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Editor's note: In this issue of AIDS Alert, there is a special report on CDC's 2005 prevention plan's achievements and failures. In the July issue of AIDS Alert, there will be comprehensive coverage of the CDC's National HIV Prevention Conference, scheduled for June 12-15, 2005, in Atlanta.

CDC's HIV prevention goals promoted in 2001 are far from a success story

Although the CDC has reached the year when its strategic plan for HIV prevention was supposed to be realized, little has changed since the plan was published in January 2001, experts say. For example, the HIV new infection rate has not changed at all, according to official estimates, and about the same proportion of HIV-infected individuals do not know their HIV status. Some experts claim the fault has been a lack of federal funding to back up the ambitious goals. cover

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CDC was ambitious with its prevention goals, but will persevere with efforts

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Big question for 2005: What happened to CDC's HIV prevention plan?

Experts say U.S. is long way from meeting goals

HIV/AIDS clinicians, researchers, and activists praised and applauded the Centers for Disease Control and Prevention (CDC) in January 2001 for the bold public plan to cut new HIV infections in half by 2005. Now, nearly halfway through 2005, the enthusiasm has turned into dismay and resignation for the status quo as the goals remain about as unattainable now as they were then.

The CDC had unrolled its HIV Prevention Strategic Plan Through 2005 to positive fanfare and raised hopes that the nation would see a major transformation in HIV prevention success, just as was seen in the treatment and care arena where illnesses and deaths were decreased dramatically because of the antiretroviral drug regimens.

The estimate of 40,000 new infections per year had been stable since the early 1990s and, while that in itself was a great public health achievement, far better than the estimated 150,000-plus new HIV cases during the epidemic's peak years, the CDC's strategic plan called for cutting the new infection rate in half by 2005. **(See chart of CDC strategic plan, p. 63.)**

The problem with the goals cited in the strategic plan is that Congress and President Bush's administration provided no additional funding for scientific-based prevention efforts during the past four years. And just as was predicted by published studies that analyzed prevention spending and needs, there have been no prevention improvements without the additional money.

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CDC guidelines on treating OIs among adults provides evidence for best practices

The CDC has confirmed that in the age of antiretroviral therapy clinicians may choose to treat some opportunistic infections (OIs) less aggressively. The CDC's recent guidelines emphasize the importance of antiretroviral therapy in reducing the incidence of OIs, particularly in individuals who have a CD4 t-cell count of less than 200 cells. But they also confirm that some OI treatment might pose more risks than benefits. 66

Providing prevention services to rural African American women presents challenges

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Adherence Strategies

A team of HIV clinicians and medical professionals at Weill Cornell Medical Center at New York Presbyterian Hospital have developed an assessment tool that is used to identify a new HIV patient's potential for adherence. The tool, consisting of 20 questions, was designed to assess the psychosocial factors that could influence a patient's adherence to antiretroviral therapy, according to a senior social worker in the Center for Special Studies at Weill Cornell 69

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Editorial Questions

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CDC data estimate no change in the new infection rate in 2005, and some experts contend it has probably crept up in the past couple of years.

“Since we don’t have good HIV incidence numbers in the United States, the next best proxy is HIV diagnoses from 30 states,” says **David Holtgrave**, PHD, professor in the departments of behavioral science and health education and health policy and management at the Rollins School of Public Health in Atlanta.

“HIV numbers seem to be ever so slightly going up in diagnoses,” he says.

The HIV epidemic in the United States appears to be stable, with variations among specific populations, such as statistically significant declines in new diagnoses among women, which are balanced by increases in HIV diagnoses among men who have sex with men (MSM), says **Ronald Valdiserri**, MD, MPH, deputy director of the CDC’s National Center for HIV, STD, and TB Prevention. (See **Q&A with Valdiserri**, p. 64.)

He says the CDC plans to work with public health and community partners to determine its next step, but there are no immediate plans to develop a new strategic plan or put a new date on the 2001 plan.

Holtgrave has published numerous studies analyzing the country’s prevention spending and achievements, and estimated as early as 2001 that it would require at least \$300 million additional prevention money per year to achieve the CDC’s goal of cutting new infections in half.¹

Without a substantial increase in prevention spending, there likely would be no decrease in new infections, he concludes from his research.

“I wanted desperately to be very, very wrong about this, but it doesn’t seem like it’s turning out this way,” Holtgrave says.

