

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member:

Subseries:

OA/ID Number: 21084

FolderID:

Folder Title:

AIDS Briefing Book, November 5, 1997 [binder] [1]

Stack:

S

Row:

66

Section:

6

Shelf:

7

Position:

3



OFFICE OF NATIONAL AIDS POLICY
EXECUTIVE OFFICE OF THE PRESIDENT

AIDS BRIEFING BOOK

NOVEMBER 5, 1997

Sandra L. Thurman, Director
808 17th Street NW, Suite 820
Washington, DC 20006

Phone: (202) 632-1090
Fax: (202) 632-1096

AIDS in the Workplace

HIV and AIDS affect every segment of society: the home, religious institutions, and the workplace. The World Health Organization estimates that a minimum of 40 million people worldwide will be infected with HIV by the year 2000. The potential worldwide economic impact of this infection rate could equal 1.4% of the world gross domestic product annually.

- It is estimated that 650,000 to 900,000 people in the United States are currently infected with HIV, the virus that causes AIDS.
- AIDS is the leading cause of death among adults between the ages of 25 and 44. More than half (53%) of our Nation's 126 million workers are in that age group.
- One in 6 large U.S. work sites (more than 50 employees) and 1 in 16 small U.S. work sites (fewer than 50 employees) have experienced an employee with HIV infection or AIDS.
- 75% of working Americans surveyed said their employees should offer a formal workplace AIDS education initiative.
- As with any catastrophic illness, AIDS can affect an employer in many ways.

- Insurance and health care costs
- Legal considerations
- Productivity
- Confidentiality and privacy
- Work disruption
- Discrimination concerns
- Consumer concerns
- Disability requirements
- Employee morale
- Job accommodation

The Centers for Disease Control and Prevention's (CDC) Business Responds to AIDS (BRTA)/Labor Responds to AIDS (LRTA) Programs are designed to help businesses and unions across the country develop and implement comprehensive workplace-based HIV and AIDS prevention education programs for employees, their families, and the community. The goals of this program are to prevent the spread of HIV, promote HIV education, prevent discrimination, and foster community service and volunteerism both in the workplace and in the community. In order to achieve these goals, BRTA/LRTA have developed materials and technical assistance to assist business and unions in forming comprehensive HIV and AIDS workplace programs.

Workplace Presentations in Vancouver

Oral

Business Responds To AIDS: Results From A National Survey In The U.S., Cynthia Jorgensen.

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

CDC

Divider Title: _____

CDC STATISTICS

**Most Recent AIDS Data
Demonstrate Increasing Impact of
Effective Prevention and Treatment Advances**

AIDS Incidence Declines for First Time

For the first time in the epidemic, there has been a decline in the estimated number of people diagnosed with AIDS annually (AIDS incidence).^{*} Between 1995 and 1996, AIDS incidence in people over age 12 declined 6%, from 60,620 to 56,730. This decline reflects the combined impact of successful prevention efforts, which have helped slow the epidemic in recent years, and the impact of new therapies in lengthening the healthy lifespan of people with HIV.

The impact of new combination drug therapies was first reported earlier this year, as AIDS deaths dropped for the first time. These surveillance data suggest that not only are new therapies delaying progression from AIDS to death, but with early diagnosis and treatment, are also helping to delay the progression from HIV infection to an AIDS diagnosis for many individuals.

Treatment Advances Dictate Changes in HIV/AIDS Surveillance

As progression to AIDS is successfully delayed for an increasing number of infected individuals, AIDS incidence will provide a less reliable indication of trends in the epidemic. For example, it is now difficult to determine how much of the drop in new cases is due to a slowing of new infections (which has been documented in recent years), and how much is due to improved treatment. To more effectively determine recent trends in HIV transmission, epidemiologists must increasingly rely on monitoring reported cases of HIV infection, rather than only reported cases of AIDS. In response to the changing epidemic, CDC is taking steps to improve the nation's ability to monitor HIV prevalence and incidence, given the new era in HIV treatment. Currently all 50 states require the reporting of AIDS diagnoses and AIDS deaths to the CDC. Thirty states also require the reporting of HIV infections among adults and/or children. State Health Departments should conduct HIV surveillance, in addition to AIDS surveillance. CDC plans to work with State Health Departments and the community to provide guidance and technical assistance to ensure that HIV/AIDS surveillance data accurately reflect the epidemic.

*AIDS Incidence Declined Most Among White Gay and Bisexual Men
but Continued to Increase Among Heterosexual Minorities*

Several trends in AIDS incidence continued in 1996, with the greatest decline occurring among white gay and bisexual men, while heterosexual incidence continued to increase--primarily among minority men and women. The continued increase in AIDS incidence in minorities underscores the need for intensified prevention efforts in this community, as well as the need to ensure timely access to HIV counseling and testing and HIV and STD treatment services.

**Note: As expected, AIDS incidence trends closely parallel earlier trends in AIDS deaths. Because combination therapies were first tried on the sickest patients (those who had already been diagnosed with AIDS), the influence of treatment was first seen in death trends. As combination therapies are increasingly used by more recently infected individuals, treatment will influence the time between HIV infection and an AIDS diagnosis.*

Between 1995 and 1996:

- AIDS incidence decreased among men (-8%), but continued to increase among women (+2%).
- AIDS incidence declined in all regions of the country, with greater declines in the Midwest (-10%), the West (-12%), and the Northeast (-8%), than in the South (-1%).
- AIDS incidence declined or leveled in all racial/ethnic groups, with decreases among whites (-13%) and Hispanics (-5%), and a leveling among blacks (0%).
- By exposure group, AIDS incidence declined among all groups, except people infected heterosexually.
 - Men who have sex with men (MSM) -11%
 - Men who have sex with men and inject drugs (MSM-IDU) -15%
 - Men who are injection drug users (IDU-Male) -6%
 - Women who are injection drug users (IDU- Female) -4%
 - Men infected through heterosexual contact +11%
 - Women infected through heterosexual contact +7%
- Looking at exposure categories by race: *See attached table for complete breakdown.*
 - the greatest proportionate declines in AIDS incidence occurred among white MSM (-15%) and white and black MSM-IDU (-17% and -13%, respectively).
 - the greatest proportionate increases occurred among black and Hispanic men and women infected heterosexually: Among black and Hispanic men infected heterosexually, increases were 19% and 13%, respectively. Among black and Hispanic women infected heterosexually, increases were 12% and 5%, respectively.

Continued Declines in Deaths Result in Increased AIDS Prevalence

Deaths continued to decline throughout 1996 (23% decline compared to 1995), and the number of people living with AIDS (AIDS prevalence) increased 11%. If declines in AIDS incidence continue, there will also be an increasing number of people living with HIV infection who have not developed AIDS (HIV prevalence) in the coming years. As HIV surveillance improves, so will our ability to monitor HIV prevalence and to better direct critical prevention and treatment services. The latest data on AIDS prevalence indicate that:

- Over one-quarter million people (235,470) were reported to be living with AIDS as of December 1996, as compared to 211,650 in 1995.
- MSM account for the largest proportion of people living with AIDS (48%), but the largest increase in AIDS prevalence occurred among men (28% increase) and women (23% increase) who were infected heterosexually.

**AIDS incidence must be estimated from AIDS cases reported each year. Researchers estimated AIDS incidence by using consistent formulas over time to adjust for changes in the AIDS surveillance case definition (or criteria used to report AIDS) and delays in AIDS case reporting. Adult and adolescent AIDS incidence figures provided in this document represent estimates of the number of AIDS opportunistic infections that occur annually.*

###



MORBIDITY AND MORTALITY WEEKLY REPORT

- 861 Update: Trends in AIDS Incidence — United States, 1996
- 867 Impact of Promotion of the Great American Smokeout and Availability of Over-the-Counter Nicotine Medications, 1996
- 871 Human Lead Absorption — Texas
- 877 Asthma Mortality — Illinois, 1979–1994

Update: Trends in AIDS Incidence — United States, 1996

Provisional surveillance data about acquired immunodeficiency syndrome (AIDS) for the first 6 months of 1996 indicated a decrease in deaths among persons with AIDS, attributed primarily to the effect of antiretroviral therapies on the survival of persons infected with human immunodeficiency virus (HIV) (1). This report describes a decline in AIDS incidence during 1996 compared with 1995 and the continued decline in AIDS deaths; the findings indicate that HIV therapies are having a widespread beneficial impact on the rate of HIV disease progression in the United States.*

Cumulative AIDS cases among persons aged ≥ 13 years reported to CDC through June 1997 from the 50 states, the District of Columbia, and the U.S. territories were analyzed by sex, age, race/ethnicity, and mode of risk/exposure[†] (2). Estimates of AIDS incidence and deaths were adjusted for delays in reporting. For analyses by risk/exposure, estimates were adjusted for the anticipated reclassification of cases initially reported without an HIV risk/exposure (2). To adjust for the 1993 expansion of the AIDS reporting criteria[‡], estimates of the incidence of AIDS-opportunistic illnesses (AIDS-OIs) were calculated from the sum of cases reported with an AIDS-OI and cases with estimated dates of diagnosis of an AIDS-OI that were reported based only on immunologic criteria (2). AIDS-OI incidence was estimated quarterly through December 1996 (the most recent period for which reliable estimates were available). Deaths among persons with AIDS were identified by review of medical records and death certificates and represent both deaths from HIV-related and other causes. AIDS prevalence was estimated as the cumulative incidence of AIDS based on the 1993 expanded AIDS case criteria minus cumulative deaths. Populations with < 500 estimated cases were excluded because the estimates of annual percentage change from 1995 to 1996 in AIDS-OI incidence, deaths, and prevalence are not reliable.

*Single copies of this report will be available until September 19, 1998, from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231 or (301) 217-0023.

[†]Categories included persons aged 20–64 years of white, black, or Hispanic race/ethnicity but excluded persons infected through receipt of contaminated blood/blood products and persons with other or no risks reported.

[‡]Conditions in HIV-infected persons that were added to the AIDS case definition in 1993 included laboratory measures of severe immunosuppression (i.e., CD4⁺ T-lymphocyte count < 200 cells/ μ L or percentage of total lymphocytes < 14) and three clinical conditions: pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

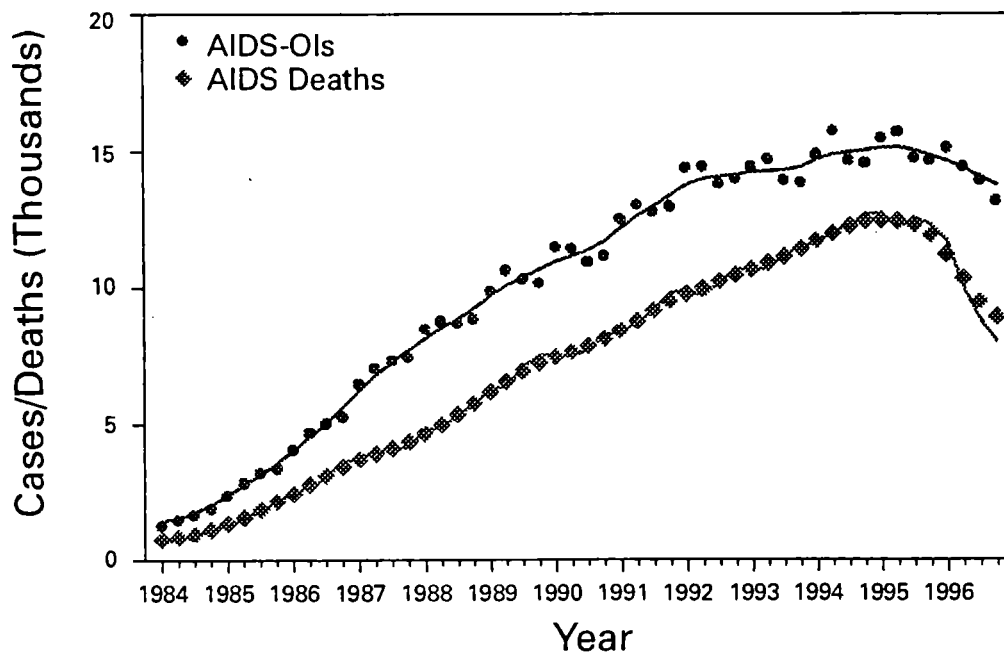
*AIDS Incidence — Continued***AIDS-OI Incidence**

During 1996, AIDS-OIs were diagnosed in an estimated 56,730 persons, a decline of 6% compared with 1995 (Figure 1). This represents the first calendar year during which AIDS-OI incidence overall did not increase in the United States.

From 1995 to 1996, AIDS-OI incidence declined in all four geographic regions of the United States (West [12%], Midwest [10%], Northeast [8%], and South [1%])[†]. AIDS-OI incidence decreased in all 5-year age groups; men; non-Hispanic whites and Hispanics; men who have sex with men (MSM); injecting-drug users (IDUs); and men who reported both of these exposures (MSM-IDUs) (Table 1). The largest proportionate declines occurred among non-Hispanic white MSM (Figure 2) and non-Hispanic white and black MSM-IDUs (Table 2). AIDS-OI incidence leveled among non-Hispanic blacks. The greatest proportionate increases in AIDS-OI incidence occurred among non-Hispanic black men (19%), Hispanic men (13%), and non-Hispanic black women (12%) who had heterosexual risk/exposures (Table 2).

[†]*Northeast*=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest*=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South*=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; and *West*=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

FIGURE 1. Estimated incidence of AIDS-opportunistic illnesses (AIDS-OIs) and estimated number of deaths among persons aged ≥ 13 years with AIDS (AIDS deaths), adjusted for delays in reporting, by quarter year of diagnosis/death — United States, 1984–1996*



*Points represent quarterly incidence; lines represent "smoothed" incidence. Estimates are not adjusted for incomplete reporting of AIDS cases.

*AIDS Incidence — Continued***TABLE 1. Estimated incidence* of AIDS-opportunistic illnesses (AIDS-OIs) and estimated number of deaths among persons aged ≥13 years reported with AIDS, by sex, race/ethnicity†, exposure category, and percentage change in AIDS-OIs and deaths from 1995 to 1996 — United States**

Characteristic	AIDS-OIs			Deaths		
	1995 No.	1996 No.	% Change from 1995 to 1996	1995 No.	1996 No.	% Change from 1995 to 1996
Sex						
Men	49,360	45,240	- 8	42,000	31,440	-25
Women	11,260	11,490	2	8,140	7,340	-10
Race/Ethnicity						
White, non-Hispanic	24,370	21,130	-13	21,700	14,670	-32
Black, non-Hispanic	24,090	24,030	0	18,840	16,460	-13
Hispanic	11,410	10,800	- 5	9,010	7,220	-20
Exposure category						
MSM‡	28,640	25,530	-11	24,880	17,310	-30
MSM-IDU¶	3,580	3,030	-15	3,310	2,490	-25
Male-IDU	12,880	12,140	- 6	10,790	8,970	-17
Female-IDU	4,950	4,750	- 4	3,830	3,440	-10
Heterosexual contact						
Male	3,420	3,790	11	2,300	2,120	- 8
Female	5,900	6,320	7	3,980	3,640	- 8
Total**	60,620	56,730	- 6	50,140	38,780	-23

*Estimates are presented rounded to the nearest 10 because they do not represent exact counts of persons with AIDS-OIs but are estimates that are approximately ±3% of the true value.

†Numbers for races other than black and white were too small for meaningful analysis. Persons of Hispanic origin may be of any race.

‡Men who have sex with men.

¶Injecting-drug user.

**Includes persons aged ≥13 years with hemophilia/coagulation disorders, transfusion recipients, or with other or no risks reported.

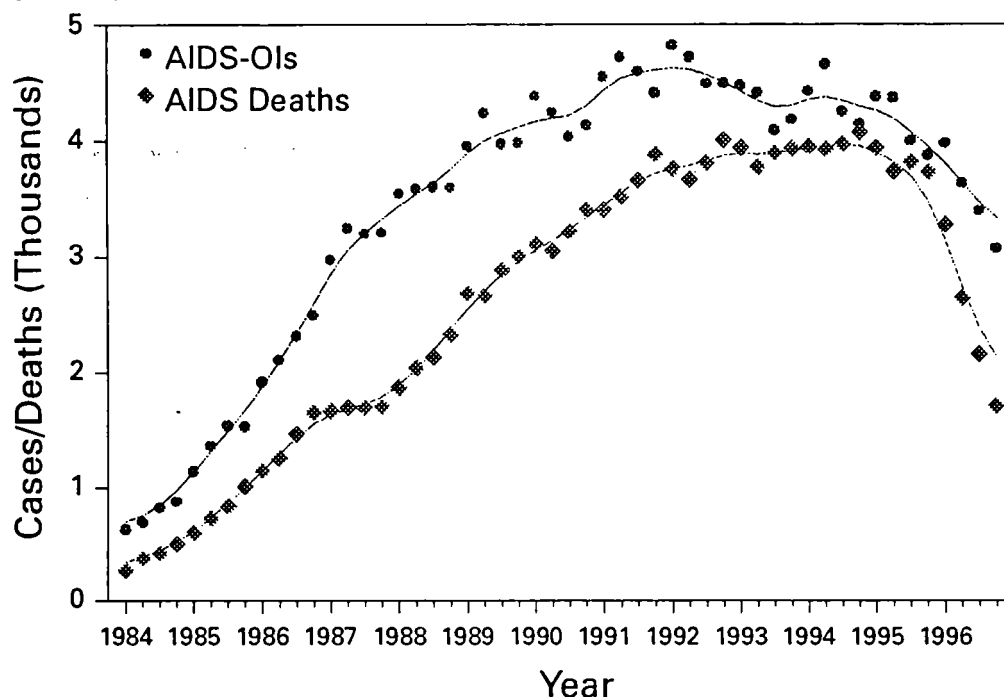
From 1995 to 1996, annual AIDS incidence changed abruptly compared with the magnitude and direction of the average annual changes in AIDS-OI incidence during 1992–1995. During these years, AIDS-OI incidence increased but was characterized by a slowing in the growth of the epidemic overall (average annual change from 1992 to 1995 was 2%) (1,2). The magnitude and/or the direction of the average annual change in AIDS-OI incidence from 1992 to 1995 was substantially different from the change from 1995 to 1996 among men (1% versus -8%) and women (10% versus 2%); whites (-2% versus -13%), non-Hispanic blacks (7% versus 0), and Hispanics (4% versus -5%); MSM (-1% versus -11%), men and women IDUs (3% versus -6% and 5% versus -4%, respectively), and MSM-IDUs (-3% versus -15%).

Deaths Among Persons Reported with AIDS

Deaths among persons reported with AIDS declined 23% in 1996 compared with 1995, with the largest declines occurring during the last three quarters of 1996 (Figure 1). From 1995 to 1996, deaths declined in all four geographic regions (West

AIDS Incidence — Continued

FIGURE 2. Estimated incidence of AIDS-opportunistic illnesses (AIDS-OIs) and estimated number of deaths among non-Hispanic white men who have sex with men aged ≥ 13 years with AIDS (AIDS deaths), adjusted for delays in reporting, by quarter year of diagnosis/death — United States, 1984–1996*



*Points represent quarterly incidence; lines represent "smoothed" incidence. Estimates are not adjusted for incomplete reporting of AIDS cases.

