the Prevention connection

A Newsletter from CDC's National Center for HIV, STD, and TB Prevention

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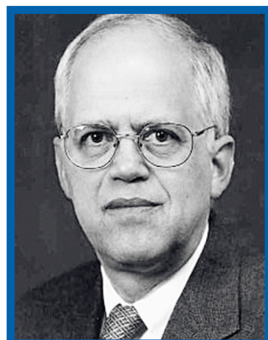
LETTER FROM THE DIRECTOR

DR. HAROLD JAFFE



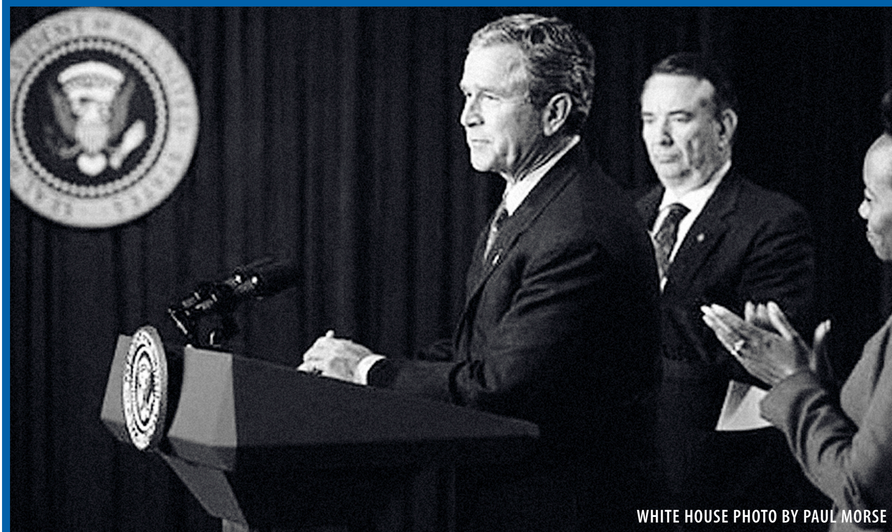
WELCOME to this edition of the *Prevention Connection*. For more than two decades, we have made remarkable strides in disease prevention, interventions and health promotion. The partnerships between CDC and state and local health departments, health care providers, academia, community-based and faith-based organizations, and governmental agencies, have helped diminish the number of U.S. newborns infected with HIV, decrease the number of domestic TB cases to an all-time low and prevent infertility through chlamydia screening.

However, huge challenges still remain. The number of people living with HIV continues to increase. Of an estimated 850,000 to 950,000 such persons, 180,000 to 280,000 are unaware they are infected with HIV.

Many individuals do not get tested until late in their infection, and others who are tested do not return to learn their test results. To address this, we have launched a new initiative, "Advancing HIV Prevention: New Strategies for a Changing Epidemic" (see page two). In addition, overall rates of primary and secondary syphilis have increased for the first time in more than a decade, due in part, to outbreaks in men who have sex with men (see page four). These outbreaks are a worrisome trend, not only because they are markers for unsafe sexual behaviors, but because they may signal growing apathy toward HIV/STD prevention in the United States.

We must revive the commitment with which the United States once faced the HIV epidemic in the 1980s and the resurgence of TB in the 1990s. We must develop new collaborations and targeted interventions if we are to reduce new HIV infections and eliminate syphilis and TB from the United States.

HIV global update



WHITE HOUSE PHOTO BY PAUL MORSE

AS HHS SECRETARY TOMMY Thompson and Uganda Ambassador Edith Grace Ssempal listen, President George W. Bush discusses his initiative to provide $15 billion for HIV/AIDS relief in Africa and the Caribbean during a speech in the Dwight D. Eisenhower Executive Office Building on Friday, January 31.

"We have the opportunity to bring that hope to millions. It's an opportunity for this nation to affect millions and millions of lives," said the President. "So that's why I've laid out the Emergency Plan for AIDS Relief. I called it in my State of the Union a work of mercy, and that's what I believe it is."