His latest research estimates that unless the nation can reduce the new HIV infection rate from its estimated 40,000, by the year 2010, there will be an additional 130,000 new HIV infections that will cost the health care network more than \$18 billion over the same period.¹

Another study shows that the HIV transmission rate for people who are unaware of their HIV serostatus is 10.79%, compared with a 1.73% HIV transmission rate for people who are aware of their HIV status, and a near-zero percentage rate for people who receive effective HIV testing and counseling.²

This research further highlights the need for well-funded, scientifically based prevention programs aimed at reducing the nation’s HIV new

CDC’s Prevention Goals January 2001-2005

Overarching National Goal:

Reduce the number of new HIV infections in the United States from an estimated 40,000 to 20,000 per year by 2005, focusing particularly on eliminating racial and ethnic disparities in new HIV infections.

1. By 2005, decrease by at least 50 percent the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained, and evidence-based HIV prevention interventions.
2. By 2005, through voluntary counseling and testing, increase from the current estimated 70 percent to 95 percent the proportion of HIV-infected people in the United States who know they are infected.
3. By 2005, increase from the current estimated 50 percent to 80 percent the proportion of HIV-infected people in the United States who are linked to appropriate prevention, care, and treatment services.
4. By 2005, strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions, and evaluate prevention programs.

International Goal:

5. Assist in reducing HIV transmission and improving HIV/AIDS care and support in partnership with resource-constrained countries.

Source: Centers for Disease Control and Prevention’s HIV Prevention Strategic Plan Through 2005. Web site: www.cdc.gov/nchstp/od/hiv_plan/.

infection rate as quickly as possible, Holtgrave says.

“We need an additional \$300 million per year for four years in order to really address the HIV prevention needs in the U.S.,” he adds. “If we get the infections down to half by that investment, then we might be able to scale back that investment.”

The nation has fallen short of achieving the other CDC prevention goals for 2005, as well, experts say.

The CDC still estimates the number of people living with HIV/AIDS who do not know their HIV status to be from one-third to one-quarter of the total number of people infected, and that was the same in 2001, says **Paul Feldman**, public affairs director for the National Association of People With AIDS in Silver Spring, MD.

And since the proportion of people who know their HIV status hasn't improved, neither has there been an increase in the proportion of HIV-infected people who are linked to appropriate care and treatment, he notes.

"There are on order one-quarter of a million Americans who need HIV care and who aren't getting it for a variety of reasons," Feldman says. "These are everything from waiting lists on AIDS Drug Assistance Programs to an unwillingness to approach the system to not being linked up with available services where Medicaid doesn't cover enough of the services," he adds.

Likewise, Feldman says he's unimpressed with the CDC's monitoring and capacity building efforts because they are burdensome and some require the reporting of client-level information that makes some HIV clients unwilling to receive services, he says.

Prevention experts reserve their biggest criticism for the political atmosphere, fostered by the Bush administration, in which additional funding for effective HIV prevention interventions is short-changed in favor of increased funding for unscientifically proven abstinence-only programs.

"In the last few years, we've become squeamish about talking about sexuality, and in fact, in many ways, we have put our heads in the sand," says **Georges C. Benjamin**, MD, executive director of the American Public Health Association of Washington, DC.

"That certainly doesn't help if you want people to know they're at risk for HIV infection," he says. "This is a disease that should have our full attention."

CDC officials may have had the best of intentions in setting the prevention goals, but their efforts were unlikely to succeed without financial and political capital behind them, says **Howard Grossman**, MD, executive director of the American Academy of HIV Medicine in Washington, DC.

"The basic problem is that the people at the CDC are trying very hard and working very hard, but they're completely hamstrung by a government that instead of putting out good prevention messages puts out lies and a resistance to science," he explains.

"Abstinence-only campaigns are receiving up to \$300 million in the new budget, and everything else has been cut," Grossman says.

"Research clearly shows that abstinence-only programs don't work. The latest data show that not only do kids who take abstinence pledges have the same number of sexually transmitted diseases as

those who don't take the pledge, but they are six times more likely to have anal intercourse and more likely to have oral intercourse," he notes.

Grossman says his criticism is not intended for the people working at the CDC. "I have nothing but respect for people at the CDC and what they'd like to do, but I think they're stymied at every turn."

The CDC's goals were ambitious, but they were appropriate, particularly the overarching goal of eliminating racial and ethnic disparities in new HIV infections, Benjamin says. "We need different prevention messages for different populations."

For example, prevention messages for the African American community could rely a lot more on radio advertisements, Benjamin says.

Also, prevention messages need to be translated into the languages of the various ethnic communities, both in the literal and figurative sense, he notes.

