Statement on HIV/AIDS

Student National Medical Association

Health Policy and Legislative Affairs Committee
Statement on HIV/AIDS

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INTRODUCTION

Human immunodeficiency virus (HIV) is a virus spread through body fluids that is characterized by the targeting of the body’s immune system. The major immune system component known to be affected by HIV infection is the CD4 T-cell. Untreated, the level of CD4 cells are critically reduced and an infected individual becomes diagnosed with acquired immunodeficiency syndrome (AIDS) when the CD4 count drops below 200 cells/mm$^3$ or the individual acquires an AIDS-defining illness/infection.$^1$

As the United States’ largest and oldest organization for minority medical students, one of the primary missions of the Student National Medical Association (SNMA) is to pursue equitable care for all individuals, especially those from medically underserved communities. Though the incidence of HIV and HIV-related mortality rates has trended down since the infection was first discovered in the 1980s, ethnic and sexual minority groups still face disproportionately high rates of newly-diagnosed HIV and AIDS cases, high rates of total HIV diagnoses, and alarmingly low rates of viral suppression.$^2$ The purpose of this policy statement is to inform the public on health disparities surrounding HIV/AIDS and offer recommendations for the improvement of these disparities.

BACKGROUND

The HIV/AIDS epidemic began in the United States in the 1980s with the identification of individuals with rare, aggressive cancers and infections who simultaneously seemed to have unexplained immune deficiencies.$^3$ Since this time, we have seen the incidence of HIV/AIDS decrease largely in part due to disease education and the availability of antiretroviral therapy.$^4$ However, the work of HIV prevention and treatment is far from finished. Currently, there are over 1 million individuals living with HIV in the United States. Strong disparities still exist with 2017 statistics citing that African-Americans and Latinos compose 43% and 26% of the annual number of HIV infections respectively.$^2$

The major groups considered today to be at-risk for newly diagnosed HIV infections are stratified by ethnic group and by transmission method including Men who have Sex with Men (MSM), Heterosexuals, and Injection Drug Users (IDU). As of 2017, gay and bisexual men accounted for 66% of all HIV diagnoses, heterosexuals account for 24% of all HIV diagnoses, and IDU-cases account for 9%. HIV is also known to disproportionately affect different age groups.
with young people aged 13 to 24 comprising 21% of all new HIV diagnoses and young gay and bisexual men accounting for 83% of all new HIV diagnoses in people aged 13 to 24 in 2017.²

Current federal initiatives aimed at the improvement of such disparities stem from the National HIV/AIDS Strategy, a five-year plan detailing the national response to the HIV epidemic. The strategy has four primary goals: (1) reducing new HIV infections, (2) increasing access to care and optimizing health outcomes for people living with HIV, (3) reducing HIV-related health disparities and health inequities, and (4) achieving a more coordinated national response to the HIV epidemic.⁵ As a result of the National HIV/AIDS Strategy, efforts targeting HIV prevention and care activities led by federal departments including the Centers for Disease Control and Prevention (CDC) and the Health Resources & Services Administration (HRSA) were developed and strengthened.

At the national level, the HIV Care Continuum was established in 2013 as the next step in tracking progress towards the goals of the National HIV/AIDS Strategy. This model, now extensively used both federally and in academia, focuses on 4 sequential goals: (1) receiving a diagnosis, (2) being linked to care, (3) being retained in care, and (4) viral suppression.⁶ Using this model, the same health disparities have been shown to describe how sexual and ethnic minorities experience HIV/AIDS in the United States through HIV/AIDS surveillance efforts from the CDC. Per the 2015 HIV Care Continuum data released by the CDC stratified by transmission method, MSMs living with HIV in 2015 had the following statistics: 62% received some HIV care, 48% were retained in HIV care, and 52% had a suppressed viral load.⁷ The year prior to that, African Americans living with HIV were shown to have the following CDC statistics: 84% had received a diagnosis, 59% received HIV medical care, 46% were retained in HIV care, and 43% had a suppressed viral load.⁷

Acknowledging that most of the data regarding the HIV/AIDS experience in the United States point towards health disparities in traditionally medically underserved groups, funding has been granted to many federal initiatives addressing HIV prevention and access to care issues. The major federal programs known to be utilized by people living with HIV (PLWH) include Medicaid, Medicare, and the Ryan White HIV/AIDS Program (RWHAP). The RWHAP is the largest federal program designed specifically for PLWH in the United States and serves approximately 52% of all people diagnosed with HIV in the United States.⁹
To address HIV prevention in specific at-risk groups, the CDC has developed multiple awareness campaigns targeted towards specific demographics regarding the use of pre-exposure prophylaxis (PREP) and post-exposure prophylaxis (PEP).

