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Reproductive Health & Wellness Program



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HIV: HISTORY AND STIGMA

In 1981, doctors in Los Angeles published an article in the CDC's *Morbidity and Mortality Weekly Report* that outlined several cases of a rare illness called *Pneumocystis carinii* pneumonia. Within days the CDC had received similar reports from across the country. As cases poured in, another rare condition called Kaposi's Sarcoma started being reported more frequently as well. These two conditions had been medical rarities until this time — conditions only seen in patients with severely compromised immune systems. Adding to the confusion was the fact that the first cases reported were all among homosexual men. This resulted in this mysterious disease being incorrectly identified as an affliction only of gay men. Over the next few years, IV drug users, women, and patients who had received blood transfusions were being diagnosed with the disease as well. As doctors discovered that the disease was not limited to a singular group of people, it became identified as "AIDS," or Acquired Immune Deficiency Syndrome. By 1986, scientists determined that this syndrome was caused by a virus — human immunodeficiency virus or HIV¹.

The HIV virus attacks the T-cells and CD4 cells that protect the body from infections. Once the virus has infiltrated the cells, it makes copies of itself until the cell bursts open, releasing these copies into the bloodstream. Destruction of these important immune system cells makes it progressively harder for the body to fight off infections such as the common cold and flu. As the HIV infection multiplies over time, symptoms get worse until the infected individual has the tell-tale signs of AIDS. At this stage, patients become exceptionally susceptible to opportunistic infections that will eventually kill them².

Thankfully, HIV/AIDS is no longer the death sentence it once was. Scientific advancements in treatment and care make it possible for people living with HIV (PLHIV) to live healthy, fulfilling lives. Treatment for HIV comes in the form of antiretroviral medications

(ARVs). These drug cocktails, although effective, can be extremely expensive and are often either unavailable or difficult to access, especially in developing nations. They also often have large side effect profiles that require control by other medications.

Due to the serious nature of HIV/AIDS and its mysterious origin, there has always been socially constructed stigma surrounding disease. This stigma began in the early 1980s when it was believed to be only a "gay man's disease". AVERT, a non-profit HIV/AIDS prevention organization, states that "AIDS-related stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV and AIDS. The consequences of stigma and discrimination are wide-ranging: being shunned by family, peers and the wider community, poor treatment in healthcare and education settings, an erosion of rights, psychological damage, and a negative effect on the success of HIV testing and treatment"³. HIV/AIDS has become stigmatized due to fear, misunderstanding, religious beliefs, the incurable nature of the disease, and because of the behaviors that it is often associated with (homosexuality, promiscuity, drug use). The constellation of reasons for stigmatization of HIV carriers results in the idea that the disease is somehow a punishment for "deviant" or immoral behavior. This stigma is manifested through the inaccurate belief that HIV/AIDS can be transmitted through activities that are not actually risky, such as kissing or simply coming in contact with someone carrying the virus³.

Extreme stigmatization combined with the fact that the disease is still incurable often makes people extremely fearful of revealing their status to friends and loved ones. It even keeps some from getting tested. In addition, the incorrect perceptions that only gay men or those engaging in "deviant sex" are susceptible to the disease leads to a false sense of security. At this point, half of the estimated 34 million

adults living with HIV/AIDS worldwide are women. Women are more susceptible to transmission through heterosexual sex, and AVERT states that "biologically women are twice more likely to become infected with HIV through unprotected heterosexual intercourse than men. In many countries women are less likely to be able to negotiate condom use and are more likely to be subjected to non-consensual sex"⁴. Globally, the HIV infection rate is rising fastest in the 15-24 age group worldwide, irrespective of sexual orientation or gender. This is no longer a "gay man's disease" as society once perceived it to be. Getting tested, asking your partner to get tested, and insisting on condom use is the safest way to prevent the transmission of HIV.



CORNER FOR THE CAUSE: WORLD AIDS DAY

December 1st is known internationally as World AIDS Day. This year's theme is "Shared Responsibility: Strengthening Results for an AIDS-Free Generation." World AIDS Day was the first global health awareness day, and has been celebrated every year on December 1st since 1988. World AIDS Day raises international awareness of the virus that killed an estimated 25 million people between 1981 and 2007. It is estimated that nearly 34 million people worldwide are currently living with the virus. The purpose of the day is to raise awareness, reduce stigma, celebrate the lives of those lost, and the lives of those who are currently living with HIV/AIDS.