"We need to communicate to people in languages they understand, not just the language, but by using the words they understand," adds Benjamin.

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1. Holtgrave DR. A proposed format for tracking the Centers for Disease Control and Prevention's national HIV prevention goal. *J Public Health Man Prac* 2005; 11(1):4-6.
2. Holtgrave DR, Anderson T. Utilizing HIV transmission rates to assist in prioritizing HIV prevention services. *Int J STD & AIDS* 2004; 15:789-792. ■

CDC plans to persevere with prevention efforts

(Editor's note: In this Q&A, AIDS Alert interviews Ronald Valdiserri, MD, MPH, deputy director of the National Center for HIV, STD, and TB Prevention at the Centers for Disease Control and Prevention. Valdiserri discusses what has been achieved with regard to the HIV Prevention Strategic Plan Through 2005, and what more needs to be accomplished.)

AIDS Alert: The first goal stated in the CDC's five-year prevention plan was to decrease by at least 50% the number of people in the United State at high risk of acquiring or transmitting HIV infection. Why has it been so difficult to accomplish this goal?

Valdiserri: That estimate [40,000] remains in

place. I think one of the issues we've been grappling with is the fact that coming up with the 40,000 estimate in today's environment is a lot more complex.

Now the good news is that we have made significant progress in improving our ability to monitor the epidemic, which was, of course, one of the major domestic goals in the plan. We are very far along in the implementation of a national HIV incidence system, which has been expanded from five sites in 2001 to 35 sites today, and we anticipate in 2006 actually having new population-based estimates on the incidence of HIV infection.

So we haven't updated the 40,000 [figure], but we anticipate with the national incidence system in 2006 we will have an updated, accurate estimate of HIV incidence.

Granted the goals were very ambitious, which is not unusual when folks get together and set goals for public health problems. But the fact that we haven't observed substantial increases in HIV incidence is significant. Many epidemiologists and modelers predicted that as treatment was made widely available and people lived longer with HIV, then we would have an increase in new infections because of increased opportunities to transmit. So I think that the fact that we haven't seen that increase is positive news, but it is true that we did not make the kind of progress that we initially had hoped to make.

AIDS Alert: In the *MMWR* Dec. 3, 2004, issue, a surveillance report says that the CDC estimates 180,000-280,000 people are infected with HIV and do not know it. Why has the goal of increasing the proportion of people who know they are infected to 95% been difficult to achieve, and will the new rapid HIV testing program help close the gap?

Valdiserri: We are seeing focal differences. As an example of that, with the availability of the licensure of the rapid HIV test in the United States, one of the ways the public health community responded to that was trying to push to make that technology more widely available and to reach out to people who might be infected and wouldn't otherwise be tested. And we invested in a number of demonstration projects, which are coming to completion.

Several of those demonstration projects have shown very promising results in terms of the number of people who are tested and the number of people who are found to be positive, especially when we compare them to some of the

more traditional, clinic-based approaches.

Now we have to scale up that effort to make sure effective models are put into place. We have plans under way to work with funded partners, particularly with health departments and community-based organizations, to scale up the findings from the demonstration projects to be able to make a substantial impact on the percentage of people who are infected but don't know it.

It's not going to be easy, and it's not going to happen quickly because we're talking about a whole national system here, but we can definitely bring that number down.

AIDS Alert: Has the United States had any improvement in the proportion of HIV-infected people who are linked to appropriate prevention, care, and treatment services?

Valdiserri: A CDC researcher has determined from a modeling exercise that about two-thirds of the people who are eligible for antiretroviral treatment and are not receiving it were not receiving it because they are undiagnosed.

There are some other issues about once people are diagnosed, but I think it goes back to the fact about how important it is to get people diagnosed early so they can get into care and also because we know that the majority of people when they find out they're infected with HIV definitely take positive steps to reduce transmission to their partners.

AIDS Alert: Have you made improvements in linking people to care who know they are infected?

Valdiserri: Anytime we're talking about cross-care systems, in HIV or any other kind of complex illness, we have to continue to work to improve referral systems and mechanisms to ensure effective referral, so I don't want to declare victory there. What I'm trying to say is if we can continue to get people diagnosed as early as possible that we're also going to make some great strides in that arena.

AIDS Alert: The fourth goal discusses strengthening the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions, and evaluate prevention programs. What has the CDC done to improve in those areas?

Valdiserri: There are three major and substantial successes there: First, we are very close — we're not there yet, but we're very close to having a new estimate of HIV incidence based on a national incidence surveillance system; we've made substantial progress in implementing that activity.

