

Tuesday, April 4, 2006 • 8:00–5:00 p.m. • Double Tree Hotel, San Jose

# HIV Care & Prevention 2006



A regional conference for physicians, nurse practitioners, prevention specialists, and other health care providers



# SPECIAL THANKS TO CONTRIBUTORS



# HIV Care & Prevention 2006

## SPECIAL THANKS TO CONTRIBUTORS:

- Kelle Brogan, MD, Medical Director: St. Mary's Hospice of Northern Nevada and Palliative Care at St. Mary's Regional Medical Center in Reno, Nevada
- Edward Brooks, MD, MPH: Ira Greene Positive PACE Clinic, Medical Director of San Jose AIDS Education & Training Center
- California STD/HIV Prevention & Training Center
- Danielle Castro, Health Educator: Community Health Partnership's Health Education & Training Center, San Jose AIDS Education & Training Center and Trans-Powerment Program
- Neva Chauprette, Psy.D.: Psychologist/Consultant
- Kathleen Clanon, MD, Medical Director: Alameda County Medical Center Combined HIV Services and East Bay AIDS Education & Training Center
- Community Health Partnership
- Philbert F. Espejo, MPH, CHES: Consultant
- Neil Flynn, MD, MPH, Professor of Clinical Medicine, Medical Director, Principal Investigator: AIDS Education & Training Center, University of California at Davis
- Christopher S. Hall, MD, MS: California STD/HIV Prevention & Training Center
- Kevin Hutchcroft, HIV/AIDS Program Director: Santa Clara County Public Health Department
- Ira Greene Trust Fund
- Ann Lyles, DDS, Peninsula Operations Manager: Community Dental Care, Faculty: San Jose AIDS Education & Training Center
- Odel Malan-Pineda: Community Health Partnership, Division of Health Education & Training Center
- Rhonda McClinton-Brown, MPH, Executive Director: Community Health Partnership
- Lawrence M. McGlynn, MD: Ira Greene Positive PACE Clinic, Faculty: San Jose AIDS Education & Training Center
- Mark Anthony Molina, MA : Asian Americans for Community Involvement
- John O'Brien, PharmD, Pharmacist Specialist: Ira Greene Positive PACE Clinic, Assistant Clinical Professor: University of Pacific and University of California at San Francisco, Faculty: San Jose AIDS Education & Training Center
- Pacific AIDS Education & Training Center, University of California at San Francisco
- Santa Clara County HIV Health Services Planning Council
- Santa Clara County HIV Prevention Community Planning Group
- Santa Clara Valley Medical Center
- Shasta Community Health Center
- Javeed Siddiqui, MD, MPH, Director of HIV Tele-Medicine Services, Faculty: AIDS Education & Training Center, University of California at Davis
- Octavio Vallejo, MD, MPH, Senior Medical Director of Medical Affairs: Gilead Sciences, Inc.



# SPECIAL THANKS TO CONTRIBUTORS



# HIV Care & Prevention 2006

## HIV CARE & PREVENTION 2006 PLANNING COMMITTEE:

- John Beleutz, MPH, Director: Community Health Partnership's Health Education & Training Center, San Jose AIDS Education & Training Center and Trans-Powerment Program
- Susan Czark, RN: Health Connections, Faculty: San Jose AIDS Education & Training Center
- Lydia Guel, Program Manager: Community Health Partnership's Health Education & Training Center, San Jose AIDS Education & Training Center
- Kevin Mason, MD, Nurse Manager: Santa Clara Valley Medical Center
- Victoria S. Olarte, RN, Staff Developer: Santa Clara Valley Medical Center
- Jennifer Shockey, MPH, Program Manager: Community Health Partnership's Health Education & Training Center, San Jose AIDS Education & Training Center and Trans-Powerment Program





# HIV Care & Prevention 2006

7.30–8.00	Registration & Breakfast	
8.00–8.15	Welcome (PINE/FIR) <i>Rhonda McClinton-Brown, MPH Executive Director, Community Health Partnership</i>	
8.15–8.35	HIV Update in Santa Clara County (PINE/FIR) <i>Kevin Hutchcroft, MPA HIV/AIDS Program Director, Santa Clara County Public Health Department</i>	
8.35–9.20	Keynote: Improving HIV Care for Latinos (PINE/FIR) <i>Octavio Vallejo, MD, MPH Senior Medical Director of Medical Affairs, Gilead Sciences, Inc.</i>	
9.20–9.30	Break	
9.30–11.00	Workshop Session I <ul style="list-style-type: none"> <li>• Update on State of the Art Antiretroviral Treatment and Management (FIR) <i>John O'Brien, PharmD: Pharmacist Specialist; Ira Greene Positive PACE Clinic, Assistant Clinical Professor: University of Pacific and University of California at San Francisco, Faculty: San Jose AIDS Education &amp; Training Center</i></li> <li>• HIV &amp; Psychiatric Illness (PINE) <i>Neva Chauppette, PsyD: Psychologist, Consultant</i></li> <li>• Transgender Awareness for HIV Healthcare Providers: Understanding the Trans in Transgender (CEDAR) <i>Jennifer Shockley, MPH and Danielle Castro: Community Health Partnership's Health Education &amp; Training Center, San Jose AIDS Education &amp; Training Center and Trans-Powerment Program</i></li> </ul>	Continuing Medical Education credit is offered by Shasta Community Health Center, a CME accredited provider. Shasta Community Health Center assumes responsibility for the content, quality and scientific integrity of this CME activity, designated for a maximum of 7 Category 1 credits toward the California Medical Association's Certification in Continuing Medical Education. Shasta Community Health Center is accredited by the Institute for Medical Quality: A Subsidiary of the California Medical Association to provide continuing medical education for physicians.
11.00–11.10	Break	
11.10–12.40	Workshop Session II <ul style="list-style-type: none"> <li>• Co-morbidities and HIV (PINE) <i>Edward Brooks, MD, MPH: Ira Green Positive PACE Clinic, Medical Director of San Jose AIDS Education &amp; Training Center</i></li> <li>• Oral Health Screening &amp; Dental Referrals: Issues for the Primary Care Provider (CEDAR) <i>Ann Lyles, DDS, Peninsula Operations Manager: Community Dental Care, Faculty: San Jose AIDS Education &amp; Training Center</i></li> <li>• HIV &amp; Women: Improving the Quality of Prevention &amp; Care (FIR) <i>Kathleen Clanon, MD, Medical Director: Alameda County Medical Center Combined HIV Services and East Bay AIDS Education &amp; Training Center</i></li> </ul>	Provider approved by the California Board of Registered Nursing, Provider Number CEP 2056, for 7 contact hours. This course also meets the qualifications for 7 hours of CE credit for MFTs and LCSWs as required by the California Board of Behavioral Sciences (Santa Clara Valley Medical Center Provider # 3316).





# HIV Care & Prevention 2006

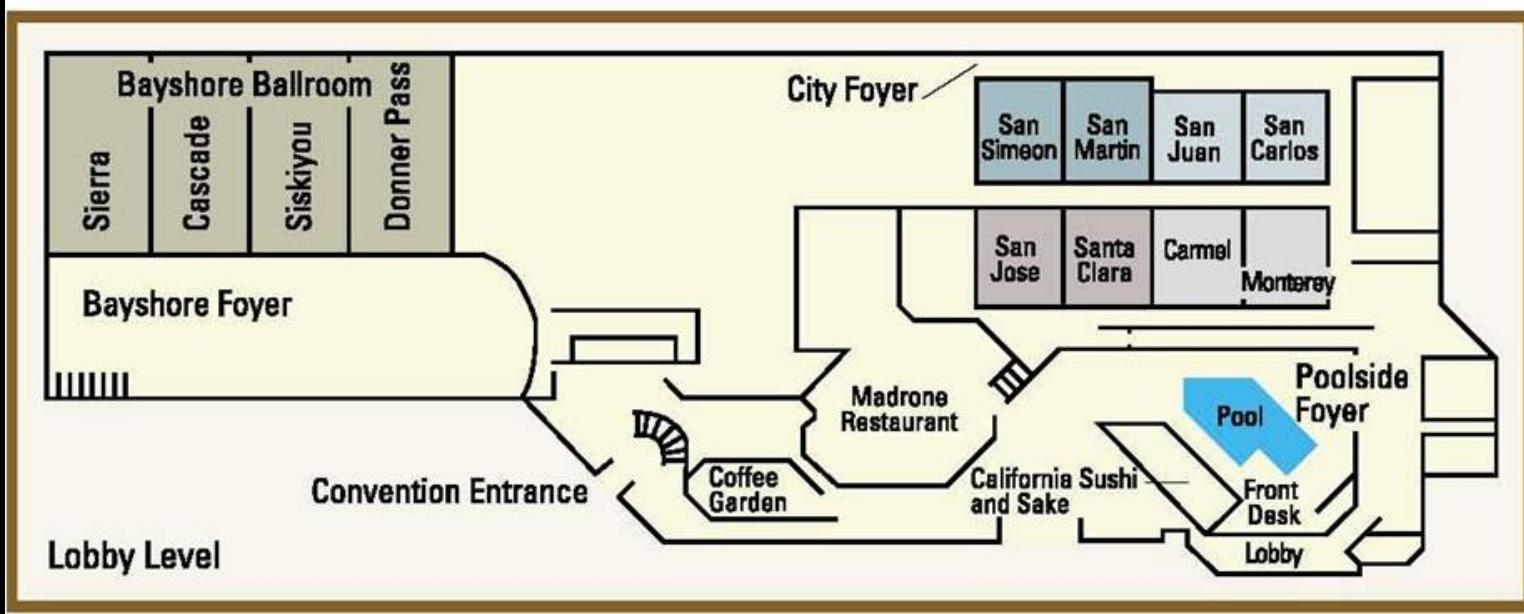
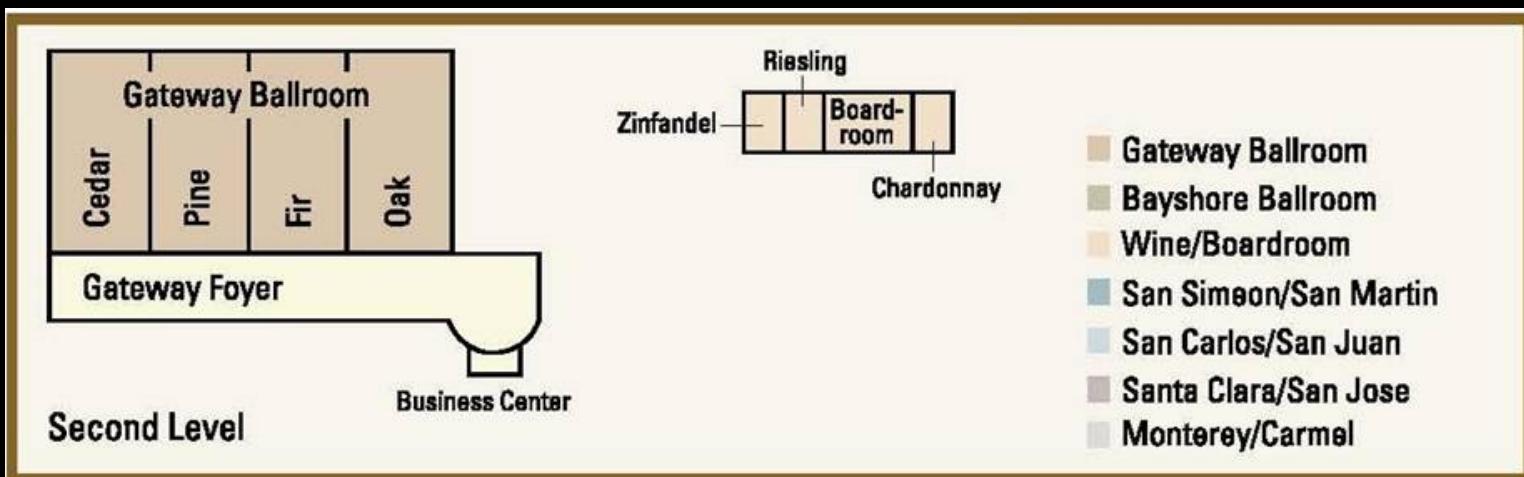
12.40-1.40	Community Resources Showcase & Lunch provided
1.40-3.10	Workshop Session III <ul style="list-style-type: none"><li>• Pain Control and Substance Use in HIV Patients (<b>FIR</b>) <i>Kelle Brogan, MD, Medical Director: St. Mary's Hospice of Northern Nevada and Palliative Care at St. Mary's Regional Medical Center in Reno, NV</i> <i>Neil Flynn, MD, MPH, Professor of Clinical Medicine, Medical Director, Principal Investigator: AIDS Education &amp; Training Center, University of California at Davis</i></li><li>• Recognizing Acute HIV Infection: Issues for the Primary Care Provider (<b>PINE</b>) <i>Javeed Siddiqui, MD, MPH, Director of HIV Tele-Medicine Services, Faculty: AIDS Education &amp; Training Center, University of California at Davis</i></li><li>• Advancing Prevention Strategies to Respond to HIV/AIDS Issues in the Asian American/Pacific Islander Community (<b>CEDAR</b>) <i>Philbert F. Espejo, MPH, CHES: Consultant</i> <i>Mark Anthony Molina, MA : Asian Americans for Community Involvement (AACI)</i></li></ul>
3.10-3.20	Break/Raffle
3.20-4.50	Workshop Session IV <ul style="list-style-type: none"><li>• HIV Prevention and Partner Notification (<b>CEDAR</b>) <i>Susan Czark, RN: Health Connections, Faculty: San Jose AIDS Education &amp; Training Center</i></li><li>• STD Overview for the HIV Care Provider (<b>PINE</b>) <i>Christopher S. Hall, MD, MS: California STD/HIV Prevention &amp; Training Center</i></li><li>• Sex, Meth, &amp; HIV (<b>FIR</b>) <i>Lawrence M. McClynn, MD: Ira Greene Positive PACE Clinic, Faculty: San Jose AIDS Education &amp; Training Center</i></li></ul>
4.50-5.00	Closing and Distribution of Certificates for Continuing Education Units ( <b>GATEWAY FOYER</b> )



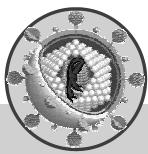


# HIV Care & Prevention 2006

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***By the end of this session, participants will be able to:***

**(PINE/FIR) HIV UPDATE IN SANTA CLARA COUNTY**

***Kevin Hutchcroft, MPA, HIV/AIDS Program Director  
Santa Clara County Public Health Department***

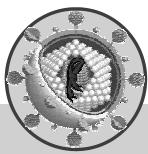
- Understand and assess the most current trends related to HIV transmission in Santa Clara County in comparison to other parts of the Bay area, the state of California, and the United States
- Identify ways in which the health care community in Santa Clara County is actively working together to address HIV trends among their patients and communities and understand how they fit within this system

**(PINE/FIR) KEYNOTE: IMPROVING HIV CARE FOR LATINOS**

***Octavio Vallejo, MD, MPH, Senior Director  
Medical Affairs at Gilead Sciences, Inc.***

- Describe the epidemiologic trends of HIV disease and AIDS in the Latino community
- Identify critical cultural issues related to the health care of Latino individuals with HIV infection
- Recognize particular considerations when treating Latinos with HIV infection
- Understand and assess the most current trends related to HIV transmission among Latinos in the South Bay area in comparison to other parts of the State of California and the United States
- Identify the barriers to accessing HIV prevention and care services for the Latino community
- Understand the strengths of the Latino community that can be built upon to deliver more effective HIV services
- Identify strategies that can be implemented to provide better HIV prevention and care services for Latinos





# HIV Care & Prevention 2006

## **Rhonda McClinton-Brown, MPH**

Rhonda McClinton-Brown is the Executive Director of the Community Health Partnership, an association of eight nonprofit community health center organizations, the City of San Jose, and Santa Clara Valley Health and Hospital Systems. Since 1990, Rhonda has represented the needs of community health centers as an active advocate for public policy and a marked improvement in access to quality health and prevention services for medically underserved communities in Santa Clara County. Rhonda served as Deputy Director of the Indian Health Center of Santa Clara Valley from 1990 through 1996. She received a Bachelor degree from the University of California at Los Angeles and a Master in Public Health from San Jose State University. At today's conference, she welcomes health care and prevention professionals from throughout the South Bay area to the HIV Care & Prevention 2006 conference.

## **Kevin Hutchcroft, MPA**

Kevin Hutchcroft received both his Bachelor of Arts and Master in Public Administration from University of Oklahoma. Kevin is the HIV/AIDS Program Director for the County of Santa Clara. He oversees the county-wide Needle Exchange and Counseling and Testing Programs and manages over 40 contracts and service agreements with community-based organizations to provide HIV/AIDS prevention, care and treatment services. At today's HIV Care & Prevention 2006 conference, Kevin brings you an "HIV Update in Santa Clara County."

## **Octavio J. Vallejo, MD, MPH**

Dr. Octavio Vallejo received his Master in Public Health from University of Miami and earned a Fellowship on Public Health and AIDS from University of California at Los Angeles for Health Promotion and Disease Prevention. Moreover, he received his Doctor of Medicine from Autonomous University of Puebla in Mexico. Octavio specializes in Epidemiology and Infectology in Public Health. He is currently the Senior Director of Medical Affairs with Gilead Sciences, Inc., but has been an active faculty member and trainer for the Pacific AIDS Education & Training Center in Los Angeles for several years. He has also been a member of the National Minority AIDS Council's Treatment Education & Adherence Materials Advisory Board for over 8 years. At today's HIV Care & Prevention 2006 conference, Octavio serves as the Keynote Speaker on "HIV Issues in the Latino Community."





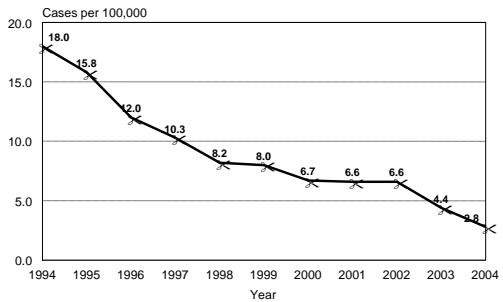
## HIV/AIDS Data, Services and Policy Developments in Santa Clara County

- Kevin Hutchcroft, MPA  
Program Director, HIV/AIDS Prevention and Control Program  
Santa Clara County Public Health Department

### HIV/AIDS Surveillance

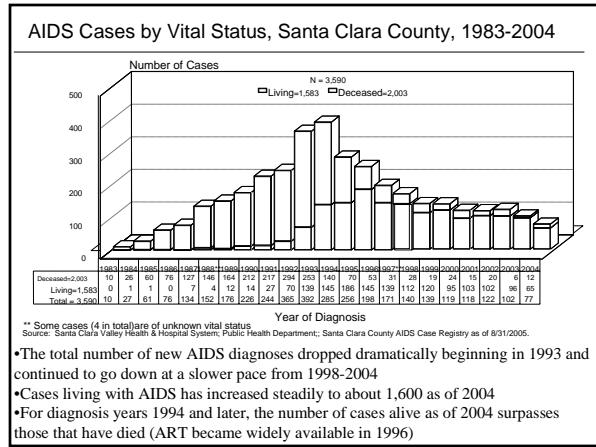
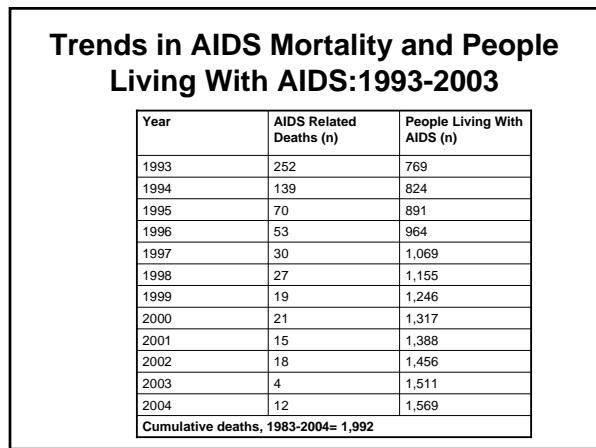
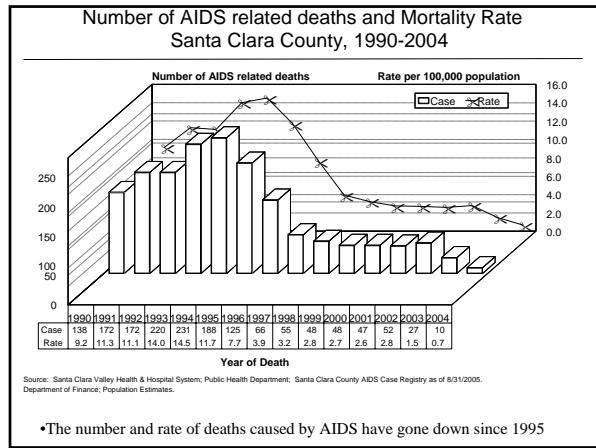
- From the beginning of the epidemic through June 2005, 3,577 individuals have been diagnosed with AIDS in Santa Clara county.
- An additional 933 cases of HIV (non-aids) have been reported between July 2002 and June 2005.
- As of December 2004, 1569 individuals are living with AIDS in Santa Clara county.
- One estimate concluded that there were 3,381 people living with HIV or AIDS in Santa Clara county.

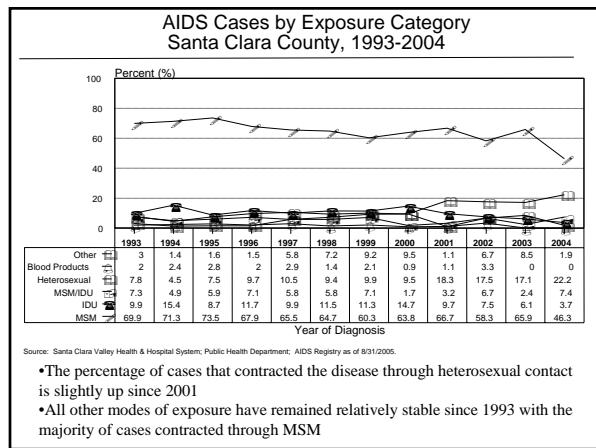
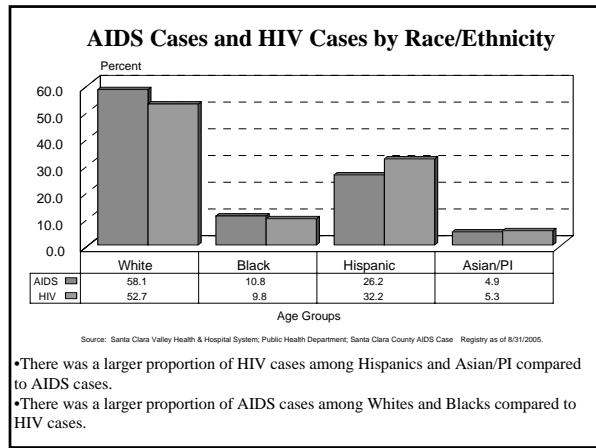
AIDS Incidence Rate, Santa Clara County, 1994-2004



Source: Santa Clara Valley Health & Hospital System; Public Health Department; Santa Clara County AIDS Case Registry as of 8/31/2005.  
Department of Finance; Population Estimates.

- The rate of new AIDS cases has gone down since 1994

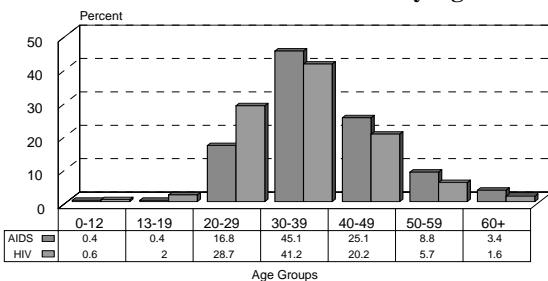




**Cumulative AIDS and HIV Cases by Gender, June 2005**

	Reported AIDS Cases		Reported HIV Cases	
	n	%	n	%
Male	3,215	89.9	806	86.4
Female	362	10.1	127	13.6
Total	3,577	100.0	933	100.0

### AIDS Cases and HIV Cases by Age



Source: Santa Clara Valley Health & Hospital System, Public Health Department, Santa Clara County AIDS Case Registry as of 8/31/2005.

- There was a larger proportion of HIV cases in the younger age groups and a larger proportion of AIDS cases in the older age groups for diagnosis years 1993-2004.

### HIV/AIDS Resources in Santa Clara County

- Ryan white care and treatment
- HIV education and prevention

### Ryan White and Santa Clara County

Ryan white title I provides HIV/AIDS primary and support services for low-income residents living in major metropolitan areas hardest hit by the HIV/AIDS epidemic.

The Santa Clara county HIV/AIDS planning council allocates Ryan white monies to fund 15 service categories.

Low income, HIV positive residents of Santa Clara county are eligible for services. Eligibility is determined at either health connections (408-961-9850, 800-325-1890) or PACE clinic (408-885-5935, 800-324-4055).

## Ryan White-supported HIV Provider and Services in Santa Clara County

- **Health connections**
  - Case management
  - Home health care
  - Emergency financial assistance
  - Transportation assistance
  - Food assistance
  - Housing assistance
  - Housing related services
- **PACE clinic**
  - Ambulatory/primary care
  - Treatment adherence
  - Mental health services

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## Ryan White-supported HIV Providers Services in Santa Clara County con't.

- Gardner family care**
  - Mental health services
  - Substance abuse services

**Public health pharmacy**
  - Medication assistance

**Onsite dental**
  - Oral health care

**AIDS legal services**
  - Legal assistance

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## Other HIV/AIDS Services

- **Neil A Christie living center**
  - Social support interventions
- **Housing for health**
  - Tenant-based rental assistance

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## HIV Prevention and Education Services

- Syringe exchange and harm reduction program
  - Needle exchange 888-308-1110
  - Drug treatment vouchers/information/referrals
- Crane center/NIGHT mobile testing 408-792-3720
  - Anonymous/confidential HIV test- counseling
  - STD screening and treatment

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## State - Funded Community-based HIV Prevention Services in Santa Clara County

- **Billy deFrank LGBT Community Center** – Online and Street outreach/information/referral targeting LGBTQ.
- **Asian Americans for Community Involvement** – Online and community outreach targeting API MSM.
- **Health Education Training Centers (Community Health Partnership)** - Transgender Outreach and Support services, Provider Training.
- **Emergency Housing Consortium** – Homeless outreach, case management.
- **Stanford Clinic** - Prevention for Positives Program.
- **Community Health Awareness Council** – HIV workshops targeting youth.

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## HIV/AIDS Policy

- Reauthorization of the Ryan White CARE Act
- Names Reporting of HIV (SB 699)
- Rapid Testing
- SB 1159

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## **Reauthorization of the CARE Act**

- California received \$221 million in CARE Act funding for Titles I and II in 2005.
- Funding Title I could move from HIV prevalence (total number of living HIV cases) to HIV incidence (total number of new HIV infections). Allocating funds based on an index of local resources would punish California for its contribution to HIV care.
- Eliminate "Hold-Harmless" provision of Title I could mean that San Francisco EMA could lose up to 21% of its federal allocation.
- Changing the base Title II formula could mean a loss of \$20 million to California.

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## **Reauthorization of the CARE Act**

- Reallocation for "core" services. De-emphasis of social support services.
- HIV data to be used as the basis for allocation instead of AIDS case data.
- If none of CA's HIV cases are included, the State could lose between \$50 to \$100 million.

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## **Names Reporting of HIV**

- 36 states have names-based HIV reporting, 5 use name-to-code systems, to allow client choice of name or code and 7 (including CA) use a code only system of HIV Reporting.
- California is the only state among the 5 largest that uses an HIV reporting system than is different from its AIDS Reporting system. The State could lose \$50 million in CARE Act resources.
- Current system is labor intensive, delays reporting.

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## **Names Reporting of HIV**

- SB 699 would make it so HIV cases are reported the same way AIDS cases are reported. Same confidentiality measures, with enhanced protections for HIV and AIDS. No documented or reported case of inappropriate disclosure from the AIDS Case Registry.
- There has been no decline in HIV testing since HIV became reportable in July 2002.

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## **HIV Names Reporting, con't.**

- Anonymous HIV Testing will still be available, in which the name of the client is not known. Anonymous testing will remain exempt from HIV reporting requirements.

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## **Rapid Testing**

- Several hundred people each year test positive for HIV in CA and do not return for results.
- Rapid Testing provides a "preliminary positive" result in 20-40 minutes (as opposed to 1-2 weeks).
- More false positives than predicted in some sites in San Francisco and Los Angeles.
- Preliminary positives must be confirmed via standard confirmatory testing.
- Despite problems reported in agencies in SF and LA, the OraQuick Advance Rapid HIV oral fluid test is functioning within the expected range across the state; overall specificity is 99.7% and statewide specificity (excluding SF and LA) is 99.9%. No evidence of a widespread problem with the test.

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### **Over the Counter Syringe Access**

- In 2004, there were 753 carrier cases of HCV and 92 adult cases of AIDS in Santa Clara County.
- No local survey on IV Drug use, but estimates are that there are nearly 15,000 regular injectors of heroin, methamphetamine, cocaine and other drugs.
- The Disease Prevention Demonstration Project (DPDP), established by SB 1159 allows a licensed pharmacist to sell up to 10 or fewer hypodermic needles without a prescription. Local governments must approve, and pharmacies have to "opt-into" the program.
- Customers may legally possess up to 10 syringes if acquired from an authorized source.

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### **Over the Counter Syringe Access**

- Santa Clara County BOS voted to "opt-in" in late 2005.
- Currently, only the Public Health Pharmacy is participating in the program, but other pharmacies are interested.
- Information must be made available to customers about Drug Treatment, HIV and HCV testing and treatment, and how to safely dispose of syringes by participating pharmacies and PHDs.

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### **Number of PLWH/A Goes Up, While Resources Go Down**

- Ryan White (federal) reduction to Santa Clara County from FY04 and FY06: \$344,472
- State revenue loss between FY04 and FY06: \$785,182
- Total County General Fund reduction between FY04 and FY06: \$961,188

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## **Incorporating Community Perspectives Into the Decision-making Structure**

- HIV/AIDS Planning Council
- Community Planning Group (Prevention)
- Syringe Exchange Community Advisory Board
- Providers' Client/Community Advisory Boards

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	HIV Care and Prevention 2006 Conference April 4, 2006
	<h2>Improving HIV Care for Latinos</h2> <p>Octavio J. Vallejo, MD, MPH Medical Science Liaison Gilead Sciences, Inc</p>

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	<h2>FACTS 2005</h2> <ul style="list-style-type: none"> <li>■ An estimated 400,000 to 500,000 HIV positive individuals in the United States are either unaware of their serostatus or receive care only intermittently</li> <li>■ Half of the people living with HIV/AIDS in the United States are not receiving appropriate primary care services</li> <li>■ 180,314 PLWH/A in need of HAART are publicly insured or underinsured</li> </ul> <p><i>HRSA CARE ACTION. July 2005</i></p>
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Progress...Wouldn't You Agree?			
	1980s	1990s	2000s
Survival with AIDS	6-18 mos	2-8 yrs	?????
HIV regimen	0 – AZT only (12 pills/day)	AZT only – HAART	1 pill QD!!
Surgery in HIV+	For what?	Rarely	Standard
OIs	KS, PCP	MAC,	Virtually nil
Vaccine	No	No	No

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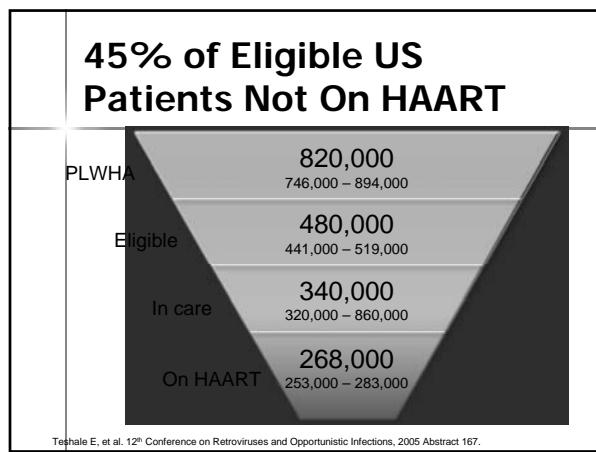
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<b>Objectives</b>	
	<ul style="list-style-type: none"> <li>■ Describe the epidemiologic trends of HIV disease and AIDS in the Latino community</li> <li>■ Identify critical cultural issues related to the health care of Latino individuals with HIV infection</li> <li>■ Recognize particular considerations when treating Latinos with HIV infection</li> </ul>

<b>Outline</b>	
	<ul style="list-style-type: none"> <li>■ Why the Latino community is a major concern?</li> <li>■ Epidemiologic trends of HIV disease in the Latino community</li> <li>■ Cultural characteristics that increase HIV vulnerability among Latinos</li> <li>■ Issues related to access to HIV care</li> <li>■ Immigration and HIV</li> <li>■ What can we do to improve health care services for Latinos? Cultural competency and more....</li> </ul>

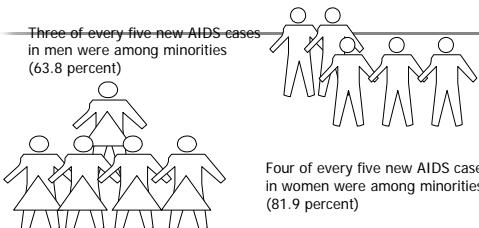
	<h2>Why the Latino Community is a Major Concern?</h2> <ul style="list-style-type: none"> <li>■ The Latino community is the fastest growing population in the U.S. and the group with the second-highest risk for HIV/AIDS</li> <li>■ The Latino population in the U.S. has increased by 57.6%; from 22.4 million in 1990, to 35.3 million in 2000</li> </ul> <p><small>U.S. Bureau of the Census 2000 Summary file (3) SF3 –Sample data The Henry J. Kaiser Family Foundation HIV/AIDS Policy Fact Sheet. Latinos and HIV July 2003</small></p>	
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	<h2>Who Composes the Latino Community?</h2> <ul style="list-style-type: none"> <li>■ Latinos are a diverse group made of a mix of ethnic groups and cultures</li> <li>■ The largest Latino groups are Mexicans, followed by Puerto Ricans, Central and South Americans, Cubans and other Latinos from the Caribbean</li> </ul> <p><small>Cover courtesy of IMPACTO LATINO. AIDS Project Los Angeles.</small></p>	
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	<h2>Outline</h2> <ul style="list-style-type: none"> <li>■ Why the Latino community is a major concern?</li> <li>■ Epidemiologic trends of HIV disease in the Latino community</li> <li>■ Cultural characteristics that increase HIV vulnerability among Latinos</li> <li>■ Issues related to access to HIV care</li> <li>■ Immigration and HIV</li> <li>■ What can we do to improve health care services for Latinos? Cultural competency and more....</li> </ul>	
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## Minorities of Color and HIV

Three of every five new AIDS cases in men were among minorities (63.8 percent)



Four of every five new AIDS cases in women were among minorities (81.9 percent)



Four of every five new AIDS cases in children were among minorities (85.6 percent)



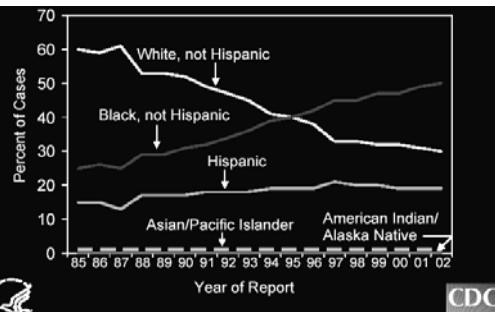
Ryan White Comprehensive AIDS Resource Emergency (CARE) Act, 2003

## LATINOS AND HIV Current trends

- The percentage of new AIDS cases among Latinos has increased in the last 15 years
- Latinos receive an AIDS diagnosis within 12 months of learning their HIV status
- HIV transmission occurs more frequently among Latino males because of male-to-male sexual contact and among Latino women through heterosexual contact



## AIDS Cases by Ethnicity, 1985-2002



CDC. HIV/AIDS Surveillance by Race/Ethnicity. March 2003.

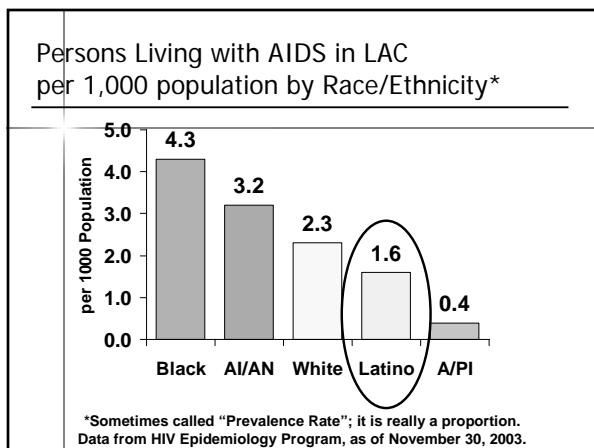
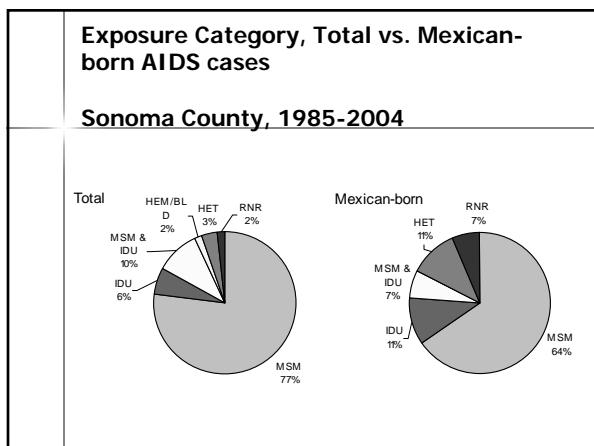
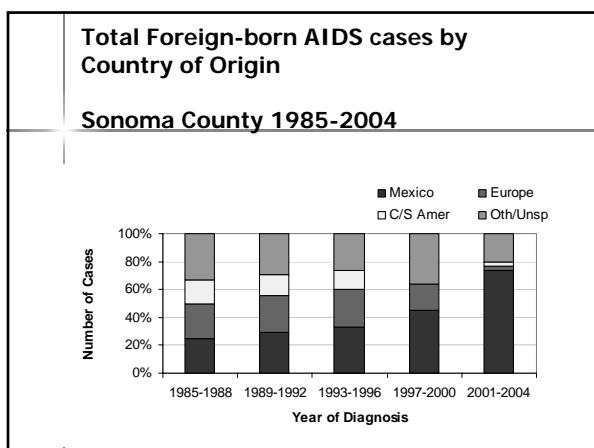
<b>Latinos with HIV/AIDS, 2001</b>			
	US Population	Latino Population	
Total (million)	288.4	38.8	13.5%
Living w/HIV	109,468	28,024	25.6%
Living w/AIDS	362,261	75,210	20.8%
AIDS Deaths	16,371	3056	18.7%

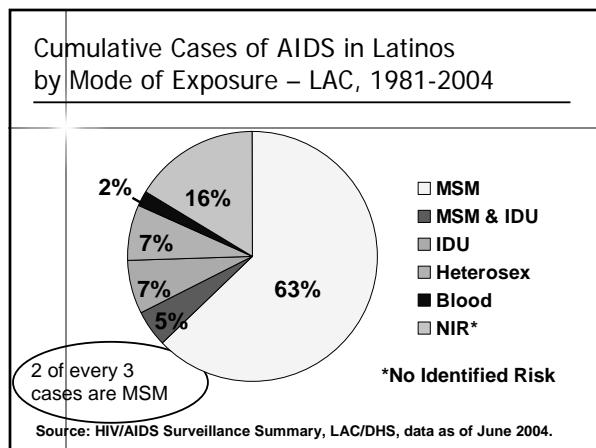
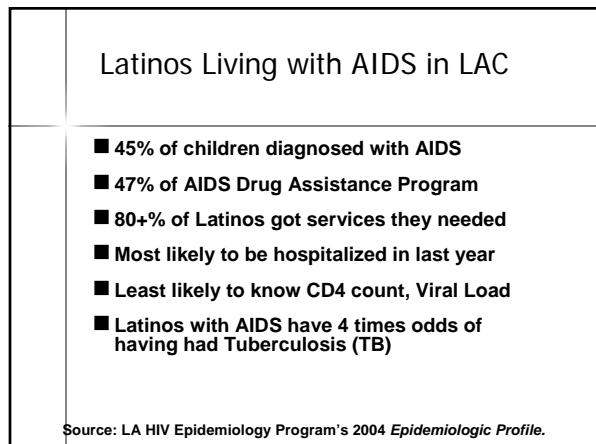
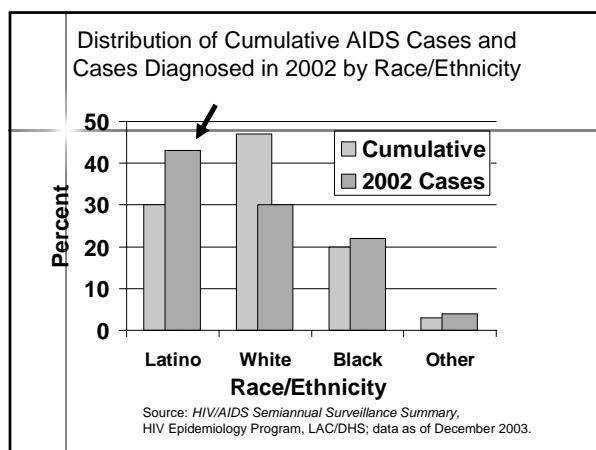
CDC. HIV/AIDS Surveillance Report. 2002;14:1-48.  
US Census Bureau. Supplemental Survey. July 2002.

<b>Latinos with AIDS in US, 2000 by Mode of Transmission, Place of Birth</b>			
	US	Mexico	Puerto Rico
MSM	30%	44%	14%
IDU	24%	9%	48%
Heterosexual	11%	14%	25%

MSM = men who have sex with men; IDU = injection drug use.  
CDC, HIV/AIDS Among Hispanics in the United States. March 11, 2002.

<b>Latino Patients Living with HIV/AIDS in 2001 by Category of Risk</b>	





	<h3>Latino MSM at risk for HIV</h3> <ul style="list-style-type: none"> <li>■ Among highest rates of new infection seen at HIV Testing sites: 3 - 5% per year           <ul style="list-style-type: none"> <li>— Latino MSM (men who have sex with men)</li> <li>— Latino MSM who inject drugs</li> <li>— Latino MSM who also have sex with women</li> </ul> </li> <li>■ Young Men's Survey of 15 – 23 year olds:           <ul style="list-style-type: none"> <li>— 2/3rd Latino MSM say ethnic identity important</li> <li>— 2/3rd Latino MSM say most people of their ethnicity disapprove of gays</li> </ul> </li> <li>■ Studies find Latino MSM don't disclose sexual orientation because of fear of being stigmatized, discriminated against, and/or marginalized</li> </ul> <p>Source: LA County HIV Epidemiology Program.</p>	
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	<h3>Outline</h3> <ul style="list-style-type: none"> <li>■ Why the Latino community is a major concern?</li> <li>■ Epidemiologic trends of HIV disease in the Latino community</li> <li>■ Cultural characteristics that increase HIV vulnerability among Latinos</li> <li>■ Issues related to access to HIV care</li> <li>■ Immigration and HIV</li> <li>■ What can we do to improve health care services for Latinos? Cultural competency and more....</li> </ul>	
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	<h3>Cultural Characteristics that Increase Vulnerability and Delay of HIV Testing and Care</h3> <ul style="list-style-type: none"> <li>■ Gender inequity</li> <li>■ Machismo</li> <li>■ Homophobia</li> <li>■ Drug or alcohol abuse</li> <li>■ Religious beliefs</li> </ul>	
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## **Latina Women at Risk**

- Traditional gender roles
    - Predetermined roles and family pressures<sup>1</sup>
    - Infidelity as part of the male social role and passive acceptance by female partners<sup>2</sup>
    - Stigma<sup>1</sup>
    - Gender Inequity
    - Domestic Violence
    - Machismo/homophobia



1. Galanti. J Transcult Nurs. 2003;14:180-185.
2. Hirsch JS. Am J Public Health. 2002;92:1227-1237.
3. Marin BV. J Transcult Nurs. 2003;14:186-192.
4. Murphy DA, et al. AIDS Care. 2003;15:217-230.

**65% of women living with AIDS reported having one sexual partner in their entire life**



CDC. Supplement to HIV/AIDS Surve

	<h2>Evolving high-risk groups</h2> <h3>Men on the Down Low ("DL")</h3>
	<ul style="list-style-type: none"> <li>■ Heterosexually identified men who have sex with men but do not tell their female partners             <ul style="list-style-type: none"> <li>- Don't "subscribe" to gay subculture</li> <li>- Usually unaware or non-disclosing of their HIV status</li> <li>- Prevalent behavior among Black and Latino men 1</li> </ul> </li> </ul> <p>1.Miller G. 11<sup>th</sup> CROI, San Francisco 2004, #83</p>



	<h2>Stigma and HIV</h2>
	<ul style="list-style-type: none"> <li>• <b>Definition</b> "an attribute that is deeply discrediting within a particular social interaction"</li> </ul> <p>Refers to unfavorable attitudes, beliefs and policies directed toward people perceived to have HIV/AIDS, as well as their loved ones, associates, social groups and communities</p> <p>Goffman. <i>Stigma: Notes on the management of spoiled identity</i></p>



This is the way many people deal with HIV

HIV & Stigma	
<ul style="list-style-type: none"> <li>• PERSON AFFECTED IS SEEN AS RESPONSIBLE FOR HAVING THE ILLNESS</li> <li>• DISEASE PROGRESSIVE AND &amp; INCURABLE</li> <li>• DISEASE NOT WELL UNDERSTOOD</li> <li>• SYMPTOMS CAN NOT BEEN CONCEALED</li> </ul>	<p>A person who is stigmatized "is reduced in our minds from a whole and usual person to a tainted, discounted one."</p>

<b>Homophobia</b>			
(scale $\alpha = .75$ )			
Made fun of as a child	64% (60-68)	As a child heard gays not normal	91% (89-94)
Violence as a child	18% (15-21)	As a child felt their gayness hurt family	70% (66-75)
Made fun of as an adult	50% (45-54)	Have had to pretend to be straight	64% (59-69)
Violence as an adult	10% (7-12)	Job discrimination	15% (12-18)
As a child heard gays grow old alone	71% (67-75)	Had to move away from family	29% (25-33)
		Police harassment	20% (17-24)

Diaz R. et al. Social discrimination & HIV Risk: The Case of the Latino Gay Men in the U.S. 2001

<b>Experiences of Homophobia</b>	
<ul style="list-style-type: none"> <li>■ “I was a devout Catholic, hated gay people, and was married twice, and actually put two women through a lot because I couldn’t accept myself. I came out when I was 30 and it was very difficult for me to deal with being gay. I tried to commit suicide...</li> <li>■ And when I had the strength to say, “Well, this is who I am” ...my family didn’t speak to me for over 15 years.”</li> </ul>	

<b>Experiences of Homophobia, continued</b>	
	<ul style="list-style-type: none"> <li>■...You also grow up being told that being gay, you’re going to be punished for it. It’s something dirty. And I guess being told that from when you’re little, it’s somewhere in the back of your head, that I’m going to be punished no matter what.”</li> </ul>

	<b>Substance Use as Coping Strategy</b>
	<p>• “I used drugs to kind of run away from the world because I didn’t know how to live. I didn’t know how to deal in a healthy manner with confrontations. I didn’t believe in myself. I didn’t know who I was... being gay, you know, I was never supported in anything. So I kind of, like, was scared and running away, and what drugs did for me was kind of keep me sane in a sense. It kept me... It was kind of a like a comforter for me.”</p> <p style="font-size: small;">Diaz R. et al. Social discrimination &amp; HIV Risk: The Case of the Latino Gay Men in the U.S. 2001</p>

	<b>Substance Use as Coping Strategy</b> <i>continued</i>
	<p>■ “A lot of gay men go through a tremendous struggle, you know, coming out, coming to terms with yourself. You go through a -- I know I went through a big process of hating myself and being happy with myself, and that still for a very long time when I was finally able to break through that it was a lot. And that’s why I say a lot of the drugs in the gay world has to do with that, coming out and all the pain that you have to go through, losing your family, losing your friends. And then dealing with AIDS on top of all that, and then dealing with this and then dealing with that. And then, yeah, who’s not going to turn to a bottle of liquor or some coke?”</p> <p style="font-size: small;">Diaz R. et al. Social discrimination &amp; HIV Risk: The Case of the Latino Gay Men in the U.S. 2001</p>

	<b>Outline</b>
	<ul style="list-style-type: none"> <li>■ Why the Latino community is a major concern?</li> <li>■ Epidemiologic trends of HIV disease in the Latino community</li> <li>■ Cultural characteristics that increase HIV vulnerability among Latinos</li> <li>■ Issues related to access to HIV care</li> <li>■ Immigration and HIV</li> <li>■ What can we do to improve health care services for Latinos? Cultural competency and more....</li> </ul>

## Economic Barriers Delay Presentation for HIV Care

- Poverty and unemployment
  - 21.4% Latinos in US in 2002 live in poverty<sup>1</sup>
- Limited access of Latinos to healthcare coverage in 1996<sup>2</sup>

Uninsured	24%
Medicare	3%
Medicaid	50%

1. US Census Bureau. The Hispanic Population in the US: 3/2002. Issued 6/2003.  
2. US Census Bureau. Health Insurance Coverage: 2001. Issued 9/2002.

