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CDC renews plan to reduce new HIV infections, but with more modest goals

It's 5 percent per year instead of 10 percent

The national five-year HIV strategic prevention plan, launched in 2001, was a failure. Everyone agrees with this assessment, including the agency that created it: the Centers for Disease Control and Prevention (CDC) of Atlanta, GA.[1,2]

The original plan, titled, HIV Prevention Strategic Plan Through 2005 (2001 Plan), had the admirable ambition of reducing new HIV infections by 50 percent over five years. It called for cutting the 40,000 annual new HIV infection rate in half by 2005. Instead, the CDC continues to estimate that we have 40,000 new HIV infections each year.

The CDC discusses the original plan's failure, as well as revised and more modest national goals in a new report that outlines an extension of the original 2001 plan. It's called the CDC HIV Prevention Strategic Plan: Extended Through 2010 (Extended Plan).

The main reason why the prevention goals weren't met is a lack of resources and funding, according to the CDC's new HIV prevention report. It would have taken a significantly expanded investment in HIV prevention to make progress toward these original goals, the CDC states in the report, which was announced and made available online in January, 2008. **(See chart of goals in revised plan, p. 17.)**

"I think that the original plan was predicated on full implementation and resources," says **Robert Janssen**, MD, director of the division of HIV/AIDS prevention at the CDC.

"Even now though, I think we do see these as achievable, but still a challenge," Janssen says.

The overarching goal in 2001 of reducing new HIV infections by 50 percent in five years was a vision that might be compared with the national "Healthy People" goals for the nation, Janssen says.

"It outlines the ideal," he says.

Members of the CDC/HRSA Advisory Committee on HIV & STD Prevention and Treatment (CHAC) recommended that the CDC extend the 2001 plan through 2010. CHAC also provided specific recommendations for objectives to be included in the extended plan.

CHAC first discussed extending the plan in 2005, and questioned the CDC about why the original goals were not met, says **Jesse Milan**, Jr., JD, the immediate past co-chair of CHAC. Milan served as co-chair during the five-year plan period.

"We agreed that a workgroup of CHAC and CDC should be created to extend the plan for three years and to update the goals and objectives," Milan recalls.

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Editor: **Melinda Young**, (864) 241-4449.
Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcmedia.com).
Managing Editor: **Leslie Hamlin**, (404) 262-5416, (leslie.hamlin@ahcmedia.com).

Editorial Questions?
Call **Leslie Hamlin** at (404) 262-5416.

"By the time we got to the fall meeting of CHAC in 2006 it was clear that the work of the workgroup was finished, and they asked CDC to come back to CHAC with revised goal statements and objectives, based on the work of the workgroup," Milan says.

It was May 2007, before the CDC provided specific numerical target goals, and these were to reduce infections by 5 percent by 2010, Milan says.

"We were aghast because how do you explain to the world that you have gone from a strategic plan that said to reduce new infections by 50 percent over five years to now a 5 percent reduction," Milan says.

CDC officials told CHAC that the new, considerably more modest goal was pragmatic given the current environment, Milan recalls.

After further discussion and debate, the CDC revised the plan to call for a 5 percent per year reduction, with no less than a 10 percent reduction by the end of 2010, he says.

"And so CHAC unanimously endorsed that as the new plan for extension," he says. "The old plan was based on new resources, so this might be the most anybody can expect, but it's certainly less than what we should hope for."

Another way to look at the extended plan is to think of it as a reality check, says **Edward Hook**, III, MD, a new co-chair of CHAC. Hook also is a professor of medicine at the University of Alabama at Birmingham (UAB).

For one thing, 2010 is less than two years away, Hook notes.

"If over the next two years we could decrease the number of people acquiring HIV in this country by 10 percent, CHAC would have such great cause for celebration," Hook says. "This epidemic is like a supertanker, and it has its own momentum; the effects of change in direction take a while to become apparent."

The 2001 strategic plan failed because it was too ambitious and there was inadequate funding and support, says **Donna E. Sweet**, MD, MACP, professor of medicine at the University of Kansas School of Medicine in Wichita, KS. Sweet is a new co-chair of CHAC.

Also, the initial plan did not have an overall strategy for implementation, Sweet says.

"The overall recommendation that the CHAC made is that whatever the goal, that there is enough planning and resources dedicated to make it feasible and doable so that it is not destined to fail," Sweet says. "We do hope for adequate,

which means by definition, more funding for this federal plan."