Secondly, we have invested in behavioral surveillance for two high-risk groups: men who have sex with men and injection drug users.

And third, I think the one point I didn't mention before that is important to point out is we have substantially improved our program evaluation activities for CDC grantees. We've always had requirements that CDC grantees, whether they're health departments or community-based organizations. For example, they are required to monitor their work and report on their efforts, but we have substantially improved the measures that will now be reported back to CDC that will help individual programs see how well they're doing to improve programmatic goals. These also will help the CDC in terms of targeting resources. So that Program Evaluation and Monitoring System has been substantially improved, and that's under way as well.

AIDS Alert: The overarching national goal included a focus on eliminating racial and ethnic disparities in new HIV infections. Comparisons of the *MMWR* reports from Nov. 28, 2003, and Dec. 3, 2004, suggest some improvements in the percentages of black men and women who had new HIV diagnoses between the periods 1999-2002 and 2000-2003, but the percentages of Hispanic men and women has risen. Do the data suggest any improvements as a result of targeted HIV prevention programs for African Americans, and what more can be done? Also, what can be and is being done to address the growing problem in the Hispanic population?

Valdiserri: It's a mixed picture. Again when we look at trends in rates of HIV diagnoses in terms of gender and race ethnicity, we have seen declines among African American females. But we have seen increases among men who have sex with men, many of whom are men of color. So I think that we've certainly had some successes, and there are a number of positives we can point to, but we need to continue to work in that regard.

That, too, is a very complex issue, that cuts across many different lines, and it's not just a matter of how good are our HIV prevention programs. It also has to do with socioeconomic status, issues of ongoing racism, and issues of unequal access to care.

If you look at many of the organizations that the CDC funds directly, the majority of those organizations are serving racial and ethnic minority communities.

We're also really putting emphasis on trying to

disseminate effective behavioral interventions to reduce risk of infection, to encourage early diagnosis, especially if these are efforts that target African Americans and other ethnic and racial minorities.

So again, I think we can point to some focal successes, but we still have a long way to go as a nation.

It's so important to look at the strategic plan for what it is, and that's a way to strengthen our collective resolve to address this ongoing, extremely important health problem that continues to trouble our nation. That's why it's important to have goals, even if they are ambitious goals, because we have something to work toward, and we can work with all of our partners. ■

CDC issues guidelines on treating OIs among adults

ART is cornerstone of treatment plan

The Centers for Disease Control and Prevention (CDC) has confirmed that in the age of antiretroviral therapy (ART), clinicians may choose to treat some opportunistic infections (OIs) less aggressively.

The CDC's recent guidelines for treating OIs among HIV-infected adults and adolescents emphasize the importance of ART in reducing the incidence of OIs, particularly in individuals who have a CD4 t-cell count of less than 200 cells. But they also confirm that some OI treatment might pose more risks than benefits.¹

"Now we have data to support what a lot of people have been doing in terms of stopping certain types of therapy," says **Aaron Glatt**, MD, professor and chairman of medicine for Our Lady of Mercy Medical Center in the Bronx, NY. Glatt is on the editorial advisory board of *AIDS Alert*.

Also, the guidelines provide a detailed analysis of various treatment options and show how strongly these options are supported by research evidence, using a rating scale of A through E and a quality of evidence scale from I to III, with recommendations followed by a letter and number rating; an A-I, for instance, suggests the strongest evidence-based best practice.

For example, the chart on *Mycobacterium avium* complex (MAC) disease states there is strong evidence from at least one well-designed trial that the preferred initial therapy consists of at least two

drugs, including Clarithromycin 500 mg PO BID and ethambutol 15 mg/kg body weight PO QD.¹

However, the guidelines say that the evidence for efficacy might not outweigh the potential for adverse effects if clinicians use NSAIDs in treating HIV patients who have developed MAC and also experience moderate to severe symptoms associated with ART-associated immune reconstitution syndrome. Likewise, the guidelines suggest the evidence is lukewarm for providing short-term treatment with systemic corticosteroid among MAC patients.¹

Another example of restraint in the guidelines involves the use of antibiotic prophylaxis for the prevention of bacterial pneumonia. The guidelines again find that the benefits might not outweigh the risks when HIV patients are prescribed them in the event of frequent recurrences because of the possibility of the development of drug resistance and drug toxicities.¹

“The bottom line is that we do not yet have all of the answers for some of these complicated and less common scenarios,” Glatt says.

