

## **HIV/AIDS INITIAL LICENSURE FLORIDA (3CE)**

Written by:

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## HIV Defined

The human immunodeficiency virus (HIV) is the virus, which causes acquired immunodeficiency syndrome (AIDS). HIV is unique from other viruses because it attacks the immune system by destroying a type of white blood cell called a T-cell.

Once infected, the disease progresses through several stages. AIDS is diagnosed once the disease reaches the final stages where the immune system is too weak to fight infections and there are a low number of T-cells.

### **Transmission**

HIV is transmitted through bodily fluids (blood, semen, vaginal fluid, breast milk) and cannot live long outside of the body. There are three main ways to transmit the virus:

- Oral, anal, or vaginal sexual contact with an infected person
- Sharing needles/syringes with an infected person
- In utero, during childbirth, or through breast milk, an infected mother may transmit HIV to her child.
- HIV can be transmitted through a blood transfusion with infected blood, but since 1985, all blood donated in the United States has been screened for HIV and thus the risk of infection in this way is quite low.
- HIV is not transmitted by shaking hands, hugging, touching a doorknob, drinking from a glass or drinking fountain, sitting on a toilet seat, or from insects.

HIV infects cells in the immune system and the central nervous system. One of the main types of cells that HIV infects is the T helper lymphocyte. These cells play a crucial role in the immune system by coordinating the actions of other immune system cells. A large reduction in the number of T helper cells seriously weakens the immune system.

HIV infects the T helper cell because it has the protein CD4 on its surface, which HIV uses to attach itself to the cell before gaining entry. This is why the T helper cell is sometimes referred to as a CD4+ lymphocyte. Once it has found its way into a cell, HIV produces new copies of itself, which can then go on to infect other cells.

Over time, HIV infection leads to a severe reduction in the number of T helper cells available to help fight disease. The number of T helper cells is measured by having a CD4 test and is referred to as the CD4 count. It can take several years before the CD4 count declines to the point that an individual needs to begin antiretroviral treatment. Without treatment, the CD4 count continues to decline to very low levels, at which point the individual is said to have progressed to AIDS.

HIV infection can generally be broken down into four distinct stages: primary infection, clinically asymptomatic stage, symptomatic HIV infection, and progression from HIV to AIDS.

## **STAGE 1: Primary HIV Infection**

This stage of infection lasts for a few weeks and is often accompanied by a short flu-like illness. In up to about 20% of people the HIV symptoms are serious enough to consult a doctor, but the diagnosis of HIV infection is frequently missed.

During this stage there is a large amount of HIV in the peripheral blood and the immune system begins to respond to the virus by producing HIV antibodies and cytotoxic lymphocytes. This process is known as seroconversion. If an HIV antibody test is done before seroconversion is complete then it may not be positive.

## **STAGE 2: Clinically Asymptomatic Stage**

This stage lasts for an average of ten years, and, as its name suggests, is free from major symptoms, although there may be swollen glands. The level of HIV in the

peripheral blood drops to very low levels but people remain infectious and HIV antibodies are detectable in the blood, so antibody tests will show a positive result.

Research has shown that HIV is not dormant during this stage, but is very active in the lymph nodes. A test is available to measure the small amount of HIV that escapes the lymph nodes. This test which measures HIV RNA (HIV genetic material) is referred to as the viral load test, and it has an important role in the treatment of HIV infection.

### **STAGE 3: Symptomatic HIV Infection**

Over time, the immune system becomes severely damaged by HIV. This is thought to happen for three main reasons:

- The lymph nodes and tissues become damaged or “burnt out” because of the years of activity.
- HIV mutates and becomes more pathogenic, in other words stronger and more varied, leading to more T helper cell destruction.
- The body fails to keep up with replacing the T helper cells that are lost.

Antiretroviral treatment is usually started once an individual’s CD4 count (the number of T helper cells) drops to a low level, an indication that the immune system is deteriorating. Treatment can stop HIV from damaging the immune system, therefore, HIV-infected individuals on treatment usually remain clinically asymptomatic.

However, in HIV-infected individuals not receiving treatment or on treatment that is not working, the immune system fails and symptoms develop. Initially many of the symptoms are mild, but as the immune system deteriorates the symptoms worsen.

Symptomatic HIV infection is mainly caused by the emergence of certain opportunistic infections that the immune system would normally prevent. This stage of HIV infection is

often characterized by multi-system disease and infections can occur in almost all body systems.

Treatment for the specific infection is often carried out, but the underlying cause is the action of HIV as it erodes the immune system. Unless HIV itself can be slowed down the symptoms of immune suppression will continue to worsen.

## **STAGE 4: Progression from HIV to AIDS**

As the immune system becomes more and more damaged, the individual may develop increasingly severe opportunistic infections and cancers, eventually leading to an AIDS diagnosis.

A clinical criteria is used by the World Health Organization (WHO) to diagnose the progression to AIDS. This differs slightly between adults and children under five. In adults and children (aged 5 or over) the progression to AIDS is diagnosed when any condition listed in clinical stage 4 is diagnosed and/or the CD4 count is less than 200 cells/mm<sup>3</sup> or a CD4 percentage less than 15. In children younger than five, an AIDS diagnosis is based on having any stage 4 condition and/or a CD4 percentage less than 20 (children aged 12-35 months) and a CD4 percentage less than 25 (children less than 12 months). The criteria for diagnosing AIDS may differ depending on individual country guidelines.

## **Examples of Opportunistic Infections and Cancers**

The table below shows examples of common opportunistic infections and cancers and the body systems that they occur in:

System	Examples of Infection/Cancer
Respiratory system	Kaposi's Sarcoma (KS) Tuberculosis (TB) Pneumocystis Jirovecii Pneumonia (PCP)
Gastrointestinal system	Cryptosporidiosis Candida Cytomegalovirus (CMV) Isosporiasis Kaposi's Sarcoma
Central/peripheral Nervous system	Cytomegalovirus Toxoplasmosis Cryptococcosis Non Hodgkin's lymphoma Varicella Zoster Herpes simplex
Skin	Herpes simplex Kaposi's sarcoma Varicella Zoster

## WHO clinical staging of HIV disease in adults and adolescents

In resource-poor settings, medical facilities are sometimes poorly equipped and tests to measure CD4 count and viral load are unavailable. In this case, another method to determine whether an individual should begin treatment is used. WHO developed a

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staging system for HIV disease based on clinical symptoms, which may be used to guide medical decision making.