## Latinos and HIV Access to health care services

- One in three Latinos (33.2%) are uninsured
- 30% report having no regular source of health care (inability to pay for care the major obstacle)
- The impact of HIV/AIDS on Latinos is part of the broader disparities in access to health care services

**Who is uninsured?**  
In 2000, 14% of Americans went without health insurance for the entire year, a Census study found.

**Percentage uninsured, by race/ethnicity:**

Race/Ethnicity	Percentage Uninsured
Hispanic	32%
Blacks	18.5%
Asian	18%
Non-Hispanic whites	9.7%

Source: Census Bureau, Health Insurance Coverage, 2000  
By William Kiser and Quin Tien, USA TODAY

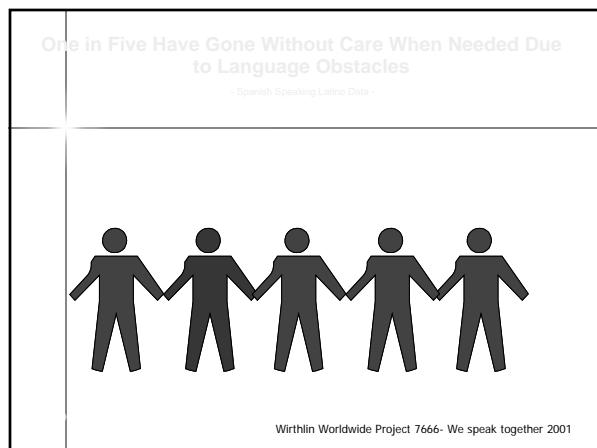
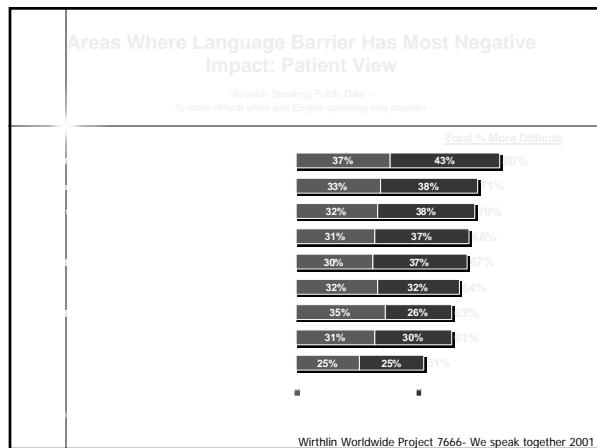
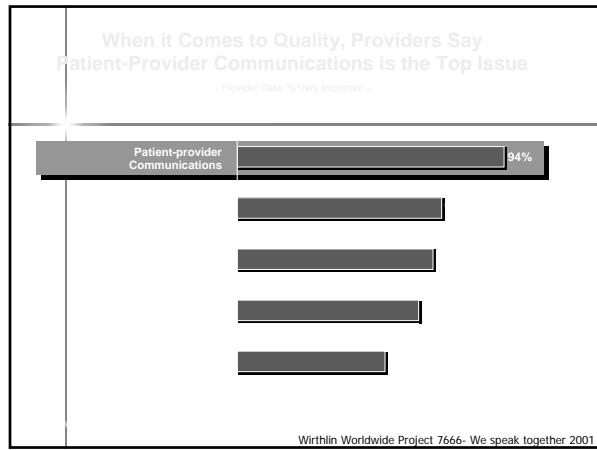
US Census Bureau. Health Insurance Coverage: 2001. Issued 9/2002.

## Low years of education and language

- Formal education
  - 43% of Latinos in US have not graduated from high school<sup>1</sup>
- Language
  - About one-third of Latinos in US are monolingual Spanish-speaking

Several studies have shown the importance of language and access to health care

1. US Census Bureau, The Hispanic Population in the US: 3/2002. Issued 6/2003.  
2. HIV/AIDS in the Latino community. [www.hispanicfederation.org](http://www.hispanicfederation.org)  
3. Essien EJ. J Natl Med Assoc. 2002;94:304-312.  
4. Pulerwitz J. AIDS Care. 2002;14:789-800.



Many Spanish Speaking Patients Rarely Visit Doctor

- Spanish Speaking Public Data -

41%	29%	30%
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Wirthlin Worldwide Project 7666- We speak together 2001

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### Advanced Disease at Diagnosis



- Delayed presentation, which is common among Latino patients,<sup>1</sup> results in
- Disproportionately high number with AIDS
- High baseline viral load
- Impaired immune status<sup>2,3</sup>
- Increased morbidity, hospitalization for OIs
- Increased mortality<sup>4</sup>
- Reduced response to ARV treatment

1. Hodges JC. XIV International AIDS Conference 2002 Abs. MoPeB3269  
2. Paris R. XIV International AIDS Conference 2002 Abs. TuPeC4702  
3. Swindells S. AIDS. 2002;16:1832-1834.  
4. Oshaugnessy MV. XIV International AIDS Conference 2002 Abs. TuPeC4753

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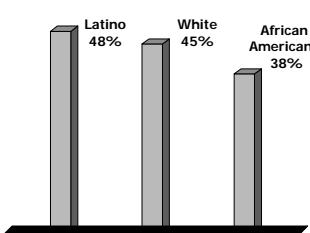


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### Percent of People with HIV/AIDS Learning of Diagnosis Late in Illness, by Race/Ethnicity, 1994-1999



Race/Ethnicity	Percentage
Latino	48%
White	45%
African Americans	38%

Note: Data based on national HIV/AIDS Surveillance data from 104,780 persons in 25 states between 1994 through December 1999. Late diagnosis within one year of the first reported HIV diagnosis. White and African American do not include those of Latino origin.

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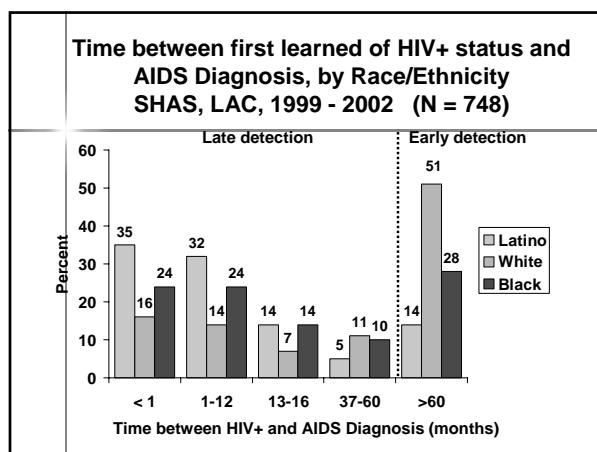
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<b>Health disparities and HIV Minorities of color</b>	
	<ul style="list-style-type: none"> <li>■ N= 367 physicians and 1,717 patients</li> <li>■ Doctors who follow guidelines recommending the delay of ARV therapy for non-adherent HIV patients are likelier to put off that treatment for Latinos, women and poor patients than they do for others.</li> <li>■ Doctors are slower to prescribe PI's for African American patients whether or not the physician follow the guidelines</li> </ul> <p><small>Wong M.D. et al. Disparities in HIV Treatment and Physician Attitudes About Delaying Protease Inhibitors for Non-Adherent Patients. Journal of General Internal Medicine April 2004</small></p>

<b>Health care system characteristics</b>	
	<ul style="list-style-type: none"> <li>• Current fabric of health care providers           <ul style="list-style-type: none"> <li>• Less than 5% of physicians, nurses and dentist are Hispanics</li> </ul> </li> <li>• Current enrollment of medical students           <ul style="list-style-type: none"> <li>• Less than 3% of the U.S. medical school enrollment is Hispanic</li> </ul> </li> </ul> <p><small>Dower C. et al. The Practice of Medicine in California, 2001</small></p>

	<h2>Outline</h2>
	<ul style="list-style-type: none"> <li>■ Why the Latino community is a major concern?</li> <li>■ Epidemiologic trends of HIV disease in the Latino community</li> <li>■ Cultural characteristics that increase HIV vulnerability among Latinos</li> <li>■ Issues related to access to HIV care</li> <li>■ Immigration and HIV</li> <li>■ What can we do to improve health care services for Latinos? Cultural competency and more....</li> </ul>

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	<h3>AIDS Cases Reported Among Latinos by Place of Birth, 2001</h3>
	<ul style="list-style-type: none"> <li>■ More than four in ten (43%) AIDS cases reported among Latinos in 2001 were among those born in the U.S.</li> <li>■ More than one fifth were among those born in Puerto Rico (22%), followed by Mexico (14%)</li> </ul>  <p>Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report, Year End Edition 2001</p>

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	<h2>Latino Immigration and HIV</h2>
	<ul style="list-style-type: none"> <li>■ There are an estimated 3 to 6 million Mexican undocumented in the U.S.(1)</li> <li>■ One-fourth of the AIDS cases in Mexico are among persons who have spent prolonged periods in the U.S.(2)</li> <li>■ AIDS statistics in Mexico report a slight trend toward "ruralization" of AIDS that might be linked to male migration to U.S.(3)</li> </ul> <div style="text-align: center;">  <p>El largo camino de los migrantes</p> <p><small>1. Lovell, BL. How many undocumented: the numbers behind the US-Mexico migration talks. Report by the Pew Hispanic Center March 2003 2. Rangel et al Factores de riesgo de infección por VIH en migrantes mexicanos: el caso de los migrantes que llegan a la casa del Migrante Centro Escalabrin y ejército de Salvaje El Colegio de la Frontera Norte IESALUD/COMUSIDA 3. Magis R. et al La situación del SIDA en México a finales de 1998. ENfermedades Infectuosas y Microbiológicas 1998;6:236-244</small></p> </div>

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## Migration-related Risk Factors for HIV Infection

- Constant mobility
- Cultural
- Linguistic
- Geographic barriers to health care services
- Change in sexual practices
- Limited education
- Psychosocial factors
- Isolation
- Discrimination
- Poverty
- Chronic underemployment
- Substandard housing

Organista, KC et al. Migrant laborers and AIDS in the United States: A Review of the literature. AIDS Educ. Prev. 1997;9:83-93

## Examples of HIV Risk Behaviors and Practices

- Adoption of new sexual practices
  - Seeking companionship to compensate for the alienating aspects of migration experience.
  - Fewer constraints or social control on behaviors
  - Exposure to previously unknown or unacceptable sexual behaviors and practices
  - Exchange sexual services for money, food or lodging
- Low levels of knowledge relating to the mechanisms of HIV infection and prevention
- Multiple partners
- Low condom use
- Increased alcohol and drug use
- Limited access to medical care and HIV testing

HIV Risk Ten Times Higher for Migrant Farm-workers. Public Health Rep. 1994;109:459

## HIV Prevalence Studies among Migrants California and Mexico

HIV Prevalence among MSM's	California: 5%- 35%/Mexico-based studies 3.6% - 31%
HIV Prevalence and risk behaviors among Mexican migrant farm-workers	California two studies 0%
HIV Prevalence among sex workers	Mexico studies: 0.1% - 0.5% for Females; 12% for Males
HIV Prevalence among Intravenous drug users	California: 10%-18% (without nationality) Mexico: 5.9% among Males; 1.9% among females
HIV Prevalence among lower-risk Mexican migrant populations (heterosexuals, blood donors, and pregnant women)	Mexico: Heterosexuals: 0.09% General population to; 3% people recruited in high-risk venues. Blood donors: 0.04% - 0.18% Sentinel surveillance pregnant women 0.03% Pregnant women Tijuana: 1.26%
Sexually transmitted infections	California: 10.1% chlamydia, 1.2% Gonorrhea, 0.3% syphilis, 0.0% for HBV (pregnant women) 1.2% syphilis prevalence migrant and seasonal farm-workers 12% syphilis prevalence undocumented Hispanic day laborers in L.A. county.
Tuberculosis	1992: 61% of California's TB cases were foreign-born. 2001: 75% of California's TB cases were foreign-born (31.8% were from Mexico).

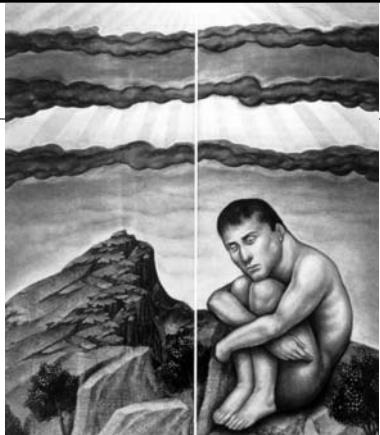
Sanchez, M. et al. The epidemiology of HIV among Mexican migrants and recent immigrants in California and Mexico. J Acquir Immune Defic Syndr. 37:4:2004

## Immigration and HIV What needs to be done?

- Access to basic needs: healthcare, housing, and employment may help reduce HIV risk, morbidity and mortality among immigrants
- Culturally-relevant educational and training materials in Spanish, and educational programs tailored for the needs of specific subgroups of immigrants
- HIV surveillance must be improved to understand the scope of HIV among immigrants



Bronfman N. et al. *Perspectives on HIV/AIDS prevention among Immigrants on the U.S.-Mexico border. The Spread of HIV among Latinos*. Westview Press: Boulder CO, 1996



## Outline

- Why the Latino community is a major concern?
- Epidemiologic trends of HIV disease in the Latino community
- Cultural characteristics that increase HIV vulnerability among Latinos
- Issues related to access to HIV care
- Immigration and HIV
- What can we do to improve health care services for Latinos? Cultural competency and more....

	<p><b>Latinos and HIV</b>  <b>Treatment services must take account:</b></p> <ul style="list-style-type: none"> <li>Latinos appreciate mutual respect in social relationships, especially with authority figures</li> <li>They strive to preserve personal integrity in interactions with others</li> <li>A Latino/a receiving medical or drug treatment must feel that he or she is treated with respect and valued, or treatment will be rejected</li> </ul> 
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	<p><b>Latinos and HIV</b>  <b>Treatment services must take account:</b></p> <ul style="list-style-type: none"> <li>Latinos have a different perception of time, with a more flexible understanding of punctuality</li> <li>Saving time is seen as less important than smooth, warm social relationships</li> <li>A Latino patient may see as rudeness a hurried pace or focus on saving time on the part of a caregiver</li> </ul> 
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	<p><b>Latinos and HIV</b>  <b>Treatment services must take account:</b></p> <ul style="list-style-type: none"> <li><b>Familismo.</b> Emphasis on the family as the primary social unit and source of support.  <i>"Strong ties within Latino families."</i></li> <li><b>Simpatia.</b> The importance in the culture of polite and cordial social relations. (central cultural value and social expectation). Shuns assertiveness, direct negative responses and criticism. <i>"Como Usted diga"</i></li> </ul>
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## Latinos and HIV

### Treatment services must take account:

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# Cultural Competency

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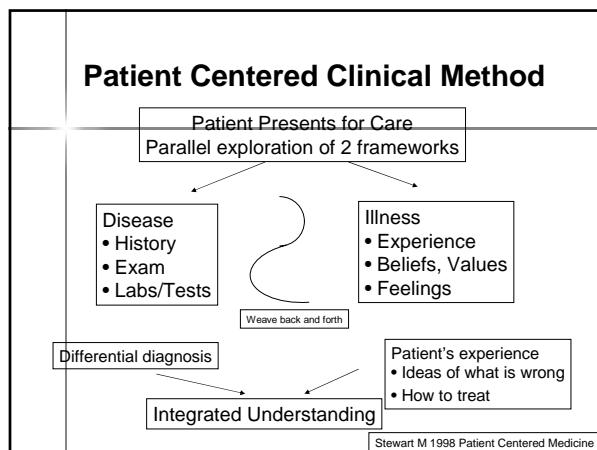
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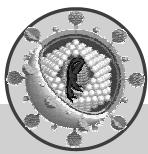
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<b>Kleinman's Questions</b>	
<ul style="list-style-type: none"> <li>■ What do you call the problem?</li> <li>■ What do you think has caused the problem?</li> <li>■ Why do you think it started when it did?</li> <li>■ What do you think the sickness does? How does it work?</li> <li>■ How severe is the sickness? Will it have a long or short course?</li> <li>■ What do you fear the most about the sickness?</li> </ul> <p><i>Kleinman A. Ann Inter Med. 1978</i></p> <p>What does HIV means to you?    What do you think will happen?    What do you fear the most?</p>	

<b>Summary</b> <b>Latinos and HIV/AIDS</b>	
<ul style="list-style-type: none"> <li>• Increase in number of new infections</li> <li>• Increase in number of Latinos newly diagnosed with AIDS</li> <li>• Stigma associated to HIV/AIDS</li> <li>• Late detection of HIV status and advanced disease</li> <li>• Lack of access to health care</li> <li>• Misperceptions and ignorance about the U.S. health care system</li> <li>• Characteristics of the health care system in U.S.</li> <li>• Language barriers</li> </ul>	





# HIV Care & Prevention 2006

*By the end of this session, participants will be able to:*

## (FIR) Update on State of the Art Antiretroviral Treatment and Management

*John O'Brien, Pharm D, Pharmacist Specialist: Ira Greene Positive PACE Clinic, Assistant Clinical Professor: University of Pacific and University of California at San Francisco, Faculty: San Jose AIDS Education & Training Center*

- Describe the efficacy, dosing, and side effects of recently FDA-approved antiretroviral therapies commonly utilized in HIV treatment
- Recognize drug-drug interactions that can occur with antiretroviral medications and be aware of recommended dose adjustments/drug substitutions
- Effectively manage salvage therapy in patients who have failed multiple drug regimens
- Describe the elements of treatment for at least 4 common opportunistic infections in HIV patients
- Describe how resistance testing is used to help manage the most effective antiretroviral therapy for HIV patients

## (PINE) HIV and Psychiatric Illness

*Neva Chauprette, Psy D: Psychologist, Consultant*

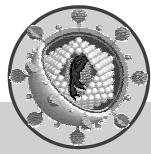
- Identify mental health issues associated with HIV seroconversion as well as psychiatric side effects of HIV medications
- Minimize drug interactions and toxicities among patients being treated with psychiatric medications in conjunction with antiretrovirals
- Recognize the rise in methamphetamine use and its implications on rates of HIV transmission in the South Bay area
- Identify psychiatric issues that are associated with substance use and HIV and will improve their capacity to effectively serve these clients
- Utilize credible and reliable mental health, HIV, and substance abuse referral sources

## (CEDAR) Transgender Awareness for HIV Healthcare Providers: Understanding the Trans In Transgender

*Jennifer Shockley, MPH, Program Manager and Danielle Castro, Health Educator: Community Health Partnership's Health Education & Training Center, San Jose AIDS Education & Training Center and Trans-Powerment Program*

- Recognize terms and concepts regarding transgender people's lives and experiences, including gender identity as opposed to sexual orientation
- Identify barriers to accessing HIV prevention and care services for the transgender community
- Identify strategies that can be implemented to improve HIV prevention and care services for transgender people





# HIV Care & Prevention 2006

## **John G. O'Brien Pharm D.**

John O'Brien is a pharmacist specialist at the Ira Greene Positive PACE Clinic of Santa Clara Valley Medical Center and an Assistant Clinical Professor with the Division of Clinical Pharmacy at the University of California in San Francisco and the University of Pacific. He serves as an expert pharmacist faculty member and consultant for San Jose AIDS Education and Training Center. In addition, John is a consulting pharmacist for California Collaborative Treatment Group, University of California at San Diego, University of California at Irvine, University of California at Los Angeles, University of Southern California, and Santa Clara Valley Health and Hospital System. John received his Bachelor of Arts in Physiology from University of California at Santa Barbara and earned his Pharmaceutical Doctor from University of California at San Francisco. At today's HIV Care & Prevention 2006 conference, John gives an "Update on State of the Art Antiretroviral Treatment and Management."

## **Neva Chauppette, Psy. D.**

Dr. Neva Chauppette earned her Bachelor of Arts in Psychology from Southeastern Louisiana University and received her Master in Applied Behavioral Analysis from Jacksonville State University. In addition, she earned her Doctor of Psychology from Pepperdine University in Culver City, California. Dr. Chauppette is a licensed Psychologist in part-time private practice in Los Angeles and the full-time Project Director of a mobile medical clinic that provides free and comprehensive HIV, Hepatitis ABC, and STD services to substance abusers in and out of treatment. Dr. Chauppette is a consultant to numerous HIV and chemical dependency treatment facilities throughout California. She has worked in the field of substance abuse and HIV since 1988. At today's HIV Care & Prevention 2006 conference, Dr. Chauppette speaks on "HIV & Psychiatric Illness."

## **Jennifer A. Shockey, MPH**

Jennifer Shockey received her Bachelors in Health Science from California State University at Fresno and earned her Master in Public Health from San Jose State University. Her diverse experience in the field of HIV education and prevention for the past ten years includes her work with injection drug users, youth, and the lesbian, gay, bisexual, transgender community, as well as sex workers. She is currently a Program Manager for the Health Education and Training Center, a division of Community Health Partnership, by overseeing the Minority AIDS Initiative and the Trans-Powerment Program. She also acts as a faculty member for the San Jose AIDS Education & Training Center by training health care providers interested in improving their ability to serve the transgender community. She earned her Master of Public Health from San Jose State University in 2004.

## **Danielle R. Castro**

Danielle Castro has volunteered in the field of HIV/AIDS prevention and education for over ten years. Her advocacy and outreach efforts have been predominantly related to transgender issues as she is trans-identified. Danielle is a member of both the Santa Clara County HIV Prevention Community Planning Group and the Santa Clara County HIV Health Services Planning Council. She is a co-founder of both the Transgender Youth Group at the Billy De Frank Center and the San Jose Steering Committee for the Transgender Day of Remembrance. Moreover, Danielle is a recipient of the 2005 Human Relations Award for District 2 of the County of Santa Clara. She has worked with the San Jose AIDS Education and Training Center as an independent consultant on transgender health care issues since 2003 and joined the HETC staff under the Trans-Powerment program in October 2005. At today's HIV Care & Prevention 2006 conference, Danielle co-facilitates with Jennifer Shockey on "Transgender Awareness for HIV Healthcare Providers: Understanding the Trans in Transgender."





## Update on State of the Art Antiretroviral Therapies

**John G. O'Brien, PharmD**

Pharmacist Specialist, PACE Clinic, SCVHHS  
Asst. Clinical Prof., UOP and UCSF Schools of Pharmacy  
Faculty, Pacific AIDS Education & Training Center

### CASE

- Mr. G a 43 yo Latin man, CD4 50 viral load 28K, h/o cryptococcal meningitis 11/03
- 12/18/05 diagnosed w/ PCP pneumonia (moderate) pt has h/o septral allergy 11/03 and 7/04 so began:
  - Clindamycin/primaquine developed rash on day 7
  - Seen in clinic 12/27 Trimethoprim/dapsone (TMP/dapsone) pt readmitted to the hospital 1/2/06 w/ severe relapse of his PCP

### OI's

- Cryptococcal meningitis: Most common serious fungal infection
- CD4 < 150 is risk to develop
- S/Sx's: FEVER, HA, N/V, photophobia
- Morbidity/Mortality comes from increased intracranial pressure (> 25cm/H2O)
- Treatment:
- IV amphotericin B .7 to 1 mg/kg/day + 5FC (flucytosine) 100mg/kg divided 4 times/day po
- Treat for 2 weeks then give po fluconazole 400mg

## OI- PCP

- Risk CD4 < 200 or % CD4 < 14
- S/Sx's: Fever, cough, SOB (dry), developing over days-wk
- D.O.C: septrta (SMX/TMP) 15mg/kg/day given 3 times daily, IV initially then po
- Clindamycin/primaquine: 600-900mg tid/primaquine 30mg of base daily
- IV pentamidine: 3-4 mg/kg/day, base on IBW
- IV trimetrexate/leukovirin: 45mg/m<sup>2</sup> leukovirin 20mg/m<sup>2</sup> 4 times/day.
  - ALL THERAPIES X 21 DAYS.
- If PaO<sub>2</sub> < 70 then give prednisone 40mg bid,40mg/day x 5 days, 20mg/day x 11 days

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## CASE

Mr.G was manifesting 'cumulative' toxicity from IV pentamidine therefore ID service recommended septrta desensitization over 6 hr Several desensitization protocols from 5 hrs to 16 days This was successful and pt received 5 days of septrta after which time he developed a rash (pt had rash 2 prior times) Patient then got trimethoprim/dapsone again and seen in clinic 10 days later improving from pneumonia. Trimethoprim was d/c'd and patient continued dapsone for prophylaxis vs. PCP.

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## CASE

During admission pt had a genotype resistance test Clinic visit 1/27/06: genotype showed resistance to EFV, therefore pt was taken off sustiva and placed on atazanavir 300mg/ritonavir 100mg and truvada 1 daily was continued

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## CASE

Pt slowly improved on IV Pentamidine  
His serum creatinine increased after 5 days due to dosage  
    > 4mg/kg/day

Pt was not weighed upon admission

- Pt's K and LFTs also increased b/c of pentamidine:
- Main toxicities of pentamidine:
- Very nephrotoxic, causes both decreased (more severe) and increased BG's
- Liver and bone marrow toxicity occurs, but less commonly

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## CASE

- 1) Why did pt become resistant?
- 2) Was boosted reyataz the best choice?
- 3) Why does the pt have some many allergic reactions?
- 4) Is the patient predisposed to the nephrotoxicity of TDF because of pentamidine?
- 5) Is patient still at risk of getting cryptococcal meningitis (fungal) and PCP again?

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### 1) Why did pt become resistant?

- Most likely do to non-adherence, develops rapidly w/ NNRTI class
- This might be because if pt stop/start all meds @ same time, and with the different half-lives ( $t_{1/2}$ 's) of the RTI's vs NNRTIs the virus might actually be exposed to only 1 drug ( ie MonoTx) for days/wks.
- The K103N mutation confers cross resistance to the entire NNRTI class (EFV, NVP, DLV)

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**2) Was boosted reyataz the best choice?**

- Yes, probably, although pt had been on ATV briefly about 2 yrs ago
- Data from BMS 045: compared atazanavir 300mg/ritonavir 100mg vs. kaletra 3 capsules BID after 48 wks in 120 patients each group
- 1.58 log drop for ATV/r vs. 1.7log drop for Kaletra respectively
- Atazanavir 300mg/ritonavir 100mg/day is well tolerated with low pill burden

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**3) Why does the pt have some many allergic reactions?**

- Data to show that patients w/ AIDS and OI have altered metabolism
- Lee,B and Benowitz 1990
- Latin pts have highly likelihood of reactions to septra and NNRTIs
- Deresi (ICAAC 2000)
- Kemper et al, Annals of Pharmacotherapy 2001
- Further observation in the PACE Clinic supports the above.

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**4) Is the patient predisposed to the nephrotoxicity of TDF because of pentamidine?**

- Yes, we need to monitor him closely for both adherence and toxicity to the TDF
- Pt has h/o non-adherence w/ ARVs and meds for treatment and/or prophylaxis of OI
- At least 4/8 case of mod-severe nephrotoxicity with tenofovir has been in patients who have had either: IV amphotericin, been dehydrated, and underlying DM
- Mr. G has had both amphotericin B AND IV pentamidine: 2 of the most nephrotoxic drugs we use

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**5) Is patient still at risk of getting cryptococcal meningitis (fungal) and PCP again?**

- He will need to be on prophylaxis for the meningitis for LIFE with fluconazole 200mg/day (after the 8-10 weeks of fluconazole 400mg daily)
- the prophylaxis for PCP - dapsone until his CD4 are > 200 for 3-6 months

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**Recommended Regimens for Treatment-Naïve (never been on therapy) Patients**

**Preferred regimens**

EFV +  
(3TC or FTC) + (AZT or TDF)

LPV/r +  
(3TC or FTC) + AZT

**Alternative regimens**

**NNRTI-based**

EFV + (3TC or FTC) + (ABC, ddI or d4T)  
NVP + (3TC or FTC) + (AZT, d4T, ddI,  
ABC or TDF)

**3 NRTI-based**

ABC + AZT + 3TC – only when a preferred or an alternative NNRTI- or PI-based regimen cannot or should not be used

**PI-based**

ATV + (3TC or FTC) + (AZT, d4T, ABC or ddI) or  
(TDF+RTV 100mg/d)  
FPV + (3TC or FTC) + (AZT, d4T, ABC, TDF or ddI)  
FPV/r + (3TC or FTC) + (AZT, d4T, ABC, TDF or ddI)  
IDV/r + (3TC or FTC) + (AZT, d4T, ABC, TDF or ddI)  
LPV/r + (3TC or FTC) + (d4T, ABC, TDF or ddI)  
NFV + (3TC or FTC) + (AZT, d4T, ABC, TDF or ddI)  
SQV/r + (3TC or FTC) + (AZT, d4T, ABC, TDF or ddI)

DHHS Guidelines for the Use of ARV Agents in HIV-1-Infected Adults and Adolescents, 04/07/05

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**Classes of ARVs:**  
**4 Main types**

- Nucleoside RT inhibitors (RTI)
- Protease Inhibitors (PI)
- Non-nucleoside RT inhibitors (NNRTI)
- Fusion inhibitors

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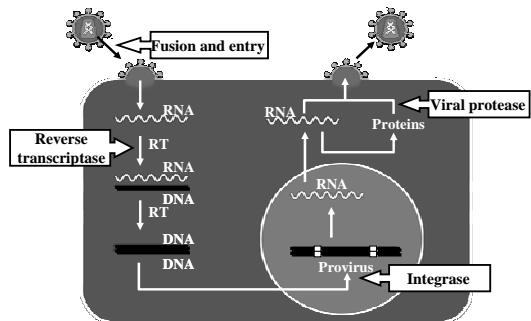
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## HIV Replication



## RTI

- Using fixed dosing combination tablets:
  - Truvada (emtriva/viread) 1 tablet daily
  - Epzicom (ziagen/epivir) 1 tablet daily
  - Combivir (azt/3tc) 1 tablet TWICE DAILY
  - D4t (zerit) + 3tc.
  - Truvada clearly the best FDC based on recent clinical trials: safety, effectiveness and simplicity

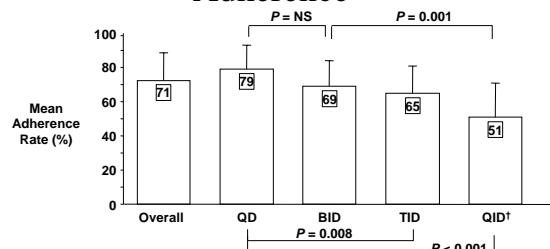
## RTI side effects

- Main toxicities thought to be mediated by cumulative damage to the mitochondria
- Side effects:
  - Most serious is lactic acidosis (liver failure), fatal in about 50% of patients
    - Pancreatitis
      - Neuropathy'
      - Bone marrow suppression
        - Renal toxicity
  - ? Fat loss (lipoatrophy)
  - Worst drugs: d4t and ddI
  - Least tdf, 3tc, ftc
  - Azt and ABC in the middle

## HIV now a Chronic Treatable Condition

- HIV, like DM, HTN, and heart disease is managed like a chronic disease
- Patients require regular follow up with MD every 2-4 months and also blood work about every 3 months
- Goals of treatment:
  - Improve immune system function = T-cells
  - Suppress viral replications = HIV viral load

## Impact of Dose Frequency on Adherence\*



\*Analysis of electronic monitoring of adherence in 76 studies in a variety of disease areas.

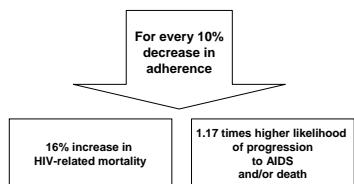
†QID = four times a day.

Adapted from: Claxton AJ et al. *Clin Ther.* 2001;23:1296-1310.

## Adherence

- What is the level of adherence to ARVs in order to suppress the virus and improve or restore immune system function?

## Adherence Impacts HIV-Related Mortality and AIDS Progression<sup>\*1</sup>

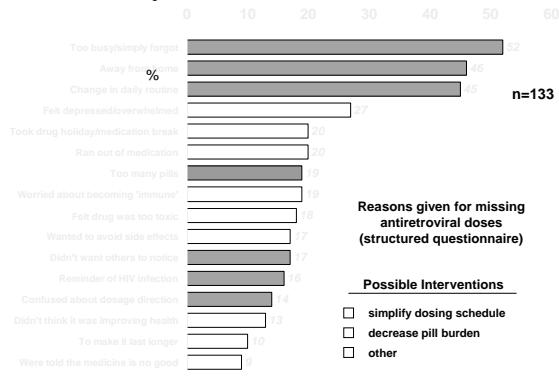


\*Prospective, observational study of 950 ART-naive patients treated with triple combination therapy; adherence was estimated by prescriptions dispensed.

<sup>1</sup> Hogg et al. 7th CROI 2000, Abstract 73.

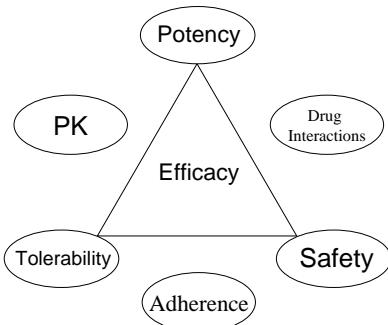
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## Why Patients Miss Doses



Adapted from: Gifford AL et al. JAIDS 2000; 23: 386-395

## Long-term Efficacy of HAART in 2006



## Pharmacogenomics

- Most around ABC- malle et al – Australia
- NNRTIs: EFV, Hass et al, and Ribalado et al. from CROI 2005.

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### Discontinuation of NNRTI-based regimens: STOP Study

- Steady-state half-life: NVP: 25–32 h
  - EFV: 40–55 h
- PK study: 10 patients stopping 2 NRTIs + EFV
  - 5/10 had EFV  $T_{1/2}$  40–50 h
  - 5/10 had EFV  $T_{1/2}$  >100 h
    - 4/5 black African women
    - 3/5 had therapeutic levels (>1000 ng/mL) 2 weeks after stopping EFV
- Primary infection study: 25 patients with VL <50 c/mL stopping therapy after treatment for early infection
  - No resistance at Week 4 when ZDV/3TC continued 5–7 days after stopping EFV
- Potential options for discontinuation of NNRTI-based regimens
  - Continue NRTIs 7 days after stopping NNRTI\*

Taylor S, et al. 11<sup>th</sup> CROI, San Francisco 2004, #131

\*British HIV Association recommendation

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## Efavirenz clearance and race

- In Stop study (UK) of pts discontinuing EFV, Black Africans more likely to have slow EFV elimination<sup>[1]</sup>
  - In excess of EC<sub>95</sub> for up to 14–21 days after stopping
- In pharmacologic evaluations of EFV in ACTG 5095
  - EFV clearance lower in Blacks & Hispanics vs. whites ( $P < .001$ )<sup>[2]</sup>
  - Increasing rate of discontinuations seen with decreasing clearance ( $P = .052$ ) and increasing Cmax ( $P = .048$ )<sup>[2]</sup>
  - Prevalence of CYP2B6 T/T genotype more common in African Americans (20%) vs. whites (3%), and associated with 3-fold higher EFV levels<sup>[3]</sup>
  - T/T genotype associated with adverse CNS symptoms ( $P = .04$ )<sup>[3]</sup>

1. Taylor S, et al. #131. 2. Ribaudo H, et al. #132. 3. Haas D, et al. #133.

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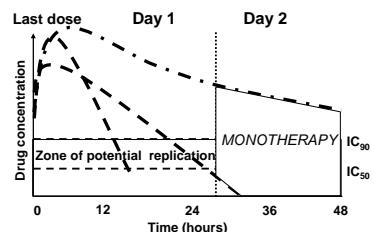
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## Stopping drugs with different half lives



Taylor S, et al. 11<sup>th</sup> CROI, San Francisco 2004, #131



Mucosal involvement with NVP-Vietnamese male

## Non-nucleosides: NNRTIs

- 3 available, but only 2 are used
- BEST is efavirenz- EFV (Sustiva) 600mg
  - given once at night without food
- Nevirapine – NVP (Viramune) 200mg
  - Need to begin dosing with 1 tablet daily for a FULL 14 days, then if NO rash, fever, or flu-like symptoms go up to bid
  - Consider Monitor LFT's weekly for about 4 weeks.
- Nevirapine thought to have more hepatitis (drug induced), however recently PACE Clinic has had a case of life-threatening hepatitis to Sustiva
- CAUTION IS WARRANTED FOR BOTH DRUGS WITH REGARD TO HEPATITIS.

## NNRTI side effects

- Rash is most common: for nevirapine can be up 30% or more in certain populations (Latin/Hispanic and ? Asian)
- Rash is MORE severe with NVP than EFV
- Rash about 15% with EFV

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## NNRTI side effects

- Hepatitis secondary to the NNRTIs is thought to be more common in those with HCV or Hepatitis B co-infection
- If CD4 for women are > 250 do NOT use nevirapine
- If CD4 for men > 400 do NOT use NVP
- Above these cut offs the incidence of severe hepatitis goes up 12 fold and 5 fold respectively

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## Protease Inhibitors

- Used with the RTI
- 7 available, Focus on 3
- Kaletra (lopinavir 200mg/50mg) tablet
  - 2 tablets twice daily
- Atazanavir 300mg/ with ritonavir 100mg once daily with food
- Tipranavir 250mg/ritonavir 100mg
  - 2 tipranavir with 2 ritonavir twice daily with food

Others used: saquinavir/ritonavir, fosamprenavir, nelfinavir

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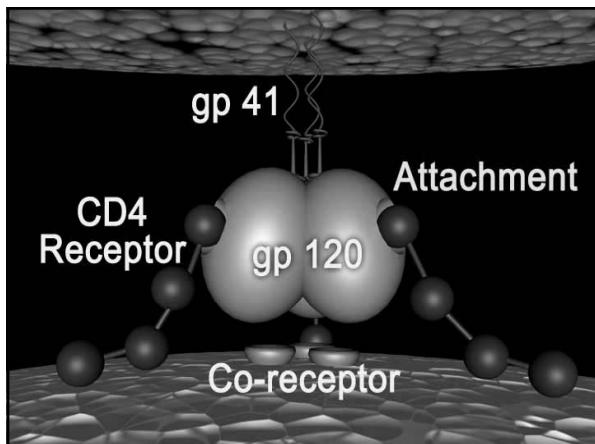
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## Protease Inhibitor Side Effects

- ALL PI meds cause GI toxicity to varying degrees: nelfinavir the most atazanavir the least
- Fosamprenavir: rash in about 10% of pts
- Atazanavir can increase levels of indirect bilirubin in about 50% of patients, but is not indicative of liver toxicity
- All PI can worsen lipid profile (atazanavir to a lesser extent)
- Lopinavir/ritonavir and indinavir show increase insulin resistance, although all might lead to the development of DM



## Fusion Inhibitors

- Fusion inhibitors (Fuzeon, T-20)
- Block the entry of the virus into the cell
- Used subQ bid 90mg
- Major side effect is injection site reactions
  - Can be painful and last up to 1 wk
  - And can SIGNIFICANTLY AFFECT ADHERENCE

## LIPIDS

- Not something we thought about 5-6 yrs ago in most patients
- With patients aging and most PI regimens boosted w/ ritonavir
- Lipid abnormalities common
- Triglycerides implicated with RTV, more recently d4t (Gilead 903 data)
- Triglyceride levels of 1000-2000 not uncommon
- Triglycerides ARE an important CV risk factor
- Increased total CHOL:
  - LDL often not known due to high TG's

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## Treatment of lipids

- If patient has high LDL cholesterol and/or low HDL begin w/ a 'statin drug'
- If patient is on a Protease inhibitor do NOT use: Zocor (simvastatin) or Mevacor (lovastatin) because of severe drug interaction
- If patient has high triglycerides best Rx is Tricor (fenofibrate)
- If possible we try to avoid the combination of a statin and fibrate.

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## Drug interactions

- Is versed or halcion safe to use in patients also on PI's such as Kaletra?
- Do medications like dilantin (phenytoin), tegretol (carbamazepine) and phenobarbital affect drug levels of ARVs?
- Do ARVs interact with Lithium?
- Do HIV interact with each other?

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## Drug interactions

- Many drugs have not been formally studied with ARVs
- This means there is a certain amount of ‘guess work’ in order to predict what will happen
- People and how they breakdown medication within the body are very different.
- Genetics of the patient does play a role in metabolism of medications- not just ARVs
- Example: Sustiva and AA or Latino(a)

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## Examples of drug interactions

- Kaletra and depakote (valproic acid)
- The Kaletra can lower the levels of depakote and lead to either seizures or loss of control of mania.
- Ziprasidone (geodon), trazadone, ambien, and pimozide all have potential life threatening drug interactions with PI ARVs
- Antidepressants like elavil are ELEVATED by Kaletra or ritonavir and this can cause seizures
- Lamictal and NNRTI medications and abacavir (Ziagen) can all cause severe rashes or allergic reactions

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## Antiretroviral Therapy Adherence

### 4 question reassessment at every health care visit

- What medications are you taking?
  - Memorize names
  - Needs picture chart
  - Can’t remember even with pictures
- How are you taking your medications?
  - Each med, timing of each dose
- How many doses have you missed?
  - Last 3 days? Last week? Since last visit?
  - Is there a pattern? - Design an intervention
- Are you experiencing any drug side effects?

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## Drug combinations to avoid

- Triple nucleoside/tide combinations alone, i.e. w/out an NNRTI (such as efavirenz or nevirapine) or a PI:
- ddI/TDF/3tc
- TDF/ABC/3tc
- Avoid ddI/TDF with NVP or EFV in naïve patients (especially those with high viral loads/low CD4)<sup>3</sup>

3 DHHS guidelines 10/05

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## ABC-HSR

- 2 cases w/in the past 4 months
- 1 severe, 1 moderate
- Usual symptoms/signs:
- Fever (often > 101F)
- Rash- typical drug rash
  - N/V/ abdominal pain
  - Flu like symptoms, myalgias
  - Cough, SOB, or URI type presentations
- Median time of onset is 9 days, but can happen out to 6 weeks.

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Abacavir rash day 10- Latina

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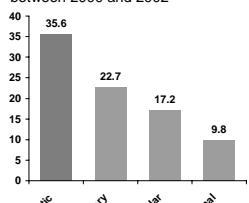
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### Nonopportunistic Illnesses in Today's HIV Patient

Nonopportunistic illnesses contributing to death as a percentage (%) of all deaths between 2000 and 2002



Palella FJ, et al. 11th Conference on Retroviruses and Opportunistic Infections; 2004. Poster 872.

### HIV and HCV Co-infection Epidemiology

[drw1]

- 25 - 30% PACE Clinic pts
- 30 - 35% of U.S. HIV+ pts

### CASE- HCV

- MM, 48 yo WF HIV +, CD4 280 viral load < 75 copies/ml
- + HCV, child-pugh 8-9 (moderate liver impairment)
- LFTs: Tbili: 2.8, AST/ALT 260/154,
- Alk phos 296, ALB 2.9
- CBC: plts 55K.

## Slide 47

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drw1 Find a breakdown of Epidemiology

US

CA

Bay Area

By risk factor

dwarren, 5/11/2005

## CASE- HCV

- H/o IDU: heroin
- H/o seizures due to cocaine usage
- Chronic neck/shoulder as well as neuropathy pain.
- Methadone 30mg am/40mg pm for pain

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## CASE- HCV

- Link to calculate level of liver dysfunction:  
<http://homepage.mac.com/sholland/contrivances/childpugh.html>
- Uses: albumin, INR, and bilirubin levels alone with: presence or absence of ascites or hepatic encephalopathy

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End Stage Liver Disease Determining & Interpreting Child-Pugh Scores Score			
	1 Point	2 Points	3 Points
Bilirubin, mg/dL	<2	2-3	>3
Albumin, mg/dL	>3.5	3.5-2.8	<2.8
(INR, IU)	<1.7	1.7-2.3	>2.3
Ascites	Absent	Mild - Mod	Severe
Encephalopathy	Absent	Mild (I-II)	Severe (III-IV)

C-P Class	Score	Interpretation
Class A:	5-6	(Mild Liver Dysfunction)
Class B:	7-9	(Moderate Liver Dysfunction)
Class C:	10-15	(Severe Liver Dysfunction)

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## CASE

- Meds atazanavir 300mg daily + Truvada (emtricitabine/tenofovir)
- Admitted 6 times over the past 6 months for worsening of hepatic encephalopathy
- Pt non-adherent with her lactulose
- Other meds: topimax, gabapentin
- Spironolactone/lasix/rifixin and propranolol for liver

**Table 1. Use of nucleoside reverse-transcriptase inhibitors (NRTIs) in the treatment of liver disease.**

NRTI	Standard dosage	Manufacturer recommendation	Author recommendation
Zidovudine	300 mg po b.i.d.	No recommendation <sup>a</sup>	No change
Lamivudine	150 mg po b.i.d.	No change	No change
Emtricitabine	200 mg po q.d.	No change	No change
Stavudine	30–40 mg po b.i.d.	No change	No change
Didanosine	125–200 mg po b.i.d.	No recommendation <sup>b</sup>	No change <sup>c</sup>
Tenofovir	300 mg po b.i.d.	No recommendation <sup>b</sup>	No change
Abacavir	300 mg po b.i.d.	No recommendation <sup>b</sup>	No change

NOTE. "Liver disease" is defined as cirrhosis (diagnosed by biopsy or on the basis of clinical evidence) and a Child-Pugh score of >5.

<sup>a</sup> Data suggest a significant effect of hepatic impairment on plasma zidovudine pharmacokinetics. A lack of data precludes altered dosing recommendations. Clinical experience suggests that standard dosing is well tolerated.

<sup>b</sup> Known metabolic pathways would not suggest a significant effect of hepatic impairment.

<sup>c</sup> Should not be coadministered with ribavirin during hepatitis C therapy.

D Wyles, Gerber, J. CID 2005; 40:174-81

**Table 2. Use of nonnucleoside reverse-transcriptase inhibitors (NNRTIs) in the treatment of liver disease.**

NNRTI	Standard dosage	Manufacturer recommendation	Author recommendation(s)
Nevirapine	200 mg po b.i.d.	No recommendation	No change; should not be used for HCV-positive patients <sup>a</sup>
Efavirenz	600 mg po q.d.	No recommendation	No change

NOTE. "Liver disease" is defined as cirrhosis (diagnosed by biopsy or on the basis of clinical evidence) and a Child-Pugh score of >5. HCV, hepatitis C virus.

<sup>a</sup> Data indicate increased fibrosis and fibrosis progression rates among HCV-positive patients who are treated with nevirapine.

D Wyles, Gerber, J. CID 2005; 40:174-81

For NVP- be aware of CD4 cutoffs

**Table 3. Use of protease inhibitors (PIs) in the treatment of liver disease.**

PI	Standard dosage	Manufacturer recommendation	Author recommendation
Nelfinavir	1250 mg po b.i.d.	No recommendation	No change <sup>a</sup>
Indinavir	800 mg po q8h	600 mg po q8h	600 mg po q8h <sup>b,c</sup>
Saquinavir	1200 mg po t.i.d.	No recommendation	No change
Lopinavir and ritonavir	400/100 mg po b.i.d.	No recommendation	400 mg of lopinavir po b.i.d. <sup>d</sup> and 100 mg of ritonavir po b.i.d. <sup>d</sup>
Amprenavir	1200 mg po b.i.d.	450 mg po b.i.d. <sup>e</sup> or 350 mg po b.i.d. <sup>f</sup>	1200 mg po q.d. or 600 mg po b.i.d. <sup>g</sup>
Atazanavir	400 mg po q.d.	300 mg po q.d. <sup>h</sup>	300–400 mg po q.d. <sup>i</sup>

NOTE. "Liver disease" is defined as cirrhosis (diagnosed by biopsy or on the basis of clinical evidence) and a Child-Pugh score of >5.

<sup>a</sup> Hepatic impairment significantly increases the levels of nelfinavir. Data do not indicate increased toxicity.

<sup>b</sup> If ritonavir is boosted, the indinavir/ritonavir dosage is 200/100 mg po b.i.d.

<sup>c</sup> Consider therapeutic drug monitoring.

<sup>d</sup> Levels are significantly increased, but there are very limited data; consider therapeutic drug monitoring.

<sup>e</sup> Child-Pugh score of 5–8 (roughly class A).

<sup>f</sup> Moderate hepatic impairment and severe hepatic impairment produce changes in the area under the curve (AUC) for amprenavir that are similar to those in the AUC for ritonavir. In the clinical setting, ritonavir is frequently added to treatment with amprenavir to obtain a consistent plasma concentration.

<sup>g</sup> Child-Pugh class B; not recommended for Child-Pugh class C.

