WISCONSIN AIDS/HIV UPDATE

Prevention through education

AIDS/HIV Program - Wisconsin Division of Public Health - Department of Health & Family Services –Summer 2006

HIV Surveillance

HIV Care and Support Services

HIV Prevention

Hepatitis

News Items

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Wisconsin AIDS/HIV Surveillance Summary

Cases reported 1983 through June 30, 2006

	Cumulative		Reported 2000 - 2006		Presumed alive	
Total	**Cases**	**Percent**	**Cases**	**Percent**	**Cases**	**Percent**
Cases	9,319	100.0%	2,471	100.0%	5,797	100.0%
Deaths	3,522	37.8%	168	6.8%	-	-
Current disease category						
AIDS	6,265	67.2%	1,177	47.6%	2,992	51.6%
Non-AIDS	3,054	32.8%	1,294	52.4%	2,805	48.4%
Risk Exposure Categories						
Men who have sex with men	4,867	52.2%	1,125	45.5%	2,759	47.6%
Injecting drug use	1,358	14.6%	269	10.9%	794	13.7%
Men who have sex with men and inject drugs	641	6.9%	141	5.7%	388	6.7%
Hemophilia/Coagulation disorder	121	1.3%	4	0.2%	44	0.8%
High-risk heterosexual contact	1,132	12.1%	392	15.9%	859	14.8%
Transfusion-associated	81	0.9%	9	0.4%	27	0.5%
Mother with/at risk	84	0.9%	28	1.1%	66	1.1%
Undetermined/Other	1,035	11.1%	503	20.4%	860	14.8%
Gender						
Female	1,537	16.5%	540	21.9%	1,140	19.7%
Male	7,782	83.5%	1,931	78.1%	4,657	80.3%
Race/Ethnicity						
White	5,218	56.0%	1,153	46.7%	2,878	49.6%
Black	3,097	33.2%	937	37.9%	2,192	37.8%
Hispanic	847	9.1%	321	13.0%	617	10.6%
Asian/Pacific Islander	54	0.6%	24	1.0%	43	0.7%
American Indian	86	0.9%	22	0.9%	50	0.9%
Multi-racial	10	0.1%	10	0.4%	10	0.2%
Unknown/Other	7	0.1%	4	0.2%	7	0.1%
Age at Diagnosis						
Under 5	79	0.8%	25	1.0%	60	1.0%
5-12	21	0.2%	3	0.1%	15	0.3%
13-19	238	2.6%	81	3.3%	185	3.2%
20-29	2,854	30.6%	689	27.9%	1,935	33.4%
30-39	3,724	40.0%	891	36.1%	2,262	39.0%
40-49	1,732	18.6%	551	22.3%	1,007	17.4%
50 years and older	663	7.1%	231	9.3%	325	5.6%
Year of Report						
Before 1990	1,485	15.9%				
1990	672	7.2%				
1991	656	7.0%				
1992	683	7.3%				
1993	650	7.0%				
1994	514	5.5%				
1995	562	6.0%				
1996	426	4.6%				
1997	447	4.8%				
1998	381	4.1%				
1999	372	4.0%				
2000	389	4.2%				
2001	336	3.6%				
2002	388	4.2%				
2003	364	3.9%				
2004	417	4.5%				
2005	374	4.0%				
2006	203	2.2%				

Wisconsin AIDS/HIV Surveillance Summary

Cases by DHFS region and county, cases reported 1983 through June 30, 2006

	Cumulative		Reported 2000-2006			Presumed alive		
Region/County	Cases	Percent	Cases	Percent	Average Rate*	Cases	Percent	Rate**
Northeastern Region								
BROWN	309	3.4%	87	3.6%	5.5	187	3.3%	82.5
CALUMET	9	0.1%	1	0.0%	0.4	5	0.1%	12.3
DOOR	19	0.2%	5	0.2%	2.6	12	0.2%	42.9
FOND DU LAC	44	0.5%	14	0.6%	2.1	27	0.5%	27.8
GREEN LAKE	9	0.1%	6	0.2%	4.5	8	0.1%	41.9
KEWAUNEE	4	0.0%	1	0.0%	0.7	2	0.0%	9.9
MANITOWOC	43	0.5%	12	0.5%	2.1	25	0.4%	30.2
MARINETTE	30	0.3%	8	0.3%	2.6	16	0.3%	36.9
MARQUETTE	10	0.1%	1	0.0%	0.9	6	0.1%	37.9
MENOMINEE	17	0.2%	5	0.2%	15.7	12	0.2%	263.0
OCONTO	16	0.2%	1	0.0%	0.4	5	0.1%	14.0
OUTAGAMIE	110	1.2%	40	1.7%	3.5	72	1.3%	44.7
SHAWANO	26	0.3%	4	0.2%	1.4	11	0.2%	27.1
SHEBOYGAN	74	0.8%	22	0.9%	2.8	44	0.8%	39.1
WAUPACA	15	0.2%	7	0.3%	1.9	10	0.2%	19.3
WAUSHARA	11	0.1%	6	0.2%	3.7	8	0.1%	34.6
WINNEBAGO	140	1.5%	31	1.3%	2.8	73	1.3%	46.6
Northeastern Region Total	**886**	**9.8%**	**251**	**10.4%**	**3.1**	**523**	**9.3%**	**45.1**
Northern Region								
ASHLAND	11	0.1%	4	0.2%	3.4	8	0.1%	47.4
BAYFIELD	11	0.1%	3	0.1%	2.9	8	0.1%	53.3
FLORENCE	1	0.0%	1	0.0%	2.8	1	0.0%	19.7
FOREST	8	0.1%	0	0.0%	0.0	5	0.1%	49.9
IRON	10	0.1%	4	0.2%	8.3	4	0.1%	58.3
LANGLADE	10	0.1%	4	0.2%	2.8	7	0.1%	33.8
LINCOLN	7	0.1%	2	0.1%	1.0	3	0.1%	10.1
MARATHON	89	1.0%	32	1.3%	3.6	54	1.0%	42.9
ONEIDA	21	0.2%	5	0.2%	1.9	11	0.2%	29.9
PORTAGE	53	0.6%	17	0.7%	3.6	26	0.5%	38.7
PRICE	7	0.1%	2	0.1%	1.8	1	0.0%	6.3
SAWYER	7	0.1%	1	0.0%	0.9	3	0.1%	18.5
TAYLOR	3	0.0%	0	0.0%	0.0	2	0.0%	10.2
VILAS	16	0.2%	6	0.2%	4.1	9	0.2%	42.8
WOOD	52	0.6%	9	0.4%	1.7	28	0.5%	37.1
Northern Region Total	**306**	**3.4%**	**90**	**3.7%**	**2.7**	**170**	**3.0%**	**35.2**
Southeastern Region								
JEFFERSON	40	0.4%	10	0.4%	1.9	21	0.4%	28.4
KENOSHA	275	3.0%	83	3.4%	7.9	172	3.1%	115.0
MILWAUKEE	4,697	51.8%	1,172	48.5%	17.8	2,941	52.4%	312.8
OZAUKEE	43	0.5%	15	0.6%	2.6	27	0.5%	32.8
RACINE	284	3.1%	79	3.3%	6.0	176	3.1%	93.2
WALWORTH	77	0.8%	23	1.0%	3.5	42	0.7%	44.8
WASHINGTON	52	0.6%	12	0.5%	1.5	32	0.6%	27.2
WAUKESHA	201	2.2%	55	2.3%	2.2	120	2.1%	33.3
Southeastern Region Total	**5,669**	**62.5%**	**1,449**	**60.0%**	**10.3**	**3,531**	**62.9%**	**175.9**

