

## PREVENTION WITH POSITIVES: INTEGRATING HIV PREVENTION INTO HIV PRIMARY CARE

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### I. INTRODUCTION

The goals of preventing HIV transmission include both decreasing transmission from those known to be infected and preventing those with established HIV infection from acquiring new strains of HIV (superinfection) or other sexually transmitted infections (STIs). HIV/AIDS care systems should include prevention as part of comprehensive HIV care and should partner with primary care systems and community prevention providers to promote coordinated health care and prevention services for newly diagnosed patients.

This chapter focuses on the importance of ongoing secondary prevention efforts, sometimes referred to as “prevention with positives.” HIV prevention requires a combination of strategies that includes medical, behavioral, programmatic, individual, and community-level interventions.

The following are strategies for use by clinicians and clinic staff to prevent HIV transmission:

#### Clinician/Healthcare Team Interventions

- Educate and counsel people about reducing HIV transmission risk behaviors, such as risky sexual activities and sharing syringes, and encourage safer-sex practices, including the use of barriers, such as male or female condoms, among all patients
- Become familiar with the evidence-based prevention interventions that are offered at community-based settings so that patients’ referrals to these interventions are properly matched according to specific patient risks
- Identify HIV-infected women who wish to become pregnant and provide preconception counseling; refer HIV-infected pregnant women for early prenatal care and antiretroviral therapy (ART)
- Screen for, diagnose, and treat other STIs
- Promote the use of sterile injection equipment for injection drug users through education, prescription, and referral to syringe access programs (syringe exchange and Expanded Syringe Access Programs)
- Make appropriate referrals for the management of substance use, including alcoholism treatment, methadone maintenance, buprenorphine treatment, opioid overdose prevention programs, mental health assessment and treatment, and other necessary support services
- Recommend ART to patients with serodiscordant partners, even when CD4 is  $>500$  cells/mm<sup>3</sup>, to prevent transmission
- Promote adherence to treatment among patients who are receiving ART to ensure maximal viral suppression and thereby reduce the risk of transmission.
- Encourage partner testing
- Assist with HIV disclosure and advocate for active health department involvement in providing partner notification

### Clinic-Level Interventions

- Ensure that HIV testing for uninfected partners is available onsite or easily accessible
- Make HIV post-exposure prophylaxis for uninfected partners available onsite or easily accessible
- Aggressively monitor and promote retention in care. HIV-infected patients who are retained in care are more likely to reduce risk behaviors.<sup>1,2</sup> Make supportive services available as needed to facilitate retention in care
- Make HIV educational brochures, posters, and videos available in waiting areas and for distribution to patients. Materials should be written in the appropriate language and at the appropriate levels of literacy for the patient population
- Make condoms visibly available in the clinic
- Where electronic health records are used, implement prompts and reminders to enhance implementation of prevention
- Monitor prevention interventions through the clinic quality management program

## **II. PREVENTION OF SEXUAL TRANSMISSION**

Risk assessment and risk-reduction counseling is an ongoing process that cannot be achieved during the course of one visit. As part of the process, clinicians should ask direct questions in a nonjudgmental manner, provide information, and try to understand the patient's beliefs and motivations that may contribute to risk-taking behavior. As trust is built and the patient discloses information, the clinician can work with the patient to address specific risk behaviors and barriers to achieving behavior change.

### **Key Point:**

Prevention should be viewed as a lifelong activity that changes as patients progress through their lives. Effective risk-reduction counseling requires ongoing discussion and flexibility to adapt to patients' evolving needs and lifestyles.

### **A. Obtaining a Sexual Risk Assessment and History**

#### **RECOMMENDATIONS:**

**Clinicians should obtain a baseline sexual risk assessment for all HIV-infected patients (see Table 2). (AII)**

**Ongoing sexual risk assessments should occur at least every 3 to 4 months. The content and intensity of prevention interventions should be tailored as the clinician learns more about the patient's behaviors and health beliefs. (AIII)**

**Clinicians should stress the confidential nature of discussions and maintain a nonjudgmental attitude regarding sexual activities to encourage patients to be open and honest. (AIII)**

## 1. General Approach to Assessing Sexual Risks

By creating a supportive and nonjudgmental atmosphere while obtaining a sexual risk assessment, the clinician encourages trust, honesty, and openness. Questions about sexual behavior may be asked in the context of other healthy human functions, such as diet/appetite, exercise, sleeping patterns, and relationships. The following are examples of open-ended and closed-ended questions that a clinician might use to begin the discussion about sexual health and risk behaviors. Open-ended questions may encourage the patient to share more information about behaviors (see Table 1). See Appendix A for further examples.

<b>Table 1</b> <b>Examples of Open- and Closed-Ended Questions</b>	
<b>Open-ended</b>	<b>Closed-ended</b>
<ul style="list-style-type: none"><li>• <i>Tell me a little about your sex life and how safer sex fits into it.</i></li><li>• <i>Tell me about the people who you've had sex with recently.</i></li><li>• <i>Tell me how alcohol and/or drugs affect your sex life.</i></li></ul>	<ul style="list-style-type: none"><li>• <i>Do you have a sex partner?</i></li><li>• <i>Do you have sex with males, females, or both?</i></li><li>• <i>How often do you have sex?</i></li><li>• <i>Do you engage in insertive anal sex, receptive anal sex, or both (top, bottom, or both)?</i></li><li>• <i>Do you use alcohol or recreational drugs when having sex?</i></li><li>• <i>How often do you use condoms when you have sex?</i></li><li>• <i>Where do you usually meet your sex partners?</i></li></ul>

## 2. Components of Sexual Risk Assessment

### **RECOMMENDATIONS:**

**Clinicians should include the components listed in Table 2 when obtaining a baseline risk assessment. (AII)**

**Clinicians should assess whether HIV-infected women of childbearing potential might be pregnant or wish to become pregnant. Clinicians should discuss the importance of barrier protection in addition to contraception with women of childbearing potential who are not specifically considering pregnancy but are sexually active (see [Preconception Care for HIV-Infected Women](#)). (AI)**

**Clinicians should screen for alcohol and substance use at baseline and at least annually and should assess whether patients are more likely to engage in high-risk sexual activity while using. (AII)**

A baseline risk assessment should include the components listed in Table 2. Regardless of the patient’s experience and current risk behaviors, clinicians should use the opportunity to provide education about HIV transmission. Ongoing assessments and counseling can become individualized as the clinician learns about the patient’s attitudes, behaviors, and health beliefs. Patients should be encouraged to discuss changes in sexual activity and/or partners, but clinicians should also routinely ask about changes in sexual behavior and partners since patients change their behavior over time and may not remain abstinent or in monogamous relationships.

