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WOMEN

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WOMEN

OVERVIEW OF CURRENT STATISTICAL DATA REGARDING WOMEN AND HIV
(AS OF SEPTEMBER 1997)

GENERAL INFORMATION

AIDS PREVALENCE: Women now account for 20% of all adults with AIDS in the United States, compared to 42% globally (AP). As of January 1996, 70,000 American women have been diagnosed as having AIDS; as many as three times that number are HIV+ (Journal of the American Medical Association (JAMA)).

AIDS INCIDENCE: After rising an average of 2% per year between 1992 and 1995, AIDS incidence among all persons dropped by 6% from 1995 to 1996 (AP). While among men the decrease was even more substantial at 8%, *among women AIDS incidence actually increased by 2%.* This follows a 68% increase between 1991 and 1995 --- *this increase is more than any other group of persons reported as having AIDS, regardless of race or mode of exposure to HIV*, leaving women the fasting growing group with AIDS in the United States (CDC).

AIDS-RELATED DEATHS: Between 1995 and 1996 there was a 23% decrease in the number of AIDS related deaths among all persons; among women there was a 10% decrease (CDC). The decrease in the morbidity rate among AIDS patients is attributed primarily to effective drug therapy combing protease inhibitors, such as Crixivan and Norvir, with reverse transcriptase inhibitors, such as AZT.

STATISTICAL BREAKDOWNS

RACE/ETHNICITY: The distribution of cases of AIDS reported among women in 1996 is as follows: 57% Black, 22% White, 20% Hispanic (JAMA).

MODE OF TRANSMISSION (JAMA):

- Through the 1980's, AIDS spread among women primarily through the sharing of needles. IDU (Injection Drug Use)-related cases have slowed since 1992, leaving heterosexual contact the major source of infection among women.
- 52% of cases reported in 1996 were due to heterosexual contact; 43% stemmed from IDU.
- Among IDU women, AIDS incidence decreased by 4% between 1995 and 1996. Among women who were infected by heterosexual contact, incidence increased by 7% over the same period.
- Heterosexual transmission was attributed mostly to sex with an HIV infected partner of unreported risk (53%) and sex with an IDU (38%).

REGION: The Southern and Northeastern regions of the country account for the far majority of female AIDS cases. In 1996, the Northeast retained the greatest portion of newly reported cases, 44%, while the South provided 38% (JAMA). *Increase in incidence rates among women in the South, however, is the highest in the nation.*

ENVIRONMENT: 74% of AIDS cases reported among women in 1996 were in metropolitan areas consisting of more than 1 million people; 20% were in areas in which the population ranged from

50,000 to 1 million (JAMA).

BIRTH COHORT (JAMA):

- Injection drug users: 48% of IDU-related cases in 1996 were among women born between 1950 and 1959. 35% were among women born between 1960 and 1969.
- Heterosexual contacts: 40% of the 1996 case distribution were among women born between 1960 and 1969, 33% among women born between 1950 and 1959. *Since 1991, however, there has been a sharp increase in heterosexually infected women born between 1970 and 1971.*

PRENATAL TRANSMISSION (AP):

- Approximately 2000 HIV+ babies are born in the United States each year (5 each day).
- There are 40% more AIDS cases solely among children under 5 (HIV incurred at birth) than among all people ages 5 to 19.
- There is a 25% probability that an HIV+ woman will transmit the virus to her unborn child. *Treatment with AZT can reduce that likelihood to 5%.*

http://www.cdcnac.org/abstracts/women.html

Research Offers Best Promise for Female-Controlled HIV Prevention

Women account for an increasing proportion of newly reported AIDS cases in the United States. The proportion of female adult and adolescent AIDS cases increased from 7% of the annual total in 1985 to 19% in 1995. Overall, estimated AIDS incidence is increasing most rapidly among people infected heterosexually. Between 1993 and 1994, heterosexually-acquired AIDS incidence increased 17%. During that time, the annual rate of increase among men actually slowed, to 5%. But the annual rate of increase among women was 10%.

Trends like this point to the ongoing importance of female-controlled HIV protection. CDC researchers are working with scientists worldwide to evaluate the effectiveness of female condoms and to develop effective topical microbicides that can kill HIV and the pathogens that cause other STDs. As with any new tool for prevention, scientists must also determine what influences people's willingness and ability to use these methods. CDC behavioral scientists are simultaneously working to evaluate the factors that will contribute to women's use of these products and how these new prevention methods can and should be balanced with existing prevention options.

Biomedical and Behavioral Research: Prevention Building Blocks

CDC has a broad array of behavioral and biomedical research on determinants of transmission of HIV and STD in women and prevention methods. Among the biomedical research being conducted are studies that examine:

- HIV in cell-free and cell-associated cervicovaginal secretions
- HIV infectivity by contraceptive method
- Clinical trials of microbicide-containing gel
- Risk factors for cervicovaginal HIV shedding and the effect of STD treatment on shedding
- The efficacy of the female condom
- Natural history of HIV disease in women

Behavioral researchers are seeking to better understand the social and individual factors that influence women's sexual risk behaviors, and thus how to best design and deliver community-wide interventions that advance women along the continuum of behavior change. Research topics include:

- Determinants of female condom use
- The effectiveness of hierarchical prevention messages for women of color (African-Americans and Latinas) within a framework of prevention choices, from safest (abstinence) to safer (using a condom with sexual partners) to less safe (using spermicide only)
- How socially disadvantaged women communicate about sex and sexual risk reduction, and how that affects their acceptance, short-term use, and personal and partner reactions to the female condom
- Acceptability of nonoxynol-9 to women
- Women's preferences among spermicide formulations (film, foam, suppositories, tablets, jelly)

A Closer Look at Topical Microbicide Research

Microbicides are chemical compounds that can kill HIV and other sexually transmitted pathogens, such as herpes, chlamydia, syphilis, gonorrhea, and human papilloma virus. Microbicides are most often talked about in the context of female-controlled prevention methods, but they may also be able to be used by men who have sex with men.

Several steps are involved in putting any new product into people's hands. The U.S. Food and Drug Administration (FDA) is the licensing and regulatory agency, and works with CDC to share information and develop policies related to new technologies. Product development and testing can take many years, as each of the following steps is completed:

- *Pre-clinical Testing* -- New products are typically tested on animals for safety and biologic activity. To gauge effectiveness, a consistent set of laboratory standards is needed; in the case of microbicides, HIV infectivity assays may be more useful than other measures. If the product is shown to be safe for animals and effective, human studies are conducted.
- *Phase I* -- In addition to examining human safety, dosage and toxicity are often determined by having a few healthy people use the product. These trials are limited, and may not include participants who share characteristics of the product's target population -- for example, sexually active women who have a history of STDs.
- *Phase II* -- The product is used by a larger number of subjects to study dosage, toxicity, possible side effects, and other factors.
- *Phase III* -- Tests on large numbers of volunteers, usually thousands, to verify Phase II results and monitor long-term side effects. To measure the disease reduction effect, volunteers are usually people at higher risk for disease than those who took part in Phase I or II testing.

Even with *expedited review*, in which the second and third phases are combined, microbicide development and testing could

take as long as 5-10 years.

In the interim, continued research into existing microbicide products other biomedical options and behavioral research on women's knowledge, attitudes, beliefs, and actions related to HIV/AIDS, sexual activity, substance use, and related factors will be vital to developing a constellation of effective prevention choices. As research sheds light on prevention, CDC will continue to provide communities with the information they need to create, deliver, and evaluate programming for women and others.

For more information on women and HIV, see these companion documents: **HIV and AIDS Trends**; **CDC's Role in HIV Prevention: Research and Support for Community Action**; **Mother-to-Child HIV Transmission Decreases in the U.S. But Challenges Remain To Perinatal Prevention**; **The Control of Sexually Transmitted Diseases as an HIV Prevention Strategy**; and **Developing Health Skills for a Lifetime: CDC's Role in Preventing HIV Infection Among Young Americans**.

Women/Microbicide Presentations in Vancouver

Oral

Heterosexual Risk for HIV among Puerto Rican Women: Does Power Influence Self-protective Behavior? Harrison, Janet S.

HIV Prevalence among U.S. Childbearing Women, 1989-1994, Susan Fischer Davis.

Declining Prevalence of Gonorrhea (GC) and Chlamydia (CT) in Female Sex Workers (FSW), Chiang Rai, Thailand, 1991-94, Peter H. Kilmarx.

Risk of HIV Transmission During The Seroconversion Period, Ann Duerr.

Poster

Methodologic Issues in Microbicidal Development, Margaret Scarlett, Ann Duerr.

Predicting Contraceptive Use among Women at Risk for or Infected with HIV, Christine Galavotti.

Breastfeeding Among HIV-Infected Women, Los Angeles and Massachusetts, 1988-1993, Jeanne Bertolli.

Who Uses HIV Prevention Counseling for Women? Bobby Milstein

Involving the Community: A Model for Community-level HIV Prevention Activities, Bobbie Person.

Prevalence of High-Risk Sexual Behavior among HIV-Infected Women, Tedd V. Ellerbrock.

Risk Factors for HIV Seroconversion among Young Women in a Rural Community in the Southeastern United States, Kenneth L. Dominguez.

High Prevalence of Abnormal Vaginal Flora And Bacterial Vaginosis in Women With or at Risk For HIV Infection, Dora Warren.

Direct Assessment of Physical Barrier Method Failure Using A Self-Sampling Technique, Amy S. Bloom.

Estimating Factors Influencing Acceptance and Adherence to Zidovudine Treatment to Prevent

Vertical Transmission of HIV, Brenda F. Seals.

Geographical Variation of AIDS Associated Kaposi's Sarcoma (KS) in Europe, Shahul H. Ebrahim.

Lack Of Timely Prenatal Care Among Women Infected With HIV: Implications For Prevention Of Perinatal HIV Transmission In The United States, Anna Shakarishvili.

Perinatal Zidovudine Use after Perinatal ZDV Recommendations in the United States, Sherry L. Orloff.

Trends in HIV Seropositivity Among Clients Attending Publicly Funded HIV Counseling and Testing Sites Across the U.S.A., 1990--1994, Ronald Valdiserri.

HIV Seroincidence Among Persons Attending Sexually Transmitted Disease Clinics In The United States, 1988-1995, Hillard Weinstock.

Association of Penicillin Mass Treatment Program with Sexually Transmitted Diseases among Female Sex Workers in

http://www.cdcnac.org/abstracts/women.html

Indonesia, M. Riduan Joesoef.

Preventing Perinatal HIV Infection: Costs And Effects Of A Recommended Intervention In The U.S., Paul G. Farnham.

Sexual Involvement with Older Men: HIV-Related Risk Factors for Adolescent Women, Bonita Westover.

Risk Factors for Pneumocystis Carinii Pneumonia: Delayed Diagnosis of HIV-infection and Failure to Receive Prophylactic Therapy, Jeffrey S. Duchin.

The HIV Outpatient Study (HOPS) Description and Initial Findings, Scott D. Holmberg.

Detection of Phylogenetically Linked HIV Strains Among a Population of Epidemiologically Unrelated Women, Marcia L. Kalish.

Analysis of Genetic Diversity of HIV-1 in Cote D'Ivoire Using Restriction Fragment Length Polymorphism (Rflp) Analyses, John Nkengasong.

Mother-to-Child HIV Transmission Decreases in the U.S. But Challenges Remain For Perinatal Prevention

As the lead federal agency for preventing HIV, CDC has several key responsibilities: surveillance of the American epidemic; biomedical and behavioral prevention research; support of prevention programs and provision of technical assistance; evaluation of what works; strategic communications; and HIV/AIDS prevention technical assistance to states and communities. Recent reductions in mother-to-child, or perinatal, HIV transmission reflect the effectiveness of this multi-level prevention strategy. Challenges remain -- chief among them the need to ensure pregnant women have prenatal care early in pregnancy and can sustain care throughout pregnancy and beyond.

Increasing Impact on Women

Through December 1994, CDC received reports of 58,428 cumulative cases of AIDS among adult and adolescent women (13 years of age and older) in the U.S. Women account for more and more AIDS cases--they were only 7% of all AIDS cases in 1985, but jumped to 19% in 1995. AIDS is now the third leading cause of death among women 25-44. And AIDS is actually increasing faster in women than it is in men. In 1994 alone, 14,081 women were reported with AIDS. Women of childbearing age account for the vast majority of those cases: 84% were reported in women 15-44 years old. In 1993, an estimated 7,000 HIV-positive women gave birth in the U.S., or about 1 in every 625 births. Not every baby born to an infected mother is also infected. In fact, without preventive treatment, the mother-to-child transmission rate was 15-30%, or about 1,000-2,000 infants in 1993.

In 1994, clinical trials in the U.S., Canada, and France conducted by America's National Institutes of Health and France's National Institute of Health and Medical Research (INSERM) showed that some HIV-infected women could reduce the risk of transmitting the virus to their babies by as much as two-thirds by taking zidovudine (ZDV or AZT) during pregnancy, labor and delivery, and by giving their babies AZT for the first 6 weeks after birth. In 1994, CDC issued guidelines for using AZT during pregnancy and, in 1995, published guidelines for routinely counseling all pregnant women about HIV and offering them an HIV test.

What's Working To Prevent Mother-to-Child Transmission

The guidelines for routine counseling and voluntary testing, coupled with AZT treatment if the mother is HIV infected, are showing positive effects on the American perinatal transmission rate.

Among women in CDC's Perinatal AIDS Collaborative Transmission Study (PACTS), AZT use increased following the publication of CDC guidelines. In 1994, after the guidelines were published, the women and children enrolled in PACTS had an 11% rate of perinatal transmission

-- down from 21% before the guidelines, and lower than ever before. And the effect of other factors on mother-to-child transmission -- such as the mother's stage of AIDS and CD+4 count, and the elapsed time from rupture of membranes (water breaking) to delivery -- is becoming more clear, making early and sustained prenatal care vital to preventing perinatal transmission.

Prenatal Care Is Vital To Preventing Perinatal Transmission

Related studies by CDC researchers address the role of other factors, particularly prenatal care, in reducing mother-to-child transmission and pediatric AIDS.

> Behavioral research demonstrates that the majority of women infected with HIV are interested in AZT treatment during pregnancy and for their children after birth. But women's interest and commitment to adhering to the AZT treatment regimen seems particularly sensitive to obstetricians' attitudes, underscoring the importance of educating health care providers about the benefits of AZT during pregnancy.
>
> Another study shows that AZT use has increased since the publication of CDC's treatment guidelines, but, early on, was variable by hospital. Researchers examined AZT rates in hospitals in the New York City area, Atlanta and Baltimore and found that usage ranged from 33% of enrolled mothers to 90%, depending on the hospital and the populations it served. The lowest rates of AZT use were among women who used cocaine during pregnancy and women with fewer AIDS-related illnesses. Researchers continue to examine usage rates to determine their increase over time, and to determine health care workers' and pregnant women's attitudes to treatment regimens.
>
> Researchers are studying the association of HIV transmission and no or late prenatal care with demographic, social, and other characteristics of infected women in Texas. The data show that some women receive very late or no prenatal care and that lack of timely care is associated with drug use, having less than 12 years of education and being unmarried. To further reduce perinatal HIV transmission and other adverse pregnancy outcomes, comprehensive interventions to increase early prenatal care are needed.

Related behavioral research shows breastfeeding is much more common -- though still rare, at less than 1% -- among women whose HIV infection is not known before delivery. In contrast, infected women who received comprehensive prenatal care, including counseling and voluntary HIV testing, were less likely to breastfeed their babies.

Routine Counseling, Voluntary Testing, and AZT Are Cost-Effective

Economic analysis shows that prenatal care, including HIV counseling and testing and AZT for infected mothers and their children, is cost effective. Without intervention, a 25% mother-to-infant transmission rate would result in 1,750 HIV-infected infants annually in the U.S., and lifetime medical costs of $282 million. Researchers estimated the cost of intervention at $67.6 million, preventing 656 infant HIV infections and a savings of $105.6 million in medical care costs, and a net cost-savings of $38.1 million. These results strongly support routine counseling, voluntary testing, and AZT use.

It is possible that these savings could be increased, if research shows a shorter course of ZDV during pregnancy is just as effective. Several clinical trials of short-course ZDV during pregnancy are underway in sub-Saharan Africa. In developing countries, the extensive ZDV course used in the U.S. is not feasible. If it can be demonstrated that a short course works, it will be a promising advance for addressing the terrible toll perinatal transmission takes internationally. A model presented by a CDC researcher indicates that a national perinatal HIV prevention program in most sub-Saharan African countries would reduce transmission and provide significant societal savings, after the substantial initial investment in public health infrastructure and drugs.

PERINATAL PRESENTATIONS IN VANCOUVER

Oral

Cost Effectiveness of Short-Course Zidovudine to Prevent Perinatal Human Immunodeficiency Virus Type-1 Infection in a Sub-Saharan African Developing Country Setting, Gordon Mansergh.

Declining Mother-to-child HIV Transmission Following Perinatal Zidovudine Recommendations, United States, R. J. Simonds.

Perinatal HIV Transmission Risk and the Effect of Pregnancy or Infant Zidovudine Use in a Multicenter Study, 1994-1995, Richard W. Steketee.

Poster

Breastfeeding Among HIV-Infected Women, Los Angeles and Massachusetts, 1988-1993, Jeanne Bertolli.

Early Diagnosis of Perinatal HIV Infection Comparing DNA-Polymerase Chain Reaction and Plasma Viral RNA Amplification, Teresa M. Brown.

Preventing Perinatal HIV Infection: Costs And Effects Of A Recommended Intervention In The U.S., Paul. G. Farnham.

