everyone knows everyone."

So if people volunteer to be peer recruiters for the center's project, the community would know they were positive, and that has been the center's greatest challenge in finding recruits, Boyles explains.

One solution has been to drop the title of recruiter, she adds. "Recruiter has negative connotations, particularly with the military climate right now, people recruiting for the military, to go to war."

Instead the center's staff will say, 'We have this project, and we know you are concerned about people in the community, and we think you'd be good working with us to find people who are HIV-positive,' Boyles says.

The social networking program also needs adjustments in some urban settings: For example, high-risk populations in San Francisco are sensitive to partner counseling and referral services because there's resistance to name-based HIV reporting, says **Cicily Emerson**, MSW, director of prevention services at Continuum in San Francisco.

"It's a struggle to establish trust to get people to come in for testing," she says. "I do see [social networking] being effective if you get the right recruiter."

Gifts also an incentive

Also, Continuum traditionally offers small gifts, such as $10 gift cards, as incentives to people who come in for HIV testing, Emerson says.

Some homeless and other high-risk people are regularly tested for HIV because they shop around for the incentives, she explains. "That's part of their way of life."

"Where you have a highly transient population, it can be difficult to use the social network approach because the people who are stable and in recovery have left the old associates behind," Emerson adds. "The other challenge is around name-based reporting and the fact that most test counselors haven't discussed disclosure with people before, so they don't have that mindset."

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1. Diagnoses of HIV/AIDS — 32 states, 2000-2003. *MMWR* 2004; 53(47):1,106-1,110.

2. UNAIDS, World Health Organization. *AIDS Epidemic Update, December 2004.* 1-87. ■

Special Report on Prevention Initiatives

CDC's prevention initiative shows no testing increase

Various demonstration projects funded

Officials with the Centers for Disease Control and Prevention (CDC) expect to see some results from the HIV Prevention Initiative in 2004, although the data remain to be analyzed and the 2003 data demonstrated no impact.

Launched in April 2003, the initiative's main objective was to increase the number of people who are aware of their HIV serostatus and to bring prevention messages to them, says **Robert Janssen**, MD, director of divisions of HIV/AIDS prevention — surveillance and epidemiology support at the CDC.

"I think the major and most visible thing that's happened is supporting the implementation of rapid HIV testing in our programs, whether in health clinics we fund or in community outreach," he says. "We've done a bit to increase access to testing for HIV, but we don't have [2004] data yet."

The 2003 data showed that the total number of HIV tests conducted in 2003 was the same as for 2002, and the total number of HIV-positive tests identified in 2003 was the same as for 2002, Janssen explains.

"But the demonstration projects weren't funded until late in 2003, and so wouldn't be felt in the data," he says.

Janssen also notes that more rapid HIV tests are being used, but in some instances, they are being used rather than enzyme immunoassays. "So we wouldn't necessarily see an increase in testing if that's going on," he adds.

The CDC primarily is focusing on bringing HIV rapid testing to areas where there might be a large number of people who are unaware they are HIV-positive, Janssen says.

"So we may not necessarily see an increase in testing, but what we want to do is try to increase the proportion of positive tests," he notes.

For example, HIV testing in correctional facilities has resulted in finding high prevalence of positive HIV tests when compared to the general population, Janssen says.

The 2004 data, which Janssen expects will show an increase in testing, will not be available for analysis until later in 2005.

"We've heard from a number of areas that people at high risk for HIV are coming in to get tested," he says. "They've heard about the availability of the rapid test and want to get that test."

The state of New York has reported that one-third of the people who have been tested with the rapid HIV test had never been tested before and said they wouldn't use any other test, Janssen adds.

The hope, he says, is that the rapid HIV test will attract people who have never been tested before, including people who might not go to their provider or medical clinic office to get tested.

The CDC-funded demonstration projects, costing $23 million in 2003, are meant to be models for testing and are intended to find high-risk populations, Janssen notes.

Expanded testing

For example, one demonstration project supports the routine offering of HIV testing in an emergency department setting; another provides HIV testing in short-stay correctional facilities, where the rapid test works best for people who may only be in the facility for a few days, he says.

One of the things that federal officials are concerned about involves HIV-positive individuals who are not in treatment for their disease and who often progress to AIDS-defining illnesses before they are diagnosed and/or routinely treated, Janssen says.

From 2000-2003 data, the CDC found that 37% of people who were diagnosed with HIV were also diagnosed with AIDS at the same time, he says.

"So they clearly were infected from three to 15 years and were just now being diagnosed with HIV and AIDS at the same time," Janssen adds.

So by pushing for increased rapid HIV testing in communities in which there are large at-risk populations, CDC officials hope to catch these HIV-infected individuals earlier in their infection and to get them into treatment before they develop AIDS, he continues.

"Our funding of CBOs is to work with medical providers as they do outreach into the community to identify people who are infected and to link them back into medical services," Janssen says.

