

Executive Summary

In 2002, 294,494 HIV tests were conducted at Florida's registered testing sites, representing an 8.5% increase (approximately 23,000 tests) over the previous year and a new record high in the history of Florida's counseling and testing program. This large increase was comprised entirely of confidential tests, as anonymous testing decreased. Declines in testing were also recorded in three major risk groups: IDU, sex partner at risk, and STD diagnosis. Persons identifying heterosexual sex as their highest risk accounted for the majority of the increase in testing. Large increases in testing were also recorded among non-Hispanic whites and substantial increases were recorded among persons aged 13 or older. Testing with OraSure accounted for 23% of all HIV tests conducted in 2002.

The number of positive HIV tests recorded increased by 2.3% in 2002, although the overall positivity rate decreased from 2.4% in 2001 to 2.3% in 2002. Despite declines in testing, MSM accounted for 25.1% of all positive tests reported in 2002, yielding a positivity rate of 10.1% (10.7% when combined with IDU). While heterosexuals accounted for 20.3% of positive tests, the positivity rate for this risk group was only 0.8%. Adults age 30 and older continue to record high positivity rates. Black MSM and IDU also continued to experience higher positivity rates than their white and Hispanic counterparts. The overall positivity rate with OraSure testing was 3.2%, and analysis indicated that an increasing number of counties were able to achieve higher positivity rates with OraSure than with traditional blood testing.

Since 1985, when the Florida Department of Health began collecting data on HIV testing at registered testing sites across the state, over 3.4 million anonymous and confidential tests have been conducted. Today, over 1,600 public and private sites are registered with the Department of Health to provide HIV counseling, testing, and referral services. Social and demographic data, including risk behaviors, are collected at these sites, and are compiled along with test results by the Early Intervention Section of the Bureau of HIV/AIDS in Tallahassee. While this database is currently not unduplicated, and as such, cannot be used to provide data on the number of individuals tested, it does constitute a record of the number of tests conducted. It is a crucial source of information about the nature and direction of the epidemic, and is used to inform and evaluate HIV prevention activities and policy making at the state and local level.

Trends in HIV Testing

Figures 1a and 1b show testing trends in Florida between 1986 and 2002. Testing levels increased rapidly through the early 1990s. After 1992, the number of tests performed increased slowly, peaking at just over 255,000 in 1996. Then, in both 1997 and 1998, testing volume dropped by over 13,000 (approximately 5% per year). A small increase in 1999 was followed by much larger increases between 2000 and 2002. Testing levels are now at the highest level in sixteen years. In contrast, positivity rates dropped sharply in the 1980s, as more and more people at relatively lower risk were tested, and have remained generally stable throughout the 1990s. In 2002, the overall positivity rate was 2.3%, slightly lower than that reported in 2001 (2.4%). The actual number of positive tests identified each year has also declined at a relatively steady rate since peaking in 1991, although small increases have been recorded since 1999.

Figure 1a. HIV Tests Conducted in Florida and Seropositivity Rates, 1986-2002

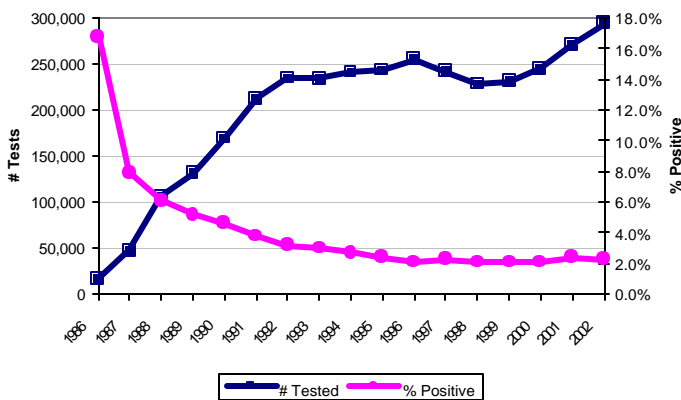


Figure 1b. HIV-Positive Tests in Florida and Seropositivity Rates, 1986-2002

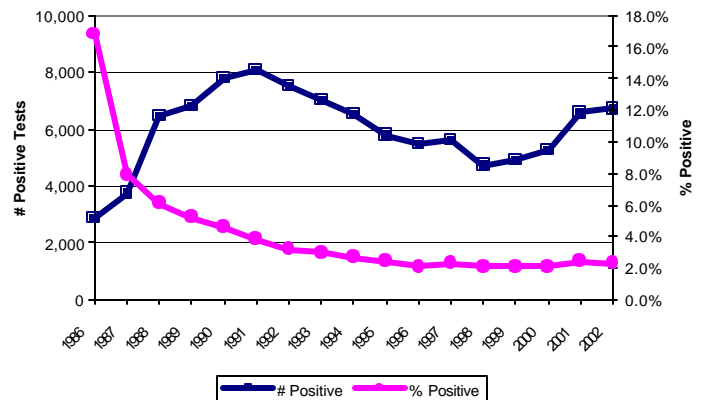


Figure 2 compares testing levels at anonymous and confidential sites by quarter, from January 1997 through December 2002. Some observable patterns may be seasonal or related to specific events; National HIV Testing Day occurs annually on June 27, and sharp increases in testing numbers have been recorded in the weeks around this event. Increasing levels of confidential testing are most apparent in the first two quarters of 1997 and 1998, followed by stronger declines in the third and fourth quarters. The same upward and downward trend occurred in 1999, but with little overall effect on annual testing totals. In 2000 and 2001, the late year downward trend was not as strong as first and second quarter gains, resulting in an overall increase in testing those years. In 2002, large increases in the first three quarters were followed by a relatively moderate decline in the fourth quarter, resulting in an overall increase in testing

volume. In contrast, quarterly levels of anonymous testing have remained fairly stable over most of this period, although a sizeable decline was observed in the last quarter of 2002. Anonymous testing accounted for 9.6% of all tests conducted in the last quarter of 2002, compared to 10.9% in the last quarter of 2001.

Figure 2. Number of HIV Tests Completed at Anonymous and Confidential Sites in Florida, January 1997-December 2002

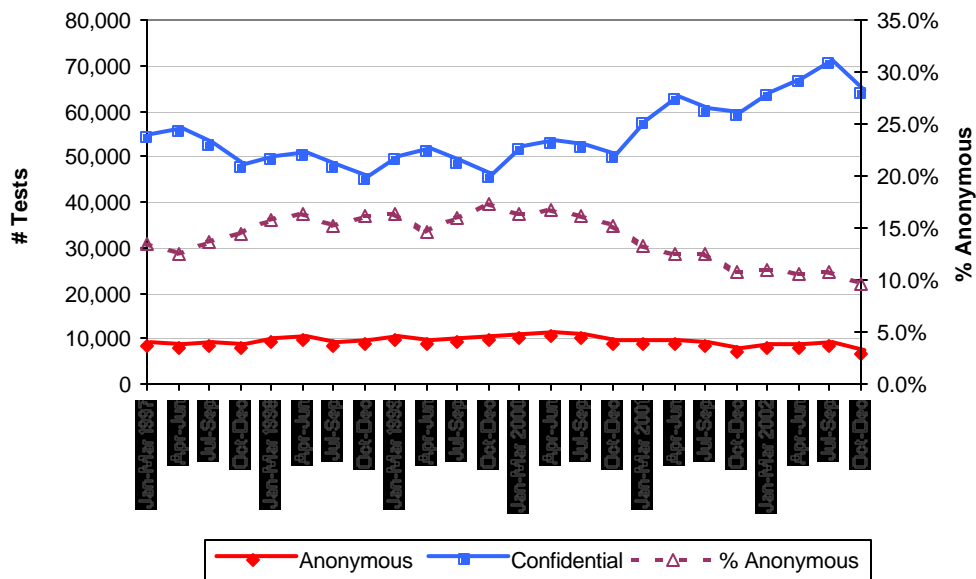
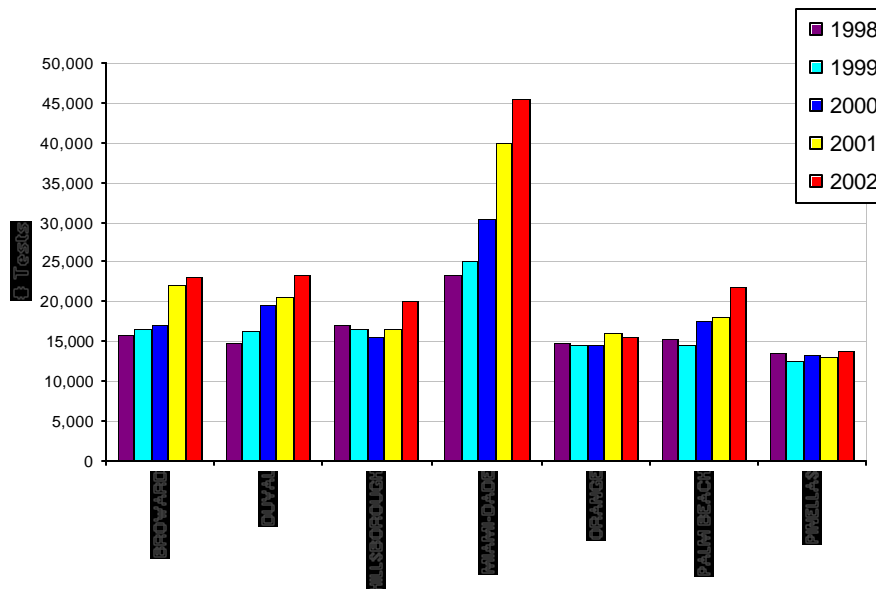


