

HIV IN ARKANSAS

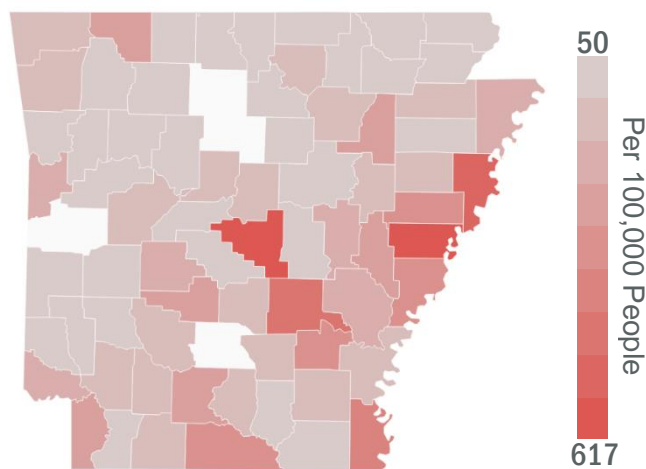
Key Policy Issues

DECEMBER 2019

Overview

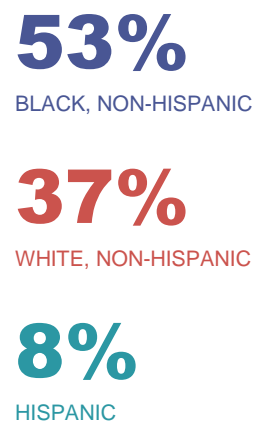
There has been significant progress in preventing and treating human immunodeficiency virus (HIV), but the disease remains a persistent problem in Arkansas and across the nation. According to the Centers for Disease Control and Prevention (CDC), 38,739 people in the U.S. received an HIV diagnoses in 2017, and the South accounted for 52% of new HIV diagnoses. In Arkansas, more than 6,000 people live with HIV/AIDS. In 2017, 8.4 of every 100,000 Arkansans were newly diagnosed with HIV¹. In 2016, the rate of death among people diagnosed with HIV in Arkansas was three per 100,000 people. Gay or bisexual men and people who inject drugs were the most affected by new HIV diagnoses.² Figure 1 illustrates the prevalence of HIV in Arkansas by county; Figure 2 shows the numbers of new HIV/AIDS cases in Arkansas by year.

FIGURE 1: PREVALENCE BY COUNTY (2016)



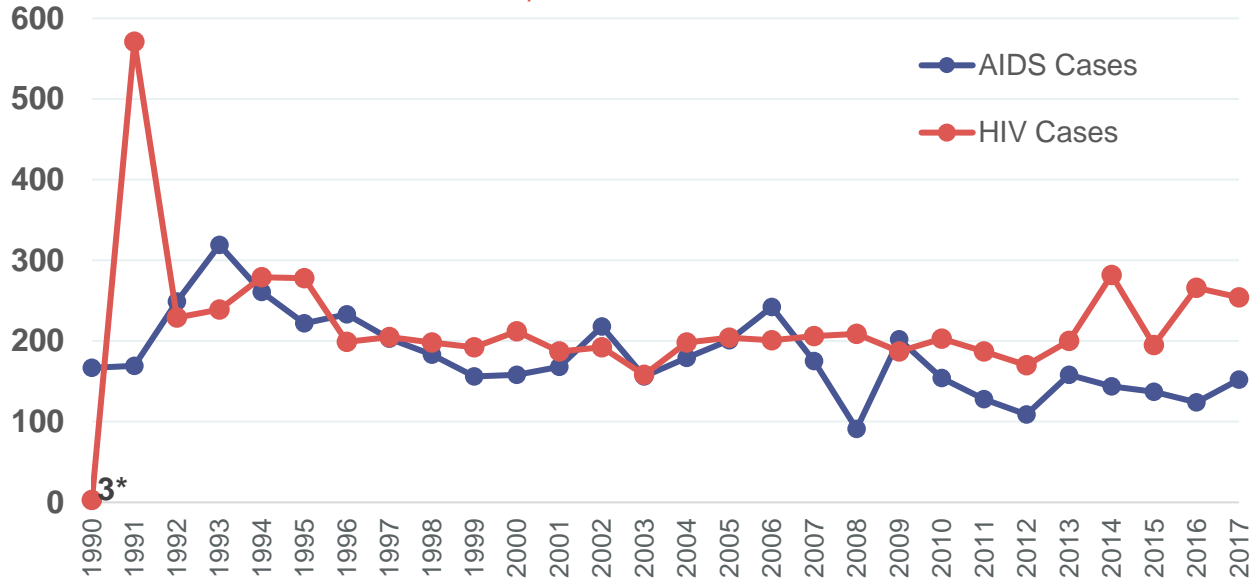
Source: AIDSvu. (No data are available for unshaded counties.)

