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Health and Human Services (HHS) [1]

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0- HHS

Office of HIV/AIDS Policy

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TO: Sandy Thurman
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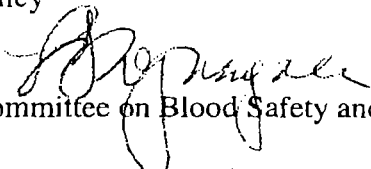
FROM: ERIC GOOSBY, M.D.
202-260-8863

Thanks

Assistant Secretary for Health
Surgeon General
Washington, D.C. 20201

DATE: June 9, 2000

TO: Eric P. Goosby, M.D.
Director, Office of HIV/AIDS Policy

FROM: Stephen D. Nightingale, M.D. 
Executive Secretary, Advisory Committee on Blood Safety and Availability

SUBJECT: Needs of Blood Programs in sub-Saharan Africa - **INFORMATION**

The World Health Organization has estimated that 80% of the world's population has access to only 20% of the global supply of safe blood, and that as many as 13 million of the 35 million units of blood that are transfused annually throughout the world are not tested for HIV or hepatitis. For these reasons, WHO has designated blood safety the theme for World Health Day 2000, and a major focus of its efforts in the developing world over the next five years.

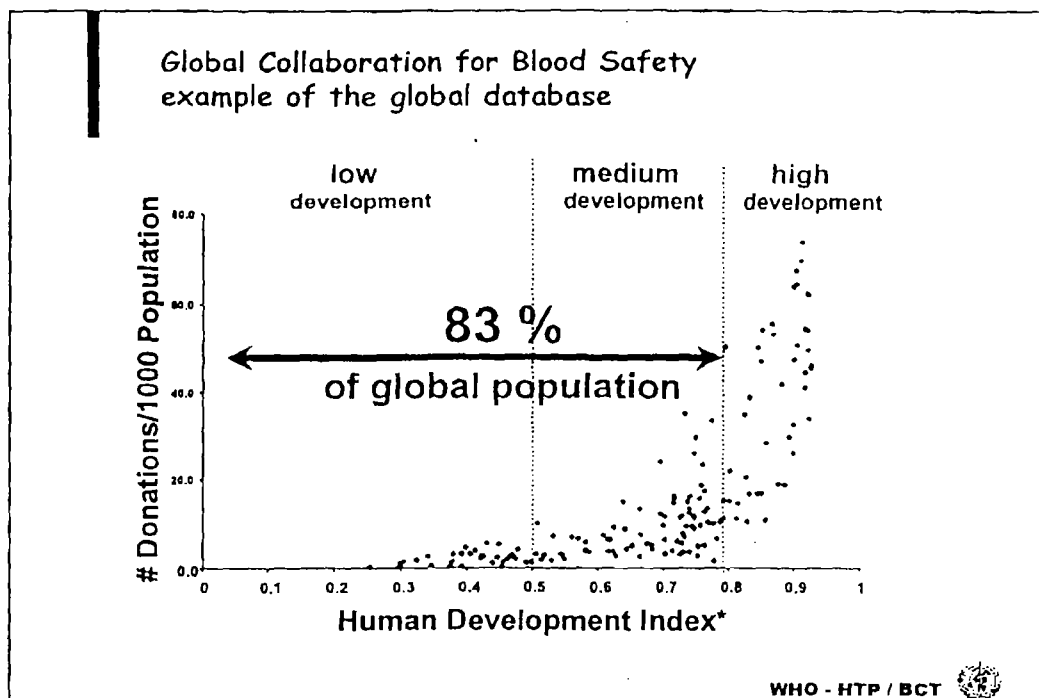
Use of blood in developing countries is only known approximately, and demand for blood even more so. Donation rates in countries with a low human development index is approximately 18 times lower than in countries with a high development index (Figure). In countries such as the United States, half of all blood is used for patients over age 65 (joint replacement, cardiac surgery, and cancer therapy account for most of this use). For individuals under 65, the majority of blood use is for cancer therapy, complications of childbirth, trauma, and inherited diseases such as sickle cell anemia and thalassemia. In developing countries, blood use in urban medical centers may approach the pattern of developed countries, but blood use in the countryside would be primarily for trauma, complications of childbirth, and inherited blood diseases. In areas infested with malaria or intestinal parasites, treatment of anemia due to these infections also generates demand for blood transfusions. As economic development of the countryside proceeds, the pattern of blood use would be expected to change toward the urban pattern.

The major obstacles to safe blood in developing countries - unfortunately, in both urban and rural areas - are the use of paid donors or "replacement" donors; the very high rates of transfusion-transmissible diseases in the donor population, and limited funding for both infrastructure and specific tests. The goal of the WHO Global Collaboration for Blood Safety, and of all concerned workers in the field, is to implement the standard of voluntary blood donation throughout the world, albeit in a manner responsive to local customs and resources. In both South Africa and Zimbabwe, for example, successful blood donor pools have been constructed from secondary school students who acquire the habit of repeat donation and retain the habit afterwards (repeat

donors are much safer in all settings studied than occasional donors). Judicious support of such programs, particularly for infrastructure and for performance of specific tests, would enable them to expand their catchment areas and serve as models for the development of other blood centers. An investment of approximately \$500,000 US per annum over a period of 5 to 10 years in each of 20 to 40 blood centers throughout sub-Saharan Africa for the purpose of implementing full volunteer donation and uniform testing of donations could have a substantial impact on the estimated 10% of HIV infections in sub-Saharan Africa caused by blood transfusion.

The blood centers most likely to benefit from this support, at least initially, would be those in urban areas. For rural populations, the infrastructure necessary to insure a safe blood supply will take years to develop. In the interim, a potential solution is the deployment of blood substitutes. The Department of Defense anticipates deployment of the equivalent of 65,000 units of a blood substitute around the world within 5 years, and a private company (Biopure) has begun Phase III clinical trials and construction of a manufacturing facility in South Africa for the commercial deployment of a bovine hemoglobin-based blood substitute. For trauma and obstetrical accidents in rural areas of developing countries, these products could have a substantial impact on mortality. At present, clinical trials remain to be completed. However, the challenge of these trials appears to be no greater than the challenge of determining how to deploy them in developing economies of limited resources and substantial need. A modest investment in efforts to solve this problem could return substantial benefits in the future.

FIGURE



0443

FY 2001 HIV/AIDS FUNDING RECOMMENDATION PACKAGE

DEPARTMENT: Health and Human Services

AGENCY: Office of Minority Health

PROGRAM: Demonstration for At-Risk Pregnant Women

* FUNDING AMOUNT:

FY 1999 <u>ENACTED</u>	FY 2000 <u>ENACTED</u>	FY 2001 PRESIDENT'S BUDGET <u>REQUEST</u>	FY 2001 INITIATIVE <u>RECOMMENDED</u>	\$ <u>CHANGE</u>
N/A	N/A	N/A	\$7.5 million	+\$7.5 million

NOTE: FILL IN THE AMOUNT INDICATED UNDER EACH HEADER. THE COLUMN MARKED FY 2001 INITIATIVE RECOMMENDED REFLECTS THE FUNDING LEVEL RECOMMENDED BY YOUR ORGANIZATION. UNDER THE CHANGE COLUMN, INCLUDE THE DIFFERENCE BETWEEN THE PRESIDENT'S BUDGET REQUEST AMOUNT AND THE AMOUNT RECOMMENDED BY YOUR ORGANIZATION.

DESCRIPTION OF PROGRAM/PROJECT/FOCUS AREA EMPHASIZED -- EXPLAIN WHAT IT IS DESIGNED TO DO AND TO ACCOMPLISH:

Last year, the Office of Minority Health funded a small program that supports the dissemination of printed HIV testing resources, guidelines and technical assistance to obstetrical/emergency and/or urgent care providers who serve at-risk pregnant women who have sought little or no prenatal care. Client education materials on HIV testing will also be developed. It is recommended that an additional \$7.5 million above the President's request be provided to expand this effort to cover the nation, including the Virgin Islands, Guam and other territories and to add a perinatal vertical transmission component. The final funding recommendations should be made in consultation with the Summit Health Institute for Research and Education, the original grant recipient.

JUSTIFICATION FOR WHY THE EFFORT SHOULD RECEIVE YOUR RECOMMENDED FUNDING LEVEL: (INCLUDE A NARRATIVE AND SUPPORTING DATA, EXTENT OF THE PROBLEM, NUMBER OF PEOPLE PROJECTED TO BE SERVED, NUMBER GOING UNSERVED [AND PROVIDE DATA SOURCE])

In just over a decade, the proportion of all AIDS cases reported among adult and adolescent women nearly tripled from 7 percent in 1985 to 22 percent in 1997. HIV/AIDS was the fourth leading cause of death among U.S. women aged 25-44 in 1996, and the leading cause of death among African American women in this age group. The disproportionate impact of HIV on African American women is reflected in the data tracing the epidemic among these populations. HIV incidence among African American women represents 60 percent of all new AIDS cases among women. Furthermore, the annual AIDS case rate among African American women is 16 times that of white women. Additionally, more than 7,000 children are born to HIV-infected mothers each year. Children of color are disproportionately represented among these AIDS cases --- 61 percent are African American. The grave impact of HIV disease on African American children indicates the need for intensified efforts to prevent infection among African American women and to reach larger numbers of HIV-positive pregnant women, at points of entry for those who are particularly at-risk, as well as for those who are accessing prenatal care and prevention services. The need for improved HIV testing services and development of standards of care has been supported by the Public Health Service Office of Women's Health and Office of AIDS Policy Care/Treatment Working Group. This group has identified the development of standards of care for HIV-infected women for health care providers pertaining to OB/GYN care a priority, particularly at points of entry typically accessed by women at risk such as emergency rooms.

Form: mt633

RECOMMENDED BILL LANGUAGE:

NOT APPLICABLE

RECOMMENDED REPORT LANGUAGE:

Of the funds provided, \$7.5 million is appropriated to expand efforts already underway at the Office of Minority Health targeting minority women of childbearing age. The committee recognizes the disturbing trends related to HIV-infection in minority women and children populations. Funds provided will support the nationwide development of standardized treatment and care practices for emergency room personnel, perinatal educational materials, and other resources for primary care providers. The Committee recognizes the efforts of the Summit Health Institute for Research and Education (SHIRE) in this area.

PREPARED BY:

NAME: Anita Estell

ORGANIZATION: Rainbow/PUSH, PUSH for Life Advisory Board

PHONE: _____ **FAX:** _____ **E-MAIL:** _____

0-HHS

DEPARTMENT: Department of Health and Human Services
AGENCY: Centers for Disease Control, SAMSHA, and HRSA
PROGRAM: Expansion of HIV prevention efforts targeting youth at risk

• FUNDING AMOUNT:

FY 1999	FY 2000	BUDGET	FY 2001 PRESIDENT'S INITIATIVE REQUEST	\$ RECOMMENDED \$200 million	CHANGE
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NOTE: FILL IN THE AMOUNT INDICATED UNDER EACH HEADER. THE COLUMN MARKED FY 2001 INITIATIVE RECOMMENDED REFLECTS THE FUNDING LEVEL RECOMMENDED BY YOUR ORGANIZATION. UNDER THE CHANGE COLUMN, INCLUDE THE DIFFERENCE BETWEEN THE PRESIDENT'S BUDGET REQUEST AMOUNT AND THE AMOUNT RECOMMENDED BY YOUR ORGANIZATION.

DESCRIPTION OF PROGRAM/PROJECT/FOCUS AREA EMPHASIZED – EXPLAIN WHAT IT IS DESIGNED TO DO AND TO ACCOMPLISH:

The Centers for Disease Control (CDC) is the major recipient of funds from the Federal government earmarked for HIV Prevention activities. The allocations to youth specific prevention efforts are too small to effectively respond to the scope of the problem or to reach all youth at risk. Additional resources and channeling a significant proportion of these resources to youth at highest risk is needed to stem the rising epidemic in this population. Current estimates place youth under age 25 as contributing to half the new cases of HIV identified annually. This reality should be accompanied by at least half of the total prevention dollars directed to youth, should be committed to youth programs.

Form: mm633

DESCRIPTION OF PROGRAM/PROJECT/FOCUS AREA EMPHASIZED - EXPLAIN WHAT IT IS DESIGNED TO DO AND TO ACCOMPLISH: (CONTINUED)

A wide net must be cast to successfully reach a majority of youth. Resources should be deployed to community-based and comprehensive health care facility programs that provide services for youth of color who are at high risk; females, gay males and substance abusers. School-based prevention efforts should also be recipients of increased funding to improve the quality and effectiveness of their HIV prevention efforts.

The goal of these efforts is to improve the knowledge base of American youth about the reality of HIV in their population and encourage the adoption of behaviors that will at least minimize and at best prevent adding to the number of youth infected. Recognition of being "at-risk" as a result of educational programming may also translate into more youth deciding to be tested for HIV and becoming aware of their aerostats, providing an additional opportunity to reinforce prevention messages and link high-risk HIV (-) and HIV (+) to developmentally appropriate and culturally sensitive care sites. All programs that provide services to high-risk youth such as family-planning agencies, substance abuse programs and STD clinics and receive governmental funding should be required to document the provision of HIV prevention education.

The prevention activities funded by CDC and SAMHSA should carefully reviewed to identify new and creative ways of reaching young people. Programs that have been most successful in addressing the needs of youth at highest risk; youth of color, females, gay males, substance abusers and the growing number of homeless and runaway youth should be widely distributed and replication site funding should be made available.

**JUSTIFICATION FOR WHY THE EFFORT SHOULD RECEIVE YOUR RECOMMENDED FUNDING LEVEL:
(INCLUDE A NARRATIVE AND SUPPORTING DATA, EXTENT OF THE PROBLEM, NUMBER OF PEOPLE
PROJECTED TO BE SERVED, NUMBER GOING UNSERVED [AND PROVIDE DATA SOURCE])**

The Federal government supports many programs aimed at prevention of HIV. Funding in FY 1999 was \$775 million with \$658 million being allocated to the Centers for Disease Control. CDC activities include the cooperative funding agreements and technical support to all 50 states, seven territories, the District of Columbia, Puerto Rico and six cities for HIV counseling and testing, health education and risk-reduction programs, public information projects and community planning. In FY 1998, the 261 million expended for these programs, resulted in about a 59 million allocation to youth-serving programs. For a population contributing as much as 50% to the number of new HIV infections annually, these allocations are woefully inadequate.

School-based prevention efforts funded by the CDC totaling approximately 45 million in FY 1999 was allocated to all 50 states, seven territories, the District of Columbia, and education departments in 18 major cities to plan, execute and evaluate HIV education. Included in these monies is support for training of more than 180,000 teachers/year on effective administration of HIV programs. Expansion dollars are needed to reach more schools, particular those in rural environments, to improve the quality and scope of existing programs and increase the capacity to train more teachers annually. There are many schools with model HIV education programs and their curriculum should be shared with school districts. Technical support dollars should be increased to assist those school where health education is either lacking or of poor quality.

From 1995 to 1998, the CDC funded 20 national organizations to develop, implement and evaluate HIV/AIDS prevention communications programs. A program targeting youth was the focus of six of these programs and included an effort by the National Council of Negro Women's directed to African-American young women. More youth programs are needed, specifically those employing social-marketing campaigns to reach out of school youth, particularly drop-outs who may be homeless or runaway and at increased risk for HIV because of survival sex and substance abuse.

The Substance Abuse and Mental Health Services Administration (SAMHSA) also funds community-based programs targeting youth. In 1999, the Congressional Black Caucus initiative resulted in increased funding for SAMHSA's substance abuse prevention and treatment services for youth of color that will improve their nationwide system for developing, documenting and disseminating successful approaches to prevent drug and alcohol. The 1997 Youth Risk Behavior Survey indicates an increasing percentage of high school students admitting to use of marijuana and cocaine and more than 1:50 reporting ever use of injection of an illegal drug. Out of school youth are not represented in this survey and community-based prevention/treatment programs will likely be the only mechanism to reach these potentially vulnerable young people.

Form: mm633

DEPARTMENT: Health and Human Services

AGENCY:

PROGRAM: Director of Comprehensive HIV/AIDS Initiatives for Adolescent/Young Adult populations

FUNDING AMOUNT:

FY 1999 ENACTED	FY 2000 ENACTED	BUDGET INITIATIVE	FY 2001 PRESIDENT'S REQUEST	FY 2001 RECOMMENDED	CHANGE
				\$	
				50 million	

NOTE: FILL IN THE AMOUNT INDICATED UNDER EACH HEADER. THE COLUMN MARKED FY 2001 INITIATIVE RECOMMENDED REFLECTS THE FUNDING LEVEL RECOMMENDED BY YOUR ORGANIZATION. UNDER THE CHANGE COLUMN, INCLUDE THE DIFFERENCE BETWEEN THE PRESIDENT'S BUDGET REQUEST AMOUNT AND THE AMOUNT RECOMMENDED BY YOUR ORGANIZATION.

DESCRIPTION OF PROGRAM/PROJECT/FOCUS AREA EMPHASIZED -- EXPLAIN WHAT IT IS DESIGNED TO DO AND TO ACCOMPLISH:

This position, based in the Office of AIDS Policy under the direction of Dr. Eric Goosby is a critically needed link to foster communication and better coordination among the key agencies receiving federal allocations for programs targeting youth at high risk for HIV infection and HIV (+) adolescent and young adults. These agencies, the CDC, HRSA, NIH and SAMSHA have been leaders in funding programs that address HIV prevention, outreach, health care and research among the 12-24 year old population. Each agency would identify a key person to work with the Director of Comprehensive HIV/AIDS Initiatives for Adolescent/Young adult populations to facilitate aggressive advancement of a comprehensive youth agenda that builds upon lesson learned, averts program duplication and includes best practices. This will assist in channeling resources to build upon an existing body of collective knowledge

This interagency council would assist the Director in the preparation of a comprehensive, clearly defined strategic national plan following a meticulous review of previous and currently funded programs and a detailed assessment of programmatic needs in the areas of prevention, outreach, care and research. The Youth and HIV/AIDS 2000 report to the President developed by the Office of National AIDS Policy in collaboration with the AIDS Alliance for Children, Youth and Families and the Institute of Medicine's HIV Prevention report requested by the CDC should be included in developing the strategic plan.

The Office of AIDS Policy in collaboration with the interagency council would establish 18-20 Centers of Excellence (COE) to discharge the responsibility of providing a comprehensive service model for HIV (+) youth and put into practice key elements of their national plan identified as best practices. These Centers would combine comprehensive clinical services outreach linked to community-based, youth serving agencies (HRSA) with prevention (CDC and SAMSHA) and relevant research via the Adolescent Trials Network (NIH). They would be well funded to enable multi-disciplinary staff and youth peer educators to deliver an integrated model of care, prevention and research for youth. These centers would adopt a leadership role in developing meaningful collaborations with community-based organizations and local service providers to help advance the youth agenda established by the interagency council and provide HIV training and technical assistance to youth service and HIV service providers.

Form: m0633

DESCRIPTION OF PROGRAM/PROJECT/FOCUS AREA EMPHASIZED - EXPLAIN WHAT IT IS DESIGNED TO DO AND TO ACCOMPLISH: (CONTINUED)

This approach brings together the collective wisdom of the experts in prevention, education, outreach, counseling and testing, health care services and research and houses their current key findings in an organized environment, the Centers of Excellence. There will be a tremendous economic and human resource benefit of a well coordinated effort to decrease the number of youth who become infected with HIV, improve counseling and testing among the adolescent/young adult population and provide multidisciplinary quality care services to assist those who are HIV (+) live longer and delay advancement to AIDS.

Form: nm633

**JUSTIFICATION FOR WHY THE EFFORT SHOULD RECEIVE YOUR RECOMMENDED FUNDING LEVEL:
(INCLUDE A NARRATIVE AND SUPPORTING DATA, EXTENT OF THE PROBLEM, NUMBER OF PEOPLE
PROJECTED TO BE SERVED, NUMBER GOING UNSERVED [AND PROVIDE DATA SOURCE])**

The increasing representation of adolescents and young adults among the population of persons infected with HIV, and the practiced high risk behaviors of youth that place them in harms way of becoming infected indicates the need for more resource allocations and better coordination among the key agencies receiving these resources. The federal government supports a variety of programs administered by the Centers for Disease Control (prevention, education, counseling and testing), the Health Resources and Service Administration (care, outreach, education, counseling and testing), the Substance Abuse and Mental Health Services Administration (prevention) and NIH (research). Many of these programs have advanced the collective knowledge of what works, what does not and what is needed to move a meaningful adolescent/young adult agenda forward to improve detection of positive adolescents, link them to appropriate care sites to mount an aggressive campaign to prevent new infections. Communication at an interagency level is critical to avoid duplication of effort and improve the dissemination of information to the growing population of providers and community-based organizations working with populations of adolescent and young adults. The coordinated efforts and ample resources deployed that have resulted in significantly impacting perinatal transmission of HIV is a model to be used in advancing the adolescent/young adult agenda.

Current estimates indicate that young people under the age of 21 years comprise at least one-fourth and perhaps as many half of the individuals who become infected with the Human Immunodeficiency Virus annually. The most recent data from the Centers for Disease Control provides supporting evidence for the increasing prevalence of HIV infection in the adolescent and young adult population. The number of HIV infected youth aged 13-19 years increased 20% between 1997 to 1998 from 586 to 727. A similar increase was noted among the 20-24 year population with 1,605 reported infections in 1997 and 1,999 in 1998. By June of 1999, more than 3,500 adolescents and 25,200 youth aged 20-24 had been diagnosed with AIDS.

There are many youth infected with HIV who are unaware of their status and many who know their status, but have not engaged in care. The CDC estimates that there are currently between 12,000 to 38,000 13-19 year olds and 62,000 to 185,000 20-24 year olds who are HIV (+) and the majority of these young people are probably unaware of their status. There is a growing need for more developmentally appropriate and youth-friendly multidisciplinary centers of health care to serve as primary care linkages for the growing number of youth impacted by HIV and to serve as educators for other service providers with less experience working with adolescent/young adult populations. There is also a need, based on the discrepancies between the number of infected youth and those in care for active outreach and case finding efforts that are connected with a primary care site.

Form: nm633

RECOMMENDED BILL LANGUAGE:

The secretary of the DHHS will establish an individual with extensive expertise in the areas of HIV Prevention, outreach, health care and research to coordinate interagency activities that moves the adolescent/young adult agenda forward.

RECOMMENDED REPORT LANGUAGE:

PREPARED BY:

NAME:

ORGANIZATION:

PHONE: _____

FAX: _____

E-MAIL: _____

Form: nm633

DEPARTMENT: Department of Health and Human Services
AGENCY: CDC and possibly HRSA
PROGRAM: Project Access and Adolescent outreach efforts

▪ FUNDING AMOUNT:

FY 1999 ENACTED	FY 2000 ENACTED	BUDGET	FY 2001 PRESIDENT'S INITIATIVE REQUEST	FY 2001 RECOMMENDED	CHANGE
				\$ 75 million	

NOTE: FILL IN THE AMOUNT INDICATED UNDER EACH HEADER. THE COLUMN MARKED FY 2001 INITIATIVE RECOMMENDED REFLECTS THE FUNDING LEVEL RECOMMENDED BY YOUR ORGANIZATION. UNDER THE CHANGE COLUMN, INCLUDE THE DIFFERENCE BETWEEN THE PRESIDENT'S BUDGET REQUEST AMOUNT AND THE AMOUNT RECOMMENDED BY YOUR ORGANIZATION.

DESCRIPTION OF PROGRAM/PROJECT/FOCUS AREA EMPHASIZED — EXPLAIN WHAT IT IS DESIGNED TO DO AND TO ACCOMPLISH:

There is an urgent need to increase youth participation in HIV counseling and testing. Many youth, particularly those from minority ethnic groups that are at highest risk are still under the misconception that HIV is a disease of whites, specifically gay white males. Youth must be educated about the growing epidemic in sexually active and substance abusing minority communities to be able to self-identify behavioral risk and hopefully take the next step, to get tested. Service providers to youth must also be educated to include as a part of routine care, HIV prevention education and periodic assessments of high risk behavior(s) as a part of routine care, and encourage HIV testing when indicated.

Needed, is an effective, reproducible educational campaign that makes the direct connection between HIV risk and the importance of HIV testing, incorporating language and images that appeal to a large segment of youth. This program will also provide information on access to youth-friendly health care centers. Such a program achieves two major goals that will positively impact the long term health and well being of adolescents and young adults. The first is that there will be a demonstrable increase in the number of youth who know their HIV status. For youth identified as HIV (-), there is an immediate opportunity to provide secondary prevention strategies that build upon their existing knowledge base of how to stay safe, and facilitate linkages to adolescent-friendly care sites. The second is that there will be increased identification of HIV (+) youth who can make a prompt transition into developmentally appropriate, youth-friendly health care systems in order to avail themselves of the promising new treatments for HIV.

The Adolescent Medicine HIV/AIDS Network (AMHARN), an NICHD funded initiative has had a leadership position in advancing the existing literature on HIV infection in adolescents and young adults. Project ACCESS (Adolescents Connected to Counseling, Education and Special Services), the outreach program of AMHARN employs a social marketing concept targeting urban youth living in the African-American and Latino communities hardest hit by the HIV epidemic. ACCESS was initiated in New York City, in 1997 under the leadership of Dr. Donna Futterman, from Montefiore Medical Center in the Bronx. This campaign utilized public service announcements, town hall meetings, street outreach and other

Form: mt633

DESCRIPTION OF PROGRAM/PROJECT/FOCUS AREA EMPHASIZED - EXPLAIN WHAT IT IS DESIGNED TO DO AND TO ACCOMPLISH: (CONTINUED)

communication vehicles to raise the awareness of HIV infection in youth that culminated in a "get tested" week. The number of youth who phoned into a hot-line number that directed them to the closest youth-friendly testing site and who ultimately underwent testing was a significant increase from past, localized efforts. With financial support from the Congressional Black Caucus, Project ACCESS was successfully implemented in six other cities in 1999: Miami, Baltimore, Washington, D.C., Philadelphia and Los Angeles.

The entry of a young person into a testing site is a window of opportunity to provide targeted prevention messages, information about youth-friendly health care sites and ideally engagement in a regular source of health care. Project ACCESS is an important example of a program that works and is reproducible across geographical and cultural lines.

Form: nns33

**JUSTIFICATION FOR WHY THE EFFORT SHOULD RECEIVE YOUR RECOMMENDED FUNDING LEVEL:
(INCLUDE A NARRATIVE AND SUPPORTING DATA, EXTENT OF THE PROBLEM, NUMBER OF PEOPLE
PROJECTED TO BE SERVED, NUMBER GOING UNSERVED (AND PROVIDE DATA SOURCE))**

The Centers for Disease Control (CDC) currently estimates that there are approximately 200,000 Americans, including adolescents and young adults infected with HIV who are unaware of their status. Less than half of American youth have ever been tested for HIV. Their access to HIV counseling and testing facilities can be severely limited by a variety of factors including a lack of knowledge about available sites, no method of transportation and conflicts between school hours and hours of clinic operations. Not all facilities are equipped to offer counseling in languages other than English and sites that work primarily with adult populations may not be youth-friendly.

In addition to access issues, many youth do not feel personally at risk for HIV infection despite behaviors that place them in harm's way. They are unresponsive to messages developed for adult populations and not engaged with social or medical agencies that can provide education. In the context of health education in schools, there are facts provided, but it is unaccompanied by strong language that clearly states the importance of knowing one's status.

The CDC and the Health Resources and Services Administration (HRSA) have encouraged HIV counseling and testing among youth, but the amount of federal resources allocated to this effort are meager compared to the size of the youth HIV epidemic. The delay in diagnosis exacts a significant toll on economic and human resources costs when HIV infections are not realized until there are symptoms of AIDS.

Preliminary Project Access data available from four of the six sites (Los Angeles, Miami, Philadelphia and New York) demonstrates an 45% increase in the number of HIV tests performed in adolescent/young adult populations during their get tested week. Youth identified to be HIV (+) during the get tested week totaled 18 versus 2 in the month preceding the campaign. While these numbers are small, they are significant, as these are young people who may not have otherwise tested. Increased funding for programs like Project Access that have been successful with meager budgets and limited time lines to carry out the campaign and expansion to other cities will increase the number of youth who know their status and can be engaged in care.

