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The vision for providing HIV services is a coordinated community and statewide effort supported by public and private partnerships to provide comprehensive services that assure:

- All residents, regardless of age, race, gender, class, sexual orientation, or ethnic background, are equipped with appropriate information to make informed behavioral decisions and choices that will not place them and those with whom they interact at risk for HIV infection;

- Support for strong, positive community attitudes and social norms;

- Communities have the necessary resources for prevention, testing, and interventions to reduce the spread of HIV/AIDS; and

- Communities have the necessary comprehensive, community-based, culturally competent, affordable network of care services to maximize the quality of life for those individuals living with HIV/AIDS.
The mission of the Division of HIV/AIDS Services (DHAS) is to prevent, treat and reduce the spread of HIV/AIDS in New Jersey. The DHAS monitors the epidemic and assures through its resources that individuals who are at risk for or infected with HIV have access to culturally competent, community-based networks that provide qualitative and comprehensive services.
Purpose of the Annual Report

This annual report provides a summary of the major programmatic activities conducted by the Division of HIV/AIDS Services (DHAS) during 2007, which have contributed to accomplishing our mission of reducing the spread of HIV disease. It is a useful document for gaining some measure of where we are in the battle against HIV transmission in New Jersey. Specifically, this report will provide an overview of the HIV epidemic in New Jersey; identify the various funding sources that support programming; highlight programmatic activity conducted in 2007; describe the role of policy development and planning as it relates to service delivery; and outline the challenges that remain ahead in pursuit of our mission.
Despite claims to the contrary, human beings are generally optimistic about most things. We see current events as not that bad (even though we wish them to be better), and we see the future as improving, because we really cannot conceive (or are willing to accept) that they will get worse. So it is also with HIV/AIDS that is, assuming you can get the average person to even consider it as a topic worthy of discussion. We simply want things to be better in terms of the HIV epidemic. And we believe that it must be better because you just don’t hear that much about it. There is little in the newspapers and not too much on the evening news. Just some passive conversation at parties. No big name entertainers or athletes seem to be dying from AIDS. And with the sting of death seemingly removed because people with HIV are living longer, with what has increasingly become a manageable disease, we fear HIV/AIDS less! Thus, HIV has become removed from our daily lexicon of concern, and is somehow overshadowed in a competitive potpourri of issues including: high gas prices, war, terrorism, rising crime, raising children, paying bills, foreclosures and just plain making it through another day. But as that 1970’s song says, “when you get right down to it,” HIV/AIDS is still a major public health problem in New Jersey. We now know that there are more people living with HIV than we previously thought . . . and many of them are not aware of their infection. In addition, many are not in care, and continue to expose their partner(s) to infection. And there is still no vaccine.

The devastation of HIV/AIDS upon the African American and Latino populations rivals that of some Sub-Saharan countries. Almost 8 out of every 10 people living with HIV in New Jersey are African American and Latino. While the human desire is to look at most things in a positive way, we tend to either ignore or spin a negative tale in a positive way. Such is the case with HIV. Despite the spin that everything is cool and that things “. . . ain’t that bad . . .,” things are bad. People are still getting infected. People with HIV disease are still dying. And increasingly, complacency, indifference and apathy are becoming the new frontiers that must be overcome in this battle against HIV. We hope that the activities and interventions described in this report help us continue to wage the necessary battle to overcome all of these challenges, both old and new.
The Fight Against AIDS Continues...

Overview of the Epidemic in New Jersey

Nationally, New Jersey continues to rank fifth in cumulative AIDS cases, third in cumulative pediatric AIDS cases and has the highest proportion of women living with AIDS. Ten counties account for 83 percent of persons living with HIV/AIDS in the state with Essex and Hudson Counties having the highest rate of infection (see map of New Jersey).

Approximately half of the persons living HIV/AIDS are between the ages of 25 and 44 years of age, however as the infected population ages, a greater proportion of those living with HIV/AIDS are 50 years of age and older.

The HIV/AIDS epidemic in New Jersey is increasingly and disproportionately impacting minorities, particularly African American women. During 2004-2005 the rate of HIV/AIDS among African American women was 26 times higher than the rate among non-Hispanic White women, and among Hispanic women the rate was 8 times higher than the rate among non-Hispanic White women. At the end of December 31, 2007, minorities represented 78 percent of persons living with HIV/AIDS.

Over 69,000 New Jersey residents have been reported with HIV/AIDS and 33,623 were living with HIV/AIDS as of December 31, 2007. Another estimated 15,000 New Jerseyans are infected with HIV, but do not know it.
As of December 31, 2007

- One in 64 Black non-Hispanics was living with HIV/AIDS;
- One in 185 Hispanics was living with HIV/AIDS; and
- One in 728 White non-Hispanic was living with HIV/AIDS.

More people living with HIV/AIDS in 2007 were exposed through sexual contact than through any other mode of exposure. However, injection drug use continues to be a major mode of transmission.

