



ILLINOIS HIV PLANNING GROUP ILHPG NEWSLETTER

Newsletter 12

Winter2015



CALENDAR OF EVENTS

2016 ILHPG/Integrated HIV Care and Prevention Planning Meetings (all will be conducted by webinar):

Dates are yet to be determined. When they are finalized, the meeting schedule will be posted on the www.ilhpg.org website.



March 30-31, 2016:
Illinois Minority Health Conference– Bloomington



UPDATES FROM THE CO-CHAIRS

Good day, everyone!

We would like to thank all the Illinois HIV Planning Group members and community partners who attended the Illinois HIV Planning Group (ILHPG) meeting held in Springfield on October 27. The Membership Committee Co-chairs and representatives from the interview team provided an overview of the interview and selection process to select new ILHPG voting members for 2016. From the eight applications received, seven applicants were selected by the team. These seven applicants filled five of the membership gaps related to race/ethnicity, age, risk group affiliation, and expertise area that the planning group had identified at the start of its new member recruitment cycle in June. At the October meeting, the ILHPG voted unanimously to accept the recommendations of the interview team. It is with great pleasure that we now announce the appointment of the following new members, terms effective January 1, 2016, to the ILHPG:

- ◆ Ayanna Armstrong, Chicago House
- ◆ Terry Beard, Central Illinois Care Connect
- ◆ Francisco Cabas, Biolytical Laboratories
- ◆ Jill Dispenza, Center on Halsted
- ◆ Peter McLoyd, The CORE Center
- ◆ Kim Rice, University of Illinois, McKinley Health Center
- ◆ Carmella Williams, Human Resources Development Institute

In addition, the following people have recently been appointed as new Regional Implementation Group (RIG) representatives on the ILHPG:

- ◆ Fred Joiner, Fifth Street Renaissance
- ◆ Tracey Vogelsang, Heart of Illinois HIV Care Connect

We are all very excited to have these new members, who represent diverse populations, experience, and expertise, on our planning group. Welcome!!!

Submitted by Janet Nuss, IDPH ILHPG Coordinator and Co-chair and Tobi-Velicia Johnson, ILHPG Community Co-chair

INTEGRATED PLANNING

STEERING COMMITTEE UPDATE

The third integrated HIV care and prevention planning meeting of 2015 was held August 27 in Rockford. There were 78 people in attendance. Thanks to everyone who attended, including a special thanks to presenters and all who assisted with planning and conduct of the meeting.

At the meeting there was a panel discussion led by the IDPH HIV Surveillance Administrator and the following representatives from Region One: the care and prevention lead agents, a disease investigation services (DIS) worker, a Ryan White Part C clinic manager, a clinic nurse specializing in treatment adherence, and a harm reduction provider. The panel began with a presentation on the current HIV epidemiologic data in the region. Then both the care and prevention lead agents spoke about all the services they provided in the region, their client demographics, and their successes and challenges in identifying new HIV positive individuals, linking and retaining them in care, and helping them to achieve viral suppression. The panel discussed some collaborative efforts happening in the region between prevention and care, between Part B and Part C providers, and between Part B and other supportive service providers.

At the meeting, Ryan White Part B program staff provided a summary of the 2014 Ryan White client satisfaction survey results -statewide and broken out by region. The Integrated Planning Steering Committee Co-chairs provided the group with an overview of the Integrated HIV Care and Prevention Plan Guidance that had been received from the federal HIV care and prevention funding agencies. This guidance directs the efforts of the steering committee and essentially guides the content and activities that take place at the integrated meetings.

After the presentations concluded, as has been done at previous integrated planning meetings this year, attendees were assigned to regional breakout groups and had roundtable discussions about HIV care and prevention needs, gaps, barriers, and challenges in their regions. Thanks to everyone who identified issues and shared their comments and suggestions with others at the table. All comments were collected and have since been compiled into a report and summarized according to the categories of HIV prevention and care needs, gaps, and barriers identified in the Integrated HIV Care and Prevention Plan Guidance. Breakout group discussions at future integrated planning meetings will focus on brainstorming to identify actions and strategies the state and regions can implement to address the gaps and barriers. From there, we will prioritize tasks, assign entities responsible for overseeing the accomplishment of the tasks, and establish realistic timelines.

Please continue to partner with us and share thoughts and ideas helpful to HIV planning. It is through community engagement and input that we will be able to effectively reduce new HIV infections, reduce health disparities, and improve health outcomes for people living with HIV.