Form: m5633

FY 2001 HIV/AIDS FUNDING RECOMMENDATION PACKAGE

DEPARTMENT: Department of Health and Human Services

AGENCY: Health Care Financing Administration

PROGRAM: State Grants and Demonstrations or Research, Demonstration and Evaluation

*** FUNDING AMOUNT:**

<u>FY 1999 ENACTED</u>	<u>FY 2000 ENACTED</u>	<u>FY 2001 PRESIDENT'S BUDGET REQUEST</u>	<u>FY 2001 INITIATIVE RECOMMENDED</u>	<u>\$ CHANGE</u>
State Grants Authority:				
0	0	\$16 million	\$250 million	+\$234 million
OR				
Research, Demonstration & Evaluation Authority				
\$50 million	\$62.9 million	\$55 million	\$250 million	+\$195 million

NOTE: FILL IN THE AMOUNT INDICATED UNDER EACH HEADER. THE COLUMN MARKED FY 2001 INITIATIVE RECOMMENDED REFLECTS THE FUNDING LEVEL RECOMMENDED BY YOUR ORGANIZATION. UNDER THE CHANGE COLUMN, INCLUDE THE DIFFERENCE BETWEEN THE PRESIDENT'S BUDGET REQUEST AMOUNT AND THE AMOUNT RECOMMENDED BY YOUR ORGANIZATION.

DESCRIPTION OF PROGRAM/PROJECT/FOCUS AREA EMPHASIZED -- EXPLAIN WHAT IT IS DESIGNED TO DO AND TO ACCOMPLISH:

There are two programmatic activities sponsored by HCFA that could possibly support a demonstration that would allow states to expand Medicaid coverage to asymptomatic HIV-infected persons, and other low-income persons currently not covered by either HRSA or HCFA programs: (1) the State Grants and Demonstrations program and (2) the Research, Demonstration and Evaluation program. Funding would be made available under only one of these accounts. Some research is required to ascertain which would be the most appropriate vehicle.

For FY01, the **State Grants and Demonstration** program has two key components – a \$250 million initiative authorized under the Ticket to Work and Work Incentives Improvement Act, and a legislative proposal providing competitive grants to states so that they may improve the coordination of homeless services.

The **Research, Demonstration and Evaluation** program at HCFA allows the Agency to fund research and demonstration projects that are related to its mission, but that may fall outside of the traditional scope of categorical programs. Last year, as a part of the FY00 budget, the program received an appropriation of \$62.9 million, representing a \$12 million increase above the amount provided in FY99. Moreover, as a part of the FY00 Omnibus Appropriations bill, 15 specific initiatives were earmarked under this account. However, there was no reference to the need to conduct a broader assessment of prevention, screening, testing and access to treatment needs of low-income minority populations disproportionately affected by HIV/AIDS, who currently are without care, many of whom are asymptomatic HIV-infected individuals who have no access to either the HRSA or Medicaid programs. Moreover, no direction was provided to encourage HCFA to be more proactive in developing strategies that would more effectively address these concerns.

JUSTIFICATION FOR WHY THE EFFORT SHOULD RECEIVE YOUR RECOMMENDED FUNDING LEVEL: (INCLUDE A NARRATIVE AND SUPPORTING DATA, EXTENT OF THE PROBLEM, NUMBER OF PEOPLE PROJECTED TO BE SERVED, NUMBER GOING UNSERVED [AND PROVIDE DATA SOURCE])

We support the efforts of the AIDS Action Council to provide earmarked funding for a Medicaid demonstration. However, while the AIDS Action Council recommends \$100 million to support such a demonstration, the Rainbow/PUSH Advisory team recommends that \$250 million be provided to support a demonstration initiative. HCFA officials have indicated that it would cost about \$5 billion a year to provide treatment and care for the approximately 200,000 to 300,000 persons who are neither covered by HRSA or HCFA programs. Therefore, in light of the need, a larger appropriation is requested.

Despite the existence of federal AIDS programs, such as ADAPs and the other components of the Ryan White CARE Act, Medicaid serves as the foundation of AIDS care through its provision of both comprehensive health care and drug therapies. While ADAPs provide limited prescription drug coverage for some uninsured and underinsured people with HIV and AIDS, these programs cannot (and are not designed to) meet the needs associated with comprehensive primary care and diagnostic services.

Medicaid provides access to health care coverage for low-income, uninsured, disabled people. Most low-income individuals who are HIV positive, who have not been diagnosed with AIDS, are not eligible for Medicaid, because they do not meet the program's disability standards or other categorical eligibility requirements. Therefore, with the exception of some women and children, the majority of people with HIV/AIDS must become disabled by AIDS in order to qualify for Medicaid. Thus, despite the fact that early clinical intervention (including primary care, prevention services, and medication therapies), has been shown to improve health and delay the onset of even more expensive opportunistic infections, most HIV positive individuals must wait until they are disabled by AIDS before they can receive Medicaid.

As the AIDS epidemic moves increasingly into economically disenfranchised communities, fewer individuals with HIV have private health insurance. This fact highlights the need to reform the Medicaid program to allow low-income HIV-positive persons to qualify for Medicaid before they are disabled by an AIDS related illness. By supporting a demonstration to allow certain states to expand coverage under Medicaid to include asymptomatic patients, a larger number of low-income persons, many of whom come from minority communities, would receive the treatment and health care they need to stay alive and remain as healthy as possible. Moreover, this effort is consistent with HCFA efforts to expand coverage in certain states by expediting the Section 1115 State waiver requirements. The demonstration would assist the states in meeting some of the costs associated with expansion.

RECOMMENDED BILL LANGUAGE:

TO BE DEVELOPED, THERE MAY BE A NEED TO ADDRESS SECTION 1115 WAIVER REQUIREMENTS.

RECOMMENDED REPORT LANGUAGE:

The committee recognizes that approximately 200,000 to 300,000 people who have HIV/AIDs are without access to care. Many of these individuals are asymptomatic and come from low-income, minority communities. In order to strengthen efforts already underway at HCFA to allow states to expand Medicaid coverage to include HIV-infected persons currently not covered, \$250 million is provided to support competitive grants to be awarded to up to 15 States to assist them with covering costs associated with any expansion, and to coordinate efforts. The Committee also asks HCFA, in collaboration with HRSA, to develop strategies and recommendations related to providing increased testing, screening and access to treatment services to low-income HIV-infected persons who currently are without care. These recommendations shall be submitted to the committee by March 2001.

PREPARED BY:

NAME: Anita Estell

ORGANIZATION: For the Rainbow/PUSH, PUSH for Life Advisory Board

PHONE: _____ FAX: _____ E-MAIL: _____

FY 2001 HIV/AIDS FUNDING RECOMMENDATION PACKAGE

DEPARTMENT: Health and Human Services
AGENCY: Health Resources Services Administration
PROGRAM: AIDS Drug Assistance Program (ADAP)

*** FUNDING AMOUNT:**

FY 1999 <u>ENACTED</u>	FY 2000 <u>ENACTED</u>	FY 2001 PRESIDENT'S BUDGET <u>REQUEST</u>	FY 2001 INITIATIVE <u>RECOMMENDED</u>	\$ <u>CHANGE</u>
\$461 million	\$528 million	\$554 million	\$1.2 billion	+600,000,000

NOTE: FILL IN THE AMOUNT INDICATED UNDER EACH HEADER. THE COLUMN MARKED FY 2001 INITIATIVE RECOMMENDED REFLECTS THE FUNDING LEVEL RECOMMENDED BY YOUR ORGANIZATION. UNDER THE CHANGE COLUMN, INCLUDE THE DIFFERENCE BETWEEN THE PRESIDENT'S BUDGET REQUEST AMOUNT AND THE AMOUNT RECOMMENDED BY YOUR ORGANIZATION.

DESCRIPTION OF PROGRAM/PROJECT/FOCUS AREA EMPHASIZED -- EXPLAIN WHAT IT IS DESIGNED TO DO AND TO ACCOMPLISH:

The ADAP program is authorized under Title II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The program provides HIV/AIDS-related prescription drugs to low income, uninsured and underinsured individuals in the 50 states, the District of Columbia, Puerto Rico, Guam and the Virgin Islands. Each of these jurisdictions establishes financial and clinical criteria for entry into their ADAP and determines which treatments will be covered on its ADAP drug formulary. Each state ADAP operates within its jurisdiction's unique health care delivery and financing system. These factors have contributed to significant differences across state ADAP programs.

The introduction of combination antiretroviral therapy in late 1995 heralded an era of significant change for state ADAPs. Since that time, these programs faced greatly increased pharmaceutical costs and a large influx of new clients, leading to ADAP budget shortfalls and program restrictions in some states. To respond to the increasing demand for access to new HIV treatments, Congress appropriated special supplemental funding under Title II of the CARE Act in 1996 specifically to fund ADAPs. This annual supplemental ADAP appropriation now far exceeds funding for all other health care services covered under Title II and is the largest program-specific funding stream under the CARE Act.

Form: mt633

JUSTIFICATION FOR WHY THE EFFORT SHOULD RECEIVE YOUR RECOMMENDED FUNDING LEVEL: (INCLUDE A NARRATIVE AND SUPPORTING DATA, EXTENT OF THE PROBLEM, NUMBER OF PEOPLE PROJECTED TO BE SERVED, NUMBER GOING UNSERVED [AND PROVIDE DATA SOURCE])

There have been significant funding increases for the ADAP program during the last four years. In FY 1996, the program received an appropriation of \$52 million, and in FY2000, \$528 million were appropriated. These increases have played a very important role in helping states meet the challenge of continuing growth in program expenditures and client utilization. However, ADAP access problems have persisted over time in several jurisdictions, and continued disparities exist in terms of who has access from state to state. Additionally, the Department of Health and Human Services estimates that 200,000 to 300,000 HIV-infected persons currently receive **no care** -- through either the programs supported by HRSA or Medicaid. The requested increase of \$600 million would allow an additional 50,000 untreated and uninsured persons access to vitally needed therapies. According to national AIDS organizations and federal officials, the estimated cost of treatment for HIV-infected persons is about \$12,000.00 per person.

Form: mt633

RECOMMENDED BILL LANGUAGE:

The Committee provides \$1.2 billion for the AIDS Drug Assistance Program.

RECOMMENDED REPORT LANGUAGE:

Of the funds appropriated, the committee provides \$1.2 billion for the AIDS Drug Assistance Program (ADAP). This funding level represents a \$600 million increase above the President's request, and will allow approximately 50,000 additional HIV-infected persons, who currently are untreated and uninsured, access to treatment. Funds should be targeted towards untreated populations in the areas with the highest need. The Committee encourages HRSA to work with HCFA to identify recommendations and strategies that will assist the states in providing treatment services to an estimated 200,000–300,000 HIV-infected persons who currently have no access to care, many of whom live in rural and otherwise isolated areas. A report on these recommendations and strategies shall be submitted to the committee by March of 2001.

PREPARED BY:

NAME: Anita Estell

ORGANIZATION: For the Rainbow PUSH, PUSH for Life Advisory Board

PHONE: (202) 333-5270 **FAX:** _____ **E-MAIL:** _____

FY 2001 HIV/AIDS FUNDING RECOMMENDATION PACKAGE

DEPARTMENT: Health and Human Services

AGENCY: Public Health Services or Health Resources and Services Administration

PROGRAM: Office of Minority Health or Health Professions Training for Diversity

- FUNDING AMOUNT:

Public Health Services

FY 1999 <u>ENACTED</u>	FY 2000 <u>ENACTED</u>	FY 2001 PRESIDENT'S BUDGET <u>REQUEST</u>	FY 2001 INITIATIVE <u>RECOMMENDED</u>	\$ <u>CHANGE</u>
N/A	N/A	N/A	\$29.2 million	\$29.2 million

OR

Health Resources Services Administration

FY 1999 <u>ENACTED</u>	FY 2000 <u>ENACTED</u>	FY 2001 PRESIDENT'S BUDGET <u>REQUEST</u>	FY 2001 INITIATIVE <u>RECOMMENDED</u>	\$ <u>CHANGE</u>
N/A	N/A	N/A	\$29.2 million	\$29.2 million

NOTE: FILL IN THE AMOUNT INDICATED UNDER EACH HEADER. THE COLUMN MARKED FY 2001 INITIATIVE RECOMMENDED REFLECTS THE FUNDING LEVEL RECOMMENDED BY YOUR ORGANIZATION. UNDER THE CHANGE COLUMN, INCLUDE THE DIFFERENCE BETWEEN THE PRESIDENT'S BUDGET REQUEST AMOUNT AND THE AMOUNT RECOMMENDED BY YOUR ORGANIZATION.

DESCRIPTION OF PROGRAM/PROJECT/FOCUS AREA EMPHASIZED -- EXPLAIN WHAT IT IS DESIGNED TO DO AND TO ACCOMPLISH:

Correctional Health Care Training and Placement Program for Minority Practitioners

The Correctional Health Care Training and Placement program is designed to work in partnership with our nation's historical black colleges and universities (HBCU). The goal of this program is to develop a long-term strategy directed toward the elimination of racial and ethnic disparities in health care delivery systems by increasing the number of minority health care practitioners providing health care services within the correctional institutions. The objective of the program is to develop a professional training program for students preparing for their residency and nursing practicum. The training and placement program will be designed to compliment their medical and nursing school training and will focus on

morbidity and treatment issues particular to HIV disease and other infectious and chronic disease among correctional populations. The training program will include case studies and/or other related material that will be geared toward increasing the student's knowledge and understanding of the science of correctional and public health medicine.

Sixteen schools will be identified to participate. (the Minority Schools of Public/Allied Health). Each school will be awarded \$250,000 per year for a total of \$1.25 million per school, which is 19.2 million of the total request or, 65.7%. In addition, students participating will receive an incentive up to \$5000 per student, per year, depending on their academic requirements and needs. The student incentive program's estimated cost is \$2.5 million over a five-year period. This represents 8.6% of the total request. On average, the total number of students participating will be six (6) per school. Each school will be required to have an on-site coordinator responsible for monitoring the efficacy of the program including developing recruitment strategies, providing academic guidance and assisting in the placement of students in jails, prisons and juvenile facilities. The on-site Coordinator will work directly with the executive agency responsible for the overall administrative oversight of the program. The national minority correctional health care entity responsible for the administrative over-site of the program will be funded at a rate of \$1.5 million per year at a rate of \$7.5 million over a 5-year period or 25.6% of the total request.

Form: mt633

JUSTIFICATION FOR WHY THE EFFORT SHOULD RECEIVE YOUR RECOMMENDED FUNDING LEVEL: (INCLUDE A NARRATIVE AND SUPPORTING DATA, EXTENT OF THE PROBLEM, NUMBER OF PEOPLE PROJECTED TO BE SERVED, NUMBER GOING UNSERVED [AND PROVIDE DATA SOURCE])

Assessment of Need: Population

¹In an editorial in the *American Journal of Public Health*, Alan Berkman, MD, CCHP, asserted, "the chain of common humanity is only as strong as its weakest link, and for the current generation of public health planners, prisons are the breaking point."ⁱ Currently, the United States incarcerates more of its citizens than any other industrialized country. More than two million citizens are detained in our nation's jails, prisons, and juvenile confinement facilities. Of which, the majority are minority men, women, and children serving time as a result of the federal government's response to illicit drug activity and its legislative efforts to strengthen sentencing laws. This number does not include community corrections-- those on probation and parole. By virtue of their participation in drug activity and their consumption of drugs and/or alcohol, many of these individuals in correctional systems will have engaged in criminal acts and will be at risk for:

- 1) HIV/AIDS and/or other sexually transmitted diseases (STDs);
- 2) Tuberculosis (TB);
- 3) Hepatitis and/or
- 4) A major psychiatric disorder.

For example, in the last ten years, HIV/AIDS has emerged as the epidemic of injection drug users and, more specifically, an epidemic disproportionately affecting poor people and racial minorities. Recent data suggest that for African Americans between 25-44 years of age, "AIDS is the leading cause of death and that 45% of all reported AIDS cases are among African Americans." An important fact to be noted is that while there is a high percent of AIDS cases among racial minorities "the rate of infection among incarcerated minorities is higher than minorities in the general population."ⁱⁱ According to the Bureau of Justice Statistics (BJS), in "1997, 22,518 state prisoners and 1,030 federal prisoners were known to be HIV positive. Of the inmates known to be HIV positive, 6,184 had confirmed AIDS, while 16,503 either showed symptoms of HIV infection or were asymptomatic"ⁱⁱⁱ

Women in correctional settings have even higher rates of HIV infections. The "vast majority of inmate AIDS deaths occur among men; however, HIV seroprevalence is often higher among female inmates."^{iv} It can be inferred that high rates of HIV infection among female inmates may be related to the "nature of the crimes for which women are commonly incarcerated [i.e., nonviolent economic crimes associated with drug use and sex work]."^v These high rates of infection are exacerbated by the fact that women are a group that has been traditionally deprived of services in a correctional setting because facilities were designed for men and often do not have the necessary equipment and space to provide gynecological services. Because early manifestations of HIV may present as gynecological symptoms, many women may go undiagnosed and therefore do not receive the benefits of early treatment. Because 8 to 10 percent of women are pregnant when they enter these institutions^{vi}, women also require pre- and post-natal care. Proper nutritional care and vitamin supplements are essential to prevent risks to the fetus and to the mother. Furthermore, if women are pregnant and HIV-positive, it is necessary for them to

receive antiretroviral therapy to reduce the risk of transmission to the fetus; however, many facilities do not have systems in place to ensure this standard of care,^{vii} increasing the risk that incarcerated women who are HIV-infected will transmit the virus to their babies.

For juveniles, a population whose incarceration rate has increased exponentially, the incidence of HIV/AIDS and other STDs also demonstrates the critical need for health intervention. At the end of 1994, there were forty-one state and city/county systems that had participated in the National Institute of Justice (NIJ) and Centers for Disease Control and Prevention (CDC) survey. The NIJ/CDC survey was designed to measure prevalence of HIV/AIDS and the incidence of sexually transmitted diseases (STDs) among confined juveniles. Out of the 41 states and city/county systems responding, there were "60 cumulative cases of AIDS and four (4) cases of AIDS among confined juveniles at year-end 1994."^{viii}

Although the number of confirmed cases of AIDS among juveniles appears to be small, the low incidence rate may be attributed to the fact that it may take an individual several years to progress to the end stages of the disease, so those infected during their adolescent years may not show any signs of illness until their adulthood. For juveniles, a more accurate indicator of risk for HIV/AIDS is to examine the health risk behaviors of youth. A Center for Disease Control study found that "compared with the total U.S. population of equivalent age, the incidence rates for gonorrhea were 152 times higher among confined juvenile offenders."^{ix} This indicates that youth who are incarcerated are engaging in unprotected sexual activity at a much higher rate than the general population of adolescents, placing them at higher risk for HIV/AIDS and hepatitis. Additionally, the physical manifestations of specific sexually transmitted diseases, like gonorrhea, may facilitate the transmission of HIV, further increasing the risk of infection for these youth.

Another health concern, which disproportionately affects incarcerated populations, is tuberculosis; "the rates of TB infection and disease are much higher for inmates than for the general population."^x More than 900 prison and jail inmates were reported to be under treatment for active TB disease in 1994.^{xi} Over the past few years, rates have begun to decline, due, in part to aggressive screening, treatment, and discharge planning programs that have been instituted in specific correctional settings, for example, Cook County and Los Angeles County jails and in New York City. These programs must be more widely adopted and serve as models of successful health interventions if the rate is to continue to decline.

Since the behavioral risk factors for hepatitis are the same as HIV/AIDS, it is logical to assume that this is a population that is also at high risk for infection with hepatitis. Both strains of this virus are widespread among injection drug users^{xii}—a risk group that is concentrated in our nation's confinement facilities. Incarcerated populations also have a higher incidence of mental illness and substance abuse, which further complicates the delivery of care and health prevention messages in these settings. In reviewing inmate mental health status issues, the General Accounting Office (GAO), reported that in 1991, "between 6 to 14 percent of incarcerated populations had a major psychiatric disorder and between 2 and 10 percent of the incarcerated population were people with mental retardation."^{xiii} They also reported that the majority (82%), of prison inmates used alcohol or other drugs and/or had other mental disorders. This rate was found to be "more than twice the rate found in the general population outside of corrections or other institutional settings."^{xiv}

According to a report by the University of California Center for AIDS prevention studies, "There are more IDUs [injection drug users] in correctional facilities in the US than in drug treatment centers, hospitals, or social services."^{xv} This makes corrections the first line of defense and presents an additional challenge for the correctional health care provider who must coordinate services with mental health and substance abuse professionals. The high rate of substance abuse and psychiatric disorders necessitates the development of specific interventions that will be accessible and comprehensible to those in multiple risk groups.

This data demonstrates the critical and immediate necessity of providing health care interventions to those incarcerated to reduce the risks of life threatening illnesses. Without a broad-based policy and implementation plan, the government expenditure for correctional and community health care will continue to increase, requiring expensive treatment regimens for chronic illnesses that may have been prevented through earlier intervention strategies. In addition, failure to address these health issues will result in an increased morbidity and mortality in the incarcerated population and the community where many of these individuals live.

Because of high turn over rates in our nation's confinement facilities, people in these institutions return to the community. If they have access to care in the institution but fail to receive follow-up services upon release, they may be likely to develop treatment-resistant strains of HIV, T.B., and hepatitis and potentially infect others in the community with these diseases. The point is not to contribute to labeling inmates as disease carriers or social pariahs, but rather to recognize the historical connection between poverty, race, and incarceration and to view inmates as a part of a community both inside and outside the institutional setting. The interaction between these institutions and the larger community represents an opportunity for education, treatment, and prevention, but it also carries the risk of further infection if these linkages are not established and maintained. **This connection in combination with the disproportionate incarceration of poor people of color places correctional health care at the center of any systemic plan to improve the delivery of health care services in low-income minority communities.**

Racial and Ethnic Disparities In the Delivery of Health Care To Those Incarcerated

Despite notable progress in the overall health of incarcerated persons, there are continued disparities in the rate of illnesses and deaths experienced by incarcerated minorities, compared to the U.S. population as a whole.^{xvi} This can be substantiated by simply looking at the rate of HIV infection and deaths associated with complications of HIV with our nation's prisoners. These disparities can be attributed to many factors including but not limited to:

- 1) cultural and linguistic differences between care giver and patient;
- 2) inability of care giver to appropriately assess, diagnose, and treat because of a lack of sensitivity by the care giver;
- 3) patient's distrust of the care giver because of historical abuses by public health agencies, i.e. Tuskegee;
- 4) failure of the system to engage the patient in their own care;
- 5) the overall inability of the system to meet the severity of inmate medical needs [i.e., HIV/AIDS, substance abuse/mental health, TB, hepatitis, sickle cell anemia, renal disease, asthma, heart disease and other chronic disorders]; which includes a failure of screening and prevention services;
- 6) a previous lack of access to health services; and

7) institutional resistance.

In addition to the above-mentioned factors, there are societal considerations that contribute to the racial and ethnic disparities in the delivery of health care. For instance, there are some who believe that criminals are not worthy of treatment and care and that funding should be directed toward law enforcement and prison construction efforts, rather than effective prison-based health care. Such opposition serves as an impediment to delivering quality health care.

In addition to the societal considerations, there are also financial considerations. For example, one could logically assume that as the rate of incarceration continues to grow exponentially, the health status of the population would inevitably place extreme financial stress on the health care delivery system. In addition to the cost associated with the number of persons detained, the cost to the community must also be factored into the equation. For instance, about 12,000,000 people enter or are released from some kind of jail or prison each year^{xvii} many may be released without diagnosis and/or care or without finishing an established treatment regimen. This circumstance is particularly dire with respect to HIV/AIDS, hepatitis, and tuberculosis-- all life-threatening illnesses. This impacts the rates of exposure and infection in the larger community as those released may continue to engage in high-risk behavior for HIV/AIDS and/or hepatitis or may transmit tuberculosis, an airborne bacteria, in public spaces.

Increasing the number of qualified minority practitioners is key to addressing racial and ethnic disparities in health care delivery among correctional populations especially in light of the factors that tend to contribute to these disparities. However, African American, Hispanics and Native Americans are greatly under-represented in this profession. In 1997-98, African Americans accounted for 3 percent and Hispanics for 5 percent of all physicians in the United States.^{xviii} It is logical to infer that this trend is also a part of the correctional health care community, where physicians of color are particularly needed. For example, the Cook County Jail is the largest single site facility in the country. It is also the largest provider for mental health services in the State of Illinois. On any given day, there are more than 10,000 people detained. In 1997, "there were 96,420 admissions. Of those admitted into custody, 77% were African American and 11% were Hispanic."^{xix} Despite the racial composition of those admitted into custody, minority physicians are grossly underrepresented. As of May 1999, there was only one African American physician on staff.

One can only assume that similar disparities exist in other jurisdictions. Therefore, in order to address the contributing factors identified there must be an increase in the number of under-represented African American and Hispanic health professionals recruited, trained, and placed in our nation's correctional institutions. By employing professionals who reflect the cultural community of the patients, this initiative will not only decrease the cultural and linguistic barriers that may impede the effective diagnosis and delivery of care, it will also increase the likelihood of success for reaching those incarcerated with meaningful and applicable prevention messages and strategies.

Number of People Projected to be Served

It is anticipated that over a 5-year period, approximately 500 health care practitioners would participate in the Correctional Health Care Training and Placement program.

RECOMMENDED BILL LANGUAGE:

The Committee provides \$29.2 million for a Correctional Health Care Training and Placement Program for Minority Practitioners

The Health Resources and Services Administration and/or the Public Health Services play a critical role in ensuring access to appropriate care and treatment for Americans, especially the disadvantage [i.e. incarcerated], who have not proportionately benefited from advances in health care. In addition, they also play a critical role in developing strategies to eliminate racial and ethnic disparities in health care delivery by developing projects of national significance that outreach to all communities especially those communities at the highest risk. Correctional health care has become a critical link for public health interventions, especially since it is the setting where many minorities and others who are typically medically disadvantaged access organized health care. A Correctional Health Care Training and Placement Program for Minority Practitioners is the missing link between eliminating health care disparities in this setting. A program of this magnitude that links HBCU with jails, prisons and juvenile confinement facilities would be a program worth replicating and one of national significance.

RECOMMENDED REPORT LANGUAGE:

Of the funds provided, \$29.2 million is available to support the establishment of a correctional health care training and placement program for minority practitioners. Given that this training and placement program is considered a specialty and one of national significance and given that it will attempt to eliminate health care disparities within correctional health care through the placement of minority practitioners who will be trained and specializing in HIV care and treatment, the request for funding for this program, should be administered through and by a national minority correctional health care entity.

PREPARED BY:

NAME: Lydia L. Watts, MJ

ORGANIZATION: Rainbow/PUSH Coalition

PHONE: 202-333-5270

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- ⁱ Berkman A: Prison health: The Breaking Point. *Am J Public Health* 85: 1616-1618, 1995, page 1616.
- ⁱⁱ Ronald L. Braithwaite, Hammett, Theodore M. and Mayberry, Robert M. *Prisons and AIDS: A Public Health Challenge*. 1996, page 7.
- ⁱⁱⁱ Peter M. Brien, Beck, Allen J. *HIV in Prisons 1994*. U.S. Department of Justice, Bureau of Justice Statistics Bulletin. Washington, D.C.: 1996, page 1.
- ^{iv} *ibid* page 9.
- ^v Stevens, J., Zierler, S., Dean, D., Goodman, A.K., Chalfen, E., DeGroot, A.S. *Prevalence of Prior Sexual Abuse and HIV Risk-taking Behaviors in Incarcerated Women in Massachusetts*, *J. Correctional Health Care*, 1995; 2:137-149.
- ^{vi} Smith, BV and Dailard, C: Female Prisoners and AIDS: on the Margins of Public Health and Social Justice. *AIDS and Public Policy Journal*, pages 78-84, 1994. page 80.
- ^{vii} *ibid*. page 81.
- ^{viii} *HIV/AIDS Education and Prevention Programs For Adults in Prisons and Jails and Juveniles in Confinement Facilities*, Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, 1996; Vol. 45, No. 13. page 269.
- ^{ix} *ibid* page 269.
- ^x Hammet, TM, Gaiter JL, Crawford, C: Reaching Seriously At-Risk Populations: Health Interventions in Criminal Justice Settings. *Health Education and Behavior* 25 (1): 99-120, 1998 page 103.
- ^{xi} *ibid*. page 103.
- ^{xii} *ibid*. page 110.
- ^{xiii} General Accounting Office, *Mental Ill Inmates: Better Data Would Help Determine Protection and Advocacy Needs*. April 1991.
- ^{xiv} Abram, Karen M. And Teplin, Linda A., *Co-Occurring Disorders Among Mentally Ill Jail Detainees*, *American Psychologist*, Oct, 1991, pp. 1036-45.
- ^{xv} University of California at San Francisco. *What are Inmates' HIV Prevention Needs?* <http://www.caps.uscf.edu/inmatestext.numi>. 1999.
- ^{xvi} *Racial and Ethnic Disparities in Health 1998*. U.S. Department of Health and Human Services. Washington, D.C. page 1.
- ^{xvii} Doolen, Dave: Public and Correctional Health Leaders Address Growing Health Emergency. *CorrectCare*. 2000, Vol.14. Page 1.
- ^{xviii} Green, Jay: Pew: Encourage Minority Physicians. *American Medical News*. December 28, 1998. Page 14.
- ^{xix} Cook County Jail 1997 Annual Report.

