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Preventing HIV:

New Tools, New Hope



by Sam Kalibala, MD, Sarah Littlefield, MPH
and Robert Valadéz, MSW

AIDS in the U.S. has changed dramatically since the epidemic began 30 years ago. The advent of HIV combination therapy was a game changer for everyone living with the virus, turning what was once a fatal disease into a manageable condition. And now, signs are pointing to these same drugs as a way to bolster HIV prevention.

HIV medications have been used for some time to prevent HIV transmission, including the prevention of mother-to-child transmission and post-exposure prophylaxis (PEP, giving HIV meds after exposure to the virus). Studies have also shown that the likelihood of transmitting HIV to someone else decreases in people whose viral load has been suppressed by HIV treatment. Research is under way to expand this list further. For example, microbicides that

contain HIV drugs and pre-exposure prophylaxis (PrEP) have both recently shown promising results in clinical trials.

Twenty years ago, these prevention strategies were merely a wish list based on the scientific logic that a drug that can lower the viral load of HIV in the body should also be able to reduce transmission of the virus. Slowly, these wishes are becoming realities.

Microbicides

Microbicides are gels or creams used in the vagina or rectum that are designed to prevent or reduce the sexual transmission of HIV and other sexually transmitted infections (STIs). Last July, the long-awaited results of the CAPRISA 004 trial were finally reported. This trial studied the safety and effectiveness of a gel containing Viread. It studied 889 women, aged 18-40, in South Africa who were advised to use the gel within the 12 hours before sex, and within 12 hours after sex.

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ACRIA Trials in Progress

Cenicriviroc (TBR-652)

People with HIV who are 18 and older and who have not taken HIV meds will take either Cenicriviroc (an experimental CCR5 inhibitor) or Sustiva for a year. Everyone will also take Truvada.

BI 201335

People aged 18 to 70 who have hepatitis C virus but not HIV, and who have not taken interferon, will take BI 201335 (an experimental HCV protease inhibitor) with peg-interferon and ribavirin for 12-48 weeks.

Ibalizumab

People who are HIV negative will receive four weekly injections of ibalizumab (a monoclonal antibody) to study its safety and effect on the immune system.

Selzentry

People with HIV who are 18 and older and who have not taken HIV meds will take either Selzentry or Truvada for 22 months. Everyone will also take Prezista with Norvir.

For more information on these trials, contact us at 212-924-3934, ext. 121.

Compensation is available is available for some studies.

LETTERS TO THE EDITOR

To the Editor,

I'm an HIV positive patient living with HIV for three years, and I've been taking Atripla for the past six months.

I read your publication in Spanish at the Immunological Hospital where I get my lab work done every three months. It's very interesting and I learn more about the many diseases of HIV, especially my own illness.

I'd be highly appreciative if I could get my own copy. I'm 70 years old.

Thanks,

Felix
Carolina, Puerto Rico

To the Editor:

Thank you for your great informative publication. The Community Orientation Re-entry Program (CORP) at Sing Sing Correctional Facility supports and provides services to people with HIV and help to educate all those who need care for HIV.

We would truly appreciate receiving more copies of *Achieve*.

Sincerely,

William

Achieve would love to hear from you! Please send your comments to: Letters to the Editor, *Achieve*, 230 W. 38th St., 17th floor, New York, NY 10018
Or email them to: achieve@acria.org

Results from the study found there were 39% fewer new HIV infections in women who used the gel compared with those who used a placebo (dummy) gel. In women who used the gel more regularly, infections were reduced by 54%. Further, the study found that there was no resistance to Viread among women who used the gel and acquired HIV during the study. The gel also appeared to lower the transmission of herpes virus.

It is important to note that the CAPRISA results are only the first step toward an effective microbicide. The trial was done in a specific population, and the small number of participants limits the ability to apply the results to the general population. Furthermore, questions remain about the timing in applying microbicides. Can it be taken immediately before sex? Due to the dosing strategy of the study, no conclusions can be made about how the timing of use affects its effectiveness. More studies are being conducted to confirm and expand on the CAPRISA findings. These studies will also provide further information on the use of a daily gel and the rectal use of the gel.

PrEP

In November 2010, results of the first study looking at the safety and effectiveness of a daily oral dose of Truvada to prevent HIV infection were reported. The study, known as “iPrEx,” was done from 2007 and 2010, and included 2,499 HIV-negative men who have sex with men (MSM) and transgender women who have sex with men. Participants were from Peru, Ecuador, Brazil, the U.S., South Africa, and Thailand.

People in the study took either a daily Truvada pill or a placebo. Everyone was interviewed once a month, tested for HIV, and counseled on adherence. They were given a physical exam every three months and tested for other STIs, receiving treatment if needed.

In addition to finding daily Truvada safe, the study found about 44% fewer infections in those taking it. Further, it found that PrEP reduced HIV infection by 58% among participants at higher risk for HIV (those who reported having

unprotected receptive anal intercourse). This is a major step forward, as it is the first study to show the effectiveness of PrEP. Once again, the effectiveness of the drug was linked to adherence. Almost all of the men in the study who got HIV even though they were assigned to take



Truvada didn't have any Truvada in their blood – meaning they most likely were not taking it at all.

The other interesting finding was that adherence was not only lower than expected, it was also lower than people reported or than was shown by pill counts. Participants claimed at least 90% adherence, but measuring drug levels in their blood found that in reality it was about 50%. Based on pill counts and self-reports, the effectiveness of PrEP in people who took more than half their doses was 50%, and it was 73% in people who took more than 90% of their doses. People who took less than 90% of their doses showed only a 21% reduction in HIV infection. But the significantly lower actual adherence levels make analyses based on pill counts unreliable.

More data and results are expected in the months to come, and a rollover study is under way. This study offers Truvada to all HIV-negative iPrEx participants, and will provide important information on

any changes in adherence and risk behavior when people know they are using a partially effective prevention strategy.

Several other PrEP trials are under way in African and Asian countries, in heterosexuals and drug users. PrEP is also being studied for different routes of HIV

transmission, including vaginal intercourse and intravenous drug use. One study is comparing daily Truvada with or without a Viread microbicide, to look for differences in effectiveness, drug resistance risk, costs, and tolerance. Results are expected in early 2013, but we can expect to receive information on some of the studies later this year.

The Future

There are important questions to answer about the use of these new tools. With current ADAP waiting lists at 6,000 in the U.S., there must be careful planning as to how these methods would be used in the areas they are most needed. It is estimated that as many as half of all HIV-positive people in the U.S. are not currently receiving treatment. Black men, who are among the most vulnerable to HIV, show even lower rates of treatment. Efforts must be made to ensure that those at highest risk for infection are able to use the most up-to-date prevention methods.

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Data suggest that PrEP can have a huge impact on the epidemic in the U.S. and be cost-effective if the following conditions are met: reaching MSM at highest risk for infection; providing PrEP along with other prevention tools, including condoms and risk-reduction counseling; and ensuring high levels of adherence among those taking the meds.

The target population for a vaginal microbicide will most likely be women in Africa. Sex workers, women who are unable to ensure monogamy, or those who are unable to use condoms for a variety of reasons, will also be targeted. Further, should microbicides prove effective in preventing HIV through anal sex, MSM would also be a target population.

People will need to come forward and identify themselves as part of the groups described above, so the success of a microbicide will depend heavily on community education. The gel will also need to be readily available and offered with confidential counseling services. But it should not replace condoms since it will not offer 100% protection. It must be explained to users that microbicides are part of a package, not a single magic bullet.

PrEP will likely be given to those most at risk. One group would be HIV-negative people with partners who have HIV. This means there will need to be increased counseling of people with HIV about disclosure. PrEP may also be recommended for people who have sex with someone who is at high risk for HIV. This includes sex workers and their clients, certain MSM, intravenous drug users, and men with more than one partner. PrEP will have to be stopped in people who become HIV positive or have severe side effects. This shows the need for regular follow-up, including HIV testing.

Risks

Since Truvada is already available by prescription, the CDC and other public health agencies are developing guidelines on its use as PrEP. Without this guidance, unsafe and ineffective use may occur. Among these concerns are the use of other HIV meds not used in the study and not proven safe for HIV-negative people; using a dosing schedule not proven effective (such as just before

sex or only after sex); not screening for HIV before starting PrEP or waiting long periods of time before retesting for HIV; and providing prescriptions for PrEP without other HIV prevention support, such as condoms and risk-reduction counseling.

Additionally, reports suggest that some people are already using HIV meds not prescribed to them, following unapproved PrEP regimens. Studies of how they get the meds, and from whom, may help to eliminate a black market that could undermine any benefits of PrEP. A critical concern is that people who sell their HIV meds will miss their own doses, leading to drug resistance. This puts their health at risk and could increase community viral load.

The New York State AIDS Institute is currently seeking advice from an advisory group of clinicians to determine next steps, but it will take several months before

could be justified when condoms themselves cost a few cents each. In the U.S., we would need cost-effectiveness analyses, perhaps calculating the cost of PrEP per infection avoided, to convince insurers and Medicaid that it is worth the money.