He suggests that in those problem cases, the physician weigh the benefits and advantages for that particular patient and treat accordingly. “And be careful to closely monitor for evidence that you made the wrong decision,” Glatt says.

In the case of the OI *Campylobacter jejuni*, the guidelines suggest that for mild disease a clinician might withhold therapy unless the symptoms persist for several days, and the CDC panel says there is little evidence to support a clinician prescribing an additional aminoglycoside in bacteremic patients.¹

“It’s important for people to understand there are some situations where the benefits of treatment are unclear, and the cardinal rule of medicine is, first, to do no harm,” he explains.

“So it might be better if the HIV patient takes less OI medications, because it will improve adherence, reduce side effects, and save money,” Glatt continues.

The guidelines also provide a great deal of information about the treatment of OIs in pregnant women, noting that there have been no large studies conducted on the epidemiology or manifestations of HIV-1-associated OIs in this population.¹

The CDC panel suggests clinicians take into consideration the potential for physiologic changes during pregnancy to affect the presentation of acute OIs, such as the pregnant woman’s increased cardiac output by 30% to 50% and the placental transfer of drugs.¹

The use of diagnostic testing also needs to be closely weighed against the risk to the fetus, and the CDC panel recommends pregnant women who have an OI but who are not on antiretroviral therapy should be started on ART with OI therapy immediately, depending on the fetus’ gestational age, maternal HIV-1 RNA levels, and clinical conditions, as well as the potential for toxicities and drug interactions.¹

“As with all prescribing, but especially to pregnant women, open discussions between the physician, patient, and husband, when the patient’s married, are essential to obtain the best outcome medically and legally,” Glatt notes.

Here are a few examples of the guidelines’ OI treatment recommendations:

- **Cytomegalovirus (CMV) disease**

The CDC guidelines suggest there is strong evidence for using Ganciclovir (GCV) intraocular implant and valganciclovir 900 mg PO QD in treating CMV retinitis when there are immediate sight-threatening lesions. They also say treatment should be considered in patients with CMV pneumonitis who have histologic evidence of CMV pneumonitis and who do not respond to treatment of other pathogens, but there is no compelling evidence to provide maintenance therapy.¹

Also, the CDC panel says there is no compelling evidence either for or against the recommendation of delaying ART among patients with CMV neurologic disease because of concerns about their disease worsening as a result of immune recovery inflammatory reaction.¹

The guidelines recommend against preemptive treatment of patients with CMV viremia when there’s no evidence of organ involvement.¹

Glatt recommends regular ophthalmologic examination for patients with HIV, especially when the CD4 cell count drops below 100, and urgent evaluation anytime new signs or symptoms occur.

“Many internists do not have the necessary expertise in funduscopy, and early consultation with an ophthalmologist is crucial,” he points out.

- **Herpes simplex virus (HSV) disease**

Initial treatment or for recurrent genital HSV, the CDC guidelines recommend the use of Famciclovir 500 mg PO BID or valaciclovir 1 g PO BID or acyclovir 400 mg PO TID for seven to 10 days.

However, the CDC panel notes there is no compelling evidence either for or against the recommendation to use these three drugs in treating

patients with frequent or severe recurrences as a chronic suppressive therapy.¹

- **Human papillomavirus (HPV) disease**

The CDC panel recommends a patient-applied treatment of podofilox 0.5% solution or 0.5% gel to be applied to all lesions BID on three consecutive days and repeated weekly for up to four weeks. The guidelines specifically do not recommend the use of intralesional interferon-alfa because of the high cost, difficult administration, and potential for systemic side effects.¹

In general, the guidelines are an excellent resource for physicians providing HIV care, Glatt notes.

"They are indicative of the steady, albeit sometimes frustratingly slow, progress we are making in the fight against HIV/AIDS," he says.

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1. Benson CA, Kaplan JE, Masur H, et al. Treating opportunistic infections among HIV-infected adults and adolescents: Recommendations from the CDC, the National Institutes of Health, and the HIV Medicine Association/ Infectious Diseases Society of America. *MMWR* 2004; 53(RR15):1-112. Web site: www.cdc.gov/mmwr/preview/mmwrhtml/rr5315a1.htm. ■

Reaching rural African American women difficult

Researcher discusses chief issues

Poverty and inequality are among the major challenges faced by the rural African American women at risk for HIV infection, and these increase this population's potential for becoming infected, an expert says.