FY 2001 HIV/AIDS FUNDING RECOMMENDATION PACKAGE

DEPARTMENT: Health and Human Services

AGENCY: Centers for Disease Control

PROGRAM: HIV/AIDS, STDs, TB – Correctional Health Care Surveillance Initiative

*** FUNDING AMOUNT:**

FY 1999 <u>ENACTED</u>	FY 2000 <u>ENACTED</u>	FY 2001 PRESIDENT'S BUDGET <u>REQUEST</u>	FY 2001 INITIATIVE <u>RECOMMENDED</u>	\$ <u>CHANGE</u>
N/A	N/A	N/A	\$32 million	+\$32 million

NOTE: FILL IN THE AMOUNT INDICATED UNDER EACH HEADER. THE COLUMN MARKED FY 2001 INITIATIVE RECOMMENDED REFLECTS THE FUNDING LEVEL RECOMMENDED BY YOUR ORGANIZATION. UNDER THE CHANGE COLUMN, INCLUDE THE DIFFERENCE BETWEEN THE PRESIDENT'S BUDGET REQUEST AMOUNT AND THE AMOUNT RECOMMENDED BY YOUR ORGANIZATION.

DESCRIPTION OF PROGRAM/PROJECT/FOCUS AREA EMPHASIZED -- EXPLAIN WHAT IT IS DESIGNED TO DO AND TO ACCOMPLISH:

The CDC Office of HIV/AIDS has begun to expand its efforts related to correctional health care. For instance, last year, it funded a historic continuity of care effort. Despite these efforts there is a need to more accurately document the burden of disease, by developing surveillance systems that streamline and simplify the disease diagnosis and reporting process.

The project will help to develop reporting software and model screening, notification, and treatment protocols for HIV/AIDS, STDs, TB, hepatitis C and other diseases. Because jail stays are often short, these surveillance systems must be efficient and user-friendly. Additionally, both jails and prisons need assistance in building the infrastructure and obtaining the technology required for a modern surveillance system. Currently, there is no national standardized system in place.

Even more specifically, under the project, corrections personnel will receive training on the importance of accurate reporting and using the reporting software. Technical assistance will be provided to help correctional facilities implement screening procedures in accordance with the model protocols that are developed and to assure that treatment guidelines can be followed. Surveillance systems will improve the health of the incarcerated and will help discharge planners make links to appropriate service providers upon release, thus insuring the health of the community as well. HBCUs, and other minority organizations will be engaged in the implementation of the effort.

JUSTIFICATION FOR WHY THE EFFORT SHOULD RECEIVE YOUR RECOMMENDED FUNDING LEVEL: (INCLUDE A NARRATIVE AND SUPPORTING DATA, EXTENT OF THE PROBLEM, NUMBER OF PEOPLE PROJECTED TO BE SERVED, NUMBER GOING UNSERVED [AND PROVIDE DATA SOURCE])

U.S. prisons and jails now hold 2 million persons, disproportionately composed of racial and ethnic minorities. Approximately 12 million inmates are released into the community annually, mostly from City and County jails. Data compiled by the CDC and other organizations reveal that inmates are at higher risk for many serious diseases and mental disorders than the general U.S. population (Please see other correctional health care briefing materials for background).

At the direction of the subcommittee on appropriations for the Commerce, Justice, State and Judiciary and Related Agencies, in FY97, a \$1 million study was initiated by the National Institute of Justice to determine the health status of soon-to-be-released inmates. The initial findings from that study indicate a substantial lack of capabilities within correctional institutions to identify, monitor, and report on the incidence and prevalence of serious diseases. The lack of such capabilities and information pose a serious threat to inmates, correctional employees and public health generally.

Epidemiology, education and prevention strategies fall under the jurisdiction of CDC. Because of the increasing number of diseases identified in correctional environments, and in response to the Congressional Black Caucus HIV/AIDS initiative, the CDC recently developed a correctional health care initiative within the agency.

With the funds requested, the surveillance system first would be implemented in prisons across the country because they are more likely to have some basic infrastructure. By the end of year three, the surveillance system will be expanded to include the nation's 50 largest jails. In subsequent years, the surveillance system will be implemented in the next tier of city and county jails.

The project will provide an important tool in achieving reductions in disease transmission and addiction, and will help to improve the health and safety of communities across the country, particularly communities of color.

RECOMMENDED BILL LANGUAGE:

NOT APPLICABLE

RECOMMENDED REPORT LANGUAGE:

The initial findings of a Department of Justice study conducted by the National Commission on Correctional Health Care (NCCHC) indicate a substantial lack of capabilities within correctional institutions to identify, monitor, and report on the incidence and prevalence of serious diseases, particularly mental illness, chronic diseases and infectious diseases such as HIV/AIDS, hepatitis C, and tuberculosis. The committee finds that the lack of such capabilities and information pose a serious threat to the health of the general public, as well as to inmates and correctional employees. Therefore, of the funds appropriated, \$32,000,000 is provided to support the development of a national monitoring and reporting system in response to findings identified in the NCCHC study. The CDC should engage the NCCHC, HBCUs, minority correctional health care organizations, and minority-owned firms in the development and implementation of this project. Additionally, the committee encourages the agency to develop a plan outlining short-term and long-term strategies related to both contagious and chronic diseases and other issues related to correctional health care. The plan should be submitted to the committee by March 1, 2001.

PREPARED BY:

NAME: Anita R. Estell, in collaboration with the NCCHC

ORGANIZATION: Rainbow/PUSH, PUSH for Life Advisory Group

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FY 2001 HIV/AIDS FUNDING RECOMMENDATION PACKAGE

DEPARTMENT: Health and Human Services

AGENCY: Centers for Disease Control and Prevention

PROGRAM: National Center for HIV, STD & TB Prevention-Continuity of Care

* FUNDING AMOUNT:

FY 1999 <u>ENACTED</u>	FY 2000 <u>ENACTED</u>	FY 2001 PRESIDENT'S BUDGET <u>REQUEST</u>	FY 2001 INITIATIVE <u>RECOMMENDED</u>	\$ <u>CHANGE</u>
N/A	N/A	N/A	\$21 million	\$21 million

NOTE: FILL IN THE AMOUNT INDICATED UNDER EACH HEADER. THE COLUMN MARKED FY 2001 INITIATIVE RECOMMENDED REFLECTS THE FUNDING LEVEL RECOMMENDED BY YOUR ORGANIZATION. UNDER THE CHANGE COLUMN, INCLUDE THE DIFFERENCE BETWEEN THE PRESIDENT'S BUDGET REQUEST AMOUNT AND THE AMOUNT RECOMMENDED BY YOUR ORGANIZATION.

DESCRIPTION OF PROGRAM/PROJECT/FOCUS AREA EMPHASIZED -- EXPLAIN WHAT IT IS DESIGNED TO DO AND TO ACCOMPLISH:

In 1999, CDC, using its internal funding mechanism, launched a three-year initiative targeting 7 of the largest jails systems in the nation. This request seeks to expand the program to include 5-7 new demonstration sites.

According to the 1997 NIJ/CDC survey, 92% of state/federal prison systems and 76% of city/county jail systems reportedly provide some discharge planning for inmates with HIV disease. Specific types of clinical and psychosocial services covered in discharge planning include the enrollment in Medicaid and related benefit programs, monitoring CD4 counts and HIV viral load, access to HIV medications, drug treatment, HIV counseling, other psychosocial support, and STD services. Inmates, in most state/federal systems and in some city/county systems are given referrals for most of these services. However, in 1997, CDC/NIJ survey found that fewer systems actually make appointments for inmates to receive these services in the community. Although referrals are important, the frequent absence of appointments and additional support and assistance in making contact with and keeping appointments for services means that many released inmates never make contact and never receive the services they need. Instead, many quickly relapse to substance use and crime, often returning to jail and/or prison.

Improved discharge planning, stronger community linkages, and continuity of care between the correctional facility and the community will help offenders negotiate the post-release period as well as provide them with the opportunity to make significant positive changes in their lives. In designing programs for recently released persons, it is important to note that HIV and the treatment and care of

ones health may not be the first thing on their mind once release. Therefore, programs must place HIV services in their appropriate context and seek to help participants address their immediate survival needs and ongoing psychosocial concerns. Moreover, there exist a major disconnection between health and human services available to inmates returning to the community from correctional facilities. The need exist to improve the quality of discharge planning for such populations in coordination with available and emerging resources in the community.

The proposed project is intended to enhance the existing CDC/HRSA demonstration project by adding seven (7) additional jurisdictions to the already existing program. Funding for these seven states should be funnel through state health departments with significant collaboration from correctional systems (prisons, jails, half-way houses, transitional centers) and community –based organizations. During FY 99, seven states were funded through CDC (California, Florida, Georgia, Illinois, Massachusetts, New Jersey, and New York) to build existigon existing cooperative agreements between corrections, community agencies, and state health departments. These projects are in the first year of implementation, and promise to deliver important lessons learned about how the discharge planning process can be involved.

The proposed project addresses the following important issues in corrections, criminal justice and public health:

- HIV/AIDS and other infectious diseases are disproportionately prevalent among African Americans, Latinos/as, and members of other racial and ethnic minorities in the U.S.
- The vast number of inmates return to the community where they may place themselves and others at risk;
- Inmates with HIV may have difficulty maintaining their treatment regimen and continue to access care once released;
- Rates of post release relapse to high-risk behaviors and criminal activity are high;
- Continuity of care programs that include discharge planning, and linkages to primary and secondary providers tend to improve clinical outcomes, reduce high risk behavior and enable the offender to make a smoother transition upon return to the community

JUSTIFICATION FOR WHY THE EFFORT SHOULD RECEIVE YOUR RECOMMENDED FUNDING LEVEL: (INCLUDE A NARRATIVE AND SUPPORTING DATA, EXTENT OF THE PROBLEM, NUMBER OF PEOPLE PROJECTED TO BE SERVED, NUMBER GOING UNSERVED [AND PROVIDE DATA SOURCE])

Prevalence rates of infectious disease, risky health behaviors, and social problems among correctional inmates are high (Hammett, Gaiter, and Crawford 1998: Center on Addiction and Substance Abuse, 1998 Hammett, Harmon, and Rhoades, 1998; Hammett, Maruschak, and Harmon, in press 1999). In general, too little attention is paid to these problems during incarceration. Yet these factors not only endanger inmates, they also put their partners at-risk. Currently, over 7 million people are released from jails and prisons each year (Hammett, Harmon, and Rhodes, 1998). From a public health perspective, correctional institutions provide opportunities to introduce education, prevention and treatment efforts to a high-risk population. Regrettably however, these opportunities have not been fully exploited. (Braithwaite: 1996).

An integrated continuum of care with a cadre of providers within a network is the best model for addressing the multiplicity of medical and psychosocial problems of inmates. The key components of the continuum of care model include the following: 1) screening and early identification; 2) case management; 3) psychosocial support; 4) hospice care; 5) substance abuse treatment; 6) discharge planning; 7) continuity of care and 8) community linkages.

RECOMMENDED BILL LANGUAGE:

Not Applicable

RECOMMENDED REPORT LANGUAGE:

The committee recognizes the need to strengthen continuity of care linkages between correctional facilities and the communities where they are located. In an effort to expand the programs launched in 1999, of the funds provided, \$21 million is appropriated to support the funding of 5-7 new sites.

PREPARED BY:

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ORGANIZATION: Rainbow/PUSH Coalition: PUSH for Life Advisory Board

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Form: mt633

FY 2001 HIV/AIDS FUNDING RECOMMENDATION PACKAGE

DEPARTMENT: Health and Human Services

AGENCY: Office of the Secretary

PROGRAM: HIV/AIDS – Intra-agency Technical Assistance Initiative

* FUNDING AMOUNT:

FY 1999 <u>ENACTED</u>	FY 2000 <u>ENACTED</u>	FY 2001 PRESIDENT'S BUDGET <u>REQUEST</u>	FY 2001 INITIATIVE <u>RECOMMENDED</u>	\$ <u>CHANGE</u>
N/A	N/A	N/A		+\$74 million (For a 5-year initiative)

NOTE: FILL IN THE AMOUNT INDICATED UNDER EACH HEADER. THE COLUMN MARKED FY 2001 INITIATIVE RECOMMENDED REFLECTS THE FUNDING LEVEL RECOMMENDED BY YOUR ORGANIZATION. UNDER THE CHANGE COLUMN, INCLUDE THE DIFFERENCE BETWEEN THE PRESIDENT'S BUDGET REQUEST AMOUNT AND THE AMOUNT RECOMMENDED BY YOUR ORGANIZATION.

DESCRIPTION OF PROGRAM/PROJECT/FOCUS AREA EMPHASIZED -- EXPLAIN WHAT IT IS DESIGNED TO DO AND TO ACCOMPLISH:

Pursuant to the Congressional Black Caucus efforts, the Department of Health and Human Services has provided funding to support the establishment and operation of technical assistance centers targeting minority communities. This request seeks to strengthen this effort by expanding the scope of services to be provided by an African American Capacity-Building Assistance network that would be engaged at the local and regional levels. Of course, if the following proposal needs to be expanded to include persons from other racial and ethnic groups, it can be easily modified or replicated.

The proposal will put into place a two-tiered technical assistance program, cutting across the relevant agencies (e.g., HRSA, CDC, PHS, and SAMSHA), that would be managed by minority organizations in collaboration with institutions of higher education, CBOs, research institutions and government agencies. One tier of the project will have a regional focus, and the other will target specific communities that have been hard hit by the epidemic. In addition to addressing regional concerns, the Regional Prevention Intervention Centers (RPIC) would serve as a resource for the Local Prevention Intervention Centers (LPIC). The local centers would also serve as resource/research sites, with interactive media capabilities, electronic communication expertise and other capabilities, allowing persons from the community to visit the centers should they not have access to computers, the Federal Register, or need assistance with identifying funding opportunities, technical assistance services and

other resources. **The goal is to create a system to support and develop the capacity of the African American community to respond to the health disparities associated with HIV/AIDS, substance abuse, mental health and medical health care by building the capacity of local and regional agencies, and ultimately the services to be delivered.**

1. REGIONAL PREVENTION INTERVENTION CENTERS (RPIC)

Capacity Building Assistance Center Network

Focus

This proposal requests funds to provide Capacity-Building Assistance to community-based organizations serving African American populations heavily affected by HIV throughout the United States of America. The project, entitled *African American CBA Network* (AACBA), will operate throughout the United States with a regional approach. Another name may be required to address the concerns of other racial and ethnic groups. But, for the purpose of this concept piece, the project's target population will include individuals and/or agencies that provide services to African Americans from a diverse high-risk population, including but not limited to men who have sex with men; substance abusers; persons with repeated STD infections; TB infected individuals; women and youth at high risk for HIV infection; recently released inmates, and homeless persons in high-risk situations. Marketing of the project's services will be first and foremost to existing HIV/AIDS service providers. Secondary audiences will include health departments (state and local) and their community planning groups, social service providers, civic organizations, faith communities, and minority health care service providers.

Coalition

The AACBA should be coalition based. Participating organizations should have a national reputation and expertise in providing capacity building assistance services. In addition to national minority HIV/AIDS organizations, historically black colleges and universities, and minority Schools of Public Health, and other minority organizations should be engaged. This national HIV prevention effort will foster reduction of HIV in African American communities. The proposed project will extend these activities into the new millennium with a new approach to capacity-building assistance. The AACBA will seek to respond to growing gaps in services and to provide capacity-building assistance to African American communities to support infrastructure development that responds to HIV/AIDS and other minority health disparities.

Regional Structure

The AACBA will be regionally structured to provide capacity building assistance services with as much local expertise as possible. Each coalition member will form a Prevention Intervention Center (PIC) in each of the respective regions. Four regions will be covered: Southern, Northeastern, Midwestern, and Western. These PICs will be supported by an Administrative Core and a Communications and Dissemination Core. The centers will be located in high, medium and low HIV prevalence cites.

Capacity Building Assistance Services

The project's capacity-building assistance will be delivered through a variety of mechanisms: Skills Building, Information Transfer, Technology Transfer, Technical Consultation and Technical Services. Skills building training will include: Intervention Design and Development,

Program Evaluation, Social Marketing, Behavioral Science. Information Transfer will include regional PIC newsletters, a national multimedia web site, and list serve for quick transfer of electronic information. Technology Transfer will be delivered in conjunction with other capacity-building delivery mechanisms on topics such as Program Evaluation, Coalition Building and Community Planning.

Relationships with CBOs

Participation of African American CBOs should be first and foremost in implementing this proposal. African American CBOs will expand their involvement in the implementation and evaluation of the AACBA as described hereafter. AACBA will involve African American CBOs and other HIV prevention stakeholders by developing an Advisory Board consisting primarily of existing HIV/AIDS services providers. This includes but is not limited to prevention providers, substance abuse agencies, faith community, mental health and medical care entities. The Advisory Board will consist of two committees: Communication/Linkages and Performances/Services. AACBA's implementation activities will be shared with these delegates on the Advisory Board to empower communities at risk. The Advisory Board will serve as a vital part in the planning and operation of this project. The advisory board will also assist in evaluation activities of the project. Advisory Board members and evaluation staff will collaborate to measure effectiveness of capacity-building activities.

Response to CBA Requests

Technical Consultation and Services will be the most important component of the project and delivered as requested from community-based organizations. AACBA will (1) conduct a follow-up comprehensive needs assessment throughout the United States to affirm current HIV prevention capacity-building technical assistance needs for community-based organizations, (2) develop a strategic plan for delivering skills building training throughout the United States, (3) deliver skills building sessions throughout the project, (4) prioritize technical consultation and technical service requests as received, (5) staff capacity-building assistance requests, (6) assign staff or consultants from a national consultant pool, (7) deliver technical consultation or technical services, (8) evaluate all project services, and (9) provide follow-up at 3, 6, and 9 month intervals.

Budget Request

\$2.0 million per RPIC = \$8.0 million a year for start-up costs

1.5 million per RPIC = \$6.0 million a year for operations

The five-year total = \$32.0 million

2. LOCAL PREVENTION INTERVENTION CENTERS (LPIC)

The following recommendations related to the establishment of Local Prevention Intervention Centers will:

- Complement existing capacity building and technical assistance activities underway as a result of CBC funds.
- Respond to the issues identified by minority HIV/AIDS service providers through several national surveys of agency need.

- Use HIV/AIDS epidemiology, morbidity and mortality statistics, and other health indicator data.
- Assume no fee for services and programs to non-for profit organizations and minority community based entities.

PURPOSE:

- Create and support locally structured and regional complementary technical assistance centers.

GOAL:

- Develop community-based resource, information and technical assistance centers in communities of color (COC).
- Develop the capacity of COC to respond to the HIV/AIDS epidemic and other minority health related conditions.
- Improve the capacity of COC to develop and sustain organizational infrastructures that support the delivery of effective and efficient minority health and social services.
- Engage and develop COC for the purpose of increasing community awareness, leadership, participation, and support for HIV/AIDS and other minority health services.

STRUCTURE:

- Ten Centers will be created in high, medium and low HIV/AIDS prevalence areas for COCs.
- The Centers should be developed by minority community based agencies, small minority consulting firms and technical assistance providers with history and experience in capacity building, technical assistance, HIV/AIDS and minority health in COCs. The Centers should partner with local academic, research institutions and government agencies.
- Centers must have the capacity or capability to serve each COC (African American, Latino, Asian Pacific Islander). Centers must develop community advisory boards.
- While Centers will have a local focus, they also will serve multiple jurisdictions based on geographic need and resources.

SERVICES:

The Centers will provide a variety of services to achieve the goals. Category of services will include but not be limited to:

- Organizational Capacity Building
- Community Capacity Building
- Information Technology
- Coalition Development
- Grant writing training

PROGRAMS:

Programs will be created with input from Advisory boards. Types of services will include but not be limited to:

- Leadership Development

- Provider Training
- Financial Management
- Internet Training

COST:

Start - up cost (<i>range</i>):	\$ 1, 000,000 per Center (\$10M/yr)
Annual Operating (<i>range</i>) :	\$ 800,000 per center (\$8 M/yr)

Total for LPIC: 1-year Start-up costs	= \$10 million
4-year operating costs	= \$32 million
	\$42 million

Range includes costs for doing business in New York and Los Angeles as well as Mississippi and Savannah.

Total for RPIC and LPIC: \$74 million for five years

JUSTIFICATION

Responding to the issues identified by minority HIV/AIDS service providers through several national surveys of agency need, and consistent with concerns raised in meetings with federal officials, where stakeholder organizations continue to reveal the lack of capacity and pressing technical assistance challenges facing communities of color, additional funding is required to build capacity. While some steps have been taken to address this issue, there is a need to: (1) expand the scope of services to be provided by the regional technical assistance centers initiative recently announced by CDC, (2) provide technical assistance and other capacity building resources in centers that are located in the communities that have the highest incidence of HIV infection in minority populations, and (3) create the capacity for communities of color to integrate and address other minority health care issues/services.

Consider, for example, if a local church or Boys and Girls club want to address the HIV/AIDS issue (or any other health care issue, issue), using educational, prevention, screening, testing or access to care programs, in either rural or urban areas, where can they go to obtain technical assistance or use a resource library? Additionally, and most importantly, these centers will put into place an infrastructure at the local and regional levels that will assist communities of color in dealing with other health issues such as cancer, hypertension, diabetes, substance abuse, violence, etc. Finally, by taking a coalition approach, the project will leverage resources that already have been invested in communities of color.

RECOMMENDED BILL LANGUAGE:

NOT APPLICABLE

RECOMMENDED REPORT LANGUAGE:

1. Regional Prevention and Intervention Centers (RPIC)

The committee recognizes the need to expand the capacity-building resources for minority populations disproportionately affected by HIV/AIDS and other diseases. Therefore, of the funds provided, \$32 million is appropriated to support and expand the regional technical assistance efforts currently funded by CDC, and to establish four Regional Prevention Intervention Centers (RPIC). This initiative is a part of a two-tiered technical assistance effort, cutting across relevant agencies within the Department (e.g., HRSA, CDC, PHS, and SAMSHA). Up to two grants shall be awarded to minority-managed organizations, which are strongly encouraged to collaborate with community-based organizations, institutions of higher education (particularly HBCUs and other minority serving institutions), and government agencies in designing and implementing their programs. In no way should funding of this initiative affect funding of other Department-sponsored technical assistance programs underway targeting communities of color.

2. Local Prevention and Intervention Centers (LPIC)

The committee recognizes the need to expand the capacity-building resources for minority populations disproportionately affected by HIV/AIDS and other diseases at the local level. Therefore, of the funds provided, \$42 million is appropriated to establish up to ten local resource/research technical assistance sites that have interactive media capabilities, electronic communication expertise and other capabilities, allowing persons in need of assistance from the community to visit the centers. This initiative is a part of a two-tiered technical assistance effort, cutting across relevant agencies within the Department (e.g., HRSA, CDC, PHS, and SAMSHA). Competitive grants shall be awarded to minority-managed organizations, which are strongly encouraged to collaborate with community-based organizations, institutions of higher education (particularly HBCUs and other minority serving institutions), and government agencies. In no way should funding of this initiative affect funding of other Department-sponsored technical assistance programs underway targeting communities of color.

Prepared by:

Tonia Schaffer, Mark Colomb and Anita Estell for the Rainbow/PUSH, PUSH for Life Advisory Board

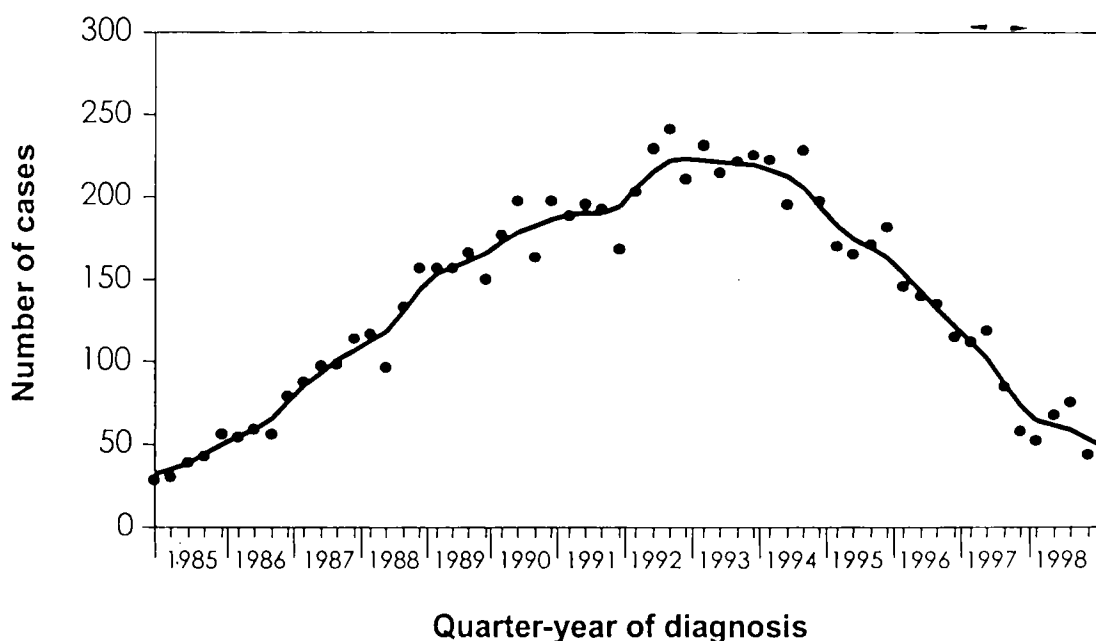
HIV/AIDS

Surveillance Report

U.S. HIV and AIDS cases reported through December 1999

Year-end edition Vol. 11, No. 2

Perinatally Acquired AIDS,* 1985-1998, United States



*Adjusted for reporting delays and unreported mode of HIV exposure. Data reported through December 1999.

Acquired immunodeficiency syndrome (AIDS) is a specific group of diseases or conditions which are indicative of severe immunosuppression related to infection with the human immunodeficiency virus (HIV).



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention
National Center for HIV, STD, and TB Prevention
Atlanta, Georgia 30333



The *HIV/AIDS Surveillance Report* is published semiannually by the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC), Atlanta, GA 30333. The year-end edition contains additional tables and graphs. All data are provisional.

Suggested Citation: Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, 1999;11(No. 2):[inclusive page numbers].

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Single copies of the *HIV/AIDS Surveillance Report* are available free from the CDC National Prevention Information Network, P.O. Box 6003, Rockville, MD 20849-6003; telephone 1-800-458-5231 or 1-301-562-1098. Individuals or organizations can be added to the mailing list by writing to CDC, MASO/MSB/IDS, Mailstop A-22, 1600 Clifton Rd., N.E., Atlanta, GA 30333. Internet users may view an electronic copy of the *Report* by visiting CDC's home page (www.cdc.gov) and selecting the topic "Publications, Software, & Products." Confidential information, referrals, and educational material on AIDS are available from the CDC National AIDS Hotline: 1-800-342-2437, 1-800-344-7432 (Spanish access), and 1-800-243-7889 (TTY, deaf access).