Another project involves providing rapid testing in conjunction with partner notification and referral and counseling services. That allows

those partners to be tested on the spot.

Janssen also notes that a social network approach is being used. In it, someone who is HIV-positive is asked about friends he or she thinks might be positive or exposed to HIV so they can be tested, he says.

"In that study, we're finding the prevalence of new HIV diagnoses is 6%, while what we're seeing in the national counseling and testing system of 2 million tests per year is a 1.4% prevalence of positive tests."

This social network approach appears to be doing an efficient job of identifying people with HIV who do not know their serostatus, he says.

"It's being tested in more than one location, and we're funding community-based organizations to do it," Janssen says.

"We have had, in some areas, anecdotal reports that the numbers of people tested has increased and that the number of people testing positive has increased," he notes.

The CDC has not heard any reports that communities are having difficulty providing resources to the people who have tested positive, although this has been a concern among AIDS advocacy groups.

"We have not heard specific concerns that people have not been able to get into services once they've tested positive," Janssen adds. ■

Special Report on Prevention Initiatives

Repeated testing advised for at-risk MSM groups

Some may need testing more than once a year

The Centers for Disease Control and Prevention (CDC) generally recommends that people engaging in high-risk behaviors for HIV infection should be tested once a year, but when people believe they may have been exposed to the virus, the testing should be more frequent.

"We found that a fairly large proportion of men who have sex with men (MSM) have had an HIV test and have had a recent HIV test, but a significant number haven't been tested within the past 12 months even though they reported having engaged in sex with other men," says **Travis Sanchez**, DVM, MPH, epidemiologist with the CDC.

The 19% who have not been tested within the past year is high enough to be of concern, he points out.

These men were more likely to be older and were less likely to report that a partner has asked them about an HIV test, Sanchez explains.

"They were less likely to role-play or to have one-on-one conversations with a prevention worker about HIV and safer sex," he adds.

"That last note comes with the caveat that the details of the survey can't distinguish between activities that could have revolved around the HIV testing session, such as pre- and post-test counseling and prevention activities."

It's most likely that people who were getting prevention counseling also were getting an HIV test at the same time, Sanchez says.

"I think our goal of keeping up these intensive efforts of testing groups at risk for HIV infection and understanding the HIV risk pattern among MSM are important," he notes. "We want to improve HIV testing rates among MSM, and this supports the prevention activities we also think are very important."

One strategy for improving testing rates among high-risk MSM would be for medical providers to offer HIV testing as a routine part of medical care, similar to other types of annual health screenings, Sanchez suggests.

He says one interesting piece of data that came from the study was that of MSM who had had an HIV test, only 30% of those people had a health care provider recommend the test.

"Another strategy specifically related to HIV testing is to look at new models for HIV testing outside of the medical setting," Sanchez adds.

"For instance, the rapid HIV test gives us the possibility of taking the HIV test out to where people at risk can be found, instead of having them come into a facility to be tested." ■

Special Report on Prevention Initiatives

Massachusetts project cuts a wide swath of care

Nontraditional testing sites is main focus

A Massachusetts community-based organization (CBO) provides rapid HIV testing services to clients at homeless shelters, domestic violence shelters, youth groups, churches, a community college, and other sites, as part of a demonstration project

funded by the Centers for Disease Control and Prevention (CDC).

The Health Services Partnership of Dorchester had provided comprehensive HIV services and testing for more than a decade before accepting CDC funding for the rapid HIV testing demonstration project, says **George Odongi**, MBChB, MPH, communicable disease prevention programs director.

"With this demonstration project, our target population is a minority population living within the city of Dorchester, close to downtown Boston. We serve a big population of African Americans, Hispanic, Vietnamese, Caribbean immigrants, and a sizeable number of people from Haiti," he adds.

The demonstration project's intent is for the CBO to offer rapid HIV testing in nonclinical settings and then linking clients who test positive into care, Odongi explains.

Since the program began in October 2003, the CBO has tested more than 1,400 clients, finding 30 positive tests among them, he says.

"This is the highest amount of positives we've tested since I joined the program four years ago," Odongi adds. "So far, we've been able to respond because we have two HIV specialists at each center, working full time, and whenever there's a new positive, that's considered an emergency — and we get a doctor who will take the person into care immediately."

Those testing positive are encouraged to participate in a comprehensive HIV program with case managers who provide assessments and schedule clients for clinical evaluations, he points out. "We have comprehensive health care in two health care centers, and we have nearly everything: clinical care, women's health, family medicine, eye clinic, and urgent care," Odongi notes.

Health Services Partnership also works with a high school, a community college, and a correctional department.

"We go to six different shelters within our service area, and we have four youth programs that we work with," he says.

In addition, the partnership has three different community-based programs for people from Haiti, a public health institute, and an Asian-Creole group, plus four groups for Hispanics, Odongi adds.