Other populations are also feeling the effects of HIV/AIDS. Increasingly, HIV has become a problem of persons 50 years of age and older. The rise in HIV cases among this population is emerging as a significant issue for men and women. Several factors contribute to why this population is at increased risk for HIV. The immune system weakens with age and as a result the body has less ability to fight infection. Similarly, persons 50 years of age and older tend to have more chronic health conditions which may interfere with HIV treatment and medications. Other factors include: the lack of perceived risk, low frequency of condom use and HIV testing, and the lack of education among health care professionals, physicians and others concerning risk behaviors in the older population.
Overview of the Epidemic

Persons Living with HIV/AIDS

Number of Cases in each county as of December 31, 2007
Division of HIV/AIDS Services

Funding

SFY 07
7/1/06 – 6/30/07
Federal, State and Other Funds by Funding Source

Federal, State and Other Funds By Funding Source

- Ryan White Part B - $47,617
- ADDP Pharmaceutical Rebates - $36,002
- State Appropriation - $33,891
- Prevention Cooperative Agreement - $13,322
- Surveillance Cooperative Agreement - $3,290
- HOPWA Grant - $1,064
- Morbidity Grant - $512
- Surveillance (Not in Care) - $303
- Enhanced Perinatal Surveillance - $217
In 2007 a significant portion of funding (over 74 percent) supported an expanding network of programming for the care and treatment of over 14,500 HIV infected citizens.
In 2007 the DHAS conducted a variety of programs and activities in a coordinated effort to educate the public, increase overall awareness and more effectively reduce and/or prevent at-risk behaviors as a way to prevent transmission of HIV infection, increase the percentage of individuals who know their HIV status and increase access to care and treatment of persons living with HIV. The ribbon provides a summary of how all the pieces of the puzzle come together, allowing the Division to accomplish its mission.
The monitoring of disease through surveillance is a basic public health function and an essential part of the Division’s mission. Surveillance is critical in helping determine resource allocation and targeting and evaluating HIV services. Routine AIDS surveillance has been conducted in New Jersey since 1983, and HIV surveillance since 1992.

One of the more significant events that occurred during 2007 involved the Centers for Disease Control and Prevention (CDC) funded activity called the Medical Monitoring Project (MMP). The goal of this project is to assess the quality of medical care received by persons who are HIV positive and receiving treatment in New Jersey. This is accomplished through patient interviews and a review of their medical records to determine, among other things, risk behaviors, medication adherence and laboratory measurements.

In 2007, the DHAS expanded this project by reaching out to 500 HIV infected individuals who were receiving medical care. These individuals were contacted by mail as well as follow-up phone calls to seek their participation in the project. Although recruitment efforts have been slow due to poor client feedback, a total of 14 clients have participated. Data collection will continue next year.
The National HIV Behavioral Surveillance (NHBS) is a four-year CDC initiative, designed to assess and track risk behaviors of selected populations living in Newark Eligible Metropolitan Areas (Newark, Union, Morris, Sussex and Warren Counties). This initiative consists of three cycles that are used to evaluate three populations who are at high risk for HIV. They are as follows:

- **Cycle 1**: Men Who Have Sex With Men (MSM)
- **Cycle 2**: Injecting Drug Users (IDU)
- **Cycle 3**: Heterosexuals At Risk for HIV (HET)

The assessment of risk behaviors among the MSM and IDU (Cycle 1 and Cycle 2) populations were completed in 2004 and 2006. During 2007, DHAS staff conducted interviews of 794 HET individuals living in Newark. Of the 794 who completed the interview, 98 percent of the individuals took an HIV test. Of those, 5 percent tested positive for HIV. Further data collection and review will continue in 2009 and 2010.

In addition, to activities associated with the NHBS, initial work on the Partner Study (PS), a supplement to the NHBS was completed in 2007.

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**Epidemiologic Studies:**
**National HIV Behavioral Surveillance**

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**HIV/AIDS TIMELINE HIGHLIGHTS**

**1980**
First report of AIDS within New Jersey.
The PS involved interviews with African Americans and Latinas and their sexual partners about their sexual and other HIV risk behaviors.

The purpose of the PS is to determine:
- The risk behaviors of the male partners of minority women.
- How closely the perceptions of minority women match the behaviors of their male sex partners.
- Dynamics among couples where one partner has HIV and the other does not (i.e., sero-discordant couples).

Preliminary results suggest that of the 362 women determined to be eligible for an interview, 97 percent participated in the survey process. Of these women, 25 male partners agreed to complete a Partner Survey as well as have an HIV test. Women who declined to participate in the Partner Survey indicated that they were simply uncomfortable in asking their male partner to complete a survey. Future analysis of the high-risk heterosexual and PS shall be conducted in 2008.

Initiated in 2005 the Incidence Surveillance (IS) project continues to be integrated into the activities of routine HIV surveillance. The goal of this project is to determine the proportion of HIV cases that represent new infections (less than 6 months post exposure). A laboratory test known as Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS) is performed on blood that remains left over after an HIV specimen is obtained. From this remaining blood specimen a determination can be made about whether an individual is newly infected (i.e., less than six months old) or ongoing. In 2007, all counseling and testing sites using the rapid HIV testing technology were enrolled in the project along with several other high volume private laboratories. From 2005 through 2007 a total of 1,063 specimens were analyzed using the STARHS technique. Of

HIV test is first used to test blood supply. Actor Rock Hudson dies of AIDS.
Beginning in 2005, New Jersey was selected as one of five project areas by the CDC to participate in a pilot project called the “Never In Care” (NIC) study. The purpose of this study is to determine the following:

- Number of persons who are reported to the state as having HIV, but who have not obtained medical care within a 15 month period;
- Barriers to receiving HIV medical care and how circumstances, experiences, beliefs, attitudes and cultural norms may contribute to a lack of access to medical care; and
- How to encourage those to access and participate in medical care.

The study will involve the administration of an interview and the collection of a blood specimen for CD4 and viral load testing. The goal is to recruit 300 eligible participants by September of 2009.

