



## PENNSYLVANIA HIV PREVENTION COMMUNITY PLANNING UPDATE

*A quarterly publication of the Pennsylvania Department of Health, Division of HIV/AIDS*

### **The Evolution of HIV Prevention**

Rodger L. Beatty, PhD LSW

Changes, few like them, occur daily in spite of us. In 1982 when I commenced work in the world of Gay Related Immune Deficiency (GRID) affected communities banded together to fight for their lives. As well chronicled in Randy Shilt's And the Band Played On (1987) public health and government in general were doing very little addressing the growing AIDS crisis. Community-based AIDS service organizations (CBO & ASO) developed across the landscape in people's homes, associated with other established agencies and eventually creating their own presence.

Those early days focused on helping people dying of this strange and frightening disease. Much time was spent on the telephone and looking at newspapers as a source of information. The first Pennsylvania ASO was the Philadelphia AIDS Task Force, soon followed by the Pittsburgh AIDS Task Force, the South Central AIDS Assistance Network in Harrisburg with many more responding to the growing epidemic in their communities. Yeah, sorry no instant email and cell phones then.

Any prevention was focused on providing what became known as AIDS 101. Early Epidemiologists shared that the infection patterns showed this epidemic had a similarity to a blood-borne sexually transmitted virus such as Hepatitis B. Hence, the Hepatitis B model was frequently used. Also by examining infection patterns in those early days it was evident that it was specific behavior between individuals that transmitted HIV. So prevention education was for anyone who would listen and focused on; this is the virus, this is how it is transmitted & how to protect oneself and often a personal perspective of living with HIV and dying with dignity.

The virus was identified in 1983 and testing for the presence of antibodies to this virus arrived in 1985. Many folks still do not see HIV testing as a prevention method, but indeed it is paramount in preventing further spread of the virus.

AZT (today known as ZDV-Zidovudine) was the only treatment. In part due to the ever growing numbers ZDV was initially administered in almost lethal doses, but it was indeed the only treatment option. It was not at all unusual to attend multiple funerals in a week as the numbers of infected, ill and dying folks

increased during the late 80's and early 90's. It was challenging getting people tested and then being able to offer them so little in viable treatment. ZDV as a treatment option soon burned out as it eventually was overwhelmed by the virus. So it provided some little quantity of life, but certainly no remote quality of life. People knew that if they tested HIV-positive the pattern was about two years for an opportunistic infection to develop and hence being defined as AIDS and then about two more years till death due to complications from AIDS.

In 1994 the Centers for Disease Control and Prevention (CDC) embarked on a major shift in HIV prevention. Community HIV prevention planning became the mantra and has remained so until recently. It was a shift from the typical top-down approach to significantly engaging the affected community to better determine what would work best for them in preventing HIV-infection. This approach soon turned to the much needed targeted HIV prevention to those most at risk for acquiring HIV with evidence-based interventions at individual, group and community levels. There was the CDC development of the Diffusion of Effective Behavioral Interventions (DEBI) targeting specific communities. HIV testing

## 2 PA HIV Prevention Community Planning Update

continued with developments in rapid or oral testing techniques and the never popular attempts at home-test kits.

The next major event was the life altering introduction of effective drug cocktails (Highly Active Anti-Retroviral Treatment-HAART or AIDS Retroviral Treatment-ART) in 1995. We can now offer effective life extending treatment if one tests HIV-positive. However, with more HIV-positive folks surviving this has created an ever growing reservoir of HIV-infected people who potentially could transmit virus to others.

In 2003 the CDC introduced the concept of “prevention for positives.” That is resources were to be focused on secondary prevention efforts on those who are already HIV-infected and counseling them on not transmitting the virus. That took the focus from primary prevention, but continues with keeping individuals from getting HIV infected.

In 2006 the CDC provided guidelines for routine HIV testing. The concept is to integrate routine HIV testing into other encounters with healthcare. If one comes into the emergency room or sees their physician it should become routine to offer an HIV test along with the battery of other tests being routinely offered. This should also “normalize” the process and begin to reduce stigma still associated with HIV. The challenge in Pennsylvania and many other states was the time to provide pre- and post-

counseling into the process as required by statute. Pennsylvania just amended Act 148 to eliminate the pre-test counseling in order to implement routine testing. The Pennsylvania Department of Health has wisely taken a two prong approach to providing routine HIV testing in healthcare settings and to continue HIV testing with pre- and post-test counseling with targeted populations most at risk for HIV infection.