The physiological effects of alcohol and substance use may encourage high-risk sexual activity. Clinicians should ask about alcohol and substance use and should assess whether the patient is more likely to participate in high-risk sexual behaviors while using. For more information regarding substance use screening, refer to [Screening and Ongoing Assessment for Substance Use](#).

Pregnancy and contraception should be discussed with both men and women. Clinicians should assess whether women of childbearing potential might be pregnant, wish to become pregnant, or are sexually active and not using contraception. Clinicians should ask men whether they or their partners are considering having children. For more information, see [Preconception Care for HIV-Infected Women](#).

<b>Table 2</b> <b>Elements of an Initial Sexual Risk Behavior Assessment</b>
<ul style="list-style-type: none"> <li>• Satisfaction with sex life (<i>Are you happy with your sex life? Do you find your sex life satisfying?</i>)</li> <li>• History of STIs</li> <li>• Current STI symptoms</li> <li>• Sexual practices, including vaginal, anal, digital, and oral sex</li> <li>• Methods currently used to reduce risk, such as condom use</li> <li>• Drug or alcohol use and sexual activity during use</li> <li>• Exchanging sex for money, drugs, or a place to sleep</li> <li>• Use of erectile dysfunction agents</li> <li>• Methods of contraception and interest in conceiving</li> <li>• Information about partners               <ul style="list-style-type: none"> <li>○ Number of partners in the last 3 months</li> <li>○ Age of partners*</li> <li>○ Gender of partners</li> <li>○ Where partners are met</li> <li>○ Disclosure of HIV status to partners, discussion of safer sex with partners</li> <li>○ HIV and STI status of partners</li> </ul> </li> </ul>
<p>*Inquiring about the age of partners may be useful when obtaining a sexual risk assessment in younger men and women because it is often harder for them to negotiate safer sex with older partners.</p>

## B. Risk-Reduction Counseling for Sexual Transmission

### RECOMMENDATIONS:

#### Clinicians should:

- **Routinely encourage HIV-infected individuals and their partners to adopt safer sexual practices** (AII)
- **Educate HIV-infected patients about the risks associated with the patient's specific sexual behaviors** (see Table 4) (AII)
- **Tailor messages according to the patient's relationship status and ongoing transmission risk behaviors** (see Appendix A for examples of scripted dialogue that could be used for risk-reduction counseling) (AII)

<b>Table 3 Elements of Risk-Reduction Counseling for Sexually Active HIV-Infected Patients</b>
<p>For patients who are sexually active, risk-reduction counseling should include the following:</p> <ul style="list-style-type: none"><li>• Review of safer sexual practices to prevent transmission of HIV and other STIs (see Table 4):<ul style="list-style-type: none"><li>○ Instructions about consistent, correct male and female condom use</li><li>○ Importance of avoiding use of lambskin condoms and nonoxynol-9</li><li>○ Strategies to avoid intoxicating substances that can lead to unsafe sex, or if the patient is unwilling or unable to avoid these substances, discuss pre-planning when using drugs that lower inhibitions (e.g., have condoms available)</li><li>○ Avoidance of activities that irritate the mucosal surfaces before sex occurs, such as douching and use of sex toys or hyperosmolar lubricants</li><li>○ Avoidance of exposure to pre-ejaculatory fluid, because it may contain HIV</li><li>○ Reducing number of sexual partners, particularly those who are at-risk, such as those who are HIV-negative or of unknown status</li></ul></li><li>• Clarification that an undetectable plasma viral load does not guarantee elimination of the risk of HIV transmission, even though it greatly reduces the likelihood that HIV will be transmitted</li><li>• Reassurance that behaviors that do not involve exchange of or exposure to potentially infectious bodily fluids cannot transmit HIV</li><li>• How to communicate about HIV status with prospective sexual partners</li></ul>

**Table 4**  
**HIV Risk-Reduction Counseling for Specific Sexual Practices**

<b>Sexual Exposure</b>	<b>Risk of HIV Transmission</b>	<b>Advise the Patient to:</b>
<b>Anal intercourse</b>	<ul style="list-style-type: none"> <li>• High risk</li> <li>• Receptive anal intercourse with an infected source: 0.5% to 3.0%<sup>3,4</sup></li> <li>• Insertive anal intercourse with an infected source: 0.065%<sup>3,5</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Use latex or polyurethane condoms</li> <li>• <b>Avoid</b> using lambskin condoms or condoms lubricated with nonoxynol-9 because lambskin is not an effective barrier to HIV, and nonoxynol-9 may cause anal irritation, which may enhance transmission</li> </ul>
<b>Vaginal intercourse</b>	<ul style="list-style-type: none"> <li>• High risk</li> <li>• Receptive vaginal intercourse with an infected source: 0.1% to 0.2%<sup>3,5</sup></li> <li>• Insertive vaginal intercourse with an infected source: 0.05%<sup>3,5</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Use a latex or polyurethane male or female condom</li> <li>• <b>Avoid</b> using lambskin condoms or condoms lubricated with nonoxynol-9 because lambskin is not an effective barrier to HIV, and nonoxynol-9 may cause vaginal irritation, which may enhance transmission</li> </ul>
<b>Oral sex</b>	<ul style="list-style-type: none"> <li>• Receptive fellatio with ejaculation—conflicting data, but low risk, although riskier than fellatio without ejaculation<sup>6,7</sup></li> <li>• Receptive fellatio without ejaculation—biologically plausible, but low risk<sup>6,7</sup></li> <li>• Insertive fellatio with or without ejaculation—biologically plausible, but low risk<sup>6,7</sup></li> <li>• Cunnilingus—biologically plausible, but low risk for both insertive and receptive partners</li> <li>• Anilingus—biologically plausible, but low risk</li> </ul>	<ul style="list-style-type: none"> <li>• Use condoms during fellatio or a dental dam during cunnilingus<sup>a</sup></li> <li>• Learn how to cover mucous membranes with a variety of barriers (e.g., dental dams, non-lubricated condoms, and plastic wrap)</li> <li>• <b>Avoid</b> oral sex if either partner has open lesions, such as herpes or syphilis, in either oral or genital areas. Condoms will not extend protection to ulcerative and viral lesions, including warts, outside of the area that is covered</li> <li>• <b>Refrain</b> from cunnilingus during menstruation</li> <li>• For patients who are unwilling to wear condoms, encourage them to withdraw before ejaculation</li> </ul>
<b>Mutual masturbation and/or digital sex (using fingers or toes)</b>	Low risk	<ul style="list-style-type: none"> <li>• <b>Avoid</b> sharing sex toys.<sup>b</sup> If sex toys are shared, they should be covered with barrier protection</li> <li>• Clean sex toys after each use</li> <li>• Consider use of condoms if uninfected partner has sores or cuts on hands. Latex finger condoms or surgical gloves can also be used to protect fingers and hands</li> <li>• <b>Avoid</b> using lambskin condoms or condoms lubricated with nonoxynol-9 because lambskin is not an effective barrier to HIV, and nonoxynol-9 may cause anal irritation, which may enhance transmission</li> </ul>

<sup>a</sup> Educate patients about non-lubricated and/or flavored condoms that are available and are often preferred during oral sex (e.g., Kiss of Mint).

