

ADAP Advocacy Association Newsletter – October 2008

"HIV Prevalence Estimates -- United States, 2006"
CDC's *Morbidity and Mortality Weekly Report* - 10/03/08
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Under Reported: AIDS in America!

By Brent B. Shimmin

On August 2, 2008, the [Centers for Disease Control](#) (CDC) and [The Journal of the American Medical Association](#) (JAMA) simultaneously released revised estimates of HIV/AIDS infection rates in the United States as of 2006, using "new technology and methodology that more directly measure the number of new HIV infections". The revised figure of 56,300 new infections reflects a 40% increase over the CDC's previously published estimates of 40,000.

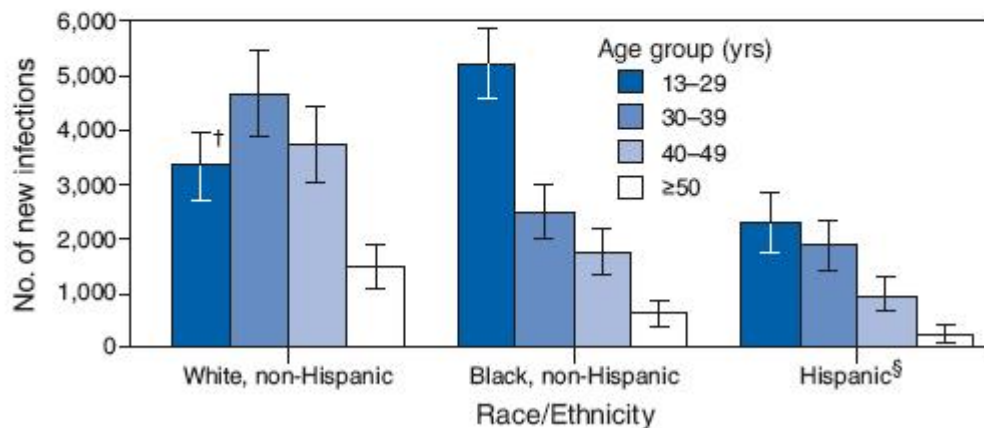
The CDC is quick to point out that "[i]t should be noted that the new incidence estimate does not represent an actual increase in the numbers of HIV infections, but reflects a more accurate way of measuring new infections. A separate CDC historical trend analysis published as part of this first analysis suggests that the annual number of new infections was never as low as 40,000 and that it has been roughly stable since the late 1990s".

The new figures show that 73% of new infections were male, 53% of whom were infected as a result of having unprotected sex with other men (MSM), 12% were infected by sharing needles and syringes during intravenous drug use (IDU) and 31% were infected during "high-risk heterosexual contact", which the CDC describes as "[h]eterosexual contact with a person known to have, or to be at high risk for, HIV infection". 80% of new female infections were found to be the result of "high risk heterosexual contact".

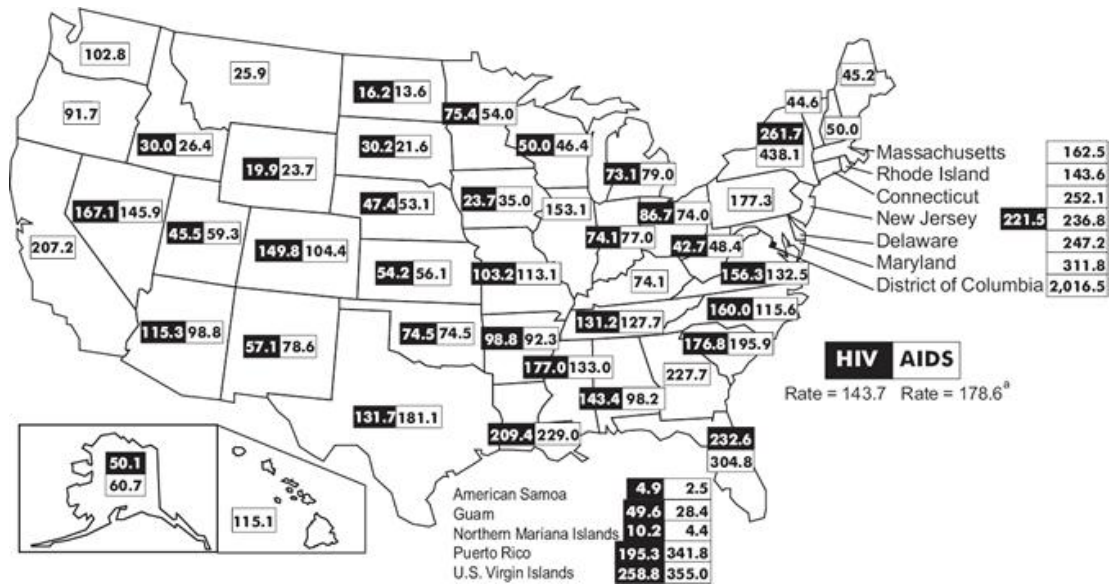
Racially, the highest rates of infection, for both males (40%) and females (61%), were among African-Americans. In general, the incidence rate among black males in all age ranges was 5.9 times that of white males, but among males aged from 13 to 29, that figure increased to 7.1. The rates for Latino males were 2.2 greater than those of whites. The rates for black women were 14.7 times the rates of white women, the rates for Latinas were 3.8 times those of white women. 80% of females reported infection through "high risk heterosexual contact", though the figure was less than half of that for males, ranging from 20% for blacks to 6% for whites.