During 2007, the CDC used New Jersey’s preliminary NIC data as part of a national abstract that was presented at the HIV/AIDS Prevention Conference held in Atlanta, GA. The national abstract focused on the demographic characteristics of persons who are HIV positive, but not receiving medical care. In New Jersey between November 1, 2005 and October 31, 2006, 2,142 persons were added to the state’s HIV registry, of which 606 (22 percent) were determined not to be in medical care. The data for the “not in care” population shows that persons between the ages of 18 and 34 were significantly less likely to be in care compared to those aged 35 and older; African Americans (54 percent) and Hispanics (26 percent) were less likely to be in care than Whites (17 percent); and men (66 percent) were less likely to receive care than women (34 percent).
The chain of HIV transmission continues in New Jersey because people infected with HIV continue to participate in risky behaviors with uninfected partners. While many people with HIV are aware of their infection, it is estimated that one out of every four of them are not. It is this group that perpetuates this chain of infection. To help break this chain of infection, the DHAS developed the Notification Assistance Program (NAP) in 1988. NAP is the only DHAS surveillance initiative that provides direct services to patients throughout the state. This program locates HIV infected people who fail to return for their test results, notifies them of their infection, and attempts to transition them into care. Additionally, NAP field investigators elicit the names of sex and/or needle sharing partners (or “contacts”) for the purpose of locating and notifying them that they may have been exposed to HIV, and to test them for HIV. This notification process has long been a standard public health practice modeled after the successful approach used for decades in Sexually Transmitted Disease Clinics.

In 2007, NAP counseled 612 individuals infected with HIV compared to 315 individuals in 2006. This increase is due to the following change in procedure. Prior to 2006, NAP staff only contacted HIV infected individuals that were referred by testing sites because the individual had failed to return for their test results. Beginning in 2006, NAP staff also began contacting HIV infected individuals who were reported to the HIV/AIDS disease registry.

Of the 612 HIV infected individuals counseled, 407 were contacted as a result of interfacing with the HIV/AIDS registry. A total of 287 were referred into medical care. Field staff investigators elicited 200 names of partners or “contacts” for a contact index of .70. NAP staff also found 152 partners during 2007, with 9 testing positive, for an overall seropositivity rate of 10 percent.
New Jersey continues to be a leader among states in the reduction of mother-to-child HIV transmission. Dramatic reduction in mother-to-child transmission has occurred since the Pediatric AIDS Clinical Trial Group (PACTG) 076 Clinical Trial showed that antiretroviral agents starting in the second trimester can reduce the risk of transmission. A comprehensive approach to reducing mother-to-child transmission includes HIV counseling and voluntary testing of pregnant women in conjunction with antiretroviral agents, laboratory monitoring and an elective caesarean section at 38 weeks of gestational age for women with a viral load > 1,000 has been extremely successful in New Jersey. Of 1,315 pediatric HIV/AIDS cases in New Jersey, 1,229 (93 percent) are a result of mother-to-child transmission. The number of infants born with HIV infection each year has dropped from 91 in 1993 to 2 infants in 2007. The goal is the maximal reduction of mother-to-child transmission.

The Centers for Disease Control and Prevention (CDC) published recommendations in September 2006 for “opt out” HIV testing, meaning that women will automatically be tested for HIV unless they elect not to be. As a result of these recommendations Acting Governor Codey signed a bill into law on December 26, 2007 which requires that pregnant women will be tested for HIV as part of routine prenatal care in the first and third trimesters of pregnancy, unless they opt-out. Specifically, this law requires healthcare providers to test pregnant women for HIV as part of routine prenatal care unless the woman refuses testing. This law changes the HIV testing of pregnant women in New Jersey from an “opt in” system which required written consent or refused as previously required by P.L. 1995, c.174 to “opt out” testing. With an opt-out approach, HIV testing is included in the routine panel of prenatal tests.

Perinatal transmission has decreased from 91 children or 21% of those exposed in 1993 to 2 children or 2% of those exposed in 2007.
The law also requires the testing of newborns whose mother’s HIV status is either positive or unknown at the time of delivery. It further stipulates that the Commissioner of the Department of Health and Senior Services will develop regulations to ensure that all pregnant women are routinely tested for HIV during the first and third trimester if their status is unknown. Similarly, the Commissioner is required to establish these regulations to be consistent with the most recent CDC recommendations.

During 2007 the DHAS will begin drafting these regulations on HIV screening for pregnant women and newborns. This law will become effective in June of 2008.
The Centers for Disease Control and Prevention report that there are over 1.2 million Americans infected with HIV, and at least one out of every four of them do not know it. Despite numerous educational efforts and testing campaigns, many people have not been tested for HIV, and thus remain unaware of their status. Many continue to engage in high-risk behaviors, putting numerous others at risk of being infected, and further expanding the epidemic. Whether it is a lack of information, motivational issues or missed opportunities for testing, the result has been a disturbing 56,000 new HIV infections per year nationwide for the last several years.

In an effort to reduce the expansion of this epidemic, and to increase the number of people who know their status, the CDC published guidelines in September of 2006 that recommend the integration of HIV testing into routine medical care in all healthcare settings for persons aged 13 to 64, including pregnant women. These guidelines encouraged states to remove certain barriers to testing (e.g., separate written consent and dedicated counseling), and established the means for the provision of “opt-out” testing, where an individual would have to say that they did not want to be tested for HIV.

In acknowledging the intent of these guidelines, the DHAS continued its expansion of rapid HIV testing in various healthcare venues. By the end of 2007, 122 sites have been licensed to provide rapid HIV testing, including 23 mobile units and 21 emergency departments (ED) where for many people who are uninsured poor or have no primary healthcare provider; this is their only access to medical care.

