

MODULE 2

FLORIDA DEPARTMENT OF HEALTH

STUDY GUIDE

HIV/AIDS: 101

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POPULATIONS SIGNIFICANTLY AFFECTED BY HIV

Individuals who are members of certain population groups or who are involved in particular activities or circumstances can put them at higher risk for acquiring or transmitting HIV. This unit will provide participants with an opportunity to increase awareness as it relates to HIV/AIDS issues in terms of:

- A. Domestic violence
- B. Substance use/abuse
- C. Men who have sex with men (MSM)
- D. 30+ age group
- E. Youth
- F. Homeless populations
- G. Incarcerated populations
- H. Occupational Exposure to HIV

DOMESTIC VIOLENCE

Domestic abuse is a pattern of behaviors used to establish power and control over an intimate partner, often leading to the threat or use of violence. Abuse is any controlling, hurtful act, word, or gesture that injures another's body or emotions. Domestic abuse takes many forms and may escalate in severity. These forms demonstrate themselves as acts of domestic abuse and generally fall into one or more of the following categories:

- Psychological abuse may include emotional, verbal, and financial abuse and may be experienced as intimidation, terrorizing, name-calling, jealousy, destroying property, eliminating access to finances, threats directed toward other family members, children, or household pets.
- Sexual abuse may include denying privacy, forcing performance of sexual acts that are not comfortable, unwanted sexual touching, and/or partner rape.
- Physical abuse may include pushing, slapping, biting, kicking, hitting with objects, restraining, and/or the use of a weapon.

Domestic violence affects millions of people in the United States each year. It has been connected to increased rates of substance abuse and risky sexual behaviors. As a healthcare professional, you may be in a position to assist a client in preventing further abuse or in reducing his/her risk of abuse. In some cases, you may be the only person to whom the client has ever disclosed his/her abusive relationship. You cannot force an adult client to take action to deal with their violent situation. (In the case of elder and child abuse, you have more leeway in reporting abusive situations.) However, you are there to offer the client an opportunity to access linkage services.

Many people think of domestic violence only as the abuse of a female by her male sex partner. In fact, 95 percent of reported abuse victims are females. However, domestic violence occurs in same sex couples as it does in heterosexual couples. The terms domestic violence or domestic abuse also include the abuse of a male by a female partner or partner abuse within a male-male or female-female relationship. Questions and references about relationships should use terms such as "partner" rather than "husband/wife", "boyfriend/girlfriend", or "spouse".

In 1995, the Florida legislature passed a bill requiring that information and referrals be provided by Florida's HIV/AIDS program for those in need of domestic violence services. Since then, domestic violence has been addressed routinely as part of HIV pre- and post-test counseling.

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Indicators of abuse may be physical or psychological. With physical indicators, the most common site of injuries is the head, face, neck and areas usually covered by clothing, such as the chest, breast and/or abdomen. Psychological indicators may include, but not be limited to, anxiety and panic disorder, depression, suicide attempts, and/or substance abuse.

In a clinic situation, other signs of abuse may be indicated when the client's partner overtly displays jealousy, obsession or possessiveness of partner. The partner may insist on accompanying the client, answering all questions and/or refusing to leave the treatment area. Although educational materials should be available in waiting areas and examination rooms, be aware that providing the abused client with written material may increase his/her risk of abuse should his/her partner find such material.

Battered clients may appear frightened, ashamed, evasive or embarrassed, or they may appear perfectly normal. Health care workers should be aware that a client's family history, cultural background, and/or religious beliefs may also influence his/her perception of abuse. The Violence against Women Act has special provisions that address domestic violence in migrant populations. This information, along with other domestic violence legislation, may be accessed from the Florida Coalition against Domestic Violence website (www.fcadv.org/) or call 1-850-425-2749. Additionally, referrals for victim assistance can be made through the Florida Domestic Violence Hotline. (See below.)

Deciding to leave an abusive relationship is typically the most dangerous time for a victim, even if there has been no prior physical abuse. If clients indicate a reluctance to leave their partner immediately, then a safety plan should be reviewed. Remember to be supportive and not pressure clients if they are not ready at this point. Victims will typically consider leaving seven times before they leave for good.