UGANDA

HIV INFECTION PREVENTED IN INFANTS THROUGH HEALTH INTERVENTIONS

IN 2002, PRESIDENT BUSH ANNOUNCED a $500 million International Mother-to-Child HIV Prevention Initiative, which seeks to increase the availability of preventive care, including drug treatments, and build health care delivery systems that reach up to one million women annually and reduce mother-to-child transmission by forty percent among women treated within five years or less in twelve African countries and the Caribbean. The initiative would be implemented by the Department of Health and Human Services and the United States Agency for International Development (USAID), building on the current efforts of the two agencies.

Currently, many countries in Africa have HIV seroprevalence rates of 20 percent to 40 percent in pregnant women. In 2001, more than 700,000 infants were perinatally infected with HIV. With effective interventions, risk of transmission can be reduced by up to 50 percent.

Preventing mother-to-child transmission (PMTCT) of HIV is a high priority for CDC's Global AIDS Program (GAP), which has been working to build countries' capacity to prevent MTCT since its inception in 2000. GAP, a division of NCHSTP, is providing supplemental funding to 11 of 14 countries designated in the President's initiative. Among those countries is Uganda, where the antenatal HIV seroprevalence is near 10 percent.

The Uganda Offices of CDC and USAID recently supported a two-year pilot program at Mulago Hospital in Kampala, where nearly 35,000 pregnant women receive prenatal care services. The program, which concluded in 2002, employed 10 full-time counselors who privately met

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NEW CDC INITIATIVE:

ADVANCING HI

"I worked for a long time at San Francisco General Hospital, and I have, I think, firsthand experience about how sad it is when people acquire this infection and don't get the appropriate medical care that they deserve and need. And there are a lot of barriers to getting the services people need, but one of the barriers is access to diagnostic HIV testing. So one of the main themes of this new initiative is to open up the door to testing so that people can learn their status and get the appropriate treatment and prevention services that they deserve and need."

Dr. Julie Louise Gerberding, M.D., M.P.H.
Director, Centers for Disease Control and Prevention

IN APRIL, THE CENTERS FOR DISEASE Control and Prevention announced a new initiative—"Advancing HIV Prevention: New Strategies for a Changing Epidemic"—to increase HIV testing and provide HIV-infected individuals with treatment, care, and prevention services. The new initiative, which was released in the April 18 edition of *Morbidity and Mortality Weekly Report*, consists of four key strategies for HIV prevention: making HIV testing a routine part of medical care, implementing new models for diagnosing HIV infections outside medical settings, preventing new infections by working with persons diagnosed with HIV and their partners, and further decreasing perinatal HIV transmission.

The overall goal is to reduce barriers to early HIV diagnosis and increase access to state-of-the-art medical care, treatment, and ongoing prevention services for the 850,000 to 950,000 people living with HIV in the United States. It is estimated that the majority of new HIV infections (approximately 40,000 annually) are transmitted by those who are unaware they are infected, and an estimated one-quarter of those who are living with HIV in the United States do not know they are infected. To achieve this goal, CDC is working in partnership with other U.S. Department of Health and Human Services agencies and other governmental entities and non-governmental organizations to implement the strategies outlined in the new initiative.

Strategy: Make HIV Testing a Routine Part of Medical Care

As part of the new initiative, CDC is strongly encouraging all health care providers to include HIV testing, when indicated, as part of routine medical care on the same voluntary basis as other diagnostic and screening tests.

CDC also is encouraging the removal of real and perceived barriers to routine testing, and thus is promoting the adoption of simplified HIV testing procedures—that do not require extensive prevention counseling.

To accomplish this strategy, CDC is working closely with professional medical associations and other pertinent organizations to promote routine HIV testing and will work with public and private payers to encourage appropriate reimbursement incentives.

