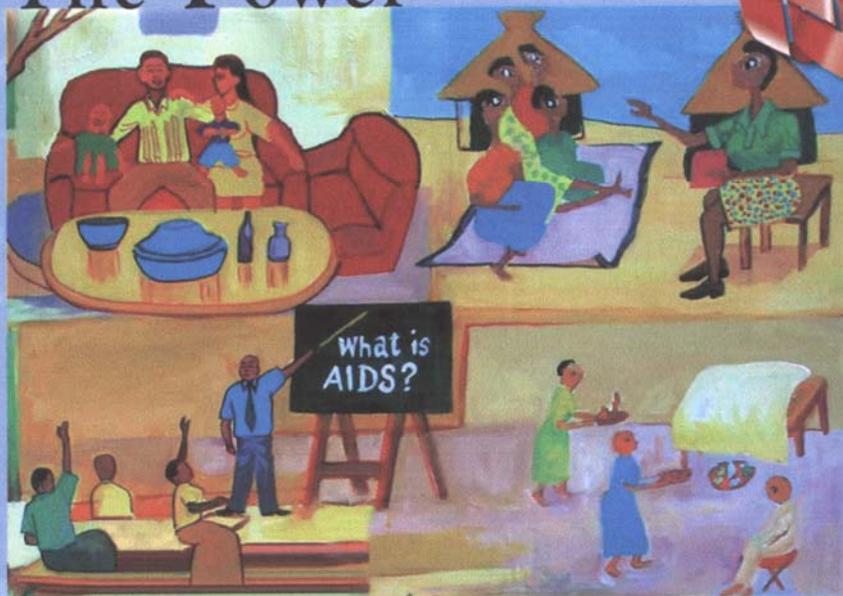


Stop AIDS; Keep the Promise—Leadership

The Power



of PARTNERSHIPS

World AIDS Day Booklet
2008



STATE OF MAINE
 DEPARTMENT OF EDUCATION
 23 STATE HOUSE STATION
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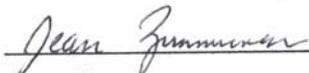
Dear HIV Educator,

As you can see, this year we are providing the World AIDS Day Booklet in a new format. We are very excited to offer you this wealth of HIV prevention information on our website for you to download. We are using this avenue of dissemination as a cost cutting measure, but we also feel that it really will be more efficient for you to use because you will have all the information in a convenient format available to use as you need it.

It has been over two decades since the beginning of the HIV/AIDs epidemic. Since then, more than half a million people have died of AIDs in America. There are currently more than one million people living with HIV and AIDS in America and around a quarter of these are unaware of their infection. In 2007, a total of 2.5 million people in the world were newly infected, 2.1 million people died and new infections occurred at a rate of 6800 a day. **About 40% of new infections are among young people between the ages of 15-24.** These are facts that we cannot ignore. We must provide the "Leadership to Keep the Promise" of HIV education.

Educators often ask us for updates and new information about AIDs, and here you will find a wealth of resources. You will see updates of HIV statistics – world, U.S. and Maine – a timeline of the AIDS epidemic, testing information and background information around World AIDS Day. The source websites are included so that you can continue to update information or use the sites for student projects. As in the past, sample lessons are included that can be used for World AIDS Day or when you teach your HIV prevention unit. Also, you will find additional resources including some basic HIV facts, terminology and support for teaching HIV prevention education. We have also included our training schedule so that you can plan your calendar and arrange to attend one of our HIV prevention curricular trainings.

It is our hope that this online booklet will provide you with the updates and the information that will enhance your good work with the youth of Maine. We thank you for your continued efforts. If we can be of any assistance, please contact us.


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2008

World AIDS Day Booklet

Theme: Stop AIDS; Keep the Promise—Leadership

Provided by:

**State of Maine Department of Education
HIV Prevention Education Program**

**Compiled and edited by
Lois Cooper**

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Contact: HIV Prevention Education Program, Maine Department of Education, 23 State House Station, Augusta, Maine 04333-0023; Tel: 207-624-6692; Web: maine.gov/education/hiv.



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World AIDS Day

According to UNAIDS estimates, there are now 33.2 million people living with HIV, including 2.5 million children. During 2007 some 2.5 million people became newly infected with the virus. Around half of all people who become infected with HIV do so before they are 25 and are killed by AIDS before they are 35.

Around 95% of people with HIV/AIDS live in developing nations. But HIV today is a threat to men, women and children on all continents around the world.

Started on 1st December 1988, World AIDS Day is about raising money, including raising money for AIDS charity AVERT, but as importantly it is about increasing awareness, fighting prejudice and improving education. World AIDS Day is important in reminding people that HIV has not gone away, and that there are many things still to be done.

The theme for World AIDS Day 2008

World AIDS Day was originally organised by UNAIDS, who chose the theme after consultation with other organisations. In 2005 UNAIDS handed over responsibility for World AIDS Day to an independent organisation known as The World AIDS Campaign (WAC).

The WAC's slogan for their work is "Stop AIDS: Keep the Promise". This is an appeal to governments, policy makers and regional health authorities to ensure that they meet the many targets that have been set in the fight against HIV and AIDS, and especially the promise of universal access to HIV treatment, care, support and prevention services by 2010. This campaign will run until 2010, with a related theme chosen for World AIDS Day each year.

The theme for 2007 and 2008 is "leadership", highlighting the need for innovation, vision and perseverance in the face of the AIDS challenge. The campaign calls on all sectors of society such as families, communities and civil society organisations - rather than just governments - to take the initiative and provide leadership on AIDS.

Stop AIDS in Children

This year at AVERT we are continuing our Stop AIDS in Children campaign, calling for urgent action in the prevention of mother-to-child transmission (PMTCT).

Currently only 9% of pregnant women living with HIV in the developing world are provided with drugs to prevent the virus being transmitted to their babies. As a result, nearly half a million children become infected with HIV every year. The Stop AIDS in Children campaign is calling on governments and international agencies to urgently improve PMTCT coverage worldwide.

Watch the video to learn more about the campaign.

Previous World AIDS Day themes

World AIDS Day themes over the years have included:

- **2008** - Stop AIDS; Keep the Promise - Leadership
- **2007** - Stop AIDS; Keep the Promise - Leadership
- **2006** - Stop AIDS; Keep the Promise - Accountability
- **2005** - Stop AIDS; Keep the Promise
- **2004** - Women, Girls, HIV and AIDS
- **2003** - Stigma & Discrimination
- **2002** - Stigma & Discrimination
- **2001** - I care. Do you?
- **2000** - AIDS : Men make a difference
- **1999** - Listen, Learn, Live: World AIDS Campaign with Children & Young People
- **1998** - Force for Change: World AIDS Campaign With Young People
- **1997** - Children Living in a World with AIDS
- **1996** - One World, One Hope
- **1995** - Shared Rights, Shared Responsibilities
- **1994** - AIDS & the Family
- **1993** - Act
- **1992** - Community Commitment
- **1991** - Sharing the Challenge
- **1990** - Women & AIDS
- **1989** - Youth
- **1988** - Communication

To learn more about what is happening around the world, or to list any events that you may be holding locally this World AIDS Day, please visit the WAC's events calendar.



The AIDS red ribbon

The red ribbon is an international symbol of AIDS awareness that is worn by people all year round and particularly around World AIDS Day to demonstrate care and concern about HIV and AIDS, and to remind others of the need for their support and commitment.

The red ribbon started as a "grass roots" effort; as a result there is no one official AIDS ribbon manufacturer, and many people make their own. It's easily done - just use some ordinary red ribbon and a safety pin!

What can I do to support World AIDS Day?

There are many ways in which you can support World AIDS Day. For example:

- Raise awareness of HIV and AIDS in your area
- Wear a red ribbon and ask others to do the same
- Sign up as a supporter of the [Stop AIDS in Children campaign](#)
- Protect yourself and your partners - this is the first and best way to stop the spread of HIV
- If you are worried - get tested

At school or work, you can support World AIDS Day by:

- Having a dressing up, down or fancy dress day
- Putting up some posters - get people talking
- Making and selling red ribbons
- Organising a creative writing/poster campaign
- Setting up a debate or a quiz - there are lots of ideas for topics on our site
- Cooking an international meal or having a cake sale
- Arranging a sponsored three-legged race or balloon release
- Getting your friends, family, colleagues or pupils to express their feelings and expand their knowledge about AIDS
- Using your imagination!

World AIDS Day on the web

The internet is a great way to reach people all around the world - other people in many countries are reading this page right now. People now spend more of their daily lives online - at work, at school, at home. People shop, chat, make new friends, study and work online. If you want to get a message to as many people as possible, this could be the way to do it.

Think about:

- Providing information on your website about World AIDS Day, and about any local events taking place in your community.
- Asking your school, college or employer to provide information on their website.
- Listing your event on the World AIDS Campaign and/or National AIDS Trust website.
- Learning more about HIV and AIDS: AVERT.org has a great deal of information about AIDS, about the global epidemic, HIV and AIDS statistics and education.

Take the World AIDS Day quiz

Think you know your stuff for World AIDS Day? Try our World AIDS Day quiz!



Raise money for AVERT

Assessing the needs of an AIDS orphan

in rural KwaZulu Natal, South Africa

Raising money for AVERT will help valuable AIDS work to continue, as well as raising awareness about HIV. Quite simply, helping AIDS charities saves people's lives.

For World AIDS Day this year we are asking people to help us support our Tholulwazi project in the northern part of KwaZulu Natal, South Africa. You can read more about Tholuwazi and how AVERT is helping in our about AVERT page.

Unlike many AIDS charities we receive no government funding, so we rely entirely on donations to support our overseas projects. To learn about the many ways you can donate to AVERT, please visit our donations page.

Together we can work towards an AIDS-free world

Last updated September 26, 2008 <http://www.avert.org/worldaid.htm>

What is AIDS?

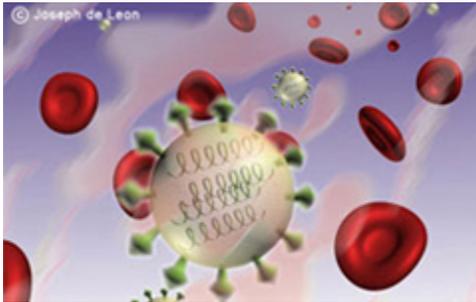
People have been warned about HIV and AIDS for over twenty years now. AIDS has already killed millions of people, millions more continue to become infected with HIV, and there's no cure – so AIDS will be around for a while yet.

AIDS is one of the biggest problems facing the world today and nobody is beyond its reach. Everyone should know the basic facts about AIDS.

What is AIDS?

AIDS (*Acquired Immune Deficiency Syndrome*) is a medical condition. People develop AIDS because HIV has damaged their natural defenses against disease.

What is HIV?



HIV (Human Immunodeficiency Virus)

HIV is a virus. Viruses infect the cells that make up the human body and replicate (make new copies of themselves) within those cells. A virus can also damage human cells, which is one of the things that can make a person ill.

HIV can be passed from one person to another. Someone can become infected with HIV through contact with the bodily fluids of someone who already has HIV.

HIV stands for the '*Human Immunodeficiency Virus*'. Someone who is diagnosed as infected with HIV is said to be 'HIV+' or 'HIV positive'.

Why is HIV dangerous?

The immune system is a group of cells and organs that protect your body by fighting disease. The human immune system usually finds and kills viruses fairly quickly.

So if the body's immune system attacks and kills viruses, what's the problem?

Different viruses attack different parts of the body - some may attack the skin, others the lungs, and so on. The common cold is caused by a virus. What makes HIV so dangerous is that it attacks the immune system itself - the very thing that would normally get rid of a virus. It particularly attacks a special type of immune system cell known as a CD4 lymphocyte.

HIV has a number of tricks that help it to evade the body's defences, including very rapid mutation. This means that once HIV has taken hold, the immune system can never fully get rid of it.

There isn't any way to tell just by looking if someone's been infected by HIV. In fact a person infected with HIV may look and feel perfectly well for many years and may not know that they are infected. But as the person's immune system weakens they become increasingly vulnerable to illnesses, many of which they would previously have fought off easily.

The only reliable way to tell whether someone has HIV is for them to take a blood test, which can detect infection from a few weeks after the virus first entered the body.

When HIV causes AIDS

A damaged immune system is not only more vulnerable to HIV, but also to the attacks of other infections. It won't always have the strength to fight off things that wouldn't have bothered it before.

As time goes by, a person who has been infected with HIV is likely to become ill more and more often until, usually several years after infection, they become ill with one of a number of particularly severe illnesses. It is at this point in the stages of HIV infection that they are said to have AIDS - when they first become seriously ill, or when the number of immune system cells left in their body drops below a particular point. Different countries have slightly different ways of defining the point at which a person is said to have AIDS rather than HIV.

AIDS is an extremely serious condition, and at this stage the body has very little defence against any sort of infection.

How long does HIV take to become AIDS?

Without drug treatment, HIV infection usually progresses to AIDS in an average of ten years. This average, though, is based on a person having a reasonable diet. Someone who is malnourished may well progress to AIDS and death more rapidly.

Antiretroviral medication can prolong the time between HIV infection and the onset of AIDS. Modern combination therapy is highly effective and, theoretically, someone with HIV can live for a long time before it becomes AIDS. These medicines, however, are not widely available in many poor countries around the world, and millions of people who cannot access medication continue to die.

How is HIV passed on?

HIV is found in the blood and the sexual fluids of an infected person, and in the breast milk of an infected woman. HIV transmission occurs when a sufficient quantity of these fluids get into someone else's bloodstream. There are various ways a person can become infected with HIV.

Ways in which you can be infected with HIV:

- *Unprotected sexual intercourse with an infected person* Sexual intercourse without a condom is risky, because the virus, which is present in an infected person's sexual fluids, can pass directly into the body of their partner. This is true for unprotected vaginal and anal sex. Oral sex carries a lower risk, but again HIV transmission can occur here if a condom is not used - for example, if one partner has bleeding gums or an open cut, however small, in their mouth.
- *Contact with an infected person's blood* If sufficient blood from an infected person enters someone else's body then it can pass on the virus.
- *From mother to child* HIV can be transmitted from an infected woman to her baby during pregnancy, delivery and breastfeeding. There are special drugs that can greatly reduce the chances of this happening, but they are unavailable in much of the developing world.
- *Use of infected blood products* Many people in the past have been infected with HIV by the use of blood transfusions and blood products which were contaminated with the virus - in hospitals, for example. In much of the world this is no longer a significant risk, as blood donations are routinely tested.
- *Injecting drugs* People who use injected drugs are also vulnerable to HIV infection. In many parts of the world, often because it is illegal to possess them, injecting equipment or works are shared. A tiny amount of blood can transmit HIV, and can be injected directly into the bloodstream with the drugs.

It is not possible to become infected with HIV through:

- sharing crockery and cutlery
- insect / animal bites
- touching, hugging or shaking hands
- eating food prepared by someone with HIV
- toilet seats

HIV facts and myths



People with HIV look just like everybody else

Around the world, there are a number of different myths about HIV and AIDS. Here are some of the more common ones:

'You would have to drink a bucket of infected saliva to become infected yourself' . . . Yuck! This is a typical myth. HIV *is* found in saliva, but in quantities too small to infect someone. If you drink a bucket of saliva from an HIV positive person, you won't become infected. There has been only one recorded case of HIV transmission via kissing, out of all the many millions of kisses. In this case, both partners had extremely badly bleeding gums.

'Sex with a virgin can cure HIV' . . . This myth is common in some parts of Africa, and it is totally untrue. The myth has resulted in many rapes of young girls and children by HIV+ men, who often infect their victims. Rape won't cure anything and is a serious crime all around the world.

'It only happens to gay men / black people / young people, etc' . . . This myth is false. Most people who become infected with HIV didn't think it would happen to them, and were wrong.

'HIV can pass through latex' . . . Some people have been spreading rumours that the virus is so small that it can pass through 'holes' in latex used to make condoms. This is untrue. The fact is that latex blocks HIV, as well as sperm - preventing pregnancy, too.

What does 'safe sex' mean?

Safe sex refers to sexual activities which do not involve any blood or sexual fluid from one person getting into another person's body. If two people are having safe sex then, even if one person is infected, there is no possibility of the other person becoming infected. Examples of safe sex are cuddling, mutual masturbation, 'dry' (or 'clothed') sex . . .

In many parts of the world, particularly the USA, people are taught that the best form of safe sex is no sex - also called 'sexual abstinence'. Abstinence isn't a form of sex at all - it involves avoiding *all* sexual activity. Usually, young people are taught that they should abstain sexually until they marry, and then remain faithful to their partner. This is a good way for someone to avoid HIV infection, as long as their husband or wife is also completely faithful and doesn't infect them.

What is 'safer sex'?

Safer sex is used to refer to a range of sexual activities that hold *little* risk of HIV infection.

Safer sex is often taken to mean using a condom for sexual intercourse. Using a condom makes it very hard for the virus to pass between people when they are having sexual intercourse. A condom, *when used properly*, acts as a physical barrier that prevents infected fluid getting into the other person's body.

Is kissing risky?

Kissing someone on the cheek, also known as social kissing, does not pose any risk of HIV transmission.

Deep or open-mouthed kissing is considered a very low risk activity for transmission of HIV. This is because HIV is present in saliva but only in very minute quantities, insufficient to lead to HIV infection alone.

There has only been one documented instance of HIV infection as a result of kissing out of all the millions of cases recorded. This was as a result of infected blood getting into the mouth of the other person during open-mouthed kissing, and in this instance both partners had seriously bleeding gums.

Can anything 'create' HIV?

No. Unprotected sex, for example, is only risky if one partner is infected with the virus. If your partner is not carrying HIV, then no type of sex or sexual activity between you is going to cause you to become infected - you can't 'create' HIV by having unprotected anal sex, for example.

You also can't become infected through masturbation. In fact nothing you do on your own is going to give you HIV - it can only be transmitted from another person who already has the virus.

Is there a cure for AIDS?



HIV medication can **slow** the progress of the virus

Worryingly, surveys show that many people think that there's a 'cure' for AIDS - which makes them feel safer, and perhaps take risks that they otherwise shouldn't. These people are wrong, though - there is still no cure for AIDS.

There is antiretroviral medication which slows the progression from HIV to AIDS, and which can keep some people healthy for many years. In some cases, the antiretroviral medication seems to stop working after a number of years, but in other cases people can recover from AIDS and

live with HIV for a very long time. But they have to take powerful medication every day of their lives, sometimes with very unpleasant side effects.

There is still no way to cure AIDS, and at the moment the only way to remain safe is not to become infected.

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WHERE NEXT?

AVERT.org has more about:

- [The global AIDS epidemic](#)
- [HIV transmission and testing](#)
- [Prevention of HIV transmission](#)
- [HIV/AIDS treatment and care](#)

Last updated October 02, 2008 <http://www.avert.org/aids.htm>

25 Years of AIDS

UNAIDS – Join United Nations Program on HIV/AIDS

In June 1981, scientists in the United States reported the first clinical evidence of a disease that would later become known as acquired immunodeficiency syndrome or AIDS. Twenty five years later, the AIDS epidemic has spread to every corner of the world. Around 40 million people are today living with HIV and over 25 million have died of AIDS. But 25 years of struggle to control the epidemic have also yielded a growing list of breakthroughs.

1959

- The oldest specimen of the human immunodeficiency virus (HIV) ever detected in a blood sample – donated by a man in Leopoldville, Congo.

1981

- The first cases of unusual immune system failures are identified among gay men, women and injecting drug users.

1982

- Acquired immunodeficiency syndrome (AIDS) is defined for the first time. In the course of the year the three modes of transmission are identified: blood, mother-to-child, and sexual intercourse.

1983

- Dr. Luc Montagnier in France isolates lymphadenopathy-associated virus (LAV), later to become known as human immunodeficiency virus or HIV.
- A heterosexual AIDS epidemic is revealed in Central Africa.

1984

- Dr. Robert Gallo in the U.S. identifies HIV as the cause of AIDS.

1985

- The global scope of the growing epidemic becomes manifest. By 1985, at least one case of HIV has been reported in each region of the world.
- The first HIV antibody tests are commercialised in the United States and in Europe, and HIV screening of blood donations begins.
- More than 2000 people attend the first International Conference on AIDS in Atlanta.
- A clinical case definition of AIDS is developed for developing countries at a World Health Organization (WHO) workshop on AIDS in Bangui, Central African Republic.
- Film star Rock Hudson becomes the first international icon to disclose he has AIDS.

1986

- An International Steering Committee for People with HIV/AIDS is created – later to become the Global Network of People Living with HIV/AIDS (GNP+).

1987

- Africa's first community-based response to AIDS (The AIDS Support Organisation or TASO) is formed in Uganda. It becomes a role model for similar groups around the world.
- In February, WHO establishes the Special Programme on AIDS.
- AIDS becomes the first disease ever debated on the floor of the United Nations General Assembly.
- The first therapy for AIDS – azidothymidine (AZT) – is approved for use in the United States.

1988

- The International AIDS Society is founded – an organisation of professionals working on HIV/AIDS.
- Health Ministers from around the world meet in London and discuss the AIDS epidemic for the first time.
- WHO declares 1 December as World AIDS Day.
- Women now account for half of adults living with HIV in sub Saharan Africa (as assessed by recent models informed by national surveys).

1990

- By 1990 around 1 million children had lost one or both parents to AIDS.

1991

- The red ribbon becomes an international symbol of AIDS awareness.
- The global network of non-governmental and community-based organizations ICASO (International Council of AIDS Service Organizations) is formed to mobilize communities and their organizations to participate in the response to AIDS.

1992-1993

- HIV prevalence in Uganda and Thailand begins to decrease as a result of countrywide mobilization against the epidemic.

1994

- At the Paris AIDS Summit, 42 national governments declare that the principle of greater involvement of people living with HIV (GIPA) is critical to ethical and effective national responses to the epidemic.
- Scientists develop the first treatment regimen to reduce mother- to-child HIV transmission.

1995

- An HIV outbreak in Eastern Europe is detected among injecting drug users.

1996

- The Joint United Nations Programme on HIV/AIDS (UNAIDS) becomes operational.
- Evidence of the efficacy of highly active antiretroviral therapy is presented for the first time at the 11th International AIDS Conference in Vancouver.
- Brazil becomes the first developing country to provide antiretroviral therapy through its public health system.

1997

- With the support of UNAIDS the first public antiretroviral therapy programme in Africa, the Drug Access Initiative is launched, first in Kampala and later in Abidjan.
- The Global Business Council on HIV/AIDS is created (later to become the Global Business Coalition on AIDS).
- USAID publishes the first "Children on the Brink: Strategies to Support HIV/AIDS," report highlighting the epidemic's impact on children.

1998

- The first short-course regimen to prevent mother-to-child transmission is announced.
- The Treatment Action Campaign (TAC) is established in South Africa to mobilize national support for access to treatment by people living with HIV.
- Thirty-nine pharmaceutical companies file a law suit against the South African government to contest legislation aimed at reducing the price of medicines.

1999

- The first efficacy trial of a potential HIV vaccine in a developing country starts in Thailand.

- The UN launches the International Partnership against AIDS in Africa to bring together key stakeholders to mount an intensified response to the epidemic.

2000

- The UN Security Council discusses AIDS for the first time.
- The Millennium Development Goals are announced as part of the Millennium Declaration and include reversing the spread of AIDS, tuberculosis and malaria as one of eight key goals.
- UNAIDS and WHO announce a joint initiative with five pharmaceutical companies to increase access to HIV treatment in developing countries (the Accelerating Access Initiative).

2001

- UN Secretary-General Kofi Annan launches a call to action in Abuja, calling for a 'war chest' of US\$ 7-10 billion to be spent annually on AIDS in developing countries.
- The first UN General Assembly Special Session on HIV/AIDS unanimously adopts the Declaration of Commitment on HIV/AIDS, which declares AIDS a global catastrophe and calls for worldwide commitment to fight AIDS.
- The World Trade Organisation adopts the Doha Declaration allowing for wider access to HIV treatment through generic drugs.

2002

- The Global Fund to Fight AIDS, Tuberculosis and Malaria becomes operational and approves the first round of grants.

2003

- US President George Bush announces the US\$ 15 billion President's Emergency Plan for AIDS Relief during the State of the Union Address.
- WHO and UNAIDS launch the '3 by 5' initiative with the aim of helping low- and middle-income countries increase the number of people who have access to antiretroviral therapy from 400 000 to 3 million people by the end of 2005.

2004

- UNAIDS launches the Global Coalition on Women and AIDS.
- An agreement is reached on the 'Three Ones' principle – one national AIDS framework, one national AIDS authority and one system for monitoring and evaluation – as guiding principles for engagement on AIDS by national and international actors.

