

WISCONSIN AIDS/HIV UPDATE

Prevention through education

AIDS/HIV Program - Wisconsin Division of Public Health - Department of Health & Family Services - Summer 2007

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Comments and suggestions for future topics are welcomed.

Wisconsin AIDS/HIV Surveillance Summary

Cases reported 1983 through June 30, 2007

	Cumulative		Reported 2002-2006		Reported in 2007		Presumed alive	
	Cases	Percent	Cases	Percent	Cases	Percent	Cases	Percent
Total cases	9,713	100.0%	1,950	100.0%	190	100.0%	6,107	100.0%
Current disease category								
AIDS	6,531	67.2%	919	47.1%	57	30.0%	3,186	52.2%
Non-AIDS	3,182	32.8%	1,031	52.9%	133	70.0%	2,921	47.8%
Risk Exposure Categories								
Men who have sex with men (MSM)	5,069	52.2%	926	47.5%	73	38.4%	2,924	47.9%
Injecting drug use (IDU)	1,391	14.3%	179	9.2%	13	6.8%	809	13.2%
MSM and IDU	674	6.9%	126	6.5%	8	4.2%	410	6.7%
Hemophilia/Coagulation disorder	120	1.2%	3	0.2%	0	0.0%	43	0.7%
High-risk heterosexual contact	1,164	12.0%	276	14.2%	8	4.2%	883	14.5%
Transfusion-associated	84	0.9%	8	0.4%	1	0.5%	30	0.5%
Mother with/at risk	85	0.9%	19	1.0%	0	0.0%	67	1.1%
Undetermined	1,126	11.6%	413	21.2%	87	45.8%	941	15.4%
Gender								
Female	1,617	16.6%	406	20.8%	39	20.5%	1,205	19.7%
Male	8,096	83.4%	1,544	79.2%	151	79.5%	4,902	80.3%
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Race/Ethnicity								
White	5,410	55.7%	943	48.4%	90	47.4%	3,030	49.6%
Black	3,230	33.3%	700	35.9%	64	33.7%	2,292	37.5%
Hispanic	903	9.3%	255	13.1%	28	14.7%	664	10.9%
Asian/Pacific Islander	63	0.6%	24	1.2%	3	1.6%	52	0.9%
American Indian	88	0.9%	17	0.9%	0	0.0%	51	0.8%
Multi-racial	11	0.1%	10	0.5%	1	0.5%	10	0.2%
Unknown	8	0.1%	1	0.1%	4	2.1%	8	0.1%
Age at diagnosis*								
Under 5	82	0.8%	18	0.9%	1	0.5%	6	0.1%
5-14	36	0.4%	6	0.3%	0	0.0%	35	0.6%
15-19	241	2.5%	69	3.5%	8	4.2%	31	0.5%
20-24	1,074	11.1%	246	12.6%	27	14.2%	165	2.7%
25-44	6,864	70.7%	1,247	63.9%	105	55.3%	3,025	49.5%
45 years and older	1,408	14.5%	364	18.7%	49	25.8%	2,824	46.2%
Unknown	8	0.1%	0	0.0%	0	0.0%	10	0.2%

* For cases presumed alive, age is the age on 06/30/2007.

Year of Report

Before 1990	1,485	15.3%
1990	672	6.9%
1991	656	6.8%
1992	683	7.0%
1993	650	6.7%
1994	514	5.3%
1995	562	5.8%
1996	426	4.4%
1997	447	4.6%
1998	381	3.9%
1999	372	3.8%
2000	389	4.0%
2001	336	3.5%
2002	388	4.0%
2003	364	3.7%
2004	417	4.3%
2005	374	3.9%
2006	407	4.2%
2007	190	2.0%



Wisconsin AIDS/HIV Surveillance Summary

Cases by DHFS region and county, cases reported 1983 through June 30, 2007

Northeastern Region	<u>Cumulative</u>		<u>Reported 2002-2006</u>			<u>Reported in 2007</u>			<u>Presumed alive</u>		
	Cases	%	Cases	%	Rate*	Cases	%	Rate**	Cases	%	Rate**
BROWN	323	34.8%	63	32.1%	5.6	10	37.0%	4.4	197	35.4%	86.9
CALUMET	10	1.1%	1	0.5%	0.5	1	3.7%	2.5	6	1.1%	14.8
DOOR	20	2.2%	5	2.6%	3.6	1	3.7%	3.6	12	2.2%	42.9
FOND DU LAC	47	5.1%	10	5.1%	2.1	1	3.7%	1.0	30	5.4%	30.8
GREEN LAKE	9	1.0%	4	2.0%	4.2	0	0.0%	0.0	8	1.4%	41.9
KEWAUNEE	4	0.4%	1	0.5%	1.0	0	0.0%	0.0	2	0.4%	9.9
MANITOWOC	44	4.7%	11	5.6%	2.7	1	3.7%	1.2	26	4.7%	31.4
MARINETTE	34	3.7%	6	3.1%	2.8	2	7.4%	4.6	19	3.4%	43.8
MARQUETTE	10	1.1%	0	0.0%	0.0	0	0.0%	0.0	6	1.1%	37.9
MENOMINEE	17	1.8%	3	1.5%	13.2	0	0.0%	0.0	11	2.0%	241.1
OCONTO	16	1.7%	0	0.0%	0.0	0	0.0%	0.0	5	0.9%	14.0
OUTAGAMIE	115	12.4%	34	17.3%	4.2	3	11.1%	1.9	75	13.5%	46.6
SHAWANO	27	2.9%	3	1.5%	1.5	1	3.7%	2.5	12	2.2%	29.5
SHEBOYGAN	83	8.9%	21	10.7%	3.7	5	18.5%	4.4	53	9.5%	47.1
WAUPACA	15	1.6%	7	3.6%	2.7	0	0.0%	0.0	10	1.8%	19.3
WAUSHARA	11	1.2%	6	3.1%	5.2	0	0.0%	0.0	8	1.4%	34.6
WINNEBAGO	144	15.5%	21	10.7%	2.7	2	7.4%	1.3	77	13.8%	49.1
Region total***	929	100.0%	196	100.0%	3.4	27	100.0%	2.3	557	100.0%	48.0

Northern Region	<u>Cumulative</u>		<u>Reported 2002-2006</u>			<u>Reported in 2007</u>			<u>Presumed alive</u>		
	Cases	%	Cases	%	Rate*	Cases	%	Rate**	Cases	%	Rate**
ASHLAND	11	3.5%	4	5.9%	4.7	0	0.0%	0.0	8	4.5%	47.4
BAYFIELD	11	3.5%	1	1.5%	1.3	0	0.0%	0.0	8	4.5%	53.3
FLORENCE	1	0.3%	1	1.5%	3.9	0	0.0%	0.0	1	0.6%	19.7
FOREST	8	2.5%	0	0.0%	0.0	0	0.0%	0.0	5	2.8%	49.9
IRON	10	3.2%	4	5.9%	11.7	0	0.0%	0.0	4	2.2%	58.3
LANGLADE	10	3.2%	4	5.9%	3.9	0	0.0%	0.0	7	3.9%	33.8
LINCOLN	7	2.2%	2	2.9%	1.3	0	0.0%	0.0	3	1.7%	10.1
MARATHON	92	29.3%	21	30.9%	3.3	2	33.3%	1.6	57	32.0%	45.3
ONEIDA	23	7.3%	5	7.4%	2.7	2	33.3%	5.4	13	7.3%	35.3
PORTAGE	54	17.2%	14	20.6%	4.2	1	16.7%	1.5	27	15.2%	40.2
PRICE	7	2.2%	1	1.5%	1.3	0	0.0%	0.0	1	0.6%	6.3
SAWYER	7	2.2%	0	0.0%	0.0	0	0.0%	0.0	3	1.7%	18.5
TAYLOR	4	1.3%	0	0.0%	0.0	1	16.7%	5.1	3	1.7%	15.2
VILAS	16	5.1%	3	4.4%	2.9	0	0.0%	0.0	9	5.1%	42.8
WOOD	53	16.9%	8	11.8%	2.1	0	0.0%	0.0	29	16.3%	38.4
Region total***	314	100.0%	68	100.0%	2.8	6	100.0%	1.2	178	100.0%	36.9

Southeastern Region	<u>Cumulative</u>		<u>Reported 2002-2006</u>			<u>Reported in 2007</u>			<u>Presumed alive</u>		
	Cases	%	Cases	%	Rate*	Cases	%	Rate**	Cases	%	Rate**
JEFFERSON	41	0.7%	7	0.6%	1.9	1	1.0%	1.4	21	0.6%	28.4
KENOSHA	291	4.9%	70	6.2%	9.4	9	8.7%	6.0	187	5.1%	125.0
MILWAUKEE	4,866	82.7%	899	79.8%	19.1	78	75.7%	8.3	3,061	83.0%	325.6
OZAUKEE	43	0.7%	13	1.2%	3.2	0	0.0%	0.0	27	0.7%	32.8
RACINE	297	5.0%	59	5.2%	6.2	4	3.9%	2.1	186	5.0%	98.5
WALWORTH	81	1.4%	24	2.1%	5.1	1	1.0%	1.1	44	1.2%	46.9
WASHINGTON	57	1.0%	10	0.9%	1.7	4	3.9%	3.4	37	1.0%	31.5
WAUKESHA	208	3.5%	44	3.9%	2.4	6	5.8%	1.7	126	3.4%	34.9
Region total***	5,884	100.0%	1,126	100.0%	11.2	103	100.0%	5.1	3,689	100.0%	183.8

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Southern Region	<u>Cumulative</u>		<u>Reported 2002-2006</u>			<u>Reported in 2007</u>			<u>Presumed alive</u>		
	Cases	%	Cases	%	Rate*	Cases	%	Rate**	Cases	%	Rate**
ADAMS	25	1.4%	4	1.0%	4.3	0	0.0%	0.0	13	1.2%	69.7
COLUMBIA	37	2.1%	9	2.4%	3.4	0	0.0%	0.0	18	1.6%	34.3
CRAWFORD	23	1.3%	4	1.0%	4.6	0	0.0%	0.0	10	0.9%	58.0
DANE	1,206	69.4%	271	71.1%	12.7	25	73.5%	5.9	801	71.0%	187.8
DODGE	48	2.8%	13	3.4%	3.0	1	2.9%	1.2	35	3.1%	40.7
GRANT	29	1.7%	2	0.5%	0.8	2	5.9%	4.0	13	1.2%	26.2
GREEN	32	1.8%	5	1.3%	3.0	0	0.0%	0.0	17	1.5%	50.5
IOWA	15	0.9%	4	1.0%	3.5	0	0.0%	0.0	8	0.7%	35.1
JUNEAU	12	0.7%	3	0.8%	2.5	0	0.0%	0.0	7	0.6%	28.8
LAFAYETTE	8	0.5%	2	0.5%	2.5	0	0.0%	0.0	5	0.4%	31.0
RICHLAND	8	0.5%	0	0.0%	0.0	1	2.9%	5.6	4	0.4%	22.3
ROCK	236	13.6%	50	13.1%	6.6	5	14.7%	3.3	158	14.0%	103.7
SAUK	49	2.8%	12	3.1%	4.3	0	0.0%	0.0	35	3.1%	63.4
VERNON	9	0.5%	2	0.5%	1.4	0	0.0%	0.0	4	0.4%	14.3
Region total***	1,737	100.0%	381	100.0%	7.6	34	100.0%	3.4	1,128	100.0%	112.7