Strategy: Implement New Models for Diagnosing HIV Infections Outside Medical Settings

The initiative places special emphasis on new approaches and technologies that make it easier for people to get tested for HIV, to get their results quickly, and, if infected, gain access to treatment and prevention services.

To execute this strategy, CDC is creating new program models to increase HIV testing in high-prevalence, non-medical settings by encouraging the use of HIV rapid tests, which were recently approved by the Food and Drug Administration. This approach will facilitate the testing and care of individuals with HIV who may not have access to traditional medical settings.

Pilot projects will be established to help identify the most effective models for HIV diagnosis and referral outside traditional medical settings. In 2004, CDC will implement these models through grants to health departments and community-based organizations (CBOs).

Strategy: Prevent New Infections by Working with Persons Diagnosed with HIV and Their Partners

After learning they are infected with HIV, many individuals modify their behavior to reduce their risk for transmitting HIV; however, some people might require ongoing prevention services to change their risk behavior or to maintain the change. Later this year, CDC, together with Health Resources and Services Administration (HRSA), the National Institutes of Health, and the Infectious Diseases Society of America, will publish and disseminate *"Recommendations for Incorporating HIV Prevention into the Medical Care of Persons with HIV Infection."*

COMMUNITY FOCUS:

NEW ORLEANS

KNOW NOW!, BROTHERHOOD, INC., AND *CAN* FOSTER AWARENESS AND PREVENTION

"I CAN'T CHANGE WHERE I'VE BEEN, but I can change where I am going," reads a New Orleans billboard depicting a young woman. The poster is part of the KNOW NOW! social marketing campaign that uses a variety of media to promote knowledge of HIV status and encourage counseling and testing.

KNOW NOW! stands out among public health communication campaigns because of its business marketing approach. In addition to defining audiences by age, race, and gender, CDC used databases that divide the population into marketing clusters with information on consumer buying habits, media use, and economic status. CDC researchers chose five of those marketing clusters to target in five cities—Detroit, Houston, Miami, New Orleans and Jackson, Miss. Statistical analysis determined that by targeting those five clusters, it is possible to reach almost 70 percent of those at highest risk for HIV.

The New Orleans pilot program targets sexually active, predominately lower-income African-American single men and women, aged 18 to 24. Radio public service announcements, print advertisements, postcards, posters, transit advertisements and point-of-purchase displays deliver the messages deemed most effective for the New Orleans audience.

The campaign emphasizes recruiting non-traditional businesses and organizations to become KNOW NOW! partners. Displaying KNOW NOW! literature in venues such as beauty shops and retail stores creates word-of-mouth buzz and helps the message reach a different audience than public health clinics and community-based organizations traditionally attract. Radio spots reinforce the message; people connect the literature at various venues with what they've heard on the air.

Get Tested. Get the Results
KNOW NOW!
1-877-4U2-KNOW

Community Awareness Network

Along with KNOW NOW!, CDC supports a variety of New Orleans-based HIV prevention programs, including a community mobilization project from the NO/AIDS Task Force. The project, called the Community Awareness Network (CAN), targets men who have sex with men (MSM) in the French Quarter/Marigny area of the city. Based on the notion that community members have the insight and knowledge to determine what is most effective for their constituents, CAN collaborates with various social groups and venues to use their ideas, resources, and energy to target prevention messages for particular subpopulations of MSM.

CAN implemented Popular Opinion Leader, a science-based intervention model developed to train community leaders, to integrate HIV prevention messages into their daily routines. CAN also utilizes a variety of visual media to promote HIV prevention, including putting posters up in bars, and distributing bookmarks and calendars. The organization addresses how drug use, low self-esteem, and peer networks can affect how often people engage in risky sexual behaviors.