TABLE 2. Estimated incidence* of AIDS-opportunistic illnesses (AIDS-OIs) among persons aged ≥ 13 years, by race/ethnicity†, sex, and exposure category, and percentage change from 1995 to 1996 — United States

Exposure category	White, non-Hispanic			Black, non-Hispanic			Hispanic		
	1995	1996	% Change from 1995 to 1996	1995	1996	% Change from 1995 to 1996	1995	1996	% Change from 1995 to 1996
Men									
MSM‡	16,600	14,060	-15	7,330	7,110	-3	4,250	3,900	-8
IDU†	2,470	2,280	-8	6,840	6,540	-4	3,470	3,240	-7
MSM-IDU	1,690	1,410	-17	1,290	1,120	-13	**	**	**
Heterosexual	640	620	-2††	1,970	2,340	19	780	880	13
Women									
IDU	1,090	1,030	-5††	2,920	2,860	-2	900	820	-9
Heterosexual	1,270	1,220	-4	3,300	3,700	12	1,270	1,330	5

*Estimates are presented rounded to the nearest 10 because they do not represent exact counts of persons with AIDS-OIs but are estimates that are approximately $\pm 3\%$ of the true value.

†Numbers for races other than black and white were too small for meaningful analysis. Persons of Hispanic origin may be of any race.

‡Men who have sex with men.

†Injecting-drug user.

**Excluded because estimates were < 500 .

††The annual percentage changes were calculated from modeled point estimates before rounding.

AIDS Incidence — Continued

[33%], Midwest [25%], Northeast [22%], and South [19%]); among men and women; among all racial/ethnic groups; and in all risk/exposure categories (Table 1).

AIDS Prevalence

Approximately 235,470 persons in whom AIDS has been diagnosed are still living, and from 1995 to 1996, the prevalence of AIDS increased 11% (Table 3). MSM accounted for the largest proportion (48%) of persons with AIDS, and the largest proportionate increases in prevalence occurred among men and women who acquired AIDS through heterosexual contact (28% and 23%, respectively), the only risk/exposure category that experienced increases in AIDS-OI incidence.

Reported by: State and local health depts. Div of HIV/AIDS Prevention—Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, CDC.

Editorial Note: The findings in this report document the first overall decline in the annual incidence of AIDS-OIs in the United States. Concurrently, annual deaths among persons aged ≥ 13 years reported with AIDS also have decreased. Temporal trends in AIDS cases and deaths are the result of changes in the rate of new HIV infections, AIDS diagnoses resulting from progression of HIV disease to AIDS, and deaths of HIV-infected persons. The declines in AIDS-OI incidence and deaths reflect the impact of both HIV prevention efforts and the use of antiretroviral therapies and AIDS-OI prophylaxis.

During 1996, AIDS-OI incidence declined for almost all populations and in all regions of the country, and deaths declined substantially (23%) compared with 1995. The actual decline in AIDS-OI incidence is probably greater than the estimates in this report because there are insufficient longitudinal clinical data to model the impact of the newly available antiretroviral therapies on AIDS-OI incidence. However, the 1996 AIDS surveillance data are consistent with reports that recent improvements in HIV

TABLE 3. Estimated prevalence* of AIDS among persons aged ≥ 13 years, by sex and exposure category, and percentage change from 1995 to 1996 — United States

Exposure category	1995		1996		% Change from 1995 to 1996
	No.	(%)	No.	(%)	
Men					
MSM†	101,970	(48)	111,860	(48)	10
IDU‡	43,800	(21)	48,000	(20)	10
MSM-IDU	14,170	(7)	14,660	(6)	3
Heterosexual	9,620	(5)	12,300	(5)	28
Total	173,560	(82)	191,040	(81)	10
Women					
IDU	17,840	(8)	19,700	(8)	10
Heterosexual	18,610	(9)	22,860	(10)	23
Total	38,080	(18)	44,440	(19)	17
Total¶	211,650	(100)	235,470	(100)	11

* Estimates are presented rounded to the nearest 10 because they do not represent exact counts of persons with AIDS-OIs but are estimates that are approximately $\pm 3\%$ of the true value.

† Men who have sex with men.

‡ Injecting-drug users.

¶ Includes persons aged ≥ 13 years with hemophilia/coagulation disorders, transfusion recipients, or with other or no risks reported. The sum of the estimates for men and women may not equal total annual estimates because of rounding.

AIDS Incidence — Continued

care are preventing or delaying the onset of AIDS-OI and deaths among many populations of HIV-infected persons (3). Recent declines in AIDS incidence also have been reported in several western European countries and have been attributed to widespread use of combination antiretroviral therapies (4).

Data from CDC's Adult/Adolescent Spectrum of Disease (ASD) (5) project indicate that an increasing proportion of HIV-infected persons are receiving combination antiretroviral therapy. Among HIV-infected persons observed in clinical care in ASD during 1995–1996, the prescribed use of combination antiretroviral therapy increased from 24% of 5027 persons in the second half of 1995 to 65% of 2973 persons in the second half of 1996 (CDC, unpublished data, 1997). Use of these therapies is expected to increase because revised HIV treatment guidelines recommend earlier initiation of combination antiretroviral therapy in HIV-infected persons without AIDS-defining conditions (6).

Ensuring timely access to HIV-care services for HIV-infected persons remains important because in many persons HIV infection is not diagnosed until AIDS is diagnosed (7). To enable HIV-infected persons to benefit from treatment advances, HIV counseling and testing programs in screening and health-care settings must better facilitate early diagnosis of HIV infection and ensure that HIV-infected persons have access to care and treatment services.

Despite the decreases in AIDS-OI incidence and deaths in 1996, AIDS-OI incidence remained high, and HIV infection remained a leading cause of death among persons aged 25–44 years (8). AIDS-OI incidence continued to increase among persons who were infected through heterosexual contact. Until effective vaccines are developed, continued emphasis on behavioral risk-reduction and other prevention strategies targeted to these populations is the most effective way to reduce HIV infections.

The 1996 AIDS surveillance trends illustrate how surveillance data are now affected by both patterns of HIV incidence and HIV treatment advances. In comparison, surveillance based on a diagnosis of HIV infection is not affected by changes in the progression of HIV disease. CDC supports both HIV and AIDS surveillance in 30 states. Among these states, the number of prevalent HIV and AIDS cases combined is approximately 2.5 times greater than the number of prevalent AIDS cases alone (1,2). HIV/AIDS surveillance programs in these states provide a more timely measure of emerging patterns of HIV transmission, a more complete estimate of the number of persons with HIV infection and disease, and a better mechanism to evaluate access to HIV testing and medical and prevention services than AIDS surveillance alone (9).

Although AIDS surveillance continues to be essential for understanding reasons for the lack of timely access to HIV testing and care and the failure of treatment regimens to delay HIV disease progression, HIV surveillance is becoming increasingly important as more infected persons receive effective antiretroviral therapy. In June 1997, the Council of State and Territorial Epidemiologists (CSTE) recommended that all states implement HIV case reporting by name from health-care providers and laboratories (10). The Association of State and Territorial Health Officers has provisionally endorsed the CSTE recommendation pending a vote of its full membership. CDC recently provided additional resources to state and local surveillance programs that plan to or are conducting HIV case surveillance in addition to AIDS surveillance.

All states and territories should conduct HIV case surveillance as an extension of their AIDS Surveillance programs, and CDC is developing HIV surveillance policy and

AIDS Incidence — Continued

technical guidance to assist all states and territories to conduct HIV/AIDS case surveillance. CDC and CSTE recently convened a consultation** to discuss the objectives and methods of conducting HIV/AIDS case surveillance. CDC will continue to foster a collaborative approach among public health authorities, health-care providers, and the community to meet their information needs and to ensure the confidentiality of HIV/AIDS surveillance data.

References

1. CDC. Update: trends in AIDS incidence, deaths, and prevalence—United States, 1996. *MMWR* 1997;46:165–73.
 2. CDC. HIV/AIDS surveillance report. Atlanta: US Department of Health and Human Services, Public Health Service, 1996; (vol 8, no. 2).
 3. Hammer SM, Squires KE, Hughes MD, et al. A controlled trial of two nucleoside analogues plus indinavir in persons with human immunodeficiency virus infection and CD4 cell counts of 200 per cubic millimeter or less. *N Engl J Med* 1997;337:725–33.
 4. Hamers F, Downs A, Alix J, Brunet JB. AIDS trends in Europe: decrease in the west, increase in the east. *Eurosurveillance* 1997;2:36–7.
 5. Farizo KM, Buehler JW, Chamberland ME, et al. Spectrum of disease in persons with human immunodeficiency virus infection in the United States. *JAMA* 1992;267:1798–805.
 6. Carpenter CC, Fischl MA, Hammer SM, et al. Antiretroviral therapy for HIV infection in 1997: updated recommendations of the International AIDS Society–USA panel. *JAMA* 1997;277:1962–9.
 7. Wortley PM, Chu SY, Diaz T, et al. HIV testing patterns: where, why, and when were persons with AIDS tested for HIV? *AIDS* 1995;9:487–92.
 8. Ventura SJ, Peters KD, Martin JA, Maurer JD. Births and deaths: United States, 1996. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, National Center for Health Statistics, 1997. (Monthly vital statistics report; vol 45, no. 12, suppl).
 9. CDC. Public health uses of HIV infection reports—South Carolina, 1986–1991. *MMWR* 1992;41:245–9.
 10. Council of State and Territorial Epidemiologists. CSTE: position statement ID-4. National HIV surveillance: addition to the National Public Health Surveillance System. Atlanta: Council of State and Territorial Epidemiologists, 1997.
- AIDS Incidence — Continued

**The Consultation on the Future of HIV/AIDS Surveillance was held in Atlanta on May 21–22, 1997, sponsored by CSTE and CDC. Documents presented at the meeting and a meeting transcript can be obtained from the CDC National AIDS Clearinghouse after October 31, 1997.

1996 HIV/AIDS Trends Provide Evidence of Success in HIV Prevention and Treatment

AIDS Deaths Decline for First Time

For the first time in the epidemic, there has been a marked decrease in deaths among people with AIDS. The decline in deaths is likely due to both the slowing of the epidemic overall and to improved treatments over the past several years, which have lengthened the lifespan of people with AIDS. While it is too soon to determine the impact protease inhibitors will have on these trends, these drugs promise to further lengthen the lifespan of individuals living with HIV. Additionally, the estimated number of people diagnosed with AIDS each year (AIDS incidence) continued to slow, with an increase of only 2% in 1995, reflecting in part the ongoing success of prevention efforts.

As treatment advances continue to improve survival, we will face a number of key challenges:

- First, if the number of new HIV infections each year (HIV incidence) remains stable or increases, and deaths continue to decrease, there will be an increasing number of people living with HIV and AIDS. Additional resources will likely be needed for services, treatment, and care.
- Second, to continue to provide the necessary data to plan, direct, and evaluate HIV prevention efforts. HIV/AIDS surveillance systems must adapt to changes in medical practices which increase survival following diagnosis of HIV or AIDS. If progression to AIDS is successfully delayed for an increasing number of individuals, AIDS case reports may no longer provide a reliable indication of trends in the epidemic and will underrepresent the need for treatment services. Surveillance systems will therefore need to improve methods to monitor the number of individuals with HIV infection.
- And finally, as we continue to work to develop better treatment options, we must not lose sight of the fact that preventing HIV infection reduces the number of people who need to undergo complex, costly treatment regimens. Prevention remains our best and most cost-effective approach for bringing the HIV/AIDS epidemic under control and saving lives.

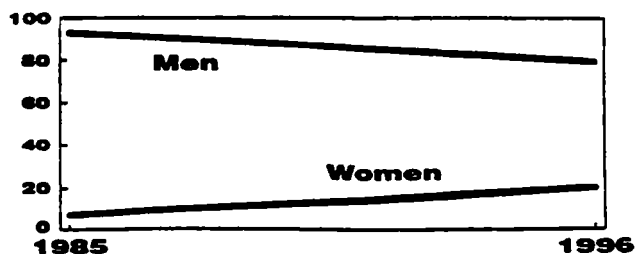
The 1996 Data: Trends in Case Reports, Estimated AIDS Incidence and Deaths

AIDS Cases Reported through December 1996

- 581,429 people with AIDS have been reported to date.
- Of these, 488,300 (84%) were men, 85,500 (15%) were women, and 7,629 (1%) were children.
- In 1996, blacks accounted for a larger proportion of AIDS cases (41%) than whites for the first time.

Women account for an increasing proportion of newly reported AIDS cases. The proportion of female adult and adolescent AIDS cases increased from 7% of the annual total in 1985 to 20% in 1996. In contrast, the proportion of male adult and adolescent AIDS cases decreased from 93% of the annual total in 1985 to 80% in 1996.

Proportion of newly reported AIDS cases by gender



Trends in AIDS Incidence through 1995:

Between 1994 and 1995, the estimated number of people diagnosed with AIDS (AIDS incidence) increased 2%, from 61,200 to 62,200. These estimates reflect a slowing in the growth of the epidemic, with an average of 15,200 people diagnosed each quarter between January 1994 and June 1996. Hopefully, with a combined strategy to prevent new infections and to provide early diagnosis and treatment for people who are infected, AIDS incidence will soon begin to decline.

During 1995:

- AIDS incidence rates per 100,000 people in the population were 7 times higher among blacks (99) than among whites (15), and three times higher among Hispanics (50) than among whites.
- AIDS incidence rates were much lower among women (10) than among men (48).
- AIDS incidence remained relatively constant among men who have sex with men (decline of 2%) and IDUs (increase of 2%), but continued to increase substantially among people infected heterosexually (17% increase).

Trends in Mortality:

In 1995, the CDC AIDS surveillance system documented approximately 50,000 AIDS deaths. 1995 marked the smallest increase to date in AIDS deaths. During the first 2 quarters of 1996, the estimated number of AIDS deaths (22,000) was 13% less than the estimated number of AIDS deaths during the first two quarters of 1995 (24,900), marking the first decline in AIDS deaths since the beginning of the epidemic. Not surprisingly, trends in AIDS deaths closely parallel trends documented recently in AIDS incidence. AIDS deaths have not declined among women or among heterosexuals.

- AIDS deaths declined in all four regions of the country: (Northeast 15%, South 8%, Midwest 11%, West 16%).
- Deaths declined among men by 15% but increased among women by 3%.
- Deaths declined among MSM by 18% and 6% among IDUs, but increased 3% among heterosexuals.
- Deaths declined among all racial/ethnic groups, but declines were greater among whites (21%) than among blacks (2%) and Hispanics (10%).
- HIV infection remains the leading cause of death among 25-44 year olds, accounting for 19% of deaths in this age group.

Trends in AIDS Prevalence:

The number of people living with AIDS continues to increase. As of mid-1996, an estimated 223,000 people were living with AIDS.

- AIDS prevalence has increased 10% since mid-1995.
- The largest number of people living with AIDS by risk category are MSM (44%), followed by IDU (26%), and heterosexuals (12%).
- The greatest proportionate increase in AIDS prevalence from mid-1995 to mid-1996 occurred among those infected heterosexually (19%), while the greatest increase in the number of people living with AIDS occurred among MSM (5,100).

HIV/AIDS

Surveillance Report

U.S. HIV and AIDS cases reported through June 1997

Midyear Edition Vol. 9, No. 1

Contents

Commentary	3
AIDS tables	
Table 1. AIDS cases and annual rates per 100,000 population, by state	5
Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population	6
Table 3. AIDS cases by age group, exposure category, and sex	8
Table 4. Male adult/adolescent AIDS cases by exposure category and race/ethnicity	9
Table 5. Female adult/adolescent AIDS cases by exposure category and race/ethnicity	10
Table 6. Pediatric AIDS cases by exposure category and race/ethnicity	11
Table 7. AIDS cases in adolescents and adults under age 25, by sex and exposure category	12
Table 8. AIDS cases by sex, age at diagnosis, and race/ethnicity	13
Table 9. AIDS cases, case-fatality rates, and deaths, by half-year and age group	14
Table 10. AIDS cases by year of diagnosis and definition category	15
Table 11. Health care workers with documented and possible occupationally acquired AIDS/HIV infection, by occupation	15
Table 12. Adult/adolescent AIDS cases by single and multiple exposure categories	16
AIDS figures	
Figure 1. Male adult/adolescent AIDS annual rates per 100,000 population	17
Figure 2. Female adult/adolescent AIDS annual rates per 100,000 population	17
Figure 3. Male adult/adolescent AIDS cases	18
Figure 4. Female adult/adolescent AIDS cases	18
Figure 5. Pediatric AIDS cases	19
Figure 6. Estimated incidence of AIDS, AIDS-opportunistic illness, and deaths of persons with AIDS	19
Figure 7. Investigations of adult/adolescent AIDS cases ever classified as risk not reported or identified	20
Estimated AIDS-opportunistic illness tables	
Table 13. Estimated AIDS-opportunistic illness incidence, by region of residence and year of diagnosis	21
Table 14. Estimated AIDS-opportunistic illness incidence, by race/ethnicity and year of diagnosis	21
Table 15. Estimated AIDS-opportunistic illness incidence, by age group, sex, exposure category, and year of diagnosis	22
Estimated deaths tables	
Table 16. Estimated deaths of persons with AIDS, by region of residence and year of death	22
Table 17. Estimated deaths of persons with AIDS, by race/ethnicity and year of death	23
Table 18. Estimated deaths of persons with AIDS, by age group, sex, exposure category, and year of death	23
Estimated persons living with AIDS tables	
Table 19. Estimated persons living with AIDS, by region of residence and year	24
Table 20. Estimated persons living with AIDS, by race/ethnicity and year	24
Table 21. Estimated persons living with AIDS, by age group, sex, exposure category, and year	25
HIV Infection tables	
Table 22. HIV infection cases by state and age group	26
Table 23. Male adult/adolescent HIV infection cases by exposure category and race/ethnicity	27
Table 24. Female adult/adolescent HIV infection cases by exposure category and race/ethnicity	28
Table 25. Pediatric HIV infection cases by exposure category and race/ethnicity	29
Table 26. HIV infection cases in adolescents and adults under age 25, by sex and exposure category	30
Table 27. HIV infection cases by sex, age at diagnosis, and race/ethnicity	31
Table 28. Persons reported to be living with HIV infection and with AIDS, by state and age group	32
Technical Notes	33



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

CDC
CENTERS FOR DISEASE CONTROL
AND PREVENTION

Notice to readers: This issue of the *HIV/AIDS Surveillance Report* includes six new tables and a figure. Tables 16 through 18 present estimated deaths of persons with AIDS. Tables 19 through 21 present estimates of persons living with AIDS. Figure 6 presents the estimated incidence of AIDS, AIDS-opportunistic illnesses, and deaths of persons with AIDS. See Commentary.

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

Suggested Citation: Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, 1997;9(No. 1):[inclusive page numbers].

Centers for Disease Control and Prevention David Satcher, M.D., Ph.D.
Director

National Center for HIV, STD and TB Prevention Helene D. Gayle, M.D., M.P.H.
Director

Division of HIV/AIDS Prevention — Surveillance and Epidemiology Kevin M. De Cock, M.D.
Director

Surveillance Branch John W. Ward, M.D.
Chief

Reporting and Analysis Section Patricia L. Fleming, Ph.D.
Chief

Russ P. Metler, R.N., M.S.P.H.
Surveillance Report Coordinator

Statistics and Data Management Branch Xenophon M. Santas
Acting Chief

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

Single copies of the *HIV/AIDS Surveillance Report* are available free from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone 1-800-458-5231 or 1-301-217-0023. Individuals or organizations can be added to the mailing list by writing to MASO/MSB/IDS, CDC, Mailstop A-22, 1600 Clifton Rd., N.E., Atlanta, GA 30333. Internet users may view an electronic copy of the *Report* by visiting CDC's home page (www.cdc.gov) and selecting the topic "Publications, Software, & Products." Confidential information, referrals, and educational material on AIDS are available from the CDC National AIDS Hotline: 1-800-342-2437, 1-800-344-7432 (Spanish access), and 1-800-243-7889 (TTY, deaf access).