## **Clinical Stage I:**

- Asymptomatic
- Persistent generalized lymphadenopathy

## **Clinical Stage II:**

- Moderate unexplained weight loss (under 10% of presumed or measured body weight)
- Recurrent respiratory tract infections (sinusitis, tonsillitis, otitis media, pharyngitis)
- Herpes zoster
- Angular cheilitis
- Recurrent oral ulceration
- Papular pruritic eruptions
- Seborrhoeic dermatitis
- Fungal nail infections

## **Clinical Stage III:**

- Unexplained severe weight loss (over 10% of presumed or measured body weight)
- Unexplained chronic diarrhea for longer than one month
- Unexplained persistent fever (intermittent or constant for longer than one month)
- Persistent oral candidiasis
- Oral hairy leukoplakia
- Pulmonary tuberculosis
- Severe bacterial infections (e.g. pneumonia, empyema, pyomyositis, bone or joint infections, meningitis, bacteraemia)
- Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis
- Unexplained anaemia (below 8 g/dl), neutropenia (below 0.5 billion/l) and/or chronic thrombocytopenia (below 50 billion/l)



## **Clinical Stage IV:**

- HIV wasting syndrome
- Pneumocystis pneumonia
- Recurrent severe bacterial pneumonia
- Chronic herpes simplex infection (orolabial, genital or anorectal of more than one month's duration or visceral at any site)
- Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs)
- Extrapulmonary tuberculosis
- Kaposi sarcoma
- Cytomegalovirus infection (retinitis or infection of other organs)
- Central nervous system toxoplasmosis
- HIV encephalopathy
- Extrapulmonary cryptococcosis including meningitis
- Disseminated non-tuberculous mycobacteria infection
- Progressive multifocal leukoencephalopathy
- Chronic cryptosporidiosis
- Chronic isosporiasis
- Disseminated mycosis (extrapulmonary histoplasmosis, coccidiomycosis)
- Recurrent septicaemia (including non-typhoidal Salmonella)
- Lymphoma (cerebral or B cell non-Hodgkin)
- Invasive cervical carcinoma
- Atypical disseminated leishmaniasis
- Symptomatic HIV-associated nephropathy or HIV-associated cardiomyopathy

*\*Reference for above: World Health Organization 2012: [http://www.who.int/topics/hiv\\_aids/en/](http://www.who.int/topics/hiv_aids/en/)*

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HIV has been found in low quantities in the tears and saliva of some AIDS patients; however, the Centers for Disease Control and Prevention (CDC) suggests that simply because a small amount of the HIV may be present in such bodily fluids doesn't necessarily mean that HIV can be transmitted by that fluid. There are no known cases of HIV transmission by tears or saliva.

Though HIV is not transmitted through closed-mouth (casual) kissing, the CDC does warn against engaging in open-mouth (french) kissing with an infected person because of the risk of coming into contact with blood.

To date, HIV has not been found in the sweat of AIDS patients, nor are there any known cases of HIV transmission by sweat.

Having a sexually transmitted disease (STD), such as gonorrhea, syphilis, Chlamydia trachomatis infection can increase the risk of transmission of HIV.

## **Protection/Prevention**

Condoms, when used correctly and consistently, can greatly reduce the risk of transmission during oral, anal, or vaginal sexual contact. Condoms are considered to be medical devices and are regulated by the Food and Drug Administration (FDA) and are tested for defects. It is important to note that condoms may be made from different materials; however, only condoms made from latex or polyurethane are effective to protect against transmission. Condoms made from lambskin or other natural membranes have occasionally been shown to allow viruses to pass through the porous material and therefore they are not recommended to protect against transmission.

If using needles or syringes, do not share those needles or syringes. Make sure any needles, syringes, or other medical devices are clean.

When caring for someone who is infected with HIV take the following precautions:

- Wear gloves when coming into contact with the infected person's (IP) blood or other bodily fluids.
- Cuts, sores, lesions (on either the IP or the caregiver) should be covered with bandages.
- Avoid sharing the IP's razors or toothbrushes.

## Global Situation and Trends

Since the beginning of the epidemic, more than 60 million people have been infected with the HIV virus and approximately 30 million people have died of AIDS. In 2010, there were an estimated 34 million people living with HIV, 2.7 million new infections, and 1.8 million AIDS-related deaths. The WHO African Region is the most affected, where 1.9 million people acquired the virus in 2010. The estimated 1.2 million Africans who died of HIV-related illnesses in 2010 comprised 69% of the global total of 1.8 million deaths attributable to the epidemic.

### Number of people (all ages) living with HIV

As of 2010, the number of people living with HIV is 34.0 million [31.6 million–35.2 million], compared to 28.6 million [26.7 million–30.9 million] in 2001 – a 17% increase. This reflects the high numbers of people newly infected with HIV along with significantly expanded access to antiretroviral therapy, which has helped to reduce the number of people dying from AIDS-related causes, especially since 2004–2005.

The WHO African Region still bears an inordinate share of the global HIV burden. Although the rate of new HIV infections has decreased, the total number of people living with HIV continues to rise. In 2010, that number reached 22.9 million [21.7 million–24.2 million], 68% of the global total.

## Number of deaths due to HIV/AIDS

The annual number of people dying from AIDS-related causes worldwide is steadily decreasing from a peak of 2.2 million [2 100 000–2 500 000] in 2005 to an estimated 1.8 million [1 600 000–1 900 000] in 2010. AIDS-related mortality began to decline in 2005–2006 in sub-Saharan Africa, South and South-East Asia and the Caribbean and has continued subsequently.

Two signal developments have caused this decline: first, the increased availability of antiretroviral therapy, as well as care and support, to people living with HIV, especially in sub-Saharan Africa; and second, fewer people newly infected with HIV since the late 1990s. The effects of antiretroviral therapy are especially evident in sub-Saharan Africa, where an estimated 460 000 (or 30%) fewer people died from AIDS related causes in 2010 than in 2004, when access to antiretroviral therapy began to be dramatically expanded.

## Size of the epidemic

- Number of people (all ages) living with HIV  
34.0 million [31.6–35.2 million] people were living with HIV worldwide in 2010
- Number of women and children living with HIV  
3.4 million [3.0–3.8 million] children were living with HIV worldwide at the end of 2010
- Prevalence of HIV among adults aged 15–49 (%)  
Globally, 0.8% [0.8–0.8%] of the adult population were living with the HIV virus in 2010, while the WHO African Region is the most affected (4.7% [4.5–4.9%])
- Number of deaths due to HIV

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1.8 million [1.6–1.9 million] people died of AIDS-related illnesses worldwide in 2010

More than 25 million people have died of AIDS since 1981. Africa has over 14 million AIDS orphans. At the end of 2008, women accounted for 50% of all adults living with HIV worldwide.