CAN also has an Internet component that communicates HIV prevention messages to MSM in New Orleans, specifically in chat rooms. Up to 150 people have come in for counseling and testing as a result of the chat room intervention. The state of Louisiana will soon partner with CAN to help expand its Internet program. CAN also helps sponsor social activities, such as a book club, softball games, and game nights that give MSM a social alternative to bars.

Brotherhood, Inc.

CDC's Division of HIV/AIDS Prevention also supports three separate HIV prevention projects developed by Brotherhood, Inc., a minority nonprofit community-based organization. The first project is Brotherhood's African-American HIV

V PREVENTION

New Strategies for a Changing Epidemic

To reach individuals who are HIV infected, but are not receiving ongoing treatment and care, CDC, in partnership with HRSA, will promote prevention and treatment services—inside and outside traditional medical settings.

Furthermore, CDC is establishing demonstration projects through health departments to provide prevention case management and counseling for people living with HIV and is increasing emphasis on partner notification. Through the new initiative, CDC is piloting new approaches to partner notification, including offering rapid HIV testing to partners and using peers to conduct partner notification, prevention counseling, and referral. CDC grantees will be required to employ standardized procedures for prevention interventions and evaluation activities.

Strategy: Further Decrease Perinatal HIV Transmission

More than 300 infants contract HIV annually because their mothers are infected. To reduce these infections, CDC is recommending that health care providers notify their pregnant patients that an HIV test will be included in their standard battery of prenatal tests, unless they "opt-out" or decline HIV testing.

In addition, CDC encourages clinicians to routinely screen any infant whose mother's HIV status is unknown. Jurisdictions should consider whether a mandatory screening policy for these infants is the best way to achieve such routine screening.

CDC will work closely with the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Nurse-Midwives to ensure providers are aware of these new recommendations and gain support for their implementation.

By using the rapid HIV test kits, women of unknown HIV status can be tested during labor and newborns can be tested immediately after delivery. If positive, antiretroviral interventions can be offered. CDC is encouraging this use of the rapid HIV test and is developing guidance for using rapid tests during labor and delivery, or postpartum if the mother was not screened before giving birth. Training will be made available for health departments and providers in conducting prenatal testing. In addition, CDC will expand its activities to monitor the integration of routine prenatal testing into medical practice.

The Food and Drug Administration has approved three rapid HIV test kits, which can be used at delivery. Although the use of the HIV rapid test facilitates receipt of test results, HIV-positive test results will require confirmation by Western Blot or immunofluorescence assays.

To track the impact of the new initiative, CDC is expanding the HIV surveillance system by implementing a national behavioral surveillance system. Currently, 49 states require reporting of HIV infections to public health authorities. CDC also will monitor the implementation of the new activities outlined in the initiative through new performance indicators for state and local health departments, CBOs, and other systems.

With continued collaboration between state and local health departments, national and regional governmental and non-governmental organizations and CBOs, the four strategies of the new initiative should give every HIV-infected individual the opportunity to be tested, have access to quality medical care and to the prevention services needed to prevent further HIV transmission.

To read the announcement of the initiative, visit: www.cdc.gov/mmwr/preview/mmwrhtml/mm5215a1.htm

For more information on CDC's HIV programs, visit www.cdc.gov/hiv

Prevention and Education Initiative for Orleans Parish.

For this project, the Brotherhood staff developed a culturally specific curriculum to teach community leaders how to formulate and carry out community action plans. The staff provides resources and technical assistance to the trainees, who conduct educational sessions and other activities at their churches, civic groups, social clubs, and the Orleans Parish schools.

By the end of 2002, the project had trained more than 100 residents how to enlighten other community members about HIV/AIDS education and prevention. Such training helps foster Brotherhood's goals: assess barriers related to risky sexual behaviors and early HIV testing among African Americans; devise a culturally specific prevention program to increase HIV/AIDS awareness in the African-American community; train community leaders and residents in HIV/AIDS prevention; and provide targeted outreach to African Americans at greatest risk.