Figure 3 shows trends in testing among some of the larger counties in Florida. Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach, and Pinellas counties together account for 53% of all HIV tests conducted between 1998 and 2002. Between 1999 and 2000, the level of

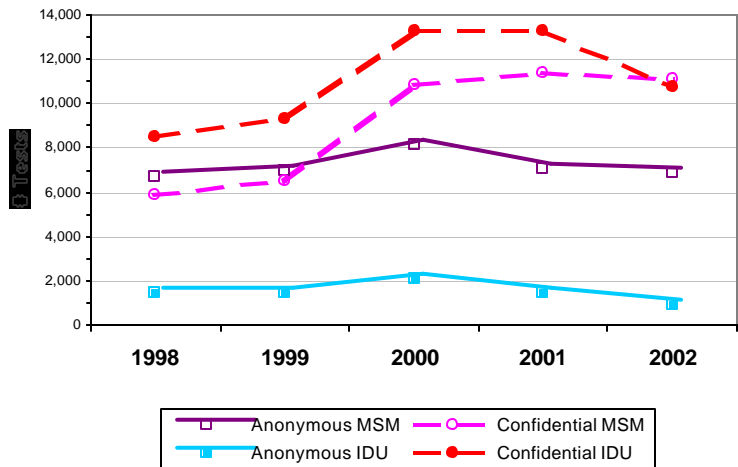
Figure 3. HIV Testing Levels Among Florida Counties that Perform More than 10,000 HIV Tests per Year, 1998-2002



testing in these seven counties increased overall by almost 10% (over 10,000 tests), although a slight decrease was experienced by Hillsborough and Orange counties. In 2001, statewide testing levels were again on the rise, with substantial contributions from Broward, Miami-Dade, and Orange counties. In 2002, the number of tests conducted in Miami-Dade County continued to increase, along with substantial increases from Duval, Hillsborough, and Palm Beach counties.

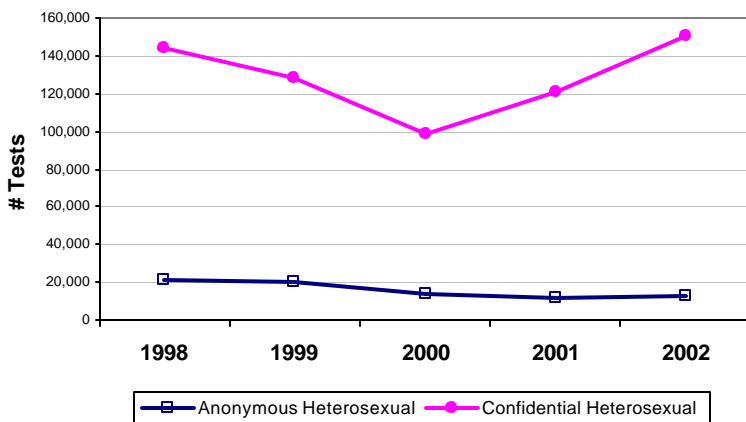
Figure 4a displays trends in anonymous and confidential testing within two high-risk groups: men who have sex with men (MSM)¹ and injecting drug users (IDU). Between 1998 and 1999, the number of anonymous tests administered to MSM was greater than that of confidential tests. However, confidential testing in this risk group increased dramatically in 2000, while anonymous testing showed a much smaller increase. In 2002, although the number of confidential tests among MSM far exceeded the number of anonymous tests, the overall number of tests actually declined from 2001 for this risk group.

Figure 4a. Number of HIV Tests Completed at Anonymous and Confidential Sites, MSM and IDU Risk Groups, 1998-2002



Among injecting drug users, levels of anonymous testing have consistently been much lower than levels of confidential testing. In 1998 and 1999, roughly 1,400 anonymous tests were recorded annually among IDU. In 2000, the number of tests increased 46.9% from 1999, but has decreased since.

Figure 4b. Number of HIV Tests Completed at Anonymous and Confidential Sites, Heterosexual Risk Group, 1998-2002



has decreased since. In 2002, only 874 tests were recorded in this risk group. Confidential testing among IDU followed a pattern very similar to that of MSM - a steady rise from 1998 to 1999, followed by a dramatic increase in 2000 - but has been decreasing since. Between 2001 and 2002, the number of confidential tests decreased by 18.9%.

Figure 4b shows anonymous and confidential testing trends among those

¹ The MSM category here includes MSM who are intravenous drug users (MSM/IDU).

who identified heterosexual sex as their highest risk. The number of confidential tests administered in this risk group rose steadily throughout the mid-1990s and peaked in 1998. Testing levels dropped considerably in 1999 and 2000. In 2001, the number of tests conducted in this risk group increased 22.7% from 2000. By 2002, an additional 30,000 tests were conducted compared with the previous year, thus representing the highest testing volume during this five-year period. The trend for heterosexuals testing anonymously has been steadily decreasing; testing levels peaked at just over 20,000 in 1998, then declined over the next four years to roughly 12,000 in 2002. In the mid 1990s, the proportion of anonymous tests where heterosexual sex was identified as the highest risk varied between 25-40%, but following a pattern similar to confidential testing among heterosexuals, that share had risen to 58% by the end of 1998, and remained above 50% in 1999 (data not shown). However, in 2000 and 2001 the proportion of anonymous tests accrued to this risk group returned to lower levels, and then increased slightly in 2002. This high-volume, typically low-risk group annually accounts for a very large proportion of all HIV tests.

The overall decline in testing that was observed in the latter half of the 1990s might be due to the historical progression of the epidemic. A natural decline in testing levels may be expected as the proportion of the population who know their HIV status increases over time relative to the proportion of the population who do not. The accessibility and acceptance of HIV testing has also changed considerably since the beginning of the epidemic. In the early years, a high proportion of HIV testing occurred in the health department. Over time, HIV testing became a routine procedure in more and more situations outside of the health department, such as blood donation, routine doctor visits, prenatal care, application for insurance, application for military service or employment. The increased presence of private laboratories and home testing methods has also diminished the untested population base from which the health department can draw.