Politics also played a role in the plan's failure. Due to political concerns, a variety of policy barriers exist, including a federal prohibition on funding needle exchange programs, which have been proven scientifically to reduce HIV transmission among injection drug users (IDUs).[1]

Another reason why the 2001 plan was unable to meet its goals was because of the HIV prevention successes of the 1980s and 1990s, Hook says.

During the first 15 years of the epidemic, public HIV prevention campaigns and the introduction of highly-active antiretroviral therapy (HAART) helped to reduce new HIV infections to 40,000 per year from the late 1980s high of an estimated 160,000 per year.

"We've taken the low-hanging fruit, and now it's the hard work, the heavy lifting," he explains. "I think these are appropriate goals and targets for us, but making them is going to be a push."

The key will be to target prevention efforts on people who already are infected because this is the most efficient use of prevention resources, Hook says.

Targeting prevention messages to HIV positive people also might be the only method that will work over the long run, says **Michael S. Saag**, MD, professor of medicine at the University of Alabama at Birmingham and the director of the UAB Center for AIDS Research. **(See story on what might work now in HIV prevention, p. 15.)**

"I'll take a radical view and say that I can't imagine that any primary care prevention programs for sero-negatives will have any chance of working," Saag says. "The reason I'm saying that is we've had 20-some odd years of the epidemic, and we haven't made a dent."

The strategic plan did result in some very positive new initiatives and programs, Janssen notes.

There have been some prevention successes in recent years, including the dramatic decline in mother-to-child (MTC) HIV transmission, according to the extended plan.

In 1991, there were 1,650 documented cases of mothers transmitting HIV to their children. Now there are an estimated 150 cases of MTC transmission per year.[2]

Also, there were declines in the proportion of youth reporting engaging in sexual intercourse between 1991 and 2005.[2]

The CDC has trained several thousand prevention providers to use effective prevention interventions, Janssen says.

"I think one of the things we've done a good job on is expanding HIV prevention to include prevention for people living with HIV," Janssen says. "That continues to be an important gap for us, getting medical providers to increase prevention services when taking care of people with HIV."

Also, the agency has awarded $35 million to state and local health departments to implement testing guidelines, particularly in areas where there's a high HIV prevalence, Janssen says.

"We continue to be challenged by [the lack of] reimbursement for HIV testing and screening," Janssen says.

Even Medicaid does not reimburse providers for HIV screening, except among pregnant women, he adds.

The CDC will continue to push for routine testing, however, he says, "We've been working very hard to implement the 2006 recommendations for routine screening in health care settings," Janssen says. "We have had workshops with emergency room providers across the country, particularly in high-HIV prevalence areas." ■

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Prevention experts discuss what might work to reduce HIV incidence

Focus on African Americans and MSM

In the extended HIV prevention plan by the Centers for Disease Control and Prevention (CDC) in Atlanta, GA, there is renewed focus on expanding HIV testing and focusing on African Americans and the men who have sex with men (MSM) communities.[1]

The plan also calls for the CDC to address HIV transmission in prisons and to increase HIV screening in medical care settings.[1]

The plan's short-term goal is to reduce the

number of new HIV infections in the United States by 5 percent a year, or at least by 10 percent through 2010. This is to be done with a focus on eliminating racial and ethnic disparities in new infections.[1]

Experts say this will be difficult because of existing barriers to getting prevention messages across to those most at risk of infection.

HIV prevention is a tough message, and it's hard to reach the populations who need to hear it, says **Michael S. Saag**, MD, professor of medicine at the University of Alabama at Birmingham and the director of the UAB Center for AIDS Research.

"There is distrust among people who are disenfranchised, and there's an incredible belief system among sero-negatives that this will not happen to them," Saag explains.

In a recent commentary about how to decrease the new HIV infection rate in the United States, experts suggested these main strategies:

- Find more people infected with HIV and provide them with counseling and other preventive services.[2]
- Provide behavioral interventions to people with HIV to help lower their risk behaviors. These interventions should focus on transmission-related risk behaviors, such as substance use, mental illness, health care access issues, etc.[2]
- Increase the percentage of HIV-infected people who have access to health care and treatment.[2]
- Focus prevention interventions on people who are at behavioral risk for HIV infection.[2]
- Educate the public about HIV to reduce stigma and increase general knowledge about the disease.[2]

The most important prevention strategy is to get people who are infected tested and into treatment and care, Saag says.

There are several reasons why HIV prevention messages targeting people who already are infected will work, Saag says.

First, people who are HIV positive and are in treatment are already practicing a very important prevention strategy, he says.