Domestic Violence and the HIV-Positive Client

Remember, risk assessment for domestic violence should be included as a routine part of HIV-seropositive client counseling. It should be recognized that all relationships have the potential for abuse. If an HIV-positive client is in an abusive relationship, the health care worker must assess which method of partner notification will diminish the risk of violence to the client. It may be, at that time, the client is ready to access domestic violence services or proceed to a shelter.

In making arrangements for HIV-infected domestic violence victims, remember that discrimination based on HIV/AIDS status in matters such as housing, employment, state programs, and public accommodations (including hospitals and physician's offices) is illegal in Florida. It must be stressed that notifying an abusive partner about a client's HIV status could place the client in danger.

Florida Domestic Violence Hotline: 1-800-500-1119.

IMPAIRED JUDGMENT & HIV TRANSMISSION - SUBSTANCE ABUSE/USE

The most efficient means of transmitting HIV is through blood-to-blood contact. If enough HIV-infected blood gets into the body, infection may occur. However, a sufficient amount of HIV-infected blood must enter the bloodstream to cause infection. It may take as little as a few drops for infection to occur. History has shown that exposure of infected blood to intact skin (i.e., no open sores or lesions) has not transmitted the virus. However, the chances of becoming infected from shooting drugs and sharing needles may be as high as 1 in 2 in some areas of the United States.

Alcohol, Non-injection Drugs and HIV

Shooting drugs and sharing needles is certainly a behavior that puts an individual at risk for transmitting or acquiring HIV. Substance abusers who do not use injectable drugs are also at high risk of infection. Substance abuse and HIV goes beyond the issue of needles. People who abuse alcohol, speed, crack cocaine, poppers or other non-injected drugs are more likely than non-substance users to be HIV positive or to become seropositive. People with a history of non-injection substance abuse contribute to the spread of the epidemic when users trade sex for drugs or money, or when they engage in risky sexual behaviors they might not engage in when sober.

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Since the middle to late 1980s, crack cocaine has been the drug of choice for many drug users in communities across America. Although the act of smoking the drug does not put a person directly at risk, the behavior that may accompany the drug use could. Pipes and paraphernalia could also transmit the virus due to sharp edges (and thus possible breakage of the mucous membrane in the mouth) from crude hand made pipes. Furthermore, many crack users may have oral lesions and/or blisters caused by the hot temperature of the pipe. (This could facilitate HIV transmission through oral sexual contact.) Individuals in many communities who are addicted to crack cocaine support the cost of their addiction by having sex in exchange for the drug or money. In the course of a single day, these addicts may each have several sexual partners and may not be in a state of mind to think about using any type of barrier protection (like condoms) against HIV or other sexually transmitted diseases.

There are probably a lot of reasons why substance abusers are at higher risk for HIV. The reasons most likely vary by drug and social context: crack abusers may have different risks than alcohol abusers, for example. For non-injecting substance abusers, HIV infection is not caused by drug use but by unsafe sexual behavior.

The abuse of legal drugs may cause a similar prevention problem. Good judgment is often impaired during this type of substance abuse, and any measures to prevent the transmission of HIV by the individual may go by the wayside. Being drunk with alcohol may help cause a person to do things they would not do if they were sober and in control of their senses. Prescription analgesics (such as Oxycontin) or sedatives (such as Valium or Xanax) may, if used improperly, have a similar effect. If a person's inhibitions are reduced and his/her guard is down during a prescription drug induced high, sexual contact could take place with an infected person without barrier protection, and transmission could occur.