In developing countries, where generic forms of Truvada are available for as low as \$143 a year, the picture is very different. If PrEP is approved in these countries, the biggest dilemma may center on providing HIV drugs for prevention when only 36% of people with HIV have access to these same drugs to save their lives. This lack of access to treatment makes justifying funding for PrEP challenging. Treatment alone, however, is not enough to stop the epidemic. With 56,000 new HIV infections in the U.S. and 2.7 million new infections worldwide, it is imperative that we utilize every prevention option available.

Some have asked how a “chemical condom” that costs \$38 a day could be justified when condoms themselves cost a few cents each. In the U.S., we would need cost-effectiveness analyses to convince insurers and Medicaid that it is worth the money.

guidelines are published. The AI is urging providers and patients to wait for guidelines to be released before using PrEP. The CDC recently released interim guidelines for use of PrEP for MSM. The guidelines specifically discourage anyone other than high-risk, HIV-negative MSM from using it (since there are no data in other groups), and instruct users to follow the regimen used in the iPrEx study. This includes daily dosing of Truvada, regular HIV testing, treatment of other STIs, and risk-reduction counseling and condoms. The interim guidelines also provide information on how best to discontinue PrEP.

The Cost

The retail price of Truvada is \$14,000 a year in the U.S., and even though insurers and Medicaid pay less than that, the price to them is still in the thousands. If it is approved for PrEP, some have asked how a “chemical condom” that costs \$38 a day

The Way Forward

Education about these two prevention methods will most likely be centered in health care facilities. This will require that they have enough personnel and supplies to provide high-quality services that are available to the most vulnerable people. And before these new methods are widely used, the general community, and people with HIV, must be educated about them. Education needs to be correct, easily available, and constantly updated about new prevention methods. Both microbicides and PrEP are still in the development phase, and each new result will bring both new information and new questions. ■

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Young People and HIV

A Realistic Approach to Prevention

by Jennifer Augustine and Emily Bridges

Young people in the U.S. continue to be at risk for HIV. In 2008, according to the CDC, 16% of people with HIV were between 13 and 24 years old. A 2006 study suggested that “15% to 30% of all cases of HIV occur among individuals younger than 25 years.” Hardest hit have been young people of color, and young men who have sex with men. What can HIV prevention programs do to help young people protect their health and their futures?

An Unequal Epidemic

According to the CDC, the majority (72%) of new HIV cases in young people are among men, and most of those (85%) are attributed to male-to-male sexual contact. Most new HIV cases among women are attributed to heterosexual contact. For both young men and women, the vast majority of new infections occur among minority youth. In the U.S., African-Americans and Latinos account for 87% of all new HIV infections among 13- to 19-year-olds and 79% among 20- to 24-year-olds. Yet together they make up only about 32% of people in this age group in the general population.

Men who have sex with men (MSM) are the only risk group in which the rate of new infections has increased steadily each year since the 1990s, even as it has decreased among other populations. Each day, nine young African-American men are diagnosed with HIV.

Young people aged 15 to 24 are the group most likely to experience sexually transmitted infections (STIs), a risk factor for HIV. The CDC has estimated that young people account for up to half of the nation’s 19 million new STI infections each year. These

rates are even higher among minority youths. In 2006, young African-American men between 15 and 19 years of age had 39 times the rate of gonorrhea compared with white men in the same age range. A recent study of STIs among young women aged 15 to 19 found that 48% African American women in this age range had an STI, compared with about 20% of white women.

Only 13% of high school students have been tested for HIV. In one nationwide study, 10% of young MSM tested positive, and 69% of those were unaware they had HIV.

Many young people engage in behaviors that put them in danger. For example, 39% of all high school students say they didn’t use a condom the last time they had sex, while 46% of young MSM had unprotected anal intercourse in the last year. Sexual relationships with multiple partners that overlap in time increase many young people’s risk for HIV. Studies have found that because of medications that allow HIV-positive people to live longer, some young people may be taking more sexual risks as they become less fearful of HIV. This includes unprotected sex with untested or known HIV-positive individuals.

Testing

Young people face barriers to HIV testing, including stigma, confidentiality concerns, or fear that their parents may be informed. In addition, many young people are unaware of

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their HIV status. Nationwide, only 13% of high school students have been tested for HIV. In one nationwide study, 10% of young MSM tested positive, and 69% of those who did had previously been unaware that they had HIV. Another study revealed that young black MSM had a nearly seven times greater chance of having unrecognized HIV infection as young white MSM.

Especially among racial and sexual minority youth, having older partners means young people are even more likely to be exposed to HIV and STIs. Compared with black and Latina peers whose first sex occurred with a male of their own age, young women whose partner was older were significantly less likely to use condoms during first sex, and to have used them consistently since becoming sexually active. One study of young MSM found that the odds of HIV infection increased significantly as the age of their sexual partners increased. People in the study whose partners were five or more years older had twice the odds of getting HIV as study participants as a whole.

Among young women, dating violence and sexual assault also play a role in HIV transmission, and 20% report experiencing dating violence. Women who experience violence are less likely to use condoms than those who do not, and they feel more uncomfortable negotiating condom use. In one study, half of girls who reported HIV or STIs had been physically or sexually abused.

Why the Difference?

A common misconception is that young African-Americans are simply not as careful as whites in protecting their sexual health. But research has shown that even when risk factors are equal, sexually active minority youth face a higher risk of HIV and STIs. The people in their “pool” of sexual partners are more likely to be HIV-positive or have an STI, raising the odds of infection. But why?

Several linked issues contribute to higher infection rates among African-American young people. Racism is the most significant contributor, especially for those living in the South. Racism is intertwined with underemployment and unemployment, decreased access to medical care, and with incarceration.

Almost 25% of African-Americans live in poverty, compared with 11% of whites. Those who live in poverty are more likely to commit crime, especially drug-related crime. They are more likely to live in unstable neighborhoods with higher rates of crime and more liquor stores. Poverty also contributes to problem alcohol use, which leads to unemployment and unstable relationships. Unstable relationships can lead to unprotected sex if partners are afraid that insisting on condoms will endanger the relationship.

Meanwhile, strict sentencing laws around drug-related crime have resulted in the incarceration of millions of African Americans, especially men. More than

one in four are incarcerated during their lifetime. Certainly, unprotected sex in prison is one way HIV can be transmitted.

Research has shown that even when risk factors are equal, sexually active minority youth face a higher risk of HIV and STIs.

Men in prison have less sex overall, but more risky sex than men who are not incarcerated. Another effect of imprisonment is strained relationships with long-term partners or wives. This can lead to concurrent partnerships.

Those living in poverty also have less access to medical treatment and may go for long periods of time either unaware they have HIV or an STI or without treatment.

In addition to racism, the social stigma surrounding homosexuality also adds to health issues. Men who are secretive about same-sex behavior may have decreased access to medical treatment. They may be less likely to seek treatment and may be diagnosed later than those who are openly gay.

For young people of color who become sexually active, the deck is stacked against them in terms of maintaining their sexual health. HIV prevention efforts, which teach healthier behaviors like using condoms, are still vital, but are only a part of a successful prevention strategy. Addressing other factors which contribute to the spread of HIV is important.

Effective Strategies

Complex issues are fueling HIV transmission among young people, particularly young people of color. In order to address that, interventions must address individual behavior and the social and cultural issues that fuel HIV transmission. The following critical components for HIV/STI prevention are drawn from research.

- **Teach skills.** The ability to use condoms, negotiate safer sex, build relationships, communicate with steady and casual partners, make decisions, and say “no” strengthens teens’ ability to make healthy choices.
- **Involve young people.** Involving young MSM in creating and carrying out programs reduces risky behaviors while building their spirit of self-determination and self-worth. Plus, research has shown that identifying peer leaders is an effective way of reaching young people.
- **Use risk reduction strategies.** Programs should include information about reducing the number of partners, the relative risk of specific behaviors (e.g., anal sex vs. oral sex), understanding one’s own level of risk, and other ways to reduce HIV risk beyond abstinence and condom use.
- **Support comprehensive sexuality education.** Many students encounter misinformation and harmful stereotypes in HIV prevention education and sexuality education. Abstinence-only programs often rely on stereotypes of gender roles and use heterosexual relationships as models. This not only ignores lesbian, gay, bisexual, and transgender (LGBT) young people, but contributes to stigma against those who don’t fit a traditional masculine role. Comprehensive sex education should include instruction on risk reduction for all teens, including LGBT young people.
- **Adopt an ecological approach to prevention.** An ecological approach attempts to create more effective and culturally competent programs by looking at a young person’s entire world (family, community, relationships, and influences) and by creating peer, group, and family-level interventions.
- **Support structural interventions.** These approaches promote health by changing the environment – creating social norms that address behavior and encourage HIV testing. This could lead to a lower community viral load and result in fewer HIV transmissions. Some interventions require changes to law and policy in order to link HIV-positive youth to care, ensure continuity of care, promote treatment adherence, and improve standards on when to start HIV medications. Policymakers

must also address LGBT young peoples’ increased vulnerability to negative health outcomes. This includes creating policies that protect against bullying and discrimination, and youth-led programming to reduce social isolation and stigma. Providers can also participate by creating youth-friendly services and contributing to efforts to reduce the stigma around HIV.