Detection of Phylogenetically Linked HIV Strains Among a Population of Epidemiologically Unrelated Women, Marcia L. Kalish.

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HOUSING

Divider Title: _____

HOUSING

HOPWA Formula Allocations in FY 1997

Resources for Long-Term Comprehensive Strategies to Provide Housing and Related Services for Persons Living with HIV or AIDS

Office of Community Planning and Development
U.S. Department of Housing and Urban Development

The Housing Opportunities for Persons with AIDS (HOPWA) program provides annual formula-based allocations to metropolitan areas and States as resources for devising long-term comprehensive strategies for meeting the housing needs of low-income persons with HIV/AIDS and their families. Eligible formula areas have at least 1,500 cumulative reported cases of AIDS, as of March 31, and metropolitan areas have a population of at least 500,000. Statistics from the Centers for Disease Control and Prevention on cumulative cases and area incidence are used in making formula calculations.

In FY 1997, 80 jurisdictions qualified to receive formula grants, including 53 Eligible Metropolitan Statistical Areas (EMSAs) and 27 States. The recipient is the State or, for the EMSA, the most populous city in that area, which is the first jurisdiction named in the EMSA title listed below (except as noted). State grants are for areas that are outside of any EMSA in the State. These funds are made available to communities through the area's consolidated plan process.

The FY 1997 HUD appropriation provided a total of $196 million for the HOPWA program of which ninety percent, $176.4 million, is used for formula allocations to eligible jurisdictions. The remaining ten percent, $19.6 million, is reserved for a national competition which will be announced by a NOFA at a later date. The allocations listed below are the final amounts available under the appropriation act and include the transfer of $25 million to the HOPWA account from funds that were recaptured in the Department's Annual Contributions Account for Assisted Housing. These amounts were released on December 6, 1996 and replace the original allocations that were announced in notification letters of November 18, 1996.

This chart also notes (by *) that the State of Delaware, Columbus OH, Memphis TN, Nashville TN, and Richmond VA, will be newly eligible for formula allocations in FY 1997; the four new EMSAs reduce the service areas of four prior State grantees (AR, MS, OH and TN) and Virginia is not eligible for formula funds in FY 1997.

1997 Formula Grantee	Allocation (in 000s)	Grant Number
New England Region		
Connecticut (outside of the Hartford and New Haven EMSAs)	792	CT26H97-F001
Hartford CT MSA	1,020	CT26H97-F002
New Haven-Meriden CT PMSA	969	CT26H97-F003
Massachusetts (outside the Boston EMSA)	1,052	MA06H97-F004
Boston MA-NH PMSA	1,803	MA06H97-F005

1997 Formula Grantee	Allocation (in 000s)	Grant Number
New York, New Jersey Region		
New Jersey (outside of 6 EMSAs)	729	NJ39H97-F006
Paterson for Bergen-Passaic NJ PMSA	1,218	NJ39H97-F007
Jersey City NJ PMSA	2,644	NJ39H97-F008
Woodbridge for the Middlesex-Somerset-Hunterdon NJ PMSA	617	NJ39H97-F009
Dover Township for the Monmouth-Ocean NJ PMSA	554	NJ39H97-F010
Newark NJ PMSA	5,597	NJ39H97-F011
New York State (outside the New York City and Nassau EMSAs)	2,301	NY36H97-F012
Islip for the Nassau-Suffolk NY PMSA	1,205	NY36H97-F013
New York NY PMSA	41,829	NY36H97-F014
Mid-Atlantic Region		
Delaware *	410	DE26H97-F015
Pennsylvania (outside the Philadelphia and Pittsburgh EMSAs)	948	PA26H97-F016
Philadelphia PA-NJ PMSA	3,118	PA26H97-F017
Pittsburgh PA MSA	459	PA28H97-F018
Richmond-Petersburg VA MSA *	429	VA36H97-F019
Virginia Beach for the Norfolk-Virginia Beach-Newport News VA-NC MSA	556	VA36H97-F020
Baltimore MD PMSA	3,596	MD06H97-F021
Washington DC-MD-VA-WV PMSA	4,383	DC39H97-F022
Southeast Region		
Alabama	986	AL09H97-F023
Florida (outside of 6 EMSAs)	2,808	FL29H97-F024
Fort Lauderdale FL PMSA	3,979	FL29H97-F025
Jacksonville FL MSA	949	FL29H97-F026
Miami FL PMSA	8,832	FL29H97-F027
Orlando FL MSA	1,352	FL29H97-F028
Tampa-St Petersburg-Clearwater FL MSA	1,493	FL29H97-F029
West Palm Beach-Boca Raton FL MSA	2,622	FL29H97-F030
Georgia (outside the Atlanta EMSA)	1,106	GA06H97-F031
Atlanta GA MSA	4,090	GA06H97-F032

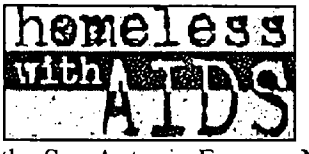
1997 Formula Grantee	Allocation (in 000s)	Grant Number
Kentucky	494	KY36H97-F033
Mississippi (outside the Memphis MSA)	641	MS26H97-F034
North Carolina (outside the Norfolk EMSA)	1,707	NC19H97-F035
Puerto Rico (outside the San Juan EMSA)	1,619	PR46H97-F036
San Juan-Bayamon PR PMSA	4,559	PR46H97-F037
South Carolina	1,453	SC16H97-F038
Tennessee (outside the Memphis and Nashville MSAs)	448	TN37H97-F039
Memphis, TN-AR-MS MSA *	450	TN37H97-F040
Nashville, TN MSA *	397	TN37H97-F041
Midwest Region		
Illinois (outside of the Chicago and St. Louis EMSAs)	467	IL06H97-F042
Chicago IL PMSA	3,805	IL06H97-F043
Indiana (outside the Indianapolis MSA)	535	IN36H97-F044
Indianapolis IN MSA	524	IN36H97-F045
Michigan (outside the Detroit EMSA)	603	MI28H97-F046
Detroit MI PMSA	1,374	MI28H97-F047
Minneapolis-St Paul MN-WI MSA	636	MN46H97-F048
Ohio (outside the Cleveland and Columbus EMSAs)	1,027	OH16H97-F049
Cleveland-Lorain-Elvyria OH PMSA	592	OH16H97-F050
Columbus, OH MSA *	429	OH16H97-F051
Wisconsin (outside the Minneapolis EMSA)	668	WI39H97-F052
Southwest Region		
Arkansas (outside the Memphis MSA)	489	AR37H97-F053
Louisiana (outside the New Orleans EMSA)	883	LA48H97-F054
New Orleans LA MSA	1,737	LA48H97-F055
Oklahoma	650	OK56H97-F056
Texas (outside of 5 EMSAs)	1,709	TX21H97-F057
Dallas TX PMSA	2,640	TX21H97-F058
Fort Worth-Arlington TX PMSA	582	TX21H97-F059
Houston TX PMSA	3,316	TX21H97-F060
Austin-San Marcos TX MSA	704	TX59H97-F061
San Antonio TX MSA	709	TX59H97-F062

1997 Formula Grantee	Allocation (in 000s)	Grant Number
Great Plains Region		
Kansas City MO-KS MSA	781	MO16H97-F063
St. Louis MO-IL MSA	843	MO36H97-F064
Rocky Mountain Region		
Denver CO PMSA	1,126	CO08H97-F065
Pacific/Hawaii Region		
Phoenix-Mesa AZ MSA	851	AZ39H97-F066
Hawaii	474	HI08H97-F067
Las Vegas NV-AZ MSA	554	NV39H97-F068
California (outside of 8 EMSAs)	2,229	CA39H97-F069
Oakland CA PMSA	1,584	CA39H97-F070
Sacramento CA PMSA	613	CA39H97-F071
San Francisco CA PMSA	9,412	CA39H97-F072
San Jose CA PMSA	616	CA39H97-F073
Los Angeles-Long Beach CA PMSA	10,102	CA16H97-F074
Santa Ana for the Orange County CA PMSA	1,082	CA16H97-F075
Riverside-San Bernardino CA PMSA	1,230	CA16H97-F076
San Diego CA MSA	2,101	CA16H97-F077
Northwest/Alaska Region		
Portland-Vancouver OR-WA PMSA	758	OR16H97-F078
Washington State (outside of the Seattle and Portland EMSAs)	434	WA19H97-F079
Seattle-Bellevue-Everett WA PMSA	1,317	WA19H97-F080
1997 Formula Total	176,400	80 Grantees

Notes: Allocations to 80 jurisdictions are made to 53 cities on behalf of their metropolitan areas and to 27 States for areas outside of qualifying metropolitan areas. The five first-time FY97 HOPWA grantees are noted by (*). This allocation is based on the amount designated for HOPWA under the "Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1997," Pub. L. 104-204, approved September 26, 1996.

For More Information: *Contact the HUD State or area office or the Office of HIV/AIDS Housing, U.S. Department of Housing and Urban Development, 451 Seventh Street, SW, Room 7154, Washington, D.C. 20410, phone (202) 708-1934; TTY 1-800-877-8339, FAX: (202) 708-1744. Descriptions of area consolidated plans and HOPWA competitive grants and information on other HUD programs are available on the HUD HOME Page on the World Wide Web at http://www.hud.gov/home.html.*

Express-News Online Special Feature



In a five-day series, the San Antonio Express-News continues its comprehensive investigation into the spread of HIV and the growing AIDS crisis in a marginalized population: the homeless.

Day 1

- **Homeless-AIDS a problem that hides in plain sight**
- **The nurse**

Day 2

- **Often AIDS is secondary to finding a place to sleep**
- **Cowboy**

Day 3

- **AIDS drugs offer hope but new treatments for homeless raise questions**
- **Randy**

Day 4

- **Settling an unsettled problem**
- **Ed**

Day 5

- **Leaders demand action**
- **Mario**

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Express-News Online Special Feature

Homeless-AIDS a problem that hides in plain sight

By Marina Pisano
Express-News Staff Writer

It's a rainy, bleak day, but it's even bleaker under the expressway bridge near Josephine Street - a nether world of smashed wine bottles, supermarket carts, broken furniture and scraps of clothing arranged with odd neatness.

Photo by Gloria Fermiz
A homeless HIV-positive woman, who was once a surgical nurse and does not want her face shown, walks amid her space under a San Antonio highway bridge.

Suddenly, a mound of grimy blankets stirs. A woman with sleep-tangled blond hair emerges from the black folds, grinning and smoothing out the ancient, stained mattress under her.

This is private space, "home" for the 40-year-old former surgical nurse. She ignores the disheveled boyfriend who has just joined her, ignores the nerve-jarring vibration and loud rumble of highway traffic overhead - and reveals she has HIV, the virus that causes acquired immune deficiency syndrome.

With a fatalism nourished by Thunderbird wine and the streets, she refuses to go to a shelter. And she refuses AIDS drugs, saying they make people sick. Meanwhile, the virus batters her frail body.

She accepts her prognosis with a raspy laugh and a shrug.

"I'll probably die right here under the bridge."

The nurse has plenty of company - people living and dying on the edge.

Homeless Americans have become a growing repository of HIV, spreading the virus into a marginalized segment of the population. They have limited access to treatment to improve their lives and prevention to limit exposure to others.

In San Antonio, HIV has spread to almost 2,800 homeless people, a whopping 16 percent of the total homeless population of 17,274, according to the city Department of Community Initiatives.

The number of homeless people with the virus represents 25 percent of more than 11,000 HIV cases in San Antonio. About 1,400 San Antonians suffer full-blown AIDS.

Estimates for the number of homeless people infected nationwide range from as low as 5 percent to 21 percent in some cities, according to studies by independent researchers, the Centers for Disease Control and Prevention and the federal health and housing departments.

Among the general population, the infection rate is less than 1 percent.

"Anyone who can't see the public-health issues in this has got his head in the ground," says Don Maison, founding executive director of AIDS Services of Dallas.

The grim scene under bridges and in alleys of American cities contrasts with rising hope among other HIV carriers for a life prolonged by a new class of drugs. For many homeless, those treatments are as far out of reach as a brick bungalow in the suburbs.

Often scorned by other street people and isolated from families and friends, many HIV-infected homeless are not only sick and malnourished, but sexually promiscuous, hooked on drugs or alcohol and mentally ill - all barriers to controlling the epidemic.

To many who assist the homeless, it's hard to look at the infected, multiple-diagnosed homeless and fragmented public services and not think the proverbial sky is falling.

"Sometimes you have to say that to get people's attention," says Dr. Andrew Moss, principal researcher in a seven-year study of infected homeless people at the University of California's San Francisco General Hospital. "But the sky isn't falling.

"The sky already fell."

Outlook dim

Public health and housing agencies have taken notice and are spending more money to corral the street epidemic. But the overall outlook remains discouraging:

- Researchers fear welfare reform will increase the rolls of the homeless, a surge that could coincide with more HIV infections caused by relaxed attitudes toward the virus. San Antonio's homeless population rose 5 percent from 1995 to 1996.
- Most medical treatment for the homeless comes from hospital emergency rooms, drop-in community clinics or the jail infirmary - if they receive any at all.
- Most cities suffer a shortage of transitional and long-term public housing, a gap experts say is the greatest single barrier to effective care of the HIV-infected homeless.In San Antonio, only 25 emergency shelter beds are specifically set aside for homeless-HIV/AIDS patients (at Casa Martin), and only a few of 24-hour beds are available in other shelters for people too sick to be on the street all day.
- As HIV gains ground on the street, so do opportunistic diseases such as tuberculosis. And TB - highly contagious through coughing and sneezing - could be a potential problem for the mainstream population.

Infectious-disease specialists differentiate between TB infection and TB disease, noting that not all who carry the infection develop the disease. But studies show HIV infection is the strongest-known risk factor for the development of TB disease in such carriers.

"Homeless people with AIDS are much more likely to get TB, and

TB is more easily transmitted than HIV. Lately, there's also more concern about drug-resistant TB," says Dr. Dennis Culhane, associate professor of social work and public policy at the University of Pennsylvania, who is studying the infected homeless in Philadelphia.

Dr. Fernando Guerra, director of the San Antonio Metropolitan Health District, estimates up to 10 percent of the homeless carry TB, compared with 4 percent in the population overall.

Researchers fear far-reaching implications.

"This (AIDS) is an epidemic, and you can't control its transmission when people are transient and homeless," Culhane observes.

Photo by Gloria Ferniz
Concerned that police will see his open beer, container, Randy Willey - who has AIDS - hides it in a downtown alley before looking for a place to relieve himself.

Growing public apathy presents another concern. If support wanes for homeless programs, social workers fear lawmakers will back off from model outreach efforts now under way.

The Winter 1997 Harte-Hanks Texas Poll showed 48 percent of Texans thought homelessness was a serious problem in their community. Nine years ago, 85 percent thought it was serious.

If anything, experts predict, homelessness could reach new highs as welfare reform puts more people onto the streets.

In a report last year by the U.S. Conference of Mayors, service providers in San Antonio and virtually all 29 cities surveyed said they expect to see increases in homelessness and hunger as a result of welfare reform.

San Antonio saw the largest jump - 36 percent - in requests for emergency shelter over the previous year among cities surveyed.

"There is absolutely reason for alarm," says Dr. Steven Goldfinger of Harvard Medical School and a senior psychiatrist at the Massachusetts Department of Mental Health. "Welfare reform is going to drive up the number of homeless people, dramatically."

The scope of HIV

Welfare reform is just one of the controversies facing homeless advocates. Some experts also debate the scope of HIV infections on the street.

In San Antonio, Dr. Guerra estimates the homeless infection rate at 5 percent or less, and he argues that social programs have inflated the number. No health district study has been done to confirm his estimate.

"If it were as high as they say, we'd end up having to quarantine people," he says.

But Rolando Morales, acting director of the San Antonio Department of Community Initiatives, says his department's figures - representing the 16 percent infection rate - are unduplicated counts from health and social-services providers.

Goldfinger says the HIV-infection rate is rising in the general population and among the homeless, paradoxically, partly because of recent breakthroughs in treatment.

"We are seeing people no longer viewing AIDS as a death sentence and saying, 'Oh, it will take 10 years before I'm sick, and, by then, they'll have new treatments.' Adolescents are particularly vulnerable because they think they're going to live forever."

Studies show men are more likely to get infected through intravenous drug use. But, a troubling two-thirds of homeless women in some studies had - as their only risk factor - heterosexual contact with a person at unknown risk for HIV.

For the nurse and many homeless women and men, trading sex for money, shelter or food is a means of survival.And it's a survival strategy that can end up killing them - and others.

A real threat

To anyone who thinks HIV-infected street people scrounging for Dumpster scraps and sleeping in doorways are far removed from "nice folks," says Jesse Sanchez, think again.

"I can drive down Broadway at night and see three people who I know are infected. Some of them I recognize from our food bank. And they are out there soliciting. They do what they have to do to survive," says Sanchez, executive director of the Hispanic AIDS Committee, which runs Casa Martin.

And, safe sex is not a major priority among the homeless.

The pleasure-seekers who pick them up may go on to other sexual encounters, spreading the virus. They may drive back to middle-class homes and families.

While AIDS itself can trigger a loss of income and resources and the descent into homelessness, the process works both ways. Advocates say more people are already on the streets when they get the virus.

Drawing from interviews with homeless people living with AIDS, Culhane in his study found women were overrepresented in the AIDS population that subsequently became homeless. The argument could be made, he says, that women usually have lower incomes than men to start with; so more wind up poor and on the street.

Real numbers

The state plans to use Culhane's computer program model to get its first solid number on homelessness, the Texas Count Project, says Ann Denton, who works on housing programs for the homeless for the Texas Department of Housing and Community Affairs and the Interagency Council on Homelessness.