Submitted by Janet Nuss, ILHPG Coordinator, ILHPG Co-chair, Integrated Planning Steering Committee Co-chair, Illinois Department of Public Health

MEN AND WOMEN IN PRISON MINISTRIES– 2015 First Ladies Health Lunch

This article recently appeared in the MWIPM Quarterly Journal of Re-Entry Information. The original article can be found at the following link: <https://mwipm.wordpress.com/2015/09/03/men-and-women-in-prison-ministries-quarterly-journal-of-re-entry-information/> .

Submitted by: Reverend Doris Green, Men and Women in Prison Ministries, Founder and CEO, ILHPG Member



From left to right:
Ms. Hataria James;
Julie Morita, M.D. Commissioner of CDPH;
Ms. Cynthia Tucker, V.P. of Prevention, AFC;
and Val Warner, Host Windy City

Men and Women in Prison Ministries (MWIPM) volunteered for the 7th year in a row for the First Ladies Health Luncheon held at the Ritz-Carlton Hotel in Chicago on June 13, 2015. The Luncheon is part of an ongoing health initiative sponsored by Walgreens to bring awareness and preventive care measures to the African American communities.

The First Ladies Health Luncheon featured Cece Winans, gospel artist and singer, who spoke about her own issues with high blood pressure. The Luncheon also featured real –life testimonials from those affected by HIV. Val Warner of Windy City Live interviewed a client of MWIPM, Ms. Hataria James, who gave her testimony of living with HIV.

Each year, the First Ladies Health Day simultaneously offers free health tests in over 50 churches in the Chicago area. These life-saving health screenings range from HIV/Aids testing, blood pressure and glucose screenings, to various awareness and prevention methods such as Cancer awareness through early detection and prevention initiatives.

This remarkable event is what helps the overall mission of MWIPM to “provide services that will promote spiritual and cultural awareness, health education.....on a community based level”. Together we stand to continue fighting the spread of chronic illness in the African American communities through prevention methods.

STRAIGHT BLACK MEN SIDELINED IN AIDS FIGHT

Freddie Allen (NNPA)

This article was posted on the Seattle Medium website on Sept 21, 2015. Excerpts are listed here; the entire article can be viewed at the following link: <http://seattlemedium.com/straight-black-men-sidelined-in-aids-fight/>. Former ILHPG member Justin Wooley is quoted in the article.

Submitted by Chris Wade, HIV Care Connect, Project Coordinator, Illinois Public Health Association, ILHPG Parliamentarian

WASHINGTON (NNPA)- Heterosexual Black men were largely invisible at the 2015 United States Conference on AIDS last week, a long-term absence that will continue to impact the future of the AIDS epidemic in the Black community.

Even though heterosexual Black women continue to outpace their White and Latino counterparts in the rate of HIV infections, little attention was paid to the role that straight Black men should play in combating the epidemic in the Black community.

The CDC reported that heterosexual males account for 13 percent of the new HIV infections among Blacks, while women make up 25 percent and men who have sex with men (MSM) account for 51 percent.

In 2010, the same percentages of undiagnosed HIV infections among men were attributed to male-to-male sexual contact (19 percent) and heterosexual contact (19 percent).

The CDC also reported that, "From 2000 to 2010, HIV infection was the 7th leading cause of death overall for black men, but was not a leading cause of death for other races/ethnicities."

Health care providers struggle to bring heterosexual Black men into the health care setting, other groups protest louder and garner desperately needed resources.

Dawn Smith, a clinician and researcher at the HIV/AIDS prevention division at the Centers for Disease Control and Prevention, said that Black men who have sex with men (MSM) have a group identity that straight Black men lack.

"[Black MSM] want to get in a room together, because they have issues that they want to discuss," said Smith. "Straight men don't have that."

The Black AIDS Institute, a national HIV/AIDS think tank focused on the Black community, hosted a summit on pre-exposure prophylaxis (PrEP) one day before the start of the 2015 United States Conference on AIDS that featured a breakout session designed to help health care providers introduce heterosexual Black men to PrEP.

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Justin Wooley, former ILHPG member, now works for the Black AIDS Institute.

STRAIGHT BLACK MEN SIDELINED IN AIDS FIGHT

Freddie Allen (NNPA)

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Kier Gaines, a college and career development counselor at Kingsman Academy Public Charter School in Washington, D.C., and co-facilitator for the session on men, said that for Black men specifically, health is usually only a concern when symptoms develop, “but you can contract HIV and for all intents and purposes you can look and feel fine for months.”