"We work with a faith-based initiative and meet with them periodically, offering our services at their site based on programs they're having," he says.

"We also have a van for rapid testing with a mobile laboratory with counseling rooms, and we go to specific community-based sites and offer testing at those sites."

Each day, the van travels to six sites, Odongi says.

For example, every Wednesday evening, the van travels to a site where men who have been convicted of domestic violence meet for a court-mandated group session. When the session has breaks, the men are able to receive a rapid HIV test. HIV testing staff also provide prevention and health education to the men and offer them condoms and other preventive items, he says.

"Most of the men are there for a month or two, so the counselors engage them before the session begins, in between, and after — it's a continuous process," Odongi explains. "It doesn't end with just one visit."

The partnership has had a clinic within Dorchester High School for some time, which is managed by the organization, he says.

"One of our nurse practitioners manages the clinic, and we work with her as she prepares groups of students for prevention and health education," Odongi notes. "Students who would like to be tested for HIV are referred to our health center, which is across the street."

The partnership also provides HIV testing at Roxbury Community College every Thursday morning, and while no positive cases have been found so far, the response to the free testing has been favorable, he says.

The partnership's staff includes 11 people from different ethnic backgrounds, so various languages found in the community, including Vietnamese, Asian-Creole, and Hispanic, are represented, Odongi adds. ■

Special Report on Prevention Initiatives

Social network enlists community recruiters

Targeted testing has produced 8% positive rate

The Center for Multicultural Wellness and Prevention in Orlando, FL, has identified 14 HIV-positive cases out of 173 people tested in its first year of a demonstration project funded by the Centers for Disease Control and Prevention (CDC).

"It is a fairly high percentage compared with national outreach HIV testing," says **Laud Jean-Jacques**, program coordinator.

"We're reaching more HIV-positive people than we did previously," he says. "Our [goal] was 0.05 under extended outreach [testing], but with the social network program we're reaching 8%."

Specific requirements for recruiters

The center's staff recruits HIV-positive or high-risk HIV-negative people, targeting Hispanics and blacks primarily of Caribbean and African descent, to be recruiters.

The recruiters participate in a program of counseling and testing before joining, Jean-Jacques explains.

The goal is to find recruiters who are meeting other high-risk people in the community, so people who are HIV-positive but who have low-risk behaviors and were infected by a partner who did not share their monogamous behavior are not asked to be recruiters, he says.

"We are looking for people who are out in the street, like at a bar venue or even in a park to meet people, and who do drugs, have multiple sex partners — these are the people we target," Jean-Jacques notes.

"We prefer to have HIV-positive people as recruiters, but they have to be adherent to treatment, and you might not find that person because he might not be disciplined enough to be part of a group or organization."

Recruiters refer their associates to the center for testing by giving them cards with information about HIV and the center, he says.

Sometimes the recruiter will go out into the community with an outreach worker and the outreach worker will ask the associates to be tested, Jean-Jacques adds.

Another part of the program is venue referral in which the recruiter points out a place where people engaging in high-risk behaviors congregate. The outreach worker will contact the owner of the site and ask permission for a health promoter to informally make contacts, he continues.

When network associates agree to be tested, the center offers them the choice of coming into the center for testing or having an outreach worker come to their home or to some other location of their choice, Jean-Jacques points out.

The program has 16 recruiters, about half of whom are active at one time, he says.

After some months of participating, a recruiter often runs out of contact associates to refer to the center's testing program, and so new recruiters have to be found, Jean-Jacques explains.

The program has been successful so far, but needs to be continued longer than what the two-year CDC funding calls for, he says.

"I know it's a demonstration project, but we had a contractors meeting last month at the CDC, and we were all saying that two years is not enough time," Jean-Jacques adds.

"The first year, we sold the project to our community, so it's only a year later when people are really getting interested because they're seeing results."

Ideally, it should be a three-year demonstration project, although it does not appear that an extension will be possible with CDC funding, he notes. "I think we're going to keep using the program because we have seen the results." ■

Special Report on Prevention Initiatives

Harlem center focuses on prevention for positives

Risk-reduction strategies are main focus

The Harlem United Community AIDS Center in New York City recognizes that HIV-positive people who engage in high-risk activities are not going to change their behaviors overnight, so the center focuses on reducing their risk behaviors one step at a time.

The prevention-for-positives program, which is funded through the Centers for Disease Control and Prevention (CDC), begins with counselors meeting with HIV-positive clients, says **Tata Traore**, program director.

"In other programs, we usually have case managers who take care of clients' needs, the millions of needs like entitlements, housing, Medicare, etc.," she says. "With this program, the counselors are solely counselors."

Evaluating readiness for participation

Counselors meet with clients to evaluate their readiness for the program. If they determine other needs have not been met, clients are referred to the various services they need, Traore says.