President Clinton's new National AIDS Strategy, presented last December, addresses HIV-infected homeless with addiction or mental-health problems.And recently, the government's housing, social services and health agencies joined in an effort to improve delivery of health care to HIV-infected persons, including the

homeless and others at risk.

"This is the first time that a public-health agency has gone outside of the public-health community and linked with another agency. For us, that's very exciting," says Barney Singer, who directs the Health Resources and Service Administration's Special Projects of National Significance (SPNS) programs.

Collaborative grants have been awarded to Baltimore and San Francisco to develop programs handling the complicated needs of the HIV-infected homeless who also have addictions or mental illness. Stepped-up outreach under the expressways and in soup kitchens draws street people to a central site or to SRO (single-room occupancy) hotels for team-delivered services.

Some $4.2 million in funding is coming from the Ryan White Comprehensive AIDS Resources Emergency Act over the next five years. HUD is kicking in $7.1 million through its Housing Opportunities for People with AIDS program (HOPWA) to the two cities and six other projects.

San Antonio is not one of the collaborative grant cities. But as part of the overall community-grant initiative, the University of Texas Health Science Center at San Antonio received $400,000 for La Frontera, a partnership with community organizations that serves migrant and seasonal farm workers with HIV/AIDS.

One bright spot

Fred Karnas, the HUD deputy assistant secretary overseeing homeless programs, points to one bright spot in the fiscal and philosophical assault on public-housing programs.

"Homeless programs have (more than) doubled in the past three or four years," Karnas says - from about $100 million in funding in 1993 to $204 million in the 1998 budget.

Karnas is convinced Andrew Cuomo, the new HUD secretary, will follow the lead of former boss Henry Cisneros in advocating for the homeless. Cuomo has met with members of President Clinton's AIDS advisory council to discuss housing issues.

HIV-homeless advocates aren't so optimistic, fearing a congressional assault on Section 8 and other public-housing programs that will make already scarce stable housing even scarcer for street people.

On the street, advocates see a medical-ethical issue in getting the potent multiple drug therapies using protease inhibitors out to the homeless. The therapies are prolonging life for many with AIDS.

More official attention

One indication of increased official attention to this complex issue is the Community Team Training Institute on Homelessness being held in Washington through Tuesday. A collaborative between federal housing and health agencies, the institute and representatives from five communities are discussing the needs of homeless people with multiple disorders, including HIV/AIDS.

Whatever comes down, cautions Richard Sorian, former spokesman for the president's Office of AIDS Policy, which

coordinates federal efforts, "One thing we don't want to do is pit the mainstream population against the homeless in all this."

Agreeing is Jerry Permenter, executive director of the Alamo Area Resource Center, an agency providing many social services to people with HIV/AIDS."

We shouldn't get bogged down in the politics of blame that has affected our handling of AIDS," says Permenter, who believes tackling the homeless-HIV issue starts with caring.

"There are a thousand reasons to care. (It's) just our basic human instinct and compassion."

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Express-News Online Special Feature

The nurse

By Marina Pisano
Express-News Staff Writer

She was - is - a pretty woman with delicate features and long blond hair, and when the Thunderbird wine starts kicking in, she's animated and chatty and fun to be with.

Fun if you ignore her terribly thin, frail-looking body. Fun if you don't notice the unhealthy cast to her fair complexion. Fun if you don't think about the fact that this charming woman is a 39-year-old homeless person with AIDS seated on a dirty mattress under an expressway bridge.

Photo by Gloria Ferniz
The nurse tries to stay warm in the afternoon sun after a night of near freezing temperatures last winter.

It's a million miles from the comfortable life she once led.

"I grew up in a nice family (in Detroit). Big-time rich. I can't think of anything I didn't have - except a swimming pool. What happened was, I was a nurse, and I stole drugs at the hospital," recounts the woman who asked to remain anonymous because she has friends in nursing here.

"I worked on the surgical floor, midnight shift. All the IV painkillers the patients didn't ask for, I signed out for them, but I used them myself. I got addicted and lost my (nursing) license."

A costly addiction

Addiction cost her not only her profession, but her family. When she left Michigan she also left behind a broken marriage and a daughter, now a teen-ager living with her paternal grandmother.

"She's doing fine," the nurse says of her daughter, picking up the story."I came here with my boyfriend (about four years ago). We had money. We were working, but he got murdered. If I knew who did it, I'd kill them," the nurse says, convincingly.

Things fell apart after that.

"I got HIV from this guy who got it five years before even meeting me. He got real sick and was throwing up blood; so I went to the hospital with him. They said, 'You know what? You're HIV.'

"When they told me he was dead, I said, 'Thank God.' He's going to hell. He killed me - maybe not yet, but . . . . Because this happened, my mom hates me. My whole family hates me. But my mom visits me when I'm in the hospital."

She has been hospitalized more than 14 times in the last two years.

"Over a week stay each time. I've had pneumonia four times. I just

got my gall bladder out. I wait until I'm really sick, and then I call the ambulance. The EMS drivers all know me."

Her case worker at Casa Martin worries because she has had PCP, pneumocystis carinii pneumonia, the most common life-threatening, opportunistic infection associated with AIDS.

But the nurse plays down her condition.

"I almost had that kind of pneumonia. I'm close to that."

Photo by Gloria Ferniz
Appearing before county court at Law Judge Anthony J. Ferro on soliciting charges, the nurse pleads her case to be let out of jail.

She's no longer on Septra, a prophylactic drug to prevent infections such as PCP. She refuses to take AZT or the new protease inhibitors. The reasons defy her education and intelligence.

"They say the new drugs make you live longer. But they make you sick. You lose your hair and look like (expletive). My mother told me not to take the medication. She said it's just like cancer chemotherapy. I'd rather die young."

Living on the streets, having sex with different men, she's vulnerable to more than AIDS-related illnesses, venereal diseases and tuberculosis.

"I got my elbow crushed one night by these two little girl gangbangers. The doctors in the E.R. put seven pins in my elbow. I'm supposed to go back for surgery, but I'm afraid because they said they might have to amputate it. There's no bone left."

She hasn't gone back.

She could go to Casa Martin, the shelter for homeless/HIV-infected people run by the Hispanic AIDS Committee, and get help.

But she only goes to the agency for its weekly food bank and to pick up mail and a Supplemental Security Income disability check each month.

Truth is, she feels bored and confined in shelters and programs. Stressful as it is, she likes the free, unstructured life under the bridge - sharing a bottle of cheap wine and a cigarette, exchanging stories with street buddies, people-watching, eluding the cops at the Stop-N-Go near the Josephine Street bridge.

"I don't like the rules there," she says of Casa Martin. "They make you go to meetings all day, and then there's AA (Alcoholics Anonymous) and NA (Narcotics Anonymous) meetings, and you have to be in at 10 o'clock (p.m.). It's like being in jail."

Her boyfriend - also homeless and HIV-infected - was at Casa Martin, where alcohol and drugs are banned. But, she "rescued" him, as she puts it. He went back for a time but soon rejoined her.

Impermanence is the one constant in her life.

For a time, she rented a front room in an old house. But the once stately, now-decrepit, white-columned home is slated to be condemned.

"I find places to stay," she says. "But I always end up getting evicted because of homeless people I know. These (expletives) always find me. The landlord complains there's too much traffic in and out. Then I end up going back to the bridge."

Photo by Gloria Ferniz
The nurse and Smokey, with whom she had a brief relationship, chat in a vacant lot near U.S. 281 and Josephine Street. Smokey, a Houston man, chose to become homeless for awhile to be near the nurse, but eventually left because of her alcohol abuse.

A long arrest record

The nurse calculates that she has been in jail more than 30 times. Arrested by vice cops several months ago on two charges of soliciting for prostitution, she sits in jail for a couple of weeks before going to court. Alone and dressed in blue prison clothes, she looks like a weary child who has stayed too long at a theme park.

She pleads no contest, and Judge Anthony J. Ferro, noting her homelessness, orders her to pay court costs and serve 20 days in jail, including time served.

She doesn't deny having sex with lots of men, but she denies soliciting and rejects any suggestions of revenge sex.

"I'm very angry, but I'm very over it. I'm not out to hurt any man. They know what I have. If they want to wear a rubber when we have sex, let them. Anyway, a woman is not going to give it to a man unless he has open sores, something to contact blood. I know that from teaching it as a nurse."

AIDS experts confirm it is more difficult for a woman to transmit HIV to a man.

Her case worker says she does solicit sex and has infected several homeless men.

On the street, rationalization comes easy. But there's no talking away AIDS.

"I don't do drugs anymore," she insists. "I just drink, but I don't get drunk. But I do feel like I'm getting sicker. When I start thinking about seeing my mother, you know it's getting bad."

"The freedom is all I like about being out here," she says of the streets, her eyes filling with tears. "But I'm very nervous, and I'm very scared of dying."

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Express-News Online Special Feature

Often AIDS is secondary to finding a place to sleep

By Marina Pisano
Express-News Staff Writer

Every day, the homeless encounter enormous obstacles to effective treatment for HIV and AIDS.Lack of basic hygiene and nutrition. Drug abuse. Alcoholism. Mental illness.

But, as health officials and advocates for the HIV-infected homeless population emphasize, by far the greatest single barrier to rehabilitation is the absence of stable, sustained housing.

"If an individual has HIV and has substance abuse and is homeless, HIV is not the first problem they confront every day. It's waking up under a bridge," says Barney Singer, director of the Special Projects of National Significance programs of the Health Resources and Services Administration (HRSA).

Photo by Gloria Ferniz
Randy Willey, a homeless man with AIDS, sleeps in the doorway of a soup kitchen after a long night of drinking.

We can't deal with health problems until we can get their housing stabilized."

The reality is that without a place to stay, without a reliable schedule of meals, it's difficult for even highly motivated patients to comply with complicated, rigorous multiple-drug regimens required for AIDS treatment.

Yet studies show that 33 percent to 50 percent of people living with AIDS are either homeless or in imminent danger of becoming homeless.

The scarcity of housing in San Antonio for HIV-infected homeless people and, indeed, all of the homeless, was brought home in a report from the U.S. Conference of Mayors released last December.

The city's Department of Community Initiatives counted 1,278 emergency shelter beds in San Antonio in 1996, including those for families. The city's homeless population was more than 17,000.Only 25 of the shelter beds - all at Casa Martin - are reserved for the 2,800 homeless people in San Antonio who are infected with HIV.

Sheltered lives

Case managers working with homeless men and women find they often refuse to go to shelters, preferring their freewheeling street life over shelter rules.

These facilities aren't supposed to discriminate against someone

with HIV/AIDS. But those who present a risk of transmission are barred - such as John Robert "Cowboy" Jones, a razor-wielding self-mutilator.

Photo by Gloria Ferniz
An abandoned hotel at Pecos and Commerce streets occasionallly is occupied by some of downtown San Antonio's homeless.

"I've been in the shelter when Cowboy said he was gonna cut himself, and people just backed away, scared of all the blood flyin'," one homeless man says. A San Antonio Metropolitan Ministry Center shelter employee confirms Jones was asked to leave because he was a danger to others.

On the other hand, many of the infected homeless interviewed say they feel unwelcome, ostracized and even victimized in shelters. Some say shelters offer minimal help.

"Being here is like living on the streets anyway," says a frail-looking Cuban-born man with AIDS at the SAMM Center who didn't want his name used. "What good is it if I have to be out on the street again by 6 o'clock (a.m.)? I'm sick."

The SAMM Center sets aside 15, 24-hour beds for women and men who are sick, often those recovering from hospital stays. But they must have a doctor's letter, and most infected homeless people don't see doctors regularly, if at all.

And there is risk for the infected as well.

Fred Karnas, the deputy assistant secretary overseeing the U.S. Department of Housing and Urban Development's homeless programs, says shelters are doing heroic work.

But, truth be told, he says, "Health is compromised in these large open settings. Shelters are not healthy places to be."

For anyone with an HIV-weakened immune system, dormitory-type shelters increase exposure to potentially life-threatening communicable diseases, such as tuberculosis or hepatitis.

Shelter alternatives

Casa Martin, named for a now-deceased, 28-year-old who was rejected by his family, prides itself on a more homelike setting. Since opening its doors four years ago, it has served more than 600 people, including families.

Jesse Sanchez, executive director of the Hispanic AIDS Committee, which operates the facility, says the shelter this summer had to turn away families for the first time.

Residents enter a highly structured program that begins at 6 a.m., providing case management, substance-abuse counseling, dispensing of prescribed AIDS medication by on-staff nurses and other services for three months - all at no cost. Non-residents get case management and groceries.

HUD money

Casa Martin has a new $67,000 grant from the Texas Department of Housing to hire a registered nurse for basic non-AIDS medical care and to pay the first month's rent for transitioning clients.

Most of its funding - about $216,000 - comes from HUD's Housing Opportunities for People with AIDS program (HOPWA) through the city's Department of Community Initiatives.

Established by Congress in 1990, HOPWA is the only federal housing program providing comprehensive community-based housing specifically for HIV-infected people. Support, social and health services are funded as well.

Such community-based programs are vital, says Karnas. HOPWA was funded at $204 million for fiscal year 1998, an increase over previous years. Most of the money is spent based on a formula using total AIDS cases and competitive bidding.

"Ninety percent of that money goes to communities based on a complicated formula," he explains. "You have to have over 1,500 AIDS cases. About 80 communities are eligible. The other 10 percent of funding is awarded on a national competition."

Karnas notes that other HUD programs fund a continuum of housing strategies for the homeless, working with community nonprofit agencies.

They include Shelter Plus Care, which funds rental assistance and supportive services, targeting persons with disabilities, including HIV/AIDS; and the Section 8 Single Room Occupancy (SRO) Moderate Rehabilitation Program, which provides long-term rental assistance for SRO units.

Funding cuts feared

But AIDS-housing advocates point out that HOPWA increases actually are going toward newly eligible cities. And they fear deep cuts in other public-housing programs for the homeless.

"The biggest problem we see is that - best-case scenario in Congress - HUD will be flat-funded in order to just fund existing Section 8 and existing housing authority projects," says Betsy Lieberman, executive director of AIDS Housing of Washington state and a nationally recognized expert on the subject, who advises agencies in other states.

Karnas admits, "Separate from the homeless programs and HOPWA, the big issue is Section 8. If we don't solve Section 8, all the other programs will be under huge pressure. But, I feel recognition of housing needs (in Congress) is better than it has been in the past."

House of Hope

One example of a long-term housing program locally is House of Hope, founded by Raye Hall in 1989 in memory of her son, Robert, who died of AIDS.

House of Hope receives $75,000 a year from HUD programs, including HOPWA money, through the city's Department of Community Initiatives. It owns 19 multiple-family properties for the disabled/HIV-infected in San Antonio, with five more units in

Corpus Christi. About 30 House of Hope dwellings are home to HIV-infected people and families.

"They (tenants) pay 30 percent of their net income (in rent)," explains Hall, who has strict rules against alcohol and drug abuse. She said the money usually comes from the federal Supplemental Security Income disability program. "Some are able to work. If their income is zero, we help them get on disability. If they're not eligible for disability, they need to get a job. We don't believe in coddling people if they can work. Our average (resident) income is less than $500 (a month)."

Jerry Permenter, executive director of the Alamo Area Resource Center - which offers hot lunches, counseling, transportation and financial assistance for the HIV-infected - uses HOPWA emergency assistance funds to lodge homeless persons in motels for a few days. It's a short respite from life under the expressways, vital in colder weather.

"We rotate that among people who need it. We also have a small benevolence fund for this purpose - under $2,000. Demand is high," Permenter says.

Not enough beds

Longer-term housing for the homeless generally is inadequate. According to figures from the Department of Community Initiatives, 332 transitional-housing units were available for individuals and families in 1996. In addition, 88 SRO units were in hotels.

As HUD's Karnas sees it, "The answer isn't more emergency shelters."

Instead, the latest strategy is to come up with low-income or assisted housing that is stable, long-term and closely tied to health care, addiction programs, psychiatric care and other social services.

Photo by Gloria Ferniz
Jesse Sanchez, executive director of the Hispanic AIDS Committee, listens to a couple of Casa Martin residents lying in the lower bunks. There are 25 beds in the Casa Martin shelder for AIDS and HIV-infected homeless.

Right now, shelters make referrals to other agencies for such services, but experts say teaming them at one site, or taking the combined services out to the homeless, will work better.

HUD and HRSA oversee grants to Baltimore and San Francisco for pilot projects following that model.

Drugs and street life

Many doctors won't even prescribe the powerful and expensive protease inhibitor-antiviral combinations for AIDS patients without some assurance of sustained housing to aid compliance.

Some AIDS drugs must be taken before eating, some with food. Some need to be refrigerated - something that can't be found on the streets.

It's crucial to take the protease inhibitors as directed, explains Dr.

Jean Smith, associate professor of infectious diseases at the University of Texas Health Science Center. If patients take them incorrectly or suddenly stop, they may develop a drug-resistant strain of the virus, dooming chances of future treatment for themselves and others.

A roof and bed are not just warm, fuzzy notions, says Karnas.

"Housing is a medical issue."

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Express-News Online Special Feature

Cowboy

By Marina Pisano
Express-News Staff Writer

He looks as if he might have worked horses in Montana or someplace, and he did for a while.

Nowadays, John Robert "Cowboy" Jones - wiry, weathered-looking, dressed in worn jeans and boots - spends his days ranging over downtown side streets. Nights, he often beds down across from the Greyhound Bus Terminal on a concrete ramp behind a fast-food restaurant.