The *HIV/AIDS Surveillance Report* is accessible via Internet: <http://www.cdc.gov/hiv>

HIV/AIDS Surveillance Supplemental Report, "AIDS Cases Diagnosed in 1997 and 1998, by Sex, Race/Ethnicity, Age at Diagnosis, and Risk Exposure", volume 5, number 3, is available on the Internet:
<http://www.cdc.gov/hiv/stats/hasrsupp.htm>

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Commentary

As of the end of 1999, a total of 733,374 AIDS cases had been reported to CDC. Of these, 82% were men, 18% were women and 1% were children less than 13 years of age; 43% were in whites, 37% in blacks, 18% in Hispanics, <1% in Asians and Pacific Islanders, and <1% in American Indians and Alaska Natives; and 47% were in men who have sex with men, 25% in injection drug users, 10% in persons infected heterosexually, and 2% in persons infected through blood or blood products. During the 1990s the epidemic shifted steadily toward a growing proportion of AIDS cases in blacks and Hispanics and in women and toward a decreasing proportion in MSM, although this group remains the largest single exposure group (see Tables 23 and 24). Blacks and Hispanics, among whom AIDS rates have been markedly higher than among whites, have been disproportionately affected since the early years of the epidemic. In absolute numbers, blacks have outnumbered whites in new AIDS diagnoses and deaths since 1996 and in the number of persons living with AIDS since 1998. The proportion of women with AIDS increased steadily, reaching 23% in 1999, and the proportion infected heterosexually also increased, surpassing (in 1994) the proportion infected through injection drug use. Midway through the 1990s, effective therapies became available and their effects on decreases in AIDS incidence and in deaths were detected at the population level through surveillance as early as 1996. As deaths have decreased, AIDS prevalence has steadily increased year to year, a trend that will continue as long as the number of persons with a new AIDS diagnosis exceeds the number of persons dying each year.

The steep decline in perinatally acquired AIDS (Cover figure) has been one of the dramatic changes of the 1990s, resulting from the rapid implementation of the use of zidovudine (ZDV) to prevent perinatal transmission. The increased use of ZDV took place after publication of the findings of the AIDS Clinical Trial 076 and of the Public Health Service guidelines on the use of ZDV to reduce HIV transmission. More recently, some of the decline in perinatal AIDS can also be ascribed to improved treatments for HIV-infected children, which delay the onset of AIDS-defining illnesses. The rate of perinatal transmission is expected to continue to decline as a result of more aggressive courses of treatment (e.g., combination therapy)

and more use of obstetric procedures, such as elective cesarean section, that reduce transmission.

CDC's current perinatal prevention initiative is focusing efforts in the states and cities that account for most cases of perinatal transmission. Activities include educating providers about the importance of offering counseling and testing to all pregnant women, intensification of outreach to increase prenatal care among high-risk women, public information campaigns, and examining the feasibility of testing at delivery for women who have had no prenatal care. Pediatric HIV surveillance will play an important role, helping to gauge the extent to which intensified prevention efforts contribute to reduced transmission.

HIV data for states with name-based HIV surveillance systems are presented side by side with AIDS data from all states. The distribution of reported HIV and AIDS cases cannot be compared directly because the HIV tables represent only the states that currently report cases of HIV infection, whereas the AIDS tables represent all states and territories. Differences in the distribution of risk, for example, may reflect differences in the epidemic in states that report HIV and those that do not. Note that new HIV diagnoses and persons living with diagnosed HIV infection do not provide a direct measurement of HIV incidence and HIV prevalence because not all infected persons have received a diagnosis of HIV infection. In addition, HIV surveillance data should be interpreted with knowledge of local practices because the data are influenced by the availability of HIV test facilities and the proportion of HIV-infected persons who seek or who defer testing. Finally, HIV data are affected by whether states report prevalent HIV cases or just new diagnoses when they implement HIV reporting. Persons are counted only once in the HIV/AIDS system, thus persons who are reported as having HIV and AIDS are counted only as AIDS cases.

As of December 1999, in the 34 areas with name-based HIV reporting (including Connecticut and Oregon, where only pediatric cases are reportable), 113,167 persons were reported as living with diagnosed HIV (not AIDS); in 1999, 21,419 HIV cases were reported. Women account for 32% of the cases reported in 1999. Among women, blacks and Hispanics account for 77% of cases; among men, blacks and Hispanics account for 59% of cases. Persons aged 13-24 years account for 15% of reported HIV cases,

and women account for 49% of cases in this age group. CDC estimates that in the U.S. approximately two thirds of persons living with HIV and AIDS have been tested confidentially. States with HIV reporting can use this information to approximate their total HIV prevalence.

Although new HIV diagnoses do not represent new infections, they can provide information on trends in HIV incidence in certain subgroups. This is especially true for persons under age 25 at diagnosis (Table 25). Because risk behaviors generally are initiated during the late teens, persons who receive a diagnosis before age 25 are most likely to have been infected recently. Assuming stable screening practices and testing behaviors, trends in that age group indicate whether incidence among persons under age 25 is stable, increasing, or decreasing. Given that a substantial portion of new infections occur in that age group, this information is very useful for understanding the patterns of HIV incidence and for targeting prevention efforts.

Guidelines for the surveillance of HIV and AIDS, published in December 1999, recommend integrated HIV and AIDS surveillance. In addition, both the adult and pediatric HIV case definitions were updated to reflect current diagnostic methods and clinical practice. For adults, the results of tests for detectable viral load were included in the case definition to facilitate the reporting of prevalent cases in areas that are initiating HIV surveillance. The pediatric case definition, expanded to reflect changes in clinical practice, now also incorporates the results of viral load tests.

CDC continues to assist states with the implementation and evaluation of HIV reporting systems and to assist with the interpretation of data as the focus shifts from AIDS to HIV. As more states initiate HIV infection reporting, HIV surveillance increasingly complements AIDS surveillance. The integrated HIV/AIDS surveillance system will provide information on the entire population of persons living with HIV infection who have been tested confidentially. This framework will offer a means of collecting additional data on representative samples of persons; these data in turn, will provide the information required to understand the evolution of the epidemic.

Suggested reading:

CDC. HIV/AIDS Surveillance Supplemental Report: Characteristics of Persons Living with AIDS at the End of 1997, 1999;5(No. 1):1-13.

CDC. HIV/AIDS Surveillance Supplemental Report: AIDS Cases Diagnosed in 1997 and 1998 by Sex, Race/Ethnicity, Age at Diagnosis, and Risk Exposure, 1999;5(No. 3):1-12.

CDC. National HIV Prevalence Surveys, 1997 Summary. Atlanta, GA: CDC; 1998:1-25.

CDC. Success in implementing PHS guidelines to reduce perinatal transmission of HIV. *MMWR* 1998;47:688-91.

CDC. Guidelines for national human immunodeficiency virus case surveillance, including monitoring for human immunodeficiency virus infection and acquired immunodeficiency syndrome. *MMWR* 1999;48(No. RR-13):1-31.

All the *MMWR* articles are available at www.cdc.gov/nchstp/hiv_aids/pubs/mmwr.htm.

Persons reported to be living with HIV infection¹ and with AIDS, by state and age group, reported through December 1999²

Reporting area	Living with HIV infection ³			Living with AIDS ⁴			Cumulative totals		
	Adults/adolescents	Children <13 years old	Total	Adults/adolescents	Children <13 years old	Total	Adults/adolescents	Children <13 years old	Total
Alaska (Jan. 1988)	4,766	43	4,809	2,824	24	2,848	7,590	67	7,657
Alaska (Jan. 1987)	—	—	—	223	1	224	223	1	224
Alaska (July 1989)	4,040	38	4,078	2,888	9	2,897	6,928	47	6,975
Alaska (July 1989)	1,858	20	1,878	1,450	23	1,473	3,308	43	3,351
Alaska (Nov. 1985)	—	—	—	42,314	214	42,528	42,314	214	42,528
Alaska (Nov. 1985)	5,258	27	5,285	2,721	6	2,727	7,979	33	8,012
Alaska (July 1992) ⁵	—	97	97	5,414	76	5,490	5,414	173	5,587
Alaska (July 1992)	—	—	—	1,075	15	1,090	1,075	15	1,090
Alaska (July 1997)	—	—	—	5,654	92	5,746	5,654	92	5,746
Alaska (July 1997)	14,081	141	14,222	32,388	608	32,996	46,469	749	47,218
Alaska (June 1986)	—	—	—	9,573	90	9,663	9,573	90	9,663
Alaska (June 1986)	—	—	—	911	5	916	911	5	916
Alaska (June 1986)	278	5	283	209	—	209	487	5	492
Alaska (July 1988)	—	—	—	8,633	126	8,759	8,633	126	8,759
Alaska (July 1988)	3,088	35	3,123	2,444	17	2,461	5,532	52	5,584
Alaska (July 1988)	252	3	255	566	4	570	818	7	825
Alaska (July 1999)	633	7	640	893	5	898	1,526	12	1,538
Alaska (July 1999)	—	—	—	1,459	13	1,472	1,459	13	1,472
Alaska (Feb. 1993)	6,442	105	6,547	5,105	54	5,159	11,547	159	11,706
Alaska (Feb. 1993)	—	—	—	418	7	425	418	7	425
Alaska (Feb. 1993)	—	—	—	8,998	163	9,161	8,998	163	9,161
Alaska (Feb. 1993)	—	—	—	5,949	79	6,028	5,949	79	6,028
Alaska (April 1992)	4,243	92	4,335	4,180	33	4,213	8,423	125	8,548
Alaska (Oct. 1985)	2,409	27	2,436	1,521	13	1,534	3,930	40	3,970
Alaska (Aug. 1988)	3,926	45	3,971	1,843	29	1,872	5,769	74	5,843
Alaska (Oct. 1987)	4,049	41	4,090	3,993	17	4,010	8,042	58	8,100
Alaska (Oct. 1987)	—	—	—	156	—	156	156	—	156
Alaska (Sept. 1995)	448	6	454	435	4	439	883	10	893
Alaska (Feb. 1992)	2,514	23	2,537	2,021	11	2,032	4,535	34	4,569
Alaska (Feb. 1992)	—	—	—	461	4	465	461	4	465
Alaska (Jan. 1992)	11,687	367	12,054	13,766	258	14,024	25,453	625	26,078
Alaska (Jan. 1998)	526	3	529	864	6	870	1,390	9	1,399
Alaska (Jan. 1998)	—	—	—	50,483	803	51,286	50,483	803	51,286
Alaska (Feb. 1990)	8,459	107	8,566	4,121	52	4,173	12,580	159	12,739
Alaska (Jan. 1988)	59	1	60	44	1	45	103	2	105
Alaska (June 1990)	5,042	65	5,107	4,039	43	4,082	9,081	108	9,189
Alaska (June 1988)	2,107	16	2,123	1,522	9	1,531	3,629	25	3,654
Alaska (Sept. 1988) ⁵	—	16	16	1,929	7	1,936	1,929	23	1,952
Alaska (Sept. 1988) ⁵	—	—	—	10,096	174	10,270	10,096	174	10,270
Alaska (Sept. 1988) ⁵	—	—	—	857	7	864	857	7	864
Alaska (Feb. 1986)	6,203	99	6,302	4,176	32	4,208	10,379	131	10,510
Alaska (Jan. 1988)	170	5	175	64	1	65	234	6	240
Alaska (Jan. 1992)	5,259	51	5,310	4,047	18	4,065	9,306	69	9,375
Alaska (Jan. 1999) ⁵	2,668	279	2,947	22,352	153	22,505	25,020	432	25,452
Alaska (April 1989)	734	6	740	883	7	890	1,617	13	1,630
Alaska (April 1989)	—	—	—	169	2	171	169	2	171
Alaska (July 1989)	7,254	73	7,327	5,284	84	5,368	12,538	157	12,695
Alaska (July 1989)	—	—	—	3,703	15	3,718	3,703	15	3,718
Alaska (Jan. 1989)	488	3	491	451	4	455	939	7	946
Alaska (Nov. 1985)	2,125	27	2,152	1,471	12	1,483	3,596	39	3,635
Alaska (June 1989)	63	—	63	70	2	72	133	2	135
Subtotal	111,129	1,873	113,002	287,110	3,432	290,542	398,239	5,305	403,544
U.S. dependencies, possessions, and associated nations									
Guam	—	—	—	18	—	18	18	—	18
Pacific Islands, U.S.	—	—	—	2	—	2	2	—	2
Puerto Rico	—	—	—	8,656	175	8,831	8,656	175	8,831
Virgin Islands, U.S. (Dec. 1998)	162	3	165	210	9	219	372	12	384
Total	111,291	1,876	113,167	296,322	3,622	299,944	406,980	5,498	412,471

¹Includes only persons reported with HIV infection who have not developed AIDS.

²Persons reported with vital status "alive" as of the last update. Excludes persons whose vital status is unknown.

³Includes only persons reported from areas with confidential HIV reporting. Excludes 1,939 adults/adolescents and 56 children reported from areas with confidential HIV infection reporting whose area of residence is unknown or are residents of other areas.

⁴Includes 326 adults/adolescents and 6 children whose area of residence is unknown.

⁵Connecticut has confidential HIV infection reporting for pediatric cases only; Oregon has confidential infection reporting for children less than 6 years old; Texas reported only pediatric HIV infection cases from February 1994 until January 1999.

Table 2. AIDS cases and annual rates per 100,000 population, by area and age group, reported through December 1999, United States

Area of residence	1998		1999		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Alabama	484	11.1	476	10.9	5,724	68	5,792
Alaska	29	4.7	15	2.4	450	5	455
Arizona	636	13.6	880	18.4	6,947	36	6,983
Arkansas	202	8.0	194	7.6	2,745	38	2,783
California	5,620	17.2	5,445	16.4	114,780	586	115,366
Colorado	313	7.9	319	7.9	6,733	28	6,761
Connecticut	667	20.4	586	17.9	10,827	174	11,001
Delaware	171	23.0	186	24.7	2,342	22	2,364
District of Columbia	989	189.7	838	161.5	12,062	169	12,231
Florida	5,334	35.8	5,468	36.2	74,163	1,376	75,539
Georgia	1,286	16.8	1,678	21.5	21,429	199	21,628
Hawaii	158	13.3	100	8.4	2,331	15	2,346
Idaho	32	2.6	25	2.0	472	2	474
Illinois	1,293	10.7	1,557	12.8	22,962	258	23,220
Indiana	482	8.2	363	6.1	5,722	40	5,762
Iowa	71	2.5	87	3.0	1,221	9	1,230
Kansas	123	4.7	171	6.4	2,243	12	2,255
Kentucky	280	7.1	277	7.0	3,110	24	3,134
Louisiana	948	21.7	854	19.5	11,851	119	11,970
Maine	31	2.5	80	6.4	907	9	916
Maryland	1,629	31.8	1,525	29.5	19,934	297	20,231
Massachusetts	906	14.7	1,454	23.5	15,012	206	15,218
Michigan	708	7.2	649	6.6	10,478	104	10,582
Minnesota	188	4.0	190	4.0	3,557	23	3,580
Mississippi	415	15.1	421	15.2	3,981	56	4,037
Missouri	439	8.1	531	9.7	8,713	56	8,769
Montana	29	3.3	13	1.5	307	3	310
Nebraska	72	4.3	67	4.0	1,006	10	1,016
Nevada	258	14.8	242	13.4	4,092	26	4,118
New Hampshire	37	3.1	46	3.8	841	9	850
New Jersey	2,114	26.1	2,043	25.1	39,481	735	40,216
New Mexico	209	12.1	93	5.3	1,903	8	1,911
New York	8,667	47.7	7,703	42.3	133,843	2,219	136,062
North Carolina	789	10.5	794	10.4	9,632	113	9,745
North Dakota	7	1.1	7	1.1	103	1	104
Ohio	683	6.1	547	4.9	10,671	121	10,792
Oklahoma	286	8.6	148	4.4	3,414	25	3,439
Oregon	204	6.2	225	6.8	4,575	16	4,591
Pennsylvania	1,737	14.5	1,967	16.4	22,678	310	22,988
Rhode Island	126	12.8	107	10.8	1,932	21	1,953
South Carolina	776	20.2	959	24.7	8,643	79	8,722
South Dakota	13	1.8	16	2.2	154	4	158
Tennessee	694	12.8	759	13.8	7,689	49	7,738
Texas	3,949	20.0	3,181	15.9	51,079	370	51,449
Utah	139	6.6	155	7.3	1,806	21	1,827
Vermont	20	3.4	20	3.4	363	5	368
Virginia	996	14.7	943	13.7	12,044	162	12,206
Washington	438	7.7	360	6.3	8,965	33	8,998
West Virginia	84	4.6	69	3.8	1,004	9	1,013
Wisconsin	203	3.9	152	2.9	3,353	27	3,380
Wyoming	6	1.2	15	3.1	172	2	174
Subtotal	45,970	17.0	45,000	16.5	700,446	8,309	708,755
U.S. dependencies, possessions, and associated nations							
Guam	2	1.3	10	6.6	31	—	31
Pacific Islands, U.S.	—	—	—	—	4	—	4
Puerto Rico	1,710	44.3	1,247	32.1	23,160	386	23,546
Virgin Islands, U.S.	35	29.6	39	32.6	432	17	449
Total¹	47,915	17.4	46,400	16.7	724,656	8,718	733,374

¹U.S. totals presented in this report include data from the United States (50 states and the District of Columbia), and from U.S. dependencies, possessions, and independent nations in free association with the United States. See Technical Notes. Totals include 589 persons whose area of residence is unknown.

Table 3. HIV infection cases¹ by area and age group, reported through December 1999, from areas with confidential HIV infection reporting

Area of residence (Date HIV reporting initiated)	1999	Cumulative totals		
		Adults/ adolescents	Children <13 years old	Total
Alabama (Jan. 1988)	519	4,963	44	5,007
Arizona (Jan. 1987)	694	4,347	39	4,386
Arkansas (July 1989)	214	1,888	20	1,908
Colorado (Nov. 1985)	325	5,494	28	5,522
Connecticut (July 1992) ²	5	—	105	105
Florida (July 1997)	6,402	14,329	143	14,472
Idaho (June 1986)	28	332	5	337
Indiana (July 1988)	301	3,272	36	3,308
Iowa (July 1998)	169	255	3	258
Kansas (July 1999)	287	650	7	657
Louisiana (Feb. 1993)	971	6,770	118	6,888
Michigan (April 1992)	499	4,964	106	5,070
Minnesota (Oct. 1985)	230	2,556	30	2,586
Mississippi (Aug. 1988)	464	4,110	46	4,156
Missouri (Oct. 1987)	472	4,201	41	4,242
Nebraska (Sept. 1995)	79	470	6	476
Nevada (Feb. 1992)	232	2,734	24	2,758
New Jersey (Jan. 1992)	1,330	13,094	377	13,471
New Mexico (Jan. 1998)	145	538	3	541
North Carolina (Feb. 1990)	1,017	9,240	117	9,357
North Dakota (Jan. 1988)	2	67	1	68
Ohio (June 1990)	919	5,393	67	5,460
Oklahoma (June 1988)	219	2,219	17	2,236
Oregon (Sept. 1988) ²	—	—	16	16
South Carolina (Feb. 1986)	717	6,776	103	6,879
South Dakota (Jan. 1988)	21	189	5	194
Tennessee (Jan. 1992)	897	5,431	51	5,482
Texas (Jan. 1999) ²	2,563	2,697	292	2,989
Utah (April 1989)	64	747	6	753
Virginia (July 1989)	878	7,743	77	7,820
West Virginia (Jan. 1989)	49	517	3	520
Wisconsin (Nov. 1985)	184	2,264	28	2,292
Wyoming (June 1989)	9	69	—	69
Subtotal	20,905	118,319	1,964	120,283
U.S. dependencies, possessions, and associated nations				
Virgin Islands, U.S (Dec. 1998)	153	164	3	167
Persons reported from areas with confidential HIV reporting who were residents of other areas ³	361	2,098	59	2,157
Total	21,419	120,581	2,026	122,607

¹Includes only persons reported with HIV infection who have not developed AIDS.

²Connecticut has confidential HIV infection reporting for pediatric cases only; Oregon has confidential HIV infection reporting for children less than 6 years old; Texas reported only pediatric HIV infection cases from February 1994 until January 1999.

³Includes 336 persons reported from areas with confidential HIV infection reporting, but whose area of residence is unknown. See Technical Notes.

Table 4. AIDS cases and annual rates per 100,000 population, by metropolitan area and age group, reported through December 1999, United States

Metropolitan area of residence (with 500,000 or more population)	1998		1999		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Akron, Ohio	54	7.8	49	7.1	552	1	553
Albany-Schenectady, N.Y.	119	13.7	77	8.9	1,621	24	1,645
Albuquerque, N.Mex.	88	13.0	48	7.1	1,033	2	1,035
Allentown, Pa.	39	6.3	78	12.6	777	8	785
Ann Arbor, Mich.	20	3.7	28	5.0	366	9	375
Atlanta, Ga.	939	25.1	1,027	26.6	15,097	107	15,204
Austin, Tex.	292	26.4	277	24.2	3,687	25	3,712
Bakersfield, Calif.	84	13.3	92	14.3	962	8	970
Baltimore, Md.	1,158	46.7	1,012	40.6	13,335	206	13,541
Baton Rouge, La.	184	32.0	189	32.6	1,750	19	1,769
Bergen-Passaic, N.J.	286	21.4	247	18.4	5,175	80	5,255
Birmingham, Ala.	140	15.4	140	15.3	1,776	22	1,798
Boston, Mass.	809	13.8	1,217	20.6	13,222	182	13,404
Buffalo, N.Y.	115	10.0	172	15.1	1,732	18	1,750
Charleston, S.C.	113	20.8	115	20.8	1,435	12	1,447
Charlotte, N.C.	193	14.0	162	11.4	1,976	22	1,998
Chicago, Ill.	1,100	13.8	1,352	16.9	19,880	229	20,109
Cincinnati, Ohio	100	6.2	57	3.5	1,823	15	1,838
Cleveland, Ohio	242	10.9	181	8.1	3,161	42	3,203
Columbia, S.C.	157	30.8	282	54.6	1,871	16	1,887
Columbus, Ohio	101	6.9	86	5.8	2,104	13	2,117
Dallas, Tex.	652	20.4	627	19.1	11,736	37	11,773
Dayton, Ohio	55	5.7	48	5.0	934	17	951
Denver, Colo.	234	12.1	236	11.9	5,370	19	5,389
Detroit, Mich.	486	10.9	422	9.4	7,205	71	7,276
El Paso, Tex.	121	17.4	91	13.0	996	10	1,006
Fort Lauderdale, Fla.	825	54.7	939	61.2	11,861	240	12,101
Fort Worth, Tex.	219	13.8	134	8.2	3,057	25	3,082
Fresno, Calif.	65	7.5	65	7.4	1,108	14	1,122
Gary, Ind.	52	8.3	43	6.8	672	3	675
Grand Rapids, Mich.	49	4.7	41	3.9	730	3	733
Greensboro, N.C.	110	9.4	172	14.6	1,569	20	1,589
Greenville, S.C.	124	13.5	136	14.6	1,382	6	1,388
Harrisburg, Pa.	115	18.6	73	11.8	941	8	949
Hartford, Conn.	253	22.8	178	16.0	3,749	46	3,795
Honolulu, Hawaii	105	12.0	76	8.8	1,702	12	1,714
Houston, Tex.	1,564	39.8	934	23.3	18,340	154	18,494
Indianapolis, Ind.	216	14.2	184	12.0	2,718	17	2,735
Jacksonville, Fla.	259	24.8	302	28.6	4,136	68	4,204
Jersey City, N.J.	324	58.6	251	45.4	6,257	118	6,375
Kansas City, Mo.	177	10.2	206	11.7	3,768	14	3,782
Knoxville, Tenn.	75	11.3	46	6.8	681	6	687
Las Vegas, Nev.	228	17.3	205	14.8	3,330	25	3,355
Little Rock, Ark.	67	12.1	56	10.0	989	14	1,003
Los Angeles, Calif.	1,837	19.9	2,083	22.3	40,479	230	40,709
Louisville, Ky.	168	16.8	158	15.7	1,535	16	1,551
McAllen, Tex.	50	9.6	29	5.4	330	9	339
Memphis, Tenn.	284	26.0	327	29.6	2,841	15	2,856
Miami, Fla.	1,547	71.9	1,420	65.3	22,401	471	22,872
Middlesex, N.J.	150	13.4	114	10.1	3,001	69	3,070
Milwaukee, Wis.	115	7.9	88	6.0	1,838	16	1,854
Minneapolis-Saint Paul, Minn.	172	6.1	179	6.2	3,164	17	3,181
Mobile, Ala.	88	16.5	93	17.4	1,095	13	1,108
Monmouth-Ocean, N.J.	125	11.4	105	9.5	2,685	61	2,746
Nashville, Tenn.	189	16.4	233	19.9	2,399	17	2,416
Nassau-Suffolk, N.Y.	426	15.9	347	12.9	6,358	111	6,469
New Haven, Conn.	360	22.1	344	21.0	6,161	122	6,283
New Orleans, La.	455	34.8	414	31.7	6,557	62	6,619
New York, N.Y.	7,424	85.5	6,336	72.7	113,075	1,984	115,059
Newark, N.J.	869	44.6	918	47.0	16,000	316	16,316

Table 4. AIDS cases and annual rates per 100,000 population, by metropolitan area and age group, reported through December 1999, United States (continued)

Metropolitan area of residence (with 500,000 or more population)	1998		1999		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Norfolk, Va.	344	22.2	273	17.5	3,466	60	3,526
Oakland, Calif.	414	17.9	346	14.7	7,744	42	7,786
Oklahoma City, Okla.	147	14.2	42	4.0	1,571	7	1,578
Omaha, Nebr.	42	6.1	44	6.3	702	3	705
Orange County, Calif.	340	12.5	265	9.6	5,343	33	5,376
Orlando, Fla.	473	31.5	445	29.0	5,592	77	5,669
Philadelphia, Pa.	1,311	26.5	1,660	33.5	17,511	259	17,770
Phoenix, Ariz.	462	15.8	691	22.9	4,975	23	4,998
Pittsburgh, Pa.	121	5.2	91	3.9	2,252	17	2,269
Portland, Oreg.	156	8.6	162	8.8	3,698	8	3,706
Providence, R.I.	122	13.5	98	10.8	1,813	20	1,833
Raleigh-Durham, N.C.	124	11.5	134	12.1	1,847	21	1,868
Richmond, Va.	207	21.7	184	19.1	2,426	25	2,451
Riverside-San Bernardino, Calif.	490	15.7	381	11.9	6,519	51	6,570
Rochester, N.Y.	120	11.1	181	16.8	2,253	13	2,266
Sacramento, Calif.	184	11.8	138	8.7	3,040	24	3,064
Saint Louis, Mo.	199	7.8	303	11.8	4,442	39	4,481
Salt Lake City, Utah	114	9.0	127	10.0	1,565	14	1,579
San Antonio, Tex.	265	17.2	204	13.0	3,773	28	3,801
San Diego, Calif.	533	19.3	550	19.5	10,122	52	10,174
San Francisco, Calif.	966	57.4	856	50.8	27,111	40	27,151
San Jose, Calif.	150	9.1	152	9.2	3,018	14	3,032
San Juan, P.R.	1,064	53.1	808	40.0	14,566	241	14,807
Sarasota, Fla.	73	13.4	99	18.0	1,322	21	1,343
Scranton, Pa.	42	6.8	12	2.0	411	4	415
Seattle, Wash.	277	12.0	241	10.3	6,370	19	6,389
Springfield, Mass.	97	16.4	179	30.4	1,598	24	1,622
Stockton, Calif.	48	8.7	62	11.0	722	13	735
Syracuse, N.Y.	66	9.0	82	11.2	1,210	10	1,220
Tacoma, Wash.	53	7.8	48	7.0	774	8	782
Tampa-Saint Petersburg, Fla.	545	24.2	539	23.7	7,886	98	7,984
Toledo, Ohio	23	3.8	21	3.4	536	10	546
Tucson, Ariz.	122	15.4	113	14.1	1,432	9	1,441
Tulsa, Okla.	75	9.7	68	8.7	1,054	8	1,062
Vallejo, Calif.	107	21.6	110	21.7	1,321	9	1,330
Ventura, Calif.	45	6.1	47	6.3	773	3	776
Washington, D.C.	1,593	34.2	1,529	32.3	21,364	284	21,648
West Palm Beach, Fla.	528	51.1	457	43.5	6,918	203	7,121
Wichita, Kans.	39	7.2	61	11.1	679	2	681
Wilmington, Del.	125	22.1	155	27.1	1,871	15	1,886
Youngstown, Ohio	29	4.9	47	8.0	350	—	350
Metropolitan areas with 500,000 or more population	39,202	22.9	37,546	21.7	608,425	7,387	615,812
<i>Central counties</i>	<i>38,202</i>	<i>24.5</i>	<i>36,628</i>	<i>23.3</i>	<i>596,361</i>	<i>7,257</i>	<i>603,618</i>
<i>Outlying counties</i>	<i>1,000</i>	<i>6.5</i>	<i>918</i>	<i>5.8</i>	<i>12,064</i>	<i>130</i>	<i>12,194</i>
Metropolitan areas with 50,000 to 500,000 population	4,845	10.1	4,946	10.2	69,893	810	70,703
<i>Central counties</i>	<i>4,477</i>	<i>10.5</i>	<i>4,594</i>	<i>10.7</i>	<i>65,266</i>	<i>737</i>	<i>66,003</i>
<i>Outlying counties</i>	<i>368</i>	<i>6.6</i>	<i>352</i>	<i>6.2</i>	<i>4,627</i>	<i>73</i>	<i>4,700</i>
Nonmetropolitan areas	3,432	6.2	3,445	6.2	42,727	494	43,221
Total¹	47,915	17.4	46,400	16.7	724,656	8,718	733,374

¹ Totals include 3,638 persons whose area of residence is unknown.