Once clients are enrolled in the prevention program, the counselor spends one hour, twice a

month with them, focusing solely on prevention, she says.

"They also participate in monthly groups where we hope they are influenced by other participants in the group, and for those who are not ready to change, this is peer-level counseling," Traore explains.

Identifying risk behaviors

Counseling sessions include asking clients to identify risk behaviors they have that they would like to work on. Then clients decide which steps they'll take, and these steps are what they will take over a six-month period while they are meeting with the counselor, she says.

"Instead of trying to eliminate every risk factor, we want people to understand it's their responsibility to not infect the community," Traore says.

"We target their own choices and decisions, and we focus on behavior change depending on what a person identifies as an issue."

For example, while most clients may decide to focus on their sexual behavior or substance use, occasionally someone's goal may be to develop healthy relationships or learn who their sexual partners are, she says.

"Sometimes, we have people who have multiple partners because for multiple reasons that's what works for them at that moment," Traore says.

"And sometimes, a person's goal can be to achieve partner notification, and they need assistance with that."

A single session's goal might be to reduce the number of sexual partners from 10 to five, she adds.

At additional sessions, the counselor will help the client figure out why he or she has engaged in this risky behavior and then help the client brush up on the objectives that were set in previous sessions, Traore says.

Counselors assess whether clients are engaging in risky behaviors, other than what the client has chosen to focus on, and when the client needs additional help with issues like adherence to medications, the counselor will make referrals, Traore notes.

"It's client-centered — most of the information comes from them," she says.

Clients and counselors will discuss behavior change plans, and if a strategy doesn't look feasible, then the counselor will suggest they try something else, Traore adds. ■

Special Report on Prevention Initiatives

Have tents, will travel in San Francisco

Testing facility travels to clients

Continuum of San Francisco has a goal of finding people who are unaware that they are HIV-positive through its grant from the Advancing HIV Prevention Initiative of the Centers for Disease Control and Prevention (CDC).

"We estimate there are 1,200 people just in our neighborhood who are HIV-positive and don't know it," says **Cicily Emerson**, MSW, director of prevention services for Continuum.

A real outreach effort

"The Tenderloin area has a high rate of homelessness and lots of residential hotels and a lot of street activity, including sex work, heavy drug dealing, panhandling; and it's basically a busy area with a lot of street activities," she says. "So the idea was to reach out and try to engage the ones who were positive and get them into HIV care and reduce their risk."

To meet this goal, Continuum has invested in two inflatable tents measuring about 20 feet in diameter. One of the tents contains a lobby, and the other has individual counseling rooms.

The tents are stored and transported to testing sites each day in a mobile van, and Continuum has permits to set up the tents in parks, Emerson explains.

"The tents are eye-catching, and we try to do at least 18 [rapid HIV] tests in one day," she notes. "The counseling session can be short or long, depending on the client's risk factors."

Also, the Continuum staff working in the tents include a lab manager because California requires professionals to handle phlebotomy, Emerson says.

The lobby tent is for setting up appointments, and contains a television that plays movies while people wait.

There also are ventilation and cooling systems inside the tents, which are powered by electricity generators, she adds.

The mobile testing sites provide clients with harm-reduction kits that include condoms, lubrication, and safe injection kits with a tourniquet

and bleach, as well as with snacks and beverages, Emerson notes.

Those tested also are given a gift incentive valued at $10, she adds.

Clients can make an appointment to be tested at the tent via a toll-free number or by walking in on one of the regular days the tent is in their neighborhood, Emerson says.

"The tents are set up, weather permitting; but most of the time, it's fairly temperate here. The temperature doesn't fluctuate too much," she explains.

The reason Continuum uses the tents instead of relying on the mobile van is because the tents create a warmer and more private environment, Emerson says.

"The idea is to have something that's more versatile than a van," she adds. "And maybe it will reduce the stigma a little because when there's a mobile health van, a lot of people know what it is, and everyone knows what a person is doing there." ■

Special Report on Prevention Initiatives

Rapid HIV testing popular with Chicago CBO clients

Testing has found 2% positive rate

The Night Ministry of Chicago provides rapid HIV testing in nonclinical settings, extending services to some of the most difficult to reach, high-risk populations, including homeless youths and others.

"It's challenging to figure out ways to reach people and to continue to reach people," says **Jenny Tsang**, MPH, rapid HIV testing coordinator. "The Night Ministry has such a long history of working with homeless people that we have a decent reputation among people, and they trust us and come back to us."

The Night Ministry has conducted HIV testing for years and had started rapid HIV testing before receiving a grant from the Centers for Disease Control and Prevention (CDC).

"We worked with the city of Chicago and their pilot project, and that's how we did rapid HIV testing in mobile units and figured out how to make it work," she says. "When we actually started testing for the CDC, we had a pretty good protocol in place on how to do things."