Some terms to remember in the discussion of impaired judgment and HIV transmission are:

- **Direct Transmission:** Direct sexual contact with people infected with HIV who have IDU and/or alcohol histories
- **Indirect Transmission:** Sex partner of a person who has had unprotected sex with an IDU infected with HIV; Babies born to sex partners of IDU with HIV
- **Impairment:** Drugs and alcohol can cloud a person's judgmental capacity. They may make a person more apt to do things he/she wouldn't normally do...such as have sex without using a condom. A person might not clean his/her needles/syringes properly.
- **Co-Factor:** Alcohol and drug use can assist HIV in progressing quicker in the body. The unhealthy life style associated with alcohol and drug use can also assist in the progression of HIV.
- **Denial:** Many people who have a drinking problem or abuse mood-altering prescription drugs may not acknowledge it. For example, they may have blackouts and not remember what they have done.

Injecting Substances

Substances may be injected four ways by injection drug users (IDUs):

1. Subcutaneous (a.k.a. "Sub Q", "Popping"): piercing the skin, but not as far as the muscle
2. Intramuscular (a.k.a. "IM"): piercing the skin into the muscle
3. Deep Intramuscular (a.k.a. "Deep IM"): longer needle used, piercing deeper into the muscle
4. Intravenous (a.k.a. "IV"): into the vein.

If a person injects drugs and shares needles, they are engaging in a behavior that puts them at increased risk for HIV. Counselors must be as knowledgeable and comfortable talking about injection drug use and needle-sharing behavior as they are discussing sexual behavior.

Any type of needle sharing may transmit HIV. If an infected body-builder injects anabolic steroids then shares the needle with someone else, the virus may be transmitted. It is not just heroin, cocaine, or some other street injecting drug use that transmits HIV. Sharing tattoo needles or needles for ear and/or body piercing may be a means of transmitting HIV. Sharing contaminated needles has resulted in the second highest number of reported AIDS cases (behind sexual contact) in the United States.

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Most Americans who are infected through blood-to-blood contact have become infected through sharing infected needles, syringes, and injection drug use equipment. Many times this involves illicit drugs (heroin, etc.), but not always. It can involve injecting prescription drugs, whether injected by the person they are prescribed for or someone else. Injection drug use equipment, including syringes, needles, cotton balls, water, etc. should never be shared.

Needle Exchange Programs

Needle exchange programs are in effect in some areas of the country. At the time this manual was printed, there were no legally operating needle exchange programs in Florida. These programs allow injecting drug users to bring in their used needles and exchange them for new, sterile needles. Various studies have shown that these projects may help reduce HIV transmission. The concept, however, is still very controversial in the political arena.

Handling Used Needles & Syringes Safely

An injection drug user (or anyone, for that matter) can easily get stuck or scratched with a needle that has been left out. If there is a needle stick or scratch, it is important not to panic. The area where the stick/scratch occurred should be washed with soap and water as soon as possible. Later, it should be covered with a clean bandage/Band-Aid.

Needle stick risks are reduced when used needles are properly disposed (such as putting them in an impermeable container). It is also important to never recap needles and syringes. Many people have been stuck this way.

Reference

National Clearinghouse for Alcohol and Drug Information (A Service of the Substance Abuse and Mental Health Services Administration); website: <http://www.health.org>.

MEN WHO HAVE SEX WITH MEN/GAY/BISEXUAL/TRANSGENDER PERSONS

The gay community is as diverse as any other population; the needs vary depending on the individual. From newly self-identified gay youth to men who have sex with men (MSM) that do not admit or acknowledge their behavior, these individuals come with a unique set of HIV risk behaviors that must be dealt with accordingly. Health departments and community-based organizations (CBOs) work to develop strategies to increase knowledge of HIV status among MSM and increase the proportion of HIV-infected MSM who are linked to appropriate care and prevention services.

MSM of African Decent

HIV/AIDS has had a disproportionate impact on racial/ethnic minority MSM, especially blacks and Hispanics. Race/ethnicity itself is not a risk factor for HIV infection. However, among racial/ethnic minority MSM, social and economic factors including homophobia, high rates of poverty and unemployment, and lack of access to prevention services and health care may serve as barriers to receiving HIV prevention information or accessing HIV testing, diagnosis, and treatment.