CONTRACEPTIVE USE FOR HIV+ WOMEN

As the HIV epidemic has progressed, the burden of the disease has slowly but surely shifted from men to women. Although increases in HIV incidence have slowed globally, there are more women living with HIV infection than ever before. This increased long-term prevalence has important consequences for how other medical issues should be managed in the presence of an HIV infection. For women, who require regular complex medical care, this medical discourse takes on even greater significance.

The complications of treating the women's health issues of HIV positive women pose a serious public health challenge. In particular, encouraging contraceptive use among HIV positive women is a relatively new field of public health practice that faces moral scrutiny. It is possible that some might believe that provision of contraception to HIV positive women would only encourage sexual behaviors that risk spreading the disease to others. However, this reactionary proposition should be countered with the understanding that promoting contraceptive use among women with HIV allows these women to control their reproductive capacity while also reducing the probability of mother-to-child transmission of HIV⁵.

Thus, if contraceptive use among HIV positive women should be encouraged by medical service providers, we should examine the interactions between antiretroviral drugs (ARVs) and the hormones present in many birth control methods.

One recent meta-analysis evaluated 20 peer-reviewed publications and 42 pharmaceutical package labels to determine which contraceptive methods were less effective in the presence of ARVs⁵. Combined oral contraceptive pills (COCs) were found to show decreased estrogen and progestin levels when taken concurrently with specific ARVs, rendering these contraceptives less effective. Data about the efficacy of the patch, ring, and implant were lacking. However, it is likely that a similar mechanism of action would render these methods less effective in the presence of ARVs. The two methods that proved to be highly effective in the presence of ARVs were Depo-Provera and the levonorgestrel intrauterine system (Mirena). The authors recommend that HIV positive clients be offered the full range of contraceptive methods with additional counseling explaining the decreased efficacy associated with COCs, patches, rings, and implants.

WHO WAS RYAN WHITE?

In the United States, people who are infected with HIV, who cannot receive medical care from any other source, are covered by the Ryan White Program. The Ryan White Program, enacted in 1990, was passed in response to an HIV/AIDS epidemic that was spiraling out of control and, perhaps more directly, in response to the activism of a single teenager, Ryan White. Ryan, a hemophiliac, contracted HIV from one of his regular blood transfusions at a time when the disease was misunderstood and unnecessarily feared. He was banned from attending his local public school due to his condition and began a crusade that would eventually change the public's perception of HIV/AIDS. Without question, the image of Ryan White, a young white male who contracted HIV through no fault of his own, created an unpolluted tributary through which the American people could pour their sympathy. And that sympathy was desperately needed: AIDS incidence in the 1980s peaked at nearly 130,000 new cases per year⁶. The spread of HIV/AIDS combined with the public outcry for government intervention created bipartisan support for the Ryan White Program.

AT HOME HIV TEST KITS: ETHICS AND EFFICACY

The CDC released a study in 2008 that estimated 1.1 million people are living with diagnosed or undiagnosed HIV in the United States.⁶ They estimate that around 200,000 of those people are undiagnosed. In 2012, the FDA approved the OraQuick HIV test for over the counter sale. This approval means that people are now able to take a rapid HIV test in the privacy of their home after a simple oral swab and 20 minute wait. The availability of the OraQuick test over-the-counter also means that no professional counseling will accompany reception of the result. If an individual tested positive in a health center, it is likely that a counselor would be there for emotional support, medical advice, referrals for medical treatment, and assistance with informing sexual partners. If the result was negative, the counselor would then be able to help develop a plan to modify risky behaviors and encourage regular testing.

Many people are hesitant to visit a physician for testing, many do not have access to affordable medical services that provide testing, many are fearful of stigmatization and judgment, and many just don't want to deal with the hassle. In an ideal world, these people could take tests at home and in the event of a positive result, immediately seek medical attention to control the virus. Bioethicists fear that

in reality this will not be the case. A contributor for MSNBC News wrote, "unless someone discusses the significance of the test result with you telling you what can be done to battle the problem, there is a pretty good chance you will either say 'Thank goodness I did not test positive; and keep doing whatever it is you are doing even if it is bad for you – or test positive and say 'I have a problem and I am so ashamed or frightened I won't do anything at all about it'⁷. Testing in the presence of a counselor would eliminate this latter possibility and encourage negative patients to be tested at least once every year. The counselor would remind the patient that there is a three month lag between the time of exposure and the presence of antibodies in the blood or saliva — that a negative result might not stay negative.