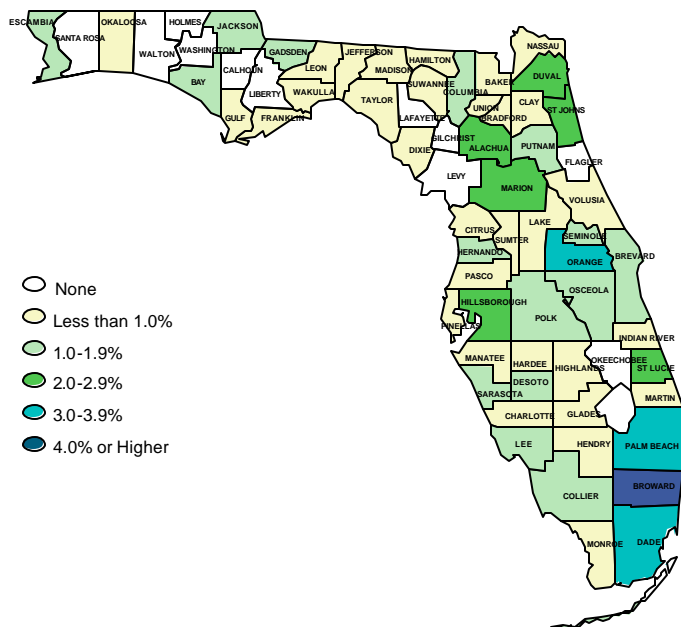
Approximately 70% of persons with HIV in Florida know they are infected (based on estimates from the Centers for Disease Control and Prevention). Since 1999, the Department of Health has focused on increasing that proportion. A variety of strategies have been pursued, including the increased use of OraSure in outreach settings; broader use of incentives; improved risk assessment and targeted testing; increased testing in correctional settings; increased emphasis on partner counseling and referral services; expansion of non-traditional, community-based testing programs; increased use of mobile vans; directly-funded CDC testing programs; and a social marketing campaign encouraging persons at risk for HIV to be tested. In early 2001, the Bureau of HIV/AIDS adopted several goals that will continue to guide our prevention, early intervention, and care efforts. One of those goals is to increase the proportion of HIV-infected persons who know their status from 70% to 95% by 2005. It is hoped that these strategies and initiatives will help us achieve that goal. These strategies may have led to the 28.9% increase in testing between 1998 and 2002.

HIV Counseling and Testing in 2002

In 2002, 294,494 HIV tests were performed at registered HIV testing sites in Florida. Of these, 6,723 were positive, resulting in an overall positivity rate of 2.3%. Positivity rates for individual counties are shown in Figure 5. Broward County recorded the highest positivity rate (5.2%), followed by Miami-Dade County (3.8%), Palm Beach County (3.2%), and Orange County (3.2%). Overall, six counties reported positivity rates higher than the state average for 2002. Eleven counties reported no positive HIV tests in 2002. As always, these data should be viewed critically; while low positivity rates may be an accurate representation of HIV prevalence in a given area, they may also indicate that high-risk populations are not being reached. Conversely,

high positivity rates could indicate access by high-risk populations, or they might be a result of operational factors, such as, a standard recommendation that all clients receiving a positive result retest. Additional counseling and testing data for individual counties are available from the Early Intervention Section.

Figure 5. HIV Seropositivity Rates by County, 2002



Race/Ethnicity

Approximately 42% of all tests (122,558) were performed on persons who identified themselves as non-Hispanic white, as compared to 107,664 (36.6%) for non-Hispanic blacks, and 51,562 (17.5%) for Hispanics (Figure 6a). However, whites only accounted for 22.6% (1,519) of all positive tests (Figure 6b), with a positivity rate of 1.2%. In contrast, blacks accounted for 59.1% (3,976) of positive tests, resulting in a positivity rate of 3.7%. Among the Hispanic population, the proportion of positive tests (14.1% or 948) was more consistent with their testing level; the positivity rate for this group was 1.8% (data not shown). Testing among Asians, Native Americans, and other racial/ethnic groups was limited; the combined category of “other” accounted for 2.0% of all tests and 1.5% of positive tests.

Figure 6a.
Total HIV Tests by Race/Ethnicity,
Florida, 2002 (N=294,494)

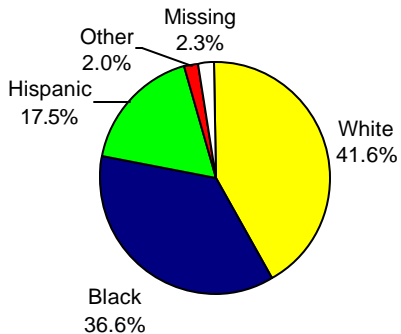
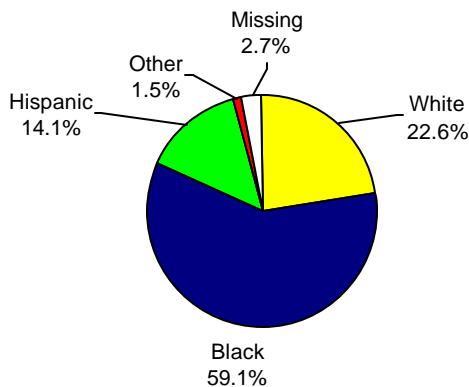
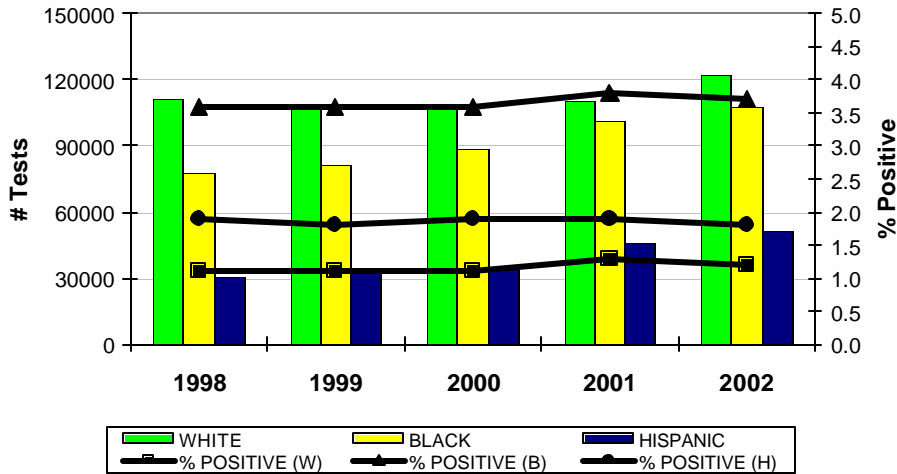


Figure 6b.
HIV-Positive Tests by Race/Ethnicity,
Florida, 2002 (N=6,723)



As Figure 6c shows, testing levels among these three racial/ethnic groups increased in 2002. Specifically, between 2001 and 2002, testing increased by 10.9% (11,996 tests) among whites, 12.0% (5,539 tests) among Hispanics, and 6.1% (6,172 tests) among blacks. Nonetheless, positivity rates in these three groups have remained fairly stable for the past five years.

Figure 6c. Number of HIV Tests & Positivity Rates by Race/Ethnicity, Florida, 1998-2002



Sex/Gender

In 2002, 177,975 HIV tests were performed on females (60.4%); 115,732 (39.3%) were performed on males (Figure 7a). However, males accounted for 63.1% of all positive tests, yielding a positivity rate of 3.7%, while females accounted for 36.7%, with a 1.4% positivity rate (Figure 7b). As with race/ethnicity, these patterns have remained very stable for several years (data not shown).

