Positively Palm Beach

Treasure Coast Health Council

July—August
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Summary of Changes to the National *HIV Surveillance Report*

The annual *HIV Surveillance Report* provides a broad overview of the current epidemiology of HIV disease in the United States and 5 U.S. dependent areas. CDC funds state and territorial health departments to collect surveillance data on persons diagnosed with HIV infection; all personal identifiers are removed from these data before being transmitted to CDC via a secure data network. Data are analyzed by CDC and then displayed, for this report, by age, race/ethnicity, sex, transmission category, or jurisdiction. As a source document, the *HIV Surveillance Report* is intended to provide a basic understanding of the HIV epidemic in the United States and is not intended to provide in-depth analyses of special populations or issues of interest. Those more specialized analyses are more suited to supplemental reports such as CDC's supplement surveillance reports, slide series, and peer-reviewed manuscripts.

Changes to the *HIV Surveillance Report* for 2008 were made in response to requests from public health partners, Surveillance Coordinators and AIDS Directors, in order to make better use of data collected through surveillance and to best characterize the HIV epidemic in the United States. This document provides a summary of and an explanation for these changes as well as general description about the report contents and format.
Additional factors contributing to the overall need to make changes to the report include:

- As of April 2008, all states had implemented confidential name-based HIV infection reporting. This is a tremendous change in the operation of our surveillance system and requires some changes to how we display our data. However, it should be noted that only 37 states have been reporting HIV infection data to CDC long enough (defined as being submitted to CDC by at least January 2005) to apply statistical adjustments to the data and be included in CDC's estimates in this report. The *HIV Surveillance Report* for 2012 (issued in 2014) will be the first time the data from all 50 states will be included in the estimates.

- In 2008, changes were made to the case definition for HIV infection. The new case definition combined the two previous case definitions for HIV and AIDS, and established a new disease staging classification. This change in the new case definition prompted our changes to the title of the report and new terminology HIV infection throughout the report.

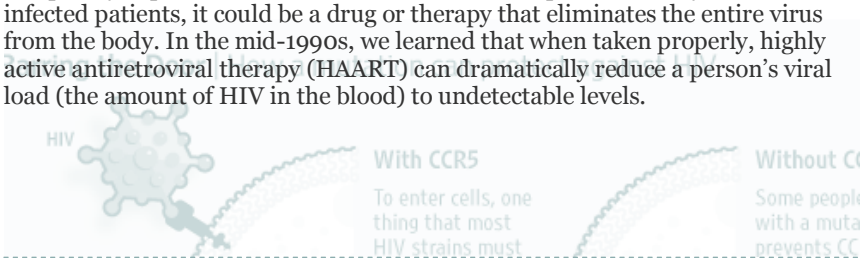
- Advancing technologies and effectiveness of highly active anti-retroviral therapy (HAART) is changing the epidemic of HIV infection so people are living longer and healthier lives. Therefore, in order to accurately track the epidemic, growing emphasis needs to be placed on HIV surveillance rather than AIDS surveillance, a gradual process that is reflected in changes to the report.

INSIDE THIS ISSUE

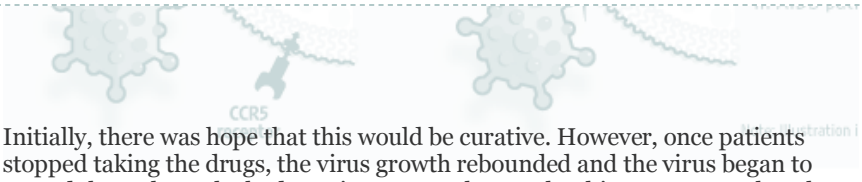
Pursuing a "Cure" for HIV/AIDS – Two Distinct Approaches

Contrary to what you may have heard or read on the Internet, there is currently no cure for HIV/AIDS. While some say that there may never be a cure, I believe there is reason for hope. That's because some of our best scientists are working on two distinct approaches to finding a cure for HIV/AIDS, both of which are starting to gain traction within the HIV/AIDS research community.