Western Region	<u>Cumulative</u>		<u>Reported 2002-2006</u>			<u>Reported in 2007</u>			<u>Presumed alive</u>		
	Cases	%	Cases	%	Rate*	Cases	%	Rate**	Cases	%	Rate**
BARRON	38	6.4%	10	7.6%	4.4	1	10.0%	2.2	23	6.4%	51.2
BUFFALO	5	0.8%	1	0.8%	1.4	2	20.0%	14.5	3	0.8%	21.7
BURNETT	14	2.4%	4	3.0%	5.1	1	10.0%	6.4	10	2.8%	63.8
CHIPPEWA	28	4.7%	7	5.3%	2.5	0	0.0%	0.0	16	4.4%	29.0
CLARK	15	2.5%	9	6.8%	5.4	0	0.0%	0.0	11	3.1%	32.8
DOUGLAS	54	9.2%	5	3.8%	2.3	2	20.0%	4.6	29	8.1%	67.0
DUNN	15	2.5%	3	2.3%	1.5	0	0.0%	0.0	8	2.2%	20.1
EAU CLAIRE	89	15.1%	16	12.1%	3.4	0	0.0%	0.0	51	14.2%	54.8
JACKSON	7	1.2%	1	0.8%	1.0	0	0.0%	0.0	2	0.6%	10.5
LA CROSSE	182	30.8%	49	37.1%	9.1	3	30.0%	2.8	123	34.2%	114.8
MONROE	27	4.6%	6	4.5%	2.9	1	10.0%	2.4	16	4.4%	39.1
PEPIN	2	0.3%	0	0.0%	0.0	0	0.0%	0.0	2	0.6%	27.7
PIERCE	24	4.1%	4	3.0%	2.2	0	0.0%	0.0	15	4.2%	40.8
POLK	24	4.1%	6	4.5%	2.9	0	0.0%	0.0	11	3.1%	26.6
RUSK	6	1.0%	1	0.8%	1.3	0	0.0%	0.0	3	0.8%	19.5
ST CROIX	39	6.6%	5	3.8%	1.6	0	0.0%	0.0	27	7.5%	42.8
TREMPEALEAU	11	1.9%	1	0.8%	0.7	0	0.0%	0.0	5	1.4%	18.5
WASHBURN	10	1.7%	4	3.0%	5.0	0	0.0%	0.0	5	1.4%	31.2
Region total***	590	100.0%	132	100.0%	3.7	10	100.0%	1.4	360	100.0%	50.5

* 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.

Technical notes

1. These reports are compiled by the Wisconsin AIDS/HIV Program and are based on AIDS and HIV infection case surveillance data collected by the Wisconsin Division of Public Health (DPH). They do not include data from the Counseling and Testing Site Program. In Wisconsin, state statutes require health care providers to report cases of AIDS and HIV infection to the DPH. For information about reporting requirements or procedures contact the Wisconsin AIDS/HIV Program (608/267-5287).
2. These reports include cases and deaths received through the specified date. Data in this report are provisional. Completeness of reporting for AIDS cases in Wisconsin is estimated to be over 85% but may vary by geographic region, risk exposure categories, and demographic groups. Completeness of reporting may be somewhat less for persons with HIV infection who do not meet the Centers for Disease Control and Prevention (CDC) surveillance case definition for AIDS. Thus, at any time, reported cases of HIV infection represent only part of the total number of diagnosed cases and because cases remain undiagnosed, reported HIV infection underestimates total HIV infection morbidity.
3. If first diagnosed in Wisconsin, cases are assigned to a county based on residence at time of diagnosis. If a case was first diagnosed in another state and has subsequently moved to Wisconsin, the case is assigned to the Wisconsin county of residence when first reported in Wisconsin.
4. "Cumulative cases" includes all cases reported from 1983 (the year case reporting began) to the date specified on the report.
5. "Cases presumed alive" refers to cases reported for which no documentation of death has been received. Because of delays in reporting of deaths, these data should be considered provisional.
6. Cases classified as "AIDS" includes only cases which meet the CDC surveillance case definition for AIDS.
7. For surveillance purposes, cases are counted only once in a hierarchy of exposure categories. Persons with more than one reported mode of exposure to HIV are classified in the first category in the hierarchy, except for men with a history of both sexual contact with other men and injecting drug use which constitutes a separate category. In Wisconsin reporting of sexual orientation is only required for AIDS cases.
8. The risk exposure category "high-risk heterosexual contact" includes persons who report specific heterosexual contact with persons with, or at increased risk for, HIV infection.
9. The risk exposure category "mother at risk" includes children who were born to mothers with, or at risk of, HIV infection.
10. The risk exposure category "undetermined" includes cases currently under investigation; cases with incomplete exposure history because the patients refused interview, died before they could be interviewed, or were lost to follow-up; cases for whom follow-up exposure history is available but no exposure mode was identified; and cases with exposure categories not listed in the hierarchy.
11. For cases of HIV infection, "age" is the age when HIV infection was first diagnosed.

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HIV among American Indians in Wisconsin

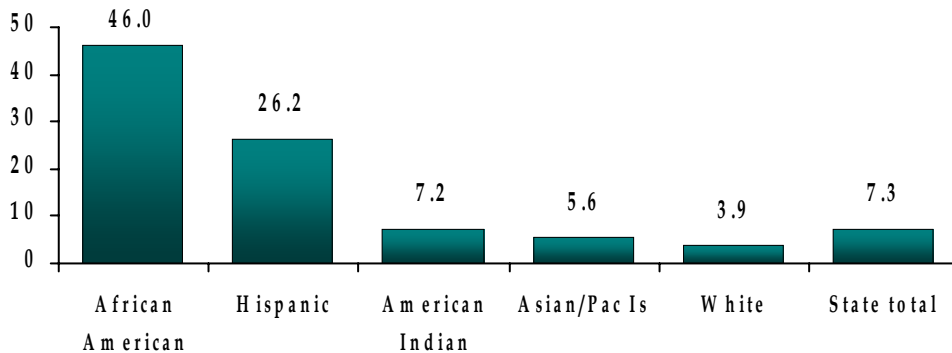
Wendy Schell, MS, HIV Surveillance Coordinator, AIDS/HIV Program, Wisconsin Division of Public Health

According to the 2000 census, there are 47,228 American Indians living in Wisconsin, comprising 0.9% of the total Wisconsin population. Since HIV surveillance began in Wisconsin, a total of 88 cases of HIV infection have been reported among American Indians. Although this represents less than 1% of the total number of cases reported in Wisconsin, when population size is taken into account, the rate of infection among American Indians for the past five year time period (2002-2006) ranks third after African Americans and Hispanics. Similar trends are have been noted nationally.¹

Statistics

- Since HIV surveillance began and through 2006, 88 cases of HIV infection have been reported among American Indians in Wisconsin, representing 0.9% of the reported cases. Seventeen of 88 cases were reported in the most recent five years (2002-2006).
- Fifty-one cases are currently presumed to be alive, living with HIV infection.
- The average annual rate (per 100,000 persons) of HIV infection among American Indians for the period 2002-2006 was 7.2, compared with 46.0 for African Americans, 26.2 for Hispanics, 5.6 for Asians and Pacific Islanders and 3.9 for whites (Figure 1).

Figure 1. Average annual reported cases of HIV infection per 100,000 population, by race/ethnicity, 2002-2006, Wisconsin



- 89% of cases were 20-44 years old at the time of diagnosis; 5 cases (6%) were infected perinatally (during pregnancy, birth or through breast feeding).
- Males accounted for 62.5% of the total cases reported. The primary risk for HIV infection among American Indian adolescent and adult males was men who have sex with men (MSM): 38.5%, men who have sex with men and inject drugs (MSM&IDU): 21.2%, and men who inject drugs (IDU): 25% (Figure 2).

- Women accounted for 37.5% of the cases reported. The primary risk for HIV infection among American Indian adolescent and adult females is high risk heterosexual sex: 51.7%, followed by injection drug use (IDU): 37.9% (Figure 2).
- Cases have been reported from 23 counties, in all regions of the state, with more than 10 cases reported from each of two counties: Menominee and Milwaukee.

Figure 2. Risk categories of HIV infection among American Indians, Wisconsin, cases reported through December 31, 2006

Risk exposure	Cumulative		2002-06	
	Cases	Percent	Cases	Percent
Adult and adolescent males				
MSM	33	59.6%	8	66.6%
<i>MSM, Non-IDU</i>	21	38.5%	4	33.3%
<i>MSM&IDU</i>	12	21.2%	4	33.3%
IDU	13	25.0%	3	25.0%
High-risk heterosexual	4	7.7%	0	0/0%
Other	1	1.9%	0	0.0%
Unknown	3	5.8%	1	5.9%
Adult and adolescent females				
IDU	11	37.9%	1	20.0%
High-risk heterosexual	15	51.7%	2	40.0%
Unknown	3	10.4%	2	40.0%
Children				
Perinatal transmission	5	100%	0	0.0%

Discussion

The profile of HIV infection seen in the American Indian population in Wisconsin is similar to that seen nationally. While race and ethnicity are not, by themselves, risk factors for HIV infection, Native communities in Wisconsin and nationally are likely to face challenges associated with increased risk for HIV infection, including the following:

- The presence of a sexually transmitted disease (STDs) can increase the chance of contracting or spreading HIV.² In Wisconsin in 2004, the rate of STDs among American Indians was 733/100,000 population, the second highest in the state.
- Persons under the influence of illicit drugs or alcohol are more likely to engage in risky behaviors, such as unprotected sex.³ Results of the 2005 National Survey of Drug Use and Health indicate that the rate of current illicit drug use was higher among American Indians and Alaskan Natives (12.8%) than among persons of other races or ethnicities.⁴ Injection drug use was listed as a risk factor in 41% of persons with HIV in the American Indian

population compared with 21% among all persons reported with HIV infection in Wisconsin.

- The most effective HIV prevention interventions are tailored to specific audiences. Wisconsin is home to 11 different tribes. Because each tribe has its own culture and beliefs, one intervention for all is not appropriate and it is challenging to create programs for each tribe.
- Access to HIV testing and issues concerning confidentiality are important for many American Indians. There may be limited access to testing in rural areas and concerns of confidentiality are an issue in close knit communities.