Among MSM, the number of estimated infections blacks aged 13-29 was 5220 (48%), whites was 3300 (31%) and Latinos 2300 (21%). But as the ages increase, the numbers change: among MSM aged 30-39, 5600 whites (34% of that age range) were infected, but among blacks, that figure drops to just over 2000 (see table below):

FIGURE. Estimated number* of persons with new human immunodeficiency virus (HIV) infections among men who have sex with men, by race/ethnicity and age group — United States, 2006



The map below (taken from the CDC's website) also reflects the updated estimates as of 2006. It breaks down estimated total cases of HIV and AIDS by state for individuals over 13 years of age, per 100,000 population:



The state with the largest infections per capita remains New York as it's been since the beginnings of the pandemic. Washington, DC, due to its relatively small population (compared to an entire state) and majority African-American citizenry shows a disproportionately high rate of 2016.5. Due to its overall high population, California's rates appear relatively low, belying large concentrations of infections in Los Angeles, San Francisco and other urban zones, and the same can be said for Texas. Florida sticks out with surprisingly high estimates of 232.6 cases of HIV and 304.5 cases of AIDS, higher than New Jersey's 221.5 and 236.8, respectively.

But what really strikes the attentive observer is the rates throughout the Southeastern states, most of which are heavily rural. The AIDS rates of Georgia (227.7) and Louisiana (229.0) are higher than California (207.2) or Nevada (145.9), which has the highest rates of the western states. South Carolina (195.9) is higher than Illinois (153.1) or Pennsylvania (177.3) or Massachusetts (162.5). The rates in Mississippi (133.0) and Tennessee (127.7) are more than double the rates of Wisconsin (46.4) or Minnesota (54.0), and dwarf Iowa's rate (35.0). Alabama (98.2), with a population of 4,599,030 has a higher rate than Michigan (79.0), with a population of just over 10,000,000 (figures per 2006 US Census).

These new figures are the result of using a serologic testing algorithm for recent HIV seroconversion (STARHS). According to the abstract titled "Applicability of Population-Based STARHS HIV Incidence Measure in Determining Recency of Individual Infection among Patients Attending STD Clinics" and published by the NIH:

BACKGROUND:

STARHS uses a less sensitive EIA with the standard EIA to distinguish persons with recent HIV infection. STARHS has been used with anonymized, remnant sera from persons attending sexually transmitted disease (STD) clinics to calculate rates of incident infection.

The 6-month window period used in STARHS analyses for calculating population-based HIV incidence is the mean for a tested population; as individual results would be distributed on either side of the mean, this window may not be applicable for use in determining the recency of an individual infection.

METHODS:

HIV-positive remnant serum specimens from a cross-sectional, anonymous unlinked HIV serosurvey of patients attending STD clinics in Atlanta, Baltimore, Chicago, Denver, Houston, Los Angeles, Miami, New Orleans, and Newark between 1997 and 1999 were retested with STARHS. STARHS results were compared with self-reported HIV testing history information.

RESULTS:

Of the 6922 patients reporting a previous negative HIV test less than 6 months before their clinic visit, 1.4% (94) had an HIV-positive remnant serum result for their current clinic visit. However, 77% (72/94) of these had a reactive (longstanding) STARHS result. Of the 733 patients reporting a previous positive HIV test, 4% (27) had a non-reactive (recent) STARHS result. For 52% (14/27) of these, the previous HIV-positive test was reported as occurring over 6 months previous to the current clinic visit.