When people think of the word "cure," some imagine a magic elixir that can completely wipe out a disease or illness from a sick person. Ideally for HIV-infected patients, it could be a drug or therapy that eliminates the entire virus from the body. In the mid-1990s, we learned that when taken properly, highly active antiretroviral therapy (HAART) can dramatically reduce a person's viral load (the amount of HIV in the blood) to undetectable levels.



"Ideally for HIV-infected patients, it could be a drug or therapy that eliminates the entire virus from the body."



Initially, there was hope that this would be curative. However, once patients stopped taking the drugs, the virus growth rebounded and the virus began to spread throughout the body again. We now know why this occurs: HIV has the ability to hide within certain places in the body (called "reservoirs") and lay dormant for many years. To find a cure, we need to identify and eliminate all these HIV reservoirs. While this is no doubt a very difficult goal to achieve, scientists are working toward uncovering HIV's favorite hiding places.

Another approach known as a "functional cure" would allow HIV-infected individuals to live without the need for lifelong antiretroviral treatment and remain healthy. Some scientists believe that by aggressively treating early HIV infection using a potent combination of existing and next-generation drugs, we may be able to minimize the number of established HIV reservoirs. By doing this, the body's immune system would be protected from the initial wave of viral destruction HIV causes, allowing it to keep the virus in check for an extended period of time. The National Institutes of Health (NIH) is currently conducting preliminary studies to determine whether this approach could be effective. At the same time, NIH also is inviting scientists worldwide to get involved in the effort to help clarify basic aspects of the HIV reservoirs and to design other strategies for curing HIV/AIDS.

To help end the HIV/AIDS pandemic, we must pursue a multi-pronged approach with a cure as a major goal. We need to provide HIV-infected people with a means of either mitigating the effects of HIV or ridding themselves of infection. If we're successful with either of these two cure approaches, we'll be taking a big step forward in bringing an end to the pandemic.

By Carl W. Dieffenbach, Ph.D., Director of NIAID Division of AIDS

KEY REFERENCES THAT EXPLAIN THE HIV EPIDEMIC IN THE UNITED STATES

Following are some of the key indicators of HIV disease in the United States and the references that best explain them.

- **HIV incidence in the United States**: Hall HI, Song R, Rhodes P, et al. Estimation of HIV incidence in the United States. *JAMA* 2008;300(5):520-529.

HIV incidence in the United States by subpopulation estimates: CDC. Subpopulation estimates from the HIV Incidence Surveillance System—United States, 2006. MMWR 2008. 57(36);985-989.
HIV prevalence in the United States: CDC. HIV prevalence estimates—United States, 2006. *MMWR*. 2008;57(39):1073-1076.

- **Estimate of undiagnosed persons with HIV in the United States**: Campsmith, ML, Rhodes PH, Hall HI et al. Undiagnosed HIV prevalence among adults and adolescents in the United States at the end of 2006. *J Acquir Immune Defic Syndr*. 2010;53(5):619-624.

- **HIV transmission rates**: Holtgrave DR, Hall HI, Rhodes PH, et al. Updated annual HIV transmission rates in the United States, 1977-2006. *J Acquir Immune Defic Syndr* 2009;50(2):236-238.

Lifetime risk of HIV infection: Hall, HI, An Q, Hutchinson A, et al. Estimating the lifetime risk of a diagnosis of the HIV infection in 33 states, 2004-2005, *J Acquir Immune Defic Syndr* 2008;49(3):294-297.

- **Deaths from HIV**:

CDC. WISQARS Leading Causes of Death Reports, 1999 – 2006.

o NCHS. Deaths: Final data for 2006. Statistics Reports 2009;57(14).

ESTIMATE OF NUMBER OF MSM IN THE UNITED STATES AND MSM'S RATES OF HIV AND SYPHILIS: PURCELL DW, JOHNSON C, LANSKY A, ET AL. PRESENTED AT 2010 NATIONAL STD PREVENTION CONFERENCE; ATLANTA, GA. ABSTRACT #22896.