- 60,790 people were tested for HIV with the rapid HIV test in 2007;

1992
Confidential named HIV reporting begins in New Jersey. Tennis champion Arthur Ashe announces he has AIDS. Actor Robert Reed dies of AIDS.
The Fight Against AIDS Continues...

HIV Testing: Knowing Your Status

Knowing Your Status

- 99 percent of the individuals received their test results;
- 122 sites were available in 2007 to conduct rapid HIV testing; and
- 70 percent of those testing positive with the rapid HIV test were “new” positives in 2007.

Because most ED patients are not admitted, there exists an opportunity to identify individuals early who may be infected with HIV using a rapid test. In 2007, EDs had the highest percentage of patients who tested HIV positive when compared to other publicly funded sites. A total of 8,102 individuals were tested in 2007 using the rapid HIV test in hospital EDs. Of those, 138 (1.7 percent) tested positive. The entire testing network of over 400 programs (which includes over 122 rapid testing sites) tested 75,352 individuals in 2007, with 843 testing HIV positive for a seropositivity rate of 1.12 percent. Of the 75,352 people tested for HIV in 2007, 81 percent were tested using the rapid HIV test.

Rapid HIV Test

- Simple finger stick
- Results in just 20 minutes

HIV/AIDS TIMELINE HIGHLIGHTS....

OraSure testing began in New Jersey.
The FDA approves protease inhibitors as standard treatment.
The prevention of HIV disease is the operational mission of the Division of HIV/AIDS Services. Every initiative and intervention is operationalized with the intent of preventing one from being infected with HIV, to reduce one’s risk from being exposed to or transmitting HIV, or to facilitate access to care of those infected, in an effort to maximize positive health outcomes and reduce further transmission.

**Drop-in Centers**

Drop-in Centers provide interventions and activities to reduce HIV risk behaviors that put injection drug users, other drug users, homeless, sex workers, and the overall community at-risk for HIV, STD and hepatitis infections. Services include: health education/risk reduction, comprehensive risk reduction services, basic needs (social service support, personal care items, showers, food etc.), skills building, referral, HIV counseling and testing and referral. The goal of the Drop-in Center is to develop a continuum of services that allow individuals an opportunity to enter the system at any point and move through it at their own pace.

DHSS-DHAS currently funds five Drop-in Centers in New Jersey specifically targeting injection drug users (IDUs), homeless and sex workers in the following cities: Atlantic City, Camden, Jersey City, Newark and Paterson. In 2007 Drop-in Center staff provided drop-in center services to 1,654 individuals of whom 186 (11 percent) were identified as people living with HIV. A total of 123 high-risk individuals successfully completed small group counseling. These centers enrolled 146 individuals in comprehensive risk reduction counseling, of whom 56 (38 percent) were HIV positive.

**CDC reports AIDS as the leading cause of death for men aged 25-44 in 64 cities. Government sponsored report calls for increased funding for needle exchange programs in order to help prevent the spread of HIV.**
The Fight Against AIDS Continues...

Prevention Services For Women

Since the earliest days of the epidemic in the United States, New Jersey has had the highest proportion in the country of AIDS cases in women. Among women, African Americans and Latinas have been most disproportionately impacted in New Jersey’s epidemic. This fact has kept women among the highest priorities of the New Jersey HIV Prevention Community Planning Group for HIV prevention services. The DHAS has responded to this need by funding 26 HIV prevention programs for women, with an additional eight for teenaged girls, located at 22 community-based agencies across the state. This statewide network of HIV prevention resources for women is supported by approximately $3.2M in state and federal funding each year. In addition, free confidential rapid HIV testing and counseling is offered to women at more than 150 locations across New Jersey.

The 34 prevention programs for women are as diverse as the epidemic itself. They provided outreach services to at least 10,130 women in 2007, of which 50 percent were African American, and Latinas accounted for 43 percent of women outreached. Each program offers a variety of prevention activities designed to meet the needs of each individual woman. In 2007, 53 percent of the 80,000 people tested at publicly funded HIV test sites were women. Among the 2053 women who participated in individual counseling or educational sessions, 62 percent were African American and 30 percent were Latina. Of the women who were enrolled in Comprehensive Risk Counseling Sessions, 50 percent were African American and 42 percent were Latina. Among these women, 47 percent were non-injecting drug users, 34 percent were sex workers, and 23 percent were HIV positive.

HIV/AIDS TIMELINE HIGHLIGHTS....

Congress reauthorizes Ryan White CARE Act. Combination therapy viewed by scientists as more effective in suppressing HIV.
New Jersey continues to face a growing epidemic of hepatitis C. The CDC suggests that greater than 155,000 New Jerseyans are infected with the hepatitis C virus, resulting in more than 450 deaths per year. Like HIV, hepatitis C is transmitted largely through injection drug use with contaminated syringes. Additionally many people living with HIV in New Jersey are co-infected with one or more types of viral hepatitis, despite the fact that both hepatitis A and hepatitis B are vaccine preventable diseases. Because of this connection and the fact that there is no vaccine against hepatitis C, the integration of hepatitis services into HIV prevention is critical, and can ensure that individuals have access to information regarding viral hepatitis prevention and treatment.

The DHAS has been working with healthcare providers to train them on how to prevent hepatitis and HIV transmission. The DHAS conducted 40 training sessions and has reached more than 600 individuals since its inception in 2004. These trainings included the following: hepatitis screening; modes of transmission; information on hepatitis A, B, and C as well as HIV; ways to incorporate hepatitis into prevention messages; risk for hepatitis; vaccinations; available resources; and support services for clients.