Of particular concern are the "non-identified" MSM. Often referred to as being on the "down low" (DL), these men put their unsuspecting partners at risk by committing acts that they do not own up to. Men on the DL compromise the health status of both their male and female partners by lying to both about their behavior and often not using protection. Regardless of race, men who call themselves heterosexual, but are involved in secret sexual relationships with men, are contributing to the rising incidence of HIV infection among women.

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Young MSM

Young men who have sex with men, regardless of label or community attachment, bring their own particular brand of needs to the table. Often times, the sexuality of youth is taken for granted and a supportive outlet is rarely present. There needs to be a safe place for lesbian, gay, bisexual, transgender, and questioning youth to interact with each other, as well as positive role models. Transgendered youth are particularly disenfranchised. They need to be recognized and given a safe space. Overall, lesbian, gay, bisexual, transgender, and questioning youth suffer from a severe lack of services.

When addressing HIV prevention, it is important to realize that the attention span of youth is limited, so interventions need to be dynamic. Though most youth have grown up with the reality of HIV/AIDS, misconceptions about the disease and their risks are blatant. Health care professionals must be sure to clear up any mistaken beliefs about HIV when working with youth.

THIRTY (30) PLUS AGE GROUP

Historically, adolescents and people in their twenties have received the most emphasis for encouraging HIV testing. When looking at statistics for reportable sexually transmitted diseases in Florida (year 2004, excluding HIV/AIDS), a large percentage of the infections occurred in people ages 15-29. It is clear that many people in this age group are putting themselves at risk for HIV.

However, AIDS and HIV cases reported through 2005 are less stark in contrast for similar age groups. Persons ages 13 through 29 account for only about 16 percent of the Florida AIDS cases. For HIV cases reported, the proportion is about 28 percent. Therefore, in roughly 84 percent of those AIDS cases (and about 72 percent of the HIV cases reported), the client is age 30 or above.

What is very surprising to many people is the impact HIV/AIDS has had on people over age 50 in our state. In Florida, with its large retirement community, the percentage of people older than 50 with AIDS is above the national average. In fact, 14 percent of cumulative AIDS cases in Florida were in the 50-plus age group; 12 percent of the HIV cases (not AIDS) were in that age group. (Actual rates of HIV infection itself are difficult to determine in senior adults since many in that age group are not routinely tested for the antibodies.)

Sexually active older people may be less likely to use condoms for various reasons. For example, if a female has completed menopause, she may not be concerned about using barrier protection because she is not concerned about pregnancy. Ironically, older women may have more dryness in the vaginal area, which in turn could lead to more microscopic tears when having sex. This can provide a portal of entry for HIV to get to the blood stream.

Age differences may play a role in condom use. For example, a much older person may not think their younger sex partner has "been around" enough to be at high risk for HIV. As with other relationships, the older person may be concerned about losing the relationship if condom use is suggested.

Medical professionals may not consider HIV testing for older clients (particularly ages 50 and older). In part, this may be due to a physician's unwillingness to discuss sexual and/or drug issues with older clients.

As a health care professional, it is imperative that you are willing to address, in a culturally sensitive manner, the issues of sexual and/or drug risks for older clients. The risk behaviors are the same regardless of the person's age. Be aware that a person of one age (e.g., 65 years) may react differently to such topics than a person of another age (e.g., 21 years). These clients have probably had very different life experiences and have a different level of comfort in discussing intimate issues about themselves.