FUTURE PRIORITIES FOR NIAID'S HIV PREVENTION RESEARCH

As we begin to discuss the restructuring of NIAID's clinical trials networks, let us first focus on the Institute's HIV prevention research agenda. Developing new biomedical tools that can safely and effectively prevent HIV acquisition and transmission is critical to addressing the global HIV/AIDS pandemic. Currently, we are exploring several promising HIV prevention strategies that, if proven successful, could have a significant impact on reducing the incidence of new infections. These strategies include microbicides — gels, foams, creams, and other formulations designed to prevent sexual transmission of HIV — and pre-exposure prophylaxis (PrEP), attempting to block HIV infection by providing antiretroviral medicines to people who are not infected with HIV but who are at high risk for infection. HIV vaccines are also a major focus of our prevention research efforts, but we will discuss that area specifically in an upcoming blog post.

Vaginally or rectally applied microbicides could potentially provide women and men with a means of protecting themselves against sexually transmitted HIV infection. Non-human primate studies have shown that antiretroviral -based microbicides protect against HIV infection, and these types of products are now being tested in people. Nearly a dozen clinical studies are currently evaluating different microbicide candidates and delivery methods, such as the VOICE trial, which is comparing oral antiretroviral medicines to an antiretroviral-based topical gel for HIV prevention. That study is being conducted by the NIAID -supported Microbicide Trials Network. Future microbicide research efforts will focus on evaluating new products, formulations and routes of administration with the goal of finding a safe and effective microbicide that is reliably used by its intended population.

Using antimicrobial drugs prophylactically has been shown to be effective in preventing other infectious diseases, such as malaria, and lends hope that a similar strategy using antiretroviral medicines could do the same for preventing HIV acquisition. The strategy also has been shown to block HIV transmission from infected mothers to their infants and currently is being explored further in the multinational clinical trial known as the PROMISE study. That trial, which is being conducted by the NIAID-supported International Maternal Pediatric Adolescent AIDS Clinical Trials network, is examining how antiretroviral regimens may best reduce the risk of HIV transmission from infected pregnant women to their babies during pregnancy and breastfeeding while preserving the health of the children and mothers.

In addition to the PROMISE study, several other studies are underway that are evaluating PrEP among different populations with some results expected later this year or early into 2011.

Moving forward in designing and evaluating microbicides and PrEP, questions related to adherence and behavior must be considered. These prevention tools will only be effective if they are used properly and consistently, and we need to be sure that benefits of the interventions are not obviated by increased risky behavior.

In addition to microbicides and PrEP, there is a range of other possible approaches to preventing HIV acquisition and transmission that could be evaluated, including strategies designed to increase utilization of HIV testing, behavioral interventions aimed at reducing HIV risk, and approaches to reducing alcohol or drug use, which contribute to increased risk for HIV infection. Additionally, structural interventions – those focused on at-risk communities groups as compared to individuals – could be evaluated as well.

Integrating proven HIV prevention strategies is another important area of exploration. As the number of validated prevention approaches increases, we need to determine optimal combinations in terms of impact and cost-effectiveness. Given that we are unlikely to find a prevention strategy that is fully effective for everyone, a multi-pronged approach tailored to different communities is the best way to end the global HIV/AIDS pandemic. This will require strong partnerships with the Centers for Disease Control and Prevention (CDC), the President's Emergency Plan for AIDS Relief, and other NIH institutes and centers. For example, NIAID and CDC are preparing to launch the HIV Prevention Trials Network (HPTN) 065 study, or TLC+, a feasibility study that will involve expanded HIV testing, better linking of those who test HIV positive to medical care and treatment, and improving adherence to HIV treatment.

Given what I've noted here about NIAID's current HIV prevention research agenda and potential future directions, please consider the following:

- Have we considered the most important scientific priority areas for HIV prevention? If not, what are we missing?
- Among the priority areas that we have identified, what is the appropriate balance to pursue (e.g., should we devote the majority of our attention to one area in particular)?
- How will a "test and treat" research agenda be affected if it is discovered that expanded HIV testing and linkage to care and antiretroviral treatment provides both a clinical benefit to the individual infected with HIV and a reduction in HIV transmission to the larger population?
- Are there remaining research issues associated with preventing mother-to- child HIV transmission?
- What are the emerging opportunities in combination prevention? What threshold of reduced HIV incidence in animal models should be sufficient to initiate a clinical trial?
- What other HIV prevention-related questions should be considered as important scientific priorities?