Figure 7a.
Total HIV Tests by Sex,
Florida, 2002 (N=294,494)

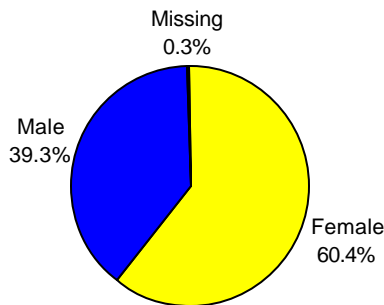


Figure 7b.
HIV Positive Tests by Sex,
Florida, 2002 (N=6,723)

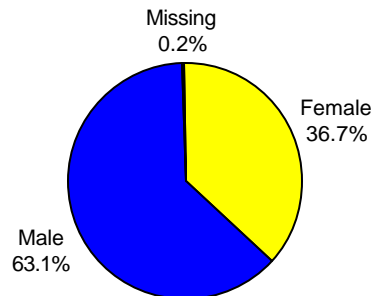
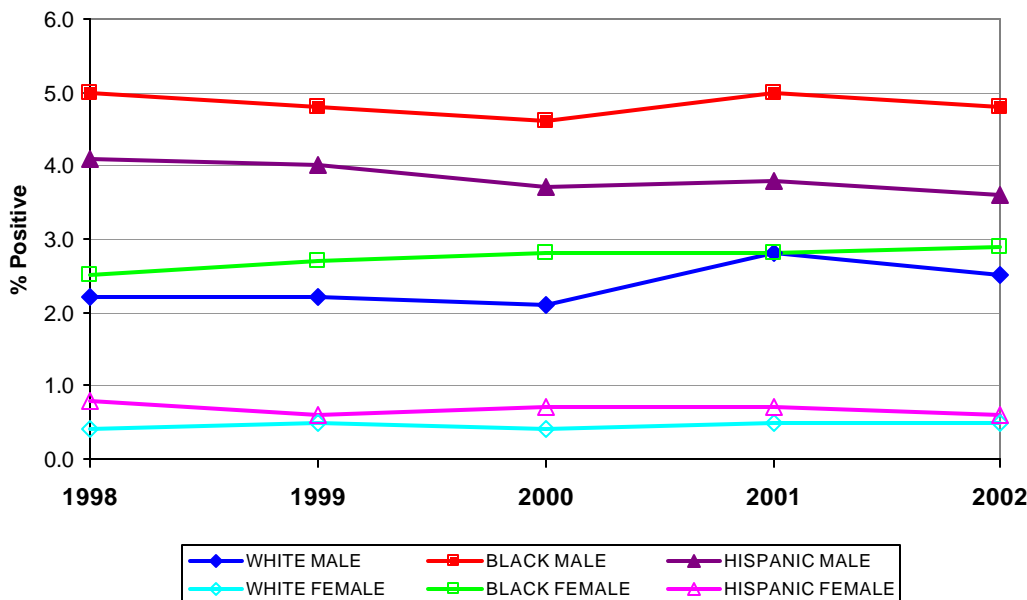


Figure 8 shows positivity rates for males and females by race/ethnicity from 1998 to 2002. Black males continue to have the highest positivity rates, followed by Hispanic males, black females, and white males. White females exhibit the lowest positivity rates over time.

Figure 8. HIV Seropositivity by Sex and Race/Ethnicity, Florida, 1998-2002



Age

Children under the age of 13 recorded approximately 1,000 tests in 2002 and accounted for less than 1% of positive tests (Figures 9a and 9b). However, the positivity rate for this age group was 2.3% in 2002 (Figure 9c). Teenagers represented 19.2% (56,565) of all tests, but only 2.9% (196) of positive tests, resulting in a positivity rate of 0.4%. Persons between the ages of 20-29 continued to represent the highest proportion of tests (109,162 or 37.1%), yet only 17.3% of the positive tests (1,162), resulting in a positivity rate of 1.1%. With only 21.7% of tests conducted, the 30-39 age group accounted for the highest proportion of positive tests in 2002 (2,418 or 36.0%). The 40-49 age group accounted for only 13.5% of all tests in 2002, but 29.9% of positive tests and the highest positivity rate among all age groups (5.1%). Although the 50+ age group was not tested in very high numbers (19,023 or 6.5%), they accounted for 11.4% of positive tests, giving this group the second highest positivity rate, 4.0%. The next highest positivity rate accrued to the 30-39 age group at 3.8%.

Figure 9a.
Total HIV Tests by Age Group,
Florida, 2002 (N=294,494)

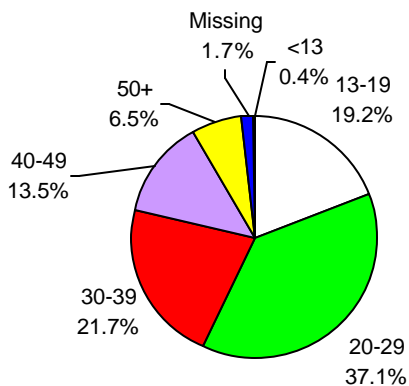


Figure 9b.
HIV Positive Tests by Age Group,
Florida, 2002 (N=6,723)

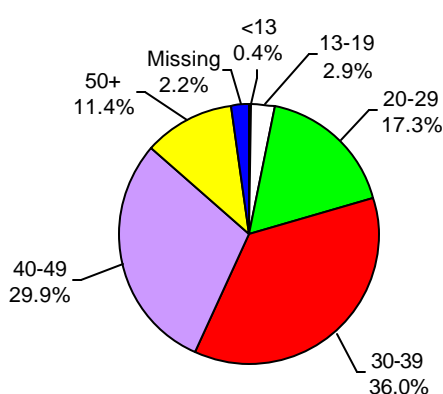
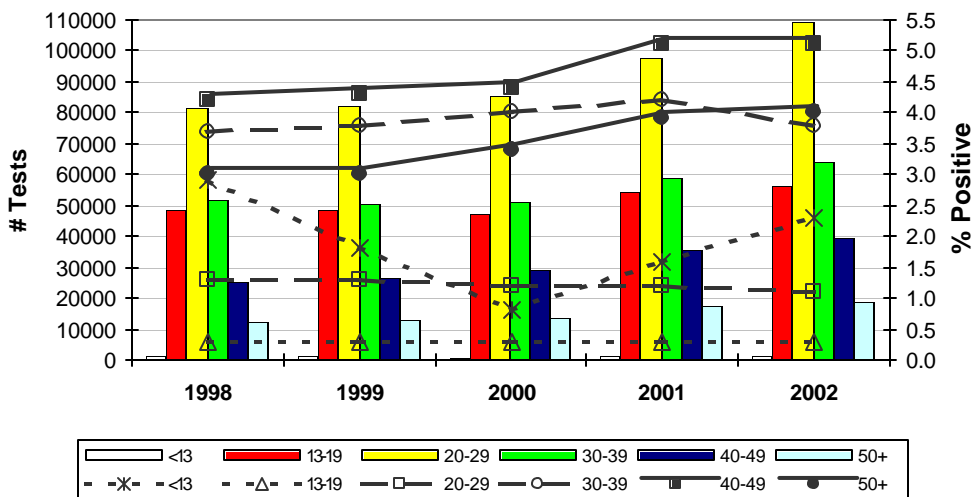


Figure 9c shows testing patterns and positivity rates from 1998 to 2002. The distribution of testing across age groups has not changed significantly over time. In 2002, marked increases in testing were seen in all age groups, particularly among persons over age 20. Positivity rates for persons aged 13-29 were the least variable during the past five years. Among all other age groups, positivity rates fluctuated between 1998 and 2000 but have increased since. In particular, this variability in the <13 age group is primarily attributed to the low volume of tests conducted. The 40-49 age group consistently recorded the highest positivity rates between 1998 and 2002.

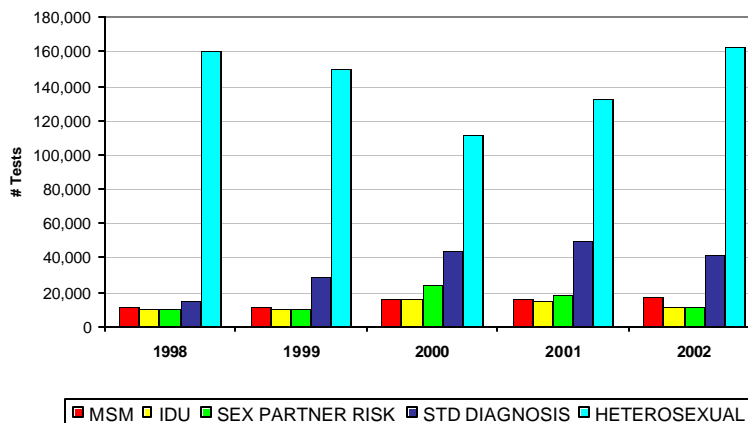
Figure 9c. Number of HIV Tests & Positivity Rates by Age Group, Florida, 1998-2002



Risk Exposure

Because individuals may engage in more than one risk behavior, each HIV test record is categorized according to the highest level of risk reported by the client. As Figure 10 shows, persons who identified heterosexual sex as their highest risk behavior comprise the majority of HIV tests conducted from 1998 to 2002. The total number of tests conducted in this risk group increased steadily throughout the mid-1990s; by 1998, just over 70% of HIV tests were performed on persons who identified heterosexual sex as their highest risk.