"I'm basing that on the biological concept of if we theoretically identified every HIV positive person in the world and treated them to undetectable levels of virus, then there'd be no further transmission of HIV," Saag says.

Secondly, targeting HIV prevention interventions to people who already are infected is cost-efficient because this group is already receiving HIV services of some kind.

People who are HIV positive already are seeing doctors and clinics to receive their care, so they could be receiving continuous prevention messages and interventions during those visits.

"We need more money to do this," says **Edward Hook**, III, MD, a professor of medicine at the University of Alabama at Birmingham (UAB). Hook is a co-chair of the CDC/HRSA Advisory Committee on HIV & STD Prevention and Treatment (CHAC).

"We cannot allow new infections to continue to occur at the same time we're trying to optimize the management of the disease," Hook says.

The solution is further interagency collaboration and coordination, Hook suggests.

Collaboration is needed because the challenges to preventing new HIV infections cut across governmental boundaries and often include cultural and political barriers.

For example, research shows that condoms and interventions to increase condom use can reduce HIV transmission among young people at risk of becoming infected.

But changing the minds of people who believe that to teach prevention encourages sexual activity is a challenge, Hook says.

"The HIV epidemic and problems manifested by our epidemic are interwoven, and the challenges to controlling it are interwoven throughout national societies," Hook says. "We need to address it at that level, and we need it coordinated."

For instance, the federal-wide agencies need better integration with regard to goals, synergies, and cooperation, including HRSA and CDC, Hook says.

"And the U.S. Department of Education could be included," he adds. "What about having national HIV prevention as a national goal to protect America's youth?"

The nation might achieve a 5 percent reduction in new HIV infections per year if the U.S. would adopt an opt-out HIV testing policy, Saag says.

It's a realistic goal to use opt-out, standardized testing for HIV to find as many HIV positive individuals as possible, to get them into HIV care, and to reduce the transmission rate as a result, he says.

The challenge will be to increase funding to handle the influx of newly-identified positives.

Saag recently published an editorial which says the adoption of a policy of opt-out universal testing for HIV will increase the number of new HIV patients seeking care by at least 25 percent over the next few years.[1]

Goals/Objectives of the CDC HIV Prevention Plan

Short-term Milestone 1: By 2010, decrease by at least 10 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.

Transmission Objectives:

1. Among people living with HIV, increase the proportion who consistently engage in behaviors that reduce risk of HIV transmission.
2. Modified - Among men who have sex with men (MSM), increase the proportion who consistently engage in behaviors that reduce risk for transmission of HIV.
3. Modified - Among sexually active, HIV-infected women and HIV-infected sexually active heterosexual men, increase the proportion who consistently engage in behaviors that reduce risk for transmission of HIV.
4. Modified - Among injection drug users (IDUs), increase the proportion that abstain from drug use or, for those who do not abstain, use harm reduction strategies to reduce risk of HIV transmission.
5. Modified - Among adolescents living with HIV, increase the proportion who consistently engage in behaviors that reduce risk for transmission of HIV, particularly among out-of-school high-risk youth.
6. New - Increase the proportion of persons living with HIV who effectively access partner notification services.
7. New - Among persons living with HIV, increase the proportion who receive evidence-based interventions, including mental health, substance abuse, and other appropriate interventions for co-morbid conditions.
8. New - Among person with acute HIV infection, increase the proportion reached by appropriate HIV behavioral interventions.
9. New - Increase the proportion of persons living with HIV who disclose their HIV infection before a risk encounter with a new partner and increase the proportion of persons at risk for HIV infection who disclose their HIV status before their first risk encounter with a new partner.
10. Modified - Increase the proportion of HIV-infected pregnant women who are routinely tested and access prevention interventions including antiretroviral medication, caesarean sections (when appropriate) and infant formula feedings to interrupt perinatal transmission of HIV.

Source: HIV prevention strategic plan: extended through 2010 (extended plan). Centers for Disease Control and Prevention. October, 2007; available at http://www.cdc.gov/hiv/resources/reports/psp.

Existing HIV clinics do not have the capacity to absorb those people, Saag says.

"We need to assure they can get into care and that clinics have the capacity to take care of their patients," Saag says. "Clinics aren't there to give away care — we need to be paid for what we do, and we need to redouble efforts to have the money we need to operate."

The new 2010 extended plan includes a goal to make HIV testing routine, says **Donna E. Sweet**, MD, MACP, professor of medicine at the University of Kansas School of Medicine in Wichita, KS. Sweet also is a co-chair of CHAC.

