



A New Paradigm for Hope

by Barb Wood

Last year the 20th Anniversary of the discovery of HIV was observed. There was a story to be told about AIDS, about suffering and loss and stigma-

tized groups. It was about a time when gay activists, public health programs and researchers focused on one epidemic, and hoped for the magic bullet that would make it all go away.

'Color Me Healthy' Promote Healthy Lifestyles in Communities of Color – the upcoming Michigan STD and HIV conference in November has a new paradigm with a positive affirmation. Keynotes and workshops will look at the big picture for the community now most affected by this epidemic. For African Americans HIV is just one piece of a multi-epidemic under the umbrella of 'health disparities.'

MDCH has focused on the larger issues for African Americans for years, but this conference marks a whole new paradigm for hope. This is not just a Michigan refocus. From the Centers for Disease Control and Prevention (CDC) to national black organizations, leaders are rethinking the approach to HIV/AIDS. Kevin Fenton, director of the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention said in a Kaiser webcast this summer, "There are social determinants of disease. The social context is driving multi-epidemics." A panel of national speakers – most notably Fenton and Phill Wilson, executive director of the Black AIDS Institute – discussed the social context of AIDS in the August webcast, *What Would it Take to Eliminate the Disproportionate Burden of HIV/AIDS Among African-Americans?*¹

A number of national reports have been released emphasizing the crisis of AIDS in the African American community^{2,4&5}. All identify the larger context of this epidemic in social norms and health disparities.



The Michigan STD & HIV Conference speakers began discussing the growing epidemic among African Americans years ago. They drew the big picture of contributing health and social problems like homophobia (and other social and religious and taboos that contribute to denial and stigma), racism

(specifically institutionalized racism), poverty, multiple epidemics of HIV, STDs and hepatitis, lack of accessible addiction and mental health treatment, gender inequality in sexual relationships, social sexual norms (i.e. multiple sex partners), lack of universal health coverage in the U.S. and the resultant health care disparities, social health norms and myths that have basis in historical reality.

But we needed a paradigm shift. What we have had in the past is a failure to communicate risk to this community, a failure to break the political glass ceiling on science-based prevention, a failure of systems and bureaucracies to work synergistically as well as collaboratively to address the multiple needs of those most at-risk in a timely manner, a failure of leadership in the faith profession to act compassionately, a failure by providers to integrate HIV prevention and care into other health services, and a failure of individuals and civil rights advocates to step up and fight for HIV awareness, prevention and care as a civil rights issue.

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DHWDC News

MDCH Division of Health Wellness and Disease Control

HAPIS

Continuum of Care Unit (COC) Michigan Dental Program (MDP)

The Michigan Dental Program (MDP) has opened enrollment effective September 1, 2007. Please contact Diane Rydahl at 888-826-6565 if you have any questions about the program.

HIV/AIDS Continuum of Care Services RFP

Two health departments will become MDCH COC service providers for the first time under the new Ryan White Awards. Ingham County Health Department will provide ambulatory outpatient care and Central Michigan District Health Department will provide case management and other supportive services. It is anticipated that 500 people will receive primary and specialty care through Ingham County with Part B/MHI resources. The two other health departments that were successful applicants and who have historically provided case management services are Marquette County Health Department and District Health Department Number 10. Eight other community-based organizations, hospitals, and or clinics will also receive MDCH COC funding. Several of these agencies are also federally-qualified health centers. Funding awards begin on October 1, 2007.

New Ryan White Act, New Service Definitions, New Standards, New Training

The newly enacted Ryan White HIV/AIDS Treatment Modernization Act of 2006 changes how Ryan White funds can be used, with an emphasis on providing life-saving and life-extending services for people living with HIV. Under the new law, at least 75 percent of

funds must be spent on core medical services, which include ambulatory outpatient medical care, medications/treatment, mental health treatment, outpatient substance abuse recovery, oral health care, early intervention services, and medical case management.

The new HRSA service definition of Medical Case Management

states that Medical Case Management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. These services ensure timely and coordinated access to medi-



cally appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical Case Management now includes the provision of treatment adherence counseling.

This new service definition is similar to Michigan case management practices; however, Michigan's Standards and the HIV/AIDS Case Management Certification Training did not fully address treatment adherence counseling. Consequently, new Medical HIV Case Management Standards of Service and a new Medical Case Management Certification and Training curriculum are being developed.

This new training will take place the week of October 22, 2007 and will be presented in a series of three (3), two-day training sessions. See the Michigan HIV News website, Care news page for further details on this, as well as the new COC TA conference calls schedule and registration form.

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Emergent Global Issues

Looking at the big picture — a new World Health Organization report on global health security in the 21st century says it is very likely a deadly new infectious disease will emerge. According to WHO's 2007 World Health Report, new diseases have been discovered at the "unprecedented" rate of one or more per year since the 1970s. "It would be extremely naïve and complacent to assume that there will not be another disease like AIDS, another Ebola, another SARS [Severe Acute Respiratory Syndrome], sooner or later," the report said. Agence France Presse, (08.23.2007)

Meanwhile, HIV is far from under control. In sub-Saharan Africa, which still bears the biggest burden globally, gender inequality is acknowledged to be increasing infections among women. And research released this summer shows that the sex-trafficking of women and girls is fueling epidemics in Asia. An international conference this summer addressed this and other emergent issues for that region of the world.

Speaking at the International Women's Summit on HIV/AIDS in Nairobi, Kenya, in July, UNAIDS Chief Peter Piot said the growing feminization of AIDS is the most significant development of the epidemic. Sixty percent of adults in sub-Saharan Africa with HIV are female. World Health Organization (WHO) Director Margaret Chan said cultural obstacles to women's advancement need to

be overcome in order for HIV/AIDS to be brought under control. Agence France Presse, (07.05.2007)

New research released in August suggests policies that stop the demand for sex-trafficked women and girls, prevent trafficking, and protect former sex workers may significantly reduce the spread of HIV. "More and more evidence suggests that sex trafficking is affecting a greater number of women and children across the globe," said Dr. Jay Silverman of the Harvard School of Public Health Silverman. Among girls trafficked before age 15 (one in seven of all trafficked females), two-thirds were HIV-positive according to Silverman et al research in the Nepal/India border region. Clients pay more for young girls, who are more vulnerable to HIV and lack access to medical care, related Silverman. Washington Times, (08.27.2007)

The 8th International Congress on AIDS in Asia and the Pacific (ICAAP8) was held in August in Colombo, Sri Lanka. WHO's Southeast Asia regional director, said, "In the Asia-Pacific region, we are at high risk of a massive spread of HIV," adding, "This is not only due to the large size of the population and the high burden of sexually transmitted infections, but

also due to the prevailing risk behaviors and vulnerabilities as well as inherent social stigma." Reuters, (08.23.2007)

According to the UNAIDS Asia-Pacific regional director, recent international HIV/AIDS efforts have focused on India and Thailand, but Bangladesh, China, Indonesia and Pakistan could be the next front lines. Xinhua/People's Daily, (08.23.2007)



Experts at the close of the conference said that safeguarding the rights of vulnerable groups — including sex workers, injection drug users (IDUs) and trafficked women

and children — is vital and should be done in conjunction with prevention efforts. Reuters, (08.23.2007).