<sup>b</sup> HIV could be transmitted if sex toys become covered with secretions or blood and the partner has open wounds.

Risk-reduction counseling should be individualized, with the aim of moving the patient to a safer part of the risk spectrum. For example, if a patient's primary risk behavior is unprotected anal sex, the patient's goal should be to increase their use of condoms; if a patient's primary risk behavior is fellatio with ejaculation, the patient could be counseled to reduce exposure to ejaculate by either withdrawal or use of barrier protection.

Clinicians should promote and reinforce safer behaviors the patient may have already adopted, while also helping to identify ongoing risk behaviors or situations. Motivational interviewing approaches may be effective when encouraging patients to adopt safer behaviors. Encouraging patients to set their own goals to reduce specific risk behaviors will increase the likelihood that they will achieve behavior change. More resources on motivational interviewing are available at [www.motivationalinterview.org](http://www.motivationalinterview.org)

Clinicians may become discouraged when patients in the early stages of change seem to ignore motivational counseling. Periodic training in methods of motivational counseling and in prevention interventions that have been shown to be effective, such as Diffusion of Effective Behavioral Interventions (DEBIs), may alleviate provider fatigue. DEBIs provide training and assistance on evidence-based HIV/STI prevention interventions. Examples of DEBIs targeted to people living with HIV include [CLEAR](#) and [Healthy Relationships](#). Clinicians should explore whether the implementation or adaptation of DEBIs would increase the effectiveness of prevention programs in their clinic setting. Some DEBIs may be adaptable to the clinic setting whereas others will require referral to agencies which can effectively implement them. Training and technical assistance may be available for specific DEBIs.

Peer counseling can also be highly effective for delivering risk-reduction messages. Peer counselors often have similar social and cultural backgrounds as the individuals they are counseling, which provides a relevant context for prevention interventions.

## 1. Viral Load and Transmission Risk

### RECOMMENDATION:

**Clinicians should educate HIV-infected patients about the following:**

- **ART is an important prevention strategy because it reduces viral burden, thereby reducing the risk of HIV transmission to sexual partners (AI)**
- **Adherence to ART is an achievable and important strategy because strict adherence enables ART to reduce transmission risk (AI)**
- **The use of condoms is still recommended for all patients, including those with undetectable viral load levels because an undetectable viral load does not completely eliminate the risk of HIV transmission (AI)**

Studies have shown a correlation between low HIV plasma viral load and lower risk of HIV transmission.<sup>8,9</sup> Effective ART is associated with a substantially lower risk of HIV transmission in serodiscordant couples by lowering viral load.<sup>10,11</sup>

The main message of clinicians to HIV-infected patients should be that non-detectable viral load greatly reduces transmission risk and, therefore, adherence to ART is of the utmost importance. However, clinicians should still carefully counsel patients about transmission in the setting of undetectable or low viral load levels since many patients believe it is impossible to transmit HIV in such cases.

Counseling for patients with undetectable viral loads should include discussion of the following:

- An undetectable viral load greatly **reduces but does not completely eliminate** the risk of HIV transmission
- Plasma viral load levels do not always correlate with genital viral burden<sup>12-14</sup>
- The type of sexual activity and presence of concurrent STIs play an important role in whether or not transmission will occur
- Viral load levels are transient; having an undetectable viral load at one point in time does not necessarily equate with having an undetectable viral load in the future
- The importance of condom use to protect against STIs and superinfection with other strains of HIV (see Section II. B. 3. *Superinfection*)

## 2. Safer Sexual Practices

### Use of Barrier Methods

#### **RECOMMENDATIONS:**

**Clinicians or members of the healthcare team should educate HIV-infected patients about both male and female condoms and dental dams and should:**

- **Reinforce condom use for all sexually active patients, regardless of relationship status (AI)**
- **Provide patients with access to condoms (AI)**
- **Recommend polyurethane condoms for patients with latex allergy (AI)**
- **Advise patients to *avoid* using lambskin condoms or condoms that are lubricated with nonoxynol-9 (AI)**
- **Instruct patients about the effectiveness of different kinds of condoms and how to use condoms properly (AI)**
- **Advise patients to avoid oil-based lubricants with latex condoms (only water-based lubricants should be used); water- or oil-based lubricants can be used with polyurethane condoms (AI)**
- **Instruct patients about the use of dental dams during oral sex (BII)**

Consistent and correct condom use is highly effective in preventing the transmission of HIV.<sup>15</sup> Some patients may be hesitant to accept the use of male or female condoms; however, condoms should be offered with clear instructions and support for their use.<sup>16</sup> HIV-infected patients should be advised that consistent condom use will reduce their risk of acquiring other STIs, such as gonorrhea, chlamydia, trichomoniasis, and syphilis.<sup>17</sup> Dental dams are latex squares that can be placed over the labia or anal area for protection during oral-vaginal or oral-anal sex. Use of hyperosmolar lubricants and those that contain nonoxynol-9 should be avoided because they can cause mucosal irritation, which may increase susceptibility to HIV.<sup>18-21</sup> See Appendix B for more information on types of condoms and correct use of condoms.

Condoms, dental dams, and lubricants are available to non-profit organizations and healthcare facilities through the [NYS Condom Program](#) and can be ordered online. In New York City, free male and female condoms can be obtained through the [New York City Free Condom Initiative](#), which includes a [condom locator](#) that can be downloaded to a smartphone.

Patient handouts on how to properly use male and female condoms can be accessed at <http://www.health.state.ny.us/diseases/aids/publications/index.htm>

### Sexual Disinhibition Related to Alcohol and Substance Use

#### **RECOMMENDATIONS:**

##### **Clinicians should:**

- **Screen for alcohol and substance use at baseline and at least annually (AIII)**
- **Discuss how alcohol and substance use may affect decision-making regarding engagement in high-risk sexual behaviors (AIII)**
- **Help patients identify methods to either avoid substance use or to reduce HIV transmission risks while using substances (AII)**
- **Refer patients in need of treatment to substance use treatment services (AII).** See [AIDS Institute Resource Directory](#) for programs that provide substance use treatment services and harm-reduction counseling

Screening for and addressing substance use problems is an important aspect of prevention of HIV transmission. The physiological effects of alcohol and substance use may increase the risk of HIV transmission by encouraging high-risk sexual activity. For example, while using intoxicating substances, some patients may neglect to use condoms, have multiple partners, or participate in high-risk activities that they might normally avoid when not influenced by substances.