In developing and transitional countries, 9.5 million people are in immediate need of life-saving AIDS drugs; of these, only 4 million (42%) are receiving the drugs.

The number of people living with HIV has risen from around 8 million in 1990 to 34 million today, and is still growing. Around 67% of people living with HIV are in sub-Saharan Africa.

### Notes

- Adults are defined as men and women aged 15 or above, unless specified otherwise.
- Children orphaned by AIDS are defined as people aged under 18 who are alive and have lost one or both parents to AIDS.
- All the statistics on this page should be interpreted with caution because they are estimates

### HIV/AIDS in the United States

#### Fast Facts

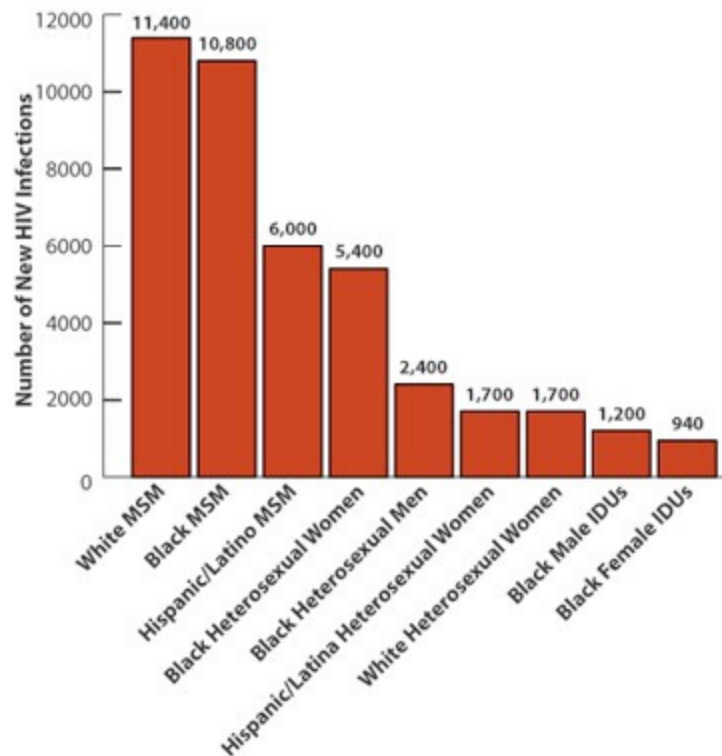
- More than 1.1 million people in the United States are living with HIV infection and 1 in 6 are unaware of their infection.
- MSM, particularly young, black MSM, are most severely affected by HIV.
- By race, blacks/African Americans face the most severe burden of HIV.

CDC estimates that 1,144,500 persons aged 13 years and older are living with HIV infection, including 180,900 (15.8%) who are unaware of their infection. Despite increases in the total number of people in the U.S. living with HIV infection in recent years (due to better testing and treatment options), the annual number of new HIV infections has remained relatively stable. However, new infections continue at far too high of a level, with approximately 50,000 Americans becoming infected with HIV each year.

In 2011, an estimated 49,273 people were diagnosed with HIV infection in the United States. In that same year, an estimated 32,052 people throughout the U.S. were diagnosed with AIDS. Since the epidemic began, an estimated 1,155,792 people in the U.S. have been diagnosed with AIDS.

An estimated 15,529 people with AIDS died in 2010, and nearly 636,000 people with AIDS in the U.S. have died since the epidemic began.

## Estimates of New HIV Infections in the United States, 2009, for the Most-Affected Subpopulations[2]



*Subpopulations representing 2% or less of the overall US epidemic are not reflected in this chart.*

### By Risk Group

**Gay, Bisexual, and Other Men Who Have Sex with Men (MSM)[1]** of all races and ethnicities remain the population most severely affected by HIV.

- Although MSM represent about 4% of the male population in the United States, in 2010, MSM accounted for 78% of new HIV infections among males and 63% of all new infections. MSM accounted for 52% of all people living with HIV infection in 2009, the most recent year these data are available.

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- In 2010, white MSM continued to account for the largest number of new HIV infections of any group in the U.S. (11,200), followed closely by black MSM (10,600).
- The estimated number of new HIV infections was greatest among MSM in the youngest age group. In 2010, the greatest number of new HIV infections (4,800) among MSM occurred in young black/African American MSM aged 13-24. Young black MSM accounted for 45% of new HIV infections among black MSM and 55% of new HIV infections among young MSM overall.
- Since the epidemic began, an estimated 302,148 MSM with an AIDS diagnosis have died, including an estimated 5,909 in 2010.

### **Heterosexuals and Injection Drug Users** also continue to be affected by HIV.

- Heterosexuals accounted for 25% of estimated new HIV infections in 2010 and 27% of people living with HIV infection in 2009.
- Since the epidemic began, almost 85,000 persons with an AIDS diagnosis, infected through heterosexual sex, have died, including an estimated 4,003 in 2010.
- HIV infections among women are primarily attributed to heterosexual contact (84% in 2010) or injection drug use (16% in 2010). Women accounted for 20% of estimated new HIV infections in 2010 and 24% of those living with HIV infection in 2009.
- Injection drug users represented 8% of new HIV infections in 2010 and 16% of those living with HIV in 2009.
- Since the epidemic began, nearly 182,000 injection drug users with an AIDS diagnosis have died, including an estimated 4,218 in 2010.

### **By Race/Ethnicity**

- Blacks continue to experience the most severe burden of HIV, compared to other races and ethnicities. Blacks represent approximately 12% of the U.S.



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population, but accounted for an estimated 44% of new HIV infections in 2010.