Three UN agencies announced at the ICAAP8 a joint effort to expand HIV prevention programs targeting IDUs in Asia. In some countries in the region, up to 70 percent of new HIV infections are linked to injection drug use, said UNAIDS, the UN Office on Drugs and Crime, and the WHO. Associated Press, (08.21.2007)

However, China reported that unsafe sex has eclipsed IDU as the main transmission route. Reported statistics suggest the epidemic there is moving into the general public. Reuters, (08.20.2007)

NATIONAL NEWS BRIEFS

Two important pieces of legislation were introduced in the House of Representatives in August. The Early Treatment for HIV Act (ETHA) would give states the option of amending their Medicaid programs for low-income persons to allow for early treatment of HIV, before they develop AIDS. A Senate version of ETHA was introduced in March. For more than a decade, advocates have pushed for the changes found in ETHA, but political and financial issues have blocked it. Bay Area Reporter (08.09.2007) Also introduced was legisla-

tion that would lift the ban against letting people with HIV/AIDS travel or immigrate to the United States. Oakland Tribune (08.05.07)

New Drugs - In August the Food and Drug Administration's (FDA) Antiviral Drugs Advisory Committee unanimously recommended accelerated approval of raltegravir, in combination with other antiretroviral therapy for treatment-experienced patients. If approved, raltegravir will be the first of a new class of antiretroviral drugs, integrase inhibi-

tors. AIDSInfo At-A-Glance (Volume 3 Issue 38) Research reported this summer could lead to the development of more members of the fusion inhibitor class, active against enfuvirtide-resistant HIV of antiretroviral drugs. (Volume 3 Issue 32)

The FDA also approved Selzentry (maraviroc), a CCR5 co-receptor antagonist used in combination with other antiretroviral products for the treatment of adults infected with CCR5-tropic HIV-1. This is the first drug approved in the new class of anti-HIV medications called CCR-5 co-receptor antagonist. FDA-HIV-AIDS Digest (#2007-23)

Reaching the African American Community

MDCH RECEIVES MINORITY AIDS INITIATIVE (MAI) FUNDING CONTRACTS WITH APM TO PROVIDE SERVICES

In late August, the Michigan Department of Community Health (MDCH) announced it was awarded Minority AIDS Initiative (MAI) funding through the federal Health Resources and Services Administration.

MDCH is scheduled to receive \$141,887 each year, for a three-year project period, beginning August 2007. MAI provides funding for projects to evaluate and address the disproportionate impact of HIV/AIDS on racial and ethnic minorities.

MDCH will use these funds to contract with AIDS Partnership Michigan (APM) to provide two projects. The first assists eligible minority incarcerated persons transitioning back into the community with access to medical care and HIV medications. The second will increase medical services and medication access for eligible minority HIV positive youth.

"In addition to continuing to fund current programs and working to contain costs, MDCH has a unique opportunity to support some of our most vulnerable citizens," said Janet Olszewski, MDCH Director. "Receiving this additional funding is an important step in addressing and reducing those health disparities experienced by racial and ethnic minorities in Michigan."

Community Re-entry targets HIV positive prisoners and their release from Michigan Department of Corrections (MDOC) facilities. Annually, MDOC facilities release approximately 70 HIV positive individuals in need of community-based, follow-up assistance that links released prisoners to the AIDS Drug Assistance Program, other medication programs and medical care and treatment providers.

For the other project, Youth Link, APM will partner with the Ruth Ellis Center to link minority youth who are living with HIV to medical care and treatment services. The project will work to establish trust and assess barriers to accessing medical care and ADAP services including mental/emotional challenges and substance use, and provide HIV education/information. Linkage to HIV case management will address basic needs. The project will also recruit successful peer models to provide ongoing mentoring and support particularly as it relates to retention in medical care and treatment adherence.

National HIV Test Day: A Resounding Success

Participating agencies were reenergized this year by a new MDCH mini-grant process for new and innovative NTD events proposals. Twenty-one agencies (includes CBO's, university health clinics and local health departments) received mini-grant funding.

Preliminary data shows 1,794 clients – **an increase of 442 over last year** – tested, yielding 7 new positives. Many of the testing events were geared towards African American youth, and included culturally appropriate themed entertainment to draw the largest crowds possible.

A final report of all NTD events will be completed by September 30, 2007. For more information, please contact Lisa Taton-Murphy at tatonl@michigan.gov.

Detroit/MDCH Collaboration for Quality

The MDCH Part D staff and the Detroit Health, Wellness and Disease Control staff worked together to spear-head an All Titles/Parts meeting to discuss developing Quality Indicators for all funded Ryan White grantees. See the document that was developed on the Michigan HIV News website. All Part B and D contractors will be required to collect data consistent with the quality indicators. This document is on the Michigan HIV News website (mivhivnews.com/care.htm).

Special Recognition

Kathryn Wright, MD had a vision to provide non-judgmental, youth-sensitive care to adolescents and young adults living with HIV/AIDS.



Kathryn Wright, MD

In 1994, Dr. Wright's vision became the Horizons Project, which has evolved into Detroit's premier HIV/AIDS agency for youth. After more than 20 years of service to the Division of Adolescent Medicine at The Children's Hospital of Michigan, Dr. Wright is retiring.

At the June meeting of the Michigan HIV/AIDS Council, Dr. Wright was presented the Lifetime Achievement Award by the Comprehensive School Health Coordinator's Association. "Dr. Wright is an outspoken advocate for comprehensive sex education programs for young people...She asserted that adults have a responsibility to teach youth about sex from a medical and scientific perspective, and not from a judgmental and moral stance that poses barriers to healthy and responsible adult sexual decision making," said Wendy Sellers in presenting the award.

Horizons Project is holding a special fundraising event on Friday, October 12 in Detroit, to celebrate Dr. Wright's retirement.

Proceeds from this event will directly support the programming of The Horizons Project of The Children's Hospital of Michigan. For more information contact Linda Hyter (313) 924-9493 or lhyter@dmc.org. There are several levels of contribution available. An individual ticket for the event costs \$75.