NEW HIV CASES IN ARKANSAS: 2017



Source: Arkansas Department of Health

FIGURE 2: NEW HIV/AIDS CASES BY YEAR IN ARKANSAS



Source: Arkansas Department of Health

* The landscape for HIV diagnoses in Arkansas changed in 1990 and 1991 with the Federal Comprehensive AIDS Resources Emergency (CARE) Act and the Ryan White Part B Program.

Policy Interventions

Though new diagnoses have remained steady, federal and state efforts to prevent, reduce, and eventually eliminate HIV/AIDS have gained vigor with the advancement of new treatment and prevention options. Recently, the Trump administration has proposed an initiative, *Ending the HIV Epidemic: A Plan for America*, that seeks to end HIV in America in the next 10 years. The plan relies on five key pillars: early diagnosis; rapid and effective treatment; evidence-based prevention; rapid response to new HIV clusters; and local HIV HealthForce — a diverse workforce of public health professionals and experts — in targeted areas.³ Arkansas is one of seven states selected to

receive funding to accelerate progress to end the HIV epidemic and has a task force devoted to strategic planning. As part of the initiative, the Arkansas Department of Health is working to recruit and train primary care providers as well as expand access to telemedicine to improve access to quality HIV care in rural areas of the state, especially southeast Arkansas. Other

HIV PREVALENCE IN ARKANSAS BY EXPOSURE CATEGORY: 2017

56%

MALE SEX W/MALE

20%

INCREASED RISK HETEROSEXUAL

9%

INJECTION DRUG USE



strategies being considered include policies favoring treatment as prevention, pre-exposure prophylaxis, post-exposure prophylaxis, syringe service programs, and de-criminalization of HIV.

TREATMENT AS PREVENTION

Treatment as prevention is an effort focused on people living with HIV. When taken as directed, antiretroviral therapy (ART) reduces the amount of HIV in the body (viral load) to a very low level, which helps a person recover immune function and prevents transmission to others.⁴ Due to advances in ART, less frequent dosing for treatment is required with fewer side effects.⁵

There is evidence to suggest the “test and treat” strategy offers public benefit.⁵ Experts

The U=U campaign (Undetectable = Untransmittable) encourages viral suppression to improve health and prevent sexual transmission of HIV.

recommend treatment as early as possible — with the trend moving toward rapid-start or same-day-as-diagnosis — to prevent transmission and improve outcomes.⁶

However, one in seven people with HIV in the U.S. do not know they are infected. This strategy should be used as

complementary to others to prevent HIV, such as universal HIV screening of adolescents and adults 15 to 65 years of age and, as required in Arkansas, all pregnant women.^{7, 8}

POST-EXPOSURE PROPHYLAXIS

Post-exposure prophylaxis (PEP) means taking ART after potential exposure to HIV in order to prevent HIV infection.⁹ The therapy must be started within 72 hours after exposure to HIV.

California is the first state to pass a law that prohibits insurers from subjecting PEP and pre-exposure prophylaxis (PrEP) to prior authorization or step therapy, allowing pharmacists to furnish these drugs without a physician’s prescription.¹⁰ The intent is to increase access to these medications in areas with higher poverty, higher concentrations of the uninsured, and larger minority populations.