<sup>h</sup> For treatment-experienced patients, atazanavir (400 mg) should be used. Boosting of atazanavir with ritonavir is not recommended.

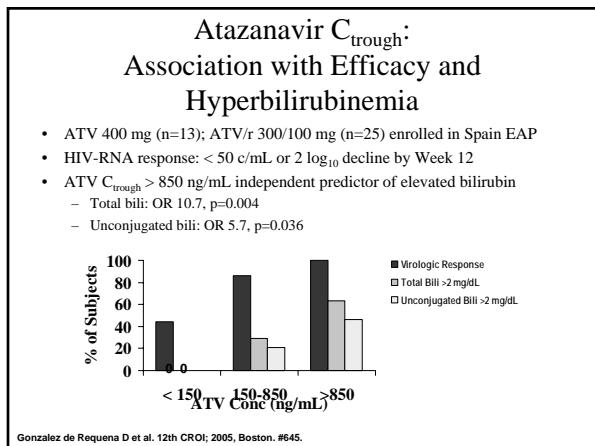
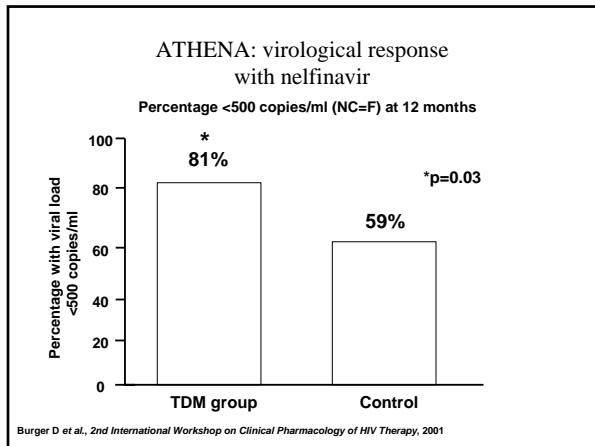
D Wyles, Gerber, J. CID 2005; 40:174-81

## Case: Ms. W

- PharmDs fill her med box q week
- Pt also drinking 8-10 cans of boost/day because she had lost all teeth
  - Because of the protein load- this is worsening her encephalopathy
  - Protein should be restricted to 60-75gm/day
- Now pt has not only problems with fluid gain, but also fat weight from all her boost

## TDM: Not ready for prime time

- All medications in the PI and NNRTI class can be measured
- No established therapeutic levels
- Often a C min (C trough) is measured
- This is what most likely correlates with efficacy
- Recent study from CROI 2006- Best et al from CCTG looked at checking lopinavir levels.



**CASE**

- Hepatic Impairment will likely affect atazanavir metabolism and other drugs metabolized thru the liver.
- There are clear guidelines to dose reduce nRTI medications for RENAL Dysfunction:
  - Dose reduce all nRTI ARVs except abacavir for Clcr < 50ml/min
  - < 15ml/min for AZT (ZDV) to 300-400mg/day.

## Herbal Case

- 36 yo Ms. S WF, w/ HCV
- ARVS: fosamprenavir 1400mg/ritonavir 200mg, Truvada 1 tab once daily.
- H/o using meth
- Seen by PMD 1/30/06: pt admit to using Khat instead of meth
- Labs on this day:
- AST: 302, ALT: 160
- Baseline 10/05: AST 30, ALT 26
- Pt without Sx's.

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## Khat-Abyssinian (Arabian) Tea, Gat, Qut, Tohat, Tohai

<http://www.naturaldatabase.com>

- Contains cathinone has 1/10<sup>th</sup> the activity of amphetamine and has similar chemical structure to amphetamine
- In high doses the Khat can cause paranoia, psychosis, and aggression
- Can be psychologically addictive
- In females thought to enhance sexually desire

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## CASE: Khat

- Severe reactions can include cirrhosis
- ? If pt w/ underlying HCV is more at risk for liver toxicity w/ Khat
- fosAPV/rtv- and other Protease inhibitors lead to a 2-3 fold increase in levels of amphetamines
- It is possible that since cathinone has structure like amphetamine that there could a drug interaction with the pt's fosAPV/rtv.

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### CASE: Khat

- Plan: contact Ms. S and d/c Khat and recheck LFTs
- If increasing will need to d/c ARVs as the ARVs can rarely cause liver toxicity.

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### HERBS- HIV

- Overall need to proceed with EXTREME Caution
- 3 reasons:
  - 1) drug-drug interactions
  - 2) effects on stimulation of immune system and potentially increasing viral replication
  - 3) Direct toxicity to patient

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### New Classes of medications- available in 1-3 years

- Entry inhibitors: WORK somewhat like fusion inhibitors, but can be given orally
- They block co-receptors on the outside of the immune cells (CD4 cells)
- Integrase inhibitors: Gilead has 1 in phase I/II development (Merck also has 1)

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## Summary

- HIV/AIDS is a chronic manageable condition that requires life-long adherence to combination ARVs
- Adherence to ARVs is > 95%
- Resistance of the virus to ARVs is common
- Side effects toxicity occur in most patients as some point in time

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## Summary

- HIV/AIDS should ONLY be managed by expert clinicians (MD's, NP/PA, PharmD, RN, RD)
- Drug-drug and drug-disease interactions are common and potentially life-threatening
- Mental illness/depression are common and need to treated
- A team approach to treatment of HIV/AIDS is needed

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## What significance does HIV treatment have?

- Treatment with combinations of HIV medications (ARVs or HAART) can lead to long term, sustained improvement to the immune system.
- Patients can (will) live a normal life span IF, and ONLY if they take ARVs
- Adherence (or compliance) to ARVs is absolutely critical for the above to happen

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## HIV & PSYCHIATRIC ILLNESS

Presented by  
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## PREDISPOSING PSYCHIATRIC ILLNESSES

- PSYCHIATRIC DISORDERS THAT APPEAR TO ELEVATE RISK FOR HIV EXPOSURE:
  - Substance Abuse / Dependence
  - Personality Disorders – Cluster B
  - Mood Disorders
  - Sexual Disorders NOS
  - Attention Deficit Disorder
  - Gender Identity Disorder
  - Dementia (resulting from)

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## PREDISPOSING PSYCHIATRIC ILLNESSES

- PSYCHIATRIC DISORDERS THAT APPEAR TO ELEVATE RISK FOR HIV EXPOSURE:
  - Substance Abuse / Dependence
    - Amphetamines
    - Depressants
  - Symptoms
    - Assume majority of clients with this history
    - Evaluate any history of treatment and current desire for such
    - Is treatment a condition of parole?
    - Needle risk / HIV / Hepatitis C
    - Methamphetamine
    - Sex addiction
  - Treatment
    - Mandated vs. Voluntary
    - Stage of Change

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## PREDISPOSING PSYCHIATRIC ILLNESSES

- PSYCHIATRIC DISORDERS THAT APPEAR TO ELEVATE RISK FOR HIV EXPOSURE:

### Personality Disorders – Cluster “B”

- Histrionic
- Borderline
- Narcissistic
- Antisocial

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## PREDISPOSING PSYCHIATRIC ILLNESSES

- Personality Disorders

- Histrionic Personality Disorder
  - Sex as organizing principle
  - Prostitution vs. Sex Addiction
- Borderline Personality Disorder
  - Crisis management
  - Countertransference management
  - Realistic expectations
  - Boundary maintenance with humor
- Narcissistic Personality Disorder
  - Sense of entitlement
  - Rage containment
  - Countertransference
- Antisocial Personality Disorder
  - “Play the naïvete” – modus operandi
  - Charming and seductive
  - Calculating and cunning
  - External gains

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## PREDISPOSING PSYCHIATRIC ILLNESSES

- PSYCHIATRIC DISORDERS THAT APPEAR TO ELEVATE RISK FOR HIV EXPOSURE:

### Mood Disorders

- Bipolar I / Bipolar II
  - Mania and hypomania pose the risk
  - Normal moods at mid cycle
- Major Depressive Disorder
  - Assess for alcoholism and drug abuse
  - Trauma history
  - Suicide: history / current status
- Treatment
  - Psychopharmacology ([www.PsyD-fx.com](http://www.PsyD-fx.com))
  - Cognitive Behavioral approaches

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## PREDISPOSING PSYCHIATRIC ILLNESSES

- PSYCHIATRIC DISORDERS THAT APPEAR TO ELEVATE RISK FOR HIV EXPOSURE:

### Sexual Disorders Not Otherwise Specified

#### **Sex Addiction / Cybersex Addiction**

- Versus Prostitution
- Symptoms
- Treatment - [www.sexualrecovery.com](http://www.sexualrecovery.com)

#### **Ego-Dystonic Homosexuality**

- Symptoms
- Treatment

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## PREDISPOSING PSYCHIATRIC ILLNESSES

- PSYCHIATRIC DISORDERS THAT APPEAR TO ELEVATE RISK FOR HIV EXPOSURE:

### Attention Deficit Disorder

- Predominantly hyperactive-impulsive type
  - Symptoms
  - Treatment
    - Behavioral
    - Psychopharmacological

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## PREDISPOSING PSYCHIATRIC ILLNESSES

- PSYCHIATRIC DISORDERS THAT APPEAR TO ELEVATE RISK FOR HIV EXPOSURE:

### Gender Identity Disorder

- Male to Female, Sexually attracted to Males
- Symptoms**
- Treatment**
- Supportive psychotherapy
  - Hormone therapy

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## HIV PSYCHOPHARMACOLOGY

- [www.nynjaetc.org](http://www.nynjaetc.org)

- "Recreational Drugs and HIV Antiretrovirals: A Guide to Interactions for Clinicians" - Summer '05
- "Psychiatric Medications and HIV Antiretrovirals: A Guide to Interactions for Clinicians" - Fall '04

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## Psychiatric Side Effects of HIV Medications

- Sustiva®

- Insomnia
- Confusion
- Inability to concentrate
- Dizziness
- Vivid dreams
- See [www.aidsmeds.com](http://www.aidsmeds.com) - "Tips and Tricks on Taking"
- False Positive Urine Screen for THC

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## **Transgender Awareness for HIV Healthcare Providers:**

Understanding the “trans” in transgender



Jen Shockey, MPH and Danielle Castro  
April 4, 2006

HIV Care and Prevention Conference 2006



SAN JOSE  
AIDS  
Education and  
Training Center

Curriculum developed by Samuel Lutie  
[www.tqtrain.org](http://www.tqtrain.org)

## **Training Objectives**

- Recognize terms and concepts regarding transgender people's lives and experiences, including gender identity as opposed to sexual orientation.
- Identify barriers to accessing HIV prevention and care services for the transgender community.
- Identify strategies that can be implemented to improve HIV prevention and care services for transgender people.

## **Trainers and Audience**

- Who are the trainers?
- What does the audience want from them?
- What issues would you like to see addressed in this training? What are some of the questions or specific needs that you have?

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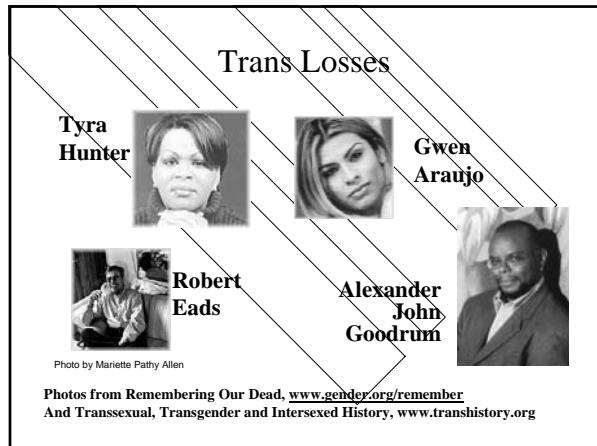
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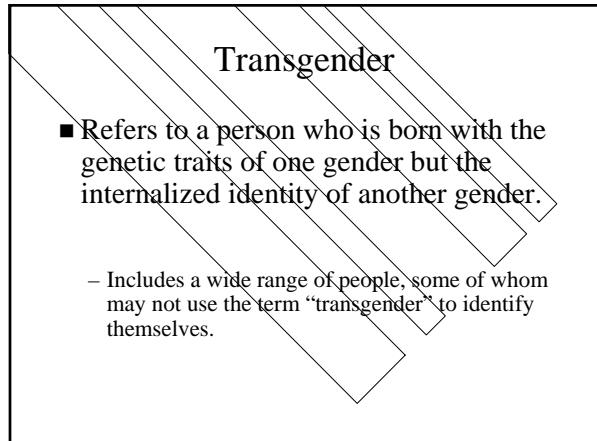
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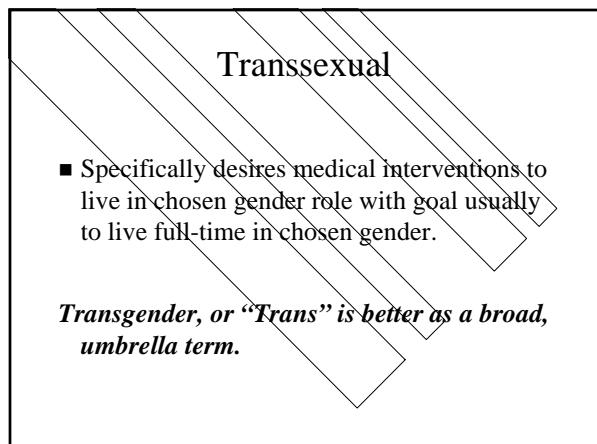
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## Language and Concepts

### ***FTM, Female-to-Male, Transman***

- Someone assigned female at birth who identifies more as a boy or man.
- Transgender man, or simply man

### ***MTF, Male-to-Female, Transwoman***

- Someone assigned male at birth who identifies more as a girl or woman.
- Transgender woman, or simply woman



## Cross Gender Hormones

- What do Hormones Do?
- Very strong pull to allow for confirmation in chosen gender
- Difficult to obtain through medical providers
- Leads to street market and unmonitored use

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## Access to Cross Gender Hormones can:

- Improve self-esteem
- Prevent suffering and risk taking
- Improve adherence to treatment for chronic illness
- Increase opportunities for preventative health care

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## HIV and Hormones

- There are no significant drug interactions with drugs used to treat HIV.
- Several HIV medications change the levels of estrogens.
- Cross gender hormone therapy is not contraindicated in HIV disease at any stage.
- Transgender patients need ongoing care, not just access to hormones.

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## Gender Confirmation Surgery

- There are many kinds of surgery, but the general population focuses on genital reconstruction.
- Using the terms like "Pre-op" Post-op" and "non-op" tends to focus on genital surgery as a marker of "realness"
  - » This is not accurate. People pursue, or don't pursue, surgery for many reasons.
  - » Because surgery is so hard to access for those who do want it, trans people should not be defined by their surgical status.
- HIV alone should not restrict access to surgery (see [www.hbigda.org](http://www.hbigda.org))

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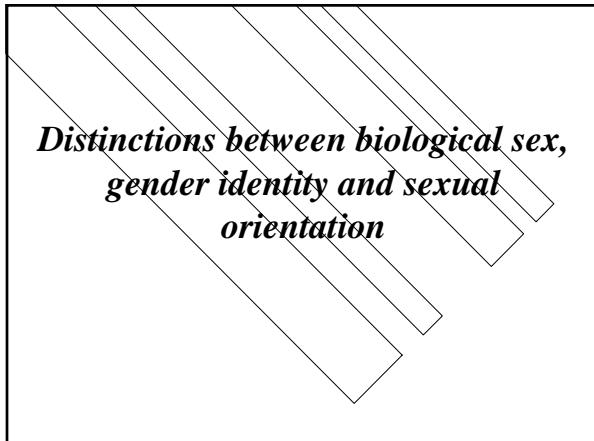
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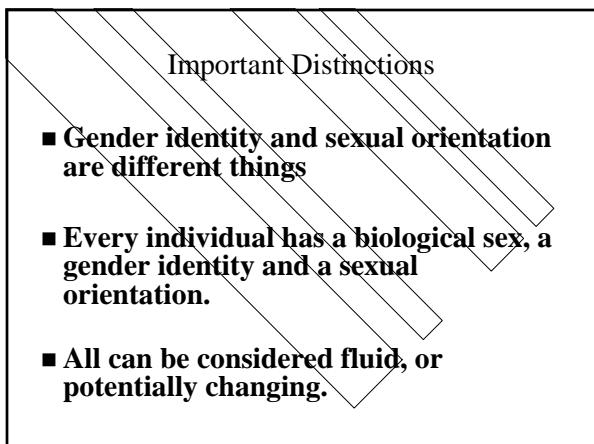
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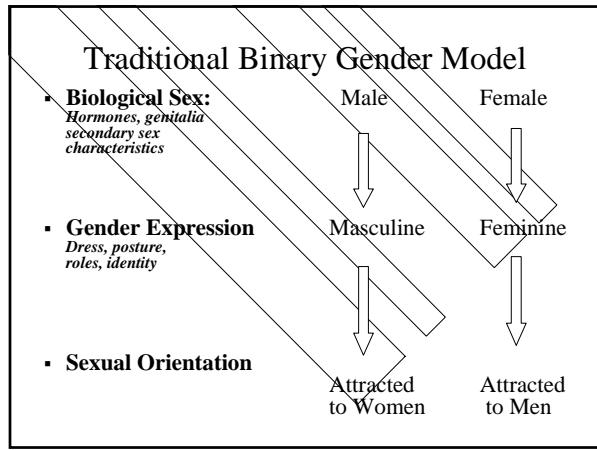
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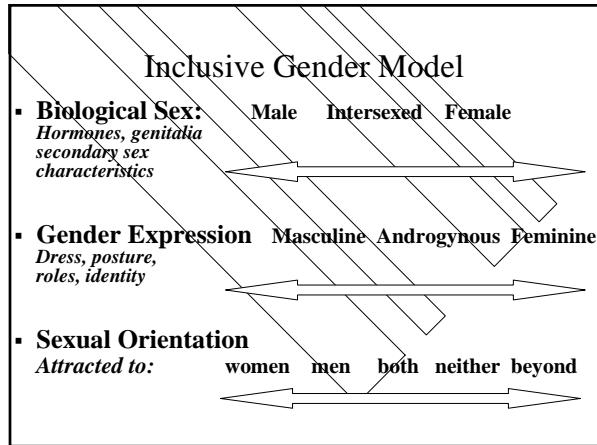
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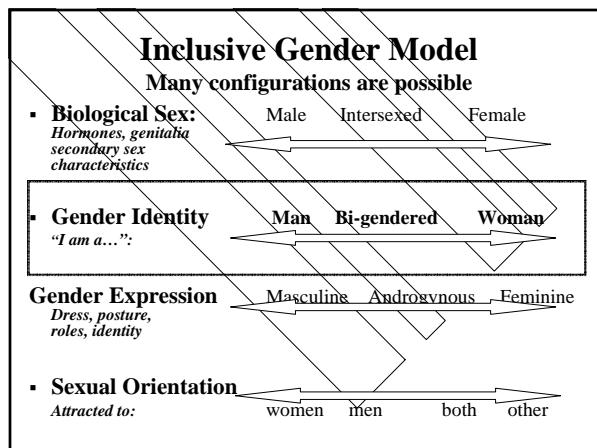
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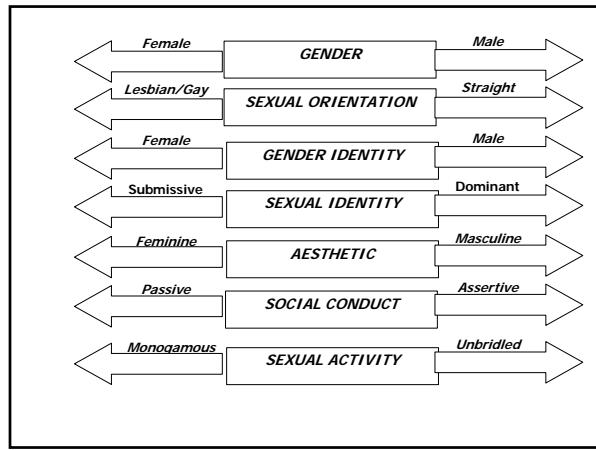
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### **Exercise/Discussion**

What do you call someone who?

...is biologically male, has a feminine gender expression, and is sexually attracted to men?  
Attracted to women?

...is biologically female, has a masculine gender expression, and is sexually attracted to men? To women?

Consider If their Gender Identity is as a Man  
Vs.  
If their Gender Identity is as a Woman.

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**Identity: “Who I Am” is central**

Gender Identity    Man    Bi-gendered    Woman

*“I am a...”:*

**IDENTITY:** is the crux.  
Not biological sex or assigned sex **But, who I believe myself to be.**

You can have two people with penises in the bed and not be homosexual if one of those people identifies as a woman and the other identifies as a man.

Their sexual orientation is based on their gender identity, not anatomy.

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**HIV Prevalence and Risks for Transgender People**

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**Multiple Risks**

Studies in several large cities have shown that transgender people, particularly trans women are at high risk for:

- Poverty and Unemployment
- Addiction
- Incarceration
- Homelessness
- **HIV Disease**

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## Rates for HIV

- Philadelphia: 4%-19%
- Los Angeles: 22%
- Houston: 27%
- Washington, DC: 32%
- San Juan: 14%
- Chicago: 14%-19%
- New York: 21%-30%

[www.transresearch.org](http://www.transresearch.org),  
collection of Trans HIV research maintained by  
Jessica Xavier, MPH

1996 San Francisco UCSF study:  
**35% among all MTFs;**  
**63% among African-American MTFs**  
(Clements-Nolle, Am. Journal of Public Health, June 2001)



## Risk Factors

- Social stigma
  - Discrimination, violence, poverty, isolation
- Survival sex work
  - Unprotected sex, substance use/abuse
- Gender validation through sex
  - Multiple partners, unprotected sex
- Lack of regular contact with providers
  - No regular screenings for HIV/STDs
- Multiple injection risks
  - Silicone, hormones, IDU

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## Barriers to Services

- Lack of information on real risks for trans people
- Mis-information within community
  - Low perception of risks
- Data collection has ignored trans identities.
  - Numbers drive funding and programs
- CDC has placed TG women in MSM category for funding and prevention programs
  - Thanks to years of advocacy by trans activists, CDC and state health depts have begun to address these issues

## Transgender vs. MSM

- Transwomen don't identify with messages targeting men.
- Transwomen have higher rates of discrimination in employment, housing and education.
- Greater avoidance of medical providers.
- HIV not highest priority. Health priority is access to trans care.
- High incidence of sex work and substance abuse

## FTM (Transmen) and HIV Risk

- Even fewer studies than for MTF Trans people
- Low prevalence in studies where included
- FTMs do engage in survival sex, IDU and sex with non-trans men
- Gay-identified FTMs have gender validated by sex with non-trans men.
- Lack of research and information on best ways to reach or serve transmen.  
(Minnesota study)

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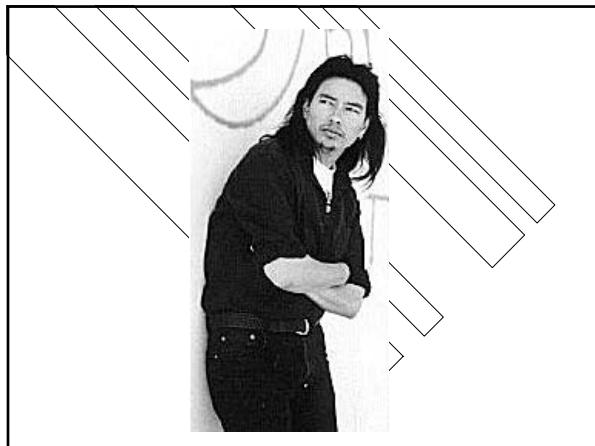
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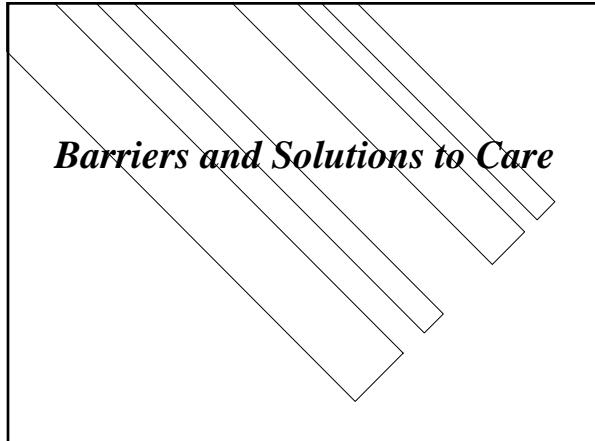
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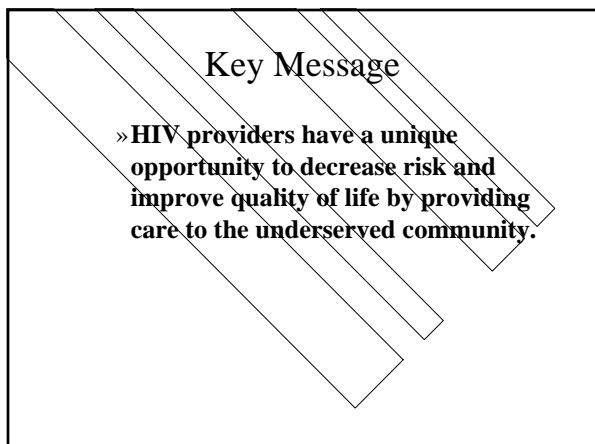
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### **Barriers to Care: For Providers**

- Lack of knowledge and information
- Personal discomfort
- Lack of clinical research, studies, literature
- Lack of agency support
- Not enough people doing the work
  - Fear of being inundated

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### **Barriers to Care: Patients**

- Fear of disclosure/exposure
- Social and geographic isolation
- History of bad experiences with health care providers
- In-take forms, office environment, alienating process
- Lack of insurance coverage
  - Even for those with insurance, Trans-related care is often denied in insurance policies.

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## Goal of Treatment

- To improve their **quality of life** by facilitating their transition to a physical state that more closely represents their sense of themselves.

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## Benjamin Standards

- HBIGDA: Standards of Care for Gender Identity Disorders
- 6th Version, 2001 ([www.hbigda.org](http://www.hbigda.org))
- Eligibility criteria for Hormones:
  - 18 years or older
  - Knowledge of Social and Medical Risks and Benefits
  - 3 months: Psychotherapy OR Real Life Experience.

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## Brainstorm on Trans-Friendly Care

In pairs, or moving brainstorm:

- 1) One or two things you can do to improve your knowledge/comfort in treating a transgender patient.
- 2) One or two things you can do to make your practice or site more trans-welcoming.

We will share insights!

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## Suggestions for Making Your Agency Trans-Friendly

- Don't just add "T" without taking it seriously.
- Train all staff--front office, security guards, director
- Make in-take forms trans friendly,
  - include "chosen name" not just legal name;
  - include more than M/F as gender choices, have range
- Challenge trans-phobia—in staff and community
- Have Trans-inclusive literature in waiting room
- Have Unisex bathrooms!
- Honor presenting gender and self-diagnosis
- Resource: Transgender Law Center:  
[www.transgenderlaw.org](http://www.transgenderlaw.org)

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## In closing...

- Acceptance is a learned process for us all
- Understand that the trans-communities are desperately seeking non-judgmental and caring educators, clinicians, employers, providers and allies
- Thank you for investing the effort to become one of those caring individuals.
- Closing thoughts from audience?

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Protocols for Hormone Therapy:  
TG Resources

- **HBIGDA/Harry Benjamin Standards of Care:** ([www.hbigda.org](http://www.hbigda.org))
- **Tom Waddell Transgender Clinic:** Tom Waddell and other clinics have developed protocols to help standardize and normalize care.  
(<http://www.dph.sf.ca.us/chn/HlthCtrs/transgender.htm>)
- Gender Education and Advocacy:  
<http://gender.org/>

Contact for more medical info:

- **Lori Kohler, MD**  
Associate Clinical Professor  
Department of Family and Community Medicine  
University of California, San Francisco  
Phone: (415) 476-2040  
Email: [LKohler@fcm.ucsf.edu](mailto:LKohler@fcm.ucsf.edu)
- HIV InSite (<http://hivinsite.ucsf.edu/>) for more information

**THANK YOU!**

*For more info contact:*

Jen Shockey, MPH or Danielle Castro



408-289-9260

[jen@chpscc.org](mailto:jen@chpscc.org)



[danielle@chpscc.org](mailto:danielle@chpscc.org)

[www.chpscc.org](http://www.chpscc.org)



## **BASIC TIPS FOR HEALTH CARE AND SOCIAL SERVICE PROVIDERS FOR WORKING WITH TRANSGENDERED PEOPLE**

1. **Outing:** Remember that revealing the transgendered status of any transgendered person without his or her expressed permission is outing that person, and it has the same potential for harm as outing a gay man, lesbian, or bisexual man or woman. Outing is Invasion of Privacy.
2. **Appearance:** Do not assume that someone who appears to be crossdressed is a "transvestite". Someone who appears to be crossdressed to you may or may not be living full-time in their presenting gender, or they may intend to do so in the future. The appropriate term for someone who engages in crossdressing on an occasional basis is *crossdresser*.  
**Usage Tips:** Instead of the stigmatizing "transvestite", use *Male Crossdresser* or *Female Crossdresser* if it's clear that they are not living full-time nor intend to do so.
3. **Living Status:** If a transgendered person is living full-time in a gender not associated with their birth sex (i.e., someone who appears to be a "man living as a woman" or a "woman living as a man") that person should be referred to at all times with terms appropriate to their presenting gender, regardless of their surgical status or body state (see below).  
**Usage Tips:** *Transgendered Woman* is appropriate for Male-To-Female persons.  
*Transgendered Man* is appropriate for Female-to-Male persons.  
*Transgendered Person* is appropriate for someone of either above types.  
*Transgendered People* is appropriate for mixed groups (both gender vectors).
4. **Surgical Status:** Almost all transsexuals – pre-operative, post-operative or non-operative – and many transgendered people are extremely sensitive about their surgical status and/or their body's physical state. Accordingly, questions about this should be avoided or, if medically necessary, asked very sensitively. Moreover, this information should be considered confidential and should not be shared with others unless it is medically necessary.  
**Usage Tips:** Regardless of their surgical status, the appropriate term for a Male-To-Female transsexual is Transsexual Woman, and for a Female-to-Male transsexual, Transsexual Man.
5. **Avoid Aspersion by Using Quotation Marks:** Never put the appropriate pronouns or possessive adjectives of transgendered persons in quotes. Never put their sexual orientations or genitalia in quotes.

**Main Office:**

P.O. Box 65  
Kensington, MD 20895

**West Coast Office:**

5245 College Ave, #142  
Oakland, CA 94618

**Southeastern Office:**

P.O. Box 33724  
Decatur, GA 30033

- 6. Pronouns and Possessive Adjectives:** It is extremely offensive to refer to transgendered persons using pronouns and possessive adjectives that refer to their birth sex (i.e., "he" or "his" for Male-To-Female persons, "she" or "her" for Female-to-Male persons). It is equivalent to calling a gay man a "faggot" or a lesbian a "dyke", or misperceiving or mislabeling anyone's gender.

**Usage Tips:** At all times, use pronouns and possessive adjectives appropriate to the gender expression presented by a transgendered person.

If you are uncertain, ask what they prefer.

Some transgendered persons, especially transgendered youth, prefer the new pronoun **ze** (pronounced "zee") in lieu of he/she, and the new possessive adjective **hir** (pronounced "here") in lieu of his/her.

- 7. Self-Identification:** Transgendered people are found in all races, classes, cultures and ages, and thus some variance in terminology should be expected. Self-identification is an important personal right, and many transgendered people like to describe themselves very uniquely. Accordingly, when in doubt, just ask an individual transgendered person how they wish to be identified.

**Usage Tips:** If you're not sure how to address someone, just ask: "Please excuse me, but I'm not sure how I should address you."

Or simply use their first name or last name. It's sometimes customary for patients or clients in clinical situations to be asked by their last name when it's time to see their providers.

- 8. Safer Sex Counseling:** If you're not sure about a transgendered person's anatomy, use sensitive terminology for both MTFs and FTM斯 that avoids specific anatomical references.

**Usage Tips:** Do you have unprotected genital-genital contact with an exchange of body fluids (including semen, vaginal fluids and ejaculate, or blood) ?

Do you have unprotected manual/genital contact (genital or anal fisting, hand jobs, masturbating your partner, etc.) ?

Do you have unprotected oral-genital contact (blow jobs, going down, etc.) ?

Do you have unprotected oral/anal contact (rimming) ?

Do you share an FTM prosthetic device, a dildo or other sex toy without washing OR without using or changing the condom ?

Do you have unprotected genital/anal contact (anal penetration) ?

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*GEA is a national nonprofit organization dedicated to improving the lives  
of all gender variant people regardless of their social identities.*



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## Transgender Law 101

### I. Identity Documents

#### A. State of the law

- Driver's License – name may be changed without a court order. Gender marker may be changed without applicant having undergone any form of prescription or surgical treatment. Medical service provider must sign DMV form 328. People under the age of 18 will need parental support to apply unless person is an emancipated minor.
- Social Security Number – name and gender marker may be changed with appropriate supporting documentation. Must be done at social security office.
- Common Law Name Change – while this method of changing a person's name is falling quickly into disfavor due to concerns about identity fraud, it remains a recognized method of a legal name change.
- Court Ordered Name Change -- allowed under California law (California Code of Civil Procedure sec. 1275 et seq.). No court can ask if the petitioner has undergone any medical procedure prior to requesting a change of name as no such requirement exists under California law. People under the age of 18 will need parental support to apply unless person is an emancipated minor. California court forms NC-100, NC-110, NC-120, NC-130 (additional forms necessary if a minor).
- “Legalizing” Gender – California allows anyone born in California to change the gender marker on a California birth certificate with an appropriate court order (California Health and Safety Code sec 103425 et seq). While the statute explicitly applies to people born in California, equitable jurisdiction has been held to give court authority to grant change of gender for people born outside of California. Some restrictions apply.
- Birth Certificate – name and gender marker may be changed pursuant to a court order. Old birth certificate is sealed and new one is issued (California Health and Safety Code sec 103425 et seq).
- Passport – name may be changed either with a court order or proof that the person has been using the name for the past five years (this last route to a name change seems to be a consistent practice, but not written policy seems to confirm it). Passport office has policy requiring “completed sex reassignment surgery” for issuance of a 10 year passport. No clear guidance on what this phrase means.

- Selective Service – transgender men seeking government support for programs like educational loans will need to get a waiver of selective service filing requirement. This can be done through submitting a Request for Status Information Letter available at [www.sss.gov/PDFs/SILForm.pdf](http://www.sss.gov/PDFs/SILForm.pdf).
- Immigration Service Records and Documents -- green card, visa, employment authorization, and/or naturalization certificate. All of these records can be changed. However, some confusion exists around what supporting documentation a person would need to do so.
- Non-government records (bank, credit cards, etc.) – each company will have its own policy, but few restrictions (mostly anti-fraud policies) should apply that would prevent a person from changing their name and gender with each of these institutions.

## **II. Marriage and Custody Rights**

### A. State of the law for marriage rights

- “Pre-Transition” Marriages – while the term “pre-transition” is an oversimplification for someone’s identity, it is used here to represent those marriages that are begun prior to a person transitioning. These marriages are strongly believed to remain valid. No case law or statute exists directly on point, however, California law is well settled that the only way to dissolve a marriage are divorce or death. Transition does not, by itself, dissolve a marriage.
- “Post-Transition” Marriages -- while the term “post-transition” is an oversimplification for someone’s identity, it is used here to represent those marriages that are begun after a person transitions. No explicit prohibitions exist in California or federal law to prevent a transgender person from entering into a heterosexual marriage. However, challenges – with mixed results -- have been made to the validity of marriages involving a transgender person in a number of cases across the U.S. The one case that has been fully litigated in California found that the underlying marriage was valid.
- While we have every reason to believe that the validity of marriages involving transgender people will be upheld in California, it is important that couples preserve as many rights as possible in the event that their marriage is ruled invalid upon challenge. Key steps to doing so include: a memorandum of understanding between the spouses, financial power of attorney, health care directive, and a will.

### B. State of the law for custody rights

- Biological children -- No explicit prohibition exists in California regarding the rights of a transgender person to retain custody or visitation rights to their biological child. However, a parent’s transgender identity is often an issue used in a custody hearing to the detriment of the transgender parent.
- Children of a Post-Transition Marriage – many times, the transgender spouse in a post-transition marriage will adopt children of the marriage via spousal rights. Occasionally, one partner will challenge the transgender parents rights or responsibilities to that child by attacking the underlying marriage. In addition to the arguments used in the post-transition

section mentioned above, additional arguments for finding parental rights and responsibilities exist in California law.

### **III. Employment and Housing** (TLC has a brochure for each area)

#### A. State of the law

- California – beginning on January 1, 2004, FEHA explicitly protects transgender people due to the passage of Gender Nondiscrimination Bill of 2003.
- Federal – likely, protection in Employment as sex under Title VII of the Civil Rights Act. Transsexualism and Gender Identity Disorder are *explicitly excluded* from protection under the ADA.

### **IV. Public Accommodation**

#### A. State of the law

- California – no explicit protection, but likely covered as sex and, when appropriate, disability under the Unruh Act (California Civil Code sec 1801 et seq.).
- Federal – unclear, but presumably protection exists as sex under Title II of the Civil Rights Act.

### **V. Immigration**

#### A. State of the Law

- General -- The Citizenship and Immigration Service (formerly the INS) does not bar transgender people from immigrating to the United States. As noted above, people can change the name and gender on their US immigration documents. While for years, “post-transition” marriages valid in the state in which they were performed were recognized for the purposes of fiancé and spousal visas. However, recent developments at the immigration service have cast doubts upon whether the service will continue to recognize them or not. (At time of publication, litigation is pending on this issue.)
- Asylum -- The Ninth Circuit has recognized transgender people’s ability to apply for asylum based on gender identity persecution.

### **VI. Police Conduct and Prison/Jail Conditions**

#### A. State of the law

- Street harassment – some police regulations and policies require officers to address transgender people by their proper name and pronoun. Searches of transgender people can not be done for the limited purpose of determining a person’s “biological gender.”
- Prison/Jail housing – as far as we know all California and federal prisons house inmates based on their “biological gender.” Often times, however transgender prisoners are housed in “soft cell” areas.

- Access to medicine and medical care - in California prisons, the stated policy of penal facilities is to maintain inmates on any medication they were taking when they were incarcerated. For jails, policies vary from county to county.

## **VII. Health Care** (TLC has a Medi-Cal pamphlet)

- A. State of the law
  - Private Health Insurance – private health insurance will often explicitly exclude coverage for transition related procedures. Insurance carriers that do not explicitly exclude coverage sometimes try to deny coverage based on claims that procedures are “cosmetic” or “experimental.” Such claims are unlikely to survive legal challenge.
  - Public Health Insurance -- Medicare denies coverage. No current case law explicitly prohibits these denials. Medi-Cal, however, should not be denying any funding requests from otherwise eligible recipients. Case law supports the position that such blanket denial by Medi-Cal (and any other state Medicaid health program) is unlawful.
  - Discrimination in the Provision of Care – many transgender people find that they face discrimination from their health care providers or staff members at clinics or hospitals. Such discrimination is likely illegal under Unruh.

## **VIII. Youth Issues**

- A. State of the law
  - A number of laws affect the ability of transgender people under the age of 18 to get treatment for and recognition of their gender identity. Many, but not all of these laws require that youth have permission of their parent or guardian unless they are emancipated. Youth are protected against gender identity based discrimination and harassment in a school setting (California Education Code 200).

*This document is intended to convey basic information about laws and regulations affecting our ability to express our gender identity. It is not intended to serve as legal advice. While every effort has been made to provide readers with accurate information, the law is often changing, especially in this area. Anyone with a specific legal question is strongly encouraged to contact the Transgender Law Center or another source of legal information to discuss the facts surrounding your particular circumstances.*

## **Transgender/Transsexual & GLBT Resources**

- **Wingspan:** Southern Arizona's Lesbian, Gay, Bisexual and Transgender Community Center. 300 E. 6th St., Tucson, AZ 85705. (520) 624-1779 (<http://www.wingspan.org>)
- **Southern Arizona Gender Alliance:** offers support, social, and discussion groups that reflect the various aspects of gender and society. These include educational forums and trainings for businesses, service providers, and community members to learn more about the issues facing transgender people and how our allies can be supportive and inclusive. The SAGA Speakers Bureau provides speakers and panelists for your class, event, business, or training. . c/o Wingspan, 300 East Sixth St. Tucson, AZ 85705. (520) 867-0083. (<http://www.sagatucson.org>)
- **Gender Education and Advocacy (GEA):** National educational resource on gender diversity, focused on the needs, issues, and concerns of gender variant people. Home of the renowned "Remembering Our Dead" pages. ([www.gender.org](http://www.gender.org))
- **PFLAG (Parents and Friends of Lesbians and Gays):** Provides support and resources to the parents, families, and friends of GLBT people. 1726 M St., NW, STE. 400, Washington, DC 20036. (202) 467-8180. ([www.pflag.org](http://www.pflag.org)) **Tucson chapter:** PFLAG Tucson, P.O. Box 36264, Tucson, AZ 8574 ([www.pflagtucson.org](http://www.pflagtucson.org))
- **Intersex Society of North America:** Education, advocacy, and support for intersex people. P.O. Box 3070, Ann Arbor MI, 48106-3070. ([www.isna.org](http://www.isna.org))
- **The International Journal of Transgenderism (IJT):** Multicultural, peer-reviewed journal of scholarly work in the area of transgenderism. Excellent source of medical, social, psychological documentation of the transgender issues. ([www.symplosion.com/ijt](http://www.symplosion.com/ijt))
- **Harry Benjamin International Gender Dysphoria Association, Inc. (HBIGDA):** Professional organization devoted to understanding and treatment of gender identity disorders. 1300 S. 2nd St. - Suite 180, Minneapolis, MN 55454. (612) 625-1500. ([www.hbigda.org](http://www.hbigda.org))

## **Recommended Reading**

- *True Selves: Understanding Transsexualism-For Families, Friends, Coworkers, and Helping Professionals* (1996). Mildred L. Brown, Chloe Ann Rounseley. Jossey-Bass. 350 Sansome St., San Francisco, CA 94104. (415) 433-1740.
- *Physician's Guide to Transgendered Medicine.* Dr. Sheila Kirk, MD (1996). Together Lifeworks. PO Box 93, Watertown MA, 02272-0093
- *Our Trans Children.* Xavier, J., Sharp, N., & Boenke, M. (1988). PFLAG: Parents, Families, and Friends of Lesbians and Gays. ([www.pflag.org](http://www.pflag.org))
- *Recommendations for treatment: Intersex infants and children.* (Pamphlet) Intersex Society of North America. ([www.isna.org](http://www.isna.org))
- *Transsexual Workers: An Employer's Guide.* Janis Walworth, MS (1998). Center for Gender Sanity. PO Box 451427, Westchester, CA 90045
- *Body Alchemy: Transsexual portraits.* (Photography). Loren Cameron (1996). Cleis Press. (800) 780-2279
- *Coping With Crossdressing.* JoAnn Roberts, Ed. (1992). Creative Design Services. (610) 640-9449

## **Other Publications Available from SAGA**

- *Gender Identity 101: A Transgender Primer* (Full version) Also available online at [www.sagatucson.org](http://www.sagatucson.org)
- *Trans In The Workplace: A Guide For Managers, Supervisors, and Human Resources Personnel* (brochure)
- *Trans In The Workplace: A Guide For the Transgendered, Transsexual and/or Gender-Variant Employee* (brochure)
- *TransMedia: Resources for Journalists*

# **Gender Identity 101: A Transgender Primer**

A resource guide for educators, health care professionals, businesses, social service organizations and interested allies & community members

## **Southern Arizona Gender Alliance**



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**Transgender** (or TG) refers to people whose appearance and behavior don't conform to the cultural "norm" for the gender into which they were born. In other words, TG people, to varying degrees, "transgress" cultural norms as to what a man or a woman "should be". Of course, not all people who transgress cultural norms in regards to gender are, or should be, considered TG as we are discussing here. In that case, that would include a male nurse or a woman who works as a pipe fitter. However, when transgender is used in the case of a "sexual minority", we are generally referring to one of the following five categories:

- **Transsexuals** were born into one gender but identify psychologically and emotionally as the other. Those born physically male but who present as female are called Male to Female or MTFs. Those born female but who present as male are called Female to Male or FTMs. The primary way transsexuals differ from other TG people is that in almost all cases, they seek to modify their bodies through hormonal treatments, Sexual Reassignment Surgery or both.
- **Intersexed** people were born exhibiting some form of "indeterminate" genitalia (subjectively judged so by a doctor to be either a clitoris that is "too large" or a penis that is "too small."), a combination of both male and female genitalia, or ambiguous chromosomes. At birth, the attending physician or parents (or both) "choose" which gender to raise the child, necessitating ongoing surgical and/or hormonal treatments.
- **Crossdressers** identify as, and are completely comfortable with, their physical gender at birth, but will occasionally dress and take on the mannerisms of the opposite gender. Most crossdressers are heterosexual men.
- **Drag Performers** dress and act like the "opposite" sex for the entertainment of an audience. For them, drag is a job - not an identity. Some are gay - some are not. Some identify as transgendered - most do not.
- **Gender blenders, bi-gendered, and others** - Some TG people find characterizations of gender more limiting than liberating. They may or may not identify as one or the other in a binary gender system and many times will assume a mixture of male and female dress and characteristics, combining elements of both.

## **Gender Identity & Sexual Orientation: What's The Difference?**

There is a great deal of unnecessary confusion about this. To put it simply, Gender Identity is who you are; Sexual Orientation refers to whom you love or have sex with. Some view them as two completely separate concepts. For others, the two are intricately entwined. Either way, what is most important to remember is that a certain gender identity does not necessarily mean a certain sexual orientation. A person who is TG may be gay, lesbian, bisexual or straight. Additionally, there are MTFs who identify as lesbian and FTMs who identify as gay men.

## **Hormones & Surgeries**

For some TG people, hormonal and/or surgical modifications are not necessary in order for them to express their gender identity. Others find that the financial costs are prohibitive, or that they have a physical condition that precludes their being able to take advantage of the procedures. And still others may object to hormonal and/or surgical modifications for personal, spiritual, or political reasons.

Of those who do elect to modify their bodies, hormones and Sexual Reassignment Surgery (SRS) are typically used. Hormones are controlled substances used to either masculinize or feminize physical characteristics and must be prescribed by a medical doctor. Various surgical procedures are also used by both MTFs and FTMs, ranging in cost from \$3,000 to over \$100,000 depending upon the procedure. Any medical doctor or psychiatrist can prescribe hormones once they determine their patient is suitable. However, SRS requires highly specialized surgical expertise and should be done only by those experienced in such procedures.

In order for a transsexual to receive hormones and SRS, they must, in most cases, go through stringent reviews by medical doctors and psychologists to determine if the person is indeed transsexual and if they are emotionally and psychologically suited for sexual reassignment.

## **Issues Facing Gender-Variant People**

- Few communities include "gender identity" or "gender expression" in their protection ordinances.
- Most insurance plans specifically exempt coverage for SRS, hormones, counseling and electrolysis, forcing TG people to cover all these expenses out of pocket.
- Of the fifty states, only Minnesota and Rhode Island protect TG people from job and housing discrimination.
- TG youth living on the streets are more likely than other youth to engage in prostitution or consensual sex with a variety of partners without using safe sex techniques.

## **How Do I Deal with a Transgender Person?**

- It is extremely important to refer to a TG person by the pronoun appropriate to their *presented* gender. When in doubt, ask. NEVER use the word "it" when referring to someone who is transgendered, either in their presence or to others when they are not present. To do so is incredibly insulting and disrespectful.
- Do NOT "out" someone (tell others that they are TG) without his or her permission. Also, do not assume that everyone knows. Some TG people "pass" very well and the only way someone would know would be if they were told. The decision to tell someone about their gender issues should be left to the TG person themselves.
- Never ask a TG person how he or she has sex or what their genitals look like. That is inappropriate in every situation.
- Do NOT assume a TG person is straight. Do not assume they are gay, lesbian or bisexual, either.

# what are the HIV prevention needs of male-to-female transgender persons (MTFs)?

## what does being transgender mean?

Transgender is an umbrella term used to describe persons who cannot or choose not to conform to societal gender norms associated with their physical sex.<sup>1</sup> Such individuals have gender identities, expressions or behaviors not traditionally associated with their birth sex. Transgender persons live their lives to varying degrees as their chosen gender and may self-identify as female, male, trans-women or -men, non-operative transsexuals, pre-operative transsexuals, transsexuals who have completed surgical sex reassignment, transvestites or cross-dressers, among others. These terms vary regionally and over time.