Comprehensive sex education should include instruction on risk reduction for all teens, including LGBT young people.



Conclusion

No single strategy will work to reduce HIV among young people. But research has shown that culturally competent programs that include information about abstinence, contraception, and condoms can be effective in helping young people reduce risk behaviors. In addition, open and honest parent-child communication about HIV can help them make good decisions. Finally, resources must be directed at understanding the epidemic’s impact on the young, addressing the issues that contribute to the epidemic, and developing and testing a vaccine. ■

Jennifer Augustine is the Division Director of Health and Social Equity at Advocates for Youth.

Emily Bridges is Director of Public Information Services at Advocates for Youth.

Speak Out For Safer Sex

Young people from New Alternatives (a program for homeless LGBT youth) were asked to describe some of the challenges they face in staying HIV negative.

Courtney, 20

In my generation, AIDS has become genocide that is equivalent to any war. I had a scare once. My mom told me she received a letter from my lawyer saying I had HIV. But she never took me to get tested. I found out later that she was lying because she was prejudiced against my lifestyle (I like girls). I was actually HIV negative.

Just a few days ago, I had sex with a girl I knew for almost a year – or at least, I thought I knew her. I always distance myself from sex, especially being homeless. She and I talked over the phone for a while and eventually got serious enough to have a relationship. I would make general statements like, “If I ever have sex with a girl, I’m going to get her tested and we would have safe sex for three months until the test came back negative” and so on.

But, when things went down between us, that went completely out of my head. I figured, “Hey, I know her, she respects herself, let me stop being paranoid.” A few weeks later we had an argument when I asked her the last time she had sex, and she told me it was only two weeks before we did. Now I’m being treated for an infection in my throat. Just when I thought it was safe to let my guard down for someone I “loved,” I’m paying a visit to a doctor and taking medication. Although I know my HIV status, she probably doesn’t know hers, and one careless step could have been the end of my healthy life. In the end, it is in our power to decide to have safe sex, so you can’t blame other people.

Vincenzo, 24

If I look deep inside myself, past the painful shyness, the desire to be loved, and lack of self-respect, I can find the core of what makes it difficult for me to stay HIV negative: poor self-esteem. I’ve been sexually abused and homeless, and I lack an ability to be assertive when it comes to looking my partner in the eye and saying the dreaded word, “condom.” Even thinking the word is embarrassing. We don’t talk about sex at all. I don’t dare ask if it is true for them, but for me, sex is dirty. The less I think about what we are doing, how uncomfortable I am as we lie slithering against each other in bed, the more I will be able to convince myself everything is all right in the mirror tomorrow. After all, I should be grateful they want to have sex with me at all. I have a voice

that whispers to me that I am “damaged goods,” a voice that sounds so much like my mother’s.

So it starts with us lying in bed, a casual touch turning into something more because I don’t say, “Wait, where are the condoms?” He does not put one on. It’s a story that repeats itself thousands of times in countless lives, and it very well may be the disease of self that opens the way for HIV.

Teaching youth self-respect and empowering them are potent tools for prevention when coupled with proper sex education and HIV facts. Too often, I hear young people say, “It can’t happen to me,” or, worse, “I don’t care if it happens to me, we all die one day.” HIV just isn’t about death. It’s about health care, money, medications, and maintenance. The stigma of others’ ignorance is still rampant. Maybe youth should be taught that the sting of rejection from a partner who does not want to wear protection will fade in memory, but looking at the pill bottles will be a daily reminder if you contract HIV.

“It starts with us lying in bed, a casual touch turning into something more because I don’t say, “Wait, where are the condoms?” He does not put one on. It’s a story that repeats itself thousands of times in countless lives.”

Terelle, 19

I find it extremely hard to stay HIV negative because I personally have a high sex drive. I don’t want to say I’m a sex addict, but I have been having sex since I was 12. Both genders, all ages, all races, and I can honestly say that I have probably had over 100 partners. Some coins [for pay], some just random sex acts, and some boyfriends. I don’t always strap up so I am at risk for a lot of STIs, but I have never had one. My luck could run thin and I could get infected tomorrow. It’s scary. I would really hate to be another statistic in the world.

If youth would get smart, get tested every three months, wrap it up, and stop being scandalous, everyone would be okay. And I pray for the day we find a cure because I have lost too many people.

Danyal, 23

Promiscuity is something that plagues many communities. Personal decision-making skills are a major part of avoiding risky behavior. Making the best decisions for myself on a daily basis is what helps me remain HIV negative. The power of knowing is monumental. With the knowledge of how to prevent HIV and a commitment to practice this knowledge through safe sex and abstinence, one can combat infection.

Oftentimes young people fall victim to the pressure to have sex without protection. It can be hard, but we all have a responsibility to do our best to protect ourselves and our community. Personally, I have made a decision not to have sex until I am exclusively involved with someone whom I feel is ready to be a part of my life, and even then protecting myself from HIV will continue to be a priority.

Nathaniel, 22

When it comes to staying HIV negative, for me it's difficult. I identify as heterosexual, yet I've done things with men to survive. I became homeless at a young age and I didn't believe in selling drugs, so I was introduced to sex work. I learned to swallow my pride along with other things. Men would approach me and offer me excessive amounts of money, yet I would never let anyone penetrate me nor would I allow myself to penetrate anyone else. I thought oral sex was cool because I went through sexual abuse in my early childhood.

I needed the money and I felt secure enough that no one could make me feel "less than" because of what I was doing. Then I experienced gluttony and greed, when a man offered me a huge amount of money to allow him and his friend to come in my mouth. At that moment, it was a life-or-death situation. I'd never done anything that unsafe, yet we were talking about so much money. So I made a decision that took me in a whole new direction. After that, I was offered even more money to have oral sex with seven men, and extra money not to use a condom and to swallow. I was thinking about it, when I came to a shelter called Sylvia's Place, and learned how much danger I was putting myself in. So I let go of the excuses and the easy way of making a living.

To date I am HIV negative and am certified to teach others about the importance of knowing their status and respecting their bodies and themselves. To help those who aren't aware,



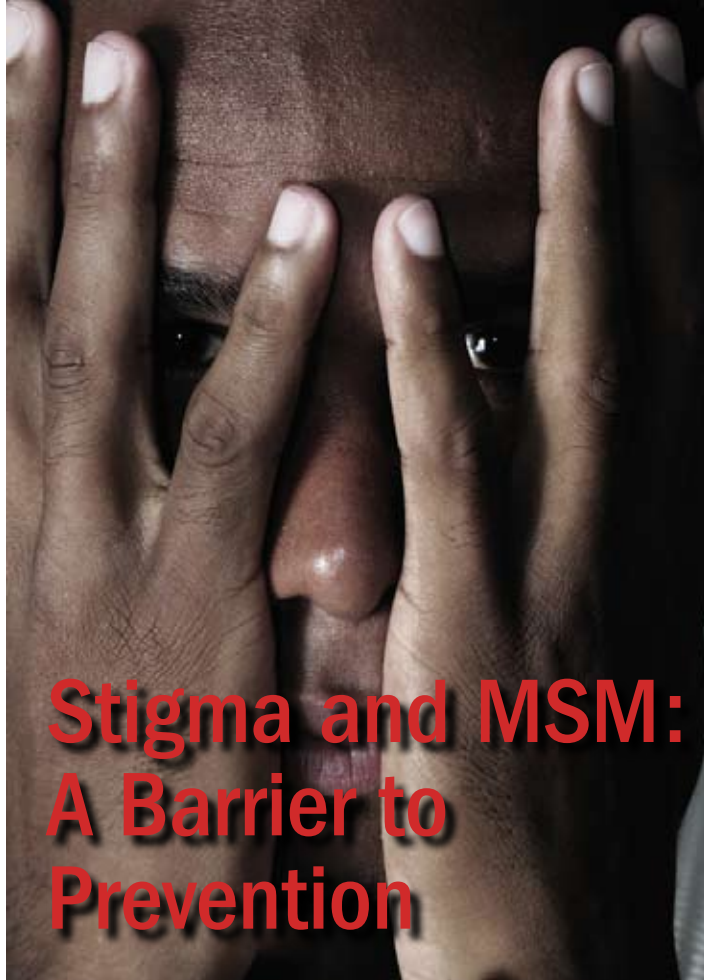
it would be highly beneficial to open up more resources for homeless youth, and allow them to be themselves without restrictions. I feel if it weren't for Sylvia's Place, I could have been another young person caught out there.

Jovany, 22

I didn't find it hard to stay negative, until I entered what I thought was a picture-perfect relationship. Everything was normal at the beginning, and I truly thought I had met my soulmate. We talked about our status and even spoke about getting tested together. As the relationship progressed, I began to see his real character. He was not only emotionally abusive to me, but also verbally abusive to me in public. I tried leaving him so many times. He would show up at my job (which led to my termination), harass my friends in trying to get hold of me, and even threaten to take my life. Once all ties had been severed, I could finally breathe. I couldn't believe I ever allowed a "man" to treat me the way that he did. I had finally forgiven him when I found out about his infidelities.