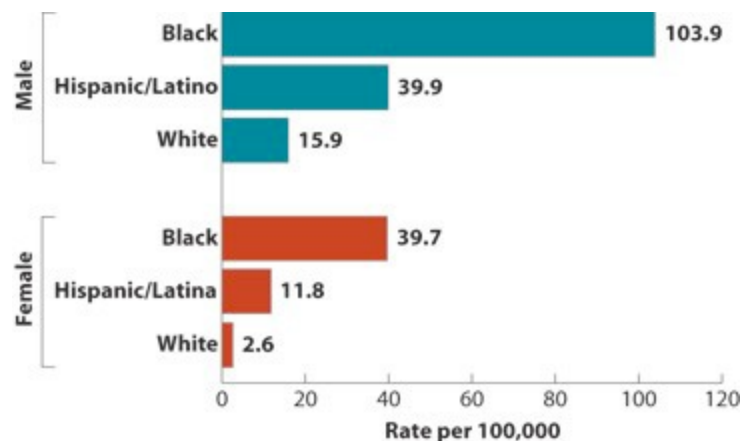
Blacks accounted for 44% of people living with HIV infection in 2009.

- Since the epidemic began, more than 260,800 blacks with AIDS have died, including an estimated 7,678 in 2010.
- At some point in their life, approximately 1 in 16 black men will be diagnosed with HIV infection, as will 1 in 32 black women.

**Hispanics/Latinos** are also disproportionately affected by HIV.

- Hispanics/Latinos represented 16% of the population but accounted for 21% of new HIV infections in 2010. Hispanics/Latinos accounted for 19% of people living with HIV infection in 2009.
- Since the epidemic began, an estimated more than 96,200 Hispanics/Latinos with AIDS have died, including 2,370 in 2010.

### Estimated Rate of New HIV Infections, 2009, by Gender and Race/Ethnicity [2]



## References

- The term **men who who have sex with men (MSM)** is used in CDC surveillance systems. It indicates the behaviors that transmit HIV infection, not how individuals self- identify in terms of their sexuality.
- Prejean J, Song R, Hernandez A, Ziebell R, Green T, et al. (2011) Estimated HIV Incidence in the United States, 2006-2009. *PLoS ONE* 6(8): e17502. doi: 10.1371/journal.pone.0017502.

## Statistics

*HIV Prevalence: The number of people living with HIV/AIDS in a given year.*

*HIV Incidence: The number of new HIV infections in a specific population during a specific time.*

CDC now estimates that 1.1 million adults and adolescents (prevalence rate: 447.8 per 100,000 population) were living with diagnosed or undiagnosed HIV infection in the United States at the end of 2010. The majority of those living with HIV were nonwhite (65.4%), and nearly half (48.1%) were men who have sex with men (MSM). The HIV prevalence rates for blacks (1,715.1 per 100,000) and Hispanics (585.3 per 100,000) were, respectively, 7.6 and 2.6 times the rate for whites (224.3 per 100,000).

In 2010, CDC estimated that approximately 56,300 people were newly infected with HIV in 2010 (the most recent year that data are available). Over half (53%) of these new infections occurred in gay and bisexual men. Black/African American men and women were also strongly affected and were estimated to have an incidence rate than was 7 times as high as the incidence rate among whites.

In 2010, the estimated number of people diagnosed with AIDS in the United States was 35,962, of whom 35,934 were adults and adolescents, 26,355 were males, 9,579 were females, and 28 were children under the age of 13.

The CDC estimated that the cumulative number of diagnoses of people diagnosed with AIDS in 2010 was 1,018,428, of whom 1,009,220 were adults and adolescents, 810,676 were males, 198,544 were females, and 9,209 were children under 13.

In 2010, the estimated number of cases of HIV/AIDS diagnosed in the United States was 42,655, of whom 42,495 were adults and adolescents, 31,518 were males, 10,977 were females, and 159 were children under 13.

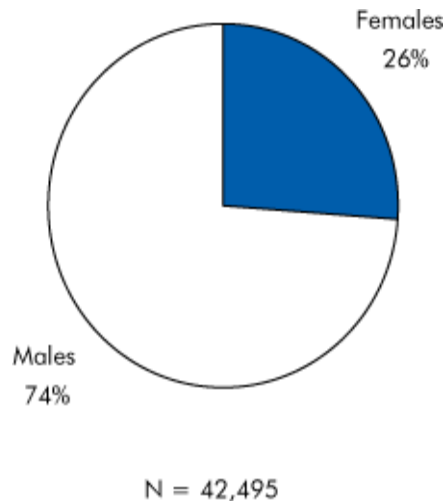
At the end of 2010, an estimated 1.1 million persons in the United States were living with diagnosed or undiagnosed HIV/AIDS [1]. In 2007, 42,655 new cases of HIV/AIDS in adults, adolescents, and children were diagnosed in the 33 states with long-term, confidential name-based HIV reporting [2]. CDC has developed an innovative system designed to estimate the number of new HIV infections (or incidence) for the United States in a given year. Using this technology, CDC estimates that 56,300 new infections occurred in the United States in 2010 [3].

Florida's has the highest HIV infection rate among 40-44 year olds in the United States.

## **By Sex**

In 2010, nearly three quarters of HIV/AIDS diagnoses among adolescents and adults were for males [2].

## Sex of adults and adolescents with HIV/AIDS diagnosed during 2010



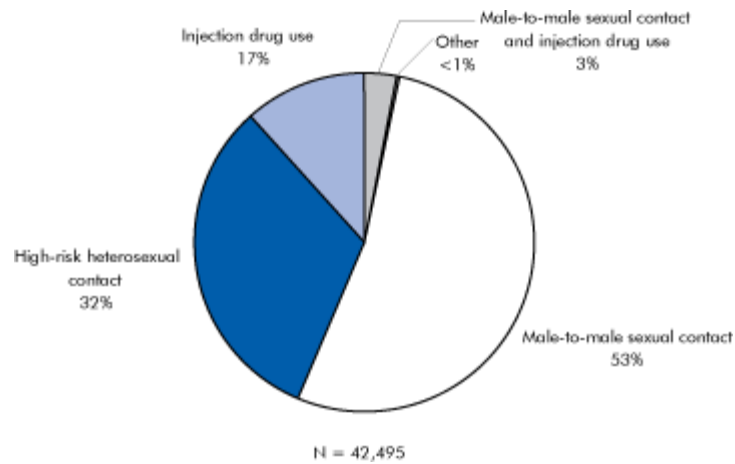
*Based on data from 34 states with long-term, confidential name-based HIV reporting.*