New and Improved Report from MDCH HIV Surveillance

The MDCH *Quarterly HIV/AIDS Report, Michigan* has a totally new look! The July 2007 Report has more information and easy on the eyes formatting. New “Front Matter” contains useful information for those new to reading HIV/AIDS statistics, i.e. epi terminology; it also has newly defined risk categories (see below). The new Table 1 on page 6 of this issue shows both estimated and reported prevalence and a comparison to 2006 census estimates. Table 5 on page 7 gives a comparison of 2006 reported HIV to accumulated cases by race/ethnicity, risk, age and disease status.

The complete 9-page Report is available on our website in PDF (www.mihivnews.com/statistics/july_07/Jul07.pdf).

HIV Surveillance in Michigan

Reports of HIV infection and AIDS are submitted to state and local health departments under Michigan law by providers making the diagnoses. In addition, MDCH implemented PA 514 in April 2005, requiring laboratories to report HIV test results. The addition of laboratory reporting to the HIV surveillance system has increased the case reports received and has improved reporting completeness. Anonymous HIV reports (without name or other identifier) are excluded from this report because we cannot estimate duplication, update status, or obtain missing data. A total of 1,839 complete anonymous reports have been reported in Michigan.

HIV Prevalence Estimates for Michigan

HIV prevalence (total # of persons living at one point in time) estimates in this report are based on adding the following three components and rounding: 1) the number of cases living with HIV/AIDS, 2) the number of known HIV+ cases not yet reported, estimated at 10 percent of the reported living HIV/AIDS cases, and 3) the number of HIV+ cases that have not yet been tested, estimated at 25 percent of the total cases living with HIV/AIDS (identical to the CDC estimate).

Categorical estimates of HIV infection are calculated from

the distribution of reported cases among each group of confidentially reported persons living with HIV or AIDS. The proportion of total cases is multiplied by 17,000. For example, 77 percent of combined HIV and AIDS reports are among men. Therefore, the number of HIV-infected men in Michigan is estimated to be 13,070 = (76.9% X 17,000). Estimates are rounded to the nearest 10 and the minimum estimate is 10.

New Risk Categories

■ **Blood Recipient** - All hemophiliacs, blood transfusion recipients, and organ recipients who received blood products prior to 1985 and all persons documented to have ever received an infected organ or unit of blood.

■ **Heterosexual** - includes both HRH (High Risk Heterosexuals, male and female) and PH (Presumed Heterosexual, females). HRH (High Risk Heterosexuals) are defined as males and females whose sexual partners are known to be HIV-infected or at high risk for HIV. The partners meet one of the following criteria: a history of sexual contact with bi-sexual males (for females), IDU, hemophiliacs, HIV+ transfusion recipients, or other HIV+ persons of unknown risk. PH (Presumed Heterosexual) are females whose only reported risk is heterosexual contact, and their male partners’ risk and HIV status is unknown. Note: Male PH stats are included in the Undetermined category.

■ **IDU (Injection Drug User)** - Persons who have a history of injecting drugs

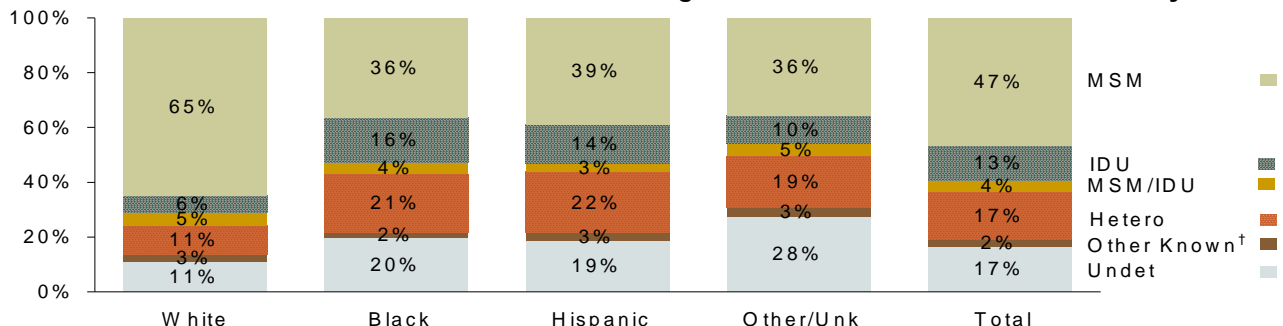
■ **Perinatal** - HIV transmission from mother to child during birth or through breastfeeding.

■ **MSM (Men who have sex with men)** - Males who have a history of sexual contact with other men or with men and women

■ **MSM/IDU** - MSM who also have a history of injecting drugs

■ **Undetermined** – includes PH (Presumed Heterosexual, male) - Males whose only reported risk is heterosexual contact, and their female partners’ risk and HIV status is unknown; and Unknown - Males and females with no identified risk.

FIGURE 1. Mode of HIV Transmission Among Prevalent HIV/AIDS Cases by Race



†The 'Other Known' category in Figure 1 is a combination of 'Blood Products' and 'Perinatal' from Table 2