Gaines said that getting straight Black men into the room to even talk about HIV prevention is a tall order.

Smith said straight Black men grapple with health care in ways that MSM and women don't.

“A lot of men feel like being sick is being weak and so they don't want to talk about health,” said Smith.

Gaines encounters the same resistance pushing men to get tested for HIV as he does encouraging Black men to get prostate exams.

As a heterosexual man working as a health care advocate specializing in STD prevention and awareness, Justin Wooley, a consultant with the Black AIDS Institute, said that he constantly has to fight against the stigma associated with HIV/AIDS and the misperception that HIV is simply a disease of gay men.

“There's almost no room for me to be an advocate,” said Wooley. “If we were talking about saving puppies with three legs in Alaska nobody would ask me, ‘Are you heterosexual or homosexual?’ It would just be about saving puppies.”

Wooley added: “I always have to validate why I care about [the epidemic] as a heterosexual Black man.”

Some AIDS activists say that the lack of focus on the HIV infection rates of straight Black men is owed to how they have been labeled in the epidemic. Heterosexual Black men diagnosed with HIV who are also intravenous drug users (IDUs) are often characterized by health care professionals as IDUs, a message that often alienates straight men who don't inject drugs.

Yet, targeting Black IDUs is not completely unwarranted.

After four days of plenaries, presentations and protests at the 2015 USCA, the absence of a vocal and targeted message for heterosexual Black men remained a blind spot in the fight against the AIDS epidemic in the Black community.

“We're trying to pretend that all the men who are having sex with women are also having sex with men,” said Smith. “We have to break that up and we have to say that there are Black men who are only having sex with women and they need to be a part of the conversation, too.”

Smith continued: “Nothing in the epidemic has happened without people from the various groups standing up and saying, ‘What about me?’ [Straight Black men] have to stand up, and say, ‘How come you're having a whole conference and there are no sessions about me?’”

UPDATED CDC TREATMENT GUIDELINES FOR STDs

Marguerite Smith, MS, MPH, Information Systems Procedures Specialist, Illinois Department of Public Health STD Program

This article was previously submitted to the Illinois Primary Health Care Association Fall Newsletter. Excerpts are listed here.

Submitted by: Lesli Choat – STD Counseling and Testing Coordinator, Viral Hepatitis Prevention Coordinator - Illinois Department of Public Health

On June 5, 2015 the Centers for Disease Control and Prevention (CDC) published the *Sexually Transmitted Diseases Treatment Guidelines, 2015*. This document updates CDC's Sexually Transmitted Diseases (STD) treatment guidelines from 2010. The information provided in this article will outline the current recommendations for the treatment of chlamydia, gonorrhea, and syphilis as well as provide additional updates from the guidelines.

Recommended Treatment of Chlamydia, Gonorrhea, and Syphilis

The recommended treatment for chlamydia is one gram of Azithromycin orally in a single dose or 100 milligrams (mg) of Doxycycline orally twice a day for seven days. The recommended treatment for chlamydia during pregnancy is one gram of Azithromycin orally in a single dose. The guidelines for chlamydia during pregnancy changed 500 mg of Amoxicillin orally three times a day for seven days to an alternative treatment.

The recommended treatment for gonorrhea is dual therapy of 250 mg of Ceftriaxone intramuscularly (IM) in a single dose plus one gram of Azithromycin orally in a single dose that is to be administered together on the same day, preferably under direct observation. If Ceftriaxone is not available, the alternative treatment is 400 mg of Cefixime orally in a single dose plus one gram of Azithromycin orally in a single dose administered at the same time.

It is no longer recommended to treat gonorrhea by monotherapy with two grams of Azithromycin two grams due to concerns that gonorrhea is developing resistance to macrolides that ultimately results in treatment failure. Because of the development of tetracycline resistance in gonorrhea and the convenience and compliance of single-dose therapy, doxycycline is no longer a recommended or alternative option as the second antimicrobial for the dual treatment of gonorrhea.

Allergic reactions with third-generation cephalosporins (Ceftriaxone and Cefixime) in persons with a history of penicillin allergy are uncommon. However, in persons with an IgE-mediated penicillin allergy (e.g. anaphylaxis), the alternative regimens are dual therapy with single doses of 320 mg orally of Gemifloxacin plus two grams of Azithromycin or dual therapy with single 240 mg doses of intramuscular Gentamicin plus two grams orally of azithromycin. Providers treating persons with cephalosporin or IgE-mediated penicillin allergy should consult with an infectious disease specialist.