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

The HIV/AIDS logo on the cover is used with permission of the American Red Cross.

Federal Recycling Program



Printed on Recycled Paper

Commentary

In addition to the importance of HIV/AIDS surveillance data for tracking and forecasting trends in the epidemic, data on the number of persons reported with AIDS are used to target and allocate resources for prevention and treatment services. Some of the tables and figures presented in the *HIV/AIDS Surveillance Report* include *counts of cases* (e.g., tables 1-3, 22; figures 3-5) which represent the number of individuals reported with AIDS or HIV infection. The number of cases reported cumulatively or during a recent time period indicates the size and characteristics of the populations affected by the epidemic and the distribution and impact of HIV/AIDS nationally.

Through June 30, 1997, a cumulative total of 612,078 persons with AIDS were reported to CDC by state and territorial health departments (table 1). Of these, 84 percent were adult/adolescent men, 15 percent were adult/adolescent women, and 1 percent were children (under 13 years of age). Of adults/adolescents reported during the last 12 months (July 1996–June 1997), 36 percent were white, 43 percent were black, and 20 percent were Hispanic. Men who have sex with men accounted for the largest proportion of reported cases (38 percent). Among 609 children reported in the last 12 months, 15 percent were white, 63 percent were black, and 21 percent were Hispanic (table 6). Over 90 percent of these children were infected perinatally. In addition, 29 states that conduct HIV case surveillance of adults, adolescents, and/or children reported 86,972 persons who were diagnosed with HIV (excluding persons tested anonymously) but not yet diagnosed with AIDS (table 22). The demographic and risk/exposure characteristics of reported cases of AIDS and HIV are presented in tables 1-12 and 22-28.

Many factors affect the number of cases of HIV or AIDS that will be reported to CDC in any given time period. Current and historic HIV transmission patterns, patterns of HIV testing and access to care, the impact of therapy on the course of HIV disease, and variations in surveillance prac-

tices over time or from one jurisdiction to another are factors that affect the interpretation of surveillance case report data.

Tables 16-21 and figure 6 have been added to this edition of the surveillance report to more fully represent current trends in the epidemic. In addition to the estimated numbers of cases diagnosed with AIDS-defining opportunistic illnesses (AIDS-OIs) presented in tables 13-15, this report includes estimated numbers of deaths of persons reported with AIDS, and estimates of the prevalence of AIDS. CDC has received requests for data describing trends in AIDS prevalence and deaths. These data are of interest as a measure of the impact of antiretroviral therapy on AIDS trends. Because they do not represent actual counts of persons with AIDS who were reported to CDC, the estimates are presented as rounded numbers in the tables.

In 1996, the estimated number of persons diagnosed with an AIDS-OI decreased for the first time, from 61,300 estimated cases in 1995 to 57,200 in 1996 (tables 13-15). The actual decrease in AIDS-OI incidence is likely to be greater than the estimated decrease in this report. The estimates of AIDS-OI incidence are based on the estimates of disease progression rates among persons enrolled in CDC's Adult/adolescent Spectrum of Disease Project, but there are not yet sufficient data to estimate the effects of the use of recently available antiretroviral treatments. Also for the first time in 1996, the estimated deaths among persons with AIDS declined to 39,200 from 50,700 in 1995 (tables 16-18). The cumulative number of persons estimated to have been diagnosed with AIDS based on the 1993 case definition and who have not been reported as deceased (i.e., the estimated number of prevalent AIDS cases or persons who are living with AIDS), continued to increase, from 215,000 estimated cases in 1995 to 239,000 cases in 1996 (tables 19-21).

The estimates are derived from models which adjust surveillance data to account for delays in reporting cases to CDC and for changes in the

AIDS case definition over time. Estimates of AIDS incidence and deaths are not adjusted for incomplete reporting. To illustrate how these estimates are used to monitor trends, figure 6 presents three estimated incidence curves. The top curve represents the number of cases diagnosed with AIDS using the 1993 definition criteria after adjustments for reporting delays. It represents the distribution of all cases diagnosed with AIDS and illustrates the distorting effect of the change in the case definition. The middle curve represents the estimated number of cases diagnosed with AIDS-OIs and accounts for the change in case definition and reporting delays. It shows the gradual slowing in the growth of the epidemic during the mid-1990's and the recent decline in AIDS-OI incidence using consistent diagnostic criteria over time. The bottom curve represents the reported number of deaths of persons with AIDS using the 1993 case definition after adjustments for reporting delays. It shows the substantial recent decline in deaths of persons with AIDS. The convergence of the top and middle curves in figure 6 illustrates that the temporary distorting effect that the expansion of the AIDS surveillance case definition had on temporal trends has waned. In the near future, it will no longer be necessary to adjust for the effect of the 1993 expanded case definition when presenting estimated numbers of AIDS cases diagnosed in a given year or when comparing trends in diagnoses overtime, from approximately 1996 forward.

The estimation procedures and the sources of data included in the models are described in the Technical Notes of this report. Because the analysis and interpretation of surveillance data require an understanding of how the data are collected, reported, and analyzed, as well as their uses and limitations, readers of this report are encouraged to review the Technical Notes and consult the references listed under Suggested Reading.

Suggested Reading

- CDC. Update: trends in AIDS incidence—United States, 1996. *MMWR* 1997;46: 861-67.
- CDC. Update: trends in AIDS incidence, deaths, and prevalence—United States, 1996. *MMWR* 1997;46:165-73.
- CDC. AIDS among children—United States, 1996. *MMWR* 1996;45:1005-10.
- CDC. *HIV/AIDS Surveillance Report*, 1996;8 (No.2):1-39.
- CDC. AIDS associated with injecting-drug use—United States, 1995. *MMWR* 1996;45: 392-98.
- CDC. First 500,000 AIDS cases—United States, 1995. *MMWR* 1995;44:849-53.
- CDC. Update: trends in AIDS among men who have sex with men—United States, 1989-1994. *MMWR* 1995;44:401-04.
- CDC. Update: AIDS among women—United States, 1994. *MMWR* 1995;44:81-84. Erratum: *MMWR* 1995;44:135.

Table 1. AIDS cases and annual rates per 100,000 population, by state, reported July 1995 through June 1996, July 1996 through June 1997; and cumulative totals, by state and age group, through June 1997, United States

State of residence	July 1995– June 1996		July 1996– June 1997		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children < 13 years old	Total
Alabama	664	15.6	521	12.2	4,441	63	4,504
Alaska	37	6.1	44	7.2	380	5	385
Arizona	656	15.2	532	12.0	5,237	21	5,258
Arkansas	285	11.5	243	9.7	2,238	32	2,270
California	10,540	33.4	8,177	25.7	101,020	549	101,569
Colorado	597	15.9	432	11.3	5,935	27	5,962
Connecticut	1,518	46.4	1,198	36.6	9,002	172	9,174
Delaware	319	44.5	264	36.4	1,908	14	1,922
District of Columbia	1,049	189.2	1,196	220.2	9,799	147	9,946
Florida	7,686	54.2	6,725	46.7	60,930	1,270	62,200
Georgia	2,495	34.6	2,108	28.7	17,808	177	17,985
Hawaii	207	17.6	144	12.2	2,014	14	2,028
Idaho	45	3.9	44	3.7	392	2	394
Illinois	2,148	18.2	1,753	14.8	19,095	224	19,319
Indiana	653	11.3	564	9.7	4,746	33	4,779
Iowa	129	4.5	105	3.7	1,020	8	1,028
Kansas	256	10.0	189	7.3	1,909	10	1,919
Kentucky	314	8.1	405	10.4	2,380	21	2,401
Louisiana	1,361	31.4	1,232	28.3	9,548	112	9,660
Maine	80	6.5	55	4.4	774	9	783
Maryland	2,287	45.4	2,175	42.9	15,955	268	16,223
Massachusetts	1,294	21.3	1,126	18.5	12,331	192	12,523
Michigan	1,032	10.8	949	9.9	8,681	89	8,770
Minnesota	322	7.0	248	5.3	3,075	20	3,095
Mississippi	414	15.4	448	16.5	3,006	44	3,050
Missouri	845	15.9	691	12.9	7,437	50	7,487
Montana	30	3.4	42	4.8	246	3	249
Nebraska	98	6.0	99	6.0	834	9	843
Nevada	457	29.8	466	29.1	3,275	25	3,300
New Hampshire	99	8.6	68	5.8	721	8	729
New Jersey	3,981	50.1	3,777	47.3	34,178	693	34,871
New Mexico	113	6.7	229	13.4	1,517	5	1,522
New York	13,242	72.8	12,525	68.9	111,541	2,008	113,549
North Carolina	977	13.6	859	11.7	7,637	105	7,742
North Dakota	10	1.6	10	1.6	85	–	85
Ohio	1,107	9.9	930	8.3	9,001	108	9,109
Oklahoma	279	8.5	288	8.7	2,861	25	2,886
Oregon	500	15.9	357	11.1	4,007	14	4,021
Pennsylvania	2,266	18.8	2,127	17.6	18,136	252	18,388
Rhode Island	181	18.3	162	16.4	1,652	16	1,668
South Carolina	967	26.4	815	22.0	6,592	69	6,661
South Dakota	17	2.3	10	1.4	118	4	122
Tennessee	901	17.2	796	15.0	5,901	46	5,947
Texas	4,375	23.3	4,928	25.8	41,863	322	42,185
Utah	197	10.1	159	7.9	1,429	20	1,449
Vermont	40	6.8	32	5.4	313	3	316
Virginia	1,506	22.8	1,255	18.8	9,548	151	9,699
Washington	773	14.2	764	13.8	7,898	32	7,930
West Virginia	147	8.1	113	6.2	793	8	801
Wisconsin	326	6.4	253	4.9	2,892	24	2,916
Wyoming	14	2.9	17	3.5	151	2	153
Subtotal	69,836	26.6	62,649	23.6	584,250	7,525	591,775
U.S. dependencies, possessions, and associated nations							
Guam	4	2.8	2	1.4	19	–	19
Pacific Islands, U.S.	–	–	2	0.7	4	–	4
Puerto Rico	2,135	56.9	2,210	58.4	19,220	363	19,583
Virgin Islands, U.S.	32	30.6	56	53.4	317	13	330
Total¹	72,085	27.0	64,966	24.1	604,176	7,902	612,078

¹ U.S. totals presented in this report include data from the United States (50 states and the District of Columbia), and from U.S. dependencies, possessions, and dependent nations in free association with the United States. See Technical Notes. Totals include 367 persons whose state of residence is unknown.

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported July 1995 through June 1996, July 1996 through June 1997; and cumulative totals, by area and age group, through June 1997, United States

Metropolitan area of residence	July 1995– June 1996		July 1996– June 1997		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Akron, Ohio	33	4.9	75	11.0	418	–	418
Albany-Schenectady, N.Y.	210	23.8	193	22.0	1,340	20	1,360
Albuquerque, N.Mex.	53	8.0	135	20.1	838	2	840
Allentown, Pa.	105	17.1	78	12.7	629	8	63
Ann Arbor, Mich.	38	7.3	24	4.5	304	7	311
Atlanta, Ga.	1,768	51.4	1,416	40.0	12,734	93	12,827
Austin, Tex.	293	29.1	276	26.5	3,041	19	3,06
Bakersfield, Calif.	167	27.1	66	10.6	738	4	742
Baltimore, Md.	1,516	61.4	1,529	61.8	10,583	186	10,769
Baton Rouge, La.	221	39.2	273	48.1	1,279	18	1,297
Bergen-Passaic, N.J.	490	37.5	520	39.7	4,489	69	4,558
Birmingham, Ala.	211	23.7	156	17.4	1,385	19	1,404
Boston, Mass.	1,129	19.6	952	16.4	10,895	168	11,063
Buffalo, N.Y.	46	3.9	385	32.8	1,273	15	1,288
Charlotte, N.C.	198	15.3	156	11.8	1,538	19	1,557
Chicago, Ill.	1,809	23.5	1,437	18.6	16,544	199	16,743
Cincinnati, Ohio	272	17.1	117	7.3	1,532	14	1,546
Cleveland, Ohio	246	11.0	277	12.4	2,613	36	2,649
Columbus, Ohio	192	13.4	176	12.2	1,857	12	1,869
Dallas, Tex.	1,007	33.8	904	29.7	10,017	35	10,052
Dayton, Ohio	116	12.2	91	9.6	808	15	823
Denver, Colo.	447	24.4	327	17.5	4,767	19	4,786
Detroit, Mich.	724	16.8	578	13.4	5,984	64	6,048
El Paso, Tex.	120	17.7	114	16.7	715	2	717
Fort Lauderdale, Fla.	1,221	86.4	1,127	78.4	9,713	224	9,937
Fort Worth, Tex.	199	13.3	310	20.3	2,580	25	2,605
Fresno, Calif.	145	17.1	89	10.3	953	13	96
Gary, Ind.	67	10.8	87	14.0	553	3	556
Grand Rapids, Mich.	85	8.5	69	6.8	608	3	611
Greensboro, N.C.	177	15.7	102	8.9	1,246	19	1,265
Greenville, S.C.	138	15.6	124	13.8	1,081	2	1,083
Harrisburg, Pa.	93	15.2	104	16.9	683	5	68
Hartford, Conn.	511	46.0	412	37.1	3,065	46	3,111
Honolulu, Hawaii	141	16.2	95	10.9	1,468	11	1,479
Houston, Tex.	1,332	35.8	1,806	47.6	14,988	136	15,124
Indianapolis, Ind.	332	22.5	229	15.3	2,285	13	2,298
Jacksonville, Fla.	386	39.3	367	36.4	3,458	65	3,523
Jersey City, N.J.	631	114.5	605	109.8	5,528	113	5,641
Kansas City, Mo.	342	20.4	228	13.5	3,302	12	3,314
Knoxville, Tenn.	65	10.1	65	10.0	529	6	53
Las Vegas, Nev.	374	32.7	382	31.8	2,597	24	2,621
Little Rock, Ark.	86	15.8	96	17.5	821	10	831
Los Angeles, Calif.	3,889	42.8	3,232	35.4	35,753	221	35,974
Louisville, Ky.	150	15.2	248	25.0	1,128	14	1,142
Memphis, Tenn.	302	28.3	290	26.9	2,103	15	2,118
Miami, Fla.	2,356	115.1	1,799	86.6	18,757	448	19,205
Middlesex, N.J.	330	30.6	261	23.9	2,652	66	2,718
Milwaukee, Wis.	162	11.1	151	10.4	1,573	14	1,587
Minneapolis-Saint Paul, Minn.	278	10.2	220	8.0	2,720	16	2,736
Mobile, Ala.	109	21.2	84	16.2	855	11	866
Monmouth-Ocean, N.J.	288	27.4	236	22.2	2,380	59	2,439
Nashville, Tenn.	293	26.8	272	24.3	1,867	16	1,883
Nassau-Suffolk, N.Y.	639	24.1	664	25.0	5,395	83	5,478
New Haven, Conn.	855	52.6	670	41.1	5,160	120	5,280
New Orleans, La.	730	55.5	640	48.7	5,461	56	5,517

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported July 1995 through June 1996, July 1996 through June 1997; and cumulative totals, by area and age group, through June 1997, United States — Continued

Metropolitan area of residence	July 1995– June 1996		July 1996– June 1997		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
New York, N.Y.	11,303	131.0	10,129	117.2	95,275	1,828	97,103
Newark, N.J.	1,525	78.7	1,552	80.0	13,729	297	14,026
Norfolk, Va.	545	35.5	492	31.9	2,676	57	2,733
Oakland, Calif.	663	30.2	548	24.8	6,787	39	6,826
Oklahoma City, Okla.	117	11.5	153	14.9	1,331	7	1,338
Omaha, Nebr.	64	9.5	72	10.6	588	3	591
Orange County, Calif.	514	19.8	358	13.6	4,636	27	4,66
Orlando, Fla.	589	42.5	495	34.9	4,387	68	4,455
Philadelphia, Pa.	1,697	34.3	1,589	32.1	13,908	211	14,119
Phoenix, Ariz.	462	17.4	333	12.1	3,698	12	3,710
Pittsburgh, Pa.	227	9.5	179	7.5	1,996	16	2,012
Portland, Oreg.	354	20.6	269	15.3	3,270	8	3,278
Providence, R.I.	167	18.4	154	17.0	1,548	15	1,563
Raleigh-Durham, N.C.	173	17.4	152	14.8	1,528	21	1,549
Richmond, Va.	279	30.1	246	26.3	1,946	25	1,97
Riverside-San Bernardino, Calif.	658	22.2	562	18.6	5,423	47	5,470
Rochester, N.Y.	323	29.7	302	27.8	1,741	11	1,752
Sacramento, Calif.	277	19.0	213	14.4	2,611	24	2,635
Saint Louis, Mo.	436	17.2	418	16.4	3,766	31	3,797
Salt Lake City, Utah	175	14.6	141	11.6	1,257	14	1,271
San Antonio, Tex.	374	25.6	369	24.8	3,166	26	3,192
San Diego, Calif.	1,140	43.4	810	30.5	8,689	49	8,738
San Francisco, Calif.	1,785	108.5	1,376	83.1	24,748	37	24,785
San Jose, Calif.	296	18.8	217	13.6	2,662	13	2,675
San Juan, P.R.	1,300	66.3	1,381	70.2	12,048	228	12,276
Sarasota, Fla.	122	23.2	108	20.4	1,102	21	1,123
Scranton, Pa.	32	5.1	39	6.2	337	4	341
Seattle, Wash.	540	24.5	496	22.2	5,689	18	5,707
Springfield, Mass.	169	28.5	157	26.5	1,288	23	1,311
Stockton, Calif.	81	15.4	64	12.0	592	13	605
Syracuse, N.Y.	78	10.4	182	24.4	952	7	959
Tacoma, Wash.	69	10.6	62	9.4	636	8	64
Tampa-Saint Petersburg, Fla.	752	34.5	656	29.8	6,485	85	6,570
Toledo, Ohio	65	10.6	56	9.2	468	10	478
Tucson, Ariz.	144	19.1	141	18.4	1,145	6	1,151
Tulsa, Okla.	90	12.0	83	11.0	872	8	880
Ventura, Calif.	89	12.6	68	9.5	665	2	66
Washington, D.C.	2,066	45.8	2,019	44.2	17,426	252	17,67
West Palm Beach, Fla.	833	85.3	725	73.0	5,694	186	5,880
Wichita, Kans.	78	15.3	61	11.9	562	2	564
Wilmington, Del.	272	49.8	216	39.2	1,526	9	1,535
Youngstown, Ohio	29	4.8	27	4.5	264	—	264
Metropolitan areas with 500,000 or more population	59,069	36.0	52,989	32.0	506,700	6,680	513,380
<i>Central counties</i>	<i>57,848</i>	<i>38.7</i>	<i>51,785</i>	<i>34.3</i>	<i>497,218</i>	<i>6,560</i>	<i>503,778</i>
<i>Outlying counties</i>	<i>1,221</i>	<i>8.5</i>	<i>1,204</i>	<i>8.2</i>	<i>9,482</i>	<i>120</i>	<i>9,602</i>
Metropolitan areas with 50,000 to 500,000 population	7,825	16.0	7,160	14.5	61,181	758	61,939
<i>Central counties</i>	<i>7,345</i>	<i>16.8</i>	<i>6,694</i>	<i>15.2</i>	<i>57,450</i>	<i>694</i>	<i>58,144</i>
<i>Outlying counties</i>	<i>480</i>	<i>9.0</i>	<i>466</i>	<i>8.6</i>	<i>3,731</i>	<i>64</i>	<i>3,795</i>
Nonmetropolitan areas	4,696	8.7	4,353	8.0	33,634	444	34,078
Total¹	72,085	27.0	64,966	24.1	604,176	7,902	612,078

¹ Totals include 2,681 persons whose area of residence is unknown.