TABLE 1. Demographic Information on Prevalent HIV/AIDS Cases

| | <i>ESTIMATED PREVALENCE*</i> | | <i>REPORTED PREVALENCE</i> | | | | | | <i>CENSUS 2006 ESTIMATES</i> | |
|------------------------------------|------------------------------|-------------------------------|----------------------------|-------|---------------------|-------|----------------------|-------|------------------------------|---------|
| | Number | Rate per 100,000 [†] | HIV, not AIDS | | AIDS | | Total | | Number | Percent |
| RACE/ ETHNICITY[§] | | | | | | | | | | |
| White | 6,090 | 78 | 2,182 | (35%) | 2,467 | (36%) | 4,649 | (36%) | 7,846,335 | (78%) |
| Black | 9,980 | 701 | 3,665 | (59%) | 3,960 | (58%) | 7,625 | (59%) | 1,424,394 | (14%) |
| Hispanic | 650 | 165 | 219 | (4%) | 279 | (4%) | 498 | (4%) | 393,281 | (4%) |
| Asian/PI | 70 | 30 | 25 | (0%) | 32 | (0%) | 57 | (0%) | 237,073 | (2%) |
| Am Indian/AN | 60 | 111 | 28 | (0%) | 17 | (0%) | 45 | (0%) | 54,231 | (1%) |
| Multi/Unk | 140 | N/A | 58 | (1%) | 50 | (1%) | 108 | (1%) | 140,329 | (1%) |
| SEX & RACE | | | | | | | | | | |
| Males | 13,070 | 263 | 4,607 | (75%) | 5,377 | (79%) | 9,984 | (77%) | 4,969,692 | (49%) |
| White Males | 5,290 | 137 | 1,837 | (30%) | 2,205 | (32%) | 4,042 | (31%) | 3,873,261 | (38%) |
| Black Males | 7,080 | 1051 | 2,528 | (41%) | 2,878 | (42%) | 5,406 | (42%) | 673,766 | (7%) |
| Hispanic Males | 500 | 240 | 162 | (3%) | 221 | (3%) | 383 | (3%) | 208,505 | (2%) |
| Other Males | 200 | 93 | 80 | (1%) | 73 | (1%) | 153 | (1%) | 214,160 | (2%) |
| Females | 3,930 | 77 | 1,570 | (25%) | 1,428 | (21%) | 2,998 | (23%) | 5,125,951 | (51%) |
| White Females | 790 | 20 | 345 | (6%) | 262 | (4%) | 607 | (5%) | 3,973,074 | (39%) |
| Black Females | 2,910 | 388 | 1,137 | (18%) | 1,082 | (16%) | 2,219 | (17%) | 750,628 | (7%) |
| Hispanic Fmls | 150 | 81 | 57 | (1%) | 58 | (1%) | 115 | (1%) | 184,776 | (2%) |
| Other Females | 70 | 32 | 31 | (1%) | 26 | (0%) | 57 | (0%) | 217,473 | (2%) |
| RISK* | | | | | | | | | | |
| Male-Male Sex | 7,930 | N/A | 2,730 | (44%) | 3,322 | (49%) | 6,052 | (47%) | N/A | N/A |
| Injection Drug Use | 2,130 | N/A | 686 | (11%) | 942 | (14%) | 1,628 | (13%) | N/A | N/A |
| MSM/IDU | 750 | N/A | 250 | (4%) | 324 | (5%) | 574 | (4%) | N/A | N/A |
| Blood Products | 190 | N/A | 55 | (1%) | 89 | (1%) | 144 | (1%) | N/A | N/A |
| Heterosexual | 2,960 | N/A | 1,144 | (19%) | 1,118 | (16%) | 2,262 | (17%) | N/A | N/A |
| HRH | 2,200 | N/A | 811 | (13%) | 870 | (13%) | 1,681 | (13%) | N/A | N/A |
| PH-Female | 760 | N/A | 333 | (5%) | 248 | (4%) | 581 | (4%) | N/A | N/A |
| Perinatal | 200 | N/A | 106 | (2%) | 45 | (1%) | 151 | (1%) | N/A | N/A |
| Undetermined | 2,840 | N/A | 1,206 | (20%) | 965 | (14%) | 2,171 | (17%) | N/A | N/A |
| PH-Male | 1,500 | N/A | 559 | (9%) | 586 | (9%) | 1,145 | (9%) | N/A | N/A |
| Unknown | 1,340 | N/A | 647 | (10%) | 379 | (6%) | 1,026 | (8%) | N/A | N/A |
| AGE AT HIV DIAGNOSIS | | | | | | | | | | |
| 0 - 12 years | 230 | N/A | 118 | (2%) | 54 | (1%) | 172 | (1%) | N/A | N/A |
| 13 - 19 years | 590 | N/A | 276 | (4%) | 176 | (3%) | 452 | (3%) | N/A | N/A |
| 20 - 24 years | 2,010 | N/A | 885 | (14%) | 649 | (10%) | 1,534 | (12%) | N/A | N/A |
| 25 - 29 years | 2,830 | N/A | 1,062 | (17%) | 1,097 | (16%) | 2,159 | (17%) | N/A | N/A |
| 30 - 39 years | 6,280 | N/A | 2,151 | (35%) | 2,647 | (39%) | 4,798 | (37%) | N/A | N/A |
| 40 - 49 years | 3,650 | N/A | 1,226 | (20%) | 1,561 | (23%) | 2,787 | (21%) | N/A | N/A |
| 50 - 59 years | 1,160 | N/A | 379 | (6%) | 508 | (7%) | 887 | (7%) | N/A | N/A |
| 60 years and over | 250 | N/A | 77 | (1%) | 113 | (2%) | 190 | (1%) | N/A | N/A |
| Unspecified | 10 | N/A | 3 | (0%) | 0 | (0%) | 3 | (0%) | N/A | N/A |
| TOTAL | 17,000 | 168 | 6,177 (100%) | | 6,805 (100%) | | 12,982 (100%) | | 10,095,643 (100%) | |

*See pages i and ii for descriptions of prevalence estimate calculations and risk category groupings. Risk categories used in Michigan are newly defined as of the July 2007 quarter.

†To calculate "1 out of x" statements, divide the census number by prevalence. For example, for non-Hispanic whites: 7,846,335 / 6,090 = 1288. Thus, an estimated 1 out of every 1,288 non-Hispanic white persons in Michigan are living with HIV.

§ In this report, persons described as white, black, Asian/Pacific Islander (PI), or American Indian/Alaska Native (AN) are all non-Hispanic; persons described as Hispanic might be of any race.