The Night Ministry works primarily with homeless people at night, but also has a health outreach bus that drives to seven different neighborhoods, each twice a week, Monday through Saturday, Tsang explains.

The organization also has a program for pregnant and parenting teens, and it runs a homeless shelter for youths, ages 14 to 21, who are not wards of the state, she says.

"On our bus, we have a nurse who can do general health care, diabetes monitoring, blood pressure monitoring, mental health services; and we always have a minister on board who can provide pastoral care," Tsang notes.

Building relationships

"The whole crux of our organization is we build relationships with people; people can always depend on us to be there," she explains. "We provide coffee, cookies, and condoms; and we have staff who provide a listening ear."

In a typical night, the bus staff will see about 200 people, including children, and provide adults sexually transmitted disease testing, hepatitis C testing and screening, and HIV testing, Tsang says.

Of the people tested for HIV, about 2% are positive, and that rate has been consistent since before the organization began the CDC demonstration project, she notes.

However, with the rapid testing, nearly everyone receives their test results, so there's greater opportunity for interventions and referrals for HIV-positive clients, Tsang adds.

"We have two full-time staff dedicated to HIV testing," she says.

The rapid HIV test takes about 20 minutes to administer and is accompanied by pre-test results counseling, Tsang says.

Counseling ranges from the basic questions, such as, "What do you know about HIV? How is HIV transmitted?" to a risk assessment survey in which a client is asked about the last time he or she had sex and whether the sex was protected, etc., she adds.

"We have paperwork required by the CDC and the city, and so we go through all of that and do a slightly more extensive risk assessment," Tsang explains.

"When we're done with all of the paperwork, we discuss what's going on with that client and develop a risk-reduction plan with the client."

The risk-reduction plan may ask the client

what he or she wants to do for protection in the future, including risk-reduction strategies of trying to use a condom 50% of the time, she says.

If the test results are positive for HIV, then clients are asked how they feel and a second, confirmatory test is offered, Tsang notes.

"We ask where they want to seek care, how they want to tell others, and then we review with the client basic prevention [information] and give them whatever referrals they need," she says.

"We have clients come back to us to pick up their confirmatory test results, and we provide them with bus cards to help them get to and from doctors' appointments."

The Night Ministry also gives clients a telephone calling card they can use to make appointments, and staff refer clients to physicians who will provide HIV primary care, Tsang adds.

"Some of our clients are regulars with us; and with those clients, we check in and see how things are going whenever we see them," she says. "For clients who are not regulars, we give them the best referrals we can and hope they will follow up on these." ■

Special Report on Prevention Initiatives

Rural HIV service center needs a creative approach

HIV testing has been done in karaoke bar

The Southwest Louisiana Area Health Education Center in Lafayette has found some creative solutions to the problems HIV staff have with trying to identify high-risk populations for HIV testing and counseling.

Since the organization serves a rural population in a small enough community where everyone knows each other, center staff have made some adjustments to the HIV rapid testing and social network demonstration projects funded through the Centers of Disease Control and Prevention (CDC).

"There's still a lot of stigma and discrimination related to HIV in this area," says **Robin Boyles**, director of health education. "It's probably more than what you would have in urban metropolitan areas."

The program has two active recruiters, who are not referred to by that title, but whose job it is to bring in high-risk clients for HIV testing.

CE/CME *questions*

5. HIV surveillance data from 2003, reported by the CDC, show HIV diagnoses among men who have sex with men (MSM) rose by what percentage between 2000 and 2003?
   A. 4.9%
   B. 10.8%
   C. 13.2%
   D. 23.9%

6. Also, HIV surveillance data from 2003 show African American women are how many times more likely to be HIV-positive than white women?
   A. 5 times
   B. 10 times
   C. 16 times
   D. 19 times

7. The CDC launched its national HIV testing initiative in early 2003. Now data from 2003 show the total number of HIV tests conducted in 2003 and the total number of HIV-positive tests identified have _____ compared with 2002.
   A. increased
   B. decreased
   C. remained the same
   D. are inconclusive

8. Global HIV/AIDS numbers released in late 2004 show women worldwide represent what percentage of people living with HIV?
   A. 38%
   B. 45%
   C. 52%
   D. 57%

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. 24**. If any of your answers are incorrect, re-read the article to verify the correct answer. At the end of each six-month semester, you will receive an evaluation form to complete and return to receive your credits.

The center's a little behind in its goal of having three recruiters, but the staff's focus has been on finding the right people, she says.

"We are enlisting people to recruit who really have contact with networks," Boyles explains. "One of the recruiters has recruited 35 people; and while we haven't tested any positives yet, we know when we talk with people about their risk behaviors that they're at very high risk for HIV."

Potential recruiters are provided with an orientation and coaching session, and they are encouraged to provide names of at-risk individuals within their social network, she says.