Table 3. AIDS cases by age group, exposure category, and sex, reported July 1995 through June 1996, July 1996 through June 1997; and cumulative totals, by age group and exposure category, through June 1997, United States

	Males				Females				Totals					
	July 1995– June 1996		July 1996– June 1997		July 1995– June 1996		July 1996– June 1997		July 1995– June 1996		July 1996– June 1997		Cumulative total ¹	
Adult/adolescent exposure category	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	29,773	(52)	24,146	(48)	–	–	–	–	29,773	(42)	24,146	(38)	298,699	(49)
Injecting drug use	13,701	(24)	11,576	(23)	5,219	(37)	4,574	(33)	18,920	(27)	16,150	(25)	154,664	(26)
Men who have sex with men and inject drugs	3,528	(6)	2,684	(5)	–	–	–	–	3,528	(5)	2,684	(4)	38,923	(6)
Hemophilia/coagulation disorder	366	(1)	250	(0)	27	(0)	15	(0)	393	(1)	265	(0)	4,567	(1)
Heterosexual contact:	3,249	(6)	3,357	(7)	5,940	(43)	5,459	(40)	9,189	(13)	8,816	(14)	54,571	(9)
<i>Sex with injecting drug user</i>	969		794		2,078		1,666		3,047		2,460		22,890	
<i>Sex with bisexual male</i>	–		–		400		298		400		298		2,768	
<i>Sex with person with hemophilia</i>	11		5		37		36		48		41		390	
<i>Sex with transfusion recipient with HIV infection</i>	37		33		69		40		106		73		86	
<i>Sex with HIV-infected person, risk not specified</i>	2,232		2,525		3,356		3,419		5,588		5,944		27,656	
Receipt of blood transfusion, blood components, or tissue ²	323	(1)	245	(0)	274	(2)	244	(2)	597	(1)	489	(1)	8,075	(1)
Other/risk not reported or identified ³	6,497	(11)	8,385	(17)	2,479	(18)	3,422	(25)	8,976	(13)	11,807	(18)	44,677	(7)
Adult/adolescent subtotal	57,437	(100)	50,643	(100)	13,939	(100)	13,714	(100)	71,376	(100)	64,357	(100)	604,176	(100)
Pediatric (<13 years old) exposure category														
Hemophilia/coagulation disorder	2	(1)	3	(1)	–	–	1	(0)	2	(0)	4	(1)	232	(3)
Mother with/at risk for HIV infection ³	331	(93)	291	(91)	335	(95)	261	(90)	666	(94)	552	(91)	7,157	(91)
<i>Injecting drug use</i>	96		79		92		61		188		140		2,878	
<i>Sex with an injecting drug user</i>	55		36		44		36		99		72		1,304	
<i>Sex with a bisexual male</i>	4		7		7		4		11		11		16	
<i>Sex with person with hemophilia</i>	–		2		1		–		1		2		27	
<i>Sex with transfusion recipient with HIV infection</i>	–		–		–		–		–		–		26	
<i>Sex with HIV-infected person, risk not specified</i>	60		59		62		58		122		117		98	
<i>Receipt of blood transfusion, blood components, or tissue</i>	2		5		1		5		3		10		150	
<i>Has HIV infection, risk not specified</i>	114		103		128		97		242		200		1,62	
Receipt of blood transfusion, blood components, or tissue ²	10	(3)	2	(1)	2	(1)	3	(1)	12	(2)	5	(1)	375	(5)
Risk not reported or identified ³	13	(4)	24	(8)	16	(5)	24	(8)	29	(4)	48	(8)	138	(2)
Pediatric subtotal	356	(100)	320	(100)	353	(100)	289	(100)	709	(100)	609	(100)	7,902	(100)
Total	57,793		50,963		14,292		14,003		72,085		64,966		612,078	

¹Includes 11 persons known to be infected with human immunodeficiency virus type 2 (HIV-2). See *MMWR* 1995;44:603-06.

²Thirty-seven adults/adolescents and 3 children developed AIDS after receiving blood screened negative for HIV antibody. Twelve additional adults developed AIDS after receiving tissue, organs, or artificial insemination from HIV-infected donors. Four of the 12 received tissue, organs, or artificial insemination from a donor who was negative for HIV antibody at the time of donation. See *N Engl J Med* 1992;326:726-32.

³See table 11 and figure 7 for a discussion of the "other" exposure category. "Other" also includes 63 persons who acquired HIV infection perinatally but were diagnosed with AIDS after age 13. These 63 persons are tabulated under the adult/adolescent, not pediatric, exposure category.

Table 4. Male adult/adolescent AIDS cases by exposure category and race/ethnicity, reported July 1996 through June 1997, and cumulative totals, through June 1997, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	13,805	(68)	194,042	(76)	6,251	(32)	61,894	(38)	3,675	(37)	38,765	(44)
Injecting drug use	2,302	(11)	22,962	(9)	5,984	(31)	57,409	(36)	3,198	(32)	32,724	(37)
Men who have sex with men and inject drugs	1,309	(6)	20,385	(8)	951	(5)	12,246	(8)	391	(4)	5,915	(7)
Hemophilia/coagulation disorder	181	(1)	3,442	(1)	36	(0)	466	(0)	26	(0)	376	(0)
Heterosexual contact:	585	(3)	3,881	(2)	1,883	(10)	10,511	(7)	841	(8)	4,263	(5)
<i>Sex with an injecting drug user</i>	151		1,505		451		4,036		182		1,323	
<i>Sex with person with hemophilia</i>	1		24		3		12		1		8	
<i>Sex with transfusion recipient with HIV infection</i>	14		138		14		120		5		75	
<i>Sex with HIV-infected person, risk not specified</i>	419		2,214		1,415		6,343		653		2,857	
Receipt of blood tranfusion, blood components, or tissue	119	(1)	3,043	(1)	81	(0)	960	(1)	39	(0)	516	(1)
Risk not reported or identified ¹	2,026	(10)	8,598	(3)	4,425	(23)	17,498	(11)	1,738	(18)	6,197	(7)
Total	20,327	(100)	256,353	(100)	19,611	(100)	160,984	(100)	9,908	(100)	88,756	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ²			
	July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	267	(60)	2,884	(75)	91	(51)	822	(59)	24,146	(48)	298,699	(58)
Injecting drug use	23	(5)	203	(5)	34	(19)	210	(15)	11,576	(23)	113,635	(22)
Men who have sex with men and inject drugs	9	(2)	128	(3)	22	(12)	231	(17)	2,684	(5)	38,923	(8)
Hemophilia/coagulation disorder	4	(1)	61	(2)	2	(1)	27	(2)	250	(0)	4,378	(1)
Heterosexual contact:	32	(7)	111	(3)	8	(4)	28	(2)	3,357	(7)	18,811	(4)
<i>Sex with an injecting drug user</i>	6		27		3		12		794		6,906	
<i>Sex with person with hemophilia</i>	–		–		–		–		5		44	
<i>Sex with transfusion recipient with HIV infection</i>	–		7		–		1		33		342	
<i>Sex with HIV-infected person, risk not specified</i>	26		77		5		15		2,525		11,519	
Receipt of blood tranfusion, blood components, or tissue	3	(1)	98	(3)	2	(1)	7	(1)	245	(0)	4,634	(1)
Risk not reported or identified	106	(24)	365	(9)	20	(11)	65	(5)	8,385	(17)	32,854	(6)
Total	444	(100)	3,850	(100)	179	(100)	1,390	(100)	50,643	(100)	511,934	(100)

¹See figure 7.

²Includes 601 men whose race/ethnicity is unknown.

Table 5. Female adult/adolescent AIDS cases by exposure category and race/ethnicity, reported July 1996 through June 1997, and cumulative totals, through June 1997, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	1,039	(38)	9,156	(43)	2,627	(32)	23,646	(46)	866	(33)	7,984	(43)
Hemophilia/coagulation disorder	2	(0)	89	(0)	8	(0)	63	(0)	3	(0)	32	(0)
Heterosexual contact:	1,082	(40)	8,338	(39)	3,080	(38)	18,482	(36)	1,236	(47)	8,596	(46)
<i>Sex with injecting drug user</i>	375		3,567		880		7,961		399		4,335	
<i>Sex with bisexual male</i>	102		1,224		136		1,043		48		426	
<i>Sex with person with hemophilia</i>	19		250		12		59		4		30	
<i>Sex with transfusion recipient with HIV infection</i>	15		275		17		142		7		91	
<i>Sex with HIV-infected person, risk not specified</i>	571		3,022		2,035		9,277		778		3,714	
Receipt of blood transfusion, blood components, or tissue	73	(3)	1,733	(8)	126	(2)	1,098	(2)	37	(1)	508	(3)
Risk not reported or identified ¹	526	(19)	2,003	(9)	2,321	(28)	8,121	(16)	511	(19)	1,543	(8)
Total	2,722	(100)	21,319	(100)	8,162	(100)	51,410	(100)	2,653	(100)	18,663	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ²			
	July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	9	(11)	80	(17)	18	(45)	124	(48)	4,574	(33)	41,029	(44)
Hemophilia/coagulation disorder	1	(1)	4	(1)	1	(3)	1	(0)	15	(0)	189	(0)
Heterosexual contact:	36	(44)	219	(46)	12	(30)	95	(36)	5,459	(40)	35,760	(39)
<i>Sex with injecting drug user</i>	8		63		3		49		1,666		15,984	
<i>Sex with bisexual male</i>	5		54		3		15		298		2,768	
<i>Sex with person with hemophilia</i>	1		5		–		2		36		346	
<i>Sex with transfusion recipient with HIV infection</i>	1		16		–		–		40		525	
<i>Sex with HIV-infected person, risk not specified</i>	21		81		6		29		3,419		16,137	
Receipt of blood transfusion, blood components, or tissue	6	(7)	87	(18)	1	(3)	12	(5)	244	(2)	3,441	(4)
Risk not reported or identified	30	(37)	89	(19)	8	(20)	29	(11)	3,422	(25)	11,823	(13)
Total	82	(100)	479	(100)	40	(100)	261	(100)	13,714	(100)	92,242	(100)

¹See figure 7.

²Includes 110 women whose race/ethnicity is unknown.

Table 6. Pediatric AIDS cases by exposure category and race/ethnicity, reported July 1996 through June 1997, and cumulative totals, through June 1997, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	2	(2)	157	(11)	1	(0)	34	(1)	1	(1)	37	(2)
Mother with/at risk for HIV infection:	81	(90)	1,037	(74)	345	(90)	4,374	(95)	121	(93)	1,679	(92)
<i>Injecting drug use</i>	20		433		88		1,740		32		685	
<i>Sex with injecting drug user</i>	10		199		42		648		16		444	
<i>Sex with bisexual male</i>	7		65		3		56		1		38	
<i>Sex with person with hemophilia</i>	1		16		–		5		1		6	
<i>Sex with transfusion recipient with HIV infection</i>	–		11		–		8		–		7	
<i>Sex with HIV-infected person, risk not specified</i>	19		121		69		634		29		214	
<i>Receipt of blood transfusion, blood components, or tissue</i>	4		42		3		76		3		3	
<i>Has HIV infection, risk not specified</i>	20		150		140		1,207		39		254	
Receipt of blood transfusion, blood components, or tissue	1	(1)	183	(13)	3	(1)	90	(2)	1	(1)	92	(5)
Risk not reported or identified ¹	6	(7)	23	(2)	34	(9)	88	(2)	7	(5)	25	(1)
Total	90	(100)	1,400	(100)	383	(100)	4,586	(100)	130	(100)	1,833	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ²			
	July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	–	–	3	(7)	–	–	1	(4)	4	(1)	232	(3)
Mother with/at risk for HIV infection:	–	–	27	(66)	4	(100)	25	(96)	552	(91)	7,157	(91)
<i>Injecting drug use</i>	–		4		–		11		140		2,878	
<i>Sex with injecting drug user</i>	–		4		4		8		72		1,304	
<i>Sex with bisexual male</i>	–		2		–		–		11		16	
<i>Sex with person with hemophilia</i>	–		–		–		–		2		27	
<i>Sex with transfusion recipient with HIV infection</i>	–		–		–		–		–		–	
<i>Sex with HIV-infected person, risk not specified</i>	–		8		–		2		117		982	
<i>Receipt of blood transfusion, blood components, or tissue</i>	–		1		–		–		10		150	
<i>Has HIV infection, risk not specified</i>	–		8		–		4		200		1,629	
Receipt of blood transfusion, blood components, or tissue	–	–	10	(24)	–	–	–	–	5	(1)	375	(5)
Risk not reported or identified	–	–	1	(2)	–	–	–	–	48	(8)	138	(2)
Total	–	–	41	(100)	4	(100)	26	(100)	609	(100)	7,902	(100)

¹See figure 7, footnote 1.

²Includes 16 children whose race/ethnicity is unknown.

Table 7. AIDS cases in adolescents and adults under age 25, by sex and exposure category, reported July 1995 through June 1996, July 1996 through June 1997; and cumulative totals through June 1997, United States

Male exposure category	13-19 years old						20-24 years old					
	July 1995– June 1996		July 1996– June 1997		Cumulative total		July 1995– June 1996		July 1996– June 1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	68	(34)	85	(39)	629	(34)	874	(59)	750	(57)	10,259	(63)
Injecting drug use	11	(5)	8	(4)	114	(6)	185	(12)	123	(9)	2,038	(12)
Men who have sex with men and inject drugs	6	(3)	5	(2)	83	(4)	100	(7)	67	(5)	1,717	(11)
Hemophilia/coagulation disorder	63	(31)	38	(17)	713	(38)	69	(5)	31	(2)	599	(4)
Heterosexual contact:	11	(5)	15	(7)	62	(3)	95	(6)	99	(8)	655	(4)
<i>Sex with injecting drug user</i>	3		1		17		17		17		230	
<i>Sex with person with hemophilia</i>												
<i>Sex with transfusion recipient with HIV infection</i>												
<i>Sex with HIV-infected person, risk not specified</i>	8		13		42		75		82		410	
Receipt of blood transfusion, blood components, or tissue	8	(4)	11	(5)	80	(4)	6	(0)	5	(0)	103	(1)
Risk not reported or identified [†]	35	(17)	56	(26)	171	(9)	159	(11)	234	(18)	979	(6)
Male subtotal	202	(100)	218	(100)	1,852	(100)	1,488	(100)	1,309	(100)	16,350	(100)
Female exposure category												
Injecting drug use	12	(7)	15	(9)	164	(15)	146	(18)	118	(15)	1,650	(29)
Hemophilia/coagulation disorder	–	–	–	–	10	(1)	2	(0)	1	(0)	14	(0)
Heterosexual contact:	100	(56)	71	(41)	590	(54)	445	(56)	439	(56)	3,067	(54)
<i>Sex with injecting drug user</i>	23		16		229		139		101		1,337	
<i>Sex with bisexual male</i>	4		6		34		29		22		226	
<i>Sex with person with hemophilia</i>	1		–		13		4		3		49	
<i>Sex with transfusion recipient with HIV infection</i>												
<i>Sex with HIV-infected person, risk not specified</i>	72		48		312		267		311		1,43	
Receipt of blood transfusion, blood components, or tissue	7	(4)	10	(6)	76	(7)	9	(1)	7	(1)	112	(2)
Risk not reported or identified	59	(33)	76	(44)	261	(24)	192	(24)	222	(28)	877	(15)
Female subtotal	178	(100)	172	(100)	1,101	(100)	794	(100)	787	(100)	5,720	(100)
Total	380		390		2,953		2,282		2,096		22,070	

[†]See figure 7.

Table 8. AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through June 1997, United States

Male Age at diagnosis (years)	White, not Hispanic		Black, not Hispanic		Hispanic		Asian/Pacific Islander		American Indian/ Alaska Native		Total ¹	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Under 5	480	(0)	1,911	(1)	703	(1)	15	(0)	11	(1)	3,124	(1)
5-12	310	(0)	378	(0)	245	(0)	8	(0)	2	(0)	945	(0)
13-19	773	(0)	653	(0)	386	(0)	21	(1)	17	(1)	1,852	(0)
20-24	6,929	(3)	5,746	(4)	3,458	(4)	131	(3)	63	(4)	16,350	(3)
25-29	34,486	(13)	21,058	(13)	13,613	(15)	474	(12)	269	(19)	69,978	(14)
30-34	60,527	(24)	34,920	(21)	21,615	(24)	865	(22)	374	(27)	118,424	(23)
35-39	57,986	(23)	37,336	(23)	19,989	(22)	844	(22)	304	(22)	116,601	(23)
40-44	42,054	(16)	28,422	(17)	13,800	(15)	683	(18)	204	(15)	85,274	(17)
45-49	25,152	(10)	15,671	(10)	7,580	(8)	388	(10)	83	(6)	48,928	(9)
50-54	13,461	(5)	8,142	(5)	3,936	(4)	211	(5)	32	(2)	25,815	(5)
55-59	7,378	(3)	4,566	(3)	2,217	(2)	126	(3)	23	(2)	14,330	(3)
60-64	4,162	(2)	2,487	(2)	1,215	(1)	55	(1)	13	(1)	7,942	(2)
65 or older	3,445	(1)	1,983	(1)	947	(1)	52	(1)	8	(1)	6,440	(1)
Male subtotal	257,143	(100)	163,273	(100)	89,704	(100)	3,873	(100)	1,403	(100)	516,003	(100)
Female												
Age at diagnosis (years)												
Under 5	458	(2)	1,907	(4)	700	(4)	11	(2)	13	(5)	3,097	(3)
5-12	152	(1)	390	(1)	185	(1)	7	(1)	-	-	736	(1)
13-19	190	(1)	725	(1)	178	(1)	6	(1)	1	(0)	1,101	(1)
20-24	1,313	(6)	3,153	(6)	1,195	(6)	29	(6)	25	(9)	5,720	(6)
25-29	3,756	(17)	8,066	(15)	3,303	(17)	58	(12)	44	(16)	15,233	(16)
30-34	5,062	(23)	12,186	(23)	4,682	(24)	99	(20)	68	(25)	22,135	(23)
35-39	4,281	(20)	11,835	(22)	3,925	(20)	90	(18)	53	(19)	20,213	(21)
40-44	2,720	(12)	7,791	(15)	2,500	(13)	69	(14)	27	(10)	13,119	(14)
45-49	1,421	(6)	3,555	(7)	1,315	(7)	50	(10)	21	(8)	6,374	(7)
50-54	785	(4)	1,812	(3)	698	(4)	24	(5)	11	(4)	3,333	(3)
55-59	556	(3)	1,043	(2)	446	(2)	16	(3)	6	(2)	2,069	(2)
60-64	394	(2)	633	(1)	223	(1)	18	(4)	3	(1)	1,272	(1)
65 or older	841	(4)	611	(1)	198	(1)	20	(4)	2	(1)	1,673	(2)
Female subtotal	21,929	(100)	53,707	(100)	19,548	(100)	497	(100)	274	(100)	96,075	(100)
Total	279,072		216,980		109,252		4,370		1,677		612,078	

¹Includes 607 males and 120 females whose race/ethnicity is unknown.