Photo by Gloria Ferniz
Cowboy shows off the scars across body from his self-mutilation.

He avoids shelters.

"In the shelter, I'd pass out drunk and wake up robbed of my money," he explains. "Anyway, they don't like to let me in ' cause of all the cuttin, (self-mutilation) I've done. They're afraid of the blood."

As Cowboy, 39, tells it, the trail to homelessness, self-mutilation and HIV infection has been a lonely, bruising ride at full gallop.

"All my life, I was mad and angry because of the life I got given. The folks who adopted me beat me, molested me, abused me - physically and mentally. Our family doctor molested me when I was 12."

As for getting infected with the virus that causes AIDS, "Who knows where it came from," he says, almost disinterestedly. "It was my promiscuous lifestyle. I was a homosexual prostitute. I was involved in pornography. I was a dope shooter. I had sex with women whenever I wanted.

"I gave it to my wife," he adds. "She said I was a (expletive) and told me to get the hell out of her life. But she knew from the git-go what I had. She said, 'We'll die together, honey.'

"It's been seven years since we broke up."

Sitting in the warm afternoon sun on the step of Community Ministries Center on North Alamo Street playing a harmonica, Cowboy looks peaceful enough.

"Sounds good. Got a good beat to it, doesn't it?" he says of the vaguely familiar tune he's blowing into the harmonica. He pulls out a collection of six or seven harmonicas from the large cloth tote bag that contains his world.

But sometimes, when his "medication" isn't working right, Cowboy gets loud and unpredictable, possibly dangerous.

His medication is speed."Crystal Meth(edrine). Speed kills. It makes some people crazy. But, it just calms me down," he claims.

God and sharp weapons

Truth is, the musician is on intimate terms with two verities: sharp weapons and the piercing word of God. He frequently quotes scripture from a small, marked-up, green-covered Bible he carries - a gift from a bikers-for-Jesus group.

"When they first told me in 1982 I was HIV, I went weird. I was an evil person. I didn't care who I gave it to. I went up and down Corpus Christi beatin' up anybody I felt like hittin'. I was ready to kill anybody who walked the face of this Earth. I was puttin' people in the hospital.

Photo by Gloria Ferniz
Cowboy heards for 'the freeway' after a man stole his money promising a nonexistant job.

"I tried to hurt myself. I broke bottles over my head. I was what they call - what is that word? Not suicidal but a self-mutilator. I cut myself all over my body. Used a razor or a knife. Once in Billings, Mont., I almost cut my jugular (vein). I was that close to death. Another time when I was stoned on pot, I took a (electric) saw and tried to take a cast off my arm. Almost took my hand off - cut the bone. I said, 'Oh, my God. What have I done?'

"He strips off his shirt to reveal more than a dozen scars from self-inflicted cuts on his abdomen, chest, neck and arms.

After one self-mutilation incident, Cowboy was taken to the San Antonio State Hospital for a psychiatric examination."They told me, 'You're a little off, but you're not psychotic.' "

Jail and violence

Cowboy ended up in jail late last year for smashing a storefront window. He went into hiding after slashing a man's face with a knife during a fight because the man's friends were after him.

Rage started building in Cowboy early last December, after a burly man called Bear befriended him and promised to take him to a ranch he said he owned in Alaska to care for his horses. It was a chance for a fresh start in a place with no bad memories.

When Cowboy's disability check arrived, Bear asked for money to buy him a bus ticket to Anchorage. But Cowboy never saw his cash or Bear again. Turns out, he had run the same Alaska horse-ranch scam on several other street people.

"Here we are homeless, and we're being victimized," Cowboy said angrily.

In the past 10 months, Cowboy has been run out of Corpus Christi by police, jailed for infractions in San Antonio, sent to the state hospital for observation, released and jailed again for aggravated assault (spitting on a police officer).

Through it all, the only thing Cowboy can count on is his little Bible and his faith.

"Praise God, I quit being a drunk and evil-minded," he says. "He's (Jesus is) gettin' to me every day. By golly, there's a change in John Jones. I don't like drunks. I used to be like 'em. The police tell me, 'We like you now that you're not drunk, John. Cool. Go on and have a nice day.' "

Photo by Gloria Ferniz
Cowboy shows off the three most impartant things to him: his boots, his harmonica and 'the Word,' in the form of a religious pamphlet.

No medicines

Cowboy doesn't take anything to fight AIDS because, he says, Jesus - the ultimate protease inhibitor - is on the case.

"I don't get any medical treatment. Don't need it," he explains. "I'm not gonna die of AIDS because Jesus healed me. By his stripes, he healed me. I believe he did. But, they keep coming back with a positive reading. I can't explain it. I don't know what God's planned."

Cowboy was rushed unconscious to University Hospital in early September. The doctor told him he had bacteria in his lungs and put him on antibiotics. His hepatitis was getting better, but his viral load, the amount of HIV in his blood, was high. He refused AIDS medication but demanded the doctor tell him his T-cell count. Cowboy's count has been as low as zero, well below the 200 level for full-blown AIDS.

He senses his life is rushing toward an ending straight out of "the scary book" in the Bible - Revelations.

"You can't tell by looking at me, but I'm movin' fast. I'm ridin' a fast train. Sometimes it slows down like a little roller coaster. Then it goes back up again.

"I say, 'Lord, don't let me die like this.' But he's not gonna let me die like this. Y'all are my sisters; so I'll tell you. He talked to me on paper. He told me he had called me and loved me, but his patience was runnin' out fast."

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Express-News Online Special Feature

AIDS drugs offer hope but new treatments for homeless raise questions

By Marina Pisano
Express-News Staff Writer

With recent advances in the treatment of AIDS , the stakes have changed dramatically for both the HIV-infected homeless and public policymakers.

"It used to be we'd rehabilitate them out of homelessness - for what? To die of AIDS . That's changing. People are living longer," says Rolando Morales, who oversees homeless programs for the San Antonio Department of Community Initiatives.

New drug therapies combining antivirals such as AZT and DDI, and protease inhibitors such as saquinavir and indinavir, aren't cures. But doctors are finding that for many patients, they are a way to turn certain death into a chronic illness to be lived with for years.

Protease inhibitors slow the pace at which HIV makes new copies of itself. Effects are tracked by measuring the viral load, or the amount of HIV in the blood.

Stunning declines in blood viral load, in some cases to zero, have been seen, though experts caution the virus may remain somewhere in the brain or other organs.

Though the shortage of long-term, stable housing among the infected homeless is the biggest obstacle to state-of-the-art medical care, some researchers are having limited success with treatment.

"Living under a bridge doesn't mean they can't follow a routine," says Dr. Joshua Bamberger, a researcher and clinician at the University of California's San Francisco General Hospital. "I'm not saying it's common or easy. But, some people are remarkable at being able to organize their lives around pill-taking."

Still, additional addictions and multiple health problems among the homeless , coupled with the stigma of AIDS , make the triumphant march of medical science academic.

Most infected homeless people receive their only health care in hospital emergency rooms or walk-in clinics. Some don't know they are HIV-positive until they become sick with AIDS -related diseases, such as pneumocystis carinii (PCP), pulmonary tuberculosis, recurrent pneumonia or invasive cervical cancer.

A vicious circle The toll of street life is easy to spot, says Dr. Jean Smith, an associate professor of infectious diseases at the University of Texas Health Science Center in San Antonio. She treats many homeless AIDS patients at the downtown FFACTS

clinic - Family Focused AIDS /HIV Clinical Treatment and Services.

"I remember one (infected homeless) man who came in terribly emaciated," Smith says. "He had thrush in his mouth and horrible esophagitis; so he couldn't swallow anything. Our social workers got him a place to stay. We got him on medication, and two weeks later he was doing much better. Then, he disappeared.

"I didn't see him again for four months, and then he showed up in the E.R."

The man's medical condition had again deteriorated, Smith says.

Physicians treating these patients often find tuberculosis as well. While not everyone who carries TB infection actually develops the TB disease, the progression is far more likely in the HIV-infected, whose weakened immune systems mean they become sicker, faster.

Clinic social workers used to refer HIV-homeless patients to the San Antonio Aids Foundation, which has skilled nursing care. But, the foundation now offers residential hospice care mainly to those in final stages of the disease.

"The last stages of AIDS come a whole lot faster when you don't have tender-loving care," says Raye Hall, who runs the nonprofit House of Hope, a more permanent housing program for homeless people, most disabled by HIV/ AIDS .

"I would say the average person living on the streets with AIDS - you'd be lucky to live six months."

Toxic treatment While some people make it into clinics, others walking the streets with the AIDS virus get their only medical treatment when they're arrested by police and jailed.

"We are seeing more and more who are infected come in here, including women who are picked up for prostitution," says Dr. John C. Sparks, who directs Bexar County's 84-bed jail medical facility. "We always have three or four people in the infirmary who are at a stage where they have very little immunity left; so we segregate them to protect them from disease."

Booze and drugs

Among the obstacles to effective treatment are alcohol and drug addiction - the very behaviors that frequently land people on the streets.

Indeed, the two biggest entry points into homelessness are prisons and substance-abuse treatment centers. Intravenous drug use and unprotected, promiscuous sex, endemic on the streets, are the most frequent modes of HIV transmission.

Smith says booze and drugs directly collide with advanced, multiple drug therapies.

"All these protease inhibitors are liver-metabolized, and alcohol can complicate that. Some people abuse drugs; so they abuse AIDS drugs. They think taking twice as much is better, but with some of these medications, you increase the toxicity when you

take more."

Dr. Elena Villavicencio, who treats some shelter residents at the Camden Clinic, insists patients be stable and sober before she will prescribe the multiple-drug AIDS therapies.

"They need to have a healthy lifestyle to do this. They can't be drinking or using drugs," she explains, adding, "We give patients lots of support in this with nutrition and psychological help." Mental illness is yet another huge barrier to effective medical treatment and compliance.

It's common to see delusional street people talking to themselves or acting out. Fully one-third of the homeless have a major mental illness.

"Not just mild emotional disorders," says Dr. Steven Goldfinger of Harvard Medical School, who has researched psychiatric problems of the homeless . "But severe manic-depressive disorder or schizophrenia."

The combative, unruly, sometimes psychotic behavior of mentally ill homeless people bars them from some shelters for safety reasons - excluding them also from available social services and health-care agencies.

Then there's denial, not unusual among AIDS patients dealing with a deadly disease, but far more serious in delusional people. Some say they don't believe their HIV test results or T-cell counts. They are convinced they're cured of the virus and refuse medical care.

In addition, AIDS -related dementia may develop and become another impediment.

As Smith points out, "The first thing you have to do with these mentally ill patients is stabilize them with psychiatric treatment."

Success is possible

There are potential successes.

Ruth, one former Casa Martin resident in San Antonio, says she was infected by her abusive husband and fled home with her two children, now 16 and 11.

With the new combination-drug treatment, her viral load -the amount of HIV virus in the blood - has dropped from a count of several hundred thousand to 7,000. Her T-cell count has soared from 88 to 488.

T-cells are white blood cells that play a crucial role in regulating the immune system. Anything over 500 is considered normal, and healthy people usually have counts of about 1,000. Full-blown AIDS is defined as a count under 200 with the presence of certain AIDS-related illnesses.

Ruth moved into an apartment with HIV-infected boyfriend Jose in January. Doctors say his viral load is now undetectable, thanks to protease inhibitors, and he is working again.

Ruth has gained weight and feels healthy enough to volunteer at the Casa Martin food bank.

"In the beginning, I was afraid because I thought I was going to die right away," she says. "But, with the new medication, I hope to live for many years.

And for the first time since becoming infected andhomeless , Ruth is allowing herself and her children the luxury of hope.

Fragmented help

Fragmented help Not all patients respond so well to the potent drugs. Others improve, only to become sick again if the medications stop. Long-term effects aren't fully understood.

The lack of a well-developed, coordinated public-health strategy among agencies remains a barrier to offering anything beyond crisis care. Homeless people with no calendars or clocks and few coping skills can't make connections or appointments.

But perhaps the ultimate barrier to large-scale treatment of the infected homeless is the enormous cost - $15,000 a year or more for multiple drug therapies and six-figure annual health-care bills for each person with AIDS .

The FFACTS and Camden clinics treat patients without money or insurance. And, for people without insurance or Medicaid who qualify, Texas has a prescription-drug assistance program to help pay for expensive medications.

But some question whether public money should be spent on the homeless - people who often won't obey shelter rules, won't get drug or alcohol-abuse counseling and won't take medications.

"I do not think that we should spend our tax money on anyone who will not take care of themselves and obey shelter rules and take some responsibility. Giving them the new medications would be like pouring money down the drain," argues Hall of the House of Hope. "We have rules, we expect people to abide by those rules."

Others, such as Jerry Permenter, executive director of the Alamo Area Resource Center, which provides services to HIV-infected persons, see things differently.

"Health care in this country should be a civil right," he flatly declares.

Doctors and researchers raise deep concerns about the ethics of denying life-prolonging AIDS treatment to people on the margins of society - in effect, making the homeless a disposable subclass.

Goldfinger says there isn't a prayer things will improve until awareness increases of the HIV-infected homeless issue and its public-health and social implications.

"This is an intensely complicated social, political and medical issue," Goldfinger says.

There's no quick, neat solution or single piece of legislation to fix things. And, given the tight fiscal and political climate, not much optimism about bold solutions to this complex problem.

"Most localities do not have the funding or the political will to provide quality care to this population," Goldfinger ventures. "For someone on protease inhibitors and AZT with any kind of reasonable care and follow-up, the medical costs can run more than $100,000 a year. We don't even want to spend that on taxpayers."

Still momentum for action is building.

Cities such as San Francisco and Baltimore have come up with integrated-service pilot projects that may get more HIV-infected homeless to come in out of the cold for effective care.

For the HIV homeless , time is running out.

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Express-News Online Special Feature

Randy

By Marina Pisano
Express-News Staff Writer

"You're lookin' good today, honey. You're lookin, fine."

Randy L. Willey turns on the old male charm as a woman gets out of a nearby car, but the worn-out line is a triumph of reflex over reality.

It's not likely the woman is going to look at a shabby, bearded street person dressed in a bizarre-looking, long, red woman's coat and hurling jeremiads. The preppy striped shirt he wears isn't likely to fool her for a second.

Resigned to rejection, Randy, as a point of pride, pulls an old driver's license out his pocket.

"This is what I used to look like," he says, smiling and fingering the face of a handsome, clean-shaven young man with startling green eyes and sandy-colored hair. "Looked like a movie star, didn't I?"

The photo was taken after the abuse at home but before years of drugs, promiscuous sex and scruffy life on the road took their toll.

At 34, Randy is homeless and has AIDS. His wild temper has made him unwelcome at the very places that might help him. He's scary. And, sometimes, he's scared.

"I pull my own teeth. (He keeps a self-extracted molar on a string.) I sew my own wounds when I get shot or stabbed. Everytime I try to go get help, they say, 'Step on the property, you get arrested,'" he sarcastically parrots people who have driven him out of one clinic or agency after another.

"Try to get my teeth fixed - try to get medical treatment - 'Step on the property, get arrested.' Oh sure, I get AZT. Yeah, right. People are knocking themselves out trying to give me stuff."

Life, as he recounts, started out bad and got worse fast. "I'm from Lincoln, Delaware. I've been on my own since I was 11. I've gone coast to coast 22 times. It finally caught up with me because I've done everything imaginable. You name it. Only thing I never done was stick no needle in my arm. That's why I never did heroin. Now they keep stickin' needles in my arm to draw blood. I can't stand those damn needles.

"The lover I was with did drugs. That's how I got (HIV) infected - about 12 years ago. I didn't do nothin' about it because I was in denial. When he died (in 1995), I knew. He died a horrible death because he trusted AZT and those damn drugs. Just made him die faster.

"You will never get me to take those drugs. Never," Randy vows. "Those drugs have chemical imbalances that will destroy the

immune system. The government makes those new AIDS drugs to kill us. They say, 'They're faggots. Let's kill 'em off.' Now, there's the truth. God has put the truth in my mind. He talks to me."

Instead of medical science, Randy puts his faith in "beer vitamins," God and terrifying prophesies.

"You know what the antichrist is? Heaven and hell. Here I am. Here I sit. Heaven and hell. And, I'm not going anywhere. Not yet. That's the truth. Believe it or not. I could tell you things of the universe that you would not believe.

"I can tell you this. In the year 2003, the resurrection starts. Aliens will come. I'll tell you how to destroy 'em in case I'm not around. All you have to do is pour salt on them. Pour salt on them."

One moment, Randy, who usually camps along undeveloped stretches of the river bank downtown, smiles nicely and hands a coin to a passing child. The next, he is a wild-eyed Jeremiah.

Police officers say be careful, he can get hostile with people, especially if they don't give him change.

Randy claims the cops harass him. The day after being jailed briefly for a disturbance, hes furious over "police brutality."

When he's angry, Randy, who is almost 6 feet tall, jumps to his feet, the pupils of his eyes hypnotic, drugged-out pinpoints, his voice as deep and lyric as a Shakespearean actor's. Pushing his face close, he spits as he pours out wrath, daring the listener to back away.

Just as quickly, he laughs and sits back down on the sidewalk.

Randy's past run-ins with the law turn far more serious when he is arrested for aggravated sexual assault. He currently is being treated in the jail medical unit.

Out on the street, before his arrest, Randy issued a dark waqrning: His twin brother, Rickey, is coming to visit.

"I'm the good twin. He's the evil one,'" he points out. "But I can control him. He will behave around me because I can knock him out with one blow. But he is truly a madman, and he is evil. He worships the devil. I worship the Lord thy God. God had a purpose when he made us. You cannot have good without evil. You cannot have evil without good. Everything that happens to me, happens to him. Everything that happens to him, happens to me.