"Success depends on both funding and providers buying into routine testing and truly trying to find the 250,000 to 300,000 people in this country who are infected but do not know it and who are almost certainly responsible for a very high percentage of new infections," Sweet says.

The CDC has made it a priority to test people for HIV as part of the prevention strategy.

"Getting people to learn their HIV status remains critical because it's one of our most effective ways for two reasons," Janssen says. "For one, people have to know their status to get into care, and, two, once people learn their HIV status, they protect their partners from getting infected."

National HIV prevention efforts have not been implemented at the level that's needed, Janssen notes.

"Two years ago there was a behavioral surveillance study of MSM that found about 20 percent of those men had made contact or been involved in an HIV intervention in the previous 12 months," Janssen says. "It was only 20 percent, so the reach of our HIV prevention interventions has been pretty low."

By contrast, some international HIV prevention efforts have reported an impact on 80 percent of the desired population, Janssen says.

"I don't know if that's true, but it's what people have reported internationally," he adds. ■

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Online film successful in reducing certain HIV risk behaviors

At-risk people watch 9-minute video

Internet-browsing men who have sex with men (MSM) apparently will respond to a dramatic, online short film with a message about reducing sexual risk behaviors, new research shows.

Investigators created a 9-minute video drama called "The Morning After" available for viewing online at www.hivbigdeal.org. They recruited more than 1,000 men through banner ads on a popular MSM Web sites: www.manhunt.net.[1]

"We had recruited men for other studies from that site, and we used a banner that was put on an exit page, so virtually everyone saw it," says **Mary Ann Chiasson**, DrPH, vice president of Medical and Health Research Association in New York, NY.

Participants completed a baseline behavioral questionnaire, watched the video, and then answered additional survey questions.[1]

There also was an online consent form that explained the study, Chiasson adds.

Researchers also requested that participants include their email address, and 971 responded with a working email address, Chiasson says.

This request apparently did not turn off potential participants, and 522 men, or 54 percent, responded to a follow-up survey at three months, she notes.

"This was the first time we've done a follow-up online," Chiasson says. "We were extremely pleased with the results because we didn't know if people would be willing to watch the movie or complete the follow-up survey."

Investigators were not permitted by the institutional review board (IRB) to ask participants about their HIV status on the first questionnaire because of confidentiality concerns regarding the simultaneous request for email addresses, Chiasson says.

"So, we didn't ask about their HIV status until the second survey," she adds.

From that data, they found that 6.7 percent of the men who self-identified as HIV negative had developed a new HIV infection within the three months after viewing the video, Chiasson explains.

"I think probably the men who were really concerned about their risk behavior were motivated to test," she says.

Other findings were that after viewing the intervention video, the men were three times more likely to disclose their HIV status to their sexual partners, Chiasson adds.

"I think disclosure is an area that needs to be looked at a lot more," Chiasson says. "To us, these findings were quite important."

The survey asked participants, at the three-month follow-up, questions about their thoughts about the video and how it affected them.

"One of the most striking findings is that men found the video provocative," Chiasson says. "This was the whole point of the video's structure, to initiate critical thinking in the men who viewed it."

The video begins with an attractive young man named Josh looking at dating profiles of other men via the Internet. It shows him instant messaging one man and arranging a date. They meet at a bar, drink, and end up in bed. The next morning Josh wakes up first and heads to the bathroom to wash his face. He opens the medicine cabinet to find toothpaste and spots a pill bottle. It's a prescription for an HIV antiretroviral pill.

Josh makes an excuse to his partner and leaves, immediately calling his best friends who meet him at a café. He tells them what happened and that he doesn't even remember if his partner Eric had used condoms the night before. They tell Josh that he has to cut back on his drinking and start asking partners about their HIV status. Then Eric spots Josh from the street, crosses over to his table at the café, and the two men have their own conversation about HIV disclosure, responsibility, and protection.

The video ends with the message that HIV still is a big deal, and the Website provides a list of resources, referrals, and links for more information.

The video was designed to set up a situation that might happen to MSM and to encourage them to think about it, she adds.

"We asked them if they had ever been in a situation like that, and 50 percent of the men said they had," Chiasson says. "Our pre-design focus groups had tapped into a situation that does happen to people."

The video has been available online since June, 2006, and through 2007, there were more than 30,000 hits to view it. The video is also available on YouTube, and it's had 16,000-plus hits there, Chiasson says.

"We're going to be starting a marketing campaign in the spring of 2008," she says.