"They give us names, and it could be just a first name because some recruiters don't want to give full names since these are their friends and they don't want to set them up for something," Boyles notes.

Then the center's staff will review the names with the recruiter and find out the best way to reach individuals, she says.

The center also provides HIV testing at churches and local organizations since it would be a hardship for many people to have to come into the center for testing, Boyles adds.

Typically, the center will set up a date in which HIV testing can be done at the church or community site. Staff give the recruiters cards with this date and address to pass out to associates who might need HIV testing services. Sometimes, recruiters will open up his or her home for testing, she notes.

Other rapid HIV testing sites include community centers, housing developments, barbershops, and hair salons, where staff will set up a private testing area in a back office or room, Boyles says.

"We do go out and check out these places to make sure they are adequate and the temperature is fine because the rapid test needs to stay within a certain temperature," she adds.

"Barbershops and hair salons often are a community institution where people go and will sometimes hang out, and a lot of information is transferred back and forth from hairstylists to customers."

HIV testing staff try to saturate the social network possibilities of recruiters by talking with them about all of their weekly activities and contacts, Boyles says.

For example, one recruiter visits a karaoke club every week, and the club serves a clientele of men who have sex with men. The center received permission from the club owner to set up a center in a back room for HIV testing, and the recruiter talked with the club's clients about having a rapid HIV test. That allowed the center to conduct 18 HIV tests in three hours, she says.

Likewise, if a social recruiter played pickup basketball regularly, then the center might send staff to that site to make HIV information and testing available, Boyles says. ■

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*

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

5. B **6. D** **7. C** **8. B**

AIDS ALERT®
INTERNATIONAL

World health community focuses on problems of women, HIV, and violence for 2005

Women comprise nearly half of epidemic

World health officials are focusing in 2005 on improving intervention and prevention programs that target women, particularly young women, who appear to be shouldering some of the heaviest burdens of the epidemic in sub-Saharan Africa.

By the end of 2004, the number of women infected with HIV amounted to about 45% of the total HIV cases worldwide. In the epidemic's epicenter of sub-Saharan Africa, women represent almost 57% of the total HIV cases; and 76% of people ages 15-24 years who are infected with HIV are female.[1]

"In a nutshell, women are making up 50% of the people living with HIV, but the main new finding is that in every single region, the percentage of women among people living with HIV is going up," says **Peter Piot**, MD, executive director of UNAIDS of Geneva.

Piot spoke in preparation of World AIDS Day on Dec. 1, 2004, addressing the current state of the world's AIDS epidemic.

"This is an emerging pattern that we had seen first in Africa, in sub-Saharan Africa, but it's now confirmed in about every region . . . , and we're also [seeing] trends over fairly long periods, over basically two decades in this report," he says.

The trend has profound implications for the future of the epidemic, Piot adds.

"One, we've got to really put women at the heart of the response to AIDS if we're going to stop this epidemic," he says. "And secondly, we need to go beyond ABC in terms of HIV prevention."

Violence prevention needed

HIV interventions targeting women need to include violence prevention and access to basic education and employment opportunities, says **Karen Stanecki**, MPH, senior advisor on demographics and related data in the department of social mobilization and information for UNAIDS.

She also is the chairwoman of the Monitoring the AIDS Pandemic (MAP) Network. Stanecki spoke with Piot as part of UNAIDS' World AIDS Day activities.

Microbicide research also needs to be a chief focus in the search for ways to reduce the rate of HIV infection among women, she adds.

"Infection rates among young women are especially high," Stanecki points out. "Millions of young people are becoming sexually active each day with no access to prevention services, and young women are about three times more vulnerable to HIV infections than their male counterparts."

HIV/AIDS researchers and world health officials cite the lack of empowerment as a main reason for the high infection rate among young women in sub-Saharan Africa and other developing nations.

"The empowerment of women is an essential step," says **Allan Rosenfield**, MD, dean of the Mailman School of Public Health at Columbia University in New York City.

"Many women, particularly those in their teens, have little ability to refuse sexual activity in some [regions] or to insist on condom use," he explains. "Women's groups in these countries will play an increasingly effective role in this regard."

This is why the development of a microbicide would be a major step forward in allowing women to protect themselves when their partner refuses to use a condom, Rosenfield adds.

"Unfortunately, an effective microbicide is at least five years away," he notes.

"In the interim, much more attention needs to be given to the use of female condoms, when the

partner refuses to use condoms," Rosenfield points out.

Another issue is that women often lack access to existing HIV/AIDS prevention and treatment programs in developing nations, Piot continues.

The World Health Organization (WHO) is collecting data on who has access to antiretroviral therapy, but anecdotal evidence suggest that women are shortchanged, he adds.

"Just one example: I was, a month ago, in Addis Ababa in Ethiopia; and I visited . . . a hospital [that is] one of the few centers [that is] providing antiretroviral therapy," Piot says. "And I asked, 'Out of about 1,500 [patients], how many are women?' And the answer was about one-third, 30%."