"But, remember, when I introduce you, do not attempt to talk to him. He will converse through the mind, and you'll have the interview of a lifetime. You may photograph him, but he will come out as a black blur. He's coming. He's getting closer. And, he is truly scary."

On another day, Randy (CUT) is lying flat on his back on the sidewalk. He coughs repeatedly and admits he's exhausted.

"I can walk a block or so, and then I gotta sit down. I feel like crap. It's (AIDS is) deteriorating me. I got these spores on my body. Had pneumonia twice. Now, my eyes, every now and then, go fuzzy and black. I'm afraid I'm just fallin' apart. Jesus has

healed my legs though (AIDS-related neuropathy that affects legs). They feel better. But, he's got a way to go."

Still, as he says in Biblical-epic tones, AIDS holds no terror for him.

"I fear not death - do you? The greatest thing that can happen to me is if I die. I'm God's greatest warrior, but I'll be even more powerful when I'm dead. Then I'll really do God's work.

"Power is when I'm mad. I can jump up and have the strength of 10 men -100 if I want to. I hope you never see it. If you do, just walk away. Walk away."

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Express-News Online Special Feature

Settling an unsettled problem

By Marina Pisano
Express-News Staff Writer

SAN FRANCISCO - This progressive city, a hotbed of the AIDs epidemic, could lead the way in the struggle to bring better treatment and prevention to America's HIV-infected homeless.

San Francisco's Bridge Project, launched in April, is on the leading edge. It has received one of two innovative, collaborative grants awarded by the federal government. Its goal is to develop community programs that offer integrated, multidisciplinary services for HIV-infected homeless who have addictions or mental illness.

Advocates know what hasn't worked. They say fragmented health and social services and the lack of stable, long-term housing have defeated efforts to serve the infected homeless .

This new program changes that. Here, treatment starts with a stable place to live.

"The whole idea is to make the client the center of the services vs. the agency being the center," says Patricia Chiapellone, author of the Bridge Project proposal.

The Bridge will receive $1.2 million over the next three years from the federal housing department and $2 million over five years from the federal health department.

With those resources, its multidisciplinary teams go to several SRO (single room occupancy) hotels in the downtown, skid-row Tenderloin area and recruit clients - up to 90 people at any one time.

The program subsidizes part of their rent and provides them with primary medical care, nursing, substance-abuse counseling, support groups and other services.

Affordable housing is critically lacking in San Francisco, where the vacancy rate is 1 percent and rents can be prohibitive. Compounding the shortage have been reductions in public housing and Section 8 rental-assistance funding and the increase in homelessness, says Anna D'Amato, housing coordinator for the San Francisco AIDS Foundation.

"You hear complaints that people die while they're waiting for housing - and some do die," she says.

The housing crisis is especially painful for the 30,000 people infected with HIV in San Francisco, D'Amato says. More than 7,000 are living with AIDS in this city of 730,000 people.

San Antonio, with about 1 million people, has 1,380 AIDS cases, and it's estimated that more than 10,800 people in Bexar County are HIV positive.

The city's Department of Community Initiatives says 2,764 of San Antonio's 17,274 homeless people are HIV-positive. The Centers for Disease Control and Prevention estimates that up to 21 percent of the nation's homeless are infected.

The Bridge Project approaches alcohol and drug addiction from the "harm reduction" model, which means substance abusers and alcoholics are not required to be clean and sober to be in the program.

"That's the most controversial piece," Chiapellone says. "The most visible form of harm reduction is needle exchange, but we are not a needle-exchange program."

But the Bridge can link clients with programs that teach people how to clean needles. Its overall approach is to build from the self-esteem that comes with having a place to live, curb HIV-spreading behaviors and gradually reduce drug dependency.

"Obviously, we would like to see people enter treatment," says Stephanie Eng, Tenderloin AIDS Resource Center program supervisor and part of the Bridge review committee. "But, if they're strung out on drugs and not ready for it, is there not a system to help them in that in-between level? We think there is."

Ellen Dayton, an HIV-homeless outreach nurse practitioner at the Bridge-affiliated Tom Waddell Health Center, says primary health care can work wonders for the infected homeless , even if few are able to take the new AIDS combination-drug therapies.

"There are some very basic things you can do," she says, "immunizations, TB testing, check for hepatitis A and hepatitis B, prevention treatment. If they're mentally ill, depressed, I can treat depression. And, I see a lot of depression with drug addiction. I see a lot of sickness in older alcoholics. But treatment starts with a stable place to live."

Across the country, Health Care for the Homeless Inc. of Baltimore, the other recipient of special federal grants, is taking a different path to reach the same goal with a collaborative grant of almost $2 million over three years.

Baltimore outreach workers go out to parks, abandoned houses, soup kitchens and emergency shelters, building trust with HIV-infected street people and bringing them into a main downtown site for case management, comprehensive primary health care, therapy, help for substance addiction, transportation, food, vocational counseling and other services.

Housing counselors, working with city departments, get them into transitional and long-term housing.

Many approaches

Meanwhile, other cities also are trying multiservice projects.

Seattle, with an estimated 20,000 homeless , is renovating the historic Lyon Building into a 64-unit residence for infected homeless. About $1.25 million in funding is coming from foundations, corporations and government sources. Services include 24-hour security, shared meals, health services and mental

health and substance-abuse counseling.

AIDS Services of Dallas opened Hillcrest House last September, currently home to 64 HIV-infected, formerly homeless persons, many with chronic alcohol or drug-abuse problems. "I think we have the best program in the country," says Don Maison, whose agency also operates two other residences for people with HIV/AIDS.

San Antonio projects

In San Antonio, Casa Martin is the closest thing to housing with integrated-services for the infected homeless . Residents enter a highly structured program that includes case management, mental-health services and substance-abuse counseling. Nurses supervise AIDS medication prescribed by doctors out in the community.

But with funding for just 20 beds and a three-month stay for clients, the program can't accomplish all that it might, says Jesse Sanchez, special projects director for the Hispanic AIDS Committee, which runs Casa Martin. The agency is working with state and corporate funding sources to buy another building.

"The ideal situation," Sanchez says, "would be to transition people, after three months, into an apartment where they are assuming responsibility for their lives but are still required to come every day to meetings or twice a week to counselors and continue some sort of structure. That's what we hope to do."

Dr. Steven Goldfinger of Harvard Medical School is writing a white paper for the federal government on AIDS among the homeless-mentally ill, and he is convinced prevention - especially condoms and clean needles - is the best solution.

Targeted communities

Important prevention and education work is being done on San Antonio's streets.

BEAT AIDS has a strong presence in the San Antonio African-American community.

The Mujeres Project focuses on HIV-infected women and children. And the San Antonio Metropolitan Health District passed out condoms to help stabilize an outbreak of hepatitis in the city's young gay community last summer.

But Jerry Permenter, executive director of the Alamo Area Resource Center, has a more ambitious goal. He's writing a proposal for a federally funded project he hopes will reach greater numbers of San Antonio's HIV-infected homeless , especially those with multiple diagnoses.

The project calls for a 40-unit, long-term housing facility with on-site case managers, health care, substance-abuse counselors and other services. Permenter estimates the project would need $600,000 to $1 million and a major commitment by his agency, other community agencies and city officials.

He says the San Antonio AIDS Coalition, an umbrella organization of about 20 AIDS -related agencies, could play a role

in reaching the infected homeless .

Whatever the city, one thing is clear: Any hope for effective, lasting solutions rest as much with better strategies and innovative coalitions as with money.

"Funding is critical and important, but sometimes we can be more creative when we take the time to look at what resources there are and how to connect them off," says Rolando Morales, acting director of San Antonio's Department of Community Initiatives, which oversees homeless programs and delivery of services.

Moral issues

But one model may not suit all. Certain aspects of the projects in San Francisco, Baltimore or Seattle may not fly in San Antonio, especially if, as San Francisco AIDS/homeless researcher Dr. Andrew Moss cautions, treatment bumps up against moral issues, as with San Francisco's harm-reduction model.

Morales urges cities to look beyond the short-term. "We have to prioritize prevention over intervention - nonjudgmental AIDS -prevention education, including information on abstinence and condoms," he says.

In the end, reaching an isolated community may come down to public willingness to foot the steep bills for AIDS treatment - more than $100,000 a year, per person - plus mental health and substance-abuse treatment costs.

Meanwhile, there is a certain ambivalence among advocates about raising awareness about the needs of the HIV-infected homeless . They fear turning a light on the subject may spark a backlash against this community of people, further marginalizing them.

But Tom Henderson, the lone Texan on the president's 35-member National AIDS Advisory Council, is pressing the issue.

"What the council can do is make sure we keep this very high on the agenda of the president, the cabinet secretaries and the executive branch," says Henderson, who is HIV-infected and works in Texas Land Commissioner Garry Mauro's office in Austin.

"You can't isolate HIV and act as if it doesn't have anything to do with homelessness or substance abuse or other problems in a person's life."

Hard life goes on

While solutions are explored, the isolated, stigmatized HIV-infected homeless scrape through another day on the urine-soaked streets of the Tenderloin and debris-strewn lots of San Antonio, living on the edge.

Panhandling near San Francisco's historic St. Mary's Church, Michael Shepard, 36, who has AIDS and became homeless six months ago, yearns for healing but prepares for the worst.

"You know, there are a lot of people who have chosen this (the street) as their lifestyle. Not me," he says. "If I thought I had to do this the rest of my life, I'd be out there on Golden Gate Bridge."

Express-News Online Special Feature

Ed

By Marina Pisano
Express-News Staff Writer

SAN FRANCISCO - Seated on his bed by the window, the late-afternoon California sun igniting his red hair and beard, Ed looks frail, almost caved-in, his face deeply lined and gaunt.

"I came out here 17 years ago from Houston for the gay life," says the former restaurant kitchen manager. "Came out for a visit and decided to stay. Texas was pretty hostile to gays."

He's not sure how he got infected with HIV, the virus that causes AIDS - "sexual or IV (intravenous drug use)," he reckons.

He does know that it was eight years ago and that today his T-cell count is down to 50 - a count under 200 is considered full-blown AIDS. His blood HIV viral load is in the hundreds of thousands. He has lost 70 percent of the vision in his right eye, he has neuropathy in his legs and unspecified intestinal problems.

Perhaps worst of all, he has the AIDS-wasting syndrome, signaling advanced disease and already has dropped 80 pounds from his once-strapping 6-foot-tall frame.

"I'm 38," he replies to the inevitable question about age, politely ignoring the reaction on visitors' faces. He looks 20 years older.

No, he doesn't do drugs or alcohol anymore. Can't.

"My stomach doesn't seem to function anymore," he observes during an interview in March. "The first thing I do every morning is take my anti-nausea pill. Usually I can gauge my day on whether I can keep anything down. I have to be very cautious. A cold milkshake is one of the few things I can stomach."

Next to Ed's hospital-type bed a portable TV sits on a chair. IV equipment is within reach, along with shopping bags containing the liquid nutritional supplements that keep him alive. For 14 hours every night, he hooks himself up and takes in food through a permanent IV line. He gets infection-fighting antibiotics for several hours.

Ed receives most of his primary medical care at San Francisco General Hospital, but the new protease inhibitors are of no use to him. He can't keep them down any more than he can soup-kitchen suppers or fast-food tacos.

The one bright spot in his life is that, unlike this city's many HIV-infected homeless, he's not living on the street anymore. He has a dreary walk-in closet of a room and bath - rent $450 a month - on the fourth floor of the Ambassador Hotel, a landmark in the city's seedy downtown Tenderloin area.

Warren Goldenberg, an AIDS social worker, says "it's one step up from the street."

The hotel became a celebrated gay-friendly address decades ago. When the AIDS epidemic hit San Francisco in the early 1980s, it also became a safe, non-discriminatory place for infected gays to live and die.

Nowadays, the SRO (single-room occupancy hotel) is a rundown shadow of its former self. Water regularly leaks from broken pipes. A creaky elevator breaks down often, and then there's the fecal matter in the dilapidated communal bathrooms. Rats and roaches carry out nocturnal raids.

Catholic Charities manages Ed's disability benefits and assists with rent, and visiting nurses check on him regularly. But the Ambassador Program, once a model for HIV-infected homeless services, is in a state of uncertainty and flux.

The Bridge Project, a federally-funded program run by Lutheran Social Services, is putting infected homeless into better-maintained SRO hotels where they are served by teams of health and social services providers.

Having a place of their own means everything to them, even if the furnishings come out of Dumpsters, says Goldenberg, who worked for the Ambassador Program but is now with the Bridge Project.

One of the few meaningful personal possessions in Ed's room is a compact disc recording by Sheryl Crow. "I like her singing a lot," he says of Crow's folk-with-an-edge style.

"Here. You take it," he says to his visitors. "I don't have a CD player, and I'll probably never get a chance to listen to it. You take it. Enjoy it."

If Ed hasn't lost his generosity, he has lost touch with his family. One of his closest friends died of AIDS.

But while Ed's body and world shrink, he still finds pleasure in walking around the Tenderloin, "bonding" with street people and sharing the food he can't eat.

Later, in the dark hallway outside Ed's room, Goldenberg says that most termminal- AIDS residents prefer to spend their last days in the Ambassador rather than a hospice.

"Everybody dies alone. But at least here in the hotel, there's a sense of community. People don't feel so alone."

Ed died Sept. 4 of complications from AIDS. Friends at the Ambassador recently gathered for a memorial. He was cremated, and his ashes were sent to relatives near Houston.

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Express-News Online Special Feature

Leaders demand action

By Marina Pisano
Express-News Staff Writer

Mayor Howard Peak, a state public health official and advocates of the homeless Wednesday called for better ways to meet the needs of a small, but growing population of HIV-infected homeless who receive limited and fragmented services.

Peak said Wednesday he has asked the city's top public health official for a status report on the HIV-infected homeless and plans to ask a City Council committee to add the needs of this population to its agenda.

The newly formed San Antonio AIDS Coalition, lamenting the lack of coordination between agencies, also says it will study the issue. The Hispanic AIDS Committee, which operates the only emergency shelter specifically for this group, is joining with other organizations to form a task force to conduct a needs assessment among the homeless . It also is launching a fund-raising campaign to buy a building to provide transitional housing for HIV-infected homeless .

And in Austin, a member of President Clinton's 35-member National AIDS Advisory Council said San Antonio's dilemma demands new ideas and alliances.

Disturbed by a series of reports about HIV-infected homeless people in the San Antonio Express-News this week, Peak said he has asked for a public- health perspective report on the matter from Dr. Fernando Guerra, director of the San Antonio Metropolitan Health District.

"It's disturbing in a number of respects that we have (homeless) people out there with these problems. I don't know what we can do for some of them, but we need to figure out who we can reach," Peak said.

Guerra did not return telephone calls seeking comment.

Peak also plans to ask the council's Committee on Social Services to add the needs of homeless persons with HIV/ AIDS to its current examination of gaps and duplications in services provided by public, community and nonprofit agencies.

"With the committee's assessment, we'll be in a better position to know what we need to do," the mayor added.

Right now, there are almost 2,800 homeless persons walking around San Antonio with HIV/ AIDS , according to the city's Department of Community Initiatives. Many of these men and women face other medical problems, mental illness or drug or alcohol abuse. Some of the women are victims of domestic violence.

Peak's concern was echoed in Austin.

"We do see the homeless population becoming more disproportionately affected by this disease, and we will turn our attention to it," said Dr. Charles Bell, director of the HIV Bureau of the Texas Department of Health.

But Bell said "This is a difficult population to reach because AIDS treatment may not be a priority for them. Housing and food are higher on their agenda. We are going to have to develop new strategies to help them. I'd like to see more of a dialogue on this with housing (department). I'd like to see more partnering with them."

That kind of innovative approach and collaborative effort is already under way between federal housing and health and human services departments in the funding of projects in San Francisco and Baltimore, which are considered in the forefront of such programs.

Housing Opportunities for People with AIDS, the federal housing department's cornerstone program for this population, is one example of that kind of partnering in Texas, Bell said.

Today, the City Council is scheduled to consider more than $700,000 of new funding for that program, which covers housing and support and social services administered through the Department of Community Initiatives. The HOPWA funding is expected to be approved, Peak said.

Health officials and advocates for the HIV-infected homeless say the greatest single need for this population is stable, sustained housing.

Housing ensures better delivery of HIV/ AIDS treatment, especially the new, potent "cocktails" of protease inhibitors and more established AIDS drugs that are having dramatic results with many patients.

The treatments require a strict regimen of dosages before and after meals. Sustained housing also provides some stability for alcohol, drug, mental health and HIV-related social services. Model programs around the country combine services with housing.

Bexar County Commissioners Court Judge Cyndi Krier says the county has seen "the same need for housing that you have seen with your series, and they've acted on it."

The HIV Health Services Planning Council is the body appointed by the Commissioners Court to allocate federal funds under the Ryan White CARE Act Title I. Krier, the county's highest elected official, is responsible for distributing Title I money.

In fiscal 1997, the county had no Title I funds allocated for housing. Next year, the county will get more than $100,000 for housing and housing-related services.

Harrison Grindle, program coordinator for Ryan White Title I funding, says the amounted is small compared to the more than 700,000 allocated for medical services for people with HIV/ AIDS regardless of their housing status.

"But it's a start, it's something," said Grindle, who noted that

persuasive testimony from several homeless people and Jesse Sanchez of the Hispanic AIDS Committee convinced council members of the pressing need.

Sanchez, executive director of the Hispanic AIDS Committee, said he and other organizations have their own plan of action action. They are forming a task force to conduct a needs assessment of this often hidden segment of the city.