2005

- At the G8 Summit in Gleneagles, Scotland, leaders pledge to come as close as possible to universal access to antiretroviral treatment worldwide by 2010.
- At the 2005 UN World Summit in New York, world leaders agree to take action to scale up HIV prevention, treatment, care and support with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it.
- Indian Prime Minister Manmohan Singh establishes the National Council on AIDS.
- Chinese Premier Wen Jiabao announces increased measures to fight AIDS.
- A 'Global Task Team on improving coordination among multilateral institutions and international donors to further strengthen the AIDS response in countries' recommends measures to improve effectiveness of the international response to AIDS.
- UNICEF and UNAIDS launch 'Unite for Children Unite Against AIDS,' a global campaign focusing on the enormous impact of AIDS on children.
- By the end of 2005 1.3 million people in low- and middle-income countries are receiving access to antiretroviral therapy.

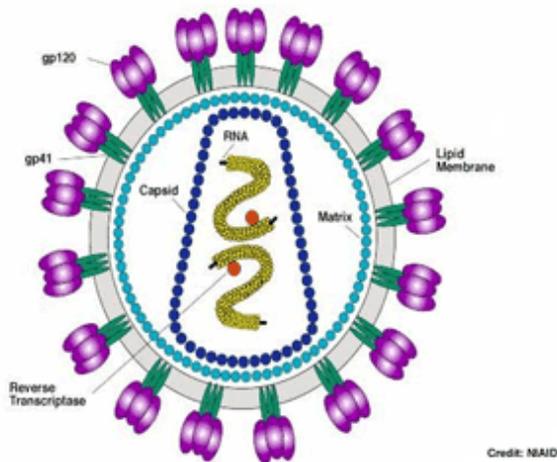
www.unaids.org

Basic Information

HIV

HIV stands for human immunodeficiency virus. This is the virus that causes AIDS. HIV is different from most other viruses because it attacks the immune system. The immune system gives our bodies the ability to fight infections. HIV finds and destroys a type of white blood cell (T cells or CD4 cells) that the immune system must have to fight disease.

Organization of the HIV-1 Virion

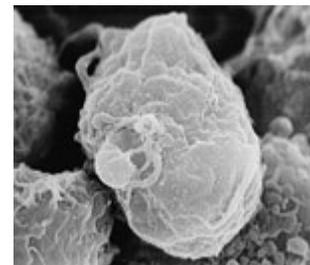


Structure of the Human Immunodeficiency Virus, courtesy of NIAID.

For more information [view our questions and answers on HIV science](#).

AIDS

AIDS stands for acquired immunodeficiency syndrome. AIDS is the final stage of HIV infection. It can take years for a person infected with HIV, even without treatment, to reach this stage. Having AIDS means that the virus has weakened the immune system to the point at which the body has a difficult time fighting infection. When someone has one or more specific infections, certain cancers, or a very low number of T cells, he or she is considered to have AIDS. For more information [view our questions and answers on HIV science](#).



Electron microscope image of HIV, seen as small spheres on the surface of white blood cells.

Origin of HIV



Scientists identified a type of chimpanzee in West Africa as the source of HIV infection in humans. The virus most likely jumped to humans when humans hunted these chimpanzees for meat and came into contact with their infected blood. Over several years, the virus slowly spread across Africa and later into other parts of the world. For more information [view our question and answer on the origin of HIV](#).

Brief History of HIV in the United States

HIV was first identified in the United States in 1981 after a number of gay men started getting sick with a rare type of cancer. It took several years for scientists to develop a test for the virus, to understand how HIV was transmitted between humans, and to determine what people could do to protect themselves.

In 2008, CDC adjusted its estimate of new HIV infections because of new technology and developed by the agency. Before this time, CDC estimated there were roughly 40,000 new HIV infections each year in the United States. New results shows there were dramatic declines in the number of new HIV infections from a peak of about 130,000 in the mid 1980s to a low of roughly 50,000 in the early 1990s. Results also shows that new infections increased in the late 1990s, followed by a leveling off since 2000 at about 55,000 per year. In 2006, an estimated 56,300 individuals were infected with HIV.

AIDS cases began to fall dramatically in 1996, when new drugs became available. Today, more people than ever before are living with HIV/AIDS. CDC estimates that about 1 million people in the United States are living with HIV or AIDS. About one quarter of these people do not know that they are infected: not knowing puts them and others at risk.

How HIV Is and Is Not Transmitted

HIV is a fragile virus. It cannot live for very long outside the body. As a result, the virus **is not transmitted** through day-to-day activities such as shaking hands, hugging, or a casual kiss. You cannot become infected from a toilet seat, drinking fountain, doorknob, dishes, drinking glasses, food, or pets. You also cannot get HIV from mosquitoes.

HIV is primarily found in the blood, semen, or vaginal fluid of an infected person. HIV is transmitted in 3 main ways:

- Having sex (anal, vaginal, or oral) with someone infected with HIV
- Sharing needles and syringes with someone infected with HIV
- Being exposed (fetus or infant) to HIV before or during birth or through breast feeding

For more information [view our questions and answers on transmission](#).

HIV also can be transmitted through blood infected with HIV. However, since 1985, all donated blood in the United States has been tested for HIV. Therefore, the risk for HIV infection through the transfusion of blood or blood products is extremely low. The U.S. blood supply is considered among the safest in the world. For more information [view our question and answer on blood safety](#).

Risk Factors for HIV Transmission

You may be at increased risk for infection if you have

- injected drugs or steroids, during which equipment (such as needles, syringes, cotton, water) and blood were shared with others
- had unprotected vaginal, anal, or oral sex (that is, sex without using condoms) with men who have sex with

- men, multiple partners, or anonymous partners
- exchanged sex for drugs or money
- been given a diagnosis of, or been treated for, hepatitis, tuberculosis (TB), or a sexually transmitted disease (STD) such as syphilis
- received a blood transfusion or clotting factor during 1978–1985
- had unprotected sex with someone who has any of the risk factors listed above

Preventing Transmission

Your risk of getting HIV or passing it to someone else depends on several things. Do you know what they are? You might want to talk to someone who knows about HIV. You can also do the following:

- Abstain from sex (do not have oral, anal, or vaginal sex) until you are in a relationship with only one person, are having sex with only each other, and each of you knows the other's HIV status.
 - If both you and your partner have HIV, use condoms to prevent other sexually transmitted diseases (STDs) and possible infection with a different strain of HIV.
 - If only one of you has HIV, use a latex condom and lubricant every time you have sex.
- If you have, or plan to have, more than one sex partner, consider the following:
 - Get tested for HIV
 - If you are a man who has had sex with other men, get tested at least once a year.
 - If you are a woman who is planning to get pregnant or who is pregnant, get tested as soon as possible, before you have your baby.
 - Talk about HIV and other STDs with each partner before you have sex.
 - Learn as much as you can about each partner's past behavior (sex and drug use), and consider the risks to your health before you have sex.
 - Ask your partners if they have recently been tested for HIV; encourage those who have not been tested to do so.
 - Use a latex condom and lubricant every time you have sex.
 - If you think you may have been exposed to another STD such as gonorrhea, syphilis, or *Chlamydia trachomatis* infection, get treatment. These diseases can increase your risk of getting HIV.
 - Get vaccinated against hepatitis B virus.
- Even if you think you have low risk for HIV infection, get tested whenever you have a regular medical check-up.
- Do not inject illicit drugs (drugs not prescribed by your doctor). You can get HIV through needles, syringes, and other works if they are contaminated with the blood of someone who has HIV. Drugs also cloud your mind, which may result in riskier sex.
- If you do inject drugs, do the following:
 - Use only clean needles, syringes, and other works.
 - Never share needles, syringes, or other works.
 - Be careful not to expose yourself to another person's blood.
 - Get tested for HIV test at least once a year.
 - Consider getting counseling and treatment for your drug use.
 - Get vaccinated against hepatitis A and B viruses.
- Do not have sex when you are taking drugs or drinking alcohol because being high can make you



more likely to take risks.

To protect yourself, remember these ABCs:

A=Abstinence

B=Be Faithful

C=Condoms

For more information [view our questions and answers on HIV prevention.](#)

Symptoms of HIV Infection

The only way to know whether you are infected is to be tested for HIV. You cannot rely on symptoms alone because many people who are infected with HIV do not have symptoms for many years. Someone can look and feel healthy but can still be infected. In fact, one quarter of the HIV-infected persons in the United States do not know that they are infected. For more information [view our question and answer on symptoms.](#)

HIV Testing

Once HIV enters the body, the body starts to produce antibodies—substances the immune system creates after infection. Most HIV tests look for these antibodies rather than the virus itself. There are many different kinds of HIV tests, including rapid tests and home test kits. All HIV tests approved by the US government are very good at finding HIV. For more information [view our questions and answers on testing.](#)

Finding a Testing Site

Many places offer HIV testing: health departments, doctors' offices, hospitals, and sites specifically set up to provide HIV testing.

You can locate a testing site by visiting the [CDC HIV testing database](#) or by calling CDC-INFO (formerly the CDC National AIDS Hotline) at 1-800-CDC-INFO (1-800-232-4636) 24 Hours/Day. You do not have to give any personal information about yourself to use these services to find a testing site.

Additional Resources for Basic Information

- [CDC Questions and Answers on HIV/AIDS](#)
- [CDC Fact Sheet: HIV and Its Transmission](#)
- [CDC Fact Sheet: HIV Type 2](#)
- [MedLine AIDS Tutorial \(NLM\)](#)
- [HIV Infection and AIDS: An Overview \(NIH\)](#)
- [The Evidence That HIV Causes AIDS \(NIH\)](#)
- [How HIV Causes AIDS \(NIH\)](#)
- [The Origin of HIV \(NIH\)](#)
- [Glossary of HIV/AIDS-Related Terms \(AIDSInfo\)](#)

www.cdc.gov/hiv/topics/basic

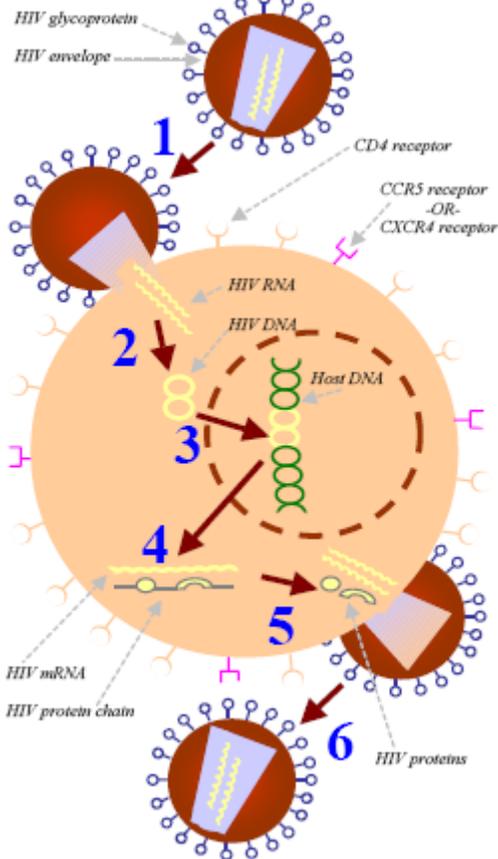
The HIV Life Cycle

Terms Used in This Fact Sheet:

CD4 receptor: A protein present on the outside of infection-fighting white blood cells. CD4 receptors allow HIV to bind to and enter cells.

Co-receptor: In addition to binding a CD4 receptor, HIV must also bind either a CCR5 or CXCR4 co-receptor protein to get into a cell.

T-lymphocyte: A type of white blood cell that detects and fights foreign invaders of the body.



1 Binding and Fusion: HIV begins its life cycle when it binds to a **CD4 receptor** and one of two **co-receptors** on the surface of a CD4⁺ **T- lymphocyte**. The virus then fuses with the host cell. After fusion, the virus releases RNA, its genetic material, into the host cell.

2 Reverse Transcription: An HIV enzyme called reverse transcriptase converts the single-stranded HIV RNA to double-stranded HIV DNA.

3 Integration: The newly formed HIV DNA enters the host cell's nucleus, where an HIV enzyme called integrase "hides" the HIV DNA within the host cell's own DNA. The integrated HIV DNA is called provirus. The provirus may remain inactive for several years, producing few or no new copies of HIV.

4 Transcription: When the host cell receives a signal to become active, the provirus uses a host enzyme called RNA polymerase to create copies of the HIV genomic material, as well as shorter strands of RNA called messenger RNA (mRNA). The mRNA is used as a blueprint to make long chains of HIV proteins.

5 Assembly: An HIV enzyme called protease cuts the long chains of HIV proteins into smaller individual proteins. As the smaller HIV proteins come together with copies of HIV's RNA genetic material, a new virus particle is assembled.

6 Budding: The newly assembled virus pushes out ("buds") from the host cell. During budding, the new virus steals part of the cell's outer envelope. This envelope, which acts as a covering, is studded with protein/sugar combinations called HIV glycoproteins. These HIV glycoproteins are necessary for the virus to bind CD4 and co- receptors. The new copies of HIV can now move on to infect other cells.

For more information:

Contact your doctor or an *AIDSinfo* Health Information Specialist at 1-800-448-0440 or <http://aidsinfo.nih.gov>.

A Service of the U.S. Department of Health and Human Services
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HIV Transmission-Frequently Asked Questions

From AVERT.org

What are the main routes of HIV transmission?

These are the main ways in which someone can become infected with HIV:

- Unprotected penetrative sex with someone who is infected.
- Injection or transfusion of contaminated blood or blood products, donations of semen (artificial insemination), skin grafts or organ transplants taken from someone who is infected.
- From a mother who is infected to her baby; this can occur during pregnancy, at birth and through breastfeeding.
- Sharing unsterilised injection equipment that has previously been used by someone who is infected.

Can I be infected if my partner doesn't have HIV?

No. Like all sexually transmitted infections, HIV cannot be 'created', only passed on. If you are sure that your partner does not have HIV, then there is no risk of acquiring it, even if you do have unprotected sex (whether it be vaginal, anal or oral). However, pregnancy and other sexually transmitted diseases (if your partner has one) remain a risk, so you should still use a condom or other suitable form of birth control wherever possible.

How safe is oral sex?

Although it is possible to become infected with HIV through oral sex, the risk of becoming infected in this way is much lower than the risk of infection via unprotected sexual intercourse with a man or woman.

When giving oral sex to a man (sucking or licking a man's penis) a person could become infected with HIV if infected semen came into contact with damaged and receding gums, or any cuts or sores they might have in their mouth.

Giving oral sex to a woman (licking a woman's vulva or vagina) is also considered relatively low risk. Transmission could take place if infected sexual fluids from a woman got into the mouth of her partner. The likelihood of infection might be increased if there is menstrual blood involved or if the woman is infected with another sexually transmitted disease.

The likelihood of either a man or a woman becoming infected with HIV as a result of receiving oral sex is extremely low, as saliva does not contain infectious quantities of HIV.

More information can be found in our [oral sex & HIV](#) page.

What are the chances of becoming infected with HIV if he doesn't come inside me?

Whilst research suggests that high concentrations of HIV can sometimes be detected in precum, it is difficult to judge whether HIV is present in sufficient quantities for infection to occur. To guard against the possibility of infection with HIV or any other STD it is best to practise safer sex, i.e. sex with a condom.

Is deep kissing a route of HIV transmission?

Deep or open-mouthed kissing is a very low risk activity in terms of HIV transmission. HIV is only present in saliva in very minute amounts, insufficient to cause infection with HIV.

There has been only one documented case of someone becoming infected with HIV through kissing; a result of exposure to infected blood during open-mouthed kissing. If you or your partner have blood in your mouth, you should avoid kissing until the bleeding stops.

Are lesbians or other women who have sex with women at risk for HIV?

Lesbians/bisexual women are not at high risk of contracting HIV through woman-to-woman sex. Very few women are known to have passed HIV on to other women sexually, though it is theoretically possible if infected vaginal fluids or blood from an HIV positive partner enter the other woman's vagina (perhaps on fingers or sex toys).

AVERT has more information about [lesbians](#), bisexual women & HIV.

Is unprotected anal intercourse more of an HIV risk than vaginal or oral sex?

Unprotected anal intercourse does carry a higher risk than most other forms of sexual activity. The lining of the rectum has fewer cells than that of the vagina, and therefore can be damaged more easily, causing bleeding during intercourse. This can then be a route into the bloodstream for infected sexual fluids or blood. There is also a risk to the insertive partner during anal intercourse, though this is lower than the risk to the receptive partner.

Does 'fingering' during sex carry a risk of HIV transmission?

Inserting a finger into someone's anus or vagina would only be an HIV risk if the finger had cuts or sores on it and if there was direct contact with HIV infected blood, vaginal fluids or semen from the other person. There might also be a risk if the person doing the fingering had HIV and their finger was bleeding.

Is there a connection between HIV and other STDs (sexually transmitted diseases)?

HIV and other STDs can impact upon each other. The presence of STDs in an HIV infected person can increase the risk of HIV transmission. This can be through a genital ulcer which could bleed or through increased genital discharge.

An HIV negative person who has an STD can be at increased risk of becoming infected with HIV through sex. This can happen if the STD causes ulceration or breaks in the skin (e.g. syphilis or herpes), or if it stimulates an immune response in the genital area (e.g. chlamydia or gonorrhoea). HIV transmission is more likely in those with ulcerative STDs than non-ulcerative.

Using condoms during sex is the best way to prevent the sexual transmission of diseases, including HIV. AVERT.org has more information on [STDs](#).

Can I become infected with HIV through normal social contact/activities such as shaking hands/toilet seats/swimming pools/sharing cutlery/kissing/sneezes and coughs?

No. HIV is not an airborne, water-borne or food-borne virus, and does not survive for very long outside the human body. Therefore ordinary social contact such as kissing, shaking hands, coughing and sharing cutlery does not result in the virus being passed from one person to another.

Can I become infected with HIV from needles on movie/cinema seats?

There have been a number of stories circulating via the Internet and e-mail, about people becoming infected from needles left on cinema seats and in coin return slots. These rumours appear to have no factual basis.

For HIV infection to take place in this way the needle would need to contain infected blood with a high level of infectious virus. If a person was then pricked with an infected needle, they could become infected, but there is still only a 0.4% chance of this happening.

Although discarded needles can transfer blood and blood-borne illnesses such as Hepatitis B, Hepatitis C and HIV, the risk of infection taking place in this way is extremely low.

Further information on this topic can be found on the [CDC website](#).

Is there a risk of HIV transmission when having a tattoo, body piercing or visiting the barbers?

If instruments contaminated with blood are not sterilised between clients then there is a risk of HIV transmission. However, people who carry out body piercing or tattooing should follow procedures called 'universal precautions', which are designed to prevent the transmission of blood borne infections such as HIV and Hepatitis B.

When visiting the barbers there is no risk of infection unless the skin is cut and infected blood gets into the wound. Traditional 'cut-throat' razors used by barbers now have disposable blades, which should only be used once, thus eliminating the risk from blood-borne infections such as Hepatitis and HIV.

Are healthcare workers at risk from HIV through contact with HIV positive patients?

The risk to healthcare workers being exposed to HIV is extremely low, especially if they follow universal healthcare precautions. Everyday casual contact does not expose anyone, including healthcare workers, to HIV. The main risk is through accidental injuries from needles and other sharp objects that may be contaminated with HIV.

It has been estimated that the risk of infection from a needlestick injury is less than 1 percent. In the UK for instance, there have been five documented cases of HIV transmission through occupational exposure in the healthcare setting, and twelve possible/probable cases. In the US, there were 56 documented cases of occupational HIV transmission up to June 2000.

The risk posed by a needlestick injury may be higher if it is a deep injury; if it is made with a hollow bore needle; if the source patient has a high viral load; or if the sharp instrument is visibly contaminated with blood. For further information, see our [HIV and healthcare workers](#) page.

Am I at risk of becoming infected with HIV when visiting the doctor or dentist?

Transmission of HIV in a healthcare setting is extremely rare. All health professionals are required to follow infection control procedures when caring for any patient. These procedures are called universal precautions for infection control. They are designed to protect both patients and healthcare professionals from the transmission of blood-borne diseases such as Hepatitis B and HIV.

If blood splashes into my eye, or I get some in my mouth, can I become infected with HIV?

Research suggests that the risk of HIV infection in this way is extremely small. A very small number of people - usually in a healthcare setting - have become infected with HIV as a result of blood splashes in the eye.

Blood in the mouth carries an even lower risk. The lining of the mouth is very protective, so the only way HIV could enter the bloodstream would be if the person had a cut, open sore or area of inflammation somewhere in their mouth or throat (if the blood was swallowed). Even then, the person would have to get a fairly significant quantity of fresh blood (i.e. an amount that can be clearly seen or tasted) directly into the region of the cut or sore for there to be a risk. HIV is diluted by saliva and easily killed by stomach acid once the blood is swallowed.

Can I become infected with HIV through biting?

Infection with HIV in this way is unusual. There have only been a couple of documented cases of HIV transmission resulting from biting. In these particular cases, severe tissue tearing and damage were reported in addition to the presence of blood.

Can I be infected with HIV through contact with animals such as dogs and cats?

No. HIV is a Human Immunodeficiency Virus. It only affects humans. There are some other types of immunodeficiency viruses that specifically affect cats and other primates, namely the Feline Immunodeficiency Virus (FIV) and Simian Immunodeficiency Virus (SIV). These viruses are of no risk to humans.

Some people have expressed concern that they could become infected if scratched by an animal that has previously scratched an HIV positive person. This is exceptionally unlikely, and there are no documented cases of transmission occurring in this way.

Can I get HIV from a mosquito?

No, it is not possible to get HIV from mosquitoes. When taking blood from someone, mosquitoes do not inject blood from any previous person. The only thing that a mosquito injects is saliva, which acts as a lubricant and enables it to feed more efficiently.

Can HIV be transmitted in household settings?

HIV is overwhelmingly transmitted through sexual contact, through intravenous drug use, through infected blood donations and from mother to child during pregnancy, birth and breastfeeding. HIV is not transmitted through everyday social contact. There have however been a few cases in which it is thought that family members have infected each other through ways other than those stated above.

A case in Australia in the late 1990s involved two sisters. Both tested positive within a month of each other. The risk exposure for the older sister was identified as being sexual contact she had with a Russian man. The younger sister had had no obvious risk exposures, and investigators concluded that the only possible risk exposure was them sharing a razor to shave their legs. Further analysis established that they did have the same Russian virus strain, not commonly found in Australia.

The other case involved a mother and son, again in Australia, who both tested HIV positive. He had had risk exposures in Thailand some years before, whereas the mother could not identify a possible exposure. The son had had the skin condition psoriasis some time earlier, and the mother's application of the cream to his skin lesions was identified as the only possible route of infection. Analysis showed that they both had the same strain, found in Thailand and not common in Australia.

Whilst HIV transmission between family members and members of the same household is possible, it occurs in extremely low numbers and documented cases are very rare.

Can I become infected with HIV if I inject drugs and share the needles with someone else, without sterilising them?

There is a possibility of becoming infected with HIV if you share injecting equipment with someone who has the virus. If HIV infected blood remains within the bore (inside) of the needle or in the syringe and someone else then uses it to inject themselves, that blood can be flushed into the bloodstream. Sharing needles, syringes, spoons, filters or water can pass on the virus. Disinfecting equipment between uses can reduce the likelihood of transmission, but does not eliminate it. More information can be found in our [Injecting drugs, drug users and HIV](#) page.

Can I transmit HIV to my baby during pregnancy or breastfeeding?

An HIV-infected pregnant woman can pass the virus on to her unborn baby either before or during birth. HIV can also be passed on during breastfeeding. If a woman knows that she is infected with HIV, there are drugs she can take to greatly reduce the chances of her child becoming infected. Other ways to lower the risk include choosing to have a caesarean section delivery and not breastfeeding. Read more about [HIV and pregnancy](#).

Does donating blood or having a blood transfusion mean that I am putting myself at risk from HIV?

Some people have been infected through a transfusion of infected blood. In most countries, however, all the blood used for transfusions is now tested for HIV. In those countries where the blood has been tested, HIV infection through blood transfusions is now extremely rare. Blood products, such as those used by people with hemophilia, are now heat-treated to make them safe.

Donating blood at an approved donation centre should carry no risk, as all equipment should be sterile and blood collection needles are not reused.

Can HIV be transmitted outside of the body?

Whilst HIV may live for a short while outside of the body, HIV transmission has not been reported as a result of contact with spillages or small traces of blood, semen or other bodily fluids. This is partly because HIV dies quite quickly once exposed to the air, and also because spilled fluids would have to get into a person's bloodstream to infect them.