During 2007, the DHAS requested that HIV prevention service grantees begin collecting outcome data on hepatitis. Thus far, agencies have helped 74 clients to get fully vaccinated for hepatitis A, and 138 to get vaccinated for hepatitis B. An additional 772 clients have received a combination of hepatitis A vaccine and hepatitis B vaccine. Of those, 181 individuals are now fully vaccinated. In addition agencies reported that they have tested 2927 clients for hepatitis C and of the 945 who tested positive, 559 are now enrolled into care.
Prevention

Needle Exchange: Reducing Injecting Drug Use

Shortly after Governor Corzine signed into law P.L. 2006, c.99 (the “Bloodborne Disease Harm Reduction Act”) in December of 2006 the DHSS and DHAS conducted activities to facilitate the implementation of Syringe Exchange Programs (SEPs). The DHAS released a “Request for Proposals” and accepted applications from agencies to operate SEPs in 2007. The DHAS approved four municipalities to operate a syringe exchange program (SEP). They are Atlantic City, Camden, Newark and Paterson. To facilitate implementation the DHAS developed regulations and guidelines for SEPs. These operational guidelines included standards for medical waste, occupational exposures (needle stick injuries), referrals and HIV testing.

Atlantic City became the state’s first operational SEP on November 27, 2007, as a collaboration between the authorizing entity, the Atlantic City Department of Health, and its partner agency, the South Jersey AIDS Alliance through its “Oasis Drop-in Center.” Because the Oasis Drop-in Center is located directly across the street from the local drug treatment agency they are able to provide immediate linkages to drug treatment. On the first day of operation the Oasis Drop-in Center saw 20 people who were registered in the SEP. By the end of 2007, the Center had enrolled a total of 127 participants. It is anticipated that the other three cities will begin operating SEPs by the end of February 2008.

HIV/AIDS TIMELINE HIGHLIGHTS....

Although a government report acknowledges that needle exchange programs decrease the spread of HIV/AIDS and do not lead to increased drug use, it does not recommend lifting the ban against federal funding of them.

1998
The DHAS continued to operate four Patient Incentive Programs (PIP) in 2007 at drug treatment centers in Asbury Park, Atlantic City, Newark and Trenton. These PIP projects provide drug treatment on demand, HIV testing, risk reduction counseling, education, and on-site HIV care and treatment to injecting drug users at high risk for acquiring or transmitting HIV infection. During 2007, these four projects admitted 640 patients, 493 (77 percent) of whom were new to the program. Among those admitted in 2007, 26 percent completed treatment protocols, 35 percent remained active in PIP, 23 percent dropped out, and 16 percent were transferred to another level of care. The HIV seropositivity rate for PIP in 2007 was 3 percent, identifying 13 new HIV positive individuals of the 692 HIV rapid tests provided.

Patient Incentive Program (PIP)

PIP projects provide drug treatment on demand to injecting drug users at high risk.

HIV/AIDS TIMELINE HIGHLIGHTS

Surveillance definition is revised to include viral loads.
The Health Incentive Program for Women (HIP4W) is designed to reduce the transmission of HIV among female sex partners of at-risk men. Women in the program receive HIV testing, harm and risk reduction counseling, and life skills enhancement, which are designed to bring about and sustain long-term behavior change. Eligible clients must not be current drug injectors nor have been users within the past six months. In 2007, 145 clients participated in the 180 day program on HIV prevention, medical treatment, employment skill building, job readiness training along with prevention education on HIV and drug use, risky sexual behaviors, sexually transmitted diseases, relationships, stress and nutrition. Support systems are also in place to assist clients with their behavior change choices. The HIP4W projects are operational both in Newark and Trenton.
27th Anniversary of AIDS reporting in the United States.
Although there has been progress, the severity of the devastating impact HIV has on the African American and Latino populations in New Jersey continues. While combining for only 25 percent of the state’s population, 80 percent (or 8 out of every 10) of those living with HIV/AIDS in New Jersey are African American and Latino. HIV/AIDS remains a leading cause of death for both African American and Latinos, driven partially by getting tested later in their infections, denying risk, and failure to access care in a timely manner. Denial, fear, stigma and lack of knowledge and trust continue to shape why African Americans and Latinos do not get tested for HIV.

Poverty, discrimination, homophobia, racism, lack of healthcare, language barriers and incarceration are a few of the complex factors that make African Americans and Latinos more vulnerable to HIV infection. And while a lot of innovative programming continues to evolve, there is an ever-growing demand to do more . . . and to do things that are more effective at addressing and resolving problems. Several years ago, the DHAS incorporated community mobilization initiatives as a core component of interventions to prevent and reduce HIV transmission in the African American and Latino communities.

Community mobilization is a process that is used by the DHAS to engage all sectors of the population in a community-wide effort to address and reduce the spread of HIV transmission. This process allows the DHAS to bring together and work with policymakers, faith leaders, healthcare professionals, advocacy groups, small businesses and others to build stronger and healthier communities.

Part of this process involves mobilizing resources, disseminating information, generating support and fostering cooperation across public and private sectors in the community. Several programs have been implemented by the DHAS to help build stronger communities.
Strong communities are essential for success in eliminating disparities in health outcomes and increasing quality and length of life. Project Rebuild is a 12 week structured intervention designed to combat community epidemics by focusing on the family rather than on the individual. Rebuild seeks to incorporate the use of communication and free expression as a way to help a family discussion of HIV and reduce risk behavior. Project Rebuild focuses on the “stages of change.” In 2007, 325 individuals (235 families) were successfully enrolled and participated in this program.