*Because male-to-female transgender individuals (MTFs) have higher rates of HIV-related risks and HIV than female-to-male transgender persons, this fact sheet will focus on MTFs.*

## Says who?

1. Gender Education and Advocacy. Gender Variance: A Primer. 2001. [www.gender.org/resources/dge/gea01004.pdf](http://www.gender.org/resources/dge/gea01004.pdf)

2. Clements-Nolle K, Marx R, Guzman R, et al. HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons in San Francisco: Implications for public health intervention. *American Journal of Public Health*. 2001;91:915-921.

3. Simon PA, Reback CJ, Bemis CC. HIV prevalence and incidence among male-to-female transsexuals receiving HIV prevention services in Los Angeles County (letter). *AIDS*. 2000;14: 2953-2955.

4. Elifson KW, Boles J, Posey E, et al. Male transvestite prostitutes and HIV risk. *American Journal of Public Health*. 1993;83:260-262.

5. Kellogg TA, Clements-Nolle K, McFarland W, et al. Incidence of Human Immunodeficiency Virus (HIV) among male-to-female transgendered persons in San Francisco. *Journal of the Acquired Immune Deficiency Syndromes*. in press.

6. McGowan CK. Transgender needs assessment. the HIV Prevention Planning Unit of the New York City Department of Health. December 1999.

7. Green J. Investigation into Discrimination against Transgendered People: A Report by the Human Rights Commission, City and County of San Francisco. 1994;1:8-10 & 43-52.

8. Nemoto T, Luke, D, Mamo L, et al. HIV risk behaviors among male-to-female transgenders in comparison with homosexual or bisexual males and heterosexual females. *AIDS Care*.1999;11:297-312.

## what places MTFs at risk?

Transphobia, or the pervasive social stigmatization of MTFs, greatly exacerbates their HIV risk. This intense stigmatization results in their social marginalization, which includes the denial of educational, employment and housing opportunities.<sup>7,8</sup> It also creates multiple barriers to accessing health care. Such marginalization lowers MTFs' self esteem, increases the likelihood of survival sex work and lessens the likelihood of safer sex practices.<sup>9</sup> All of this leads to high rates of HIV, STDs, drug use and attempted suicide.

MTFs primarily have sex with men and are likely to engage in receptive anal sex, which puts them at increased risk.<sup>2,3,10</sup> Some MTF sex workers are willing to not use condoms with their paying partners if they are offered more money.<sup>8</sup> However, some studies show that most unprotected sex occurs with primary partners, not paying partners.<sup>3</sup>

## what are barriers to HIV prevention?

Psychosocial factors such as poverty, low self-esteem, depression, feelings of isolation, rejection, and powerlessness are cited by MTFs as barriers to sexual and drug risk reduction. For example, many MTFs state that they engage in unprotected sex because it validates their female gender identity and boosts their self-esteem.<sup>10, 11</sup>

For many MTFs, securing employment and housing are more pressing issues than HIV and must be addressed before HIV prevention efforts can be effective.<sup>11</sup> Many transgender individuals do not access HIV prevention or health services due to the insensitivity of service providers and health care staff<sup>11,12</sup> or fear of being revealed as transgender.<sup>13</sup> Some HIV prevention programs for MTFs face challenges renting space due to transphobia.

## what's being done?

The Transgender Resources and Neighborhood Space (TRANS) Project, at the Center for AIDS Prevention Studies (CAPS) in San Francisco, CA, provides workshops addressing substance abuse, HIV, commercial sex work, self care and general life skills. It also hosts an informal drop-in center where clients can relax, shower and socialize. MTF outreach workers facilitate all activities. The Project collaborates with Walden House Transgender Recovery Program, which provides expanded therapy, counseling, mentorship programs and life training skills that address the unique needs of MTFs.<sup>14</sup>

*The Program in Human Sexuality (PHS) at the University of Minnesota developed and evaluated a community-based program for MTFs based on the health belief model and eroticizing safer sex. Although the program was well received, feedback from participants stressed the need for a comprehensive health-based approach because clients' concerns around gender overrode their HIV concerns. PHS now offers All Gender Health seminars based on a sexual health model that address HIV risk in the context of participants' lives and cover topics such as stigmatization, dating, sexual functioning, substance abuse and violence. They combine education with entertainment, featuring MTF celebrities and MTF health professionals.<sup>15</sup>*

The Transgender Harm Reduction Program in West Hollywood, CA, conducts outreach to MTFs at risk--both those living on the streets and in the suburbs. The program consists of outreach, community skills building workshops, mentoring and job training. Workshop topics include grooming and hygiene, legalization and documentation, health care and hormone therapy, as well as explicit HIV risk reduction. Implicit in the program is the importance of increasing self esteem in order to adopt safer behavior.<sup>16</sup>

*Gender Identity Support Services for Transgenders (GISST) in Boston, MA, has been serving HIV- and HIV+ individuals since 1993. GISST provides AIDS education, HIV testing, alcohol and drug rehabilitation, counseling, job training, social skills, social acceptance and gender identity counseling. They host luncheons on topics such as surgery and hormones, featuring speakers, videos and clients sharing experiences.<sup>17</sup>*

## what more should be done?

Societal fear and intolerance toward transgender persons severely limit the ability of many MTFs to lead healthy lives. Some cities and states have enacted transgender anti-discrimination laws in housing and employment, and areas without such laws should consider this. Transgender activism and advocacy have helped advance these changes.

*Peer-based prevention efforts for MTFs should be developed and evaluated, including: 1) late night/early morning outreach for sex workers; 2) needle exchange programs that offer hormone syringes; and 3) individual and group interventions that focus on the psychosocial barriers to HIV risk reduction. Hiring and training MTFs for prevention programs would provide much-needed employment opportunities to this community as well as facilitate culturally appropriate HIV prevention efforts.<sup>12</sup>*

Making hormone therapy more accessible may be a good way to encourage MTFs to use health services where they could obtain HIV prevention information. Such interventions will be most effective if they are coupled with housing, education and employment efforts. Prevention efforts need to include partners and friends of MTFs.

*MTFs have been invisible in the Centers for Disease Control and Prevention (CDC) HIV classification system, showing up as either men who have sex with men or heterosexual women. Transgender-specific categories need to be included on all federal and local data collection forms.*

There is a great need for transgender sensitivity training for all public service providers, including doctors, nurses and clinic staff (receptionists), and law enforcement and emergency services workers (police, paramedics, firefighters). Advocacy for increased access to health care and cultural relevancy within research, policy work and education have been cited as ways to improve transgender health.<sup>18</sup>

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## **Transgender Health and the Law:** Identifying and Fighting Health Care Discrimination

### **Health Care Access**

Like most people in the United States, transgender and gender non-conforming people have great difficulty securing affordable, comprehensive health care. The situation is compounded by systemic discrimination and health care providers' lack of basic cultural competency on transgender issues. Gender identity discrimination in the form of ignorance, insensitivity, and outright bigotry is alienating and keeps people from accessing medically necessary care, such as hormone therapy, surgery, and mental health services. Health care injustice has life-long effects on people's ability to learn, work, and care for themselves mentally and physically.

### **What is Gender Identity Discrimination?**

Gender identity discrimination in health care settings occurs when you are denied equal access to health care and services, and/or you are subjected to a hostile or insensitive environment because you are, or are perceived to be, transgender or gender non-conforming. Such discrimination may be compounded with discrimination based on other characteristics (i.e. race, sex, sexual orientation, disability, etc.). Some examples of gender identity-related health care discrimination are: 1) being denied complete or partial health insurance coverage; and 2) inappropriate treatment from health care providers, facilities, or community-based organizations.

### **Discrimination in Private Health Insurance<sup>1</sup>**

#### **Denial of Coverage**

Many transgender people have their applications for health insurance denied when they disclose their transgender status or transition-related medical history (such as hormone level tests) to a potential insurer. Such denial of coverage is most common when applying for a private individual plan, but could also happen when applying for employer-based and other group plans. If your application for coverage is denied on the basis of your transition-related medical history or transgender status, you may have some legal recourse. Depending on the reason given for the

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<sup>1</sup> This section of this pamphlet pertains particularly to private health insurance. TLC has a separate publication on public health insurance titled: *Medi-Cal and Gender Reassignment Procedures*.

denial, you may be able to take action against the insurance company. Contact TLC for suggestions on filing an appeal.

### **Treatment Exclusion for Transgender-Related Care and Services**

Most health insurance policies still specifically exclude transgender-related care and services. This often means that you will not be covered for procedures like: hormone therapy, transition-related surgery, and/or gender identity-related mental health services. While the legality of such exclusions is not yet clear, you do have options other than filing a lawsuit. If you are denied coverage under one of these exclusions, you should file a timely appeal with your insurance company. Filing such an appeal can be time-consuming, but it generally costs little, if any, money. Even if you do not prevail, the information you provide about the medical necessity of the procedures you have requested helps educate the insurer about transgender health issues, thus advancing transgender access to health care. TLC can give you some suggestions on how to file a comprehensive appeal.

If transgender-related care and services are not specifically excluded in your policy, your insurance company might still deny the claim on the basis that these procedures are considered cosmetic or experimental. However, in deciding cases related to Medi-Cal, California courts have determined that transition-related procedures are neither cosmetic nor experimental. If your insurance company has used this explanation to justify denial of coverage, contact TLC about appealing the decision.

### **Treatment Exclusion for Non-Transgender Services**

Unfortunately, some insurance companies broadly interpret language excluding transgender-related care and services to deny coverage for non-transition-related procedures for transgender individuals. Insurers justify these exclusions by stating that your current medical problem is somehow related to your transition. For example, the insurer might argue (often times without any proof) that liver damage or blood clotting results from hormone therapy. Or, they may refuse to cover expenses related to a defective breast implant on the basis that the implant was “elective surgery.” While the law is unclear in this area, such a denial is likely a violation of your policy. If your insurance company has used this explanation to justify denial of coverage, contact TLC about appealing the decision.

### **Treatment Exclusion for “Gender-Specific” Services**

Because the U.S. health care system largely overlooks the needs of transgender people, certain health care services are believed to be accessed only by men and other services only by women. This system of binary gender designation can be problematic for transgender health care recipients. Sometimes, transgender patients will have trouble scheduling certain appointments (such as an FTM getting a gynecological appointment) or making sure that they receive thorough examinations (such as an MTF having to remind her primary care physician to test her for prostate cancer).

And all too often, transgender people are denied coverage for medically necessary procedures because their documented gender does not correspond to the “gender-specific” service. Female-to-male transgender people, in particular, may have difficulty obtaining gynecological services or treatment for gynecological cancers. If you experience a denial of this sort, you should not hesitate to appeal it. Contact TLC if you would like assistance preparing your appeal.

### **Should I Change My Gender Marker on My Current Insurance?**

Because of such problems, many transgender people are rightfully concerned about changing the gender marker in their medical records to reflect their gender identity. Changing the gender marker on your insurance is likely to alert the insurance company that you are transgender, and could possibly jeopardize your benefits. We urge you to contact TLC before doing so.

### **Which Gender Marker Should I Use When I Sign Up With A New Insurer?**

The unfortunate reality is that regardless of what your gender marker is in your health records, it is possible that you will face denial for gender-specific procedures. FTMs who list their gender as male may have no trouble receiving testosterone, but may not be able to access gynecological services, or vice versa. Similarly, MTFs who designate female in their medical records may access female hormones but not care for prostate or testicular cancer. If you want to discuss what avenue might be best in your situation, contact TLC.

### **Discrimination by Providers of Health Care and Services**

In addition to being denied health insurance coverage, you may experience gender identity-related health care discrimination when seeking care and services from doctors, nurses, hospital staff, and/or other health care providers (such as acupuncturists, chiropractors, or mental health therapists). Gender identity discrimination can also occur in residential/long-term care facilities (such as mental health or drug treatment facilities) and public health community-based organizations (such as HIV prevention agencies).

Discriminatory conduct can include: inappropriate name or pronoun use, invasive inquiries about your genitalia or transgender status, denial of access to the restroom or housing facility that corresponds to your gender identity, use of epithets, and/or hostile or intimidating behavior. Some examples of discrimination are: being forced to revert to the gender you were assigned at birth in order to access health care, or having a dentist or ear/nose/throat doctor ask questions about your genitals.

Since most medical schools and other health care training programs do not educate their students on transgender health issues, this kind of inappropriate behavior happens too often. While state law is not explicit on this issue, such conduct is likely illegal. If you experience this kind of discrimination, you can contact TLC or you can contact one of the following agencies:

**The Department of Fair Employment and Housing** is the state agency that investigates complaints of discrimination, including discrimination in public accommodations. They can be reached at 1-800-884-1684. You can find out more information about them at [www.dfeh.ca.gov](http://www.dfeh.ca.gov).

**The Medical Board of California** is the state agency that licenses and investigates misconduct of a variety of health care professionals in California (see a list of which professionals at [www.medbd.ca.gov](http://www.medbd.ca.gov)). The Board can also accept discrimination complaints against health care professionals and will send an advisory letter to a professional when a complaint is filed. To file a complaint, call 1-800-633-2322.

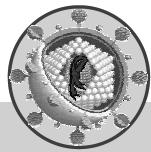
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This pamphlet was produced by TLC's Health Care Access Project (HCAP), a joint effort of TLC and The California Endowment. If you have questions about HCAP or would like to book a free workshop on transgender health law issues, contact Willy Wilkinson at [Willy@transgenderlawcenter.org](mailto:Willy@transgenderlawcenter.org).

The information in this pamphlet is not meant to substitute for advice from an attorney or appropriate agency. Because of the changing nature of the law, we cannot be responsible for any use to which it is put.

July 2004





# HIV Care & Prevention 2006

*By the end of this session, participants will be able to:*

**(PINE) Co-morbidities and HIV**

*Edward Brooks, MD, MPH: Ira Greene Positive PACE Clinic, Medical Director of San Jose AIDS Education & Training Center*

- Describe the changing patterns in the morbidity and mortality of HIV-infected individuals in the setting of prolonged survival in the HAART era
- Understand the impact of co-infection with hepatitis C (HCV) on HIV, and HCV natural history and treatment outcomes
- Understand the evolving burden of both AIDS-defining and non-HIV associated malignancies
- Gain familiarity with the metabolic syndromes associated with HIV infection and antiretroviral therapy
- Provide an update on the risk of cardiovascular disease in HIV-infected individuals

**(CEDAR) Oral Health Screening & Dental Referrals: Issues for the Primary Care Provider**

*Ann Lyles, DDS, Peninsula Operations Manager: Community Dental Care, Faculty: San Jose AIDS Education & Training Center*

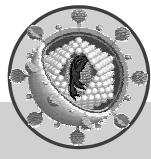
- Understand the importance of oral health as an integral part of total patient care
- Use a simple oral health screening tool to recognize urgent oral health issues, including signs of methamphetamine use and acute symptoms of HIV infection
- Utilize credible sources for dental referrals and consultations in the South Bay area
- Provide appropriate information when referring someone for dental care

**(FIR) HIV & Women: Improving the Quality of Prevention and Care**

*Kathleen Clanon, MD, Medical Director: Alameda County Medical Center Combined HIV Services and East Bay AIDS Education & Training Center*

- Understand the most current trends relative to HIV risk factors and transmission among women in the South Bay area in comparison to other parts of the Bay area, the state of California, and the United States
- Distinguish gender-specific barriers to accessing HIV prevention and care services
- Identify principles of HIV therapy during pregnancy and strategies for prevention of mother-to-child transmission





# HIV Care & Prevention 2006

## **Edward Michael Brooks, MD, MPH**

Dr. Edward Brooks received his Bachelor of Arts in Biology from Cornell University and his Master in Public Health from University of California at Berkeley. He earned his Doctor of Medicine from University of California at Davis. Currently, Dr. Brooks is the Associate Chief of AIDS Medicine at Ira Greene PACE Clinic of Santa Clara Valley Medical Center and serves as the Medical Director for the San Jose AIDS Education & Training Center. He is also a Clinical Instructor at Stanford University's School of Medicine. At today's HIV Care & Prevention 2006 conference, Dr. Brooks speaks on "Co-Morbidities and HIV."

## **Ann M. Lyles, DDS**

Dr. Ann Lyles is the managing dentist for Community Dental Care, a clinic for HIV-positive residents of San Mateo County. She is a graduate of the University of Southern California's School of Dentistry and completed a General Practice Residency at Los Angeles County's University of Southern California. Dr. Lyles is now an Adjunct Clinical Assistant Professor at the USC School of Dentistry where she served as Director of the Special Patients Clinic for three years. She has also been an attending faculty member for the University of the Pacific's Advanced Education in General Dentistry Clinic in Union City. Dr. Lyles has worked with the San Jose AIDS Education and Training Center as an expert faculty member and trainer for 8 years. At today's HIV Care & Prevention 2006 conference, she speaks on "Oral Health Screening and Dental Referrals: Issues for the Primary Care Provider."

## **Kathleen Anne Clanon, MD, FACP**

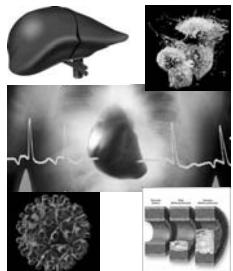
Dr. Kathleen Clanon received her Bachelor of Arts in English from the University of California at Berkeley, and a Doctor of Medicine from University of California at Davis. Since 1988, she has been working as a primary care physician and overseeing other clinicians in care of people with HIV. Moreover, Kathleen has been responsible for establishing and maintaining multidisciplinary HIV prevention and care programs for low-income people, including the development of new programs and securing annual funding. In addition, since 1989, she has been the principal trainer and Director of the East Bay AIDS Education and Training Center, for which she is responsible for developing and delivering curricula for physicians, nurses, and other health professionals on care of people living with HIV. At today's HIV Care & Prevention 2006 conference, she speaks on "HIV and Women: Improving the Quality of Prevention & Care."





HIV Care and Prevention 2006

## Comorbidities and HIV



Edward Brooks, MD  
Ira Greene PACE Clinic  
Santa Clara Valley Medical Center

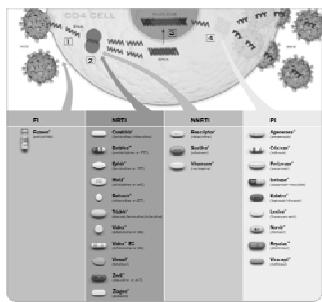
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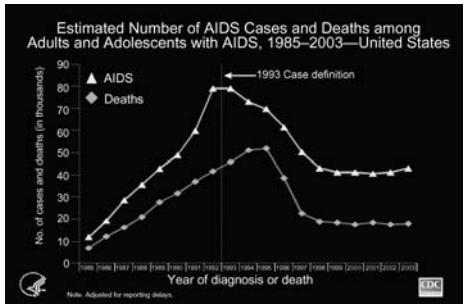
## Objectives

- Describe the changing patterns in morbidity and mortality in the setting of prolonged survival in the HAART era
- Understand the impact of co-infection with hepatitis C on HIV and HCV treatment outcomes
- Understand the evolving burden of both AIDS-defining and non-HIV associated malignancies
- Gain familiarity with metabolic syndromes associated with HIV infection and antiretroviral therapy
- Provide an update on the risk of cardiovascular disease in HIV-infected individuals

## The HAART Era



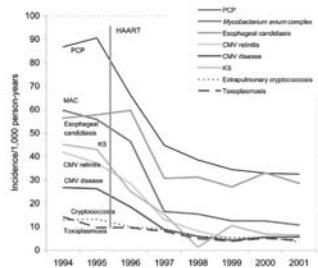
## Declining Morbidity and Mortality



## AIDS-Defining Illnesses

- Candidiasis of bronchi, trachea, or lungs (see Fungal Infections)
- Candidiasis, esophageal (see Fungal Infections)
- Cervical cancer, invasive\*
- Coccidioidomycosis, disseminated (see Fungal Infections)
- Cryptococcosis, extrapulmonary (see Fungal Infections)
- Cryptosporidiosis, chronic intestinal (>1 month duration) (see Enteric Diseases)
- Cytomegalovirus disease (other than liver, spleen, or lymph nodes)
- Cytomegalovirus retinitis (with loss of vision)
- Encephalopathy, HIV-related\* (see Dementia)
- Herpes simplex, chronic ulcer(s) (>1 month duration) or bronchitis, pneumonitis, or esophagitis
- Histoplasmosis, disseminated (see Fungal Infections)
- Isosporiasis, chronic intestinal (>1 month duration) (see Enteric Diseases)
- Kaposi's sarcoma
- Lymphoma, Burkitt's
- Lymphoma, immunoblastic
- Lymphoma, primary, of brain (primary central nervous system lymphoma)
- Mycobacterium avium complex or disease caused by *M. Kansaei*, disseminated
- Disease caused by *Mycobacterium tuberculosis*, any site (pulmonary† or extrapulmonary†) (see Tuberculosis)
- Disease caused by *Mycobacterium*, other species or unidentified species, disseminated
- *Pneumocystis carinii* pneumonia
- Pneumonia, recurrent\* (see Bacterial Infections)
- Progressive multifocal leukoencephalopathy
- *Salmonella* septicemia, recurrent (see Bacterial Infections)
- Toxoplasmosis of brain (encephalitis)
- Wasting syndrome caused by HIV infection?

## Declining Morbidity from Opportunistic Infections



Morris A, Lundgren JD, Masur H, Walzer PD, Hanson DL, Frederick T, et al. *Emerg Infect Dis* 2004

## Trends in HIV Mortality

- Deaths in a cohort of HIV-infected individuals compared in 1990 to 2003
- Deaths from AIDS-defining conditions declined from 80% in 1990 to 56% in 2003
- Proportion of non-HIV related deaths increased from 9% to 32%
- Cancer was second leading cause of death in 2003
- Deaths from heart disease increased from 8% to 22%
- Increases observed in deaths from diabetes, hepatitis and anal cancer

Crum NF et al, *J Acquir Immune Defic Syndr* 41: 194 - 200, 2006.

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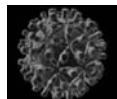
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## Comorbidities and HIV:



### Hepatitis C

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## Mortality Due to Liver Disease in HIV-Infected Individuals

- Retrospective review of causes of death in HIV-positive patients in 1991 compared to 1998/99
- 50% of deaths in 1998/99 due to ESLD compared to 11.5 % in 1991
- ESLD the leading cause of death of HIV+ patients in 1998/99; 93.8% were HCV+
- 55% of those who died of ESLD in 1998/99 had CD4 > 200 or undetectable viral load

Bica I et al, *CID* 32: 492-7, 2001

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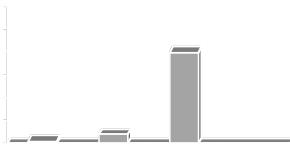
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## Mortality Due to Liver Disease in HIV-Infected Individuals



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## Epidemiology of Hepatitis C

- 3.9 million in U.S. have been infected with HCV
- New estimate puts this number as high as 5 million\*
- 2.7 million have chronic HCV infection
- 36,000 new infections per year
- 70% of infected have chronic liver disease
- Leading cause of death from liver disease
- 8-10,000 deaths annually

\*Edlin B. Abstract 44. Presented at: 56th Annual Meeting of the American Association for the Study of Liver Disease; Nov. 11-15, 2005; San Francisco.

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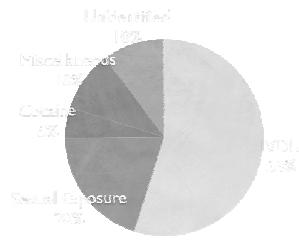
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## Risk Factors for HCV Infection



Bronkhorst MV, Pacific AETC

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## Prevalence of HCV in Select Groups

- Injection drug-users: 52-90%
- Hemophiliacs: 60-85%
- Homosexual males: 4-8%
- Incarcerated persons: 32%
- HIV+ individuals: 30-40%

Bronkhorst MV, Pacific AETC

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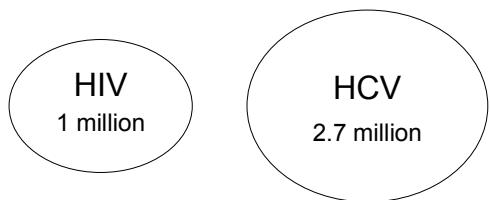
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## Coinfection with HIV and HCV



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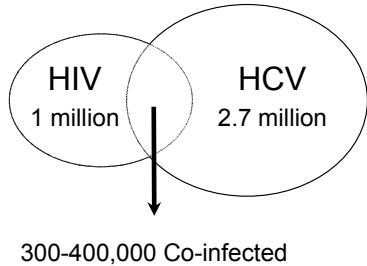
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## Co-infection with HIV and HCV



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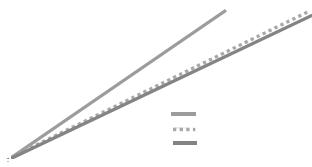
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## Effect of Co-infection on HIV Outcomes

- London cohort: Co-infected individuals had higher likelihood of AIDS-defining illness or decline in CD4 to < 200 (Stebbing J et al, *CID* 41(6): 906-911, 2005)
- VA Cohort: Risk of death in co-infected patients on HAART was 30-80% higher (Backus LI et al, *J AIDS* 39(5): 613- 619, 2005)
- EuroSIDA Cohort: No difference in virologic control or CD4 responses, but higher risk of liver disease-related deaths (Rockstroh JK et al, *J Infect Dis.* 2005;192:992-1002)
- NCI Meta-analysis: Mean increase in CD4 after 48 weeks of HAART was 33 cells/mm<sup>3</sup> less in co-infected patients (Miller MF et al, *CID* 41(5):713-20, 2005)

## Effect of Co-infection on HCV Outcomes



## Effect of Co-infection on HCV Outcomes

- VA Cohort study of HCV mono-infected versus HCV/HIV co-infected patients
- Prior to HAART, co-infection was a predictor of progression to cirrhosis (HR = 1.48)
- In the HAART era, co-infection is not a significant predictor of cirrhosis (HR = 0.99)

Kramer JR et al, *Am J Gastroenterol.* 2005;100:56-63.

## Effect of HAART on HCV Outcomes

- Brescia HIV Liver Cohort: 60% co-infected with HCV
- 36% of all deaths 1997-2004 were liver-related
- 96% of the liver-related deaths occurred in patients co-infected with HCV/HIV
- HAART reduced the risk of liver-related death by 68%

Puoti M et al, 2nd Intl Workshop HIV/HCV Coinfection, Amsterdam, abstract 3, 2006.

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## Effect of Co-infection on HCV Outcomes

- In the setting of HCV-associated cirrhosis, the risk for development of hepatocellular carcinoma (HCC) is 1-4% per year
- VA Cohort of co-infected patients
- Incidence of hepatocellular carcinoma in either the pre- or post-HAART era is similar in mono-infected versus co-infected patients (RR 1.04)

Kramer JR et al, *Am J Gastroenterol*. 2005;100:56-63.

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## Effect of Co-infection on HCV Outcomes

- Italian cohort of HIV-infected individuals with hepatocellular carcinoma
- Median age at diagnosis was 42, compared to 65 in the HIV-negative controls
- Time to diagnosis following estimated first exposure to HCV was 10 years shorter than reported for HIV-negative patients
- There was a higher prevalence of multifocal and infiltrating lesions, and a higher rate of extrahepatic metastases (OR = 11.8)
- Survival was shorter in HIV-infected patients (HR = 1.63)

Puoti M et al, *AIDS* 18:2285-93, 2004

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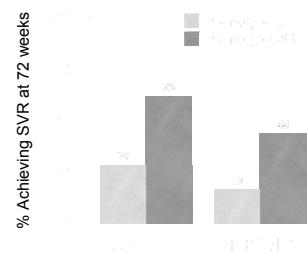
## Treatment of HCV Infection

- Standard of care is 24-48 week course of weekly SC pegylated interferon in combination with daily oral ribavirin
- Goal is sustained virologic response (SVR) at week 24 post-treatment
- 50-60% success rate for HCV genotype 1
- 80-90% success rate for HCV genotypes 2/3
- In U.S., genotype 1 is the most common

## HCV Treatment Outcomes in Co-infected Patients

- **APRICOT Trial** (Torriani FJ et al, NEJM 351: 438-50, 2004)
  - Interferon alfa-2a tiw + ribavirin vs.
  - Pegylated interferon alfa-2a + placebo vs.
  - Pegylated interferon alfa-2a + ribavirin
- **RIBAVIC Trial** (Carrat F et al, JAMA 292: 2839-48, 2004)
  - Interferon alfa-2b + rivavirin vs.
  - Pegylated interferon alfa-2b + ribavirin

## HCV Treatment Outcomes in Co-infected Patients



## Predictors of HCV Treatment Success

- Non-genotype 1 HCV
- Low HCV viral load (< 800,000)
- Absence of cirrhosis
- CD4 T-lymphocyte count > 500
- HIV viral load < 10,000
- Age < 40
- Elevated AST

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## Adverse Effects of HCV Therapy

- Flu-like symptoms
- Nausea
- Anemia/cytopenias
- Depression/mood lability
- Decreased CD4 T-lymphocyte levels
- Thyroiditis

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## Exclusion Criteria for HCV Therapy

- Ongoing alcohol or drug use within prior 6 months
- Active psychiatric illness
- Active medical illness or recent opportunistic illness
- CD4 Lymphocyte count < 200
- Decompensated cirrhosis
- Severe anemia, neutropenia or thrombocytopenia
- Pregnancy

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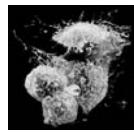
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## Rates of Treatment in HIV/HCV Coinfection

- Boston Medical Center (Fleming CA et al, CID 36: 97-100, 2003)
  - Of 149 coinfected patients referred for HCV treatment, only 29% were eligible
  - Of the eligible patients, only 16 enrolled in treatment
- Veterans Affairs VACS-3 Cohort (Fultz SL et al, CID 36: 1039-46, 2003)
  - Only 30% of 300 patients with coinfection were referred to GI for evaluation
  - Of those not referred, 73% had contraindications to treatment
  - Of those referred, 30% were eligible, but only 2 patients or 3% received treatment
- Alameda County (K Clannon, MD)
  - 1.8% of 271 coinfect ed patients treated for HCV in 2000

## Comorbidities and HIV:

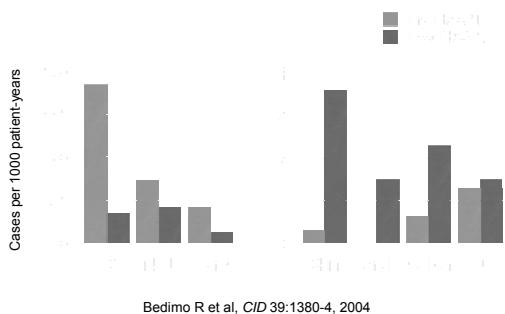


### Malignancies

#### AIDS-Defining Malignancies

- Kaposi's Sarcoma
- Non-Hodgkin's Lymphoma
- Primary CNS Lymphoma
- Invasive Cervical Cancer

## Trends in Cancer Incidence



Bedimo R et al, *CID* 39:1380-4, 2004

## Non-Hodgkins Lymphoma

- Currently the most common AIDS-related malignancy
- 11-15% of all deaths in HIV+ patients in the HAART era
- Aquitaine Cohort-France:
  - 25% of cases in patients with CD4 > 350
  - Reduced risk of NHL associated with:
    - Receipt of HAART for ≥ 6 months
    - Undetectable viral load

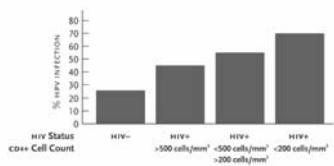
Bonnet F et al, *CID* 42:411-17, 2006

## Cervical Cancer

- Rate of cervical cancer 5 times higher in HIV+ women
- Most common malignancy in HIV+ women
- SIL in HIV+ women are more frequent, of higher grade and progress more rapidly
- WIHS Cohort: 40% of HIV+ women had abnormal PAP smears (17% in HIV- women)
- HPV present in 58% compared to 26%

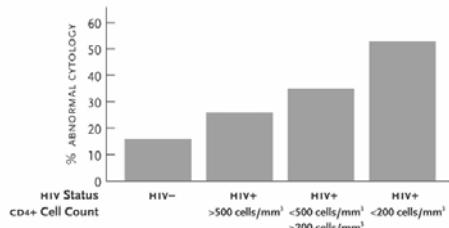
Palefsky JM et al, *J Natl Cancer Inst* 91:226-39, 1999.

## Cervical Cancer



Palefsky JM et al, *J Natl Cancer Inst* 91:226-39, 1999.

## Cervical Cancer



Palefsky JM et al, *J Natl Cancer Inst* 91:226-39, 1999.

## Effect of HAART on Cervical Cancer

- Heard I et al, *AIDS* 12(12): 1459-64, 1998
  - Prevalence of SIL declined from 69% to 53% after median of 5 months on HAART
- Minkoff, H et al, *AIDS* 15(16): 2157-64, 2001
  - 40% of women on HAART showed regression of HPV-associated cervical lesions
- Moore AL et al, *AIDS* 16(6): 927-9, 2002
  - Prevalence of cervical abnormalities increased from 55% to 62% after 6 months of HAART

## Reducing Cervical Cancer Risk

- Obtain PAP smear twice in the first year following diagnosis of HIV
- If normal, then continue annual PAP smears
- More frequent screening in women with history of abnormal PAP
- Colposcopy and biopsy for all abnormal PAP results
- WIHS Cohort: No difference in incidence of cervical cancer between HIV+ and HIV- women

Massad LS et al, *AIDS* 18(1): 109-13, 2004

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## Anal Cancer

- Rate in general population is 0.8 per 100,000
- Incidence in gay men prior to HIV epidemic was 35 per 100,000
- Risk for HIV+ men is double or 70 per 100,000
- Risk is 6.8 times higher for HIV+ women and 37 times higher for HIV+ men

Palefsky J, *The PRN Notebook* 9(2): 24-31, 2004

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## Anal Cancer

- Anal HPV infection found in 93% of HIV+ MSM and 61% of HIV- men
- In women rates of anal HPV were 76% and 42% respectively in WIHS cohort
- In one cohort, new cases of HSIL occurred in 15% of HIV+ men and 5% of HIV- men in < 2 years
- Risk of HSIL was 7.5 times higher in men with a CD4 < 500

Palefsky J, *The PRN Notebook* 9(2): 24-31, 2004

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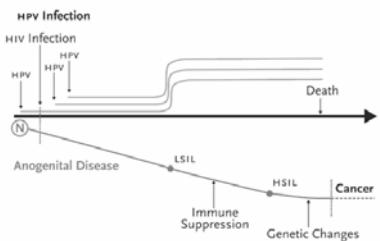
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## Effect of HAART on Anal Cancer

- Palefsky JM *Semin Oncol* 27:471-9, 2000
  - HIV+ men with ASIL 6 months after starting HAART:
  - 57% had no change, 21% had regression, 13% progressed
- Bower M, et al, *J AIDS* 37: 1563-65, 2004
  - No difference in anal cancer incidence or survival pre-HAART vs. post-HAART
  - 67% of anal cancer in post-HAART era occurred in patients on HAART

## Anal Cancer



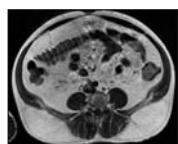
Palefsky J, *The PRN Notebook* 9(2): 24-31, 2004

## Reducing Anal Cancer Risk

- Sensitivity of anal cytology (PAP) equal to cervical PAP (80%)
- Correlation of grade of dysplasia to actual biopsy pathology not completely accurate
- Anal cytology twice in first year, then annually for all HIV+ men and women
- Follow anal PAP with digital rectal exam to evaluate for palpable lesions
- Evaluate abnormal cytology results with high resolution anoscopy and biopsy

Palefsky J, *The PRN Notebook* 9(2): 24-31, 2004

## Comorbidities and HIV:



### Metabolic Syndromes

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## Metabolic Disorders in the HAART Era

- Lipodystrophy
- Insulin Resistance/Diabetes
- Dyslipidemia
- Cardiovascular Disease

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## Lipodystrophy

- Body fat distribution abnormalities occurring in HIV+ patients receiving HAART
- Prevalence estimated at 40-50%
- Associated with protease inhibitor and non-nucleoside reverse transcriptase inhibitor use
- A variety of host factors including age, gender, baseline BMI, and duration of HIV infection may contribute

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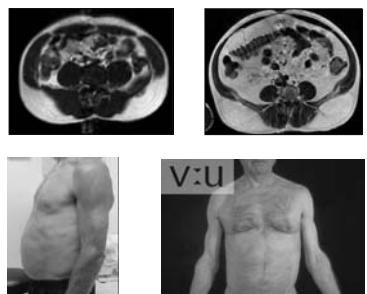
## Lipodystrophy

- Lipoatrophy
  - Loss of subcutaneous fat in the limbs and face
  - Characterized by weight loss, prominent veins in extremities
- Lipohypertrophy
  - Increased intra-abdominal visceral fat
  - Dorsocervical fat pad or "buffalo hump"

## Lipoatrophy



## Lipohypertrophy



## Lipohypertrophy



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## Etiology of Lipodystrophy

- Antiretroviral Medications
- Alterations in gene expression
- Mitochondrial dysfunction
- Cytokine activation
- Immune dysregulation
- Hormonal alterations
- Genetic predisposition

Kotler DP, <http://clinicaloptions.com/2004lipos>

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## Treatment of Lipodystrophy

- Modification of antiretroviral therapy
- Surgical correction
- Exercise
- Thiazolidinediones and metformin
- Treatment of hypogonadism
- Treat co-morbid metabolic disorders?

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## Treatment of Lipodystrophy



d4T      TDF

Zhong L, et al. EACS 2005. Abstract PE9.3/5.

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## The Spectrum of Insulin Resistance

- Impaired glucose tolerance:
  - Glucose 140-199 mg/dL two hours after glucose challenge
  - Often have normal fasting glucose levels
- Impaired fasting glucose:
  - Fasting glucose of 100-125 mg/dL
- Diabetes:
  - Fasting glucose  $\geq$  126 mg/dL or glucose  $\geq$  200 after glucose challenge

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## Insulin Resistance and HIV

- Multicenter AIDS Cohort Study
  - 14% prevalence of diabetes among HIV-positive individuals
  - 5% prevalence among HIV-negative controls
  - Risk of developing diabetes 4.4 times higher among HIV-positive individuals

Brown TT et al, *Arch Intern Med* 165: 1179-84, 2005

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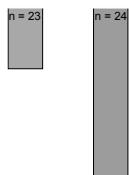
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## Insulin Resistance and Protease Inhibitors

- Patients naive to protease inhibitor use:
  - 24% impaired glucose tolerance
  - 0% diabetes
- Patients receiving protease inhibitors:
  - 47% impaired glucose tolerance
  - 13% diabetes

Behrens G et al, AIDS 13: F63-70, 1999

## Insulin Resistance and Protease Inhibitors



Noor MA et al, Lipodystrophy Workshop 2005. Abstract 16.

## Insulin Resistance and Lipodystrophy

Prevalence of Metabolic Abnormalities in HIV-infected Patients With Lipodystrophy.<sup>[51]</sup>

Clinical Feature	HIV-infected Subjects With Lipodystrophy, % (n = 71)	Framingham Control Subjects, % (n = 213)	P Value
2-hr glucose level > 140 mg/dL	35.2	5.2	.001
2-hr glucose level > 200 mg/dL	7.0	0.5	.01
Cholesterol level > 200 mg/dL	67.1	48.1	.03
Triglyceride level > 200 mg/dL	57.1	8.9	.001
HDL level < 35 mg/dL	45.7	16.9	.001

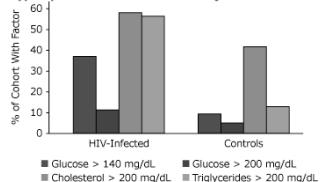
HDL, high-density lipoprotein.

Note: HIV-infected subjects and control subjects matched for age and body mass index.

Hadigan C et al, C/D 32: 130-9, 2001

## Dyslipidemia and HIV

Figure 2. Abnormal oral glucose tolerance and hyperlipidemia in HIV-infected subjects on HAART<sup>[2]</sup>

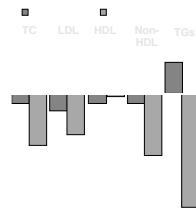


Grinspoon S et al, *Trends Endocrinol Metab* 12: 413-19, 2001

## Dyslipidemia and Protease Inhibitors

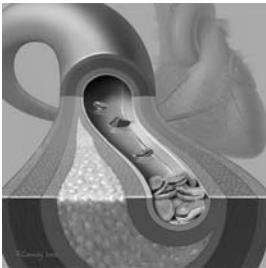
- Behrens G et al, *AIDS* 13: F63-70, 1999
  - 57% of patients receiving protease inhibitors had hyperlipidemia
- Mulligan K et al, *JAIDS* 23: 35-43, 2000
  - Increase in cholesterol of 32 mg/dL (23%)
  - 27% increase in LDL cholesterol

## Dyslipidemia and Protease Inhibitors



Gatell J et al, EACS 2005. Abstract PS1/1.

## Cardiovascular Disease and HIV



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## Risk Factors for Coronary Artery Disease

- Age: > 55 for women, > 45 for men
- Diabetes
- Family history of heart disease
- Hypertension
- Smoking
- Total cholesterol > 240 or HDL <35

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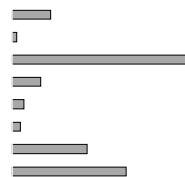
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## Risk Factors in HIV-Positive Individuals



Fris-Moller N et al, AIDS 17: 1179-93, 2003

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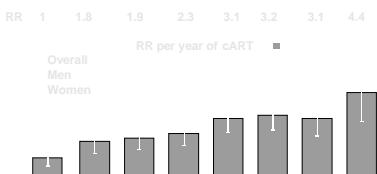
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## Cardiovascular Disease and HAART



El-Sadr W et al, 12th CROI. 2005. Abstract 745.

## Cardiovascular Disease and HAART

- Incidence of MI:
  - Unexposed to HAART: 1.39 per 1,000 patient-years
  - HAART  $\geq$  6 years: 6.07 per 1,000 patient-years
- Similar risk in men and women
- Similar risk in younger vs. older patients
- Relative risk of MI 1.10 per each year of HAART even when controlled for lipids

El-Sadr W et al, 12th CROI. 2005. Abstract 745.

## Reducing Cardiovascular Risk

- Address lifestyle risk factors including diet, exercise and smoking
- Baseline fasting lipid panel, recheck 3-6 months after initiating new HAART
- If goal lipid levels not achieved:
  - Consider modifying antiretroviral therapy
  - Initiate statin and or fibrate therapy

Dube MP et al, CID 37: 613-27, 2003

## Questions?

Edward Brooks, MD  
Ira Greene PACE Clinic  
Santa Clara Valley Medical Center  
[embrooks@sbcglobal.net](mailto:embrooks@sbcglobal.net)  
(408) 885-4694

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Ann Lyles, DDS

HIV Care and Prevention 2006  
Breakout Session Outline

*Oral Health Screening & Dental Referrals:  
Issues for the Primary Care Provider*

Reasons for making a dental referral:

1. ADA guidelines - Adults should have at least one oral examination and two dental cleanings per year
2. Oral lesions require treatment and could be signs of serious systemic conditions
3. Oral health problems affect quality of life issues like eating, communication and ability to work.
4. Dentists can promote HAART compliance and identify compliance issues

Common oral health conditions affected by HIV

1. Xerostomia, leading to rapid caries progression, and worn and fractured teeth
2. Fungal, viral and bacterial infections

Steps for Oral Health Screening and Referral - refer to handouts:

1. Adult Oral Health Screening Guide
2. Adult Oral Health Screening Form
3. Referral for Dental Treatment

# Adult Oral Health Screening Guide

\*Ask patient to remove dentures/plates

## Extraoral:

### **General**

Asymmetry of face, head or neck

### **TMJ**

Popping or clicking, tenderness

Deviation on opening or closing

### **Salivary glands**

Swelling or tenderness

### **Lymph nodes**

Swelling or tenderness

### **Lips**

Color, texture, ulcerations or growths

Dryness, white or red cracked areas in corners of mouth

## Intraoral:

### **Buccal and labial vestibules**

Lift upper lip, pull down lower lip

Use tongue blade to check left and right

Color, texture of gingiva and mucosa

Swelling

Raised or ulcerated lesions, growths

### **Tongue**

Ask patient to stick out tongue

Discolored, coated or eroded dorsum

Pattern of papillae

Grasp with gauze to check lat. borders

White, red lesions on ventral surface

Palpate tongue for unusual masses

### **Floor**

Elevate tongue, check color, texture

Palpate

### **Palate**

Patient's mouth open wide

Check with and without direct light

Examine hard and soft palate

Color, texture changes

Raised or ulcerated areas, growths

### **Pharynx**

Have patient yawn/inhale through mouth

Color, texture variations

Swelling, ulcerations, growths

### **Teeth**

Missing, loose or fractured teeth

Brown to black spots on teeth

Tartar buildup, esp. lower lingual

Plaque or food debris

Temporary fillings

## Quick questions to screen for dental needs:

- Have you seen a dentist for a checkup and cleaning in the past year? Five years?
- Are you having any pain in your mouth right now? When you eat or drink?
- Do your gums bleed when you brush your teeth?
- Do you have any dentures or plates?

## Reasons to refer for oral health care:

- Tooth decay may not hurt till it's too late to save the tooth. Chronic gum disease may not hurt at all. Early referral can save teeth, prevent infection and maintain good nutrition.
- Gum disease and tooth decay progress very rapidly in people with HIV because the virus and medications can change the flow and composition of saliva.
- Oral abscesses can cause fever, sinus infection and airway obstruction.
- Painful teeth or sore gums can prevent consumption of a healthy diet.
- Poorly-fitting dentures cause abnormal outgrowths of the gums, ulcerations and fungal infections. Dentures require maintenance at least once a year to ensure proper fit and good hygiene.

## Adult Oral Health Screening

Note to patient or guardian: This oral health screening was not completed by a licensed dentist. No x-rays were taken. A screening is just a quick look to identify urgent needs and does not take the place of a complete examination by a dentist. Serious oral health problems may be missed in a brief visual screening. A complete dental examination is recommended at least once a year, even if you have no dental pain.

	No visible signs of oral problems. See your dentist at least once a year.
	Visible signs of oral problems. Recommend evaluation by a dentist within a month.
	Visible signs or patient related symptoms of urgent oral needs. <b>Recommend immediate evaluation by a dentist.</b>

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Patient: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Evaluator: \_\_\_\_\_ Date of evaluation: \_\_\_\_\_

Reasons for referral:	Yes	No	Unable to assess	Dental referral type
Oral pain				Urgent care
Possible gum abscess or boil				Urgent care
Large cavities/caries				Urgent care
Small cavities/caries				Early care
Discomfort while eating				Early care
Oral soft tissue lesions				Early care
Missing or broken fillings or crowns				Early care
Fractured teeth				Early care
Broken or painful dentures				Early care
Inflamed or bleeding gums				Early care
Missing teeth				Routine care
Presence of plaque or food debris				Routine care
Denture maintenance				Routine care
Last dental exam or cleaning >1 year ago				Routine care

## Referral for Dental Treatment

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

1. Please send CBC with differential and most recent HIV-1 RNA PCR to the dentist.
2. Diagnosis:  HIV+ asymptomatic       HIV+ symptomatic       AIDS
3. Please list all medications this patient takes (or attach a list):  
 None
4. Is this patient at risk for prolonged bleeding after minor surgical procedures?  
 Yes     No      \* Please send a coagulation panel if one has been done.
5. Is this patient known to have active tuberculosis?  
 Yes     No      Date of negative PPD, sputum or chest x-ray \_\_\_\_\_
6. Is this patient at risk for bacterial endocarditis during or following procedures that cause bacteremia? (i.e., prosthetic heart valve, previous bacterial endocarditis, MVP with regurgitation, etc.)    **What is the condition requiring prophylaxis?**  
 Yes     No
7. Do you feel that this patient's immune status is so compromised that prophylactic antibiotics should be given before procedures that cause bacteremia (i.e. abs neut<500)?  
 Yes     No
8. Please list any types of substance abuse you are aware of and current recovery status:  
 None
9. Please list any psychiatric conditions this patient has:  
 None

Thank you for helping to ensure the safest possible dental treatment for our patient.

Name of person completing form (please print)

Phone number

Signature

Date





## *HIV and Women: Improving the Quality of Prevention and Care*



K. Clanon, MD  
[Kclanon@jba-cht.com](mailto:Kclanon@jba-cht.com)  
4/4/06

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### **Agenda**

- Epidemiology and Transmission
- HIV Treatment in Women
- Pregnancy and Family Planning
- Psychological and Social Considerations

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### **Epidemiology and Transmission**

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## U.S. Totals

- CDC estimates 1 million people in U.S. are living with HIV.
- Estimates of new cases vary widely, but approx. 15,000 per year is commonly quoted.

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## CDC HIV/AIDS Surveillance Report

- 32% of new adult cases of HIV infection are in women
- Of new cases among women, African Americans and Latinas account for 77%
- Fourth leading cause of death among women age 25 to 44.

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## HIV Transmission Risk Behaviors for Women U.S.

- Heterosexual - 62%
  - African American - 63%
  - White - 18%
  - Hispanic - 18%
  - Other - 1%
  - Primary risk behavior for all age groups of women
- IVDU - 35%
- Other - 3%

CDC 2000. Pennsylvania/Mid-Atlantic AETC

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## Santa Clara County

There are 1558 known people living with AIDS in S.C.C., 11% women.