First, investigators need to complete enrollment for a randomized, controlled trial that features a second episode to "The Morning After," titled, "The Test," Chiasson says.

In the second episode, the same characters appear, and Josh gets tested for HIV.

"We're very pleased with this intervention and hope to be continuing it in the future," she says. "There is room for all kinds of HIV interventions, and I think an inexpensive intervention that may not be as intensive, but can reach many people, has the potential for changing behavior."

Since making the video available online and discussing it at national conferences, investigators have been asked by HIV providers and clinics for DVD copies, Chiasson says.

"People want to use it in small groups for discussion and counseling," Chiasson notes. "It stimulates conversation and critical thinking." ■

[Editor's note: For those who would like to obtain a copy of "The Morning After," it is available on-line for a free download at www.hivbigdeal.com, or they can contact Mary Ann Chiasson, DrPH, at MAChiasson@mhra.org.]

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New Jersey governor OKs law requiring HIV screening

Medical Device Daily *Staff Report. This article originally appeared in the December 31, 2007, issue of* Medical Device Daily.

New Jersey Gov. Richard Codey has signed legislation requiring healthcare providers to test pregnant women for HIV as part of routine prenatal care. The bill also requires testing of newborns whose mother's HIV status is either positive or unknown at the time of delivery.

According to the Kaiser Foundation, New Jersey is the first state to push HIV testing for both pregnant women and newborns.

"Since the early 1990s, we've made great strides in reducing the HIV transmission rate to newborns. But even one infected baby is one too many," said Codey. "Today, New Jersey becomes the first state to require universal opt-out HIV testing for pregnant women, a move that has the potential to dramatically reduce the transmission of HIV from a pregnant mother to her newborn."

Codey sponsored the bill as the Senate president. He was acting governor while Gov. Jon Corzine was out of the country for the holidays.

The CDC (Atlanta) estimates that perinatal transmission rates can be reduced to less than 2% with universal screening of pregnant women in combination with prophylactic administration of antiretroviral drugs, a Cesarean delivery, and avoidance of breast feeding.

The legislation requires that all pregnant women be tested for HIV as early as possible in their pregnancy and again during their third trimester. In addition, each birthing facility in the state is now required to test any newborn whose mother's HIV status is either positive or unknown at the time of delivery.

"Early detection is the key to helping people living with HIV/AIDS to live longer with a better quality of life. Currently, we have the treatment available to help prevent the transmission of HIV from mothers to their babies," said **Sen**. **Loretta Weinberg** (D–Bergen), a primary sponsor of the bill. "This measure is a huge step forward in terms of protecting all babies while helping to educate mothers."

The measure moves New Jersey from "opt in" status to "opt out" status, meaning women will automatically be tested unless they choose not to be. Physicians and healthcare practitioners now are required to provide women with information about HIV and AIDS, the benefits of being tested, the medical treatment available to treat HIV infection, and the reduced rate of transmission to a fetus if an HIV-infected pregnant woman receives treatment.

Arkansas, Michigan, Tennessee, and Texas require health care providers to test a mother for HIV unless the mother asks not to be tested, while Connecticut, Illinois, and New York test all newborns for HIV.

The Commissioner of the Department of Health and Senior Services is responsible for adopting regulations to carry out the testing requirements, as well as guidelines for the information that physicians must provide their patients on testing, treatment, and counseling.

In 2005, a task force of the Agency for Healthcare Research and Quality (Rockville, Maryland) issued a recommendation suggesting that all pregnant women — not just those identified as at risk for contracting HIV — be screened for the infectious disease. (*Medical Device Daily*, July 6, 2005).

Some of the companies that produce HIV tests include:

- Calypte Biomedical (Lake Oswego, Oregon), which markets Aware HIV-1/2 OMT oral fluid rapid test.
- OraSure Technologies (Bethlehem, Pennsylvania), which makes the OraQuick Advance Rapid HIV-1/2 Antibody Test.
- Laboratory Corporation of America Holdings (Burlington, North Carolina), which has introduced an enhanced HIV Screening Assay to identify individuals with primary HIV infection.

A Canadian provider of rapid HIV testing in the United States has previously supported this type of recommendation.

Giles Crouch, VP of global sales and marketing for MedMira (Halifax, Nova Scotia), which makes the MiraWell Rapid HIV Test, said, "The CDC gives one direction that's very useful, but you need more than one [recommendation]. It's sort of a second seal of approval for healthcare providers. Rapid testing in maternity settings is still quite new, and now the tests that are out there are proven reliable." (*Medical Device Daily*, July 6, 2005). ■

Global HIV vaccine trials face ethical challenges

Enrollment in AIDS-stricken countries faces scrutiny

HIV vaccine trials likely will continue for a decade or longer, raising questions about ethical considerations of enrolling participants across the globe.