Brotherhood also operates the Men of Color AIDS Prevention Project (MOCAPP) with support from CDC. MOCAPP is aimed at African-American MSM and male commercial sex workers. Brotherhood developed a curriculum, *Saving Our Own,* to train more than 90 African-American MSM as peer educators. Other activities include a targeted media campaign, street outreach in the French Quarter, venue-based outreach at MSM bars, and community awareness sessions.

CDC also funded Brotherhood, Inc.'s New Orleans Youth AIDS Prevention Project to target young men of color who have sex with men (YMSM) and their sexual partners. The program uses street- and venue-based outreach, peer education, and provides a "safe house" where young men can come for discreet HIV counseling and testing. The doorway looks like the entrance to an apartment, so visitors do not risk being seen going into a health clinic.

Brotherhood also operates Trinity House, a group home offering assisted-living housing to low-income people living with HIV and AIDS.

For more information on: KNOW NOW! in New Orleans, contact Jackie Rosenthal, at (404) 639-8890 or jrosenthal@cdc.gov

NO/AIDS, contact Jean Redmann, at (504) 821-2601 x 245 or d1noatf@bellsouth.net

CAN, contact Felicia Wong, at (504) 945-4000 or Cmproj@bellsouth.net

Brotherhood, Inc., contact Robert Swayzer, at (504) 566-7955 or www.brotherhoodinc.org

CDC- funded HIV prevention programs in New Orleans, contact Donna E. Alexander, project officer, at (404) 639-5231 or dea3@cdc.gov

NEW TB TREATMENT GUIDELINES

REVISED GUIDELINES FOR THE treatment of tuberculosis (TB) were presented in the February 15 issue of the *American Journal of Respiratory and Critical Care Medicine*. The guidelines were jointly developed and approved by CDC, the American Thoracic Society and the Infectious Diseases Society of America. These guidelines replace the previous version, which was published in 1994.

The new guidelines focus on the latest aspects of therapy and include four recommended regimens for treating patients with drug-susceptible TB. Each regimen has an initial phase of two months followed by the choice of several options for the continuation period of four to seven months. Directly observed therapy is recommended for patients because of the higher rates of treatment completion.

The guidelines also include sections on drug interactions; management of relapse, treatment failure, and drug resistance; organization and supervision of treatment; research agenda for TB treatment; treatment of TB in low-income countries: Recommendations of the World Health Organization and the International Union against TB and Lung Disease; and treatment of special populations, including children and adolescents, pregnant women and those living with HIV.

Of new importance, the guidelines now clearly assign the responsibility for successful treatment of TB—which includes not only prescribing an appropriate regimen, but also ensuring adherence to the regimen until treatment is completed—to the private provider or public health program, rather than to the patient.

First published in 1971, the jointly developed guidelines are intended to advise both public health programs and health care providers in all aspects of the clinical and public health management of TB in low-incidence countries.

For more information, email Dr. Ram Koppaka at vcr4@cdc.gov or Dr. Rick O'Brien at rjo1@cdc.gov

For a copy of the guidelines, please visit: http://www.thoracic.org/adobe/statements/treattb.pdf

The Prevention Connection Newsletter, the National Center for HIV, STD and TB Prevention,

The Centers for Disease Control and Prevention

Send comments, story ideas and address changes to Cynthia G. Crick, NCHSTP Office of Communications, at cog7@cdc.gov or 404-639-8890.

www.cdc.gov/nchstp/

SYPHILIS ELIMINATION update: REMAINING CHALLENGES

IN OCTOBER 1998, CDC LAUNCHED the National Plan to Eliminate Syphilis from the United States. Together with public and private partners, CDC began an effort to capitalize on the steady decline of new primary and secondary (P&S) syphilis cases since 1990. Diminishing syphilis helps to facilitate HIV prevention, improve infant health, decrease public health costs, and erase a glaring racial health disparity.