Then I found out I was HIV positive. I have had only three sexual partners in my life, so I know who I got the virus from. I was absolutely devastated. I felt stupid for not using protection. I supposed that because he told me that he loved me and cared for me, that was reason enough. Wrong answer!! The struggle I now face is confronting him or moving on with my life and forgiving him. I chose the latter and have made a conscious decision to not let this experience or virus leave a sour taste in my mouth for life. ■

For more info: www.newalternativesnyc.org



Stigma and MSM: A Barrier to Prevention

Stigma and discrimination against men who have sex with men (MSM) have been well documented around the world. The challenges they face can vary from everyday personal hardships to high-level factors such as hostility from civil society organizations, religious bodies, government, and law enforcement. In many cases, homophobia is perpetuated by policies that criminalize MSM or neglect their basic human rights. Harassment, rejection, and violence lead many MSM to actively hide their feelings and relationships, denying themselves the social support that could improve their health and quality of life.

Discrimination and High-Risk Behavior

Studies have shown that MSM who experience discrimination and harassment are more likely to engage in risky sexual behavior. Violence and threats from family members and other sources have been linked with heightened risk behaviors, such as unprotected anal sex. Hostile behaviors directed against Latino gay men in the U.S. – including harassment from their families and the need to pretend to be heterosexual – have also been linked with high-risk sexual behavior.

In many cultures, the pressure to marry and have children can also place enormous stress on gay men. Studies in China have revealed that expectations of male gender roles contributed to higher levels of stigma, which may be linked to higher rates of unprotected anal intercourse. When gay men succumb to pressure and enter into heterosexual marriage, they often maintain sexual relationships with male partners. This can result in unseen sexual networks, increasing HIV risk and making it difficult to reach them with prevention information.

Mental Health

A growing body of evidence links discrimination and poor mental health in gay men. Stress research has shown that expectations of rejection and actual events of discrimination and violence contribute to mental health problems. In the U.S., gay men who live in states with laws that discriminate against same-sex couples have been found to exhibit hopelessness, chronic worry, and hypervigilance, common psychological responses to perceived discrimination. Social discrimination directed at gay, bisexual, and transgender high school students has been shown to lead to a greater risk of self-harm, suicidal thoughts, risky sex, and substance use.

Sex “Criminals”

Nearly 80 countries criminalize same-sex acts, with penalties ranging from fines to imprisonment, and in seven nations, death. Facing such laws, MSM cannot disclose their sexual behavior to a health care provider without risking criminal sanctions. This can hinder provision of vital prevention information, testing, and care. Furthermore, outreach workers providing HIV prevention information and services to MSM may be accused of supporting illegal activities, such as “promoting homosexuality,” and be subjected to fines, imprisonment, harassment, or violence.

Over 20 countries in Asia criminalize homosexuality, in a region where higher HIV prevalence rates have been recorded among MSM compared with the general population. In Africa, MSM are 3.8 times more likely to be HIV-positive than the general population. Yet a majority of African countries punish same-sex behavior with criminal sanctions. Several countries have recently shown renewed interest in same-sex criminalization by expanding criminal penalties or putting forward new laws. For example, in 2009, legislation was introduced in Uganda that would increase existing same-sex criminal penalties to include life imprisonment and, in some cases, the death penalty.

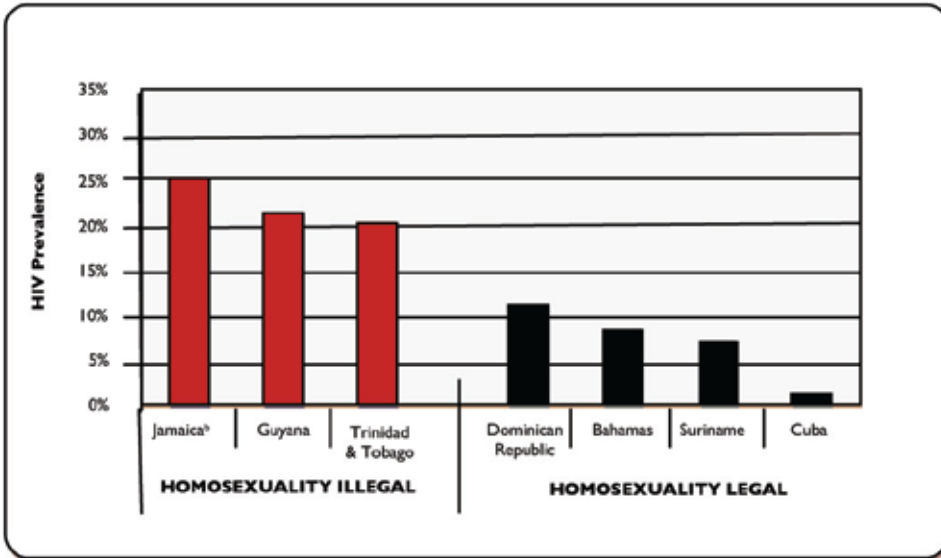
Legislation was introduced in Uganda that would increase same-sex criminal penalties to include life imprisonment and, in some cases, the death penalty.

Criminalization of homosexuality can worsen HIV epidemics. HIV prevalence data from the Caribbean offers a striking example. As the following chart illustrates, countries that criminalize homosexuality demonstrate higher rates of HIV among MSM than those that do not. This is a pattern that can be found across regions around the world.

Stigma and Health Care

Hostile conditions push MSM underground, making them extremely difficult to reach. A recent survey of MSM in low- and middle-income countries found that only about half used a condom the last time they had anal sex with another man, and fewer than a

HIV Prevalence Among MSM in Caribbean Countries



Adapted from UNAIDS Report on the Global AIDS Epidemic 2008 and UNAIDS Progress Report Towards Universal Access to HIV Prevention, Treatment, Care and Support in the Caribbean

third had tested for HIV in the last year. Because HIV resources are often offered at sites that provide other health services, homophobia in these settings can make it particularly difficult for MSM to get care. Even health care workers who declare acceptance of homosexuality have been known to display homophobic attitudes when providing services, breaching ethics standards and compromising the care of sexual minorities.

In recent decades, many governments and global institutions have emphasized primary health care, but many primary care providers still lack specialized knowledge about caring for MSM. They may, intentionally or unintentionally, express disapproval, driving them away. These behaviors can range from nonverbal gestures to disparaging remarks or ridicule. This makes MSM less likely to openly discuss their sexuality and more likely to provide inaccurate sexual histories.

An HIV diagnosis in itself can lead to significant stigma and discrimination, even from the systems that deliver HIV care. In Vietnam, nearly 100% of people with HIV in a recent study had experienced some form of discrimination because of their HIV status. In South Africa, HIV-positive men of all sexual orientations reported considerable emotional distress and discrimination. In Tanzania, people living with HIV reported “name calling, mocking and pointing fingers at those infected, and abusive language.”

The root causes of stigma against people with HIV are many and varied. Lack of knowledge about HIV is an important factor, leading to misperceptions and fear of contracting the virus. Negative images of people with HIV in the media and linking HIV with illegal or “immoral” behavior (including sex between men) increase stigma. The growing trend toward criminalizing HIV transmission heightens the stigma. This stigma is realized through various forms of discrimination, including loss of family and community support, loss of housing, and loss of employment. The resulting isolation can be devastating. In India, for example, one study found an unwillingness to buy food from or share a meal with people with HIV. The dual stigma against MSM with HIV can hamper involvement in prevention efforts, decrease the chance of early intervention, and reduce quality of life.

Homophobia

It is estimated that HIV prevention services reach fewer than one in ten MSM globally. One recent study reported that fewer than half of MSM in low- and middle-income countries have access to information about HIV. It is not surprising then that MSM end up bearing the bulk of the epidemic’s burden in many countries.

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David Kato, above left, was a leading HIV and gay rights activist who was killed in Uganda in 2011.

It is important to note that this difference in HIV prevalence is not unique to developing nations. The resurgence of the epidemic among MSM in high-income countries is well documented. According to UNAIDS, sex between men represents the dominant mode of transmission in Australia, North America, and the European Union. The CDC reports that the rate of new HIV diagnoses among MSM in the U.S. is more than 44 times that of other men. The National AIDS Trust estimates that MSM account for a third of new infections every year in the United Kingdom.

In low- and middle-income countries, MSM often do not have legal protections against hate crimes or other discrimination. This further limits their access to health information and services. The result can be seen in regions where MSM are at higher risk for HIV transmission and are also excluded from mainstream society. In Latin America for instance, male-to-male sex is the primary mode of HIV transmission. This region also has the largest number of homophobic crimes in the world, based on the reported number of murders due to sexual orientation.