CONCLUSIONS:

The STARHS strategy may be useful for modeling incident infection on a population basis. However, given the extent of possible misclassification, STARHS results should only be interpreted with caution at the individual level, and programs using STARHS for routine surveillance, planning and evaluation activities should include comprehensive collection of HIV testing history data as well as medication use and AIDS indicator data to enhance accuracy of interpreting STARHS results.

Essentially, they compared the number of confidential but reported reactive (positive) HIV tests with the number of anonymous positive STD tests taken from clinics in nine cities throughout the US. This information is more reliable because it is based on real sexual behavior and does not rely on extrapolating anecdotal data across the entire population spectrum. In this way it is more scientific and more accurate than previous estimates. Potential overestimation is mitigated, at least in part, by using a six-month time window, which is extremely conservative. The CDC itself uses a time window between exposure to the virus and seroconversion of 13 weeks maximum, except in extreme cases of immune deficiency as is found among chronic IDUs and patients undergoing chemotherapy for cancer treatment. The conclusion include a caveat at the end regarding the interpretation of these statistical numbers on an individual basis, and suggests other ways of cross-referencing the data to enhance the accuracy of the results, including tracking testing history to indicate risk patterns and monitoring medication usage to better indicate actual cases of AIDS and HIV.

On September 4, 2008, Eurosurveillance, Europe's leading journal on infectious disease epidemiology, prevention and control, published an abstract from the European Centre for Disease Prevention and Control (ECDC) and their efforts to use STARHS methodology to better estimate the infection rates in Europe. This American refinement in statistics has proven to be of use throughout the world in their efforts to better predict the resources required, and enhance the treatment of, people living with HIV/AIDS.

Back at home, these revised figures lay out the challenges we face in coping with the public health emergency of HIV/AIDS in the years ahead. As these figures amply demonstrate, the prevention message isn't working. Risk reduction needs to be a top priority of the next administration. The utter failure of abstinence-only (or even abstinence-predominant) needs to give way to realistic and pragmatic educational efforts targeted to specific sub-sets of the population with an obviously required focus directed at those at highest risk of infection: Women and young MSM of color.

There also needs to be recognition that HIV/AIDS in the 21st century is no longer just an issue for the larger cities on either coast. As bad as the figures are for the rural deep-south, it will only get worse unless educational and preventative outreaches are made to the people living in those areas. If left unchecked, there promises to be an explosive humanitarian and public health crisis of mammoth proportions in those states.

There also needs to be an official recognition of this reality within and among the states involved. The sophisticated and long-established infrastructure of care and support for those living with the virus that exists in the larger cities is wholly lacking in these places. As far back as 2004, the NIH issued an abstract titled "Assessing HIV/AIDS Consumer Needs in the Southern US", but four years later it still seems like news.

According to the Southern AIDS Coalition's website:

The Southern AIDS Coalition, was formed in 2001 as a membership organization of government representatives, corporations, and community advocates. This unique partnership is borne from the burgeoning numbers of people whose new infection rates are much higher than the rest of the U.S. population. Federal funds do not meet the needs of those living with HIV in the South and are not equally distributed across the country. The HIV/AIDS outbreak is at the state of emergency in the southern United States. The disparate impact of this epidemic on southern citizens – especially within communities of color – must be addressed. The Southern AIDS Coalition works to provide southern citizens an opportunity for adequate HIV/AIDS prevention information, treatment, and health care.

Hopefully, armed with the latest statistics available, the disparity of treatment standards and funding will be addressed as we move forward. The government's revised figures on HIV/AIDS in America now show what many advocates have been saying for years. The problem is bigger, and shows signs of only getting worse. With so much attention being shown overseas on the international AIDS crisis, is America's own backyard being overlooked?



PUBLIC HEALTH & EDUCATION

CDC Releases Subpopulation Estimates from Data on Annual New HIV Infections; New Infections High Among Blacks, MSM

[Sep 12, 2008]

The majority of new HIV infections in the U.S. in 2006 occurred among men who have sex with men, according to a study released Thursday in [CDC's Morbidity and Mortality Weekly Report](#), the [New York Times](#) reports. In addition, blacks have the highest incidence rates of any racial and ethnic group in the U.S. The study was a follow-up to a CDC [study](#) released last month that found there were about 56,300 new HIV infections in 2006, the most recent year for which data are available (Harris, *New York Times*, 9/11).