From 7/02-6/04, 845 cases of HIV were reported in S.C.C., 14% women.

Why the difference in AIDS % women vs HIV % women?

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## HIV Transmission Risk Behaviors for Women S.C.C.

- Heterosexual – 65.5%
- IVDU – 16.8%
- Other – 4.4%
- Unknown – 13.3%

*S.C.C. Public Health Dept 2005*

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## Do Women Know their HIV Risks?

U.S. Women newly diagnosed with AIDS 2004

- IDU 20%
- Heterosexual Contact 37%
- *Unknown* 42%

In previous years, with further info  
the unknown risk category for women  
reclassified as follows:

- IDU 27%
- Heterosexual contact 68%

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## Risk Factors for Male to Female HIV Transmission

- Anal Intercourse
- Lack of male circumcision
- Genital ulcers (syphilis, herpes simplex, chancroid)
- Sexually Transmitted Diseases
- Multiple sexual partners

Pennsylvania/Mid-Atlantic AETC

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## Special Considerations

- Early Adolescent
  - immaturity of the female genital tract increases risk of transmission
- Women over 50 years of age
  - atrophic vaginitis caused by decreased lubrication
  - older women may not perceive themselves at risk

Pennsylvania/Mid-Atlantic AETC

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## Young People are at Risk for HIV

New diagnosis of HIV in 2002-04

Santa Clara County

1.8% were age 13-19

29.2% were age 20-29

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## **What Works for Prevention?**

- Condoms, male and female
- Needle exchange
- Preventing and treating other STIs (esp. in young, sexually active population.)
- Circumcision (reduces risk for the uncircumcised.)
- HAART, keeping viral load low
- Behavioral counseling

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## **Female Controlled Barriers**

- Nonoxynol -9 showed increases in transmission.
- Female condom not generally useable in stealth mode, and is expensive.
- Female condom reusable 11 times (cleaned with bleach and water.)
- Polyurethane, so can be used by couples with latex allergy in either partner.

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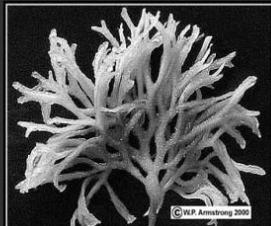
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## **What is Carraguard™ ?**

- Population Council's lead candidate microbicide
- Derived from seaweed (carrageenan)
- Packaged in single-dose Micralax® applicators



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## Epidemiology Resources

- **World:** [www.unaids.org](http://www.unaids.org)
- **U.S.:** [www.cdc.gov](http://www.cdc.gov)
- **Santa Clara County:**  
[www.sccphd.org](http://www.sccphd.org)

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## Presentation and Natural History



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## Presentation & Natural History What's Different?

- Less K.S.
- More thrush/esophageal candida (30% increase compared to men)
- More herpes simplex
- More Tb
- More bacterial pneumonia

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## Viral Load: Men vs. Women

Metanalysis of 13 studies; total 6702 men and 3894 women

- 9 cross-sectional studies showed .13-.35 log lower v.l. in women vs. men with same CD4
- 4 longitudinal studies showed .33-.78 log lower v.l. in women vs men with same CD4
- Controlled for age, race, risk, and use of ART.

Gandhi, et al; *Clin Infect Dis*, Aug 1 2002

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## Viral Load: Men vs. Women

DHHS Guidelines 11/03:

In patients with CD4>350,  
“Clinicians may wish to consider  
lower plasma HIV RNA thresholds  
for initiating therapy for women.”

If CD4 >350, sex differences are  
minimal, so usual therapy is  
recommended.

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## HAART in Women

- More rashes and more hepatitis in women with nevirapine.
- Fat redistribution; more accumulation, less atrophy.
- DHHS Guidelines: avoid efavirenz if trying to get preg or might get preg.

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## HIV-Related Gynecological Conditions

- Vaginal candidiasis
- Human Papilloma Virus
- Genital Ulcers
- Pelvic Inflammatory Disease
- Cervical Dysplasia/Neoplasia
- Menstrual Disturbances

*HRSA:BPHC & AETC  
Pennsylvania/Mid-Atlantic AETC*

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## Diagnostic Studies

### ■ Pap smear

- two studies the first year of diagnosis
- annually if normal
- recommended every 6 months if HIV is symptomatic

### ■ Colposcopy

*USPHS/IDSA 2001  
Pennsylvania/Mid-Atlantic AETC*

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## Pregnancy and Family Planning

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## **Preconception Counseling/Care for HIV Infected Women of Childbearing Age**

- Goal:
  - Optimal maternal health for pregnancy
  - Stable, maximally suppressed VL
- ACOG advocates preconception counseling for all women of childbearing age as a part of primary care
- Effective contraception, if wanted, to reduce unintended pregnancy
- Counsel about perinatal transmission risks, prevention strategies, potential effects of HIV treatment on pregnancy and infant
- Screen for and treat infectious diseases, STDs

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## **Preconception Care (continued)**

- Begin or modify ARV therapy
  - Avoid ARV medications with toxicities to developing fetus
  - Choose those that reduce the risk of transmission
  - Evaluate/control for therapy-associated side effects
- Evaluate and prophylax for OIs, give immunizations as needed
- Optimize maternal nutritional status, start folic acid supplementation
- Screen for maternal psychological and substance abuse disorders

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## **Perinatal HIV Transmission May Occur**

- Antepartum (25-24%)
  - during pregnancy
- Intrapartum (65-75%)
  - during labor
  - during delivery
- Postpartum-through breast feeding (rare in US)

HRSA:BPHC & AETC

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## Perinatal HIV Transmission in the U.S.

- Rate was 16-25% in early 1990's
- 11% in 1995 when AZT Rx started
- <2% now, with modern Rx
- Still 280-370 babies per year born with HIV in the U.S.

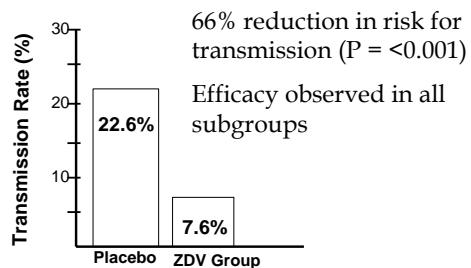
## ACTG 076

A phase III randomized placebo-controlled trial of zidovudine (ZDV) for the prevention of maternal-fetal HIV transmission

Treatment regimen

- **Antepartum**  
100 mg ZDV po 5x day, started at 14-34 weeks gestation
- **Intrapartum**  
During labor, 1-hour initial dose 2 mg/kg IV followed by continuous infusion of 1 mg/kg/hr until delivery
- **Postpartum/infant regimen**  
2 mg/kg po q 6 hr for 6 weeks, start 8-12 hours after birth

## Results of ACTG 076



## **Follow-up of Uninfected Infants in ACTG 076: ZDV versus Placebo**

- No significant difference in growth
- No difference in CD4 and CD8 counts between groups
- No differences in Bayley developmental scores in uninfected infants in ACTG 219
- Follow-up of infants with exposure to nucleoside analogues is ongoing due to the potential for mitochondrial toxicity
- In the U.S., no cases of mitochondrial toxicity have been identified

## **Follow-up of Women in ACTG 076**

- Median follow-up 4.2 years
- No substantial differences in CD4 count, time to progression to AIDS, or death in women who received ZDV compared to those who received placebo

## **Reducing HIV Transmission with Suboptimal Regimens**

- Partial ZDV regimens: (New York cohort)
  - Transmission rates
    - 6.1% with prenatal, intrapartum, and infant ZDV
    - 10% with only intrapartum ZDV
    - 9.3% if only infant ZDV started within first 48 hours
    - 26.6% with no ZDV

## Pregnancy and MTCT (Mother to Child Transmission)

DHHS Guidelines 11/05: Use HAART if

- Woman meets usual criteria for HAART.
- Woman has viral load >1000.
- Low v.l.<1000 and use of HAART have **independent** effects on reducing MTCT.

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## Pregnancy and MTCT

DHHS Guidelines: If viral load <1000 off HAART, options include:

- Usual HAART
- Dual nucs (CMBV)
- Mono AZT

**Last two are controversial!**

*DHHS Guidelines 11/05*

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## MTCT

### DHHS Guidelines:

- Avoid efavirenz.
- Include AZT if at all possible if so.
- Remember AZT/D4T antagonism.
- Avoid ddI/d4T due to lactic acidosis.
- OK to wait until week 10-12 to start.

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### **Julia P.**

24 yo in supportive relationship with boyfriend. Unplanned but welcome pregnancy now week 8. Not on HAART. CD4 400, V.L.571c. No comorbidities.

*Recommendations?*

*How would you counsel her?*

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### **Yvonne R.**

34 yo with spotty prenatal care due to schizophrenia. Not clear she has taken ARVs. Now presents in labor.

*Recommendations?*

*If you had seen her earlier, what would you have recommended during pregnancy?*

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### **Antepartum/Intrapartum Management Considerations**

- Avoid amniocentesis
- Avoid premature rupture of membranes
- Avoid fetal scalp monitoring
- Delay episiotomy

HRSA:BPHC & AETC  
Pennsylvania/Mid-Atlantic AETC

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## Rapid Testing at Delivery to Late-Presenting Women

- High risk of perinatal transmission in women without antenatal care and without HIV counseling and testing
- Rapid HIV test should be available for this group
- ARV prophylaxis should be initiated as soon as possible after a positive rapid HIV test (before confirmatory test results are available)

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## Cesarean Section to Reduce Perinatal HIV Transmission

- Pregnant women should be counseled re: potential benefits and risks of scheduled C/S to reduce perinatal transmission
- C/S reduces transmission in women with unknown VL who are not on ART or are receiving only ZDV
- May be effective in women with VL $\geq$ 1000 copies/mL; unproven benefit in women on ART

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## Cesarean Section to Reduce Perinatal HIV Transmission

- Unclear whether scheduled C/S offers any benefit to women on ART with VL  $\leq$ 1000 copies/mL, given the low transmission rate
- Complications of C/S somewhat more frequent than in HIV-uninfected women
- Patient's decision should be respected

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## After Pregnancy

**Stop HAART or not?**

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## HIV and Contraception

Condoms alone or with:

- IUDs
- Diaphragms
- BCPs
- Injectables

*DHHS Guidelines 2003, www.hivatis.org*

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## BCP and HAART

- RTV, NFV, LPV/RTV, NVP, and EFV can decrease levels of estradiol components.
- Recommend the use of progestin agents instead (Micronor or Ovrette, Depoprovera, Norplant.)
- Plan B should be used over Preven for emergency contraception.

*DHHS Guidelines 2003, www.hivatis.org*

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## Psychosocial Considerations



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## How Well Are We Doing?

1999 CDC info presented at ICAAC:

- 91% of U.S. pts in care were on ART
- 29% on HAART had V.L. <50
- 51% had V.L. <5000

*Bozzette, oral presentation 9/02*

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## How Well Are We Doing?

Groups with higher likelihood of detectable virus:

- Women
- People of color
- IDU's
- People on Medicaid

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## Why are women among these groups?



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## Challenges in Caring for Women with HIV

- Statistically economically poorer than men
- More likely to be single parents
  - lack of child care
  - lack of support
- More likely to be uninsured

HRSA:BPHC & AETC  
Pennsylvania/Mid-Atlantic AETC

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## Why these groups?

Higher mortality/morbidity clearly associated with:

- HAART not prescribed or poorly prescribed (access to expert clinician.)
- Adherence to HAART.
- Starting HAART at CD4>200.

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## **Impact of Adherence**

Hogg et al

2403 PWHIV with longitudinal  
pharmacy refill data avail.

Each 10% decrease in refill adherence  
assoc with 16% increase in risk of  
death (P<.001)

*San Francisco, 7th CROI 2000, abs 73*

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## **Maria H.**

28 year old with a 2 year old son.

- Currently pregnant 20 weeks with a wanted child.
- HIV tested at her prenatal clinic and found to be positive.
- Her Ob advised her to terminate the pregnancy and referred her to you for further follow-up.

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## **Maria H.**

- She has told no one in her family, including her husband.
- Maria's baseline PE is normal except for small, mobile cervical lymph nodes.
- Labs T4=250 viral load 10,000

*What are some of the issues you are  
considering in these first visits?*

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### **Non-medication issues**

- Social isolation
- Testing son and husband/sexual partner
- Counseling re: risk to fetus
- Domestic violence/economic dependence
- Others?

*How would you approach  
these issues with her?*

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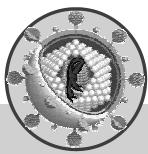
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# HIV Care & Prevention 2006

*By the end of this session, participants will be able to:*

## **(FIR) Pain Control and Substance Use in HIV Patients**

*Kelle Brogan, MD, Medical Director: St. Mary's Hospice of Northern Nevada and Palliative Care at St. Mary's Regional Medical Center in Reno, NV*

*Neil Flynn, MD, MPH, Professor of Clinical Medicine, Medical Director, Principal Investigator: AIDS Education & Training Center, University of California at Davis*

- Identify common pain syndromes in persons living with HIV/AIDS and address the implications of health habits on the amount of pain relief obtained
- Improve their understanding of state of the art pharmacological strategies for treatment of pain in persons living with HIV/AIDS
- Address barriers and challenges to effective pain management while working with substance using and/or addicted clients
- Identify examples and strategies of aberrant behavior in chemically dependent patients living with HIV/AIDS
- Integrate alternative and complimentary medicinal treatment strategies into comprehensive care

## **(PINE) Recognizing Acute HIV Infection: Issues for the Primary Care Provider**

*Javeed Siddiqui, MD, MPH, Director of HIV Tele-Medicine Services: University of California at Davis*

- Recognize the manifestations of acute and chronic HIV infection
- Identify effective risk assessment strategies and testing methods for establishing a diagnosis
- Acknowledge the importance of timely health maintenance practices and access to health care services

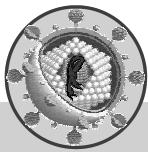
## **(CEDAR) Advancing Prevention Strategies to Respond to HIV/AIDS Issues in the Asian American and Pacific Islander (AAPI) Community**

*Philbert F. Espejo, MPH, CHES: Consultant*

*Mark Anthony Molina, MA: Asian Americans for Community Involvement*

- Understand and assess the current trends relative to HIV transmission among AAPIs in the South Bay vis-a-vis other parts of the Bay area, the state of California, and the United States and identify the need for HIV prevention services for AAPIs
- Identify barriers and challenges in HIV prevention and testing services for the AAPI community
- Understand the strengths of the AAPI community that can be built upon to deliver more effective HIV services
- Identify effective prevention strategies to provide better HIV prevention and care services for Asian-Americans and Pacific Islanders





# HIV Care & Prevention 2006

## **Kelle L. Brogan, M.D.**

Dr. Kelle Brogan received her Master in Molecular Biology from Arizona State University and her Doctor of Medicine from University of Nevada. Moreover, she is currently the Medical Director in St. Mary's Hospice of Northern Nevada and a Clinical Faculty for Hospice and Palliative Care at University of Nevada's School of Medicine. Until recently, Dr. Brogan held her own private practice with Sage Alliance Internal Medicine for several years. At today's HIV Care & Prevention 2006 conference, she co-facilitates with Dr. Flynn to present the workshop session on "Pain Control and Substance Use in HIV Patients."

## **Nell M. Flynn, MD, MPH**

Dr. Neil Flynn is currently the Medical Director and Principal Investigator for 24 Northern California counties with the AIDS Education & Training Center at the University of California at Davis. He received his Bachelor of Arts in Bacteriology from University of California at Los Angeles, a Master in Public Health from University of California at Berkeley, and a Doctor of Medicine from Ohio State University. At today's HIV Care & Prevention 2006 conference he co-facilitates the session on "Pain Control and Substance Use in HIV Patients" with Dr. Kelle Brogan.

## **Javeed Siddiqui, MD, MPH**

Dr. Javeed Siddiqui is currently the Associate Medical Director and the Director of HIV Tele-Medicine Services out of the Center for Health and Technology at the University of California at Davis. He received his Bachelor of Science and Master in Public Health from Tulane University before completing his Doctor of Medicine at the University of Missouri. Dr. Siddiqui is an active faculty member with both the California Emergency Preparedness Network and the AIDS Education & Training Center at UC Davis. At today's HIV Care & Prevention 2006 conference, he speaks on "Recognizing Acute HIV Infection: Issues for the Primary Care Provider."

## **Philbert F. Espejo, MPH, CHES**

Philbert F. Espejo was, until recently, the Sensitivity Program Trainer for the Targeted Expansion Project for Outreach and Treatment project (otherwise known as the TEPOT Program) in the Center for AIDS Prevention Studies at the University of California in San Francisco. He has assisted in the development of the TEPOT curriculum and has presented HIV education workshops and sensitivity trainings for both clients and staff in substance abuse and mental health treatment settings. He earned his Master of Public Health degree from San Jose State University specializing in Community Health Education. He is also a Certified Health Education Specialist. He recently joined the Ira Greene Positive PACE Clinic team with the Santa Clara Valley Health and Hospital System and will co-facilitate today's session on "Advancing Prevention Strategies to Respond to HIV/AIDS Issues in the AAPI Community" with Mark Anthony Molina.

## **Mark Anthony Molina, MA**

Mark Anthony Molina has thirteen years of leadership and management experience in program design and implementation, research, monitoring and evaluation, and community outreach. He managed the United Nations Population Fund with the Philippines programmatically and financially for two years. Mark earned his Bachelor's of Arts in Sociology from University of the Philippines and received his Master of Arts in Population Science from the Institute of Population Research at Peking University. Currently, he is the HIV/AIDS Prevention Coordinator for Asian Americans for Community Involvement and is a new chairperson for the Santa Clara County HIV Community Planning Group. At today's HIV Care & Prevention 2006 conference, Mark co-facilitates the session on "Advancing Prevention Strategies to Respond to HIV/AIDS Issues in the AAPI Community" with Philbert Espejo.





# Pain Control in HIV Patients and Substance Users

Kelle Brogan, M.D.



## Introduction

- Since the introduction of potent combination antiretroviral therapy in 1996, HIV has been transformed from a uniformly fatal illness to a chronic treatable disease.
- As with other chronic illnesses, treating pain and other distressing symptoms in order to improve quality of life can be difficult.



## Quality of life

- Despite increasingly prolonged survival times, patients with HIV continue to suffer from:
  - Physical distress/pain
  - Spiritual distress/pain
  - Psychological distress/pain
  - Social isolation
  - Grief



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## Common Symptoms of HIV Disease

- Anorexia or weight loss
- Fatigue
- Pain: Assess "Total Pain"; neuropathic pain often the most difficult type to treat effectively.
- Dyspnea
- Nausea, dysphagia, odynophagia, diarrhea, constipation
- Anxiety and/or depression
- Skin problems, pruritis
- Confusion, delirium, delusional states, dementia
- Sleep disturbances- insomnia, hyper somnolence



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## Types of Pain Syndromes

- Somatic Pain: muscle or bone; responds well to NSAIDS, Cox 2 inhibitors or corticosteroids. (Corticosteroids used mostly in the last 6 months of life).
- Visceral Pain: heart, abdominal organs etc. Usually responds best to narcotics.



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## Types of Pain Syndromes

- Neuropathic Pain: Two major types
  - 1) Paroxysmal, lancinating, shooting- responds well to anticonvulsants such as gabapentin. Start at 100-300 mg bid and gradually increase to 3600mg daily in 3-4 divided doses, as needed or tolerated.
  - 2) Numbing, burning, tingling- responds well to TCA, ie. Amitriptyline. Start at 10 mg qhs and increase by 10 mg q 3 days up to 200 mg qhs, as needed or tolerated.

Note: It may take up to two weeks to determine the total benefit of these medications on neuropathic pain.



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## The WHO Three Step Analgesic Ladder

- Opioid for Moderate to Severe Pain  
  +/- Non-Opioid +/ Adjuvant
- Opioid for Mild to Moderate Pain  
  + NonOpioid +/-Adjuvant
- Non-Opioid for Mild Pain  
  +/- Adjuvant



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## Guidelines to Giving Opioids

- Administer on a timed basis: ie. Long acting or sustained release
- Give a minimum of 10% of the 24 hour dose for prn breakthrough dose.
- Use familiar opioids
- There is no ceiling dose
- Add adjuvants



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## Steps in Pain Control

- Detailed assessment
- Determine the cause of the pain
- Management of the pain
- Reassessment



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## Moderate to Severe Pain

- Morphine Sulfate X 1
- Oxycodone X 1.5-2
- Hydromorphone X 4
- Fentanyl X 12.5



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## Duragesic Conversions in Chronic Pain

- Duragesic 25 ug/h q 72 hours is approximately equal to:
  - 1) Morphine 60 mg daily
  - 2) Oxycodone 30 mg daily
  - 3) Hydromorphone 15 mg daily



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## Key Points in Duragesic Usage

- NEVER use Duragesic patch for acute pain management. It takes 12-17 hours for SQ depot to get to blood stream and the same amount of time for the effect of the drug to wear off once the patch is removed.
- There is more rapid absorption in patients with fever and in patients who are markedly cachectic and may not last the full 72 hours.



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## Opioid Formulations

- Morphine- MS Contin, Oramorph
- Oxycodone- Oxycontin
- Hydromorphone- Palladone
- Fentanyl-Duragesic



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## Compounding

- Suppositories: rectally, vaginally, stoma
- Concentrated Oral solutions: morphine and oxycodone 20-50 mg/ml; hydromorphone 10 mg/ml
- PLO- pleuronic lethicin organogel
- Intranasal
- Fentanyl lollipop
- Trouches



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## Adjuvants

- Antidepressants: Elavil, Doxepin, Pamelor, Cymbalta
- Anticonvulsants: Neurontin, phenobarbitol, Tegretol, Dapakene, Klonopin
- Corticosteroids: dexamethasone,
- Muscle relaxants: Flexeril, Lioresal (baclofen), Klonopin, Valium, Versed
- Psychostimulants: Ritalin (methylphenidate)



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## Non-Opioids/Co-analgesics

- Acetaminophen
- Tramadol
- NSAIDS: ibuprofen, naproxen, rectal indomethacin
- Cox 2 inhibitors: Celebrex, Mobic



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## Acetaminophen

- Percocet, Roxicet, Lortab, Vicodin
- Limitations: ceiling dose- 4 gm/day- 7.5 gm can be fatal in an adult, 95% excreted by the liver.
- If a person is taking twelve percocet 5/500 mg daily, this is equal to 6 gm of tylenol daily. A better choice would be Oxycontin 30 mg bid, MS Contin 60 mg bid, or Duragesic 50 ug/h q 72 hours. There will be steadier narcotic blood levels, less clock watching and less risk of liver dysfunction.



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## Methodone

- Long half-life 1-3 days
- Steady state in 1-2 weeks
- Cumulative toxicity
- Difficult to titrate
- Costs pennies



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## Simplified Methadone Conversion

estimated oral      oral morphine  
methadone/day = equivalents/day +15  
(mg)                (mg) \_\_\_\_\_  
                                15



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## Opioid Induced Nausea

- Morphine is by far the worst but it can happen with the others
- In a patient who is opioid naïve consider giving compazine 10 mg po qid, compazine spansules 15 mg bid, or phenergan 25 mg po qid for three days when starting a long acting narcotic.



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## Opioid Induced Constipation

- Unless the patient has chronic diarrhea, assume at the beginning that they will have constipation from narcotics.
- Consider using:
  - 1) Stool softeners.
  - 2) Bowel stimulants- metaclopramide, senna ("Smooth Move Tea").
  - 3) Miralax in patients who are taking adequate fluids.



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## Symptomatic Relief of Odynophagia

"Brogol solution"

Benadryl 25mg/5ml 80 ml  
Prednisone 5mg/ml 40 ml  
Tetracycline 125mg/5ml 80 ml  
Nystatin 100k u/ml 40 ml

Sig: 30 ml S and S QID



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## Sleep Disturbances

- Hypersomnia: See fatigue and depression- consider Provigil 200 mg daily, Ritalin 5-10 mg one to two times a day or long acting Ritalin
- Insomnia: Identify causes-Pain, medications, depression and anxiety. Consider TCA, Restoril, Ambein, Lunesta, etc.



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## Depression and Anxiety

- Aggressively treat depression and anxiety!!!!!!!!!!!!!!
  - 1) Depression with neuropathic pain: Elavil 10-50 mg qhs or Cymbalta 30-90 mg daily
  - 2) Depression with insomnia: Elavil 10-50 mg qhs, Doxepin 10-50 mg qhs, Paxil 20-40 mg qhs
  - 3) Depression with anxiety: Zoloft, Effexor, Lexapro
  - 4) Pure anxiety: Xanax XR, Ativan, Buspar
  - 5) Counseling: psychosocial/spiritual support



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## Sedation at the End of Life

Patients who are experiencing extreme pain or severe dyspnea at the end of life frequently experience high levels of anxiety and restlessness as well. This is very distressing, not only for the patient but for all who are involved in the patient's care. When the symptoms of unrelenting pain and dyspnea are severe, sedating the patient may be the most humane and appropriate action.



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## Sedation at the End of Life

As always, the intent of the palliative therapy should be the relief of the patient's distress, even if unavoidable effects include loss of consciousness or possible shortening of the patient's life



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## Sedation at the End of Life

### Medications:

- 1) Benzodiazepines: lorazepam (Ativan) PO, IV or SL or midazolam (Versed) SQ
- 2) Opioids: morphine or hydromorphone (Dilaudid) IV or SQ
- 3) Alternatives: chlorpromazine (Thorazine) IM, PR or PLO 50-100 mg every 2-8 hours or phenobarbital IV, PR or PLO 60-130 mg every hour as needed for sedation
- 4) Any combination of the above



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## Behaviors That Increase the Risk of Disease Progression

- Intractable substance abuse
- Incomplete adherence to antiretroviral medications
- Injection drug use-Hep B, C and bacterial endocarditis
- Alcohol abuse
- Social isolation and a general lack of social support



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## Chronic Pain Management in the Drug-Using HIV Patient

Neil Flynn, M.D., M.P.H.  
Professor of Clinical Medicine  
Department of Internal Medicine  
Division of Infectious Diseases  
And  
Center for AIDS Research, Education, and Services (CARES)  
Sacramento

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### The Problem(s)

- People with HIV/AIDS have chronic pain and become tolerant of opiates
  - Escalating doses
  - Withdrawal when opiates decreased or stopped
- Drug users get HIV
- Methadone maintenance is restricted
- Physicians fear opiates

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### PWHIV Have Pain

- Chronic
  - Neuropathy
  - Low back pain
- Acute
  - Opportunistic infections
  - Malignancies
  - Musculoskeletal injuries
- Pain exacerbated by stress, depression, anxiety, chronic illness

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## Drug Users Get HIV

- Lowered pain threshold
- Opioid tolerance
  - Reduced analgesic effect
  - High doses of opiates required
- Drug-seeking behaviors
  - “Demanding”
  - “Ungrateful”
  - “Whining”
  - Illicit use on top of prescribed analgesics

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## Drug Users Get HIV

- Provider prejudice, ignorance, fear, judgment
- Methadone maintenance availability is severely restricted
- Methadone or buprenorphine maintenance may be the only way to get adherence

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## Physician Fears

- Creating opiate dependence
- Prescribing opiates over a long period of time for chronic pain management
- Being taken advantage of: an easy mark
- Overdose: accidental or intentional
- Restriction of prescribing privileges, reprimand
- Being perceived as too liberal with pain medications by colleagues

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## Additional Problems

- Pain management specialists not readily available to treat pain in PWHIV
  - PWHIV frequently uninsured, can't pay cash
  - PMSs don't like to deal with patients with drug use history
- Physicians heretofore poorly trained in pain management

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## Harm Reduction

- Do whatever is necessary to keep patient alive
- Don't let pain or opiate dependence get in the way of adherence to ARVs
- If methadone maintenance is not available, and patient continues heroin use, consider buprenorphine, or long-term pain management with methadone +

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## Pain Management in the Tolerant Patient

- Patient agrees to reduce dose whenever possible
  - Patient shares responsibility for own dosing
- Provider agrees to keep patient comfortable
- Use combination of opioids and long-acting opiates
- As tolerance increases, use methadone for baseline maintenance

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## Summary

- Physicians are fearful of opiate analgesics
- PWHIV have more pain than average population
- Drug user PWHIV may be tolerant of opiate analgesics and require relatively high doses and for long periods of time
- Drug users have poor access to methadone maintenance and PMSSs
- Do what is necessary to maintain patient comfort even if it makes us uncomfortable

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## Some Useful References

- Internet
  - American Academy of Pain Management
    - aapainmanage.org
  - MedlinePlus
    - Nlm.nih.gov/medlineplus/pain.html
  - StopPain
    - Stoppain.org/for\_professionals/compendium

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## Some Useful References

- References
  - Alford DP, Compton P, Samet. Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. Ann. Int. Med. 2006;144(2):127-34
  - Breitbart W, Dibiase L. Current perspectives on pain in AIDS. Oncology (Williston Park) 2002;16(6):818-29, 34-5; 16(7):964-8

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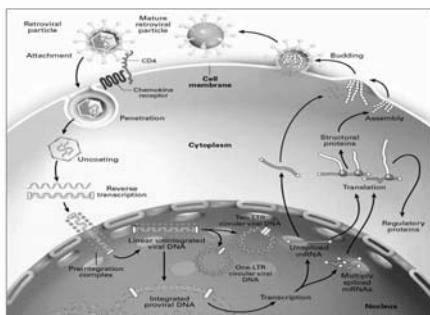


## Recognizing Acute HIV Infection: Issues for the Primary Care Provider

Javeed Siddiqui M.D.,M.P.H  
Division of Infectious and Immunologic Diseases  
University of California, Davis

## HIV Replication

### HIV Replication Cycle



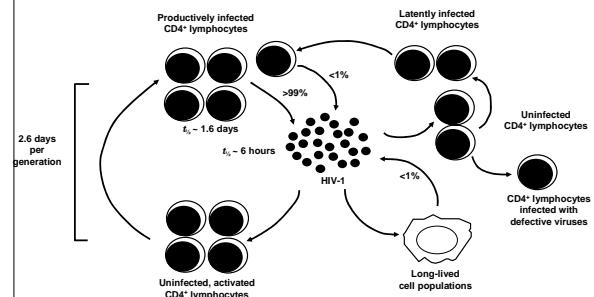
Furtado M, et al. N Engl J Med 1999;340:1614-22. Copyright© 1999 Massachusetts Medical Society

## HIV Dynamics

- $10^9$  new virions produced each day
- Cell free virus in plasma has T1/2 of 6 hours
- Productively infected CD4 cells have T1/2 of 1.6 days
- Time from release of new virion to infection of new cell and release of another new virion is 2.6 days (140 new generations of virus each year)

Perelson A, et al. Science 1996;271:1582-6.

## The Dynamics of HIV-1 Infection in Vivo



Perelson A, et al. Science 1996;271:1582-6.

## HIV Transmission

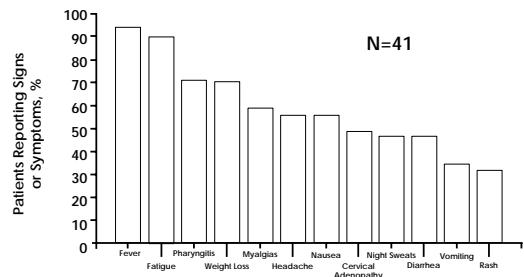
- HIV survives 6 hours outside a cell
- HIV survives >1.5 days inside a cell
- Infected body fluids transmit HIV via:
  - Sexual contact
  - Breast milk
  - Transplacental infection of fetus
  - Blood-contaminated needles
  - Organ transplants
  - Artificial insemination
  - Blood transfusion

## Clades

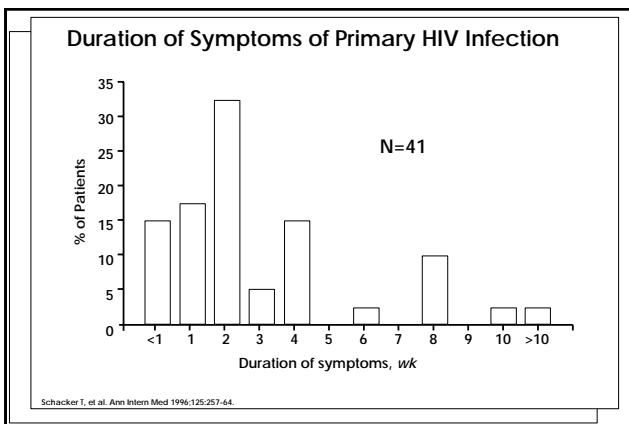
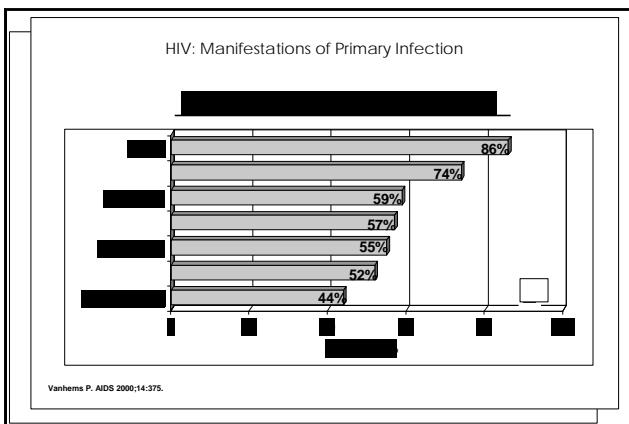
- HIV-1 is the most common. It has 11 clades:
  - 90% of U.S. infections caused by clade B
  - Clade C predominates in sub-Saharan African
  - Clades B, C, & E are in south and southeast Asia
- HIV-2 is seen in western Africa

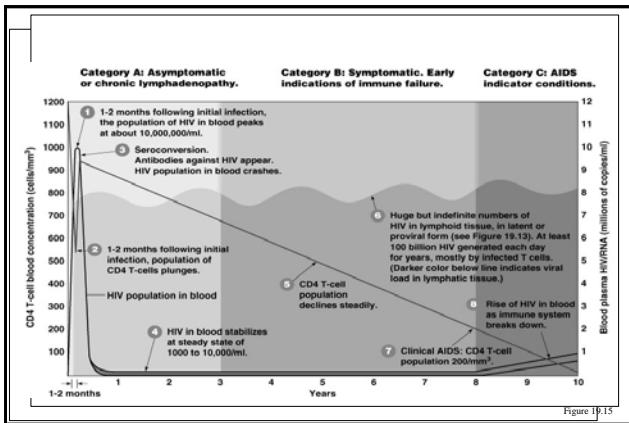
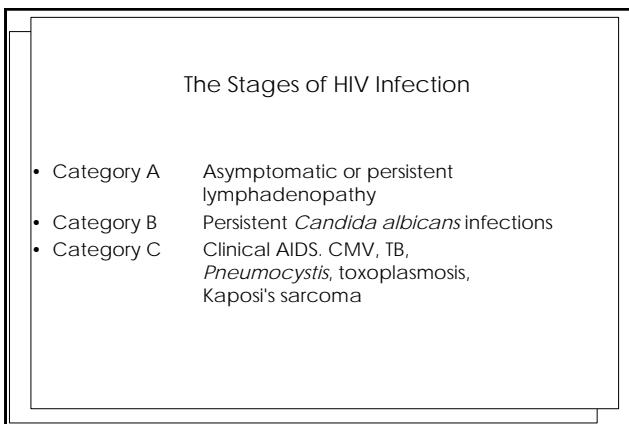
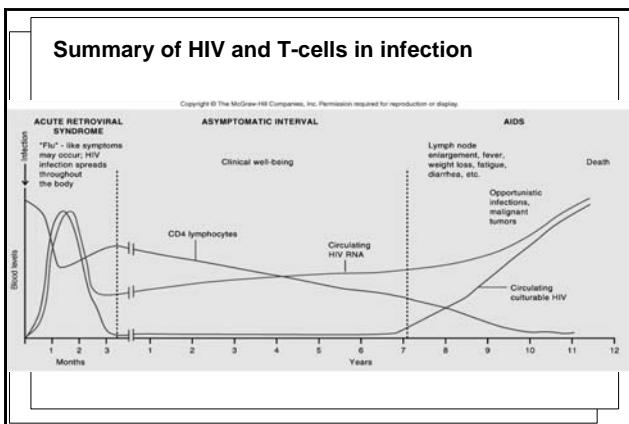
## Natural History of HIV

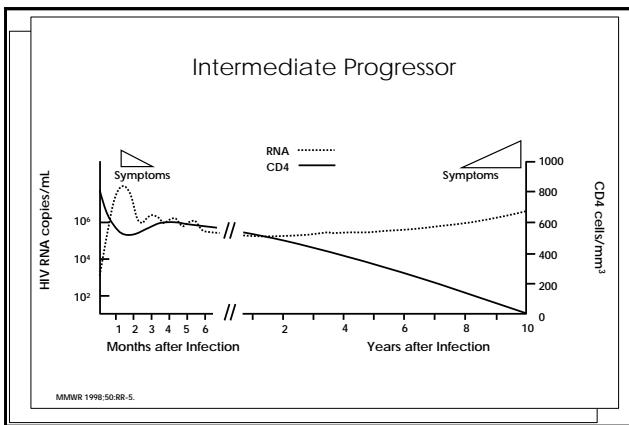
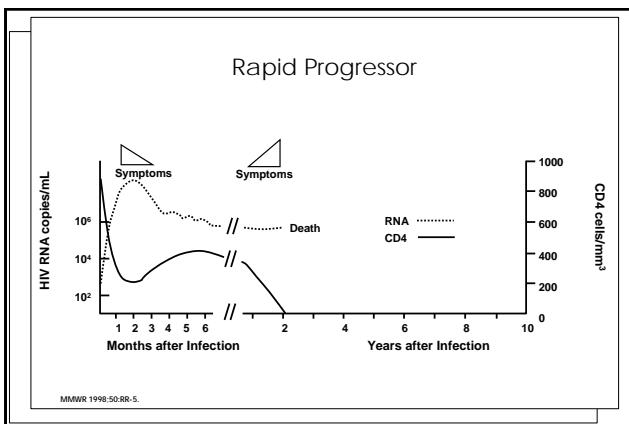
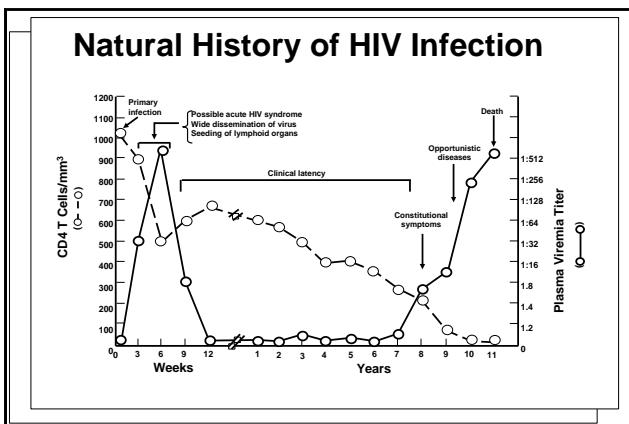
### Clinical Features of Primary HIV Infection

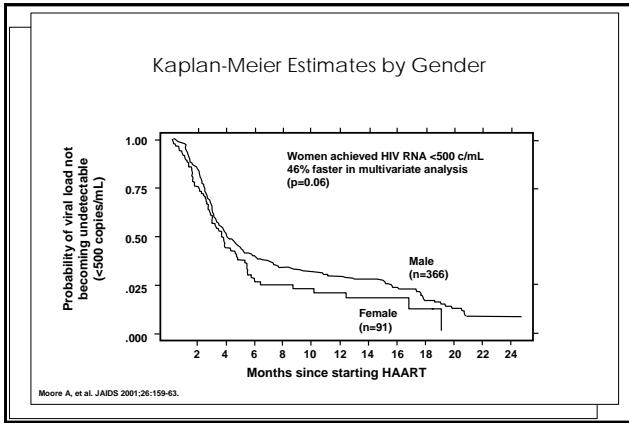
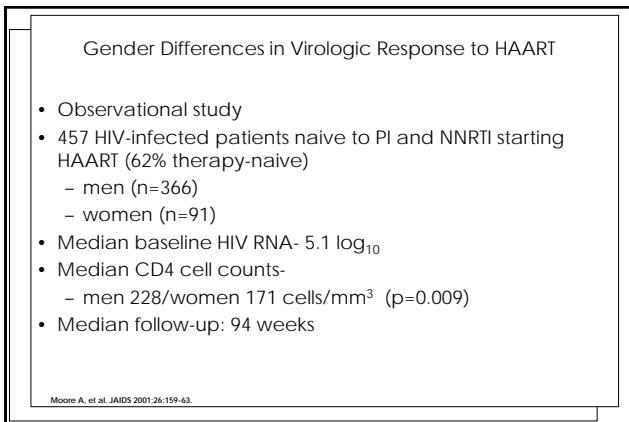
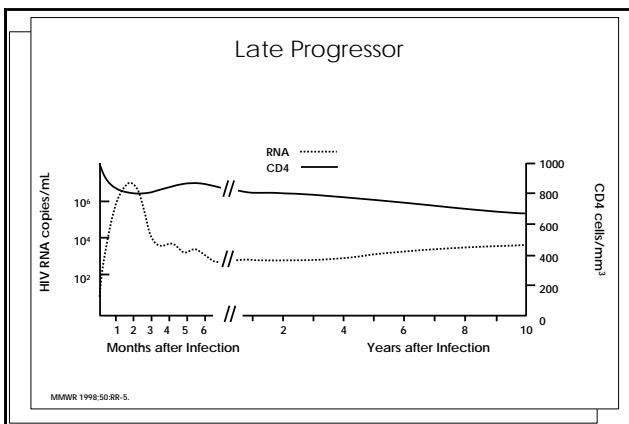


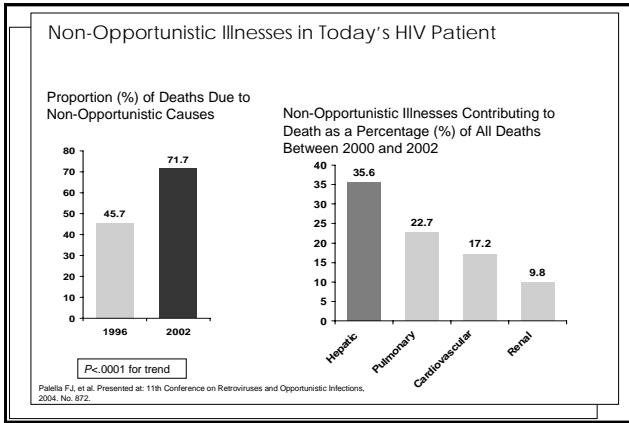
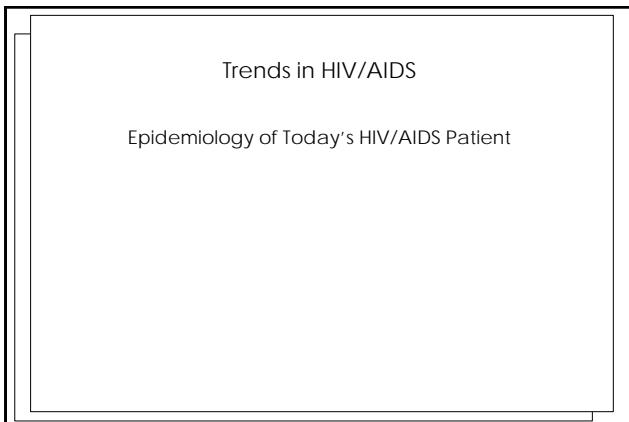
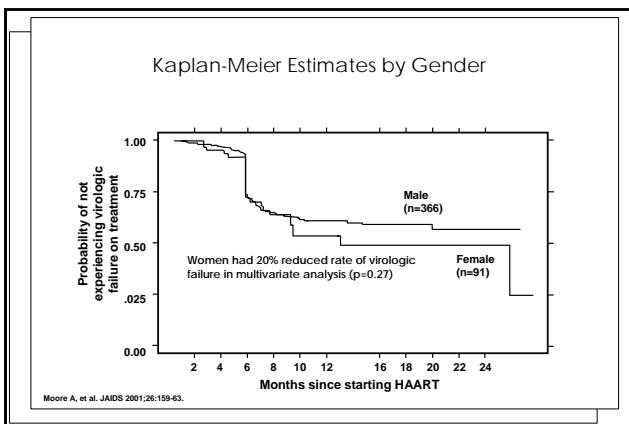
Schacker T, et al. Ann Intern Med 1996;125:257-64.











### Who is Today's HIV Patient?

- HIV patients today are living longer, and new treatment considerations are emerging
- Patients frequently present with comorbid conditions, such as hepatitis C (HCV) coinfection, mental illness, and substance abuse<sup>1-4</sup>
- The major causes of death in today's patient are non-opportunistic illnesses, especially hepatic, pulmonary, cardiovascular, and renal complications<sup>5</sup>

1. Sulkowski M. Curr Infect Dis Rep. 2001;3:469-476. 2. Centers for Disease Control and Prevention. [http://www.cdc.gov/hiv/pubs/facts/HIV-HCV\\_Coinfection.htm](http://www.cdc.gov/hiv/pubs/facts/HIV-HCV_Coinfection.htm). Accessed September 23, 2004. 3. Kimmel PL, et al. Ann Intern Med. et al. 2003;139:214-226. 4. Bing EG, et al. Arch Gen Psychiatry. 2001;58:721-728. 5. Pallela F, et al. 11th Conference on Retroviruses and Opportunistic Infections, 2004; Poster 872.

### WHEN TO TREAT ?

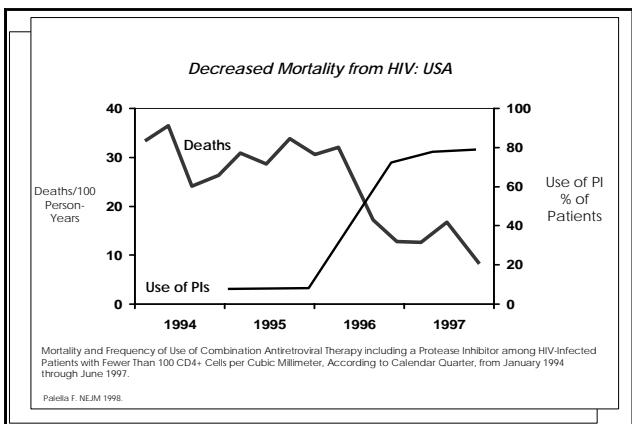
#### When to Start Therapy

##### Earlier treatment

- Control of viral replication easier to achieve and maintain
- Potentially reduced likelihood of lipodystrophy and serious adverse reactions
- Delay or prevention of immunodeficiency
- Lower risk of resistance
- Decreased risk of HIV transmission

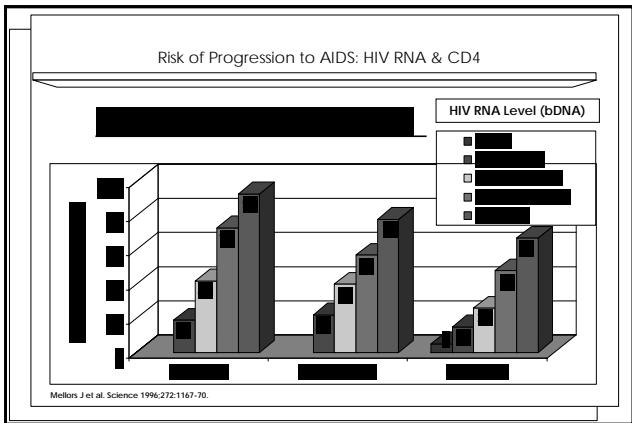
##### Later treatment

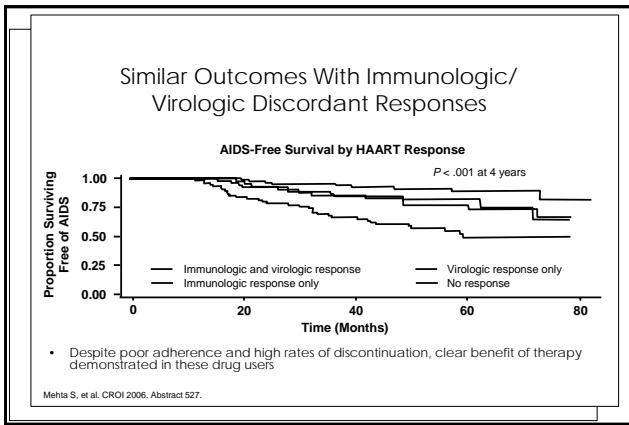
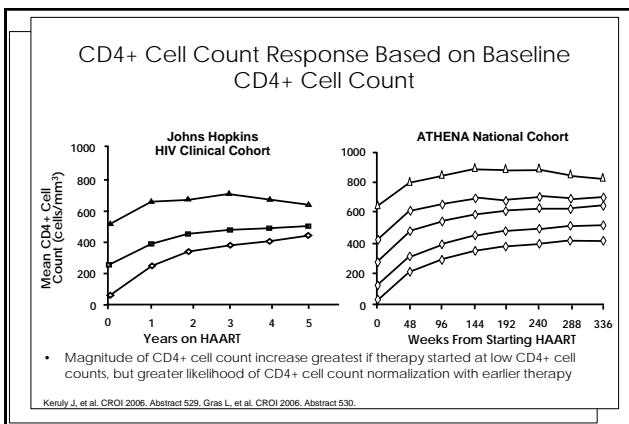
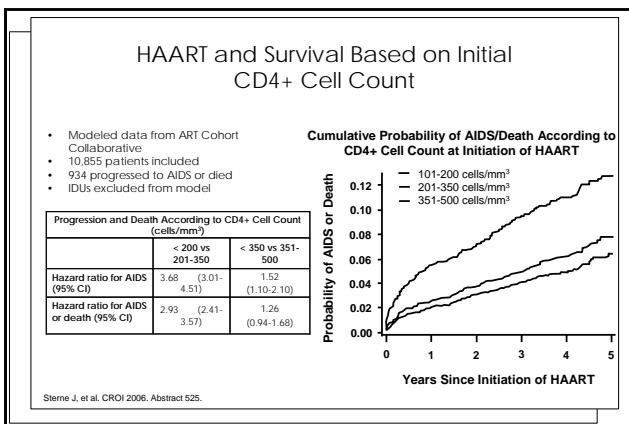
- Immunologic recovery occurs in majority of patients
- Avoid drug-related reduction in quality of life
- Minimize cumulative drug-related adverse events
- Limit development of drug resistance in those with poor adherence



**DHHS GUIDELINES**  
JULY 2004

CLINICAL CATEGORY	CD4 COUNT	VIRAL LOAD	RECOMMENDATIONS
Symptomatic AIDS	<200	Any value	TREAT
Asymptomatic AIDS	< 200	Any Value	TREAT
Asymptomatic	200 - 350	Any Value	Treatment should be offered if <20,000 low probability of AIDS defining illness within 3 yrs
Asymptomatic	> 350	>30,000 [ bDNA] >55,000 [PCR]	Some expert would treat because 3-yr risk of developing AIDS 30%.