Region/County	Cumulative Cases	Cumulative Percent	Reported 2000-2006 Cases	Reported 2000-2006 Percent	Reported 2000-2006 Average Rate*	Presumed alive Cases	Presumed alive Percent	Presumed alive Rate**
Southern Region								
ADAMS	25	0.3%	6	0.2%	4.6	13	0.2%	69.7
COLUMBIA	36	0.4%	8	0.3%	2.2	17	0.3%	32.4
CRAWFORD	22	0.2%	6	0.2%	5.0	9	0.2%	52.2
DANE	1,147	12.6%	339	14.0%	11.4	750	13.4%	175.8
DODGE	44	0.5%	13	0.5%	2.2	31	0.6%	36.1
GRANT	27	0.3%	3	0.1%	0.9	11	0.2%	22.2
GREEN	32	0.4%	7	0.3%	3.0	17	0.3%	50.5
IOWA	14	0.2%	5	0.2%	3.1	7	0.1%	30.7
JUNEAU	12	0.1%	4	0.2%	2.4	7	0.1%	28.8
LAFAYETTE	8	0.1%	2	0.1%	1.8	5	0.1%	31.0
RICHLAND	7	0.1%	0	0.0%	0.0	4	0.1%	22.3
ROCK	225	2.5%	63	2.6%	5.9	149	2.7%	97.8
SAUK	48	0.5%	16	0.7%	4.1	34	0.6%	61.6
VERNON	9	0.1%	2	0.1%	1.0	4	0.1%	14.3
Southern Region Total	**1,656**	**18.2%**	**474**	**19.6%**	**6.8**	**1,058**	**18.8%**	**105.7**
Western Region								
BARRON	36	0.4%	9	0.4%	2.9	21	0.4%	46.7
BUFFALO	2	0.0%	0	0.0%	0.0	0	0.0%	0.0
BURNETT	13	0.1%	7	0.3%	6.4	9	0.2%	57.4
CHIPPEWA	27	0.3%	7	0.3%	1.8	17	0.3%	30.8
CLARK	15	0.2%	10	0.4%	4.3	11	0.2%	32.8
DOUGLAS	51	0.6%	11	0.5%	3.6	26	0.5%	60.1
DUNN	15	0.2%	4	0.2%	1.4	8	0.1%	20.1
EAU CLAIRE	89	1.0%	22	0.9%	3.4	52	0.9%	55.8
JACKSON	7	0.1%	1	0.0%	0.7	2	0.0%	10.5
LA CROSSE	167	1.8%	49	2.0%	6.5	108	1.9%	100.8
MONROE	25	0.3%	7	0.3%	2.4	14	0.2%	34.2
PEPIN	2	0.0%	0	0.0%	0.0	2	0.0%	27.7
PIERCE	24	0.3%	7	0.3%	2.7	15	0.3%	40.8
POLK	21	0.2%	4	0.2%	1.4	8	0.1%	19.4
RUSK	6	0.1%	1	0.0%	0.9	3	0.1%	19.5
ST CROIX	38	0.4%	8	0.3%	1.8	26	0.5%	41.2
TREMPEALEAU	11	0.1%	2	0.1%	1.1	5	0.1%	18.5
WASHBURN	10	0.1%	4	0.2%	3.6	5	0.1%	31.2
Western Region Total	**559**	**6.2%**	**153**	**6.3%**	**3.1**	**332**	**5.9%**	**46.5**

* Average annual number of cases reported during the specified period per 100,000 population.

** Number of cases presumed alive per 100,000 population.

*** Totals do not include cases reported from State and Federal Correctional Centers.

Wisconsin AIDS/HIV Surveillance Special Focus

Figure 1. Percentage of reported cases of HIV infection among race/ethnic minorities, 1990-2005, Wisconsin

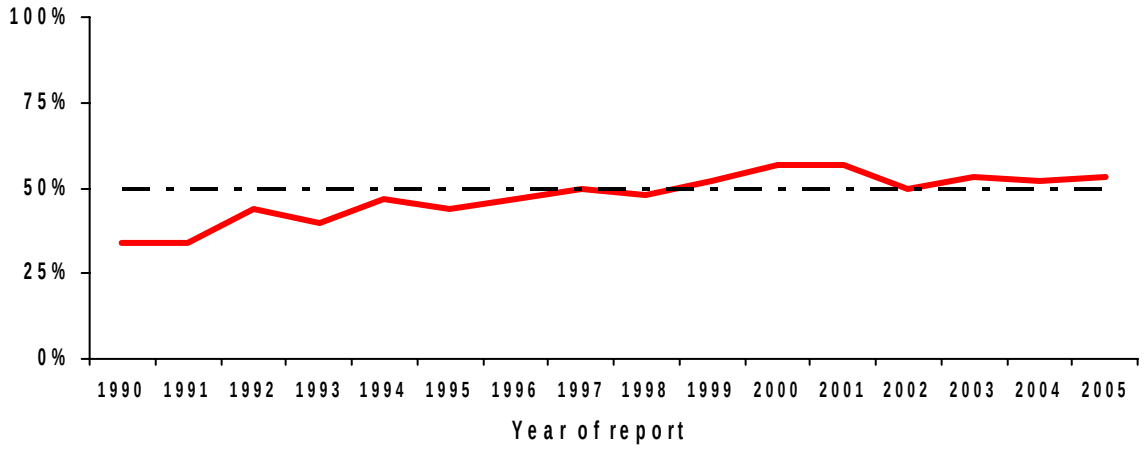
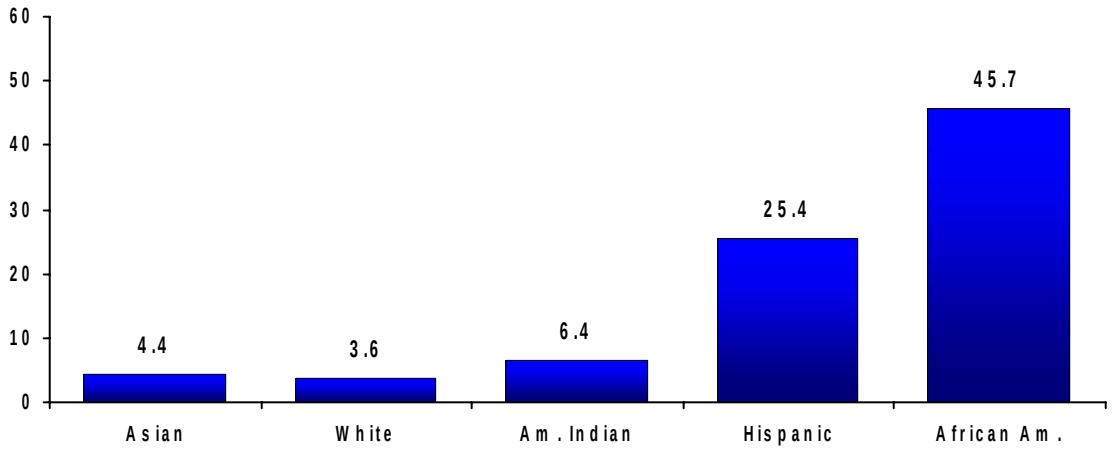


Figure 2. HIV infection per 100,000 population by race/ethnicity, cases reported in 2005, Wisconsin



- While race/ethnic minorities comprise about 12% of the Wisconsin population, between 2000 and 2005 more than half of new cases were among members of race/ethnic minority groups (figure 1).

- In 2005 the average annual rate of reported HIV infection was 13-fold greater for African Americans, seven-fold greater for Hispanics, and nearly two-fold greater for American Indians compared to the rate among whites (figure 2).

- The race/ethnic disparity among females is even greater. In 2005, approximately three-fourths of all females reported with HIV infection were members of race/ethnic minority groups. Compared to white females, African American females had reported rates of HIV infection that were 36-fold greater and Hispanic females had reported rates that were 16-fold greater.

Wisconsin AIDS/HIV Insurance Premium Subsidy Program

Janice Lipsey, Wisconsin AIDS/HIV Insurance Program Coordinator, AIDS/HIV Program, Division of Public Health

The Wisconsin AIDS/HIV Insurance Premium Subsidy Program (Insurance Subsidy Program) helps persons with HIV maintain access to health insurance when they reduce their work hours, take unpaid medical leave, or terminate employment because of their HIV infection. The program does this by subsidizing (covering all or part of the cost of) policy premiums. Clients may apply using the dual-application used for both the ADAP and Insurance Subsidy Programs made available through the website of the Wisconsin AIDS/HIV Program at http://www.dhfs.wisconsin.gov/aids-hiv/.

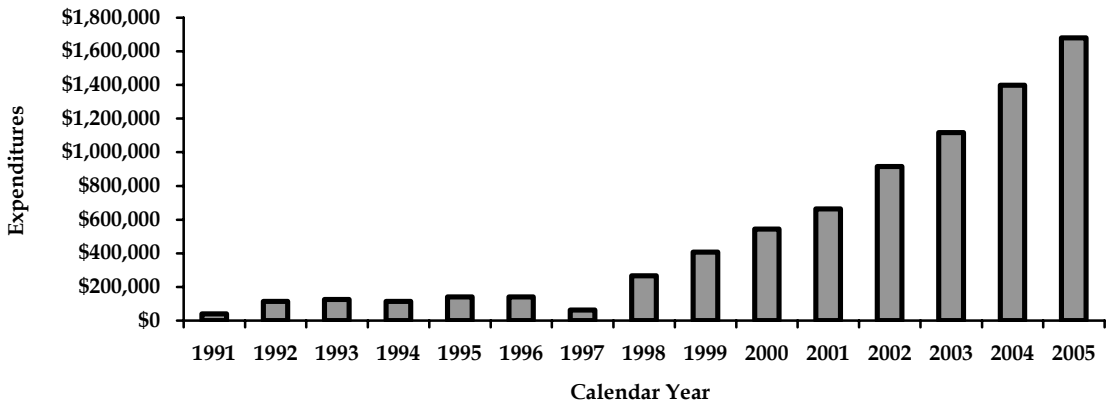
Active client enrollment and average monthly premium by insurance type, December 2005

Insurance type	Clients	Percent of clients	Average monthly premium
HIRSP[1] major medical	152	29%	$345
HIRSP Medicare supplement	93	18%	$373
COBRA[2]	107	20%	$367
Other Major Medical	125	24%	$322
Medical Leave	6	1%	$436
Non-COBRA group	9	2%	$243
Other individual (non-HIRSP)	23	4%	$502
Other Medicare supplement	10	2%	$275
Total	525	100%	$358

[1]HIRSP-The Wisconsin Health Insurance Risk Sharing Plan is a health insurance available to Wisconsin residents who, due to their medical conditions, are unable to find adequate health insurance coverage in the private market.