New Jersey receives $11.7 million in state funding to support AIDS Drug Distribution Program (ADDP).
The IMPACT initiative continues to be active in the following 10 cities: Atlantic City, Camden, Jersey City, Elizabeth, New Brunswick, Plainfield, Paterson, Newark, Asbury Park and Trenton which comprise 64 percent of all African Americans living with HIV/AIDS in New Jersey:

The IMPACT initiative utilizes existing state and local resources to bring together consumers and key leaders to: 1) raise the level of awareness of HIV/AIDS as a major public health concern; 2) improve the ability to change those behaviors that place community members at risk for HIV/AIDS; 3) increase the influence of existing programs to effect positive behavior change; and 4) strengthen social norms and values supporting HIV/AIDS prevention efforts and facilitate positive behavior change. One of the more significant IMPACT initiative activities conducted during 2007 was the continued expansion of the availability of rapid HIV testing. The DHAS expanded its network of rapid testing sites into 35 new health care venues in 2007, including community health centers, emergency departments of urban-based hospitals and faith-based organizations. Of the estimated 56,000 individuals tested with the rapid testing technology in 2007 over 60 percent were African Americans. There is also a corps of eight IMPACT initiative mobile units throughout the state, which facilitate the provision of HIV testing by being able to go where the people are in the community.

HIV/AIDS TIMELINE HIGHLIGHTS....

55 sites licensed to perform rapid HIV testing.
Division of HIV/AIDS Services

Community Mobilization

Project FAITH was initiated because the role of the faith sector is critical in our effort to more effectively engage the African American community. Interventions that seek to change risk behaviors and/or social norms are more effective when coupled with the deeply held faith practices in the community. Because these faith practices are key to behavior change, the community and group level prevention initiatives target faith leaders in various houses of worship to utilize their leadership in communicating the appropriate culturally sensitive message. During 2007, Project FAITH, in collaboration with the DHAS, hosted the following outreach forums:

- The Black Church Week of Prayer for the Healing of AIDS – March 2007
- The Black Church Lights the Way, HIV Testing – June 2007
- World AIDS Day – December 2007

More than 4500 individuals attended and participated in these and other events such as health fairs and two home based health education classes.

Former Governor Codey signed into law Senate Bill 2481, legislation which permits a minor (at least 13 years old) to be tested for HIV without parental consent.
Community Mobilization

Latinos continue to be disproportionately affected by HIV/AIDS in New Jersey, while accounting for 20 percent of all new HIV infections despite the fact that they compromise only 14 percent of the state’s population. One in every 185 Latinos is infected with HIV. Eighteen percent of women living with HIV in New Jersey are Latina, and 63 percent of those infections are transmitted through heterosexual contact.

Project LISTOS was initiated in 2005 to help address the disproportionate impact of HIV/AIDS in Latino communities. Six agencies are currently operational in the following communities: El Club Del Barrio in Newark, Horizon Health in Jersey City, PROCEED in Elizabeth, the Hispanic Family Center in Camden, the Spanish Community Center in Atlantic City and the City of Trenton. These agencies use “Promotores” to conduct intensive outreach and HIV testing. The promotores function as advocates by helping individuals access rapid HIV testing, navigate the health care system, ensure medications are purchased and taken, as well as provide information on safer sex and healthier lifestyles. During 2007, outreach impacted 1,197 high-risk individuals and 713 were successfully referred for HIV testing.
The DHAS supports a statewide network of comprehensive clinical care centers for the medical management of both individuals and families living with HIV disease. These centers called Early Intervention Programs (EIPs) provide an array of services that include HIV medical care, counseling, referrals, medical education, and access to dental care, medication, case management services and clinical trials.

There are 20 statewide programs that provide these services. During 2007 more than 8500 individuals received medical services in these facilities. These programs are not only linked with other providers in their regions, but also receive funding from other sources. This approach allows a coordinated effort in maintaining the continuum of care for clients. The DHAS believes that these critical linkages, particularly to support services, are an important component in the development and planning of a client’s care and treatment. As a result of this, comprehensive care is the improvement in an individual’s overall health care and quality of life.

**HIV/AIDS TIMELINE HIGHLIGHTS**

The CDC issued its testing guidelines by recommending that all adults/adolescents be routinely tested for HIV.
The Fight Against AIDS Continues...

Care and Treatment

Reauthorization of the CARE Act Legislation

Toward the end of 2006 the President signed the reauthorization of the Ryan White CARE Act. The CARE Act has been the main source of funding for primary medical care and support services for people living with HIV/AIDS in New Jersey.

For over 16 years, New Jersey has depended on the availability of the CARE Act funds to build and maintain networks of care services currently accessed by more than 21,000 people.

The reauthorized legislation has substantive changes from the previous law, which will result in a net loss of funding to New Jersey. The new legislation is known as the “Ryan White HIV/AIDS Treatment Moderization Act of 2006. It included a change in the funding formula, a redistribution of money, a reduction in available funds and a redesign of the Title structure. The new legislation requires 75 percent of Ryan White funds to be used on “core medical services,” which eliminated most of the funding for supportive programs such as: housing, client advocacy, food vouchers and home-delivered meals.

Four of the six New Jersey areas hardest hit by the epidemic were reassigned to lower “tiers.” These areas, now called Transitional Grant Areas (TGAs), are no longer eligible to receive the maximum amount of funding. All regions of the State were required to compete for federal funds awarded under the Minority AIDS initiative.

While the newly designed formulas did not result in the devastating funding reductions many thought, New Jersey did experience an overall loss of about $2 million in Ryan White funding. The impact of much of this loss was mitigated by state funding provided by the DHAS to the Eligible Metropolitan Areas (EMAs) and TGAs. As such, the existing continuum of care in New Jersey was not negatively impacted.