The Hispanic AIDS Committee operates the 25-bed Casa Martin, the only emergency shelter in the city specifically for the HIV-infected homeless .

The task force will include homeless people, as well as agencies such as the Center for Health Policy Development and the Health Education Training Centers Alliance of Texas at the University of Texas Health Science Center.

Sanchez also is launching a fund- raising campaign to buy a building to provide transitional housing for HIV-infected homeless moving from Casa Martin into longer-term housing.

The issue cries out for new ideas and alliances, said Tom Henderson, a member of President Clinton's 35-member National AIDS Advisory Council, who is HIV-infected and works in Texas Land Commissioner Garry Mauro's office in Austin.

"The problem, as your articles point out, is you have to deal with a multitude of problems," Henderson said. "Until we are prepared to deal with homelessness and HIV/AIDS in some comprehensive fashion, we're not going to get anywhere."

Dianne Sherman, recently named director of the Department of Community Initiatives, agreed.

"One thing we need to do more of is better coordination within the city. We can make better progress if we coordinate with housing and community development. We do that with HOPWA money, but we could do more with the health department and the county without duplicating services," she said.

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Express-News Online Special Feature

Mario

By Marina Pisano
Express-News Staff Writer

Mario Ibarra thought he was holding it all together pretty well until that morning last year in September when he woke up and found his wife, Jan, lying next to him.

Dead.

"I'd never seen a dead person that close before. They (police) said she was probably dead for about three hours," he recalls. "She was on a lot of medication. Guess she OD'd. If they gave her 60 pills, she'd eat 'em all in two days. Eat 'em like candy. I don't think she meant to kill herself. She probably just wanted to get away for a while."

His wife had AIDS . She was taking AZT and abusing it and other drugs -holding "pill-swapping parties," he says, with an HIV-infected homeless man who was on medication for depression.

At the end, Mario, 32, became her full-time care-giver, bathing her and making sure she ate. The intense, dark-haired man, who describes himself as an alcoholic and recovering drug addict, also is infected.

"I got it (HIV virus) from my wife. She had it for five years and didn't know it. She got tested when she found out her ex-boyfriend was full-blown AIDS . She got tested, and then I got tested (April 1996) and found out I had it. I haven't been to a doctor since I got diagnosed. My T-cell could was 333 (then).

"I'm not pissed off," he adds. "If she hadn't infected me, it woulda been somebody else. I had a problem with drugs from 20 to 27. I used other people's needles. I knew it was gonna happen, sooner or later."

Some street people who knew the couple say Mario took advantage of his wife and used her SSI check - Supplemental Security Income disability benefits -to buy illicit drugs.

Mario credits Jan with pulling him out of homelessness - they met on a bus while she was working as a waitress. When she could no longer work, her disability income was the only thing between him and the street. Her death plunged him back into homelessness .

So, yeah, he admits. In a way, he's angry.

"She died and left me stuck (financially and emotionally). You finally met someone you want to spend your life with, and she comes home one day and tells you, 'Hey, I'm sick. You gotta get tested.'

"Now it's pretty much just movin' from one bridge to another bridge," he says of his life and "work" - panhandling. Mostly he

hangs behind some businesses, off Broadway near the Brackenridge Park golf course.

"It's hard when you got cops harassin' you for bein'homeless . They don't catch no criminals, but they always find time to bother people trying to make it."

Mario likes to point out he's a home-town boy.

"I was born at home over there on 24th Street. Lived right here all my life. The first time I got married, I was 14 - straight out of seventh grade. I got a 18-year-old daughter and 11-year-old daughter. I haven't seen either one of 'em for a long time. My ex-wife remarried. I've had three common law (marriages)."

"We're not a real tight family," Mario says. "My dad says it's my own fault I'm homeless . But when you done it and seen it all before, it (street life) becomes natural."

Still, he observes, "my mom and dad, the little bit they can give me means a lot. They loved my wife for who she was. And, bein' their son, they feel there's a lot of good in me. They love me."

Mario has a sister who takes him home from time to time. He gets cleaned up and rests for a few days. But he always goes back to the street.

"I've never even thought about goin' to a shelter. It's too confining , like bein' in jail," he says, a place he is familiar with. "The same with Casa Martin (a shelter and substance-abuse program for HIV-infected homeless). They wanted me to go there, but that's like a jail, too. I'm not a convict. I'm an alcoholic. And, I need my sauce."

Last winter, the Alamo Area Resource Center, where Mario often goes for a hot lunch, used some of its funds to put him up in a motel room for a week. Recently, the center got him into more permanent housing, but he soon was evicted for breaking the landlord's rules.

"He's slowly drinking his life away on the streets," says his sister.

A case worker at the center helped Mario with his application for SSI disability benefits. But, with new, tougher requirements, he was denied.

It doesn't help that he avoids medical treatment. Mario once walked out of a detox program at the veterans hospital that was required before doctors could treat his bleeding ulcer.

As for HIV/AIDS , "I don't like doctors and I sure as hell don't like taking medication. Sometimes I feel sick or I'm runnin' a fever, but I've learned to live with it. I can just keep on goin', keep on goin', keep on goin'. I don't like pills. I'm not gonna carry around a bedroll and a sack of pills. I know people who get AZT, and they don't even take 'em. They throw 'em in the river."

Picked up for vagrancy several weeks ago, he is released a few hours later and returns to the only life he knows.

"He's slowly drinking his life away on the streets," says his sister.

But, "It was easier to be homeless before I got sick," Mario admits. "Now I worry that if I catch cold or pneumonia, I might not come out of it. Everything's different now."

A year after finding his wife lying lifeless beside him, Mario is still grieving, still adrift in his hometown and still infected.

"It was weird. She was sick, but there were some good times. I was there for her. Now it's like it's just me. I've had me for 32 years now, and I've gone nowhere.

"I was talkin' to this guy one time about my wife and cryin' and cryin'," he recounts. "These guys come up to me and said they'd pray with me. They asked me what was wrong. And, I said, 'Other than my wife dyin', nothin'.' They said, 'Oh, you'll meet somebody.'

"And, I said, 'Oh yeah. Show me the scenario here. I'm gonna meet somebody and when I tell 'em I'm sick, infected, they're gonna embrace me and love me.'

"The best thing that could happen to me is to meet another infected person. But then it's gonna happen all over again. Someone's gonna die on me, or I'm gonna die on someone else.

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Communities of Color

Divider Title: _____

COMMUNITIES OF COLOR

HIV/AIDS IN MINORITY POPULATIONS

As of December 1996

Source: **HIV/AIDS Surveillance Report, Centers for Disease Control and Prevention, Vol.8, No. 2**

OVERALL CASES:	PERCENT OF CASES	
	AIDS	**HIV**
White	46.3	39.4
Black	34.9	51.8
Hispanic	17.7	6.1
Asian/Pacific Islander	0.7	0.3
American Indian/Alaska Native	0.3	0.6

Note: Rounding errors; HIV infection is reported in only 29 states

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WITHIN THE MINORITY POPULATION ONLY:

	PERCENT OF CASES	
	AIDS	HIV
Black	65.0	85.5
Hispanic	33.0	10.0
Asian/Pacific Islander	1.3	0.5
American Indian/Alaska Native	0.5	0.9

Note: Rounding Errors; HIV is only reported in 29 states

AIDS case rates

White	13.5/100,000 population
Black	89.7/100,000 population
Hispanic	41.3/100,000 population
Asian/Pacific Islander	5.9/100,000 population
American Indian/Alaska Native	10.7/100,000 population

NUMBER OF AIDS CASES TO DATE/DEATHS

	Cases	Deaths	Percent Deaths
White	268,856	177,014	65.8
Black	203,189	119,538	58.8
Hispanic	103,023	61,856	60.4
Asian/Pacific Islander	4,131	2,477	59.9
American Indian/Alaska Native	1,569	848	54.0
Total	581,429	362,004	62.3

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NEEDLE EXCHANGE

Divider Title: _____

NEEDLE EXCHANGE

Office of National AIDS Policy

Executive Office of the President

URGENT: "AIDS" "Needles" "Congress"

For Immediate Release
October 31, 1997

Contact: Jeff Kamen
(202) 632-1090

White House AIDS Czar Praises,Challenges Congress on Needle Exchanges; Hails Conference Committee Vote to Retain HHS Secretary's Power To Remove Restriction on Funding of Needle Exchange Programs

"Let Science Drive this Policy," Urges Sandra Thurman
"New Public Opinion Poll Should Help."

Programs Underway Show Cut of HIV Infection Rate & No New Drug Users

(Washington, DC) ----Sandra Thurman, the White House AIDS Policy Director, today congratulated and challenged the House and Senate after conferees voted late last night to preserve the power of the Secretary of Human Services to removed current restrictions on federal funding of needle exchange programs. There are more than 100 such programs across the nation. All studies of needle exchange programs have shown that they reduce the spread of HIV/AIDS without encouraging drug abuse.

Thurman, the principal policy advisor to President Clinton on HIV/AIDS said, "It took genuine political courage for members of Congress to let science drive this policy and I challenge them to move forward in that spirit."

A floor vote in both houses is expected soon.

"The results of the new Harris poll, which shows that 71 percent of the American people support removing current restrictions on Federal funding for needle exchange programs should help some members of Congress to remember to keep politics out of public health considerations," Thurman said in a statement released by her office.

"With last night's vote, the debate on this issue has turned a significant corner. In this bill, Congress began the process of defining essential elements of needle exchange programs worthy of federal funding. Bi-partisan support for moving forward is based on a willingness to follow the science, but it took some old fashioned guts for the lawmakers to ignore those who would play politics with this issue. What we are talking about here is simple: if the science says needle exchange programs slash HIV infection rates and don't encourage drug use, then that translates into lives saved.

"We know that there are those who are committed to stopping needle exchange programs and they are expected to try to do so legislatively over the next six months. But when you consider that the American Medical Association, the American Public Health Association, the American Bar Association and the American Academy of Pediatrics all endorse needle exchanges as a proven method for attacking the spread of this deadly disease, few questions should remain about what is good public health policy, and we will continue to explain the facts to anyone who will listen.

"Over the next several months, I will be urging Congress to continue to act based on the scientific facts and not out of ignorance or fear." ###

The Science of Prevention: CDC's Role in Reducing HIV Infection Among Injection Drug Users

To date, more than a third of all reported AIDS cases in the United States are among injection drug users (IDUs), their heterosexual sex partners, and children whose mothers were IDUs or sex partners of IDUs. This disturbing trend continues: In 1995, 35% of reported AIDS cases were IDU-associated. And as a percentage of cases among heterosexuals, IDU-associated AIDS cuts a wide swath, accounting for 66% of AIDS cases among women and 85% of cases among straight men in 1995. In contrast, only 10% of MSM (men who have sex with men) reported a history of injection drug use.

CDC is the lead federal government agency responsible for tracking and preventing HIV/AIDS. In cooperation with other federal agencies and offices responsible for addressing drug use -- for example, the Center for Substance Abuse Prevention (CSAP), the Center for Substance Abuse Treatment (CSAT), the National Institute for Drug Abuse (NIDA), and the White House Office of National Drug Control Policy (ONDCP) -- CDC works to address the HIV/AIDS risks presented by illicit drug use. CDC also works directly with communities to give them the tools they need to address the unique prevention needs of IDUs, their sex partners, and their children.

Translating Science Into Practical Community-Level Prevention

Nationwide, approximately 475,000 drug treatment slots are available at any given time. There is an estimated 1.5 million active drug users. Clearly, Americans' need for drug treatment outstrips capacity to provide it. And, clearly, treating people's addiction reduces and, in many instances, eliminates their risk for HIV infection. What to do, then, to keep people safe from HIV until they can get into treatment?

As communities across America grapple with this question, CDC continues to provide them the science they need to make sound local decisions. Both biomedical and behavioral science information is vital to developing sound prevention programs.

For example, in 19XX, CDC, CSAP, CSAP, and NIDA issued a "bleach bulletin" alerting state and community prevention programs to the benefits of IDUs cleaning their syringes with bleach and water. But continuing research into the mechanisms of HIV transmission has shown that syringes are not the sole reservoir for HIV. Water used to rinse syringes, cottons used to filter drugs as they are drawn into needles, and even the shared drug itself -- not the shared syringe -- can harbor human immunodeficiency virus and serve as pools for transmission.

CDC has provided this information to communities, along with behavioral recommendations for users who continue to inject to use a sterile syringe for each injection and not to share water or cottons.

Users in Communities with NEPs Less Likely To Be HIV+

Research presented in Vancouver shows that IDUs want to use sterile syringes, when they're available.

- A study of 543 active users in Atlanta; Baltimore; Long Beach, California; Miami; Philadelphia; and Connecticut shows that IDUs were more likely to have used a reliable source of virus-free needles in cities with a needle-exchange program (NEP) or without paraphernalia laws that put them at risk of arrest and prosecution if they are carrying a syringe. IDUs reported using needles from reliable sources for fewer injections. The majority reported that it was easy to use a syringe only once, but 39% reported that obtaining sterile syringes was difficult.

- Another study of 3,252 IDUs in seven sites across the country shows that they are more likely to participate in needle exchange if they live within 15 minutes of the NEP. Importantly, NEP users are more likely to be those at highest risk for HIV infection -- that is, to have injected with used needles and to get their syringes from varied and unreliable sources such as friends, drug and needle dealers, sex partners, and family. Even where NEPs exist, however, users reported difficulty obtaining sterile syringes.

- A 1990-94 study of 1,353 IDUs in drug treatment in Los Angeles, New York City, Baltimore, and Seattle shows that 84% reported sharing needles less than half the time. And those who got needles from an NEP were less likely to share. In contrast, obtaining new needles from friends was associated with increased sharing. HIV incidence was estimated at 0% per person-year in LA and 1% per person-year in NYC.

Changing Community Laws Is Another Prevention Avenue

In July 1992, Connecticut changed its state laws to permit purchasing up to 10 syringes without a prescription and possessing up to the same number. CDC worked with the state health department to evaluate the effects of the law changes. Highlights of two studies include:

83% of pharmacists in Connecticut sold syringes without prescriptions following the law change.

IDUs used the pharmacies instead of the street for their syringes. In high drug-use areas, the number of non-prescription syringes sold increased dramatically, with little change in sales of prescription syringes. But in low drug-use areas, there was little change in any syringe sales.

Users reported a substantial decrease in sharing syringes.

IDUs age, duration of drug use, and frequency of injection did not change. The number of active IDUs did not change.

Many Tools Are Needed To Combat Two Complex Epidemics

Communities use the biomedical and behavioral science CDC provides to design, develop, deliver, and evaluate HIV prevention programming for IDUs. Research shows there are a variety of prevention tools -- drug prevention and treatment, NEPs, removing legal restrictions to sterile syringes -- that could help prevent HIV transmission. CDC will continue to provide communities with the information they need to tailor local solutions to local problems.

IDU Presentations in Vancouver

Oral

The AIDS Community Demonstration Projects(ACDP): A Successful Multi-Site Community-Level Behavioral Intervention, Martin Fishbein. (Oral)

Needle/Syringe Sources, Reuse, and Opinions Toward "One Set One Shot" Among Active Injection Drug Users (IDUs) in Six U.S. Cities, Alice Gleghorn. (Oral)

Condom Carrying and its Relationship to Condom Use among High Risk Populations, Carolyn Guenther-Grey. (Oral)

New Partners in HIV Prevention: The Role of Pharmacists in Increasing Drug Users' Access to Sterile Syringes, Linda Wright-De Agero. (Oral)

Poster

The Impact of Street Outreach for HIV Prevention in 5 High Risk Populations, John E. Anderson. (Poster)

Injection and Syringe Sharing among HIV-Infected Injectors: Implications for Prevention of HIV Transmission, Theresa Diaz. (Poster)

Can Enough Syringes be Provided to Allow Drug Injectors to Use New Syringe for Every Injection? Steve L. Jones. (poster)

AIDS among Heterosexual Injection Drug Users in the United States; Regional Diversity in an Ongoing National Epidemic, J. Stan Lehman. (Poster)

HIV Seroincidence, Needle Acquisition, and Predictors of Needle Sharing Among Injection Drug Users Entering Drug Treatment, Martha S. Miller. (Poster)

Access to Sterile Needles in the Collaborative Injection Drug Users Studies (CIDUS), Edgar Monterroso. (Poster)

Trends in AIDS Associated with Injecting Drug Use, United States, 1985-1995, Allyn K. Nakashima. (Poster)

Trends in AIDS Incidence among Women in the United States: a Birth Cohort Analysis, Pascale Wortley. (Poster)

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VACCINE INITIATIVE

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THE VACCINE INITIATIVE

THE WHITE HOUSE

WASHINGTON

HE PRESIDENT INTRODUCES INITIATIVES TO FULFILL HIS COMMITMENT TO DEVELOP AN AIDS VACCINE

Today President Clinton challenged the nation to commit itself to the goal of developing an AIDS vaccine within the next ten years. The President also announced a number of important initiatives to help fulfill this commitment, including high-level international collaboration, a dedicated research center for AIDS vaccine research at the National Institutes of Health (NIH), and outreach to scientists, pharmaceutical companies, and patient advocates to maximize the involvement of both the private and public sectors in the development of an AIDS vaccine. The President has already taken steps to enhance the possibility of developing an AIDS vaccine by increasing funding for NIH vaccine research and development over 33 percent in the last two years. The initiatives the President announced today, which build on an exceptional commitment to develop better ways to prevent, diagnose, treat, and eventually cure AIDS, include:

- **A New NIH AIDS Vaccine Center.** A dedicated intramural HIV vaccine research and development center is being established at the National Institutes of Health. This vaccine center, which will be fully operational within the next several months, is uniting outstanding scientists in immunology, virology, and vaccinology to join in a highly-collaborative effort to develop an AIDS vaccine. Bringing together a broad array of researchers in an intensely-focused environment has been a successful way of developing vaccines in the past.