HIV-related resources in Wisconsin

The Wisconsin Division of Public Health has historically supported HIV prevention efforts among American Indian communities. This includes HIV counseling and testing at tribal health centers and prevention efforts coordinated by the Great Lakes Inter-Tribal Council that includes teen and elder prevention education, mentoring, training support, technical assistance, and capacity building of member tribes. In addition, AIDS service organizations provide access to care and support services for Tribal members living with HIV and their families. For more information regarding HIV-related services for members of Native communities in Wisconsin, contact Karen Johnson at 608-266-1808 (phone) or johnskm@dhfs.state.wi.us (email).

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Wisconsin HIV Community Planning Network meets in the Northern region

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The Wisconsin HIV Community Planning Network held its two-day June northern regional meeting in Stevens Point. Northern region members hosted local community dialogues on June 13 and the Statewide Action Planning Group on June 14. Members and guests discussed issues, successes and challenges within the region and within special populations. Service providers and consumers presented local perspectives during a panel presentation and round table discussions. Wisconsin AIDS/HIV Program staff provided topical information on the HIV epidemic and prevention and care initiatives. Reference articles and meeting notes from regional meetings can be viewed online at <http://www.wihiv.wisc.edu/communityplanning>.

Get Involved! You, too, can have a voice in HIV community planning in Wisconsin.

Individual Information Exchange

Individuals living or working anywhere in the state may access HIV Community Planning Network information including meeting schedules and minutes and other HIV related resources and information via the Network website at anytime. Individuals may also receive listserv email messages that will provide new topics of interest, health and advocacy alerts. Sign-up through the website: <http://www.wihiv.wisc.edu/communityplanning>

Local Community Dialogues

In addition to accessing community planning information anywhere at “any time” via the Individual Information Exchange, individuals are invited to attend half day Local Community Dialogue meetings. Volunteer and register for meetings through the website:

<http://www.wihiv.wisc.edu/communityplanning>

Statewide Action Planning Group

This is the core work group of the Network. Members are selected through an application process for three year terms. The next application period begins November 2007.

Interested individuals can join the network at “any time” through a website dedicated to HIV community planning. The website (<http://www.wihiv.wisc.edu/communityplanning>) provides resource information and a calendar of events.

Upcoming Regional Meetings Scheduled for 2007

Western Region - Eau Claire	September 19, 2007 - Local Community Dialogues September 20, 2007- Statewide Action Planning Group
Southeastern Region - Milwaukee	November 14, 2007 - Local Community Dialogues November 15, 2007 - Statewide Action Planning Group

For more information on the community planning model, contact Lynn Tarnoff at 608-890-1424 (phone) or tarnoff@wisc.edu (email).

Update on Wisconsin's 2007 Ryan White Part B funding

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As a result of a federal funding formula change for states and territories, Wisconsin received a substantial increase in Ryan White Part B (formerly Title II) base funding for federal fiscal year 07 (April 07 - March 08). Part B is the source of grants to local agencies to provide HIV care services. The new funding formula counts living persons with HIV infection (including AIDS) rather than previously counting only living persons with AIDS. The new formula also increased funding to states like Wisconsin with large rural areas that receive no Part A (formerly Title I) funds. The following table outlines, by agency and service, funding allocations for FY 2007 Ryan White grants to local community partners in Wisconsin. Funding increases were directed to agencies awarded funding through the HIV Ryan White Care Services Request for Proposals (RFP). In addition, the AIDS/HIV Program will utilize \$350,000 to implement a laboratory testing reimbursement program and \$307,250 to pay for health insurance premiums for eligible low-income persons with HIV.

FY 2007 Ryan White Part B Funding by Agency and Service

Agency	Medical ¹ Care	Oral Health	MH & SA ²	Case Management	Legal Services	Adherence	Other ³ Support	Total
AN	\$5,000	\$51,380	\$19,800	\$87,320	\$12,500	\$30,000	\$20,000	\$226,000
ARCW	\$414,078	\$211,561	\$126,950	\$162,461	\$15,100		\$61,000	\$991,150
CHE							\$53,000	\$53,000
HCHM			\$19,400	\$66,000				\$85,400
LAS					\$30,100			\$30,100
MCW ID	\$60,000			\$67,350				\$127,350
MCW Peds	\$210,600							\$210,600
MHSI	\$90,875		\$70,375	\$40,500				\$201,750
NCSDC			\$10,000	\$66,000				\$76,000
SSCHC	\$65,000		\$127,500	\$55,000				\$247,500
UMOS			\$50,000	\$104,600			\$10,000	\$164,600
UWHC				\$66,000		\$30,000		\$96,000
Total	\$845,553	\$262,941	\$424,025	\$714,631	\$57,700	\$60,000	\$144,000	\$2,509,450

Key:

- AN = AIDS Network
- ARCW = AIDS Resource Cntr of WI
- CHE = Comprehensive Health Education
- HCHM = Health Care for the Homeless of Milwaukee
- LAS = Legal Aid Society of Milwaukee
- MCW ID = Medical College of Wisconsin, Dept. of Medicine, Division of Infectious Diseases
- MCW Peds = Medical College of WI, Dept of Pediatrics
- MHSI = Milwaukee Health Services, Inc.
- NCSDC = New Concept Self Development Cntr, Inc.
- UMOS = United Migrant Opportunity Service
- UWHC = UW Hospital and Clinics, HIV Program

¹ Includes Primary Medical Care, Nurse Case Management and Adherence Counseling delivered in a medical setting

² Mental Health and Substance Abuse Services

³ Includes Medical Transportation Services, Emergency Financial Assistance and Psychosocial Support

HIV social work case management: professional values, ethics, and boundaries

Kevin R. Roeder, PhD, MSW, LCSW, Associate Professor, Professional and Graduate Studies Division, University of Wisconsin – Green Bay

Kevin Roeder conducted the one-day workshop on professional values, ethics, and boundaries for HIV case managers described in this article. He previously served as a two-term board member of a statewide AIDS service organization (ASO), three-term elected chair of a regional Ryan White Consortium, the HIV Liaison for the Wisconsin Chapter of the National Association of Social Workers, the Director of Life Care Services as well as a social work case manager for a regional ASO, and a three-summer volunteer with the Camp Heartland Project. Kevin's applied ethics and boundaries experiences include teaching developing practitioners in higher education, conducting numerous related trainings for helping professionals, and experience in and development of professional ethics committees.

The Wisconsin AIDS/HIV Program in connection with Wisconsin HIV/AIDS Prevention Training System sponsored a one-day workshop in June that examined the professional values, ethical principles, and healthy boundaries that guide HIV social work case management. Case managers from around the state working in AIDS service organizations as well as community-based organizations were in attendance.

A variety of training premises guided workshop content. One premise centered on the case manager's ability to recognize and fully integrate the professional values, ethical perspectives, and healthy boundaries needed for exemplary HIV social work case management. In relationship to this, the workshop provided a forum for participants to discuss and problem-solve a multitude of daily practice challenges they face.

Another premise included the assumption that ethical practice and the maintenance of effective boundaries permeate all areas of social work case management activity, which not only includes our work with clients, but how we relate to our organizations/agencies and colleagues. Thus, value conflicts, ethical dilemmas, and boundary challenges were explored on those levels as well.

Training objectives included: further clarifying the six core values, various relevant ethical perspectives (from the *Code of Ethics* of the National Association of Social Workers), and the four main types of boundaries inherent in social work case management and understanding how these govern professional practice; presentation of an ethical decision-making model; further understanding of the continuing education (MPSW 8) and code of conduct (MPSW 20) requirements as legal requisites for certified and licensed social workers in the state of Wisconsin; and finally, having opportunities for self-assessment and reflection as they relate to one's practice of social work case management and recognizing how one consciously uses her or himself in practice.

In brief, exploration of specific practice challenges included the following:

- A “gifted” and “very public” agency volunteer is one of my clients. Because this client is so well known in the community, I find that in a variety of professional and personal circles, I am often asked about how s/he is doing. How should I respond when this happens?
- One of my clients is also an agency colleague. I’m not sure what or how much information I’ve learned from working with her/him can be shared upon request, by and to, her or his supervisor. What should I do when I am asked for client-specific information by my colleague’s supervisor?
- One of my clients just told me that s/he broke the law or has a detailed criminal history. Does this alter the way I provide services in any way?
- A client of the agency who is HIV+ and another person (who is a good friend of mine), just started dating. How should I handle this situation?
- Sometimes a potential client will call the agency requesting specifically, a gay or HIV+ case manager. How should these requests be managed?
- I have just found out that a client, to whom I provide substantial services, is a non-resident of the United States. What do I do?
- One of my clients has invited me to a social function. Can I go?
- Over time a number of clients have given me gifts. Is it okay to accept them?

Related references on professional ethics and boundaries in social work and helping professions

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Hepworth D, Rooney R, Rooney G, Strom-Gottfried K, Larsen J. Direct social workpractice: theory and skill. 7th ed. Belmont (CA): Brooks/Cole; 2006.

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These practice challenges (and others), invited detailed discussion on a variety of important topics including: confidentiality, dual and multiple relationships, privacy issues, informed consent, conflicts of interest, the use of a professional's power and authority, extending professional activities into personal ones, payment for services, and cultural competency. Consequently, a number of ethical decision-making skills were discussed, including strategies for resolving value conflicts, ethical dilemmas, and boundary challenges.

The instructional format included interactive lecture, focused discussion, group work, and video and practice exercises, all designed to foster application of workshop content to various practice situations. Participants in this training were able to earn 5 continuing education hours.

CDC revises treatment guidelines for managing gonorrheal infections

In April, the CDC announced the fluoroquinolones are no longer recommended for the treatment of gonorrhea in the United States. Over the past several years, cases of gonorrhea that were fluoroquinolone-resistant (QRNG) have steadily increased. Recommended options for treating gonorrhea are now limited to a single class of antibiotics, cephalosporins. Within this class, CDC recommends ceftriaxone, available only as an injection, as the preferred treatment for all types of gonorrhea infection (genital, anal, and pharyngeal). The revised treatment guidelines were published in the April 13, 2007 *Morbidity and Mortality Weekly Report (MMWR)* Vol 56, No 14:332-336, and are available from the CDC website at www.cdc.gov/std/treatment/.

HIV Counselor Perspectives highlights methamphetamine use and HIV risk

The April 2007 issue of *HIV Counselor Perspectives*, a quarterly publication of the AIDS Health Project (AHP) at the University of California, San Francisco, examines the topic of methamphetamine use and HIV risk. Current research continues to demonstrate that methamphetamine use is associated with an increased risk for HIV transmission, especially for men who have sex with men but others as well. The April issue of *Perspectives* addresses methamphetamine use and HIV risk by examining related research and implications for counseling. The publication also presents a case study and a brief knowledge self-test. The April 2007 issue of *HIV Counselor Perspectives* (Volume 16, Number 2) can be viewed and downloaded from the AHP website by clicking on the following address: http://128.218.135.112:8080/searchblox/servlet/FileServlet?url=%2FUsers%2Fsweigle%2FDesktop%2FPerspectives_PDF%2F2007%2FPersp0407.pdf&col=2.