Since none of the studies so far have found a vaccine candidate that prevents HIV infection, one of the biggest ethical concerns is promoting inflated hope among trial subjects.

"There is the concern that despite having been told that this is research and the vaccine may not succeed in preventing HIV infection, participants will engage in risky behavior in the hope or belief that the vaccine will work," says **Ruth Macklin**, PhD, a member of the HIV Vaccine Advisory Committee at the World Health Organization, and a professor of Biomedical Ethics in the department of epidemiology and population health at Albert Einstein College of Medicine in the Bronx, New York.

"Evidence indicates, however, that participants in the trials have not actually engaged in 'behavioral disinhibition' — that is, engaging in behavior that is any more risky than when they are not in a trial," Macklin notes.

One reason HIV vaccine research is more ethically challenging is because HIV remains a stigmatizing condition, Macklin says.

"Phase III trials are almost always conducted on populations at high risk of becoming infected," she says. "Even though the participants are not infected when they enroll, if it becomes known that they are in a preventive vaccine trial, they might, therefore, be stigmatized."

The stigma factor isn't an issue for other types of vaccine trials, Macklin says.

There also has been the ethical challenge of pursuing the vaccine in the areas that need it most.

The HIV virus is different in various regions of the world, and any vaccine that is developed will need to be created specifically for the dominant virus present in the area where it will be given.

The challenge has been in starting vaccine trials in the resource-poor areas hardest hit by the pandemic, says **Pat Fast**, MD, PhD, executive director of medical affairs for the International AIDS Vaccine Initiative (IAVI) of New York.

"There wasn't enough emphasis being given to people who needed the vaccine the most, including the people in Africa and Asia," Fast says. "Less developed countries have fewer ways to protect themselves against HIV."

So, organizations such as IAVI and the Bill and Melinda Gates Foundation have provided the funding and infrastructure necessary to initiate vaccine research in resource-poor countries.

HIV vaccine research is very expensive, and it requires collaboration, Fast says.

For instance, the IAVI shares information with

the U.S. Military HIV Vaccine Research Program and the Medical Research Council in the United Kingdom. The organization also receives Gates Foundation funding, as well as money from the United States and European governments, she adds.

"You have to go into these countries and spend time and make sure people have a sustainable operation that's not just dependent on one trial," Fast says. "You don't want to go in and set up the trial, and then when you leave and people go away, the facilities fall apart."

The goal is a long-term effort so that when the AIDS vaccine finally is discovered, the existing infrastructure can be used for other health care and research projects, she adds.

An ethical challenge related to HIV vaccine work is that the vaccine is likely to make participants test positive for HIV even when they are not really infected, Macklin says.

"If participants are in a setting where there is mandatory testing, such as in the military, it must be made clear to the testing authorities that although the participants have antibodies, they are not infected," Macklin says. "This is usually handled by providing a card to each participant, affirming that they are enrolled in HIV vaccine research."

Another ethical concern has involved worries that researchers might not counsel vaccine participants fully about practicing safe sex because of their desire to see if the vaccine succeeds in preventing infection, Macklin says.

"That is, if no one engages in risky behavior, there is no chance that anyone will be exposed to HIV and, therefore, no way of knowing whether the vaccine is efficacious," Macklin says. "However, there is no evidence that researchers are failing to counsel vaccine trial participants appropriately."

Vaccine trial investigators even distribute free condoms to encourage participants to have the safest possible sex, Macklin says.

"Both the informed consent process and the counseling are designed not only to provide full information to participants, but also, the vaccine trials have employed a test of understanding before potential participants can be enrolled," Macklin says. "By this method, researchers try to ensure that participants fully understand that the vaccine may not work, that they may test positive even if not infected, and that they are well-informed about the best method to prevent becoming HIV infected."

FDA Notifications

FDA grants tentative approval of generic efavirenz tablets

On Dec. 20, 2007, the FDA granted tentative approval for a generic formulation of efavirenz tablets, 600 mg, manufactured by Emcure Pharmaceuticals of Pune, India The application was reviewed under the expedited review provisions of the President's Emergency Plan for AIDS Relief (PEPFAR).

As with all generic applications, the FDA conducts an on-site inspection of each manufacturing facility, and of the facilities performing the bioequivalence studies, prior to granting approval or tentative approval to these applications to evaluate the ability of the manufacturer to produce a quality product and to assess the quality of the bioequivalence data supporting the application.