Statement by the President on National HIV Testing Day

25 Jun 2010, 1:37pm

This Sunday is National HIV Testing Day, an occasion to raise awareness of the steps each of us can take as individuals to fight HIV/AIDS. As we mark this day, I would like to renew my call for all Americans to help reduce the risk of infection by getting tested for HIV and learning their HIV status. One in five Americans who are currently living with HIV-- more than 230,000 people -- do not know their status. The majority of HIV infections are spread by those who are unaware that they have the disease. And research shows that people who know their status take better care of themselves and take steps to reduce the risk of transmitting HIV to others. That is why it is so important that people get tested.

In recent years, we have made huge advances in HIV research, prevention and care. Still, HIV and AIDS remains an epidemic in this country. That is why my Administration is launching in the coming days a comprehensive National HIV/AIDS Strategy focused on reducing new HIV infections, increasing access to care, and reducing HIV-related health disparities. But government cannot address this important issue alone. We need the commitment of businesses, churches and faith groups, philanthropic organizations, the scientific and medical communities, educational institutions and others. And all of us have a responsibility to reduce our risk and know our status, to continue to support those already affected by this disease, and to fight the stigma and discrimination people still face. So on this National HIV Testing Day, let us all recommit to do our part to help stop the spread of HIV and AIDS

BARACK OBAMA~

Epidemiologic Differences Between Native-Born and Foreign-Born Black People Diagnosed with HIV Infection in 33 U.S. States, 2001–2007

SYNOPSIS

Objective. Few studies have examined the extent to which foreign-born people contribute to the human immunodeficiency virus (HIV) epidemic among non-Hispanic black people in the U.S. We sought to determine differences in the epidemiology of HIV infection among native- and foreign-born black people, using data from the national HIV surveillance system of the Centers for Disease Control and Prevention.

Methods. We estimated the number of HIV infections among black adults and adolescents diagnosed from 2001 to 2007 in 33 U.S. states. We compared annual HIV diagnosis rates, distributions of demographic characteristics and HIV-transmission risk factors, late diagnoses of HIV infection, and survival after an acquired immunodeficiency syndrome (AIDS) diagnosis for native- and foreign-born black people.

Results. From 2001 to 2007, an estimated 100,013 black adults and adolescents were diagnosed with HIV infection in 33 U.S. states, for which countryof-birth information was available. Of these, 11.7% were foreign-born, with most from the Caribbean (54.1%) and Africa (41.5%). Annual HIV diagnoses decreased by 5.5% per year (95% confidence interval [CI] –5.9, –5.0) among native-born black people. Decreases were small among foreign-born black people (–1.3%; 95% CI –2.6, –0.1), who were more likely to be female, have HIV infection attributable to high-risk heterosexual contact, be diagnosed with AIDS within 12 months of HIV diagnosis, and survive one year and three years after an AIDS diagnosis.

Conclusions. The epidemiology of HIV infection differs for foreign-born black individuals compared with their native-born counterparts in the U.S. These data can be used to develop culturally appropriate and relevant HIV-prevention intervetions.

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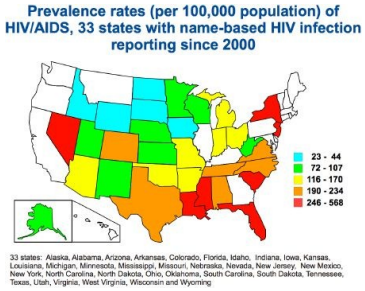

Does Education Matter? Examining Racial Differences in the Association Between Education and STI Diagnosis Among Black and White Young Adult Females in the U.S.

Objectives. Education has long been considered a protective factor against sexual risk behaviors and sexually transmitted infections (STIs) among adolescents; however, few have explored this association and determined differences across racial/ethnic groups of young adult females on a national scale. The purpose of this study was to (*1*) describe the association between education and STI diagnosis among a national sample of black and white young adult females and (*2*) examine racial differences in this association.