The recommended treatment of syphilis is based on the stage of the disease. The recommended treatment for early stages of syphilis (primary, secondary, and early latent) is Benzathine penicillin G 2.4 million units IM in a single dose. The recommended treatment for late latent syphilis is Benzathine penicillin G 7.2 million units, administered as three doses of 2.4 million units IM each at one week intervals.

Syphilis in non-pregnant, penicillin allergic persons may be treated with doxycycline. Early stages of syphilis may be treated with Doxycycline 100 mg orally twice daily for 14 days. Late latent syphilis may be treated with Doxycycline 100 mg orally twice daily for 28 days.

Syphilis during pregnancy must be treated with the penicillin regimen appropriate to their stage of syphilis. If a pregnant woman is allergic to penicillin, she must be desensitized and treated with penicillin. *(continued on page 7)*

UPDATED CDC TREATMENT GUIDELINES FOR STDs

Marguerite Smith, MS, MPH, Information Systems Procedures Specialist, Illinois Department of Public Health STD Program

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Benzathine penicillin G is the only known effective antimicrobial for prevention of maternal transmission of syphilis to the fetus.



Other Topics Covered in the Guidelines

The 2015 STD treatment guidelines include a special populations section that contains information on screening and prevention recommendations for several populations including pregnant women, adolescents, children, persons in correctional facilities, men who have sex with men (MSM), women who have sex with women (WSW), and transgendered women and men.

The guidelines recommend annual screening tests for MSM for HIV serology, syphilis serology, urethral infection of chlamydia or gonorrhea if they have had insertive anal intercourse in the preceding year, rectal infection of chlamydia or gonorrhea if they have had receptive anal intercourse in the preceding year, and pharyngeal infection of gonorrhea if they have had receptive oral intercourse in the preceding year.

The guidelines also cover emerging issues, including information about Hepatitis C virus (HCV) and *Mycoplasma genitalium*. While HCV has traditionally not been spread through sex, there is now more evidence that sexual transmission of HCV can occur especially in persons infected with HIV. Due to the possibility that HIV infected persons may acquire HCV, HIV infected persons should be screened for HCV at initial evaluation and at least annually. A one-time HCV screening is also recommended for the birth cohort born during 1945-1965.

The use of Pre-Exposure Prophylaxis (PrEP) for HIV is new to the prevention methods in the clinical prevention guidance section. PrEP is the daily use of HIV antiretroviral drugs to prevent the acquisition of HIV in HIV-negative, high-risk individuals. Antiretroviral resistance has not been found in persons that were initially HIV negative and later became infected while using PrEP. The U.S. Public Health Service (USPHS) recommends clinicians evaluate HIV-negative men and women with sexual or illicit injection drug use behaviors and epidemiological factors that place them at higher risk for HIV infection to use PrEP as a prevention option. The full PrEP guidelines can be found at: <http://www.cdc.gov/hiv/prevention/research/prep/index.html>

Expedited Partner Therapy (EPT), which is also sometimes called Patient Delivered Partner Therapy (PDPT), is the clinical practice of treating the sex partners of persons who receive chlamydia or gonorrhea diagnoses by providing medications or prescriptions to the patient. The use of EPT is recommended by CDC and has been legal in Illinois since 2010. The Illinois EPT law protects prescribing physicians from civil and professional liability, except for willful and wanton misconduct. The Illinois EPT law can be found here: <http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=096-0613&GA=096>

The guidelines state that EPT has been most effective when patients are given packaged medications directly instead of a prescription since many persons do not fill a prescription given to them by a sex partner. Research has shown that the use of EPT has reduced STI re-infection in the index patient with approximately 20% fewer index patients infected with chlamydia and approximately 50% fewer index patients infected with gonorrhea at follow-up. Due to the recommendation that MSM should be screened for HIV if they have been exposed to another STI, EPT is not recommended in MSM.

For the full 2015 STD treatment guidelines and other resources, such as, a link to download an app of the 2015 STD treatment guidelines please visit:

<http://www.cdc.gov/std/tg2015/default.htm>

UPCOMING HIV TRAINING OPPORTUNITIES

HIP eLearning – High Impact Prevention eLearning courses are now available at <https://effectiveinterventions.cdc.gov/en/Home.aspx>

The following online courses are available:

Anti-Retroviral Treatment and Access to Services (ARTAS) This online module is a required activity that contains information that is necessary for the more advanced classroom training. The content of this module will provide you with background information on ARTAS, its theoretical basis and core elements, the logic model, keys to getting started and pre-implementation activities, and an overview of the client sessions with helpful tips. This online pre-course training takes about one hour to complete.