Free Subscription to Electronic Publications from the AIDS Health Project

The AIDS Health Project (AHP) at the University of California, San Francisco provides HIV-related mental health services and related training and resources for health and human service providers. The following AHP newsletters provide health and human service providers valuable information regarding HIV-related counseling.

FOCUS: A Guide to AIDS Research and Counseling

FOCUS is published 10 times a year. A searchable index of issues back to 1991 is located on the web at http://www.ucsf-ahp.org/HTML2/services_providers_publications_focus.html.

HIV Counselor PERSPECTIVES

Published four times a year, *PERSPECTIVES* is focused on prevention workers providing HIV antibody testing and prevention counseling. A searchable index of issues back to 1996 is located on the web at http://www.ucsf-ahp.org/HTML2/services_providers_publications_counselor.html.

To subscribe to these electronic publications, visit the AHP website at http://ucsf-ahp.org/epubs_registration.php.

NASTAD releases updated report on HIV/AIDS among African Americans

In April 2007, the National Alliance of State and Territorial AIDS Directors (NASTAD) released an updated version of its 2001 monograph *HIV/AIDS: African American Perspectives and Recommendations for State and Local Health Departments*. The document, titled *Why we can't wait: The Tipping Point for HIV/AIDS Among African Americans* seeks to strengthen and increase the response to HIV/AIDS in the African American community by calling for coordinated and decisive action among health departments and the communities they serve. The updated monograph prioritizes recommendations and emphasizes "new considerations" that have developed since the original publication. The document is organized under the five key issue areas of:

- usage and interpretation of epidemiologic data,
- capacity building,
- coalition and partnership building,
- program implementation, and
- behavioral research.

The monograph *Why we can't wait: The Tipping Point for HIV/AIDS Among African Americans* can be viewed and downloaded from the NASTAD website at <http://www.nastad.org/>.

Annual HIV testing: a key prevention intervention for men who have sex with men

Mark Ringstrom, Evaluation and Research Assistant and Jim Stodola, Counseling and Testing Coordinator; AIDS/HIV Program, Wisconsin Division of Public Health

Introduction

On September 22, 2006, the U.S. Centers for Disease Control and Prevention (CDC) released revised recommendations for HIV testing in health care settings. The recommendations focus on HIV screening for all persons between 13 and 64 years of age. Subsequent testing is recommended at least annually for persons at high risk for acquiring HIV, including men who have sex with men (MSM). Medical advances in HIV treatment have significantly improved health outcomes for many persons with HIV disease. In addition to individual benefits, annual testing has public health benefits and could affect recent increases in HIV rates among MSM in Wisconsin. The Wisconsin AIDS/HIV Program endorses annual testing among MSM in a manner that integrates testing with other prevention interventions and establishes the practice as a community norm.

Background

Historically, the population most affected by HIV infection in Wisconsin has been MSM. In 2006, 73% of HIV cases were among MSM, including 67% among MSM without a history of injection drug use, and 6% among MSM who reported injection drug use (MSM & IDU). After a significant decline in the 1990's, MSM-attributed cases have increased in recent years. Between 2001 and 2006, cases reported among MSM increased 55% and cases among MSM & IDU increased 10%.¹

The end of year 2005 *CDC HIV/AIDS Surveillance Report* documented that in 33 areas with name-based HIV infection reporting the number of newly diagnosed cases increased 13% among MSM (including MSM/IDU) between the years of 2001 and 2005, while decreasing 17% among females and 19% among other males (i.e. non-MSM).² Although reasons for increased incidence among MSM are not clear, the recent data suggests a need to refine prevention strategies designed for MSM.

Annual testing as a prevention strategy

HIV testing can affect individual behavior and reduce overall incidence. Studies document that most persons take steps to reduce risk to others once they become aware of their HIV-positive status.^{3,4} In addition, medical treatment may reduce the ability to transmit the virus by reducing viral load. The CDC estimates that 67% of transmission events result from persons unaware of their serostatus and transmission is estimated to be 3.5 times higher among persons who are unaware of their infection. Given this, knowledge of serostatus can be an effective prevention strategy.⁵

There is evidence that serostatus knowledge is already being used within the MSM community. A Men's Health Survey conducted among MSM at gay pride events in Midwestern states,

including Wisconsin, found that MSM with known HIV infection had fewer partners and were more likely to have had their last sexual encounter with a man who was also HIV-positive.

Frequency of HIV testing also correlates with reduced incidence. Studies from the National HIV Behavioral Surveillance (NHBS) system have documented lower levels of infection among persons who had recently been tested.⁶ NHBS is an ongoing behavioral surveillance system that collects cross-sectional data among populations at high risk for HIV, including MSM. To assess testing behaviors among MSM, the CDC analyzed data from five cities participating in the NHBS system. MSM were interviewed regarding their sexual, drug-use, and testing behaviors and their use of prevention services. Of the 1,767 MSM tested after informed consent, 25% tested positive. Forty-eight percent of the men testing positive were previously unaware of their status. Men who were not tested in the prior year were more likely to have previously unrecognized infection, leading to the conclusion that MSM should be encouraged to test at least annually to decrease HIV transmission.

Among MSM interviewed in the NHBS study, 92% indicated they have had an HIV test, however only 64% had a test in the previous 12 months.⁶ Similarly, 92% of MSM participating in the Men's Health Survey in Wisconsin indicated they have had a HIV test, with only 67%* having a test within the preceding year. Although the relationship between testing frequency and lower levels of infection were not clarified in the study, these figures suggest a need to assess testing frequency when working with MSM and to refine messages to promote testing at least annually.

Factors influencing HIV testing among MSM

Addressing factors that influence testing among MSM will be key to establishing a community norm for annual testing. Factors that positively influence the decision of MSM to take a HIV test include^{7,8}

- assurance of privacy and anonymity regarding the testing session,
- having had a previous testing experience that was affirmative and encouraging,
- self-perception of risk,
- self-perception of the ability to change sexual and other risk-associated activities, and
- perceived social norm regarding testing.

Factors that negatively influence the decision of MSM to take a HIV test include⁹

- perception of not being at risk,
- lack of time to devote to getting tested,
- fear of being judged or treated poorly based on sexual activities,
- fear of being treated poorly based on race/ethnicity, and
- fear that one will be perceived as having engaged in higher levels of risk than peers.

* HIV testing was offered at the PrideFest event where the Wisconsin Men's Health survey was conducted. Some persons who reported being tested in the previous 12 months also reported being tested the day they were surveyed. Results are based on men attending the 2005 PrideFest and likely do not represent all MSM in Wisconsin.

Integrating HIV testing with evidence-based interventions

Behavioral interventions have proven effective as an HIV prevention tool, reducing self-reported risk activities among MSM. Data from 33 HIV behavioral interventions with MSM noted a 25% reduction in unprotected anal intercourse and a 61% increase in condom use.¹⁰ A decrease in number of sexual partners was also noted. The risk reduction was maintained for the majority of participants 12 months after the intervention. It remains uncertain, however, whether the described level of effect could contribute to significant reductions in HIV incidence, particularly given a low percent of the total MSM population participate in these interventions.

People participating behavioral interventions can, however, serve as a bridge to the greater community and help define behavioral standards within their social circles. Nine community-based organizations in 7 U.S. cities participated in a CDC study of the influence of social networks on rates of identified HIV infection at testing sites.¹¹ A total of 133 persons participating in HIV prevention interventions or care services were asked to recruit 3-5 persons within their social circles for HIV testing. Six percent of the 814 persons recruited tested positive. This is six times the national average for public HIV test sites. Populations most likely to recruit associates who tested positive were MSM with 16% a positivity rate, transgender persons with a 20% positivity rate, and MSM/IDU with a 26% positivity rate. In turn, a number of persons testing negative subsequently participated in prevention interventions and served as advocates for others to access testing, and persons testing positive were linked to case management and care services. More fully integrating testing, prevention, and care benefits each of these services and can serve as means to establish annual testing among MSM as a community norm.

Establishing annual HIV testing as a community norm

Wisconsin HIV Community Planning Network--an advisory body for the AIDS/HIV Program's prevention and care services comprised of a network of persons representative of the HIV epidemic and representatives of community-based organizations-- provided recommendations for promoting annual testing among MSM at their March 2007 meeting. Foremost among these was the need to change current (long-standing) testing messages and promotional materials that frequently prompt MSM to "get tested," or "take the test." Given data on the percent of MSM who have taken the test at sometime in the past versus the percent that have tested in the past 12 months, messages to "get tested" were deemed insufficient to promote routine and regular testing. The recommendation is to use messages that promote testing annually as a community norm. For example, other jurisdictions have coined phrases that could be adopted such as "just part of the routine" and the self-efficacy phrase "you're worth it."

Another key recommendation is to switch from directive-based to informational messages that will allow MSM to make informed decision. The recommendation is to keep messages brief while providing key facts. These would include information on increasing HIV rates among MSM, the benefits of annual testing, and the availability of effective treatment. The recommendation includes acknowledging the racial, ethnic, and geographic diversity of MSM by tailoring the style, content and delivery of testing messages for these subgroups.

Additional recommendations include:

- educating providers on the rationale for annual testing among MSM;
- using a comprehensive, integrated approach to promote annual testing

- integrating the promotion of annual testing with other prevention efforts and behavioral interventions;
- distributing materials in a variety of traditional gay and non-gay venues, including: bars, the internet, community-based organizations, neighborhood businesses, health care facilities, and churches;
- using surveillance data and geo-mapping to target the distribution of materials
- utilizing persons participating in prevention and care services to distribute materials promoting routine, annual testing;
- utilizing influential peers and community organizations to promote routine, annual testing, and;
- utilizing individual-level interventions to assess date of last test and establish personalized triggers for annual testing--such as a birthday, holiday, or annual community event.

Conclusion

The increasing disproportionate burden of HIV among MSM highlights the need to promote HIV testing as a routine, annual practice on individual, group, and community levels. Throughout the remainder of 2007, the Wisconsin AIDS/HIV Program will continue to seek community input on annual testing among MSM and discuss the implementation of the Wisconsin Community Planning Network's recommendations with HIV testing sites and prevention and care providers.