- **A Global AIDS Vaccine Research Initiative.** The United States is proposing that the leaders of the eight major industrialized nations meeting at the Denver Summit in June agree to support a worldwide AIDS vaccine research initiative. The proposal calls for each nation to make a commitment to provide the necessary investments in their country to accelerate research toward the development of an HIV/AIDS vaccine as a scientific and public health priority. Joint meetings of key scientists from participating nations will address research progress, identity scientific gaps and opportunities, and design collaborative programs.

- **A Challenge to Pharmaceutical Manufacture Industry to Invest in Innovative Research to Develop an AIDS Vaccine.** We can only be successful in developing an AIDS vaccine if private and public sectors make this goal a priority. The President is challenging the pharmaceutical industry to join the government in a partnership to realize this important goal.

Background on HIV/AIDS. HIV/AIDS remains a global public health threat. More than 29 million men, women and children around the world have been infected with HIV -- more than 3 million infections occurring within the last year. Without an effective vaccine, AIDS will soon overtake tuberculosis and malaria as the leading cause of death among persons between 25-44 years of age. Between 650,000-900,000 Americans are estimated to be living with HIV disease, and over 300,000 Americans have already died from AIDS.

Clinton Administration Accomplishments on HIV/AIDS. The Clinton Administration has made a sustained commitment to addressing the HIV epidemic through investments in prevention, research and treatment.

- **Increased funding for the NIH vaccine by 33 percent.** Funding for NIH vaccine research and development has increased over 33 percent in the last two years -- from $111.1 million in FY 1996 to $148 million proposed in the President's FY 1998 budget.

- **Funding for AIDS research, prevention and care increased by more than 50 percent in the first four years of the Clinton Administration.** Funding for AIDS Drug Assistance Programs (ADAP), which help low-income people purchase needed therapies, has tripled, while funding for the Ryan White CARE Act increased 158 percent. The approval of new AIDS drugs has greatly accelerated, with 16 new AIDS drugs and two diagnostic tests.

White House Press Release

Commencement Address By The President At Morgan State University

The White House

Office of the Press Secretary

For Immediate Release May 18, 1997

Commencement Address By The President
At **Morgan State University**

Edward P. Hurt Gymnasium
Baltimore, Maryland

10:30 A.M. Edt

The President: Thank you. Dr. Richardson, Judge Cole, Governor Glendenning, Lieutenant Governor Kennedy-Townsend, Mr. Mayor, City Council President, other elected officials, Mr. Speaker, Senator Miller, Senator Sarbanes, Congressman Cardin and Congressman Cummings, my great partners, to the Board of Regents, to faculty, staff, to distinguished alumni, to the magnificent band and choir. I thought it was a great day when I got here, but I know it is now. Thank you very much. (Applause.)

To the members of the class of 1997, your family and your friends -- (applause) -- congratulations on this important day in your lives, the lives of your nation, and the life of this great institution.

Your diploma reflects a level of knowledge that will give you the chance to make the most of the rapidly unfolding new reality of the 21st century. It gives your country a better chance to lead the world toward a better place, and it reaffirms the historic mission of **Morgan State** and the other historically black colleges and **universities** of our great land.

When the doors of college were closed to all but white students, **Morgan State** and the nation's other historically black institutions of higher education gave young African Americans the education they deserved and the pride they needed to rise above cruelty and bigotry.

Today, these institutions still produce the lion's share of our black doctors and judges and business people, and **Morgan State** graduates most of the black engineers and scientists in the great **state** of Maryland. (Applause.)

I am here today not because **Morgan State** is just a great .istorically black **university**, it is a great American **university**. (Applause.) You have produced some of our nation's finest leaders. Your grads like Parren Mitchell, Kweisi Mfume and Earl Graves. (Applause.) Judicial leaders like Judge Bell and Judge Cole; public servants like **State** Treasurer Dixon and on a very personal note, my fine assistant, Terry Edmonds, Class of 1972, the first African American ever to serve as a speechwriter for the President of the United **States**. (Applause.) There he is.

Now, you're getting too much applause now, Terry. (Laughter.)

You graduate today into a world brimming with promise, enriched with opportunity. Our economy is the strongest in a generation, our unemployment the lowest in 24 years, with the largest decline in income inequality since the 1960s.

On Friday we finalized the details of an historic agreement with the leaders of Congress to balance the federal budget for the first time in nearly three decades, in a way that will keep our economy going and in balance with our values, caring for those in need, extending health care to 5 million more children, cleaning and preserving and restoring our environment, helping people to move from welfare to work, and, most important, funding the largest investment in education in a generation and the largest increase in higher ·ducation since the G.I. bill in 1945, more than 50 years ago. Applause.)

It will open the doors of college to all, with the largest increase in Pell Grant scholarships in three decades, $35 billion in tax relief to help families pay for higher education, including tax deductions for the cost of all education after high school, and our Hope Scholarship tuition tax credits to make the first two years of college as **universal** by the year 2000 as a high school diploma is today. (Applause.)

And this agreement contains a major investment in science and technology, inspired in our administration by the leadership of Vice President Gore, to keep America on the cutting edge of positive change, to create the best jobs of tomorrow, to advance the quality of life of all Americans.

This is a magic moment, but like all moments it will not last forever. We must make the most of it. In commencement addresses across the nation this year, I will focus our attention on what we must do to prepare our nation for the next century, including how we can make sure that our rich diversity brings us together rather than driving us apart, and how we must meet our continuing obligation to lead the world away from the wars and Cold War of the 20th century through the present threats of terrorism and ethnic hatred, weapons proliferation and drug smuggling, to a more peaceful and free and prosperous 21st century.

But today here, I ask you simply to imagine that new ·entury, full of its promise, molded by science, shaped by echnology, powered by knowledge. These potent transforming forces ·an give us lives fuller and richer than we have ever known. They

can be used for good or ill.

If we are to make the most of this new century, we -- all of us, each and every one of us, regardless of our background --must work to master these forces with vision and wisdom and termination. The past half-century has seen mankind split the om, splice genes, create the microchip, explore the heavens. We enter the next century propelled by new and stunning developments.

Just in the past year we saw the cloning of Dolly the sheep, the Hubble telescope bringing into focus dark corners of the cosmos never seen before, innovations in computer technology and communications, creating what Bill Gates calls "the world's new digital nervous system," and now cures for our most dreaded diseases -- diabetes, cystic fibrosis, repair for spinal cord injuries. These miracles actually seem within reach.

The sweep of it is truly humbling. Why, just last week we saw a computer named Deep Blue defeat the world's reigning chess champion. I really think there ought to be a limit to this. No computer should be allowed to learn to play golf. (Laughter.) But, seriously, my friends, in science, if the last 50 years were the age of physics, the next 50 years will be the age of biology. (Applause.)

We are now embarking on our most daring explorations, unraveling the mysteries of our inner world and charting new routes to the conquest of disease. We have not and we must not shrink from exploring the frontiers of science. But as we consider how to use the fruits of discovery, we must also never retreat from our commitment to human values, the good of society, our basic sense of right and wrong.

Science must continue to serve humanity, never the other y around. The stakes are very high. America's future -- indeed, ne world's future -- will be more powerfully influenced by science and technology than ever before. Where once nations measured their strength by the size of their armies and arsenals, in the world of the future knowledge will matter most. Fully half the growth in economic productivity over the last half-century can be traced to research and technology.

But science is about more than material wealth or the acquisition of knowledge. Fundamentally, it is about our dreams. America is a nation always becoming, always defined by the great goals we set, the great dreams we dream. We are restless, questing people. We have always believed, with President Thomas Jefferson, that "freedom is the first born daughter of science." With that belief and with willpower, resources and great national effort, we have always reached our far horizons and set out for new ones.

Thirty-six years ago, President Kennedy looked to the heavens and proclaimed that the flag of peace and democracy, not war and tyranny, must be the first to be planted on the moon. He gave us a goal of reaching the moon, and we achieved it -- ahead of time.

Today, let us look within and step up to the challenge of our time, a challenge with consequences far more immediate for the life and death of millions around the world. Aids will soon overtake tuberculosis and malaria as the leading infectious killer in the world. More than 29 million people have been infected, 3 million in the last year alone, 95 percent of them in the poorest parts of our globe.

Here at home, we are grateful that new and effective

anti-Hiv strategies are available and bringing longer and better lives to those who are infected, but we dare not be complacent. Hiv is capable of mutating and becoming resistant to therapies, and could well become even more dangerous. Only a truly effective, preventive Hiv vaccine can limit and eventually eliminate the threat of Aids.

This year's budget contains increased funding of a third over two years ago to search for this vaccine. In the first four years, we have increased funding for Aids research, prevention and care by 50 percent, but it is not enough. So let us today set a new national goal for science in the age of biology. Today, let us commit ourselves to developing an Aids vaccine within the next decade. (Applause.) There are no guarantees. It will take energy and focus and demand great effort from our greatest minds. But with the strides of recent years it is not longer a question of whether we can develop an Aids vaccine, it is simply a question of when. And it cannot come a day too soon.

If America commits to find an Aids vaccine and we enlist others in our cause, we will do it. I am prepared to do all I can to make it happen. Our scientists at the National Institutes of Health and our research **universities** have been at the forefront of this battle.

Today, I'm pleased to announce the National Institutes of Health will establish a new Aids vaccine research center dedicated to this crusade. And next month at the Summit of the Industrialized Nations in Denver, I will enlist other nations to join us in a worldwide effort to find a vaccine to stop one of the world's greatest killers. We will challenge America's pharmaceutical industry, which leads the world in innovative research and development to work with us and to make the successful development of an Aids vaccine part of its basic mission.

My fellow Americans, if the 21st century is to be the century of biology, let us make an Aids vaccine its first great triumph. (Applause.)

Let us resolve further to work with other nations to deal with great problems like global climate change, to break our reliance on energy use destructive of our environment, to make giant strides to free ourselves and future generations from the tyranny of disease and hunger and ignorance that today still enslaves too many millions around the world. And let us also pledge to redouble our vigilance to make sure that the knowledge of the 21st century serves our most enduring human values.

Science often moves faster than our ability to understand its implications, leaving a maze of moral and ethical questions in its wake. The Internet can be a new town square or a new Tower of Babel. The same computer that can put the Library of Congress at our fingertips can also be used by purveyors of hate to spread blueprints for bombs. The same knowledge that is developing new life-saving drugs can be used to create poisons of mass destruction. Science can enable us to feed billions more people in comfort, in safety, and in harmony with our earth; or it can spark a war with weapons of mass destruction rooted in primitive hatreds.

Science has no soul of its own. It is up to us to determine whether it will be used as a force for good or evil. We must do nothing to stifle our basic quest for knowledge. After all, it has propelled from field to factory to cyberspace. But how we use the fruits of science and how we apply it to human endeavors is not properly the domain of science alone or of scientists alone. The answers to these questions require the application of ethical and

moral principles that have guided our great democracy toward a more perfect union for more than 200 years now. As such, they are the province of every American citizen.

We must decide together how to apply these principles to e dazzling new discoveries of science. Here are four guideposts. .rst, science and its benefits must be directed toward making life better for all Americans -- never just a privileged few. Their opportunities and benefits should be available to all. Science must not create a new line of separation between the haves and the have-nots, those with and those without the tools and understanding to learn and use technology.

In the 21st century a child in a school that does not have a link to the Internet or the student who does not have access to a computer will be like the 19th century child without school books. That is why we are ensuring that every child in every school, not matter how rich or poor, will have access to the same technology by connecting every classroom and library to the Internet by the year 2000. (Applause.)

Science must always respect the dignity of every American. Here at one of America's great black **universities** let me underscore something I said just a few days ago at the White House. We must never allow our citizens to be unwitting guinea pigs in scientific experiments that put them at risk without their consent and full knowledge. (Applause.)

Whether it is withholding a syphilis treatment from the black men of Tuskegee or the Cold War experiments that subjected some of our citizens to dangerous doses of radiation, we must never go back to those awful days in modern disguise. We have now apologized for the mistakes of the past; we must not repeat them -- never again. 'Applause.)

Second, none of our discoveries should be used to label or discriminate against any group or individual. Increasing knowledge about the great diversity within the human species must not change the basic belief upon which our ethics, our government, our society are founded. All of us are created equal, entitled to equal treatment under the law. (Applause.)

With stunning speed, scientists are now moving to unlock the secrets of our genetic code. Genetic testing has the potential to identify hidden inherited tendencies toward disease and spur early treatment. But that information could also be used, for example, by insurance companies and others to discriminate against and stigmatize people.

We know that in the 1970s, some African Americans were denied health care coverage by insurers and jobs by employers because they were identified as sickle cell anemia carriers. We also know that one of the main reasons women refuse genetic testing for susceptibility to breast cancer is their fear that the insurance companies may either deny them coverage or raise their rates to unaffordable levels. No insurer should be able to use genetic data to underwrite or discriminate against any American seeking health insurance. This should not simply be a matter of principle, but a matter of law, period. (Applause.)

To that end, I urge the Congress to pass bipartisan legislation to prohibit insurance companies from using genetic creening information to determine the premium rates or eligibility of Americans for health insurance.

Third, technology should not be used to break down the wall of privacy and autonomy free citizens are guaranteed in a free society. The right to privacy is one of our most cherished freedoms. As society has grown more complex and people have become more interconnected in every way, we have had to work even harder to respect the privacy, the dignity, the autonomy of each individual.

Today, when marketers can follow every aspect of our lives, from the first phone call we make in the morning to the time our security system says we have left the house, to the video camera at the toll booth and the charge slip we have for lunch, we cannot afford to forget this most basic lesson.

As the Internet reaches to touch every business and every household and we face the frightening prospect that private information -- even medical records -- could be made instantly available to the world, we must develop new protections for privacy in the face of new technological reality. (Applause.)

Fourth, we must always remember that science is not God. (Applause.) Our deepest truths remain outside the realm of science. We must temper our euphoria over the recent breakthrough in animal cloning with sobering attention to our most cherished concepts of humanity and faith.

My own view is that each human life is unique, born of a miracle that reaches beyond laboratory science. I believe we should respect this profound gift. I believe we should resist the temptation to replicate ourselves. But this is a decision no President should make alone. No President is qualified to understand all of the implications.

That is why I have asked our distinguished National Bioethics Advisory Commission, headed by President Harold Shapiro of Princeton, to conduct a thorough review of the legal and ethical issues raised by this new cloning discovery. They will give me their first recommendations within the next few weeks, and I can hardly wait.

These, then, are four guideposts, rooted in our traditional principles of ethics and morals, that must guide us if we are to master the powerful forces of change in the new century. One, science that produces a better life for all and not the few. Two, science that honors our tradition of equal treatment under the law. Three, science that respects the privacy and autonomy of the individual. Four, science that never confuses faith in technology with faith in God.

If we hold fast to these principles, we can make this time of change a moment of dazzling opportunity for all Americans.

Finally, let me say again: Science can serve the values and interests of all Americans, but only if all Americans are given a chance to participate in science. We cannot move forward without the voices and talents of everyone in this stadium, and especially those of you who are going on to pursue a career in science and technology.

African Americans have always been at the forefront of American science. This is nothing new. Nothing -- not slavery, not discrimination, not poverty -- nothing has ever been able to hold back their scientific urge or creative genius. (Applause.)

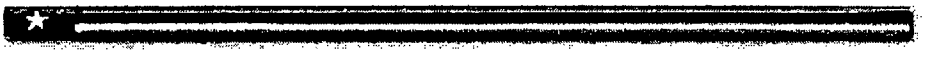
Benjamin Banneker was a self-taught mathematician,

surveyor, astronomer, who published an annual almanac and helped to design the city of Washington. George Washington Carver was born a slave, but went on to become one of our nation's greatest agricultural scientists. Ernest Everett Just of Charleston, South Carolina, is recognized as one of our greatest biologists. Charles Drew lived through the darkest days of segregation to become a pioneer in blood preservation. And today you honor an African American doctor at Johns Hopkins **University** who is truly one of the outstanding physicians of our time. (Applause.)

All these people show us that we don't have a person to waste and our diversity is our greatest strength in the world of today and tomorrow. Now, members of the class of 1997, it is your time. It is up to you to honor their legacy, to live their dreams, to be the investigators, the doctors, and the scholars who will make and apply the discoveries of tomorrow, who will keep our science rooted in our values, who will fashion America's greatest days.

You can do it. Dream large. Work hard. And listen to your soul. Thank you and God bless you all. (Applause.)

End 10:57 A.M. Edt



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HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Monday, Sept. 29, 1997

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FIRST GRANTS FOR INNOVATIVE AIDS VACCINE RESEARCH AWARDED

The National Institute of Allergy and Infectious Diseases (NIAID) has selected the first grant recipients in its new program to foster innovative research on AIDS vaccines. Earlier this year, NIAID announced the INNOVATION Grant Program for Approaches in HIV Vaccine Research, designed to speed the pace of discovery and development in vaccines to prevent HIV disease.

"President Clinton has challenged the nation to develop a vaccine against AIDS in the next ten years," said HHS Secretary Donna E. Shalala. "These grants will help to foster the kind of fresh, innovative thinking we need to achieve that goal."

"We are extremely pleased by the overwhelming response to this announcement. The 49 grants we are funding will explore creative approaches to vaccine design and involve many investigators new to AIDS research," commented NIAID Director Anthony S. Fauci, M.D.