**SCOPE OF THE PROBLEM**

While great strides have been made to address prevention and treatment of HIV/AIDS in the United States, the disparities related to the high concentration of HIV diagnoses among sexual minorities and communities of color must still be considered. In any attempt to address those statistics, it is also extremely important to acknowledge the areas in the United States that have the highest frequency of new infections. Particularly, that is the Southern United States which has consistently reported the highest rates of newly-diagnosed HIV/AIDS and the highest HIV-related death rates of any US Region despite having less federal government and private foundation funding per person living with HIV than the US overall.10

Furthermore, when considering statistics regarding groups that have been nationally identified as high-risk for HIV/AIDS, the disparities in the Southern United States are very similar to what is seen nationally which leaves hope in finding strategies to effectively solve the issue of HIV/AIDS in these at-risk communities. Per a study commissioned by the HIV/AIDS Policy Clinic at Duke University titled “The State of HIV in the US Deep South,” the percentage of new HIV-diagnoses coming from African-American patients in the 2014 HIV Surveillance data from the CDC was slightly higher than the overall US. (53.5% vs 44%) Similarly, there has also been a rise in the percentage of new men who have sex with men (MSM) HIV diagnoses (56.0% in 2008 to 67.8% in 2014) that parallels overall US statistics. (59.9% to 69.8% in the same timeframe).10

Many studies have pointed to four major factors as strong contributors to HIV/AIDS disparities in high-risk groups: Stigma, Poverty, Incarceration, and Comorbid Substance Use and Mental Health Disorders.

**Stigma**

There has long been a studied relationship between stigma and HIV/AIDS. Those that experience stigma often feel marginalized and are more vulnerable to HIV and those living with HIV are more vulnerable to experiencing continued stigma. Unfortunately, despite decades of public information campaigns and awareness initiatives, there are still persistent irrational societal
fears and negative attitudes and judgements both towards HIV as a disease and PLWH. This has detrimental consequences to patient outcomes.

Per the 2017 UNAIDS report, “Confronting discrimination: overcoming HIV-related stigma and discrimination in health-care settings and beyond,” studies on stigma and discrimination and health-seeking behaviors show that perceptions of high levels of stigma and discrimination against PLWH can cause a person diagnosed with HIV to be 2.4 times more likely to delay linkage to care and delay starting antiretroviral therapy until they are very ill.11 This means that some individuals may not seek medical care after being diagnosed with HIV until their immune system has been compromised enough that they become symptomatic. However, when considering the average duration of time that it takes for CD4 counts to drop low enough to make PLWH symptomatic, there lies 4-7 years on average for the risk of HIV transmission between infection and becoming symptomatic solely due to HIV/AIDS or acquiring an opportunistic infection.

HIV-stigma as it relates to sexual minority groups in the US is a growing field of research driven out of failed previous attempts at reducing the number of new diagnoses and increasing rates of viral suppression. There is much that still needs to be learned about how to strategically work with this group to combat the HIV epidemic, but some studies have begun to delve into the concerns of PLWH from this at-risk group and have made recommendations for where the focus should be placed moving forward.

When looking particularly at HIV-related stigma faced by minority MSM, stigma related to homophobia frequently cause minority MSM to struggle with gay identity and engage in riskier sexual behaviors.12 Some studies delving deeper into the perceptions of stigma faced by this group have listed minority MSM concerns of homophobia in their community and “risky behavior that happens when your sexuality is always hidden” among fear of losing support from family and friends and low self-esteem as major barriers to HIV prevention and HIV care that must be considered if any type of intervention is initiated.13 Future research in HIV-stigma for minority MSM addressing how to be more effective in communicating both with minority communities about HIV-stigma and MSM patients about sexual behaviors and the use of PREP is also a growing field of study. This is likely to be more fruitful than previous attempts due to community collaboration on these efforts moving forward in normalizing HIV testing and prophylaxis and addressing the stigmas and false beliefs surrounding HIV.
Poverty

The relationship of HIV infection risk and socioeconomic status is one that has been researched thoroughly within the last decade as talks of health disparities regarding HIV transmission and care have been prioritized and considered. Perhaps the most interesting finding from this research is that unlike other chronic diseases linked to socioeconomic disparities, HIV infection almost exclusively impacts people who face economic adversity. Per the 2011 HIV surveillance data from the CDC, HIV prevalence is found to be the highest among people at or below the poverty level. The same report shows high concentrations of HIV infection among the unemployed.\(^\text{14}\)

To address concerns for access to care for PLWH with limited incomes, a HIV/AIDS diagnosis and proof of low income has become a qualifier for medical benefits for most federally funded programs including the Ryan White HIV/AIDS Program. However, when a person makes an income above the income cap set by medical care program grantees defining the term “low-income” they become ineligible for benefits. Subsequently, pre-existing poverty is exacerbated by new HIV diagnoses especially in the setting of rising health insurance costs.\(^\text{15}\) Thus, even with access to medical care through Ryan White funding, other basic needs like food security and housing stability are still major concerns affecting health outcomes of PLWH.