According to the study, 72% of new HIV infections in 2006 among men were contracted through male-to-male sexual contact, including 81% of new infections among white men, 63% among black men and 72% among Hispanic men. Among MSM with new HIV infections, 46% were white, 35% were black and 19% were Hispanic, according to the study (Fox, [Reuters](#), 9/11). Blacks accounted for 46% of all new infections in 2006, although they account for 12% of the U.S. population, the study said (*New York Times*, 9/11).

The study found that the number of new HIV infections among black MSM ages 13 to 29 is about twice that of white or Hispanic MSM in the same age group. Most new infections among black and Hispanic MSM occurred in men ages 13 to 29, while most new infections among white MSM occurred in men ages 30 to 39, followed by those ages 40 to 49 (Fernandez, [San Francisco Chronicle](#), 9/12).

Girls and women accounted for 27% of all new HIV infections, and 80% of new infections among girls and women were transmitted through high-risk sexual contact with men, the study said. Among women, 61% of new infections occurred among blacks, 23% among whites and 16% among Hispanics (*Reuters*, 9/11). The rate of new infections among black women is almost 15 times higher than among white women; the rate among Hispanic women is nearly four times higher than white women, the study said (*New York Times*, 9/11).

An accompanying CDC [fact sheet](#) discusses redoubling HIV prevention efforts, especially among the black community, adding that the "alarming number of new infections among young black MSM underscores the need to ensure that each new generation has the knowledge and skills to prevent HIV infection beginning early in their lives" (*Reuters*, 9/11). The fact sheet also noted that HIV prevention efforts have not reached 80% of MSM in 15 cities nationwide. CDC recommended increasing HIV testing programs and strategies to target prevention efforts toward people at high risk of HIV transmission (*New York Times*, 9/11).


Reaction

Kevin Fenton -- director of CDC's [National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention](#) -- said CDC already has designed two prevention programs targeted toward black MSM, adding that other programs can be adapted for other groups. "We've already put in place a number of interventions," Fenton said, adding that the "response has already begun." According to Fenton, CDC this year will begin promoting HIV testing specifically to blacks. He added that he will testify in congressional hearings next week about the need for increased HIV/AIDS prevention funding (Lauerman, [Bloomberg/Philadelphia Inquirer](#), 9/12).

Fenton said the study serves as a "powerful reminder that the U.S. epidemic of HIV disease is far from over" (*New York Times*, 9/11). Fenton said the study will help health workers more effectively target prevention messages to "ensure that HIV infection doesn't become a rite of passage" for young MSM. Public health officials "need to reach each new generation ... early in their lives to provide the knowledge and skills they'll need to prevent [HIV] infection," Fenton said, adding, "At the same time, we must develop strategies for keeping [older MSM] HIV-free for life."

Richard Wolitski, acting director of CDC's [Division of HIV/AIDS Prevention](#), said the high number of new infections among younger MSM can be attributed to factors such as a "lack of access to effective HIV prevention services and underestimation of personal risk." He added that "many younger men have not personally experienced the severity of the early AIDS epidemic" (*San Francisco Chronicle*, 9/12). The Times reports that young black men are more likely to have been incarcerated, and HIV/AIDS among former inmates is high primarily because of behaviors outside of prison, according to studies. According to Wolitski, young black MSM, more so than white MSM, also tend to have partners who are older and therefore more likely to already be living with HIV (*New York Times*, 9/11).

Phill Wilson, CEO of the [Black AIDS Institute](#), said CDC's response is insufficient to address HIV/AIDS among the black community. "The fundamental question is, 'Why aren't we doing a better job of responding to the epidemic in black America?'" Wilson said (*Bloomberg/Philadelphia Inquirer*, 9/12). Mark Cloutier, CEO of the [San Francisco AIDS Foundation](#), said that the "house has been on fire for African-American gay men for many years," adding that HIV "keeps spreading" among black MSM but health workers "aren't bringing the fire corps to it" (*San Francisco Chronicle*, 9/12).

 The study is available [online](#).

A kaisernetwork.org interview with Fenton from the XVII International AIDS Conference about the updated HIV incidence numbers is available [online](#). A kaisernetwork.org interview with Wilson from the XVII International AIDS Conference about the updated HIV incidence numbers also is available [online](#).