"The types of sexual networks people have also help amplify transmission," says **Adaora Adimora**, MD, MPH, an associate professor of medicine in the division of infectious disease, department of medicine at the University of North Carolina School of Medicine in Chapel Hill.

Adimora is scheduled to speak about prevention targeting rural African American women at the Centers for Disease Control and Prevention's 2005 National HIV Prevention Conference, scheduled for June 12-15 in Atlanta.

"This is not simply due to increased numbers of sexual partners, because some of the women,

according to a case control study we did, do not necessarily have a lot of partners," she says. "But they are women who have high-risk partners or whose partners have concurrent partnerships."

Another factor that goes hand-in-hand with the women's poverty and educational disadvantages is ongoing or past drug use, Adimora notes.

"It's not clear to me that the crack epidemic in North Carolina is over," she says. "We still see a lot of HIV transmission related to current or past crack use and a fair amount of HIV transmission related to the risk behaviors of the women's partners."

However, social context and sexual networks are major contributors to the HIV epidemic's impact on African American women, Adimora's research has shown.

For example, studies involving interviews with focus groups of African Americans from rural North Carolina have shown there is a social context to their sexual relationships that includes pervasive economic and racial oppression, boredom, lack of recreational opportunities in the community, and substance abuse. Those are combined with a perception that there is a shortage of black men and this shortage's role in concurrent sexual partnerships.¹

These social context factors may contribute to sexual patterns that place individuals at greater risk for infection from HIV and other sexually transmitted infections (STIs), Adimora explains.

"People talked eloquently in the focus groups about what their lives are like, and the way they talked about them made it pretty clear they were aware of the risk," she says.

"They talked about the extensive racial discrimination in employment, things that made it difficult to own houses, and they talked about the imbalance of men to women," Adimora notes.

"The sex ratio among African Americans is much lower than for other racial ethnic groups in the U.S. because of the deaths of black men from disease and violence, and it's further lowered by the incarceration of black men."

These perceptions were pervasive among the black men and women, ages 18 to 59, who participated in the focus groups, she adds.

"The second thing we did was look at the prevalence of concurrent partnerships among African Americans in Eastern North Carolina and in some other rural areas," Adimora says. "And we found that, once again, it was associated with a person being a man, being single, or having a sex partner who was incarcerated."

Investigators were surprised to find that a fourth

of the men included in the study of a general population of African American men in rural Eastern North Carolina had a history of incarceration, she notes.

“There was a high prevalence of concurrency of overlapping partnerships in the past five years of black people in this region, and most of the people believed their recent partner had a concurrent partnership,” Adimora adds.

The relevance of the concurrent partnerships is that it may increase heterosexual HIV among the rural African American population, another study concludes.²

“We also did look at people with newly diagnosed HIV infections, and they were more likely to have concurrent partnerships,” she says. “The striking thing about the HIV cases was they were more likely to be poor than the general black population.”

HIV clinicians and public policies promoting HIV prevention may find it especially difficult to target interventions to rural African Americans

because of the social context that cannot be easily addressed Adimora explains.

“We’re used to having a tool, something that we can use to fix the problem, and in this situation there are fairly profound social structural reasons, social-political, and socioeconomic reasons that contribute to the current problem,” she adds. “We need to reframe the debate and do something about social factors, such as making meaningful change to racial disparities, poverty, and inequality, and advocating for research and interventions that have the potential to impact underlying causes and inequality.”

References

1. Adimora AA, Schoenbach VJ, Martinson FEA, et al. Social context of sexual relationships among rural African Americans. *Sex Transm Dis* 2001; 28(2):69-76.
2. Adimora AA, Schoenbach VJ, Martinson F, et al. Concurrent sexual partnerships among African Americans in the rural south. *Ann Epidemiol* 2004; 14:155-160. ■

ADHERENCE STRATEGIES

New tool measures potential for adherence

Tool is part of multidisciplinary approach

A team of HIV clinicians and medical professionals at Weill Cornell Medical Center at New York Presbyterian Hospital in New York City have developed an assessment tool that is used to identify a new HIV patient’s potential for adherence.

The tool, consisting of 20 questions, was designed to assess the psychosocial factors that could influence a patient’s adherence to antiretroviral therapy, says **Chuck Finlon**, CSW, senior social worker in the Center for Special Studies at Weill Cornell.

“As adherence became an issue and it became clear that 95% adherence was what was needed, we formed a multidisciplinary adherence committee about four years ago,” he says. “We reviewed literature and looked at why patients were failing — what factors got in the way of their ability to take meds regularly.”