THIRTY (30) PLUS AGE GROUP

- Young people under 25 account for half of the 4.8 million people estimated to have been infected with HIV in 2003 (Henry J. Kaiser Family Foundation, HIV/AIDS Policy Fact Sheet, The Global Impact of HIV/AIDS on Youth, July 2004).
- CDC estimates that at least half of HIV infections in the United States are acquired before age 25 (CDC Fact Sheet [2005], Young People at Risk: HIV/AIDS among America's Youth).
- The majority of young women with HIV/AIDS are infected through heterosexual encounters (CDC, MMWR, February 20, 2004/53(06); 125-129).
- Young men who have sex with men remain at high risk for HIV, particularly young men of color (CDC HIV incidence among young men who have sex with men – seven US cities, 1994-2000. MMWR 2001; 50:440-4).
- Research suggests that young females' increased risk for HIV infection may be correlated with sexual contact with older males (CDC, Heterosexual Transmission of HIV – 29 States, 1999-2002, MMWR February 20, 2004/53(06); 125-129).
- Studies have found that an increased risk for HIV infection exists among homeless, lower income, and school drop-out youth.
- Diaz T, Chu S, Buehler, J, et al. Socioeconomic differences among people with AIDS: results from a multistate surveillance project. *American Journal of Preventive Medicine* 1994; 10:217-222.
- Office of the Surgeon General. The Surgeon General's call to action to promote sexual health and responsible sexual behavior, 2001 (<http://www.surgeon-general.gov/library/sexualhealth/call.htm>).
- National Network for Youth. Toolkit for Youth Workers: Fact Sheet. Runaway and Homeless Youth, 1998. Available from the National Network for Youth, 1319 F Street, Suite 401, Washington, DC 20004; (202)783-7949.
- Simmons, M.J.; LaLota, M.; Problem Behaviors versus the Situational Adversity Approach: HIV Risk Behaviors of Homeless Youth in Fort Lauderdale. *Florida Public Health Review*, 2005; 2: 96-107.
- Nationwide, among currently sexually active students, 63 percent reported condom use during their last sexual intercourse (CDC. Surveillance Summaries, May 21, 2004. MMWR 2004/53(No. SS-2).

HOMELESS POPULATIONS

HIV is a significant issue facing homeless populations. Numerous studies have shown that rates of HIV/AIDS infection are three to nine times higher (varying among geographic locations) among persons who are homeless or unstably housed compared with persons with adequate and stable housing. Immediate survival is often the main concern for people experiencing homelessness. HIV prevention or even treatment may be seen as secondary to accessing food or shelter. Interventions with this population often require numerous linkages with additional services. About one-third of all homeless, single adults suffer from mental illness and impairments. Alcohol and injection drug use rates range from 20-80 percent among homeless adolescents and adults. Prostitution, victimization, and unprotected sexual activity are also factors that add to this population's increased risk for HIV infection. Furthermore, homeless persons often suffer from other co-infections (e.g., tuberculosis, hepatitis C) and a wide range of chronic health conditions (e.g., arthritis, heart disease, high blood pressure, seizure disorder). Such multiple conditions may complicate and accelerate the progression of HIV.

Due to the transitory nature of this population, anonymous HIV testing should not be encouraged and rapid testing should be recommended, if available.

INCARCERATED POPULATIONS

Given the high prevalence not only of HIV infection, but also of risk behaviors in incarcerated persons, HIV risk education is perhaps the most important part of HIV prevention counseling. Incarcerated populations often engage in high-risk sexual activities without protection because barrier methods (e.g., condoms) are not readily available. Sometimes these activities occur without consent, and persons are too embarrassed to discuss it. This presents an even greater challenge for HIV counselors in identifying HIV risks, particularly for male inmates who may not acknowledge same sex activities.

A study done in the United States (although no specific data exists for Florida) has demonstrated that inmates participate in a number of high-risk behaviors while incarcerated, including intravenous drug use (IDU), which is the risk behavior that contributes most to new HIV, HBV, and HCV infections. Additionally, it is highly probable that an inmate who is being treated for IDU has been exposed to unsafe sex (trading sex for drugs or money, for instance), meaning possible exposure not only to blood borne viruses like HBV and HCV, but also to HIV and other STDs.

Many incarcerated individuals may not participate in these risky behaviors on the “outside” and they go on with their regular lives once released, possibly infecting their partners. HIV testing and post-test counseling prior to release should be strongly encouraged with incarcerated populations. Effective 7/1/02, Florida law requires all inmates in state prison (DOC facilities) to be tested for HIV at least 60 days prior to release.