TABLE 5. Demographic Information on Persons Ever Diagnosed* with HIV

| | 2006† | | | | | | CUMULATIVE (through 2006) | | | | | |
|------------------------------------|------------|--------------|------------|--------------|------------|---------------|---------------------------|--------------|--------------|--------------|---------------|---------------|
| | Male | | Female | | Total | | Male | | Female | | Total | |
| RACE/ETHNICITY | | | | | | | | | | | | |
| White | 227 | (35%) | 36 | (19%) | 263 | (31%) | 7,166 | (41%) | 900 | (20%) | 8,066 | (37%) |
| Black | 379 | (59%) | 142 | (74%) | 521 | (62%) | 9,401 | (54%) | 3,393 | (75%) | 12,794 | (58%) |
| Hispanic | 25 | (4%) | 8 | (4%) | 33 | (4%) | 596 | (3%) | 160 | (4%) | 756 | (3%) |
| Asian | 4 | (1%) | 1 | (1%) | 5 | (1%) | 55 | (0%) | 15 | (0%) | 70 | (0%) |
| Am Indian | 4 | (1%) | 2 | (1%) | 6 | (1%) | 46 | (0%) | 17 | (0%) | 63 | (0%) |
| Multi/Unk | 6 | (1%) | 3 | (2%) | 9 | (1%) | 147 | (1%) | 45 | (1%) | 192 | (1%) |
| RISK[§] | | | | | | | | | | | | |
| Male-Male Sex | 369 | (57%) | N/A | -- | 369 | (44%) | 10,121 | (58%) | N/A | -- | 10,121 | (46%) |
| Injection Drug Use | 31 | (5%) | 16 | (8%) | 47 | (6%) | 2,583 | (15%) | 1,474 | (33%) | 4,057 | (18%) |
| MSM/IDU | 13 | (2%) | N/A | -- | 13 | (2%) | 1,222 | (7%) | N/A | -- | 1,222 | (6%) |
| Blood Products | 0 | (0%) | 0 | (0%) | 0 | (0%) | 388 | (2%) | 64 | (1%) | 452 | (2%) |
| Heterosexual | 16 | (2%) | 103 | (54%) | 119 | (14%) | 697 | (4%) | 2,301 | (51%) | 2,998 | (14%) |
| HRH | 16 | (2%) | 37 | (19%) | 53 | (6%) | 697 | (4%) | 1,648 | (36%) | 2,345 | (11%) |
| PH-Female | N/A | -- | 66 | (34%) | 66 | (8%) | N/A | -- | 653 | (14%) | 653 | (3%) |
| Perinatal | 0 | (0%) | 3 | (2%) | 3 | (0%) | 122 | (1%) | 99 | (2%) | 221 | (1%) |
| Undetermined | 216 | (33%) | 70 | (36%) | 286 | (34%) | 2,278 | (13%) | 592 | (13%) | 2,870 | (13%) |
| PH-Male | 113 | (18%) | N/A | -- | 113 | (14%) | 1,493 | (9%) | N/A | -- | 1,493 | (7%) |
| Unknown | 103 | (16%) | 70 | (36%) | 173 | (21%) | 785 | (5%) | 592 | (13%) | 1,377 | (6%) |
| AGE AT HIV DIAGNOSIS | | | | | | | | | | | | |
| 0 - 12 years | 2 | (0%) | 3 | (2%) | 5 | (1%) | 166 | (1%) | 103 | (2%) | 269 | (1%) |
| 13 - 19 years | 46 | (7%) | 5 | (3%) | 51 | (6%) | 364 | (2%) | 176 | (4%) | 540 | (2%) |
| 20 - 24 years | 87 | (13%) | 20 | (10%) | 107 | (13%) | 1,498 | (9%) | 492 | (11%) | 1,990 | (9%) |
| 25 - 29 years | 80 | (12%) | 25 | (13%) | 105 | (13%) | 2,822 | (16%) | 699 | (15%) | 3,521 | (16%) |
| 30 - 39 years | 173 | (27%) | 58 | (30%) | 231 | (28%) | 6,807 | (39%) | 1,620 | (36%) | 8,427 | (38%) |
| 40 - 49 years | 185 | (29%) | 50 | (26%) | 235 | (28%) | 4,078 | (23%) | 1,018 | (22%) | 5,096 | (23%) |
| 50 - 59 years | 56 | (9%) | 26 | (14%) | 82 | (10%) | 1,299 | (7%) | 326 | (7%) | 1,625 | (7%) |
| 60 years and over | 16 | (2%) | 5 | (3%) | 21 | (3%) | 375 | (2%) | 95 | (2%) | 470 | (2%) |
| Unspecified | 0 | (0%) | 0 | (0%) | 0 | (0%) | 2 | (0%) | 1 | (0%) | 3 | (0%) |
| DISEASE STATUS*[¶] | | | | | | | | | | | | |
| AIDS - Same time | 191 | (30%) | 42 | (22%) | 233 | (28%) | 6,985 | (40%) | 1,342 | (30%) | 8,327 | (38%) |
| AIDS - Short lag | 54 | (8%) | 7 | (4%) | 61 | (7%) | 1,238 | (7%) | 344 | (8%) | 1,582 | (7%) |
| AIDS - Long lag | 7 | (1%) | 2 | (1%) | 9 | (1%) | 4,207 | (24%) | 1,119 | (25%) | 5,326 | (24%) |
| HIV, not AIDS | 393 | (61%) | 141 | (73%) | 534 | (64%) | 4,981 | (29%) | 1,725 | (38%) | 6,706 | (31%) |
| TOTAL | 645 | (77%) | 192 | (23%) | 837 | (100%) | 17,411 | (79%) | 4,530 | (21%) | 21,941 | (100%) |

*Includes deceased cases

†Data for cases diagnosed in 2006 may be incomplete at this time

§ See page i for description of risk category groupings. Risk categories used in Michigan are newly defined as of the July 2007 quarter.

¶ The definitions of disease status are as follows:

AIDS - Same time = Concurrent HIV and AIDS diagnoses (diagnoses within the same month)

AIDS - Short lag = AIDS diagnosed 1 month to 12 months after HIV diagnosis

AIDS - Long lag = AIDS diagnosed more than 12 months after HIV diagnosis

HIV, not AIDS = Has not been diagnosed with AIDS

NOTE: <5 and ** = 1, 2, 3, or 4 cases

For complete Michigan and latest National statistics:
www.mihivnews.com/stats.htm

STD Summaries from the CDC HIV/STD/TB Prevention News Updates

“Sexually Transmitted Wart Virus Ups Mouth Cancers”

Reuters, (08.27.2007)

Young men should be vaccinated against the STD human papillomavirus (HPV) in a bid to protect them from rising rates of oropharyngeal cancers, researchers at the University of Texas M.D. Anderson Cancer Center in Houston said recently.

Oropharyngeal cancers, mostly those of the tonsil and base of tongue, appear to be on the increase in certain populations, and HPV transmitted by oral sex is the likely culprit, the scientists said. Certain HPV strains cause genital warts, and they can also cause cancer. Drs. Erich Sturgis and Paul Cinciripini looked at various studies and concluded that HPV type 16 was especially likely to be linked with certain cancers of the tonsil and base of tongue.

While smoking is a well-known risk factor, rates of these cancers have remained steady, despite declines in tobacco use.

They cited one study, by Dr. Maura Gillison of Johns Hopkins University and colleagues, of 100 patients with oral or throat cancers who were compared to 200 healthy people. Participants with six or more oral sex partners had a high risk of the cancer. Evidence of HPV-16 was found in 72 percent of the tumors.

According to federal health officials' estimates, more than a quarter of US girls and women ages 14-59 are infected with HPV. CDC recommends HPV vaccination for females ages 11-26 to prevent cervical cancer.

“[We] encourage the rapid study of the efficacy and safety of these vaccines in males and, if successful, the recommendation of vaccination of young adult and adolescent males,” said Sturgis and Cinciripini.

The study, “Trends in Head and Neck Cancer Incidence in Relation to Smoking Prevalence: An Emerging Epidemic of Human Papillomavirus-Associated Cancers?” was published early online in

the journal *Cancer* (2007;doi:10.1002/cncr.22963).

“Chlamydia Common Among Young Women and Men”

Reuters, (07.16.2007)

A recent nationally representative survey of 6,632 people ages 14-39 found a significant number had chlamydia. Based on samples taken between 1999 and 2002, researchers estimated 2.2 percent of Americans within that age group had chlamydia infection and 0.24 percent had gonorrhea.

Sexually active adolescents, particularly girls, were well represented in the numbers having either infection, according to Dr. S. Deblina Datta and CDC colleagues. Almost half of those who had gonorrhea also had chlamydia. Young women have an “unacceptably high burden” of chlamydia infection, said researchers. Prevalence of chlamydia and gonorrhea was roughly the same in men and women but was disproportionately high among non-Hispanic black residents.