Scientists agree that HIV does not survive well in the environment, making the chance of environmental transmission remote. To obtain data on the survival of HIV, laboratory studies usually use artificially high concentrations of laboratory-grown virus. Although these concentrations of HIV can be kept alive for days or even weeks under controlled conditions, studies have shown that drying of these high concentrations of HIV reduces the amount of infectious virus by 90 to 99 percent within a few hours.

Since the HIV concentrations used in laboratory studies are much higher than those actually found in blood or other specimens, the real risk of HIV infection from dried bodily fluids is probably close to zero. Incorrect interpretation of conclusions drawn from laboratory studies have unnecessarily alarmed some people. AVERT.org has additional [facts about HIV and AIDS](#).

Does circumcision protect against HIV?

There is very strong evidence showing that circumcised men are about half as likely as uncircumcised men to acquire HIV through heterosexual sex. However, circumcision does not make a man immune to HIV infection, it just means that it's less likely to happen. Male circumcision probably has little or no preventive benefit for women. Read more about [HIV and circumcision](#).

If I am taking antiretroviral drugs and have an 'undetectable' viral load, am I still infectious?

Even if your tests show that you have very low levels of HIV in your blood, the virus will not have been totally eradicated and you will still be capable of infecting others. Some drugs do not penetrate the genitals very well and so do not disable HIV as effectively there as they do in the blood. This means that while you may have little active virus showing up on blood tests, there may still be quite a lot of HIV in your semen or vaginal fluids. Transmission may be less likely when you have a low viral load, but it is still possible so you should always take appropriate precautions.

For more information on this issue read AVERT's [HIV transmission and antiretroviral therapy briefing sheet](#).

AVERT.org has more about:

- [HIV testing and transmission](#)
- [Ways you can get infected with HIV](#)
- [Questions and answers about HIV testing](#)
- [An introduction to AIDS treatment](#)

Last updated September 29, 2008

Glossary of HIV/AIDS Terms

AIDS-dementia complex – a typically progressive condition caused by HIV infection of the brain wherein deterioration of neural and physical capacities occurs.	Lymphadenopathy – a swelling of the lymph nodes and other tissues of the immune system.
American Association for World Health (AAWH) – an educational and charitable, non-profit, non-governmental agency, whose purpose is to inform the American people about world health issues and challenges and to strengthen public support through activities and programs that improve health conditions worldwide.	Lymph nodes – pockets of white blood cells located in the neck, armpits, groin, and other body regions that fight infection by filtering out germs and producing antibodies.
Centers for Disease Control and Prevention (CDC) – A major agency of the United States Public Health Service designed to protect the health of the U.S. populace by providing leadership and direction in the prevention and control of infectious disease and other preventable conditions.	Nongonococcal urethritis (NGU) – infection of the urethra (tube that carries urine from the bladder) that can be caused by several different sexually transmitted organisms such as chlamydia.
Cervicitis – inflammation of the cervix.	Opportunistic infection – an infection with a microorganism that does not ordinarily cause disease, but that becomes pathogenic in a person whose immune system is impaired, as by HIV infection.
Chlamydia – a sexually transmitted organism that may cause damage to an infected individual’s reproductive organs and is a major cause of pelvic inflammatory disease (PID) and nongonococcal urethritis (NGU).	Pan American Health Organization (PAHO) – World’s oldest international health agency that serves as the Regional Office for the Americas of WHO, whose mission is to foster and coordinate the efforts of the countries in the Western Hemisphere to fight disease, lengthen life, and promote the physical and mental health of their populations.
Helper T-lymphocyte – the conductor of the immune system and where HIV lives while in the body.	Pandemic – an epidemic of worldwide scope.
Herpes simplex virus (HSV) – a common virus spread by direct contact that causes sores on or near the face and causes genital herpes (genital sores).	Pelvic inflammatory disease (PID) – a serious infection of the upper genital tract in women that often damages the fallopian tubes, making it difficult or impossible for a woman to have children
HIV encephalopathy – see AIDS-dementia complex.	Pneumocystis carinii pneumonia (PCP) – a protozoan infection of the lungs and the leading cause of death among people with AIDS.
HIV wasting syndrome – a condition of HIV characterized by involuntary loss of weight and strength.	Thrush – A fungal infection of the mouth and throat with symptoms of milky white flakes.
Human papillomavirus (HPV) – a group of viruses that cause genital warts, one of the most common sexually transmitted diseases in the United States.	World Health Organization (WHO) – a specialized agency within the United Nations system, dedicated to helping the nations of the world work together to solve common health challenges.
Immune system – the body’s defense system against foreign substances with lymphocytes as one of the system’s primary components.	
Kaposi’s sarcoma – a cancer or tumor of the walls of the blood vessels or the lymphatic vessels resulting in red and violet skin patches.	



August 2, 2008

FOR IMMEDIATE RELEASE

Contact: Julie Scofield (202-434-8090)

New HIV Incidence Estimates Confirm Failed Policies of the Bush Administration

WASHINGTON, DC – State and territorial AIDS directors demand that the United States (U.S.) government dramatically scale up efforts to end the domestic HIV/AIDS epidemic.

Using new technologies to estimate HIV incidence, the Centers for Disease Control and Prevention (CDC) now estimates that 56,300 new infections occurred in the U.S. in 2006, a number significantly higher than the previous estimate of 40,000 - a less precise count that had remained static for over a decade. “The release of these data serves as the clarion call that America’s response to the HIV/AIDS epidemic must be brought to scale,” stated Julie Scofield, Executive Director of the National Alliance of State and Territorial AIDS Directors (NASTAD).

CDC’s revised incidence estimate provides definitive evidence that HIV prevention has not been adequately funded to decrease the number of new HIV infections occurring each year. HIV prevention funding represents only four percent of the domestic federal HIV/AIDS budget. In comparison, the President’s Emergency Plan for AIDS Relief (PEPFAR) dedicates 22 percent of global funding to prevention. Rather than investing in domestic HIV prevention, the U.S. government has cut funding to state and local health departments by more than \$28 million since FY2003. When adjusted for inflation, experts estimate the CDC’s domestic HIV prevention budget decreased over 19 percent since FY2002.

Experts have demonstrated the relationship between federal funding and HIV prevention program effectiveness. In fact, CDC estimates there was a remarkable decline from a high of approximately 130,000 annual HIV infections in the late 1980s to a low of close to 50,000 in the early 1990s. During this time, CDC’s prevention budget increased by almost fifty percent. The new data also reveal that the number of new infections increased in the late 1990s to between 55,000 and 58,500 per year and has remained relatively stable at this level since 2000, a time when prevention funding began eroding. Because of this, along with restrictive ideological policies challenging targeted prevention messages for gay men, banning the use of federal funds for needle exchange programs, and wasting millions of dollars on failed abstinence-only programs, HIV prevention programs have been thwarted in their ability to equip those at risk with the tools and information they need to remain uninfected. Only through their perseverance to serve the populations they are mandated to protect have health departments and community partners navigated these unacceptable hurdles.

The new estimation technology also provides more accurate estimates of new infections among specific populations, confirming what many health departments have recognized for years: the HIV/AIDS epidemic continues to disproportionately impact gay and bisexual men of all races and ethnicities and African American men and women. It is now estimated that in 2006, men who have sex with men (MSM) accounted for 53 percent of new infections. Infection rates among blacks were seven times greater than whites and nearly three times higher than Hispanics, a group that also was disproportionately affected.

The new estimates also underscore America's pervasive indifference toward racism, homophobia, poverty and sexism. The continuing apathy about these root causes of health disparities continues to impede efforts to meet the needs of those most at risk for being infected with HIV. To this end, confronting oppression and stigma must be at the foundation of a scaled up strategy to end the HIV/AIDS epidemic in America.

"For years, prevention efforts serving gay men have been stifled by ideologues," remarked Julie Scofield, NASTAD's Executive Director. "It is clear that the nation's HIV prevention efforts must be delivered in a manner that respects the real life experiences of gay and bisexual men and African Americans, all who unacceptably bear the greatest burden of HIV disease. Woefully inadequate funding and personal biases have created the perfect storm, leaving thousands of gay men and African Americans to pay the ultimate price. Until the nation recognizes the connection between oppression and health, we will never be successful in our work to end this dreadful disease among all Americans," Scofield continued.

In December of 2007, NASTAD released a road map for ending the epidemic in the U.S., *The Blueprint: Ending the HIV/AIDS Epidemic through the Power of Prevention*. This document and its accompanying policy agenda detail the steps that must be taken in order to turn the tide on HIV/AIDS in America. The *Blueprint* challenges the nation to lift its veil of indifference and commit to ending the epidemic through the power of prevention. Chief among the recommendations is a call for an increase of at least \$600 million for CDC's core HIV prevention program to bring the historically underfunded program to scale.

"We know prevention works when it's available," stated Scofield. "Rates of infection among persons who use injection drugs have plummeted when appropriate services are made available. The same is true for babies born to HIV-infected mothers. We must take every opportunity to ensure every American has access to tools and services that prevent infection. Prevention has not failed; we have failed to capitalize on the potential of prevention," remarked Scofield.

NASTAD is a nonprofit national association of state health department HIV/AIDS program directors who have responsibility for administering HIV/AIDS and viral hepatitis health care, prevention, education, and supportive services programs funded by state and federal governments. NASTAD's vision is a world free of HIV/AIDS. For more information, visit www.NASTAD.org.

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Worldwide HIV & AIDS Statistics by Avert.org

Global HIV/AIDS estimates, end of 2007

The latest statistics on the world epidemic of AIDS & HIV were published by UNAIDS/WHO in July 2008, and refer to the end of 2007.

	Estimate	Range
People living with HIV/AIDS in 2007	33.0 million	30.3-36.1 million
Adults living with HIV/AIDS in 2007	30.8 million	28.2-34.0 million
Women living with HIV/AIDS in 2007	15.5 million	14.2-16.9 million
Children living with HIV/AIDS in 2007	2.0 million	1.9-2.3 million
People newly infected with HIV in 2007	2.7 million	2.2-3.2 million
Children newly infected with HIV in 2007	0.37 million	0.33-0.41 million
AIDS deaths in 2007	2.0 million	1.8-2.3 million
Child AIDS deaths in 2007	0.27 million	0.25-0.29 million

More than 25 million people have died of AIDS since 1981.

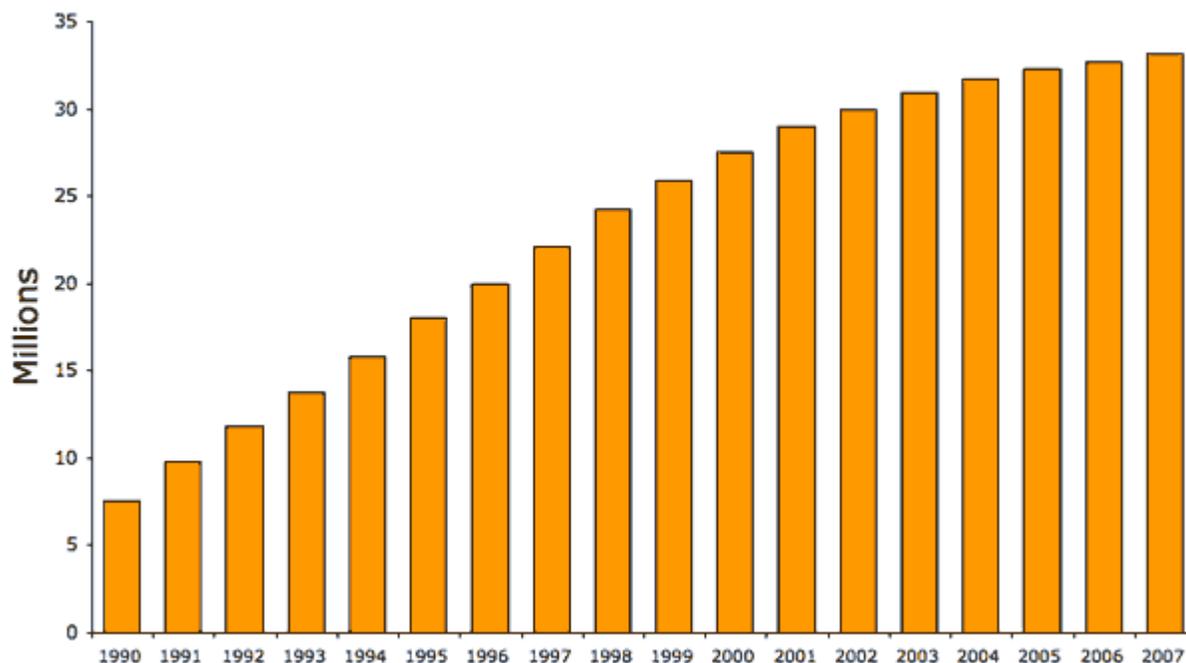
Africa has 11.6 million AIDS orphans.

At the end of 2007, women accounted for 50% of all adults living with HIV worldwide, and for 59% in sub-Saharan Africa.

Young people (under 25 years old) account for half of all new HIV infections worldwide.

In developing and transitional countries, 9.7 million people are in immediate need of life-saving AIDS drugs; of these, only 2.99 million (31%) are receiving the drugs.

Global trends



The number of people living with HIV has risen from around 8 million in 1990 to 33 million today, and is still growing. Around 67% of people living with HIV are in sub-Saharan Africa.

Regional statistics for HIV & AIDS, end of 2007

Region	Adults & children living with HIV/AIDS	Adults & children newly infected	Adult prevalence*	Deaths of adults & children
Sub-Saharan Africa	22.0 million	1.9 million	5.0%	1.5 million
North Africa & Middle East	380,000	40,000	0.3%	27,000
Asia	5 million	380,000	0.3%	380,000
Oceania	74,000	13,000	0.4%	1,000
Latin America	1.7 million	140,000	0.5%	63,000
Caribbean	230,000	20,000	1.1%	14,000
Eastern Europe & Central Asia	1.5 million	110,000	0.8%	58,000
North America, Western & Central Europe	2.0 million	81,000	0.4%	31,000
Global Total	33.0 million	2.7 million	0.8%	2.0 million

* Proportion of adults aged 15-49 who were living with HIV/AIDS

During 2007 more than two and a half million adults and children became infected with HIV (Human Immunodeficiency Virus), the virus that causes AIDS. By the end of the year, an estimated 33 million people worldwide were living with HIV/AIDS. The year also saw two million deaths from AIDS, despite recent improvements in access to antiretroviral treatment.

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.

AVERT.org has more about:

- [Understanding HIV and AIDS statistics](#)
- [UK statistics summary](#)
- [USA statistics summary](#)
- [Worldwide statistics commentary](#)

Sources:

- [UNAIDS 2008 Report of the global AIDS epidemic](#)

Last updated August 01, 2008

The HIV/AIDS Epidemic in the United States

March 2008

The first cases of what would later become known as AIDS were reported in the United States in June of 1981.¹ Since that time, more than 1.7 million people in the U.S. are estimated to have been infected with HIV, including more than 565,000 who have already died and approximately 1.2 million living with HIV/AIDS today.^{2,3,4} The response to the U.S. epidemic has yielded numerous successes, but challenges remain:

- New HIV infections each year are down from a peak of more than 150,000 in the 1980s, to approximately 40,000 per year today, but have remained at that level for more than a decade.^{5,6} In addition, the Centers for Disease Control and Prevention (CDC) will be releasing updated national HIV incidence estimates later this year² which are expected to indicate that new infections are higher than previously thought.
- HIV testing is important for both prevention and treatment efforts and rapid testing is now much more widely available. Yet approximately 25% of those infected with HIV do not know it³ and many people are diagnosed late in HIV disease (in 2005, 38% of HIV diagnoses progressed to AIDS within a year²). The CDC now recommends routine HIV testing in health care settings for all people aged 13–64.⁷
- Advances in HIV/AIDS treatment have substantially reduced AIDS-related morbidity and mortality and extended the lives of many. New treatments, however, are not a cure and do not benefit or reach all people with HIV. A recent analysis found that only 55% of those who met clinical criteria for antiretroviral (ARV) therapy were receiving it in 2003.⁸
- The epidemic continues to have a disproportionate impact on certain populations, particularly racial and ethnic minorities.

progression to AIDS, all states have moved to confidential name-based HIV reporting, which will provide a fuller picture of the epidemic over time (note: a new HIV diagnosis is not necessarily a new HIV infection). Among the 38 states/areas that have conducted confidential name-based HIV infection reporting for a sufficient length of time to support analysis, there were an estimated 36,817 HIV cases in 2006.²

- As of the end of 2006, an estimated 565,927 deaths had occurred among people with AIDS, including 14,627 in 2006.² HIV-related mortality rates rose steadily through the 1980's, peaking in 1995.⁹ Since then, the age-adjusted HIV death rate has declined by more than 70%, including a 4% decline between 2003 and 2004.⁹ This is largely due to HAART but also to the decrease in annual new HIV infections in the 1990s compared to the prior decade. In 2004, HIV was the 6th leading cause of death for those aged 25–44, down from #1 in 1995.¹⁰
- HIV transmission patterns have shifted over time. Heterosexual transmission accounts for a growing share of new AIDS cases, rising from 3% in 1985 to 32% in 2006. Over that same period, the share of new AIDS diagnoses attributable to sex between men fell from 64% to 43%. The share due to injection drug use was 19% in 1985, peaking at 31% in 1993, and dropping to 18% in 2006.^{2,11}

Impact Across the Country

- AIDS cases have been reported in all 50 states, the District of Columbia, and the U.S. dependencies, possessions, and associated nations. Ten states/areas account for 71% of cumulative AIDS cases reported since the beginning of the epidemic (Figure 2). Nine of these states also rank in the top 10 by number of AIDS cases reported in 2006. The AIDS case rate per 100,000 provides a different measure of the epidemic's impact, since it reflects the concentration of AIDS cases after accounting for differences in population size across states.² The District of Columbia has the highest AIDS case rate in the nation. Six of the top 10 states by AIDS case rate are in the South.

Figure 1: Key Snapshot of the U.S. Epidemic Today^{2,3,4,5,6}

- Number of new HIV infections each year: **40,000**
- Number of people living with HIV/AIDS: **1.2 million**, including more than 440,000 with AIDS
- Number of AIDS deaths since beginning of epidemic: **565,927**, including 14,627 in 2006
- Percent of people infected with HIV who don't know it: **25%**

Overview and Key Trends

- Of the more than 1.2 million people living with HIV/AIDS, 34% are estimated to have AIDS (the most advanced stage of HIV disease), 42% to be HIV positive but not yet progressed to AIDS, and the remainder still undiagnosed.³
- The AIDS case surveillance system is one of the most complete in the U.S., providing data from all states/territories over most of the course of the epidemic. By the end of 2006, cumulative AIDS diagnoses were estimated to have reached 1,014,797, including 37,852 diagnosed in 2006.²
- AIDS cases declined significantly after the introduction of highly active antiretroviral therapy (HAART) in 1996, since HAART slows the progression of HIV to AIDS. In more recent years, these declines have ended and AIDS cases were stable between 2005 and 2006.²
- Because AIDS cases do not provide a current understanding of the epidemic, given the lag time between HIV infection and

Figure 2: Top Ten States by Cumulative Reported AIDS Cases and by AIDS Case Rate Per 100,000²

State	Cumulative AIDS Cases Through 2006 (%)	State	AIDS Case Rate 2006
New York	177,262 (17.9%)	District of Columbia	146.7
California	142,918 (14.4%)	Virgin Islands	29.5
Florida	105,614 (10.6%)	Maryland	29.0
Texas	70,127 (7.1%)	New York	28.5
New Jersey	49,528 (5.0%)	Florida	27.3
Illinois	33,902 (3.4%)	Puerto Rico	21.6
Pennsylvania	33,782 (3.4%)	Louisiana	19.2
Georgia	31,965 (3.2%)	Georgia	17.1
Maryland	30,571 (3.1%)	South Carolina	16.3
Puerto Rico	29,911 (3.0%)	Pennsylvania	15.2
Subtotal	705,580 (71.1%)	--	--
U.S. Total	992,865 (100%)	U.S. Case Rate	12.9

- AIDS cases have been concentrated primarily in large U.S. metropolitan areas (85% cumulatively, and 81% in 2006). The top ten metropolitan areas account for 52% of cumulative reported AIDS cases.² Over time, the share of cases occurring in smaller metro and rural areas has increased slightly.

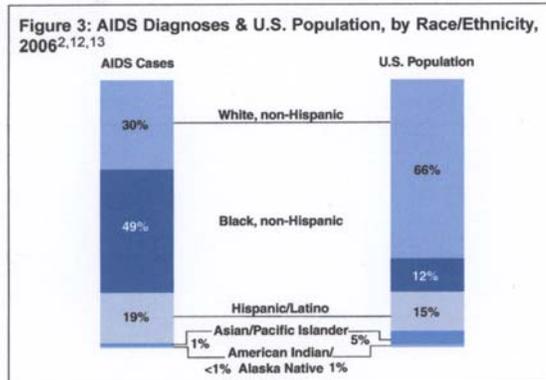
The Henry J. Kaiser Family Foundation: 2400 Sand Hill Road, Menlo Park, CA 94025 Phone: (650) 854-9400 Facsimile: (650) 854-4800 Website: www.kff.org

Washington, DC Office: 1330 G Street, NW, Washington, DC 20005 Phone: (202) 347-5270 Facsimile: (202) 347-5274

- By region, the Northeast had the highest AIDS case rate per 100,000 in 2006 (17.4), followed by the South (15.7), West (8.8), and Midwest (6.3).^{2,12} The South accounted for almost half (46%) of new AIDS cases in 2006, almost twice as many as the Northeast (26%), the next highest region. The South also has the greatest number of people estimated to be living with AIDS, followed by the Northeast, West, and Midwest.² Between 2002 and 2006, AIDS cases decreased by 10% in the West and 6% in the Northeast, and remained stable in the South and Midwest. Deaths decreased in all regions over this period.²

Impact on Racial and Ethnic Minorities¹³

- Racial and ethnic minorities have been disproportionately affected by HIV/AIDS since the beginning of the epidemic, and represented the majority of new AIDS cases (70%), people living with AIDS (64%), and AIDS deaths (72%) in 2006.²
- Blacks and Latinos account for a disproportionate share of new AIDS diagnoses, relative to their size in the U.S. population (Figure 3); they also account for a disproportionate share of new HIV/AIDS diagnoses in the states/areas with confidential HIV name-based reporting.²
- Based on the CDC's HIV/AIDS prevalence estimate,³ there are more than 500,000 Blacks living with HIV and AIDS in the U.S. Analysis of national household survey data found that more than 2% of Blacks in the U.S. were HIV positive, higher than any other group.¹⁴
- Blacks also have the highest AIDS case rates of any racial/ethnic group, followed by Latinos, American Indian/Alaska Natives, whites, and Asian/Pacific Islanders. The AIDS case rate per 100,000 for Blacks in 2006 was almost 9 times that of whites.²



- Blacks accounted for 56% of deaths due to HIV in 2004; Latinos accounted for 14%.¹⁵ Survival after an AIDS diagnosis is lower for Blacks than other racial/ethnic groups.²
- HIV was the 4th leading cause of death for Black men and 3rd for Black women, aged 25–44, in 2004, ranking higher than their respective counterparts in any other racial/ethnic group.¹⁰

Impact on Women and Young People

- Women represent a growing share of new AIDS cases, rising from 8% in 1985, to 20% in 1995, and reaching 27% in 2000, the same share as today.^{2,11} Based on the CDC's HIV/AIDS prevalence estimate³, approximately 300,000 women are living with HIV and AIDS in the U.S.
- Women of color are particularly affected. Black women account for two thirds (66%) of new AIDS cases among women in 2006; Latinas represent 16% and white women, 17%.^{2,13}
- Young adults and teens, under the age of 25, continue to be at risk. Most young people are infected through sex.¹⁶
- Among youth, teen girls and minorities have been particularly affected. In 2005, teen girls represented 43% of AIDS cases reported among 13–19 year olds. Black teens represented 69% of cases reported among 13–19 years olds; Latino teens represented 17%.¹⁶

- Perinatal HIV transmission has declined significantly in the U.S., largely due to antiretroviral treatment. Still, perinatal infections continue to occur each year, the majority of which are among Blacks.^{2,17}

Impact on Men Who Have Sex with Men

- Despite declines in HIV infection rates among men who have sex with men (MSM) since the early years of the epidemic, they continue to be at high risk for infection, accounting for an estimated 59% of AIDS cases among men in 2006, and cases among MSM have increased in recent years.² Studies indicate that risk behavior continues among MSM and that they are at significantly greater risk for HIV infection than other groups in the U.S.^{14,18}
- Younger MSM and MSM of color are at particularly high risk. CDC studies have found high HIV incidence and prevalence among MSM in some cities, particularly among Black and Latino MSM, and low levels of awareness of infection status among those with HIV.^{18,19}

The U.S. Government Response

- In FY 2008, U.S. federal funding for HIV/AIDS is estimated to total \$23.3 billion. Of this, 50% is for care, 12% for research, 10% for cash and housing assistance, 4% for prevention, and 25% for combating the international epidemic.²⁰
- Key programs that provide health insurance coverage, care, and support to people with HIV/AIDS in the U.S. include Medicaid, Medicare, the Ryan White Program, and HOPWA, the Housing Opportunities for Persons with HIV/AIDS Program. Social Security's income programs for those who are disabled (SSI and SSDI) are also important sources of support.
- A variety of federally and state-supported prevention services are provided by state and local health departments and community organizations. The CDC recently updated the nation's *HIV Prevention Strategic Plan*, which calls for reducing the number of new HIV infections in the United States by 5% per year, or at least by 10% through 2010, focusing particularly on eliminating racial and ethnic disparities in new HIV infections.²¹

References

- 1 CDC, *MMWR*, Vol. 30, 1981.
- 2 CDC, *HIV/AIDS Surveillance Report*, Vol. 18, 2008.
- 3 Glynn MK and Rhodes P. "Estimated HIV Prevalence in the United States at the end of 2003." Presentation, National HIV Prevention Conference, June 2005.
- 4 UNAIDS, Kaiser Family Foundation analysis of CDC data.
- 5 CDC, *Comprehensive HIV Prevention Essential Components of a Comprehensive Strategy to Prevent Domestic HIV*, 2006.
- 6 CDC, *HIV Prevention in the Third Decade*, 2005.
- 7 CDC, *MMWR*, Vol. 55, RR14, 2006.
- 8 Teshale EH et al., "Estimated Number of HIV-Infected Persons Eligible for and Receiving HIV Antiretroviral Therapy, 2003—United States," Abstract #167, *12th Conference on Retroviruses and Opportunistic Infections*; February 2005.
- 9 NCHS, *Health, United States*, 2007.
- 10 CDC, Slide Set: HIV Mortality (through 2004).
- 11 CDC data request; 2006.
- 12 U.S. Census Bureau, 2006 Population Estimates (Note: AIDS case rates by region calculated by KFF).
- 13 Calculations based only on cases for which race/ethnicity data were provided.
- 14 McQuillan GM et al., "Prevalence of HIV in the US Household Population: The National Health and Nutrition Examination Surveys, 1988 to 2002." *JAIDS*, Vol. 41, No. 5, April 2006. Note, among those aged 18–49.
- 15 NCHS, "Deaths: Final Data for 2004", *NVSR*, Vol. 55, No. 19; 2007
- 16 CDC, Slide Set: HIV/AIDS Surveillance in Adolescents and Young Adults (through 2005).
- 17 CDC, *MMWR*, Vol. 55, No. 21; 2006.
- 18 CDC, Fact Sheet: HIV/AIDS Among Men Who Have Sex with Men; June 2007.
- 19 CDC, *MMWR*, Vol. 54, No. 24; 2005.
- 20 Kaiser Family Foundation analysis of data from OMB and HHS, 2008.
- 21 CDC, *HIV Prevention Strategic Plan: Extended Through 2010 (Extended Plan)*; 2007.