In addition to substance use screening, clinicians should discuss alcohol and substance use in the context of sexual behaviors. Clinicians should discuss alcohol and substance use in a nonjudgmental manner and should help the patient identify methods to either avoid these substances or to reduce transmission risks while using substances. Some patients may be more receptive to risk-reduction counseling if they are given an option that does not involve abstaining from alcohol and/or substance use. For more guidance on management of patients who are not willing or able to reduce or stop use, see [Working With the Active User](#).

### Partner Selection: Serosorting

#### **RECOMMENDATIONS:**

**Clinicians should discuss partner selection as a component of safer-sex education. For patients who choose to engage in serosorting and do not use condoms, clinicians should discuss the possible risks of acquiring or transmitting resistant HIV strains or other STIs. (BIII)**

**Clinicians should obtain more frequent STI screening for patients who report serosorting without the use of condoms. (AI)**

The term *serosorting* refers to selection of sexual partners based on HIV serostatus. For HIV-infected individuals who consistently only have sex with other HIV-infected individuals, acquisition of superinfection and other STIs remains a risk if condoms are not used.<sup>22,23</sup> Clinicians should obtain more frequent STI screenings coupled with periodic re-discussion of risks for patients who choose to engage in serosorting but who do not use condoms.<sup>24</sup>

### 3. Superinfection

#### **RECOMMENDATION:**

**Clinicians should educate HIV-infected individuals about the risk of acquiring a different strain of HIV from HIV-infected sexual and drug-using partners. (BIII)**

Dual infection can occur when a person is infected with two heterologous strains of HIV around the time of seroconversion (co-infection) or later in the course of the disease (superinfection).<sup>25-28</sup> The genetic diversity of the HIV virus, reflected by the existence of distinct viral subtypes or clades, provides evidence that dual infections do occur. Regardless of the timing, it is clear that prior infection with HIV confers no protection against future infections.

Although uncertainty exists about the incidence and clinical consequences of superinfection, patients should be educated about the risk of acquiring additional strains of HIV through unsafe sexual practices and needle sharing. Clinical consequences may include a rebound in viral load, decline in CD4 count, or incomplete response to therapy due to decreased susceptibility of the new strain to the patient's current regimen.<sup>29</sup> However, there is biological plausibility that use of ART protects against superinfection. Acquisition of a new wild-type virus would usually be blocked by antiretroviral medications that the exposed individual is taking. If a drug-resistant HIV-1 virus is present, it is unlikely that it would be resistant to all three of the active antiretroviral agents in the exposed individual's ART regimen. Although both HIV-1 superinfection and multi-drug resistant transmitted virus have been documented and continue to occur, they have occurred almost exclusively in individuals not taking effective ART.

#### **C. The Role of STI Screening and Treatment**

##### **RECOMMENDATIONS:**

**Clinicians should screen HIV-infected patients for STIs at baseline and at least annually (see Table 5). Clinicians should re-screen patients for STIs if they have had any new sex partners since the last screening, or if they report that their partner has had any new sex partners. (AI)**

**Clinicians should inquire about the following STI symptoms at baseline, annually, and when clinically indicated: (AI)**

- **Penile and vaginal/cervical discharges**
- **Ulcerative lesions**
- **Anorectal or pharyngeal pain**
- **Difficulty or pain during sex, urination, defecation, or menstruation**
- **Pruritus, burning, or bleeding in the anogenital area**
- **Rash**
- **For women, abdominal pain with or without fever**

**When an HIV-infected patient presents with symptoms or a diagnosis of an STI, clinicians should:**

- **Perform a risk assessment and provide appropriate risk-reduction counseling (AII)**
- **Consider both HIV exposure and STI exposure to partners**
- **Offer assistance with partner notification if needed, or refer patient to other sources for partner notification assistance (CNAP, PNAP) (AI)**

Because patients may be reluctant to report signs or symptoms of STIs or other genital abnormalities, it is important that clinicians examine for vaginal/cervical or penile discharge and carefully inspect the anogenital area, including the vulva and vagina in women and the scrotum, including the posterior scrotum in men, for lesions indicative of STIs, including ulcers, fissures, macules, papules, vesicles, and nodules. Clinicians should examine for lesions attributable to HPV, syphilis, and classic herpes simplex virus (HSV), as well as atypical HSV presentations, such as non-healing gluteal cleft maceration. In addition to a genital examination, a careful pelvic examination is essential for women. For more guidelines on STIs in HIV-infected patients, see [Management of STIs in HIV-Infected Patients](#).

**Table 5**  
**Routine Screening for Sexually Transmitted Infections<sup>a</sup>**

Examination

- Examination for the following (baseline and as part of the annual comprehensive physical examination):
  - Oral lesions, including warts, ulcers, or other lesions on the tongue, palate, and buccal mucosa
  - Genital warts ([HPV](#))
  - Ulcerative genital disease including classic and atypical [HSV](#)
  - Presence of abnormal vaginal/cervical or urethral discharge (gonorrhea, chlamydia, trichomoniasis)
  - Visible anal and perineal lesions
  - Rash
  - Presence of inguinal lymphadenopathy
- Digital rectal examination (baseline and annually)
- For women, thorough bimanual pelvic examination (baseline and annually)
- For men, examination of the urethral meatus, palpation of the penile urethra and testicles, and examination of the scrotum, including the posterior scrotum (baseline and annually)

Syphilis

- RPR or VDRL for syphilis with verification of reactive test by confirmatory FTA-Abs or TP-PA (at baseline and at least annually). Patients with continued high-risk behavior should be screened for syphilis every 3 months

Gonorrhea and chlamydia

- For sexually active women under the age of 25, screen all sites of exposure<sup>b</sup> for gonorrhea and chlamydia (at baseline and annually)
- For women 25 years of age or older, screen at baseline (screen annually when they have had a recent STI, have multiple sexual partners, have had a new sexual partner, or have a sexual partner with symptoms of an STI)
- For all HIV-infected men with ongoing high-risk sexual behaviors for gonorrhea and chlamydia, screen all sites of exposure<sup>b</sup> (at baseline and annually)

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RPR, rapid plasma reagin; VDRL, venereal disease research laboratory; FTA-Abs, fluorescent treponemal antibody absorption; TP-PA, *Treponema pallidum* particle agglutination.

<sup>a</sup> Patients who continue to engage in unsafe sexual practices are at increased risk for STIs. More frequent screening may be indicated for patients at higher risk.