The findings “support current recommendations” to screen sexually active females age 25 and younger for chlamydia, to re-test those with previous chlamydia infection, and to co-treat individuals with gonorrhea for chlamydia, the CDC team concluded. “Despite the considerable prevalence of chlamydia in males, the value of screening males needs to be better defined,” they added.

The full report, “Gonorrhea and Chlamydia in the United States Among Persons 14 to 39 Years of Age, 1999 to 2000,” was published in *Annals of Internal Medicine* (2007;147(2):89-96).

“US Tracks Serious Form of Syphilis in Gay Men”

Reuters, (06.28.2007) Will Dunham

On Thursday, CDC detailed reports from four US cities of symptomatic early neurosyphilis among HIV-positive men who have sex with men (MSM). Symptomatic early neurosyphilis is a rare manifestation of the disease that usually oc-

curs within the first 12 months of infection.

Syphilis in its early stages can typically be cured with antibiotics, whereas neurosyphilis can lead to blindness or stroke, said Dr. Thomas Peterman of CDC's Division of STD Prevention. “These are primarily infections that people are probably getting because they're not using condoms,” said Peterman, an author of the report.

The cases came from Los Angeles, San Diego, Chicago and New York from January 2002 to June 2004. Of the 49 cases, 63 percent were non-Hispanic whites, 18 percent were non-Hispanic blacks and 14 percent were Hispanic. Their average age was 38.

Since declining to a record low in 2000, the US syphilis rate has risen. The report is further evidence that the increase in new US syphilis cases is being driven by gay and bisexual men, many of them also HIV-positive, said CDC.

The sexual behavior that puts a person at risk for syphilis is the same that can lead HIV infection, as syphilis facilitates HIV infection. However, some of the co-infected MSM believed they did not need to use condoms because they were already HIV-infected, said Peterman. “There are a number of studies that continue to show that there are some HIV-infected and some uninfected [MSM] who continue to have large numbers of [sexual] partners and anonymous sex.”

“I think the bigger message is that we need to get control of syphilis,” Peterman said. “And control of syphilis would require safe-sex behavior, reducing the number of partners, and using condoms with those partners. And for [MSM], it means getting tested for HIV and other STDs at least once a year.”

The report, “Symptomatic Early Neurosyphilis Among HIV-Positive Men Who Have Sex with Men - Four Cities, United States, January 2002-June 2004,” was published in *Morbidity and Mortality Weekly Report* (2007;56(25):625-628).

For HIV Research & Reports see the website.

Statewide Training

Schedules and/or contacts for training provided by CHAG, MAPP, the MATEC Michigan AIDS Education and Training Center and MDCH are provided on the website (www.mihivnews.com/train.htm).

MDCH Training

You will find on the website the complete Division of Health Wellness and Disease Control training schedule for 2007. Following is a listing of those with registration deadlines through September. Application forms are available at: www.mihivnews.com/dhwdc_train.htm.

Please be aware that **HAPIS Lansing trainings will no longer be held at the Comfort Inn**. Trainings will now be held in multiple locations in the Greater Lansing area. Please refer to training confirmation letters for location and directions to individual trainings. If you register for a training and have not received a confirmation letter within five days prior to the training, please contact Julie Babb at (517) 241-5909.

Certified Addiction Counselor Credits: All the trainings included in this calendar can be used to obtain continuing education credits for certified addiction counselors (CAC).

HAPIS HIV Prevention/Test Counselor Related Training

For more details on these trainings please see the entire calendar on the website. To register for prevention/test counselor trainings, contact Training Unit Secretary Julie Babb at (517) 241-5903.

Nurses Contact Hours: Nurses may obtain contact hours for the Module 1-3 Training. There is a \$10.00 administration fee charged per course payable at the door by check or money order to "State of Michigan" or cash payment.

Module 1: Basic Knowledge Training

| <u>Dates</u> | <u>Location</u> | <u>Reg.</u> |
|---------------|-----------------|-------------|
| October 29-30 | Detroit | Oct. 5 |
| December 3-4 | Lansing | Nov. 9 |

Module 2: HIV Prevention Specialist Certification Training

| <u>Dates</u> | <u>Location</u> | <u>Reg.</u> |
|----------------|-----------------|-------------|
| November 13-14 | Detroit | Oct. 19 |
| December 5-6 | Lansing | Nov. 9 |

Module 3: HIV Test Counselor and PCRS Certification Training for CBOs

| <u>Dates</u> | <u>Location</u> | <u>Reg.</u> |
|----------------|-----------------|-------------|
| November 8-9 | Lansing | Oct. 19 |
| November 15-16 | Detroit | Oct. 26 |

Module 3: HIV Test Counselor and PCRS Certification Training for LPH

| <u>Date</u> | <u>Location</u> | <u>Reg.</u> |
|----------------|-----------------|-------------|
| December 12-14 | Lansing | Nov. 16 |

LPH Staff: to register please use the PCRS Training Application form. Contact Tracy Peterson-Jones for more information at (313) 456-4422.

Information Based Testing for Low-Morbidity Public Health Departments

This new web course is designed to provide people who will be providing HIV testing in low-morbidity local health departments with information essential to answer basic questions about HIV, provide the elements of informed consent for HIV testing, and deliver or initiate the delivery of HIV test results. This course is available to anyone with web access, however, **this course DOES NOT replace** the test counselor certification course series (Modules 1-3) for persons providing test counseling at CBOs and high mobility LPH.

Accessing the Web Course

This course is accessible at <http://mi.train.org> or www.hapis.org/courses. All persons who require verification of course completion must take the exam and must register and enter the course through MITRAIN. Announcements and references for low-morbidity LPH will be posted on www.hapis.org/courses.

One-Day HIV Prevention Specialist/Test Counselor Update

Topic: Health Disparities

This will focus on disparities in health and health care among people of color; review current disparities in sev-

eral areas of health, including cancer, infant mortality and HIV; examine factors that contribute to disparities; and build a plan of action for addressing health disparities in your HIV work.

| <u>Dates</u> | <u>Location</u> | <u>Reg.</u> |
|--------------|-----------------|-------------|
| October 24 | Detroit | Sept. 28 |

Please see the complete training calendar for additional update options.

Partner Counseling and Referral Services (PCRS)

Contact Tracy Peterson-Jones at (313) 456-4422 or PetersonT@michigan.gov. PCRS training is required for those individuals who will provide HIV test counseling, elicitation and/or field investigations, and are currently working at an LPH Dept. receiving HIV categorical funding. (See Module 3 for LPH.)