Health care professionals must realize that for many persons who are incarcerated, access and opportunity for healthcare outside the prison walls are limited by multiple psychosocial and logistical obstacles. Incarceration is a unique opportunity for education and empowerment of these persons regarding health promotion, disease prevention, and treatment. However, incarceration does create real concerns about loss of confidentiality and fear of stigma that can prevent one from presenting for voluntary testing while in custody. HIV testing and education should be offered more than once during incarceration, especially to persons with the following conditions:

- Pregnancy, diagnosis of cervical neoplasm, and/or dysplasia in women
- Diagnosis of a prior or current sexually transmitted disease, diagnosis of hepatitis B or C, history of commercial sex work, history of sexual abuse, or history of drug use for men and women.

Denial, fear of illness, and concern about confidentiality are major deterrents for inmates. Concern about the cost of treatment by jails and correctional facilities may also contribute to delays in diagnosis. Every effort should be made with incarcerated clients and jail/prison staff to overcome these barriers. Given the short duration of time many inmates spend in county jails, rapid HIV testing should be used whenever possible.

INCARCERATED POPULATIONS

Healthcare personnel who have contact with blood or other potentially infectious materials (OPIM) may have occupational exposure to HIV or other blood borne pathogens, primarily hepatitis B and hepatitis C. Infection control precautions should be followed at all times.

The risk for getting HIV after a needle stick or an injury with a sharp instrument is about 1 in 300 or 0.3 percent. The risk is higher with one or more of the following factors present:

- An exposure to blood from a terminally-ill AIDS patient
- An exposure caused by a needle which was used in a blood vessel
- An exposure caused by a visibly bloody device
- A deep puncture.

Occupational exposure to the mucous membranes from a bloody splash is lower than a needle stick, less than 1 in 1,000 or 0.1 percent. Risk of HIV-infection after exposure via the skin is considered to be even less.

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All healthcare personnel should be familiar with their facility's exposure control plan as well as infection control precautions (routine use of barriers, e.g., gloves and/or goggles when anticipating contact with blood or body fluids, washing hands or other skin surfaces immediately after contact with blood or body fluids, and careful handling and disposal of sharp instruments during and after use).

There are standard guidelines for the management of healthcare personnel exposures to HIV and recommendations for post-exposure prophylaxis (PEP) from the CDC (Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post-exposure Prophylaxis; June 29, 2001). These guidelines may be accessed through the CDC's web site: www.cdc.gov). These guidelines outline the considerations in determining whether or not PEP is indicated and which PEP medicines should be used. As written in the summary page of the June 29, 2001 guidelines, "Occupational exposures should be considered urgent medical concerns to ensure timely post-exposure management and administration of HBIG, hepatitis B vaccine, and/or HIV PEP." If PEP is indicated, it is best to start treatment as soon as possible after the exposure, hopefully within the first hour or two. Treatment is generally indicated for 28 days and the risk of HIV infection (from the single occupational exposure) is reduced by about 81 percent. The treatment generally involves multiple drugs and, as with any drug, there can be side effects. Clinicians may call the National Clinicians' PEpline at 1-888-HIV-4911, 24 hours a day, 7 days a week for consultation about PEP.

Healthcare personnel with an occupational exposure to HIV should receive the same pre-test counseling as other clients. Care should be taken to carefully explain the window period and risk reduction methods. Explanation about the possible test results should specifically include that if the baseline test, done on the exposure date, were to come back positive, it means the employee was previously infected with HIV prior to the current occupational exposure. If the baseline test is negative, then the employee should be retested according to his/her facility's exposure control plan protocol, generally at 6 weeks, 3 months, and 6 months. While the employee is in the window period, he/she should be strongly counseled about risk reduction methods so as to not infect their partner(s), in the event they would seroconvert from the occupational exposure.

In Florida, workers involved in a documented significant exposure who consent to testing but who object to name reporting may be tested using unique numerical identifiers rather than their names. Should a person test HIV positive, use of the unique numerical identifiers will ensure that he/she is not reported by the laboratory.

References

Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post-exposure Prophylaxis (June 29, 2001).

National HIV/AIDS Clinicians' Consultation Center, University of California, San Francisco at San Francisco General Hospital, Frequently Asked Questions about Post-Exposure.