### By Transmission Category

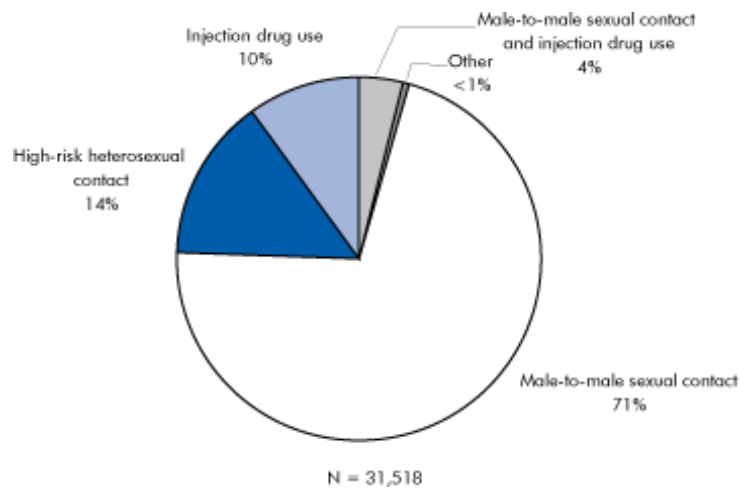
In 2010, the largest estimated proportion of HIV/AIDS diagnoses among adults and adolescents were men who have sex with men (MSM). This category accounted for 53% of the overall diagnoses and 71% among men [2]. High-risk sexual contact (sexual contact with persons known to have HIV infection or have a higher risk of contracting HIV infection) accounted for 11% of the overall diagnoses.

## Transmission categories of adults and adolescents with HIV/AIDS diagnosed during 2007.

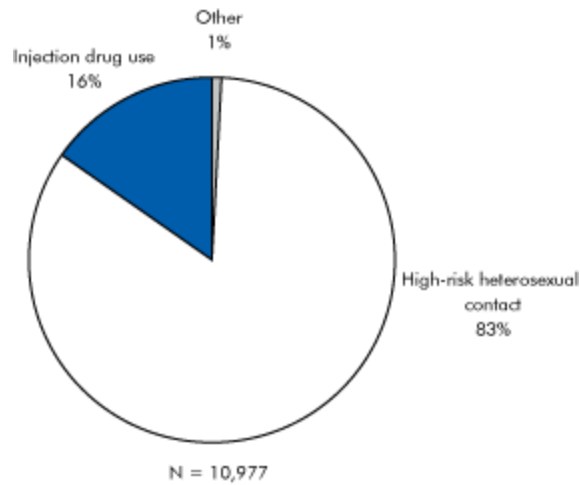
### All Adults and Adolescents



### Male Adults and Adolescents



## Female Adults and Adolescents

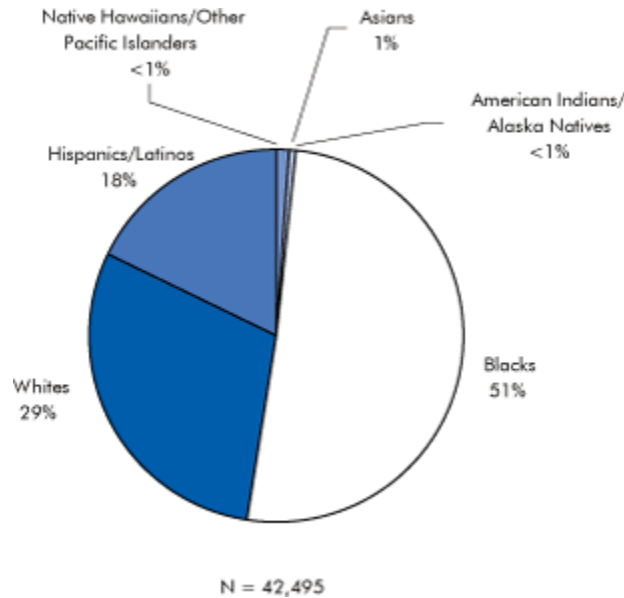


*Based on data from 34 states with long-term, confidential name-based HIV reporting.*

### **By Race/Ethnicity**

Blacks/African Americans accounted for over half (51%) of the estimated number of HIV/AIDS diagnoses made during 2010, followed by whites (29%) and Hispanic/Latinos (18%). These numbers do not account for individuals of unknown race/ethnicity or those who choose not to identify with any particular race/ethnicity [2].

## Race/ethnicity of persons (including children) with HIV/AIDS diagnosed during 2010

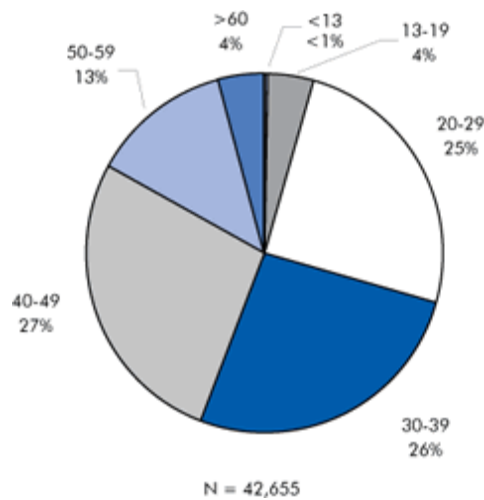


*Based on data from 34 states with long-term, confidential name-based HIV reporting.*

### By Age

In 2010, persons aged 40-49 accounted for the largest proportion of newly diagnosed HIV/AIDS cases (27%). Persons aged 30-39 were the second largest proportion (26%), followed closely by persons aged 20-29 (25%) [2].

Age of persons with HIV/AIDS diagnosed during 2010



Based on data from 34 states with long-term, confidential name-based HIV reporting.

## Trends in AIDS Diagnoses and Deaths

Beginning in the mid 1990s, advances in HIV treatments slowed the progression of HIV infection to AIDS. Better treatments also led to dramatic decreases in deaths among persons with AIDS living in the 50 states and the District of Columbia.

In general, the trend in the estimated numbers of AIDS cases and deaths remained stable from 2002 through 2005. Estimates for 2007—the most recent year for which these data are available—suggest that the number of AIDS cases have remained relatively stable, and that the number of deaths decreased. However, it is too early to determine whether this trend will hold.

Estimated numbers of AIDS diagnoses, deaths, and persons living with AIDS, 2003–2007

	2003	2004	2005	2006	2007	Cumulative
<b>AIDS DIAGNOSES</b>	38,893	37,633	36,127	35,695	35,962	1,018,428



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	2003	2004	2005	2006	2007	Cumulative
<b>DEATHS OF PERSONS WITH AIDS</b>	17,082	16,570	16,249	14,989	14,110	562,793
<b>PERSONS LIVING WITH AIDS</b>	372,136	393,200	413,077	433,783	455,636	N/A

*Based on data for the 50 states and the District of Columbia.*

<sup>a</sup>From the beginning of the epidemic (1981) through 2007

N/A (not applicable) Source: CDC. HIV/AIDS Surveillance Report, 2007. Vol. 19.