PROMISE (Peers Reaching Out and Modeling Intervention Strategies) for HIP: An

Overview is a pre-requisite for the two-day in-person training on PROMISE, but can be taken on its own to learn background information on this intervention. You will need about an hour to complete the course. In the pre-course training, you will learn:

- How Community PROMISE is HIP compliant
- The four core elements of PROMISE and how to utilize them
- How to implement PROMISE for HIP in both the clinic and community setting

Traditional PROMISE Overview is a very solid intro course that will explore multiple topics related to this community intervention. The course is offered in five parts and takes two to four hours to complete.

An Introduction to Couples HIV Testing and Counseling (CHTC) in the U.S. is a prerequisite for the two-day in-person training on CHTC, but can be watched on its own to get some basic information about this approach. This online pre-course training takes about two hours to complete.



Training of Facilitators of the d-up: Defend Yourself! This course is designed for the staff of community-based organizations, health departments, and other organizations planning to implement a community level intervention for Black gay men. *d-up!* This online course is divided into 14 chapters and offline assignments. Completion can be accomplished in as little as a week and a half and as long as 45 days.

PfH - Safer Sex: An Overview for Providers is a 30-minute course. The primary target audience is physicians who treat people living with HIV. In addition, anyone providing medical care or other support services to this population may find this information useful. Continuing education for this course is available through the CDC Training and Continuing Education Online system.

Every Dose Every Day, An HIV Medication Adherence eLearning Training Toolkit:

Continuing education for these four courses is available through the CDC Training and Continuing Education Online system.



HEART (Helping Enhance Adherence to Antiretroviral Therapy) strategy uses a collaborative problem-solving approach to improve HIV medication adherence.

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UPCOMING HIV TRAINING OPPORTUNITIES

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Partnership for Health—Medication Adherence emphasizes the importance of the patient-provider relationship in promoting adherence.



In the **Peer Support** strategy, HIV-positive patients with optimal adherence are trained by clinic staff to provide adherence support to others living with HIV, through structured group meetings and one-on-one phone calls.

SMART (Sharing Medical Adherence Responsibilities Together) Couples is for committed, HIV-discordant couples. This strategy, delivered by a clinician, social worker or case manager, promotes adherence by enhancing support from the HIV-negative partner, and addressing sexual transmission concerns within the couple dyad.



Personalized Cognitive Counseling (PCC): An Overview for Managers is an online course that takes about 90 minutes to complete.

The Prevention Benefit of ART is a self-paced course that is divided into four modules that will take approximately one hour to view. Continuing education for this course is available through the CDC Training and Continuing Education Online system.



Prevention with Positives (PwP) in Action is a 30-minute graphic novel designed to give staff at clinics, community-based organizations and health departments a look at a highly collaborative option for PwP.



The CDC on-line **Rapid HIV Testing Training Course** has four modules, and takes approximately five hours to complete.



RESPECT has four modules and takes approximately two hours and 40 minutes to complete.



The Video Opportunities for Innovative Condom Education & Safer Sex (**VOICES/VOCES**) e-course takes approximately six hours to complete.

REGISTER NOW FOR HIP eLEARNING COURSES!

**Submitted by Karen Pendergrass, Illinois Department of Public Health,
HIV Section Training Administrator**

COMING OUT DAY AT UNIVERSITY OF ILLINOIS - SPRINGFIELD

Sunday, October 11 was recognized as National Coming Out Day (NCOD), a day to encourage lesbian, gay, bisexual, transgender, and questioning (LGBTQ) individuals to take steps in the coming out process and to commemorate the 1987 National March on Washington for LGBTQ equality. NCOD is celebrated across the country by many individuals as well as LGBTQ organizations and agencies as a way to promote LGBTQ awareness and to combat homophobia.

On Wednesday, October 7, the University of Illinois in Springfield (UIS) celebrated NCOD with the “Closet Door on the Quad” event. All LGBTQ individuals and allies were encouraged to walk through a door that set up in an outdoor commons area and to tell their about their personal experiences in the LGBTQ community. Many students told their coming out stories, and others encouraged their peers to stay strong in times of discrimination and hardship. The students’ testimonials were uplifting and encouraging to all who attended.