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Detection of acute HIV infection: targeted diagnosis by nucleic acid testing

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Summary: Acute HIV infection (AHI), occurring during the initial weeks following the acquisition of HIV infection, is a period of high viral replication and is associated with increased transmissibility of HIV. AHI presents a challenge because it is undetectable by the most commonly used HIV antibody assays. This article reviews three alternate ways to detect AHI: individually targeted nucleic acid testing (NAT) via polymerase chain reaction (PCR), pooled screening testing with PCR, and p24 direct antigen detection. The article also examines the feasibility of utilizing these alternate ways to detecting AHI in the Wisconsin HIV Counseling, Testing, and Referral Program and in HIV Partner Counseling and Referral Services. Targeted NAT with PCR is identified as a viable option for detecting AHI and its impact on pre- and post-testing counseling is highlighted.

Background

The ability to detect acute HIV infection (AHI) is a growing priority as public health continues to encourage early detection and prevention of HIV transmission. Because it is the stage of infection prior to antibody response, AHI is undetectable by common antibody screening assays such as the enzyme linked immunoassay (ELISA) and Western blot, and with seroconversion typically complete by 8 to 12 weeks, a person with AHI would likely test negative for HIV antibody during this period.^{1,2} Diagnosis of AHI is also complicated by the fact that symptoms associated with AHI are frequently nondescript and present in only half of infected individuals.^{1,3}

The diagnosis of AHI has important public health considerations. AHI is associated with the highest rates of secondary HIV transmission. In addition, the administration of antiretroviral therapy during AHI has the potential to positively impact the course of disease.

Elevated risk of HIV transmission during AHI is associated with biological and behavioral factors.^{4,5} Biologically, the acute phase of infection is characterized by the highest levels of viremia prior to the onset of AIDS. Viral titers reach their peak around 21 days post infection, then sharply decline inversely to the body's mounting immune response and seroconversion.⁶ Quinn et al. found a strong positive correlation between viral load and the rate of HIV transmission, with each log increase in viral load associated with a 2.45 fold increase in the risk of transmission.⁵

Behavioral factors contribute to the elevated rate of HIV transmission during AHI.^{7,8} Because persons with AHI are seldom aware of their infection, they may continue risk behaviors that originally caused their infection and subsequently place others at risk of infection. Research indicates most persons who become aware of their HIV positive status demonstrate reductions in risky sexual and/or intravenous drug use behaviors.^{7,8}

A disproportionately high level of transmission is attributed to acutely infected individuals. It is estimated that 40% of new cases occurs through transmission from persons with AHI. A computer modeling study of transmission suggests that a majority of new HIV infections are transmitted in the acute viremic phase.^{4,9,10}

Early diagnosis and intervention is an important consideration for the HIV infected person. The peak viral load achieved during AHI determines the eventual viral set point during persistent infection. Persons with higher viral set points progress more rapidly toward AIDS and death.^{3,11,12} Treatment with antiretroviral therapy during AHI may lead to a lower set point and a more favorable course of disease. Early treatment can contribute to improved clinical outcomes due to limited viral dissemination, lessened damage to the immune system, and protection of antigen presenting cells which are an important to the integrity of the immune system. There is also evidence that treatment during AHI may benefit from the relatively homogeneity of the viral population, especially when combination chemotherapy is used.^{3,13} However, the degree to which treatment of AHI actually alters the long term clinical course of disease is unclear.¹⁴

Detecting AHI with nucleic acid testing

The mode of detection of AHI displaying the most promise for a low prevalence area like Wisconsin is nucleic acid testing (NAT) with polymerase chain reaction (PCR). PCR is a molecular biological technique that enzymatically replicates and exponentially amplifies DNA (or RNA using reverse transcriptase PCR). By using species-specific primers, nucleic acid from a chosen biological agent, such as HIV-1, can be selectively amplified and detected to verify the presence of the agent. Viral RNA and proviral DNA are abundantly present in the serum of an acutely infected individual and can therefore be used for the diagnosis of AHI. Among the attributes of NAT with PCR are its high levels of specificity and sensitivity and its drastic reduction of the pre-diagnostic window period.

In October 2006, the FDA approved Gen-Probe's APTIMA HIV-1 RNA Qualitative Assay for the diagnosis of AHI. All other PCR-based HIV assays are approved for monitoring viral load to manage care or to screen donated blood and tissue. The federal Centers for Disease Control and Prevention revised recommendations for HIV testing of adults and adolescents suggests that, where AHI is a possibility, a plasma RNA test should be used in conjunction with an HIV antibody test to detect AHI.¹⁵ Beyond viral load tracking and blood and tissue screening, PCR-based HIV assays have proven to be critically important in identifying HIV infection in newborns of HIV positive mothers, due to the infants lacking antibody response.

PCR detection of HIV-1 nucleic acid is often used as the gold standard by which other testing methods are compared.^{16,17,18} With sensitivities of NAT with PCR averaging 50 RNA copies per mL, and peak viremia during acute infection ranging anywhere from 1,000 to 1,000,000 copies per mL, detection of HIV infection at set point is highly predictive and confirmed.

The length of the pre-diagnostic window is a function of when a person becomes viremic. Kahn estimates that initial viremia occurs as early as 3 days or as late as 11 days after infection.¹⁵ Other studies indicate that detection with PCR can shorten the pre-diagnostic window period to 11 days.^{1,19,20} With the window of detection ranging anywhere from 3 to 11 days post infection, NAT with PCR can significantly improve detection of AHI over that of conventional antibody testing.

Additional methods of detecting AHI

Two additional methods of detecting AHI exist: pooled HIV RNA testing and p24 antigen testing. Though neither method has been selected for the detection of AHI in Wisconsin at this time, an overview of these methods will highlight their points of distinction. Pooled RNA testing, currently used in screening donated blood, employs nucleic acid assays in testing pooled serum specimens from the entire testing population. Aliquots from each serum sample are combined into intermediate pools representing 10 specimens each, from which aliquots are combined to form a master pool representing 5 intermediate pools or 50 individual specimens. Master pools are subjected to NAT with PCR. Those that test positive are deconstructed until the individual positive sample can be identified. The number of pools and the number of samples within pools are not strictly defined but are chosen to maximize effectiveness for the specific prevalence of the testing population. The pooling protocol limits the number of tests required to screen the population and identify individual positive cases.

Studies in North Carolina and California have evaluated the feasibility and success of pooled RNA testing to detect AHI in routine HIV testing populations. In a preliminary North Carolina study, 4 cases of AHI were identified out of 8155 individuals with negative antibody tests. This represented a 10% increase in positive diagnoses compared to the conventional HIV testing algorithm.²¹ A second study conducted statewide in North Carolina revealed 23 confirmed cases of AHI, representing a 3.9% increase in positive diagnoses over that with standard antibody testing.²² In the California trial, 11 cases of AHI were identified among 2722 individuals in San Francisco County, a 10.5% increase in diagnosis over traditional methods. One case of AHI was identified out of 2148 individuals in Los Angeles County, a 7.1% increase in diagnostic yield over traditional methods.²

The utility and cost effectiveness of pooled RNA programs are open to debate. Some suggest that the relative cost effectiveness of pooling over individual testing may be lost in settings with high prevalence of HIV infection.²¹ Presumably, this is the result of requiring too many tests for the deconstruction of master and intermediate pools in order to identify a large number of positive samples. Likewise, populations with low prevalence but high rates of testing may be inefficient because of the large number of tests required to identify very few cases of AHI. The application of pooled RNA testing in Wisconsin remains under consideration. Detailed cost analysis is needed to determine its merit for Wisconsin.

Direct detection of viral protein, specifically p24, via enzyme immunoassay is another alternative for detecting AHI. This is available as a stand-alone p24 antigen test or as part of a fourth-generation antigen and has been used for blood supply screening. This method results in a window period of detection somewhere between that of NAT with PCR and antibody assays. Because HIV RNA is the first and only detectable virus-specific marker for 1 to 5 days subsequent to viremia, there is a delay before p24 antigen assays can detect infection.²³ Weber et. al. demonstrated a delay in detection of 2.75 days and a sensitivity and specificity of 99.73% and 100% respectively.²³ This same study indicates that the use of p24 antigen for diagnosis of AHI is tentative due to potential false positives resulting from cross reactivity. Economies of scale and a comparatively longer pre-diagnostic window make antigen testing a less appealing alternative for detecting AHI compared to targeted NAT.

Conclusions

The use of individually targeted NAT with PCR is an attractive method to begin addressing the problem of identifying persons acutely infected with HIV. While pooled RNA testing is an attractive application of PCR, its effectiveness in a low prevalence state like Wisconsin requires further analysis.

The success in implementing a program for individually targeted NAT with PCR relies on the timely identification and testing of individuals who display disproportionate risk for recent HIV infection and a propensity for secondary transmission. The primary indication for targeted NAT is recent high risk contact with a known HIV infected individual. Secondly, individuals who have high risk behaviors, who are already immunosuppressed or who have health conditions that may result in accelerated progression to AIDS may benefit from NAT with PCR and early therapeutic interventions.

The success of any program to detect AHI is tied to its ability to expedite entry into specialized HIV care and early antiretroviral treatment. To achieve this, pre- and post-test counseling of clients considered at risk of early HIV infection would be modified to include a discussion of AHI, the heightened infectivity associated with AHI and the importance of prompt medical care.

In addition to its epidemiologic utility in monitoring the HIV epidemic, targeted NAT testing with PCR expands the scope and effectiveness of testing options in public health. Early detection of AHI is important in interrupting the transmission of HIV and increasing the health and quality of life of persons living with HIV.

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Building skills for health literacy

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What does it mean to be health literate? The Joint Committee on Health Education Standards defines health literacy as:

- an individual's capacity to obtain, interpret, and understand basic health information and services and
- competence to use such information and services in health-enhancing ways.

While health content knowledge is important and a major focus of school-based education and public health, the skill to use information and services in health-enhancing ways is critical to improve the health literacy of future generations.

Of the eight National Health Education Standards, one focuses on core content and seven standards focus on skills, including accessing accurate information, analyzing influences, goals

setting, decision making, interpersonal communication, self-management, and advocacy. To support attainment of specific health literacy skills, the Wisconsin Department of Public Instruction developed the resource document *Building Skills for Health Literacy: Human Sexuality*. This resource is intended to assist middle and high school health education professionals in creating instructional units that teach and assess skills consistent with health education standards regarding human sexuality. The document challenges educators to look at units from a skill perspective rather than a content perspective and to explore what it means to teach a skill.

Building Skills for Health Literacy: Human Sexuality is available in print only and free of charge and can be ordered by contacting Jackie Brashi at jackie.brashi@dpi.state.wi.us (email) or 608-266-4447 (phone). For further information regarding this resource, contact Emily Holder at emily.holder@dpi.state.wi.us (email) or 608-267-9170 (phone).

Overview of 2006 Wisconsin HIV Partner Counseling and Referral Services

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

HIV partner counseling and referral services (PCRS) is an essential HIV prevention intervention and one of the key strategies the federal Centers for Disease Control and Prevention's (CDC) promotes in advancing HIV prevention. PCRS was initiated in Wisconsin in 1988 and has been provided through specially trained local public health staff in most health departments (LHD). The main goal of PCRS is to stop the chain of HIV transmission by notifying sex and needle sharing partners identified by the person infected with HIV (the index client) about their unknown exposure to HIV and providing counseling and testing services.