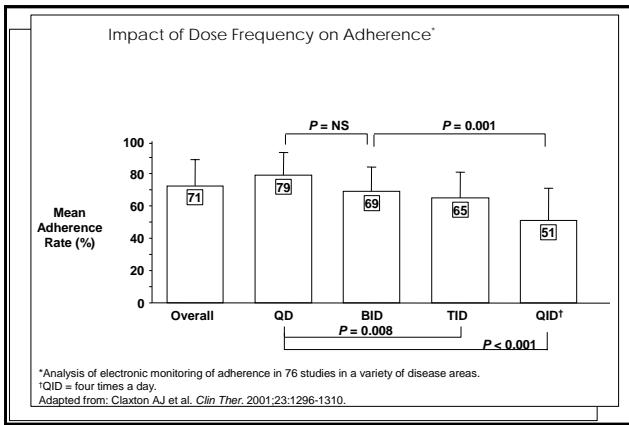
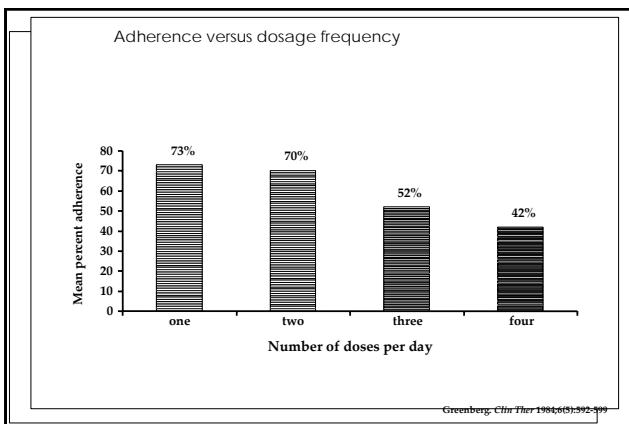
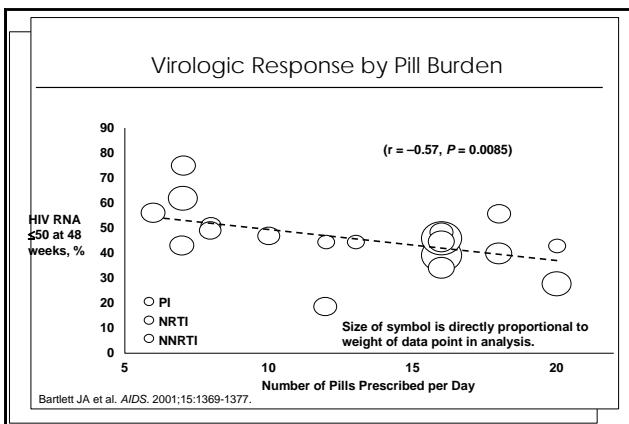
### When to Start HAART: HOPS Cohort

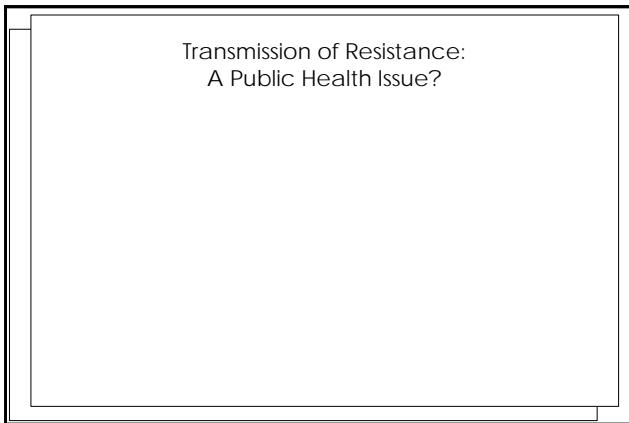
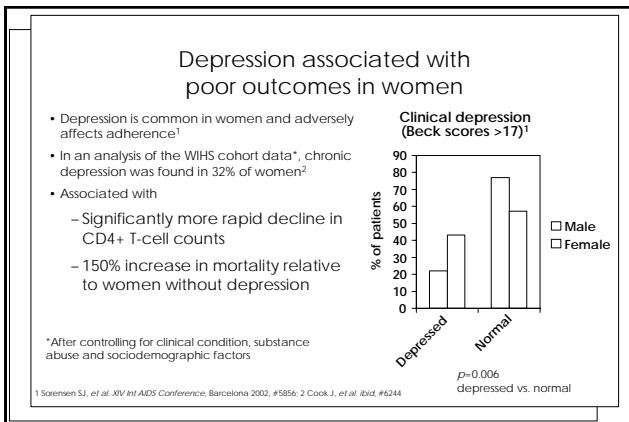
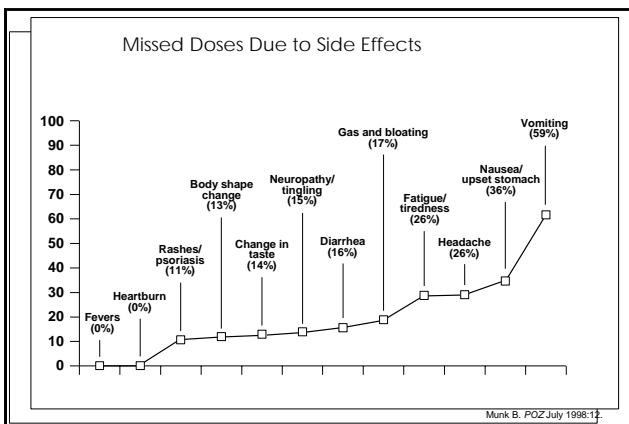
- Prospective, dynamic cohort followed since 1993, N > 8000
- Among patients who started HAART at higher CD4+ cell counts
  - Lower mortality and incidence of OIs
  - Better CD4+ cell count responses to HAART
  - Lower incidence of renal insufficiency, neuropathy, and lipoatrophy
- Within pre-HAART CD4+ cell count strata, better outcomes with consistent use of HAART vs interrupted HAART
- Benefit extended even to those who started therapy with CD4+ cell count 350-500 cells/mm<sup>3</sup> and > 500 cells/mm<sup>3</sup>
- Use of specific ARVs influenced the risk of developing neuropathy and lipoatrophy, but not renal insufficiency. Greater risk of toxicity during the first 1-2 years of therapy for most agents
- Limitation of study: only a minority of patients had paired CD4+ cell counts and HIV viral load determinations

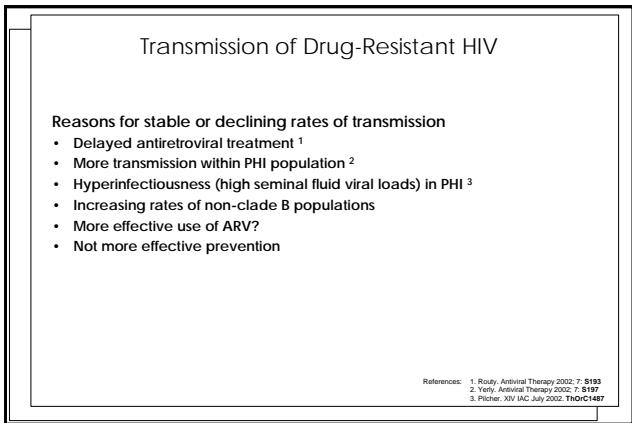
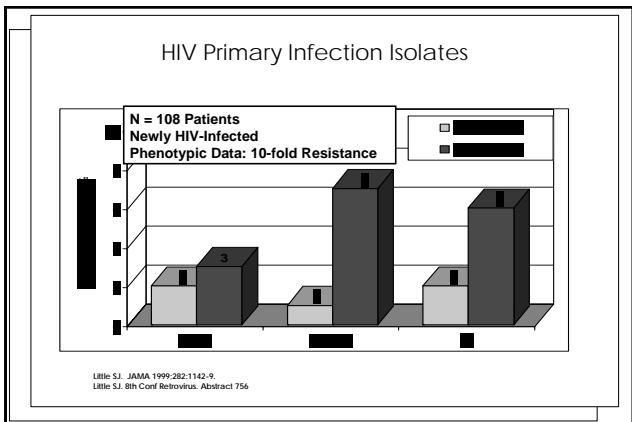
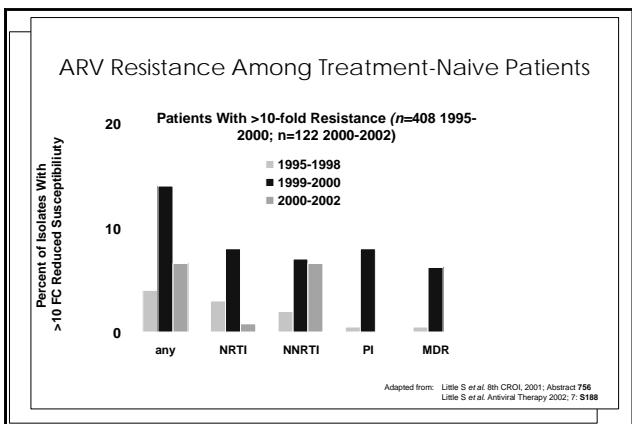
Lichtenstein KA, et al. CROI 2006. Abstract 769.

### Adherence Issues

### Issues In Treatment Strategies









# HIV & the AAPI Community

*Prevention Issues and Strategies that Work*

Philbert F. Espejo, MPH, CHES  
Mark Molina, MA



## Current Trends

- HIV/AIDS update
  - Local
  - National
- ▲ Others
  - ▲ Health concerns
  - ▲ Associated risks



## Barriers and Challenges

- Culture
- Language
- Economic
- Legal
- ▲ Clinician approach
  - ▲ Western vs. Eastern
  - ▲ Model minority myth
  - ▲ Stigma and discrimination



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## Strengths of the Community

- **Culture**
  - Strong group norms
  - Collective norms
- ▲ **Effective service delivery**
  - ▲ Sensitive, clients pace, considering culture and behaviors around it
  - ▲ Presence of existing models that can be replicated




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## Prevention Strategies

- **Programs**
  - Culturally competent / Bi-cultural approach to HIV prevention services
  - Adapting and tailoring evidenced based interventions
  - Increased resources to confront stigma
- ▲ **Community**
  - ▲ Outreach efforts
  - ▲ Increased representation of AAPI in HIV community planning group
  - ▲ Increased involvement in the design and implementation of the programs




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## Resources

- **Resources**
  - Local
  - State / National
- ▲ **Agency Capacities**
  - ▲ Language
  - ▲ Multi-services “One stop shop”




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# what are Asian and Pacific Islander HIV prevention needs?

## are A&PIs at risk for HIV?

Asians and Pacific Islanders (A&PIs) are as susceptible to HIV infection as are other racial or ethnic groups. A&PIs are the fastest growing population in the US. From 1980 to 1994, the A&PI population doubled from 1.6% to 3.0% of the total US population. It is estimated that the A&PI population will increase to 4.4% of the US total, over 12 million persons, by the year 2020.<sup>1</sup>

While the number of reported AIDS cases among A&PIs remains small—about 1% of total cases reported in the US<sup>2</sup>—underreporting and a lack of detailed HIV surveillance about A&PIs may mask the true nature of the epidemic among A&PIs. Only the states of California, Hawai'i and New Mexico, local health departments in Los Angeles, San Francisco, Oakland and New York City and the territory of Guam report AIDS cases among A&PIs by ethnicity/national origin.<sup>3</sup>

## who are A&PIs at risk?

A&PIs are extremely diverse, comprising over 40 different nationalities that speak over 100 languages and dialects. A&PIs include Chinese, Filipinos, Koreans, Hawaiians, Indians, Japanese, Samoan, Vietnamese, among others.<sup>4</sup> The 2000 Census will count Asian Americans separately from Native Hawaiians and other Pacific Islanders.

*AIDS cases by exposure category among A&PIs can be compared to other racial/ethnic populations. The proportion of men who have sex with men (MSM) to injection drug users (IDUs) with AIDS in A&PI men (75% / 5%) is very similar to White men (76% / 9%) and different from Black (38% / 26%) and Hispanic men (44% / 37%). Among women, 46% of A&PI women report sex with an HIV+ or high risk partner as a risk indicator, compared to 39% for White, 36% for Black, and 46% for Hispanic women.<sup>5</sup>*

AIDS cases among A&PIs vary by region in the US, with most cases concentrated in the East and West Coasts and in Chicago, Hawai'i and Guam. New York City and San Francisco account for about 38% of total AIDS cases among A&PIs in the US.<sup>5</sup>

## what puts A&PIs at risk?

A&PIs are often stereotyped as the “model minority” in terms of health, education and economics. However, A&PIs are often underserved in health care. Because of the rapidly increasing size of and the differences within the A&PI communities, there is still little data on health status and behavioral risks. A&PIs have higher rates of many preventable diseases that are strongly associated with HIV, such as tuberculosis and hepatitis-B.<sup>6</sup> In fact, A&PIs have the highest rate of PCP as their AIDS-defining illness, which might indicate barriers to accessing PCP prophylaxis medications.<sup>7</sup>

*Many gay A&PI men do not perceive themselves to be at risk for HIV. For example, a study of gay A&PI men in San Francisco, CA, found that most (57%) of the men practicing anal intercourse used alcohol before intercourse. One fourth (24%) of the men reported unprotected anal intercourse. However, 85% believed they were unlikely to contract HIV and 95% believed they were unlikely to transmit HIV.<sup>8</sup>*

A study of Asian drug users not in treatment in San Francisco, CA, revealed that drug users who are hidden from the street drug scene engage in HIV risk behaviors. Patterns of drug use, sexual behaviors and characteristics of social networks among Asian drug users are unique to their ethnicity, gender and immigrant status. For example, Filipino drug users had engaged in riskier behaviors than the other groups, such as having sex with IDUs, having drug using sex partners, and having sex while using drugs.<sup>9</sup>

*Immigrant A&PI women who work in massage parlors often engage in activities that put them at risk for HIV infection. However, for many of the women, immediate survival needs take priority over HIV prevention, or even health care. Problems with the police, sex work, immigration, family planning and language barriers all need to be addressed as risk factors for this population.<sup>10</sup>*

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## what are barriers to prevention?

There are cultural, linguistic, economic and legal barriers to HIV prevention among A&PIs. For example, cultural avoidance of discussing issues of sexual behavior, illness and death can be barriers to HIV prevention. In addition, although A&PI MSM are at significant risk for HIV, the lack of peer and community support for sexual and racial diversity often are barriers to self-esteem and positive self-identity.<sup>11</sup> Foreign-born A&PIs may have low or no English skills, and very few programs provide interventions in A&PI languages.<sup>5</sup>

*The exclusion of most HIV+ individuals under US immigration law prevents many A&PIs from obtaining permanent immigration status and scares immigrants away from government services such as HIV testing. The disqualification of many immigrants from Medicaid, SSI and other public benefits under the welfare and immigration laws also deters A&PIs from preventive health care, including HIV prevention.<sup>12</sup>*

## what's being done?

The HIV community planning process requires that states and cities prioritize their HIV prevention based on epidemiology. A&PIs should be prioritized in areas where there is higher incidence of HIV/AIDS cases among A&PIs such as Los Angeles, CA, San Francisco, CA, New York City, NY and Hawai'i. However, in areas where there may be lower numbers of A&PI HIV/AIDS cases reported, it is still important for the community planning group and the health department to collect data about the unmet needs of A&PI communities for HIV prevention.<sup>11</sup>

*Effective HIV prevention and education programs for A&PIs can use many culturally appropriate strategies. For example, given strong group and collective norms, it is important to implement interventions that incorporate the entire family and community rather than focus solely on individual behavior change. For more marginalized A&PI populations such as A&PI gay men, peer-based programs are important. Interventions that include the development of nonverbal and other more indirect communication skills also are more culturally appropriate. Outreach activities can be conducted at cultural events, bars, churches and temples, beauty parlors and massage parlors.<sup>13</sup>*

One prevention program in San Francisco, CA, used culturally tailored brief group counseling to reduce HIV risk among A&PI MSM. The project fostered positive ethnic and sexual identities by addressing topics such as having dual identities, community, racism and homophobia, and practiced eroticizing and negotiating safer sex. Men who participated became more knowledgeable and more concerned about HIV infection, and reported fewer sexual partners. Chinese and Filipino men reported reductions in unprotected anal intercourse.<sup>14</sup>

## what still needs to be done?

Rapidly growing and diverse A&PI communities need comprehensive HIV/AIDS-related surveillance data, including data disaggregated by A&PI national origin/ethnicity.<sup>5</sup> More research on the cultural protective factors and cultural barriers to effective HIV prevention among A&PIs is also needed.<sup>15</sup>

*Given that by year 2000 Asia will report the highest number of new HIV infections globally, and given projected immigration and migration patterns of A&PIs, a greater focus on HIV prevention targeting A&PIs living in the US is critical.<sup>5,16</sup>*

More resources are needed to develop, evaluate and replicate linguistically accessible and culturally appropriate HIV prevention interventions for A&PI communities. While programs for A&PI MSM must remain a high priority, attention must be focused on other A&PIs at risk, including A&PI youth, transgenders and women. As with all well-developed HIV prevention interventions, it is critical to conduct a community needs assessment, engage members of the target community in the design and implementation of programs, and recruit A&PI community members as paid staff and volunteers.<sup>11,15</sup>

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**\*ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM, \*\*CAPS**

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# what are men who have sex with men's (MSM) HIV prevention needs?

## what do MSM need?

revised 12/00

**M**en who have sex with men (MSM) are not a single homogenous group, but represent a wide variety of people, lifestyles and health needs. From middle class gay men, to homeless runaways, to injection drug users (IDUs) to incarcerated men, MSM have many different identities and associated risks for HIV and other infectious diseases. MSM refers to any man who has sex with a man, whether he identifies as gay, bisexual or heterosexual.

*Despite success in changing sexual behaviors, MSM continue to be disproportionately affected by HIV/AIDS. MSM account for the largest percentage of persons with AIDS in the US (53%), even as the percentage of AIDS cases among IDUs (25%) and heterosexuals (10%) has increased.<sup>1</sup> In 1997, the prevalence rate of HIV for MSM in 4 urban communities was 17% overall, 29% for African-American MSM and 40% for MSM-IDUs.<sup>2</sup>*

HIV is not an issue that exists by itself, but is woven into many aspects of men's lives. Risk for HIV is embedded in many other core issues such as dating and intimacy, sexual desire and love, as well as alcohol and recreational drug use, homophobia, abuse and coercion, racism and self-esteem.<sup>3</sup> HIV prevention programs must be informed by all these elements.

## sexual health

**T**here is not enough sexuality education for young people in the US, and almost no same-gender sexuality education. Like many teenagers, young MSM may only learn about sex through distorted media or pornographic images. In general, men in today's society are pressured to prove their manhood through sexual activity and aggressiveness, while women receive messages on moderation and caretaking. Given this, many MSM face additional challenges learning about dating, intimacy and forming relationships, or about desire, sexual functioning and arousal. Discomfort with one's sexuality and identity can lead to sexual risk taking.<sup>4</sup>

*In Minnesota, "Man-to-Man: Sexual Health Seminars" are based on the sexual health model. This model assumes that if MSM are more sexually literate, comfortable and competent, they are more likely to be able to reduce risk in the context of sexual behaviors and relationships. The program uses comprehensive sexuality education, cultural specificity and empirical research to help MSM reduce HIV risk long-term. The program was effective in reducing internalized homonegativity and unprotected anal intercourse.<sup>5</sup>*

HIV is not the only sexual health concern for MSM. Other sexually transmitted diseases (STDs) such as herpes and genital warts can negatively affect health and sexuality. Several states have seen an increase in drug-resistant gonorrhea among MSM, making it more difficult to treat.<sup>6</sup>

## homophobia, racism and self esteem

**H**omophobia and racism are prevalent in the US. Internal and external homophobia and racism can lead to low self-esteem, which can lead to increased risk behavior such as sexual aggression, difficulty negotiating safer sex, and drug or alcohol abuse.

*MSM of color are disproportionately affected by many social and health-related ills such as HIV. African American and Latino MSM are more likely than their White counterparts to engage in high-risk activities and to be HIV-infected. Social and cultural factors may limit the ability of MSM of color to protect themselves from HIV. A study of Latino gay men in urban centers found that men who reported high-risk behavior also reported significantly higher rates of financial hardship, experiences of racism and homophobia, incidence of domestic violence and a history of coercive childhood sexual abuse.<sup>7</sup>*

*Hermanos de Luna y Sol*, an HIV prevention intervention for Latino gay/bisexual men in San Francisco, CA, deals with the common history of oppression among Latino gay men, including issues of homophobia, machismo, sexual abuse, racism and separation from family and culture.<sup>8</sup> In Washington, DC, US Helping US (UHU) is a multi-modal prevention program for Black MSM that addresses the psychological and emotional stress that they may experience as racially and sexually oppressed minorities. UHU provides mental health services, community building and anti-homophobia social marketing.<sup>9</sup>

## Says who?

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## alcohol and recreational drug use

The prevalence of drug use is higher among MSM than among heterosexuals,<sup>10</sup> although decreases recently have been noted in all alcohol and drug use categories except amphetamines.<sup>11</sup> In many areas of the US, gay bars--often sex-charged environments where alcohol and drugs are prevalent--are the only venues for MSM to meet and socialize with each other. Drug use may vary greatly by region and subculture.

*Substance use puts MSM at risk for HIV for several reasons: 1) MSM-IDUs are at risk if they share infected injection equipment; 2) substance use is associated with high risk sexual behavior; 3) background HIV prevalence rates are higher for MSM-IDUs and MSM who abuse drugs but do not inject, increasing the likelihood of transmission.<sup>12</sup>*

Substance use can serve as a trigger or an excuse for unprotected sex. Some MSM have trouble having sex without getting high first; others prefer having sex while high, believing recreational drugs increase their libido. For some MSM, drug use provides a sense of community and bonding at gay clubs and circuit parties. A survey of MSM who attend circuit parties found that serodiscordant unprotected anal sex was more likely to occur among men who used amphetamines (speed), Viagra and amyl nitrites (poppers).<sup>13</sup>

*For many MSM-IDUs, drug use, rather than sexual orientation, forms their personal identity. Many MSM-IDUs identify as heterosexual. Too often MSM-IDUs are missed in prevention programs that target MSM but leave out IDUs, or programs that target IDUs but don't address sexual orientation. MSM-IDUs have high rates of HIV infection, high frequency of unprotected sex and high rates of poverty, addiction and its related social and physical ills.<sup>12</sup>*

The Stonewall Project in San Francisco, CA is a harm reduction program for MSM who use speed. The project provides education and assistance and has been successful at reaching MSM of different sexual and social identities.<sup>14</sup> Across the US, several cities have opened social centers for gay men where no alcohol is served and drugs are not allowed. One HIV prevention program for young gay men helps develop community centers where young men can socialize without alcohol.<sup>15</sup>

## what is sexual risk?

The perception of sexual risk for HIV varies among MSM and may change from one sexual situation to another. Throughout the HIV epidemic, MSM have engaged in sophisticated decision-making about what they consider to be risky.<sup>16</sup> Some men decide for themselves it is OK to not use a condom if they are the top (insertive partner), if they are having oral sex or if their or their partner's viral load is undetectable. MSM may make these decisions because the scientific evidence of HIV risk is cloudy, or simply because they are comfortable with some level of risk. HIV prevention programs should help MSM to make realistic and healthy choices based on factual information.

*MSM have engaged in a hierarchy of strategies for maintaining safer sex that are fluid and context-dependent. Most MSM are able to manage sexual risk with effective strategies such as monogamy with concordant partners, consistent condom use with repeated testing, condom use outside of relationship or abstinence. Other MSM use strategies that are not known to be effective (see above paragraph). A small minority of MSM choose to engage in known risk activities such as unprotected anal intercourse without knowledge of partner serostatus.*

Unprotected anal intercourse between an HIV+ and an HIV- man remains the greatest risk for HIV transmission among MSM. This has proven to be the biggest challenge for HIV prevention. The intimacy of skin-to-skin contact during intercourse is a powerful and important draw. Many MSM feel their sexual identity, as well as the hard-won goals of gay sexual liberation, are based on having sex--including anal intercourse--in a free and unconstrained manner.

*A majority of MSM consistently manage sexual risk, yet there is little understanding or research of men who are largely safe, and how their values of nurturance and caretaking, ethics, hopes for collective survival, or relations with friends and community help support them. Only recently have HIV+ MSM been targeted with messages and programs featuring "prevention altruism" that make use of MSM's strengths. HIV prevention efforts need broader, more emotionally-resonant concepts that build on what is good in MSM's lives.<sup>17</sup>*

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# what are women's HIV prevention needs?

## are women at risk?

**Y**es. In 1997, women comprised 22% of all AIDS cases in the US. Heterosexual contact is the leading risk exposure category for all women (38%), and 29% of those are due to sex with an injection drug user (IDU). Injection drug use accounts for 32% of all cases.<sup>1</sup> The majority of women who have sex with women (WSW) acquired HIV via drug use or sex with a man, although a few women have been identified infected via same-sex contact.

*Women are one of the fastest growing populations being infected with HIV, and the number of AIDS cases among women increases steadily each year. Women under 30 made up 22% of AIDS cases among women in 1996. Because the time from HIV infection to developing AIDS can be long, many of these women acquired HIV in their teens.<sup>2</sup>*

African American and Hispanic women have been disproportionately affected by AIDS. AIDS rates for African American and Hispanic women are 17 and 6 times higher than for white women. In 1997, African American women made up 60% of all female AIDS cases, Hispanics 20% and Whites 19%.<sup>1</sup>

## what places women at risk?

**M**ale-to-female transmission is estimated to be eight times more likely than female-to-male;<sup>3</sup> in 1997, 38% of women contracted HIV through heterosexual contact, as opposed to 7% of men. Reasons for this are twofold: there are more men than women in the US infected with HIV, which increases the likelihood that women would have an infected sex partner; and HIV is more easily transmitted from men to women due to the greater exposed surface area in the female genital tract.<sup>1</sup>

*Sexually transmitted diseases (STDs) other than HIV can increase the risk of new HIV infections at least two to five times. Genital ulcers and immune response associated with STDs make it easier for HIV to enter the body. There are an estimated 12 million new cases of STDs every year, and populations at highest risk for HIV infection also have disproportionately high rates of other STDs.<sup>4</sup> Treatment of STDs can be an effective HIV prevention strategy.*

Injection and non-injection drug use puts women at increased risk for HIV infection and is strongly linked to unsafe sex. In one study, female IDUs reported sharing needles 32% of the time, and obtained used needles from their regular sex partner 71% of the time.<sup>5</sup> Women who smoke crack cocaine, particularly women who have sex in exchange for money or drugs, are at high risk for HIV infection via sexual transmission.<sup>6</sup>

*Sexual abuse and coercion places many women at risk. In one study, physical and sexual abuse were "disturbingly common" throughout life among women at high risk for HIV infection. Childhood sexual abuse (42%) and physical abuse (42%) was also common. Women who have been abused are more likely to use crack cocaine and have multiple sex partners.<sup>7</sup> Public health agencies need to raise public awareness about sexual abuse and coercion and help women and men develop the skills needed to prevent it.*

## what are barriers to prevention?

**W**omen do not wear the condom. For women to protect themselves from HIV infection, they must not only rely on their own skills, attitudes, and behaviors regarding condom use, but also on their ability to convince their partner to use a condom. Gender, culture and power may be barriers to maintaining safer sex practices with a primary partner. HIV prevention strategies must target both women and men in heterosexual couples and address gender norms in sexual decision-making.<sup>8</sup>

*Women are disproportionately represented among the poor. Because of this, women are less likely to have health insurance and access to health care services. Many minority women living in poverty are also disproportionately affected by HIV. For these women, the struggle for daily survival may take precedence over concerns about HIV infection, whose impact may not be seen for several years.<sup>9</sup>*

Like many people in committed relationships, women may find intimacy in their relationship to be more important than protection against HIV. Unsafe sex may be linked to emotional and social (not necessarily financial) dependence on men. The ideal of monogamy, including assuming their partner's fidelity, may increase AIDS risk denial.<sup>10</sup>

updated 8/98

## Says who?

1. CDC. *HIV/AIDS Surveillance Report*. 1998;9:10.

2. CDC. Update—HIV/AIDS and women in the United States. Fact sheet prepared by the CDC. July 1997.

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4. Wasserheit JN. Epidemiological synergy. Interrelationships between human immunodeficiency virus infection and other sexually transmitted diseases. *Sexually Transmitted Diseases*. 1992; 177:167-77.

5. Leonard LE, Baskerville B, Hotz S. Risk factors for needle sharing in women who inject drugs. 11th International Conference on AIDS, Vancouver, British Columbia. 1996. Abstract #TuC2503.

6. Edlin BR, Irwin KL, Faruque S, et.al. Intersecting epidemics: Crack cocaine use and HIV infection among inner-city young adults. *New England Journal of Medicine*. 1994; 331:1422-7.

7. Vlahov D, Wientge D, Moore J, et al. Violence among women with or at risk for HIV infection. 11th International Conference on AIDS, Vancouver, British Columbia. 1996. Abstract #TuD135.

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## **what are the methods for protection?**

Women are more likely to protect themselves from pregnancy using methods that do not depend on partner cooperation, such as oral contraceptives. However, oral contraceptives like the pill do not protect against STDs and HIV. Female-controlled methods to prevent HIV transmission are needed. Traditionally, abstinence, condoms and dental dams have been the main methods of protection. In 1993, Reality®, a female condom, was introduced on the market but to date, results have been mixed as to its efficacy, affordability and interest in use.

*Vaginal microbicides that would prevent STD transmission but allow for pregnancy have been developed and piloted in some prevention programs. Further efforts need to include large-scale efficacy trials and to increase scientific interest and support from pharmaceutical companies to develop microbicides that prevent HIV infection.<sup>11</sup>*

## **what is being done?**

Recruiting women as community leaders was the basis for an effective HIV prevention program among low-income urban women living in housing developments. Women opinion leaders were trained to lead risk reduction workshops, provide HIV educational materials and condoms, and conduct HIV education through community events. The women effectively mobilized their residential community through tailored prevention messages and activities.<sup>12</sup>

*Because women at risk are not always visible as a specific population or community, programs must strive to be where women are. A program provided HIV prevention services for women visiting their incarcerated male partners at San Quentin State Prison. The program, based at the visitor's center, trains women visitors as HIV educators, and the educators provide group and individual peer education. The program is low cost and has been well-accepted by visitors and by the prison.<sup>13</sup>*

Interventions that promote HIV counseling and testing for both members of a couple should be considered. The California Partner Study provided couple counseling in combination with social support to serodiscordant heterosexual couples (where one partner is HIV positive and the other HIV negative). As a result, condom use increased and no new HIV infections were reported among the couples.<sup>14</sup>

*Most drug treatment programs are staffed by men and oriented towards male clients. Allowing pregnant women to enroll in drug treatment, and allowing women to bring children with them would be helpful. In San Francisco, CA, a women-only needle exchange program was well accepted and used by female drug users. The number of needles exchanged and number of visits was similar between women who attended the women-only exchange versus mixed gender exchanges. However, women who visited the women-only exchange were more likely to receive health care and to receive additional health promotion services such as food, vitamins, coupons and clothing.<sup>15</sup>*

## **what needs to be done?**

Because women are more likely to be infected by men, and AIDS cases due to heterosexual contact are increasing, programs that specifically target men (especially IDUs) will have a beneficial impact on women. Needle exchange and drug treatment are important strategies, since almost half of all infections in women are due to injection drug use. Encouraging women to seek STD diagnosis and treatment should also be a part of effective HIV prevention strategies.

*More research needs to be done on modes of HIV transmission and risks for women, including woman-to-woman transmission. Innovative, women-specific interventions need to be evaluated. A comprehensive HIV prevention strategy uses many elements to protect as many people at risk for HIV as possible. Interventions that address sexuality, family, culture, empowerment, self-esteem and negotiating skills, as well as interventions located in varying community settings are especially important.*

**PREPARED BY KATHLEEN QUIRK, MA\* AND PAMELA DECARLO\***  
\*CAPS

9. Farmer PE, Connors MM, Simmons J., editors. *Women, poverty, and AIDS: Sex, drugs, and structural violence*. 1996. Common Courage Press, Monroe, ME.

10. Sobo EJ. *Choosing unsafe sex: AIDS-risk denial among disadvantaged women*. 1995. University of Pennsylvania Press, Philadelphia, PA.

11. Phillips DM. Microbicide development: progress and obstacles. Third Conference on Retroviruses and Opportunistic Infections. 1996.

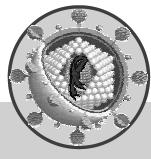
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13. Collaborative programs in prison HIV prevention. Contact: Barry Zack, Centerforce, Health Programs Division, San Quentin, CA: 415/456-9980.

14. Padian NS, O'Brien YR, Chang Y, et al. Prevention of heterosexual transmission of human immunodeficiency virus through couple counseling. *Journal of Acquired Immune Deficiency Syndrome*. 1993;6:1043-1048.

15. Lum PJ, Guydish JR, Brown E, et al. An innovative needle exchange program exclusively for women is well accepted by female injection drug users in San Francisco. International Conference on AIDS, Geneva, Switzerland. 1998. Abstract #43261. Contact: Paula Lum (415) 597-4965.





# HIV Care & Prevention 2006

*By the end of this session, participants will be able to:*

## (CEDAR) HIV Prevention and Partner Notification

*Susan Czark, RN: Health Connections, Faculty: San Jose AIDS Education & Training Center*

- Define Partner Counseling and Referral Services (PCRS)
- Explain the importance of PCRS in relation to HIV
- Initiate discussion with clients regarding the 4 partner referral options
- Explain how to refer to and utilize services available through state and local health department partner services programs
- Identify culturally competent and bilingual referral and consultation resources

## (PINE) STD Overview for the HIV Care Provider

*Christopher S. Hall, MD, MS: California STD/HIV Prevention & Training Center*

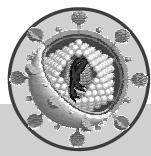
- Describe general epidemiology of the following sexually transmitted infections in Santa Clara County, California, and the U.S.: syphilis, chlamydia, gonorrhea
- List key recommendations for STD screening in men and women with HIV infection, including frequency of testing
- Identify two patient information items to be obtained in a sexual history and give two examples of open-ended questions to use to obtain this information
- Define the CDC's STD Treatment Guidelines  
List key issues in diagnosis and treatment of syphilis, gonorrhea, and rectal Chlamydia in HIV-infected persons
- Identify the relationship between STD infection and HIV transmission

## (FIR) Sex, Meth, & HIV

*Lawrence M. McGlynn, MD: Ira Green Positive PACE Clinic, Faculty: San Jose AIDS Education & Training Center*

- Recognize the rise in methamphetamine use and its implications on the rates of HIV transmission in the South Bay area
- Understand the most important issues to consider when working with patients who use street drugs
- Identify effective strategies in methamphetamine abuse treatment





# HIV Care & Prevention 2006

## Susan Ann Czark, RN

Susan Czark received her Bachelor of Science in Nursing from University of San Francisco and a Master in Community Health Nursing from University of Texas. She is currently the Clinical Educator for the Health Trust AIDS Services and an active nurse faculty member with the San Jose AIDS Education and Training Center. In addition, Susan has been an active member of the planning committee for today's HIV Care & Prevention 2006 conference and presents on "HIV Prevention & Partner Notification."

## Christopher S. Hall, MD, MS

Christopher Hall is the Deputy Director of the California STD/HIV Prevention Training Center, for which he directs general clinical training issues related to HIV and sexually transmitted diseases for this state-wide and regional training center. He is also the Medical Director at Magnet, a community health center and HIV/STD screening site out of the University of California in San Francisco, where he oversees and provides clinical services. Chris earned his Bachelor of Arts in Chemistry and Biomedical Ethics with Highest Distinction and received his Doctor of Medicine from Johns Hopkins University School of Medicine. At today's HIV Care & Prevention 2006 conference, he gives an "STD Overview for the HIV Care Provider."

## Lawrence McGlynn, MD

Dr. Lawrence McGlynn is a Clinical Instructor for Stanford University's School of Medicine and a staff Psychiatrist for the Adult HIV Psychiatry's Positive Care Program. He is an expert faculty member for the San Jose AIDS Education & Training Center with specialties in substance abuse and mental health issues as they relate to persons living with HIV. Dr. McGlynn received his Bachelor of Science in Mathematics/Computer Science from San Diego State University, his Masters in Operations Research from Stanford University, and his Doctor of Medicine from Harvard Medical School. He speaks at today's HIV Care & Prevention 2006 conference on "Sex, Meth, and HIV."





***WELCOME***  
***Prevention and Partner  
Notification***

Please fill out Participant  
Information Form and  
Pre-Course form.

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***Information Sources***

- CDC Recommendation and Curriculum
- California STD/HIV Prevention Center

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***Presenters***

- Susan Czark, RN, MSN - Nurse Case Manager
- Whitney Houston, J.D. - AIDS Legal Services
- Sil Reyes – Testing Coordinator Crane Center

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### **Story**

- Luis - Client in early 1990's
- Straight male
- 2 girlfriends
- No disclosure
- Concern/Discussion with client
- Ethical Dilemma

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### **What Happened**

- Luis: "I told my girlfriends"
- Safer sex talk?
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- Dying in Hospital
- Told me he had not disclosed HIV
- No Follow-up

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### **Luis' Dynamics**

- Client wanted me to leave him alone
- Did not want to disclose
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- Unresolved Issue at time of dying
  - Guilt?
- Shares non-disclosure

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### ***Missed Opportunity***

- No Experience- What do I do?
- Focus on Care not Prevention
  - Hospice vs Chronic Illness model
  - Lack of Skills and Tools
    - Client's Stage in Model of Change
    - Risk Assessment
    - Client Centered Counseling
    - Harm Reduction Counseling- condoms, lube, STD screening

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### ***What I needed***

- Legal
  - What are my obligations?
- Resources
  - Where do I look? Who do I ask?
- Tools
  - Guidelines
  - Client centered counseling
  - Harm reduction focus
- Practice

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### ***Answers to these questions***

- AIDS Legal Services - What is the Legal Obligation?
- County Health Department-How they assist with Disclosure?
- Tools- Disclosure Assistance
- Resources in Binder

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***Why are you here?***

- Name
- Job title
- Agency
- What you want to get out of the training?
- Share something personal about yourself?

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***Partner Notification is about Disclosure***

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***Disclosure Story***

False + Pregnancy Test at 19

Old World Catholic Family  
Catholic College  
Disclosure- sexual  
Ethical – What should I do?  
Public phone messages

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### ***Disclosure Issues***

- Complex and Difficult for Clients and Providers
- Different levels of Disclosure
  - Past
  - Current
  - Future
- Don't ask, Don't tell ethic

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### ***Disclosure -Client's Concerns***

- Rejection
  - Family/friends
  - Sexual
- Disclosure of other private information
- Possibility of physical violence
- Loss of housing and employment
- Controversy- Privacy rights

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### ***Disclosure- Provider Concerns***

- Ethical Concerns
- Powerful emotions of partners
- Care focus
- Prevention - Another thing to do

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### ***Partner Notification can help***

- Framework to help Clients, Providers and Partners
- Part of Prevention with Positives Focus

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### ***BACKGROUND***

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### ***Why all the Talk about Prevention with Positives***

- 25% of people with HIV unaware
- 40,000 new infections a year
- Routine testing and counseling - new infections in less than 1%.
- Targeted testing of sexual partners of HIV + people- 20%
- Identifying HIV can break chain of infection

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### ***Emphasis on Prevention with Positives***

- Most people who are aware of their HIV infection are practicing safer sex.
- Every HIV transmission involves a person already infected with HIV.
- People with HIV are fewer in number and easier to define than those at risk.
- Most HIV+ persons have contact with healthcare system.

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### ***"Incorporating HIV Prevention into the Medical Care of Persons Living with HIV"***

- Recommendation by the CDC, HRSA, NIH, HIVMA, July 2003
- Addresses missed opportunities
- Ask, Screen, Intervene

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### ***New Prevention Strategies for a Changing Epidemic***

- Make voluntary testing a routine part of medical care.
- Expand HIV testing outside medical settings
- Prevent new infections by working with persons diagnosed with HIV and their partners.
- Further decrease perinatal HIV transmission.

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### ***Recommendations***

- Screen for risk
- Identify and treat STDs
- Communicate prevention messages
- Discuss sex and drugs
- Reinforce positive changes
- Refer for services
- Facilitate partner notification

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**What comes to mind when you hear the term partner notification?**

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***Partner Notification***  
***vs.***  
***Partner Counseling and Referral Services (PCRS)***  
***vs.***  
***California Disclosure Assistance and Partner Services ( CDAPS)***  
***vs.***  
***Disclosure Assistance***

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## ***Legal Obligations***

- What does the law say?

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## ***What does the law and regulations say?***

- What does the law say?
- It is not mandatory that an HIV positive person share their HIV status with a partner.
- But, failure to disclose HIV positive status may result in very serious criminal and civil liability.
- Intentional transmission without disclosure or HIV status is a felony.

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## ***Legal Issues***

- Under California law, physicians may, but are not required to disclose the results of a positive HIV test to one's partner.

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### ***Legal Issues***

- Legal protections against the unwanted disclosure of HIV/AIDS status
- Is disclosure ever required by law?
- Confidentiality rules for medical providers

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### ***Public Health Department***

#### Partner Notification Models

- National Models
- Local Process

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### ***National HIV Partner Notification***

- Based on STD Partner Notification Model
- Long History- 1930s
- Brings HIV more in alignment with other STD's (names reporting, contacts, 3rd party anonymous disclosure)
- Focus on Behavioral Interventions

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### **What is HIV Disclosure Assistance?**

- A voluntary and confidential service
- Assists persons living with HIV with telling their partner(s) about possible exposure
- Facilitates linkages to services
- HIV and STDs may be handled differently based on jurisdiction

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### **3 Disclosure Options**

- **Self Disclosure** – Client wants to disclose him/herself with support from provider in developing a plan
- **Dual Disclosure** – Client wants to disclose him/herself in provider's presence
- **Anonymous 3<sup>rd</sup> Party Disclosure** – Client wants to remain anonymous while a trained professional notifies partner(s)

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### **Rationale for Disclosure Assistance**

- Disclosure Assistance provides an opportunity to:
  - Interrupt disease transmission and prevent complications
  - Provide counseling and education for reducing behavioral risks that increase the risk of STD/HIV transmission
  - Provide access to testing and other prevention services

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***Partner Counseling, Testing, and Referral in Ten States\* with Highest Reported HIV/AIDS Cases in 2002***

- Total HIV/AIDS cases = 55,167
- 22% interviewed and partners elicited through PCTRS
- Of 14,042 partners elicited
  - 16% previously known to be HIV+
- Of partners not previously known to be HIV+
  - 52 % were tested through PCTRS
  - 18% of those were newly identified HIV+

\*California, Florida, Illinois, Louisiana, New York, New Jersey, North Carolina, Pennsylvania, Texas, Virginia 

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***Disclosure Assistance in California***

- California Disclosure Assistance and Partner Services (CDAPS)

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***CDAPS in Santa Clara County***

- Partner notification is always offered to every person receiving a positive HIV positive result.
- Has been offered for many years
- Each Health Department had their own model and process

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### ***CDAPS in Santa Clara County***

- State wants uniform model
- New form to capture this information
- Procedure in Process
  - Community Taskforce  
Forms pending  
Process pending

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### ***STD – Health Department Role***

STD – not voluntary

Your positive result for syphilis, gonorrhea and chlamydia is reported

You will be notified by the health department to ask about contacts.

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### ***HIV- Role of Health Department***

Completely voluntary

Offered to you as a service

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### ***CDAPS in Action***

- 22 yr old Latino man came in for testing.
- Tested Positive for HIV - Initial Positive Test
- Given options
  - Self disclosure
  - Dual Disclosure- disclose in presence of provider
  - Anonymous third party disclosure

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### ***Self Disclosure and Dual Disclosure***

- Client chose to self disclosure to family
- Came back for confirmatory result with his whole family.
- Client and Family able to ask questions
- Referrals made

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### ***Anonymous 3rd party notification Process***

- Client opts for the Health Department to notify partners.
- Service is available to anyone in County:
  - health department
  - private doctor
  - clinic
  - self referrals

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- Health Department receives notification of request for disclosure assistance
- Communicable Disease Investigator/ Disease Investigation Specialist (CDI/ DIS) is health department contact for the request.
- Takes information about referral.
- Confirms HIV Diagnosis with Surveillance Dept.

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### ***CDAPS- 3rd party***

- Communicable Disease Specialist Role
- Discreet, confidential contact with client
  - Field visit- ask about possible partners
  - Gather partner information
    - Who
    - DOB
    - address, phone, email
    - Identifying information

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### ***Communicable Disease Specialists***

- Who performs field work?
- What is said at the door?
- How is confidentiality protected?
- How much information is needed?

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## **Questions**

- What are the chances that this partner will link this disclosure back to you?
- How do you expect this partner to react?
- Is there any chance this partner will harm you?
- What will you say if this partner accuses you of being HIV-positive?
- What will you say if your partner say, "The health worker said it was you"?

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## ***How is HIV partner notification happening now?***

- Some Local Referrals
- More Out of Jurisdiction referrals
- Clients - Self Disclosure
- Providers - Dual Disclosure

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## ***CDAPS – Work in Progress***

- Offered to all in Health Department test sites
- CDAPS Task force currently meeting
- Form for providers to gather contact information in process

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### ***Disclosure Assistance In Action: “Real Life”***

- A 22 year-old, heterosexual male tests HIV positive in a correctional setting
- Disclosure Assistance is offered and he names 3 women- a 19 year-old and a 20 year-old; information about the third woman was limited and she was unlocatable
- The names of the other 2 women are forwarded to the appropriate health jurisdiction and they are found in the same city
- Both women were found and initially did not believe they were at risk, but elected to test for HIV and both were infected
- Disclosure Assistance was offered and each accepted the service

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### ***“Real Life”: The 19 Year-Old Partner***

- This young woman was scheduled to enter nursing school at the time of her positive HIV test result; she also came from a very religious family background
- The original patient was named back and described as her steady and only lifetime partner
- She refused to believe the initial test result and took 3 subsequent HIV tests; all positive
- She had no risk factors other than unprotected vaginal sex
- She elected to enter an Early Intervention Program and reunited with the man who infected her after his release from prison

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### ***“Real Life”: The 20 Year-Old Partner***

- This partner was on her way to the Midwest to attend college at the time of being notified of her exposure to HIV
- She was indignant about her lack of risk, stating she only had sex with women
- Her HIV test result was positive
- The patient told her female partner of her HIV status in the presence of the Disclosure Assistance provider; the Disclosure Assistance provider answered medical questions only (*This is the Dual Disclosure Option*)
- The 2 women remained in the relationship and moved to the Midwest
- This patient returned annually for 3 years to the West coast for EIP care

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### ***"Real Life": Back to the 22 Year-Old Male Patient***

- A year after the initial Disclosure Assistance session and being released from prison, a discussion around new partners surfaced at an EIP session
- 1 of the 3 additional partners was a 16 year-old girl who had recently given birth to his child; she was unable to be located
- The status of the other 2 additional partners is unknown.