Figure 10. Number of HIV Tests Among Selected Risk Exposure Groups, Florida, 1998-2002



The proportion of tests administered to heterosexuals dropped to a low in 2000, only 45.6% of all tests. In 2001, the testing volume increased substantially, but this risk group still accounted for less than 50% of all tests. By 2002, that proportion increased to 55.4%. Two other risk groups with relatively

large testing volumes experienced significant fluctuations over the past five years: testing levels among those identifying a current or past STD diagnosis have generally risen from 1998 to 2001 but declined by 17% in 2002, while those claiming a sex partner risk have varied from year to year. For those identifying injection drug use, testing levels rose steadily through 2000, and have declined since. Among MSM and MSM/IDU², testing levels increased significantly in 2000, and have been decreasing since.

Figure 11. Positivity Rates by Self-Reported Risk Exposure, Florida, 2002

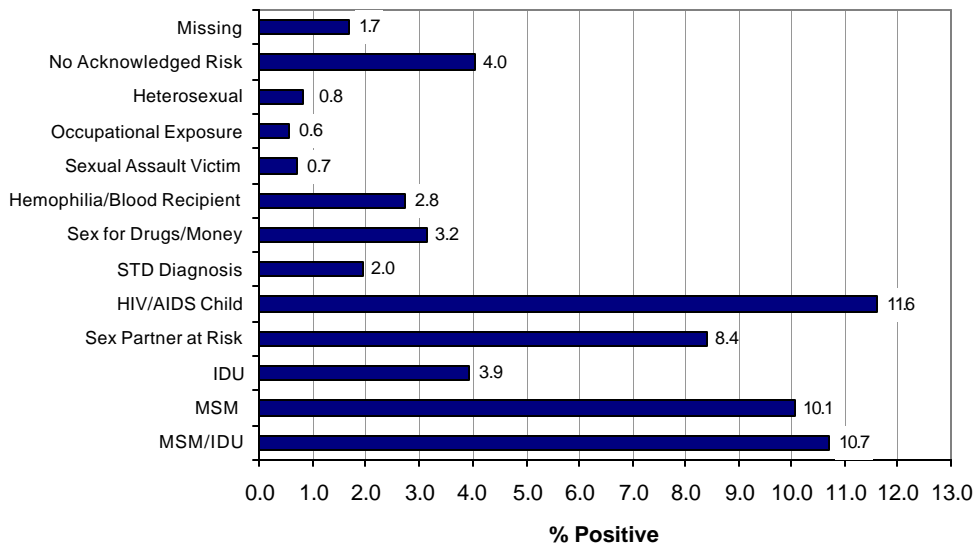
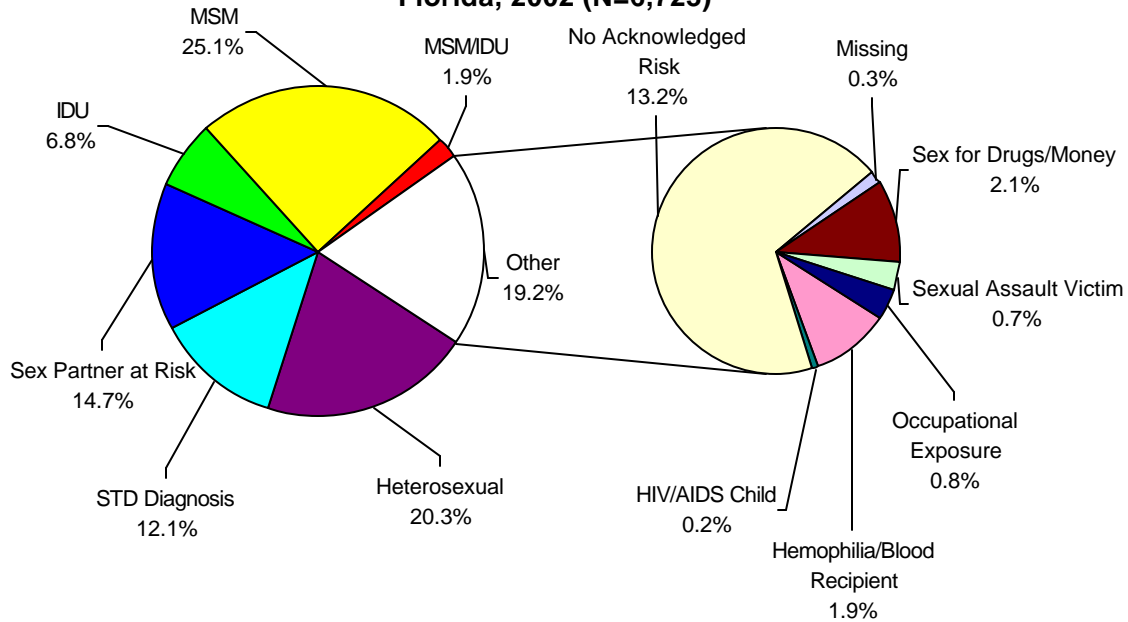


Figure 11 displays positivity rates for all risk exposure groups hierarchically. Perinatal exposure accounted for the highest positivity rate in 2002 (11.6%). This could be due in part to the small volume of tests conducted in this risk group. MSM continued to be a risk group with very high positivity rates (10.1% and 10.7% when combined with intravenous drug use). Positivity rates were also relatively high among the sex partner at risk (8.4%), IDU (3.9%), and sex for drugs or money (3.2%) categories. Alternatively, the positivity rate for the heterosexual risk group remained at less than 1.0% even though they accounted for the majority of tests conducted. Over 23,000 HIV tests were recorded in 2002 with missing risk data or no acknowledged risk. The number of tests, as well as the positivity rates within these categories (4.0% and 1.7%, respectively), suggests that some improvement in the evaluation of risk at the time of testing is warranted.

Figure 12 shows the distribution of HIV-positive test results by self-reported risk exposure for 2002. MSM accounted for the greatest number of positive tests (1,686 or 25.1% and 27.0% when combined with IDU). Persons who identified heterosexual sex as their highest risk behavior comprised 20.3% (1,368) of all positive tests. Those who reported that they had sexual relations with someone else at risk for HIV accounted for 14.7% (986) of all positive tests. Persons who reported intravenous drug use as their highest risk accounted for 6.8% (454) of all positive tests. Although no other risk group accounted for more than 3% of positive tests in Florida in 2002, 13.5% of positive tests (908) were reported with no acknowledged risk or missing risk data.

² The MSM category here includes MSM who are intravenous drug users (MSM/IDU).

Figure 12. Distribution of HIV-Positive Tests by Self-Reported Risk Exposure, Florida, 2002 (N=6,723)



Focus on Minorities

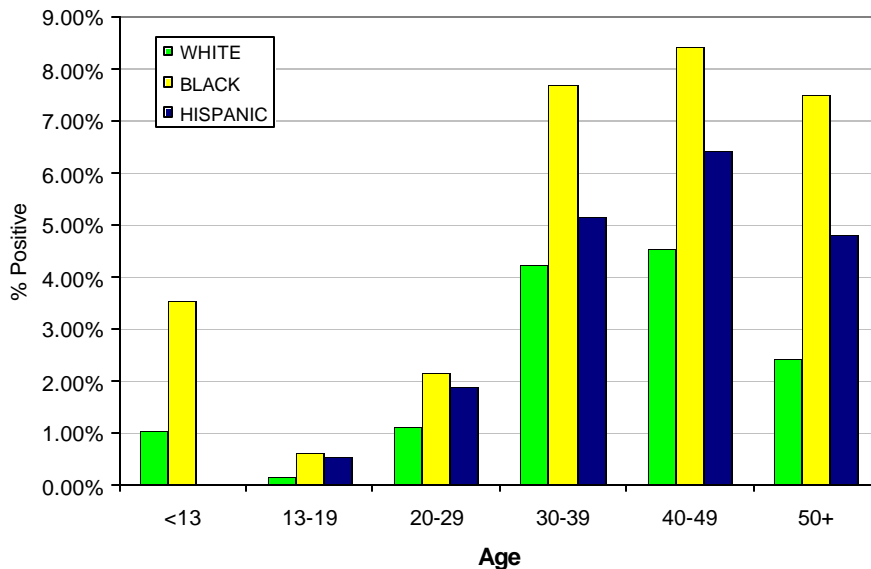
According to the 2000 Census, almost 16 million people reside in the state of Florida. The racial composition of this population is as follows: 65% white, 14% black, 17% Hispanic, and 4% "other". However, blacks comprised 56% of HIV cases and 47% of AIDS cases reported cumulatively through 2002 in Florida. Analysis of HIV Counseling and Testing data has also revealed disproportionately higher positivity rates among blacks. Further specification of the distribution of HIV testing and positivity rates across racial/ethnic populations can provide useful insights into the nature and course of the epidemic in Florida's minority communities.