At first, the clinic’s nurses, who were trained in dealing with HIV patients, began to work with patients who were medication-naïve or who were failing or changing regimens, Finlon explains.

Then the clinic started a four-module, four-week HIV treatment education course, taught by nurses, for the new HIV patient or for those who were failing their regimen, he adds.

Patients are given movie tickets as an incentive after they’ve completed the course, Finlon says.

The latest adherence strategy was to develop an assessment tool that could be used to screen patients before they are enrolled in the education course, he says. **(See sample of assessment tool, p. 70.)**

The multidisciplinary team, consisting of physicians, nurses, social workers, and others, designed the assessment tool after reviewing literature and interviewing the clinic’s staff about factors that appear to influence adherence, Finlon notes.

“For us, what works with the tool is it sparks questions and thoughts in the patient, and it lets other team members know what are the patient’s issues,” he says. “It’s put in the patient’s chart and is there for everyone to look at; and it’s a way to get people to think about the bigger issue of adherence.”

The tool is not scored or measured as part of a research project, so its questions often are open-ended with the goal of encouraging patients,

nurses, social workers, and doctors to think about the complexity of adherence, Finlon notes.

If it appears a patient is not ready to adhere to an antiretroviral regimen based on the assessment results, then the patient still is sent through the HIV training course in hopes that by its end the person will be in a better position to start taking HIV medications, he says.

Also, social workers will use the patient's answers to the tool as a starting point for discussing the aspects of a patient's life that may affect adherence.

"The patient might say, 'No, I won't take medication because I think it's going to kill me, but I'll say yes to get the doctor off my back,'" Finlon says.

The assessment tool will pick up on the patient's attitude toward medication and provide social workers with an opportunity to explore and discuss these issues.

Another barrier to adherence is substance use, particularly if it's a daily habit, he continues.

"If the patient doesn't think it's a problem then there's nothing you can do to help him with the substance abuse problem," Finlon says. "But you can talk with patients about how they think the substance abuse might affect their ability to take medications regularly."

Also if the assessment leads staff to believe a patient will have a difficult time remembering to take medications, then nurses can pre-pour the pills in a weekly pill box and make follow-up

Weill Cornell Assessment Sample Questions

The adherence assessment tool developed by a multidisciplinary team at Weill Cornell Medical Center at New York Presbyterian Hospital in New York City is used to help clinical staff better understand impediments to HIV patients' antiretroviral drug adherence. Staff ask new HIV patients to answer the tool's questions before they begin treatment, and the tool is used to help initiate a dialogue about how the patient will need to achieve 95% or greater adherence to the drug regimen. The tool has not been tested for validity or reliability.

Questions:

1. Does patient have any problems with the following?

- Medical coverage
- Telephone service
- Income (from job, SSI, SSD, public assistance, HASA PA, etc.)
- Kitchen facilities with refrigerator
- How long at current address? Plans to move soon?
- Transportation to clinic

2. How does patient learn best?

- Reading
- Pictures
- Demonstration
- Other

3. If previously on medication, what was patient's experience?

4. Does patient see a connection between HIV and AIDS?

5. Does patient believe someone can be cured of HIV or AIDS?

- What does "cured" mean to patient?

6. What does patient state he/she is doing now to care for HIV infection?

7. What are patient's concerns about starting medications?

8. How does patient suppose medication will make him/her feel?

9. Does patient know other people who have had HIV/AIDS?

- Did those others take HIV medication?
- What happened to them?
- What did patient learn from this?

10. Are the people patient lives with aware of patient's HIV status? Are there any who aren't?

11. If patient were to have problems taking medication, who does he/she think could help?

12. In the past week, how often did patient:

- Have trouble keeping his/her mind on what he/she was doing?
- Feel that everything he/she did was an effort?
- Have trouble sleeping?

13. In the past six months, what substances (alcohol, marijuana, crack, cocaine, heroin, ketamine, crystal meth, etc.) has patient used?

- Does patient believe this use will impact his/her ability to take medications?

phone calls on a daily basis for those who are at the highest risk of nonadherence, he notes.

Follow-up doctor visits are every four to six weeks, depending on the patient's answers to the assessment tool, Finlon says.

"Whenever they meet with the doctor, they meet with a social worker, so it's always a team appointment," he explains. "Depending on what issues are flagged as a problem, the social worker sits down and talks with them about it."

For example, the social worker might say, "Your housing situation is a problem, do you want to meet regularly until we can come up with a solution?" Finlon adds.

One of the more common problems is disclosing their HIV status to family members, he says.