Table 9. AIDS cases, case-fatality rates, and deaths, by half-year and age group, through June 1997, United States¹

Half-year	Adults/adolescents			Children <13 years old		
	Cases diagnosed during interval	Case-fatality rate	Deaths occurring during interval	Cases diagnosed during interval	Case-fatality rate	Deaths occurring during interval
Before 1981	85	91.8	29	8	75.0	1
1981 Jan.–June	107	88.8	37	10	80.0	2
July–Dec.	206	93.7	83	6	100.0	6
1982 Jan.–June	437	92.9	151	14	92.9	10
July–Dec.	727	92.3	296	17	82.4	4
1983 Jan.–June	1,352	94.3	527	33	100.0	14
July–Dec.	1,717	94.2	949	44	93.2	16
1984 Jan.–June	2,691	93.8	1,428	53	86.8	27
July–Dec.	3,513	94.2	2,026	66	86.4	24
1985 Jan.–June	5,175	92.9	2,875	113	82.3	47
July–Dec.	6,552	93.4	3,979	140	87.1	72
1986 Jan.–June	8,702	92.4	5,203	144	85.4	70
July–Dec.	10,254	92.9	6,729	199	80.9	98
1987 Jan.–June	13,556	91.8	7,813	229	80.3	121
July–Dec.	14,908	90.6	8,285	269	77.3	173
1988 Jan.–June	17,419	88.8	9,716	265	69.8	140
July–Dec.	17,887	88.9	11,070	347	70.0	179
1989 Jan.–June	21,039	86.2	12,755	367	69.5	175
July–Dec.	21,341	85.5	14,653	348	71.3	192
1990 Jan.–June	24,372	83.4	15,068	392	65.3	196
July–Dec.	23,749	82.2	16,052	408	60.0	199
1991 Jan.–June	28,462	79.6	17,129	409	60.6	174
July–Dec.	30,575	77.5	19,046	394	56.6	220
1992 Jan.–June	37,250	72.3	19,681	488	54.7	194
July–Dec.	40,169	69.0	20,906	448	57.1	226
1993 Jan.–June	42,367	59.8	21,309	439	51.9	254
July–Dec.	35,204	55.1	22,460	442	51.6	268
1994 Jan.–June	36,660	47.5	23,388	418	47.4	295
July–Dec.	32,786	40.4	24,275	351	44.4	253
1995 Jan.–June	34,505	31.5	23,806	303	32.7	263
July–Dec.	29,292	24.0	23,474	291	26.8	236
1996 Jan.–June	28,453	16.9	19,658	232	20.7	214
July–Dec.	21,341	12.1	13,852	150	12.7	159
1997 Jan.–June	11,323	6.4	5,551	65	10.8	71
Total²	604,176	62.0	374,656	7,902	58.2	4,602

¹Persons whose vital status is unknown are included in counts of diagnosed cases, but excluded from counts of deaths. Case-fatality rates are calculated for each half-year by date of diagnosis. Each 6-month case-fatality rate is the number of deaths ever reported among cases diagnosed in that period (regardless of the year of death), divided by the number of total cases diagnosed in that period, multiplied by 100. For example, during the interval January through June 1982, AIDS was diagnosed in 437 adults/adolescents. Through June 1997, 406 of these 437 were reported as dead. Therefore, the case fatality rate is 92.9 (406 divided by 437, multiplied by 100). The case-fatality rates shown here may be underestimates because of incomplete reporting of deaths. Reported deaths are not necessarily caused by HIV-related disease.

²Death totals include 397 adults/adolescents and 9 children known to have died, but whose dates of death are unknown.

Table 9. AIDS cases, case-fatality rates, and deaths, by half-year and age group, through June 1997, United States¹

Year	Adults/adolescents			Children <13 years old		
	Cases diagnosed during interval	Case-fatality rate	Deaths occurring during interval	Cases diagnosed during interval	Case-fatality rate	Deaths occurring during interval
Before 1981	85	91.8	29	8	75.0	1
1981 Jan.–June	107	88.8	37	10	80.0	2
July–Dec.	206	93.7	83	6	100.0	6
1982 Jan.–June	437	92.9	151	14	92.9	10
July–Dec.	727	92.3	296	17	82.4	4
1983 Jan.–June	1,352	94.3	527	33	100.0	14
July–Dec.	1,717	94.2	949	44	93.2	16
1984 Jan.–June	2,691	93.8	1,428	53	86.8	27
July–Dec.	3,513	94.2	2,026	66	86.4	24
1985 Jan.–June	5,175	92.9	2,875	113	82.3	47
July–Dec.	6,552	93.4	3,979	140	87.1	72
1986 Jan.–June	8,702	92.4	5,203	144	85.4	70
July–Dec.	10,254	92.9	6,729	199	80.9	98
1987 Jan.–June	13,556	91.8	7,813	229	80.3	121
July–Dec.	14,908	90.6	8,285	269	77.3	173
1988 Jan.–June	17,419	88.8	9,716	265	69.8	140
July–Dec.	17,887	88.9	11,070	347	70.0	179
1989 Jan.–June	21,039	86.2	12,755	367	69.5	175
July–Dec.	21,341	85.5	14,653	348	71.3	192
1990 Jan.–June	24,372	83.4	15,068	392	65.3	196
July–Dec.	23,749	82.2	16,052	408	60.0	199
1991 Jan.–June	28,462	79.6	17,129	409	60.6	174
July–Dec.	30,575	77.5	19,046	394	56.6	220
1992 Jan.–June	37,250	72.3	19,681	488	54.7	194
July–Dec.	40,169	69.0	20,906	448	57.1	226
1993 Jan.–June	42,367	59.8	21,309	439	51.9	254
July–Dec.	35,204	55.1	22,460	442	51.6	268
1994 Jan.–June	36,660	47.5	23,388	418	47.4	295
July–Dec.	32,786	40.4	24,275	351	44.4	253
1995 Jan.–June	34,505	31.5	23,806	303	32.7	263
July–Dec.	29,292	24.0	23,474	291	26.8	236
1996 Jan.–June	28,453	16.9	19,658	232	20.7	214
July–Dec.	21,341	12.1	13,852	150	12.7	159
1997 Jan.–June	11,323	6.4	5,551	65	10.8	71
Total ²	604,176	62.0	374,656	7,902	58.2	4,602

¹Persons whose vital status is unknown are included in counts of diagnosed cases, but excluded from counts of deaths. Case-fatality rates are calculated for each half-year by date of diagnosis. Each 6-month case-fatality rate is the number of deaths ever reported among cases diagnosed in that period (regardless of the year of death), divided by the number of total cases diagnosed in that period, multiplied by 100. For example, during the interval January through June 1982, AIDS was diagnosed in 437 adults/adolescents. Through June 1997, 406 of these 437 were reported as dead. Therefore, the case fatality rate is 92.9 (406 divided by 437, multiplied by 100). The case-fatality rates shown here may be underestimates because of incomplete reporting of deaths. Reported deaths are not necessarily caused by HIV-related disease.

²Death totals include 397 adults/adolescents and 9 children known to have died, but whose dates of death are unknown.

Table 10. AIDS cases by year of diagnosis and definition category, diagnosed through June 1997, United States

Definition category	Period of diagnosis											
	Before July 1993		July 1993–June 1994		July 1994–June 1995		July 1995–June 1996		July 1996–June 1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Pre-1987 definition	237,185	(62)	25,141	(35)	20,273	(30)	14,650	(25)	6,988	(21)	304,237	(50)
1987 definition	89,533	(24)	13,399	(18)	11,125	(16)	8,272	(14)	4,250	(13)	126,579	(21)
1993 definition ¹	53,544	(14)	34,184	(47)	36,547	(54)	35,346	(61)	21,641	(66)	181,262	(30)
<i>Pulmonary tuberculosis</i>	4,777		1,648		1,277		855		418		8,975	
<i>Recurrent pneumonia</i>	1,812		1,055		882		732		367		4,848	
<i>Invasive cervical cancer</i>	238		127		113		51		29		558	
<i>Severe HIV-related immunosuppression</i> ²	46,823		31,402		34,308		33,732		20,833		167,09	
Total	380,262	(100)	72,724	(100)	67,945	(100)	58,268	(100)	32,879	(100)	612,078	(100)

¹Persons who meet only the 1993 AIDS case definition and whose date of diagnosis is before January 1993 were diagnosed retrospectively. The sum of diagnoses listed for the four conditions under the 1993 definition do not equal the 1993 definition total because some persons have more than one diagnosis from the added conditions of pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

²Defined as CD4⁺ T-lymphocyte count of less than 200 cells/ μ L or a CD4⁺ percentage less than 14 in persons with laboratory confirmation of HIV infection.

Table 11. Health care workers with documented and possible occupationally acquired AIDS/HIV infection, by occupation, reported through June 1997, United States¹

Occupation	Documented occupational transmission ²	Possible occupational transmission ³
	No.	No.
Dental worker, including dentist	—	7
Embalmer/morgue technician	—	2
Emergency medical technician/paramedic	—	10
Health aide/attendant	1	12
Housekeeper/maintenance worker	1	7
Laboratory technician, clinical	16	16
Laboratory technician, nonclinical	3	1
Nurse	21	29
Physician, nonsurgical	6	10
Physician, surgical	—	6
Respiratory therapist	1	2
Technician, dialysis	1	3
Technician, surgical	2	2
Technician/therapist, other than those listed above	—	5
Other health care occupations	—	2
Total	52	114

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

²Health care workers who had documented HIV seroconversion after occupational exposure or had other laboratory evidence of occupational infection: 45 had percutaneous exposure, 5 had mucocutaneous exposure, 1 had both percutaneous and mucocutaneous exposures, and 1 had an unknown route of exposure. Forty-seven exposures were to blood from an HIV-infected person, 1 to visibly bloody fluid, 1 to an unspecified fluid, and 3 to concentrated virus in a laboratory. Twenty-four of these health care workers developed AIDS.

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

Table 12. Adult/adolescent AIDS cases by single and multiple exposure categories, reported through June 1997, United States

Exposure category	AIDS cases	
	No.	(%)
Single mode of exposure		
Men who have sex with men	286,611	(47)
Injecting drug use	124,684	(21)
Hemophilia/coagulation disorder	3,673	(1)
Heterosexual contact	53,119	(9)
Receipt of transfusion ¹	8,063	(1)
Receipt of transplant of tissues, organs, or artificial insemination ²	12	(0)
Other ³	95	(0)
Single mode of exposure subtotal	476,257	(79)
Multiple modes of exposure		
Men who have sex with men; injecting drug use	33,600	(6)
Men who have sex with men; hemophilia/coagulation disorder	151	(0)
Men who have sex with men; heterosexual contact	8,366	(1)
Men who have sex with men; receipt of transfusion/transplant	3,260	(1)
Injecting drug use; hemophilia/coagulation disorder	182	(0)
Injecting drug use; heterosexual contact	27,251	(5)
Injecting drug use; receipt of transfusion/transplant	1,541	(0)
Hemophilia/coagulation disorder; heterosexual contact	83	(0)
Hemophilia/coagulation disorder; receipt of transfusion/transplant	779	(0)
Heterosexual contact; receipt of transfusion/transplant	1,452	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder	43	(0)
Men who have sex with men; injecting drug use; heterosexual contact	4,528	(1)
Men who have sex with men; injecting drug use; receipt of transfusion/transplant	573	(0)
Men who have sex with men; hemophilia/coagulation disorder; heterosexual contact	20	(0)
Men who have sex with men; hemophilia/coagulation disorder; receipt of transfusion/transplant	34	(0)
Men who have sex with men; heterosexual contact; receipt of transfusion/transplant	252	(0)
Injecting drug use; hemophilia/coagulation disorder; heterosexual contact	60	(0)
Injecting drug use; hemophilia/coagulation disorder; receipt of transfusion/transplant	36	(0)
Injecting drug use; heterosexual contact; receipt of transfusion/transplant	892	(0)
Hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	32	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder; heterosexual contact;	8	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder; receipt of transfusion/transplant	13	(0)
Men who have sex with men; injecting drug use; heterosexual contact; receipt of transfusion/transplant	153	(0)
Men who have sex with men; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	5	(0)
Injecting drug use; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	18	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	5	(0)
Multiple modes of exposure subtotal	83,337	(14)
Risk not reported or identified⁴	44,582	(7)
Total	604,176	(100)

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

²Twelve adults developed AIDS after receiving tissue, organs, or artificial insemination from HIV-infected donors. Four of the 12 received tissue or organs from a single donor who was negative for HIV antibody at the time of donation. See *N Engl J Med* 1992;326:726-32.

³See table 11 and figure 7 for a discussion of the "other" exposure category. "Other" also includes 63 persons who acquired HIV infection perinatally, but were diagnosed with AIDS after age 13.

⁴See figure 7.

Figure 1. Male adult/adolescent AIDS annual rates per 100,000 population, for cases reported July 1996 through June 1997, United States

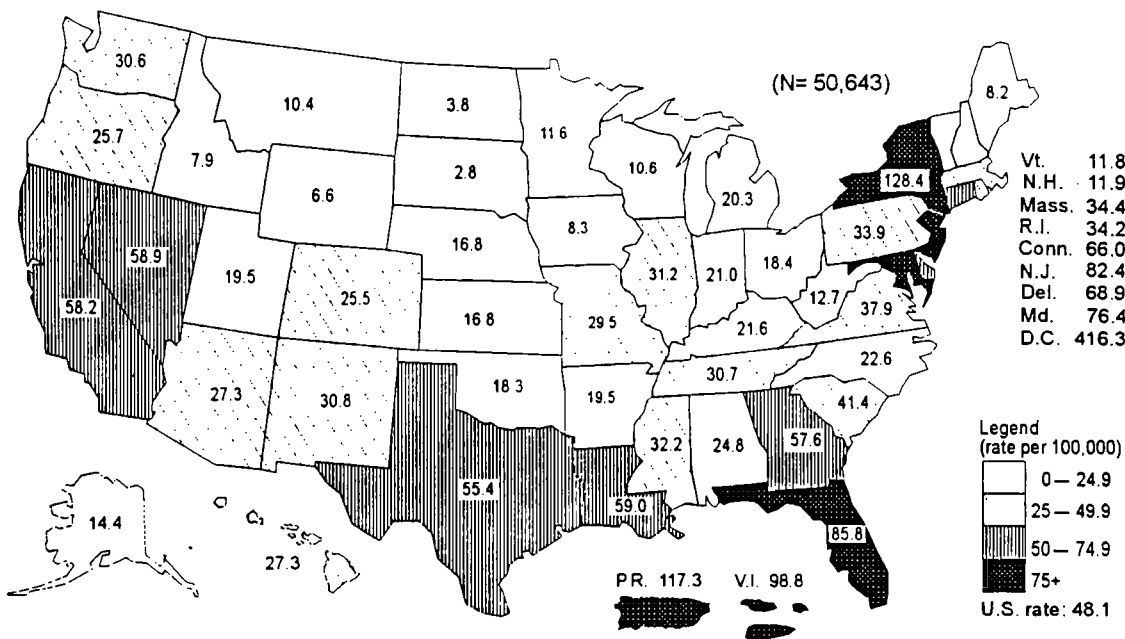


Figure 2. Female adult/adolescent AIDS annual rates per 100,000 population, for cases reported July 1996 through June 1997, United States

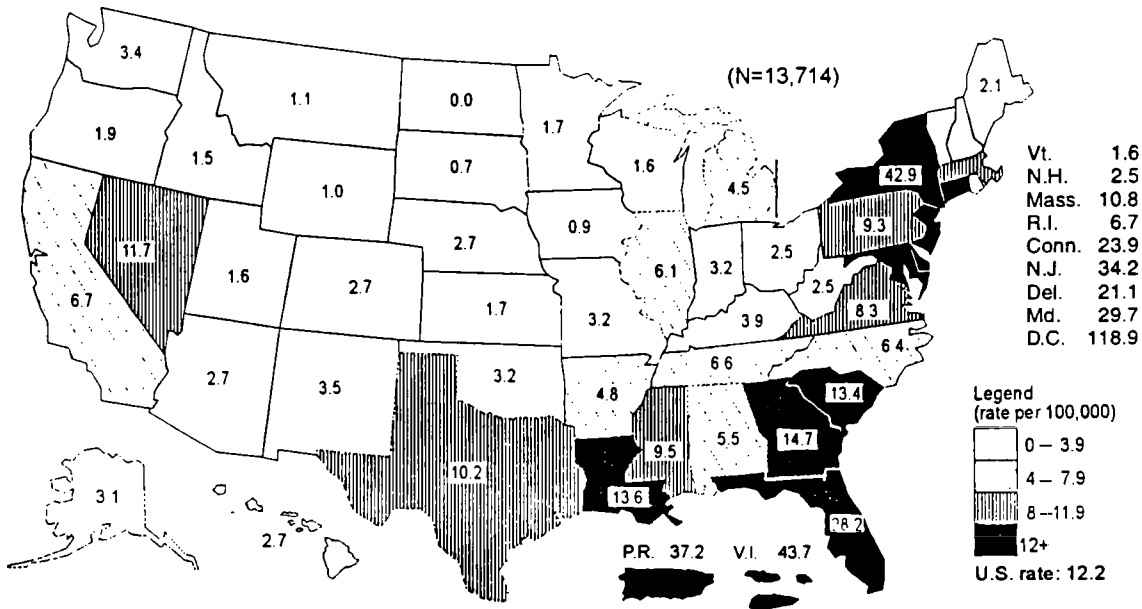


Figure 3. Male/adult adolescent AIDS cases reported July 1996 through June 1997, United States