HIV/AIDS TIMELINE HIGHLIGHTS....

Governor Corzine signed legislation permitting the establishment and operation of needle exchange programs.
Funded under Part B of the Ryan White HIV/AIDS Treatment Moderization Act of 2006, the ADDP accounts for approximately 75 percent of Part B funds awarded to the state. In large part, this federal law allows the DHAS to provide HIV medications to individuals who otherwise would be unable to afford the cost of prescription drugs. The ADDP makes HIV medications and other prescription drugs accessible for low income, uninsured and underinsured individuals. Clearly, without this type of assistance many individuals would not be able to receive the medications they need.

The program’s formulary is consistent with formularies of other publicly funded pharmaceutical reimbursement programs in New Jersey including Medicaid, General Assistance, and Pharmaceutical Assistance to the Aged and Disabled. In addition, while 75 percent of the populations served by the ADDP have incomes that are below the federal poverty level (FPL), ADDP clients are allowed to earn up to 500 percent of the FPL and still be eligible for enrollment in the program.

Since its inception, the ADDP has enrolled 23,000 clients, with approximately 5400 individuals currently enrolled. Another 200 ADDP clients have enrolled in Medicare Part D, a new federal prescription drug benefit. Fortunately, the New Jersey ADDP will be able to cover all out-of-pocket expenses for dully eligible Medicare Part D clients, including the costs of premiums, co-pays, and deductibles.

The DHAS works with other state agencies on a continual basis to meet the needs of this population and reduce state spending. The operating budget for ADDP was $76.9 million in 2007, including Ryan White, pharmaceutical rebates and a state appropriation of $6 million.
The Fight Against AIDS Continues...

Care and Treatment

Health Insurance Continuation Program

Funded under Part B of the Ryan White HIV/AIDS Treatment Modernization Act of 2006, the Health Insurance Continuation Program (HICP) pays insurance premiums on behalf of eligible clients who are unable to maintain their health insurance because they are no longer working due to their poor health status. Individuals may earn up to 500 percent of the federal poverty level and still be eligible for the program.

The New Jersey HICP is one of the most active insurance continuation programs in the nation. Since the program’s inception in 1995, more than 1,500 clients have been served, with 250 clients currently enrolled. In 2007, there were no programmatic changes, and enrollment was stable as the number of new clients offset the number of clients leaving the program. The HICP is considered to be one of the most cost effective programs within the Division of HIV/AIDS Services, as studies have shown that for every dollar spent on health insurance, seven dollars are saved to the overall health care system.
Funded under Part B of the Ryan White HIV/AIDS Treatment Moderization Act of 2006 (commonly referred to as The Ryan White Program), the HIV Home Care Program provides reimbursement for a comprehensive range of physician certified home health care services to eligible clients with chronic and/or medical dependencies resulting from the diagnosis of HIV/AIDS. Services are provided in the home and include nursing, home health aide/homemaker and personal care attendant services, respiratory therapy, physical, occupational and speech therapies, social work and mental health services, nutritional counseling, durable medical equipment, diagnostic testing, intravenous therapy, nutritional supplements and medical day care.

The HIV Home Care Program provides an alternative care setting to that of hospitals, nursing facilities and other institutional settings for low-income individuals living with HIV/AIDS who have no insurance coverage or limited insurance coverage. Income eligibility is set at 500 percent of the federal poverty level. Referrals to the HIV Home Care Program come mainly from hospitals and community-based organizations.

The HIV Home Care Program has been in existence for almost 20 years, since before the Ryan White CARE Act was enacted. It has served to bridge the gap left by other entitlement programs that provide home health care services. This program continues to be an important component in the continuum of care for individuals with HIV disease who are in need of home-based services.

The advent of antiretroviral medications has been successful in keeping people living with HIV disease healthier and living longer. In 2007, 144 clients were enrolled in the program. Of those 92 (64 percent) were between 45 and 64 years of age and 7 (5 percent) were over the age of 65. The future challenge will be tailoring services to meet the complex home care needs of the older client.
The Fight Against AIDS Continues...

Care and Treatment

Housing Opportunities For Persons With HIV/AIDS

The Housing Opportunities for Persons with AIDS (HOPWA) program, which is funded by the federal Department of Housing and Urban Development (HUD), provides tenant-based rental assistance to low income HIV infected individuals and their families. These services are provided in counties that are not eligible for direct HUD HOPWA funding. As the State Housing Authority and project sponsor for the program, the Department of Community Affairs manages the services to eligible clients. The primary objective of HOPWA is the provision of assistance to continue independent living for persons with HIV/AIDS as well as their families in New Jersey. During 2007, 317 persons benefited from this program. Using competitive HOPWA funds from HUD, tenant-based rental assistance is also provided for low-income HIV infected post-incarcerated persons and their families. These services are provided to the recently incarcerated along with the State HIV Discharge Planning Program participants in nine State Correctional Facilities. During 2007, more than 64 persons benefited from this program.

HIV/AIDS TIMELINE HIGHLIGHTS....

As a result of the 3rd reauthorization of the CARE Act, changes to ADDP include: new formulas for determining state awards which incorporates HIV/AIDS cases; new minimum formulary requirements; and changes in ADDP eligibility.
The DHAS was awarded a three-year grant in August 2007 from the Ryan White Moderization Act, Part B – Minority AIDS Initiative (MAI) of 2006. The MAI project is designed to address the disproportionate impact of HIV/AIDS and the disparities in access to care and treatment for racial and ethnic minorities.