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Maine Center for Disease Control and Prevention
Monthly STD/HIV Data Update
Cases diagnosed from January 1st to July 31st, 2008

This Monthly Update provides summary year-to-date (YTD) data about HIV and STD in Maine. For each disease, the YTD total is shown and compared with the average and median* YTD total for the past five years. Please note that totals presented here may change because of reporting delays or pending epidemiologic investigations.

For more information contact Robert Funa at (207) 287-5193 or robert.funa@maine.gov

HIV

HIV diagnoses, YTD 2008: 22
Median YTD totals, 2003 to 2007: 32

Gonorrhea

Median YTD totals, 2003 to 2007: 54
Gonorrhea diagnoses, YTD 2008: 78

Chlamydia

Chlamydia diagnoses, YTD 2008: 1,461
Median YTD totals, 2003 to 2007: 1,228

Syphilis

Syphilis diagnoses, YTD 2008: 15
Median YTD totals, 2003 to 2007: 6

* Median YTD totals represent typical annual YTD values
Maine CDC, 2008

HIV Risk Behaviors

Maine High School Youth Risk Behavior Survey Results, 2007

As the sixth leading cause of death for all 25-44 year olds living in Maine, AIDS is still a public health threat. Maine adolescents engage in behaviors that put them at risk for HIV and other sexually transmitted infections. The following data were collected from public high school students in Maine using the Youth Risk Behavior Survey (YRBS) and are representative of public high school students statewide.

Among all public high school students in Maine, 45% reported having had sexual intercourse at the time of the survey.

- The current rates of sexual intercourse for high school students have decreased significantly since 1995 (Figure A). Thus, the percentage of adolescents who reported sexual abstinence has increased.
- Female and male high school students were equally likely to have reported having had sexual intercourse (45% and 46%, respectively).
- The percentage of high school students reporting that they have had sexual intercourse increases by grade level, from 27% among 9th graders to 65% among 12th graders.

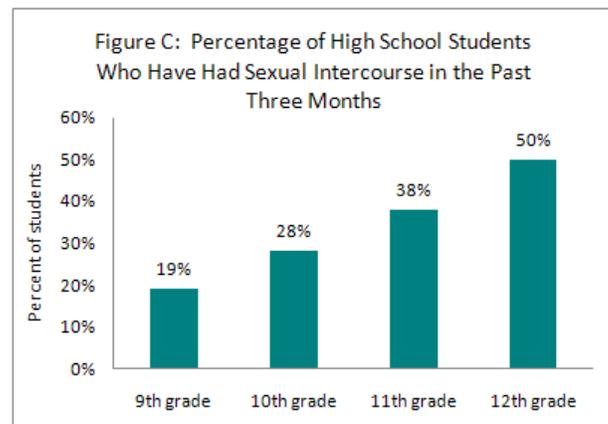
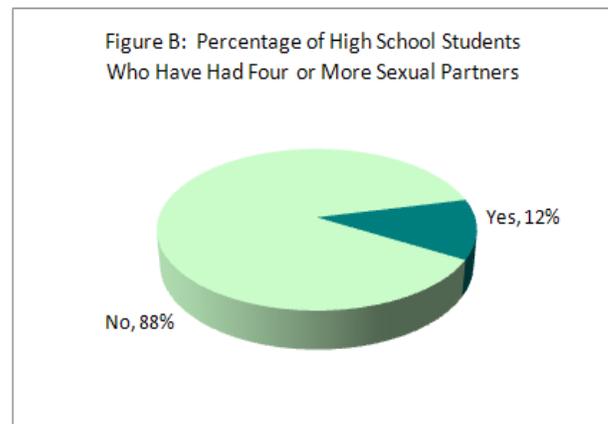
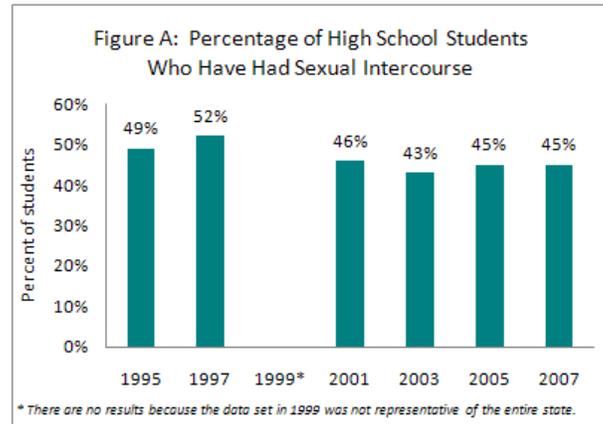
Five percent (5%) of high school students reported having had sexual intercourse before the age of 13.

Twelve percent (12%) of high school adolescents have had sexual intercourse with four or more partners (Figure B).

- Students in the 12th grade (23%) were significantly more likely than students in the 9th grade (6%) to report having sexual intercourse with four or more people.

One-third (33%) of Maine high school students reported having had sexual intercourse with one or more people in the past three months and are considered to be currently sexually active.

- Students in the 12th grade (50%) were significantly more likely than students in the 9th grade (19%) to be currently sexually active (Figure C).



Of students who had sexual intercourse in the last three months, 20% drank alcohol or used drugs before the last time they had sexual intercourse.

Fifty-nine percent (59%) of high school students who have had sexual intercourse in the past three months used a condom during last sexual intercourse.

- The percentage of currently sexually active high school students who used a condom during their last sexual intercourse has improved significantly since 1995 (Figure D).

Sexual contact with members of the same gender or with members of both genders is reported among 8% of female high school students and 5% of male high school students.

Three percent (3%) of high school students reported that they have used a needle to inject an illegal drug into their body.

Forty-two percent (42%) of Maine high school youth reported that they have talked to their parents about sex in the last 6 months (Figure E).

- Female high school students (49%) were significantly more likely than male high school students (35%) to have talked to their parents about sex in the last 6 months.

Eighty-seven percent (87%) of high school students reported that they have been taught about HIV infection in school.

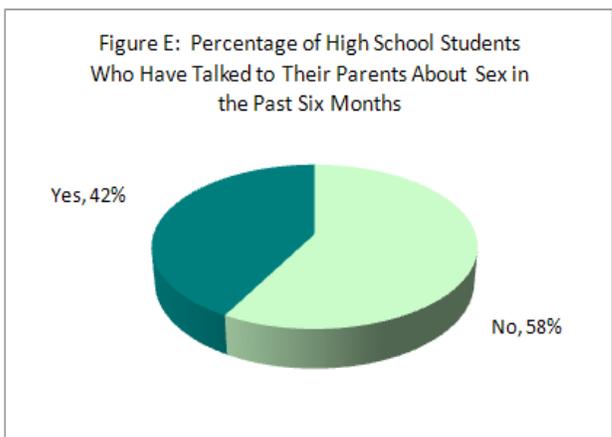
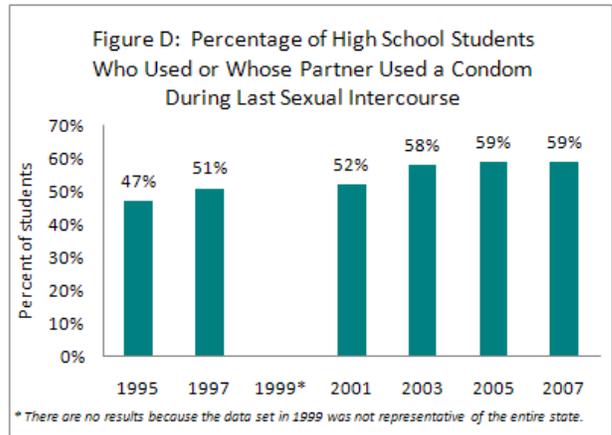
Although the following behaviors are not HIV risk behaviors, the results raise issues of violence which greatly undermines young people's ability to protect their sexual health:

Twelve percent (12%) of all students reported having been hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend in the last 12 months.

- Male and female high school students were equally likely to report having been hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend in the past year.

Eight percent (8%) of high school students reported having been physically forced to have sexual intercourse against their will.

- While female high school students (10%) were more likely than male high school students (6%) to report having been physically forced to have sexual intercourse against their will, this difference is not statistically significant.



HIV Risk Behaviors

Maine Middle School Youth Risk Behavior Survey Results, 2007

Maine adolescents continue to engage in behaviors that put them at risk for HIV and other sexually transmitted diseases. These behaviors are not limited to high school aged youth. In fact, middle school youth are participating in many behaviors that put them at risk for pregnancy, sexually transmitted infection, and HIV. The following data are results of the 2007 Youth Risk Behavior Survey (YRBS) and are representative of public middle school students statewide.

Overall, 12% of middle school students reported having had sexual intercourse. (Because of how the YRBS question is asked, one cannot assume that this indicates consensual sexual intercourse.)

- The percentage of students who have had sexual intercourse has declined over the past decade (Figure A). Thus, the percentage of middle school students who reported sexual abstinence increased in that time.
- Students in the 8th grade (17%) were significantly more likely than students in the 7th grade (7%) to have had sexual intercourse.
- Although the difference is not statistically significant, it is interesting to note that male middle school students (15%) were more likely to report having had sexual intercourse than female middle school students (9%).

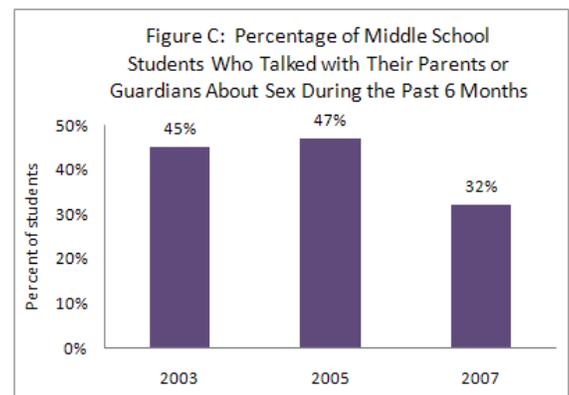
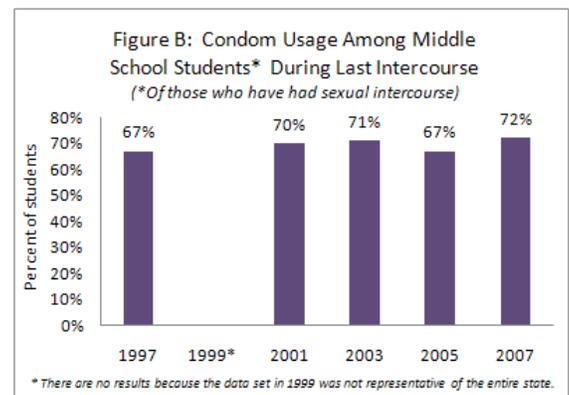
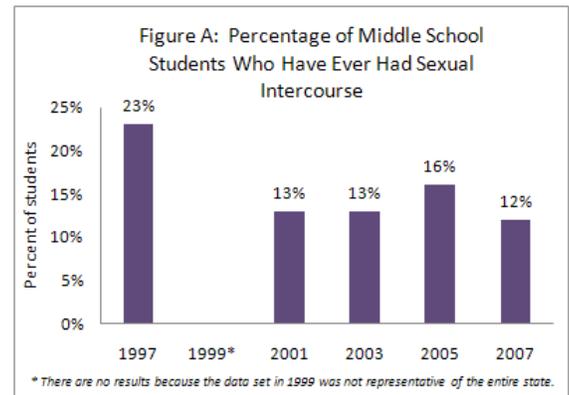
Three percent (3%) of middle school students reported having had sexual intercourse before age 11 and 4% of students indicated that they have had sexual intercourse with three or more people.

Seventy-two percent (72%) of middle school students who have had sexual intercourse reported using a condom during their last sexual intercourse experience.

- This behavior has not changed significantly over the past decade (Figure B).

Approximately one-third (32%) of middle school students have talked with their parent(s) and/or guardian(s) about sex in the past six months.

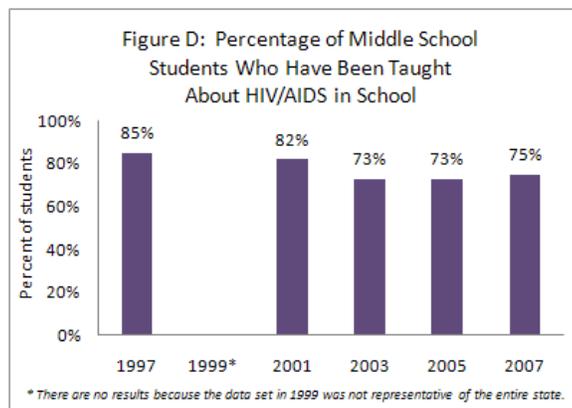
- This represents a significant decline in the past several years (Figure C).



Seventy-five percent (75%) of middle school students surveyed have been taught about AIDS or HIV infection in school.

- The percentage of students who reported that they have been taught about AIDS or HIV infection in school has decreased significantly over the past decade (Figure D).

Five percent (5%) of middle school students reported that they have used a needle to inject an illegal drug into their body.



Maine Homeless Youth HIV Risk Behaviors - 2006

The Maine Department of Education conducted a survey among homeless youth during the fall of 2005 and winter of 2006 to assess the level of behaviors which may contribute to the risk for HIV, sexually transmitted diseases, and other health problems. The survey was coordinated by New Beginnings, Inc. as part of a collaborative effort with shelters and outreach programs in several regions of the country that are funded through the federal Runaway and Homeless Youth Act. The findings are intended to supplement the biannual Youth Risk Behavior Survey which collects data from youth in Maine high schools.

Surveys were returned from 228 youth ages 12 to 22 from four agencies in Maine. The focus of the national effort was to reach homeless/street youth who were not in the “system”, that is, not in the custody of the Dept. of Human Services or the Dept. of Corrections. The following data provides a “snapshot” of the sexual and substance use behaviors of these youth. Since it was not a random sample, these results cannot be extended to the entire population of out-of-school youth with any promise of accuracy. However, the results were very consistent with earlier surveys conducted in Maine, as well as national studies of this population.

The youth in this survey were: 51% female, 48% male; 1% transgender; average age was 18.4; 87% were Caucasian; 72% identified as heterosexual. 35% had a high school diploma or GED; and 29% were pregnant or parents.

[Note: the average age of youth in this survey is most comparable to high school seniors/ first-year college]

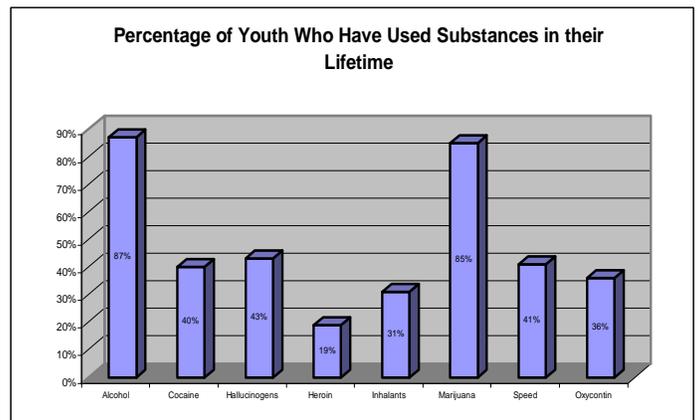
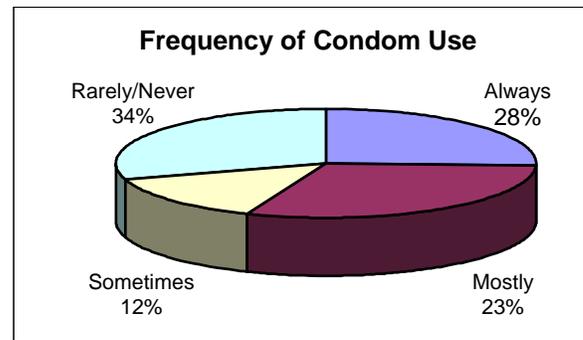
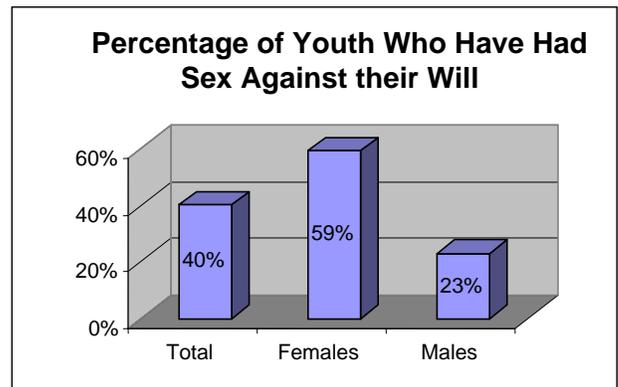
Sexual Behaviors: 89% of the youth had experienced penile-vaginal intercourse and 26% reported having had anal intercourse. The average age of first intercourse was 14. 17% reported having intercourse before the age of 13. 85% had engaged in oral sex.

40% of youth reported having been forced to have sex against their will at some point in their lives. The percentage for females (59%) was much higher than for males (23%).

77% of youth reported having four or more sexual partners in their lifetimes. 8% reported having more than 4 partners in the 3 months prior to the survey.

46% of sexually active youth reported using a condom the last time they had penile-vaginal intercourse. 60% of youth who had anal sex did not use a condom the last time. Five percent of sexually active youth reported same-sex behavior and 22% had sex with both genders.

Substance Use Behaviors: Over 90% of the youth reported using some type of drug during their lifetime, with alcohol being the most prevalent (87%). Marijuana was the most frequently used drug in the month prior to the survey (64%). 75% of youth used tobacco in the past month, with 28% smoking more than a pack per day. 11% of youth reported using intravenous needles during their lifetime. 37% reported using alcohol or drugs before the last time they had sex. 13% had traded sex for food, money, drugs or shelter.



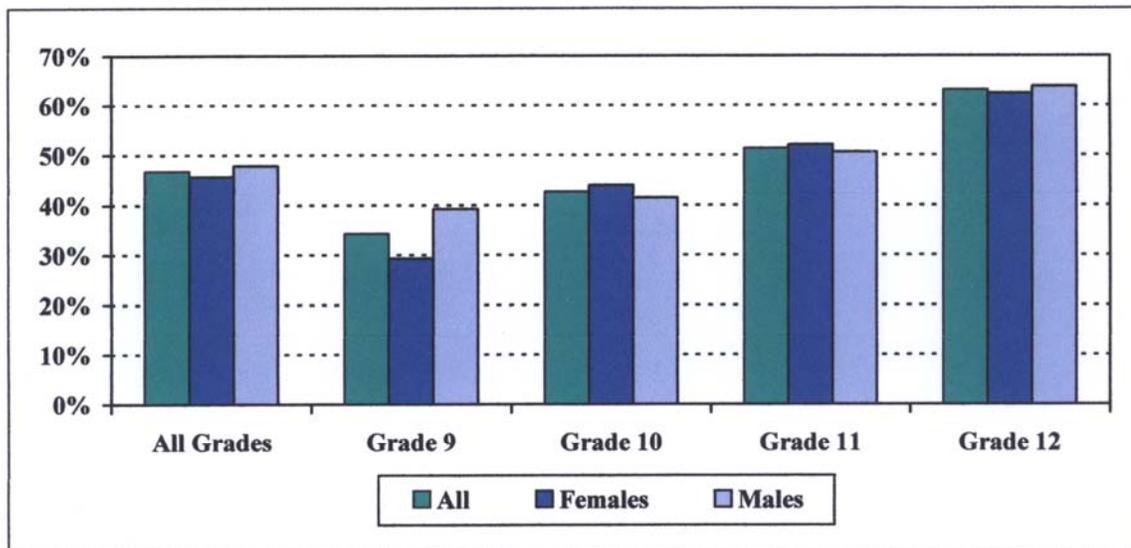


Teen Sexual Activity in the United States



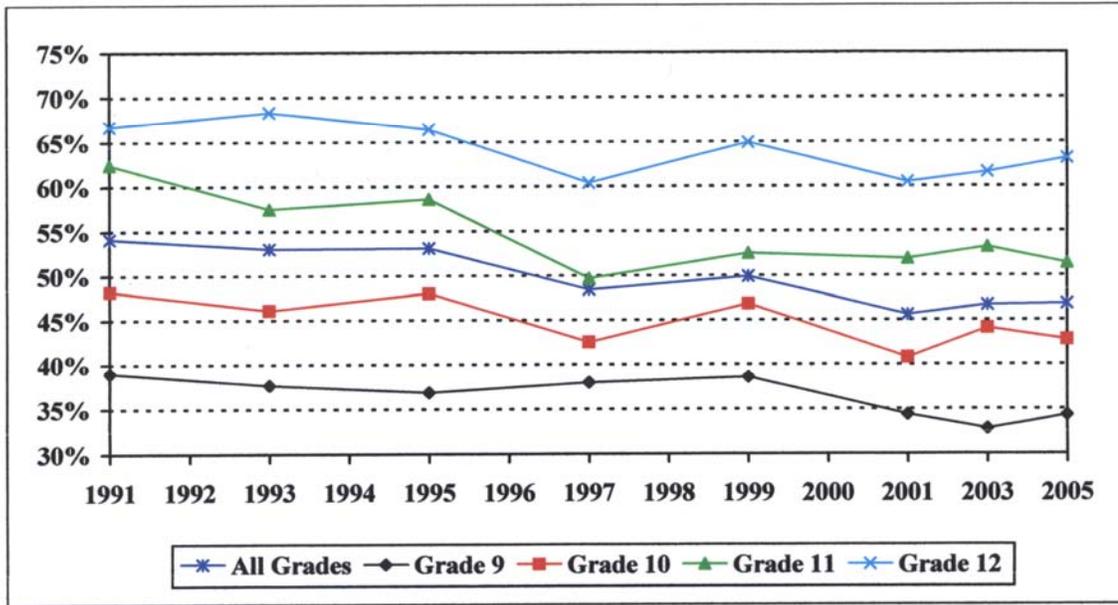
The Youth Risk Behavior Survey (YRBS) was developed by the Centers for Disease Control and Prevention in 1990 to monitor teen sexual behavior, tobacco and alcohol use, and other behaviors. The survey is conducted every two years and provides data on 9th through 12th grade students in public and private schools in the United States. The charts and tables below reflect the most recent data available (2005). Currently 46.8 percent of all high school students report they have had sexual intercourse. The percentage of high school students who have had sex decreased 13.3 percent between 1991 and 2005 (54 percent to 46.8 percent).