Recommendations

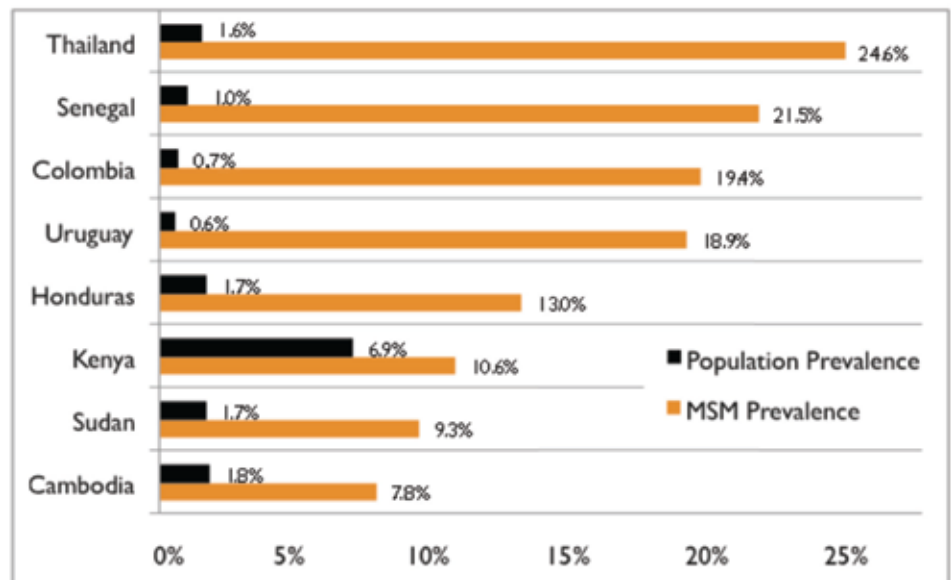
Coordinated advocacy efforts are needed to change the attitudes of individuals, families, and communities. To maximize their effectiveness, these efforts must engage gay men and MSM, including those with HIV. Universal access to HIV treatment cannot be achieved unless social, legal, and policy environments protect the rights of gay men and other MSM.

Adopt a human rights-based approach to tackling social discrimination.

Governments should adopt these guidelines:

- International Guidelines on HIV/AIDS and Human Rights: These guidelines are consistent with fundamental human rights and should constitute the core of any national AIDS strategy.
- Yogyakarta Principles (Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity): A key policy tool for the advancement of legal reform toward full equality of all people, regardless of sexual orientation or gender identity.
- UN Statement on Sexual Orientation and Gender Identity: Reaffirms the universality of human rights, condemns human rights violations based on sexual orientation and gender identity, and calls on states to ensure that sexual orientation and gender identity are never grounds for criminal penalties.

Comparison of HIV Prevalence Among MSM and Adults of Reproductive Age



Baral et al. Center for Public Health and Human Rights, Johns Hopkins School of Public Health

Advocate for legal reform

Communities must partner with global health bodies, human rights organizations, and legal institutions to repeal existing and emerging criminal laws and other policies targeting lesbian, gay, bisexual, and transgender people.

- Criminalization of same-sex acts must be repealed to create an environment that allows MSM free access to HIV services and information.
- Other laws that may be used to target MSM and other sexual minorities must be repealed, such as public assembly laws, loitering or public nuisance acts, public indecency laws, and age-of-consent laws that are stricter for same-sex acts.
- Antidiscrimination laws related to HIV, sexual orientation, and gender identity must be enacted to protect the rights of MSM and increase their use of social and health services.

Build capacity for responsive health service delivery systems

MSM are typically “hard to find” by health systems, but this can be addressed by working with community-based organizations. Primary and specialized health care should be readily available to MSM. Creating awareness of the health and social care needs of MSM among health care providers must be part of strengthening health systems.

- Provider education on stigma can help MSM obtain care without fear of discrimination or harassment.
- Training programs must be organized to dispel myths that providers may have about working with MSM, including those with HIV.
- Guidelines for health care for MSM and professional education on their issues should be routinely made available to all health care providers, from doctors to lab technicians.



- Professional health care associations should ensure that their codes of conduct address sexual minorities and people with HIV, and that they include freedom from discrimination in health care settings and human rights protections. Health care associations should actively speak out against policies that result in negative health outcomes for MSM.

Ensure access to the legal system

MSM in many countries have no recourse to justice when their rights are violated. In order to address their health care needs, they must be able to assert their rights through the legal systems that are available to the broader community.

- National governments, policy makers, and civil society must create an environment in which victims of discrimination or hate crimes may freely and confidentially obtain legal services.
- Advocates must be helped to create safe spaces where MSM can obtain support in their communities and can receive support from each other. This includes supporting the creation of MSM organizations.

Increase antistigma work

Antistigma initiatives are critical to improving access to HIV services and enabling MSM to take charge of their own health.

- National governments and donors must finance programs that combat stigma, discrimination, and violence against MSM.
- Donors should provide funding to groups that support MSM. Such organizations are in a position to act as both watchdogs and service providers, and play a key role in empowering communities to take control of their lives and advocate for change.

Develop more evidence on stigma

Limited data exist about interventions that lessen the impact of stigma and discrimination on MSM. The “People Living with HIV Stigma Index” is a significant development, gathering data from groups of people with HIV to better understand the nature of stigma. The Stigma Index will help evaluate trends in relation to interventions.

- A comprehensive study of stigma interventions must be done regularly, and “best practices” shared globally.
- Data on stigma, with attention to MSM, should be used to advocate for policy and funding changes that more effectively target the response.
- Resources must be used to scale up interventions that have been proven effective.
- Knowledge gained must be shared among all stakeholders involved in sexual rights and HIV policy.

Coordinate strategic communication

Messaging strategies must be informed by the personal and collective experiences of MSM.

- The role of the media and its impact on public opinion and policy cannot be overestimated. Regional and global media should be engaged in raising public awareness and addressing hostile attitudes toward MSM.
- Educational strategies designed to promote reporting of discrimination, homophobia, and violence must be developed and implemented. ■

Adapted from “Social Discrimination Against Men Who Have Sex With Men (MSM): Implications for HIV Policy and Programs” by The Global Forum on MSM & HIV (MSMGF). Charts used with permission from MSMGF.

Can I get an “Amen” for HIV Awareness?

by Vanessa

It still amazes me that even though the HIV epidemic has been in existence for 30 years, there are some people that still don't know how it's transmitted. The rate of infection in my community is alarming. Most importantly, our youth are at risk. So I've worked as a peer educator for six years with the Women's Institute at GMHC. My reason for becoming a peer was my personal passion to raise awareness of HIV in my community and among our youth.

Throughout my life, I have attended many Baptist churches – even though I was raised Catholic – because a lot of my family are Baptist. I visited my aunt's church where my cousins sang in the choir. I didn't feel comfortable there at first. Being a lesbian, I was used to wearing pants, but my aunt told me “Oh no! You can't wear pants to church – you have to wear a dress!” That made me very uncomfortable. When I actually thought about how God loves people, it wasn't about how I dressed – it was best to come as I am. When I grasped that concept I didn't feel bad about the preconceived notions of other church members, and I stopped hiding my sexuality. But it took a few years.

There's a stigma about gays and lesbians in the church. It's like trying to jump two hurdles, the gay hurdle and the HIV hurdle. And a lot of people think it's the same thing. But that's not the case with HIV. It affects everybody. The stigma associated with the origin of this epidemic is alive today – it's still a “gay” disease. And being gay in the Baptist church is considered taboo. I once heard a church member say, “God made Adam and Eve, not Adam and Steve.” So, there's a tremendous amount of shame and guilt associated with being HIV positive. If a person who was positive wanted to turn to

the church as a source of refuge, chances are they'd be ostracized. Which means they'd suffer in silence. When folks become silent, they feel alone and die alone.

There's an urgent need to break the silence surrounding HIV in the Baptist church. The attraction of the Baptist church is that the message there is spoken directly to the members. It's a personal message to the people – the pastors speak to real-life issues. That's why I relate more closely to the Baptist church than the Catholic church. The pastors of my aunt's church were the leaders of their congregation and of the community. That seemed like an excellent way to reach massive amounts of people who might otherwise be closed-minded to the idea of HIV education.

There's a stigma about gays and lesbians in the church. It's like trying to jump two hurdles, the gay hurdle and the HIV hurdle.

So, some years ago, I came up with the idea of reaching out to faith-based organizations. It was time for pastors to assist in raising awareness among the congregation, community, and families. Right now, there is not much dialogue in churches about HIV. Starting the conversation in the congregation would create discussions in families that would trickle down to friends and the community, especially our youth. You know, when I speak to young people about HIV, they're very eager to learn but tell me that it's just not something their peers talk about. Raising their awareness through education, we can emphasize the importance of knowing how HIV is transmitted, of using protection, and knowing your status. It's always better to know than not to know.



Some of the statistics that I present about HIV and African-Americans shock people. As I am reading them I hear gasps and see some very astonished faces. It's obvious that a lot of them are unaware of the severity of the epidemic. But I think people are more eager now to learn about HIV because it's affecting people around them. It's not just the gays anymore. If people can be open-minded about sexuality and HIV education then we'll do better. We can get more done.