Figure 1. Male adult/adolescent annual AIDS rates per 100,000 population, for cases reported in 1999, United States

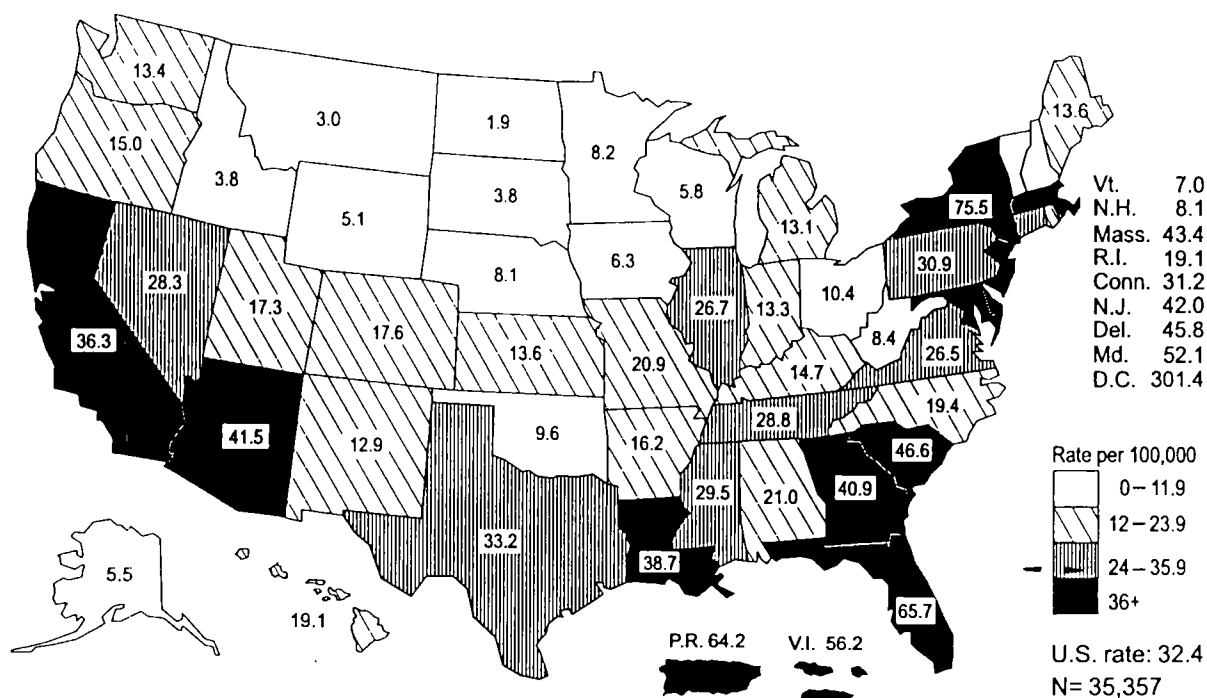


Figure 2. Female adult/adolescent annual AIDS rates per 100,000 population, for cases reported in 1999, United States

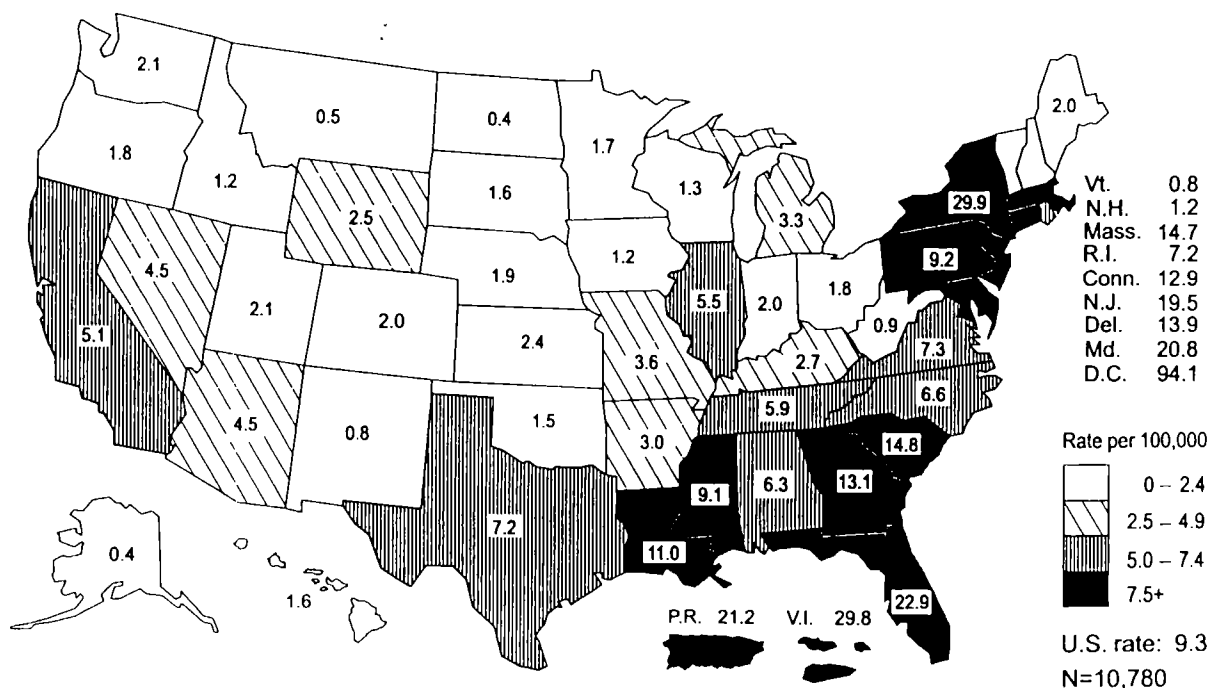


Figure 3. Male adult/adolescent HIV infection and AIDS cases reported in 1999, United States

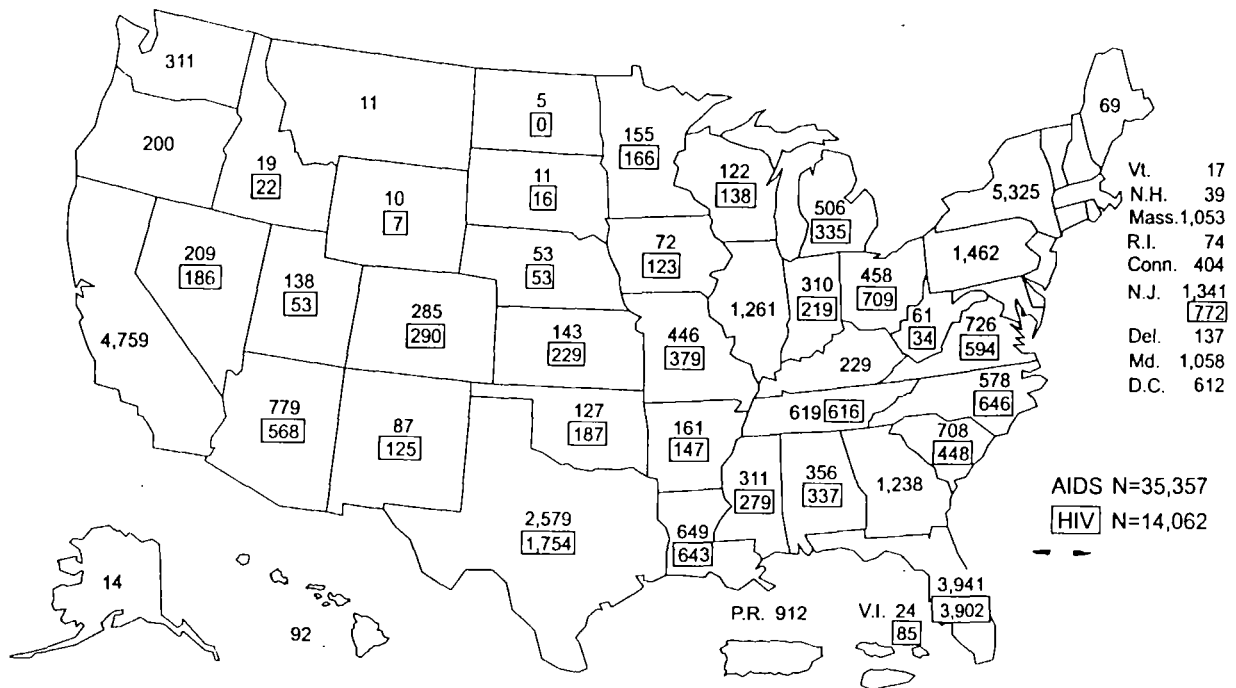


Figure 4. Female adult/adolescent HIV infection and AIDS cases reported in 1999, United States

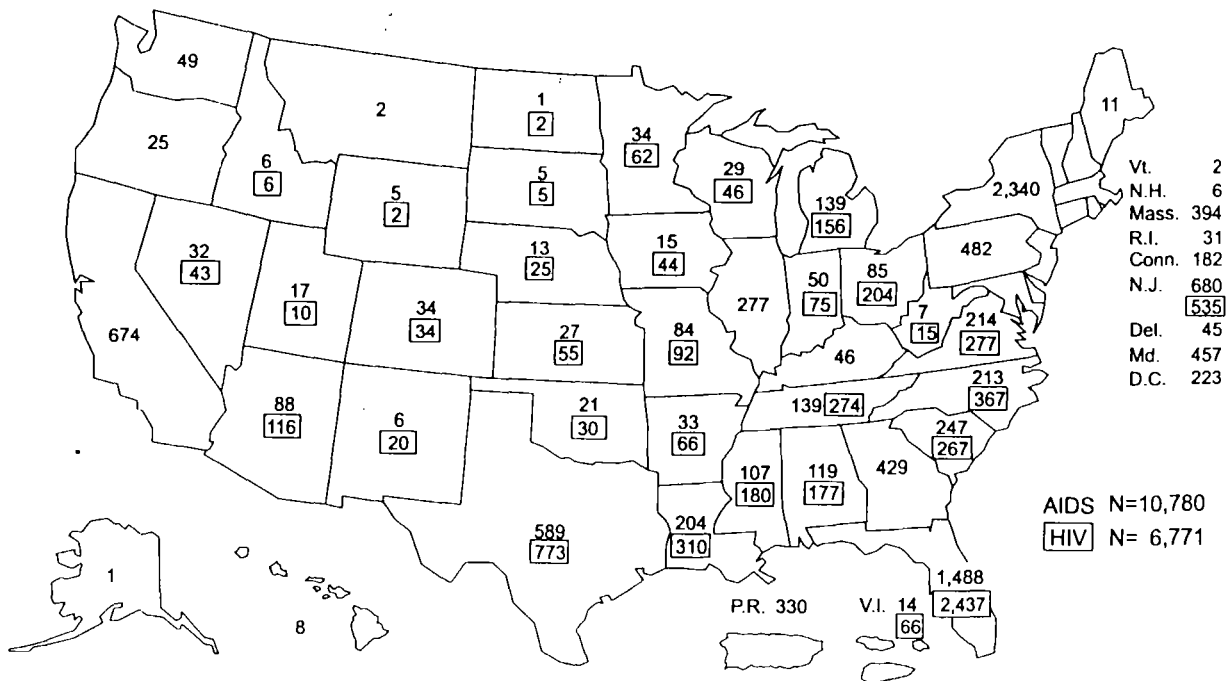


Table 5. AIDS cases by age group, exposure category, and sex, reported through December 1999, United States

Adult/adolescent exposure category	Males				Females				Totals ¹			
	1999		Cumulative total		1999		Cumulative total		1999		Cumulative total ²	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	15,464	(44)	341,597	(56)	—	—	—	—	15,464	(34)	341,597	(47)
Injecting drug use	7,207	(20)	134,356	(22)	2,931	(27)	50,073	(42)	10,138	(22)	184,429	(25)
Men who have sex with men and inject drugs	1,806	(5)	46,582	(8)	—	—	—	—	1,806	(4)	46,582	(6)
Hemophilia/coagulation disorder	139	(0)	4,803	(1)	12	(0)	272	(0)	151	(0)	5,075	(1)
Heterosexual contact:	2,858	(8)	26,530	(4)	4,281	(40)	47,946	(40)	7,139	(15)	74,477	(10)
<i>Sex with injecting drug user</i>	635		8,696		1,155		19,523		1,790		28,219	
<i>Sex with bisexual male</i>	—		—		177		3,368		177		3,368	
<i>Sex with person with hemophilia</i>	11		58		19		407		30		465	
<i>Sex with transfusion recipient with HIV infection</i>	19		398		23		581		42		979	
<i>Sex with HIV-infected person, risk not specified</i>	2,193		17,378		2,907		24,067		5,100		41,446	
Receipt of blood transfusion, blood components, or tissue ³	137	(0)	4,863	(1)	119	(1)	3,668	(3)	256	(1)	8,531	(1)
Other/risk not reported or identified ⁴	7,746	(22)	46,112	(8)	3,437	(32)	17,851	(15)	11,183	(24)	63,965	(9)
Adult/adolescent subtotal	35,357	(100)	604,843	(100)	10,780	(100)	119,810	(100)	46,137	(100)	724,656	(100)
Pediatric (<13 years old) exposure category												
Hemophilia/coagulation disorder	3	(2)	228	(5)	—	—	7	(0)	3	(1)	235	(3)
Mother with/at risk for HIV infection: ⁴	109	(87)	3,942	(88)	123	(89)	4,001	(94)	232	(88)	7,943	(91)
<i>Injecting drug use</i>	29		1,566		37		1,550		66		3,116	
<i>Sex with injecting drug user</i>	21		740		12		703		33		1,443	
<i>Sex with bisexual male</i>	4		86		1		85		5		171	
<i>Sex with person with hemophilia</i>	—		17		2		15		2		32	
<i>Sex with transfusion recipient with HIV infection</i>	—		11		—		14		—		25	
<i>Sex with HIV-infected person, risk not specified</i>	15		574		29		611		44		1,185	
<i>Receipt of blood transfusion, blood components, or tissue</i>	1		74		1		79		2		153	
<i>Has HIV infection, risk not specified</i>	39		874		41		944		80		1,818	
Receipt of blood transfusion, blood components, or tissue ³	2	(2)	239	(5)	—	—	140	(3)	2	(1)	379	(4)
Risk not reported or identified ⁴	11	(9)	74	(2)	15	(11)	87	(2)	26	(10)	161	(2)
Pediatric subtotal	125	(100)	4,483	(100)	138	(100)	4,235	(100)	263	(100)	8,718	(100)
Total	35,482		609,326		10,918		124,045		46,400		733,374	

¹Includes 3 persons whose sex is unknown.

²Includes persons known to be infected with human immunodeficiency virus type 2 (HIV-2). See *MMWR* 1995;44:603-06.

³Thirty-nine adults/adolescents and 2 children developed AIDS after receiving blood screened negative for HIV antibody. Thirteen additional adults developed AIDS after receiving tissue, organs, or artificial insemination from HIV-infected donors. Four of the 13 received tissue, organs, or artificial insemination from a donor who was negative for HIV antibody at the time of donation. See *N Engl J Med* 1992;326:726-32.

⁴See table 17 and figure 6 for a discussion of the "other" exposure category. "Other" also includes 151 persons who acquired HIV infection perinatally but were diagnosed with AIDS after age 13. These 151 persons are tabulated under the adult/adolescent, not pediatric, exposure category.

Table 6. HIV infection cases¹ by age group, exposure category, and sex, reported through December 1999, from the 34 areas with confidential HIV infection reporting²

Adult/adolescent exposure category	Males		Females		Totals ³	
	1999	Cumulative total	1999	Cumulative total	1999	Cumulative total
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Men who have sex with men	5,763 (40)	39,399 (45)	—	—	5,763 (27)	39,399 (33)
Injecting drug use	1,367 (10)	12,191 (14)	821 (12)	6,691 (20)	2,188 (10)	18,882 (16)
Men who have sex with men and inject drugs	656 (5)	5,470 (6)	—	—	656 (3)	5,470 (5)
Hemophilia/coagulation disorder	27 (0)	433 (0)	2 (0)	20 (0)	29 (0)	453 (0)
Heterosexual contact:	1,236 (9)	6,021 (7)	2,506 (37)	13,420 (40)	3,742 (18)	19,441 (16)
<i>Sex with injecting drug user</i>	235	1,346	466	3,757	701	5,103
<i>Sex with bisexual male</i>	—	—	156	1,021	156	1,021
<i>Sex with person with hemophilia</i>	2	12	11	114	13	126
<i>Sex with transfusion recipient with HIV infection</i>	8	80	17	104	25	184
<i>Sex with HIV-infected person, risk not specified</i>	991	4,583	1,856	8,424	2,847	13,007
Receipt of blood transfusion, blood components, or tissue	37 (0)	358 (0)	45 (1)	402 (1)	82 (0)	760 (1)
Other/risk not reported or identified ⁴	5,243 (37)	23,523 (27)	3,481 (51)	12,646 (38)	8,726 (41)	36,176 (30)
Adult/adolescent subtotal	14,329 (100)	87,395 (100)	6,855 (100)	33,179 (100)	21,186 (100)	120,581 (100)
Pediatric (<13 years old) exposure category						
Hemophilia/coagulation disorder	6 (5)	95 (9)	—	2 (0)	6 (3)	97 (5)
Mother with/at risk for HIV infection:	97 (84)	834 (83)	100 (85)	927 (91)	197 (85)	1,761 (87)
<i>Injecting drug use</i>	17	262	16	259	33	521
<i>Sex with injecting drug user</i>	14	109	10	132	24	241
<i>Sex with bisexual male</i>	3	14	3	18	6	32
<i>Sex with person with hemophilia</i>	—	3	—	4	—	7
<i>Sex with transfusion recipient with HIV infection</i>	—	4	—	5	—	9
<i>Sex with HIV-infected person, risk not specified</i>	27	178	27	219	54	397
<i>Receipt of blood transfusion, blood components, or tissue</i>	1	10	—	11	1	21
<i>Has HIV infection, risk not specified</i>	35	254	44	279	79	533
Receipt of blood transfusion, blood components, or tissue	1 (1)	14 (1)	1 (1)	22 (2)	2 (1)	36 (2)
Risk not reported or identified ⁴	11 (10)	62 (6)	17 (14)	70 (7)	28 (12)	132 (7)
Pediatric subtotal	115 (100)	1,005 (100)	118 (100)	1,021 (100)	233 (100)	2,026 (100)
Total	14,444	88,400	6,973	34,200	21,419	122,607

¹Includes only persons reported with HIV infection who have not developed AIDS.

²See table 3 for areas with confidential HIV infection reporting.

³Includes 7 persons whose sex is unknown.

⁴For HIV infection cases, "risk not reported or identified" refers primarily to persons whose mode of exposure was not reported and who have not been followed up to determine their mode of exposure, and to a smaller number of persons who are not reported with one of the exposures listed above after follow-up. See Technical Notes.

Table 7. AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through December 1999, United States

Male Age at diagnosis (years)	White, not Hispanic		Black, not Hispanic		Hispanic		Asian/Pacific Islander		American Indian/ Alaska Native		Total ¹	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Under 5	517	(0)	2,093	(1)	758	(1)	16	(0)	12	(1)	3,400	(1)
5-12	338	(0)	451	(0)	278	(0)	9	(0)	5	(0)	1,083	(0)
13-19	840	(0)	829	(0)	483	(0)	25	(1)	21	(1)	2,201	(0)
20-24	7,573	(3)	6,785	(3)	4,083	(4)	166	(4)	78	(4)	18,711	(3)
25-29	37,490	(13)	24,474	(12)	15,884	(15)	587	(13)	318	(18)	78,846	(13)
30-34	67,733	(23)	41,979	(21)	25,995	(24)	1,024	(22)	466	(26)	137,333	(23)
35-39	66,370	(23)	45,576	(23)	24,239	(22)	1,020	(22)	385	(22)	137,789	(23)
40-44	48,405	(17)	36,041	(18)	17,069	(16)	806	(17)	265	(15)	102,729	(17)
45-49	29,209	(10)	20,997	(10)	9,504	(9)	490	(10)	107	(6)	60,387	(10)
50-54	15,766	(5)	10,744	(5)	5,044	(5)	263	(6)	46	(3)	31,910	(5)
55-59	8,536	(3)	5,893	(3)	2,796	(3)	158	(3)	29	(2)	17,440	(3)
60-64	4,722	(2)	3,232	(2)	1,542	(1)	65	(1)	18	(1)	9,591	(2)
65 or older	3,893	(1)	2,698	(1)	1,228	(1)	66	(1)	10	(1)	7,906	(1)
Male subtotal	291,392	(100)	201,792	(100)	108,903	(100)	4,695	(100)	1,760	(100)	609,326	(100)
Female												
Age at diagnosis (years)												
Under 5	482	(2)	2,080	(3)	758	(3)	15	(2)	13	(4)	3,353	(3)
5-12	180	(1)	480	(1)	211	(1)	8	(1)	—	—	882	(1)
13-19	247	(1)	1,001	(1)	264	(1)	7	(1)	4	(1)	1,524	(1)
20-24	1,581	(6)	4,097	(6)	1,441	(6)	37	(6)	29	(8)	7,193	(6)
25-29	4,440	(16)	10,295	(14)	3,935	(16)	89	(14)	54	(15)	18,829	(15)
30-34	6,097	(23)	15,551	(22)	5,751	(23)	119	(18)	86	(23)	27,656	(22)
35-39	5,372	(20)	15,605	(22)	5,073	(20)	123	(19)	76	(20)	26,287	(21)
40-44	3,536	(13)	10,805	(15)	3,316	(13)	96	(15)	43	(12)	17,812	(14)
45-49	1,882	(7)	5,341	(8)	1,820	(7)	63	(10)	30	(8)	9,159	(7)
50-54	1,078	(4)	2,646	(4)	1,004	(4)	27	(4)	16	(4)	4,776	(4)
55-59	692	(3)	1,460	(2)	625	(3)	21	(3)	12	(3)	2,811	(2)
60-64	451	(2)	868	(1)	317	(1)	24	(4)	5	(1)	1,667	(1)
65 or older	922	(3)	860	(1)	285	(1)	23	(4)	3	(1)	2,096	(2)
Female subtotal	26,960	(100)	71,089	(100)	24,800	(100)	652	(100)	371	(100)	124,045	(100)
Total²	318,354		272,881		133,703		5,347		2,132		733,374	

¹Includes 784 males and 173 females whose race/ethnicity is unknown.

²Includes 3 persons whose sex is unknown.

Table 8. HIV infection cases¹ by sex, age at diagnosis, and race/ethnicity, reported through December 1999, from the 34 areas with confidential HIV infection reporting²

Male Age at diagnosis (years)	White, not Hispanic		Black, not Hispanic		Hispanic		Asian/Pacific Islander		American Indian/ Alaska Native		Total ³	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Under 5	162	(0)	512	(1)	86	(1)	3	(1)	1	(0)	766	(1)
5-12	90	(0)	106	(0)	33	(0)	3	(1)	—	—	239	(0)
13-19	710	(2)	1,242	(3)	111	(2)	5	(2)	14	(3)	2,102	(2)
20-24	4,839	(13)	4,942	(12)	800	(12)	45	(14)	102	(19)	10,845	(12)
25-29	8,653	(23)	7,348	(18)	1,496	(22)	79	(25)	147	(27)	17,981	(20)
30-34	9,085	(24)	8,620	(21)	1,639	(24)	82	(26)	121	(22)	19,822	(22)
35-39	6,754	(18)	7,641	(19)	1,312	(19)	35	(11)	81	(15)	16,056	(18)
40-44	3,898	(10)	5,308	(13)	749	(11)	29	(9)	46	(8)	10,194	(12)
45-49	2,017	(5)	2,793	(7)	370	(5)	16	(5)	20	(4)	5,296	(6)
50-54	1,070	(3)	1,338	(3)	158	(2)	7	(2)	10	(2)	2,625	(3)
55-59	441	(1)	672	(2)	82	(1)	3	(1)	7	(1)	1,222	(1)
60-64	248	(1)	333	(1)	54	(1)	2	(1)	2	(0)	650	(1)
65 or older	235	(1)	311	(1)	42	(1)	3	(1)	—	—	602	(1)
Male subtotal	38,202	(100)	41,166	(100)	6,932	(100)	312	(100)	551	(100)	88,400	(100)
Female												
Age at diagnosis (years)												
Under 5	160	(2)	560	(2)	85	(4)	4	(4)	7	(4)	824	(2)
5-12	45	(1)	115	(0)	30	(1)	3	(3)	1	(1)	197	(1)
13-19	554	(7)	1,965	(8)	131	(6)	6	(5)	18	(9)	2,694	(8)
20-24	1,381	(17)	3,772	(16)	343	(15)	26	(24)	35	(18)	5,604	(16)
25-29	1,711	(21)	4,433	(19)	487	(21)	24	(22)	30	(16)	6,746	(20)
30-34	1,606	(20)	4,435	(19)	503	(21)	19	(17)	33	(17)	6,673	(20)
35-39	1,215	(15)	3,427	(15)	327	(14)	10	(9)	34	(18)	5,059	(15)
40-44	632	(8)	2,241	(10)	191	(8)	8	(7)	22	(12)	3,127	(9)
45-49	386	(5)	1,093	(5)	133	(6)	5	(5)	9	(5)	1,646	(5)
50-54	164	(2)	502	(2)	63	(3)	2	(2)	1	(1)	737	(2)
55-59	96	(1)	264	(1)	40	(2)	2	(2)	—	—	407	(1)
60-64	42	(1)	158	(1)	20	(1)	—	—	1	(1)	221	(1)
65 or older	83	(1)	166	(1)	11	(0)	1	(1)	—	—	265	(1)
Female subtotal	8,075	(100)	23,131	(100)	2,364	(100)	110	(100)	191	(100)	34,200	(100)
Total⁴	46,277		64,299		9,296		422		742		122,607	

¹Includes only persons reported with HIV infection who have not developed AIDS.

²See table 3 for areas with confidential HIV infection reporting.

³Includes 1,237 males, 329 females, and 5 persons of unknown sex whose race/ethnicity is unknown.

⁴Includes 7 persons whose sex is unknown.