However, although tentatively approved generic products meet required standards, they cannot yet be fully approved and sold in the United States because of existing patents and/or exclusivity rights. But the tentative approval does make the product eligible for consideration for purchase, under the PEPFAR program, for use in nations where PEPFAR is active.

This product is a generic formulation of Sustiva tablets, 600 mg, made by Bristol Myers Squibb Co., which is subject to existing patents, as listed in the agency's publication titled, "Approved Drug Products with Therapeutic Equivalence Evaluations," also known as the "Orange Book."

Efavirenz is a Nonnucleoside Reverse Transcriptase Inhibitors (NNRTI) indicated for treatment of HIV infection in combination with other antiretroviral agents.

Fosamprenavir label is updated

The fosamprenavir (Lexiva) label was recently updated to include new drug-drug interaction information regarding phenytoin (an anticonvulsant) and paroxetine (an antidepressant).

Details of the newly added information are contained at the following Web site address: http://www.fda.gov/cder/foi/label/2007/021548s014lbl.pdf.

Final rule is out on OTC vaginal contraceptives and spermicides

The FDA issued a final rule on December 18, 2007, requiring that manufacturers of over-the-counter (OTC), stand-alone vaginal contraceptive and spermicidal products containing the chemical ingredient nonoxynol 9 (N9) include a warning stating that the chemical N9 does not provide protection against infection from HIV (the virus that causes AIDS) or other sexually transmitted diseases (STDs).

Stand-alone spermicides include gels, foams, films, or inserts containing N9 that are used by themselves for contraception. Consumers can protect themselves from the transmission of STDs and HIV by practicing abstinence, being in a monogamous relationship where neither partner is infected, and using condoms consistently and correctly.

The FDA is issuing the rule in an effort to correct misconceptions that N9 protects against sexually transmitted diseases, including HIV infection.

Nonoxynol 9 is approved as a vaginal contraceptive that works by damaging the cell membrane of sperm. It has been shown in laboratory studies to damage the cell walls of certain organisms that cause STDs and to be active against some STD-causing bacteria and viruses. Over the years, many consumers have come to believe that N-9 could reduce the potential for transmission of HIV and other STDs. The FDA believes that the membrane-damaging effect can harm the cell lining of the vagina, cervix and rectum, thereby increasing the risk of HIV and STD transmission.

The FDA is requiring that the labels warn consumers that the chemical N9 in stand-alone vaginal contraceptives and spermicides can irritate the vagina and rectum, which may increase the risk of contracting HIV/AIDS from an infected partner.

In January, 2003, the FDA proposed new warning statements and other labeling information for these products after results from a major clinical study in Africa and Thailand showed that women using a contraceptive gel product containing N9 were not protected against HIV and other STDs and were, in fact, at higher risk for HIV infection than women using a placebo gel. Because these and other studies have shown that use of products containing N9 cause vaginal and rectal irritation that can heighten the chance of becoming infected with HIV from an infected partner, the FDA believes the warning will empower consumers to make more informed decisions about the use of these products and better protect public health.

This rule is being finalized following a public comment period and a thorough analysis of information and views from consumers, health care providers, academicians, and industry. The FDA is requiring that labeling of OTC vaginal contraceptive/spermicidal products containing N9 bear the following warnings:

- For vaginal use only
- Not for rectal (anal) use
- Sexually transmitted diseases (STDs) alert: This product does not protect against HIV/AIDS or other STDs and may increase the risk of getting HIV from an infected partner
- Do not use if you or your sex partner has HIV/AIDS. If you do not know if you or your sex partner is infected, choose another form of birth control.
- When using this product, you may get vaginal irritation (burning, itching, or a rash). Stop use and ask a doctor if you or your partner get burning, itching, a rash, or other irritation of the vagina or penis.

Other information in the new labeling includes:

- Studies have raised safety concerns that products containing the spermicide nonoxynol 9 can irritate the vagina and rectum. Sometimes this irritation has no symptoms. This irritation may increase the risk of getting HIV/AIDS from an infected partner.
- You can use nonoxynol 9 for birth control with or without a diaphragm or condom if you have sex with only one partner who is not infected with HIV and who has no other sexual partners or HIV risk factors
- When used correctly every time you have sex, latex condoms greatly reduce, but do not eliminate the risk of catching or spreading HIV, the virus that causes AIDS.