[2]COBRA-The Consolidated Omnibus Budget Reconciliation Act of 1985 is a federal law that allows a person to continue their group health coverage for a period of 18 months after the date of a qualifying event such as termination of employment. Under qualifying circumstances, the period may be extended to 29 months.

Wisconsin AIDS/HIV Insurance Premium Subsidy Program expenditures by calendar year, 1991-2005



Wisconsin AIDS/HIV Insurance Premium Subsidy Program
client enrollment and expenditures, calendar years 1991 – 2005

Calendar Year	Clients Served	Expenditures
1991	60	$40,468
1992	83	$115,028
1993	97	$125,097
1994	80	$114,472
1995	94	$140,523
1996	84	$140,743
1997	61	$63,572
1998	178	$265,440
1999	247	$406,242
2000	293	$544,351
2901	311	$663,972
2002	343	$915,917
2003	366	$1,117,186
2004	411	$1,398,897
2005	444	$1,679,990

To inquire about eligibility for the AIDS/HIV Insurance Premium Subsidy Program, contact Janice Lipsey at 1-800-991-5532.

Update on Ryan White CARE Act reauthorization

Lynsey Ray, MSSW, Ryan White CARE Coordinator, AIDS/HIV Program, Wisconsin Division of Public Health

This is the second update on Ryan White CARE Act reauthorization. Congress enacted the Ryan White CARE Act in 1990 to address the unmet care and treatment needs of people living with HIV throughout the United States. The CARE Act is required to undergo reauthorization every five years. Reauthorization provides the HIV community and key stakeholders an opportunity to reexamine CARE Act priorities and assess the program's effectiveness. Since 1990, the Care Act has been reauthorized in 1996 and in 2000. The CARE Act was due to be reauthorized last fall, however, domestic and international priorities diverted Congressional attention from reauthorization. For more background information, refer to previous reauthorization update in the Spring 2006 issue of the *Wisconsin AIDS/HIV Update*.

The Ryan White CARE Act reauthorization debate increased in intensity in May when the Senate Health Education Labor and Pensions (HELP) Committee and the House Energy and Commerce Committee released an outline of the CARE Act reauthorization bill on May 9 and draft legislation (S 2823 -- Ryan White HIV/AIDS Treatment Modernization Act of 2006) on May 10. This elicited prompt responses from advocates and other community members. After a month of stakeholder meetings and debate, negotiations continued through June. Congressional debates primarily centered on major funding cuts to large states like New York,

improving state equity in the funding formulas, and increasing funding to southern states facing a growth of the epidemic.

At the same time, Congress continues to consider the appropriations (funding) component of the Ryan White CARE Act budget. Early indications are that there will be a small increase in appropriations across the titles with the majority of the increase being for the AIDS Drug Assistance Programs.

A recent Kaiser Family Foundation report (*The Ryan White CARE Act: A Side-by-Side Comparison of Current Law and Reauthorization Proposals*) provides a comparison of key provisions of the current Ryan White CARE Act compared to reauthorization proposals provided by the White House and Congress. The report is available online at http://www.kff.org/hivaids/7531.cfm

The following includes links to web-based information resources on reauthorization of the Ryan White CARE Act:

National Alliance of State and Territorial AIDS Directors
http://www.nastad.org/reauth_watch.asp

National Minority AIDS Council
http://www.nmac.org/news___events/nmac_press_releases/2822.cfm

Communities Advocating Emergency AIDS Relief (CAER) Coalition
http://www.caear.org/coalition/reauthor1.html

AIDS Action
http://www.aidsaction.org/

Presidential Advisory Committee on HIV/AIDS (PACHA)
http://www.pacha.gov

Native Peoples of North America HIV/AIDS Conference

Gail M. Nahwahquaw, BS, Life Care Services Coordinator, AIDS/HIV Program,
Wisconsin Division of Public Health

Embracing Our Traditions, Values, and Teachings was the theme of the first Native Peoples of North America HIV/AIDS Conference which took place May 2-6, 2006 in Anchorage, Alaska. Designed by and for Native people, the conference offered educational forums on HIV-related prevention, care, and treatment in American Indian, Alaska Native, Native Hawaiian, First Nations and US Territorial Pacific Islander populations. There were over 1,000 participants (including medical providers, community health providers, people living with HIV, tribal leaders, elders, and youth) from over 600 sovereign nations and 40 states and New Zealand. The conference highlighted barriers to prevention and care and treatment identified by Native communities and researchers, including the high prevalence of sexual risks among some Native

communities, the encroachment of crystal meth and other substance use, and the physical isolation of tribal communities.

Breakout and poster sessions concentrated on six tracks: research, mental health, prevention, special populations & stigma, spiritual issues, and leadership in treatment, and care and support. Other highlighted barriers included confusion and the lack of awareness regarding access, eligibility, and utilization of services such as those supported with federal Ryan White CARE Act and prevention funds.

The conference poster sessions include two poster presentations from Wisconsin. One highlighted the Menominee Tribal Clinic's *Wall of Moccasins* which features handmade moccasins that are a memorial to tribal members who died of HIV-related illnesses. Another poster, hosted by Angela Fernandez of the University of Wisconsin – Milwaukee, featured the research study Risk Factors of HIV/AIDS Among American Indian/Alaska Native Women: One Women's Story.

The Native Peoples of North America HIV/AIDS Conference provided immediate cultural connectedness among conference attendees who were Native people and focused uniquely on topics of special interest to Native people, including respect and honor of elders, the importance of spirituality, and healing through humor. The national native leaders attending the conference included representatives from the National Congress of American Indian, American Indian Physicians in America, native researchers, and individual tribal leaders. The presence of these leaders as well as the announcement of the National Native HIV/AIDS Awareness Day to be observed on March 21, 2007 ensures that HIV/AIDS will continue to be a topic of importance for indigenous people. Brief highlights of the Native Peoples HIV/AIDS Conference are posted on the web at http://www.embracingourtraditions.org/conf_overview/news.asp.

HIV/AIDS information resources for Native Americans

Angie Clark, MLIS, Manager, Wisconsin HIV/STD/Hepatitis C Information and Referral Center, AIDS Resource Center of Wisconsin

The federal Department of Health and Human Services reports that over 3,000 cases of AIDS among Native Americans have been diagnosed in the U.S. since the beginning of the epidemic. By the end of 2005, 84 cases of HIV infection were reported among Native Americans in Wisconsin. In 2005, the average annual rate of reported HIV infection was two-fold great for Native Americans compared to that of whites.

Like other racial and ethnic groups, the estimated number of Native persons living with AIDS continues to rise. A number of obstacles exist in the fight against HIV in these communities. Risk factors and barriers to prevention include: sexual risk factors, substance use, socioeconomic issues, cultural diversity, lack of access to confidential testing and care, lack of culturally competent health care providers, and taboos about discussing sexuality, homophobia, and the stigma associated with HIV infection. In addition, many people do not recognize themselves or their partners as being at risk for HIV. The development and use of culturally competent HIV prevention education materials and resources play an important role in

reaching Native communities and reducing the number of new infections. Below are some HIV prevention resources for Native Americans.

HIV/AIDS Among American Indian/Alaska Natives
CDC April 2006
http://www.cdc.gov/hiv/resources/factsheets/PDF/aian.pdf

American Indians and Alaska Natives and HIV/AIDS in the United States
HRSA January 2005
http://hab.hrsa.gov/history/fact2005/american_indians_alaska_natives_and_hivaids.htm

CAPS Fact Sheet: *What are American Indian/Alaska Natives' (AI/AN) HIV prevention needs?*
http://www.caps.ucsf.edu/nativeamerican.html

Native Americans and HIV/AIDS: Key Issues and Recommendations for Health Departments
NASTAD November 2004
http://www.ou.edu/rec/pdf/native_american_report.pdf

National Native American AIDS Prevention Center
http://www.nnaapc.org/

American Indian Health: HIV/AIDS
National Library of Medicine
http://americanindianhealth.nlm.nih.gov/health04.html

Literature on American Indian and Alaska Native HIV/AIDS Issues
http://www.ou.edu/hiv/ai_references.pdf

Clinician's Guide: Working with Native Americans Living with HIV
http://ewebs.realtimesites.net/ds-Southwestern/sout-j-1/ImagesCust/970037646-10-01-2002-10-56-57e.pdf

HIV Prevention, Early Intervention and Health Promotion: A Self-Study Module for Health Care Providers Serving Native Americans
http://ewebs.realtimesites.net/ds-Southwestern/sout-j-1/ImagesCust/970037646-10-01-2002-10-54-49e.pdf

AIDS in the Native American Community
The Body
http://www.thebody.com/whatis/race.html

Centers for Disease Control and Prevention revising recommendations for HIV testing

Jim Stodola, BSW, Counseling, Testing and Referral Coordinator; AIDS/HIV Program, Wisconsin Division of Public Health

Introduction

In March 2006, the Centers for Disease Control and Prevention (CDC) released its latest draft revision of *Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings*. When finalized, the recommendations will replace CDC's 1993 *Recommendations for HIV Testing Services for Inpatients and Outpatients in Acute-Care Hospital Settings* and revise and update CDC's 2001 *Revised Guidelines for HIV Counseling, Testing, and Referral* and *Revised Recommendations for HIV Screening of Pregnant Women*. The guidelines are intended for all public and private sector health care providers, health clinics, community clinics, and primary care settings. CDC is expected to release the final revision of the *Recommendations for HIV Testing* in September 2006. This article summarizes key sections of the draft recommendations.