The LGBTQ Resource Office at UIS invited community organizations and agencies to attend their NCOD event. Janet Nuss, ILHPG Coordinator and Co-Chair, and I were excited to represent the Illinois Department of Public Health (IDPH) as well as the Illinois HIV Planning Group at an exhibitor’s booth. Fred Joiner from 5th Street Renaissance also ran an exhibitor’s booth in order to share about his organization’s HIV/AIDS services.

Throughout the event, Janet and I were able to visit with youth while handing out free condoms, “Save Lives: Condomize” items, and HIV/ STD educational materials. With the help from several IDPH staff members, we were able to develop and administer a youth survey about HIV/STD prevention. Twenty-three youth, aged 13-29, completed the survey, and three were awarded gift cards from a random drawing. We also took the opportunity to recruit students for our upcoming Youth Seminar at the IDPH HIV/STD Conference.

Overall, this event was a great way to reach youth at the community level. Several questions on our survey prompted youth to give us advice about effective outreach, so we look forward to using this information to engage more youth in HIV and STD prevention in the future.

Submitted by: Marleigh Voigtmann, Illinois Department of Public Health, HIV Community Planning Intern, Student at UIS



LISTEN TO THE VOICES OF YOUTH: IDPH HIV/STD CONFERENCE AND YOUTH SEMINAR

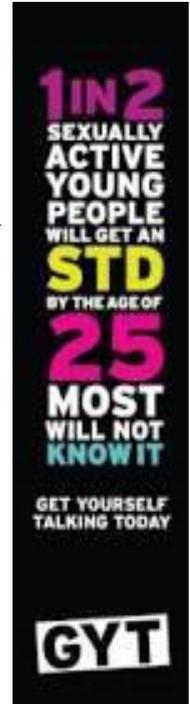
In October 2015, the Illinois HIV Planning Group was pleased to sponsor youth from around the state to come to the IDPH HIV/STD Conference and to participate in the seminar “Listen to the Voices of Youth in Planning for HIV and STD Prevention and Care”. Twelve youth, ages 17-24, from prevention regions one, four, seven, eight, and nine received scholarships to attend the conference. These scholarship recipients came from a variety of backgrounds and represented people living with HIV (PLWH), family members of PLWH, users of HIV/STD prevention services, students, and young professionals interested in HIV and STD.

The Youth Seminar was well attended by youth scholarship recipients and a variety of professionals who work with youth in HIV/ STD services. Seven panelists shared their expertise and experiences about serving youth in HIV and STD prevention and care services. The following IDPH Staff members spoke on the panel: Illinois HIV Planning Coordinator, Janet Nuss; IDPH Ryan White Part B Administrator, Jeffery Maras; HIV Prevention Administrator, Curt Hicks; STD Counseling and Testing Coordinator, Lesli Choat; and HIV Surveillance Administrator, Cheryl Ward. Reginald Patterson, the ILHPG liaison from the Illinois State Board of Education and Curtis Lewis, a youth representing a user and peer advocate for HIV pre-exposure prophylaxis (PrEP), were also part of the panel.

After the panel presentations, attendees were invited to ask questions and share their ideas and experiences related to HIV/STD prevention and care. Many youth scholarship recipients shared their personal struggles and successes associated with HIV/ STD services and eagerly expressed suggestions and ideas about how to reach youth through social media or virtual outlets. A variety of other topics like sex education in schools, PrEP access and utilization, parental roles in educating youth on healthy sexual practices, resources for LGBT youth, and involving youth in HIV/ STD planning processes and through employment were also discussed at the seminar.

Overall, the Youth Seminar was a wonderful opportunity to engage youth and to collect information that can be used in future community planning initiatives. Many youth scholarship recipients expressed their gratitude for a chance to share their thoughts and experiences in their efforts to make positive changes for other youth, and many were excited to continue to participate in similar events in the future. We plan to use the information gathered at this seminar to reach out to youth in HIV and STD planning and to engage youth in HIV/STD prevention and care services more effectively.

Submitted by: Marleigh Voigtmann, Illinois Department of Public Health , HIV Community Planning Intern



PrEP and PEP

Preventing HIV/AIDS is still an urgent need, particularly amongst young men of color ages 15-24 who have sex with men. We need to accelerate our responses across the board, employing all of the HIV prevention options that have been proven to work in our efforts to decrease the incidence of HIV.

We have a long way to go before we end the epidemic here in the U.S. In Illinois our efforts to increase HIV testing and linking people who are HIV-positive to treatment and care and linking people who are HIV-negative to an appropriate range of prevention options is crucial to addressing this epidemic. For some people, the range of appropriate prevention options may include pre-exposure prophylaxis (PrEP) and/or post exposure prophylaxis (PEP).