<sup>b</sup> Nucleic acid amplification tests (NATs) are more sensitive than culture but are not approved by the Food and Drug Administration (FDA) for use with pharyngeal or rectal specimens. Some public and private laboratories have established performance specifications according to CLIA regulations for using NATs with rectal and pharyngeal swab specimens, thereby allowing results to be used for clinical management. The Centers for Disease Control and Prevention (CDC) indicate that NAT is the preferred test for diagnosis of rectal and pharyngeal infection with *N gonorrhoeae* in MSM and for rectal infection with *C trachomatis* in MSM.<sup>30</sup> Culture, although not widely available, is effective for all potential sites of infection and permits testing for drug susceptibility.

Presentation of a new or recurring STI in HIV-infected patients indicates unsafe sexual practices and possible exposure of HIV to uninfected partners. Under such circumstances, patients require intensified risk-reduction counseling and, if needed, assistance with partner notification or referral to other sources for partner notification assistance (Partner Services Program or CNAP). For more information about partner notification, see Section II. D. *Partner Notification*.

Untreated STIs, particularly genital ulcers and bacterial vaginosis, can increase the risk of acquiring or transmitting HIV.<sup>30-34</sup> HIV-infected patients co-infected with another STI are likely to have higher levels of HIV in their genital secretions than HIV-infected patients without STIs.<sup>30,31</sup> Furthermore, HIV-infected individuals are at higher risk for acquisition of other STIs.

#### **Key Point:**

Early identification and treatment of STIs is a crucial prevention strategy. The risk of HIV transmission in patients co-infected with genital ulcer disease is increased by 2 to 6 times because of increased levels of HIV virus in semen and vaginal secretions.<sup>35-38</sup>

For specific screening, diagnosis, and treatment recommendations for syphilis, human papillomavirus, herpes simplex virus, gonococcal and chlamydial infections, lymphoma granuloma venereum, bacterial vaginosis, chancroid, trichomoniasis, and pelvic inflammatory disease, refer to [Management of STIs in HIV-Infected Patients](#).

## **D. Partner Notification**

### **RECOMMENDATIONS:**

**Clinicians should discuss the importance of partner notification with HIV-infected patients on a routine and ongoing basis for both new partners and previous partners who have not yet been notified. (AI)**

**Clinicians must discuss with HIV-infected patients their options for informing sexual and needle-sharing partners that they may have been exposed to HIV.<sup>39</sup> Clinicians and/or patients should contact the New York State Department of Health Partner Services Program (1-800-542-AIDS) or the New York City Department of Health and Mental Hygiene Contact Notification Assistance Program (CNAP) (212-693-1419) for assistance with partner notification. (AI)**

**If a risk for domestic violence is identified, partner notification should be deferred and the patient referred to a domestic violence agency** (see Section II. D. 3. *Domestic Violence Screening*). (AI)

Partner notification is a key evidence-based public health strategy for preventing HIV transmission and identifying undiagnosed HIV infection. Because sexual and needle-sharing partners of HIV-infected individuals are at high risk for infection and may not be aware of their exposure to HIV, and, because of the benefits of early diagnosis and prevention counseling, HIV-infected persons should be encouraged to actively work with Health Department Partner Services specialists to notify partners.

The Centers for Disease Control and Prevention recommend that all persons with newly diagnosed or reported HIV infection receive partner services with active health department involvement.<sup>40</sup> A recent evidence-based review of HIV Partner Counseling and Referral Services found sufficient evidence for the effectiveness of provider referral (i.e., notification by public health or other trained healthcare provider), but insufficient evidence for other approaches such as patient referral, also known as self-notification.<sup>41</sup>

By incorporating partner notification counseling into practice, clinicians play a crucial role in introducing this concept and providing active referrals to health department services. In New York State, partner notification is required by legislation<sup>39</sup> and supported by public health programs offered through the New York State Department of Health ([Partner Services Program](#)) and the New York City Department of Health and Mental Hygiene ([Contact Notification Assistance Program, CNAP](#)).

Discussion about partner notification is not a one time-event; instead, this discussion should occur during the post-test counseling visit, at the first comprehensive medical visit, and during routine monitoring visits. Clinicians should counsel patients regarding the lifelong risk of HIV transmission to their partners. When the determination is made that partner notification is necessary, clinicians must screen all HIV-infected men and women and their partners/contacts for risk of domestic violence related to partner notification. If a risk for domestic violence is identified, partner notification should be deferred and the patient should be referred to a domestic violence agency (see Section II. D. 3. *Domestic Violence Screening*).

**Key Point:**

Based on recent evidence-based reviews, it is strongly recommended that all persons with newly diagnosed or reported HIV infection receive partner services with active health department involvement. Medical providers play a key role in actively linking patients to health department partner services throughout the continuum of care.

## 1. New York State HIV Reporting and Partner Notification (HIVRPN) Law

The HIVRPN Law became effective in June 2000 and includes the following main principles:

- Laboratories, physicians, and other healthcare providers must report the names of persons with HIV infection, HIV-related illness, and AIDS to the New York State Commissioner of Health
- In all partner notification activities, the name of the infected person is never disclosed
- Physicians are required to complete a timely report listing sexual and needle-sharing partners who are known to the medical provider or whom the infected person wishes to have notified (use form DOH-4189\*)
- For each partner listed, specific plans for partner notification and the results of domestic violence screening must also be reported
- Partners are counseled and offered HIV testing
- Partner names are maintained no longer than 1 year after case closure by Partner Services
- Anonymous counseling and testing services will continue to be available

\*DOH-4189 are duplicate forms that may be ordered from the New York State Department of Health (NYSDOH) Bureau of HIV/AIDS Epidemiology by calling (518) 474-4284.

For more detailed information regarding the law, please see

<http://www.health.state.ny.us/diseases/aids/regulations/notification/hivpartner/qanda.htm>

### **Key Point:**

Medical providers are required by law to report the names of sexual and needle-sharing partners of HIV-infected individuals who are known to the provider. Patients, however, are not required to disclose partner information, and their participation in partner notification programs is voluntary.

## 2. Partner Services (PS) Program and Contact Notification Assistance Program (CNAP)

Partner Services staff can assist providers with techniques to quickly and effectively communicate the importance of referral to Partner Services to patients. Partner Services staff will work with each patient to identify sexual partners and/or needle-sharing partners as appropriate and will develop a plan to notify each partner while protecting the patient's identity. Staff can also help patients who choose to notify their partners themselves.

Partner Services and CNAP offer five options for partner notification (see Table 6).