PRE-EXPOSURE PROPHYLAXIS

PrEP is medication taken by people who don’t have HIV but are at risk of getting infected. The World Health Organization and Joint United Nations Programme on HIV/AIDS (UNAIDS) have made PrEP implementation a priority for populations at highest risk.¹¹ In 2018, at least 25 of every 100,000 people in Arkansas were users of PrEP.¹² The South has the highest number of new HIV diagnoses in the United States each year but has disproportionately fewer people using PrEP. Studies have shown that PrEP reduces the risk of getting HIV from sex by about 99% when taken daily. Among people who inject drugs, PrEP reduces the risk of getting HIV by

at least 74% when taken daily.¹³ PrEP costs less than other HIV treatments; however, the cost of ancillary services (e.g., lab tests, doctor visits) could make PrEP cost-prohibitive for some. The Department of Health and Human Services recently launched Ready, Set, PrEP to provide PrEP at no cost to people without prescription drug insurance.¹⁴ Other challenges include access, getting PrEP to targeted groups, association with negative stereotypes, and fear of stigmatization.¹⁵

SYRINGE SERVICE PROGRAMS

As Arkansas and other states battle an ongoing opioid crisis, concerns about HIV resulting from injection drug use warrant increased attention from policymakers. According to the CDC, approximately 775,000 Americans reported injecting a drug in the past year. One strategy for reducing infectious diseases such as HIV among people who inject drugs is adopting syringe service programs (SSPs), also referred to as safe syringe programs. SSPs are community-based prevention programs that provide a number of services to people who inject drugs. Typical services include access to new, sterile needles and syringes; safe disposal sites for used products; vaccinations; testing; and referral to care and treatment. There is evidence that SSPs can help people stop using drugs and reduce the spread of infections without increasing criminal activity. Individuals who are new users of SSPs are five times more likely to enter drug treatment programs than those who do not use SSPs.¹⁶ There are also potential cost savings associated with SSP investment.¹⁷ The decision to establish an SSP is made at the state or local level. Thirty-nine states have SSPs.¹⁸ Some local jurisdictions within states have implemented policies authorizing SSPs. Many states have comprehensive drug paraphernalia laws that criminalize the sale, distribution, and possession of syringes when it is known they will be used for unlawful purposes. Arkansas criminalizes possession of drug paraphernalia but not delivery, even with knowledge it may be used unlawfully.¹⁹ There are no laws in Arkansas authorizing SSPs.

DECRIMINALIZATION OF HIV

Over half of the states have some type of HIV criminalization law. These range from HIV-specific criminal laws to infectious disease laws that include HIV.²⁰ In 1989, Arkansas enacted its HIV exposure law, which imposes criminal liability on an HIV-positive individual for exposing another to HIV under certain circumstances, including exposure to blood and contributions to blood products or sexual penetration without informing the other person that he or she is HIV-positive. A person commits the offense of exposure if the person knows that he or she has tested positive for HIV, even if there is no actual transmission. This means that a patient on



treatment and not at risk of spreading HIV is criminally liable, whereas a person who is living with HIV but has not been tested is not. A conviction carries a prison term of six to 30 years.²¹ An HIV-positive individual must also inform physicians or dentists of his or her HIV-positive status.²² The threat of criminal prosecution may contribute to reduced screening, diagnosis, and appropriate treatment and thus increase the likelihood of HIV transmission. Criminal liability in these circumstances should be modernized in the context of scientific advancements and current understanding of HIV prevention and treatment.

Conclusion

Despite advancement in HIV treatment and prevention efforts, many individuals remain undiagnosed and untreated. Testing is critical for ending the HIV epidemic. Strategies such as SSPs that offer HIV testing will further progress on ending the epidemic, while barriers to testing, such as HIV criminalization laws, will impede progress. HIV stigma has deep roots in the U.S. and has shown to create barriers to prevention and treatment. Perceptions of stigma point to the need for HIV education, especially within rural communities. New efforts should support multiple approaches, including strategies to address stigma and discrimination.

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