Testing in health care settings

The following are revised recommendations for HIV testing in health settings:

- HIV testing should be offered as part of routine medical care for all persons between ages 13 and 64 years using an "opt-out" process unless the population served has a documented prevalence of undiagnosed HIV of less than 0.1%.
- Persons at high risk for HIV should undergo testing at least annually.
- General consent for medical care is sufficient for HIV testing and separate written consent for HIV testing is not recommended.
- Prevention counseling need not to be conducted as part of HIV testing.
- Prevention counseling is not recommended as part of routine screening in health settings other than settings where risk behaviors are assessed routinely (e.g., STD clinics).
- HIV test results should be provided in the same manner as results of other diagnostic tests.

Recommendations for HIV testing in health care settings that remain unchanged include the following:

- HIV testing should be voluntary and free from coercion.
- HIV testing is recommended and should be routine for persons seeking STD testing and treatment.
- Access to clinical care, prevention counseling, and support services is essential for persons with positive HIV test results.

HIV screening for pregnant women
The following are revised recommendations for screening pregnant women:

- All pregnant women should receive HIV testing as part of other routine prenatal screening tests. HIV testing should be conducted only after informing the patient that testing will be done unless the patient declines (opt-out testing).

- Repeat testing in the third trimester is recommended for all women who receive care in jurisdictions with at least 17 newly identified HIV cases per 100,000 women per year among women ages 15 to 45 years and for women among women in health care settings with at least 17 newly identified HIV case per 100,00 pregnant women per year.

- Rapid HIV testing should be performed for all women in labor who lack documented prenatal HIV test results. Women should be informed that HIV testing is recommended for all pregnant women and that a pregnant woman will be tested unless she declines (opt-out screening). Antiretroviral prophylaxis should be offered for a reactive rapid test result without waiting for confirmatory testing.

The following aspects of HIV screening for pregnant women remain unchanged:

- Pregnant women should receive appropriate health education as a routine part of prenatal care, including information about HIV and its transmission.

- Universal HIV testing with notification should be performed for all pregnant women as soon as possible during pregnancy.

- HIV testing should be repeated in the third trimester for select women with identified high risk.

- Providers should explore and address reasons for declining HIV testing.

- Access to clinical HIV specialty care, prevention counseling, and support services are essential for women with positive HIV test results.

Rationale for revised recommendations
Rationale for CDC's revised testing recommendations includes the following:

- Since 1998, the estimated number of new infections has remained stable at approximately 40,000 annually and HIV has been rising among some groups in recent years.

- Many persons from groups with increasing proportions of new HIV infections (including, woman, racial/ethnic minorities, heterosexual men and women, and person outside of major metropolitan areas) are unaware of their risks and thereby making risk based testing less effective in identifying new infection.

- Routine testing can reduce stigma associated with testing that requires assessment of risk behavior.

- Universal screening of blood donors has been proven effective in reducing transmission among recipients of blood products.

- Universal screening of pregnant women with streamlined counseling has lead to a substantial decline in the incidence of neonatal HIV/AIDS.

- Perinatal HIV transmission occurs mostly among women who lack prenatal care.

- Most persons with HIV infection substantially reduce transmission risk behaviors after they learn their status.

- Access to clinical services and highly active antiretroviral therapy that reduces viral load may reduce transmission even if a person with HIV did not change behavioral risks.

- HIV screening is as cost effective as other routine screening for chronic diseases such as hypertension, colon cancer, and breast cancer even in populations with less than 0.1% undiagnosed HIV infection.

Regulatory and legal considerations
The revised recommendations call for state health departments to review state statutes and "resolve barriers to that might conflict with these recommendations." Wisconsin statutes currently required written consent prior to HIV testing, which conflicts with the "opt-out" testing recommendations. Providers in Wisconsin will need to continue complying with these legislative requirements.

Conclusion
While support for the new recommendations is growing, some AIDS advocacy groups have expressed concerns about relaxing pre- and post-test counseling recommendations and requirements for written consent. An article in support of the changes can be viewed at www.thebody.com/kaiser/2005/feb10_05/hiv_testing. An article articulating the concerns of some AIDS advocacy groups can be viewed at www.thebody.com/cdc/news_updates_archive/2006/jun26_06/routine_hiv_testing. Because many persons who are at highest risk for HIV are least likely to access or interact with the health care system, there is a continuing need to maintain prevention and HIV testing for high-risk and disproportionately-affected populations in non-clinical settings.

Social networks testing: reaching persons at risk

Jim Stodola, BSW, Counseling, Testing and Referral Coordinator; AIDS/HIV Program, Wisconsin Division of Public Health

The federal Centers for Disease Control and Prevention (CDC) is continuing to focus its attention on the estimated 250,000 persons in the United States who are not aware they are infected with HIV and their risk for transmitting HIV to others. Health departments and community-based organizations funded by the CDC to conduct HIV testing account for 30% of positive tests in the U.S. Still, the prevalence of positives at these sites is generally low—often less than 1%. In addition to HIV testing of individuals in clinical settings as a part of routine medical care, the CDC is promoting social networks testing as a community-based approach to reach persons at increased risk for HIV infection.

Social networks testing is a recruitment strategy that utilizes the social networks of persons who are members of a community. This strategy is based on the concept that individuals usually connect with a social network and that infectious diseases are often spread through these networks. An example of a social networks HIV testing strategy is to enlist HIV-positive and high risk HIV-negative persons as recruiters and to subsequently provide HIV CTR to persons in the recruiters' networks. The prevalence of positive tests among sites participating in the CDC's Social Networks Demonstration Program between 2003 and 2005 was approximately 6%, six times higher than most HIV Counseling, Testing, and Referral programs.

On April 27, 2006 the CDC sponsored an HIV prevention satellite broadcast *Social Networks: A Recruitment Strategy for HIV Counseling, Testing, and Referral Services*. The broadcast is archived as a webcast and can be viewed through the Public Health Training Network website at http://www.phppo.cdc.gov/phtn.

The CDC has developed an interim guide on social networks testing for HIV counseling, testing and referral programs. They are anticipating announcing plans to train health departments this autumn. Agencies can begin informally applying social networks strategies to their testing services by viewing the archived April 27th broadcast and downloading the interim guide and other accompanying materials. The broadcast is available on the web at: http://www.cdc.gov/hiv/resources/guidelines/snt/pdf/SocialNetworks.pdf

Increasing perinatal testing in Wisconsin

Kathleen Krchnavek, MSSW, Counseling and Testing Specialist, AIDS/HIV Program, Wisconsin Division of Public Health and Wisconsin State Laboratory of Hygiene

On April 10, 2006, approximately 30 stakeholders involved in HIV and/or perinatal issues gathered to discuss options for increasing perinatal HIV testing in Wisconsin. The options were detailed in a briefing paper developed by the Wisconsin AIDS/HIV Program titled *Achieving Health Birth Outcomes – Perinatal Testing: Options to attain universal testing of pregnant women.* The four primary options discussed at the stakeholder meeting included:

1. Enhancing educational efforts directed to perinatal care providers and women without statutory change.
2. Statutorily requiring health care providers to offer HIV testing to pregnant women, with or without a change in informed consent laws.
3. Changing informed consent statutes in accord with recommendations by the American College of Obstetricians and Gynecologist and the Centers for Disease Control and Prevention for opt-out testing.
4. Statutorily requiring mandatory testing of newborns when a mother's HIV status is undocumented.

Comments from the stakeholder meeting generally supported the following points:

- Education to providers should be data-driven, integrated with a quality improvement process, and targeted to providers and institutions, especially those that have a poor record of implementing HIV testing to pregnant women.
- This targeted education could be implemented through a collaborative plan with professional groups such as the Wisconsin Association for Perinatal Care, Wisconsin Hospital Association, and Wisconsin HIV Primary Care Support Network.
- Opt-out testing may make HIV testing easier compared to the current process of written informed consent but the physician must still initiate this process.
- Intervention to increase perinatal HIV testing must be multi-focused (targeted at the provider, health care system, payer, and consumers) and universal (aimed to all pregnant women rather than a subset based on geography, socioeconomic status, or other variables).
- Mandatory testing of the infant as a primary intervention is not preferred.

Prior to the April 10th meeting, the AIDS/HIV Program presented the perinatal testing options at meetings with minority community based grantees of the Wisconsin AIDS/HIV Program and community partners of the Wisconsin Division of Health Care Financing (HMO Quality Technical Advisory Committee and HMO Contract Administrators). Comments from these meetings indicated general approval for mandating providers to offer HIV testing during pregnancy and little opposition to opt-out testing.