Specialized PCRS Courses

PCRS & the Internet Workshop

This workshop is a review of the PCRS Internet Protocol to assist local health department staff access the Internet and provide PCRS to partners who are identified as at risk for HIV. This course is designed to provide hands on experience to initiate the Internet as an HIV prevention tool.

| <u>Dates</u> | <u>Location</u> | <u>Reg.</u> |
|--------------|-----------------|-------------|
| October 25 | TBA | Oct. 15 |

Application: Please note application deadlines. Complete the PCRS Training Application Form For more information, contact Tracy Peterson-Jones at (313) 456-4422 or PetersonT@michigan.gov.

HIV/AIDS Case Management Certification Training

For information please contact Jane DuFrane (517)241-5933 or DuFraneJ@michigan.gov. Training is designed to certify HIV/AIDS case managers who are required to adhere to the *Principles and Standards of Service for HIV/AIDS Case Management in Michigan*.

Participants must have already completed the HIV Test Counselor Certification Training. Complete the "Case Manager Certification Application Form."

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Date Location Reg.
 October 23-26 Detroit Sept.28
 All MDCH-certified HIV/AIDS case managers must be recertified every two (2) years. See “New Ryan White Act, New Service Definitions, New Standards, New Training” in DHWDC News on page 2.



Statewide Meetings

HIV/STD and Adolescents Networking Committee

This committee is for professionals in youth serving agencies. The next meeting will be October 10 at Planned Parenthood in Ann Arbor. **Contact:** Chair Ardith Alderdyce AAardith @sbcglobal.net.

MHAC

The Michigan HIV/AIDS Council is the statewide planning group for prevention and care. The next meeting is November 15 in Eaton Rapids. **Contact:** Belinda Chandler (517) 241-5926.

Program Review Panel (PRP)

New Members Welcome - The next meeting is October 19 in Lansing. The materials deadline is October 2. **Contact:** Christina Bolden at (517) 241-5929 or e-mail: boldenc@michigan.gov.

Conferences and Events

Michigan Conferences and Events

November 1-2 Ypsilanti
13th Annual STD & HIV Conference - Color Me Healthy
 Marriott Eagle Crest Conference Center
 Download the registration brochure at: www.mihivnews.com/std_hiv_conference_2007.htm or contact Diane Drago at DMSdiane@concentric.net or 517-663-5147 for additional information. Accommodations can be made by calling 734-487-2000 (reference MDCH Health Conference) or register on-line at: <http://marriott.com/DTWYS>; enter std stda in the promotional code box.

September 29-30
 AIDS Walk Michigan

There are a total of seven AIDS Walks taking place throughout Michigan to raise important funds for local HIV/AIDS services. To get further information, register to walk or form a team, please visit www.aidswalkmichigan.org

- Ann Arbor**, Sunday, Detroit Edison Parking Lot (corner of Main and William)
- Bay City/Saginaw/Midland**, Saturday, Wenonah Park - Friendship Shell Downtown Bay City
- Detroit**, Saturday, Belle Isle Nature Zoo
- Flint**, Saturday, University Pavilion
- Grand Rapids**, Saturday, First Place Building (207 E. Fulton)
- Lansing/East Lansing**, Sunday, Valley Court Park
- Traverse City**, Sunday, Grand Traverse County Civic Center

National Conferences and Events

October 15
National Latino AIDS Awareness Day
www.omhrc.gov/hivaidsobservances/latino/index.html; for Michigan events planning contact Legia Romero at LAAN (517) 394-3560.

November 7 - 10 Palm Springs, CA
 2007 United States Conference on AIDS (USCA)
www.nmac.org/conferences%5F%5F%5Ftrainings/USCA/

December 2 - 5 Atlanta, GA
 The fifth National HIV Prevention Conference
www.2007nhpc.org/backgroundinfo.asp

December 1
 World AIDS Day

WHERE TO CALL

National Prevention Information Network: (800) 458-5231

Expanded resource center, contracted by CDC, includes STDs and TB.

HOTLINES

CDC INFO:

(800) CDC-INFO (800-232-4636)
(888) 232-6348 TTY
 Hours: 24/7

Michigan AIDS Hotline:

(800) 872-AIDS (2437)
 Hours: 9 a.m. to 5 p.m. weekdays

Hotline for Women:

(800) 554-4876
 Hours: 2 p.m. to 9 p.m. Monday, Wednesday, Friday

National HIV/AIDS Treatment

Hotline:

(800) 822-7422
 Hours: 9 a.m. to 5 p.m. weekdays, 1 p.m. to 7 p.m. Saturday
 Confidential treatment information by phone call provided by Project Inform. Volunteer operators (most are PLWH/As) can answer questions on HIV treatments and related diseases.

Find Services at:
 Michigan Go Local
 Wayne State University's Shiffman Medical Library staff has put together a tremendous new resource for locating HIV/AIDS related services in Michigan on the Internet. Linked through the National Library of Medicine (NLM), the Michigan Go Local resource is part of a large National Institutes of Health project and is connected to Medline Plus.
www.mihivnews.com/resource.htm

A New Paradigm for Hope

Continued from page 1

For this shift in awareness, we need a new game plan. The CDC's report, *A Heightened National Response to the HIV/AIDS Crisis Among African Americans*, revised June 2007², covers action strategies that include the CDC working together with other federal agencies (NIH, SAMHSA and HRSA) to develop cross agency plans for new and effective prevention interventions and mobilizing broader community action by connecting HIV/AIDS prevention with efforts against racism, homophobia, joblessness, sexual violence, homelessness, substance abuse, mental illness and poverty. The report also suggests the CDC should work with prisons, jails and detention centers to develop behavioral, social, and systems level interventions to address the HIV prevention needs of incarcerated persons as well as investigate the needs and strategies for African Americans transitioning in and out of prisons. The report also recommends expanding collaborations with community-based organizations (CBOs) serving African Americans to develop and evaluate innovative and potentially effective interventions.

Public Health views providing HIV testing as the cornerstone of HIV prevention. As we already know, the CDC's most recent push is for everyone (aged 13-24) to be tested. During the Kaiser webcast, Phill Wilson voiced the concern of many community advocates; "Will the care be

there if you test positive?" He said, "If we don't have something to offer them at that time, we are going to lose them."

Care and prevention are not separate issues. This is another barrier that must be addressed, and not just on a federal agency level, but right on down to within CBOs. Prevention counselors need to communicate with case managers. Prevention and Care managers have to work together to provide services for the most targeted and effective HIV prevention we have available, prevention for positives programs. These programs address multiple needs on both individual and group levels and provide tools and support for individuals to change behaviors.

Traditionally, we have laid all of the responsibility for prevention on individuals, to change their behavior, to protect themselves. According to public health research³ reported this summer, "In the last 50 years, the dominant view in the U.S. has been that lifestyle is the major remediable cause of ill health...While most observers acknowledge that social forces influence these choices, most interventions focus on changing individuals." Last year when the National Expert Panel on Community Health Promotion met they

reported, "This approach is inefficient, requiring health promoters, like [the mythological figure] Sisyphus, to push every person who engages in unhealthy behavior up the steep hill of disease-promoting environments toward health at the top, rather than leveling the incline by changing policy."