"We talk about their fears and issues related to age-appropriate disclosure," Finlon says. "There are so many different kinds of disclosure, such as disclosing to a 3-year-old vs. a 10-year-old or an 18-year-old or to a partner."

Social workers will ask patients these questions:

- What are the problems keeping the person from giving out this information?
- What will happen if the patient gives the information to a parent, a child, a partner?
- Has the patient told anyone in the past, and what has his/her experience been?
- Has the patient had any good experiences with disclosure?
- How did the person told about the patient's HIV status react?

"The problem with disclosure is it seems so impossible to an HIV patient," Finlon says. "They think, 'I've got this secret and if I tell anyone they'll abandon me, so I won't tell anyone.'"

Another common problem among the HIV patients seen at the New York City clinic involves housing, he adds.

"Someone will have to move from relative to relative," Finlon says. "We're based at the hospital, and so we educate patients about programs

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. 72**. If any of your answers are incorrect, re-read the article to verify the correct answer.

This concludes the six-month semester, please complete the enclosed evaluation form and return in the envelope to receive your credits.

CE/CME questions

For more information about the CE/CME program, call customer service at (800) 688-2421.

21. Which of the following was not one of the goals included in the Centers for Disease Control and Prevention's 2001 strategic HIV prevention plan?
 - A. Cut the new HIV infection rate in half to 20,000 per year.
 - B. Increase abstinence-only prevention messages from 150 programs to 300 programs.
 - C. Increase the proportion of people infected with HIV who know their serostatus from an estimated 70% to 95%.
 - D. Increase the proportion of HIV-infected people who are linked to appropriate prevention, care, and treatment programs from 50% to 80%.
22. How do the CDC guidelines on treating opportunistic infections assist clinicians in weighing the risks vs. benefits of various OI treatments?
 - A. They confirm that some OI treatment might pose more risks than benefits.
 - B. They provide a detailed analysis of various treatment options and show how strongly these options are supported by research evidence.
 - C. They use a quality of evidence scale to suggest evidence-based best practices.
 - D. All of the above
23. Which of the following is not a social context factor cited in the research on HIV risk among rural, North Carolina African American women?
 - A. Obesity
 - B. Pervasive economic and racial oppression
 - C. Boredom and lack of recreational opportunities in the community
 - D. Substance abuse
24. Which of the following is a question included on the adherence tool developed by Weill Cornell Medical Center?
 - A. If previously on medication, what was patient's experience?
 - B. Does patient see a connection between HIV and AIDS?
 - C. Does patient believe someone can be cured of HIV or AIDS?
 - D. All of the above

out there and hook them up with a community-based organization, and maybe take them around to look for an apartment."

While New York has a lot of services for people with HIV, to obtain those services is difficult, so social workers and case managers watch for signs that housing might be an obstacle to adherence, such as if a patient suddenly stops showing up for appointments regularly, he adds.

Medication side effects also are a common obstacle to adherence.

"We educate patients about possible side effects without scaring them in advance," Finlon notes. "The nurse case managers will work very intensely with patients on this issue."

For example, Finlon once had a patient who was resistant to taking her medications and then developed a brain infection. Although the patient said she'd take her medications now and was more adherent, she also was nauseous for six weeks, he says.

"She'd call every day to say she was going to stop taking her medications because they were making her sick," Finlon recalls. "I'd give her time to talk, and sometimes the nurse would call her back about certain interventions."

The staff worked closely with the woman, having the physician change her drug regimen a little and educating her about the limited number of options available to her, he says.

"The doctor thought the nausea and vomiting would go away if she could hang with it a while, and the nurse would say, 'Try to eat this instead,'" Finlon says. "The patient got through this period and is fine on the meds now."

He attributes the staff's success with the patient to their willingness to listen and empathize. "We'd say, 'It must be awful — I have no idea of what it's like to be nauseous for six weeks in a row,'" Finlon notes.

"The literature tells us the medications work if people are able to take them," he adds. "But there are a lot of things that prevent people from taking every dose, and we need to learn what is keeping a patient from taking medications and what has changed in their lives." ■

CE/CME answers

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

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

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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. ■

Clarification

In the article "Africa, India test sites for anti-HIV microbicide," (*Aids Alert*, March 2005, p. 34) it stated that cellulose sulfate (Ushercell) was "formerly called C31G." Actually, there are two separate Phase III studies currently being conducted by Family Health International — one study is of Ushercell (cellulose sulfate) and the other is of Savvy (C31G). ■