I've reached out to a few churches about starting a campaign that teaches about HIV prevention and encourages testing. Some don't call back but I keep calling them until I speak with someone. Others have

HIV ministries, but a lot of them aren't really active. And there are some church members who are very helpful – my aunt, for example. She helped me with the first campaign I worked on: “The First Ladies Care Campaign.” It was designed to get pastors' wives to encourage their congregations to support HIV education, prevention, and testing. It was my idea to choose The First Baptist Church of Crown Heights as our first effort, because my aunt had been a very active member there for over 30 years. She was instrumental in making the connection with the church's HIV ministry. After that, the idea was presented to the First Lady, Mrs. Ellen Norman, who was excited and became our campaign's first “spokesmodel.” Her photo was taken and put on a church fan with a quote on the back: “HIV and AIDS has touched all of our lives. The time for us to reach out is now.”

Some of the statistics that I present about HIV and African-Americans shock people. As I am reading them I hear gasps and see some very astonished faces.

My aunt passed away two months before the fans were presented to the congregation. Although she never spoke much about HIV, she knew the work I was doing to educate people and save lives was important. I'm forever grateful to her for assisting me in successfully starting the campaign at her church. I believe the campaign was well-received and a seed was planted to make people think. Moving forward, the next step should be a health fair where we can host a question-and-answer session, pass out HIV and STI information, create dialogue, and have a testing van present.

Once we're able to educate and have a healthy dialogue with our churches, family, and community, we can begin to protect each other and end the rising infection rate. Can I get an “Amen!”? ■

INCHING OUR WAY FORWARD: FUNDING SEX EDUCATION



by Jen Heitel Yakush

During the first two years of Barack Obama's presidency, advocates for comprehensive sex education saw positive changes. After nearly 30 years of strong support for abstinence-only-until-marriage programs, two-thirds of federal funding for these ineffective programs has been cut. At the same time, nearly \$190 million has been provided for evidence-based teen pregnancy prevention and comprehensive sex education. These new programs will help young people make safe and healthy decisions about their sexual health. With the results of the 2010 election, however, it is unknown how much further progress we will be able to make over the next two years.

We must thoughtfully chart our next steps toward the goal of comprehensive sex education – including discussions of abstinence, contraception, and prevention of HIV, other sexually transmitted diseases (STDs), and unintended pregnancy – for all school-age youth. Comprehensive sex education programs must also address self-esteem, healthy relationships, com-

munication and decision-making skills, sexual orientation, and gender identity. This article details how far we have come at the federal level, where we need to go, and with the recent election results in mind, what we may see in the coming years.

The Obama administration and Congress missed an opportunity to provide comprehensive sex education for all young people, including those who are lesbian, gay, bisexual, and transgender.

Teen Pregnancy Prevention

The President's Teen Pregnancy Prevention Initiative (TPPI) funds medically accurate and age-appropriate programs designed to reduce teen pregnancy. At least \$75 million of the funding is for programs that have been proven to reduce teenage pregnancy and its risk factors, while at least \$25 million is for testing other models and innovative strategies.

In September, the Office of Adolescent Health (OAH) awarded a total of \$110 million to several grantees: \$75 million to 75

grantees for pregnancy prevention programs that have been shown to be effective through rigorous evaluation, and \$35 million to 40 grantees to test innovative strategies. The OAH had received over 1,000 applications, demonstrating that public health agencies, community-based organizations, and public schools are hungry for funding to carry out effective, innovative, and comprehensive programs.

While sex education advocates support the TPPI, however, some also worry it may fall short of its true potential. Over half of young people have had sexual intercourse by the age of 18 and are at risk of both unintended pregnancy and STDs. It is unfortunate that the funding focuses only on teen pregnancy and does not specifically address the equally important health issues of STDs, including HIV. Nor does TPPI require a discussion of abstinence and contraception when sexual activity is discussed. While, because of strong advocacy efforts, the legislation does ensure that programs that address risk behaviors related to pregnancy can be covered, allowing HIV/STD prevention programs to be funded, the Obama administration and Congress missed an opportunity to provide comprehensive sex education that promotes healthy behaviors and relationships for all young people, including those

who are lesbian, gay, bisexual, and transgender (LGBT). Unfortunately, several abstinence-only programs did receive grants through the innovative portion. These programs are far from cutting-edge and were proven not to work in the government's own study.

Personal Responsibility Education Program

In March, President Obama signed the health care reform bill – the *Patient Protection and Affordable Care Act*. While

it unfortunately included the extension of an abstinence-only-until-marriage program, it also created the Personal Responsibility Education Program (PREP), which provides \$75 million per year from 2010 through 2014 to fund complete, medically accurate, and age-appropriate sex education to help young people reduce their risk of pregnancy and STDs, including HIV. Over \$55 million of it is dedicated to state grants. Additional funding is available for Indian tribes and tribal organizations, research and evaluation, and innovative approaches. This new funding stream is the first of its kind and will go a long way toward providing comprehensive sex education across the country. Programs funded by PREP are also required to teach life skills, such as healthy relationships, communication, and decision-making skills.

PREP programs must use approaches that have been proven by research to change behavior or must incorporate elements of effective programs. This includes delaying sexual activity, increasing condom or contraceptive use, or reducing pregnancy. They must place significant attention on both abstinence and contraception for the prevention of pregnancy and STDs, including HIV, and are required to be carried out in a culturally appropriate manner. The response to PREP has been positive: 43 states, the District of Columbia and two U.S. territories submitted funding applications.

DASH

For more than two decades, the Division of Adolescent and School Health (DASH) has worked with schools to coordinate an approach to the health issues that affect our nation's 56 million students. DASH was created as a response to the HIV epidemic, and recognizes that schools are uniquely positioned to support prevention programs. It encourages state and local education agencies to work with health departments so young people receive health education that addresses HIV, STDs, and pregnancy.

Health departments are usually unable to incorporate prevention programs into schools without partnering with education agencies. DASH is the only funding stream that coordinates the two. In 2010,

The National HIV/AIDS Strategy does not include a call for comprehensive sex education for all youth in public schools.

DASH received nearly \$60 million, with just over \$40 million being dedicated to HIV prevention and other sex education.

When President Obama released our nation's first National HIV/AIDS Strategy (NHAS) in July, sex education advocates were pleased, but not overjoyed. While there is mention of sex education, the Strategy does not include a call for comprehensive sex education for all youth in public schools. It also does not target youth, despite the fact that one-quarter of new HIV infections occur among people aged 13 to 29.

The NHAS Implementation Plan does, however, outline several of DASH's ongoing and upcoming activities. This includes

its work to ensure that school health education provides scientifically sound information about HIV and risk-reduction strategies. By the end of 2011, the CDC will develop a toolkit and work with states, cities, and school boards to carry out HIV education. It will also consider partnerships, such as with private businesses, to expand HIV/STD prevention.

Abstinence-Only Funding

In the fall of 2009, after nearly 30 years and over 1.5 billion taxpayer dollars spent on abstinence-only-until-marriage programs, we briefly saw the end to all funding for them. Sadly, conservatives in Congress were successful in bringing back the Title V abstinence-only program in the recent health care reform bill. This means another \$250 million for these ineffective programs will be available over the next five years.

While the Obama administration did issue new guidance for these programs that allows for more flexibility, programs funded with abstinence-only dollars must still exclusively teach abstinence. To qualify for these funds, programs must be designed so that abstinence is the expected outcome, and no funds can be used in

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ways that contradict the federal definition of “abstinence education.” This means that states still cannot use these funds to provide information about condoms and contraception.

When the Title V abstinence-only program first expired in June 2009, nearly half of the states had chosen not to accept the funding. Now, with the relaxed guidelines, 30 states and Puerto Rico applied for funding in 2010. While some of the states may carry out programs that focus primarily on younger ages or mentoring, this increase may result in even more young people not receiving the information they need to make healthy decisions.

The 2010 election will force those advocating for effective, comprehensive sex education to fight against bringing back old, or creating new, funding streams for abstinence-only-until-marriage programs. Ending

the Title V abstinence-only program is key to ensuring that young people are not misinformed and misguided. With a large body of research proving abstinence-only programs ineffective, Senator Frank Lautenberg and Congresswoman Barbara Lee introduced the Repealing Ineffective and Incomplete Abstinence-Only Program Funding Act of 2010. This would eliminate the Title V abstinence-only provision that promotes marriage as the only acceptable lifestyle, marginalizes LGBT youth, and censors information on avoiding pregnancy and STDs, including HIV. If the bill is passed, it will also transfer funding for the Title V abstinence-only program to PREP. This bill will be reintroduced in 2011.

Next Steps

Sexuality education should be a nonpartisan issue. Poll after poll has shown that

a majority of voters, no matter their party affiliation, believe young people should be given comprehensive information about both abstinence and contraception to protect themselves from HIV, STDs, and pregnancy. History, however, has shown us that elections matter. The recent shift in the House of Representatives will present new challenges to advocates for more comprehensive approaches to sex education. With the culture wars back in the halls of Congress, federal funding for sex education will likely be in danger. The fight will not only be to quash the new more comprehensive approaches but also to bring back the ideologically driven and ineffective abstinence-only-until-marriage programs sex education advocates have fought against for years.