The Intersection of Race/Ethnicity, Sex, and Age

One way to obtain a more specific description of HIV testing patterns and positivity rates in a population is to look at the intersection of race/ethnicity, sex, and age. Figure 8 showed that over time, black males have experienced the highest positivity rates, followed by Hispanic males, black females, and white males. White and Hispanic females consistently recorded positivity rates below 1.0%. This pattern has been further specified for 2002 by the incorporation of age.

The overall positivity rate for black males in 2002 was 4.8% (Figure 8). However, as Figure 13a shows, this rate varied considerably by age. The highest positivity rate was found among black males age 40-49 (8.4%), followed by those aged 30-39 (7.7%) and 50+ (7.5%). This is particularly informative because 20-29 year olds accounted for the largest proportion of HIV tests conducted among black males (32.9%, data not shown), and yet their positivity rate was relatively low (2.1%). Significant variation in positivity rates by age also exists among Hispanic males, whose overall positivity rate in 2002 was 3.6% (Figure 8). The highest positivity rate was found in the 40-49 age group (6.4%); the lowest in the <13 age group (0%).

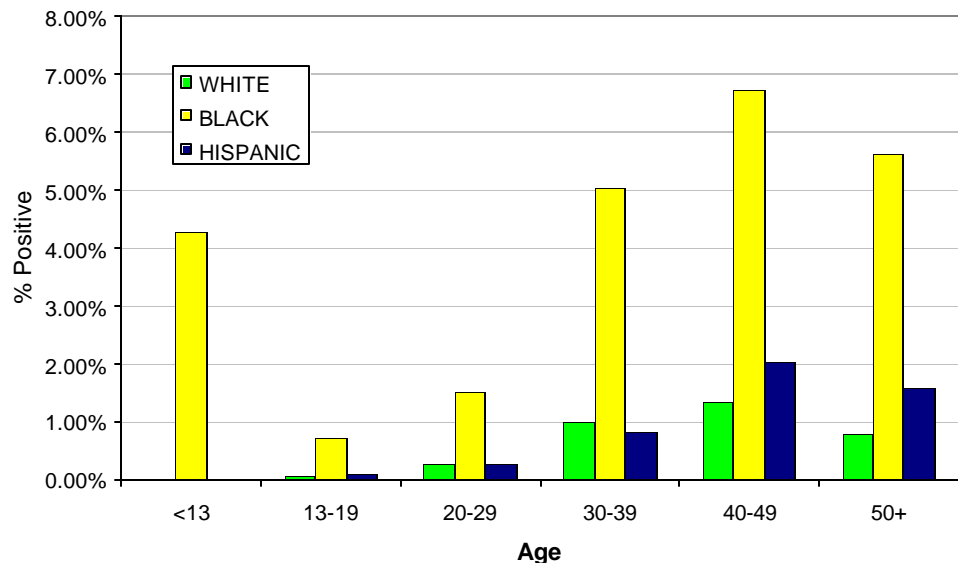
Figure 13a. Seropositivity Among Males, by Age and Race/Ethnicity, Florida, 2002



The overall positivity rate for black females in 2002 was 2.9% (Figure 8). However, Figure 13b shows that black females over the age of 40 are experiencing much higher positivity rates. While 62.0% of black females tested were between the ages of 13 and 29 (data not shown), the corresponding positivity rates were only 0.7% for 13-19 year olds and 1.5% for 20-29 year olds.

Figure 13b. Seropositivity Among Females, by Age and Race/Ethnicity, Florida, 2002

Fewer tests were administered to black females aged 30 and older, yet positivity rates were quite high: 5.0% for those in the 30-39 age group, 6.7% for those aged 40-49, and 5.6% for those aged 50 and over. Among Hispanic females, positivity rates were below the state's positivity rate of 2.3% for all age groups.



However, the positivity rates for Hispanic females in the 40-49 and 50+ age groups were 2.0% and 1.6%, respectively, slightly higher than the 0.6% reported for all Hispanic females (Figure 8). These figures suggest that increased HIV testing of older minority men and women is needed. Over the past five years, testing levels among blacks have increased by 43.6% (over 13,000 tests) for males and 37.0% (over 16,000 tests) for females (data not shown).

While actual numbers are much smaller, testing levels among Hispanics have increased by an even larger margin over the past five years, 97.7% (about 10,000 tests) for males, and 55.9% (about 10,000 tests) for females. In contrast, testing levels among white males increased by just

13.0% (over 5,000 tests) and increased among white females by 9.7% (almost 7,000 tests) during the same time-period (data not shown). These trends signal a growing awareness of HIV prevention among minority populations and increased accessibility of testing through outreach. The data presented here indicates that prevention efforts must continue to be directed towards these marginalized groups, particularly older persons of color, in order to limit new infections and to ensure that access to education and care is maintained or improved.

The Intersection of Race/Ethnicity and Risk

Male-to-male sex and intravenous drug use (separately or in combination) are behavioral practices that place individuals at high risk for HIV infection. In 2002, 29,588 HIV tests (10.0%) were performed on persons who identified themselves as men who have sex with men (MSM), IDU, or both (MSM/IDU). As shown in Figure 11, the positivity rate among MSM/IDU in 2002 was 10.7%, 10.1% among MSM, and 3.9% among IDU. However, sharp differences in testing patterns and positivity rates are evident across racial/ethnic categories within these risk groups.

Figures 14 to 16 illustrate the distribution of HIV tests and HIV-positive tests by race/ethnicity for MSM/IDU, MSM, and IDU. Individuals identifying themselves as non-Hispanic white accounted for the largest proportion of HIV tests in all three of these risk groups: 61.5% of MSM/IDU, 51.1% of MSM, and 69.8% of IDU. Whites also accounted for the majority of positive HIV tests among MSM/IDU (46.0%) and MSM (43.4%), suggesting that racial/ethnic disparities among minorities might not be particularly high in these risk groups. However, the proportion of positive tests was still greater than the proportion of tests conducted for black men in both of these risk groups. Racial/ethnic disparities appear to be stronger among intravenous drug users.

Black females, who accounted for only 7.0% of tests among IDU in 2002, comprised 27.8% of positive tests in this risk group. Similarly, black males accounted for just 10.2% of tests, but 21.6% of the positives. In contrast, white males and females together accounted for over two-thirds of tests among IDU (35.7% for females and 34.1% for males), yet their combined share of positive tests was significantly lower (32.4%). The proportion of positive tests among Hispanic male IDU in 2002 was also fairly high (12.8%), although there was no proportional difference between share of all tests and share of positive tests among Hispanic females.