However, in Ethiopia, women comprise about half of the HIV epidemic; so at least in that area, there was inequity in how treatment was dispersed, he notes.

Since the treatment at the hospital in Addis Ababa was not free, it would mean that either women lack the money to pay for their HIV treatment or their husbands are not willing to pay for it, Piot adds.

Treatment access a key factor

When clinics in sub-Saharan Africa offer free access to treatment, then they have better success in getting more women to receive care, Stanecki says.

"But when we look at any of these centers that do have some kind of fee for service, even if it's just minimal, then right away, the majority of the people who are getting treatment are men," she explains.

Even in Uganda, world health officials investigating HIV treatment access found that less than 30% of the people receiving treatment were women, Stanecki adds.

There are several infrastructure improvements that need to be made in sub-Saharan African to reduce the HIV risk young women face, Piot and Stanecki say.

"One is a legal framework that doesn't exist in most countries," Piot explains.

For example, rape is against the law when it's outside marriage, but it's not against the law when it's the husband raping the wife, and data suggest marital/partner rape is a major factor in the epidemic, he says.

"Secondly, we really have to link up with programs to keep girls in school," Piot says. "That's obviously necessary even without an AIDS epidemic, but in the case of AIDS, that is becoming key."

Third, the world health community now is getting into the issue of alleviating the consequences of the AIDS epidemic as it pertains to property and inheritance rights for women, he says.

"When a woman loses her husband because he died from AIDS, and she may be infected, she also often loses everything — her house, etc., and all the property," Piot explains. "This really is not only pushing her into extreme poverty, but puts her at risk for HIV because she often has only her body to sell."

With more funding for free HIV treatment and prevention, women's access would likely improve, officials say.

AIDS funding for developing countries is about $4 billion short of what is needed, but another challenge is to put the available money to the most efficient use, he says.

"The key challenge now is to make that money work and to make sure that it's used for evidence-based prevention and treatment programs and that it's getting to the communities," Piot continues. "So in other words, we need still to increase the funding."

One size does not fit all

An example of how a one-size-fits-all attitude toward HIV prevention is not efficient or successful for all populations is the ABC prevention program, which stands for Abstinence, Be Faithful, Use Condoms.

While it may be working in some areas and with some populations, it's not an adequate prevention strategy for young women and girls because of their lack of power, says **Desmond Johns**, MD, director of the UNAIDS New York Office in New York City.

"No. 1, given the social dynamics of relationships, it's not within the control of young women or girls to abstain — that decision is taken by her partner," he explains.

"She cannot be faithful all on her own when it's the male partners who are unfaithful or have other high-risk behavior."

Likewise, women have no control over their partners' use of condoms, Johns adds.

"Young girls and women cannot insist their partner uses a condom if the women have reason to think he's being unfaithful," he says. "So the ABC approach is not sufficient for girls."

The classic prevention approaches have to be expanded, Piot says.

"These interventions cannot happen in a vacuum and ignoring social context, the context of gender and equality," he says.

"The [AIDS epidemic] report highlights the need to address sexual violence, which is particularly affecting women, and where we see a direct link between this violence and death through AIDS, education opportunities, and inheritance laws."

Addressing societal issues

One obstacle is that it's difficult to address the issue of male violence and sexual violence, Piot says.

"So what it really shows is that in addition to the AIDS-specific interventions, we'll have to add some quite serious action to change societal norms," he explains.

"And in this case, it should be not acceptable that there is sexual violence against women, that it is not acceptable that as a societal norm that you have older men who can just exploit girls and that the girls need that or do that because they need a school uniform."

While no one expects that the solution to AIDS is to first solve the problem of poverty, there are steps that need to be taken, Piot says.

"I think all of these examples show that AIDS is a disease, but it cannot be solved by approaching it only as a public health issue," he adds. "It really requires a quite broad development approach and societal approach, but it will be more difficult."

Reference

1. UNAIDS/World Health Organization. *AIDS Epidemic Update: December 2004.* Annual report released Dec. 1, 2004; 1-30. ■

Region shows how an effective program works

Mbeya region has declining trend of HIV

While Tanzania as a nation has had no evidence of a decline in HIV prevalence, the Mbeya region has seen the prevalence among 15- to 24-year-old women decline from 20.5% in 1994-1995 to 14.6% in 2000.[1]

UNAIDS officials cite the Mbeya region as a good example of what can be accomplished if the right combination of funding, infrastructure-building, and effective prevention interventions are initiated.

Sustained effort shows success

Although Tanzania is a relatively poor country, a sustained, intensive effort at changing behavior — with a focus on young women — has been under way for 13 years and has resulted in a decline of 25% among 15- to 24-year-old women in that region, says **Desmond Johns**, MD, director of the UNAIDS New York office in New York City.