Proportion of High School Students Who Have Had Sex At Least Once, 2005 (Grades 9-12, YRBS)



	All Grades	Grade 9	Grade 10	Grade 11	Grade 12
All Teens	46.8%	34.3%	42.8%	51.4%	63.1%
Female Teens	45.7%	29.3%	44.0%	52.1%	62.4%
Male Teens	47.9%	39.3%	41.5%	50.6%	63.8%

Proportion of High School Students Who Have Had Sex At Least Once 1991 - 2005



	1991	1993	1995	1997	1999	2001	2003	2005
All Grades	54.1%	53.0%	53.1%	48.4%	49.9%	45.6%	46.7%	46.8%
Grade 9	39.0%	37.7%	36.9%	38.0%	38.6%	34.4%	32.8%	34.3%
Grade 10	48.2%	46.1%	48.0%	42.5%	46.8%	40.8%	44.1%	42.8%
Grade 11	62.4%	57.5%	58.6%	49.7%	52.5%	51.9%	53.2%	51.4%
Grade 12	66.7%	68.3%	66.4%	60.4%	64.9%	60.5%	61.6%	63.1%

Centers for Disease Control and Prevention. (June 2006). *Surveillance Summaries*. MMWR 2006:55(No.SS-5)



Young People and HIV

Young people in the United States continue to be at risk for HIV and AIDS. At the end of 2006, in 45 states with reporting, almost 46,000 young people ages 13-24 were living with HIV, comprising about sixteen percent of all HIV infections.[1] But experts believe young people may suffer from up to 30 percent of all cases of HIV in the United States.[2] Youth of color and young men who have sex with men continue to be most at risk. It is important to promote programs that seek to lessen risky sexual behaviors by encouraging condom use, delay in sexual initiation, partner reduction, and early HIV testing and treatment. But research has shown that even when risk factors are equal, minority youth are more at risk for HIV. Research and resources must be directed toward addressing the underlying social forces that contribute to these disparities.

HIV among Young People 13-24 in the United States: Racial and Sexual Minority Youth Are at Greatly Disproportionate Risk

- From 2001-2004, 62 percent of HIV/AIDS diagnoses in young people aged 13-24 were in males, and 32 percent were in females.[3]
- In 2005, blacks and Latinos accounted for 84 percent of all new HIV infections among 13- to 19-year-olds and 76 percent of HIV infections among 20- to 24-year-olds in the United States even though, together, they represent only about 32 percent of people these ages. Asian and Pacific Islanders (APIs) and American Indians and Alaska Natives account for about one percent of new HIV infections among women ages 13-24.
- Young women of color suffer disproportionate rates - in 2004, black women and Latinas accounted for 83 percent of new infections in 13- to 24-year-old women in the United States, even though, together, they represent only about 26 percent of U.S. women these ages. In addition, black women account for 62 percent and Latinas for 19 percent of cumulative AIDS cases among women ages 13-24.[4]
- Most young men who have HIV acquired it through male-to-male sexual contact, and the risk is increasing for young men who have sex with men. Between 2001 and 2005, HIV/AIDS cases among young men ages 13-24 who have sex with men increased across all ethnic groups, with young African American/Black men worst affected.[5]

- Sixty-four percent of the HIV/AIDS cases in young men ages 13-24 through 2005 were transmitted through male-to-male contact.[5]
- Fifty-seven percent of HIV/AIDS infections among young men who have sex with men were in African Americans/Blacks; 18 percent in Hispanics; and 23 percent in whites.[5]
- From 2001-2005, cases of HIV/AIDS among young black men who have sex with men increased by 74 percent.[5]

Sexual Risk Behaviors Put Many Young People In Danger

- From 2001 to 2005, the percentage of high school students reporting that they had ever had sexual intercourse increased among black (61 percent to 68 percent) and Latino/Hispanic students (48 percent to 51 percent). There was no significant increase for white students.[6]
- In 2005, the percentage of high school students reporting that they had sexual intercourse with four or more people during their life was highest among black students (28 percent). Sixteen percent of Latino students reported having 4 or more partners, and 11 percent of white students.[6]
- Among sexually active high school students in 2005, 63 percent reported using a condom at most recent sex. Male students were significantly more likely to report condom use than female students (70 percent versus 56 percent, respectively). Black students (69 percent) were significantly more likely than white or Latino/Hispanic students (63 and 58 percent, respectively) to report condom use. This significant racial/ethnic difference held for both male and female students.[6]
- Research has shown that many young people are not concerned about becoming infected with HIV.[7] In addition, young people experience many barriers to HIV testing and are more likely than other population groups to not get tested for HIV.[8]
- In addition, many people are unaware of their HIV status. Nationwide, only 12 percent of students have been tested for HIV.[6] A study in 6 major cities found that among 15- to 22-year-old MSM in the United States, about three quarters of those testing positive for HIV were unaware they had the virus, and black MSM had nearly 7 times greater odds of having unrecognized HIV infection as white men.[9]
- Concurrent partnerships (multiple simultaneous sexual relationships or sexual relationships that overlap in time) put many young people at greater risk for HIV infection.[10]

Factors Which Contribute to Unequal Risk for HIV/AIDS

- Increasingly, scientists recognize sexual networks, or connections between people living in the same community, as a driving force behind the HIV epidemic, especially for African Americans. Young people living in communities with high HIV prevalence are more at risk for HIV even if risk behaviors are the same as young people living in a community with lower HIV prevalence.[11,12]
- Dating violence and sexual assault play a role in HIV transmission. Twenty percent of youth report experiencing dating violence. Women who experience dating violence are less likely to use condoms and feel more uncomfortable negotiating condom use. In one study, half of girls who reported HIV or STIs had been physically or sexually abused.[13,14,15]

- A recent study among black women in the South, a region with unusually high rates of HIV, concluded that socioeconomic factors, including financial dependence on male partners, feeling invincible, and low self-esteem, place young black women at risk for HIV/AIDS.[16]
- Having an STI (sexually transmitted infection) puts youth more at risk for HIV.[17] Almost half of the U.S.'s over 19 million STI infections each year occur in youth ages 15-24.[18] A recent study found that one in four young women ages 15-19 has an STI.[19]

Effective Strategies for HIV Prevention Among Young People

No single strategy will work to reduce HIV/AIDS infection among young people. However, research has shown that culturally competent, honest programs, that include information about abstinence, contraception, and condoms, can be effective in helping youth reduce risk behaviors.[20,21] In addition, open and honest parent-child communication about HIV and its prevention can aid youth in making good decisions.[22,23] Finally, resources must be directed at understanding the epidemic's impact on youth; at remedying the socioeconomic disparities which contribute to the epidemic; and at developing and testing a vaccine.

References

1. HIV/AIDS Surveillance: General Epidemiology (Through 2006). Centers for Disease Control and Prevention, 2008. Accessed from <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/general/slides/general.pdf> on 4/1/08.
2. Morris, M., Handcock, M.S., Miller W.C., Ford, C.A. Schmitz, J.L., Hobbs, M.M., Cohen, M.S., Harris K.M., Udry J.R. Prevalence of HIV Infection Among Young Adults in the United States: Results from the Add Health Study. *American Journal of Public Health*. 2006 June; 96(6): 1091-1097.
3. HIV/AIDS Surveillance in Adolescents and Young Adults (Through 2005). Centers For Disease Control and Prevention, 2008. Accessed from <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/adolescents/slides/Adolescents.pdf> on 4/1/08.
4. Cases of HIV Infection and AIDS in the United States, by Race/Ethnicity, 2000-2004. *HIV/AIDS Surveillance Supplemental Report, 2006*: 12(1). Accessed from http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2006supp_vol12no1/table2.htm on 4/1/08.
5. HIV/AIDS Surveillance in Men who have Sex with Men. Centers for Disease Control and Prevention, 2008. Accessed from <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/msm/slides/msm.pdf> on 4/1/2008.
6. Eaton DK *et al.* Youth risk behavior surveillance, United States, 2005. *Morbidity & Mortality Weekly Report 2006*;55(SS-5):1-108.
7. Kaiser Family Foundation. National Survey of Teens on HIV/AIDS, 2000.
8. Henry-Reid, L.M., Rodriguez F, Bell, M.A. *et al.* Youth counseled for HIV testing in school-and hospital-based clinics. *JAMA 1998*; 90:287-92

9. MacKellar, D. *et al*, Unrecognized HIV infection, risk behaviors, and perception of risk among young men who have sex with men: opportunities for advancing HIV prevention in the third decade of HIV/AIDS. *Journal of AIDS*, Vol.38, No.5, 2005.
10. Gorbach, P.M., Drumright L.N., Holmes K.K., Discord, discordance, and concurrency: comparing individual and partnership-level analyses of new partnerships of young adults at risk of sexually transmitted infections. *Sexual Transmitted Diseases*. 2005 January; 32(1):7-12.
11. Millett *et al*. Explaining disparities in HIV infection among black and white men who have sex with men: a meta-analysis of HIV risk behaviors. *AIDS 21* (15) 2083-2091.
12. Adimora *et al*. HIV and African Americans in the Southern United States: Sexual Networks and Social Context. *Sexually Transmitted Diseases 2006*: 33 (7 suppl): S39-45.
13. Roberts TA, Klein J. Intimate Partner Abuse and High-Risk Behavior in Adolescents. *Archives of Pediatrics & Adolescent Medicine 2003*; 157:375-380.
14. Silverman JG, Raj A, Clements K. Dating Violence and Associated Sexual Risk and Pregnancy Among Adolescent Girls in the United States. *Pediatrics 2004*;114(2):e220-e225.
15. Decker *et al*. Dating Violence and Sexually Transmitted Disease/HIV Testing and Diagnosis Among Adolescent Females. *Pediatrics 2005*; 116 (2): e272-276
16. CDC. HIV Transmission among Black Women – North Carolina, 2004. *MMWR 2005*; 54(4); 89-92.
17. The Role of STD Detection and Treatment in HIV Prevention – CDC Fact Sheet, *Centers for Disease Control and Prevention*. Accessed from <http://www.cdc.gov/std/HIV/STDFact-STD&HIV.htm> on 4/1/08.
18. Centers for Disease Control and Prevention. *Trends in Reportable Sexually Transmitted Diseases in the United States, 2006*. Accessed from <http://www.cdc.gov/std/stats/trends2006.htm> on 4/1/08.
19. Centers for Disease Control and Prevention. Oral Abstract D4a – Prevalence of Sexually Transmitted Infections and Bacterial Vaginosis among Female Adolescents in the United States: Data from the National Health and Nutritional Examination Survey (NHANES) 2003-2004. 2008 National STD Prevention Conference. Accessed from <http://www.cdc.gov/stdconference/2008/media/summaries-11march2008.htm#tues1> on 4/1/08.
20. Kirby D. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Infections*. Washington, DC: National Campaign to Prevent Teen Pregnancy, 2007.
21. Alford S. *Science and Success, Second Edition: Sex Education and Other Programs that Work to Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections*. Washington, DC: Advocates for Youth, 2008.
22. Resnick MD *et al*. Protecting adolescents from harm: findings from the national longitudinal study on adolescent health. *JAMA 1997*; 278:823-32.
23. Miller KS *et al*. Patterns of condom use among adolescents: the impact of mother-adolescent communication. *Am J Public Health 1998*; 88:1542-44.

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CDC Fact Sheet

The Role of STD Prevention and Treatment in HIV Prevention

Testing and treatment of sexually transmitted diseases (STDs) can be an effective tool in preventing the spread of HIV, the virus that causes AIDS. An understanding of the relationship between STDs and HIV infection can help in the development of effective HIV prevention programs for persons with high-risk sexual behaviors.

■ **What is the link between STDs and HIV Infection?**

Individuals who are infected with STDs are at least two to five times more likely than uninfected individuals to acquire HIV infection if they are exposed to the virus through sexual contact. In addition, if an HIV-infected individual is also infected with another STD, that person is more likely to transmit HIV through sexual contact than other HIV-infected persons (Wasserheit, 1992).

There is substantial biological evidence demonstrating that the presence of other STDs increases the likelihood of both transmitting and acquiring HIV.

Increased susceptibility. STDs appear to increase susceptibility to HIV infection by two mechanisms. Genital ulcers (e.g., syphilis, herpes, or chancroid) result in breaks in the genital tract lining or skin. These breaks create a portal of entry for HIV. Additionally, inflammation resulting from genital ulcers or non-ulcerative STDs (e.g., chlamydia, gonorrhea, and trichomoniasis) increase the concentration of cells in genital secretions that can serve as targets for HIV (e.g., CD4+ cells).

Increased infectiousness. STDs also appear to increase the risk of an HIV-infected person transmitting the virus to his or her sex partners. Studies have shown that HIV-infected individuals who are also infected with other STDs are particularly likely to shed HIV in their genital secretions. For example, men who are infected with both gonorrhea and HIV are more than twice as likely to have HIV in their genital secretions than are those who are infected only with HIV. Moreover, the median concentration of HIV in semen is as much as 10 times higher in men who are infected with both gonorrhea and HIV than in men infected only with HIV. The higher the concentration of HIV in semen or genital fluids, the more likely it is that HIV will be transmitted to a sex partner.

■ **How can STD treatment slow the spread of HIV infection?**

Evidence from intervention studies indicates that detecting and treating STDs may reduce HIV transmission.

STD treatment reduces an individual's ability to transmit HIV. Studies have shown that treating STDs in HIV-infected individuals decreases both the amount of HIV in genital secretions and how frequently HIV is found in those secretions (Fleming, Wasserheit, 1999).

Herpes can make people more susceptible to HIV infection, and it can make HIV-infected individuals more infectious. It is critical that all individuals, especially those with herpes, know whether they are infected with HIV and, if uninfected with HIV, take measures to protect themselves from infection with HIV.

Among individuals with both herpes and HIV, trials are underway studying if treatment of the genital herpes helps prevent HIV transmission to partners.

■ **What are the implications for HIV prevention?**

Strong STD prevention, testing, and treatment can play a vital role in comprehensive programs to prevent sexual transmission of HIV. Furthermore, STD trends can offer important insights into where the HIV epidemic may grow, making STD surveillance data helpful in forecasting where HIV rates are likely to increase. Better linkages are needed between HIV and STD prevention efforts nationwide in order to control both epidemics.

In the context of persistently high prevalence of STDs in many parts of the United States and with emerging evidence that the U.S. HIV epidemic increasingly is affecting populations with the highest rates of curable STDs, the CDC/HRSA Advisory Committee on HIV/AIDS and STD Prevention (CHAC) recommended the following:

Early detection and treatment of curable STDs should become a major, explicit component of comprehensive HIV prevention programs at national, state, and local levels;

In areas where STDs that facilitate HIV transmission are prevalent, screening and treatment programs should be expanded;

HIV testing should always be recommended for individuals who are diagnosed with or suspected to have an STD.

HIV and STD prevention programs in the United States, together with private and public sector partners, should take joint responsibility for implementing these strategies.

CHAC also notes that early detection and treatment of STDs should be only one component of a comprehensive HIV prevention program, which also must include a range of social, behavioral, and biomedical interventions.

REFERENCES:

Centers for Disease Control and Prevention. 1998. HIV prevention through early detection and treatment of other sexually transmitted diseases - United States. MMWR 47(RR-12):1-24.

Fleming DT, Wasserheit JN. 1999. From epidemiological synergy to public health policy and practice: The contribution of other sexually transmitted diseases to sexual transmission of HIV infection. Sexually Transmitted Infections 75:3-17.

Wasserheit JN. 1992. Epidemiologic synergy: Interrelationships between human immunodeficiency virus infection and other sexually transmitted diseases. Sexually Transmitted Diseases 9:61-77.

■ **FOR MORE INFORMATION:**

Centers for Disease Control and Prevention

Division of STD Prevention (DSTDP)

<http://www.cdc.gov/std/> Division of HIV/AIDS Prevention

<http://www.cdc.gov/hiv/>

CDC-INFO Contact Center

1-800-CDC-INFO (1-800-232-4636)Email: cdcinfo@cdc.gov

American Social Health Association (ASHA)

1-800-783-9877www.ashastd.org CS115145 **CONTENT UPDATED: DECEMBER, 2007**

HIV TESTING

By AVERT, AVERTing HIV and AIDS

There are three main types of HIV test.

The first type of test is the **HIV antibody test**. This test shows whether a person has been infected with HIV, the virus that causes AIDS. Information on this page concentrates mainly on HIV antibody testing. Antibody tests are also known as ELISA (Enzyme-Linked Immunosorbent Assay) tests.

The second type of test is an **antigen test**. Antigens are the substances found on a foreign body or germ that trigger the production of antibodies in the body. The antigen on HIV that most commonly provokes an antibody response is the protein P24. Early in the infection, P24 is produced in excess and can be detected in the blood serum by a commercial test (although as HIV becomes fully established in the body it will fade to undetectable levels). P24 antigen tests are sometimes used to screen donated blood, but they can also be used for testing for HIV in individuals, as they can detect HIV earlier than standard antibody tests. Some of the most modern HIV tests combine P24 and other antigen tests with standard antibody identification methods to enable earlier and more accurate HIV detection.

Blood supplies in most developed countries are screened for HIV using an RNA PCR test, which can produce positive results several days before a DNA test.

The third type of test is a **PCR test** (Polymerase Chain Reaction test). The whole process of extracting genetic material and testing it with a PCR test is referred to as Nucleic Acid-amplification Testing or 'NAT'. PCR tests detect the genetic material of HIV itself, and can identify HIV in the blood within two or three weeks of infection.

PCR tests come in two forms: DNA PCR and RNA PCR. Babies born to HIV positive mothers are usually tested using a DNA PCR because they retain their mother's antibodies for several months, making an antibody test inaccurate. Blood supplies in most developed countries are screened for HIV using an RNA PCR test, which can produce positive results several days before a DNA test. When a person already knows that she or he is infected with HIV, they may also have a viral load test to detect HIV genetic material and estimate the level of virus in the blood. This can be performed using either an RNA or DNA PCR test. PCR tests are not often used to test for HIV in adults, as they are very expensive and more complicated to administer than a standard antibody or P24 test. However they may be offered in special circumstances, or by private clinics where patients are willing to pay.

HIV testing

The standard HIV test looks for antibodies in a person's blood. When HIV (which is a virus) enters a person's body, special proteins are produced. These are called antibodies. Antibodies are the body's response to an infection. So if a person has antibodies to HIV in their blood, it means they have been infected with HIV. There are only two exceptions to this rule. Firstly, babies born to positive mothers retain their mother's antibodies for up to 18 months, which means they may

test positive on an HIV antibody test, even if they are actually HIV negative. This is why babies born to positive mothers may receive a PCR test after birth. Secondly, some people who have taken part in HIV vaccine trials may have HIV antibodies even if they are not infected with the virus.

Some test centres may recommend testing again at 6 months if you're deemed to be at particularly high risk of infection.

Most people develop detectable HIV antibodies within 6 to 12 weeks of infection. In very rare cases, it can take up to 6 months. It is exceedingly unlikely that someone would take longer than 6 months to develop antibodies.

Getting tested earlier than 3 months may result in an unclear test result, as an infected person may not yet have developed antibodies to HIV. The time between infection and the development of antibodies is called the window period. During the window period people infected with HIV will not yet have antibodies in their blood that can be detected by an HIV test. However, the person may already have high levels of HIV in their blood, sexual fluids or breast milk. Someone can transmit HIV to another person during the window period even though they do not test positive on an antibody test. So it is best to wait for at least 3 months after the last time you were at risk before taking the test, and abstain from unprotected sex or drug use with shared needles in the meantime. Some test centres may recommend testing again at 6 months if you're deemed to be at particularly high risk of infection.

It is also important that you are not exposed to further risk of getting infected with HIV during the window period. The test is only accurate if there are no other exposures between the time of possible exposure to HIV and testing.

A negative test at three months will almost always mean a person is not infected with HIV. If an individual's test is still negative at six months and they have not had unprotected sex or shared needles again in the meantime, it means that they do not have HIV, and will not therefore go on to develop AIDS.

The only way to know for sure whether you are infected with HIV is to have an HIV antibody test. It is not possible to tell from any symptoms.

What are the reasons to have an HIV test?

Many people who have an HIV test have been worrying unnecessarily. Getting a negative result (which means you are not infected with HIV) can put your mind at rest. If your test result is positive, many things can be done to help you to cope with the HIV positive result and look after your health. If your test is positive, then:

- A doctor can keep an eye on your health. Many people who test positive stay healthy for several years. But if you fall ill, there are many drugs called antiretrovirals that can help to slow down the virus and maintain your immune system. You can also have medicines to prevent and treat some of the illnesses that people with HIV get. You may also have access to trials of new drugs and treatments.

- If you do fall ill, the doctor is going to take your symptoms more seriously if they know that you are HIV positive.
- If you know that you are HIV positive, you can take steps to protect other people. For example, by practising safe sex and informing you past sexual partners.
- Knowing that you have HIV may affect some of your future decisions and plans, for example starting a family.

Read more about learning that you are positive.

What does the HIV test involve?

In most countries, there are many places that you can get tested for HIV. It is recommended that you get the HIV test done at a health clinic, at the doctor's surgery, or at a specialist HIV/AIDS voluntary counselling and testing (VCT) site. When you attend to get tested, you will see a doctor, trained counsellor, a nurse or some other health professional in private. He or she will explain what the test involves and what the result means.

Normally a small sample of blood will be taken from your arm, sent to a laboratory and tested. In the USA and a number of places in Africa, the Middle East and Russia, oral tests are also available which do not require the use of needles. The test is always strictly confidential and only goes ahead if you agree. Your personal doctor will not be told about the test without your permission. Depending on the test used, it can take anything from a few days to a week or longer to get the result back.

A rapid HIV test is also an antibody test. The advantage of a rapid test is that you do not have to return to get your test result. The test results from a rapid test are usually available in approximately 30 minutes. Rapid tests are single-use, and do not require laboratory facilities or highly trained staff. This makes rapid tests very suitable for VCT in resource-poor countries.

How accurate are HIV tests?

Standard HIV antibody (ELISA) tests are at least 99.5% accurate when it comes to detecting the presence of HIV antibodies. This high level of *sensitivity* however means that their *specificity* (ability to distinguish HIV antibodies from other antibodies) is slightly lowered. Once an individual is out of the window period, it is more likely that they will receive a false positive result than a false negative.

Any HIV positive result given by an ELISA test must therefore be confirmed using a second test. Secondary tests include:

- Western Blot Assays – One of the oldest but most accurate confirmatory antibody tests. It is complex to administer and may produce indeterminate results if a person has a transitory infection with another virus.
- Indirect Immunofluorescence Assay – Like the Western blot, but uses a microscope to detect HIV antibodies.

- Line Immunoassay - Commonly used in Europe. Reduces chance of sample contamination and is as accurate as the Western Blot.
- A second ELISA – In resource-poor settings with relatively high prevalence, a second ELISA test may be used to confirm a diagnosis. The second test will usually be a different commercial brand and will use a different method of detection to the first.

When two tests are combined, the chance of getting an inaccurate result is less than 0.1%.

What is HIV home sampling?

It is generally recommended that the HIV test is done in a health care setting. However, in some countries 'home sampling' kits are available. With a home sampling kit, a person can take a sample (usually a blood sample) and then send it to a laboratory for testing. A few days later, the person phones up a special number, gives their individual identification code, and is given the result over the phone. If the result is positive then a professional counsellor will provide emotional support and referrals.