Atlanta: US Department of Health and Human Services, CDC; 2009.

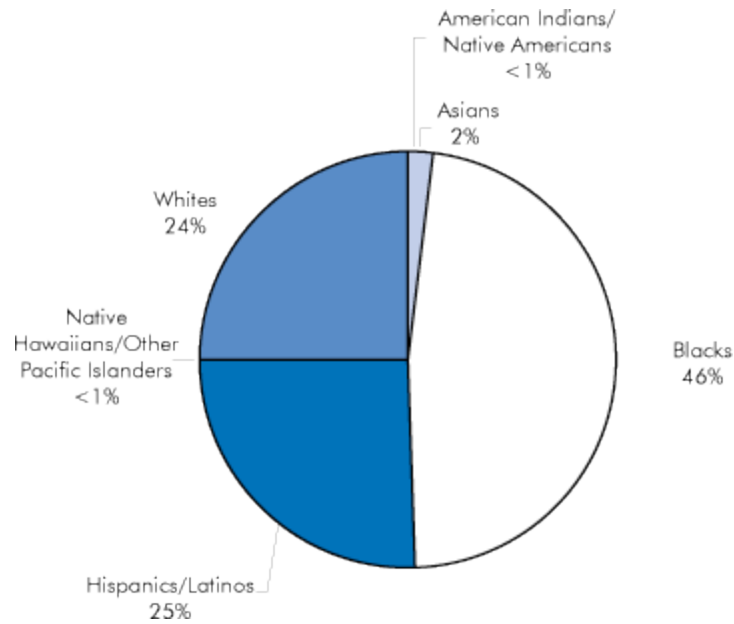
For more information, including details regarding the 34 states with long-term, confidential name-based HIV reporting, visit the [CDC HIV/AIDS Statistics and Surveillance Web site](#).

At the end of 2007 the estimated numbers of adults and adolescents living with AIDS were highest in the South and Northeast, and lowest in the Midwest. The states with the most AIDS diagnoses were found in the South, but the cities with the most AIDS cases were spread across the country. Blacks/African Americans accounted for the largest proportion of AIDS cases in all areas except the West, where whites accounted for the highest number of cases.

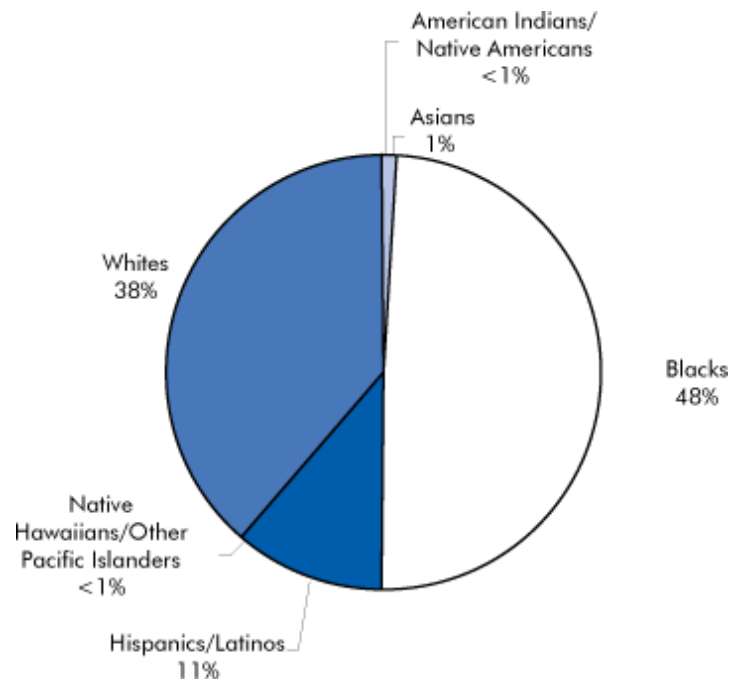
### **By Race\***

Blacks/African Americans accounted for the majority of the estimated number of AIDS diagnoses made during 2007, followed by Whites and Hispanic/Latinos.

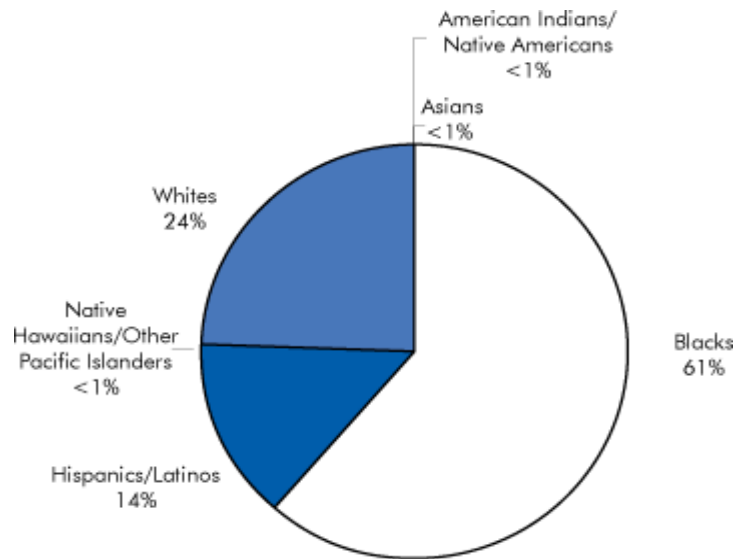
## Northeast



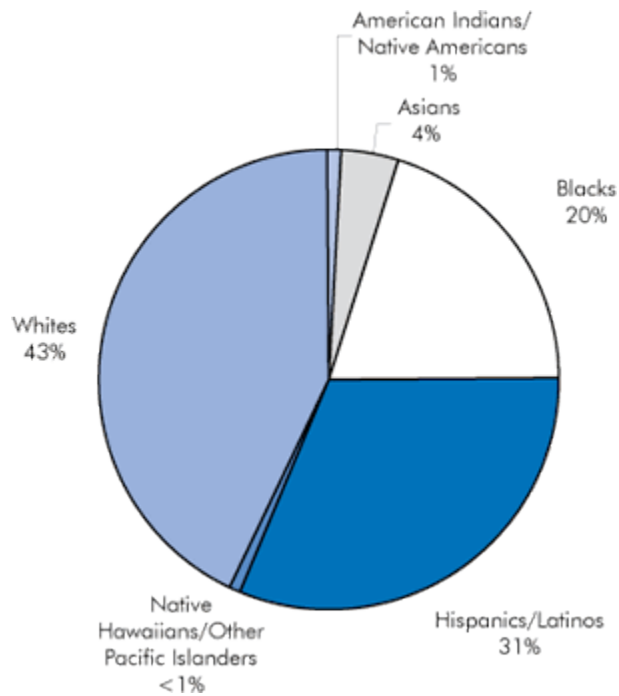
## Midwest



## South



## West



*\*Includes persons of unknown race or multiple races/other.*

## **Reported AIDS Cases in 2007 Metropolitan Statistical Areas (MSAs)**

Metropolitan Statistical Areas (MSAs) are areas that contain a core urban area with a population of 50,000 or more people. \*\*