Figure 14a.
HIV Tests among MSM/IDU by
Race/Ethnicity, Florida, 2002 (N=1,178)

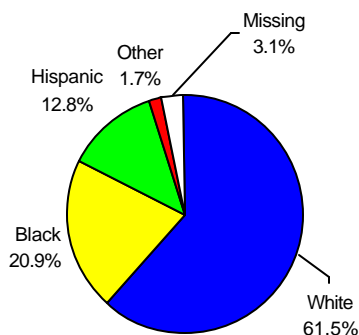


Figure 14b.
HIV-Positive Tests among MSM/IDU by
Race/Ethnicity, Florida, 2002 (N=126)

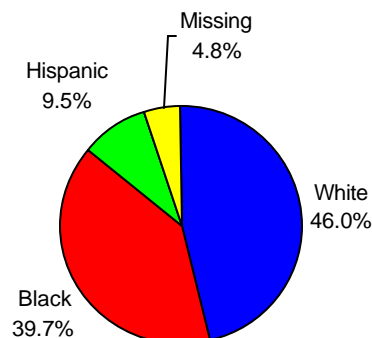


Figure 15a.
HIV Tests among MSM by
Race/Ethnicity, Florida, 2002 (N=16,778)

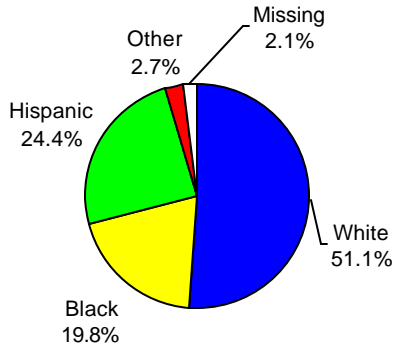


Figure 15b.
HIV-Positive Tests among MSM/ by
Race/Ethnicity, Florida, 2002 (N=1,686)

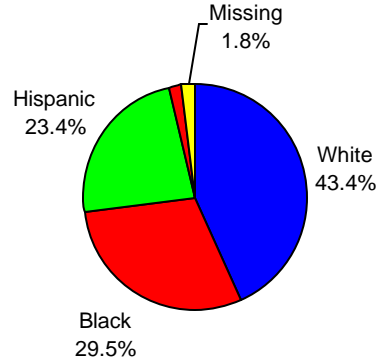


Figure 16a.
HIV Tests among IDU by Sex and
Race/Ethnicity, Florida, 2002 (N=11,632)

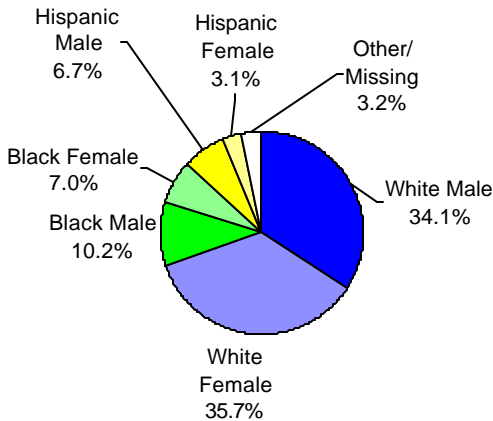


Figure 16b.
HIV-Positive Tests among IDU by Sex and
Race/Ethnicity, Florida, 2002 (N=454)

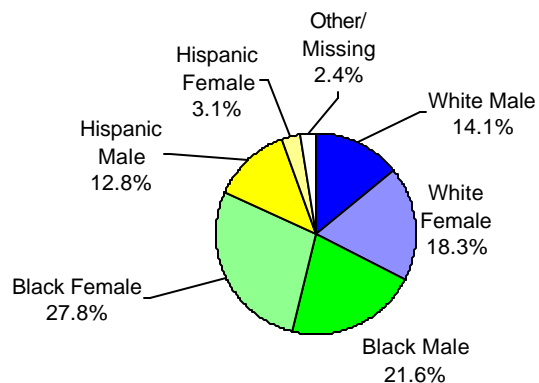
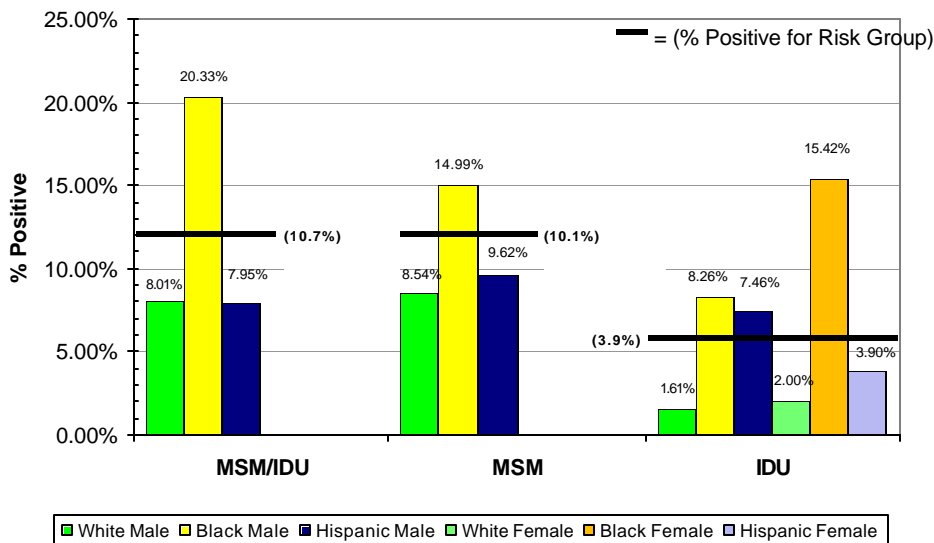


Figure 17 shows that aggregate positivity rates for MSM/IDU, MSM, and IDU mask important and occasionally dramatic differences between racial/ethnic groups. The relatively high volume of testing by whites combines with their generally lower positivity rates to pull down the average positivity rate for the whole population in each of these risk groups. For example, in 2002, the positivity rate for black MSM was 15.0%, almost 5 percentage points higher than that for all MSM (10.1%). The difference is also apparent for black female IDU, whose positivity rate in 2002 (15.4%) was 11.5 percentage points higher than the 3.9% reported for all IDU. This figure shows that blacks experienced significantly higher positivity rates in these three risk exposure groups.

Overall, MSM, IDU, and MSM/IDU accounted for 29,588 HIV tests in 2002, 18.8% were blacks and 18.2% were Hispanics. However, of the 2,266 positive tests that accrued to these three risk groups, 34.0% were blacks and 21.1% were Hispanics (data not shown). The data presented here indicate that there is a continuing need to increase testing and prevention education among minorities that engage in very high-risk behaviors.

Figure 17. Seropositivity Among Selected Risk Exposure Groups by Sex and Race/Ethnicity, Florida, 2002

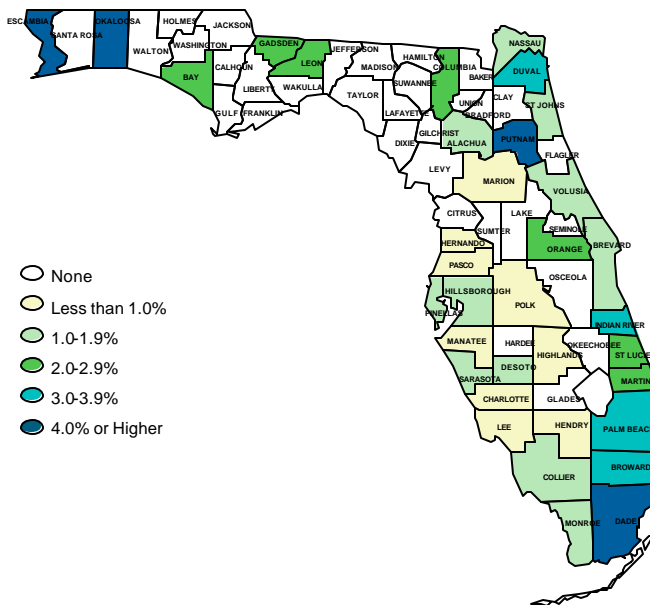


Focus on OraSure

The Bureau of HIV/AIDS has been providing Florida counseling and testing programs with OraSure Oral HIV-1 Antibody Testing Systems since February 1998. To receive OraSure, providers must complete a request form documenting their need, proposed usage and target populations. This testing method, which tests for antibodies in oral mucosal transudate, is as accurate as a blood test for diagnosis in public health and clinical settings. In Florida, OraSure is primarily for use in outreach settings, to reach high-risk persons who are less likely to access health care systems and less accepting of conventional testing methods (e.g., persons who are homeless, drug abusers, younger, or those who live in rural areas).