Based on stakeholder feedback and internal discussions, the AIDS/HIV Program is further developing recommendations for administration within the Department of Health and Family Services to increase perinatal HIV testing Wisconsin. Implementation of the recommendations will require collaborative efforts among health care system partners as well as additional resources such as staffing and training. For more information on perinatal testing initiatives, contact Kathleen Krchnavek at 608-267-3583 or krchnka@dhfs.state.wi.us.

Prenatal HIV Testing Survey Results Published in Wisconsin Medical Journal

The Wisconsin AIDS/HIV Program recently reported on a survey of hospital medical records for a random sample of women who gave birth in 2003. Survey results indicate the goal of voluntary HIV testing for all pregnant women is not currently being met in Wisconsin. For the full report, see: Hoxie NJ, Maxwell MJ, Schell W, Reiser WJ, Vergeront JM. Prenatal HIV testing in Wisconsin: results of a survey among women who gave birth in 2003. *Wisconsin Medical Journal*. 2006;105(4): 32-42. Available on the web at: http://www.wisconsinmedicalsociety.org/uploads/wmj/ACF3E6.pdf

Highlights of knowledge gained from the HIV rapid testing partner counseling and referral services project

Dhana Shrestha, MPH, Partner Counseling and Referral Services Coordinator, AIDS/HIV Program, Wisconsin Division of Public Health

From October 2003 through September 2005, the Wisconsin AIDS/HIV Program implemented an HIV rapid testing project as a part of the federal Centers for Disease Control and Prevention (CDC) Advancing HIV Prevention Initiative (AHPI). The project focused on integrating HIV rapid testing in the Wisconsin HIV Partner, Counseling and Referral Services (PCRS) Program in order to:

- increase the number of persons identified with HIV infection and
- link persons testing positive to care treatment and other effective prevention services.

The PCRS rapid testing project was implemented by local health department (LHD) staff in nine Wisconsin counties that comprise some of the highest seroprevalence areas in the state. These counties included Brown, Dane, Kenosha, Milwaukee, Waukesha, Fond du Lac, La Crosse, Beloit, and Racine. This article briefly highlights qualitative findings reported at a national investigators meeting of AHPI PCRS rapid testing project grantees.

Some of the barriers and challenges identified during the project included the following:

- PCRS staff turnover in Milwaukee was a significant challenge. The pending elimination of state-supported PCRS positions resulted in a fulltime PCRS state employee leaving his position. This bilingual employee was one of only two PCRS staff covering the Milwaukee metropolitan area where more than half of Wisconsin's HIV cases reside and where many of the cases are Hispanic.

- A statewide pertussis outbreak during the third and fourth quarter of 2004 resulted in several LHDs shifting priority staff activities to managing the pertussis outbreak.

- Project staff found the project survey questionnaire developed by the CDC as being long, cumbersome, and confusing.

- Maintaining the temperature of the rapid test kits and test kit controls during the summer was a challenge, especially at LHD offices where air conditioning was frequently not operating on weekends.

- Occasionally, it was difficult to conduct rapid testing in a partner's home because others were present and there was limited privacy.

- Some providers felt pressure in providing reactive results in 20 minutes and some clients became very anxious during the wait.

Despite several barriers, the following knowledge gained from the project and positive outcomes support the integration of rapid testing in PCRS:

- While the number of partners and cluster members who were tested did not increase in 2005, compared to 2004, partners and cluster members indicated high acceptance of rapid testing which significantly shortened the time during which persons waited to receive test results.

- Rapid testing lessened the chance that some individuals receiving PCRS-based testing might be lost to follow-up.

- PCRS staff involved in the project generally found the rapid testing technology to be very convenient and efficient.

- Receipt of test results in the field addressed many of the partners' immediate information needs, especially those who tested negative and who otherwise would have waited up to two weeks for test results.

- The time commitment for both provider and partner was reduced compared to that required for conventional testing.

- Partners initially testing negative but with recent risk behaviors returned for follow-up testing.

Summary
Initially, project staff assumed that rapid HIV field testing would increase the number of partners who elected to be tested, however, this did not happen. When questioned, partners indicated that rapid testing was not a factor that influenced their decision to be tested. Ultimately, rapid testing has simplified PCRS and has provided PCRS staff and clients an efficient and effective alternative for service delivery. The CDC is currently conducting analysis of the data set from PCRS rapid testing project sites and a final report is expected in the near future. For additional information regarding the PCRS rapid testing project or PCRS in Wisconsin, contact Dhana Shrestha, PCRS Coordinator, at 608-267-5288 (phone) or shresdm@dhfs.state.wi.us (e-mail).

2006 HIV Prevention Leadership Summit

Karen Johnson, BSW, Prevention Consultant, AIDS/HIV Program, Wisconsin Division of Public Health

The HIV Prevention Leadership Summit (HPLS) is a national meeting of HIV prevention service providers, researchers, and advocates. This article highlights select presentations from the 2006 HPLS which occurred June 4 -7, 2006 in Dallas, Texas.

The HPLS opening session theme was *Acknowledging the Past and Preparing for the Future.* This session reflected on the first 25 years of the HIV/AIDS epidemic and looked toward the future of the epidemic. Two national leaders from the Center for Disease Control and Prevention (CDC) -- Kevin Fenton, MD, PhD, Director of CDC's National Center for HIV, STD, and TB

Prevention (NCHSTP), and Janet Cleveland, MS, Deputy Director for Prevention Programs at the CDC-NCHSTP), participated in the HPLS opening session.

Dr. Fenton highlighted achievements in HIV prevention, the challenges of the changing epidemic, and opportunities for the future. In summing up the future opportunities, Fenton encouraged HPLS attendees to

- develop new partnerships,
- increase testing opportunities,
- provide prevention services to HIV positive persons,
- improve surveillance of new infections,
- integrate HIV prevention and care services, and
- watchful for use of new prevention technologies, including vaccines.

Janet Cleveland called for mobilizing a heightened response to the HIV/AIDS epidemic among African Americans. Factors contributing to the disproportionate impact of HIV on the African American community include limited access to care, limited access to effective HIV treatments, lack of awareness of one's HIV status, and high rates of incarceration. Cleveland highlighted several prevention initiatives, including the Diffusion of Effective Behavioral Interventions (DEBI) that utilizes science-based HIV prevention strategies for African American men who have sex with men (MSM) and African American women and adolescent females. CDC is currently supporting two new behavioral interventions (Willow and SIHLE) targeting African Americans in rural communities and young women. Information on the DEBI initiatives is located on the web at http://www.effectiveinterventions.org/.

In a subsequent session, Mark E. Johnson, Executive Director of the AIDS service organization Brotherhood in New Orleans, reflected on the devastation of hurricane Katrina which claimed thousand of lives and displaced hundred of families. Johnson discussed the needs of persons living with AIDS/HIV and the negative health impact of Katrina presented to persons living with HIV infection. Katrina was a wake-up call for agencies that lacked or had inadequate emergency preparedness plans. Human service organizations such as AIDS service organizations need back-up plans to maintain records, provide services, and manage staff communications during major emergencies and disasters.

A closing plenary session focused on bridging public health and corrections. Presenters from Alabama, Georgia and Maryland shared experiences in working in correctional settings and the challenges of supporting person living with HIV/AIDS in correctional facilities. Panel members discussed how to promote use of condoms as risk reduction tools rather than viewing condoms as contraband in corrections. The presenters also discussed their experiences in addressing the needs of inmates with dual diagnoses of mental illness and substance use.

Links to keynote speaker presentations (in PowerPoint) are located on the website of the National Minority AIDS Council at: http://www.nmac.org/conferences___trainings/HPLS/.

The take-home message of the 2006 HPLS was clear -- the HIV prevention community must build upon past successes in combating HIV/AIDS by continuing to mobilize individuals and communities and by developing new partnerships with business, medical settings and community leaders. Prevention efforts need to be redefined and redirected to support HIV

testing and to reach all HIV positive persons who are unaware of their HIV status. Ultimately, communities must work collaboratively to stay ahead of the curve and reduce increasing rates of new infection.

Signal-to-cut-off ratios for hepatitis C antibody tests

Sheila Guilfoyle, Hepatitis C Coordinator, AIDS/HIV Program, Wisconsin Division of Public Health

Hepatitis C antibody testing (anti-HCV) is used to determine serologic evidence of HCV infection. The test most commonly used for screening purposes is the EIA. EIA samples with high signal-to-cut-off ratios (s/co ratios) almost always (≥ 95%) indicate past or present HCV infection, and can be considered confirmed for surveillance purposes. However a HCV RNA test (PCR) is still required to determine the presence of active HCV infection.

There are several commercially available HCV screening tests. The Centers for Disease Control and Prevention has developed a reference page that discusses the use of s/co ratios for the confirmation of HCV infection.