Use a latex condom without nonoxynol 9 if you or your sex partner has HIV/AIDS, multiple sex partners, or other HIV risk factors

- Ask a health professional if you have questions about your best birth control and STD prevention methods

The FDA is issuing the final rule to provide a clear, consistent message that N9 is not effective in preventing HIV transmission, and that N9 may actually facilitate transmission of the disease for those who are at risk for HIV/AIDS. The final rule is consistent with FDA's draft guidance for N9 use with condoms.

The full text of the final rule is available at www.fda.gov/OHRMS/DOCKETS/98fr/80n-0280-nfr0003.pdf

FDA proposes to revise/update regulations regarding blood and plasma

The FDA proposes to revise and update the regulations applicable to blood and blood components, including Source Plasma and Source Leukocytes, to add donor requirements that are consistent with current practices in the blood industry, and to more closely align the regulations with current FDA recommendations. The FDA is taking this action to help ensure the safety of the national blood supply and to help protect donor health by requiring establishments to evaluate donors for factors that may adversely affect the safety, purity, and potency of blood and blood components, or the health of a donor during the donation process.

Through the years, the FDA has issued a number of guidance documents containing recommendations intended to assure a safe, pure, and potent blood supply. The Notice of Proposed Rulemaking discusses the recommendations contained in current guidance that fall under the proposed regulation, including donor eligibility and screening for HIV and certain other transfusion-transmitted infections. The FDA believe the proposed rule will more explicitly describe donor eligibility standards and will clarify the relationship between the regulations and the applicable recommendations.

The proposed rule, among other things, provides for the establishment of minimum criteria for the assessment of donor eligibility and the suitability of the donation of blood and

CE/CME *questions*

4. Which of the following is a reason cited by the Centers for Disease Control and Prevention (CDC) and HIV prevention experts on why the national HIV prevention plan did not result in a decrease in new HIV infections from 2001 to 2005?
A. The plan was never fully implemented because of a lack of adequate funding
B. New infections dropped significantly from a peak in the late 1980s, and it's much more challenging now to make further reductions in the annual new HIV infection rate
C. Political obstacles made it difficult to make the most efficient use of HIV prevention funding
D. All of the above

5. Which of the following is not one of the objectives cited by the CDC in its 2010 extended prevention plan?
A. Increase the proportion of persons living with HIV who effectively access partner notification services
B. Provide specific HIV prevention messages regarding condom use and other safe sex practices to youths between 13 and 17 years of age
C. Among persons living with HIV, increase the proportion who receive evidence-based interventions, including mental health, substance abuse, and other appropriate interventions for co-morbid conditions
D. Among person with acute HIV infection, increase the proportion reached by appropriate HIV behavioral interventions

6. A recent on-line survey of men who watched a nine-minute prevention video about two gay men and condom use had what percentage of participants respond to a follow-up survey at 3 months?
A. 37 percent
B. 41 percent
C. 54 percent
D. 77 percent

Answers: 4. (d); 5. (b); 6. (c)

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blood components. The rule is expected to have a minor net impact on blood establishments because it is already usual and customary business practice in the blood industry to assess donors for eligibility and donations for suitability. The FDA believes the primary impact of the rule will be the one-time review of current SOPs that the proposed rule would require each blood collecting establishment to conduct.

Written or electronic comments on the proposed rule, identified by Docket No. 2006N-0221, may be submitted to the agency until February 6, 2008 through any of the following methods:

Electronic Submissions: Submit electronic comments in the following ways:

- Federal eRulemaking Portal: http://www.regulations.gov/search/index.jsp. Follow the instructions for submitting comments.
- Agency Web site: http://frwebgate.access.gpo.gov/cgi-bin/leaving.cgi?from=leavingFR.html&log=linklog&to=http://www.fda.gov/dockets/ecomments. Follow the instructions for submitting comments on the agency Web site.

Written Submissions: Submit written submissions in the following ways: FAX: 301-827-6870. Mail/Hand delivery/Courier [For paper, disk, or CD-ROM submissions]: Division of Dockets Management (HFA-305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. ■

CE/CME objectives

The CE/CME objectives for *AIDS Alert*, are to help physicians and nurses be able to:

- Identify the particular clinical, legal, or scientific issues related to AIDS patient care;
- Describe how those issues affect nurses, physicians, hospitals, and clinics;
- Cite practical solutions to the problems associated with those issues.

Physicians and nurses participate in this medical education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any question answered incorrectly, please consult the source material.

After competing this activity at the end of each semester, you must complete the evaluation form provided and return it in the reply envelope provided to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you.