Daily oral PrEP provides partial protection and is not a replacement for other prevention strategies like the male and female condom. Pre-exposure prophylaxis, or PrEP, is a way for people who do not have HIV but who are at substantial risk of getting it to prevent HIV infection by taking a pill every day. The pill (brand name Truvada) contains two medicines (tenofovir and emtricitabine) that are used in combination with other medicines to treat HIV. When someone is exposed to HIV through sex or injection drug use, these medicines can work to keep the virus from establishing a permanent infection. It will not be right for everyone. It requires adherence to the medication, a confirmed HIV-negative diagnosis and ongoing monitoring. Further, there are a number of questions remaining about how PrEP can be implemented in different communities and how it will best be used by those who need it most.

The U.S. Food and Drug Administration (FDA) approval and the World Health Organization (WHO) guidance on PrEP was based on a rigorous review of data from four large scale clinical trials in different communities. PrEP, like condoms, works when used consistently and correctly. We know that PrEP will never be the answer for everyone at risk of HIV infection, but it is an important new choice in a combination of prevention options that includes male and female condoms, behavior change, harm reduction, and early and consistent treatment for HIV-positive people.

Post Exposure Prophylaxis or PEP, is an emergency treatment that can help reduce your chances of becoming permanently infected with HIV (the virus that causes AIDS) after you have been possibly exposed. PEP is given to people after events that put them at a high risk for HIV infection (for example, unprotected sex or using a dirty needle). Possible exposure to HIV is an emergency. It is important to be treated as soon as possible, because the longer you wait, the higher the chance you may become infected with HIV. Generally, PEP will only be given within 3 days (72 hours) after the event that put you at risk for HIV infection.

It can be confusing to know whether you need PEP or not. You may not know for certain if what you did put you at significant risk or if your sex partner even has HIV. Personnel at an emergency room, clinic or physician's office can help you assess your risk and whether or not PEP is appropriate. If you had unprotected sex and your partner does not know his or her status, you can ask them to go to the hospital, clinic or physician's office with you in order to get tested, if they are willing.

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PrEP and PEP

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After you have informed the triage nurse or receptionist that you might have been exposed to HIV and need PEP, you will be taken to a room to consult with a health care provider who will discuss your situation with you. If it is determined that you are at significant risk for HIV infection and are still within the time limits for PEP, some or all of the following may happen:

- ◆ You will be given a starting dose of antiretroviral drugs.
- ◆ You will take a baseline HIV test (to determine if you are already infected).
- ◆ The physician may order a Hepatitis B antibody test to make sure you have significant immunity to Hepatitis B; if not, he or she may give you a Hepatitis B vaccine.
- ◆ The physician may order liver function and other necessary blood tests to make sure you can safely take antiretroviral drugs.
- ◆ You will be given a prescription for 28 days of antiretroviral therapy.
- ◆ You will be scheduled for a follow up appointment.

Some hospitals and clinics might also give you a “starter pack” of several days’ anti-retroviral therapy so that you can continue your therapy in the event that you cannot get your prescription filled rapidly. In Illinois, many insurance plans, including Medicaid, cover PrEP and PEP.

There are no magic bullets! PrEP nor PEP, like any prevention strategy, won’t end the epidemic alone. Access to male and female condoms, routine HIV testing, and appropriate linkage to care are still greatly needed. The best-case scenario is one in which people are choosing from a menu of prevention options throughout their lives.

Today, eight million people around the world are receiving HIV treatment. We can and must facilitate access to PrEP/PEP for those who need it.

For more information on PrEP: <http://www.cdc.gov/hiv/basics/prep.html>

For more information on PEP: <http://www.cdc.gov/hiv/basics/pep.html>

If you’re a Medical Provider seeking guidance: Clinician Consultation Center
<http://nccc.ucsf.edu/>

For more information on HIV Education, Prevention, and Care in Illinois, please visit:
www.hivcareconnect.com

Submitted by: Chris Wade, HIV Care Connect Project Coordinator, Illinois Public Health Association, (309)453-9042, cwade@ipha.com



WHY HIV MEDICATION ADHERENCE IS IMPORTANT

HIV medication adherence means taking the correct dose of your medications every time, exactly as prescribed by your health care provider or recommended by your pharmacist. To successfully slow HIV replication and keep viral load suppressed, HIV medications need to be maintained at high enough levels in the blood, 24 hours a day, every day. If the drug levels become too low, drug resistance may occur.