In 2012 the CDC will embark on a new approach in this evolution of HIV prevention. In part driven by dwindling resources the focus will be on target populations in areas of high HIV/AIDS impact. Specifically that means young African American and Latino men-who-have-sex-with-men in the areas with the highest incidence. In Pennsylvania that is the established metropolitan statistical area of Philadelphia with most of the current cases of HIV.

It has been estimated that about one third of those infected with HIV do not even know that they are. Therefore great effort will be applied to getting people tested for HIV and if HIV-infected referred to treatment.

In addition, the CDC Twelve Cities Project (the twelve U.S. cities with the highest incidence of HIV) and Enhanced Community HIV Prevention Planning (ECHPP) programs will eliminate some of the bureaucratic barriers to getting people tested and into treatment. This is quite the challenge of getting individuals

to effectively embrace a lifetime of strict medication adherence. However, it certainly makes sense to get folks tested and treated in life prolonging treatment as without treatment the virus continues to assault the body.

There is a lot taking place in biomedical approaches to HIV prevention such as the use of microbicides leading to Pre-Exposure Prophylaxis (PrEP) and Post Exposure Prophylaxis (PEP).

Microbicides are agents used in tablet or gel form that have an effect on the HIV virus. Those who have been in the field might recall the infamous Nonoxynal-9 in gels. The substance was too caustic and actually increased the possibility of HIV transmission. As well ZDV was a standard of treatment following accidental HIV exposure most often due to needle sticks.

Most of us in the field are familiar with the very successful PrEP that has been utilized for some time, which is the use of ZDV with pregnant women during pregnancy to prevent the transmission of HIV to the unborn child. There was a Time Magazine article in the late 80’s about orthopedic surgeons taking ZDV prior to performing surgery.

Men and women infected with HIV reduced the risk of transmitting the virus to their sexual partners by taking oral antiretroviral medicines when their immune systems were relatively healthy, according to findings from a large-scale clinical study sponsored by the

### 3 PA HIV Prevention Community Planning Update

National Institute of Allergy and Infectious Diseases (NIAID), part of the National Institutes of Health.

The clinical trial, known as HIV Prevention Trials Network (HPTN) 052, was slated to end in 2015 but the findings are being released early as the result of a scheduled interim review of the study data by an independent data and safety monitoring board (DSMB). The DSMB concluded that it was clear that use of an antiretroviral by HIV-infected individuals with relatively healthier immune systems substantially reduced transmission to their partners.

In other words, their viral load is significantly reduced and in combination with continued and consistent use of condoms they will not infect others.

The antiretroviral Tenofovir, used alone or in combination, greatly reduces the risk of becoming infected with HIV through vaginal sex according to results from two new studies in Africa of the concept known as pre-exposure prophylaxis.

The findings confirm and expand on results announced last autumn of a similar trial in men who have sex with men in Thailand.

The lines between prevention and treatment are blurring and likewise so are the planning efforts. It needs to be a continuum of prevention and care as both are serving the same individuals.

The Pennsylvania Department of Health is currently exploring the integration of prevention and treatment planning bodies to more holistically treat those with HIV infection. Getting individuals to effective treatment is a critical step in this approach. See the following article on the HASP-Registry.

#### **HIV/AIDS Service Provider (HASP) Registry**

We are requesting your participation in an important project being implemented by the Pennsylvania Department of Health (PADOH). It is collaboration between the PADOH and the Pennsylvania Prevention Project at the University of Pittsburgh with the goal of establishing a statewide registry of HIV service providers.

In addition, it is a long-term collaborative effort with the Integrated Planning Council and the Ryan White HIV/AIDS Regional Planning Coalitions to conduct a study on the unmet needs of HIV positive men and women.

#### **All PADOH supported HIV testing sites are to complete a HASP Registry account.**

##### **Benefits of enrollment:**

- Aligns with the National HIV/AIDS Strategy (NHAS) to assist both the Centers for Disease Control and Prevention (CDC) and the PADOH to understand what services are currently being offered, what services are needed, where funding is needed, and

where resources can be better utilized within the state when planning and referring.