- The South is currently the region with the largest proportion of AIDS cases from less urban and non-urban areas, while in the Northeast and the West, more than 90% of cases were in large metropolitan areas at the time of AIDS diagnosis.
- The five MSAs with the highest number of reported AIDS cases in descending order were: New York City, New York; Los Angeles, California; Miami, Florida; Washington, DC and Philadelphia, Pennsylvania.
- The five MSAs with the highest rates of reported AIDS cases were Miami, Florida; New Orleans, Louisiana; Baton Rouge, Louisiana; Washington, DC and Baltimore, Maryland.

*\*For more information, including details on the definition of the MSAs, visit the [U.S. Census Bureau site](#).*

## **Counseling Clients with HIV/AIDS**

Under Florida law, any communication between a client and person licensed or certified under Florida Statutes, Chapter 491 (clinical social worker, marriage and family therapist or mental health counselor) is confidential; however, there are exceptions to this confidentiality. (Fla. Stat.

491.0147) When a client discloses information, which clearly threatens physical harm to someone, including the patient, and the threat is imminent, then such information may not be confidential. (Fla. Stat. 491.0147(3) Furthermore, pursuant to the American Counseling Association (ACA) Code of Ethics, the general requirement that client communications remain confidential does not apply when disclosure would be necessary to protect someone (including the client) from imminent danger. (B.1.c) In

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fact, the ACA Code of Ethics has a specific provision with regard to contagious and fatal diseases which states that a counselor is justified in disclosing a client's otherwise confidential communications if doing so would protect an identified third party who is at high risk of contracting a communicable and fatal disease from the client. (B.1.d)

## **Related Laws, Rules, Ethical Guidelines**

### *Florida Statutes*

#### *491.0147: Confidentiality and Privileged Communications*

Any communication between any person licensed or certified under this chapter and her or his patient or client shall be confidential. This secrecy may be waived under the following conditions:

- When, in the clinical judgment of the person licensed or certified under this chapter, there is a clear and immediate probability of physical harm to the patient or client, to other individuals, or to society and the person licensed or certified under this chapter communicates the information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.
- There shall be no liability on the part of, and no cause of action of any nature shall arise against, a person licensed or certified under this chapter for the disclosure of otherwise confidential communications under this subsection.

#### *394.4615 Clinical Records—Confidentiality*

Information from the clinical record may be released in the following circumstances:

- When a patient has declared an intention to harm other persons.
- When such declaration has been made, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient.

## *384.24 Unlawful Acts*

- It is unlawful for any person who has chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, genital herpes simplex, chlamydia, nongonococcal urethritis (NGU), pelvic inflammatory disease (PID)/acute salpingitis, or syphilis, when such person knows he or she is infected with one or more of these diseases and when such person has been informed that he or she may communicate this disease to another person through sexual intercourse, to have sexual intercourse with any other person, unless such other person has been informed of the presence of the sexually transmissible disease and has consented to the sexual intercourse.
- It is unlawful for any person who has human immunodeficiency virus infection, when such person knows he or she is infected with this disease and when such person has been informed that he or she may communicate this disease to another person through sexual intercourse, to have sexual intercourse with any other person, unless such other person has been informed of the presence of the sexually transmissible disease and has consented to the sexual intercourse.

## **Rules, Florida Administrative Code**

### *64B4-9.001 Requirements for Client Records*

A licensed clinical social worker, marriage and family therapist, or mental health counselor, including any registered intern or provisional licensee, shall maintain responsibility for all records relating to his clients as provided in Section 456.057, F.S. All such records shall remain confidential except as provided by law or as allowed pursuant to a written and signed authorization by the client specifically requesting or authorizing release or disclosure of records in his office or possession.

## **ACA Code of Ethics**

### **B.1 Right to Privacy**

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Exceptions—The general requirement that counselors keep information confidential does not apply when disclosure is required to prevent clear and imminent danger to the client or others or when legal requirements demand that confidential information be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception.

Contagious, Fatal Diseases—A counselor who receives information confirming that a client has a disease commonly known to be both communicable and fatal is justified in disclosing information to an identifiable third party who, by his or her relationship with the client, is at high risk of contracting the disease. Prior to making a disclosure, the counselor should ascertain that the client has not already informed the third party about his or her disease and the client is not intending to inform the third party in the immediate future.

Minimal Disclosure—When circumstances require the disclosure of confidential information, only essential information is revealed. To the extent possible, clients are informed before confidential information is disclosed.

## ***Consultation on Revised Guidelines for HIV Counseling, Testing, and Referral in Non-Health-care Settings***

### Background

On June 1–2, 2009, the Centers for Disease Control and Prevention (CDC) sponsored a Consultation on Revised Guidelines for HIV Counseling, Testing, and Referral (CTR) in Non-Health-care Settings. The consultation explored the topics of Targeting and Recruitment; Counseling; Testing; and Linkage and Referral in the non-health-care setting (i.e., health fairs, mobile vans, churches, etc.). Approximately 60 federal employees and 60 external consultants attended this consultation, including academicians, personnel from local and state health departments, community-based organizations, and prevention training centers.

The consultation began the morning of June 1 with a plenary session to review the guideline development and consultation process, and review the content of the previous guidelines published in 2001[1], emerging HIV testing technologies, background and key findings on the four main guideline topics. In the afternoon, participants could attend one of four topic-specific work group sessions to examine the current state of the research in more depth and provide recommendations to present to the entire group during the general session on the second day of the consultation. During the work group sessions, participants reviewed available data from teleconferences and literature reviews and discussed key areas that should be addressed in the revision of the guidelines, as well as gaps requiring further research. On the morning of the second day, on behalf of the smaller work group sessions, consultants external to CDC presented recommendations to the entire group during the general session and all the topics were discussed.