**Table 6  
Options for Partner Notification**

<b>Party Performing Notification</b>	<b>Description</b>
<b>Health Department Specialist</b>	With consent of the HIV/STI-infected individual, notification is performed by a health department specialist. <b>Information about the patient, including name, gender, physical description, or timeframes, is not disclosed to the partner</b>
<b>Third-Party</b>	Notification is performed by another provider, such as clinician or case manager
<b>Patient</b>	<ul style="list-style-type: none"> <li>• An HIV/STI-infected individual informs partners of the exposure. Partner Services or a third-party provider can guide patients on how to carry out the notification safely and effectively.</li> <li>• The provider negotiates a <i>contract referral</i>, or a timeframe for the patient to notify partners of their exposure to HIV/STI. If the patient is unable to achieve notification within the allotted time period, Partner Services staff or a third-party provider may notify partners directly</li> </ul>
<b>Patient and Provider</b>	The patient and provider (health department or third-party provider) notify the partner together; this is known as <i>dual referral</i>

**Key Point:**

The HIVRPN Law allows physicians to notify known partners of an HIV-infected patient with or without patient consent, but only after informing the patient that notification is imminent. All other healthcare providers must have the patient’s consent before proceeding with notification. Clinicians should contact Partner Services/CNAP for guidance and assistance with the partner notification process.

For more information and detailed guidance about Partner Services, please call **1-800-541-AIDS**, or see the NYSDOH website at:

<http://www.health.state.ny.us/diseases/aids/regulations/notification/hivpartner/reportquest.htm>

For CNAP, call **212-693-1419** or see the NYCDOHMH website:

<http://home2.nyc.gov/html/doh/downloads/pdf/chi/chi23-7.pdf>

**3. Domestic Violence Screening**

**RECOMMENDATIONS:**

**As part of post-test counseling and partner notification, clinicians must screen HIV-infected men and women and their partners/contacts for risk of domestic violence related to partner notification.**<sup>42</sup> (AII)

**Clinicians should be familiar with local domestic violence agencies and the mechanisms of referral for patients with identified risk of domestic violence resulting from partner notification. (AIII)**

Providers are required to complete domestic violence screening and assess the potential for domestic violence for each partner who will be notified under partner notification.

The following are questions that may be used for screening:

1. *Do you ever feel unsafe at home?*
2. *Are you in a relationship in which you have been physically hurt or felt threatened?*
3. *Have you ever been or are you currently concerned about harming your partner or someone close to you?*

If a risk for domestic violence is identified, partner notification should be deferred and the patient referred to a domestic violence agency. For more guidance on how to address domestic violence within the context of partner notification, please see the NYSDOH Guidelines for Integrating Domestic Violence Screening into HIV Counseling, Testing, Referral and Partner Notification at <http://www.health.state.ny.us/nysdoh/rfa/hiv/guide.htm>. The [New York State Coalition Against Domestic Violence](#) operates a 24-hour hotline that provides crisis intervention, counseling, and referral for victims of domestic violence: English: 1-800-942-6906; Spanish: 1-800-942-6908.

**E. Non-Occupational Post-Exposure Prophylaxis (nPEP)**

**RECOMMENDATIONS:**

**Clinicians should educate HIV-infected patients and their families at initial visits and annually about nPEP. Such counseling should include the benefits and limitations of nPEP. (BII)**

**The clinician or a member of the HIV care team should provide risk-reduction counseling and primary prevention counseling whenever someone is assessed for nPEP, regardless of whether PEP is initiated. (AII)**

**Non-occupational PEP should not be routinely dismissed solely on the basis of repeated risk behavior or repeat presentation for nPEP. Persons who present with repeated high-risk behavior or for repeat courses of nPEP should be the focus of intensified education and prevention interventions and should be considered candidates for [pre-exposure prophylaxis \(PrEP\)](#). (AIII)**

Non-occupational exposures that occur from blood and body fluid exposures, including sexual and needle-sharing activities, are discussed in detail in [HIV Prophylaxis Following Non-Occupational Exposure](#). Situations that may prompt a request for nPEP include condom slippage, breakage, or lapse in condom use by serodiscordant partners; unsafe needle sharing; or other exposure to blood. Clinicians should assess risk, discuss potential risks and benefits of nPEP, provide risk-reduction counseling and education, and provide follow-up care. Risk-reduction counseling for all patients who are assessed for nPEP, regardless of whether PEP is initiated, should include discussions about number of partners; consistent, correct use of male or female condoms; avoidance of intoxicating substances that can lead to unsafe sex; avoidance of activities that irritate the mucosal surfaces before sex occurs; and caution about venues where partners are met, such as the internet.

Persons who present with repeated high-risk behavior or for repeat courses of nPEP should be the focus of intensified education and prevention interventions. Intent to change behavior should be assessed, and an individualized risk-reduction plan should be developed. Clinicians providing nPEP in the case of repeated high-risk behaviors, despite behavioral intervention, should consider potential medication toxicity, adherence, potential resistance, and cost considerations when determining whether repeat courses of nPEP should be offered. The potential toxicity and risk of resistance may outweigh the benefit of nPEP for use in patients who plan to continue to engage in high-risk behaviors and who rely on nPEP as the sole intervention for HIV prevention. Use of nPEP in persons with repeated high-risk behaviors who have unrecognized acute HIV infection may increase the possibility of selection of HIV drug resistance.

### **III. PREVENTION OF HIV TRANSMISSION SECONDARY TO SUBSTANCE USE**

#### **A. Obtaining a Substance Use History and Screening for Substance Use**

##### **RECOMMENDATIONS:**

##### **Clinicians should:**

- **Obtain a baseline substance use history for all HIV-infected patients** (see Table 7) (AIII)
- **Screen all HIV-infected patients for substance use at baseline and at least annually**. Screening questions should be phrased to include alcohol and prescription and nonprescription drug use (AIII)
- **Stress the confidential nature of discussions regarding substance use to encourage patients to be open and honest** (AIII)
- **Be familiar with the names and routes of administration of commonly used street drugs** (see [What Are These Drugs?](#)) (AIII)

**When substance use risk is identified, clinicians should help the patient develop individualized goals to prevent transmission, such as abstinence, reduced use, or safer use, and should address the issue at subsequent routine visits.** (AII)

Patients often minimize or deny alcohol and substance use because of the stigma associated with addiction and because most drug use is illegal. A supportive and nonjudgmental approach will encourage trust, honesty, and openness about substance use history.

The clinician should start with less threatening questions:

- *What over-the-counter or prescription medications are you taking?*
- *How often do you use alcohol? Tobacco?*
- *Have you ever used drugs from a non-medical source?*
- *Have you ever injected any kind of drug?*

**Table 7**  
**Elements of a Baseline Substance Use History**

**Current and Past:**

- Types of drugs (past and current use)
  - Street drugs (e.g., marijuana, cocaine, heroin, “crystal” methamphetamine, MDMA/ecstasy, ketamine)
  - Prescription drugs (illicit use)
  - Alcohol
  - Injectable hormones
- Frequency of use and usual route of administration
- Sexual risk-taking while under the influence of drugs or alcohol
- Sharing needles or other injection equipment
- Number and HIV status of needle-sharing partners
- Exchanging sex for drugs
- History of treatment and actual or perceived barriers to treatment
- Methods of risk reduction and success of these methods

Screening for substance use is particularly important in HIV-infected patients because 1) both alcohol and substance use are risk factors for HIV infection acquisition and transmission, and 2) addressing problems associated with substance use can help patients improve adherence to HIV medications and adopt risk-reduction behaviors, such as practicing safer sex.