HIV drug resistance can cause your meds to stop working properly and may limit future medication options. It is also possible to transmit drug-resistant HIV to other people, making it harder for them to treat their own infection.

When selecting a new HIV medication or starting meds for the first time, you may want to look at your lifestyle to see if there are any potential adherence obstacles. Here is a list of questions for you to consider when discussing adherence and making medication decisions with your health care provider:

- Does your daily schedule change a lot?
- What is your typical eating schedule each day?
- Do you have a difficult time swallowing pills?
- Are you taking other medications?
- What side effects can you tolerate?
- What happens if you miss a dose?

Today there are several once-daily fixed-dose regimens contained in one pill. While the option of only taking one pill a day sounds appealing, these regimens may not allow for a missed dose because the doses are further apart than twice-daily doses. Missing a once-daily dosed pill could also cause drug resistance.

Medication adherence can affect anyone. Don't feel guilty about talking to your doctor about any difficulty you may have with taking your medications on time. There are certain situations that have been found to affect adherence.



Attitude: People who feel most strongly that their medication is doing them good typically have an easier time adhering to their regimens. Understanding how and why the medications work can help with adherence.

Mood: People who are depressed have a harder time adhering to HIV drug regimens than people who are not depressed. If you suspect you are depressed, talk to your health care provider.

Chaos: The amount of chaos in your life, and the stress it creates, can generate adherence problems. Chaos can include more than just an unpredictable and overwhelming schedule of activities. Try to identify and lower the chaos in your life. Your health care provider or case manager may be able to help.

Primary Caregiver: The needs and concerns of the people you're caring for can be overwhelming and become your primary focus. It's important to remember that your health must come first; you can't care for others if you don't take care of yourself.

Talk to your health care provider if you need help addressing any adherence challenges. Finding other people in your situation can also help. Join a support group or connect with other HIV-positive people in the Forums.

For more information on HIV Education, Prevention, and Care in Illinois, please visit: www.hivcareconnect.com

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MEMBER PROFILE: SCOTT FLETCHER

Advocating on behalf of people infected and affected by HIV has been a focus for Scott Fletcher for 14 years. That, however, was not always the case. After being diagnosed with HIV, he had a great deal of reluctance to speak out and a desire for personal anonymity. Scott wanted to live and ultimately die as an unknown casualty of the war on AIDS. He had no aspirations of joining in the fight. He recalls, "I was fearful that if I were to speak out too loudly I might be forced to give up custody of my son, be evicted from my home, or ostracized by my friends and family", so he simply gave a minimal amount of time and resources to agencies that would be willing to do the work.



All of that changed when in the middle part of 2001, he met Steven St. Julian. St. Julian was the Project Director for the Southern Illinois CARE Consortium. During an early meeting, Steven asked Scott to get involved with a local AIDS Service Organization and he agreed. Unbeknownst to Scott, his willingness to participate would be a pivotal point in his life. By the end of 2001, Scott had accepted the call to be an active participant in the fight against AIDS. To this day, he credits the impact that his mentor, St. Julian has had on his life and his work.

In the coming months, Fletcher would be asked to serve as an alternate for the Client Representative for the Consortium and was encouraged to apply to the Illinois HIV Planning Group (ILHPG). He has served as the group's Community Co-Chair and has co-chaired and served a number of committees over his tenure. He currently serves the committee as the Website Administrator and a community representative from Region 5, Southern Illinois. In 2011, Scott returned to school to pursue an advanced degree in Public Health, graduating with his MPH in Community Health Education from Southern Illinois University in 2013. In 2014, he was tapped to serve as the Deputy Director of Sisters and Brothers Helping Each Other, a community-based organization that provides IDU harm reduction and HIV risk reduction services in five HIV prevention regions throughout the state.

Scott sees it as his mission to assist those affected by HIV/AIDS through outreach, education, and advocacy. He counts himself as a soldier in this fight to prevent and eradicate HIV/AIDS. He works on behalf of those that are unable, unwilling, or simply too fearful of the consequences to speak on their own behalf. He remembers with respect and great admiration those heroes that he has known to have taken on the mantle until their final breath; Edward Bruner, Joseph Greene, Arlene Valentine, Lois Bates, Beth Wehrman, Rick Wadlow and Brad Daehn. Each of these has served the HIV Planning Group and have affected this epidemic through their passion and commitment. Scott is committed to working with that spirit until we can have a world without HIV/AIDS.

Submitted by: Scott Fletcher, Sisters and Brothers Helping Each Other, Deputy Director, ILHPG Website Administrator

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