PCRS benefits persons with HIV infection, their partners, and affected communities. HIV-infected persons benefit by having access to client-specific counseling and referral to support an individual's health and well being and to prevent transmission to others. Referral includes linkages to HIV-related medical services and other related health and human services. PCRS provides HIV-infected persons with the mechanism and/or support to confidentially inform sex and drug injection partners of their possible exposure to HIV. Partners of HIV-infected persons benefit by being informed of their exposure risk and being provided access to HIV testing and counseling services as well as other needed health and human services. PCRS ultimately benefit communities in reducing future rates of HIV transmission.

PCRS is offered confidentially to all HIV-infected persons reported to the surveillance unit in the Wisconsin AIDS/HIV Program. PCRS is provided by local health department (LHD) staff. Services are voluntary and are provided confidentially and in a client-centered manner that supports individual choice. When partners of HIV-infected person are notified by LHD staff, the identity of the source patient is never disclosed. Because HIV is a lifetime disease, PCRS can be provided more than once. The following table summarizes 2006 PCRS data.

Wisconsin PCRS Activities, 2006

Activities	Number
Cases receiving PCRS	488
Partners/cluster members identified	335
Partners/cluster members received PCRS	178
Partners/cluster members who tested positive previously	39
Partners never tested or who tested negative previously	46
Partners tested for HIV during PCRS	85
Partners/cluster members testing positive	15

In 2006, 488 cases (clients) received PCRS. A total of 335 partners and cluster members were identified by clients; 178 were located and provided PCRS; 85 were tested for HIV; and 15 tested positive. The seropositivity rate of 17.6% for partners tested in 2006 demonstrates the critically important role of PCRS in newly identifying persons with HIV infection and linking them with other prevention services and essential HIV-related health care services.

The Wisconsin AIDS/HIV Program continues to implement measures to increase the efficiency and effectiveness of PCRS. Rapid testing has been received positively by partners and cluster members and the integration of rapid testing in PCRS will likely increase as improvements in testing technologies (e.g. extended shelf-life of test kits) increase the feasibility of providers offering rapid testing. The AIDS/HIV Program continues to evaluate the implementation of partner elicitation (PE) at two community-based agencies providing HIV counseling and testing services. PE provides an alternative for clients who test positive to discuss partner information at a testing site rather than through PCRS at a later date. Finally, the AIDS/HIV Program will begin piloting a model of consolidated PCRS services in 2007 which will result in a select number of LHDs providing lead PCRS across multiple jurisdictions, especially in areas where neighboring jurisdictions have few cases and staff have limited opportunities to maintain skills in providing PCRS.

For further information regarding PCRS in Wisconsin, contact Dhana Shrestha, PCRS Coordinator, at 608-267-5288 (phone) or shresdma@dhfs.state.wi.us (email).

Milwaukee Alliance for Sexual Health: end of first planning phase

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The Milwaukee Alliance for Sexual Health (MASH) is a two-phase community-academic partnership committed to reducing the disproportionate impact of sexually transmitted diseases (STDs) and teen pregnancy on African American adolescents in Milwaukee. Phase one, recently completed in June 2007, focused on the development of strategic directions to guide stakeholders involved in teen pregnancy and STD prevention and intervention activities for Milwaukee’s high risk youth.

Phase one

Project accomplishments during the first year of planning, included completion of the following products:

- an epidemiologic assessment of STD rates in the City of Milwaukee, which helped to define the geographical area that might benefit most from a strategic plan;
- a community assessment of social and sexual norms and behaviors identifying many of the underlying causes of high risk sexual behavior in target communities;
- a literature review of evidence-based interventions related to teen pregnancy and STD prevention; and
- a best-practices inventory of systems-level evidence-based interventions that focused on schools, clinical practice settings, and community outreach and that could form the basis of a strategic plan after input from the community.

The project exemplified the benefits of individuals working as a multi-disciplinary team with a common purpose.

Phase two

The second year of the project, also funded by a one year planning grant, will expand MASH to create an alliance of individuals and agencies that will:

- increase coordination of STD prevention and treatment efforts,
- serve as a forum for integration of STD and teen pregnancy prevention efforts, and
- enable broader stakeholder representation.

The alliance will develop a strategic plan based on information gained in phase one and will identify ways to implement plan strategies. Phase two efforts are being driven by the City of Milwaukee Health Department and New Concept Self Development Center, as well as the Medical College of Wisconsin and the Wisconsin Division of Public Health. The alliance will expand by drawing from existing networks, community-based organizations, and the school system. It will also strive for broader representation from the public and private sectors.

For additional information on MASH, visit the project website at <http://www.mashp.net/> or contact Darryl Davidson at the City of Milwaukee Health Department at 414-286-8574 (phone) or ddavid@ci.mil.wi.us (email).

Update on rapid HIV testing technology

*Kathleen Krchnavek, MSSW, HIV Counseling, Testing & Referral Specialist,
AIDS/HIV Program, Wisconsin Division of Public Health*

Of the six rapid HIV antibody tests currently on the market and approved by the Food and Drug Administration (FDA), three are categorized as “waived” under the Clinical Laboratory Improvements Amendment (CLIA) Program. Waived tests are fairly simple to use and can be conducted outside a formal laboratory. Waived rapid HIV antibody tests have been a key advance in HIV prevention because they significantly increase the number of persons who receive their test result and are linked to needed services.

When used with whole blood specimens, the following are categorized as waived rapid HIV tests:

- OraQuick Advance, manufactured by OraSure;
- UniGold, manufactured by Trinity Biotech; and
- Clearview Stat-Pak, manufactured by Inverness Medical.

OraQuick Advance can also be used as a waived test with oral fluid specimens. When used with serum or plasma, all of these tests are categorized as “moderately complex” since running these tests require a higher standard for laboratory personnel and test sample processing.

The three rapid HIV antibody tests have comparable sensitivity and specificity and each has specific advantages, e.g.:

- OraQuick Advance is the only rapid test that can be used orally,
- UniGold test has the fastest developing time (10 minutes), and
- Stat-Pak has a long shelf-life which reduces wastage.

During the past 4 years, the Wisconsin AIDS/HIV Program has used OraQuick Advance for the majority of its rapid testing. In 2006, the Program supplied UniGold at a large STD clinic in Milwaukee because of lower costs and shorter developing time which eased clinic flow.

The AIDS/HIV Program is currently evaluating the use of the Clearview Stat-Pak test, released in spring 2007, for a significant amount of testing conducted with whole blood. Stat-Pak’s 24 month shelf-life reduces waste and opens the possibility of rapid testing at lower volume sites. It has a shorter developing time than the OraQuick Advance (15 min vs. 20 min) but a longer read time (the time period during which a result can be read) than the UniGold (5 min vs. 2 min) which improves the overall client wait time and allows enough “cushion” time for a staff person to read the result. The Stat-Pak is unique because a reactive test result can be read as soon as it develops rather than waiting the standard developing time.

Considerations for the use of various tests in different settings includes test performance (e.g. sensitivity and specificity; detection of HIV-2; temperature stability, etc.); cost; shelf-life, and ease of use. The AIDS/HIV Program will consider these factors in assessing new tests as they become available. For more information on rapid HIV antibody testing through the Wisconsin AIDS/HIV Program, contact Kathleen Krchnavek at 608-267-3583.

Information resources on social networks and HIV prevention

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

In the United States, at least one-quarter of those infected are unaware of their HIV status. To address this issue, the federal Centers for Disease Control and Prevention (CDC) recently recommended universal screening for HIV in all persons between the ages of 13-64. Because HIV disproportionately impacts patients with limited access to primary care, those at the highest risk for HIV infection are least likely to be screened. Targeted strategies such as social networks testing may increase numbers of high-risk persons tested for HIV compared to standard testing and may prove to be a cost-effective approach to targeted testing. Agencies can use social networks to identify individuals who are at high-risk for HIV infection by inviting HIV positive and high-risk HIV negative persons to identify other high-risk individuals and encourage them to be tested. Although a social networks strategy is not new, the CDC has recently released findings from the first demonstration project exhibiting the effectiveness of a social networks approach to identifying persons with undiagnosed HIV infection and linking them to appropriate care and treatment.

To find out more about social networks and HIV prevention, see the following web-based information resources:

CAPS Fact Sheet - How do sexual networks affect HIV/STD prevention?
<http://www.caps.ucsf.edu/pubs/FS/networks.php>

Social Networks Testing: A Community-Based Strategy for Identifying Persons with Undiagnosed HIV Infection
<http://www.cdc.gov/hiv/resources/guidelines/snt/index.htm>

MMWR Use of Social Networks to Identify Persons with Undiagnosed HIV Infection --- Seven U.S. Cities, October 2003 - September 2004
<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5424a3.htm>

AIDS and Social Networks: HIV Prevention Through Network Mobilization
http://www.respondentdrivensampling.org/reports/sociological_focus.pdf

NIDA: Social Networks, Drug Abuse and HIV Transmission
<http://www.nida.nih.gov/pdf/monographs/download151.html>

Global HIV Prevention Working Group calls for scaled-up prevention efforts

The Global HIV Prevention Working Group (PWG) is an international panel of more than 50 leading public health experts, clinicians, biomedical and behavioral researchers, advocates, and people affected by HIV/AIDS. The Working Group, convened by the Bill & Melinda Gates Foundation and the Kaiser Family Foundation, was launched in 2002 to inform global policy-making, program planning, and donor decisions on HIV prevention. The PWG recently released a comprehensive report addressing the need to strengthen global HIV prevention efforts.

In its report, *Bringing HIV Prevention to Scale: An Urgent Global Priority*, the PWG points out if current trends continue 60 million more HIV infections will occur by 2015 and the annual number of new infections will increase by 20% or more by 2012. While there has been a dramatic rise in antiretroviral coverage globally, there must be a sharp reduction in new infections in order to keep antiretroviral treatment widely available and to forestall millions more from dying of preventable HIV infections.

Bringing HIV Prevention to Scale provides an analysis of the complexities and interrelated factors that need to be addressed in considering a global response to HIV prevention. To scale-up comprehensive HIV prevention in diverse settings, the PWG developed recommendations for national governments, international donors, multilateral and technical agencies, health care and other settings, research, and civil society. The report *Bringing HIV Prevention to Scale* is located on the PWG website at <http://www.globalhivprevention.org>.