NIAID awarded the 49 grants, totaling more than $11.8 million, after an exhaustive evaluation of more than one hundred applications. The grants will be for either one- or two-year funding periods. The grant recipients, 28 of whom are new to NIAID's extramural research program, will be conducting research within the following areas: understanding the structure and function of the HIV envelope protein; improving animal models for vaccines and studies on the causes and progression of disease; and understanding the mechanisms of antigen processing in living organisms to maximize the immune response.

NIAID created the INNOVATION Program to encourage novel ideas and approaches while stimulating interest from a new group of scientists, including those who had not been involved in HIV research. The AIDS Vaccine Research Committee (AVRC) chaired by David Baltimore, Ph.D., president-designate of the California Institute of Technology, endorsed the concept of the INNOVATION Program.

"Traditional killed vaccine or live attenuated vaccine development methods are being pursued, but may not be the most successful for HIV," said Dr. Baltimore. "To discover the best way to tame HIV infection, we need also to focus on the newer biomedical technologies and approaches that depart from the conventional."

- More -

\e grant recipients will be conducting research to:

- Identify sites and mechanisms of viral and immune cell interactions once the virus has attached to a cell.
- Develop novel approaches to analyzing the structure of HIV. New knowledge of the biophysical characteristics of HIV's structure can bring to light additional sites for attacking it.
- Improve the immune-stimulating ability of HIV proteins.
- Study the impact of newly described or less studied cell types of the immune response to HIV. These studies may provide information on how to improve existing vaccine candidates or additional therapeutic targets.
- Explore the potential of new genetically engineered animal models.
- Study the mechanisms of action that may clarify the roles of HIV as it interacts with immune cell receptors during infection. Such studies may show researchers more opportunities to intervene in the infection and disease processes.
- Develop new vaccine formulations to improve ways in which the vaccine material is presented to the immune system. HIV is a quickly mutating virus. The chances for a vaccine interfering with the virus' progress are improved when scientists can identify better ways of alerting the immune system to potential danger.
- Develop new vectors and improve existing ones. Vectors, or carriers of vaccine materials and immune system stimulators, can greatly enhance a vaccine's effectiveness.

The grantees are:

- Christopher C. Broder, Ph.D., Henry M. Jackson Foundation for the Advancement of Military Medicine, Rockville, Md.
- John D. Clements, Ph.D., Tulane University, New Orleans
- David M. Hone, Ph.D., Maryland Biotechnology Institute, Baltimore
- Steven A. Johnston, Ph.D., University of Texas Southwest Medical Center, Dallas
- Gunter Kraus, Ph.D., University of Miami, Fla.
- Paul A. Luciw, Ph.D., University of California, Davis
- Roland M. Tisch, Ph.D., University of North Carolina, Chapel Hill
- Michael S. Marks,Ph.D., University of Pennsylvania, Philadelphia
- Harris Goldstein, M.D., Yeshiva University, New York City
- Anthony Devico, Ph.D., Maryland Biotechnology Institute, Baltimore

Xiao-Fang Yu, M.D., D.Sc., Johns Hopkins University, Baltimore
Richard A. Koup, M.D., University of Texas Southwest Medical Center, Dallas
- Peter M. Palese, Ph.D., Mount Sinai School of Medicine of the City University of New York
- Paul V. Lehmann, M.D., Ph.D., Case Western Reserve University, Cleveland
- David I. Watkins, Ph.D., University of Wisconsin, Madison
- Ruth E. Berggren, M.D., University of Colorado Health Sciences Center, Denver
- Boro Dropulic, B.Sc., Ph.D., Johns Hopkins University, Baltimore
- Ronald I. Swanstrom, Ph.D., University of North Carolina, Chapel Hill
- Mary K. Estes, Ph.D., Baylor College of Medicine, Houston
- Don C. Wiley, Ph.D., Children's Hospital, Boston
- Paul W. Parren, Ph.D., Scripps Research Institute, San Diego
- Mark A. Goldsmith, M.D., Ph.D., J. David Gladstone Institutes, San Francisco
- Kyung-Dall Lee, Ph.D., University of Michigan, Ann Arbor
- George J. Cianciolo, Ph.D., Duke University, Durham, N.C.
- Nancy L. Haigwood, Ph.D., Seattle Biomedical Research Institute
- Linqi Zhang, Ph.D., Aaron Diamond AIDS Research Center, New York City
- Leonidas Stamatatos, Ph.D., Aaron Diamond AIDS Research Center, New York City

Robert J. Collier, Ph.D., Harvard University, Cambridge, Mass.
- William C. Olson, Ph.D., Progenics Pharmaceuticals, Inc., Tarrytown, N.Y.
- Nicholas Carbonetti, Ph.D., University of Maryland, Baltimore
- Raymond J. Langley, Ph.D., Virion Systems, Inc., Rockville, Md.
- Richard C. Duke, M.Sc., Ph.D., University of Colorado Health Sciences Center, Denver
- William C. Cheevers, Ph.D., Washington State University, Pullman
- Yao Qizhi, M.D., Ph.D., Emory University, Atlanta
- Shibo Jiang, M.D., Ph.D., New York Blood Center, New York City
- Louis D. Falo, M.D., Ph.D., University of Pittsburgh
- Glenn Y. Ishioka, Ph.D., Cytel Corporation, San Diego
- Ann B. Hill, Ph.D., Oregon Health Sciences University, Portland
- Samuel J. Landry, Ph.D., Tulane University, New Orleans
- Cara C. Wilson, M.D., University of Pittsburgh
- Don P. Wolf, Ph.D., Oregon Regional Primate Research Center, Beaverton
- Carl T. Wild, Ph.D., Biotech Research Laboratories, Rockville, Md.
- Kunal Saha, M.D., Ph.D., St. Luke's Roosevelt Institute for Health Sciences, New York City
- Miroslav Malkovsky, M.D., University of Wisconsin, Madison
- Kam W. Leong, Ph.D., Johns Hopkins University
- Richard Wyatt, Ph.D., Dana-Farber Cancer Institute, Boston
- John P. Moore, Ph.D., Aaron Diamond AIDS Research Center, New York City

- Rafi Ahmed, Ph.D., Emory University, Atlanta
  Yair Argon, Ph.D., University of Chicago

Because of the importance and urgency that NIAID and the AVRC place on AIDS vaccine development, NIAID piloted a new streamlined grant award process with this program announcement. NIAID published the call for applications in March 1997 and selected recipients within six months. Based on the encouraging response from the scientific community, a second program announcement is planned.

NIAID, a component of the National Institutes of Health (NIH), conducts and supports research to prevent, diagnose and treat illnesses such as AIDS and other sexually transmitted diseases, tuberculosis and malaria, as well as asthma and allergies. NIH is an agency of the U.S. Department of Health and Human Services.

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Note: Press releases, fact sheets and other NIAID-related materials are available on the Internet via the NIAID home page at http://www.niaid.nih.gov.

AIDS VACCINE Q&AS

Q: DOESN'T THE PRESIDENT'S CHALLENGE RING HOLLOW SINCE YOU ARE NOT INVESTING ANY NEW RESOURCES DEVELOPING AN AIDS VACCINE?

A: The President has committed additional resources to developing an AIDS vaccine. In the last two years, he has increased funding for the AIDS vaccine by 33 percent and his FY 1998 budget increases spending for AIDS vaccine research by $17 million.

Moreover, scientists have informed the President that it is not only money that we need to meet the challenge of finding an AIDS vaccine, but that we also need to promote collaboration between experts in this area. That is why the President has announced that there will be a new AIDS Vaccine Center at NIH which will unite scientists in immunology, virology, and vaccinology to join in a highly collaborative effort to develop an AIDS vaccine.

That is also why is he calling on the leaders of the eight major industrialized nations meeting at the Denver summit in June to support a worldwide AIDS vaccine research initiative. These important initiatives are what scientists believe we need to do to fully commit ourselves to the goal of developing an AIDS vaccine.

Q: IN 1985, MARGARET HECKLER PREDICTED THAT WE WOULD HAVE AN AIDS VACCINE IN TWO YEARS. THAT WAS OVER TEN YEARS AGO. MOREOVER, AT A RECENT CONFERENCE, DR. ROBERT GALLO INDICATED THAT WE MAY NEVER SEE AN EFFECTIVE AIDS VACCINE. WHY SHOULD WE BELIEVE THAT THE PRESIDENT'S PROMISE THAT WE CAN DEVELOP AN AIDS VACCINE IN A DECADE?

A: We know much more about the AIDS virus today than we knew in 1985 or even in 1995. Recent scientific advances have taught a great deal about how the AIDS virus infiltrates the human and begins to destroy the human immune system. We have developed a whole new series of drugs that inhabit the reproduction of the AIDS virus.

There are many credible scientists and medical researchers who are believe that it is not a question of whether we will ever get an AIDS vaccine but when. The scientific leaders at the National Institutes of Health have said that are extremely encouraged by recent progress in the AIDS vaccine and believe that the development of a vaccine is feasible. In fact, there were

numerous presentations at the conference that spoke about the tremendous progress we have made in the AIDS vaccine development and in vaccine development in general.

The President announced today that we should commit ourselves to developing an AIDS vaccine in the next ten years. He acknowledged that there are no guarantees. But he believes that we should commit our energy, our focus, and the efforts from our greatest minds to finding an AIDS vaccine.

Q: HOW ARE THE INITIATIVES THE PRESIDENT ANNOUNCED TODAY BEING PAID FOR? ARE THEY A PART OF THE BALANCED BUDGET AGREEMENT?

A: All of the costs for developing an AIDS vaccine are being paid for by NIH's existing budget. NIH has already increased funding for AIDS vaccine research by 33 percent in the last two years -- from $111 million in FY 1996 to $148 million proposed in the President's FY 1998 budget. The President's FY 1998 budget alone calls for a $17 million increase.

Q: IF WE ARE INVESTING MORE TO DEVELOP AN AID VACCINE AREN'T WE TAKING AWAY FROM INVESTMENTS ON TREATING PEOPLE WHO ALREADY SUFFER FROM THIS DISEASE?

A: Since he took office, the President has made an extraordinary commitment to increasing our investments in AIDS. Funding for AIDS research, prevention and care increased by more than 50 percent in the first four years of the Clinton Administration. Funding for AIDS Drug Assistance Programs (ADAP), which help low-income people purchase needed therapies, has tripled, while funding for the Ryan White CARE Act increased 158 percent. The President believes that we need to continue to increase our investments in all of these areas and his FY 1998 budget reflects that commitment, with additional investments in AIDS research, prevention and care.

Q: THE BALANCED BUDGET AGREEMENT CALLS FOR CAPS ON DISCRETIONARY DOMESTIC SPENDING. WON'T ADDITIONAL FUNDING FOR AN AIDS VACCINE MEAN LESS FOR OTHER IMPORTANT PRIORITIES? WHY NOT EXPEND THIS KIND OF ENERGY AND RESOURCES ON A CURE FOR BREAST CANCER OR HEART DISEASE OR DIABETES?

A: This Administration has made a strong improving biomedical research an extremely important priority. We have increased investments in biomedical research at the National Institutes of Health by an impressive 16 percent since the President took office.

These additional investments has been used to increase investments in biomedical research in a number of important areas. For example, funding for breast cancer research has increased by 76 percent since the President took office .

Developing an AIDS vaccine is one important priority in our investments in biomedical research. Without an effective vaccine, AIDS will soon take over as the leading cause of death for persons between the ages of 25 and 44. Between 650,00 and 900,000 Americans are estimated to be living with HIV and over 300,000 have died of AIDS.
While we have made enormous strides in the last year in treating AIDS, these treatments are not always effective and are often prohibitively expensive both for Americans and throughout the world. Also scientists at NIH believe that it is only a matter of time before we develop an AIDS vaccine.
Increasing our commitment to developing a vaccine could make an enormous difference and save millions of lives both in this country and throughout the world.

STATISTICS ON THE AIDS EPIDEMIC

National Trends

- Between 650,000 and 900,000 Americans are living with HIV.
- Since the AIDS epidemic began 500,000 Americans have been reported with AIDS -- 300,000 have died.
- An estimated 40,000 to 60,000 Americans are being infected with HIV each year.
- An average of 100 Americans are diagnosed with AIDS each day and 100 to 150 become infected with HIV every 24 hours.
- AIDS is the leading cause of death among Americans aged 25 to 44.
- Women now comprise 14% of people with AIDS. If the current trends continue, an estimated 80,000 children will have been orphaned as a result of this disease by the end of the decade.
- In 1994 alone, 1,000 new pediatric cases of AIDS were reported.
- One in four new HIV infections in the U.S. occur among people under the age of 21.
- People of color have been disproportionately impacted by AIDS. As of October 1995, 38 percent of newly reported AIDS cases were with people of color

International Trends

- More than 29 million men, women and children around the world have been infected with HIV -- more than 3 million infections occurring within the last year.
- In 1995, 1.1 million adults and 350,000 children in the world died of AIDS.
- 8,500 people become infected with AIDS each day, including nearly 1,000 children.

- It has been estimated in some countries in subsaharan Africa that life expectancy has decreased by up to twenty years because of the AIDS epidemic.

- In 1992, in South Africa 2% of all women who came in for prenatal treatment were HIV positive and that number is up to 14%.

- Without an effective vaccine, AIDS will soon overtake tuberculosis and malaria as the leading cause of death among persons between 25-44 years of age.

THE PRESIDENT INTRODUCES INITIATIVES TO FULFILL HIS COMMITMENT TO DEVELOP AN AIDS VACCINE

Today President Clinton challenged the nation to commit itself to the goal of developing an AIDS vaccine within the next ten years. The President also announced a number of important initiatives to help fulfill this commitment, including high-level international collaboration, a dedicated research center for AIDS vaccine research at the National Institutes of Health (NIH), and outreach to scientists, pharmaceutical companies, and patient advocates to maximize the involvement of both the private and public sectors in the development of an AIDS vaccine. The President has already taken steps to enhance the possibility of developing an AIDS vaccine by increasing funding for NIH vaccine research and development over 33 percent in the last two years. The initiatives the President announced today, which build on an exceptional commitment to develop better ways to prevent, diagnose, treat, and eventually cure AIDS, include:

- **A New NIH AIDS Vaccine Center.** A dedicated intramural HIV vaccine research and development center is being established at the National Institutes of Health. This vaccine center, which will be fully operational within the next several months, is uniting outstanding scientists in immunology, virology, and vaccinology to join in a highly-collaborative effort to develop an AIDS vaccine. Bringing together a broad array of researchers in an intensely-focused environment has been a successful way of developing vaccines in the past.

- **A Global AIDS Vaccine Research Initiative.** The United States is proposing that the leaders of the eight major industrialized nations meeting at the Denver Summit in June agree to support a worldwide AIDS vaccine research initiative. The proposal calls for each nation to make a commitment to provide the necessary investments in their country to accelerate research toward the development of an HIV/AIDS vaccine as a scientific and public health priority. Joint meetings of key scientists from participating nations will address research progress, identity scientific gaps and opportunities, and design collaborative programs.

- **A Challenge to Pharmaceutical Manufacture Industry to Invest in Innovative Research to Develop an AIDS Vaccine.** We can only be successful in developing an AIDS vaccine if private and public sectors make this goal a priority. The President is challenging the pharmaceutical industry to join the government in a partnership to realize this important goal.

Background on HIV/AIDS. HIV/AIDS remains a global public health threat. More than 29 million men, women and children around the world have been infected with HIV -- more than 3 million infections occurring within the last year. Without an

effective vaccine, AIDS will soon overtake tuberculosis and malaria as the leading cause of death among persons between 25-44 years of age. Between 650,000-900,000 Americans are estimated to be living with HIV disease, and over 300,000 Americans have already died from AIDS.

Clinton Administration Accomplishments on HIV/AIDS. The Clinton Administration has made a sustained commitment to addressing the HIV epidemic through investments in prevention, research and treatment.

- **Increased funding for the NIH vaccine by 33 percent.** Funding for NIH vaccine research and development has increased over 33 percent in the last two years -- from $111.1 million in FY 1996 to $148 million proposed in the President's FY 1998 budget.

- **Funding for AIDS research, prevention and care increased by more than 50 percent in the first four years of the Clinton Administration.** Funding for AIDS Drug Assistance Programs (ADAP), which help low-income people purchase needed therapies, has tripled, while funding for the Ryan White CARE Act increased 158 percent. The approval of new AIDS drugs has greatly accelerated, with 16 new AIDS drugs and two diagnostic tests.

THE WHITE HOUSE

WASHINGTON

Glenda -

SO SORRY ALL YOUR HARD WORK IT TURNS OUT THAT A BOOK THIS THICKNESS WAS NEEDED! PATTY FROM ALASKA CALLED TO ASK THE QUESTIONS SHE COULD TELL AND STILL WAS HAPPY W/ WHAT YOU DID THOUGH, I WANTED TO MAKE SURE WE HAVE COPIES FOR THE FUTURE SO I'VE LEFT IT HERE B/C I WASN'T SURE THAT YOU'D SENT IT OVER TO THE PRINT SHOP TO BE COPIED WHEN WE CAN, THOUGH, CONGRESSMAN DEWITT WOULD STILL LIKE A COPY. HE CAN BE REACHED THROUGH THE CAPITOL SWITCH-BOARD @ 224-3121.

HOPE YOU HAD A GREAT TRIP!

Andi

FACSIMILE

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

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Washington, DC 20006

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TO:	Patty Everett
FAX NUMBER:	(512) 916-5108
FROM:	Anil Soni
DATE:	November 5, 1997
PAGES:	(including cover sheet)
COMMENTS:	Here is at least a little information about almost everything we discussed. If you need anything else, please let me know. Good luck!