Following the peak epidemic of syphilis in 1990, reported cases of syphilis in the United States had fallen drastically. From 1997 to 2001, P&S syphilis rates decreased 29 percent overall, and congenital syphilis cases decreased 60 percent. During this same period, the African-American: Caucasian disease ratio has been reduced 63 percent. The unprecedented low rate, combined with cases being concentrated in only 20 percent of U.S. counties, had created a unique but narrow window of opportunity to eliminate syphilis in the United States. The *National Plan* called for CDC and its partners to focus their expertise in a comprehensive effort to identify and treat infected individuals and to prevent future infections.

Last year, CDC announced that despite continued declines in syphilis rates among African Americans and women, overall rates had increased. These increases —mostly among men who have sex with men (MSM) of all races and ethnicities, many of whom are HIV infected—pose new challenges for the national effort. In 2001, rates of P&S syphilis were more than 114 percent higher for men than for women.

In response to these increases among MSM, state and local health departments and their public and private partners have increased syphilis screening, symptom recognition campaigns, and partner services. In addition, CDC efforts have included helping local areas identify effective prevention strategies; implementing an integrated surveillance initiative to enhance traditional surveillance and to monitor STDs among MSM in order to understand better how to intervene in disease transmission; establishing and deploying Rapid Response Teams to assist local areas in their disease prevention and outbreak containment efforts; conducting case control studies in Los Angeles, Miami, and New York City to assist with analysis of surveillance data to define outbreaks and to identify risk factors for acquiring syphilis among MSM; and developing a Syphilis Elimination Toolkit for use in areas with high morbidity or at risk for re-emerging increases in disease.

While all of these efforts have helped control the epidemic, syphilis rates have continued to increase in some areas. Eight U.S. cities representing 30 percent of all P&S syphilis cases in MSM in 2002 have been identified for further evaluation and intervention development. These cities are Atlanta, Chicago, Ft. Lauderdale, Houston, Los Angeles, Miami, New York City, and San Francisco. CDC's HIV/AIDS and STD prevention programs are working with health department colleagues and other key community partners in these cities to define better the epidemics in these locales and to identify approaches to decrease transmission. CDC expects to share "lessons learned" from these eight cities with other areas experiencing increases of P&S syphilis in MSM.

The resurgence of P&S syphilis in MSM represents an important challenge to the national goal of syphilis elimination, as well as to HIV prevention and the overall health of MSM. CDC and its partners must remain vigilant and adapt to keep pace with evolving trends in disease and risk behaviors.

For more information on CDC's STD Prevention Program, visit www.cdc.gov/std.

NEW SENIOR STAFF NAMED AT NCHSTP

Thena M. Durham takes on a new role at CDC as NCHSTP's deputy director for policy. She began her career at CDC in 1968 as a research microbiologist, and served in a wide variety of laboratory assignments in the communicable diseases organization that evolved into the National Center for Infectious Diseases. From 1986 to 1988, Durham served as a senior program analyst in the Office of the Director, Center for Health Promotion and Education; from 1988 to 1996, she served as Associate Director for Programs in the Office of the Director of the National Center for Prevention Services. Durham most recently served as the Executive Secretariat of CDC and ATSDR, from 1996 to 2001.

Ms. Durham received a B.S. in microbiology in 1966 from Fisk University (magna cum laude, Phi Beta Kappa) and an M.S. in developmental biology in 1968 from Purdue University.

William P. Nichols is the new associate director for management and operations of NCHSTP. He began his career at CDC in August 1983, as a disease intervention specialist, based in Cleveland, Ohio, with the Division of Sexually Transmitted Diseases. In March 1986, he was transferred to Santa Ana, Calif., as a public health advisor in the Division of Immunization, and in 1988, Mr. Nichols became deputy director of the North Carolina Immunization Program. In August 1990, Mr. Nichols accepted a position as project officer in Atlanta. In June 1991, he was named deputy associate director for management and operations in the National Immunization Program, and promoted to associate director of management and operations in August 1995. Prior to being selected for his current position, Mr. Nichols was detailed to CDC's Financial Management Office as acting chief of the Congressional Legislative Branch. He received a B.A. from Wake Forest University in 1983, and an M.P.A. from Georgia State University in 1994.