Another fear that OraQuick skeptics have is that people could be tested without their knowledge by partners or family members while they sleep. While this may seem unlikely, saliva samples are easier to come by than blood samples and this could conceivably happen.

There is a great deal of information, and potentially a great deal of needed support, that the at-home kits simply do not provide. They certainly serve a purpose and could help reduce the number of people who do not know

their HIV status, but it is then up to those people to do something with the information. The stigmatization and fear that still surrounds HIV/AIDS is a concerning factor. There have been great strides made in the treatment of symptoms and management of HIV viral loads, but it is still an incurable disease. Stigma aside, this diagnosis can become an immense emotional issue if there is not a support system in place.

The argument for OraQuick is predicated on the fact that an individual has a right to know if they are HIV positive. Without foundational research that shows that individuals using OraQuick tend to engage in reckless sexual behavior after finding out a positive result, any consideration of such an outcome is merely speculative. If the test itself is safe and the dangers imaginary, it is hard to argue that OraQuick should not be available on shelves.

If every American had access to a primary care physician and if HIV testing became standardized in preventive primary care visits for individuals of reproductive age, then there would be an argument that HIV testing should only take place in the doctor's office. Until that becomes reality we must face head on the fact that many of those who are most vulnerable to HIV infection do not have the resources to pay for a doctor's appointment to find out that they are HIV positive.

TEAM MEMBER SPOTLIGHT: MEET VICTORIA!

Name: Victoria Wells Wulsin

Hometown: East Cleveland, OH

Favorite book: Long Walk to Freedom by Nelson Mandela

Can you describe your work with SOTENI to reduce HIV/AIDS rates in Kenya?:

SOTENI began 10 years ago to break the cycle of poverty and disease among the world's most vulnerable populations. We now employ over 100 Kenyans and work with hundreds of volunteers in four remote areas to prevent and mitigate the effects of HIV/AIDS. Locally-elected management committees lead programs such as SOTENI's AIDS Barefoot Doctors, a health center, a community resource center, women's empowerment, drilling wells for clean water, planting "kitchen gardens" for nutrition and income-generation, HIV/AIDS prevention, testing, and treatment programs, agricultural projects, education and support for over 10,000 orphans, and other life-changing initiatives.

What are challenges you face doing this type of work?

1. Overwhelming and entrenched poverty.
2. Injustice for sub-populations, particularly persons living with HIV/AIDS, women, and the homeless.
3. Lack of education and lack of educational opportunities.
4. Pervasive health problems, ranging from malnutrition to chronic infections to mental illness.

What are the most rewarding aspects of working in Kenya?

1. Sitting with SOTENI's AIDS Barefoot Doctors under the trees near our health center, and hearing them talk about their work with people living with HIV/AIDS, with youth, with commercial sex workers, with the most vulnerable people in our villages.
2. Inspiring people in Cincinnati to reach beyond their comfort zones to help others less blessed than we have been blessed. This makes SOTENI live up to its name, which is Swahili for "all of us are together."
3. Holding hands (metaphorically) around the

world.

4. Seeing lives changed: people living positively with HIV/AIDS; children going to school who would otherwise be stuck on their "farms;" American volunteers becoming public health advocates; women running their own businesses; communities gathering to celebrate LIFE.

If you are interested in getting involved, call Victoria Wulsin (513-357-7273) or visit www.soteni.org.



Victoria and Issac Nalungu, laboratory technologist at the SOTENI Dispensary in Mbakalo, Kenya.