The first year award which was given in the amount of $414,015 will be utilized to identify minority populations who have tested positive for HIV disease, but show no evidence of receiving care and treatment services. The DHAS staff reaches out to these individuals in an attempt to facilitate their access to health care by providing linkages with agencies in their community. Participation in the process is completely voluntary and all matters are kept confidential.

During the initial face-to-face contact, DHAS staff provides basic HIV health information, focusing on the importance of early treatment, access to medications and prevention. The process of referral and linkages to health care and treatment also begin at the initial visit. Access to transportation through the use of bus passes and food vouchers are provided if necessary as both an incentive as well as an effort to eliminate barriers to health care. Services are provided in both English and Spanish and special emphasis is placed on ensuring access to medications.

The primary goal of the MAI project is to significantly reduce the numbers of racial and ethnic minorities who are HIV positive and not in care. It is anticipated that by improving access and adherence to medications, this initiative will lead to improved health outcomes and offer more opportunities for the prevention of HIV disease.
Current innovative epidemiologic studies and outreach programming should be continued to more effectively locate HIV infected individuals who are not in care, and facilitate their enrollment and participation in treatment regimens. In an effort to carve out an identity for HIV/AIDS within a crowded landscape of diseases, HIV/AIDS has found itself increasingly subject to charges of “exceptionalism.” It is critical that HIV adopt a more traditional public health identity in an effort to remain a credible and fundable disease. Collaboration, the sharing of information and networks, and reducing duplicative service networks must all be embraced if HIV is to maintain high visibility.

With the advent of highly active antiretroviral treatment (HAART), HIV/AIDS has increasingly become a chronic disease requiring long-term care management. Prescription drugs represent a key component of HIV/AIDS care. As such, rising prescription drug costs and shortfalls in federal funding continue to present challenges to the...
public health community and people infected and affected by HIV disease. Administered by the DHAS, the ADDP covers the costs of HIV medications and other prescription drugs for eligible individuals who have no other source of payment. The ADDP has already experienced increased demand for services and rising HIV prescription drug expenditures.

Additionally, drug resistance threatens to erase the recent advances made in antiretroviral treatment for HIV. As HIV strains resistant to HAART continue to develop within the HIV infected populations, new pharmaceutical agents must be readily available for use in these patients. The ADDP automatically adds these types of medications to its formulary and the DHAS continues to monitor changes in the epidemic, using its surveillance system, to look for drug resistant strains. However, the challenge will be to continue to secure enough federal and state funding to maintain a comprehensive drug formulary, thus providing individuals living with HIV disease with all of the medications they need to live a full and healthy life.

New Jersey must also continue to be an active participant in the ongoing effort to reauthorize the Ryan White legislation. As a high prevalence state that lost funding during 2005-2006 reauthorization, our voice is critical in helping to shape future legislation that provides adequate financial support to meet increasing patient needs, and further strengthen the role state public health departments have in providing

**HIV/AIDS TIMELINE HIGHLIGHTS**

45,000 New Jerseyans are thought to be infected with HIV and one-third remain unaware.
comprehensive, coordinated systems of care and treatment for people living with HIV/AIDS.

As we can see from this report, there has been considerable progress made in the fight against HIV/AIDS. One major achievement has been the dramatic reduction in perinatal transmission, from 21 percent (or 75 children exposed) in 1993, to 2 percent (or 2 children exposed) in 2007. Another crowning achievement has been the implementation of four (4) syringe exchange programs, which provide yet another crucial weapon in our increasingly aggressive battle against HIV. We also continue to expand the availability of rapid HIV testing in various health care venues, while furthering the integration of routine HIV testing as recommended by the CDC in its guidelines of 2006. Additionally, we continue to provide a state-of-the-art continuum of care for those infected with HIV, through a network of primary care facilities, pharmaceutical assistance, case management, home care and insurance continuation.

Although successful, we are still confronted with the continuing challenge of poverty, discrimination, racism, homophobia, access to care, language problems, etc., which provide real barriers to testing and ongoing care. One out of every four individuals infected with HIV is unaware of their infection. And many of those infected are not enrolled, and do not consistently participate in care. These failures in our system of care must be acknowledged, then effectively eliminated if we are to have any measurable amount of long-term success against HIV transmission. We must also be vigilant in directing limited resources to support those prevention interventions that have proven to work.

We have recently been informed that the number of annual infections nationally is much higher than previous estimates. Such “news”
requires revitalized strategy to more effectively address where the epidemic is going, and also a more defined national plan. This new strategy shall include the removal of the ban on using federal funding to support the operation of syringe exchange programs. This would provide a much needed funding source of support for such programming nationally, and help stabilize an effort that has proven itself to be extremely beneficial in reducing HIV transmission, while not encouraging drug use. We should also continue to allocate funding and expand the provision of innovative prevention and testing interventions to maximize the overall effort to reduce risk behavior, and promote routine testing. It is vital that we eliminate any missed opportunity that reduces our ability to make someone aware of their HIV status.

Finally, the DHAS must continue to be cognizant of new prevention interventions such as microbicides; work collaboratively with efforts to incorporate hepatitis services into HIV prevention; further expand HIV testing; renew the effort to keep HIV within the active lexicon of everyday reality; and critically evaluate every intervention in an ever demanding response to maximize the effort to accomplish our mission of reducing the transmission of HIV.
The challenge will be to continue to secure enough federal and state funding to maintain a comprehensive drug formulary, thus providing individuals living with HIV disease with all of the medications they need to live a full and healthy life.
Division of HIV/AIDS Services

Successes and Future Challenges
The Fight Against AIDS Continues...

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