The CDC web page on signal-to-cut-off ratios can be viewed at:
http://www.cdc.gov/ncidod/diseases/hepatitis/c/sc_ratios.htm
The following table from the CDC web page lists the currently available EIA screening tests and the values for interpreting the results.

Screening test kit	Signal-to-cut-off ratio predictive of a true positive ≥ 95% of the time
Ortho HCV Version 3.0 ELISA Test System	3.8
Abbott HCV EIA 2.0	3.8
Ortho Vitros Anti-HCV Assay	8.0
Abbott Axsym Antibody to HCV	10.0
Bayer Advia Centaur HCV Assay	Not Yet Available

The Wisconsin State Laboratory of Hygiene (WSLH) uses the Abbot Axsym Antibody to HCV test. A s/co ratio ≥10 is considered a confirmed HCV result for this test.

For further information on HCV testing, see the CDC's *Guidelines for Laboratory Testing and Result Reporting of Antibody to Hepatitis C Virus:*
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5203a1.htm

For information on interpreting Hepatitis C test results see the Wisconsin Division of Public Health's Hepatitis C webpage:
http://dhfs.wisconsin.gov/communicable/hepatitis/PDFs/InterpretHepCresults.pdf

Wisconsin Hepatitis C Surveillance Summary

Cases Reported 01/01/1999 through 06/30/2006

Summary

Total	22,847	100%
Confirmed (1)	18,257	80%
Unconfirmed (2)	4,590	20%

Gender

Males	15,389	67%
Females	7,281	32%
Unknown	177	1%

Race

White	9,037	40%
Black	3,026	13%
Am Indian	242	1%
Asian	98	0%
Other	59	0%
Unknown	10,385	45%

Age

0-12	72	0%
13-19	174	1%
20-29	1,045	5%
30-39	4,389	19%
40-49	10,401	46%
50+	6,691	29%
Unknown	75	0%

Ethnicity

Hispanic	718	3%
Not Hispanic	9,339	41%
Unknown	12,790	56%

Footnotes:

(1) Confirmed: A positive enzyme immunoassay test result with a high signal-to-cut-off ratio, recombinant immunoblot assay (RIBA) or polymerase chain reaction (PCR) test result, a detectable viral load or identified genotype.
(2) Unconfirmed: A positive enzyme immunoassay test result with a low or unknown signal-to-cut-off ratio and no other test result reported.

Technical Notes:

a. This report is compiled by the Wisconsin Hepatitis C Program and is based on reports of hepatitis C virus (HCV) infection submitted by laboratories and local health departments (LHDs). HCV infection is a reportable communicable disease by Wisconsin administrative rule (HFS 145, Appendix A). When cases are reported, LHDs contact persons with HCV infection to provide health education, risk reduction counseling, hepatitis A and B vaccine and medical referral as needed.

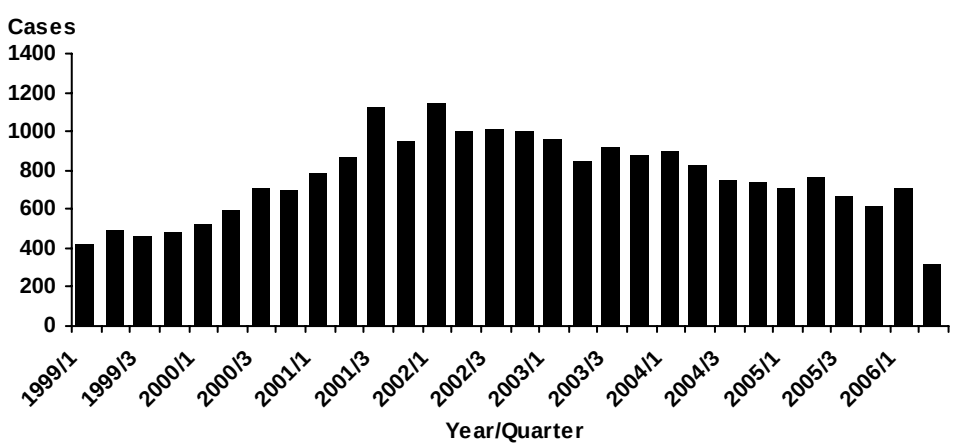
b Many cases of HCV infection are reported by laboratories. Since laboratories do not generally report demographic data such as region, race, or age, surveillance summary data by demographic characteristics are often incomplete.

c. Most reported cases of HCV infection represent chronic disease in persons who were infected years ago. Persons with acute infection are often unaware of their infection because it presents with few if any symptoms.

Reported cases by county

Adams	77	Florence	7	Marathon	162	Rusk	43
Ashland	53	Fond Du Lac	238	Marinette	89	St Croix	96
Barron	79	Forest	34	Marquette	37	Sauk	193
Bayfield	28	Grant	49	Menominee	17	Sawyer	47
Brown	411	Green	61	Milwaukee	6653	Shawano	49
Buffalo	18	Green Lake	37	Monroe	183	Sheboygan	188
Burnett	59	Iowa	31	Oconto	64	Taylor	15
Calumet	39	Iron	19	Oneida	93	Trempealeau	48
Chippewa	107	Jackson	46	Outagamie	280	Vernon	31
Clark	45	Jefferson	161	Ozaukee	165	Vilas	72
Columbia	117	Juneau	99	Pepin	7	Walworth	307
Crawford	31	Kenosha	719	Pierce	60	Washburn	48
Dane	1317	Kewaunee	26	Polk	98	Washington	186
Dodge	172	La Crosse	311	Portage	148	Waukesha	591
Door	47	Lafayette	12	Price	28	Waupaca	91
Douglas	239	Langlade	40	Racine	816	Waushara	61
Dunn	55	Lincoln	35	Richland	24	Winnebago	411
Eau Claire	229	Manitowoc	96	Rock	714	Wood	131
						Unknown	5456

Reported cases by quarter



For more information:

Questions regarding Wisconsin hepatitis C data may be directed to Sheila Guilfoyle (608) 266-5819. Annual Hepatitis C Surveillance Summaries are posted on the Wisconsin Department of Health and Family Services hepatitis C website at: www.dhfs.wisconsin.gov/dph_bcd/hepatitis/

CDC online hepatitis serology training

The Centers for Disease Control and Prevention (CDC), Division of Viral Hepatitis has launched an online hepatitis serology training course. The objectives of the course are to recognize the serologic interpretation of all forms of viral hepatitis. Continuing education credits are available for various health disciplines. Additional information about the training, computer system requirements, and registration instructions can be accessed online at: http://www.cdc.gov/ncidod/diseases/hepatitis/serology/index.htm

It's time! Integrating viral hepatitis into your work

Narra Smith Cox, PhD, Professor, Department of Professional Development and Applied Studies, University of Wisconsin - Madison

"It's Time! Integrating Viral Hepatitis Into Your Work" is a new one-day workshop offered by the Wisconsin HIV/AIDS Prevention Training System and the Wisconsin AIDS/HIV Program. The workshop will be held on Wednesday, October 25, 2006 at the Pyle Center in Madison. The course is designed for individuals providing direct services to individuals at risk for hepatitis, or living with hepatitis, as well as program managers interested in integrating viral hepatitis services into their settings. Registration information is available at www.wihivpts.wisc.edu.

HIV providers are experienced at discussing HIV prevention messages, implementing behavioral counseling, and offering service referrals to clients, yet many providers are less familiar with integrating concurrent messages about viral hepatitis. HIV and viral hepatitis have similar modes of transmission through high risk sexual activity and injection drug use. Integrating viral hepatitis prevention, care, vaccination and treatment improves the quality of life and survival of people who are living with and are at risk for viral hepatitis. This training will provide the knowledge, tools and skills to tailor viral hepatitis services in various settings, including HIV prevention programs, substance use treatment programs, and sexually transmitted disease clinics.

The course is designed so that at its conclusion participants will be able to:

- Explain basic information about hepatitis A, B, and C, including transmission, spectrum of illness, prevention, testing, and treatment.
- Describe the connections between viral hepatitis and HIV.
- Demonstrate risk assessment and tailored harm reduction messages for viral hepatitis.
- Identify opportunities and strategies to integrate viral hepatitis messages into HIV prevention services, STD clinics, drug treatment programs, and other programs serving individuals at high risk.
- Know of additional resources to support integration of viral hepatitis services into settings that serve people at high risk.

The course is based on a curriculum developed by the New York State Department of Health Viral Hepatitis Training Center and promoted by the Centers for Disease Control and Prevention.

For further information regarding this or other training opportunities available through the Wisconsin HIV Prevention Training System, contact Tara Loushine (tloushine@dcs.wisc.edu or 608-265-4551) or Narra Smith Cox (nscox@wisc.edu or 608-262-2730).

AIDS/HIV-related MMWR articles: June 2006 through July 2006

Each issue of the *Update* includes a list of AIDS/HIV-related citations from issues released during the previous months of the *Morbidity and Mortality Weekly Report (MMWR)*, published by the Centers for Disease Control and Prevention (CDC). To receive an electronic copy on Thursday of each week, send an e-mail message to lists@list.cdc.gov. The body content of your message should read "subscribe mmwr-toc". Electronic copy is also available from CDC's World-Wide Web server at http://www.cdc.gov/. Public health agencies and most libraries in hospitals, medical schools and nursing schools subscribe to the *MMWR*.