In 2002, 68,732 HIV tests were administered with OraSure, up from 62,834 in 2001, 43,672 in 2000, 30,686 in 1999, and 19,251 in 1998. The statewide positivity rate using OraSure also increased from 2.0% in 1998 to 3.2% in 2002. Positivity rates for individual counties are illustrated in Figure 18. Compared to the overall positivity rates shown in Figure 5, some counties were able to achieve higher positivity rates using OraSure. These differences may be evidence for the success of OraSure as an outreach tool. Among counties that used more than 100 OraSure tests in 2002, Miami-Dade County had the highest positivity rate (5.4%), followed by Escambia

Figure 18. HIV Seropositivity Rates Using OraSure by County, 2002



(4.4%), Okaloosa, (4.3%) and Putnam counties (4.3%). Thirty-three counties performed fewer than 100 tests in 2002; of these, 13 counties did not administer OraSure tests.

Non-Hispanic blacks accounted for the majority of OraSure tests conducted in 2002 (31,524 or 45.9%), as compared to non-Hispanic whites (21,710 or 31.6%), and Hispanics (12,033 or 17.5%). Males accounted for a slightly higher proportion than females (52.1% vs. 47.4%).

Figures 19a and 19b compare testing levels and positivity rates by race/ethnicity and sex for OraSure and blood testing in 2002. While white females dominated blood testing, the highest levels of OraSure testing were among blacks of both gender groups. White and Hispanic males were also tested in higher numbers than their female counterparts. Compared to blood testing, much higher positivity rates were recorded among black females using OraSure (3.9% vs. 2.5%). Substantial increases were also recorded for Hispanic females (1.2% vs. 0.5%). Conversely, the positivity rate for black men using OraSure was slightly lower than the rate obtained from blood tests (4.7% vs. 4.9%).

Figure 19a. HIV Blood Tests by Race and Sex, Florida, 2002

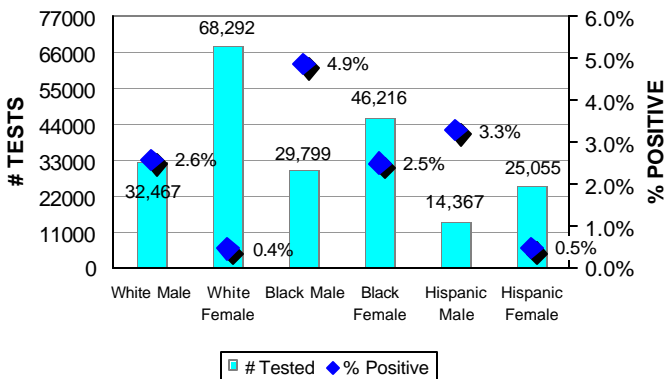
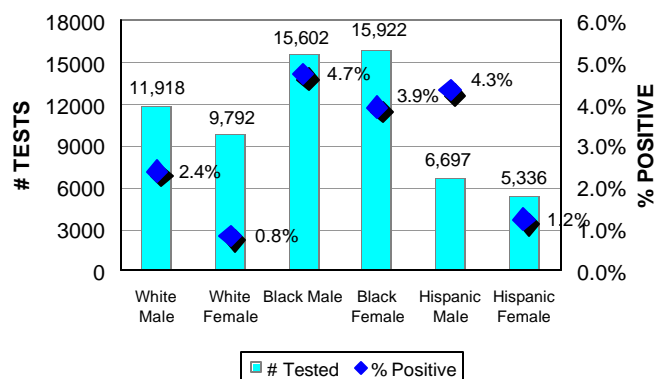


Figure 19b. HIV OraSure Tests by Race and Sex, Florida, 2002



Figures 20a and 20b compare testing levels and positivity rates by risk groups for blood and OraSure testing in 2002. Regardless of the type of test, the majority of tests were administered to persons who identified heterosexual sex as their highest risk. Compared to blood testing, the positivity rate for MSM (11.2% vs. 8.4%) and IDU (4.0% vs. 3.8%) using OraSure testing was lower. Higher positivity rates using OraSure were recorded for those whose sex partners were at risk (8.1% vs. 8.9%), STD diagnosis (1.7% vs. 3.2%), and heterosexuals (0.7% vs. 1.3%).

These data indicate that OraSure has become a valuable asset to HIV prevention programs throughout Florida. Growing evidence from the field suggests that the availability of OraSure has increased test acceptance in a variety of outreach settings, including housing projects, homeless shelters, rural communities, and high-risk youth programs. In 2002, OraSure testing accounted for over 23% of all HIV tests conducted at registered HIV counseling and testing sites, the same as in 2001, but up from 18% in 2000 and 13% in 1999. Its effectiveness as an outreach tool has been demonstrated in larger counties, where the growth of street outreach and community-based testing sites demand faster, easier, and less threatening means of testing for HIV. Similarly, OraSure has been very successful in uncovering HIV-positive cases in several rural counties with historically low positivity rates. OraSure is an important part of ongoing efforts to increase access and availability of HIV testing and counseling services

among high-risk populations, and will continue to increase the proportion of HIV-infected persons in Florida who know their status.

Figure 20a. HIV Blood Tests by Risk, Florida 2002

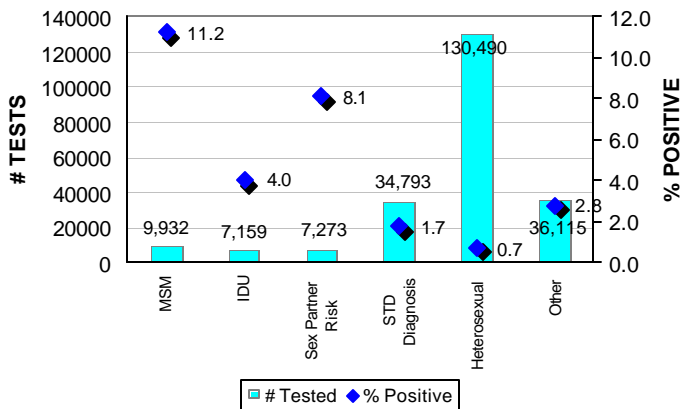
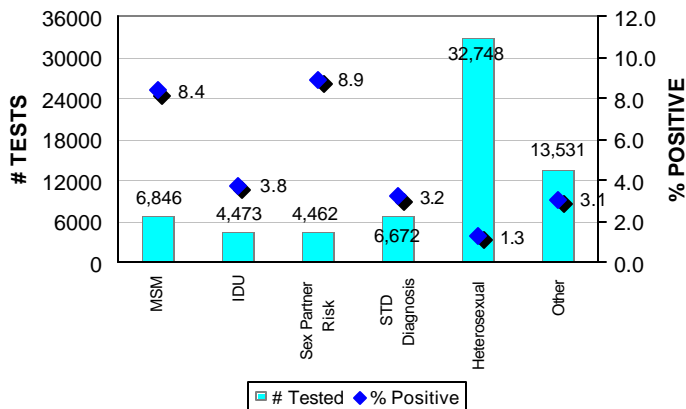


Figure 20b. HIV OraSure Tests by Risk, Florida 2002



Acknowledgement

The Bureau of HIV/AIDS would like to acknowledge the dedication and commitment of the many individuals who have worked so hard over the past year to make Florida's public HIV counseling, testing and referral system one of the best in the nation. Although too numerous to list, these individuals include: our CHD administrators, HIV/AIDS Program Coordinators, nursing directors and the many health department staff who perform HIV counseling, testing and referral services and oversee those programs; STD staff who have the difficult job of notifying the newly infected and conducting partner counseling and referral services; our 501 trainers who ensure that future counselors are prepared; our health educators and outreach workers who educate and inform; our colleagues in the state laboratories, without whom we would not have a testing program; our partners in community and faith-based organizations who reach out to those we cannot reach; staff within the bureau who work tirelessly on this program; and finally, our Early Intervention Consultants, those front line staff who have worked so diligently to ensure the success of CTR in Florida. We look forward to our continued collaboration as we strive to ensure that all Floridians have the opportunity to learn their HIV status and take steps to protect themselves and those they love.