Dr. Andrew Vernon was recently named the associate director of science of NCHSTP. He began his career at CDC in 1978 as an epidemic intelligence service officer assigned to the Oklahoma Department of Health. He subsequently served as a field epidemiologist, as assistant director for science, and as the director in the Technical Support Division in CDC's International Health Program Office. Since 1993, Dr. Vernon has worked in the Division of TB Elimination, most recently serving as the project officer and co-chair of the TB Trials Consortium. Dr. Vernon is a captain in the Commissioned Corps of the U.S. Public Health Service, a clinical assistant professor of medicine at the Emory University School of Medicine, and an adjunct assistant professor of epidemiology at Emory's Rollins School of Public Health. Dr. Vernon received an A.B. from Harvard College (magna cum laude) in 1971, an M.D. from Harvard Medical School in 1975, and an M.H.S. from the Johns Hopkins School of Hygiene & Public Health in 1987.

In other news from the senior staff, **Dr. Ronald O. Valdiserri**, the Deputy Director of NCHSTP since 1996, has penned a new book, *Dawning Answers*. Recently released by Oxford University Press, it summarizes the influence of HIV/AIDS on public health theory and practice.

/UGANDA *from page one*

with groups of pregnant women to discuss voluntary HIV testing. The program has proven to be valuable, so much so that the hospital has recruited counselors and other staff to continue it. Results of the HIV tests are delivered in counseling sessions on the same day. From 34-weeks gestation onwards the HIV-positive pregnant women are counseled and offered a nevirapine tablet to swallow at the onset of labor. Within two days of life, their newborn babies are treated with nevirapine syrup.

Pregnant with her first child, a young woman we will call Lilly tested positive for HIV. "In the group counseling session, I had already decided that if I tested positive, I would take medication and use infant formula to keep my baby alive," she said. Lilly was given a nevirapine pill, which she could take once she went into labor. After the birth, the baby was given nevirapine syrup. The child will return to the hospital at age six weeks and 18 months for blood tests to determine if she is infected. If mothers like Lilly are given nevirapine before they deliver, they abstain from breastfeeding, and their child also receives the medication, the risk of HIV transmission can be reduced by up to 50 percent.

Children whose mothers abstain from breastfeeding, but do not receive nevirapine, have a 20 percent to 25 percent risk of being infected with HIV. Without any interventions, the risk of infection can reach 45 percent—15 percent to 30 percent risk during pregnancy and delivery, 10 percent to 20 percent additional risk from breastfeeding.

With the program success at Mulago, CDC is expanding prevention activities in 16 other districts in support of a national plan to prevent MTCT. CDC supports this program by providing increased staff and technical assistance through a cooperative agreement with the Ministry of Health.

In Kampala, CDC is also collaborating with UNICEF and UNAIDS to support the Islamic Medical Association of Uganda (IMAU) to implement a community mobilization program to motivate women to utilize PMTCT services. CDC and IMAU are working with a network of Muslim, Catholic, and Protestant leaders to promote voluntary HIV testing of pregnant women and their partners, and to encourage community support of the use of nevirapine and early weaning.

For other communities, CDC, in collaboration with other partners, has developed flipcharts, posters, brochures and a video – *Hope for Your Family's Future* – to educate pregnant women and others about PMTCT and to improve its acceptance, especially in rural areas.

To learn more about GAP visit http://www.cdc.gov/nchstp/od/gap/.

UPCOMING EVENTS

NATIONAL HIV TESTING DAY
JUNE 27
www.hivtest.org

NATIONAL HIV PREVENTION CONFERENCE
JULY 27–30
www.2003HIVPrevConf.org