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### ***"Real Life": Summary***

- Confidentiality was maintained for all patients and their partners
- Multiple jurisdictions were involved
- 2 of the 3 initial partners for the male were found and neither would have known they were infected
- Disclosure Assistance was offered multiple times to the male patient and more partners were identified

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### ***Provider Role***

What about Me?

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## What are the Benefits and Concerns of Disclosure?

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<b>Key Benefits to Clinician</b>	<b>Common Concerns</b>
<ul style="list-style-type: none"><li>• Fulfils public health and ethical concerns</li><li>• Improves patient outcomes</li><li>• Provides ongoing health department support to meet legal obligations</li><li>• Can be performed by non-clinical staff</li></ul>	<ul style="list-style-type: none"><li>• Threat to confidentiality and patient/clinician relationship</li><li>• Increased work load in a time-limited environment</li><li>• Unclear legal expectations</li></ul>

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<b>Key Benefits to Patients and Partners</b>	<b>Common Concerns</b>
<ul style="list-style-type: none"><li>• Patient does not have to reveal HIV/STD status</li><li>• Fulfils ethical desires for patient</li><li>• Partner learns information about real risk</li><li>• Opens access to wide range of prevention and care services to partner</li><li>• Intervenes in spread to other partner(s) or unborn children</li></ul>	<ul style="list-style-type: none"><li>• Threat to confidentiality</li><li>• Potential for violence, especially against women, when HIV+ serostatus is revealed</li><li>• Stigma-related discrimination</li></ul>

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***Self and Dual Disclosure and  
the Provider***

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***Disclosure options and role of  
provider***

- Self disclosure – Support/Coach client
- Dual Disclosure- Help Client disclose
- Anonymous 3<sup>rd</sup> Party Disclosure- Refer to Communicable Disease Specialist

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***Self Disclosure***

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### ***Self Disclosure***

- The infected patient agrees to inform partners of possible exposure and refer to appropriate services
- Persons initially prefer to inform their partners themselves, although, many patients often find this more difficult than anticipated
- Notification by health department staff seems to be substantially more effective than notification by the infected person

*(CDC/HRSA/NIH/IDSA Recommendations)*

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### ***Self Disclosure***

- **Patient should assess own willingness & ability to:**
  - Disclose own HIV status
  - Accept that partner is not bound to protect confidentiality
  - Contact partner promptly
  - Find a private place for discussion
  - Help partner understand seriousness of HIV
  - Refer the partner for services
  - Anticipate and handle partner's reactions

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### ***Dual Disclosure***

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### **Dual Disclosure**

- The infected person elects to notify their partner(s) in the presence of the Disclosure Assistance provider
- The patient understands he/she is waiving the right to anonymity
- Typically done in a clinic or office setting
- A discussion around boundaries and session management is required **prior** to meeting with partners

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### ***Anonymous 3<sup>rd</sup> Party Disclosure***

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### ***Anonymous 3<sup>rd</sup> Party Disclosure***

- The client elects to have a trainer field staff notify partners
- Anonymous
- Provider gathers partner information
- Client does not know outcome

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## ***Provider's Role***

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### ***Provider Role in Disclosure and Prevention***

- Support and Counsel
- Behavior Change
  - Smoking
  - Diet: Weight loss, Diabetes
  - Exercise
- What Are the Tools

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### ***Provider Role in Disclosure and Prevention***

- Tools/ Behavioral Interventions
  - Harm Reduction
  - Process/Stages of Change
  - Client centered counseling
  - CDAPS / Disclosure Assistance

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### ***Harm Reduction***

Pragmatic

- Take person where they are
- Safe place to explore
  
- Goal- lower health consequences of behavior
  - Sunscreen
  - Designated Driver
  - Needle Exchange
  - Any step to lower risk

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### ***Luis and Harm Reduction***

- Provider Challenge
  - Ethical Issues
    - Luis was putting girlfriends/others at risk
    - Pregnancy risk
    - Responsible to notify?

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### ***Luis' Dilemma***

Strong emotions  
Fear  
Anxiety  
Denial  
Pressure

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***How is Luis and situation best served?***

- Provider Focused- Mandatory Disclosure Discussion
  - Shut down
  - Nothing accomplished
- Harm Reduction
  - Start where client is
  - Safe place to explore

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***Assess Client's Readiness to Change***

- Stages of Change
  - Pre-contemplation-see no need to change
  - Contemplation- see need but barriers
  - Ready for change- Prepare- first steps
  - Action- has made change for short period
  - Maintenance- change for long period

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***Luis' Stage of Change***

- Pre contemplative
  - "My girlfriend does not need to know about me having HIV."
- Next Steps?

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## **Counseling Strategies /Stages of Change**

Pre-Contemplation	Contemplation	Ready for Action	Action and Maintenance
<i>Tell 'story' about case similar to client's</i>	Focus on client's ambivalence and the <i>cost/benefit</i> to change	Build <i>self-efficacy</i> Teach and practice <i>skills</i>	Help client develop <i>support system</i>
<i>Give information specific to client's situation</i>	Offer substitute behaviors / <i>harm reduction</i> options	Develop specific <i>prevention plan</i>	Help client become a <i>role model</i>
<i>Discuss impact of client's behaviors on others</i>	Explore client's <i>self-image</i> in relation to behavior	Increase <i>access</i> to prevention services <i>Refer</i> to additional services/resources	Assist client to recognize and <i>avoid cues</i> to risky behavior Assist client to find <i>substitutes</i> Identify <i>rewards</i> for change

### **Luis- Interventions**

Give information- If you have unprotected sex you may pass HIV to your girlfriend.

Tell a story- I see another couple where the man give HIV to his girlfriend. It was very traumatic for both of them.

Discuss Impact- How would you feel if your girlfriend became HIV +?

Harm Reduction and Stages of Change models both support Client Centered Counseling

CCC is model used for Disclosure Assistance

### ***Client-Centered Counseling***

- **Respects** the priorities and concerns identified by client
- Utilizes **active listening** techniques
- Acknowledges unique **context** of client's life and circumstances
- Is **non-judgmental**
- Offers **options**, not directives
- Respects **cultural differences** and societal influences

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### ***Overview of Disclosure Model***

- **4 STEP MODEL**
  1. Transition to Disclosure
  2. Discuss Who to Tell
  3. Coaching Skills
  4. Summarize Discussion

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### ***Purpose of Model***

To provide a client-centered framework for bringing up the topic of disclosure.

To allow client to make informed choice regarding disclosure after consideration of consequences.

To help client create specific disclosure plan if ready, willing and able to disclose.

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### **Step 1: TRANSITION**

- Bridges to the topic of disclosure
- Draws on context of the current session or setting
- Checks in with client to identify how s/he is feeling regarding this issue
  - Facilitates the clients planning for disclosure
  - Is a simple invitation to discuss the topic

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### ***Support and Coach for Luis***

- ❖ Transition-
  - Your family knows about your HIV. Have you considered telling your girlfriend?
  - What are your thoughts on letting your girlfriend know you are HIV positive?

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### ***Luis***

- ❖ I don't want my girlfriend/s to know I have HIV. I don't want you to tell her/them I have HIV.
- ❖ Provider-Support Coach
  - CCC
    - Info/story/impact
    - Check in with Feelings
    - Contradictions

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***Step 1- Is client interested in talking about disclosure?***

No

If issues not resolved- leave door open

Move to Harm Reduction Step  
“What do you think about using condoms?”

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***Step 1- Is client interested in talking about disclosure?***

Unsure- Explore issues

Stages of Change Interventions  
Keep door open

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***Step 1- Is client interested in talking about disclosure?***

- Yes
- Step 2
  - Who
  - Confidentiality
  - Reaction-

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***Step 2: DISCUSS WHO TO TELL***

- Prioritize disclosure
- Explore:
  - issues
  - benefits
  - concerns
  - possible consequences specific for each person

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***Step 2: Who***

- Discuss what else might be disclosing along with HIV status
- Remind client confidentiality may be breached beyond the person disclosed to
- Ask how client believes the person will react

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***Step 2- Assess for Negative Consequences, Violence and Potential Harm***

If Yes/Possible  
STOP  
Discourage Disclosure  
Refer for assistance

If No- Continue with Discussion  
Step 3- Coach

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### ***Step 3: Coaching Skills***

- Explore when, where and how person with HIV will disclose
- Discuss securing a private place
- Ask client what they will say

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### ***Step 3- Offer Practice***

Offer Practice

Revisit Reaction

Provide referrals/support

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### ***Step 4: Summarize Discussion***

- Review what you have discussed
- Support the client's decision about disclosure, whether they choose to disclose or not
- Leave the door open for further assistance (offer ongoing assistance)

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### ***Review of Disclosure Model***

- Begin with transition statement
- Explore benefits, concerns, potential consequences
- Coach client if appropriate
  - (when, where, what they will say, etc)
- Summarize session

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### ***Do you want/need more help to support clients address disclosure?***

- HIV Disclosure and Partner Services Training
- Free training offered by the California STD branch Office and Office of AIDS
- 2 day trainings-
  - Contact Thomas Knoble- 510-620-5871
  - [www.stdhivtraining.org](http://www.stdhivtraining.org)

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### ***More Resources and Trainings***

- Trainings-
  - San Jose AIDS Education and Training Center- 408-289- 9260
  - California STD/HIV Prevention Training Center-510-625-6000
  - UCSF AIDS Health Project-415-502-4586

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- Referrals/Questions-
  - Crane Center - 408-792-3720
- Partner Notification Task Force
  - Sil Reyes - 408-792-3720

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### ***Thank you for Helping***

- Priya Ramar- Santa Clara County Health Department
- Arlene Harmon- SCCHD
- Rosemary Chavez Collins- SCCHD
- Debra Martinez - SCCHD
- Sil Reyes- SCCHD
- Fern Orenstein- California Disclosure Assistance and Partner Services (CPAPS)
- Phoenix Smith - CDAPS
- Thomas Knoble - CDAPS

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**Please fill out  
Post Course Evaluation**

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# STD Overview for the HIV Care Provider

Christopher Hall, MD, MS

California STD/HIV Prevention Training Center  
California STD Control Branch



## CDC STD Treatment Guidelines Development

- Evidence-based on 4 principal outcomes of STD therapy
- Recommended regimens preferred over alternative regimens
- Alphabetized unless there is a priority of choice
- Reviewed in April 2005
- [www.cdc.gov/std/treatment](http://www.cdc.gov/std/treatment)

## Overview of Presentation

- 2006 CDC STD treatment guidelines – *new!*
- Prevention and Screening Guidelines
- Clinical Issues:
  - Syphilis
  - Chlamydia and Gonorrhea
  - Mycoplasma genitalium (Mg)
  - Lymphogranuloma venereum (LGV)
  - Trichomonas
  - Herpes simplex virus (HSV)
  - Human Papillomavirus (HPV)
- STD Screening in the Care Setting
- Partner Management Tools

## STD Screening for MSM

STD	Site	Type of Sex
HIV	blood	oral, anal
Syphilis	blood	any
GC/CT	urethra or urine	oral, anal
GC/CT	rectum	receptive anal
GC	pharynx	receptive oral
HSV-2*	blood	

\* Some experts recommend

FREQUENCY: At least at the initial visit then annually or more frequently; based on risk

## Prevention & Screening Issues

- Sexual history taking and risk reduction counseling
- Patients should be informed about which STDs they are tested for (and which not)
- Emergency contraception should be available
- Non-occupational PEP for HIV prevention
- STD screening recommendations: pregnant women, adolescents, MSM

*Discussed at the  
2006 Guidelines Meeting*

## Indications for More Frequent Screening in MSM

- Increased prevalence of STIs in area or patient population
- Symptoms or recent history of any STI in patient or partner
- Risky sexual behavior
- Risky sexual behavior in partner
- If any of the above, then screen q 3-6 months

MMWR 2003; 52: RR-12

*Discussed at the  
2006 Guidelines Meeting*

## STD Screening for Women

- Adolescents & up to age 25
  - Annual chlamydia screening
  - Gonorrhea screening based on risk factors
  - Others STDs based on risk
  - HIV (?)
- Pregnant women (first trimester)
  - HIV
  - Syphilis serology
  - Hep B sAg
  - Chlamydia
  - Gonorrhea based on age and risk
  - Hep C based on risk
  - BV if high risk pregnancy

## Chlamydia and Gonorrhea Screening in Heterosexual Males

- Screening in males not routinely recommended
- Need evidence of reduction of infection in women to be cost effective
- However, selective screening in high prevalence populations may be beneficial
- Modeling suggests Chlamydia prevalence among males should be at least 6%
- CDC will develop separate guidance in this area

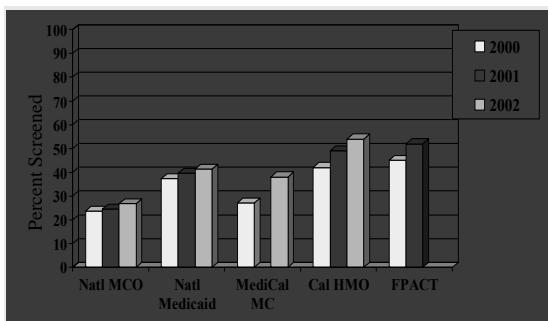
*Discussed at the  
2006 Guidelines Meeting*

## Recommend Nucleic Acid Amplification Tests for Detecting Chlamydia and Gonorrhea

- Highest sensitivity
  - Able to detect up to 40% more CT infections
  - Less dependent on specimen collection and handling
- Noninvasive
  - Urine and self-collected vaginal swabs
- Non-clinical settings
  - Pelvic and genital exams not necessary
    - Clinic intake areas
    - Community based organizations
    - Home testing



## Estimated Chlamydia Screening Coverage, Women 16-26

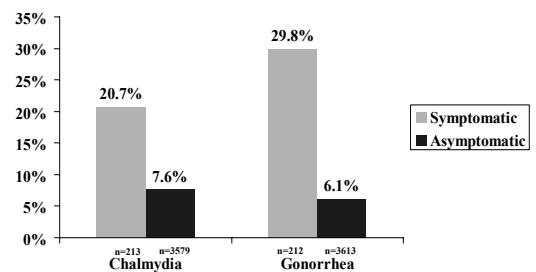


## HIV Prevention Practices at Ryan White Clinic Visits

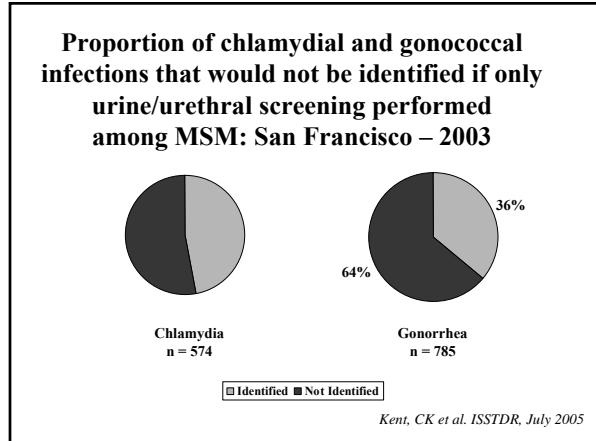
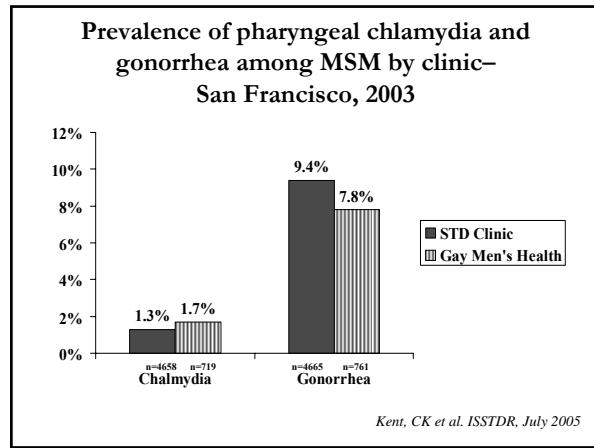
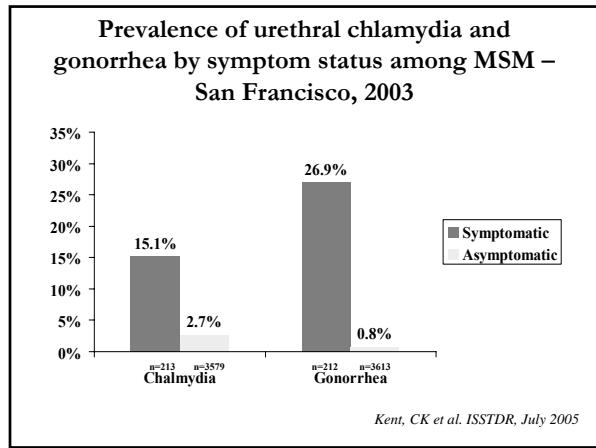
- 25% reported someone at the clinic spoke to them about "safer sex and how you can prevent giving HIV to someone else."
- 6% discussed specific sexual activities
- 7% discussed disclosure to partners
- 9% received reading material
- 6% tested for STD that day

*Morin S, Study of Ryan White Care Clinics, 2003*

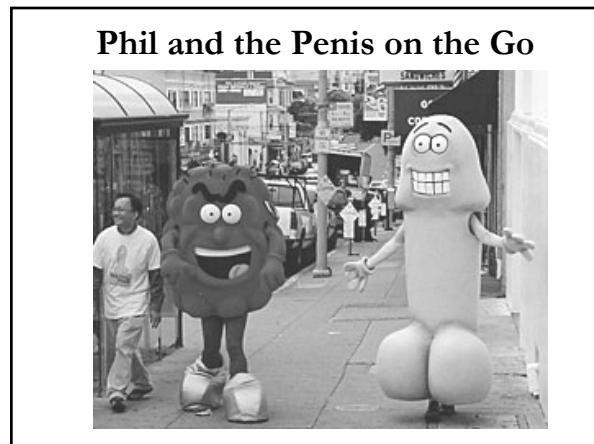
## Prevalence of rectal chlamydia and gonorrhea by symptom status among MSM – San Francisco, 2003



*Kent, CK et al. ISSTDR, July 2005*



- Obstacles to rectal and pharyngeal screening for CT and GC**
- No FDA cleared tests other than culture
    - Culture not as sensitive as NAAT
    - CT culture not routinely available & expensive
    - GC culture no longer widely available
  - Comprehensive risk assessments are not routinely done by providers
  - What to do?
    - Incorporate routine risk assessments into clinical practice
    - Create demand for rectal and pharyngeal tests
    - Work with your laboratory to perform validation study for NAAT



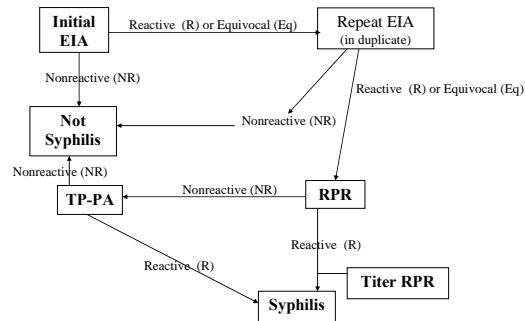


## Syphilis Issues

- Recommend against the use of azithromycin
- Note penicillin usage problems
  - BIC shortage
  - Specify use of Bicillin L-A (NOT Bicillin C-R)
- Diagnostic issues
  - New EIA testing algorithms: reflexive quantitative RPR/VDRL, alternative treponemal test for discrepancies
  - Some experts recommend CSF exam for
    - Patients with latent syphilis and RPR  $\geq 1:32$
    - HIV-infected patients and CD4 count  $\leq 350$

*Discussed at the  
2006 Guidelines Meeting*

## Syphilis EIA Testing Algorithm



## Criteria for CSF Examination

- Neurologic or ophthalmic symptoms/signs
- Evidence of tertiary disease
  - aortitis, gumma, iritis
- Treatment failure
- HIV infection with late latent or latent of unknown duration
- Some experts recommend a CSF exam in all patients with latent syphilis and an RPR titer  $\geq 1:32$  and HIV-infected patients with CD4 count  $\leq 350$

## Proposed Criteria for Performing LP in HIV-Infected Patients with Newly Diagnosed Syphilis

Stage of Syphilis	CD4-Cells	Recommendation
Primary or early latent with RPR $\leq 1:32$	$\geq 350$ $<350$	No LP Consider LP
Any stage with RPR $>1:32$	Any	Consider LP
Late-latent or syphilis of unknown duration	Any	LP indicated
Positive RPR/confirmatory test with neurologic or ophthalmic symptoms and/or signs	Any	LP indicated

Source: AIDS Clinical Care, 2003 Vol. 15, No 2

Source: NEJM 1999;341:556-62

## Syphilis Resistant to Azithromycin!



The NEW ENGLAND  
JOURNAL of MEDICINE

### Macrolide Resistance in *Treponema pallidum* in the United States and Ireland

Sheila A. Lukehart, Ph.D., Charmie Godornes, B.S., Barbara J. Molini, M.S., Patricia Sonnett, B.S., Susan Hopkins, M.D., Fiona Mulcahy, M.D., Joseph Engelman, M.D., Samuel J. Mitchell, M.D., Ph.D., Anne M. Rompalo, M.D., Christina M. Marra, M.D., and Jeffrey D. Klausner, M.D., M.P.H.

N Engl J Med 2004;351:154-8.

## Bacterial Resistance to Macrolides

- Increasing among bacterial pathogens
- Seven separate mutations of bacterial 23S ribosomal RNA (23S rRNA) confer resistance to macrolide antibiotics
- *T. pallidum* isolate “Street 14”
  - 1977: Erythromycin treatment failure of syphilis
  - 2000: Mutant 23S rRNA gene identified
- In San Francisco, the frequency of azithromycin-resistant *T. pallidum* isolates increased from 4% during 2000–2002 to 37% during 2003

## Syphilis Treatment Primary, Secondary & Early Latent

Recommended regimen for adults:

- Benzathine penicillin G 2.4 million units IM in a single dose

Alternatives (non-pregnant penicillin-allergic adults):

- Doxycycline 100 mg po bid x 2 weeks
- Tetracycline 500 mg po qid x 2 weeks
- Ceftriaxone 1 g IV or IM qd x 8-10 d
- Azithromycin 2 g po in a single dose

*Recommended for 2006 Guidelines*

## Chlamydia – Treatment Issues

### ■ Azithromycin

- Concern over high rate of persistent infection after treatment with azithromycin (4-10% for those reporting no sexual exposure)

### ■ Treatment in Pregnancy

- ADD azithromycin to first-line treatment
- MOVE erythromycin base from a first-line medication to alternative

*Discussed at the  
2006 Guidelines Meeting*

## Current Chlamydia Treatment Adolescents and Adults

### Recommended regimens:

- ◆ Azithromycin 1 g PO x 1
- ◆ Doxycycline 100 mg PO BID x 7 d

### Alternative regimens:

- ◆ Erythromycin base 500 mg PO QID x 7 d
- ◆ Erythro ethylsuccinate 800 mg PO QID x 7 d
- ◆ Ofloxacin 300 mg PO BID x 7 d
- ◆ Levofloxacin 500 mg PO QD x 7 d

**\*\* NO PROPOSED CHANGES FOR 2006 GUIDELINES \*\***

*Recommended for 2006 Guidelines*

## Proposed Chlamydia Treatment Pregnancy

### Recommended regimens:

- \* Azithromycin 1 g PO x 1
- ◆ Amoxicillin 500 mg PO TID x 7 d

### Alternative regimens:

- \* Erythromycin base 500 mg PO QID x 7 d
- ◆ Erythromycin base 250 mg PO QID x 14 d
- ◆ Erythro ethylsuccinate 800 mg PO QID x 7 d
- ◆ Erythro ethylsuccinate 400 mg PO QID x 14 d

Test of cure in 3-4 weeks

*Recommended for 2006 Guidelines*

## Gonorrhea – Treatment Issues

- Concern over increasing rates of QRNG
  - 5% QRNG threshold for changing antimicrobial regimens
- Rates among heterosexual males outside CA and HI still less than 1% in 2004
- Fluoroquinolones NOT recommended for:
  - Acquisition in CA or HI
  - MSM
  - Any foreign acquisition
- Oral cephalosporins alternatives:
  - ADD cefpodoxime 400 mg po x 1
  - ADD cefuroxime 1 g po x 1

*Discussed at the  
2006 Guidelines Meeting*

## CDC Recommends Against Fluoroquinolones for GC in MSM



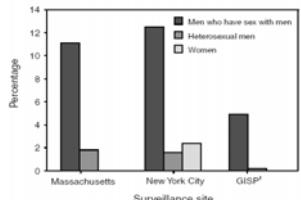
April 30, 2004 / Vol. 53 / No. 16

**Increases in Fluoroquinolone-Resistant *Neisseria gonorrhoeae* Among Men Who Have Sex with Men — United States, 2003, and Revised Recommendations for Gonorrhea Treatment, 2004**



## Fluoroquinolone-resistance GC among MSM-2003

FIGURE. Prevalence of fluoroquinolone-resistant *Neisseria gonorrhoeae* infection, by sex, sexual behavior, and surveillance site — United States, 2003\*

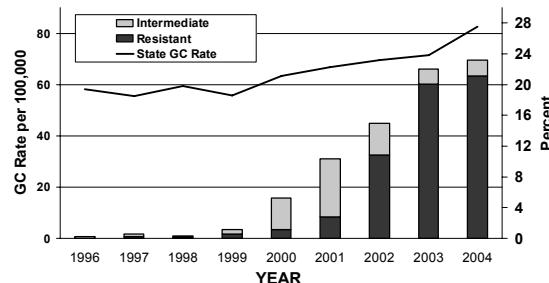


\* Data from Massachusetts and New York City are from sexually transmitted disease clinics. In the Gonococcal Isolate Surveillance Project (GISP), data from California, Hawaii, and Massachusetts are surveyed in GISP. All data are preliminary. Gonococcal Isolate Surveillance Project.



CDC. MMWR. April 30, 2004 / 53(16):335-338

## Percent of *Neisseria gonorrhoeae* Isolates with Decreased Susceptibility or Resistance to Ciprofloxacin, California GISP, 1996–2004



## Gonorrhea Treatment if QRNG Uncomplicated Genital/Rectal Infections

- **Do not fluoroquinolones** (ciprofloxacin, ofloxacin, and levofloxacin)
- **Recommended regimens** for uncomplicated gonococcal infections of the cervix, urethra, and rectum:
  - ◆ Ceftriaxone 125 mg IM in a single dose *OR*
  - ◆ Cefixime \* 400 mg orally in a single dose
  - Co-treatment of chlamydia is recommended unless chlamydia infection has been ruled out

\* if available

*Recommended for 2006 Guidelines*

## Gonorrhea Treatment if QRNG Uncomplicated Genital/Rectal Infections

- **Alternative regimens** for uncomplicated gonococcal infections of the cervix, urethra, and rectum include:
  - ◆ Single dose injectable cephalosporins: Ceftizoxime 500 mg IM, Cefoxitin 2 g IM with Probenecid 1 g PO, *or* Cefotaxime 500 mg IM *or*
  - ◆ Spectinomycin 2 g IM x 1 *or*
  - ◆ Cefpodoxime 400 mg PO x 1 *or*
  - ◆ Cefuroxime axetil 1 gm PO x 1 *or*
  - ◆ Azithromycin 2 g PO x 1
  - Co-treatment of chlamydia is recommended unless chlamydia infection has been ruled out

*Recommended for 2006 Guidelines*

## Gonorrhea Treatment if QRNG Exogenous Infections and PCN-allergic

- Pharyngeal:
  - ◆ Ceftriaxone 125 mg IM x 1 *or*
  - ◆ Azithromycin 2 g PO x 1
- For patients with PCN anaphylaxis-type allergy and where use of cephalosporins is a concern
  - ◆ Azithromycin 2 g PO x 1 *or*
  - ◆ Spectinomycin 2 g IM x 1 *or*
  - ◆ A fluoroquinolone (ciprofloxacin, ofloxacin, levofloxacin) with a test of cure

*Recommended for 2006 Guidelines*

*for patients with gonorrhea in California, Hawaii and among MSM...*



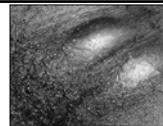
## Nongonococcal Urethritis (NGU)



- New etiologic agent: *Mycoplasma genitalium*
- No change in diagnostic criteria
- Treat for CT; azithromycin efficacy better for Mg
- Recurrent/persistent NGU:
  - Consider trich, prostatitis, non-infectious etiologies
  - Treat with metronidazole PLUS azithromycin if not used for initial infection
  - DELETE erythromycin alternatives for treating recurrent NGU

*Discussed at the  
2006 Guidelines Meeting*

## Lymphogranuloma Venereum (LGV)



- Caused by *C. trachomatis* serovars L1, L2, L3
- Clinical presentation
  - Lymphadenopathy syndrome: ulcer & inguinal adenopathy (bubo)
  - Anorectal syndrome: proctitis/protocolitis
- Complications from destructive granulomatous process including abscesses with scarring, fistulae, strictures, genital elephantiasis

## LGV Outbreak Reported



Morbidity and Mortality Weekly Report

October 29, 2004 / Vol. 53 / No. 42

### Lymphogranuloma Venereum Among Men Who Have Sex with Men — Netherlands, 2003–2004

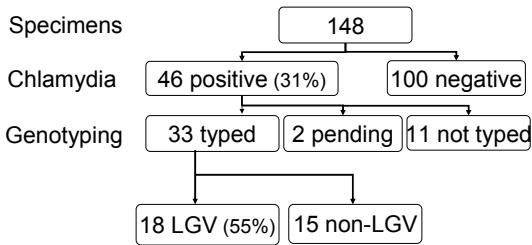
- Netherlands: 92 confirmed cases between 4/03 and 9/04
- Majority with bloody proctitis, mucopurulent anal discharge
- Similar outbreaks in 2004 in Antwerp, Hamburg, Paris, Sweden, and UK
- Recent reports in Canada and U.S.
- Nearly all MSM

## Netherlands Outbreak 2003-2004

- 92 confirmed cases between 4/03 and 9/04
  - prior average: 5 cases annually
- Majority presented with GI symptoms
  - Bloody proctitis, mucopurulent anal discharge
- Only 1 patient had genital ulcer/bubo
- All urines negative for CT\*
- Observed in this series:
  - 77% HIV+ (of those with known HIV status)
  - Concurrent STDs (6/13 included GC, HSV, syphilis, hepatitis C)

*MMWR 2004; 53 (42); 985-988; \*Nieuwenhuis.CID 2004; 39 (1 Oct); 996-1003*

## LGV in the U.S.: CDC's National Surveillance Project: November 2004 – September 2005\*



*H Lindstrom, C McLean, IDSA 2005*

## Characteristics of U.S. Patients with Confirmed LGV

15/15 Men; all men who have sex with men

Median age = 36 years (range 29 – 46)

15/16 Proctitis

1/16 Inguinal lymphadenopathy

13/16 HIV-positive

11/11 Unprotected receptive anal intercourse

1/13 Known history of travel outside the US

*H Lindstrom, C McLean, IDSA 2005*



## **Proctitis as a Sentinel Event**

*Proctitis in an HIV-negative MSM should be considered a sentinel event, necessitating education, risk assessment and risk reduction counseling, STD and HIV testing, with follow-up HIV testing at 3 months after diagnosis*

## **Trichomoniasis Issues**

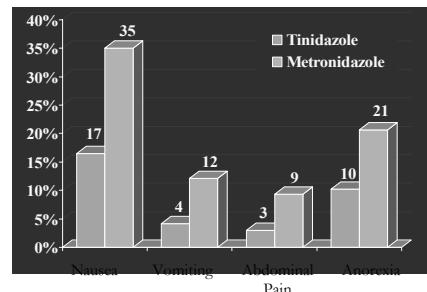
- Diagnosis on Pap test lacks specificity; recommended confirm with culture if patient is at low risk
- New treatment:
  - ADD tinidazole 2 g po x 1
  - Higher cost but better tolerated
- New management of treatment failure (after metro 2 g po x 1) and Metronidazole-resistant trichomonas

*Discussed at the  
2006 Guidelines Meeting*

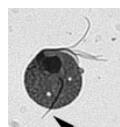
## **Tinidazole: A New Treatment Option**

- Second generation 5-nitroimidazole
  - 92%-100% effectiveness for trichomoniasis
  - Contraindicated in pregnancy (category C)
- Advantages versus Metronidazole
  - Greater tolerability (approx. ½ incidence of nausea and vomiting)
  - Longer duration of action (t<sub>1/2</sub> of 12-14 hrs vs 6-7 hrs)
  - Greater in vitro potency against protozoa and anaerobes
  - Effective in metronidazole-resistant trichomoniasis
    - 92% (22/24) cure rate in largest report
  - Enhanced penetration in genital tissues

## **GI Side Effects Tinidazole vs. Metronidazole Trichomoniasis Treatment**



*Based on 7 Comparative Trials*



## **Proposed Trichomoniasis Treatment**

### Recommended regimen:

- Metronidazole 2 g PO x 1
  - \* **Tinidazole 2 g po x 1\***
- \* Contraindicated 1<sup>st</sup> trimester of pregnancy*

### Alternative regimen:

- Metronidazole 500 mg PO BID x 7d

### Recommended regimen in pregnancy:

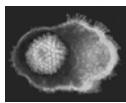
- Metronidazole 2 g PO x 1

*Recommended for 2006 Guidelines*

## **Proposed Management Trichomoniasis Treatment Failure**

- Re-treat with: Metronidazole 500 mg po BID x 7 d OR **Tinidazole 2 g po x 1**
- If repeat failure, treat with: Metronidazole or **Tinidazole 2 g po x 5 d**
- Some experts treat with: **Tinidazole 2-3 g po x 14 d**
- Susceptibility testing: Send isolate to CDC

*Recommended for 2006 Guidelines*



## HSV Issues

- Role of type-specific HSV serologic tests
- Role of suppressive therapy to reduce transmission

*Discussed at the  
2006 Guidelines Meeting*

## Genital Herpes – Testing Issues

- Type-specific HSV-2 serology tests may be useful:
  - Recurrent/atypical symptoms with negative culture
  - Clinical diagnosis without lab confirmation
  - Patients with a partner with genital HSV
- Some experts recommend serology tests:
  - Patients who request testing or as part of “comprehensive STD evaluation”
  - Multiple partners, HIV-infected, MSM with high HIV risk, (pregnancy)
- Universal screening NOT recommended

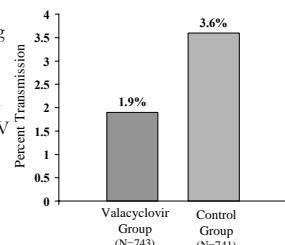
*Discussed at the  
2006 Guidelines Meeting*

## HSV Shedding and Transmission

- Asymptomatic shedding more common in first 2 years (5-10% of days), less common later (2% of days)
- Research with discordant couples finds sexual transmission ~12% per year
  - ◆ 17% male to female
  - ◆ 4% female to male
- Most sexual transmission occurs during asymptomatic shedding
- Suppression therapy reduces both shedding and transmission

## Rates of Transmission of HSV-2 to Susceptible Partners is Reduced with Once-Daily Suppressive Therapy

- 1484 heterosexual couples randomly assigned to take 500 mg of valacyclovir or placebo once daily for 8 months
- Serum samples collected monthly from susceptible partners for HSV analysis
- The valacyclovir group showed
  - decreased transmission
  - lower frequency of shedding
  - fewer copies of HSV-2 DNA when shedding occurred

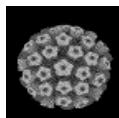


*Corey et al, NEJM 2004; 350:11-20*

## Genital Herpes – Treatment Issues

- Treatment for recurrence:
  - ADD Acyclovir 800 mg PO TID for 2 days
- Prevention of sexual transmission:
  - Antiviral treatment at suppression dose
  - Indications may include: discordant couples, persons with multiple partners, MSM
  - Reassess discordant partner annually for seroconversion
  - Counsel regarding condoms, disclosure, abstinence

*Discussed at the  
2006 Guidelines Meeting*



## HPV Issues

- Clarify uses of HPV DNA test in women
- No recommendations regarding HPV testing and anal Pap smears in MSM or HIV-infected patients
- No change in diagnosis or treatment of external genital warts

*Discussed at the  
2006 Guidelines Meeting*

## Clinical Indications for HPV DNA Testing

### Proven to be clinically useful for:

- Triage of ASCUS Pap smears
- Adjunct screening in women age 30 and over
- 12-month f/u of LSIL in adolescents
- Post-colposcopy and post-treatment follow-up

### NO proven benefit for:

- Triage of ASC-H, LSIL in adults or higher grade lesions
- STD screening in the general population
- Evaluation of sex partners
- Evaluation of genital warts

## Issues Regarding Anal Cancer Screening in MSM or HIV-infected patients

- Anal HPV DNA is prevalent so role of HPV testing in anal cancer screening is in doubt
- Little data on the natural history of anal SILs
- Questions regarding reliability of screening methods
  - Inconsistent correlation between anal Paps and histology
  - Intraobserver variability in interpretation of anal Pap smears
- Limited data on treatment efficacy and side effects
- If clinicians are conducting anal cancer screening, then collecting useful data to inform screening recommendations is recommended

*Discussed at the  
2006 Guidelines Meeting*

## A Controlled Trial of HPV Type 16 Vaccine – 3.5 year follow-up

Endpoint	Placebo Cases	HPV 16 Vaccine Cases	Vaccine Efficacy	95% Confidence Interval
HPV 16 Infection and CIN				
HPV infection	111	7	94%	88 – 98%
CIN 2/3	12	0	100%	65 – 100%

Mao et al. 44<sup>th</sup> ICAAC Nov 2004  
750 placebo; 755 vaccine



*"On the Internet, nobody knows you're a dog."*

## Innovation in Partner Notification via Internet

Individuals use Web site to notify partners

- anonymous
- free
- referrals for testing provided

<http://www.inspot.org>

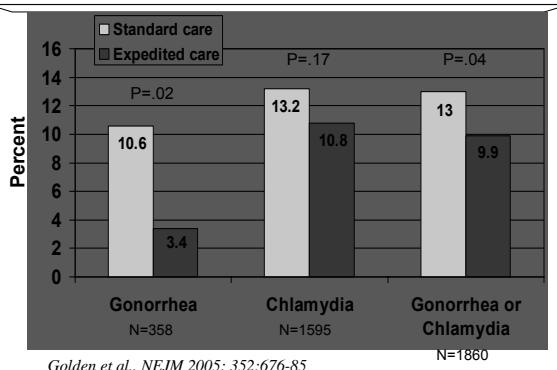


©2000 Greetings Network, Inc; Laurie Frankel

## Partner Treatment Options

- Patient referral
- Provider or clinic referral
- Health department referral
- Expedited Partner Treatment (EPT)
  - Patient-delivered partner therapy (PDPT)
  - Health department-delivered therapy
  - Pharmacy-delivered therapy

### Infection During Follow-up Among Patients Completing the EPT Trial



Golden et al., NEJM 2005; 352:676-85

### Recommendations for Chlamydia and Gonorrhea Re-Testing after Treatment

- Prefer “re-testing” to “re-screening”
- High rates of re-infection after treatment
- Recommend re-testing of females with CT; some experts suggest re-testing of males
- Consider re-testing of females with GC; some experts suggest re-testing of males
- Time frame: 3 months after treatment

Discussed at the  
2006 Guidelines Meeting

The NEW ENGLAND JOURNAL of MEDICINE

### ORIGINAL ARTICLE

#### Effect of Expedited Treatment of Sex Partners on Recurrent or Persistent Gonorrhea or Chlamydial Infection

Matthew R. Golden, M.D., M.P.H., William L.H. Whittington, A.B., H. Hunter Handsfield, M.D., James P. Hughes, Ph.D., Walter E. Stamm, M.D., Matthew Hogben, Ph.D., Agnes Clark, B.S., Cheryl Malinski, B.S., Jennifer R.L. Helmers, B.S., Katherine K. Thomas, M.S., and King K. Holmes, M.D., Ph.D.

NEJM 2005; 352:376

### Chlamydia and Gonorrhea Expedited Partner Treatment

- Expedited Partner Treatment (EPT) or Patient-Delivered Partner Treatment (PDPT)
  - Add as option for partner management for heterosexual men and women
  - First line management is clinical evaluation
  - Concern regarding co-morbidities (e.g., PID in women, HIV in MSM)
  - CDC will develop separate guidance on EPT/PDPT

Discussed at the  
2006 Guidelines Meeting

### STD Resources

- California STD/HIV Prevention Training Center
  - [www.stdhivtraining.org](http://www.stdhivtraining.org)
- National Network of STD/HIV Prevention Training Centers
  - [www.stdhivpreventiontraining.org](http://www.stdhivpreventiontraining.org)
- CDC Treatment Guidelines
  - [www.cdc.gov/std/treatment](http://www.cdc.gov/std/treatment)





## Meth, Sex, and HIV

Lawrence Michael McGlynn MD

Assistant Clinical Professor  
Director – Mental Health Services  
Stanford University Positive Care Program

April 2006

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## Overview

- o Recreational Drugs and The Brain
  - Methamphetamine
- o Methamphetamine and HIV and The Brain
- o Approaches to prevention and treatment

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Tina



Mother's Little Helper

Ice

Crystal

Chrissy

Crank

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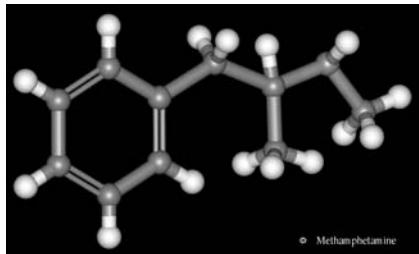
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○ Methamphetamine

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Methamphetamine Crystals  
Photo by Slutt, © 2001 Erowid.org

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How do so many people find  
meth?

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- PNP Horned Up and Ready to PNP - 38 (castro / upper market)
- Reply to: [anon-94719387@craigslist.org](mailto:anon-94719387@craigslist.org)  
Date: 2005-08-31, 11:15PM PDT

looking to party some here. horned up and looking to hook up and hang with other fun guys. good looking, versatile, laid back and have favors to share

38 5'9" 145#

neg n U b too. Bb cool.  
Pics with reply

- no -- it's NOT ok to contact this poster with services or other commercial interests

Copyright © 2005 craigslist, inc.

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Reply to: [anon-98850541@craigslist.org](mailto:anon-98850541@craigslist.org)  
Date: 2005-09-20, 3:06PM PDT

I am looking for a fun, attractive Female 25-50 to hangout with and Party and maybe play. I have Drinks, Tina, 420 and Vik's. I can host.

me handsome swim 6'4"tall in great shape, clean cut and fun

this is in or around South Bay

- no -- it's NOT ok to contact this poster with services or other commercial interests

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## Background

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## What is Amphetamine/ Methamphetamine?

- Central nervous system (CNS) stimulants; synthesized in 1887 (amphetamine) and 1919 (meth)
- Compared to amphetamine, meth has longer lasting and more toxic effects (NIDA)
- Formulations of meth:
  - Powder, waxy solid (glass), clear rock (ice)
- Administration of meth:
  - Smoke, inject – produces brief pleasurable “rush” or “flash”
  - Swallow, snort – produces euphoric high, but not a rush
  - Insert anally (“booty bumping”)

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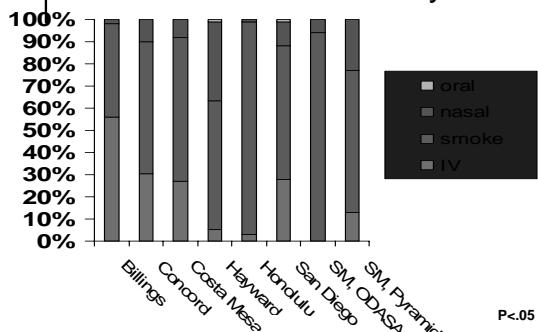
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## Route of Administration by Site



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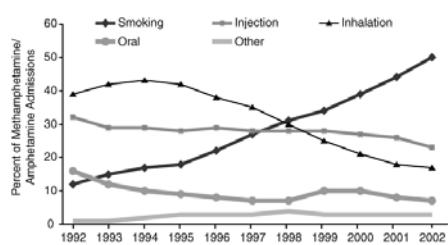
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## Admissions for methamphetamine treatment– SAMHSA, 2004



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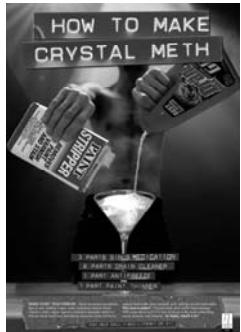
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## Crystal Meth Ingredients

- Three main ingredients
  - pseudoephedrine (Sudafed)
    - \$8.00 for 96 pills
    - crush the pills; soak in denatured EtOH 4-8 hrs
    - Filter liquid and boil it down to bottom on stove. Finish drying with hairdryer
    - Mix powder with distilled H<sub>2</sub>O. Freeze 1/2 hr.
    - Filter again; boil; hair dry again
  - Red phosphorus (matchbooks)
  - Iodine crystals

[Http://www.totse.com](http://www.totse.com)

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## Obtaining Iodine Crystals

- "Iodine is watched by the gov't and they will take your ID and put you on the list if you buy from a chemical supplier. So the safest way is to go to the pharmacy and say it's for your horse's hooves. But you'll need a lot and have to go to a lot of pharmacies"
- "New Info! You can purchase iodine tincture in gallon sizes at any Quality Farm & Fleet. It's about \$12.00 for a gallon. Just take it up to a cashier who looks young and stupid."

[Http://www.totse.com](http://www.totse.com)

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## Other Ingredients

- ☛ Coleman Fuel (sporting goods store, Walmart)
- ☛ Muriatic Acid (HCl) (hardware store)
- ☛ Acetone (hardware store)
- ☛ Methanol or denatured alcohol (hardware store)
- ☛ Tubing & PVC connectors (hardware store)
- ☛ Flask (hobby store, chemical supplier)
- ☛ Red Devil Lye (K-Mart, Walmart, grocery store)
- ☛ pH strips (hobby store, or use red cabbage)
- ☛ Vision Ware Bowl (K-Mart)

[Http://www.totse.com](http://www.totse.com)

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## What Does Meth Do in the Brain?

- Releases high levels of the neurotransmitter dopamine (->psychosis)
- Neurotoxicity -- damages brain cells that contain dopamine or serotonin (->Park.)
- High: 8-24 hours; t ½ 12 hrs

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## “Tweaking”

### Major symptoms may include:

- Dilated pupils and staring/trance state
- Severe paranoia and hallucinations
- Rapid body movement; jerking
- ‘Meth bugs’ (paresthesias, caused by an imbalance in sensory neurons) and may lead to picking one’s skin
- Increased motor activity/performing repetitive acts
- Teeth grinding
- Bad breath

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### “Meth Mouth”

Source: New York Times, June 11, 2005



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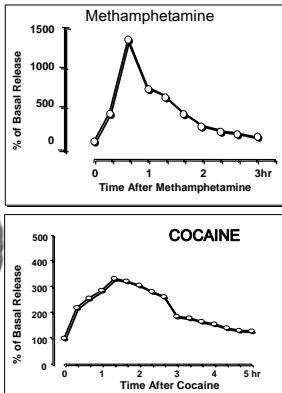
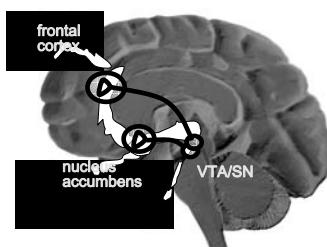
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### Dopamine Neurotransmission (Courtesy NIDA)



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### Additive Effects of HIV and Chronic Methamphetamine Use on Brain Metabolite Abnormalities

- 68 HIV+ subjects (24 meth+; 44 no drug history); 75 HIV- (36 meth+)
- N-acetylaspartate, creatine, choline, myo-inositol measured in frontal cortex, frontal white matter, and BG
- Results:
  - Damage due to HIV+ status observed in FC and FWM
  - Damage due to Meth+ observed in FC, FWM, and BG
  - Damage due to HIV+ and Meth+ observed in FC, FWM, and BG

Chang L, et al. Am J Psychiatry 162:2, February 2005.

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### "If I do meth, my CD4 goes up."

- HIV is associated with reduced volumes of cortical, limbic, and striatal structures
- Older HIV+ patients suffer disproportionate loss
- Meth is associated with *increases* in basal ganglia, parietal cortex, and (in younger) nucleus accumbens volumes
- Neurocognitive impairment associated with decreased cortical volume in HIV+
- Neurcognitive impairment associated with *increased* cortical volume in meth dependent
- HIV+/Meth+ brain volumes not associated with neurocognitive impairment. However, hippocampal volume decreases were associated with impairment in this group (lack of opposing effects).