Incarceration

Arguably one of the most interesting hot topics in HIV Research within the last decade, especially in the setting of recent marijuana legalization in many states and the current opioid crisis, is the role of mass incarceration in the HIV epidemic today. The United States is home to the largest incarcerated population in the world with almost 2.3 billion people imprisoned in a population of 323 million citizens. Nationwide, mass incarceration disproportionately affects minority communities with 38% of all incarcerated men being African-American and 32% being Hispanic despite comprising 13% and 16% of the US population respectively.\(^\text{16}\)

Mass incarceration and persistent racial disparities noted today are the result of the War on Drugs. Beginning in the 1970s, drug law violations began to be met with increasingly punitive policies that were predominantly focused on the arrest, conviction, and incarceration of drug users in low-income urban areas highly concentrated with minorities. Paralleling the rise of drug
convictions was the increasing rate of new HIV diagnoses due to high transmission risk secondary to drug use and the number of PLWH cycling in and out of federal prisons. In 2010 alone, the prevalence of HIV among the incarcerated population was approximately 5 times the prevalence of those that were not imprisoned. Concerned for the rising rates of HIV in the federal prison system, the Center for Disease Control and Prevention (CDC) responded with recommendations for HIV testing, prevention, and treatment services for inmates.\textsuperscript{17}

Later studies regarding the implementation of those CDC recommendations have shown that the adoption of those strategies in correctional facilities across the nation has been subpar. Approximately 10 million individuals are released back into the community annually, yet in a 2014 survey study of correctional facilities, less than 20\% of the surveyed prison systems provided opt-out HIV testing and only 19\% provided discharge services that met the CDC criteria.\textsuperscript{18} In another study looking at the use of antiretroviral therapy in PLWH upon discharge from correctional facilities, only 30\% of PLWH filled a prescription for antiretroviral therapy within 60 days after discharge and only 28\% were linked to care within 90 days.\textsuperscript{19,20} These are CDC direct measures of the state of HIV in the United States, yet there are clear gaps in the transition of care from the federal prison system to the community pointing at failures in the discharge planning process. The discontinuity in medical care and treatment compromises both individual health and community health by increasing the risk of HIV transmission.

\textit{Comorbid Substance Use and Mental Health Disorders}

Affective psychiatric disorders like depression, bipolar disorder, or anxiety disorder are among the most common mental health problems faced by PLWH. Per a 2001 study on the prevalence of depression in US patients receiving HIV treatment, 1 in 3 had Major Depression and 1 in 4 had a less severe type of depression.\textsuperscript{21} However, studies regarding psychological influences on HIV transmission and patient outcomes suggest that the presence of an affective disorder is a more reliable predictor of HIV risk as opposed to HIV severity or treatment compliance.\textsuperscript{15} Depression rates among PLWH are consistent with those seen in at-risk populations, suggesting that mental health disorders are likely premorbid conditions for PLWH that also have mental health disorders. Many initiatives, including the Ryan White HIV/AIDS program, have aimed to address this by the inclusion of mental health services in HIV care programs or addressing the triggers of affective disorder symptoms like stigma and discrimination.
Likewise, substance use and addiction are known risk factors for HIV transmission. The most obvious implication of the role of drug use in the state of the HIV epidemic today is the role of injection drug use (IDU) in the rising rates of HIV transmission and comorbid-Hepatitis B and C infections linked to sharing contaminated equipment. Non-injection drug use has also been indirectly linked to increasing the risk of transmission in the setting of drug addiction by influencing sexual transmission via the trading of sex for drugs. With the recent spotlight on the opioid crisis facing the United States, organizations concerned for IDU-associated HIV transmission risk remain hopeful that initiatives like needle exchange programs, PREP/PEP awareness campaigns, and treatment for opioid dependence (i.e., methadone and buprenorphine treatment) pushed heavily in awareness of the misuse of opioids and concern for complications will be sufficient to address the risk for HIV transmission in the high-risk group.

**STATEMENT OF POSITION AND RECOMMENDATIONS**

The Student National Medical Association (SNMA) is the nation’s oldest and largest organization focused on the needs and concerns of medical students of color and has been strongly dedicated to addressing the needs of underserved communities since 1964. The organization recognizes today’s disparities in the arena of HIV/AIDS prevention, care, and treatment especially in sexual minority groups and communities of color and are concerned for the rate of HIV transmission and lack of linkage to care and viral suppression in at-risk groups. Thus, the SNMA has the following position and recommendations:

1. The SNMA supports all federal programs for comprehensive medical care for PLWH including the Ryan White HIV/AIDS Program.
2. The SNMA supports and recommends further federally-funded and privately-funded research into the disparities of HIV/AIDS prevention, care, and treatment.
3. The SNMA opposes any legislation risking access to care or access to medications for individuals living with HIV out of concern for continued transmission risk, potential drug resistance, and avoidable poor patient outcomes.
4. The SNMA supports the use of pre-exposure prophylaxis and post-exposure prophylaxis for individuals at risk for HIV transmission.
5. The SNMA recommends stronger implementation of CDC recommendations for HIV prevention and treatment in federal prison systems.
6. The SNMA supports the use of needle exchange programs, PREP/PEP awareness campaigns, and treatment for opioid dependence to address IDU-related HIV transmission.
REFERENCES


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