- Ensures that agencies enrolled in the HASP Registry:
  - ✓ Are among the first in line for available funding.
  - ✓ Are already identified within their region as sources to meet unmet needs. This will prevent an overlap of services that would be created if new sources were funded.
  - ✓ Are better equipped to make quality referrals across the state.
- Allows consumers a single comprehensive place to locate services.

The HASP Registry serves as tool for gap analysis by providing a comprehensive assessment of HIV prevention, care, and treatment resources available within Pennsylvania. As part of the response to the NHAS and the CDC's Enhanced Comprehensive HIV Prevention Planning (ECHPP) Project, the Registry helps support the goals of the two projects by improving program planning and implementation to:

- Reduce new HIV infections
- Link people with HIV to care and treatment and improve health outcomes,
- Reduce HIV-related health disparities, and
- Achieve a more coordinated national response to the HIV epidemic in the United States.

## 4 PA HIV Prevention Community Planning Update

For additional information on how to enroll, contact Daniel Hinkson at [dlh49@pitt.edu](mailto:dlh49@pitt.edu).

### Web-Based Conferencing

The Pennsylvania Prevention Project is hosting web-based conferencing to assist the Department of Health and the new HIV/Treatment Planning Group to carry out their mission. The service may be employed in a variety of ways to facilitate communication and education.

Offered as an enhancement to traditional meetings, it may also provide collaborative opportunities that may not otherwise happen.

Web-conferencing service includes options for live video feeds, audio participation through phone and internet, instant distribution of files, and even the opportunity to work jointly on live applications and documents.

Possible events may include educational webinars broadcasting live presentations, small interactive meetings for work groups, and interviews or focus groups for needs assessment and planning. In some cases, web conferences can be used for skill and knowledge-based trainings that may be used to fulfill continuing education requirements. Conferences may be recorded to document events, conduct further analysis, and to archive educational information for future sharing.

To participate in the service, one only needs access to a computer with a basic high

speed internet connection and a telephone or microphone/webcam.

With this technology, HIV care and prevention providers from across the state may be able to collaborate more often, particularly when travel is not preferred. As the Pennsylvania Prevention Project more concretely develops this capacity it will be shared with the field.

### Hepatitis B, C and Liver Disease

Highly active antiretroviral therapy (HAAART) has improved the health of people living with HIV as morbidity (a diseased state or medical condition) and mortality (death) have decreased and mortality from other illnesses, including hepatitis and liver diseases, has grown.

A recent article in the World Journal of Gastroenterology (2007) Hepatitis B and C infected and liver disease trends among human immunodeficiency virus-infected individuals Bruskin et.al. share that they found chronic Hepatitis B (HBV), Hepatitis C (HCV) and liver disease were frequent diagnoses in HIV-infected people followed in the multi-site adult/adolescent spectrum of HIV-related diseases (ASD Project) from 1998 to 2004. They observed relatively low rates of HBV and HCV screening,

especially in the early years, despite consistent recommendations that HIV-infected patients be screened for both infections in the guidelines for the treatment of HIV and prevention of opportunistic illnesses.

Michael Cole  
Community Co-Chair  
(724) 982-4276  
[mikec16146@aol.com](mailto:mikec16146@aol.com)

Ken McGarvey  
Department of Health Co-Chair  
(717) 783-0572  
[kmcgarvey@state.pa.us](mailto:kmcgarvey@state.pa.us)

Rodger L. Beatty  
Facilitator  
(412) 383-1775  
(412) 383-1513 FAX  
[rbear3@pitt.edu](mailto:rbear3@pitt.edu) EMAIL

This Newsletter Is Now Available Online At <http://www.stophiv.com>  
[This newsletter is produced at the Graduate School of Public Health, University of Pittsburgh, Pennsylvania Prevention Project for the Pennsylvania Department of Health's Division of HIV/AIDS Pennsylvania HIV Prevention Com. In addition, this quarterly newsletter is intended to keep the traditionally non HIV Prevention community posted of the activities of the Pennsylvania HIV Prevention Community Planning Committee and is distributed by the Division of HIV/AIDS]