The July issue of the National Alliance of State and Territorial AIDS Directors (NASTAD) HIV Prevention Bulletin⁴, acknowledged how HIV, viral hepatitis and STD prevention programs

"Rather than focusing on a specific disease, a syndemic orientation looks first at a particular community to understand the causes of disease burden and to identify what is needed to promote the community's overall health."

typically focus efforts at the individual level. The Bulletin took a look at models of health profiles and health determinants and explored a new Model of Syndemics. A term first published in 1992, Syndemics is defined as "two or more afflictions, interacting synergistically, contributing to excess burden of disease in a population."

"Rather than focusing on a specific disease, a syndemic orientation looks first at a particular community to understand the causes of disease burden and to identify what is needed to promote the community's overall health," stated the Bulletin referring to the CDC's overview.

Using this approach and addressing

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1 Today's Topics In Health Disparities What Would it Take to Eliminate the Disproportionate Burden of HIV/AIDS Among African-Americans?

Kaiser Family Foundation webcast, on August 2, 2007; transcript and archived video <http://www.kaisernetwork.org/todaysttopics/02aug07>

2 **A Heightened National Response to the HIV/AIDS Crisis Among African Americans**, Revised June 2007, CDC Publication [See page 4, for referrals to additional resources]

<http://www.cdc.gov/hiv/topics/aa/resources/reports/heightendresponse.htm>

3 **From Lifestyle to Social Determinants: New Directions for Community Health Promotion Research and Practice**, Nicholas Freudenberg, DrPH, *Preventing Chronic Disease, Public Health Research, Practice, and Policy*, Vol. 4: No.3, July 2007

http://www.cdc.gov/pcd/issues/2007/jul/06_0194.htm

4 **Syndemics—The Ties that Bind**, NASTAD HIV Prevention Bulletin, July Issue

<http://www.nastad.org/Publications/bulletin.aspx>

5 **Why we can't wait: The Tipping Point for HIV/AIDS Among African Americans**, NASTAD 2007 Monograph

http://www.nastad.org/Docs/highlight/200758_NASTAD_Monograph_FINAL.pdf

HOPE

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the collective needs of a population, the report stated, “programs can hope to begin to alter the cycle of disease and disparity within marginalized population groups.”

NASTAD interviewed Ronald Stahl, professor and assistant dean at the University of Pittsburgh’s Graduate School of Public Health. “One of the striking findings regarding MSM [men who have sex with men] in the context of AIDS has been the high prevalence rates of other dangerous health conditions...rates of depression, drug use, violence victimization, childhood sexual abuse, tobacco use and other health problems are generally higher than among other populations of men,” said Stahl. Stahl suggests that by partnering with violence prevention, substance abuse treatment and mental health efforts we could increase the effectiveness of HIV prevention work among MSM, still the most at-risk behavioral group. “We need to identify ways via funding streams to increase cross-agency collaboration and to encourage “cross-epidemic thinking when providing services,” he said.

So, what can you do as an individual? Call your colleagues outside of HIV/AIDS (or STD) work, your favorite religious leader, your government representatives, your doctor, your local school’s social worker and school board members. Invite them to attend this year’s STD & HIV conference. Let’s stop preaching to the choir, we have networking to do.

See the MDCH-DHWDC and Michigan News pages for collaborative efforts in Michigan.

HAPIS News

Continued from page 2

Community Partnerships Unit (CPU)

HIV Screening in High Prevalence Health Care Settings

In April HAPIS issued a Request for Applications (RFA) to support planning

for and initial implementation of HIV screening in high prevalence health care settings. A total of \$359,000 has been awarded for the grant period of July 1 to December 31, 2007.

Funding was awarded to four health care facilities including the St. John’s Health Systems of Detroit, the Sinai-Grace Hospital of Detroit, the Hurley Medical Center of Flint and the Center for Family Health of Jackson. These programs are expected to help HAPIS better understand the challenges and facilitators associated with implementing HIV screening in health care settings and will guide development of technical assistance and training opportunities and resources. Contact Jeanine Hernandez at hernandezjea@michigan.gov for additional information.

An advisory group convened in July, to provide HAPIS with expert advice to support the implementation of HIV screening in high prevalence health care settings. Comprised of representatives from state and local level health care professional organizations, local public health, as well as representatives from across the Department (e.g., Surveillance, Medicaid, Administration), the advisory group will help to identify the factors that act as barriers to HIV screening, the educational and technical assistance needs of providers, and the most effective strategies for delivering education and technical assistance. Contact Liisa Randall at randall@michigan.gov for additional information.

HIV Prevention Referral Guidelines and Toolbox

The Community Partnerships Unit (CPU) recently released its *HIV Prevention Referral Guidelines and Toolbox*. The *Guidelines* are intended for HIV-prevention service providers and include general information about making and tracking HIV-prevention referrals, outline expectations about referral provision for HAPIS-funded HIV prevention programs, and provide tools to facilitate referrals and referral tracking. Electronic versions of the *Guidelines* are available on the Michigan HIV News website ([http://www.](http://www.mihivnews.com/hiv_prevention_referral_guide.htm)

[mihivnews.com/hiv_prevention_referral_guide.htm](http://www.mihivnews.com/hiv_prevention_referral_guide.htm)).

CPU staff, in collaboration with Community Health Awareness Group’s CORE team, has developed a training based on the *Guidelines* that orients agencies to the document, and includes skills-building opportunities in providing and monitoring referrals as well as developing referral networks. The training, “How to Make and Track Effective Referrals,” was delivered for the first time on July 26, 2007. Thirty participants from eleven different agencies were in attendance. The CPU staff expects to offer the training with the CORE team again in 2008. For more information about the *Guidelines* or the training, please contact Jane Conklin at conklinjane@michigan.gov.

Education, Training and Resources Development Unit (ETRDU)

HIV: Get the Basics Web Training

The *HIV: Get the Basics* web training, a web-based version of day one of the *Module 1: HIV/AIDS Basic Knowledge Training* is nearing completion. A pilot training with an entire class will take place in September. For more information, please contact Kimberly Snell at (313) 456-3394 or snellk@michigan.gov.

New Face in the Training Unit



Elizabeth Cahimba

Elizabeth (Beth) Cahimba began as a new trainer for the HAPIS training unit on Sept. 5. She is based out of the Lansing office: (517) 241-4531; cahimbae@michigan.gov.

Cahimba’s experience in the field includes community educator, case manager, and speaker’s bureau coordinator for the HIV/AIDS Resource Center (HARC) in Ypsilanti, and more recently as the HIV testing coordinator for Eastern Michigan University’s Snow Health Clinic.