Table 9. Male adult/adolescent AIDS cases by exposure category and race/ethnicity, reported through December 1999, United States

Exposure category	White, not Hispanic		Black, not Hispanic		Hispanic	
	1999	Cumulative total	1999	Cumulative total	1999	Cumulative total
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Men who have sex with men	8,106 (63)	216,564 (75)	4,511 (30)	74,434 (37)	2,584 (37)	45,867 (43)
Injecting drug use	1,485 (12)	26,856 (9)	3,770 (25)	68,491 (34)	1,899 (27)	38,338 (36)
Men who have sex with men and inject drugs	895 (7)	23,880 (8)	616 (4)	14,965 (8)	271 (4)	7,253 (7)
Hemophilia/coagulation disorder	108 (1)	3,725 (1)	19 (0)	551 (0)	9 (0)	424 (0)
Heterosexual contact:	476 (4)	5,181 (2)	1,736 (12)	15,121 (8)	615 (9)	5,986 (6)
<i>Sex with injecting drug user</i>	125	1,849	381	5,079	123	1,704
<i>Sex with person with hemophilia</i>	2	29	7	18	1	10
<i>Sex with transfusion recipient with HIV infection</i>	6	153	11	148	—	87
<i>Sex with HIV-infected person, risk not specified</i>	343	3,150	1,337	9,876	491	4,185
Receipt of blood transfusion, blood components, or tissue	63 (0)	3,133 (1)	42 (0)	1,028 (1)	25 (0)	574 (1)
Risk not reported or identified ¹	1,722 (13)	11,198 (4)	4,252 (28)	24,658 (12)	1,616 (23)	9,425 (9)
Total	12,855 (100)	290,537 (100)	14,946 (100)	199,248 (100)	7,019 (100)	107,867 (100)

Exposure category	Asian/Pacific Islander		American Indian/Alaska Native		Cumulative totals ²	
	1999	Cumulative total	1999	Cumulative total	1999	Cumulative total
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Men who have sex with men	168 (55)	3,389 (73)	63 (46)	987 (57)	15,464 (44)	341,597 (56)
Injecting drug use	14 (5)	244 (5)	22 (16)	273 (16)	7,207 (20)	134,356 (22)
Men who have sex with men and inject drugs	5 (2)	172 (4)	16 (12)	295 (17)	1,806 (5)	46,582 (8)
Hemophilia/coagulation disorder	2 (1)	67 (1)	1 (1)	30 (2)	139 (0)	4,803 (1)
Heterosexual contact:	24 (8)	165 (4)	4 (3)	47 (3)	2,858 (8)	26,530 (4)
<i>Sex with injecting drug user</i>	6	45	—	14	635	8,696
<i>Sex with person with hemophilia</i>	1	1	—	—	11	58
<i>Sex with transfusion recipient with HIV infection</i>	1	8	1	2	19	398
<i>Sex with HIV-infected person, risk not specified</i>	16	111	3	31	2,193	17,378
Receipt of blood transfusion, blood components, or tissue	6 (2)	112 (2)	1 (1)	8 (0)	137 (0)	4,863 (1)
Risk not reported or identified	84 (28)	521 (11)	29 (21)	103 (6)	7,746 (22)	46,112 (8)
Total	303 (100)	4,670 (100)	136 (100)	1,743 (100)	35,357 (100)	604,843 (100)

¹See figure 6.

²Includes 778 men whose race/ethnicity is unknown.

Table 10. Male adult/adolescent HIV infection cases¹ by exposure category and race/ethnicity, reported through December 1999, from the 32 areas with confidential HIV infection reporting²

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	1999		Cumulative total		1999		Cumulative total		1999		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	3,177	(58)	23,371	(62)	1,757	(26)	12,682	(31)	707	(42)	2,668	(39)
Injecting drug use	398	(7)	3,257	(9)	747	(11)	7,408	(18)	207	(12)	1,383	(20)
Men who have sex with men and inject drugs	343	(6)	3,050	(8)	230	(3)	1,960	(5)	66	(4)	351	(5)
Hemophilia/coagulation disorder	18	(0)	331	(1)	9	(0)	88	(0)	—	—	8	(0)
Heterosexual contact:	200	(4)	1,120	(3)	906	(13)	4,392	(11)	113	(7)	440	(6)
<i>Sex with injecting drug user</i>	52		291		158		921		19		112	
<i>Sex with person with hemophilia</i>	—		2		2		10		—		—	
<i>Sex with transfusion recipient with HIV infection</i>	3		21		4		55		—		2	
<i>Sex with HIV-infected person, risk not specified</i>	145		806		742		3,406		94		326	
Receipt of blood transfusion, blood components, or tissue	11	(0)	167	(0)	23	(0)	157	(0)	2	(0)	25	(0)
Risk not reported or identified ³	1,337	(24)	6,654	(18)	3,074	(46)	13,861	(34)	575	(34)	1,938	(28)
Total	5,484	(100)	37,950	(100)	6,746	(100)	40,548	(100)	1,670	(100)	6,813	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ⁴			
	1999		Cumulative total		1999		Cumulative total		1999		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	37	(50)	157	(51)	49	(47)	280	(51)	5,763	(40)	39,399	(45)
Injecting drug use	—	—	16	(5)	8	(8)	67	(12)	1,367	(10)	12,191	(14)
Men who have sex with men and inject drugs	3	(4)	8	(3)	11	(11)	80	(15)	656	(5)	5,470	(6)
Hemophilia/coagulation disorder	—	—	2	(1)	—	—	1	(0)	27	(0)	433	(0)
Heterosexual contact:	7	(9)	22	(7)	8	(8)	30	(5)	1,236	(9)	6,021	(7)
<i>Sex with injecting drug user</i>	1		5		4		14		235		1,346	
<i>Sex with person with hemophilia</i>	—		—		—		—		2		12	
<i>Sex with transfusion recipient with HIV infection</i>	1		2		—		—		8		80	
<i>Sex with HIV-infected person, risk not specified</i>	5		15		4		16		991		4,583	
Receipt of blood transfusion, blood components, or tissue	1	(1)	2	(1)	—	—	2	(0)	37	(0)	358	(0)
Risk not reported or identified	26	(35)	99	(32)	28	(27)	90	(16)	5,243	(37)	23,523	(27)
Total	74	(100)	306	(100)	104	(100)	550	(100)	14,329	(100)	87,395	(100)

¹Includes only persons reported with HIV infection who have not developed AIDS.

²See table 3 for areas with confidential HIV infection reporting of adults and adolescents.

³For HIV infection cases, "risk not reported or identified" refers primarily to persons whose mode of exposure was not reported and who have not been followed up to determine their mode of exposure, and to a smaller number of persons who are not reported with one of the exposures listed above after follow-up. See Technical Notes.

⁴Includes 1,228 men whose race/ethnicity is unknown.

Table 11. Female adult/adolescent AIDS cases by exposure category and race/ethnicity, reported through December 1999, United States

Exposure category	White, not Hispanic		Black, not Hispanic		Hispanic	
	1999		1999		1999	
	No. (%)	Cumulative total No. (%)	No. (%)	Cumulative total No. (%)	No. (%)	Cumulative total No. (%)
Injecting drug use	646 (34)	11,074 (42)	1,718 (25)	29,059 (42)	539 (28)	9,613 (40)
Hemophilia/coagulation disorder	4 (0)	102 (0)	5 (0)	108 (0)	3 (0)	53 (0)
Heterosexual contact:	762 (40)	10,528 (40)	2,565 (38)	25,719 (38)	906 (47)	11,222 (47)
<i>Sex with injecting drug user</i>	249	4,294	628	9,916	267	5,159
<i>Sex with bisexual male</i>	78	1,452	72	1,311	23	513
<i>Sex with person with hemophilia</i>	8	281	7	80	3	39
<i>Sex with transfusion recipient with HIV infection</i>	7	300	9	162	5	96
<i>Sex with HIV-infected person, risk not specified</i>	420	4,201	1,849	14,250	608	5,415
Receipt of blood transfusion, blood components, or tissue	25 (1)	1,789 (7)	75 (1)	1,230 (2)	15 (1)	536 (2)
Risk not reported or identified ¹	487 (25)	2,805 (11)	2,421 (36)	12,413 (18)	485 (25)	2,407 (10)
Total	1,924 (100)	26,298 (100)	6,784 (100)	68,529 (100)	1,948 (100)	23,831 (100)

Exposure category	Asian/Pacific Islander		American Indian/Alaska Native		Cumulative totals ²	
	1999		1999		1999	
	No. (%)	Cumulative total No. (%)	No. (%)	Cumulative total No. (%)	No. (%)	Cumulative total No. (%)
Injecting drug use	7 (11)	107 (17)	12 (30)	164 (46)	2,931 (27)	50,073 (42)
Hemophilia/coagulation disorder	—	5 (1)	—	2 (1)	12 (0)	272 (0)
Heterosexual contact:	32 (51)	310 (49)	12 (30)	127 (35)	4,281 (40)	47,946 (40)
<i>Sex with injecting drug user</i>	4	80	5	62	1,155	19,523
<i>Sex with bisexual male</i>	3	69	1	17	177	3,368
<i>Sex with person with hemophilia</i>	—	5	1	2	19	407
<i>Sex with transfusion recipient with HIV infection</i>	—	19	2	3	23	581
<i>Sex with HIV-infected person, risk not specified</i>	25	137	3	43	2,907	24,067
Receipt of blood transfusion, blood components, or tissue	3 (5)	96 (15)	1 (3)	14 (4)	119 (1)	3,668 (3)
Risk not reported or identified	21 (33)	111 (18)	15 (38)	51 (14)	3,437 (32)	17,851 (15)
Total	63 (100)	629 (100)	40 (100)	358 (100)	10,780 (100)	119,810 (100)

¹See figure 6.

²Includes 165 women whose race/ethnicity is unknown.

Table 12. Female adult/adolescent HIV infection cases¹ by exposure category and race/ethnicity, reported through December 1999, from the 32 areas with confidential HIV infection reporting²

Exposure category	White, not Hispanic		Black, not Hispanic		Hispanic	
	1999		1999		1999	
	No. (%)	Cumulative total	No. (%)	Cumulative total	No. (%)	Cumulative total
Injecting drug use	311 (22)	2,130 (27)	439 (9)	4,008 (18)	65 (12)	465 (21)
Hemophilia/coagulation disorder	1 (0)	11 (0)	1 (0)	9 (0)	—	—
Heterosexual contact:	555 (39)	3,343 (42)	1,671 (35)	8,941 (40)	242 (43)	970 (43)
<i>Sex with injecting drug user</i>	152	1,115	252	2,234	57	354
<i>Sex with bisexual male</i>	47	364	92	603	15	40
<i>Sex with person with hemophilia</i>	5	74	5	34	—	5
<i>Sex with transfusion recipient with HIV infection</i>	6	35	7	55	3	13
<i>Sex with HIV-infected person, risk not specified</i>	345	1,755	1,315	6,015	167	558
Receipt of blood transfusion, blood components, or tissue	12 (1)	136 (2)	29 (1)	238 (1)	4 (1)	23 (1)
Risk not reported or identified ³	544 (38)	2,250 (29)	2,594 (55)	9,260 (41)	250 (43)	791 (35)
Total	1,423 (100)	7,870 (100)	4,734 (100)	22,456 (100)	561 (100)	2,249 (100)

Exposure category	Asian/Pacific Islander		American Indian/Alaska Native		Cumulative totals ⁴	
	1999		1999		1999	
	No. (%)	Cumulative total	No. (%)	Cumulative total	No. (%)	Cumulative total
Injecting drug use	—	6 (6)	5 (15)	62 (34)	821 (12)	6,691 (20)
Hemophilia/coagulation disorder	—	—	—	—	2 (0)	20 (0)
Heterosexual contact:	10 (43)	47 (46)	17 (52)	77 (42)	2,506 (37)	13,420 (40)
<i>Sex with injecting drug user</i>	1	9	2	37	466	3,757
<i>Sex with bisexual male</i>	—	1	—	7	156	1,021
<i>Sex with person with hemophilia</i>	—	—	1	1	11	114
<i>Sex with transfusion recipient with HIV infection</i>	—	—	1	1	17	104
<i>Sex with HIV-infected person, risk not specified</i>	9	37	13	31	1,856	8,424
Receipt of blood transfusion, blood components, or tissue	—	2 (2)	—	1 (1)	45 (1)	402 (1)
Risk not reported or identified	13 (57)	48 (47)	11 (33)	43 (23)	3,481 (51)	12,646 (38)
Total	23 (100)	103 (100)	33 (100)	183 (100)	6,855 (100)	33,179 (100)

¹Includes only persons reported with HIV infection who have not developed AIDS.

²See table 3 for areas with confidential HIV infection reporting of adults and adolescents.

³For HIV infection cases, "risk not reported or identified" refers primarily to persons whose mode of exposure was not reported and who have not been followed up to determine their mode of exposure, and to a smaller number of persons who are not reported with one of the exposures listed above after follow-up. See Technical Notes.

⁴Includes 318 women whose race/ethnicity is unknown

Table 13. AIDS cases in adolescents and adults under age 25, by sex and exposure category, reported through December 1999, United States

Male exposure category	13-19 years old				20-24 years old			
	1999		Cumulative total		1999		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	43	(33)	749	(34)	495	(53)	11,570	(62)
Injecting drug use	3	(2)	137	(6)	87	(9)	2,277	(12)
Men who have sex with men and inject drugs	5	(4)	113	(5)	46	(5)	1,946	(10)
Hemophilia/coagulation disorder	10	(8)	751	(34)	23	(2)	646	(3)
Heterosexual contact:	10	(8)	89	(4)	75	(8)	885	(5)
<i>Sex with injecting drug user</i>	2		24		14		279	
<i>Sex with person with hemophilia</i>	—		1		—		4	
<i>Sex with transfusion recipient with HIV infection</i>	—		—		1		12	
<i>Sex with HIV-infected person, risk not specified</i>	8		64		60		590	
Receipt of blood transfusion, blood components, or tissue	7	(5)	91	(4)	3	(0)	107	(1)
Risk not reported or identified ¹	54	(41)	271	(12)	209	(22)	1,280	(7)
Male subtotal	132	(100)	2,201	(100)	938	(100)	18,711	(100)
Female exposure category								
Injecting drug use	17	(9)	210	(14)	65	(12)	1,924	(27)
Hemophilia/coagulation disorder	—	—	12	(1)	2	(0)	15	(0)
Heterosexual contact:	71	(39)	794	(52)	277	(49)	3,944	(55)
<i>Sex with injecting drug user</i>	12		272		68		1,537	
<i>Sex with bisexual male</i>	4		42		18		281	
<i>Sex with person with hemophilia</i>	—		15		3		55	
<i>Sex with transfusion recipient with HIV infection</i>	—		2		2		23	
<i>Sex with HIV-infected person, risk not specified</i>	55		463		186		2,048	
Receipt of blood transfusion, blood components, or tissue	3	(2)	91	(6)	2	(0)	114	(2)
Risk not reported or identified	89	(49)	417	(27)	217	(39)	1,196	(17)
Female subtotal	180	(100)	1,524	(100)	563	(100)	7,193	(100)
Total	312		3,725		1,501		25,904	

¹See figure 6.

Table 14. HIV infection cases¹ in adolescents and adults under age 25, by sex and exposure category, reported through December 1999, from the 32 areas with confidential HIV infection reporting²

Male exposure category	13-19 years old				20-24 years old			
	1999		Cumulative total		1999		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	139	(46)	1,027	(49)	683	(51)	6,035	(56)
Injecting drug use	11	(4)	110	(5)	59	(4)	614	(6)
Men who have sex with men and inject drugs	5	(2)	101	(5)	60	(4)	716	(7)
Hemophilia/coagulation disorder	6	(2)	103	(5)	7	(1)	83	(1)
Heterosexual contact:	21	(7)	155	(7)	98	(7)	705	(7)
<i>Sex with injecting drug user</i>	1		26		7		103	
<i>Sex with person with hemophilia</i>	—		2		—		—	
<i>Sex with transfusion recipient with HIV infection</i>	—		—		—		7	
<i>Sex with HIV-infected person, risk not specified</i>	20		127		91		595	
Receipt of blood transfusion, blood components, or tissue	2	(1)	10	(0)	1	(0)	28	(0)
Risk not reported or identified ³	117	(39)	596	(28)	426	(32)	2,664	(25)
Male subtotal	301	(100)	2,102	(100)	1,334	(100)	10,845	(100)
Female exposure category								
Injecting drug use	23	(4)	188	(7)	72	(7)	681	(12)
Hemophilia/coagulation disorder	—	—	—	—	—	—	3	(0)
Heterosexual contact:	224	(43)	1,334	(50)	399	(38)	2,542	(45)
<i>Sex with injecting drug user</i>	25		237		51		592	
<i>Sex with bisexual male</i>	14		94		27		219	
<i>Sex with person with hemophilia</i>	3		21		4		36	
<i>Sex with transfusion recipient with HIV infection</i>	—		4		1		18	
<i>Sex with HIV-infected person, risk not specified</i>	182		978		316		1,677	
Receipt of blood transfusion, blood components, or tissue	3	(1)	16	(1)	2	(0)	28	(0)
Risk not reported or identified	276	(52)	1,156	(43)	579	(55)	2,350	(42)
Female subtotal	526	(100)	2,694	(100)	1,052	(100)	5,604	(100)
Total⁴	828		4,797		2,386		16,449	

¹Includes only persons reported with HIV infection who have not developed AIDS.

²See table 3 for areas with confidential HIV infection reporting of adults and adolescents.

³For HIV infection cases, "risk not reported or identified" refers primarily to persons whose mode of exposure was not reported and who have not been followed up to determine their mode of exposure, and to a smaller number of persons who are not reported with one of the exposures listed above after follow-up. See Technical Notes.

⁴Includes 1 person whose sex is unknown.

Table 15. Pediatric AIDS cases by exposure category and race/ethnicity, reported through December 1999, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	1999		Cumulative total		1999		Cumulative total		1999		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	1	(3)	158	(10)	—	—	34	(1)	1	(2)	38	(2)
Mother with/at risk for HIV infection:	28	(82)	1,144	(75)	154	(91)	4,881	(96)	48	(89)	1,846	(92)
<i>Injecting drug use</i>	9		477		39		1,880		17		737	
<i>Sex with injecting drug user</i>	7		223		18		718		8		489	
<i>Sex with bisexual male</i>	1		66		2		63		1		39	
<i>Sex with person with hemophilia</i>	—		17		1		7		1		8	
<i>Sex with transfusion recipient with HIV infection</i>	—		8		—		8		—		9	
<i>Sex with HIV-infected person, risk not specified</i>	3		140		32		777		9		254	
<i>Receipt of blood transfusion, blood components, or tissue</i>	—		42		2		77		—		33	
<i>Has HIV infection, risk not specified</i>	8		171		60		1,351		12		277	
Receipt of blood transfusion, blood components, or tissue	1	(3)	189	(12)	1	(1)	89	(2)	—	—	91	(5)
Risk not reported or identified ¹	4	(12)	26	(2)	15	(9)	100	(2)	5	(9)	30	(1)
Total	34	(100)	1,517	(100)	170	(100)	5,104	(100)	54	(100)	2,005	(100)

Exposure category	Asian/Pacific Islander				American Indian/ Alaska Native				Cumulative totals ²			
	1999		Cumulative total		1999		Cumulative total		1999		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	—	—	3	(6)	1	(50)	2	(7)	3	(1)	235	(3)
Mother with/at risk for HIV infection:	—	—	31	(65)	1	(50)	27	(90)	232	(88)	7,943	(91)
<i>Injecting drug use</i>	—		4		1		13		66		3,116	
<i>Sex with injecting drug user</i>	—		5		—		7		33		1,443	
<i>Sex with bisexual male</i>	—		2		—		—		5		171	
<i>Sex with person with hemophilia</i>	—		—		—		—		2		32	
<i>Sex with transfusion recipient with HIV infection</i>	—		—		—		—		—		25	
<i>Sex with HIV-infected person, risk not specified</i>	—		9		—		3		44		1,185	
<i>Receipt of blood transfusion, blood components, or tissue</i>	—		1		—		—		2		153	
<i>Has HIV infection, risk not specified</i>	—		10		—		4		80		1,818	
Receipt of blood transfusion, blood components, or tissue	—	—	10	(21)	—	—	—	—	2	(1)	379	(4)
Risk not reported or identified	2	(100)	4	(8)	—	—	1	(3)	26	(10)	161	(2)
Total	2	(100)	48	(100)	2	(100)	30	(100)	263	(100)	8,718	(100)

¹See figure 6, footnote 1.

²Includes 14 children whose race/ethnicity is unknown.

Table 16. Pediatric HIV infection cases¹ by exposure category and race/ethnicity, reported through December 1999, from the 34 areas with confidential HIV infection reporting²

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	1999		Cumulative total		1999		Cumulative total		1999		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	6	(15)	69	(15)	—	—	20	(2)	—	—	5	(2)
Mother with/at risk for HIV infection:	30	(73)	346	(76)	138	(89)	1,184	(92)	27	(82)	207	(88)
<i>Injecting drug use</i>	3		109		24		350		4		53	
<i>Sex with injecting drug user</i>	8		72		12		130		4		36	
<i>Sex with bisexual male</i>	4		9		1		15		1		4	
<i>Sex with person with hemophilia</i>	—		4		—		2		—		—	
<i>Sex with transfusion recipient with HIV infection</i>	—		3		—		3		—		3	
<i>Sex with HIV-infected person, risk not specified</i>	8		65		35		279		11		50	
<i>Receipt of blood transfusion, blood components, or tissue</i>	1		8		—		11		—		2	
<i>Has HIV infection, risk not specified</i>	6		76		66		394		7		59	
Receipt of blood transfusion, blood components, or tissue	1	(2)	19	(4)	1	(1)	11	(1)	—	—	5	(2)
Risk not reported or identified ³	4	(10)	23	(5)	16	(10)	78	(6)	6	(18)	17	(7)
Total	41	(100)	457	(100)	155	(100)	1,293	(100)	33	(100)	234	(100)

Exposure category	Asian/Pacific Islander				American Indian/ Alaska Native				Cumulative totals ⁴			
	1999		Cumulative total		1999		Cumulative total		1999		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	—	—	2	(15)	—	—	—	—	6	(3)	97	(5)
Mother with/at risk for HIV infection:	—	—	8	(62)	—	—	7	(78)	197	(85)	1,761	(87)
<i>Injecting drug use</i>	—		2		—		2		33		521	
<i>Sex with injecting drug user</i>	—		—		—		2		24		241	
<i>Sex with bisexual male</i>	—		2		—		1		6		32	
<i>Sex with person with hemophilia</i>	—		—		—		1		—		7	
<i>Sex with transfusion recipient with HIV infection</i>	—		—		—		—		—		9	
<i>Sex with HIV-infected person, risk not specified</i>	—		2		—		—		54		397	
<i>Receipt of blood transfusion, blood components, or tissue</i>	—		—		—		—		1		21	
<i>Has HIV infection, risk not specified</i>	—		2		—		1		79		533	
Receipt of blood transfusion, blood components, or tissue	—	—	1	(8)	—	—	—	—	2	(1)	36	(2)
Risk not reported or identified	—	—	2	(15)	—	—	2	(22)	28	(12)	132	(7)
Total	—	—	13	(100)	—	—	9	(100)	233	(100)	2,026	(100)

¹Includes only persons reported with HIV infection who have not developed AIDS.

²See table 3 for areas with confidential HIV infection reporting.

³For HIV infection cases, "risk not reported or identified" refers primarily to persons whose mode of exposure was not reported and who have not been followed up to determine their mode of exposure, and to a smaller number of persons who are not reported with one of the exposures listed above after follow-up. See Technical Notes.

⁴Includes 20 children whose race/ethnicity is unknown.

Figure 5. Pediatric AIDS cases reported in 1999, United States

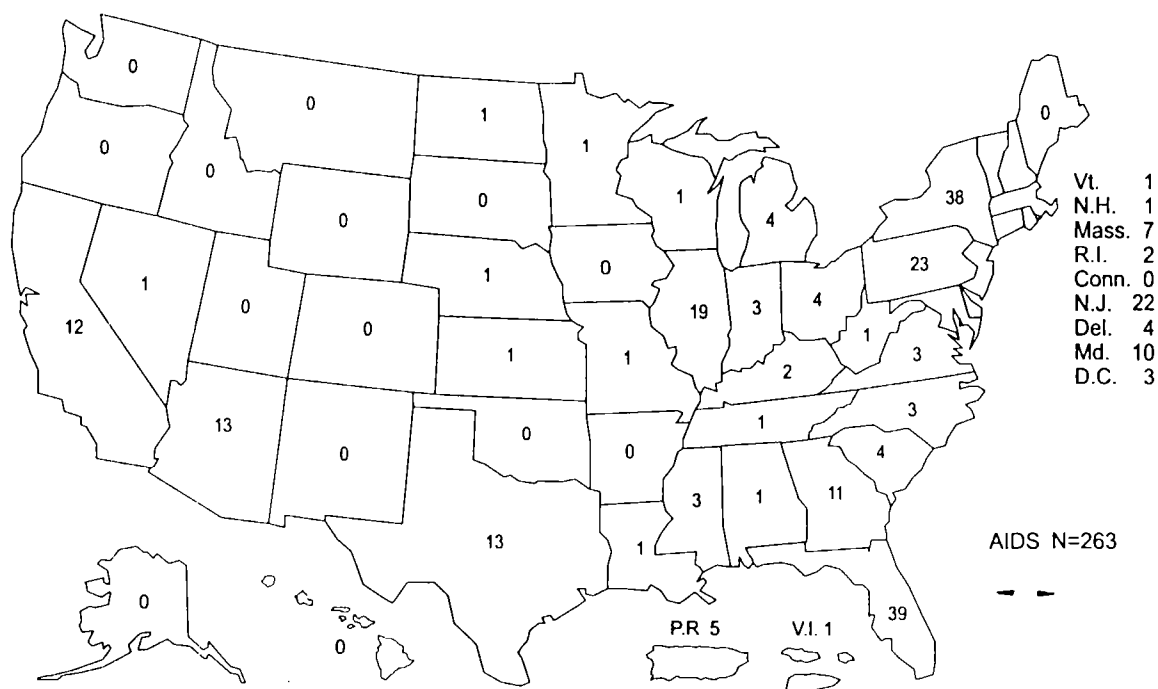


Table 17. Health care workers with documented and possible occupationally acquired AIDS/HIV infection, by occupation, reported through December 1999, United States¹

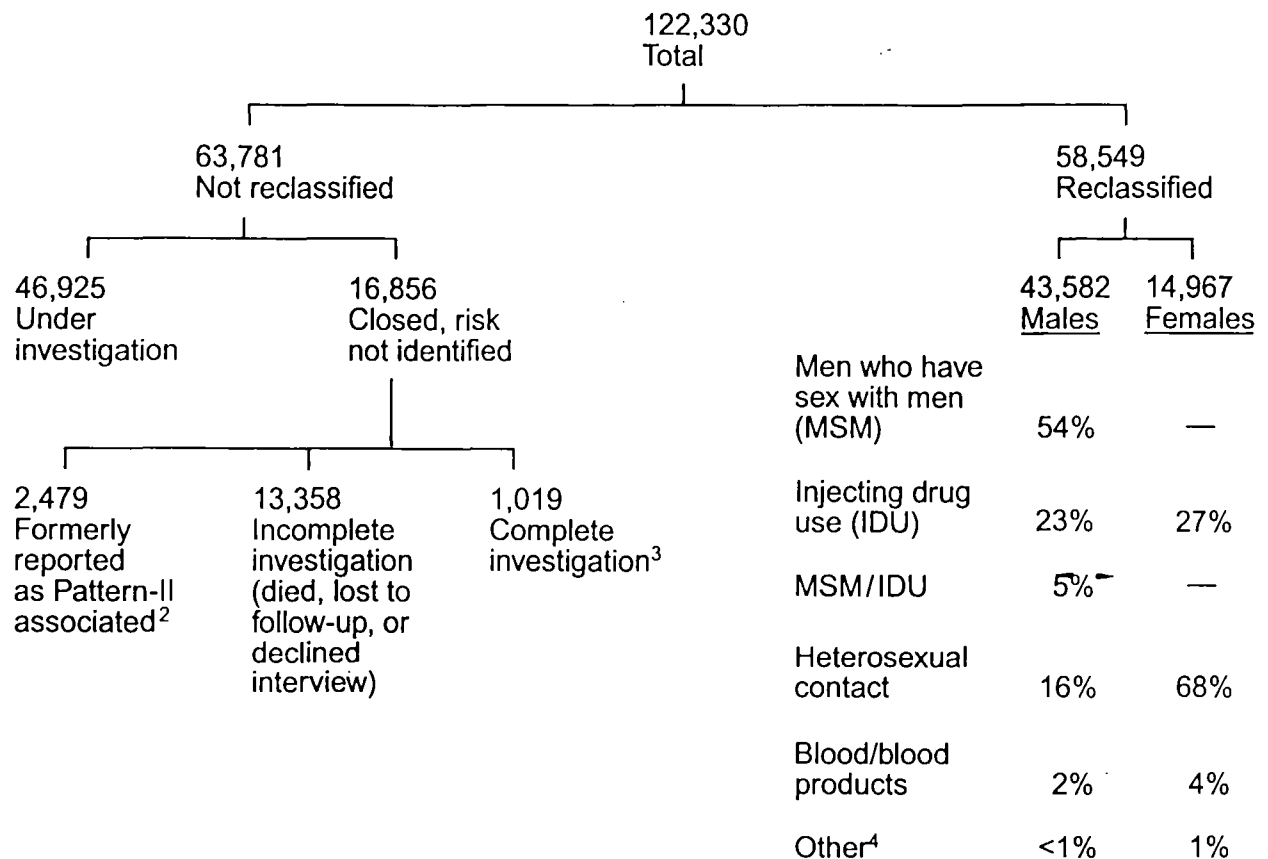
Occupation	Documented occupational transmission ²	Possible occupational transmission ³
	No.	No.
Dental worker, including dentist	—	6
Embalmer/morgue technician	1	2
Emergency medical technician/paramedic	—	12
Health aide/attendant	1	15
Housekeeper/maintenance worker	2	12
Laboratory technician, clinical	16	17
Laboratory technician, nonclinical	3	—
Nurse	23	35
Physician, nonsurgical	6	12
Physician, surgical	—	6
Respiratory therapist	1	2
Technician, dialysis	1	3
Technician, surgical	2	2
Technician/therapist, other than those listed above	—	8
Other health care occupations	—	4
Total	56	136

¹Health care workers are defined as those persons, including students and trainees, who have worked in a health care, clinical, or HIV laboratory setting at any time since 1978. See *MMWR* 1992;41:823-25.