Wisconsin Hepatitis C Surveillance Summary

Cases reported through 06/30/2007

Table 1. Reported Hepatitis C cases by year of report, Wisconsin resident cases

	1999 to 2007		2006		2007 to date	
	Cases	% (3)	Cases	% (3)	Cases	% (3)
Total	25,131	100.0%	2,286	100.0%	1,017	100.0%
Case status						
Confirmed (1)	20,284	80.7%	1,807	79.0%	841	82.7%
Possible (2)	4,847	19.3%	479	21.0%	176	19.3%
Sex						
Males	16,864	67.6%	1,494	65.4%	654	64.6%
Females	8,096	32.4%	790	34.6%	359	35.4%
Unknown	171	-	2	-	4	-
Hispanic ethnicity						
Hispanic	780	6.9%	60	6.9%	22	5.5%
Not Hispanic	10,444	93.1%	894	93.1%	377	94.5%
Unknown	13,907	-	1,332	-	618	-
Race						
White	10,123	73.3%	911	73.3%	368	81.6%
Black	3,242	23.5%	181	23.5%	67	14.9%
Am Indian	268	1.9%	21	1.9%	7	1.6%
Asian	109	0.8%	15	0.8%	4	0.9%
Other	69	0.5%	7	0.5%	5	1.1%
Unknown	11,320	-	1,151	-	566	-
Age at diagnosis						
0-9	64	0.3%	5	0.3%	3	0.3%
10-19	216	0.9%	27	0.9%	12	1.2%
20-29	1,241	5.0%	186	5.0%	82	8.1%
30-39	4,642	18.5%	275	18.5%	110	10.9%
40-49	11,148	44.5%	797	44.5%	323	31.9%
50+	7,742	30.9%	994	30.9%	483	47.7%
Unknown	78	-	2	-	4	-
Year of report						
1999	1,845	7.3%				
2000	2,508	10.0%				
2001	3,730	14.8%				
2002	4,160	16.6%				
2003	3,605	14.3%				
2004	3,217	12.8%				
2005	2,763	11.0%				
2006	2,286	9.1%				
2007	1,017	4.0%				



Table 2. Reported Hepatitis C cases by county of residence and year of report, Wisconsin resident cases

Region/County	1999 to 2007		2006		2007 to date	
	Cases	% (3)	Cases	% (3)	Cases	% (3)
Northeastern Region	2,466	12.8%	233	14.0%	101	15.1%
Brown	458	2.4%	42	2.5%	17	2.5%
Calumet	43	0.2%	2	0.1%	2	0.3%
Door	62	0.3%	11	0.7%	4	0.6%
Fond du Lac	291	1.5%	28	1.7%	21	3.1%
Green Lake	41	0.2%	6	0.4%	2	0.3%
Kewaunee	32	0.2%	3	0.2%	3	0.4%
Manitowoc	105	0.5%	14	0.8%	1	0.1%
Marinette	99	0.5%	10	0.6%	4	0.6%
Marquette	43	0.2%	5	0.3%	1	0.1%
Menominee	22	0.1%	0	0.0%	5	0.7%
Oconto	70	0.4%	5	0.3%	3	0.4%
Outagamie	307	1.6%	28	1.7%	9	1.3%
Shawano	56	0.3%	10	0.6%	4	0.6%
Sheboygan	207	1.1%	16	1.0%	9	1.3%
Waupaca	103	0.5%	15	0.9%	0	0.0%
Waushara	72	0.4%	10	0.6%	1	0.1%
Winnebago	455	2.4%	28	1.7%	15	2.2%

Region/County	1999 to 2007		2006		2007 to date	
	Cases	% (3)	Cases	% (3)	Cases	% (3)
Northern Region	1,067	5.6%	135	8.1%	57	8.5%
Ashland	59	0.3%	6	0.4%	2	0.3%
Bayfield	30	0.2%	2	0.1%	2	0.3%
Florence	8	0.0%	1	0.1%	0	0.0%
Forest	35	0.2%	2	0.1%	1	0.1%
Iron	24	0.1%	4	0.2%	1	0.1%
Langlade	47	0.2%	11	0.7%	1	0.1%
Lincoln	38	0.2%	6	0.4%	2	0.3%
Marathon	195	1.0%	33	2.0%	10	1.5%
Oneida	107	0.6%	11	0.7%	6	0.9%
Portage	170	0.9%	16	1.0%	11	1.6%
Price	35	0.2%	4	0.2%	2	0.3%
Sawyer	52	0.3%	6	0.4%	2	0.3%
Taylor	19	0.1%	2	0.1%	1	0.1%
Vilas	86	0.4%	8	0.5%	6	0.9%
Wood	162	0.8%	23	1.4%	10	1.5%

Region/County	1999 to 2007		2006		2007 to date	
	Cases	% (3)	Cases	% (3)	Cases	% (3)
Southeastern Region	10,371	54.0%	791	47.5%	260	38.9%
Jefferson	178	0.9%	19	1.1%	7	1.0%
Kenosha	866	4.5%	101	6.1%	55	8.2%
Milwaukee	6,997	36.4%	430	25.8%	100	15.0%
Ozaukee	175	0.9%	17	1.0%	3	0.4%
Racine	939	4.9%	109	6.5%	51	7.6%
Walworth	318	1.7%	14	0.8%	4	0.6%
Washington	212	1.1%	21	1.3%	14	2.1%
Waukesha	686	3.6%	80	4.8%	26	3.9%

Wisconsin AIDS/HIV Update Summer 2007

Region/County	1999 to 2007		2006		2007 to date	
	Cases	% (3)	Cases	% (3)	Cases	% (3)
Southern Region	3,278	17.1%	324	19.4%	140	21.0%
Adams	89	0.5%	8	0.5%	7	1.0%
Columbia	135	0.7%	14	0.8%	6	0.9%
Crawford	33	0.2%	2	0.1%	2	0.3%
Dane	1,528	8.0%	163	9.8%	67	10.0%
Dodge	189	1.0%	16	1.0%	7	1.0%
Grant	50	0.3%	6	0.4%	2	0.3%
Green	67	0.3%	5	0.3%	2	0.3%
Iowa	35	0.2%	3	0.2%	2	0.3%
Juneau	110	0.6%	9	0.5%	5	0.7%
Lafayette	14	0.1%	2	0.1%	1	0.1%
Richland	26	0.1%	1	0.1%	1	0.1%
Rock	784	4.1%	76	4.6%	26	3.9%
Sauk	218	1.1%	19	1.1%	12	1.8%

Region/County	1999 to 2007		2006		2007 to date	
	Cases	% (3)	Cases	% (3)	Cases	% (3)
Western Region	2,031	10.6%	184	11.0%	110	16.5%
Barron	97	0.5%	11	0.7%	12	1.8%
Buffalo	20	0.1%	0	0.0%	2	0.3%
Burnett	62	0.3%	5	0.3%	1	0.1%
Chippewa	129	0.7%	22	1.3%	4	0.6%
Clark	52	0.3%	4	0.2%	5	0.7%
Douglas	266	1.4%	18	1.1%	19	2.8%
Dunn	66	0.3%	6	0.4%	6	0.9%
Eau Claire	258	1.3%	24	1.4%	13	1.9%
Jackson	53	0.3%	4	0.2%	3	0.4%
La Crosse	341	1.8%	24	1.4%	11	1.6%
Monroe	206	1.1%	20	1.2%	6	0.9%
Pepin	8	0.0%	1	0.1%	0	0.0%
Pierce	69	0.4%	7	0.4%	7	1.0%
Polk	109	0.6%	12	0.7%	5	0.7%
Rusk	44	0.2%	3	0.2%	0	0.0%
St. Croix	104	0.5%	9	0.5%	5	0.7%
Trempealeau	50	0.3%	2	0.1%	2	0.3%
Vernon	41	0.2%	6	0.4%	5	0.7%
Washburn	56	0.3%	6	0.4%	4	0.6%

Region/County	1999 to 2007		2006		2007 to date	
	Cases	% (3)	Cases	% (3)	Cases	% (3)
Unknown county	5,918	-	619	-	349	-

Notes

Footnotes:

(1) Confirmed case: 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) Possible case:: A positive enzyme immunoassay test result with a low or unknown signal-to-cut-off ratio and no other test result reported.

(3) The percentages shown are calculated among cases with known attribute, i.e., they do not include cases with missing data.

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.

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/

Primer on viral hepatitis policymaking

The National Alliance of State and Territorial AIDS Directors (NASTAD) commemorated May as Viral Hepatitis Awareness Month by calling for heightened national awareness and action from leaders to respond to the needs of persons impacted by viral hepatitis. In a press release issued May 4, NASTAD noted that state hepatitis, HIV, STD, and immunization programs are attempting to provide life-saving viral hepatitis prevention education, hepatitis testing, and vaccinations to millions of Americans at risk while receiving minimal financial support from the federal government. The federal Centers for Disease Control and Prevention (CDC) itself is severely limited by inadequate funding directed to viral hepatitis.

To raise the level of response from policymakers and to support hepatitis advocates, NASTAD released the publication *Raising the Profile, Raising Your Voice: A Primer on Viral Hepatitis Policymaking and Programs at the Federal Level*. The document serves to educate advocates and professionals by providing a basic overview of legislative and regulatory processes to support participation in and understanding of the ways federal viral hepatitis funding and policy is made. The primer on federal hepatitis policymaking and programs can be viewed and downloaded from the NASTAD website at <http://www.nastad.org/Programs/viralhepatitis/>.

AIDS/HIV-related MMWR articles: April 2007 – June 2007

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). The MMWR is available free of charge in electronic format and on a paid subscription basis for paper copy. 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 website at <http://www.cdc.gov/hiv/resources/reports/mmwr/>. Public health agencies and most libraries in hospitals, medical schools and nursing schools subscribe to the MMWR.

Article	Issue
Rapid HIV Testing among racial/ethnic minority men at gay pride events – nine U.S. cities, 2004-2006. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5624a3.htm?s_cid=mm5624a3_e	MMWR 2007 June 22;56(24):602-4.
Rapid HIV testing in emergency departments – three U.S. sites, January 2005-March 2006. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5624a2.htm?s_cid=mm5624a2_e	MMWR 2007 June 22;56(24):597-601.

<p>Symptomatic early neurosyphilis among HIV-positive men who have sex with men --- four cities, United States, January 2002--June 2004. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5625a1.htm</p>	<p>MMWR 2007 June 29;56(25):625-8</p>
<p>Notice to readers: publication of revised HIV/AIDS surveillance report, 2005. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5625a1.htm</p>	<p>MMWR 2007 June 29;56(25):634</p>

Centers for Disease Control and Prevention website redesign

In April, the federal Centers for Disease Control and Prevention (CDC) unveiled a new website (www.cdc.gov) after being extensively tested and designed to provide better access to health and safety topics, data and statistics, news and events, expanded tools and resources, and an improved search engine. The website includes a convenient A-Z index/alphabetical listing of all of CDC's online information as well as a "Top 20 List" of the current most popular content viewed on the CDC website.