Methods. We used data from the National Longitudinal Study of Adolescent Health (Add Health) to assess the association between education and chlamydia, gonorrhea, and/or trichomoniasis (self-reported and assay-diagnosed) in 2001–2002 using logistic regression analysis.

Results. After adjustment for risk behaviors, education was inversely associated with any assay-diagnosed STI, but this association was nonsignificant among black women for self-reported STI. Additionally, black females enrolled in, or who graduated from, college had significantly higher predicted probabilities of having an STI (12.4% self-reported; 13.4% assay-diagnosed) compared with white females who had less than a high school diploma (6.4% self-reported; 2.3% assay-diagnosed).

Conclusions. Educational status was not uniformly protective against STIs for black and white females in this sample. Particularly for young black women, other factors may play a more prominent role in determining STI risk. Social determinants, such as education, should be viewed as important factors associated with STI prevalence, but their differential impact on various racial/ethnic groups should also be considered when addressing the disproportionate rates of STIs in the U.S.

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FOUNDCARE HEALTH CENTER ANNOUNCES BOARD MEMBERS AND OFFICERS

(West Palm Beach) – The FoundCare board of directors held its annual meeting and biennial elections recently to announce officers and members. Board members direct policy and conduct fundraising for programs at FoundCare Health Center, located at 2330 South Congress Avenue in West Palm Beach.

Re-elected as officers for the FoundCare board of directors are Michael J. Calhoun, President; Claire J. Arnold, Vice President; Dr. Wedler A. Alexandre, Secretary and Clement C. Brandenburg, Treasurer. Directors include Carmen Callahan, James L. Collins, Dr. David Dodson, Ken Druskin, M.L. Farrell, Paul E. Gordon and Gary Richie.

"The board's commitment to helping others is truly extraordinary," said FoundCare board president Michael Calhoun. "They mirror the professionalism, dedication, and enthusiasm of our exceptional staff in fulfilling the organization's mission to provide greater access to quality healthcare in Palm Beach County, regardless of a patient's ability to pay."

FoundCare Health Center is a nonprofit full-service community health center providing medical care for Palm Beach County residents with limited or no health insurance. FoundCare Health Center serves patients regardless of their ability to pay. Since it opened its doors a year ago, FoundCare Health Center has provided access to quality health care for over 1,700 new uninsured and under insured patients at its state-of-the-art offices.

For more information on FoundCare Health Center, please call 561.472.3022 x252 or visit www.foundcare.org.

"AIDS can destroy a family if you let it, but luckily for my sister and me, Mom taught us to keep going. Don't give up, be proud of who you are, and never feel sorry for yourself." Ryan White~

COMPREHENSIVE AIDS PROGRAM OF PALM BEACH COUNTY INC. ANNOUNCES NEW BOARD OF DIRECTORS, OFFICERS AND MEMBERS

(West Palm Beach) –Comprehensive AIDS Program of Palm Beach County Inc. (CAP) Board of Directors held its annual meeting and biennial elections recently to announce new officers. CAP board members direct policy and conduct fundraising for CAP programs.

New officers are Elizabeth A. Clark, president and Carmen Callahan, treasurer. Re-elected CAP officers are John A. Foley Esq, vice president and Maria Vazquez, secretary. The remaining directors are Keith W. Babb, Jr., Kimberly Jackson, Dr. Jeraline Marsh. Trustees include Robert Bertisch, Esq., William L. Jagoe, and Dr. Beny J. Primm.

"Any time you have a chance to help people and give back to your community is a great opportunity," Clark began. "Sadly, my brother died from AIDS years ago and being a part of an organization like CAP not only provides a service for individuals in need but also allows me to watch my time, contributions and dedication positively reflect on the community."

CAP provides and promotes education, advocacy and compassion to individuals and families infected and affected by HIV and AIDS through case management, prevention and other support services. CAP works throughout Palm Beach County to provide such support services as housing assistance, food, transportation, mental health counseling and emergency assistance.