²Health care workers who had documented HIV seroconversion after occupational exposure or had other laboratory evidence of occupational infection: 48 had percutaneous exposure, 5 had mucocutaneous exposure, 2 had both percutaneous and mucocutaneous exposures, and 1 had an unknown route of exposure. Forty-nine health care workers were exposed to blood from an HIV-infected person, 1 to visibly bloody fluid, 3 to an unspecified fluid, and 3 to concentrated virus in a laboratory. Twenty-five of these health care workers developed AIDS.

³These health care workers have been investigated and are without identifiable behavioral or transfusion risks; each reported percutaneous or mucocutaneous occupational exposures to blood or body fluids, or laboratory solutions containing HIV, but HIV seroconversion specifically resulting from an occupational exposure was not documented.

Figure 6. Results of investigations of adult/adolescent AIDS cases ever classified as risk not reported or identified, through December 1999, United States¹



¹Excludes 162 children under 13 years of age classified as "other/risk not reported or identified" in table 5. For 147 of these children, risk has not yet been identified. Three of the children were exposed to HIV-infected blood as supported by seroconversion, epidemiologic, and/or laboratory evidence — 1 child was infected following intentional inoculation with HIV-infected blood and 2 children were exposed to HIV-infected blood in a household setting (see *MMWR* 1992;41:228-31 and *N Engl J Med* 1993;329:1835-41). Twelve of the children had sexual contact with an adult with or at high risk for HIV infection (see *Pediatrics* 1998;102:e46). An additional 507 children who were initially reported without risk information have been reclassified after investigation.

²Cases associated with persons born in Pattern-II countries are no longer classified as heterosexual transmission. See Technical Notes.

³Investigations of these persons included patient interviews. Based on available information, these persons could not be reclassified into an exposure category. This group includes persons possibly infected through heterosexual contact with a partner who is not known to be HIV infected or at risk for HIV infection; persons who may choose not to disclose high-risk information; and persons with possible occupational exposure. These 1019 persons report heterosexual contact, sexually transmitted disease infections, non-injecting drug use, hepatitis infections, and occupational exposures to blood or body fluids.

⁴One hundred eighty-four adults/adolescents are included in the "other" exposure category listed here and in table 5, and were exposed to HIV-infected blood, body fluids, or concentrated virus in health care, laboratory, or household settings, as supported by seroconversion, epidemiologic, and/or laboratory evidence. See table 17, *MMWR* 1993;42:329-31, *MMWR* 1993;42:948-51, and XI International Conference on AIDS; Vancouver, Canada; Jul. 7-12, 1996;1:179 [abstract Mo.D.1728]. One person was infected following intentional inoculation with HIV-infected blood. One hundred fifty-one persons acquired HIV infection perinatally and were diagnosed with AIDS after age 13.

Table 18. Adult/adolescent AIDS cases by single and multiple exposure categories, reported through December 1999, United States

Exposure category	AIDS cases	
	No.	(%)
Single mode of exposure		
Men who have sex with men	325,843	(45)
Injecting drug use	145,767	(20)
Hemophilia/coagulation disorder	4,111	(1)
Heterosexual contact	72,700	(10)
Receipt of transfusion ¹	8,518	(1)
Receipt of transplant of tissues, organs, or artificial insemination ²	13	(0)
Other ³	184	(0)
Single mode of exposure subtotal	557,136	(77)
Multiple modes of exposure		
Men who have sex with men; injecting drug use	39,505	(5)
Men who have sex with men; hemophilia/coagulation disorder	178	(0)
Men who have sex with men; heterosexual contact	11,742	(2)
Men who have sex with men; receipt of transfusion/transplant	3,458	(0)
Injecting drug use; hemophilia/coagulation disorder	203	(0)
Injecting drug use; heterosexual contact	35,531	(5)
Injecting drug use; receipt of transfusion/transplant	1,695	(0)
Hemophilia/coagulation disorder; heterosexual contact	116	(0)
Hemophilia/coagulation disorder; receipt of transfusion/transplant	811	(0)
Heterosexual contact; receipt of transfusion/transplant	1,777	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder	52	(0)
Men who have sex with men; injecting drug use; heterosexual contact	6,183	(1)
Men who have sex with men; injecting drug use; receipt of transfusion/transplant	625	(0)
Men who have sex with men; hemophilia/coagulation disorder; heterosexual contact	24	(0)
Men who have sex with men; hemophilia/coagulation disorder; receipt of transfusion/transplant	43	(0)
Men who have sex with men; heterosexual contact; receipt of transfusion/transplant	303	(0)
Injecting drug use; hemophilia/coagulation disorder; heterosexual contact	88	(0)
Injecting drug use; hemophilia/coagulation disorder; receipt of transfusion/transplant	39	(0)
Injecting drug use; heterosexual contact; receipt of transfusion/transplant	1,081	(0)
Hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	37	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder; heterosexual contact	15	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder; receipt of transfusion/transplant	14	(0)
Men who have sex with men; injecting drug use; heterosexual contact; receipt of transfusion/transplant	181	(0)
Men who have sex with men; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	6	(0)
Injecting drug use; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	25	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	7	(0)
Multiple modes of exposure subtotal	103,739	(14)
Risk not reported or identified⁴	63,781	(9)
Total	724,656	(100)

¹Includes 37 adult/adolescents who developed AIDS after receiving blood screened negative for HIV antibody.

²Thirteen adults developed AIDS after receiving tissue, organs, or artificial insemination from HIV-infected donors. Four of the 13 received tissue or organs from a donor who was negative for HIV antibody at the time of donation. See *N Engl J Med* 1992;326:726-32.

³See table 17 and figure 6 for a discussion of the "other" exposure category. "Other" also includes 151 persons who acquired HIV infection perinatally, but were diagnosed with AIDS after age 13.

⁴See figure 6.

Table 19. AIDS cases and annual rates per 100,000 population, by race/ethnicity, age group, and sex, reported in 1999, United States

Race/ethnicity	Adults/adolescents						Children <13 years		Total	
	Males		Females		Total		No.	Rate	No.	Rate
	No.	Rate	No.	Rate	No.	Rate				
White, not Hispanic	12,855	16.2	1,924	2.3	14,779	9.0	34	0.1	14,813	7.6
Black, not Hispanic	14,946	124.8	6,784	49.0	21,730	84.2	170	2.3	21,900	66.0
Hispanic	7,019	54.4	1,948	14.9	8,967	34.6	54	0.6	9,021	25.6
Asian/Pacific Islander	303	7.6	63	1.4	366	4.3	2	0.1	368	3.4
American Indian/Alaska Native	136	18.0	40	5.0	176	11.3	2	0.4	178	8.8
Total ¹	35,357	32.4	10,780	9.3	46,137	20.5	263	0.5	46,400	16.7

¹Totals include 120 persons whose race/ethnicity is unknown.

Table 20. Adult/adolescent AIDS cases among Hispanics, by exposure category and place of birth, reported in 1999, United States

	Place of birth						Total ²
	United States ¹	Central/South America	Cuba	Mexico	Puerto Rico		
Adult/adolescent exposure category	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	
Men who have sex with men	910 (31)	282 (42)	78 (39)	546 (50)	321 (14)	2,584 (29)	
Injecting drug use	806 (28)	24 (4)	11 (6)	72 (7)	1,028 (46)	2,438 (27)	
Men who have sex with men and inject drugs	120 (4)	8 (1)	11 (6)	30 (3)	75 (3)	271 (3)	
Heterosexual contact	383 (13)	123 (18)	17 (9)	127 (12)	575 (26)	1,521 (17)	
Hemophilia/coagulation disorder or receipt of blood transfusion, blood components, or tissue	15 (1)	8 (1)	— —	9 (1)	8 (0)	52 (1)	
Risk not reported or identified ³	663 (23)	232 (34)	82 (41)	302 (28)	210 (9)	2,101 (23)	
Total	2,897 (100)	677 (100)	199 (100)	1,086 (100)	2,217 (100)	8,967 (100)	

¹Excludes persons born in U.S. dependencies, possessions, and independent nations in free association with the United States. Ancestry data for U.S.-born Hispanics are not collected.

²Includes 228 Hispanics born in locations other than those listed, and 1,663 Hispanics whose place of birth is unknown.

³See figure 6.

Table 21. Deaths in persons with AIDS, by race/ethnicity, age at death, and sex, occurring in 1997 and 1998; and cumulative totals reported through December 1999, United States¹

Race/ethnicity and age at death ²	Males			Females			Both sexes		
	1997	1998	Cumulative total	1997	1998	Cumulative total	1997	1998	Cumulative total
White, not Hispanic									
Under 15	21	6	562	11	6	413	32	12	975
15-24	35	31	2,507	21	10	467	56	41	2,974
25-34	1,312	815	53,983	250	150	4,538	1,562	965	58,521
35-44	2,696	2,033	78,861	344	274	4,906	3,040	2,307	83,767
45-54	1,423	1,226	35,784	147	116	1,907	1,570	1,342	37,691
55 or older	594	508	15,100	57	59	1,681	651	567	16,781
All ages	6,081	4,619	186,964	830	615	13,935	6,911	5,234	200,899
Black, not Hispanic									
Under 15	71	29	1,420	57	46	1,401	128	75	2,821
15-24	84	67	2,398	100	86	1,382	184	153	3,780
25-34	1,514	1,042	32,788	722	633	11,394	2,236	1,675	44,182
35-44	2,908	2,264	48,368	1,175	989	14,142	4,083	3,253	62,510
45-54	1,768	1,552	21,229	540	492	4,917	2,308	2,044	26,146
55 or older	787	674	9,073	189	199	2,171	976	873	11,244
All ages	7,132	5,628	115,386	2,783	2,445	35,440	9,915	8,073	150,826
Hispanic									
Under 15	24	10	623	16	9	568	40	19	1,191
15-24	52	27	1,315	23	12	469	75	39	1,784
25-34	760	478	19,863	214	167	4,382	974	645	24,245
35-44	1,349	1,008	25,456	342	253	4,692	1,691	1,261	30,148
45-54	620	541	10,254	136	120	1,668	756	661	11,922
55 or older	264	256	4,240	83	63	797	347	319	5,037
All ages	3,069	2,320	61,808	814	624	12,588	3,883	2,944	74,396
Asian/Pacific Islander									
Under 15	—	—	18	—	—	16	—	—	34
15-24	1	1	36	—	—	6	1	1	42
25-34	27	27	695	4	6	78	31	33	773
35-44	55	32	1,097	7	7	97	62	39	1,194
45-54	20	18	532	8	3	63	28	21	595
55 or older	19	9	240	3	4	46	22	13	286
All ages	122	87	2,619	22	20	308	144	107	2,927
American Indian/Alaska Native									
Under 15	—	—	12	—	—	8	—	—	20
15-24	—	—	25	—	—	3	—	—	28
25-34	22	19	365	7	6	69	29	25	434
35-44	32	16	376	7	7	63	39	23	439
45-54	9	8	119	4	1	24	13	9	143
55 or older	—	6	41	1	—	11	1	6	52
All ages	63	49	941	19	14	178	82	63	1,119
All racial/ethnic groups									
Under 15	116	45	2,637	84	61	2,407	200	106	5,044
15-24	172	126	6,286	144	108	2,329	316	234	8,615
25-34	3,638	2,383	107,752	1,197	962	20,466	4,835	3,345	128,218
35-44	7,044	5,359	154,271	1,876	1,531	23,911	8,920	6,890	178,182
45-54	3,842	3,347	67,963	835	732	8,584	4,677	4,079	76,547
55 or older	1,664	1,453	28,716	333	325	4,709	1,997	1,778	33,425
All ages	16,476	12,713	367,965	4,469	3,719	62,476	20,945	16,432	430,441

¹Data tabulations for 1997 and 1998 are based on date of death occurrence. Data for deaths occurring in 1999 are incomplete and not tabulated separately, but are included in the cumulative totals. Tabulations for 1997 and 1998 may increase as additional deaths are reported to CDC.

²Data tabulated under "all ages" include 410 persons whose age at death is unknown. Data tabulated under "all racial/ethnic groups" include 274 persons whose race/ethnicity is unknown.

Table 22. AIDS cases and deaths, by year and age group, through December 1999, United States¹

Year	Adults/adolescents		Children <13 years old	
	Cases diagnosed during interval	Deaths occurring during interval	Cases diagnosed during interval	Deaths occurring during interval
Before 1981	91	29	8	1
1981	319	121	16	8
1982	1,170	453	31	13
1983	3,076	1,482	77	30
1984	6,240	3,466	120	52
1985	11,776	6,878	250	119
1986	19,032	11,987	340	167
1987	28,564	16,162	506	294
1988	35,447	20,868	617	321
1989	42,674	27,591	725	176
1990	48,634	31,335	812	399
1991	59,660	36,560	812	399
1992	78,530	41,055	947	425
1993	78,834	44,730	918	541
1994	71,874	49,095	810	582
1995	68,505	49,456	667	536
1996	59,347	36,510	485	420
1997	47,149	20,736	290	209
1998	38,393	16,317	194	115
1999	25,341	10,122	93	76
Total²	724,656	425,357	8,718	5,084

¹Persons whose vital status is unknown are included in counts of diagnosed cases, but excluded from counts of deaths. Reported deaths are not necessarily caused by HIV-related disease.

²Death totals include 404 adults/adolescents and 6 children known to have died, but whose dates of death are unknown.

Table 23. Estimated male adult/adolescent AIDS incidence, by exposure category and race/ethnicity, diagnosed in 1998, and cumulative totals through 1998, United States¹

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	1998		Cumulative total		1998		Cumulative total		1998		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	8,338	(72)	221,144	(77)	5,905	(41)	80,835	(42)	3,146	(46)	48,403	(46)
Injecting drug use	1,604	(14)	27,760	(10)	4,999	(35)	74,402	(38)	2,318	(34)	40,944	(39)
Men who have sex with men and inject drugs	884	(8)	24,076	(8)	892	(6)	15,903	(8)	348	(5)	7,585	(7)
Hemophilia/coagulation disorder	86	(1)	3,803	(1)	45	(0)	685	(0)	20	(0)	489	(0)
Heterosexual contact:	591	(5)	5,940	(2)	2,418	(17)	18,625	(10)	916	(13)	7,324	(7)
<i>Sex with injecting drug user</i>	170		2,085		558		5,982		214		2,068	
<i>Sex with person with hemophilia</i>	3		35		3		18		2		11	
<i>Sex with transfusion recipient with HIV infection</i>	5		170		17		176		9		104	
<i>Sex with HIV-infected person, risk not specified</i>	413		3,650		1,840		12,449		691		5,141	
Receipt of blood transfusion, blood components, or tissue	79	(1)	3,293	(1)	85	(1)	1,193	(1)	36	(1)	646	(1)
Risk not reported or identified	27	(0)	542	(0)	43	(0)	2,200	(1)	23	(0)	299	(0)
Total	11,607	(100)	286,540	(100)	14,390	(100)	193,838	(100)	6,806	(100)	105,686	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ²			
	1998		Cumulative total		1998		Cumulative total		1998		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	194	(67)	3,508	(77)	58	(50)	1,015	(60)	17,681	(53)	355,316	(60)
Injecting drug use	39	(13)	404	(9)	31	(27)	286	(17)	9,013	(27)	144,027	(24)
Men who have sex with men and inject drugs	14	(5)	192	(4)	20	(17)	295	(17)	2,161	(6)	48,074	(8)
Hemophilia/coagulation disorder	3	(1)	70	(2)	1	(1)	31	(2)	157	(0)	5,085	(1)
Heterosexual contact:	34	(12)	235	(5)	4	(3)	57	(3)	3,974	(12)	32,244	(5)
<i>Sex with injecting drug user</i>	11		64		1		18		957		10,231	
<i>Sex with person with hemophilia</i>	1		1		—		—		9		64	
<i>Sex with transfusion recipient with HIV infection</i>	2		9		—		1		33		461	
<i>Sex with HIV-infected person, risk not specified</i>	20		161		3		38		2,975		21,488	
Receipt of blood transfusion, blood components, or tissue	6	(2)	113	(2)	—	(0)	8	(0)	207	(1)	5,263	(1)
Risk not reported or identified	1	(0)	30	(1)	1	(1)	5	(0)	96	(0)	3,053	(1)
Total	291	(100)	4,552	(100)	115	(100)	1,697	(100)	33,289	(100)	593,062	(100)

¹These numbers do not represent actual cases of men with AIDS. Rather, these numbers are point estimates adjusted for delays in the reporting of AIDS cases and for redistribution of cases initially reported with no identified risk, but not adjusted for incomplete reporting of cases. See Technical Notes.

²Totals include estimates of men whose race/ethnicity is unknown.

Table 24. Estimated female adult/adolescent AIDS incidence, by exposure category and race/ethnicity, diagnosed in 1998, and cumulative totals through 1998, United States¹

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	1998		Cumulative total		1998		Cumulative total		1998		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	714	(40)	11,521	(45)	2,392	(36)	31,661	(48)	630	(34)	10,199	(44)
Hemophilia/coagulation disorder	5	(0)	131	(1)	33	(0)	229	(0)	10	(1)	91	(0)
Heterosexual contact:	998	(56)	11,888	(46)	4,056	(61)	31,768	(48)	1,192	(64)	12,385	(53)
<i>Sex with injecting drug user</i>	325		4,782		1,104		11,785		371		5,538	
<i>Sex with bisexual male</i>	95		1,621		165		1,606		43		575	
<i>Sex with person with hemophilia</i>	19		300		6		84		5		41	
<i>Sex with transfusion recipient with HIV infection</i>	15		330		13		190		2		99	
<i>Sex with HIV-infected person, risk not specified</i>	544		4,855		2,768		18,103		771		6,132	
Receipt of blood transfusion, blood components, or tissue	50	(3)	1,900	(7)	116	(2)	1,454	(2)	29	(2)	585	(3)
Risk not reported or identified	15	(1)	218	(1)	32	(0)	928	(1)	10	(1)	80	(0)
Total	1,782	(100)	25,658	(100)	6,629	(100)	66,040	(100)	1,871	(100)	23,340	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ²			
	1998		Cumulative total		1998		Cumulative total		1998		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	11	(21)	127	(21)	16	(48)	170	(50)	3,775	(36)	53,759	(46)
Hemophilia/coagulation disorder	—	(0)	6	(1)	—	(0)	2	(1)	48	(0)	462	(0)
Heterosexual contact:	40	(75)	358	(60)	16	(48)	148	(44)	6,311	(61)	56,624	(49)
<i>Sex with injecting drug user</i>	7		99		6		68		1,818		22,297	
<i>Sex with bisexual male</i>	4		71		1		19		308		3,899	
<i>Sex with person with hemophilia</i>	1		5		—		1		30		431	
<i>Sex with transfusion recipient with HIV infection</i>	—		19		1		2		32		642	
<i>Sex with HIV-infected person, risk not specified</i>	28		164		8		58		4,123		29,355	
Receipt of blood transfusion, blood components, or tissue	2	(4)	97	(16)	1	(3)	15	(4)	198	(2)	4,056	(3)
Risk not reported or identified	—	(0)	11	(2)	—	(0)	5	(1)	57	(1)	1,243	(1)
Total	53	(100)	599	(100)	33	(100)	340	(100)	10,389	(100)	116,144	(100)

¹These numbers do not represent actual cases of women with AIDS. Rather, these numbers are point estimates adjusted for delays in the reporting of AIDS cases and for redistribution of cases initially reported with no identified risk, but not adjusted for incomplete reporting of cases. See Technical Notes.

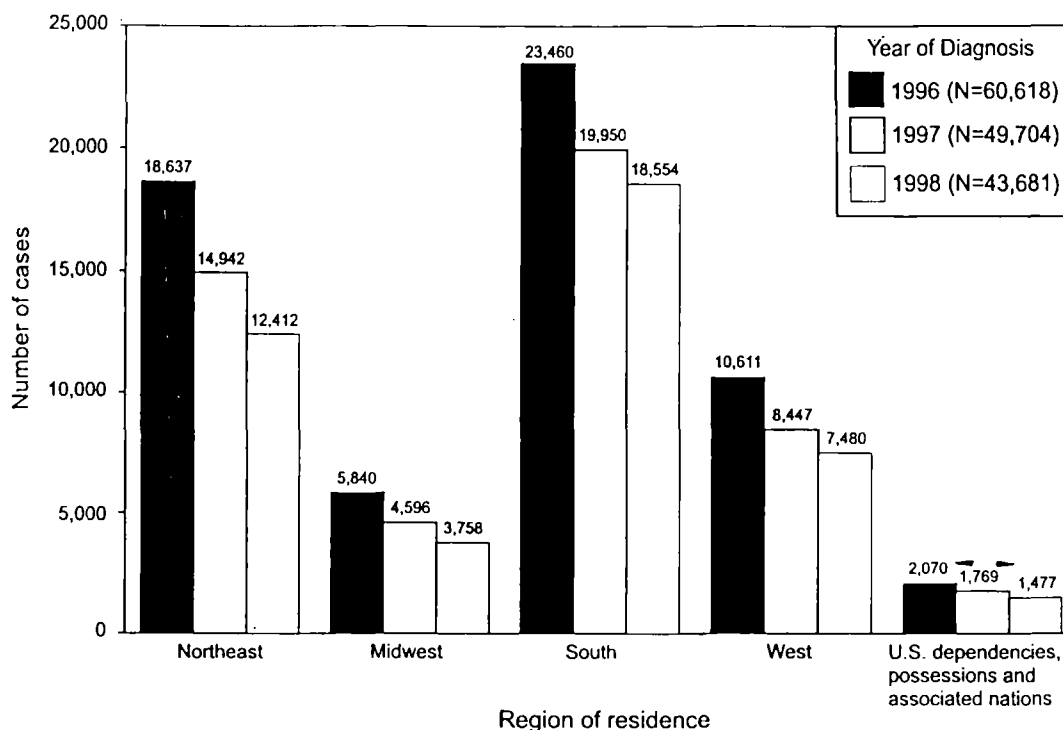
²Totals include estimates of women whose race/ethnicity is unknown.

Table 25. Estimated AIDS incidence in adolescents and adults under age 25, by sex and exposure category, diagnosed in 1998, and cumulative totals through 1998, United States¹

Male exposure category	13-19 years old				20-24 years old			
	1998		Cumulative total		1998		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	60	(53)	808	(38)	481	(61)	11,894	(65)
Injecting drug use	12	(11)	192	(9)	119	(15)	2,566	(14)
Men who have sex with men and inject drugs	6	(5)	118	(5)	51	(7)	1,992	(11)
Hemophilia/coagulation disorder	7	(6)	752	(35)	17	(2)	650	(4)
Heterosexual contact:	12	(11)	116	(5)	110	(14)	1,037	(6)
<i>Sex with injecting drug user</i>	1		30		26		321	
<i>Sex with person with hemophilia</i>	—		1		—		4	
<i>Sex with transfusion recipient with HIV infection</i>	—		—		1		13	
<i>Sex with HIV-infected person, risk not specified</i>	11		85		83		699	
Receipt of blood transfusion, blood components, or tissue	5	(4)	89	(4)	4	(1)	119	(1)
Risk not reported or identified	12	(11)	75	(3)	2	(0)	105	(1)
Male subtotal	114	(100)	2,150	(100)	784	(100)	18,363	(100)
Female exposure category								
Injecting drug use	24	(17)	289	(20)	113	(20)	2,200	(31)
Hemophilia/coagulation disorder	2	(1)	15	(1)	3	(1)	25	(0)
Heterosexual contact:	97	(69)	961	(66)	427	(77)	4,567	(65)
<i>Sex with injecting drug user</i>	18		324		98		1,726	
<i>Sex with bisexual male</i>	8		52		27		316	
<i>Sex with person with hemophilia</i>	—		15		3		57	
<i>Sex with transfusion recipient with HIV infection</i>	—		3		2		26	
<i>Sex with HIV-infected person, risk not specified</i>	71		567		297		2,442	
Receipt of blood transfusion, blood components, or tissue	4	(3)	98	(7)	6	(1)	144	(2)
Risk not reported or identified	13	(9)	89	(6)	3	(1)	76	(1)
Female subtotal	140	(100)	1,452	(100)	552	(100)	7,012	(100)
Total	254		3,602		1,336		25,375	

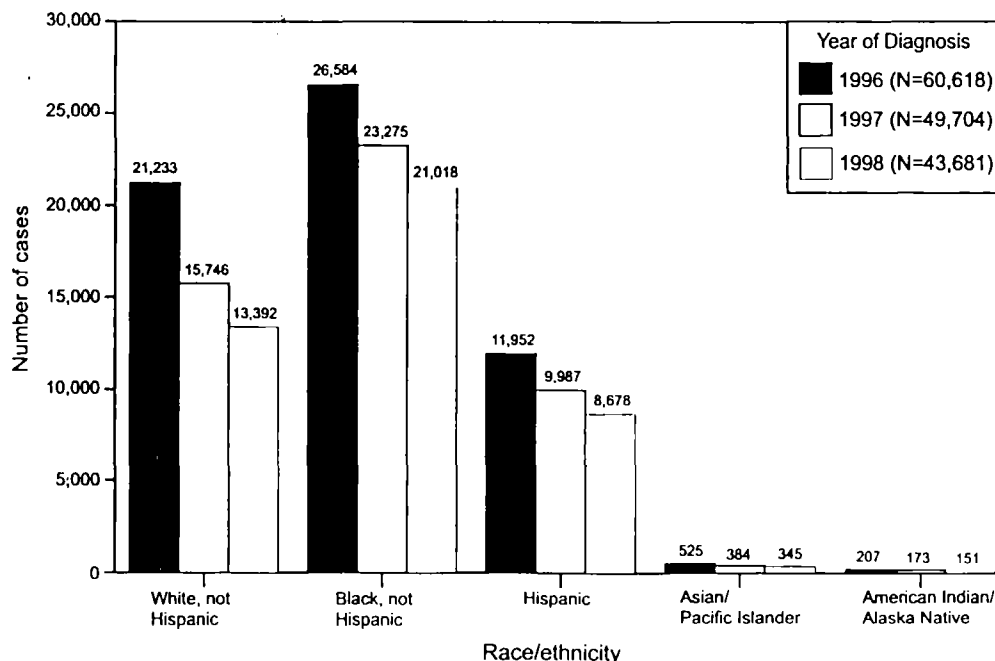
¹These numbers do not represent actual cases of persons with AIDS. Rather, these numbers are point estimates adjusted for delays in the reporting of AIDS cases and for redistribution of cases initially reported with no identified risk, but not adjusted for incomplete reporting of cases. See Technical Notes.

