

Complementary and alternative medicine use for HIV common

Complementary and alternative medicine (CAM) use has become more common for HIV/AIDS. Studies have estimated CAM use among HIV-positive persons to be between 29% and 76%.

This study assessed the association between CAM and HIV disease indicators. 391 HIV-positive adult women, in Alabama and Georgia were sampled.

60% had used one or more type of CAM. Predictors were higher educational level, absence of health insurance, longer disease duration, and higher number of infections. The most common type of CAM use were vitamins. Higher educational level, longer disease duration, and higher use among white than among African American women were associated with vitamin use. Association was found between vitamin use and decreased viral load.

HIV-infected persons should inform their physician of CAM use so that use can be monitored.

SOURCE: Mikhail, I. S. et al. (2004). Association of complementary and alternative medicines with HIV clinical disease among a cohort of women living with HIV/AIDS. *Journal of Acquired Immune Deficiency Syndromes*, 37, 1415-1422.

Beliefs about HIV resistance contributed to risk among MSM

Beliefs about HIV transmission and infection impacts sexual risk taking among men who have sex with men. This study explored factors to which men have attributed their HIV serostatus and to relate these attributes to sexual risk taking.

97 HIV-seronegative MSM in New York city were sampled.

Three beliefs were found to be related to sexual risk taking with HIV-negative/status unknown casual partners: (1) medication treatment advances; (2) low probability related to HIV transmission; and (3) a healthy immune system, capable of resisting infection. Analysis indicated that use of recreational drugs in combination with the belief that treatment advances reduce the risk of seroconversion may explain the frequency of individuals engaging in unprotected anal receptive intercourse.

Men who have sex with men who engage in unprotected anal intercourse may be influenced by perceptions that medical advances had reduced the threat of HIV transmission.

SOURCE: Halkitis, P N. et al. (2004). Beliefs about HIV noninfection and risky sexual behavior among MSM. *AIDS Education and Prevention*, 16, 448-458.

Incidence of genital warts among young adults increasing

The rate of new genital warts claims per 100,000 increased from 117.8 to 205 between 1998 and 2001 among a privately insured population in the U.S. The highest rates were among 20 to 29 year olds. The rate among 15 to 19 year olds was much higher in women than men. The incidence of genital warts as measured by rates of new claims appears to be rising.

SOURCE: Koshiol, J. E. et al. (2004). Rate and predictors of new genital warts claims and genital warts-related healthcare utilization among privately insured patients in the United States. *Sexually Transmitted Diseases*, 31, 748-752.

No change in HSV-1 found in 18 years

A comparison of national studies conducted in 1976 to 1980 and 1988 to 1994 found little change in prevalence of HSV-1. In the 1988 to 1994 study, 68% of US population 12 years and older had HSV-1 antibody. Most were seropositive by age 30.

SOURCE: Schillinger, J. A., et al. (2004). National seroprevalence and trends in herpes simplex virus type 1 in the United States, 1976-1994. *Sexually Transmitted Diseases* 31, 753-760.

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The opinions expressed here do not necessarily represent those of the cooperating universities.

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*Rural AIDS/STD prevention. rap (rap) v. *Slang*. To talk freely and openly. Vol. 8, No. 12, December 3, 2005

Nonadherence rates to HAART among rural HIV-infected persons similar to urban areas

Highly active antiretroviral therapy (HAART) has greatly improved the quality and length of life for HIV-infected persons. However, HAART has varied side effects and a complicated dosage regimen. HIV infected individuals in rural areas often report difficulties accessing HIV care and services making adherence to HAART challenging. HAART adherence studies are more likely to occur in urban areas than rural settings.

This study examined factors associated with nonadherence to HAART in patients seen in HIV clinics in nonurban Louisiana.

Methodology

A convenient sample of 273 adult patients from outpatient HIV clinics in 8 nonurban areas in Louisiana were sampled to obtain HAART adherence information. Face-to-face interviews were conducted either in the clinic or at the patient's home. Data collection was limited to certain areas to ensure that data represented rural, town, and small city circumstances.

Variables assessed were demographic characteristics, past and current patterns of sexual behavior, illicit drug use, alcohol use, depression and HAART adherence.

Adherence was defined as the subject's self-report of missing any medication in the past week.

Outcomes of the Study

Mean age was 39 years (19-66). The majority were male (71%). Six out of ten were African American. Nearly nine of ten were unmarried. Two-thirds had at or less than a high school education, and three-fourths were unemployed. Nearly two-thirds self-reported HIV status as having HIV rather than AIDS.

Major findings include:

- Overall nonadherence to HAART was 34%, a similar rate found in prior urban studies..
- Problem drinkers were more likely to be nonadherent. 13% reported binge drinking, and 13% reported problem drinking.
- Demographic and behavioral factors, such as illicit drug use and depression, were reported at high rates (e.g. 50% reported depression), but not found to be associated with adherence.
- The primary reason (22%) for nonadherence was forgetting to take medication.
- Nonadherence reasons indicated by at least 10% were: fell asleep/slept through does time (18%), were away from home (16%), felt

sick or ill (15%), was busy with other things (15%), wanted to avoid physical problems associated with the pills (14%), had problems taking pills at specified times (14%), ran out of medication (13%), did not want others see me taking the pills (11%), felt the drug was toxic or harmful (11%), felt depressed or overwhelmed (1%) and had too many pills to take (10%).

Implications for Prevention

This study found a similar nonadherence rate (34%) among a rural sample as previously established for urban samples. In urban samples nonadherence has been associated with poverty and injection drug use, but problem drinking was found to be the sole variable related to nonadherence in this rural sample. Given the association of problem drinking to nonadherence, intervention programs in rural communities should consider focusing on alcohol use.

SOURCE:

Mohammed, H. et al. (2004). Adherence to HAART among HIV-infected persons in rural Louisiana. *AIDS Patient Care and STDs*, 5, 289-296.