Clinicians need to be particularly vigilant in screening HIV-infected patients for all levels of alcohol and other substance use and abuse because even intermittent use can interfere with adherence to medications, raise the risk of side effects from medications, and reduce the patient’s ability to practice safer sex.

See [Screening and Ongoing Assessment for Substance Use](#) for more detailed guidance on screening HIV-infected patients for substance use.

**B. Risk-Reduction Counseling for Transmission Related to Substance Use**

**RECOMMENDATIONS:**

**Clinicians should discuss behavioral risk-reduction measures on a routine and ongoing basis with patients who use substances and/or consume alcohol. These discussions should include use of barrier protection, how to speak with partners about safer sex, and the circumstances under which high-risk sexual behavior might occur. (AII)**

**Clinicians should discuss avoidance of needle/syringe-sharing activity with all injection drug users, regardless of viral load, to prevent HIV transmission. Clinicians should issue prescriptions for new needles and syringes to patients who inject drugs and should discuss options for accessing new needles and syringes, including use of the Expanded Syringe Access Demonstration Program and Syringe Exchange Programs, New York State’s two syringe access initiatives. (AI)**

**Clinicians should refer patients for substance use treatment and/or mental health services, when the need is identified and readiness established.**

Reducing harm associated with risky behaviors is a common strategy used in public health. If a patient is not ready to stop using drugs, the clinician can provide information and counseling about the patient's individual risk behaviors to help him/her move to a safer part of the risk spectrum. Clinicians should also promote and reinforce safe behaviors the patient may have already adopted.

Risk-reduction counseling for patients who use substances should include the following elements:

- Discussion of pre-planning when using drugs that lower inhibitions (e.g., have condoms available)
- Clarification that an undetectable serum viral load does not eliminate the risk of transmission (see Section II. B. 1. *Viral Load and Transmission Risk*)
- Risk of acquiring a different strain of HIV through unsafe sexual practices or needle-sharing (see Section II. B. 3. *Superinfection*)
- Referral for substance use treatment and/or mental health services when indicated. See [AIDS Institute Resource Directory](#) for programs that provide substance use treatment and mental health services

Risk-reduction counseling specifically for injection drug users (IDUs):

- Access to sterile injecting equipment, including prescription for clean needles
- Safe injection practices
- Communication about HIV status with needle-sharing partners
- Risk of acquiring other diseases, such as hepatitis B and C
- Safe disposal of used sharps
- For those who are injecting hormones, referral to appropriate services where safe hormone therapy can occur

Evidence has shown that providing access to clean syringes and education does not promote drug use.<sup>43,44</sup> In New York State, pharmacies, healthcare facilities, and healthcare practitioners who are registered in the [Expanded Syringe Access Demonstration Program \(ESAP\)](#) can sell or furnish, without a prescription, hypodermic needles and syringes to individuals 18 years of age and older. No more than 10 hypodermic needles or syringes can be sold or furnished to an individual at one time.

IDUs should be informed of this initiative and should receive instruction on how to locate participating providers. Safe storage and proper disposal of sharps should also be discussed. Clinicians can obtain more information on these issues as well as a directory of [ESAP providers](#) from the NYSDOH, or by contacting the NYSDOH by email: [ESAP@health.state.ny.us](mailto:ESAP@health.state.ny.us).<sup>45</sup> [Safety Counts](#) is a DEBI that targets active injection and non-injection drug users and aims to reduce high-risk drug-use and sexual behaviors.

Refer to the following guidelines for more information on management of HIV-infected substance users:

- [Working With the Active User](#)
- [Substance Use Treatment Modalities for HIV-Infected Substance Users](#)
- [Clinical Management of Alcohol Use and Abuse in HIV-Infected Patients](#)

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## APPENDIX A

### EXAMPLES OF SCRIPTED DIALOGUE FOR RISK-REDUCTION COUNSELING RELATED TO SEXUAL TRANSMISSION

Following are examples of questions that a clinician might use when assessing risk in different situations. Many of the follow-up questions will lead smoothly into individualized risk-reduction counseling. Some questions are closed-ended, allowing for yes/no or brief answers. Open-ended questions allow for more information to be reported. Motivational interviewing, among other principles, relies on asking open-ended questions to achieve a more complete understanding of the the patient's situation. Motivational interviewing then assesses importance and confidence to achieve safer behaviors.

Examples of closed-ended questions that can be used as “openers”:

- *Are you having sex?*
- *Do you presently have a sex partner?*
- *How often do you have sex?*

Motivational Interviewing Approach:

- *Tell me a little about your sex life and how safer sex fits into it.*
- *What sex and drug use behaviors are you currently involved in? How might you be able to reduce the riskiness of these behaviors? On a scale of 1 to 10, how important is reducing risk behavior to you? On a scale of 1 to 10, how confident are you that you can do it?*

If the clinician knows that the patient is involved in a committed relationship, he/she might open the discussion with:

- *Tell me a little about your relationship.* However, the clinician needs to be careful to not just ask about the relationship, because then the patient may not reveal information about casual sexual encounters that may have occurred outside of the relationship.

For patients who say that they are not currently sexually active, the clinician might follow up with the following closed-ended questions:

- *In the next few months, do you expect that you will have sex?*
- *If you change your mind, will condoms be a part of your sex life? How do you plan to protect yourself and your partner(s)?*

An open-ended question could be stated like this:

- *It is common for people who are not currently sexually active to become sexually active again. How do you plan to protect yourself and your partner(s)?*

For patients who report using condoms, the clinician might follow up with these open-ended questions:

- *Many people are using protection for intercourse but not so much for oral sex? How do you handle that?* If the patient then reports not using condoms for oral sex, the clinician may ask whether he/she avoids exposure to ejaculate during oral sex. A discussion of relative risks should occur.
- *Some people will use protection most of the time but occasionally slip. Are there ever times when you don't use protection?* If a patient confides that his/her partner does not want to use protection, the clinician should follow with a discussion about why that might be and try to empower the infected partner to insist on protecting the other one. An offer to refer the couple for counseling should occur.

For patients who are engaging in anal intercourse, the clinician might follow up with the following closed-ended question:

- *Do you engage in insertive anal, receptive anal, or both (top, bottom, or both)?* A discussion of the differential risks should occur.