For home sampling, the major advantages are convenience, speed, privacy and anonymity. In countries where HIV tests are not free, home sampling may be a cost-effective way to get tested. But for some people the lack of face-to face counselling before and after the test may be a disadvantage. There is one company in the USA that offers an FDA-approved home sampling kit for HIV.

There is also a company in the UK that offers home sampling services using oral fluid instead of blood. However, this company only conducts a preliminary screening test instead of the full diagnostic procedure, so clients with reactive test results must visit a clinic for further testing. This service is only suitable for people at low risk of being infected.

What about home testing?

Using an HIV test kit at home means that the results are learned on the spot without any counselling. Reactive test results must be confirmed by further testing at a clinic. If purchased over the internet, there is no guarantee that the test kit is genuine or will provide accurate results. In the event of an incorrect result, there may be no legal recourse.

In many countries it is illegal to sell HIV test kits to the public. There is currently some debate about allowing them to be sold in the USA and the UK. AVERT opposes the legalisation of the sale of home testing kits in the UK because of the lack of post-test counselling.

Comparison of HIV home screening, sampling and testing services

	Home screening (UK)	Home sampling (USA)	Home testing
Method	Sampling device purchased; oral sample taken at home and sent to lab for testing	Sampling device purchased; blood sample taken at home and sent to lab for testing	Kit purchased for taking a sample and testing it at home
Notification	Reactive results given by phone; negative results given by email	All results given by phone	Results produced at home
Availability	Legal in the UK; available online for £25	Legal in the USA; sold in shops, online, by phone and mail order for \$44 (\$60 for rapid service)	Illegal in UK; not approved for sale in USA
Potential for mistakes	Oral sample may be taken incorrectly, possibly leading to a false negative result	Low potential for mistakes as blood sample is clearly visible on card	Test may be performed or interpreted incorrectly, possibly leading to a false result
Reliability	Negative results are definitive; reactive results are preliminary and must be confirmed by further tests at a clinic	All results are definitive; as reliable as conventional testing	Negative results are definitive; reactive results are preliminary and must be confirmed by further tests at a clinic
Pre-test counselling	Optional at extra cost, by phone	Optional, by phone	Unlikely to be provided
Post-test counselling	Always provided for reactive results, by phone	Always provided for positive results, by phone	Optional, by phone

HIV testing - a personal view

This page has so far contained some factual information about HIV and different types of tests. But testing is also about the lives people lead, and the personal views they hold, as Jenny explains below.

"Hi, I am a 30 year old heterosexual woman and I currently have no children. I am not an intravenous drug user or a haemophiliac. However, I have had unprotected sex with a number of heterosexual men. I know this behaviour can produce deadly results and I have had 2 negative HIV tests in the past 10 years with the last one being in 1996. Since my last HIV test I have had unprotected sex 5 times.

I hadn't recently given the subject much thought until I received notice that a local family had contracted HIV. I started thinking about my behaviour and how I have been gambling with my life and also putting the lives of others at risk, since I did not know my current status. I have been blessed with two prior negative HIV results. For the past two weeks I have been reading articles on HIV/AIDS, reading the stories of women who have contracted the virus and are courageously battling the disease, and also reading the signs and symptoms. I have prayed for guidance and for

a repeated chance to begin a new pattern in my life if only my test would come back negative just one more time.

This morning I went for another HIV test and, thank god, it came back negative. I urge everyone black, white, gay, and straight to be tested. I also want to thank the women, men and children who have contributed their stories to this site. I must have read your words a thousand times over. You have made a difference in my life." *Signed Jenny in America*

Last updated November 11, 2008

Rapid HIV Testing Using Oral Fluid

(01/03/2005) www.sexualhealth.com

by Georgan Gregg

Some people worry about deep or French kissing an HIV-positive person. HIV is NOT transmitted by saliva. The only way HIV could possibly be passed on by kissing is if there is visible blood (perhaps from dental work or injury). The US Centers for Disease Control and Prevention (CDC) considers open-mouth kissing a very low-risk activity for the transmission of HIV. However, prolonged open-mouth kissing could damage the mouth or lips and allow HIV to pass from an infected person to a partner and then enter the body through cuts or sores in the mouth. Because of this possible risk, CDC recommends against open-mouth kissing with an HIV-infected partner. One case suggests that a woman became infected with HIV from exposure to HIV-infected blood during open-mouth kissing.

HIV Testing History Testing for HIV (human immunodeficiency virus), the virus that leads to Acquired Immune Deficiency Syndrome (AIDS), began in 1985 with enzyme immunoassay (EIA) to screen donated blood. This test, like most, looked for HIV antibodies, not the virus itself. Testing sites were set up for those wishing to know their HIV status. To eliminate false-positive results (that is, the test shows infection where none exists) the US Department of Health & Human Services (HHS) recommended that no positive test result should be given to patients without another test (Western Blot) to prove infection with HIV. While these tests were a giant step forward in the fight against AIDS, the wait for test results was 1-2 weeks.

EIA and Western Blot became the "gold standard" for finding HIV antibodies, but required technology that was not possible in poor countries and wait time of several months. Even in affluent countries, up to 50% of those being tested did not return to hear their results. Simple, 'rapid' tests were recommended by World Health Organization in 1992 and by HHS in '98.

Rapid HIV tests were initially approved by the US Food and Drug Administration (FDA) for use with blood, either from a fingerstick or a tube of blood. In 1996 FDA approved HIV testing using urine samples. In March 2004 FDA approved OraQuick, the first test for use with oral fluid taken from the mouth.

Rapid oral hiv tests Compared with Blood Tests Both oral and blood tests are looking for HIV antibodies, have 99% accurate results and are FDA-approved. If HIV antibodies are found using OraQuick, the result must be confirmed with a Western Blot, to be sure of infection with HIV, the same requirement as EIA. Both oral and blood tests require that those with a negative result but a recent exposure to HIV get another test at least 3 months after the possible exposure. This is vital since antibodies may not appear until 3-6 months after infection with HIV.

OraQuick does NOT test saliva, but OMT (oral mucosal transudate). OMT comes from the cheek and gum while saliva comes from salivary glands. OMT has high concentrations of Immunoglobulin G (where antibodies can be found); saliva has practically none.

The person being tested for HIV gently swabs once, completely around both upper and lower outer gums. The swabbing is inserted into a vial of developer solution. In 20-60 minutes, 2 reddish lines indicate the presence of HIV-1, the form of the virus most commonly found in North America. Because HIV-2 is very rare in the USA, routine testing for it is not recommended.

OraQuick is not yet approved for in-home use. Home collection blood tests allow you to take your own blood sample and mail it in to be anonymously tested. Many home tests are available through the Internet, but only "Home Access" (found in most pharmacies) is FDA-approved. Home Access offers counseling and referrals and while some states require reporting of positive tests, the identity of the test user is anonymous.

Other countries are not as strict. "1-Minute Self Test Kits" are available over-the-counter in the Netherlands and other European countries. Canadian home test "Discreet" has a new test used in South America, Asia and Africa for antibodies to HIV1, HIV2 and HIV-0. There are less than 1,000 known cases of HIV-0 and the majority of those infected by this latest strain of HIV are in Africa.

oral hiv tests have several important advantages. Some people are fearful of having their finger stuck or blood drawn. Healthcare workers giving the tests have a much lower risk of exposure to HIV from oral fluid than from blood. Oral rapid tests make it easier to routinely offer HIV testing in both medical and non-medical settings (like inner-city outreach vans or rural Africa with no laboratories) or when HIV status knowledge is vital. For example, the chance of mother to infant transmission can be greatly reduced only if the mother's status is known in time. Easier testing can prevent the spread of HIV and ensure treatment for those infected.

Rapid testing makes all the difference for those who do not want to face the anxiety of waiting for HIV test results.

By Georgan Gregg, M.Ed. HIV, AIDS, Hot Safer Sex . HSAB Affiliation: Syndicated Contrib

HIV Testing in the United States

HIV testing is integral to HIV prevention, treatment, and care efforts. Knowledge of one's HIV status is important for preventing the spread of disease. Studies show that those who learn they are HIV positive modify their behavior to reduce the risk of HIV transmission.^{1,2} Early knowledge of HIV status is also important for linking those with HIV to medical care and services that can reduce morbidity and mortality and improve quality of life.^{1,2}

Key Dates in History of HIV Testing³

- 1981: First AIDS case reported
- 1984: Human immunodeficiency Virus (HIV) identified
- 1985: First test for HIV licensed (ELISA)
- 1987: First Western Blot blood test kit
- 1992: First rapid test
- 1994: First oral fluid test
- 1996: First home and urine tests
- 2002: First rapid test using finger prick
- 2003: Rapid finger prick test granted CLIA⁴ waiver
- 2004: First rapid oral fluid test (also granted CLIA waiver)
- 2006: CDC recommends routine HIV screening in U.S. health-care settings¹
- 2007: WHO/UNAIDS global guidelines recommend routine HIV screening in health-care settings⁵

Testing Recommendations & Requirements

The U.S. Centers for Disease Control and Prevention (CDC) recommends **routine HIV screening in health-care settings** for all adults, aged 13–64, and repeat screening at least annually for those at high risk.¹ HIV testing is recommended for all pregnant women and for any newborn whose mother's HIV status is unknown. Screening should be **voluntary**, but **opt-out**—that is, the patient will be notified that the test will be performed and consent is inferred unless the patient declines (as is the case for most laboratory tests in health-care settings) vs. **opt-in**, where the test is offered to the patient, who must then explicitly consent to an HIV test, often in writing. In a recent survey, approximately two-thirds of the U.S. public (65%) supported routine HIV testing; 27% said that HIV testing should be treated differently, including the need for written consent.⁶

The CDC is expected to release new testing guidelines for non-clinical settings as well. Currently, it is recommended that all those at high risk for HIV, regardless of setting, be tested routinely for HIV infection.¹ Risk behaviors include having:^{7,8}

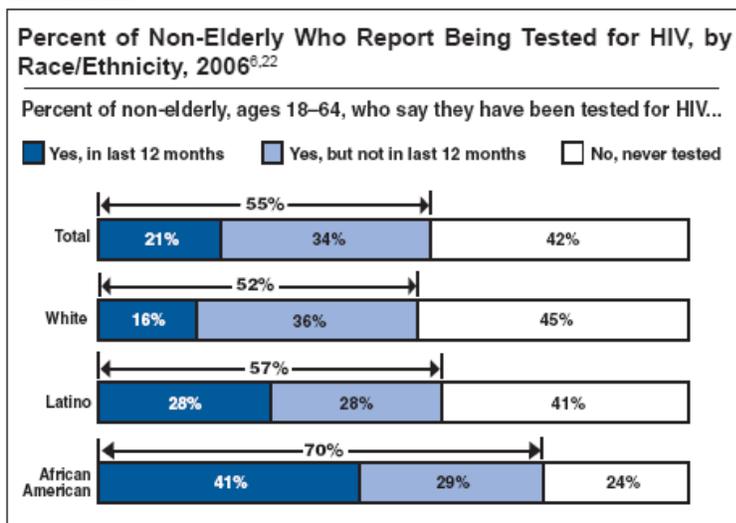
- injected drugs or steroids or shared equipment (such as needles, syringes, works) with others
- had unprotected vaginal, anal, or oral sex with men who have sex with men, multiple partners, or anonymous partners
- exchanged sex for drugs or money
- been diagnosed with or treated for hepatitis, tuberculosis, or a sexually transmitted disease, like syphilis
- had unprotected sex with anyone who falls into an above category, or with someone whose history is unknown.

HIV testing is **mandatory** in the U.S. in certain cases, including for: blood and organ donors;⁹ military applicants and active duty personnel;¹⁰ federal and state prison inmates under certain circumstances;^{11,12} newborns in some states;¹³ and immigrants.¹⁴

Testing Statistics

- More than half (55%) of U.S. adults, aged 18–64, report ever having been tested for HIV, including 21% who report being tested in the last year. The share of the public saying they have been tested for HIV at some point has increased over time.^{6,15}
- HIV testing rates vary by state, age, and race/ethnicity.^{6,15,16,17,18} For example, African Americans and Latinos are significantly more likely to report having been tested for HIV than whites (see Figure).⁶ Forty-one percent of African Americans report being tested in the last year alone.⁶
- Among the more than one million people living with HIV/AIDS in the U.S., however, an estimated 21% do not know they are infected (down from 25% in 2003) and knowledge of HIV status is even lower among some populations.^{2,19,20}
- Many people with HIV are diagnosed late in their illness; in 2005, 38% received an AIDS diagnosis within one year of testing HIV positive.²¹

- A survey of the U.S. public in 2006 found that many people want more information about HIV testing, including: the different types of HIV tests available (44%); how to protect privacy when getting tested (40%); and where to get tested (35%).⁶ African Americans and Latinos are much more likely than whites to say they need these types of information.⁶



Testing Sites & Policies

- HIV testing is offered at CDC funded testing sites (accounting for almost 2 million tests) and in other public and private settings, including free-standing HIV counseling and testing centers, health departments, hospitals, private doctors offices, and STD clinics.^{1,23} Most HIV testing is conducted in private doctors' offices.^{6,24}
- Those testing positive for HIV are most likely to have been tested in hospital settings, followed by community clinics and private doctor's offices.²⁴ Those at-risk are most likely to have been tested in private doctor's offices/HMOs or public health clinics.²⁵

As of April 2008, all states/territories had moved to **HIV name reporting** (in addition to reporting AIDS cases) where a person's name is reported to the state if they test HIV positive. The state then reports the number of unique positive HIV tests to CDC (no names

or other personally identifying information is reported to CDC; only clinical and basic demographic information is forwarded).²⁶ Over time, HIV name reporting will provide a better picture of the size of the HIV/AIDS epidemic in the United States (a state must have HIV name reporting in place for four full calendar years to allow for accurate counts to be made by CDC).²¹

HIV Testing & Reporting Policies, as of April 2008²⁶

- HIV testing may be **confidential** or **anonymous**. With confidential testing, a person's name is recorded with their test result. With anonymous testing, no name is used. All states offer confidential testing but not all offer anonymous testing. As of April 2008, 11 states offered only confidential testing.²⁶

Testing Techniques

HIV tests used for screening detect the presence of antibodies produced by the body to fight HIV infection.²⁷ Detectable antibodies usually develop within 2–8 weeks after infection, but may take longer.⁷ There are several kinds of HIV tests available in the U.S. They differ based on the type of specimen tested (whole blood, serum, or plasma; oral fluid; urine); how the specimen is collected (blood draw/venipuncture; finger prick; oral swab); where the test is done (laboratory, point-of-care site, etc.); and how quickly results are available (conventional or rapid).^{24,28} The main types of tests are:

- **Conventional blood test:** Blood sample drawn by health care provider; tested at lab. Results: a few days to two weeks.
- **Conventional oral fluid test:** Oral fluid sample collected by health care provider, who swabs inside of mouth; tested at lab. Results: a few days to two weeks. *OraSure* is the only FDA-approved HIV oral fluid test.
- **Rapid tests:**^{28,29} Sample collected by health care provider at lab or care site, depending on complexity of rapid test. Results: in as little as 10 minutes. If test is negative, no further testing is needed. If positive, test must be confirmed with a more specific test through conventional method. There are six FDA-approved rapid tests: *OraQuick Advance Rapid HIV-1/2 Antibody Test* (whole blood finger prick or venipuncture; plasma; oral fluid); *Reveal Rapid HIV-1 Antibody Test* (serum; plasma); *Uni-Gold Recombigen HIV Test* (whole blood finger prick or venipuncture; serum; plasma); *Multispot HIV-1/HIV-2 Rapid Test* (serum; plasma); and two *Clearview tests*—*Clearview HIV 1/2 Stat Pak*, *Clearview Complete HIV 1/2* (whole blood; serum; plasma). Some rapid tests have been granted CLIA waivers which allow them to be used outside laboratories settings. A recent survey of CDC-funded health departments, conducted by the National Alliance of State and Territorial AIDS Directors (NASTAD), found that rapid tests accounted for an estimated 48% of tests conducted in 2007, expected to rise to 60% this year.³⁰

• **Home Tests:** Individual performs the test by pricking finger with special device, placing drops of blood on treated card, and mailing to lab for testing. Identification number on card is used when phoning for results; counseling and referral available by phone. Results: in as little as three days. *HomeAccess HIV-1 Test System*, the only home HIV test currently approved by the FDA, may be purchased from many drug stores and online.

• **Urine Test:** Urine sample collected by health care provider; tested at lab. *Calypte* is the only FDA-approved HIV urine test. Results: a few days to two weeks.

State/Territory	Confidential/ Anonymous	HIV Reporting	Name Reporting Implementation
Alabama	C	Name	1988 January
Alaska	C, A	Name	1999 February
Arizona	C, A	Name	1987 January
Arkansas	C, A	Name	1989 July
California	C, A	Name	2006 April
Colorado	C, A	Name	1985 November
Connecticut	C, A	Name	2005 January
Delaware	C, A	Name	2006 February
District of Columbia	C, A	Name	2006 November
Florida	C, A	Name	1997 July
Georgia	C, A	Name	2003 December
Hawaii	C, A	Name	2008 March
Idaho	C	Name	1986 June
Illinois	C, A	Name	2006 January
Indiana	C, A	Name	1988 July
Iowa	C	Name	1998 July
Kansas	C, A	Name	1999 July
Kentucky	C, A	Name	2004 October
Louisiana	C, A	Name	1993 February
Maine	C, A	Name	2006 January
Maryland	C, A	Name	2007 April
Massachusetts	C, A	Name	2007 January
Michigan	C, A	Name	1992 April
Minnesota	C, A	Name	1985 October
Mississippi	C	Name	1988 August
Missouri	C, A	Name	1987 October
Montana	C, A	Name	2006 September
Nebraska	C, A	Name	1995 September
Nevada	C	Name	1992 February
New Hampshire	C, A	Name	2005 January
New Jersey	C, A	Name	1992 January
New Mexico	C, A	Name	1998 January
New York	C, A	Name	2000 June
North Carolina	C	Name	1990 February
North Dakota	C	Name	1988 January
Ohio	C, A	Name	1990 June
Oklahoma	C, A	Name	1988 June
Oregon	C, A	Name	2006 April
Pennsylvania	C, A	Name	2002 October
Rhode Island	C, A	Name	2006 July
South Carolina	C	Name	1986 February
South Dakota	C	Name	1988 January
Tennessee	C	Name	1992 January
Texas	C, A	Name	1999 January
Utah	C, A	Name	1989 April
Vermont	C, A	Name	2008 April
Virginia	C, A	Name	1989 July
Washington	C, A	Name	2006 March
West Virginia	C, A	Name	1989 January
Wisconsin	C, A	Name	1985 November
Wyoming	C, A	Name	1989 June
American Samoa	C, A	Name	2001 August
Guam	C, A	Name	2000 March
Northern Mariana Islands	C, A	Name	2001 October
Puerto Rico	C, A	Name	2003 January
U.S. Virgin Islands	C	Name	1998 December

References

- 1 CDC, *MMWR*, Vol. 55, No. RR14; September 2006.
- 2 CDC, *MMWR*, Vol. 52, No.15; April 2003.
- 3 Kaiser Family Foundation, Global HIV/AIDS Timeline, www.kff.org/hiv/aids/timeline.
- 4 Clinical Laboratory Improvement Amendments (CLIA) Waiver.
- 5 WHO/UNAIDS, www.who.int/mediacentre/news/releases/2007/pr24/en/index.html.
- 6 Kaiser Family Foundation, *Survey of Americans on HIV/AIDS*; March 2006.

- 7 CDC, www.cdc.gov/hiv/topics/testing/qa.htm.
 - 8 www.hivtest.org.
 - 9 FDA, "Keeping Blood Transfusions Safe: FDA's Multi-layered Protections for Donated Blood," Publication No. FS 02-1; February 2002.
 - 10 U.S. DoD, Instruction Number 6485.01; October 17, 2006.
 - 11 U.S. Federal Bureau of Prisons, *Legal Resource Guide to the Federal Bureau of Prisons, 2008*.
 - 12 U.S. DoJ, Bureau of Justice Statistics, *HIV in Prisons, 2006*; April 2008.
 - 13 Kaiser Family Foundation, www.statehealthfacts.org/comparetable.jsp?ind=563&cat=11.
 - 14 USCIS, I-693, Report of Medical Examination and Vaccination Record, www.uscis.gov/i-693.
 - 15 CDC, *MMWR*, Vol. 52, No.23, 2003.
 - 16 CDC, Behavioral Risk Factor Surveillance System, www.cdc.gov/brfss/index.htm.
 - 17 CDC, *MMWR*, Vol. 50, No.47, 2001.
 - 18 CDC, National Health Interview Survey, 2006. www.cdc.gov/nchs/nhis.htm.
 - 19 CDC, *MMWR*, Vol. 57, No. 39; October 2008.
 - 20 CDC, *MMWR*, Vol. 54, No.24; June 2005.
 - 21 CDC, *HIV/AIDS Surveillance Report*, Vol. 18, 2008.
 - 22 Don't know" responses not shown; not all numbers may add up due to rounding.
 - 23 CDC, *HIV Counseling and Testing at CDC-Supported Sites, United States, 1999-2004*; December 2006.
 - 24 CDC, Revised Recommendations for HIV Testing in Healthcare Settings in the U.S., Slide Set.
 - 25 CDC, "HIV Testing Survey, 2002". *HIV/AIDS Special Surveillance Report* No. 5, 2004.
 - 26 CDC, *Current Status of HIV Infection Surveillance*, as of April 2008.
 - 27 There are also HIV tests that can detect HIV before the development of antibodies, but these are not used as general screening tools.
 - 28 Greenwald JL, et al., A Rapid Review of Rapid HIV Antibody Tests, *Curr Infect Dis Rep*, Vol. 8, No. 2, 2006.
 - 29 CDC/HRET, FDA-Approved Rapid HIV Antibody Screening Tests as of February 4, 2008.
 - 30 NASTAD, personal communication, April 2008 (note: data are for 31 of 65 health departments responding to survey).
- This publication (#6094-08) is available on the Kaiser Family Foundation's website at www.kff.org.

The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park California, dedicated to producing and communicating the best possible information, research and analysis on health issues.

HIV Testing Sites in Maine

Auburn: AUBURN STD CLINIC
Tel: 795-4019

Ft. Kent: ACAP-HEALTH 1st
Tel: 834-3513

Augusta: THE HORIZON PROGRAM
Tel: 621-6201

Houlton: ACAP-HEALTH 1st
Tel: 532-5303

AUGUSTA FAMILY PLANNING
Tel: 626-3426

Kittery: FRANNIE PEABODY CENTER
Tel: 749-6818

Bangor: BANGOR STD CLINIC
Tel: 947-0700

Lubec: HEALTHWAYS HIV PROGRAM
Tel: 733-4763 or 1-877-270-4139

EASTERN MAINE AIDS NETWORK
Tel: 990-3626

WABANAKI MENTAL HEALTH
Tel: 990-0605

Machias: DOWNEAST AIDS NETWORK
Tel: 255-5849

Belfast: BELFAST FAMILY PLANNING
Tel: 338-3736

DOWNEAST HEALTH SERVICES
Tel: (800) 924-2628

Brunswick: MERRYMEETING AIDS SUPPORT SVCS
Tel: 725-4955

Norway: TRI-COUNTY HEALTH SERVICES
Tel: 743-2066

Damariscotta: DAMARISCOTTA FAMILY PLANNING
Tel: 563-1224

Portland: FRANNIE PEABODY CENTER
Tel: 749-6818

PORTLAND STD CLINIC
Tel: 874-8446

Ellsworth: DOWNEAST AIDS NETWORK
Tel: 667-3506

HEALTH 2000
Tel: 828-2001

DOWNEAST HEALTH SERVICES
Tel: 667-5304

Presque Isle: ACAP-HEALTH 1st
Tel: 768-3062 or 1-800-432-7881

Farmington: TRI-COUNTY HEALTH SERVICES
Tel: 778-4553

Rockland: ROCKLAND FAMILY PLANNING
Tel: 594-6880



WHAT IS AN HIV VACCINE?

A preventive HIV vaccine is a substance that teaches the body's immune system to recognize and protect itself against HIV, the virus that causes AIDS. HIV vaccines currently being tested in humans are made from man-made materials that **CANNOT** cause HIV infection.

- Scientists believe that an effective HIV vaccine, given before exposure to HIV, could have a number of possible outcomes. These include:
- Preventing infection in most people
 - Preventing infection in some people
 - Preparing a person's immune system to block continued infection and eliminate the virus (vaccines against measles, mumps and polio work this way)
 - Delaying or preventing the onset of illness or AIDS

The long-term goal is to develop a vaccine that is 100 percent effective and protects everyone from infection. However, even if a vaccine only protects some people, it could still have a major impact on controlling the epidemic. A partially effective vaccine could decrease the number of people who get infected with HIV; those people, in turn, would not pass the virus on to others. Even when an HIV vaccine is developed, education and other prevention efforts will be needed so that people continue to practice safe behaviors.