Figure 7. Estimated adult/adolescent AIDS incidence, by region of residence and year of diagnosis, 1996, 1997 and 1998, United States¹



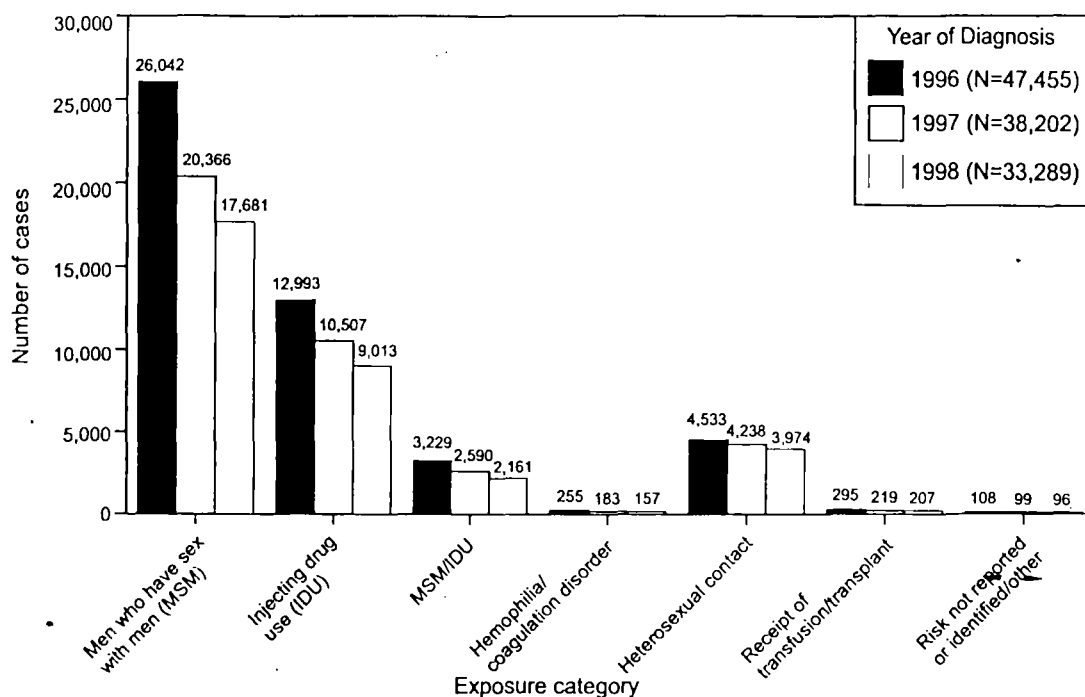
¹These numbers do not represent actual cases of persons diagnosed with AIDS. Rather, these numbers are point estimates of persons diagnosed with AIDS adjusted for reporting delays, but not for incomplete reporting. See Technical Notes for a list of states or U.S. dependencies, possessions, and associated nations which comprise each region of residence.

Figure 8. Estimated adult/adolescent AIDS incidence, by race/ethnicity and year of diagnosis, 1996, 1997 and 1998, United States¹



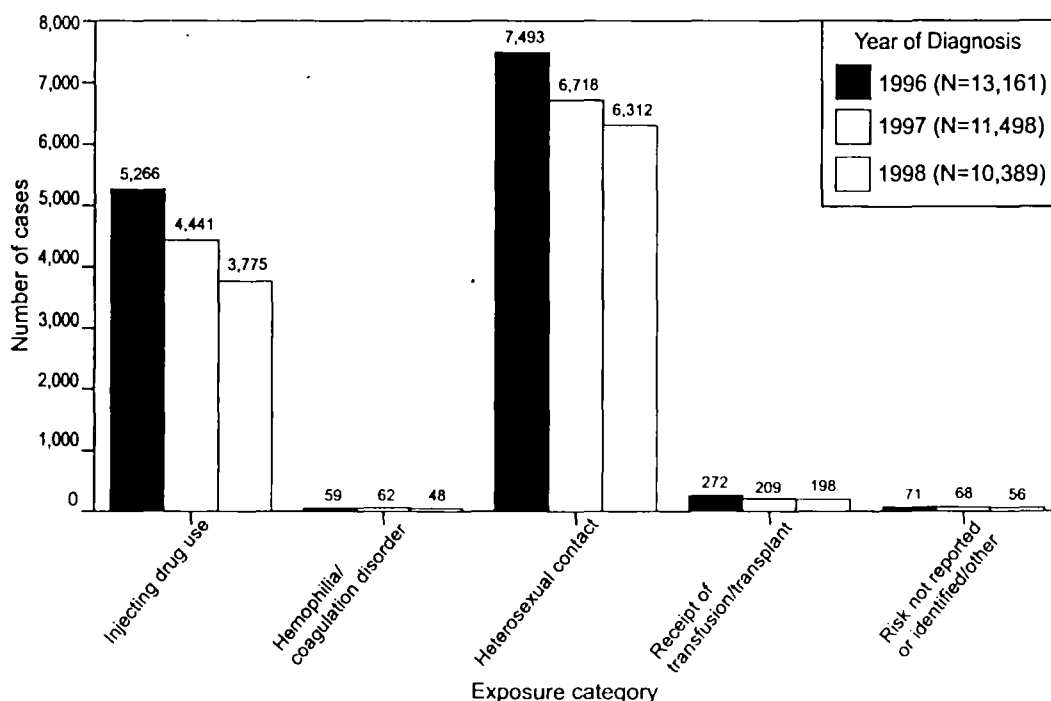
¹These numbers do not represent actual cases of persons diagnosed with AIDS. Rather, these numbers are point estimates of persons diagnosed with AIDS adjusted for reporting delays, but not for incomplete reporting. Cases with missing or unknown race/ethnicity data are included in the totals. See Technical Notes.

Figure 9. Estimated male adult/adolescent AIDS incidence, by exposure category and year of diagnosis, 1996, 1997 and 1998, United States¹



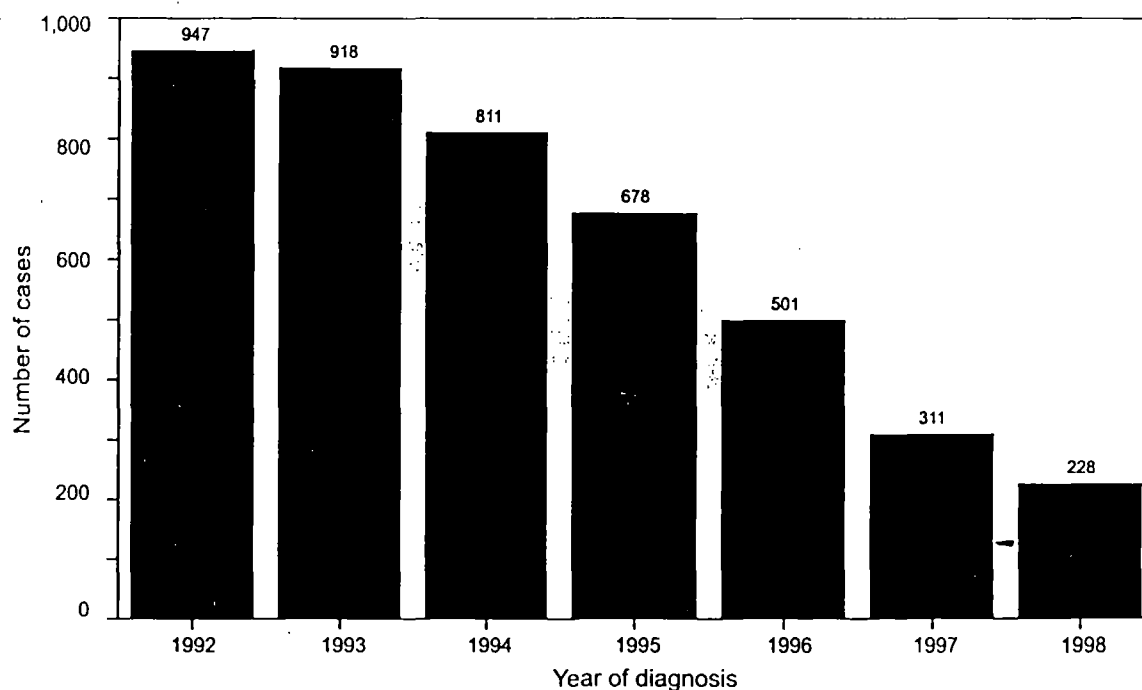
¹These numbers do not represent actual cases of men diagnosed with AIDS. Rather, these numbers are point estimates of men diagnosed with AIDS adjusted for reporting delays and for redistribution of cases initially reported with no identified risk, but not for incomplete reporting. See Technical Notes.

Figure 10. Estimated female adult/adolescent AIDS incidence, by exposure category and year of diagnosis, 1996, 1997 and 1998, United States¹



¹These numbers do not represent actual cases of women diagnosed with AIDS. Rather, these numbers are point estimates of women diagnosed with AIDS adjusted for reporting delays and for redistribution of cases initially reported with no identified risk, but not for incomplete reporting. See Technical Notes.

Figure 11. Estimated pediatric AIDS incidence, by year of diagnosis, 1992 through 1998, United States¹



¹These numbers do not represent actual cases of children diagnosed with AIDS. Rather, these numbers are point estimates based on cases diagnosed using the 1987 definition, adjusted for reporting delays. The 1993 AIDS surveillance case definition change affected only the adult/adolescent cases, not pediatric cases.

Table 26. Estimated persons living with AIDS, by region of residence and year, 1993 through 1998, United States¹

Region of residence ²	Year					
	1993	1994	1995	1996	1997	1998
Northeast	51,833	59,414	66,315	73,568	81,872	89,123
Midwest	18,424	20,330	21,783	23,636	25,993	27,941
South	58,938	68,302	75,909	85,921	97,686	109,018
West	39,431	42,994	46,000	49,726	54,653	59,430
U.S. dependencies, possessions, and associated nations	5,743	6,353	6,803	7,338	8,149	8,912
Total³	174,369	197,393	216,810	240,189	268,353	294,424

¹These numbers do not represent actual cases of persons living with AIDS. Rather, these numbers are point estimates of persons living with AIDS derived by subtracting the estimated cumulative number of deaths in persons with AIDS from the estimated cumulative number of persons with AIDS. Estimated AIDS cases and estimated deaths are adjusted for reporting delays, but not for incomplete reporting. Annual estimates are through the most recent year for which reliable estimates are available. See Technical Notes.

²See Technical Notes for a list of states or U.S. dependencies, possessions, and associated nations which comprise each region of residence.

³Totals may vary between tables due to rounding.

Table 27. Estimated persons living with AIDS, by race/ethnicity and year, 1993 through 1998, United States¹

Race/ethnicity	Year					
	1993	1994	1995	1996	1997	1998
White, not Hispanic	80,445	86,678	91,737	98,544	107,110	114,846
Black, not Hispanic	60,649	71,847	81,317	92,319	105,464	117,890
Hispanic	31,209	36,485	41,071	46,216	52,215	57,722
Asian/Pacific Islander	1,288	1,451	1,613	1,856	2,093	2,324
American Indian/Alaska Native	566	664	718	804	893	978
Total²	174,369	197,394	216,812	240,189	268,353	294,425

¹These numbers do not represent actual cases of persons living with AIDS. Rather, these numbers are point estimates of persons living with AIDS derived by subtracting the estimated cumulative number of deaths in persons with AIDS from the estimated cumulative number of persons with AIDS. Estimated AIDS cases and estimated deaths are adjusted for reporting delays, but not for incomplete reporting. Annual estimates are through the most recent year for which reliable estimates are available. See Technical Notes.

²Totals include estimates of persons whose race/ethnicity is unknown. Totals may vary between tables due to rounding.

Table 28. Estimated persons living with AIDS, by age group, sex, exposure category, and year, 1993 through 1998, United States¹

Male adult/adolescent exposure category	Year					
	1993	1994	1995	1996	1997	1998
Men who have sex with men	86,720	95,171	101,717	111,076	122,874	133,840
Injecting drug use	34,465	40,153	44,589	49,074	54,249	58,843
Men who have sex with men and inject drugs	13,645	14,635	15,369	16,034	17,203	18,181
Hemophilia/coagulation disorder	1,618	1,698	1,728	1,742	1,788	1,838
Heterosexual contact	6,086	7,890	9,771	12,219	15,011	17,765
Receipt of blood transfusion, blood components, or tissue	918	947	1,008	1,083	1,189	1,313
Risk not reported or identified	1,015	969	969	1,011	1,064	1,133
Male subtotal	144,467	161,463	175,151	192,239	213,378	232,913
Female adult/adolescent exposure category						
Injecting drug use	13,793	16,175	18,294	20,285	22,586	24,500
Hemophilia/coagulation disorder	91	108	137	167	207	240
Heterosexual contact	11,829	15,140	18,524	22,588	27,017	31,336
Receipt of blood transfusion, blood components, or tissue	766	854	908	1,006	1,120	1,243
Risk not reported or identified	383	390	392	429	477	519
Female subtotal	26,862	32,667	38,255	44,475	51,407	57,838
Pediatric (<13 years old) exposure category	3,039	3,267	3,404	3,475	3,569	3,673
Total²	174,368	197,397	216,810	240,189	268,354	294,424

¹These numbers do not represent actual cases of persons living with AIDS. Rather, these numbers are point estimates of persons living with AIDS derived by subtracting the estimated cumulative number of deaths in persons with AIDS from the estimated cumulative number of persons with AIDS. Estimated AIDS cases and estimated deaths are adjusted for reporting delays and for redistribution of cases initially reported with no identified risk, but not for incomplete reporting. Annual estimates are through the most recent year for which reliable estimates are available. See Technical Notes.

²Totals may vary between tables due to rounding.

Table 29. Estimated deaths of persons with AIDS, by region of residence and year of death, 1993 through 1998, United States¹

Region of residence ²	Year of death					
	1993	1994	1995	1996	1997	1998
Northeast	14,017	15,829	15,837	11,590	6,749	5,235
Midwest	4,770	5,183	5,433	4,019	2,272	1,836
South	14,640	16,361	17,285	13,666	8,312	7,327
West	10,285	10,597	10,235	6,917	3,549	2,721
U.S. dependencies, possessions, and associated nations	1,559	1,750	1,699	1,548	969	722
Total	45,271	49,719	50,489	37,739	21,850	17,840

¹These numbers do not represent actual deaths of persons with AIDS. Rather, these numbers are point estimates adjusted for delays in the reporting of deaths, but not for incomplete reporting of deaths. Annual estimates are through the most recent year for which reliable estimates are available. See Technical Notes.

²See Technical Notes for a list of states or U.S. dependencies, possessions, and associated nations which comprise each region of residence.

Table 30. Estimated deaths of persons with AIDS, by race/ethnicity and year of death, 1993 through 1998, United States¹

Race/ethnicity	Year of death					
	1993	1994	1995	1996	1997	1998
White, not Hispanic	21,608	22,474	21,866	14,491	7,217	5,684
Black, not Hispanic	15,460	17,844	18,971	15,909	10,333	8,744
Hispanic	7,726	8,828	9,058	6,906	4,054	3,217
Asian/Pacific Islander	307	403	360	286	149	115
American Indian/Alaska Native	136	145	192	124	86	68
Total²	45,271	49,719	50,489	37,739	21,850	17,840

¹These numbers do not represent actual deaths of persons with AIDS. Rather, these numbers are point estimates adjusted for delays in the reporting of deaths, but not for incomplete reporting of deaths. Annual estimates are through the most recent year for which reliable estimates are available. See Technical Notes.

²Totals include estimates of persons whose race/ethnicity is unknown.

Table 31. Estimated deaths of persons with AIDS, by age group, sex, exposure category, and year of death, 1993 through 1998, United States¹

Male adult/adolescent exposure category	Year of death					
	1993	1994	1995	1996	1997	1998
Men who have sex with men	23,786	25,124	24,659	16,684	8,568	6,716
Injecting drug use	9,275	10,323	10,764	8,508	5,332	4,419
Men who have sex with men and inject drugs	3,153	3,451	3,389	2,564	1,421	1,183
Hemophilia/coagulation disorder	354	348	328	241	136	107
Heterosexual contact	1,582	1,987	2,362	2,085	1,447	1,221
Receipt of blood transfusion, blood components, or tissue	314	304	262	220	113	82
Risk not reported or identified	172	148	104	67	47	28
Male subtotal	38,637	41,684	41,869	30,369	17,066	13,755
Female adult/adolescent exposure category						
Injecting drug use	3,124	3,687	3,800	3,275	2,141	1,861
Hemophilia/coagulation disorder	17	26	29	30	21	16
Heterosexual contact	2,640	3,456	3,963	3,428	2,289	1,994
Receipt of blood transfusion, blood components, or tissue	237	228	229	174	96	75
Risk not reported or identified	75	55	58	34	20	16
Female subtotal	6,093	7,452	8,078	6,942	4,567	3,961
Pediatric (<13 years old) exposure category	541	582	541	429	218	124
Total	45,271	49,719	50,489	37,739	21,850	17,840

¹These numbers do not represent actual deaths of persons with AIDS. Rather, these numbers are point estimates adjusted for delays in the reporting of deaths and for redistribution of cases initially reported with no identified risk, but not for incomplete reporting of deaths. Annual estimates are through the most recent year for which reliable estimates are available. See Technical Notes.

Technical Notes

Surveillance of AIDS

All 50 states, the District of Columbia, U.S. dependencies and possessions, and independent nations in free association with the United States¹ report AIDS cases to CDC using a uniform surveillance case definition and case report form. The original definition was modified in 1985 (*MMWR* 1985;34:373-75) and 1987 (*MMWR* 1987;36[suppl. no. 1S]:1S-15S). The case definition for adults and adolescents was modified again in 1993 (*MMWR* 1992;41[no. RR-17]:1-19; see also *MMWR* 1995;44:64-67). The revisions incorporated a broader range of AIDS-indicator diseases and conditions and used HIV diagnostic tests to improve the sensitivity and specificity of the definition. The laboratory and diagnostic criteria for the 1987 pediatric case definition (*MMWR* 1987;36:225-30, 235) were updated in 1994 (*MMWR* 1994;43[no. RR-12]:1-19).

For persons with laboratory-confirmed HIV infection, the 1987 revision incorporated HIV encephalopathy, wasting syndrome, and other indicator diseases that are diagnosed presumptively (i.e., without confirmatory laboratory evidence of opportunistic disease). In addition to the 23 clinical conditions in the 1987 definition, the 1993 case definition for adults and adolescents includes HIV-infected persons with CD4⁺ T-lymphocyte counts of less than 200/ μ L or a CD4⁺ percentage of less than 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

The pediatric case definition incorporates the revised 1994 pediatric classification system for evidence of HIV infection. Children with their first positive results on Western blot or HIV detection tests before October 1994 were categorized based on the 1987 classification system. Those tested during or after October 1994 are categorized under the revised 1994 pediatric classification system. For children of any age with an AIDS-defining condition that requires evidence of HIV infection, a single positive HIV-detection test (i.e., HIV culture, HIV PCR, or HIV antigen [p24]) is sufficient for a reportable AIDS diagnosis if the diagnosis is confirmed by a physician.

¹Included among the dependencies, possessions, and independent nations are Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Republic of Palau, the Republic of the Marshall Islands, the Commonwealth of the Northern Mariana Islands, and the Federated States of Micronesia. The latter 5 comprise the category "Pacific Islands, U.S." listed in tables 1 and 2.

Although completeness of reporting of diagnosed AIDS cases to state and local health departments varies by geographic region and patient population, studies conducted by state and local health departments indicate that reporting of AIDS cases in most areas of the United States is more than 85% complete (*J Acquir Immune Def Syndr*, 1992;5:257-64, *Am J Public Health* 1992;82:1495-99, and *AIDS* 1999; 13:1109-14.). In addition, multiple routes of exposure, opportunistic diseases diagnosed after the initial AIDS case report was submitted to CDC, and vital status may not be determined or reported for all cases. However, among persons reported with AIDS, reporting of deaths is estimated to be more than 90% complete (*JAMA* 1996;276:126-31). CDC estimates approximately 3% of AIDS cases are duplicates based on matching of the national coded surveillance database.

Included in this report are persons known to be infected with human immunodeficiency virus type 2 (HIV-2). See *MMWR* 1995;44:603-06.

Surveillance of HIV infection

Through December 31, 1999, 33 areas had laws or regulations requiring confidential reporting by name of all persons with confirmed HIV infection, in addition to reporting of persons with AIDS. Connecticut, required reporting by name of HIV infection only for children less than 13 years of age; and Oregon required reporting for children less than 6 years of age. These states initiated reporting at various times after the development of serum HIV-antibody tests. Before 1991, surveillance of HIV infection was not standardized and reporting of HIV infections was based primarily on passive surveillance. Many cases reported before 1991 do not have complete information. Since then, CDC has assisted states in conducting active surveillance of HIV infections using standardized report forms and software. However, collection of demographic and risk information still varies among states.

HIV infection data should be interpreted with caution. HIV surveillance reports may not be representative of all persons infected with HIV since not all infected persons have been tested. Many HIV-reporting states offer anonymous HIV testing and home collection HIV test kits are widely available in the United States. Anonymous test results are not reported to state and local health departments' confidential name-based HIV registries. Therefore, confidential HIV in-

fection reports may not represent all persons testing positive for HIV infection. Furthermore, many factors may influence testing patterns, including the extent that testing is targeted or routinely offered to specific groups and the availability of and access to medical care and testing services. These data provide a minimum estimate of the number of persons known to be HIV infected in states with confidential HIV reporting.

A few states use codes in lieu of names to conduct surveillance for HIV infection. These data are not included in the HIV data tables pending evaluations demonstrating acceptable performance under CDC guidelines and the development of methods to report such data to CDC.

For this report, persons greater than 18 months of age were considered HIV infected if they had at least one positive Western blot or positive detection test (culture, antigen, or other detection test) or had a diagnosis of HIV infection documented by a physician. Before October 1994, children less than 15 months of age were considered HIV infected if they met the definition stated in the 1987 pediatric classification system for HIV infection (*MMWR* 1987;36:225-30, 235). Beginning October 1994, children less than 18 months of age are considered HIV infected if they meet the definition stated in the 1994 pediatric classification system for HIV infection (*MMWR* 1994;43[no. RR-12]:1-10). This report also includes children who were diagnosed by a physician as HIV infected. Although many states monitor reports of children born to infected mothers, only those with documented diagnosis of HIV infection are included in this report.

Because states initiated reporting on different dates, the length of time reporting has been in place will influence the number of HIV infection cases reported. For example, data presented for a given annual period may include cases reported only during a portion of the year. Prior to statewide HIV reporting, some states collected reports of HIV infection in selected populations. Therefore, these states have reports prior to initiation of statewide confidential reporting. A state with confidential HIV infection reporting also may report persons testing positive in that state who are residents of other states. Therefore, when HIV data are presented by state of residence, persons reported prior to the date a state initiated reporting may have been reported from other states with confidential HIV infection reporting.

Over time, persons with HIV infection will be diagnosed and reported with AIDS. HIV infection cases later reported with AIDS are deleted from the HIV infection tables and added to the AIDS tables. Persons with HIV infection may be tested at any point in the

clinical spectrum of disease; therefore, the time between diagnosis of HIV infection and AIDS will vary. In addition, because surveillance practices differ, reporting and updating of clinical and vital status of cases vary among states. Completeness of reporting for HIV is estimated to be more than 85% complete (*MMWR* 1998;47:309-14). CDC estimates approximately 2% of HIV cases are duplicates based on matching of the national coded surveillance database.

Tabulation and presentation of data

Data in this report are provisional. Each issue of this report includes information received by CDC through the last day of the reporting period. In the first part of the report, HIV and AIDS data are tabulated by date of report to CDC. In the second part of the report, data are statistically adjusted to correct for temporal delays in the reports of cases, deaths, and unreported risk/exposure data in order to improve the presentation of trends in the epidemic and the risk characteristics of affected populations. Data for U.S. dependencies and possessions and for associated independent nations are included in the totals.

Age group tabulations are based on the person's age at first documented positive HIV-antibody test for HIV infection cases, and age at diagnosis of AIDS for AIDS cases. Adult/adolescent cases include persons 13 years of age and older; pediatric cases include children under 13 years of age.

Tabulations of persons living with HIV infection and AIDS (table 1) include persons whose vital status was reported "alive" as of last update; persons whose vital status is missing or unknown are not included. Tabulations of deaths in persons with AIDS include persons whose vital status was reported "dead" as of last update; persons whose vital status is missing or unknown are not included. Caution should be used in interpreting these data because states vary in the frequency with which they review the vital status of persons reported with HIV infection and AIDS. In addition, some cases may be lost to follow-up.

Table 4 lists AIDS case counts for each metropolitan area with an estimated 1998 population of 500,000 or more. AIDS case counts for metropolitan areas with 50,000 to 500,000 population are reported as a combined subtotal. On December 31, 1992, the Office of Management and Budget announced new Metropolitan Statistical Area (MSA) definitions, which reflect changes in the U.S. population as determined by the 1990 census. These definitions were updated most recently on June 30, 1998. The cities and counties which compose each metropolitan area listed in

departments were conducted routinely for persons reported with AIDS and as resources allowed for persons reported with HIV infection. Therefore, the percentage of HIV infected persons with risk not reported or identified is substantially higher than for those reported with AIDS.

Because recently reported AIDS cases are more likely to be reported as NIR, recent AIDS incidence in some exposure categories will be underestimated unless an adjustment is made. For estimated AIDS incidence tables and estimated AIDS trends figures, the adjustment of NIR adult/adolescent cases is based on sex-, race-, and region-specific exposure category redistributions of cases diagnosed from 1990 through 1997 that were initially assigned to the NIR category but have subsequently been reclassified. Similar adjustment of NIR pediatric cases are based on exposure category redistribution of all cases diagnosed between 1990 through 1997 and subsequently reclassified. See *J Acquir Immune Def Syndr*, 1992;5:547-55 and *J Acquir Immune Def Syndr*, 1997;14:465-74.

Trends in AIDS incidence

Because of the temporary distortion caused by the 1993 expansion of the case definition, trends in AIDS incidence were estimated by statistically adjusting cases reported based on the criteria added to the case definition in 1993. This adjustment estimated when persons reported on the basis of immunologic criteria ($CD4^+$ T-lymphocytes counts less than $200/\mu L$ or percentage less than 14) would develop an AIDS-related opportunistic illness (AIDS-OI), and thereby approximated trends in AIDS-OI incidence as if the case definition had not changed (*J Acquir Immune Defic Syndr* 1997;16:116-21). However, by the end of 1996, the temporary distortion caused by reporting prevalent as well as incident cases that met criteria added in 1993 had almost entirely waned. In addition, after the end of 1996, the incidence of AIDS-OIs could no longer be reliably estimated because data are not currently available to model the increasing effects of therapy on rate of disease progression. Therefore, from 1996 forward, trends in AIDS incidence will be adjusted for reporting delay, but not for the 1993 expansion of the case definition. These trends represent the incidence of AIDS (1993 criteria) in the population and represent persons newly diagnosed with HIV at the time of AIDS, those identified with HIV who did not seek or receive treatment, and those for whom treatment has failed. Thus, despite the effects of treatment on AIDS incidence, AIDS incidence remains an important measure of the impact and need for resources for the severely ill.

Reporting delays

Reporting delays (time between diagnosis of HIV infection or AIDS and report to CDC) may vary among exposure, geographic, racial/ethnic, age, and sex categories, and have been as long as several years for some AIDS cases. About 50% of all AIDS cases were reported to CDC within 3 months of diagnosis and about 80% were reported within 1 year. Among persons with AIDS, estimates in delay of reporting of deaths show that approximately 90% of deaths are reported within 1 year. For HIV infection cases diagnosed since implementation of uniform reporting through the HIV/AIDS reporting system on January 1, 1994, about 70% of all HIV infection cases were reported to CDC within 3 months of diagnosis and about 95% were reported within 1 year. See *MMWR* 1998;47:309-14.

Reporting delay adjustments to estimated AIDS data are calculated by a maximum likelihood statistical procedure, taking into account differences in reporting delays among exposure, geographic, racial/ethnic, age, sex, and vital status categories, but assuming that reporting delays within these groups have not changed over time (*Statist Med* 1998;17:143-54 and *Lecture Notes in Biomathematics* 1989;83:58-88).

Rates

Rates are calculated for the 12-month period per 100,000 population for AIDS cases. Population denominators for computing AIDS rates for the 50 states and the District of Columbia are based on official post-census estimates from the U.S. Bureau of Census. Denominators for U.S. dependencies and possessions and associated independent nations are based on official postcensus estimates from the U.S. Bureau of the Census International Database. Each 12-month rate is the number of cases reported during the 12-month period, divided by the 1998 or 1999 population, multiplied by 100,000. The denominators used for computing the table of race-specific rates (year-end edition only) are based on 1999 census estimates published by the U.S. Bureau of Census: "National Population Estimates for the 1990's. Monthly Post-censal Resident Population, by single year of age, sex, race and Hispanic origin"; (<http://www.census.gov/population/estimatesnation/e90s/e9999rmp.txt>). Race-specific rates are the number of cases reported for a particular racial/ethnic group during the preceding 12-month period divided by the projected population for that race/ethnicity, multiplied by 100,000.