Jernigan TL et al. Am J Psychiatry 2005; 162:1461-1472

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### Signs of Drug Use and Selling

- People who are paranoid, anxious, hyper, agitated or unable to stand still
- Pale complexion, open sores, rotting teeth, rapid weight loss
- Neglected children
- All-night activity, high volume, short-term visit. Visitors parking down the street, walking to the house, staying for brief visits.
- Odd/eccentric behavior. Yard work in middle of night, working in garage or shed all night. Secretive and defensive.
- Many vehicles in the yard or street. Users claim to earn money by working on cars. No one in house has a real job.
- Run-down house/yard. Utilities sometimes shut off.

Webber Morgan Narcotic Strike Force 2005.

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### Signs of Drug Use and Selling (cont'd)

- Frequent new renters.
- Surveillance cameras. Windows covered with sheets or blankets.
- Constant flow of property coming into home, such as stereos, tvs, etc.
- Discarded syringes, ziploc bags, glass tubes with burn residue.
- Residents do not use curb-side garbage pickup. House garbage will be stored in garbage bags and hauled away.

Webber Morgan Narcotic Strike Force 2005.

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## Meth Marketing

- ✓ You're not yourself!
- ✓ You're too fat!
- ✓ You're too lazy!
- ✓ You're not working hard enough!

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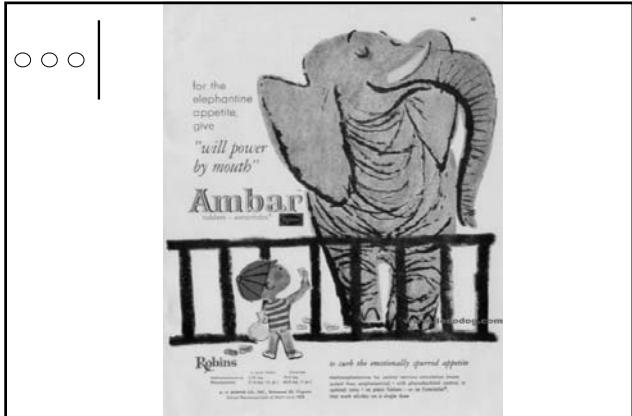
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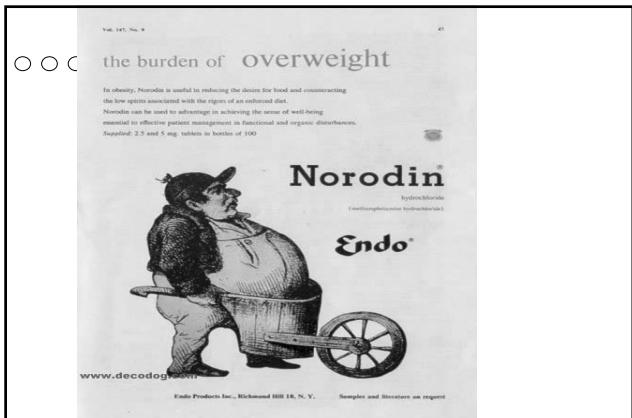
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What is different now?

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### Key Differences Between Now and Earlier Outbreaks

- The Internet
- National outbreak
- Varied sub-populations
- More smoking
- Strong association with HIV, hepatitis C, STDs
- Diffused local production, less reliance on imports
- Method of manufacture

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### Methods of manufacture

- Until mid-1990's, the P2P method was used to produce D,L-methamphetamine -- a racemic mixture
- P2P, a precursor, was regulated and subject to strict enforcement and arrest for possession - 1996
- Producers switched to the easier Birch (so-called Nazi) pseudephedrine reduction method, producing very potent D-methamphetamine
- The Birch reduction produces better "product" – diffusion brings more reliance on home production, less reliance on imported finished supplies.
- Importation of precursors and theft of precursors now rampant.

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## Prevalence and Community Dangers of Meth Use

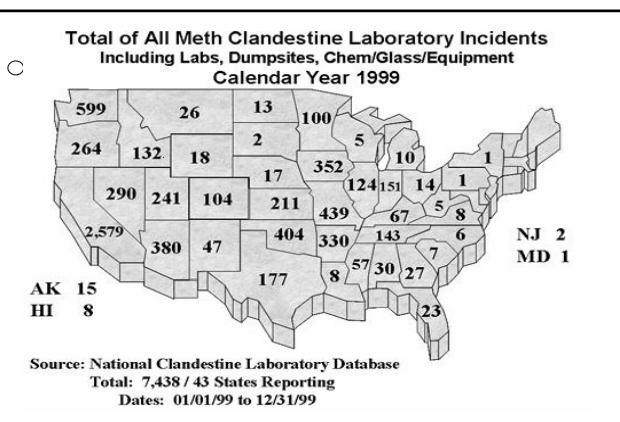
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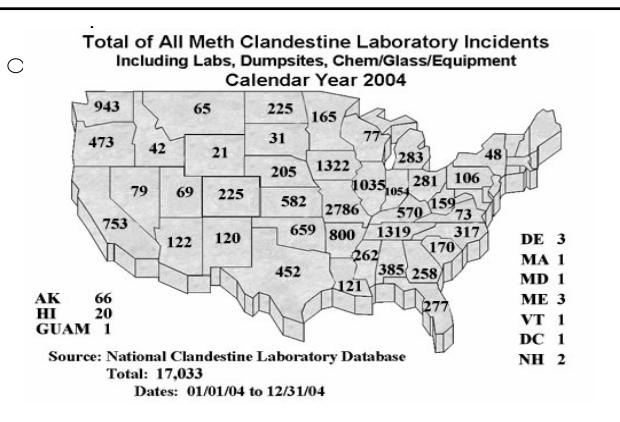
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## Lots of Studies Now Available

- o Summary of results
  - More people are using meth, and it's spreading across the country
  - Men and women use meth
  - Meth use leads to unprotected anal sex and HIV in MSM and Heterosexuals
  - Meth users more likely to be HIV+

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## Current Epidemic in Popular Media

- o 2 current contexts:
  - 1) Rapid spread of small-time and larger meth labs across the country (especially rural and reservations)
  - 2) Increasing use of meth by MSM and the close connection between meth use (as well as other club drugs) and sexual risk for these men, i.e., PNP

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## San Jose Statistics

- o Sacramento, San Diego, and Santa Clara consistently rank among top five sites nationwide for % arrestees testing positive for meth
- o FY 2003, amphetamines/meth accounted for 47% of adult admissions to treatment facilities in Santa Clara County

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## ADAM Findings Nationwide

- Methamphetamine use among men ranked San Jose second in the nation (behind San Diego).



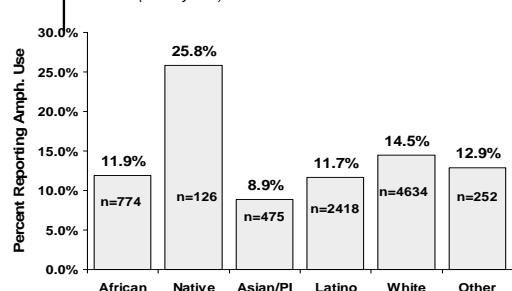
## Women arrested on meth

- Honolulu 57.4%
- San Diego 47.1%**
- o Salt Lake 45.6%
- o San Jose 45.3%**
- o Phoenix 41.6%
- o Portland, OR 29.7%
- o Tucson, AZ 23.9%
- o Des Moines 23.3%
- o Tulsa 22.9%
- o LA 18.5%**

ADAM 2003



## MSM Amphetamine Use by Race (last 2 years)



Data Source: CA MSM C&T Clients in 2003-2004 (all test sites)



## Children

- Children who live in and around the area of the meth lab become exposed to the drug and its toxic precursors and byproducts.
- 80-90% of children found in homes where there are meth labs test positive for exposure to meth. Some are as young as 19 months old.

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## Children

- Children can test positive for methamphetamine by:
  - Having inhaled fumes during the manufacturing process
  - Coming into direct contact with the drug
  - Through second-hand smoke.

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## Motivations for Methamphetamine Use and Contexts for Risk

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## Reasons or Motivations for Use

- Qualitative study of HIV+ MSM meth users (n=25):
  - To enhance sexual pleasure 88%
  - To get high 84%
  - To "party" 76%
  - To relieve boredom 72%
  - To cope with negative emotions 68%
- Quantitative study of HIV-negative heterosexual meth users (n=139):
  - To get high 50%
  - To get more energy 46%
  - To "party" 45%

Sepple et al, 2002 & Sepple et al, 2004



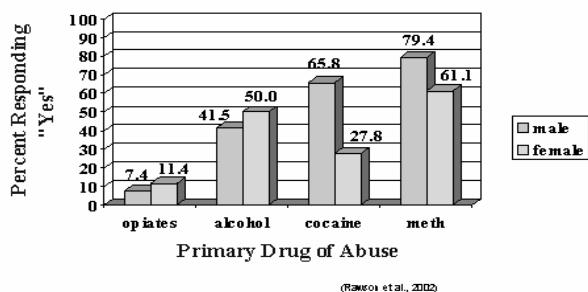
## Why do women use meth?

- To get high (men=women)
- To get more energy (men=women)
- To party (men=women)
- To lose weight (35% women> 5% men; p<0.001)
- To feel more attractive (13.5% women>0.9% men; p<.01)
- To cope with mood (35% women>15% men; p<.01)

Sepple, Patterson, Grant 2004

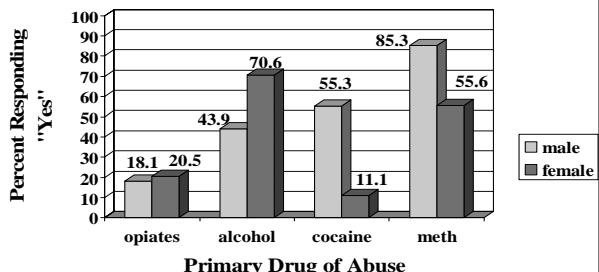


## I am more likely to have sex when using ...



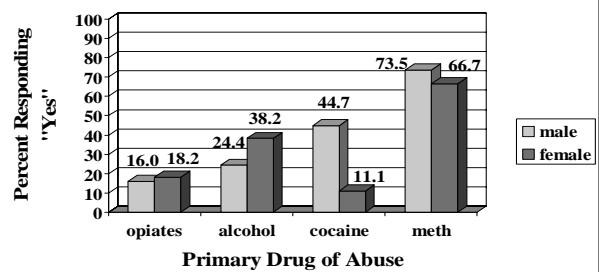
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**My sexual drive is increased by the use of ...**



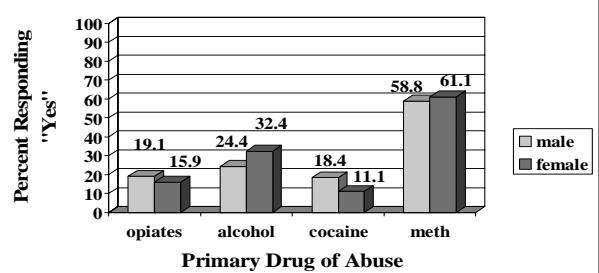
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**My sexual pleasure is enhanced by the use of ...**



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**My sexual performance is improved by the use of ...**





### HIV risk among heterosexual MA users

- Higher STD prevalence Semple 2004
- More high-risk sex Rawson 2002, Farabee 2002
- Use condoms less Molitor 1998
- More sexual partners than heroin users Gibson 2002
- More anal sex Molitor 1998, Bogart 2005
- Binge users riskier than non-binge users Semple 2003

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### Interventions to Reduce Meth Use and Sexual Risk

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### HIV Prevention Interventions for Methamphetamine Users

- Goals
  - Decrease meth use
  - Decrease sexual risk behavior
- Approaches
  - Counseling
  - Contingency management
  - Awareness campaigns
  - Structural
  - Pharmacological

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○ ○ ○ | Intervention Study for  
Methamphetamine-Dependent  
MSM

- Treatment-seeking, meth-dependent MSM enrolled in behavioral intervention with 4 arms:
  - Gay-specific cognitive behavioral therapy (CBT)
  - CBT based on MATRIX
  - Contingency management (CM -- “peeing for dollars”): \$200-1000 in vouchers; 3x weekly urines
  - CM + CBT
- 40 participants in each arm

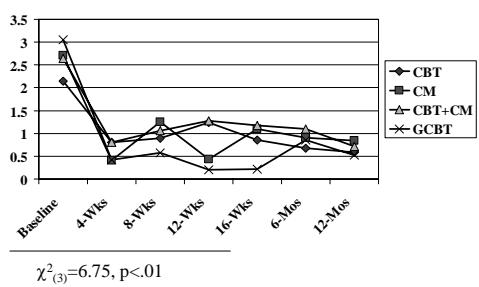
Shoptaw et al, 2005

○ ○ ○ | Results

- The following behaviors significantly decreased for all conditions by 4 months post BL (end of treatments), and 6 and 12 month later:
  - recent meth use
  - recent URA
  - recent UIA
  - recent number of partners
- No difference between groups

Shoptaw et al, 2005

○ ○ ○ | URA in Past 30 Days:  
Post-Treatment Reduction



$\chi^2_{(3)} = 6.75, p < .01$

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## Awareness Campaigns

- Evaluation is in the early stages
- Examples
  - “Huge Sale!” – HIV Prevention Forum, New York City
  - “Crystal Free and Sexy” – New York City
  - “Crystal Mess” – San Francisco DPH

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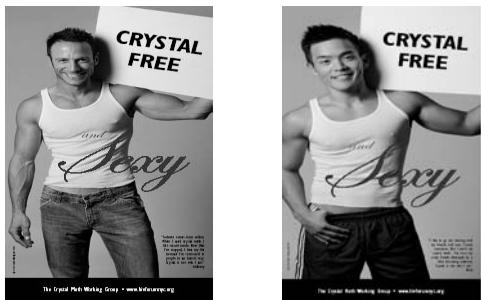
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## New York City HIV Forum



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**Your career took up  
too much time anyway.**

A crystal meth habit can suck up your job,  
your friends, your home and your health in  
about 18 months. It's happened to lots of  
guys already. What a way to clear  
your schedule.

Don't mess with crystal.  
Get help at [crystalmess.net](http://crystalmess.net)

**CRYSTAL  
MESS**

© 2002 Crystal Meth Anonymous  
www.crystalmess.net

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I wanted to  
forget about being  
HIV positive...  
crystal would blank  
my mind.  
Now I'm afraid I've  
given someone HIV.

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From my first high,  
I fell in love.

At first I only used meth on weekends,  
but then it took over my life.  
If you'd like to use less, free  
confidential support is available.



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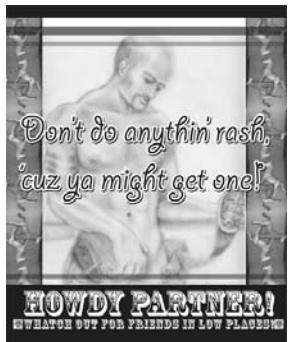
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#### Oregon's Faces of Meth



3 yrs later



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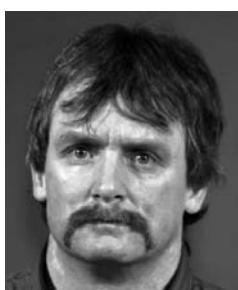
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### Structural Interventions

- Needle exchange
- Regulation of meth precursors: Federal regulation of ephedrine containing products
  - 1989: Bulk powder ephedrine
  - 1995: Medical products containing only ephedrine
  - 1996: All medical products containing ephedrine
  - 1997: Products containing pseudoephedrine

NIDA, 2005  
Cunningham, 2005

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## Precursor Restrictions Are Associated With Positive Effects

- Federal precursors restrictions followed by declines in:
  - Meth-related hospital admissions
  - Meth potency
  - Meth-related arrests
- Effects transient

Suo 2004, Cunningham 2005

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## Pharmacological Management

- Focus: enhancing dopamine while considering PNP
  - bupropion studies (effective in rats Rauhut 2003)
  - Modafanil? Atomoxetine?
  - Substitution
    - ritalin
    - dexedrine
    - adderall
- Focus: blocking dopamine
  - atypical neuroleptics

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## Summary

- Meth is a significant public health concern
- Local prevalence trends and patterns vary – basic prevalence and contextual info is important when developing programs
- Meth treatment can be effective in reducing both meth use and sexual risk

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...finally...

- Watch out!



why resumption of interrupted sleep  
is important to all your patients

### **Quaalude®** (methaqualone)



# AETC Network News

AIDS EDUCATION & TRAINING CENTERS

Providing Healthcare Professionals with Quality Education to Improve HIV Care

Winter 2006

## Mountain Plains AETC

### Capturing Level III Training Outcomes

The Mountain Plains AETC (MPAETC) is working to find new ways to capture Level III training outcomes, provider behavior change, and how participants learn and apply information from the training. Mountain Plains is currently conducting a study using an innovative method of serial interviews, journaling, and creative visual depictions of how participants learn and apply information from Level III educational experiences. Participants are interviewed immediately after Level III training and then asked to journal for 7–10 days any time they think about, talk about, or apply knowledge or skills gained through the Level III training. The study is ongoing. Initial findings are informative and have provided critical information on the course as well as longer term outcomes.

In the meantime, routine evaluation continues. In addition to pre- and post-test knowledge, skills, and willingness analysis, MPAETC also conducts a three-month follow up with regional Level III participants. At times, a Level III participant will initiate follow-up. The following vignette, provided by MPAETC nurse practitioner Suzanne Jed, MSN, APRN-BC, FNP, demonstrates a recent example.

*Several days after attending a clinical training in Denver, a participant (D) called with questions regarding her training paperwork. During the course of the conversation, D mentioned how excited she was to have recently learned about HIV labs and be able to discuss an HIV-infected patient's CD4 count with him on her shift.*

*She then mentioned that the patient was previously routinely seen for HIV care in Denver, but had moved to her area. He was now homeless with no money, and no transportation back to Denver for care. We discussed how the patient could best contact the Denver clinic in order to access his*

## Southeast AETC

### Training Mental Health and Substance Abuse Providers: Maximizing the Impact of Ryan White Care Act Funding.

**Problem:** Metro Atlanta had scores of mental health and substance abuse professionals whose HIV training needs were not being met.

**Solution:** Using the AETC platform for maximum efficiency, fund training with Title I MAI dollars. The Southeast AETC (SEATEC) is now in its fifth year of training on aspects of dual diagnosis for this group of urban mental health counselors, substance abuse workers, and case managers, receiving on average \$100,000 a year for a series of one-day trainings that reach 50–200 learners at each event.

—Continued on reverse >

## New York/New Jersey AETC

### PREVENTION during Acute HIV Infection (AHI)

Prevention of HIV transmission is of paramount importance. Historically, HIV prevention efforts have focused on HIV-uninfected subjects, whereas prevention directed at infected subjects has gained attention only recently. In 2003, the CDC, HRSA, NIH, and the HIV Medicine Association published guidelines for incorporating HIV prevention into the medical care of persons living with HIV. As important as these recommendations were, they did not address the public health importance of identifying persons in acute HIV infection (AHI).

AHI describes roughly the first three weeks following infection. At the peak of AHI, persons can be up to 1,000 times more likely to transmit HIV than those who have been infected six months or longer. Because HIV antibody tests only become detectable four–six weeks into the infection, accurate diagnosis requires the use of HIV viral load testing, which can detect the HIV virus as early as five days after infection. And therein lies the problem—few healthcare providers are diagnosing AHI. In fact, worldwide, only about one in 60,000 persons is diagnosed in the AHI phase of infection. One possible

explanation for this nation's unchanging HIV transmission rate of 40,000 per year may be that the most sexually active, most highly infectious people are routinely misdiagnosed as uninfected with HIV. Identifying and intervening with such individuals would have enormous public health benefits.

With this in mind, St. Vincent's Catholic Medical Center, a local performance site (LPS) of the New York/New Jersey AETC (NY/NJ AETC), established a training curriculum on AHI. The curriculum consists of two Level 1 training modules. The first module reviews how to identify and diagnose AHI. Included in this module is a 12-minute instructional DVD that describes AHI (available to view or download at <http://www.nynjaetc.org/clinPop6.htm>). The second module reviews prevention counseling techniques after persons with AHI have been identified and how to best streamline those recently diagnosed into appropriate HIV care settings. Before instituting these trainings, the NY/NJ AETC staff met with the Medical Director of the training site to identify key personnel to be trained and to identify barriers to testing.

—Continued on reverse >

—Continued on reverse >

# Training Mental Health and Substance Abuse Providers: Maximizing the Impact of Ryan White Care Act Funding.

*continued from page 1*

■ In 2002–2003, the training series *Still Here* focused on optimal substance abuse treatment programs for women with HIV. *Still Here* explored both residential and day treatment programs, recognizing that women may need different models and structures in treatment than men. The conferences examined some traditional substance abuse treatment models and found that many policies might not prove therapeutic for women. For example, direct confrontation might be an effective tool in substance abuse treatment for men, but it rarely works for women. As an alternative, the conference examined best practices in clinical programs for women and presented them along with the theoretical models that support those practices.

- In 2004, a gifted local actress helped SEATEC create and perform *Darlene's Story*, a dramatic narrative which explored the care needs of a homeless, schizophrenic, HIV-positive woman who uses crystal methamphetamine. The story was adapted from Lonna Shavelson's book, *Hooked*, which examines the barriers in community mental health and substance abuse treatment settings for clients with multiple, complex needs. The conference brought the impact of those barriers to life through one woman's experience.
- In 2005, SEATEC used a longitudinal, five-session model to expand the capacity of mental health and substance abuse professionals to address the cultural dynamics that profoundly influence clinical care. Using narrative therapeutic theory, the conference explored the dominant cultural narratives for clients in relation to sexuality and trauma, and for providers in relation to unrealistic expectations for successful clinical outcomes. The conference

series, *Keys to the First Doors*, asked participants to commit to a full-day workshop each month for five months, in order to include ample opportunities for synthesis and practice.

In addition to the funding from Atlanta's Title I Planning Council, the Georgia Department of Human Resources – Division of Mental Health, Developmental Disability and Addictive Disease supplemented SEATEC's efforts using HIV set-aside funds from its SAMHSA block grant, permitting SEATEC to expand training for substance abuse professionals outside the Title I catchment area into rural portions of the state. In Spring 2006, Title I training will focus on special populations with or at risk for HIV, including transgender persons, adolescents, older adults, and Latino(a)s.

SEATEC views this Title I-funded project as an opportunity to utilize AETC strategies and expertise to reach health care providers beyond the broad range of multidisciplinary, targeted AETC professions, and to develop training for a counseling-clinical setting rather than a medical-clinical setting. Through these efforts, SEATEC has trained more than 1,300 clinicians in Level I, II, and IV events during the past five years.

For additional information, please contact the Southeast AETC at (404) 727-2929 ♦

## PREVENTION during Acute HIV Infection (AHI)

*continued from page 1*

The first training took place in the Emergency Department (ED) at St. Vincent's Hospital. Eight ED physicians, four RNs and three administrators attended the CME-approved training and were encouraged to play the DVD on a loop in the ED waiting room. Approximately one month after training, one of the ED physicians identified a young man in AHI. One of the patient's sexual partners with a history suggestive of recent AHI was also identified and referred for care. Both patients were counseled on the highly infectious stage of their HIV infection and received prevention counseling. Due to the importance of these case findings, the New York City Department of Health issued a health alert on April 29, 2005, urging all providers to consider the diagnosis of AHI in patients with risk factors for HIV.

Undiagnosed AHI is a public health concern because persons who are not aware of their HIV status but who have high viral loads may continue to practice unsafe sex. Front line ED healthcare staff and community health centers that see at-risk clients should be educated on how to identify, diagnose and counsel persons in AHI.

For additional information on this AHI training curriculum, please visit the New York/New Jersey AETC website at <http://www.nynjaetc.org> or call (212) 305-8291. ♦

## Capturing Level III Training Outcomes

*continued from page 1*

*prescriptions until he transferred his care to a clinic in his new hometown. D said she was going to immediately call her worksite with this information.*

*During the course of the conversation, D also mentioned a point discussed during the training regarding treatment and care for patients who used substances. She said that before the training she thought*

*that it would be impossible for her substance using patients to be adherent to their HIV medications. After returning to her clinic and seeing this patient, she now thinks that it is not necessarily the case and that she can play a vital role in assisting with adherence. She said it was just another example of stereotypes being broken and assumptions challenged.*

For more study information please contact the Mountain Plains AETC at (303) 315-2516. ♦

  
**AETC**  
NATIONAL  
RESOURCE  
CENTER

François-Xavier  
Bagnoud Center  
University of Medicine &  
Dentistry of New Jersey  
30 Bergen Street,  
ADMC 4, PO Box 1709  
Newark, NJ 07107-3000

Tel 973.972.6587  
Fax 973.972.0399  
[nrc@aidsetc.org](mailto:nrc@aidsetc.org)  
<http://www.aidsetc.org>

*The AETC network is funded by the Health Resources & Services Administration HIV/AIDS Bureau.*

*For more information about the AETC network, visit <http://hab.hrsa.gov/programs/factsheets/aetc.htm>.*

# Managing Occupational Exposures to HIV & Hepatitis?

## PEP line

The **PEP line** offers health care providers around-the-clock advice on managing occupational exposures to HIV and hepatitis B & C.

### Who should call the PEP line ?

Clinicians caring for health care workers who are exposed to blood-borne pathogens. Exposed health care workers may call the **PEP line** but are encouraged to first seek prompt local medical attention.

**National Clinicians'  
Post-Exposure Prophylaxis  
Hotline**

**1-888-448-4911**  
**24 hours a day • 7 days a week**

**For questions regarding the clinical management  
of HIV/AIDS, contact the**

**Warmline**  
**National HIV Telephone  
Consultation Service**

**1-800-933-3413**

Offering treating clinicians current HIV clinical and drug information and expert case consultation.



**National HIV/AIDS  
Clinicians' Consultation Center**

The National HIV/AIDS Clinicians' Consultation Center is a component of the AIDS Education and Training Centers Program funded by the Ryan White CARE Act of the Health Resources and Services Administration HIV/AIDS Bureau in partnership with the Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health.

Visit the Center website [www.ucsf.edu/hivcntr](http://www.ucsf.edu/hivcntr) for additional information.

## **HIV/AIDS RESOURCE DIRECTORY OF SERVICE PROVIDERS**

### **ORGANIZATIONS OFFERING CARE & TREATMENT AND/OR PREVENTION SERVICES (INCLUDES WEB RESOURCES)**

#### **AIDS Community Research Consortium**

Address:	1048 El Camino Real, Suite B., Redwood City CA 94063
Phone(s):	650-364-6563 / 1-800-864-2272
Website:	<a href="http://www.acrc.org">www.acrc.org</a>
<b>SERVICES</b>	
<i>Care and Treatment:</i>	HIV food services program, support groups, outreach, case management,
<i>Prevention:</i>	HIV health education, hepatitis C information, workshops and focus groups
<i>Regions Served:</i>	San Mateo county, some clients from San Francisco and Santa Clara counties. Food program is limited to San Mateo county residents.
<i>Services off-site:</i>	Food delivery outside of agency for San Mateo, education in schools
<i>Multiple languages:</i>	Spanish
<i>Target population(s):</i>	People with HIV or at-risk, primarily people who are already infected who are low income and underserved

#### **AIDS Legal Services, Law Foundation of Silicon Valley**

Address:	111 West Saint John Street, Suite 315, San Jose, CA 95113
Phone(s):	408-293-3135
Website:	<a href="http://www.lawfoundation.org">www.lawfoundation.org</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	Free Legal services in the areas of: Discrimination, housing rights, public/private benefit and health insurance, simple estate planning & wills, debtor relief & consumer protection, employment rights, access to health care and breach of confidentiality issues.
<i>Regions Served:</i>	Santa Clara County
<i>Services off-site:</i>	Outreach and education, home visitation for clients who are unable to come to service site
<i>Multiple languages:</i>	Spanish, other languages through AT&T Language Inc.
<i>Target population(s):</i>	Low-income individuals with HIV

## Asian Americans for Community Involvement

Address:	2400 Moorpark Ave., Suite 300, San Jose, CA 95128 (Gordon N. Chan Community Center)
Phone(s):	408-975-2730 Ext 183
Website:	<a href="http://www.aaci.org">www.aaci.org</a>
<b>SERVICES</b>	
<i>Prevention:</i>	Community outreach programs, providing information for people at risk, informational materials about safer sex and HIV, health fairs, personalized individual counseling and education, online counseling and online chats-rooms, HIV Negative for Life program providing advocacy, support/discussion groups and HIV testing referrals
<i>Regions Served:</i>	Santa Clara County
<i>Services off-site:</i>	Education sessions held at Billy DeFrank Center
<i>Multiple languages:</i>	Most services provided in English
<i>Target population(s):</i>	Asian/Pacific Islander (API) general population, with emphasis on API men who have sex with men

## Asian American Recovery Services

Address:	1370 Tully Road, Suite 501
Phone(s):	408-271-3900
Website:	<a href="http://www.aars-inc.org">www.aars-inc.org</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	Psychosocial case management, Project CARES offers confidential services such as counseling, social support services, substance abuse treatment, and referrals
<i>Regions Served:</i>	Santa Clara County, San Mateo, San Francisco
<i>Services off-site:</i>	No
<i>Multiple languages:</i>	Vietnamese, Khmere, Tagalog, Korean, Hindi, Japanese, Cantonese
<i>Target population(s):</i>	Asian and Pacific Islander community

## Billy DeFrank LGBT Community Center

Address:	938 The Alameda, San Jose, CA 95126
Phone(s):	408-293-2429
Website:	<a href="http://www.defrank.org">www.defrank.org</a>
<b>SERVICES</b>	
<i>Prevention:</i>	Mobile HIV testing, on-line and street outreach, provide space for community-based support groups and discussion groups, social activities
<i>Regions Served:</i>	Entire county
<i>Services off-site:</i>	On-line and street outreach
<i>Multiple languages:</i>	Spanish, Tagalog
<i>Target population(s):</i>	Everyone, with an emphasis on GLBTQ community

## Bill Wilson Center

Address:	3490 The Alameda, Santa Clara, CA 95050
Phone(s):	408-243-0222
Website:	<a href="http://www.billwilsoncenter.org">www.billwilsoncenter.org</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	Program <i>Center for Living with Dying</i> : four times a year, all-day retreat for patients and their caregivers, 24/7 phone line for AIDS patients and their caregivers to give emotional support, information and referrals (408-850-6179)
<i>Prevention:</i>	Outreach to homeless youth, clean needle exchanges and cleaning kits, drop-in center, HIV prevention workshops, give out information and condoms
<i>Regions Served:</i>	Western Area: Downtown San Jose, Santa Clara, Sunnyvale, Campbell
<i>Services off-site:</i>	Through street outreach, cover downtown San Jose
<i>Multiple languages:</i>	Spanish, Vietnamese, Mandarin, Farsi, Sign, Chinese, Japanese, Tagalog
<i>Target population(s):</i>	Youth up to the age of 25, families and adults, services for different age groups

## Camino Medical Group, a Division of the Palo Alto Medical Foundation

Address:	582 S. Sunnyvale Avenue. Sunnyvale, California 94086
Phone(s):	(408) 524-5075
Website:	<a href="http://www.caminomedicalgroup.com">www.caminomedicalgroup.com</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	Primary care for people with HIV
<i>Regions Served:</i>	Santa Clara County
<i>Multiple languages:</i>	Interpreter services
<i>Target population(s):</i>	Patients with Certain Insurance Plans (HMO, PPO)

## Combined Addicts and Professional Services

Address:	66 E. Rosemary St., San Jose, CA 95112
Phone(s):	(408) 441-6088
Website:	
<b>SERVICES</b>	
<i>Care and treatment:</i>	Intensive outpatient counseling aftercare facility for patients living with HIV/AIDS and substance abuse, transitional housing, individual counseling, treatment plans, referrals to other agencies, and drug testing
<i>Regions Served:</i>	Santa Clara County
<i>Services off-site:</i>	
<i>Multiple languages:</i>	Spanish
<i>Target population(s):</i>	Chemically dependent adults, patients living with HIV/AIDS and substance abuse

## Community Health Awareness Council

Address:	711 Church Street, Mountain View, CA 94041.
Phone(s):	650-965-2020
Website:	<a href="http://www.chacmv.org">www.chacmv.org</a>
<b>SERVICES</b>	
<i>Prevention:</i>	HIV workshops in the schools handed over to HAP (Healthy Adolescent Project), train community volunteers and youth, partial leadership building and education, HIV young men's program.
<i>Regions Served:</i>	Northern Santa Clara County– Sunnyvale to Palo Alto, some San Mateo County
<i>Services off-site:</i>	HIV young men's group in the schools
<i>Multiple languages:</i>	Presentations are in English only
<i>Target population(s):</i>	Youth

## Crane Center (Santa Clara County Health Department)

Street Address:	976 Lenzen Avenue, Suite 1800., San Jose, CA 95126
Phone(s):	408-792-3720
Website:	<a href="http://www.sccphd.org/">http://www.sccphd.org/</a>
<b>SERVICES</b>	
<i>Prevention:</i>	Provide HIV, Hepatitis C, and STD testing, as well as HIV/AIDS service referrals and referrals for other services such as alcohol and drug treatment, shelters, crisis counseling and domestic violence
<i>Regions Served:</i>	Entire county, located in downtown
<i>Services off-site:</i>	No
<i>Multiple languages:</i>	English, Spanish, and phone translation services for other languages
<i>Target population(s):</i>	Open to general population, but target MSM, transgender, women of color, youth of color, monolingual Spanish-speaking clients, and high risk individuals

## Economic and Social Opportunity, Inc. (ESO)

Address:	1445 Oakland Rd., San Jose, CA 95112
Phone(s):	408-971-0888
Website:	<a href="http://www.esoi.org">www.esoi.org</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	Case management and referrals to medical services, housing, financial aid, mental health services, outreach
<i>Regions Served:</i>	Santa Clara County
<i>Services off-site:</i>	No
<i>Multiple languages:</i>	Spanish
<i>Target population(s):</i>	African-American and Latino

## EHC Life Builders – Emergency Housing Consortium

Address:	2665 North First, Suite 210, San Jose, CA 95134
Phone(s):	408-298-2660
Website:	<a href="http://www.ehclifebuilders.org">www.ehclifebuilders.org</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	Emergency shelter, provisional housing
<i>Prevention:</i>	Street outreach, safe sex materials, information about services offered, basic needs and case management, condoms and lubrication, confidential conversations with young people around safe sex, comprehensive medical care
<i>Regions Served:</i>	From San Martin to Sunnyvale, Mountain View, San Jose and Santa Clara.
<i>Services off-site:</i>	Do presentations at other organizations
<i>Multiple languages:</i>	English and Spanish
<i>Target population(s):</i>	Serving those who are homeless or at high-risk for being homeless

## Family and Children Services

Address:	950 W. Julian Street, San Jose, CA 95126
Phone(s):	408-292-9353
Website:	<a href="http://www.fcservices.org">www.fcservices.org</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	Mental health counseling for people living with HIV/AIDS
<i>Regions Served:</i>	All of Santa Clara County, offices in Campbell, Palo Alto and San Jose
<i>Services off-site:</i>	No
<i>Multiple languages:</i>	No
<i>Target population(s):</i>	Comprehensive counseling and therapy for general community

## Gardner Family Care Corporation

Address:	160 East Virginia Street, San Jose, CA,
Phone(s):	(408) 287-6200
Website:	
<b>SERVICES</b>	
<i>Care and treatment:</i>	Provide mental health services such as individual, couple, and family therapy for persons with HIV/AIDS
<i>Regions Served:</i>	Santa Clara County
<i>Services off-site:</i>	
<i>Multiple languages:</i>	Spanish, Vietnamese
<i>Target population(s):</i>	

## Health Education and Training Center, a Division of Community Health Partnership

Address:	614 Tully Road, San Jose, CA 95111.
Phone(s):	408-289-9260
Website:	<a href="http://www.chpscc.org">www.chpscc.org</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	San José AIDS Education and Training Center - provide health care professionals with the knowledge and skills necessary to care for HIV infected patients in underserved and vulnerable populations.
<i>Prevention:</i>	Trrans-Powerment program - builds strength within the transgender community by providing culturally appropriate services through workshops, outreach, and case management and by giving trans-women a forum to voice their opinions, express their concerns and meet other women with whom they can identify.
<i>Regions Served:</i>	California's central coast, Salinas Valley, and Silicon Valley
<i>Services off-site:</i>	Outreach through local bars, Gay Pride, and support groups
<i>Multiple languages:</i>	Services offered mostly in Spanish and English, Tagalog and Vietnamese if needed
<i>Target population(s):</i>	Underserved populations

## Health and Wellness Care Center

Address:	46 Race Street, San Jose, CA 95126
Phone(s):	(408) 294-2322
Website:	<a href="http://www.hawcc.org">www.hawcc.org</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	Exercise programs, massage, chiropractic services, some nutrition
<i>Regions Served:</i>	Entire county
<i>Multiple languages:</i>	Spanish, Tagalog, Polish
<i>Target population(s):</i>	General population

## Health Trust AIDS Services (formally known as Health Connections Case Mgmt Svcs)

Address:	1701A S. Bascom Ave, Campbell, CA 95008
Phone(s):	(408) 961-9850
Website:	<a href="http://www.healthtrust.org">www.healthtrust.org</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	Case management, food basket, supportive housing program, community center, housing placement services. Also broker some services: meals on wheels, home health care services (skilled and unskilled). Speakers' bureau called Positively Speaking, emergency fund assistance, emergency housing and rental assistance, dental program, and transportation.
<i>Regions Served:</i>	Santa Clara County, but target North and South County
<i>Services off-site:</i>	1) Food Basket (48A Race St., San Jose, CA 95126), once a month food basket pick up and/or delivery. 2) Neil A. Christie Living Center (1252 Park Ave., San Jose, CA 95126) drop-in community center, support groups, workshops, classes.
<i>Multiple languages:</i>	Spanish, Swahili, Japanese, Vietnamese, and utilize language bank if needed.
<i>Target population(s):</i>	People with HIV living in Santa Clara County

To download a free electronic version of this document, please visit [www.chpscc.org/sjaetc](http://www.chpscc.org/sjaetc).

Please contact the San Jose AIDS Education & Training Center at [aetc@chpscc.org](mailto:aetc@chpscc.org) or 408.289.9260 for changes or augmentations.

## Kaiser Permanente HIV/AIDS Resources and Counseling

Address:	710 Lawrence Expressway, Dept. 464, Santa Clara, CA 95051
Phone(s):	408-851-4250
Website:	<a href="http://www.kp.org">www.kp.org</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	Primary medical care and treatment, counseling, benefits assistance, health prevention and education, HIV testing.
<i>Regions Served:</i>	Entire county
<i>Services off-site:</i>	Satellite locations in Mountain View, Campbell and Milpitas
<i>Multiple languages:</i>	Spanish-speaking person on-site, telephone translation available for all languages. Educational materials in 15 different languages.
<i>Target population(s):</i>	Kaiser members

## The Living Center (The Neil A. Christie Living Center)

Address:	1252 Park Ave., San Jose, CA 95126
Phone(s):	(408) 971-0852
Website:	<a href="http://www.thelivingcenter.org">http://www.thelivingcenter.org</a>
<b>SERVICES</b>	
<i>Prevention:</i>	Classes and workshops on healthy living, complementary therapies, safer sex workshops, art classes, social activities, support groups, referrals, and resource room.
<i>Regions Served:</i>	Santa Clara County
<i>Services off-site:</i>	No
<i>Multiple languages:</i>	Spanish and Chinese
<i>Target population(s):</i>	Adults living with HIV

## Metropolitan Community Church of San Jose

Address:	65 South 7th Street, San Jose, CA 95112
Phone(s):	408-279-2711
Website:	<a href="http://www.mccsj.org">www.mccsj.org</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	Support group for people living with HIV/AIDS in conjunction with the PACE clinic, pastoral/spiritual counseling and alternative healing practices
<i>Regions Served:</i>	All over San Jose and South Bay Areas
<i>Services off-site:</i>	No
<i>Multiple languages:</i>	No
<i>Target population(s):</i>	Anybody living with HIV/AIDS

## Needle Exchange Program

(Santa Clara Department of Public Health, HIV/AIDS Prevention and Control Program)

Address:	770 S. Bascom Ave., San Jose, CA 95128
Phone(s):	408-494-7870 / 1-888-308-1110
Website:	
<b>SERVICES</b>	
<i>Prevention:</i>	Needle exchange (drug and hormone) and the provision of HIV-testing and Hepatitis C testing.
<i>Regions Served:</i>	South County in Gilroy, North County
<i>Services off-site:</i>	Currently mobile, looking for a fixed store-front setting
<i>Multiple languages:</i>	English and Spanish
<i>Target population(s):</i>	People at risk for HIV and Hepatitis C

## NIGHT Mobile Health Van Program (Neighborhood Intervention Geared to High Risk Testing)

Address:	
Phone(s):	408-494-7893
Website:	
<b>SERVICES</b>	
<i>Care and Treatment:</i>	Free, anonymous HIV testing and counseling
<i>Regions Served:</i>	All of Santa Clara County, different sites
<i>Services off-site:</i>	Mobile Van
<i>Multiple languages:</i>	Spanish
<i>Target population(s):</i>	Populations at high risk for HIV transmission: substance users, MSM, sex workers, high-risk women of childbearing age eligible for medi-cal, transgendered persons

## Northwest AIDS Education and Training Center

Address:	901 Boren Avenue, Suite 1100 Seattle WA 98104
Website:	<a href="http://www.depts.washington.edu/hivaids/">www.depts.washington.edu/hivaids/</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	A website that provides interactive, case-based modules related to the clinical care of HIV- infected persons and intended for educational and research purposes.
<i>Regions Served:</i>	No specified region
<i>Services off-site:</i>	No
<i>Target population(s):</i>	Health-care workers involved with the clinical care of HIV infected individuals

## On-Site Dental

Address:	
Phone(s):	650-286-7427
Website:	<a href="http://www.onsite-dental.com/">http://www.onsite-dental.com/</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	General dentistry, including screening and preventive services,
<i>Regions Served:</i>	Santa Clara County
<i>Services off-site:</i>	Different sites throughout Santa Clara County through Mobile Van
<i>Multiple languages:</i>	
<i>Target population(s):</i>	People living with HIV/AIDS, clients eligible for federal assistance under the Ryan White Act

## PACE Clinic (Ira Greene Partners in AIDS Care & Education)

Address:	2400 Moorepark Ste 316, San Jose, CA 95128.
Phone(s):	408-885-5935
<b>SERVICES</b>	
<i>Care and treatment:</i>	Full HIV medical services: primary care, laboratory work, nutrition counseling, psychiatry, pharmacist specialist on staff, outreach worker, health educator. Special services include: Treatment Adherence, support groups and education, Mom/Baby Clinic.
<i>Prevention:</i>	Information and materials, condom distribution, prevention with positives counseling, outreach to people with HIV infection who are not in care.
<i>Regions Served:</i>	Santa Clara County
<i>Services off-site:</i>	HIV medical care is provided at Valley Health Center San Martin (South Santa Clara County) by the PACE Clinic staff for people who live in that region. HIV Medical care is also provided by PACE staff at the Main County Jail one time per month.
<i>Multiple languages:</i>	English, Spanish, Tagalog, Italian, Portuguese, and some African dialects are available by on-site staff. All languages are available through phone translation services.
<i>Target population(s):</i>	People with HIV. Services available without restriction based on ability to pay. Most major insurance plans accepted.

## Planned Parenthood Mar Monte

Address:	1691 The Alameda San Jose, CA 95126
Phone(s):	408-297-5090
Website:	<a href="http://www.ppmarmonte.org">www.ppmarmonte.org</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	HIV testing, STD testing & treatment, condom distribution.
<i>Prevention:</i>	Comprehensive school based sexuality education, sexuality education to parent groups, juvenile hall, homeless shelters.
<i>Regions Served:</i>	40 counties in CA and NV including Santa Clara, Central Valley, Monterey, Sacramento, San Joaquin Valley, and Santa Cruz region.
<i>Multiple languages:</i>	English & Spanish
<i>Target population(s):</i>	Sexually active individuals

## ProLatino

Address:	938 The Alameda, San Jose, CA 95126
Phone(s):	408-271-6984
Website:	<a href="http://www.prolatino.org">www.prolatino.org</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	Case management referrals, mental health services, eye-care services, medical treatment
<i>Prevention:</i>	Educational support groups, one-on-one group support, food distribution, housing assistance, mental health counseling and therapy, translation and interpretation, and STD referrals
<i>Regions Served:</i>	Entire Santa Clara county, and some people from Alameda and San Mateo counties
<i>Services off-site:</i>	No
<i>Multiple languages:</i>	Spanish
<i>Target population(s):</i>	GLBT Latinos

## Santa Clara County Planning Council/ HIV Prevention CPG

Address:	1701-A S. Bascom Avenue Campbell, CA 95008
Phone(s):	408-961-9880
Website:	<a href="http://www.hivplanningcouncil.com">www.hivplanningcouncil.com</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	Direct Ryan White Care Act Title I & II funding for people living with HIV who cannot pay for the care they need.
<i>Regions Served:</i>	Santa Clara County
<i>Services off-site:</i>	No
<i>Multiple languages:</i>	English, ASL(American Sign Language), Spanish
<i>Target population(s):</i>	Individuals living with HIV who cannot pay for the care they need

## Santa Clara County Public Health Pharmacy

Address:	976 Lenzen Avenue, San Jose, CA 95126
Phone(s):	408-796-5163
Website:	<a href="http://www.scvmed.org">www.scvmed.org</a>
<b>SERVICES</b>	
<i>Care and treatment:</i>	Provide medications to HIV/AIDS clients of Santa Clara county who are eligible for the ADAP program or the Ryan White Medication Assistance program.
<i>Regions Served:</i>	Santa Clara County
<i>Services off-site:</i>	Several pharmacy locations
<i>Multiple languages:</i>	Staff who speak Vietnamese, Korean, and Spanish. Staff serve as interpreters, but call interpreter service if needed.
<i>Target population(s):</i>	General population

## Stanford Positive Care Clinic

Address:	3801 Miranda Ave, Building MB, Room 350 Palo Alto, CA 94304
Phone(s):	(650) 354-8101
Website:	<a href="http://www.stanfordhospital.com/clinicsmedServices/clinics/positiveCare/positiveCare">http://www.stanfordhospital.com/clinicsmedServices/clinics/positiveCare/positiveCare</a>
<b>SERVICES</b>	
<i>Care and Treatment:</i>	HIV primary care, treatment for Hepatitis C and other co-infections, psychiatrist and nutritionist on site two days a week
<i>Regions Served:</i>	All of Santa Clara County, get some patients from San Francisco and other counties
<i>Services off-site:</i>	None
<i>Multiple languages:</i>	Spanish
<i>Target population(s):</i>	People living with HIV/AIDS and related opportunistic infections, non-HIV gay and lesbian patients

## Web Resources for Providers and Clients

### **HIV/AIDS Resources**

AIDS Education & Training Center National Resource Center: [www.aidsetc.org](http://www.aidsetc.org)

AIDS Information on Treatment, Prevention, & Research from US Dept of Health & Human Services:  
[www.aidsinfo.nih.gov](http://www.aidsinfo.nih.gov)

California STD/HIV Prevention Training Center: [www.stdhivtraining.org](http://www.stdhivtraining.org)

Community Health Partnership of Santa Clara County: [www.chpsc.org](http://www.chpsc.org)

HIV Clinical Resource, New York State Dept. of Health: [www.hivguidelines.org](http://www.hivguidelines.org)

HIV dental information including a warm mail response system: [www.hivdent.org/main.htm](http://www.hivdent.org/main.htm)

HIV Insite information on treatment, prevention, & policy from UCSF School of Medicine's Center for HIV Information: [hivinsite.ucsf.edu](http://hivinsite.ucsf.edu)

Kaiser Network timely and in-depth coverage of health policy news, debates and discussions:  
[www.kaisernetwork.org](http://www.kaisernetwork.org)

National HIV/AIDS Clinician's Consultation Center including Warm Line, PEP Line and Perinatal HIV Hotline: [www.ucsf.edu/hivcntr/](http://www.ucsf.edu/hivcntr/)

National Minority AIDS Council: [www.nmac.org](http://www.nmac.org)

National Native American AIDS Prevention Center: [www.nnaapc.org](http://www.nnaapc.org)

Pacific AIDS Education & Training Center: [www.ucsf.edu/paetc](http://www.ucsf.edu/paetc)

San Jose AIDS Education & Training Center: [www.chpsc.org/SJAEtC](http://www.chpsc.org/SJAEtC)

University of California, San Francisco's Center for AIDS Prevention Studies: [www.caps.ucsf.edu/](http://www.caps.ucsf.edu/)

### **Client Specific Websites**

Project Inform for people living with HIV/AIDS: [www.projinf.org](http://www.projinf.org)

New Mexico AIDS InfoNet: [www.aidsinfo.net](http://www.aidsinfo.net)

The Body: [www.thebody.com](http://www.thebody.com)