HISTORY OF VACCINES

The value of vaccines was recognized approximately 200 years ago, beginning with a vaccine against smallpox. The smallpox vaccine saved millions of lives, and its success helped people understand that introducing a vaccine into the body can actually trigger a protective immune response, and prevent disease.

Today, there are numerous safe and effective vaccines. Vaccines have been used successfully against many life-threatening diseases, including measles, and polio in most of the world.

COMMUNITY PARTICIPATION IN VACCINE RESEARCH

By raising awareness and encouraging study participation, individuals and communities can contribute to the successful development of HIV vaccines. Although tens of thousands of people have already volunteered to take part in HIV vaccine studies, many more will be needed. A large HIV vaccine trial will require thousands more participants of all race/ethnicities, genders and socioeconomic backgrounds to ensure that the vaccine works in all populations.

Therefore, community support is essential in efforts to break down stigma and myths about HIV vaccine research. Developing an effective HIV vaccine depends upon individuals and communities informing, educating and supporting others.

HOW TO HELP

- Let others know you support HIV vaccine research
- Educate others about the need for an HIV vaccine
- Support vaccine trial volunteers and/or volunteer yourself

The National Institute of Allergy and Infectious Diseases (NIAID), at the National Institutes of Health (NIH), supports a comprehensive program of HIV vaccine research.

For more information about HIV vaccine, please visit www.niaid.nih.gov/hiv/vaccine or call 1-800-418-0110.

For information on equal access to vaccines contact NIAID at 1-800-418-0110.

HIV VACCINES EXPLAINED

MAKING HIV VACCINES A REALITY

HIV VACCINE RESEARCH

Our best minds. Our best science. Our best hope.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health
National Institute of Allergy and Infectious Diseases
Division of AIDS

THE NEED FOR AN HIV VACCINE

Despite the availability and success of HIV treatment drugs in the United States, the best long-term hope for controlling the AIDS epidemic worldwide is the development of safe, effective and affordable preventive HIV vaccines. Consider these facts:

- **HIV/AIDS IN THE UNITED STATES**
 ■ Nearly half a million Americans have died of AIDS since the epidemic began.
- The Centers for Disease Control and Prevention (CDC) estimate that as many as 950,000 Americans are living with HIV, and more than one-third of them do not know it.
- Each year, over 40,000 people become infected with HIV, a rate that has remained virtually unchanged in recent years. Seventy percent are men and 30 percent are women. Of these, half are younger than 25 years of age.
- Minority communities are disproportionately affected by the epidemic. More than half of all new HIV infections occur in African Americans, who make up 12 percent of the U.S. population. AIDS is the fifth leading cause of death of Americans aged 25-44, and is the number one cause of death in African American men of all ages. Nineteen percent of new HIV infections occur in Latinos, who make up 13 percent of the population.

HIV/AIDS AROUND THE WORLD

- To date, nearly 25 million men, women and children have died from AIDS worldwide.
- Currently, 40 million people are estimated to be living with HIV/AIDS and 14,000 new infections occur each day.
- Today, more than 13 million children under the age of 15 have lost one or both of their parents to AIDS, most in sub-Saharan Africa.



PREVENTIVE VERSUS THERAPEUTIC HIV VACCINES

Preventive HIV vaccines currently under development are given to HIV-negative people and are designed to prevent infection and control the spread of HIV, not to cure AIDS.

Multiple HIV vaccines may be necessary to prevent infection or disease in the same way multiple drugs are needed to treat people already infected with HIV.

Researchers are also evaluating therapeutic vaccines to treat people with HIV infection or AIDS. While the same vaccine may be tested for both preventive and therapeutic effects, what works to prevent HIV infection may not necessarily work to treat people who are already infected with HIV.

IS AN HIV VACCINE AVAILABLE NOW?

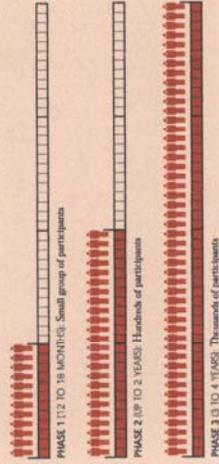
No! Scientists have been studying HIV for over two decades — and continue to make progress. Even when a promising vaccine is discovered, it will take time to test and evaluate its safety and effectiveness.

TESTING HIV VACCINES

Vaccine development requires several years of research in laboratories and animals before testing in humans can begin. A potential vaccine goes through three phases of testing in humans before the Food and Drug Administration (FDA) can consider licensing it for public use. The three phases of preventive HIV vaccine clinical trials are:

- **Phase I** — involves a small number of healthy volunteers (HIV-negative) to test the safety and various doses of the vaccine; usually lasts 12 to 18 months
- **Phase II** — involves hundreds of volunteers (HIV-negative) to test the safety and immune responses of the vaccine; can last up to 2 years
- **Phase III** — involves thousands of volunteers (HIV-negative) to test the safety and effectiveness of the vaccine; can last 3 to 4 years

Throughout all phases of human testing, independent reviewers regularly monitor the study to ensure the safety of the volunteers.



PROTECTING RESEARCH PARTICIPANTS

HIV vaccine clinical trials are voluntary. Researchers are required to obtain the informed consent of all participants to make sure they fully understand the purpose of the study, how the HIV vaccine will be tested, the number of clinical visits required and the possible risks and benefits associated with receiving the vaccine.

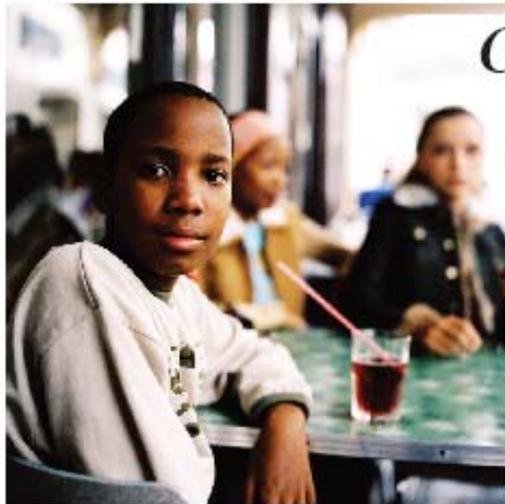
So far, few side effects have been associated with experimental HIV vaccines. Those that have occurred generally have been mild to moderate and similar to those of approved vaccines. The most common side effects are soreness at the site of the injection, a low-grade fever, and body aches, which readily disappear on their own. Throughout the study, volunteers are carefully examined to determine if there are any serious side effects associated with the vaccine.

After a volunteer receives an HIV vaccine, it is possible to test positive for HIV antibodies on a standard HIV test (i.e., ELISA) because the vaccine triggers the body to produce antibodies against HIV.

The HIV vaccines being tested in humans do not contain HIV; therefore, they cannot cause HIV infection. Other tests are available at the study sites to determine whether a volunteer is actually infected with HIV. If volunteers engage in behaviors that expose them to HIV, they may still become infected with HIV.

It is rare for volunteers to encounter problems as a result of testing positive for HIV antibodies. Testing antibody positive does not mean the person is infected. However, volunteers could potentially experience problems donating blood, getting insurance, traveling to other countries or getting employment.

All volunteers are offered an identification card to show they are part of the study, and research staff are available to help address any issues that may arise.



OPPORTUNITY KNOCKS: USING TEACHABLE MOMENTS TO CONVEY SAFER SEX MESSAGES TO YOUNG PEOPLE

teach*able mo*ment (*plural teach*able mo*ments*): a time at which a person, especially a child, is likely to be particularly disposed to learn something or particularly responsive to being taught or made aware of something.¹

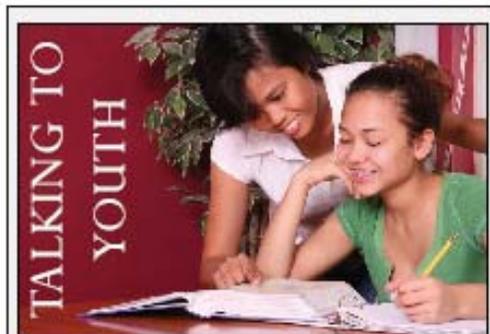
With accurate information and adequate support, young people can make healthy and responsible decisions about having sex and using contraception. Adults can be most effective by providing the information and support needed to promote responsible decision-making in youth and help ensure

transition to adulthood is safe and healthy. A key component for adults is taking advantage of teachable moments to discuss sex and the use of contraception with young people. Youth are often hesitant to talk with adults about sex. When young people are willing to discuss this topic, adults must be prepared to help them make the best decisions possible. The following information will help adults use teachable moments to talk to young people about safe sex.

SPREAD THE WORD:

Important information youth should know

- **Abstaining from sex is the only 100% sure way to prevent pregnancy.**
- **Contraception works, is available, and can be low cost or free.**
 - Plan ahead: it is much easier to think about contraception, and there are many more options *before* having sex.
 - Many types of contraception are available: a clinician can help you identify the right type for you.
 - Methods that may not have worked for a friend or relative may work well for you.
 - Talking to your partner makes it easier to make decisions together.
 - Both partners can use contraception (such as condoms and pills) to increase protection against pregnancy and STIs.
- **Emergency contraception is safe, highly effective, and available; it's the only existing way to prevent pregnancy after having unprotected sex (www.not-2-late.com).**
- **Speak Up: *It's okay to talk about sex.*** Youth can feel comfortable seeking medical advice about contraception because confidentiality laws protect their privacy.



Tips for creating a teachable moment

- Create a safe space to talk about sex.
- Bring it up! Open the door to conversation.
- Refer to popular culture when initiating a conversation.
- Keep it private: a one-on-one conversation may be best.
- Be accessible: the conversation should be on-going and relationship-building.

KEEP IN MIND

- Discussion of both pregnancy prevention and reducing sexually transmitted infections is crucial.
- It is okay to say “I don’t know” and look up answers together; be sure to use a credible source of information.
- It is important to know your own limitations and comfort level; it’s okay to refer a young person to another trusted adult if the conversation moves outside of your personal boundaries.
- Using humor, when appropriate, can go a long way.
- **Boys need information too!**

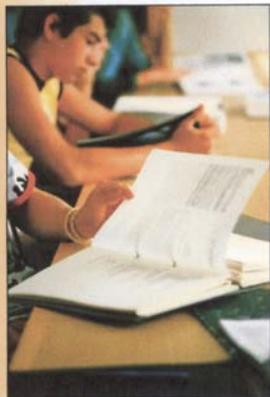
THINK BEFORE YOU SPEAK

- Set aside your personal judgments!
- Be aware of your body-language and non-verbal cues; youth don’t want to feel judged by adults.
- Don’t assume you know how it feels to be a young person today.
- Don’t make assumptions based on your personal experiences.
- If a teen asks questions about sex, it does not mean that teen is having sex.
- **Educate everyone about contraception!** Pregnancy happens as a result of vaginal intercourse, regardless of sexual identity.

ARM YOURSELF:

Gather Resources and Youth-Friendly Referrals

- Know other trusted allies and youth friendly professionals for referral.
- Build a network of trusted adults in your community.
- Display youth friendly fact sheets or pamphlets.
- Make condoms readily available in your office/home.
- Be prepared to talk about sex to all youth (e.g. LGBTQ youth, heterosexual youth, and abstinent youth).



RESOURCES

Healthy Teen Network: www.healthyteennetwork.org

Association of Reproductive Health Professionals: www.arhp.org

Planned Parenthood: www.plannedparenthood.org

Sex Etc.: www.sexetc.org (www.sxetc.org)

Teen Wire: www.TeenWire.com

¹ http://encarta.msn.com/dictionary_561539567/teachable_moment.html

² Frost, J. J. & Forrest, J. D. (1995). Understanding the Impact of Effective Teenage Pregnancy Prevention Programs. *Family Planning Perspectives*, 27 (5). <http://www.guttmacher.org/pubs/journals/2718895.html>

³ Haffner, D. (Ed.). (1995). *Facing facts: Sexual health for America's adolescents*. NY, NY: Sexuality Information and Education Council of the United States. http://www.siecus.org/pubs/Facing_Facts.pdf



REMEMBER

- Talking about sex does not lead to sex.²
- Having sexual feelings is a normal part of adolescent development.³
- Risk taking can be part of normal adolescent development; adults can be most effective by promoting healthy decision making during this stage.³
- Alter your approach according to the young person’s developmental level.³

Sex Education Programs: Definitions & Point-by-Point Comparison

Abstinence-Only Education teaches abstinence as the only morally correct option of sexual expression for teenagers. It usually censors information about contraception and condoms for the prevention of sexually transmitted diseases (STDs) and unintended pregnancy.

Abstinence-Only-Until-Marriage Education teaches abstinence as the only morally correct option of sexual expression for unmarried young people. Programs funded under the 1996 Welfare Reform Act must censor information about contraception and condoms for the prevention of STDs and unintended pregnancy.

Abstinence-Centered Education – Another term normally used to mean abstinence-only education.

Comprehensive Sex Education teaches about abstinence as the best method for avoiding STDs and unintended pregnancy, but also teaches about condoms and contraception to reduce the risk of unintended pregnancy and of infection with STDs, including HIV. It also teaches interpersonal and communication skills and helps young people explore their own values, goals, and options.

Abstinence-Based Education – Another term normally used to mean comprehensive sexuality education

Abstinence-Plus Education – Another term normally used to mean comprehensive sexuality education.

Comprehensive Sex Education	Abstinence-Only-Until-Marriage Education
Teaches that sexuality is a natural, normal, healthy part of life	Teaches that sexual expression outside of marriage will have harmful social, psychological, and physical consequences
Teaches that abstinence from sexual intercourse is the most effective method of preventing unintended pregnancy and sexually transmitted diseases, including HIV	Teaches that abstinence from sexual intercourse before marriage is the only acceptable behavior
Provides values-based education and offers students the opportunity to explore and define their individual values as well as the values of their families and communities	Teaches only one set of values as morally correct for all students
Includes a wide variety of sexuality related topics, such as human development, relationships, interpersonal skills, sexual expression, sexual health, and society and culture	Limits topics to abstinence-only-until-marriage and to the negative consequences of pre-marital sexual activity
Includes accurate, factual information on abortion, masturbation, and sexual orientation	Usually omits controversial topics such as abortion, masturbation, and sexual orientation
Provides positive messages about sexuality and sexual expression, including the benefits of abstinence	Often uses fear tactics to promote abstinence and to limit sexual expression
Teaches that proper use of latex condoms, along with water-based lubricants, can greatly reduce, but not eliminate, the risk of unintended pregnancy and of infection with sexually transmitted diseases (STDs) including HIV	Discusses condoms only in terms of failure rates; often exaggerates condom failure rates
Teaches that consistent use of modern methods of contraception can greatly reduce a couple's risk for unintended pregnancy	Provides no information on forms of contraception other than failure rates of condoms
Includes accurate medical information about STDs, including HIV; teaches that individuals can avoid STDs	Often includes inaccurate medical information and exaggerated statistics regarding STDs, including HIV; suggests that STDs are an <u>inevitable</u> result of premarital sexual behavior
Teaches that religious values can play an important role in an individual's decisions about sexual expression; offers students the opportunity to explore their own and their family's religious values	Often promotes specific religious values
Teaches that a woman faced with an unintended pregnancy has options: carrying the pregnancy to term and raising the baby, or carrying the pregnancy to term and placing the baby for adoption, or ending the pregnancy with an abortion	Teaches that carrying the pregnancy to term and placing the baby for adoption is the <u>only</u> morally correct option for pregnant teens



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In Good Company: Who Supports Comprehensive Sexuality Education?

If you support comprehensive sexuality education—medically accurate, age-appropriate education that includes information about abstinence and contraception—then you are in good company.

Medical, Scientific, and Public Health Communities Support Comprehensive Sexuality Education

✂ **The American Academy of Pediatrics (AAP)** recommends that pediatricians “encourage adolescents to postpone early sexual activity[,]...[h]elp ensure that all adolescents have knowledge of and access to contraception including barrier methods and emergency contraception supplies...[and]...advocate for implementation and investments in evidence-based programs that provide comprehensive information and services to youth.”¹

✂ **The American Foundation for AIDS Research (amfAR)** believes that “investing in comprehensive sex education that includes support for abstinence but also provides risk-reduction information” would be a more effective HIV-prevention strategy for young people than simply an abstinence-only message.²

✂ **The American Medical Association (AMA)** “urges schools to implement comprehensive, developmentally appropriate sexuality education programs” and “supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex.”³

✂ **The American Psychological Association (APA)** recommends that “comprehensive and empirically supported sex education and HIV-prevention programs become widely available to teach youth how to abstain from risky sexual behaviors and learn how they can protect themselves against HIV and other sexually transmitted diseases.”⁴ In addition, APA recommends that “public funding for the implementation of comprehensive sexuality education programs be given priority over funding for the implementation of abstinence-only...programs.”⁵

✂ **The American Public Health Association (APHA)** urges that abstinence be “provided within public health programs that provide adolescents with complete and accurate information about sexual health. Such programs should be medically accurate and developmentally appropriate...[and] based on theories and strategies with demonstrated evidence of effectiveness. Current federal funding for abstinence-only programs...should be repealed and replaced with funding for a new federal program to promote comprehensive sexuality education.”⁶

✂ **The Institute of Medicine (IOM)** recommends that “Congress, as well as other federal, state, and local policymakers, eliminate the requirements that public funds be used for abstinence-only education, and that states and local school districts implement and continue to support age-appropriate comprehensive sex education and condom availability.”⁷

✂ **The Society for Adolescent Medicine (SAM)** finds that, “Efforts to promote abstinence should be provided within health education programs that provide adolescents with complete and accurate information about sexual health, including information about concepts of healthy sexuality, sexual orientation and tolerance, personal responsibility, risks of HIV and other STIs and unwanted pregnancy, access to reproductive health care, and benefits and risks of condoms and other contraceptive methods...Current funding for abstinence-only programs should be replaced with funding for programs that offer comprehensive, medically accurate sexuality education.”⁸

Religious Communities Support Comprehensive Sexuality Education

✧ Eight religious denominations and the Office of Family Ministries and Human Sexuality, National Council of Churches of Christ, have policies supporting sexuality education in schools. The denominations are: Central Conference of American Rabbis, Church of the Brethren, Episcopal Church, Evangelical Lutheran Church of America, Presbyterian Church (U.S.A), Union for Reform Judaism, Unitarian Universalist Association, United Church of Christ, and United Methodist Church.⁹

The Education Community Supports Comprehensive Sexuality Education

✧ **The National Education Association (NEA)** recommends SIECUS' *Guidelines for Comprehensive Sexuality Education: K-12* as a resource in developing appropriate school-based curricula.¹⁰ The NEA, through its Health Information Network, "stresses medically accurate sex education that includes information on abstinence, family planning, and problems associated with preteen and teenage pregnancies. NEA urges increased federal funding for such comprehensive programs."¹¹

✧ **The American School Health Association (ASHA)** "supports comprehensive health and sexuality education programs in the schools, from kindergarten through the 12th grade. The content of this education should include medically accurate and developmentally appropriate discussions of sexuality, reproduction, fertility, methods of contraception, decision-making, delaying first intercourse, abstinence, risk assessment and risk reduction, and sexually transmitted disease prevention, with special emphasis placed on the human immunodeficiency virus (HIV)."¹²

The American Public Overwhelmingly Supports Comprehensive Sexuality Education

✧ A 2004 national poll of parents found that 93% of parents of junior high school students and 91% of parents of high school students believe it is very or somewhat important to have sexuality education as part of the school curriculum.¹³

✧ 72% of parents of junior high school students and 65% of parents of high school students stated that federal government funding "should be used to fund more comprehensive sex education programs that include information on how to obtain and use condoms and other contraceptives" instead of funding sex education programs that have "abstaining from sexual activity" as their only purpose.¹⁴

✧ Almost nine in ten self-described conservative Evangelical or born-again Christians support the teaching of sexuality education in schools.¹⁵

✧ More than 6 in 10 voters would be more likely to vote for a candidate that supported comprehensive sexuality education.¹⁶

¹ Jonathon Klein and the Committee on Adolescence, "Adolescent Pregnancy: Current Trends and Issues" *Pediatrics* (2005): 281-286.

² *Issue Brief: Assessing the Efficacy of Abstinence-Only Programs for HIV Prevention among Young People* (Washington, DC: American Foundation for AIDS Research, April 2005).

³ Policy Statement, *H-170.968 Sexuality Education, Abstinence, and Distribution of Condoms in Schools*, American Medical Association, accessed 04 January 2007, <http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-170.968.HTM>.

⁴ American Psychologists Association, *Based on the Research, Comprehensive Sex Education is More Effective at Stopping the Spread of HIV Infection, Says APA Committee*, Press Release

published 23 February 2005, accessed 19 May 2005, <<http://www.apa.org/releases/sexeducation.html>>.

⁵ "Resolution in Favor of Empirically Supported Sex Education and HIV Prevention Programs for Adolescents," American Psychologists Association. 18-20 February, accessed 4 January

2007, <http://www.apa.org/releases/sexed_resolution.pdf>.

⁶ Policy Statement, "Abstinence and U.S. Abstinence-Only Education Policies: Ethical and Human Rights Concerns," American Public Health Association, 8 November 2006, accessed 3

January 2007, <<http://www.apha.org/legislative/policy/policysearch/index.cfm?fuseaction=view&id=1332>>.

⁷ M.S. Ruiz, et al., *No Time to Lose: Getting More from HIV Prevention* (Washington, D.C: Institute of Medicine, 2000), 6.

⁸ John Santelli, et. al., "Abstinence-only education policies and programs: A position paper for the Society for Adolescent Medicine," *Journal of Adolescent Health* 38 (2006): 83-87.

⁹ *An Open Letter to Religious Leaders about Sex Education* (Norwalk, CT: Religious Institute on Sexual Morality, Justice, and Healing, 2002).

¹⁰ *Sexual Health, the Role of School Personnel*, National Education Association, accessed 19 May 2005,

<http://www.neahin.org/resources/docs/Sexual_Health_HIN_Flyer.pdf>.

¹¹ National Education Association, "NEA Urges Accurate Health Education," Press Release published 8 October 2003, accessed 4 January 2007,

<<http://www.nea.org/newsreleases/2003/nr031008.html>>.

¹² ASHA Position Statement, "Comprehensive Sexual Health Education," American School Health Association (8 October 2002), accessed 4 January 2007,

<http://www.ashastd.org/news/news_stmts_education.cfm>.

¹³ *Sex Education in America: General Public/Parents Survey*, 5.

¹⁴ *Ibid.*, 7.

¹⁵ *Sex Education in America: General Public/Parents Survey* (Washington, DC: NPR, Kaiser Family Foundation, Kennedy School of Government, 2004), Table 3.

¹⁶ *Mobilizing Support for Sex Education: New Messages and Techniques* (New York, NY: The Othmer Institute of Planned Parenthood of NYC, 2002). Updated October 2007



Maine

Selected Topics Fact Sheet, Profiles 2006

The School Health Profiles (Profiles) is a system of surveys assessing school health policies and programs in states and large urban school districts. Profiles surveys are conducted biennially among representative samples of middle and high school principals and lead health education teachers.

Health Education	Among States *		Maine %
	Median	Range	
Percentage of schools that required students to take 2 or more health education courses	43.0	(8.1 – 79.3)	49.2
Among schools that required a health education course, percentage that required students who failed the course to repeat it	55.4	(35.0 – 95.4)	50.4
Percentage of schools in which the lead health education teacher had professional preparation in health education or in health and physical education combined	45.5	(9.5 – 88.9)	40.3
Percentage of schools in which the lead health education teacher was certified, licensed, or endorsed by the state to teach health education in middle school or high school	79.6	(26.7 – 97.7)	74.2
Percentage of schools that tried to improve student skills in resisting peer pressure to engage in unhealthy behavior related to personal health and wellness in a required health education course	86.0	(42.0 – 98.8)	89.3
HIV, STD, and Pregnancy Prevention			
Percentage of schools that tried to increase student knowledge on HIV prevention in a required health education course	84.2	(35.6 – 99.3)	86.6
Percentage of schools that tried to increase student knowledge on STD prevention in a required health education course	79.9	(30.8 – 98.9)	81.1
Percentage of schools that tried to increase student knowledge on pregnancy prevention in a required health education course	80.0	(29.6 – 99.3)	81.7
Percentage of schools that taught abstinence as the most effective method to avoid pregnancy, HIV, and STDs in a required health education course	78.0	(28.5 – 99.3)	80.9
Percentage of schools that taught how to correctly use a condom in a required health education course	24.3	(1.0 – 59.1)	45.4
Percentage of schools in which the lead health education teacher received staff development during the past two years on HIV prevention	43.7	(21.3 – 63.9)	43.4
Percentage of schools with a policy on students or staff who have HIV infection or AIDS	51.6	(27.0 – 89.5)	66.4
School Health Councils			
Percentage of schools that had one or more than one group (e.g., a school health council, committee, or team) that offers guidance on the development of policies or coordinates activities on health topics	54.9	(34.7 – 73.9)	69.2

* Among the 36 participating states with weighted principal survey results and the 34 states with weighted teacher survey results.