For sexually active patients who are not in committed relationships:

Closed-ended question:

- *Do you engage in different behaviors depending on the HIV status of your partner?*

Open-ended questions:

- *Tell me about how your safer sex practices change if neither you nor your sexual partner disclose your and his/her HIV status?* After discussing this, follow up with: *How about if your partners disclose being HIV positive?* After discussing this, then follow up with: *How about if your partners disclose being HIV negative?*
- *Tell me about how you think your safer sex practices may change if or when you are in a relationship that has the prospect of becoming serious.*
- *What kind of situations and partner (characteristics and type) might tempt you to have risky sex? On a scale of 1 to 10, how important is reducing risk behavior to you? On a scale of 1 to 10, how confident are you that you can do it?*

To ascertain the role of drugs/alcohol in sexual risk-taking, some closed-ended questions can be asked:

- *Have you ever had risky sex while drunk or high?* (if patient answers yes to previous question):
- *Why do you think you took the risk?*
- *Do you mix alcohol or drugs with sex occasionally?*

Open-ended questions:

- *Tell me about your ability to practice safer sex when you drink or use drugs. What are your thoughts about trying to reduce your use of drugs & alcohol before & during sex?*
- *Tell me about the drugs you tend to use before or during sex.*
- *How does alcohol or drugs change sex?*
- *What problems might be created by using alcohol or drugs before or during sex?*

After assessment and risk-reduction counseling has occurred, the clinician might choose to conclude with something along the lines of:

- *I've given you quite a bit of information here, and, at this point, I wonder what you make of all this and what you're thinking. On a scale of 1 to 10, how important is reducing risk behavior to you? On a scale of 1 to 10, how confident are you that you can do it?*

### **Further Reading:**

#### **For more scripting and examples of motivational interviewing techniques:**

Shah SS, McGowan JP, Young SL. Prevention in positives: A case-based workshop for providers. NY/NJ AIDS Education Training Center, 2005. Accessible at:  
<http://www.aidsetc.org/pdf/p02-et/preventionbook.pdf>

## APPENDIX B

### TYPES OF CONDOMS AND PROPER USE

Types of condoms include latex, polyurethane, synthetic non-latex styrene ethylene butylene styrene (SEBS), lambskin (not an effective barrier for HIV), and female polyurethane condoms. Condoms can be non-lubricated, lubricated with water-based lubricants, or flavored. Non-lubricated and flavored condoms should be recommended for patients who have reservations about using condoms during oral sex. Polyurethane and SEBS condoms are an alternative for patients with latex allergy. One randomized crossover trial showed that a particular brand of polyurethane condoms had a higher clinical breakage rate than latex, but the complete slippage rate was the same.<sup>1</sup> In another study that compared three types of condoms, all three types had low clinical breakage and slippage rates, but the polyurethane condom did not perform as well for unrolling, stretching, comfort, and sliding during intercourse.<sup>2</sup>

Condom Types and Properties	
Condom Types	Properties
<b>Latex</b>	<ul style="list-style-type: none"><li>• Barrier protection against HIV</li></ul>
<b>Polyurethane</b>	<ul style="list-style-type: none"><li>• Efficacy in preventing HIV transmission likely to be similar to latex condoms (limited number of efficacy studies to date)</li><li>• More expensive</li><li>• Alternative for latex allergy</li><li>• Conducts heat</li></ul>
<b>Female</b>	<ul style="list-style-type: none"><li>• Efficacy in preventing HIV transmission estimated to be equivalent to, or slightly less than, the male condom (limited number of efficacy studies to date)<sup>3</sup></li><li>• Allows for direct control by the woman, especially in situations where a partner is not willing to use a condom</li><li>• Covers both internal and external genitalia</li></ul>
<b>Lubricated with nonoxynol-9</b>	<ul style="list-style-type: none"><li>• Avoid using condoms lubricated with nonoxynol-9; nonoxynol-9 may cause vaginal irritation, which may enhance transmission</li></ul>
<b>Lambskin</b>	<ul style="list-style-type: none"><li>• <b>Does not protect against HIV transmission</b> (microscopic pores allow transfer of HIV virions, but not bacterial STI pathogens)</li></ul>

Most failures of condoms are due to inconsistent or improper use. Clinicians should reinforce the following principles of proper condom use to ensure maximum protection against HIV:

- Store condoms in a cool, dry place (not in direct heat, sunlight, or wallets).
- Use new, non-expired condoms only (most condoms have an expiration date on the package). Do not reuse condoms.
- Do not use condoms that are in damaged packages, show signs of age, or are brittle, sticky, or discolored.
- Put condoms on before sex play begins. Pre-ejaculatory fluid may contain HIV.
- Press air out of the tip of the condom before putting it on.

- Roll the condom all the way down the penis to the base.
- Use only a water-soluble lubricant with latex condoms; avoid oil-based lubricants (e.g., petroleum jelly, oil, shortening, hand lotions).
- Hold onto the condom's base and pull out while the penis is still erect so the condom does not slip off.

Condoms, dental dams, and lubricants are available to non-profit organizations and healthcare facilities through the [NYS Condom Program](#) and can be ordered online. In New York City, free male and female condoms can be obtained through the [New York City Free Condom Initiative](#).

### Condom Negotiation

Both female and male patients may need guidance on condom negotiation skills. Patients should be advised to discuss safer sex and condom use before they find themselves in a sexual situation.

Advise patients to:

- Schedule a time and place outside of the bedroom to talk – condom negotiation is proven to be more difficult when you're in a sexual situation.
- Think about what your boundaries, concerns, and desires are before you initiate conversation. Make sure you don't do or agree to do anything that you're not 100% comfortable trying. Remember: it's okay to change your mind.
- Realize that your partner's principles may not match up exactly with your own, and that you may need to work to come up with solutions and alternatives that are acceptable to both of you.

#### **Tips for Negotiating Condom Use**

- Make sure you clearly state what you want
- Use only "I" statements (e.g., "I want to use a condom when we have sex.")
- Listen to what your partner is saying
- Be respectful – acknowledge your partner's feelings and opinions
- Be positive
- Use reasons for safer sex that are about you, not your partner

### **REFERENCES**

1. Cook L, Nanda K, Taylor D. Randomized crossover trial comparing the eZ.on plastic condom and a latex condom. *Contraception* 2001;63:25-31. [[PubMed](#)]
2. Frezieres RG, Walsh TL. Acceptability evaluation of a natural rubber latex, a polyurethane, and a new non-latex condom. *Contraception* 2000;61:369-377. [[PubMed](#)]
3. Minnis AM, Padian NS. Effectiveness of female controlled barrier methods in preventing sexually transmitted infections and HIV: Current evidence and future research directions. *Sex Transm Infect* 2005;81:193-200. [[PubMed](#)]