The 2010 election will force those advocating for comprehensive sex education to fight against bringing back abstinence-only programs.

If Republicans are able to bring back funding for abstinence-only-until-marriage programs, this will be considered a win to their conservative base. In one breath they will be calling for cuts to the federal deficit and “out of control” federal spending, but in the next they will be expecting immediate results that show the far-right is back in power. Science and sanity were once again prevailing in our nation’s capital. We must keep up the fight to ensure we hold our ground and build on our successes so we can provide our youth with the information they need and deserve to lead healthy lives. ■

Jen Heitel Yakush is the Director of Public Policy at the Sexuality Information and Education Council of the United States (SIECUS).

by Luis Scaccabarozzi

How many times have you seen a billboard with the message that older adults may be at risk for HIV? How many times have you heard of an HIV testing campaign targeting your grandmother? How many programs do you know of that teach your father how to practice his condom skills? From the amount of attention it gets, you'd never think that older adults are at risk for HIV or sexually transmitted diseases (STDs). Many people don't want to imagine their parents and grandparents, uncles and aunts engaging in any behavior that might place them at risk for HIV.

Even service providers with patients who might look like their older relatives have difficulty asking questions related to sexual or substance use history, or to offer an HIV test, much less any HIV risk education. Doctors are not immune to the ageist stereotypes of our society, and this can be a problem both in prevention and diagnosis of HIV in seniors. The doctor who does not see past the silver hair may not ask older patients about their sexual activity or drug use and may not give the prevention information that is routine for younger patients. Age is not a barrier to HIV – we are all at risk.

A Columbia University study showed that 45% of people over 50 reported risk factors, including multiple partners, STDs, and alcohol or drug use. .

Risk Factors

The risk factors for infection are the same regardless of age: unprotected sex or sharing needles. We tend not to think of older people as being sexually active or using drugs, but a Columbia University study showed that 45% of people over 50 reported risk factors, including multiple partners, STDs, and alcohol or drug use.

HIV has become a significant national problem among older adults. The rates of infection in this group continue to increase,



HIV Prevention and Older Adults

with 28% of people with HIV in 2006 being over 45, compared with 22% in 2001. According to the CDC, in 2009 this group accounted for 29% of all new HIV diagnoses. The CDC estimates that by 2015, half of all people with HIV in the U.S. will be over 50, and that more than a third will be women. The longer survival of people diagnosed earlier in life also accounts for much of the increasing number of older adults with HIV.

Contrary to stereotypical beliefs, older adults long for active, satisfying sex lives. The fact that sexual contact is the most common HIV transmission route among older adults confirms the presence of both sexual activity and sexual risk behaviors among this population. Results from national surveys examining the sexual activity among persons over the age of 60 indicate that more than 92% consider sex an important part of life and that 75% of those between 65 and 74 considered themselves sexually active. Although little is known about the sexual behaviors of older adults with HIV, new data suggest that sexually active older adults are engaging in risky sexual behaviors.

Taking Action

Although risk-reduction interventions tailored for the needs of people with HIV have begun to demonstrate promising results, only a few have focused on HIV-positive older adults. They include:

- **ACRIA's Community PROMISE program** – targeting older HIV-positive men who have sex with men or who are at risk for HIV, older women of color with HIV or at risk for it, and older adults who don't see themselves at risk for HIV or STDs.
- **Latino Family Services**, Hartford – targeting older Latino men with substance use and mental health issues. The organization has created a curriculum called "Healthy Men, Healthy Lives" as part of a five-session program that targets Latino men over 50. One of the sessions is dedicated exclusively to HIV and uses several tools, among them ACRIA's own "Older and Wiser" DVD and discussion manual.
- **Adults Well-Being Services**, Detroit – targeting older African-American HIV-positive men and women with substance use and mental health issues.
- **Project ROADMAP** (Reeducating Older Adults in Maintaining AIDS Prevention), Miami – an intervention designed to reduce high-risk sexual

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behaviors among older people with HIV in primary care clinics.

- **Brothers to Brothers/Sisters to Sisters**, Wright State University, Ohio – adapting Community PROMISE to target older African-Americans.

Although the CDC funds HIV interventions that use its Diffusion of Effective Behavioral Interventions (DEBI) program, none of the funded organizations target older adults. Perhaps there is a belief that HIV prevention is the same for everyone. There has long been a need

oneself during high-risk behaviors. In contrast with younger people, many older adults do not consider unprotected sex a high-risk behavior because many are no longer concerned about birth control, making them less likely to use condoms. Studies suggest that older adults' knowledge of the seriousness of HIV may not affect their perceived threat of AIDS or their use of condoms.

Multiple health problems and age-related physical changes may make older adults particularly vulnerable to HIV. For example, postmenopausal women are at greater risk for HIV because of the fragility of the vaginal mucosa, due to



to tailor approaches to target specific groups. Why hasn't the CDC made any attempt to fund a program that creates an HIV intervention for older adults?

Old and Young

Research has found differences between older adults and their younger counterparts in terms of sexual knowledge, risk behaviors, and biological factors, showing the need for age-appropriate interventions. Older age has been linked with having incorrect information about prevention, including the need to protect

decreased levels of estrogen. In addition, older patients may progress more quickly from HIV to AIDS. Furthermore, there is often a delay in diagnosis due to clinicians underestimating the risk for HIV among older adults and common HIV symptoms being mistaken for signs of aging. More importantly, older adults may not seek testing because they do not believe themselves to be at risk. Thus, cultural, biological, and behavioral vulnerabilities may make efforts to target high-risk sexual behaviors even more critical in the older population.

Key Facts

- Many older persons are sexually active but are not practicing safer sex.
- Older women are especially at risk because age-related vaginal thinning and dryness can cause tears during intercourse.
- Some older persons inject drugs or smoke crack cocaine, which puts them at risk for HIV. HIV transmission through injection drug use accounts for more than 16% of AIDS cases in people over 50.
- Some older persons may be less knowledgeable about HIV than younger people, may not perceive themselves as at risk, not use condoms, and not get tested for HIV. Older persons of color may face discrimination and stigma that can lead to reluctance to seek services, and delayed testing and diagnosis. HIV stigma may be more severe among older persons, leading them to hide their diagnosis from family and friends. This can limit the emotional and practical support they receive.
- Ageist assumptions have been challenged by several decades of research, which has generated a set of principles:
 - It is never too late to introduce healthy behavior.
 - There is a need for social and behavioral interventions across the entire lifespan, especially in light of the cumulative impact of risk factors on vulnerable populations.
 - Older adults can be recruited into health intervention studies if we address the unique barriers they face.
 - Today's interventions should place an emphasis on maintaining quality of life and reducing age-related conditions.
 - We should move toward "functional age" and away from "chronological age," because the former is less likely to fall into stereotypes such as "older people don't have sex and don't use drugs."
- Health care professionals may underestimate older patients' risk for HIV and miss opportunities to deliver prevention messages, offer HIV testing, or make early diagnoses that could help their patients get needed care.

Conclusion

1. Social marketing campaigns targeting older adults are necessary to encourage safer sex. As people get older, women increasingly outnumber men. When there are many more women than men, women have less power, putting them at a disadvantage when negotiating condom use. Campaigns promoting condom use and the female condom could provide important prevention tools.
2. Many sexually active older adults take part in high-risk activities but are unaware of the need to protect themselves. ACRIA's *Research on Older Adults with HIV (ROAH)* study looked at older adults with HIV in New York City. Of those who were sexually active, 47% used drugs or alcohol before sex. Another study found that 60% of older single women have had unprotected sex within the past decade. The CDC reports that over half of older African-American women living in rural areas have at least one risk factor for HIV.

A study in England found that STD rates more than doubled among older adults in less than a decade. While experts attribute the rise to trends such as a high divorce rate and online dating, many highlighted the lack of sexual knowledge among older adults as the



3. The CDC recommends routine HIV screening for persons up to age 64. Persons over 64 should be counseled to receive HIV testing if they have risk factors. Routine testing is intended

strategies to help older women negotiate safer sex are especially important.

5. A recent review of HIV behavioral interventions for people over 50 recommended simultaneous approaches, including building on our current understanding of behavior change and HIV prevention successes with younger people while considering important lessons learned from work with older adults in other health areas. Given the complexity of the problem, our solution must be comprehensive, learning from and intervening with individuals, families, health care professionals, communities, and society as a whole.

As people get older, women increasingly outnumber men. When there are many more women than men, women have less power, putting them at a disadvantage when negotiating condom use.

principal reason for the increase. The study recommended that “safe sex messages and sexual health research should target all sexually active members of the population, including older people.” Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases stated, “While it’s a good thing that older people are more sexually active, they need to connect the dots, see they’re at increased risk, and make sure they use condoms.”

not only to identify persons who are unaware that they are HIV infected but also to remove the stigma of being tested. Making testing routine for older persons can open a discussion about risk behavior.

4. Prevention strategies should be developed for older persons who are at risk: education to increase awareness, skills training to help negotiate risk reduction, and messages that are age-appropriate and culturally sensitive. Intervention

We must take into account the special needs of older adults and involve a variety of groups who have not traditionally been associated with HIV prevention efforts. Strategies for extending successful interventions to the entire over-50 population need development and evaluation. ■

Luis Sscaccabarozzi is Director of the HIV Health Literacy Program at ACRIA.