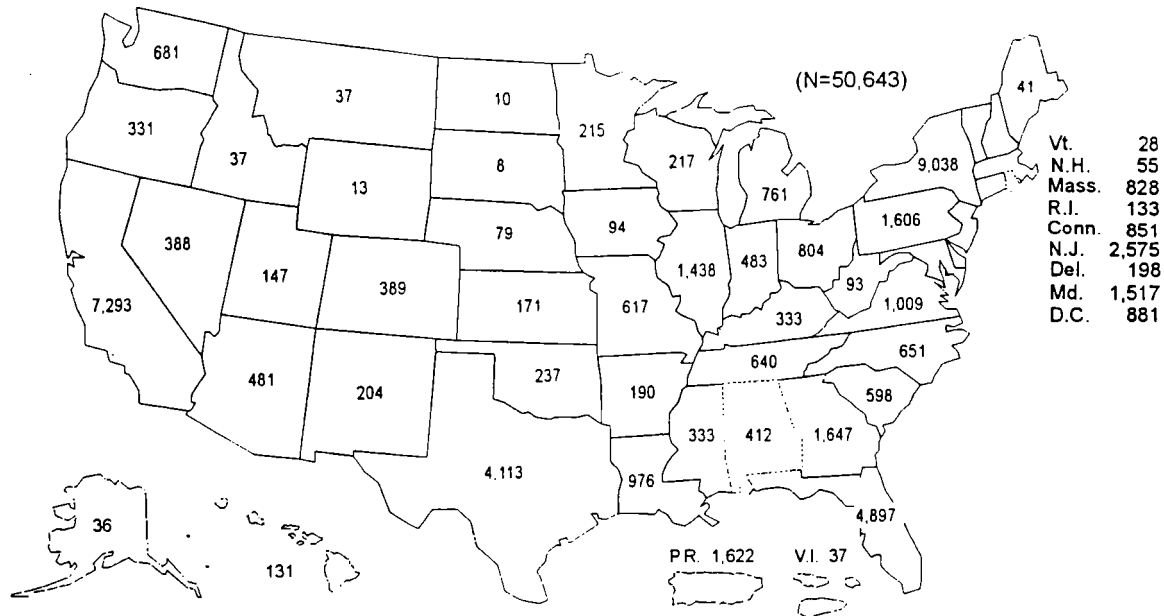


Figure 4. Female adult/adolescent AIDS cases reported July 1996 through June 1997, United States

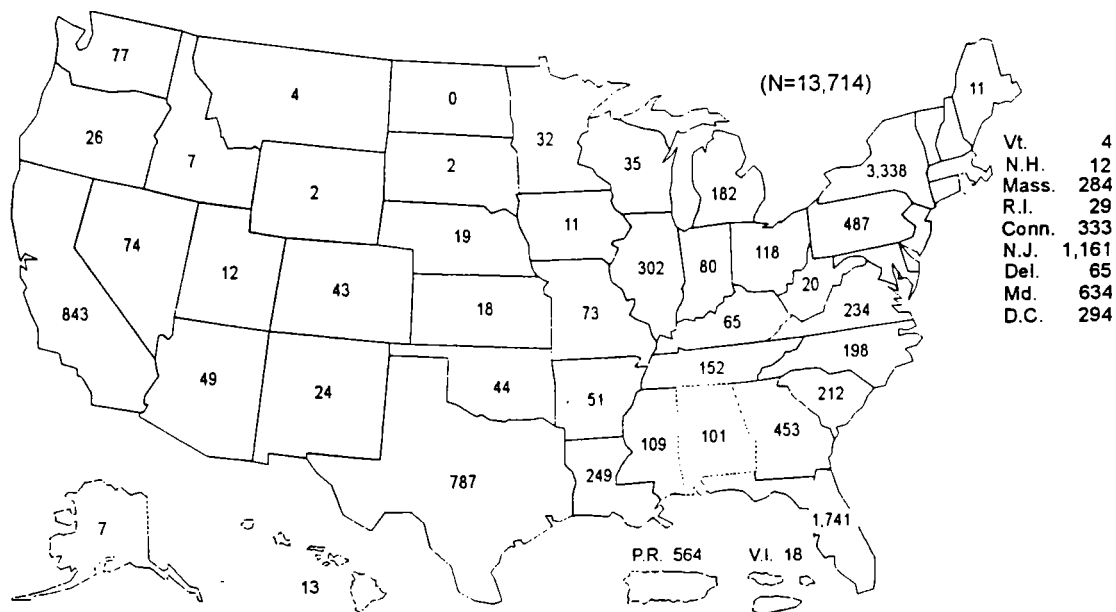


Figure 5. Pediatric AIDS cases reported July 1996 through June 1997, United States

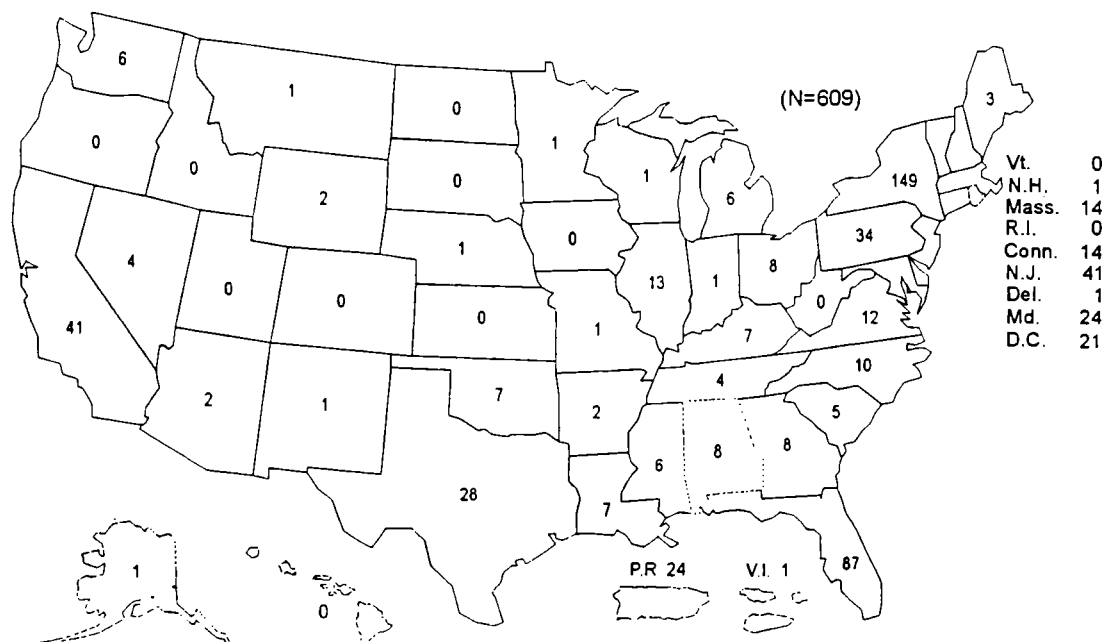
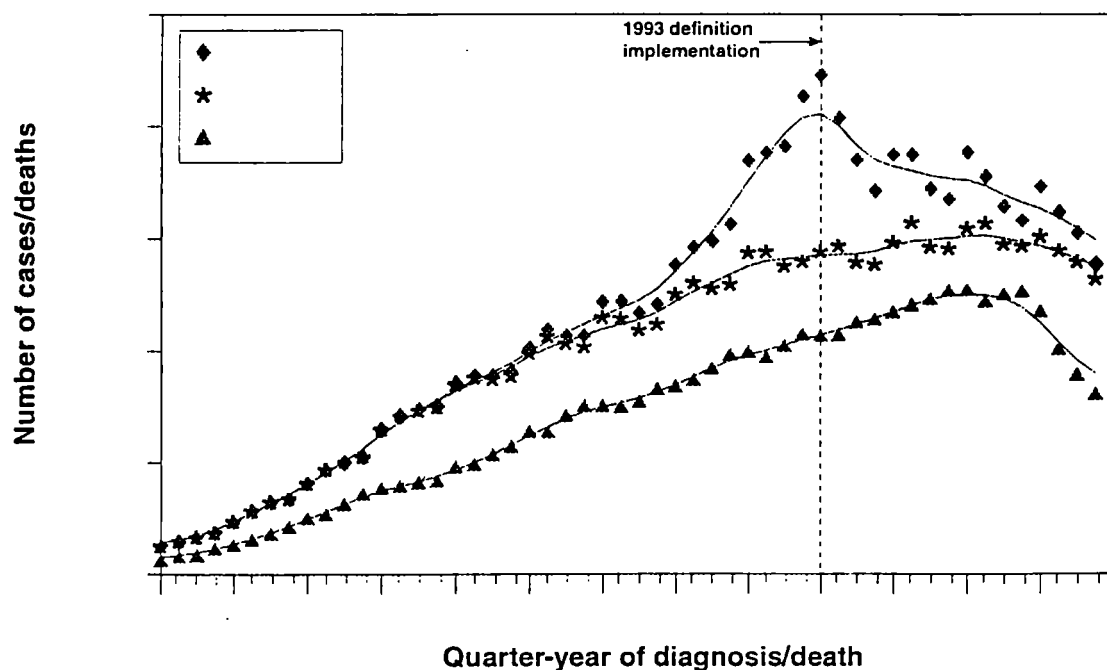
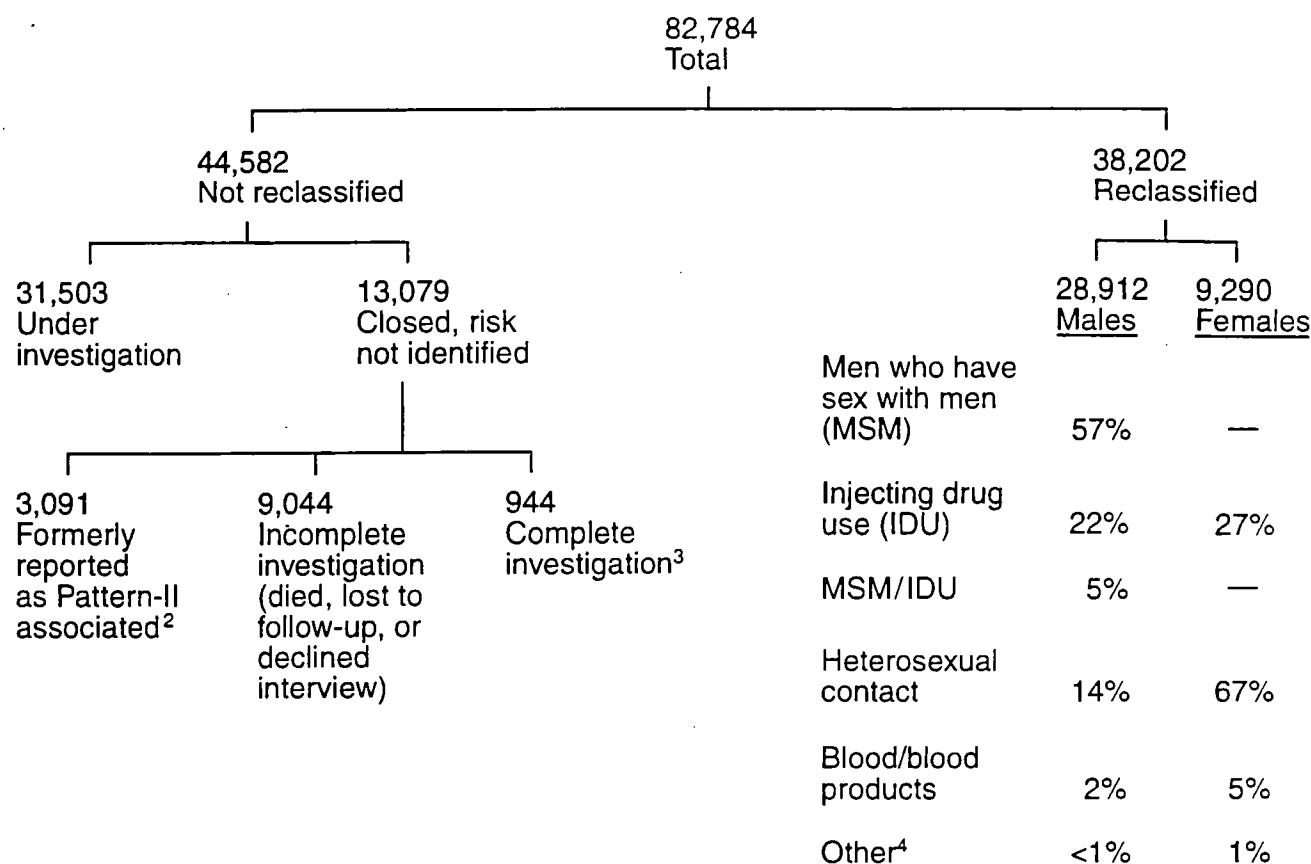


Figure 6. Estimated incidence of AIDS, AIDS-opportunistic illness (AIDS-OI), and deaths in persons with AIDS, adjusted for delays in reporting, by quarter-year of diagnosis/death, United States, 1984–1996¹



¹Estimated incidence of AIDS includes persons diagnosed using the 1993 expanded surveillance case definition, including persons whose AIDS diagnosis is based on evidence of severe immunosuppression (HIV-infected persons with CD4⁺ T-lymphocyte counts of less than 200 cells/ μ L or a CD4⁺ percentage of less than 14). Estimated AIDS-OI incidence is the sum of the observed AIDS-OI incidence and the incidence based on estimated rates of AIDS-OI diagnosis for persons reported with AIDS based only on severe immunosuppression. Points on the figure represent quarterly incidence; lines represent smoothed incidence. Estimated incidence of AIDS, estimated AIDS-OIs, and deaths are all adjusted for delays in reporting. Estimates are not adjusted for incomplete reporting of cases. See Commentary.

Figure 7. Results of investigations of adult/adolescent AIDS cases ever classified as risk not reported or identified, through June 1997, United States¹



¹Excludes 138 children under 13 years of age classified as "other/risk not reported or identified" in table 3: 129 whose risk is not identified, 2 who were exposed to HIV-infected blood in a household setting, as supported by seroconversion, epidemiologic, and/or laboratory evidence (see *MMWR* 1992;41:228-31 and *N Engl J Med* 1993;329:1835-41) and 7 children who had sexual contact with an adult with or at high risk for HIV infection (Xth International Conference on AIDS; Yokohama; Japan, Aug. 7-12, 1994;2:258 [abstract PC 0401]). An additional 411 children who were initially reported without risk information have been reclassified after investigation.

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

³Investigations of these persons included patient interviews. Based on available information, these persons could not be reclassified into an exposure category. This group includes persons possibly infected through heterosexual contact with a partner who is not known to be HIV infected or at risk for HIV infection; persons who may choose not to disclose high-risk information; and persons with possible occupational exposure. These 944 persons report heterosexual contact, sexually transmitted disease infections, non-injecting drug use, hepatitis infections, and occupational exposures to blood or body fluids.

⁴Ninety-five adults/adolescents are included in the "other" exposure category listed here and in table 3, and were exposed to HIV-infected blood, body fluids, or concentrated virus in health care, laboratory, or household settings, as supported by seroconversion, epidemiologic, and/or laboratory evidence. See table 11, *MMWR* 1993;42:329-31, *MMWR* 1993;42:948-51, and XI International Conference on AIDS; Vancouver, Canada; Jul. 7-12, 1996;1:179 [abstract Mo.D.1728]. One person was infected following intentional self-inoculation of blood from an HIV-infected person. Sixty-three persons acquired HIV infection perinatally and were diagnosed with AIDS after age 13.

Table 13. Estimated AIDS-opportunistic illness incidence, by region of residence and year of diagnosis, 1991 through 1996, United States¹

Region of residence ²	Year of diagnosis					
	1991	1992	1993	1994	1995	1996
Northeast	15,500	16,900	18,100	18,600	19,000	17,400
Midwest	5,400	6,100	6,000	6,100	6,400	5,700
South	17,200	19,800	19,700	21,600	21,700	21,500
West	12,000	12,600	11,900	12,400	12,200	10,700
U.S. dependencies, possessions, and associated nations	2,050	2,075	2,125	1,925	2,000	1,875
Total³	52,200	57,600	57,900	60,600	61,300	57,200

¹Estimates are adjusted for delays in the reporting of AIDS cases, but not for incomplete reporting of cases. Estimates of less than 1,000, 1,000 to 2,499, 2,500 to 4,999, and 5,000 or more are rounded to the nearest 10, 25, 50, and 100, respectively. Opportunistic illness refers to AIDS-defining opportunistic illnesses included in the 1993 AIDS surveillance case definition. Annual estimates are through the most recent year for which reliable estimates are available. Because there is uncertainty in AIDS-OI incidence, changes over time in AIDS-OI incidence should not be computed from these rounded estimates. See Technical Notes.

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

³The sum of the regional estimates may not equal the total annual estimates because of rounding.

Table 14. Estimated AIDS-opportunistic illness incidence, by race/ethnicity and year of diagnosis, 1991 through 1996, United States¹

Race/ethnicity	Year of diagnosis					
	1991	1992	1993	1994	1995	1996
White, not Hispanic	25,000	26,100	24,700	25,200	24,500	21,200
Black, not Hispanic	17,300	20,600	21,900	23,500	24,500	24,400
Hispanic	9,400	10,200	10,700	11,200	11,600	10,900
Asian/Pacific Islander	360	420	420	460	470	480
American Indian/Alaska Native	140	160	170	200	200	190
Total²	52,200	57,600	57,900	60,600	61,300	57,200

¹Estimates are adjusted for delays in the reporting of AIDS cases, but not for incomplete reporting of cases. Estimates of less than 1,000, 1,000 to 2,499, 2,500 to 4,999, and 5,000 or more are rounded to the nearest 10, 25, 50, and 100, respectively. Opportunistic illness refers to AIDS-defining opportunistic illnesses included in the 1993 AIDS surveillance case definition. Annual estimates are through the most recent year for which reliable estimates are available. Because there is uncertainty in AIDS-OI incidence, changes over time in AIDS-OI incidence should not be computed from these rounded estimates. See Technical Notes.

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

Table 15. Estimated AIDS-opportunistic illness incidence, by age group, sex, exposure category, and year of diagnosis, 1991 through 1996, United States¹

Male adult/adolescent exposure category	Year of diagnosis					
	1991	1992	1993	1994	1995	1996
Men who have sex with men	28,000	29,200	28,100	29,300	28,600	25,500
Injecting drug use	10,100	11,800	12,400	12,800	12,900	12,100
Men who have sex with men and inject drugs	3,650	3,950	3,600	3,650	3,600	3,050
Hemophilia/coagulation disorder	390	440	420	400	360	280
Heterosexual contact	1,500	2,075	2,500	2,900	3,450	3,800
Receipt of blood transfusion, blood components, or tissue	430	390	320	350	330	340
Risk not reported or identified	340	360	280	140	140	130
Male subtotal	44,400	48,200	47,600	49,500	49,400	45,200
Female adult/adolescent exposure category						
Injecting drug use	3,700	4,300	4,600	4,750	4,950	4,750
Hemophilia/coagulation disorder	20	20	20	20	40	40
Heterosexual contact	2,850	3,650	4,400	5,100	5,900	6,300
Receipt of blood transfusion, blood components, or tissue	300	300	280	310	310	310
Risk not reported or identified	160	160	100	70	70	70
Female subtotal	7,000	8,400	9,400	10,300	11,300	11,500
Pediatric (<13 years old) exposure category²	800	940	900	810	660	520
Total³	52,200	57,600	57,900	60,600	61,300	57,200

¹Estimates are adjusted for delays in the reporting of AIDS cases and anticipated redistribution of cases initially reported with no identified risk, but not for incomplete reporting of cases. Total estimates of less than 1,000, 1,000 to 2,499, 2,500 to 4,999, and 5,000 or more are rounded to the nearest 10, 25, 50, and 100, respectively. Opportunistic illness refers to AIDS-defining opportunistic illnesses included in the 1993 AIDS surveillance case definition. Annual estimates are through the most recent year for which reliable estimates are available. Because there is uncertainty in AIDS-OI incidence, changes over time in AIDS-OI incidence should not be computed from these rounded estimates. See Technical Notes.

²Estimates are based on cases diagnosed using the 1987 definition, adjusted for reporting delays. The 1993 AIDS surveillance case definition affected only adult/adolescent cases, not pediatric cases.