"This is where prevention messages are working and new infections are decreasing," he says.

"In a neighboring area in the same country, where there's not the same focus on prevention, the prevalence in this age group went up, so it's proof that prevention works, and it has to be done with intensity and at a scale where it makes a difference," Johns notes.

The Mbeya region's 14.6% HIV prevalence may be high by the standards of industrialized nations, but the Mbeya statistics show what could happen among young women with intense prevention efforts in place.

For instance, a neighboring region called Rukwa had only sporadic prevention interventions over the years; and in this region, the HIV prevalence among women, ages 15-24, rose from 22.5% in 1994 to 30.2% in 1999.[1]

Tanzania's AIDS epidemic dates back to 1983, and it spread continuously throughout the region, making it one of the earliest epidemics. The Mbeya region was one of the hardest hit areas; and since 1999, AIDS was the main cause of death among Tanzanian adults, ages 15 to 59 years.[2]

Germany to the rescue

But what has helped the Mbeya region is that the German government, in September 1988, helped the Ministry of Health implement a Regional AIDS Control Programme in Mbeya.

The collaboration focused on establishing a reliable HIV reference laboratory, ensuring the safety of transfused blood, establishing a surveillance system, and initiating prevention educational activities.[2]

As the HIV prevention work in the Mbeya region matured, the collaboration also initiated efforts to reduce the stigma and discrimination attached to HIV/AIDS, provided advocacy for HIV prevention and care policies among political leaders, and coordinated with other private and public organizations.[2]

The program's main interventions include a behavioral change program that uses peer education in primary schools and work places. Peer education also is used with sex workers and their clients, and there is a theater for performances that provide HIV prevention education.[3]

The Regional AIDS Control Programme also promotes condom use and has used social marketing of condoms in urban and rural areas.

Health care workers in all health facilities are trained in HIV prevention and offer case management for sexually transmitted diseases, including providing routine screening and treatment of pregnant women and their partners for syphilis.[3]

A legal-assistance element

Another program that appears to work very well in Tanzania is providing legal assistance to women and widows, as well as to orphans, says **Peter Piot**, MD, executive director of UNAIDS of Geneva. Piot spoke in preparation of World AIDS Day on Dec. 1, 2004, addressing the current state of the world's AIDS epidemic.

"We're talking about $50 to $100 a year, very small amounts of money, but these amounts of money make it possible for women to have some food, shelter, and make sure that they can feed their kids and send them to school," he points out.

"And that provides them an environment where ABC prevention [Abstinence, Be Faithful, Use Condoms] can work, where treatment programs can have a chance to have some impact because there is no way you can introduce antiretrovirals in environments and communities where everybody is hungry and where we have this devastation that we're seeing," Piot adds.

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1. UNAIDS/World Health Organization. *AIDS Epidemic Update: December 2004.* Annual report released Dec. 1, 2004; 1-30.
2. Deutsche Gesellschaft Fur Technische Zusanmenarbeit (GTZ) GmbH. *Reason for Hope: AIDS Control and Prevention in Mbeya, Tanzania.* 2002; 1-12.
3. Jordan-Harder B, Maboko L, Mmbando D, et al. Thirteen years HIV-1 sentinel surveillance and indicators for behavioural change suggest impact of programme activities in southwest Tanzania. *AIDS* 2004; 18,287-18,294. ■

Global AIDS: By the Numbers

Number of people living with HIV in 2004
Total: 39.4 million (35.9-44.3 million)
Adults: 37.2 million (33.8-41.7 million)
Women: 17.6 million (16.3-19.5 million)
Children younger than 15:
2.2 million (2.0-2.6 million)

People newly infected with HIV in 2004
Total: 4.9 million (4.3-6.4 million)
Adults: 2.6 million (3.7-5.7 million)
Children younger than 15:
640,000 (570,000-750,000)

AIDS deaths in 2004
Total: 3.1 million (2.8-3.5 million)
Adults: 2.6 million (2.3-2.9 million)
Children younger than 15:
510,000 (460,000-600,000)

REGIONAL HIV AND AIDS STATISTICS AND FEATURES OF 2002 AND 2004, IN SUB-SAHARAN AFRICA

Adults and children living with HIV
2004: 25.4 million (23.4-28.4 million)
2002: 24.4 million (22.5-27.3 million)

Adults and children newly infected with HIV
2004: 3.1 million (2.7-3.8 million)
2002: 2.9 million (2.6-3.6 million)

Adult prevalence (%)
2004: 7.4% (6.9-8.3%)
2002: 7.5% (7.0-8.4%)

Adult and child deaths due to AIDS
2004: 2.3 million (2.1-2.6 million)
2002: 2.1 million (1.9-2.3 million)

Source: UNAIDS/World Health Organization. *AIDS Epidemic Update: December 2004.* Annual report released Dec. 1, 2004; 1-30.