P(r)aying for PEP

by Luis Scaccabarozzi

Recently, an HIV service provider in New York City shared his experience after being exposed to HIV through sexual contact. He is well-informed about HIV and had received information about HIV post-exposure prophylaxis (PEP) at an ACRIA training. It was fortunate for him that he had attended this training, but many others aren't lucky enough to have this information.

PEP offers the possibility of preventing HIV transmission when exposure to HIV has already occurred, through either occupational or sexual exposure. Current guidelines recommend starting HIV medications within 36 hours of exposure and continuing them for 30 days. But more information needs to be available to those who are exposed to HIV through sex. If you ask people who are relatively well-informed about HIV what they would do if they were sexually exposed to the virus, chances are that not many will have a good grasp of PEP. This is where we rely on medical providers, even those who are not HIV specialists, to be informed of current PEP guidelines.

Many states follow the CDC's guidelines for PEP or have developed their own. These include consideration of side effects, adherence concerns, risks and benefits, cost of care, payment for medications, and public health impact. Even more important, these guidelines stress that a person who has been exposed to HIV should be able to walk into any emergency room and ask for PEP. If the person has had a significant exposure to HIV, such as unprotected anal or vaginal intercourse with someone with HIV or of unknown HIV status, PEP should be provided. PEP is not of course a substitute for proven HIV prevention methods like condoms, but in an emergency it is an important option.

When my friend walked into the ER of a hospital in the Bronx, he spoke with

intake personnel who had no clue what PEP was. He was shocked. He was repeatedly asked for an explanation, until he was forced to share that he had been exposed to HIV, with other patients sitting nearby. He informed the intake staff that New York State guidelines specify that he receive treatment within 36 hours, and that he had been exposed 28 hours earlier. They promised he would be seen quickly.

Unfortunately, when he filled the prescription, he got a surprise: he had to pay \$1,880, since his private insurance would not cover drugs for PEP.

Three hours later, he was finally able to see a doctor (now hour 31), was told that there weren't any HIV testers available, and that he would need to get tested in three months. He explained he was there for PEP and needed an immediate HIV PCR test, which would provide valuable information about the degree of his exposure. The doctor looked at him as if he was nuts, had some back-and-forth with another doctor, and finally offered PEP (now hour 32). He was given three days' worth of Viread and Combivir and a prescription for a month's supply. He was told he could take it then or wait until the morning. Fortunately, he knew enough to take it immediately, as he would have been past the suggested 36 hours by morning.

Unfortunately, when he filled the prescription, he got a surprise: he had to pay \$1,880, since his private insurance would not cover drugs for PEP. He was able to afford that, but what would have happened if he couldn't? Medicaid and

Medicare cover PEP, but many private insurance companies do not.

The next day, a doctor at the hospital called to tell him to come back for a PCR test. But when he returned to the ER, he found a different receptionist who asked him to explain what a PCR test was, why he was there, and the name of his doctor. Again he had to discuss his HIV exposure in front of other patients. When he finally saw a doctor, he was once again told he needed to wait three months to get tested. He informed him he was there for a PCR test and not an antibody test. Finally, the doctor he had spoken with earlier came to the ER and clarified everything.

The mix-up seemed to be solved . . . until the hospital found that they didn't have a PCR sample tube in the ER. The doctor apologized and stated that he was unaware of PEP guidelines. My friend asked, "So am I the first person you've treated with PEP?" The doctor said, "No, we've treated others for occupational exposure" – surprising, since he was unaware of the NYS PEP guidelines.

Fortunately, his PCR test came back negative and, due to his insistence, he had begun PEP in time. But what would have happened had he been less well-informed? Would PEP and a PCR test have been offered?

It's important that ERs not only have written guidelines for PEP but that all service providers be familiar with them. Moreover, part of the process should be not only providing three doses of medications, but also giving patients the information about which pharmaceutical companies will pay for PEP. (GlaxoSmithKline will cover costs for uninsured patients only, whereas Gilead and Abbott will cover insured patients if income requirements are met.)

Local and state health departments need to create quality assurance processes to check whether PEP is being implemented in a sensitive and timely manner, from the moment a patient walks into the ER until he or she walks out with a three-day dose and a voucher for medications if needed. Perhaps health department investigators need to do surprise mock visits to hospitals posing as patients to see if the guidelines are being implemented. ■

Toward More Positive Prevention

As health agencies look for effective HIV prevention campaigns, fear tactics are an increasingly popular option. Also referred to as negative messaging, fear-based campaigns rely on gruesome images and disturbing stories. These campaigns are controversial, but are often promoted as the only way to shake viewers out of complacency. In several recent studies on public health campaigns, however, results have shown that fear tactics are generally ineffective.

At a recent meeting in New York, community service providers expressed concern that a New York City Department of Health public service announcement would prevent their clients from getting tested for HIV. This 30-second TV spot aimed at gay and bisexual men, titled “It’s Never Just HIV” showed images of young black and Latino men suffering from conditions such as osteoporosis, dementia, and anal cancer. An HIV infection, the video explained, puts people at greater risk for these diseases. Indeed, these conditions have been found to be more common in older adults with HIV (but not in younger people). During the debate, some were concerned that the campaign would further stigmatize gay men and people with HIV, while others voiced frustration with what they considered a complacent community. Above all, the most important issue was whether or not fear-based campaigns work.

This was not the first time this question has been raised. A 2002 Yale study found that when fear levels were too high in messaging, fewer viewers processed it, and began displaying denial. A 1989 Yale study showed how attempts to elicit fear from viewers may also cause anger and sadness. Those studied felt they had less ability to practice safer behaviors, but simultaneously felt “more vulnerable to diverse negative health outcomes.” Due to a decreased sense of being able to take action, especially when suffering or death were mentioned, they were less likely to adopt risk-reducing practices.

According to a September 2010 Sigma Research brief, threatening messages also lead people to deflect their anxiety onto other groups, and that fear may attract attention but may not necessarily change behavior. In one study, men over 30 insisted that fear-based HIV-prevention posters were meant for younger men, while men under 30 thought they were intended for “scene-oriented, promiscuous gay

men.” Another study found that a fear-based HIV prevention campaign targeting Scottish teenagers was equally ineffective. Those surveyed said that the campaign would work and that they liked the messaging, but that it wasn’t actually meant for them.

Individuals who are targeted may also believe the message to be exaggerated and therefore personally irrelevant. If the negative messages seem too strong, they might rely on personal experience (never having been infected) and grow mistrustful of the message. According to Sigma, the only people who absorb fear-based messages are those already engaged in the desired practices.

The HIV stigma that arises out of fear tactics may also

deter those who are positive from disclosing to partners, especially when messages are disempowering. It can also deter those at risk from getting tested. Public health campaigns may wish to remind the public of the dangers of HIV infection given recent successes in treatment, but according to Sigma, “research conducted in the U.K. has concluded there is little or no association between optimism about HIV, given the success of antiretroviral therapy, and high-risk sexual behavior.”

Conversely, the positive impact of strengths-based public health campaigns has been widespread. Messages emphasizing what could be gained from using sunscreen were shown in a 1999 American Cancer Society study to have a greater impact in both awareness of health

benefits and actions taken. Another study in the same year showed that the likelihood to take preventive measures against breast cancer, as opposed to simply detective measures, significantly increased with positive messaging. Yale University researchers found that the likelihood of someone changing their current behavior is much higher if the change involves gain.

These case studies all show that prevention campaigns are most effective when conducted in positive, affirming ways. In order to change sexual behavior, messages must emphasize the self-efficacy that is needed to reduce one’s risk. The targeted communities must also be consulted and actively engaged in framing campaigns. Shocking images may seem like a way to change behavior, but the message that is most effective is the one that reaches out to communities and gives them the confidence and the tools necessary to make a change. ■



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**Do you have HIV?
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ACRIA offers drop-in support groups every week, facilitated by trained, supervised volunteers. They provide a welcoming and nonjudgmental environment for people who are HIV positive or negative to share their thoughts and listen to others who are going through similar experiences. Groups meet on Thursday evenings from 6:30 to 8:00 PM at:

The LGBT Community Services Center
208 West 13th Street
New York, NY 10011

No intake is required – just drop in if you want to talk!

For information about open groups, please contact Mark Condon at treatment@acria.org or at (212) 924-3934, ext. 100.

No Cuts to HIV Programs!

A CALL TO ACTION

Recently, a Republican Study Committee for the U.S. House of Representatives unveiled a plan to reduce the national debt by \$2.5 trillion over the next ten years. They propose doing this by deeply cutting non-defense discretionary spending. This means that HIV prevention and treatment services are at risk of being severely underfunded. With ADAP waiting lists longer than ever, and new HIV infections among vulnerable communities increasing, it is vital that we stop efforts to gut HIV programming.

Call your U.S. Representative today at 202-224-3121 to let them know you don't want any cuts to HIV prevention and care programs!