³The sum of the exposure category estimates may not equal the subtotal and total annual estimates because of rounding.

Table 16. Estimated deaths of persons with AIDS, by region of residence and year of death, 1991 through 1996, United States¹

Region of residence ²	Year of death					
	1991	1992	1993	1994	1995	1996
Northeast	11,700	12,900	13,900	15,800	16,100	12,600
Midwest	3,500	4,200	4,750	5,100	5,400	4,050
South	11,300	13,100	14,200	16,000	17,300	14,000
West	8,800	9,600	10,300	10,800	10,100	6,800
U.S. dependencies, possessions, and associated nations	1,300	1,375	1,525	1,725	1,725	1,725
Total³	36,600	41,100	44,600	49,400	50,700	39,200

¹Estimates are adjusted for delays in the reporting of deaths, but not for incomplete reporting of deaths. Estimates of less than 1,000, 1,000 to 2,499, 2,500 to 4,999, and 5,000 or more are rounded to the nearest 10, 25, 50, and 100, respectively. Annual estimates are through the most recent year for which reliable estimates are available. Because there is uncertainty in the estimates of deaths of persons with AIDS, changes over time in the estimates of deaths of persons with AIDS should not be computed from these rounded estimates. See Technical Notes.

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

³The sum of the regional estimates may not equal the total annual estimates because of rounding.

Table 17. Estimated deaths of persons with AIDS, by race/ethnicity and year of death, 1991 through 1996, United States¹

Race/ethnicity	Year of death					
	1991	1992	1993	1994	1995	1996
White, not Hispanic	18,900	20,400	21,400	22,300	21,800	14,700
Black, not Hispanic	11,100	13,300	15,200	17,800	19,100	16,700
Hispanic	6,200	7,100	7,600	8,700	9,100	7,300
Asian/Pacific Islander	250	270	300	400	360	290
American Indian/Alaska Native	90	80	130	140	180	100
Total²	36,600	41,100	44,600	49,400	50,700	39,200

¹Estimates are adjusted for delays in the reporting of deaths, but not for incomplete reporting of deaths. Estimates of less than 1,000, 1,000 to 2,499, 2,500 to 4,999, and 5,000 or more are rounded to the nearest 10, 25, 50, and 100, respectively. Annual estimates are through the most recent year for which reliable estimates are available. Because there is uncertainty in the estimates of deaths of persons with AIDS, changes over time in the estimates of deaths of persons with AIDS should not be computed from these rounded estimates. See Technical Notes.

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

Table 18. Estimated deaths of persons with AIDS, by age group, sex, exposure category, and year of death, 1991 through 1996, United States¹

Male adult/adolescent exposure category	Year of death					
	1991	1992	1993	1994	1995	1996
Men who have sex with men	21,000	22,800	23,700	25,100	24,900	17,300
Injecting drug use	6,800	8,000	9,100	10,200	10,800	9,000
Men who have sex with men and inject drugs	2,425	2,700	3,000	3,300	3,300	2,500
Hemophilia/coagulation disorder	270	320	340	330	310	220
Heterosexual contact	820	1,175	1,525	1,925	2,300	2,125
Receipt of blood transfusion, blood components, or tissue	380	330	320	310	280	240
Risk not reported or identified	210	240	200	170	130	80
Male subtotal	31,900	35,600	38,100	41,400	42,000	31,400
Female adult/adolescent exposure category						
Injecting drug use	2,250	2,700	3,050	3,650	3,850	3,450
Hemophilia/coagulation disorder	10	20	20	20	20	20
Heterosexual contact	1,625	1,950	2,600	3,450	4,000	3,650
Receipt of blood transfusion, blood components, or tissue	250	260	240	240	250	200
Risk not reported or identified	80	120	90	70	60	40
Female subtotal	4,250	5,100	6,000	7,400	8,100	7,300
Pediatric (<13 years old) exposure category	390	420	530	560	530	440
Total²	36,600	41,100	44,600	49,400	50,700	39,200

¹Estimates are adjusted for delays in the reporting of deaths, but not for incomplete reporting of deaths. Total estimates of less than 1,000, 1,000 to 2,499, 2,500 to 4,999, and 5,000 or more are rounded to the nearest 10, 25, 50, and 100, respectively. Annual estimates are through the most recent year for which reliable estimates are available. Because there is uncertainty in the estimates of deaths of persons with AIDS, changes over time in the estimates of deaths of persons with AIDS should not be computed from these rounded estimates. See Technical Notes.

²a sum of the exposure category estimates may not equal the total annual estimates because of rounding.

Table 19. Estimated persons living with AIDS, by region of residence and year, 1991 through 1996, United States¹

Region of residence ²	Year					
	1991	1992	1993	1994	1995	1996
Northeast	29,100	39,000	50,800	58,100	64,400	71,000
Midwest	10,800	15,100	18,300	20,200	21,600	23,300
South	33,300	46,900	59,400	69,100	76,700	87,700
West	24,300	33,000	38,900	42,400	45,500	49,900
U.S. dependencies, possessions, and associated nations	3,500	4,600	5,700	6,400	6,800	7,100
Total³	101,000	138,600	173,100	196,200	215,000	239,000

¹Estimates of persons living with AIDS are derived by subtracting the estimated cumulative number of deaths in persons with AIDS from the estimated cumulative number of persons with AIDS. Estimated AIDS cases and estimated deaths are adjusted for reporting delays, but not for incomplete reporting. Estimates of less than 1,000, 1,000 to 2,499, 2,500 to 4,999, and 5,000 or more are rounded to the nearest 10, 25, 50, and 100, respectively. Annual estimates are through the most recent year for which reliable estimates are available. Because there is uncertainty in the estimates of persons living with AIDS, changes over time in the estimates of persons living with AIDS should not be computed from these rounded estimates. See Technical Notes.

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

³The sum of the regional estimates may not equal the total annual estimates because of rounding.

Table 20. Estimated persons living with AIDS, by race/ethnicity and year, 1991 through 1996, United States¹

Race/ethnicity	Year					
	1991	1992	1993	1994	1995	1996
White, not Hispanic	51,900	68,000	80,000	86,200	91,100	98,200
Black, not Hispanic	31,200	45,500	60,400	71,500	80,900	92,200
Hispanic	16,800	23,500	30,800	36,000	40,400	45,400
Asian/Pacific Islander	690	1,000	1,275	1,425	1,575	1,850
American Indian/ Alaska Native	280	450	540	640	700	800
Total²	101,000	138,600	173,100	196,200	215,000	239,000

¹Estimates of persons living with AIDS are derived by subtracting the estimated cumulative number of deaths in persons with AIDS from the estimated cumulative number of persons with AIDS. Estimated AIDS cases and estimated deaths are adjusted for reporting delays, but not for incomplete reporting. Estimates of less than 1,000, 1,000 to 2,499, 2,500 to 4,999, and 5,000 or more are rounded to the nearest 10, 25, 50, and 100, respectively. Annual estimates are through the most recent year for which reliable estimates are available. See Technical Notes.

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

Table 21. Estimated persons living with AIDS, by age group, sex, exposure category, and year, 1991 through 1996, United States¹

Male adult/adolescent exposure category	Year					
	1991	1992	1993	1994	1995	1996
Men who have sex with men	55,400	72,800	86,900	95,500	102,000	111,900
Injecting drug use	17,900	25,800	34,100	39,700	43,800	48,000
Men who have sex with men and inject drugs	8,100	10,900	12,800	13,600	14,200	14,700
Hemophilia/coagulation disorder	970	1,400	1,575	1,650	1,650	1,650
Heterosexual contact	2,375	4,000	6,000	7,700	9,600	12,300
Receipt of blood transfusion, blood components, or tissue	700	860	970	1,050	1,150	1,275
Risk not reported or identified	910	1,125	1,225	1,175	1,200	1,275
Male subtotal	86,400	116,800	143,500	160,400	173,600	191,000
Female adult/adolescent exposure category						
Injecting drug use	6,900	10,100	13,500	15,800	17,800	19,700
Hemophilia/coagulation disorder	40	60	80	90	110	130
Heterosexual contact	4,750	7,900	11,800	15,100	18,600	22,900
Receipt of blood transfusion, blood components, or tissue	550	690	830	950	1,050	1,225
Risk not reported or identified	340	420	460	460	470	510
Female subtotal	12,500	19,200	26,700	32,500	38,100	44,400
Pediatric (<13 years old) exposure category						
	2,125	2,650	3,000	3,250	3,400	3,450
Total²	101,000	138,600	173,100	196,200	215,000	239,000

¹Estimates of persons living with AIDS are derived by subtracting the estimated cumulative number of deaths in persons with AIDS from the estimated cumulative number of persons with AIDS. Estimated AIDS cases and estimated deaths are adjusted for reporting delays, but not for incomplete reporting. Total estimates of less than 1,000, 1,000 to 2,499, 2,500 to 4,999, and 5,000 or more are rounded to the nearest 10, 25, 50, and 100, respectively. Annual estimates are through the most recent year for which reliable estimates are available. Because there is uncertainty in the estimates of persons living with AIDS, changes over time in the estimates of persons living with AIDS should not be computed from these rounded estimates. See Technical Notes.

²The sum of exposure category estimates may not equal the total annual estimates because of rounding.

Table 22. HIV infection cases¹ by state, reported July 1995 through June 1996, July 1996 through June 1997; and cumulative totals, by state and age group, through June 1997, from states with confidential HIV infection reporting

State of residence (Date HIV reporting initiated)	July 1995– June 1996	July 1996– June 1997	Cumulative totals		
			Adults/ adolescents	Children <13 years old	Total
Alabama (Jan. 1988)	540	531	4,299	36	4,335
Arizona (Jan. 1987)	374	385	3,537	37	3,574
Arkansas (July 1989)	224	218	1,534	19	1,553
Colorado (Nov. 1985)	359	405	5,154	29	5,183
Connecticut (July 1992) ²	12	11	–	95	95
Idaho (June 1986)	26	33	280	2	282
Indiana (July 1988)	374	469	2,895	23	2,918
Louisiana (Feb. 1993)	1,022	1,239	5,128	93	5,221
Michigan (April 1992)	848	745	3,806	96	3,902
Minnesota (Oct. 1985)	213	219	2,185	25	2,210
Mississippi (Aug. 1988)	536	538	3,489	40	3,529
Missouri (Oct. 1987)	529	533	3,626	42	3,668
Nebraska (Sept. 1995)	214	102	315	5	320
Nevada (Feb. 1992)	382	447	2,419	20	2,439
New Jersey (Jan. 1992)	1,936	2,282	11,676	330	12,006
North Carolina (Feb. 1990)	1,217	1,008	7,340	95	7,435
North Dakota (Jan. 1988)	4	6	63	–	63
Ohio (June 1990)	709	429	3,621	55	3,676
Oklahoma (June 1988)	239	222	1,819	12	1,831
Oregon (Sept. 1988) ²					
South Carolina (Feb. 1986)	746	722	5,995	108	6,103
South Dakota (Jan. 1988)	17	12	168	5	173
Tennessee (Jan. 1992)	861	855	4,178	43	4,221
Texas (Feb. 1994) ²	37	30	–	223	223
Utah (April 1989)	105	88	785	4	789
Virginia (July 1989)	1,188	908	6,595	69	6,664
West Virginia (Jan. 1989)	70	66	426	1	427
Wisconsin (Nov. 1985)	268	246	2,054	30	2,084
Wyoming (June 1989)	7	11	59	–	59
Subtotal	13,057	12,763	83,446	1,540	84,986
Persons reported from states with confidential HIV reporting who were residents of other states ³	314	348	1,940	46	1,986
Total	13,371	13,111	85,386	1,586	86,972

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

²Connecticut and Texas have confidential HIV infection reporting for pediatric cases only; Oregon has confidential reporting for children less than 6 years old.

³Includes 294 persons reported from states with confidential HIV infection reporting, but whose state of residence is unknown. See Technical Notes.

Table 23. Male adult/adolescent HIV infection cases¹ by exposure category and race/ethnicity, reported July 1996 through June 1997, and cumulative totals through June 1997, from states with confidential HIV infection reporting²

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	2,238	(60)	17,382	(61)	1,281	(29)	9,561	(32)	230	(35)	1,360	(35)
Injecting drug use	363	(10)	2,591	(9)	768	(17)	6,279	(21)	152	(23)	1,069	(28)
Men who have sex with men and inject drugs	227	(6)	2,342	(8)	145	(3)	1,542	(5)	30	(5)	243	(6)
Hemophilia/coagulation disorder	19	(1)	318	(1)	8	(0)	75	(0)	2	(0)	10	(0)
Heterosexual contact:	113	(3)	719	(3)	400	(9)	2,633	(9)	43	(6)	226	(6)
<i>Sex with an injecting drug user</i>	25		195		82		648		14		78	
<i>Sex with person with hemophilia</i>	–		3		1		7		–		–	
<i>Sex with transfusion recipient with HIV infection</i>	4		19		5		44		–		2	
<i>Sex with HIV-infected person, risk not specified</i>	84		502		312		1,934		29		14	
Receipt of blood tranfusion, blood components, or tissue	11	(0)	168	(1)	26	(1)	155	(1)	1	(0)	24	(1)
Risk not reported or identified ³	764	(20)	5,091	(18)	1,801	(41)	9,688	(32)	208	(31)	931	(24)
Total	3,735	(100)	28,611	(100)	4,429	(100)	29,933	(100)	666	(100)	3,863	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ⁴			
	July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	11	(34)	85	(47)	27	(43)	177	(48)	3,824	(42)	28,795	(45)
Injecting drug use	–	–	15	(8)	6	(10)	56	(15)	1,303	(14)	10,074	(16)
Men who have sex with men and inject drugs	2	(6)	4	(2)	4	(6)	51	(14)	411	(5)	4,206	(7)
Hemophilia/coagulation disorder	1	(3)	2	(1)	–	–	2	(1)	31	(0)	413	(1)
Heterosexual contact:	3	(9)	10	(6)	2	(3)	17	(5)	562	(6)	3,621	(6)
<i>Sex with an injecting drug user</i>	2		5		1		6		124		937	
<i>Sex with person with hemophilia</i>	–		–		–		–		1		10	
<i>Sex with transfusion recipient with HIV infection</i>	–		–		–		–		10		66	
<i>Sex with HIV-infected person, risk not specified</i>	1		5		1		11		427		2,608	
Receipt of blood tranfusion, blood components, or tissue	–	–	1	(1)	–	–	3	(1)	38	(0)	356	(1)
Risk not reported or identified	15	(47)	64	(35)	24	(38)	63	(17)	2,929	(32)	16,605	(26)
Total	32	(100)	181	(100)	63	(100)	369	(100)	9,098	(100)	64,070	(100)

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

²See table 22 for states with confidential HIV infection reporting.

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

⁴Includes 1,113 men whose race/ethnicity is unknown.

Table 24. Female adult/adolescent HIV infection cases¹ by exposure category and race/ethnicity, reported July 1996 through June 1997, and cumulative totals through June 1997, from states with confidential HIV infection reporting²

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	181	(22)	1,551	(29)	408	(16)	3,273	(23)	50	(18)	347	(27)
Hemophilia/coagulation disorder	3	(0)	11	(0)	1	(0)	9	(0)	–	–	–	–
Heterosexual contact:	325	(39)	2,129	(40)	884	(35)	5,262	(37)	120	(44)	520	(41)
<i>Sex with an injecting drug user</i>	112		798		196		1,583		41		228	
<i>Sex with a bisexual male</i>	34		260		52		389		3		20	
<i>Sex with person with hemophilia</i>	7		54		3		29		–		5	
<i>Sex with transfusion recipient with HIV infection</i>	3		27		8		40		1		5	
<i>Sex with HIV-infected person, risk not specified</i>	169		990		625		3,221		75		26	
Receipt of blood tranfusion, blood components, or tissue	9	(1)	114	(2)	30	(1)	218	(2)	1	(0)	19	(2)
Risk not reported or identified ³	314	(38)	1,527	(29)	1,215	(48)	5,479	(38)	103	(38)	377	(30)
Total	832	(100)	5,332	(100)	2,538	(100)	14,241	(100)	274	(100)	1,263	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ⁴			
	July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	2	(9)	8	(12)	8	(30)	51	(37)	653	(17)	5,253	(25)
Hemophilia/coagulation disorder	–	–	–	–	–	–	–	–	4	(0)	20	(0)
Heterosexual contact:	6	(27)	23	(35)	11	(41)	53	(38)	1,352	(36)	8,017	(38)
<i>Sex with an injecting drug user</i>	1		6		5		30		357		2,652	
<i>Sex with a bisexual male</i>	–		1		1		7		90		68	
<i>Sex with person with hemophilia</i>	–		–		–		–		10		88	
<i>Sex with transfusion recipient with HIV infection</i>	–		–		–		–		12		72	
<i>Sex with HIV-infected person, risk not specified</i>	5		16		5		16		883		4,52	
Receipt of blood tranfusion, blood components, or tissue	–	–	1	(2)	–	–	1	(1)	40	(1)	355	(2)
Risk not reported or identified	14	(64)	34	(52)	8	(30)	33	(24)	1,701	(45)	7,659	(36)
Total	22	(100)	66	(100)	27	(100)	138	(100)	3,750	(100)	21,304	(100)

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

²See table 22 for states with confidential HIV infection reporting.

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

⁴Includes 264 women whose race/ethnicity is unknown.

Table 25. Pediatric HIV infection cases¹ by exposure category and race/ethnicity, reported July 1996 through June 1997, and cumulative totals through June 1997, from states with confidential HIV infection reporting²

Exposure category	White, not Hispanic		Black, not Hispanic		Hispanic	
	July 1996– June 1997	Cumulative total	July 1996– June 1997	Cumulative total	July 1996– June 1997	Cumulative total
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Hemophilia/coagulation disorder	1 (2)	65 (17)	–	18 (2)	–	5 (3)
Mother with/at risk for HIV infection:	49 (92)	288 (74)	149 (90)	892 (91)	30 (88)	162 (88)
<i>Injecting drug use</i>	16	86	48	288	2	39
<i>Sex with injecting drug user</i>	11	57	23	109	8	32
<i>Sex with bisexual male</i>	1	4	1	16	–	2
<i>Sex with person with hemophilia</i>	–	3	–	2	–	–
<i>Sex with transfusion recipient with HIV infection</i>	–	4	1	3	–	–
<i>Sex with HIV-infected person, risk not specified</i>	9	55	31	160	11	33
<i>Receipt of blood transfusion, blood components, or tissue</i>	1	7	–	10	–	2
<i>Has HIV infection, risk not specified</i>	11	72	45	304	9	54
Receipt of blood transfusion, blood components, or tissue	–	18 (5)	1 (1)	8 (1)	–	4 (2)
Risk not reported or identified ³	3 (6)	18 (5)	16 (10)	61 (6)	4 (12)	13 (7)
Total	53 (100)	389 (100)	166 (100)	979 (100)	34 (100)	184 (100)

Exposure category	Asian/Pacific Islander		American Indian/ Alaska Native		Cumulative totals ⁴	
	July 1996– June 1997	Cumulative total	July 1996– June 1997	Cumulative total	July 1996– June 1997	Cumulative total
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Hemophilia/coagulation disorder	–	1 (14)	–	1 (10)	1 (0)	92 (6)
Mother with/at risk for HIV infection:	1 (100)	3 (43)	–	7 (70)	232 (89)	1,360 (86)
<i>Injecting drug use</i>	–	1	–	3	67	420
<i>Sex with injecting drug user</i>	–	–	–	1	43	200
<i>Sex with bisexual male</i>	1	2	–	–	3	2
<i>Sex with person with hemophilia</i>	–	–	–	1	–	6
<i>Sex with transfusion recipient with HIV infection</i>	–	–	–	–	1	7
<i>Sex with HIV-infected person, risk not specified</i>	–	–	–	–	51	248
<i>Receipt of blood transfusion, blood components, or tissue</i>	–	–	–	–	1	1
<i>Has HIV infection, risk not specified</i>	–	–	–	2	66	435
Receipt of blood transfusion, blood components, or tissue	–	–	–	–	1 (0)	31 (2)
Risk not reported or identified	–	3 (43)	–	2 (20)	27 (10)	103 (6)
Total	1 (100)	7 (100)	–	10 (100)	261 (100)	1,586 (100)

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

²See table 22 for states with confidential HIV infection reporting.