Since its inception in 1985, CAP has provided educational services to more than 250,000 people in a variety of settings, including prisons, county schools, on the streets in high-risk neighborhoods, in health settings, substance abuse treatment centers, methadone clinics, and others. Celebrating 25 years of service, the local organization has grown into one of the most successful community-based HIV/AIDS service organizations in the nation.

For more information on CAP programs and services please call 561.472.2466 or visit www.cappbc.org

Paws Care, Inc is a non-profit organization dedicated to helping to care for the pets of those affected by HIV/AIDS, Cancer and other Terminal Illness. Ran solely on community volunteers and funding, Paws Care is determined to provide a happy, healthy and loving environment for both the pet and its parent.

Paws Care Programs:
- Pet Food Bank-Food Donation
- Pet Accessories and Toy Donations
- In-Kind Veterinarian Services
- Temporary Emergency Boarding
- Rest of Life Adoption

Paws Care
Helping to care for the pets of those affected by HIV/AIDS, Cancer and other terminal illnesses
Contact Us at: help@pawscare.org

Paws Care believes that our pets are apart of our family and tries very hard to provide services to help those in need to keep their pets.

Paws Care Services:
- Pet Food Bank
- Pet Accessories and Toys
- Limited Veterinarian Services*
- Temporary Emergency Boarding*
- Rest of Life Pet Adoption.

* services are available in certain areas, please check with Paws Care to see if you r area has these services available. All services are based on an approved application.

A financial burden on top of facing a devastating illness is not an easy task. Paws Care works to help provide pet care needs, but we cannot do it without the help of caring people like you. Please help by donating to Paws Care.
Donations are accepted on the web via:
- Pay Pal
- Chip In

Or directly contact Paws Care to provide your donation.

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Easy Huevos Rancheros

1 Serving
This is a good brunch or lunch dish. Look for a brand of canned, low fat and low sodium all-natural refried beans. (Or, make your own.) Most of the fat in this dish is "good fat" from the avocado; if you're trying to lose weight, you might skip the avocado or substitute apple or pear.

Ingredients:
1 whole wheat flour tortilla
1/4 cup low fat, all-natural refried beans
1 egg (preferably organic)
2 tbsp salsa
1/4 avocado

Instructions:
Heat the tortilla in the oven briefly until it is slightly crisp. In the meantime, fry the egg and heat up the refried beans in the microwave. Assemble the dish by putting the beans on the crisp tortilla and topping with the fried egg. Garnish with salsa and avocado slices.

Nutritional Information:
Per serving:
297 calories
15 g total fat (3 g sat)
187 mg cholesterol
32 g carbohydrate
13 g protein
7 g fiber
386 mg sodium

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WE ARE HERE TO HELP

The Palm Beach County HIV CARE council is a community based organization supporting local public participation in the planning for a system of medical and support services for individuals and families living with HIV and AIDS. One of the founding themes of the CARE Council is the belief that people living with HIV/AIDS can live a better, healthier and more productive life with the most current treatments supported by the most practical supports. Thus, we are a partnership of medical and health support service providers, funders of those services as well as people using these services and people who love and care for those living with HIV.

We welcome you to join us in bringing the most effective treatments for HIV/AIDS to those in need, and invite you to work toward providing those services in the most effective compassionate manner.

Responsibilities of the CARE Council are part of the Ryan White HIV/AIDS Treatment Modernization Act. Under this federal legislation areas of the United States which are hit especially hard by the AIDS pandemic receive federal funds to assist in fighting the effects of the disease.

Members of the CARE Council are nominated through a process which is open to public participation. Appointment to the Council is made by the Palm Beach County Board of County commissioners for a two year term. Membership is guided by federal principals guiding participation which reflects the demographic make up of the disease in this county.
The majority of the work of the Council is done in committee and brought to the full Council for approval. All meetings of the Palm Beach County HIV CARE Council are open to the public and are run under aspects of Florida's Open Meetings Act, also referred to as the Sunshine Law.

To be removed from our mailing list please contact Tonya Fowler at 561-844-4220X 15

NOW ACCEPTING MEMBERSHIP APPLICATIONS