The redesigned website includes an expanded HIV/AIDS domain that is subdivided into a broad variety of HIV-related topical areas, some of which are linked to CDC web content outside the HIV/AIDS Prevention domain. Content addressing HIV-related topic areas have specialized tabs to access content tailored for the public and content for targeting prevention providers, in both English and Spanish. The homepage for CDC's HIV/AIDS domain is located at <http://www.cdc.gov/hiv/>.

Transitions at the Wisconsin HIV/AIDS Training System

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

Tara Loushine, Coordinator of the Wisconsin HIV/AIDS Training System, will be relocating to Duluth, Minnesota at the end of the summer. Tara was hired in 2001 as the first coordinator of the HIV/AIDS Training System and since then helped the system develop as a source of continuing education courses related to HIV prevention and care services. In the past year the Training System sponsored more than 25 training events attended by almost 400 participants from Wisconsin agencies. During her tenure with the Training System Tara managed the "behind the scenes" tasks necessary to coordinate training events, helped conceptualize and implement the website and online registration system, and provided training and technical

assistance. We appreciate her contributions to continuing education related to HIV prevention and care, and wish Tara success in her new endeavors.

As the HIV/AIDS Training System enters a new stage in its development we invite you to provide feedback about the Training System by participating in an online survey. Please go to <http://www.wihiv.wisc.edu/trainingsystem> and click on the survey tab to provide suggestions for future courses and ways the Training System can support your professional development related to HIV prevention and care services. You are also welcome to email Narra Smith Cox, HIV Training Center Director, at nscox@wisc.edu.

AIDS/HIV Program staff transitions

Miche Llanas resigned as Prevention Evaluation Coordinator in the Wisconsin AIDS/HIV Program in May. Miche joined the AIDS/HIV Program in 2000 as the coordinator of the Prevention with HIV Infected Persons Project, a national demonstration project that focused on the integration of HIV counseling and testing services in minority community-based organizations and the development of prevention case management services for HIV infected persons. In 2003, Miche assumed responsibility for coordinating three demonstration projects that were funded under CDC's Advancing HIV Prevention Initiative and, in 2006, Miche became the HIV Prevention Evaluation Coordinator. Throughout her tenure in the AIDS/HIV Program, Miche was key in developing and evaluating new approaches to HIV prevention through close collaboration with colleagues throughout the nation. Most recently, Miche spearheaded the implementation of EvaluationWeb, the newly developed web-based HIV prevention data reporting system for the Wisconsin AIDS/HIV Program. The AIDS/HIV Program staff thanks Miche for her many contributions and wishes her continuing success in the international nonprofit arena.

In July, **Gail Nahwahquaw** resigned her position as the Coordinator of Life Care Services in the Wisconsin AIDS/HIV Program, a position she has held since she joined the Program in 2000. During her tenure Gail lead a workgroup that updated the *Practice Standards and Administrative Guidelines for HIV Related Case Management* and conducted annual chart reviews at agencies funded to provide case management to monitor compliance with the standards. She had the lead role in planning several popular and successful *Caring for Ourselves* conferences for persons living with HIV. Gail was also responsible for planning quarterly training sessions for HIV case managers. Gail transferred to the Bureau of Mental Health and Substance Abuse Services in the Department of Health and Family Services where she will work with the eleven tribes in Wisconsin as well as other ethnic minority communities as the Inter-Cultural Program Coordinator. The AIDS/HIV Program staff wish Gail continuing success in her new position and thank her for all her contributions in further developing Life Care Services in Wisconsin.

Lynsey Ray resigned her position in the Wisconsin AIDS/HIV Program as Coordinator of Ryan White CARE Act Grant and HIV Early Intervention Program. Lynsey joined the AIDS/HIV Program in 2002. During her tenure Lynsey advocated for meaningful planning processes that included the perspective of persons living with HIV. She helped guide the evolution of six regional HIV Care Consortia to a single statewide consortium by coordinating a transitional

workgroup, and then took lead responsibility for planning the meetings and activities of the new consortium. Lynsey also led the development of a grant required multi-year comprehensive plan for Ryan White HIV Care Services in Wisconsin. More recently, Lynsey was instrumental in guiding the development of the HIV Community Planning Network, Wisconsin's new model for HIV care and prevention planning. Lynsey accepted the position of Program Director with the Wisconsin Primary Health Care Association. The AIDS/HIV Program staff thank Lynsey for her many contributions to the Program and wish her continuing success in her new position.

Mark Ringstrom joined the AIDS/HIV Program in July 2006 as the Evaluation and Research Assistant. Mark most recently worked in the AIDS/HIV Program as a student employee where he was responsible for coordinating data reporting activities for the HIV Counseling, Testing and Referral Program. He also conducted research on new HIV testing initiatives, including identifying acute HIV infection and annual testing for MSM. In his new position, Mark will expand upon his previous responsibilities by supporting HIV testing data-management and evaluation activities and assisting in the development and evaluation of social networks-based testing, testing based on geo-mapping, and initiatives to identify acute HIV infection. Mark graduated in May from the University of Wisconsin – Madison with a Bachelor of Science in Medical Microbiology and Immunology. The staff in the AIDS/HIV Program welcomes Mark!

Calendar

July 30-31, 2007	Miami, FL	2007 National Conference on Latinos and AIDS. Sponsor: Minority Health Care Communications, Inc. & Nurse Practitioner Alternatives, Inc. Contact: Minority Health Care Communications at 866-901-6267 (phone); 410-772-7915 (fax); www.minority-healthcare.com (website).
Aug 23-26, 2007	Washington, DC	2007 Minority Women's Health Summit. Sponsor: US Dept Health & Human Services, Office of Women's Health. Contact: www.womenshealth.gov/mwhs (website).
Sept 17-20, 2007	Chicago, IL	47th ICAAC: Interscience Conference on Antimicrobial Agents and Chemotherapy. Sponsor: American Society for Microbiology. Contact: icaac@asmusa.org (email) or http://www.icaac.org (website).
Sept 19-20, 2007	Western Region	Wisconsin HIV Community Planning Network. Contact: Lynn Tarnoff at 608-890-1424 (phone) or tarnoff@wisc.edu (email).
Sept 25-26, 2007	San Francisco, CA	Decade of HAART: Historical Perspectives and Future Directions. Sponsor: International Association of Physicians in AIDS Care (IAPAC) & The University of Medicine and Dentistry of New Jersey. Contact: IAPAC, 33 North LaSalle, Ste 1700, Chicago, IL 60602; decade@iapac.org (email); 312- 795-4930 (phone); 312- 795-4938 (fax); http://www.iapac.org (website).
October 15, 2007	National Observance	National Latino AIDS Awareness Day. Further information: www.omhrc.gov/hivaidsobservances/latino/index.html .
October 24-26, 2007	San Francisco, CA	15th Annual HIV/AIDS Conference. Sponsor: University of California San Francisco, School of Medicine. Contact:

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- <https://www.cme.ucsf.edu/cme/CourseDetail.aspx?coursenumber=MDM08K02>
(website).
- Nov 3-7, 2007 Washington, DC **American Public Health Association (APHA) 135th Annual Meeting & Exposition.** Sponsor: APHA. Contact: 202-777-2504 (phone); access@apha.org (email); www.apha.org/meetings/access.htm (website).
- Nov 7-10, 2007 Palm Springs, CA **2007 United States Conference on AIDS (USCA).** Sponsor: National Minority AIDS Council. Contact: www.nmac.org/conferences%5F%5f%5Ftrainings/USCA (website).
- Nov 8-11, 2007 Orlando, FL **Association of Nurses in AIDS Care (ANAC) 20th Annual Conference.** Sponsor: ANAC. Contact: 330-670-0101 (phone); 800-260-6780 (fax); anac@anacnet.org (email); <http://www.anacnet.org> (website).
- Nov 14-15,2007 Southeastern Region **Wisconsin HIV Community Planning Network.** Contact: Lynn Tarnoff at 608-890-1424 (phone) or tarnoff@wisc.edu (email).
- Dec 1, 2007 International Observ **World AIDS Day 2007.** Sponsor: Joint United Nations Programme on HIV/AIDS. Contact: World AIDS Campaign <http://www.worldaidscampaign.info/> (website).
- Dec 2-5, 2007 Atlanta, GA **2007 National HIV Prevention Conference.** Sponsor: Centers for Disease Control and Prevention. Contact: <http://www.2007nhpc.org/backgroundinfo.asp> (website).

Important Contacts



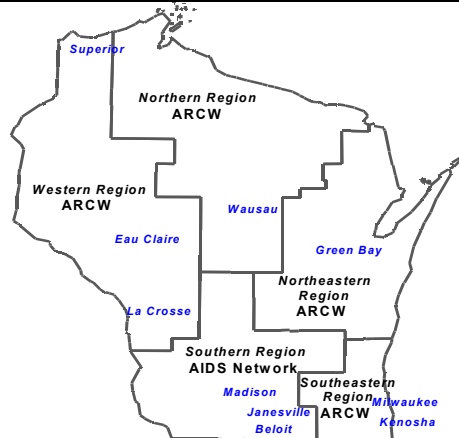
Wisconsin HIV/STD/Hepatitis C Information and Referral Center	800/334-2437
Wisconsin AIDS/HIV Program	608/267-5287
Wisconsin AIDS Research Consortium (clinical trials)	800/359-9272
Wisconsin AIDS/HIV Drug Reimbursement Program	800/991-5532
Wisconsin AIDS/HIV Continuation Coverage Premium Subsidy Program	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/CDC-INFO	800/232-4636
TTY	888/232-6348
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		

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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 57 th St Kenosha WI 53140		262-657-6644 800-924-6601 262-657-6949 (FAX)



Wisconsin AIDS/HIV Program Staff Directory

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Sheila Guilfoyle (email: guilfsm@dhfs.state.wi.us) Coordination of the Wisconsin Hepatitis C Program.	608-266-5819
Molly Herrmann, MS (email: herrmmm@dhfs.state.wi.us) Coordination of the Wisconsin HIV Prevention Community Planning.	608-267-6730
Neil Hoxie, MS (email: hoxienj@dhfs.state.wi.us) Design, implementation and analysis of seroprevalence surveys; analysis of surveillance data; projections.	608-266-0998
Karen Johnson, BSW (email: johnskm@dhfs.state.wi.us) Coordination of education & prevention initiatives for racial/ethnic minorities; adolescent prevention initiatives.	608-266-1808
Kathleen Krchnavek, MSSW (email: krchnka@dhfs.state.wi.us) Technical assistance & consultation regarding rapid HIV testing and quality assurance of HIV counseling and testing services.	608-267-3583
Miche LLanas (email: llanamr@dhfs.state.wi.us) HIV Prevention Evaluation Coordinator.	608-261-6731
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Program assistants General program support activities, data entry and word processing.	608-267-5287
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Kris Rohde (email: rohdekc@dhfs.state.wi.us)	
Linda Ziegler (email: zieglls@dhfs.state.wi.us)	