## Recommendations Presented at the Consultation:

These recommendations, which solely represented the views and experiences of the work group participants, rather than CDC, will be considered when revising the guideline document. Summaries of the recommendations shared during the general session are presented below:

### **Work Group Session I: Targeting and Recruitment**

When determining which population a program should target to identify new cases for counseling, testing, and referral (CTR) services, multiple methods can be used, including the use of epidemiological data. Epidemiological profiling with a community planning group should be augmented with available incidence data, behavioral risk indicator data, and an assessment of testing patterns. When determining the appropriate strategy to identify new cases in a place or during an event, community mapping and Geographical Information System (GIS) can be



used to identify areas where high-risk populations congregate. An assessment of the appropriateness of the place or event should also be utilized. Once a place or event is selected, CTR services should be offered to everyone.

Many strategies were recommended to identify new cases and link them to care, such as social networking approaches, social marketing, community-level interventions, agency referrals, bundling of CTR services with other health-care and non-health care related services, and the use of incentives. Formative research can be beneficial when deciding which strategy to use.

CDC should implement a monitoring and evaluation component, including community-level and process/operational goals with streamlined reporting system. Barriers encountered during recruitment should be addressed, as well as their proposed solutions.

## **Work Group Session II: Counseling**

A variety of risk-reduction approaches are available (i.e., videos, computer counseling, and face-to-face counseling) and should be considered in conjunction with an HIV testing program. There are minimum components, which should be included, in any testing service: information, consent, testing, results disclosure, and referral. Including a risk-reduction intervention before the results disclosure is highly recommended, but should not be a barrier to testing for the client. This supports the recommendation that testing be a required component of all HIV prevention programs.

The information component provided before an HIV test is administered should include: a description of the test, meaning of test results, benefits of testing, basic transmission and prevention information, referrals available, seroconversion “window” period, reporting requirements, and the procedure following a positive test result. More information needs to be provided in these guidelines regarding

consent. Recommended components to include in a brief individual/couple-level risk-reduction intervention consist of: introduction; personalized risk assessment; filling in of knowledge gap; identification of teachable moment and use of dissonance; past successes, barriers, and self-efficacy; skill-building opportunities; client-developed risk-reduction plan; self-efficacy for current risk-reduction plan; and implications of results. Ongoing technical assistance is needed for the training of counselors and supervisors, quality assurance, and support supervision.

### **Work Group Session III: Testing**

All clients should receive their HIV test results, whether or not the test result is reactive. The provision of test results during a face-to-face encounter is most desirable; however, alternatives which allow for a mechanism to verify identity are permissible. Clients should have the option of receiving a written copy of their results. The messages delivered to clients should be clear and simple, not modified based on risk. Clients should be linked immediately following a preliminary positive HIV test.

More research is needed regarding the use of incentives to improve HIV testing rates, including the use of non-monetary incentives (i.e., bundling HIV tests with other STD screenings). Retesting should be recommended following a single recent exposure, in high-prevalence populations (determined by geographic location, community or population), for high-risk MSM, and before a new sexual relationship.

### **Work Group Session IV: Linkage and Referral**

A proposed definition to linkage to HIV care is when a client sees a medical provider within 3 months and before a maximum of 6 months following their HIV diagnosis at a CTR program. Medical care includes a full medical evaluation, CD4 count, and viral load count. The community-based organization (CBO) is

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responsible for linking clients to medical care, prevention services, and other supportive services within the appropriate time period, as well as establishing a comprehensive memorandum of understanding with partner agencies to make an active referral. CBOs may have to realign their resources to support a linkage/support case manager to provide active linkage.

Primary services for newly HIV-infected clients should include medical care and a referral to a case manager. Secondary services include prevention services and support services (i.e., psychosocial, housing, and substance abuse), as well as other STD screenings, economic benefits, and partner services. Services recommended for high-risk HIV-negative clients would include referral to preventive services, education, STD screenings, and support services.

Barriers to successful linkage and referral should be addressed in the guidelines. A monitoring and evaluation system should be developed to ensure access to services and verify completed referrals. More research is needed regarding linkage to care among different demographic groups, cost-effectiveness, and working with non-traditional partner organizations and communities.

### **Conclusion:**

The consultation highlighted the need to update the 2001 Revised Guidelines for HIV Counseling, Testing, and Referral to meet the needs of organizations conducting HIV testing in non health care settings. The information obtained in this consultation will inform potential future CDC activities, the development of prevention messages, and the creation of future funding announcements. As a follow-up to this consultation, CDC will develop a guidance document on counseling, testing, and linkage in the non-health-care setting. (The revised guidelines have not yet been released)

## HIV in the United States: *At A Glance (CDC November 2013)*

### Fast Facts

- More than 1.1 million people in the United States are living with HIV infection, and almost 1 in 6 (15.8%) are unaware of their infection.
- Gay, bisexual, and other men who have sex with men (MSM<sup>1</sup>), particularly young black/African American MSM, are most seriously affected by HIV.
- By race, blacks/African Americans face the most severe burden of HIV

CDC estimates that 1,144,500 persons aged 13 years and older are living with HIV infection, including 180,900 (15.8%) who are unaware of their infection [1]. Over the past decade, the number of people living with HIV has increased, while the annual number of new HIV infections has remained relatively stable. Still, the pace of new infections continues at far too high a level— particularly among certain groups.

**HIV Incidence** (new infections): The estimated incidence of HIV has remained stable overall in recent years, at about 50,000 new HIV infections per year [2]. Within the overall estimates, however, some groups are affected more than others. MSM continue to bear the greatest burden of HIV infection, and among races/ethnicities, African Americans continue to be disproportionately affected.

**HIV Diagnoses** (new diagnoses, regardless of when infection occurred): In 2011, an estimated 49,273 people were diagnosed with HIV infection in the United States. In that same year, an estimated 32,052 people were diagnosed with AIDS. Overall, an estimated 1,155,792 people in the United States have been diagnosed with AIDS [3].

**Deaths:** An estimated 15,529 people with an AIDS diagnosis died in 2010, and approximately 636,000 people in the United States with an AIDS diagnosis have overall. [3]. The deaths of persons with an AIDS diagnosis can be due to any cause—that is, the death may or may not be related to AIDS.

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