Article	Issue
Percentage of persons aged 18--49 years with HIV infection, by age group and race/ethnicity --- United States, 1999—2002. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5521a7.htm?s_cid=mm5521a7_e	MMWR 2006 June 55(21);605.
Evolution of HIV/AIDS prevention programs – United States, 1981-2006. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5521a4.htm?s_cid=mm5521a4_e	MMWR 2006 June 55(21);597-603.
Achievements in public health: reduction in perinatal transmission of HIV infection – United States, 1985-2005. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5521a3.htm?s_cid=mm5521a3_e	MMWR 2006 June 55(21);592-597.
Epidemiology of HIV/AIDS – United States, 1981-2005. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5521a2.htm?s_cid=mm5521a2_e	MMWR 2006 June 55(21);589-592.
Twenty-five years of HIV/AIDS – United States, 1981-2006. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5521a1.htm?s_cid=mm5521a1_e	MMWR 2006 June 55(21) 585-589.
Rapid HIV test distribution – United States, 2003-2005. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5524a2.htm?s_cid=mm5524a2_e	MMWR 2006 June 55(24);673-676.
HIV risk, prevention, and testing behaviors – United States, national HIV behavioral surveillance system: men who have sex with men, November 2003-April 2005. http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5506a1.htm?s_cid=ss5506a1_e	MMWR 2006 July 55(SS06);1-16.
Investigation of a new diagnosis of multidrug-resistant, dual-tropic HIV-1 infection – New York City, 2005 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5529a1.htm?s_cid=mm5529a1_e	MMWR 2006 July 55(29):793-796.

Wisconsin Minority Health Program

The Minority Health Program is the primary point of contact on minority health for the Wisconsin Department of Health and Family Services (DHFS). The program develops initiatives to advance the health of racial and ethnic minority communities in Wisconsin.

Minority Health Program goals focus on:

- enhancing government and community awareness of minority health issues;
- fostering complete and accurate health status data and surveillance of minority populations;
- recommending and implementing strategies to eliminate health disparities in Wisconsin; and
- improving access to culturally and linguistically competent systems of care.

The Minority Health Program promotes awareness of minority health by disseminating information through multiple communication channels including presentations, data reports, and a statewide public information campaign. The program reviews minority health research, surveys best practices, and recommends policies and strategies to be adopted by public health agencies. The program also promotes collaboration among public and private sector partners to address comprehensive minority health issues.

Because of persistent high death rates among infants born to African American women, the Wisconsin DHFS is implementing a five-year action plan to eliminate racial and ethnic disparities in birth outcomes. Compared to white infants, African American infants are 3-4 times more likely to die before their first birthday. Significant disparities in birth outcomes also exist among American Indian and Hispanic populations, however, they are less that among African Americans.

To address birth outcome disparities, the DHFS has developed a five-year action plan, *A Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes*. The *Framework for Action* contains four major areas of emphasis for the next five years:

- communication and outreach;
- quality improvement;
- community and evidence-based practices; and
- using data to monitor trends and evaluate interventions.

The full report of the *Framework for Action* can be viewed on the DHFS website at: http://dhfs.wisconsin.gov/healthybirths/pdf_files/HealthyBirthsOutcomesFramework.pdf. An HIV-related action step identified in the *Framework for Action* focuses on increasing HIV testing among all pregnant. The Wisconsin AIDS/HIV Program is leading the efforts surrounding HIV prenatal testing through collaborative partnerships with professional organizations and other groups and individuals.

For additional information, visit the website of the Wisconsin Minority Health Program at http://dhfs.wisconsin.gov/health/minorityhealth/ or contract Kelli Jones, Minority Health Officer, at 608-267-2173 (phone) or joneskj@dhfs.state.wi.us (email).

amfAR issue brief focuses on HIV prevention for men who have sex with men

Increases in HIV infection among men who have sex with men (MSM), both domestically and internationally, prompted the Foundation for AIDS Research (amfAR) to release an issue brief on HIV prevention for MSM. The brief focuses on biologic, behavioral, and social/cultural factors that place MSM at increased risk for HIV infection. While several behavioral interventions (individual, small group and community) have lowered risk behaviors, amfAR's issue brief points out that some HIV social policy initiatives reinforce stigma and discrimination. The HIV prevention issue brief is located on the amfAR website at: http://www.amfar.org/binary-data/AMFAR_PUBLICATION/download_file/46.pdf.

UNAIDS releases report on global AIDS efforts

In May 2006, the Joint United Nations Programme on HIV/AIDS (UNAIDS) released its *2006 Report on the Global AIDS Epidemic*, indicating that the global HIV epidemic is slowing but that new HIV infections are continuing to increase in certain regions and countries.

The progress report noted several positive trends in the HIV epidemic, including:

- significant increases in HIV resources in most countries along with stronger political commitments and partner coordination;
- dramatic expansion in treatment access and HIV testing and counseling;
- several sub-Saharan counties report declines in the percent of young people having sex before age 15 and increases in condom use;
- countries report coverage as high as 60% of HIV-positive pregnant women receiving antiretroviral prophylaxis to prevent mother-to-child transmission.

The report also identified significant weaknesses in HIV responses, including:

- funding gaps continue despite significant increases in resources;
- there is a lack of clear signs of declining HIV prevalence in South Africa;
- many prevention programs fail to reach persons at greatest risk;
- there are reported declines in the proportion of young people achieving comprehensive knowledge about HIV;
- stigma and discrimination against people living with HIV continue to be pervasive.

The *2006 Report on the Global AIDS Epidemic* is one of the most comprehensive reports on global HIV efforts. Utilizing data from 126 countries and more than 30 civil society organizations, the UNAIDS report assessed country progress toward the six global targets set in the *UN Declaration of Commitment on HIV/AIDS* adopted by 189 UN Member States in 2001. The *Declaration of Commitment* set comprehensive, time-bound targets for the delivery of HIV prevention, treatment, care, and support directed at halting or reversing the global epidemic by 2015. The *2006 Report* can be viewed on the UNAIDS website at: http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp

National Prevention Information Network website redesign

The CDC National Prevention Information Network (NPIN) is the U.S. reference, referral, and distribution service for information on HIV/AIDS, sexually transmitted diseases (STDs), and tuberculosis (TB). NPIN produces, collects, catalogs, stocks, and disseminates materials and information on HIV/AIDS, STDs, and TB to organizations working in these areas.

NPIN completed the first phase of the redesign of its website at http://www.cdcnpin.org to include a new graphic design and a standardized style to assist users in the ease of use of the website. Noticeable redesign changes in the website include:

- Printer-friendly versions of each of the sub-pages (a "printable version" link is placed next to the title of each page).
- Unified look and feel across all of the pages.
- Added graphics to many sections for a more engaging look.
- More prominent search functions on the "Specific Searches" area. Searches can be submitted on the banner area which is present on all the pages.

The new design continues to highlight the latest prevention news, conferences, funding and features on the NPIN homepage.

MMWR reviews twenty-five years of HIV/AIDS in the United States

The June 2, 2006 issue of the *Morbidity and Mortality Weekly Report* (Volume 55, Number 21;585-605) reflects on the 25 year history of HIV/AIDS in the United States, including a succinct review of the HIV epidemic in the areas of epidemiology, prevention, and progress in perinatal HIV transmission. A PDF version of the anniversary issue of the MMWR can be viewed and downloaded from the CDC website at:http://www.cdc.gov/mmwr/PDF/wk/mm5521.pdf. HTML versions of the articles of the anniversary issue are located on the CDC website at: http://www.cdc.gov/hiv/resources/reports/mmwr/2006.htm.

CDC upgrades Division of HIV/AIDS website

The Centers for Disease Control and Prevention (CDC) recently updated the Division of HIV/AIDS website. The revised web pages increase the ease of use and utility of the CDC HIV/AIDS website. In addition to an improved search engine that can restrict searches to just the HIV/AIDS website, web pages highlight newly developed and frequently viewed content, sorted for the general public and prevention partners. The HIV/AIDS home page features information regarding global HIV/AIDS. The newly revised CDC web pages can be viewed at:

http://www.cdc.gov/hiv
http://www.cdc.gov/hiv/dhap.htm

Tatiana Dierwecther moves to the state of Oregon

Tatiana Dierwechter, HIV Prevention Unit Supervisor, resigned her position in June 2006 in order to relocate with her family to the state of Oregon later this summer. Tatiana joined the Wisconsin AIDS/HIV Program in September 1998 as the HIV Prevention Evaluator. Shortly thereafter, in spring 1999, Tatiana was appointed Supervisor of the HIV Prevention Unit. Through Tatiana's leadership and support, the HIV Prevention Unit expanded its capacity for supporting the delivery and integration of HIV prevention services in the areas of services for HIV positive persons, program evaluation, minority community-based and faith-based initiatives, rapid HIV testing, training system development, and science-based prevention interventions. Tatiana's management and communication skills fostered positive relationships with fellow employees and among the community partners of the AIDS/HIV Program. The AIDS/HIV Program extends sincere gratitude and best wishes to Tatiana for continuing success as she moves westward.