PREVENTING MOTHER TO CHILD TRANSMISSION OF HIV

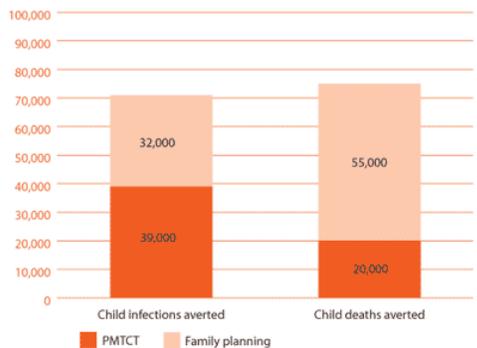
In 2008, mother-to-child transmission (MTCT) of human immunodeficiency virus (HIV) was estimated to have caused 430,000 new HIV infections in children. This accounted for 90% of all new HIV infections in children in 2008. Without intervention, the risk of MTCT of HIV is estimated to be between 20-45%.¹⁰ With intervention, this risk can be reduced drastically, to under 5%. In developed and developing countries the risk of MTCT of HIV has been demonstrated to be between 15-25% and 25-35%, respectively.¹¹ The difference between transmission rates between developed and developing countries has traditionally been attributed to improved access to high quality care including anti-retroviral therapy in developed countries; however, it is also possible that the poor nutritional status of HIV positive mothers in developing countries may contribute to the increased rates of vertical transmission seen in these places.

Modes of intervention to reduce MTCT

include preventing women from becoming HIV positive, preventing unintended pregnancies in HIV positive women, providing anti-retroviral treatment to HIV positive women, and providing anti-retroviral treatment to newborns at risk for MTCT. A standardized intervention for the prevention of MTCT, called PMTCT, has been developed by the World Health Organization (WHO). This regimen requires the provision of azidothymidine (AZT) in the antepartum period; AZT and lamivudine (3TC) plus one dose of nevirapine (Sd-NVP) during the pregnancy; and AZT plus 3TC for women in the postpartum period with Sd-NVP and AZT for infants during period as well. Evidence currently shows that provision of these particular antiretroviral drugs does not increase risk of fetal birth defects¹².

Despite the demonstrated effectiveness of the PMTCT intervention, administration of antiretroviral drugs for prolonged periods of time is very difficult to achieve in environments

where women may not have reliable access to medical care. Thus, prevention efforts focused on MTCT rely extensively on broader efforts to improve the provision of maternal and child health care.



This figure illustrates how many more child infections can be averted if family planning is incorporated into PMTCT interventions.

MEN'S HEALTH

Interested in the Men's Health Initiative for your organization? Contact the program coordinator: eric.washington@cincinnati-oh.gov

MAN TO MAN:

The Men's Health Initiative provides clinical services to young men at the Clement Health Center! It's located on the corner of Burnet Ave. and MLK. You can walk-in and get an appointment at to see a health care provider for an STI screening. After that, you'll receive a Men's Health Initiative counseling session!

thebodyshop

REPRODUCTIVE HEALTH & WELLNESS PROGRAM

Reproductive Health Suite
Clement Health Center
Cincinnati Health Department
3101 Burnet Avenue
Cincinnati, OH 45229

RHWP Hotline:
513-357-7341

Appointment scheduling through the CHD Call Center:
513-357-7320



Birth Control Sabotage Ain't No Joke!
Watch out for the Elf on the Shelf this holiday season!

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The Reproductive Health and Wellness Program (RWHP) or the body shop, is a five-year grant awarded by the Ohio Department of Health to the Cincinnati Health Department and is funded by the federal Title X program. The primary objective of this program is to provide access to contraceptives and reproductive health services to the men and women of Hamilton County, especially to the most underserved populations, so as to reduce the number of unplanned pregnancies, unwanted pregnancies, and ultimately, the number of poor pregnancy outcomes. Through these direct services, education and outreach, the program also hopes to cultivate a culture of responsibility, well-being, and empowerment in regards to sexuality and reproductive health. To date, we've enrolled nearly 4,000 individuals, and continue to grow, learn, and serve.

For additional information regarding the project, please contact Dr. Jennifer Mooney at:

jennifer.mooney@cincinnati-oh.gov

We've Been Busy!

Dr. Mooney gave a presentation on the RHWP's School Health Initiative at the March of Dimes Conference in November.

The RHWP just found a new community partner in Job-Corps. Young women will be referred to the RHWP from this great community organization starting this month.

Dr. Mooney and Data Coordinator Aalap Bommaraju are putting the finishing touches on a Community Health Grant proposal from the Center for Clinical and Translational Science and Training (CCTST).