SexED Library at www.sexedlibrary.org

SexEdLibrary provides access to lesson plans covering virtually every topic related to sexuality, background information on topics vital to all sexuality educators, and notices of training opportunities for educators and health professionals. This valuable resource is a project of SIECUS (the Sexuality Information and Education Council of the United States), an advocate for the right of all people to have accurate information, comprehensive education about sexuality, and sexual health services.

SIECUS believes that sexuality is a fundamental part of being human, one that is worthy of dignity and respect. We provide information and training opportunities for educators, health professionals, parents, and communities across the country and advocate for sound public policies to ensure that people of all ages, cultures, and backgrounds, receive high quality, comprehensive education about sexuality. And, we distribute hundreds of thousands of print and electronic resources that help millions of people understand, embrace, and respect their sexuality.

Founded in 1964 by a physician, lawyer, sociologist, family life educator, clergyman, and public health educator, SIECUS has become a trusted national resource for educators, healthcare providers, parents, journalists, policymakers, religious leaders, community members, and young people.

Myths and Stereotypes Regarding Persons Infected with HIV

Content

- Exploring myths and stereotypes regarding persons infected with HIV
- Examining the impact of HIV infection on individual and family life

Instructional Objectives

By the end of this lesson, each student will be able to...

1. Describe the impact of HIV/AIDS on individual and family life.
2. Identify myths or stereotypes regarding persons infected with HIV.
3. Express compassion/concern for persons with disabilities or illness, including those infected with HIV.

Materials Needed

1. Educational video of a person living with HIV/STDs.
2. Blank cards (4 per student).
3. Loss activity overhead transparency.
4. (Optional) PLWA guest speaker.

Related Vocabulary

PLWA (Person Living With AIDS)
PWA (Person With AIDS)

Part A

Lesson Introduction: Educational Video of a Person Infected or Affected by HIV/AIDS (25 minutes)

Note: Remind students of ground rules, emphasizing confidentiality, and respect for differences.

Pre-post question #15:
You can tell if someone is infected with HIV and other STDs just by looking at them (false).

1. Briefly introduce the video or speaker, stressing the importance of listening carefully in the class today. (See "Tips for Using Positive Speakers," page 22.)
2. At the end of the presentation, **ask students what they heard the speaker saying** about what it's like to have HIV.

Pre-post question #16:
Persons infected with HIV or other STDs still need to protect themselves from being re-exposed to HIV and other STDs (true).

Invite student questions, particularly those emphasizing how infected persons and their friends/family members **feel**. Also, what myths and stereotypes did they see or hear?

Part B

Loss Activity (estimated time: 20 minutes)

Concept

After each student identifies a special personal attribute, skill, person and plan in his or her life, he/she sees and feels the impact of losing them due to illness and death.

1. Prepare four small cards or strips of paper for each student (or ask students to tear their own).
2. Using the overhead transparency as a guide, direct students to write the following four items, one item per card or slip of paper:
 - A special **personal trait** they possess (nice hair, clear skin, muscles, sense of humor, body part, etc.)
 - A **special skill** they possess (dancing, sports, typing, singing, etc.)
 - The name of a **special person** in their life, who is currently living
 - A **future plan** which they look forward to (e.g., summer vacation at the beach, graduating from high school, getting a job, getting their license, etc.)
3. Ask students to shuffle their cards, and randomly drop one on the desk or floor in front of them.
4. Ask students to look at their cards, and to think about which one they just "lost." How would it feel to no longer have this in their life? Invite students to share their feelings.
5. Ask students to shuffle their remaining three cards, and again drop one on the desk or floor in front of them. How would it feel to lose this one? Invite students to share their thoughts and responses.
6. Finally, ask students to hold their two remaining cards in front of them, and have a partner *take one away*. How would it feel to lose this one? Invite students to share their thoughts and responses.

**PERSONAL
TRAIT**

**SPECIAL
SKILL**

**SPECIAL
PERSON**

**FUTURE
PLAN**

Note: Some teachers create a “tribute wall” (bulletin board) displaying the words, affect, respect and protect on the board.

*The students are then invited to write the initials of a person on whom HIV has had an **affect**, or someone they **respect** for staying HIV free, or someone they will **protect** in some way from infection.*

Explain that this exercise resembles the situation which many HIV infected persons experience — loss of people, loss of plans.

7. Ask students what they can *personally do to prevent* becoming HIV infected? As a student gives an appropriate response, permit them to pick up their cards.
8. Ask students to recall the good feelings they had thinking about their special attributes, their skills, special people and events, and how sad or angry they would feel if these things were unnecessarily taken from them.
9. Remind them that HIV disease robs people of these things, and that people living with HIV have experienced many of these losses. Challenge them to be careful, and to be compassionate toward others who have experienced such losses.
10. Create or review ground rules from the Getting Started Lesson.

Part C

Lesson Wrap-up

1. Praise the students for their interest and participation in today’s lesson regarding persons and families affected by HIV/AIDS.
2. Announce that the next lesson will examine the AIDS epidemic, including how HIV is and is not spread.

END OF LESSON

Classroom Enrichment Activities:

- Write a journal or mind map entry about how they feel about today’s presentation and activity.
- Write a question for the Question Box.

Family/Home Assignments:

- Write a letter to a friend or family member who has recently experienced a loss (see teacher’s note).
- Encourage students to discuss their responses to today’s speaker (or video presentation) with their parent(s) or supervising adult(s).
- Discuss how their family or living unit would handle loss.

Note: Remind students that they do not actually have to mail the letter unless they really want to. Letters should be reviewed by a parent or teacher before being sent.

Opportunities for Cross Curriculum Integration:

- Social Studies: Identify the contributions of disabled persons throughout history.
- Social Studies: Review the protection that the Americans with Disabilities Act provides PLWAs.
- Social Studies: List the prominent people who have died of AIDS.
- English: Read Ryan White's autobiography "My Own Story."

Tips for Using Positive Speakers:

WHAT TO DO BEFORE A PRESENTATION

1. Introduce the presenter by first name only. Inform students that they are going to hear a speaker that will provide some information today. Note: The presenter will reveal their personal status with HIV at a critical part of the presentation. In other words, even if you know, don't reveal the HIV status of the presenter when you introduce the person.
2. At the conclusion of the question and answer session, thank, then excuse the presenter.
3. Please process the presentation with the students immediately after the speaker has left the room.

WHAT TO DO AFTER THE PRESENTATION

1. Positive speaker presentations often evoke a wide range of emotions making it vitally important to allow time at the end of class for students to share their feelings. Use the questions below as a discussion. Feel free to add additional questions that may relate to other classroom topics.

"What feelings, or impressions did you experience during the presentation?"

"What parts of the presentations were most meaningful or most surprising to you?"

"Has hearing the story of individuals living with HIV/AIDS helped you understand some of the ways to avoid or reduce HIV risk behaviors?"

1

Knowing Your Risk for HIV/AIDS



40 mins.

OBJECTIVE(S)

- o Knowledge: To know the means of transmission for HIV.
- o Attitudes: To accurately perceive their own risk for HIV.

TEACHING METHOD

- o Brainstorming, Quiz, Group discussion

MATERIALS

- o 1 quiz sheet per participant
- o pencils / writing utensils

LESSON PLAN

1. Introduce the lesson:

"We are going to have a series of lessons on getting tested for HIV, the virus that causes AIDS. Did you realise that most people who have HIV do not actually know it because they have never been tested? Many people, especially young people, don't realise they are at risk for HIV. Even if someone looks and feels healthy, they can be infected with HIV. Taking an HIV test is the only way to know if they have been infected. Today we will explore the ways HIV can be contracted, so that we can consider whether we may be at risk and may wish to seek counselling and testing."

2. Ask participants to volunteer answers to this question: "What are the ways people can be infected with HIV?" Make sure these answers are mentioned and clearly understood (for example, write correct answers on the board):

- from their mother during pregnancy, birth or breastfeeding, if she is HIV positive
- from sexual intercourse (anal or vaginal) without a condom (even if you are married, even if it was only one time, even if it was against your will, and even if you are taking birth-control pills)
- from oral sex if there are open sores on the skin in and around the genitalia or mouth (for example, if one person has a sexually transmitted infection [STI])
- from using unclean needles, syringes or other instruments that pierce the skin. (for example, sharing needles to inject drugs; being tattooed with unsterilised equipment; or receiving unsafe blood)

3. Remind participants they cannot get HIV from:

- a toilet seat
- kissing or hugging

- masturbation
 - sharing food or drinks
 - somebody coughing or sneezing
 - a swimming pool
 - mosquitoes or other insects
 - a toothbrush
4. Pass out copies of "The HIV/AIDS Quick Quiz" to the participants, and ask them to complete it with a partner. Explain that it is not an exam, but, a short quiz to clarify what we have discussed about HIV risk. Encourage students to mark "I DON'T KNOW" instead of guessing when unsure of the answer. Allow them 10 to 15 minutes to complete the test by indicating TRUE or FALSE or I DON'T KNOW for each statement.
 5. Review the answers with the whole group. For each question, ask for a volunteer to answer. Ask the other participants if they agree. Make sure everyone agrees on the correct answers. Discuss and give additional information if necessary. Go over the points on which there was no agreement.

Correct answer to the HIV/AIDS quiz

- | | | |
|----------|-----------|-----------|
| 1. False | 8. True | 15. True |
| 2. True | 9. False | 16. False |
| 3. True | 10. True | 17. True |
| 4. True | 11. True | 18. True |
| 5. True | 12. True | 19. False |
| 6. True | 13. True | 20. False |
| 7. False | 14. False | |
6. Ask the participants to apply what we have learned to their own life...
 - "Think about the ways HIV is contracted. Now estimate your personal risk of HIV/AIDS infection at this time in your life. Have you have been exposed in any of the ways we discussed? How often have you engaged in behaviours that may put you at risk? Your answer is private, so you do not need to write your answer and you don't need to tell anyone else."
 - "If there is a chance you may have contracted HIV, or if your risk increases in the future, you may wish to consider counselling and testing. We will explore more about Voluntary Counselling and Testing (VCT) in the next lessons."

The HIV/AIDS quick quiz	TRUE	FALSE	I don't know
1. Only homosexual men, injecting drug users and prostitutes can be infected with HIV.			
2. An HIV-infected pregnant woman can pass the virus to her unborn baby.			
3. The AIDS virus attacks the body's defence system and makes a person vulnerable to other infections.			
4. You can become infected with HIV even if you are fit and healthy.			
5. You can become infected with HIV when you have unprotected anal sex.			
6. HIV can be transmitted through oral sex.			
7. If you are seronegative it means that you are immune to HIV.			
8. A baby can become infected with HIV through breastfeeding.			
9. You can get HIV/AIDS from toilet seats.			
10. You can become infected with HIV when you have unprotected intercourse one time only with an HIV-infected person.			
11. When you have an STI and practise unprotected sex, you are at greater risk of HIV infection.			
12. Married people can become infected with HIV.			
13. You can be infected with HIV and not be aware of it.			
14. You can be infected with HIV from sharing drinking glasses.			
15. Only an HIV test can determine if you are infected.			
16. HIV can be spread through coughing or sneezing.			
17. Condom use reduces the risk of HIV infection.			
18. Women who use the birth-control pill can become infected with HIV.			
19. You can get HIV infection from giving blood with sterile syringes.			
20. The HIV virus can survive outside of the body.			

SOURCE

- Action with Youth. HIV/AIDS and STD: A training manual for young people. Second Edition. International Federation of Red Cross and Red Crescent Societies, 2000. <http://www.ifrc.org>
- "Guidelines for Counselling Children who are Infected with HIV or Affected by HIV and AIDS", *HIV Counselling Series* No 7, Southern African AIDS Training Programme, Zimbabwe, & CIDA, January 2003.
- Horizons Program, Kenya Project Partners, Uganda Project Partners. *HIV Voluntary Counseling and Testing among Youth: Results from an Exploratory Study in Nairobi, Kenya, and Kampala and Masaka, Uganda*. Washington, DC: Population Council 2001.

Teacher/Facilitator reflection

- How effective do you think the lesson was in terms of:
 - Participation of all students?
 - The pitch or level of the lesson matching the students' abilities/interests?
 - Achieving the learning objectives?
- How comfortable were you with the content and methods?
- How did you adapt the lesson for your students & local situation?
- Other reflections:

WORLD AIDS DAY QUIZ

(from AVERT found at www.avert.org)

1. How do most people become infected with AIDS?
 - a. Sexual intercourse without a condom
 - b. Injecting drugs
 - c. Blood transfusion

2. When is World AIDS Day?
 - a. 1st January
 - b. 1st June
 - c. 1st December

3. What is the International symbol of AIDS awareness?
 - a. A red ribbon
 - b. A white ribbon
 - c. A pink ribbon
 - d. A white swan

4. Which people can't be infected with HIV?
 - a. Gay and lesbian people
 - b. Heterosexuals
 - c. Married people
 - d. No one

5. When was the first World AIDS Day?
 - a. 1984
 - b. 1988
 - c. 1986

6. What is the theme of World AIDS Day 2008?
 - a. Stop Stigma and Discrimination
 - b. Women and AIDS
 - c. Stop AIDS: Keep the Promise – Leadership

7. Approximately how many people worldwide were living with HIV/AIDS at the end of 2007?
 - a. 21.7 million
 - b. 33.2 million
 - c. 62.2 million

8. When did doctors in the USA first become aware of AIDS?

- a. 1971
- b. 1981
- c. 1984
- d. 1989

9. In what year was the vaccine for AIDS discovered?

- a. 1995
- b. 2002
- c. A vaccine for AIDS does not exist

10. How many adults and children worldwide were newly infected with HIV and AIDS in 2007?

- a. 2.5 million
- b. 25 million
- c. 250,000

ANSWERS: WORLD AIDS DAY QUIZ

Question 1. How do most people become infected with AIDS?

- a. Sexual intercourse without a condom

Question 2. When is World AIDS Day?

- c. 1st December

Question 3. What is the International symbol of AIDS awareness?

- a. A red ribbon

Question 4. Which people can't be infected with HIV?

- d. No one

Question 5. When was the first World AIDS Day?

- b. 1988

Question 6. What is the theme of World AIDS Day 2008?

- c. Stop AIDS: Keep the Promise – Leadership

Question 7. Approximately how many people worldwide were living with HIV/AIDS at the end of 2007?

- b. 33.2 million

Question 8. When did doctors in the USA first become aware of AIDS?

- b. 1981

Question 9. In what year was the vaccine for AIDS discovered?

- c. A vaccine for AIDS does not exist

Question 10. How many adults and children worldwide were newly infected with HIV and AIDS in 2007?

- a. 2.5 million

From: <http://cms.avert.org>

AVERT's HIV & AIDS Quiz – Easy Questions

1. Does HIV only affect gay people?
 - a. Yes
 - b. No
 - c. Only gay men
 - d. Only gay women

2. Which protects you most against HIV infection?
 - a. Condoms
 - b. Contraceptive pills
 - c. Spermicide jelly

3. How can you tell if somebody has HIV or AIDS?
 - a. Because of the way they act
 - b. They look tired and ill
 - c. There is no easy way to tell

4. Can you get AIDS from sharing the cup of an HIV positive person?
 - a. Yes
 - b. No
 - c. Only if you don't wash the cup

5. Is there a cure for AIDS?
 - a. Yes
 - b. No
 - c. Only available on prescription

6. What is HIV?
 - a. A virus
 - b. A bacterium
 - c. A fungus

7. Can insects transmit HIV?
 - a. Yes
 - b. No
 - c. Only mosquitoes

8. What does STD stand for?
 - a. Sexually Transmitted Disease
 - b. Special Treatment Doctor
 - c. Standard Transmission Deficiency

9. When was the term “AIDS” first defined?
 - a. 1977
 - b. 1987
 - c. 1982

10. The charity AVERT was set up in which year?
 - a. 1986
 - b. 1996
 - c. 2006

ANSWERS: AVERT's HIV & AIDS Quiz – Easy Questions

1. Does HIV only affect gay people?
 - b. No
2. Which protects you most against HIV infection?
 - a. Condoms
3. How can you tell if somebody has HIV or AIDS?
 - c. There is no easy way to tell
4. Can you get AIDS from sharing the cup of an HIV positive person?
 - b. No
5. Is there a cure for AIDS?
 - b. No
6. What is HIV?
 - a. A virus
7. Can insects transmit HIV?
 - b. No
8. What does STD stand for?
 - a. Sexually Transmitted Disease
9. When was the term “AIDS” first defined?
 - c. 1982
10. The charity AVERT was set up in which year?
 - a. 1986

AVERT's HIV & AIDS Quiz – Medium Questions

1. Approximately how many people are living with HIV worldwide?
 - a. 69.7 million
 - b. 33.2 million
 - c. 3.5 million

2. What does HIV stand for?
 - a. Harmful Intravenous Vaccine
 - b. Human Immunodeficiency Virus
 - c. Homosexual Injury Volition

3. What is the difference between HIV and AIDS?
 - a. HIV is a virus and AIDS is a bacterial disease
 - b. There is no difference between HIV and AIDS
 - c. HIV is the virus that causes AIDS

4. Which practice puts you most at risk of becoming infected with HIV?
 - a. Kissing
 - b. Using the same toilet as an infected person
 - c. Unprotected vaginal sex
 - d. Anal sex with a condom

5. What is abstinence?
 - a. To refrain from sex
 - b. To only have sex with one partner
 - c. To lose your virginity

ANSWERS: AVERT's HIV & AIDS Quiz – Medium Questions

1. Approximately how many people are living with HIV worldwide?
 - b. 33.2 million
2. What does HIV stand for?
 - b. Human Immunodeficiency Virus
3. What is the difference between HIV and AIDS?
 - c. HIV is the virus that causes AIDS
4. Which practice puts you most at risk of becoming infected with HIV?
 - c. Unprotected vaginal sex
5. What is abstinence?
 - a. To refrain from sex

AVERT's HIV & AIDS Quiz – Hard Questions

1. HIV can make a person ill because...
 - a. It makes a person lose weight very suddenly
 - b. It attacks the immune system
 - c. It reduces the body's core temperature
2. How much saliva would it take to infect someone with HIV?
 - a. 1 liter
 - b. 10 ml
 - c. HIV cannot be passed on through saliva
3. Which of the following helps with HIV prevention?
 - a. Circumcision
 - b. Genital piercing
 - c. Taking birth control pills
4. Which is the leading HIV-associated disease in developing countries?
 - a. Pneumonia
 - b. TB
 - c. The common cold
5. Worldwide, HIV is most common in which age range?
 - a. 0 to 14 years old
 - b. 15 to 24 years old
 - c. 25 to 34 years old

ANSWERS: AVERT's HIV & AIDS Quiz – Hard Questions

1. HIV can make a person ill because...
 - b. It attacks the immune system
2. How much saliva would it take to infect someone with HIV?
 - c. HIV cannot be passed on through saliva
3. Which of the following helps with HIV prevention?
 - a. Circumcision
4. Which is the leading HIV-associated disease in developing countries?
 - b. TB
5. Worldwide, HIV is most common in which age range?
 - b. 15 to 24 years old

HIV CURRICULUM TRAINING/WORKSHOP DATES
Maine Department of Education, HIV Prevention Education Program
 Fall 2008 - Spring 2009
 (Revised 9/08)

Date	Training Name	Audience	Location
Oct 29-30, 2008 2 days	Reducing the Risk/ Safer Choices Training	➤ Middle and High School health educators, school counselors, & others teaching health, school nurses, school health coordinators, curriculum coordinators	Spectacular Events Center, Bangor
Nov 6, 2008 1 day	2008 HIV Update (on ITV)	➤ High school health educators, school nurses, school health coordinators, curriculum coords	Univ. of Maine Augusta/ ITV sites state-wide
Nov 19-20, 2008 2 days	Best Practices in HIV Education Training	➤ High school health educators, school nurses, school health coordinators, curriculum coords	Eastland Park Hotel, Portland
Jan 21, 2009 1 day	Real Talk Training (Beginning conversations about HIV prevention and making decisions to be sexually healthy)	➤ 6/7 th grade health educators, school counselors, & others teaching health, School health coordinators, Curriculum coordinators	Hilton Garden Inn Auburn River Watch
Feb 11, 2009 1 day	Partners in Prevention Training	➤ Individuals who have been trained in Dept. of Education HIV curricula and invited school staff	Maine Principals Association, Augusta
April 14, 2009 1 day	4th Annual Comprehensive Sexuality Education Conference	➤ Health educators, curriculum coordinators, school nurses, school counselors, community health workers, youth agency staff, social workers	Augusta Civic Center
June 2009 2 days	<i>Be Proud! Be Responsible</i> Training	➤ Professionals working with at risk youth in alternative schools, shelters, drop-in centers and other similar programs	TBD
July 2009 1 day	Creating Safe Spaces for GLBTQ Youth	➤ Staff of shelters, residential programs, drop-in centers	TBD

For more information, contact the HIV Prevention Education Program at the State of Maine Department of Education at 624-6692 or e-mail: hiv.doe@maine.gov.



professional development in your pajamas!



Answer recognizes that as educators, you crave high-quality professional development that helps you become better teachers. Yet we know that many of you simply do not have the time to travel to workshops. What's more, we know that some of you are required to teach sex ed without having a background in this often-controversial subject, so you end up having to teach a subject you may know little about!

Our online professional development workshops are designed to help teachers like you. We provide high-quality training to health educators via professional development workshops you can take from the comfort of your own home. These workshops are tailored to fit both your busy schedule and your professional development needs.

Sexuality ABCs (Abstinence, Birth Control and

Condoms)— our first online course for educators nationwide — will launch in January 2008. This dynamic and highly interactive course will be the equivalent of six hours for which you will receive professional development credit. You have a month to complete the course at times that are convenient for you. Our self-directed course allows you to set your own pace while learning about adolescent sexuality.

Sexuality ABCs (Abstinence, Birth Control and Condoms) uses fun and engaging online techniques—such as podcasts, flash animation, videos, threaded discussions and interactive games—to help you:

- »» Understand trends in adolescent sexual behavior
- »» Get updated on contraceptive methods
- »» Receive sample lesson plans
- »» Practice answering FAQs from teens
- »» Review laws regarding teens accessing birth control
- »» Discover the most current resources

The registration fee is \$125. You will receive a certificate of professional development upon successful completion of the course. Additionally, the course is approved for six category one CHES credits by the National Commission for Health Education Credentialing (NCHEC). Please inquire about group discounts if you are interested in enrolling department staff from the same school or agency.

To register or receive more information, go to the Answer Web site at <http://answer.rutgers.edu>



HOTLINES AND WEBSITES FOR TEENS

HOTLINE PHONE NUMBERS

MTV “Think” Campaign (HIV, STD & Pregnancy Info):

1-888-237-2331 (1-888-BeSafe1)

Centers for Disease Control:

1-800-232-4636 (1-800-CDC-INFO)

National STD Hotline –

American Social Health Association (ASHA):

1-919-361-8488 (*not toll free*)

WEBSITES

www.ashastd.org

www.goaskalice.columbia.edu

www.iwannaknow.org

www.kidshealth.org

www.sxetc.org

www.teenadvice.org

www.teenaids.org

www.teenwire.com

MAKE YOUR PLEDGE

World Aids Campaign found at www.worldaidscampaign.org

-Either- Make your own pledge (maximum 20 words)



-or- Choose to pledge one of the following:

- I will speak to my family and/or friends about AIDS
- I will write a letter or join a rally demanding universal access
- I will volunteer or donate to an AIDS cause

Full name: _____

Email: _____

Country: _____

We would like to keep you updated on world AIDS campaigning. Check this box if you do not want to receive occasional updates from the World AIDS Campaign.

Please send your completed form to World AIDS Campaign, Warmoesstraat 149 – 151, 1012 JC Amsterdam, The Netherlands

By completing this form, you are agreeing to allow your leadership pledge and name to be used publicly for AIDS campaigning initiatives.