Aug 13-19, 2006	Toronto, Ontario, CA	**XVI International AIDS Conference**. Sponsor: International AIDS Society and partner organizations. Contact: info@aids2006.org (e-mail); www.aids2006.org.
Aug 28-31, 2006	Washington, DC	**Ryan White CARE Act Grantee Conference and the 9th Annual Clinical Conference Update**. Sponsor: Health Resources and Services Administration. Contact: http://www.rwca2006.com (website).
Sept 6, 2006	Elkhart Lake, WI	**Wisconsin HIV Prevention Community Planning Council Meeting.** Contact: Molly Herrmann at 608-267-6730 (phone) or herrmmm@dhfs.state.wi.us (e-mail).
Sept 6-8, 2006	Washington, DC	**2006 National Latina Health Summit**. Sponsor: National Latina Health Network. Contact: http://www.nlhn.net/national_latina_health_summit_2006.php (website); info@nlhn.net (email).
Sept 14-15, 2006	Denver, CO	**18th Annual Denver STD/HIV Update**. Sponsor: Denver STD/HIV Prevention Center. Contact: http://www.denverptc.org/Part1/Main.htm (website); 303-436-7226 (phone); collen.nieto@dhha.org (email).
Sept 21-25, 2006	Hollywood, FL	**2006 United States Conference on AIDS**. Sponsor: National Minority AIDS Council. Contact: For additional information including registration, program agenda, and scholarships access the website at http://www.nmac.org/conferences.
Sept 22, 2006	St. Louis, MN	**Transgender Health Update**. Sponsor: Park Nicolett Institute. Contact: 1-888-786-3119 (phone); http://www.parknicollet.com/CME/cmeConferences/transgender2006.cfm.
Oct 12-15, 2006	Toronto, Ontario	**44th Annual Meeting of the Infectious Diseases Society of American (IDSA)**. Sponsor: IDSA. Contact: Phone: 703-299-0200 (phone); 703-299-0204 (fax); info@idsociety.org (email); www.idsociety.org (website).

Oct 15, 2006	National Observance	**National Latino AIDS Awareness Day.** Sponsor: Latino commission on AIDS. Hispanic Federation. Contact: http://www.nalaad.org (website).
Oct 26-29, 2006	Las Vegas, NV	**Scaling the Heights of HIV/AIDS Nursing: 19th Annual Conference**. Sponsor: Association of Nurses in AIDS Care (ANAC). Contact: http://www.anacnet.org/conf_natlconf.php.
Nov 4-8, 2006	Boston, MA	**American Public Health Association 134th Annual Meeting: Public Health and Human Rights**. Sponsor: American Public Health Association. Contact: 202-777-2742 (phone); http://www.apha.org (website).
Nov 8-12, 2006	Oakland, CA	**6th National Harm Reduction Conference**. Sponsor: Harm Reduction Conference. Contact: www.harmreduction.org/index.html?conference/conferenceindex.html (website); 212-213-63776 ext 15 (phone); Santiago@harmreduction.org (e-mail).
Nov 17-21, 2006	Baltimore, MD	**10th Anniversary Annual International Meeting**. Sponsor: Institute of Human Virology. Contact: www.ihv.org (website); lenzner@umbi.umd.edu (email).
Dec 1, 2006	International Observance	**World AIDS Day 2006**
Dec 7-9, 2006	San Francisco, CA	**Medical Management of AIDS: A Comprehensive Review of HIV Management**. Sponsor: University of California, San Francisco School of Medicine. Contact: Office of Continuing Medical Information, phone: 415-476-4251 or e-mail: info@ocme.ucsf.edu or access the website at https://www.cme.ucsf.edu/cme/.
March 21, 2007	National Observance	**National Native HIV/AIDS Awareness Day**.

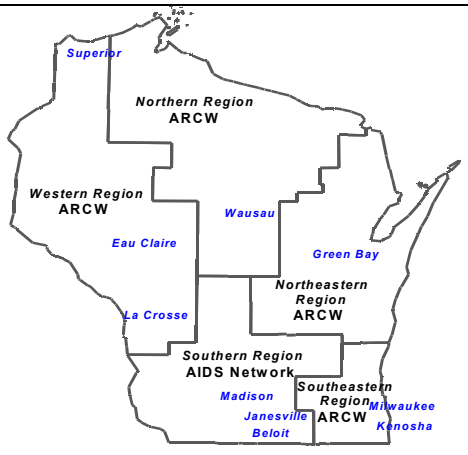
Important Contacts

Wisconsin HIV/STD/Hepatitis C Information and Referral Center..... 800/334-2437
Wisconsin AIDS/HIV Program 608/267-5287
Wisconsin AIDS Research Consortium
(clinical trials)..... 800/359-9272
Wisconsin AIDS/HIV Drug Reimbursement Program..... 800/991-5532
Wisconsin AIDS/HIV Continuation Coverage Premium
Subsidy Program..... 800/991-5532
Wisconsin Partner Referral Program
Milwaukee..... 414/286-8513 or 8512
Madison 608/267-5288
Wisconsin Office of Alcohol & Other Drug Abuse (AODA)..... 608/266-9218
Wisconsin Division of Vocational Rehabilitation
(applying for disability) 608/266-1281
Wisconsin Department of Public Instruction
AIDS/HIV consultants..... 608/267-3721 or 3750
Wisconsin HIV Primary Care Support Network..... 414-266-2672
Wisconsin Site of Midwest AIDS Training & Ed Center (MATEC) 608-258-9103
National Clinical Trials Information 800/TRIALS-A
National Drug Abuse Hotline 800/662-HELP
National AIDS Hotline.....800/342-AIDS
Hearing Impaired.....800/AIDS-TTY
Spanish Language.....800/344-SIDA
CDC National Prevention Information Network..... 800/458-5231
CDC Hepatitis Information Line:..... 888-443-7232
National STD Hotline..... 800/227-8922
National Office of Minority Health
Resource Center.....800/444-MHRC
National Cryptosporidiosis Information Line 404/330-1242

Wisconsin Counties by Region

Northern Region	Northeastern Region	Western Region	Southern Region	Southeastern Region
Ashland	Brown	Barron	Adams	Jefferson
Bayfield	Calumet	Buffalo	Columbia	Kenosha
Florence	Door	Burnett	Crawford	Milwaukee
Forest	Fond du Lac	Chippewa	Dane	Ozaukee
Iron	Green Lake	Clark	Dodge	Racine
Langlade	Kewaunee	Douglas	Grant	Walworth
Lincoln	Manitowoc	Dunn	Green	Washington
Marathon	Marinette	Eau Claire	Iowa	Waukesha
Oneida	Marquette	Jackson	Juneau	
Portage	Menominee	La Crosse	Lafayette	
Price	Oconto	Monroe	Richland	
Sawyer	Outagamie	Pepin	Rock	
Taylor	Shawano	Pierce	Sauk	
Vilas	Sheboygan	Polk		
Wood	Waupaca	Rusk		
	Waushara	St. Croix		
	Winnebago	Trempealeau		
		Vernon		
		Washburn		

Regional Offices of Designated Wisconsin AIDS Service Organizations		
Northern Region **AIDS Resource Center of Wisconsin**	1105 Grand Ave Suite 3 Schofield WI 54476	715-355-6867 800-551-3311 715-355-0640 (FAX)
Northeastern Region **AIDS Resource Center of Wisconsin**	445 S Adams St Green Bay WI 54301	920-437-7400 800-675-9400 920-437-1040 (FAX)
Western Region **AIDS Resource Center of Wisconsin**	505 Dewey St South Suite 107 Eau Claire WI 54701	715-836-7710 800-750-2437 715-836-9844 (FAX)
	Grandview Center 1707 Main St Suite 420 La Crosse WI 54601	608-785-9866 800-947-3353 608-784-6661 (FAX)
	Board of Trade Building 1507 Tower Ave Suite 230 Superior WI 54880	715-394-4009 877-242-0282 (toll free) 715-394-4066 (FAX)
Southern Region **AIDS Network**	600 Williamson St Madison WI 53703	608-252-6540 800-486-6276 608-252-6559 (FAX)
	101 East Milwaukee Street #96 Janesville WI 53545	608-756-2550 800-486-6276 608-756-2545 (FAX)
	136 West Grand Ave Suite 202 Beloit WI 53511	608-364-4027 800-486-6276 608-364-0473 (FAX)
Southeastern Region **AIDS Resource Center of Wisconsin**	820 N Plankinton Ave Milwaukee WI 53203	414-273-1991 800-359-9272 414-273-2357 (FAX)
	1212 57th St Kenosha WI 53140	262-657-6644 800-924-6601 262-657-6949 (FAX)



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Data collection and reporting of HIV infection; medical records review; assessment of HIV case reports.

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Design, implementation and analysis of seroprevalence surveys; analysis of surveillance data; projections.

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Technical assistance & consultation regarding rapid HIV testing and quality assurance of HIV counseling and
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