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

⁴Includes 17 children whose race/ethnicity is unknown.

Table 26. HIV infection cases¹ in adolescents and adults under age 25, by sex and exposure category, reported July 1996 through June 1997, and cumulative totals through June 1997, from states with confidential HIV infection reporting²

Male exposure category	13-19 years old				20-24 years old			
	July 1996– June 1997		Cumulative total		July 1996– June 1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	82	(44)	735	(46)	496	(53)	4,818	(54)
Injecting drug use	9	(5)	86	(5)	51	(5)	523	(6)
Men who have sex with men and inject drugs	8	(4)	90	(6)	39	(4)	586	(7)
Hemophilia/coagulation disorder	5	(3)	99	(6)	4	(0)	84	(1)
Heterosexual contact:	12	(6)	107	(7)	45	(5)	493	(6)
<i>Sex with injecting drug user</i>								
<i>Sex with person with hemophilia</i>								
<i>Sex with transfusion recipient with HIV infection</i>								
<i>Sex with HIV-infected person, risk not specified</i>	12		85		41		401	
Receipt of blood transfusion; blood components, or tissue-	1	(1)	10	(1)	5	(1)	36	(0)
Risk not reported or identified ³	68	(37)	477	(30)	302	(32)	2,325	(26)
Male subtotal	185	(100)	1,604	(100)	942	(100)	8,865	(100)
Female exposure category								
Injecting drug use	14	(4)	130	(7)	53	(9)	543	(14)
Hemophilia/coagulation disorder	–	–	–	–	–	–	2	(0)
Heterosexual contact:	134	(40)	816	(47)	249	(41)	1,640	(43)
<i>Sex with injecting drug user</i>	21		190		55		468	
<i>Sex with bisexual male</i>	9		59		21		15	
<i>Sex with person with hemophilia</i>	3		15		2		28	
<i>Sex with transfusion recipient with HIV infection</i>	2		4		1		16	
<i>Sex with HIV-infected person, risk not specified</i>	99		548		170		971	
Receipt of blood transfusion, blood components, or tissue	2	(1)	15	(1)	3	(0)	28	(1)
Risk not reported or identified	186	(55)	793	(45)	300	(50)	1,593	(42)
Female subtotal	336	(100)	1,754	(100)	605	(100)	3,806	(100)
Total⁴	521		3,359		1,548		12,673	

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

²See table 22 for states with confidential HIV infection reporting.

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

⁴Includes 3 persons whose sex is unknown.

Table 27. HIV infection cases¹ by sex, age at diagnosis, and race/ethnicity, reported through June 1997, from states with confidential HIV infection reporting²

Male Age at diagnosis (years)	White, not Hispanic		Black, not Hispanic		Hispanic		Asian/Pacific Islander		American Indian/ Alaska Native		Total ³	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Under 5	136	(0)	403	(1)	71	(2)	2	(1)	2	(1)	615	(1)
5-12	82	(0)	76	(0)	25	(1)	1	(1)	1	(0)	190	(0)
13-19	606	(2)	901	(3)	59	(1)	6	(3)	8	(2)	1,604	(2)
20-24	4,089	(14)	4,048	(13)	504	(13)	29	(16)	70	(19)	8,865	(14)
25-29	7,136	(25)	6,153	(20)	969	(24)	49	(27)	104	(28)	14,653	(23)
30-34	6,940	(24)	6,691	(22)	976	(25)	43	(23)	84	(23)	14,993	(23)
35-39	4,628	(16)	5,485	(18)	695	(18)	24	(13)	52	(14)	11,086	(17)
40-44	2,618	(9)	3,557	(12)	381	(10)	16	(9)	26	(7)	6,723	(10)
45-49	1,322	(5)	1,644	(5)	152	(4)	8	(4)	12	(3)	3,210	(5)
50-54	686	(2)	760	(2)	56	(1)	3	(2)	5	(1)	1,542	(2)
55-59	285	(1)	356	(1)	38	(1)	-	-	5	(1)	694	(1)
60-64	155	(1)	180	(1)	19	(0)	1	(1)	3	(1)	366	(1)
65 or older	146	(1)	158	(1)	14	(0)	2	(1)	-	-	334	(1)
Male subtotal	28,829	(100)	30,412	(100)	3,959	(100)	184	(100)	372	(100)	64,875	(100)
Female												
Age at diagnosis (years)												
Under 5	139	(3)	412	(3)	70	(5)	3	(4)	6	(4)	639	(3)
5-12	32	(1)	88	(1)	18	(1)	1	(1)	1	(1)	142	(1)
13-19	374	(7)	1,271	(9)	76	(6)	4	(6)	15	(10)	1,754	(8)
20-24	1,022	(19)	2,518	(17)	193	(14)	16	(23)	24	(17)	3,806	(17)
25-29	1,227	(22)	3,068	(21)	313	(23)	16	(23)	23	(16)	4,708	(21)
30-34	1,157	(21)	2,939	(20)	309	(23)	15	(21)	29	(20)	4,515	(20)
35-39	753	(14)	2,195	(15)	179	(13)	7	(10)	24	(17)	3,194	(14)
40-44	359	(7)	1,226	(8)	94	(7)	4	(6)	18	(12)	1,728	(8)
45-49	221	(4)	525	(4)	52	(4)	2	(3)	4	(3)	820	(4)
50-54	84	(2)	234	(2)	24	(2)	1	(1)	1	(1)	348	(2)
55-59	46	(1)	128	(1)	17	(1)	1	(1)	-	-	194	(1)
60-64	31	(1)	62	(0)	4	(0)	-	-	-	-	97	(0)
65 or older	58	(1)	75	(1)	2	(0)	-	-	-	-	140	(1)
Female subtotal	5,503	(100)	14,741	(100)	1,351	(100)	70	(100)	145	(100)	22,085	(100)
Total⁴	34,333		45,156		5,310		254		517		86,972	

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

²See table 22 for states with confidential HIV infection reporting.

³Includes 1,119 males, 275 females, and 8 persons of unknown sex whose race/ethnicity is unknown.

⁴Includes 12 persons whose sex is unknown.

Table 28. Persons reported to be living with HIV infection¹ and with AIDS, by state and age group, reported through June 1997²

U.S. state of residence (Date HIV reporting initiated)	Living with HIV infection ³			Living with AIDS ⁴			Cumulative totals		
	Adults/ adolescents	Children <13 years old	Total	Adults/ adolescents	Children <13 years old	Total	Adults/ adolescents	Children <13 years old	Total
Alabama (Jan. 1988)	4,144	35	4,179	1,956	21	1,977	6,100	56	6,156
Alaska	—	—	—	182	2	184	182	2	184
Arizona (Jan. 1987)	3,168	34	3,202	1,806	6	1,812	4,974	40	5,014
Arkansas (July 1989)	1,511	19	1,530	1,077	17	1,094	2,588	36	2,624
California	—	—	—	34,627	205	34,832	34,627	205	34,832
Colorado (Nov. 1985)	4,976	28	5,004	2,352	7	2,359	7,328	35	7,363
Connecticut (July 1992) ⁵	—	87	87	4,344	80	4,424	4,344	167	4,511
Delaware	—	—	—	850	7	857	850	7	857
District of Columbia	—	—	—	4,112	81	4,193	4,112	81	4,193
Florida	—	—	—	25,326	574	25,900	25,326	574	25,900
Georgia	—	—	—	7,662	77	7,739	7,662	77	7,739
Hawaii	—	—	—	682	4	686	682	4	686
Idaho (June 1986)	230	2	232	160	—	160	390	2	392
Illinois	—	—	—	6,493	104	6,597	6,493	104	6,597
Indiana (July 1988)	2,798	22	2,820	2,031	14	2,045	4,829	36	4,865
Iowa	—	—	—	435	4	439	435	4	439
Kansas	—	—	—	712	3	715	712	3	715
Kentucky	—	—	—	963	12	975	963	12	975
Louisiana (Feb. 1993)	4,947	86	5,033	3,983	57	4,040	8,930	143	9,073
Maine	—	—	—	337	8	345	337	8	345
Maryland	—	—	—	6,656	147	6,803	6,656	147	6,803
Massachusetts	—	—	—	4,126	76	4,202	4,126	76	4,202
Michigan (April 1992)	3,188	81	3,269	3,459	28	3,487	6,647	109	6,756
Minnesota (Oct. 1985)	2,061	23	2,084	1,207	10	1,217	3,268	33	3,301
Mississippi (Aug. 1988)	3,372	40	3,412	1,232	21	1,253	4,604	61	4,665
Missouri (Oct. 1987)	3,507	41	3,548	3,211	16	3,227	6,718	57	6,775
Montana	—	—	—	115	1	116	115	1	116
Nebraska (Sept. 1995)	301	5	306	327	4	331	628	9	637
Nevada (Feb. 1992)	2,198	19	2,217	1,512	13	1,525	3,710	32	3,742
New Hampshire	—	—	—	379	3	382	379	3	382
New Jersey (Jan. 1992)	10,615	318	10,933	11,906	259	12,165	22,521	577	23,098
New Mexico	—	—	—	598	3	601	598	3	601
New York	—	—	—	36,362	729	37,091	36,362	729	37,091
North Carolina (Feb. 1990)	6,773	89	6,862	2,797	50	2,847	9,570	139	9,709
North Dakota (Jan. 1988)	55	—	55	33	—	33	88	—	88
Ohio (June 1990)	3,224	53	3,277	3,055	36	3,091	6,279	89	6,368
Oklahoma (June 1988)	1,734	11	1,745	1,200	9	1,209	2,934	20	2,954
Oregon (Sept. 1988) ⁵	—	3	3	1,552	5	1,557	1,552	8	1,560
Pennsylvania	—	—	—	7,160	127	7,287	7,160	127	7,287
Rhode Island	—	—	—	686	3	689	686	3	689
South Carolina (Feb. 1986)	5,707	106	5,813	2,960	25	2,985	8,667	131	8,798
South Dakota (Jan. 1988)	152	5	157	44	1	45	196	6	202
Tennessee (Jan. 1992)	4,056	43	4,099	2,722	18	2,740	6,778	61	6,839
Texas (Feb. 1994) ⁵	—	211	211	17,006	127	17,133	17,006	338	17,344
Utah (April 1989)	773	4	777	599	6	605	1,372	10	1,382
Vermont	—	—	—	137	1	138	137	1	138
Virginia (July 1989)	6,177	67	6,244	3,732	81	3,813	9,909	148	10,057
Washington	—	—	—	3,115	14	3,129	3,115	14	3,129
West Virginia (Jan. 1989)	396	1	397	330	3	333	726	4	730
Wisconsin (Nov. 1985)	1,932	29	1,961	1,228	9	1,237	3,160	38	3,198
Wyoming (June 1989)	55	—	55	58	2	60	113	2	115
Subtotal	78,050	1,462	79,512	219,594	3,110	222,704	297,644	4,572	302,216
U.S. dependencies, possessions, and associated nations									
Guam	—	—	—	7	—	7	7	—	7
Pacific Islands, U.S.	—	—	—	2	—	2	2	—	2
Puerto Rico	—	—	—	6,746	166	6,912	6,746	166	6,912
Virgin Islands, U.S.	—	—	—	166	8	174	166	8	174
Total	78,050	1,462	79,512	226,726	3,285	230,011	304,776	4,747	309,523

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

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

³Includes only persons reported from states with confidential HIV reporting. Excludes 1,789 adults/adolescents and 42 children reported from states with confidential HIV infection reporting whose state of residence is unknown or are residents of other states.

⁴Includes 211 adults/adolescents and 1 child whose state of residence is unknown.

⁵Connecticut and Texas have confidential HIV infection reporting for pediatric cases only; Oregon has confidential infection reporting for children less than 6 years old.

Technical Notes

Surveillance of AIDS

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

For persons with laboratory-confirmed HIV infection, the 1987 revision incorporated HIV encephalopathy, wasting syndrome, and other indicator diseases that are diagnosed presumptively (i.e., without confirmatory laboratory evidence of the opportunistic disease). In addition to the 23 clinical conditions in the 1987 definition, the 1993 case definition for adults and adolescents includes HIV-infected persons with CD4⁺ T-lymphocyte counts of less than 200 cells/ μ L or a CD4⁺ percentage of less than 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer. All conditions added to the 1993 definition require laboratory confirmation of HIV infection. Persons who meet the criteria for more than one definition category are classified hierarchically in the following order: pre-1987, 1987, and 1993. Persons in the 1993 definition category meet only the 1993 definition.

The pediatric case definition incorporates the revised 1994 pediatric classification system for evidence of HIV infection. Children with their first positive results on Western blot or HIV detection tests before October 1994 were categorized based on the 1987 classification system. Those tested during or after October 1994 are categorized under the revised 1994 pediatric classification system. For children of any age

with an AIDS-defining condition that requires evidence of HIV infection, a single positive HIV-detection test (i.e., HIV culture, HIV PCR, or HIV antigen [p24]) is sufficient for a reportable AIDS diagnosis if the diagnosis is confirmed by a physician. The 1994 pediatric definitions for HIV encephalopathy and HIV wasting syndrome reflect increased knowledge of these conditions in children, and replace the 1987 definitions.

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

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

Surveillance of HIV infection

Through June 30, 1997, 26 states had laws or regulations requiring confidential reporting by name of all persons with confirmed HIV infection, in addition to reporting of persons with AIDS. Two other states, Connecticut and Texas, required reporting by name of HIV infection only for children less than 13 years of age; and Oregon required reporting for children less than 6 years of age. These states initiated reporting at various times after the development of serum HIV-antibody tests in 1985. Before 1991, surveillance of HIV infection was not standardized and reporting of HIV infections was based primarily on passive surveillance. Consequently, many cases reported before 1991 do not have complete information. Since then, CDC has assisted states in conducting active surveillance of HIV infection using standardized report forms and software. However, collection of demographic and risk information still varies among states.

Estimates of the prevalence of HIV infection in the United States in 1992 were between 650,000 and

¹Included among the dependencies, possessions, and independent nations are Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Republic of Palau, the Republic of the Marshall Islands, the Commonwealth of the Northern Mariana Islands, and the Federated States of Micronesia. The latter 5 comprise the category "Pacific Islands, U.S." listed in tables 1 and 28.

900,000 (*JAMA* 1996;276:126-31). However, HIV surveillance reports are not representative of all persons estimated to be infected with HIV; HIV infection data should be interpreted with caution. Because many HIV-reporting states also offer anonymous HIV testing; confidential HIV infection reports are not representative of all persons being tested in these areas. Furthermore, many factors may influence testing patterns, including the extent that testing is targeted or routinely offered to specific groups and the availability and access to medical care and testing services. These data provide a minimum estimate of the number of persons known to be HIV infected in states with confidential HIV infection reporting.

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

Because states initiated reporting on different dates, the length of time reporting has been in place will influence the number of HIV infection cases reported. For example, data presented for a given annual period may include cases reported during only a portion of the year. Prior to statewide HIV reporting, some states collected reports of HIV infection in selected populations. Therefore, these states have reports prior to initiation of statewide confidential reporting.

Over time, persons with HIV infection will be diagnosed and reported with AIDS. HIV infection cases later reported with AIDS are deleted from the HIV infection tables and added to the AIDS tables. Persons with HIV infection may be tested at any point in the clinical spectrum of disease; therefore, the time between diagnosis of HIV infection and AIDS will vary. In addition, because surveillance practices differ, reporting and updating of clinical and vital status of cases vary among states.

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

Tabulation and presentation of data

Data in this report are provisional. Each issue of this report includes information received by CDC through the last day of the reporting period. AIDS data are tabulated by date of report to CDC unless otherwise noted. Data for U.S. dependencies and possessions and for associated independent nations are included in the totals.

Age group tabulations are based on the person's age at first documented positive HIV-antibody test result for HIV infection cases, and age at diagnosis of AIDS for AIDS cases. Adult/adolescent cases include persons 13 years of age and older; pediatric cases include children under 13 years of age. Age group tabulations for AIDS cases in table 14 (year-end edition only) are based on age at death.

Tabulations of persons living with HIV infection and AIDS (table 28), include persons whose vital status was "alive" as of the last update; persons whose vital status is missing or unknown are not included. Tabulations of deaths in persons with AIDS include persons whose vital status was "dead" as of the last update; persons whose vital status is missing or unknown are not included. Caution should be used in interpreting these data because states vary in the frequency with which they review the vital status of persons reported with HIV infection and AIDS. In addition, some cases may be lost to follow-up.

Table 12 (year-end edition only) tabulates AIDS-indicator conditions reported during the last year. These data are known to underreport AIDS-indicator conditions and should be interpreted with caution. Reported conditions overrepresent initial AIDS-indicator illness because follow-up for subsequent indicator diseases is resource intensive and has not been systematic or standardized in most health departments. The 1993 AIDS surveillance case definition for adults and adolescents added reporting of HIV-infected persons with severe HIV-related immunosuppression ($CD4^+$ T-lymphocyte count of less than 200/ μ L or less than 14 percent). Since implementation of the 1993 definition, reporting of AIDS cases based on AIDS-defining opportunistic infections has decreased (*AIDS* 1994; 8:1489-93).

Table 2 lists AIDS case counts for each metropolitan area with an estimated 1996 population of 500,000 or more. AIDS case counts for metropolitan

areas with 50,000 to 500,000 population are reported as a combined subtotal. On December 31, 1992, the Office of Management and Budget announced new Metropolitan Statistical Area (MSA) definitions, which reflect changes in the U.S. population as determined by the 1990 census. These definitions were updated most recently on July 1, 1996. The cities and counties which compose each metropolitan area listed in table 2 are provided in the publication "Metropolitan Areas as of June 30, 1995" (available by calling the National Technical Information Service, 1-703-487-4650, and ordering accession no. PB95-208880). Standards for defining central and outlying counties of metropolitan areas were published in the Federal Register (*FR* 1990;55:12154-60).

The metropolitan area definitions are the MSAs for all areas except the 6 New England states. For these states, the New England County Metropolitan Areas (NECMA) are used. Metropolitan areas are named for a central city in the MSA or NECMA, may include several cities and counties, and may cross state boundaries. For example, AIDS cases and annual rates presented for the District of Columbia in table 1 include only persons residing within the geographic boundaries of the District. AIDS cases and annual rates for Washington, D.C., in table 2 include persons residing within the several counties in the metropolitan area, including counties in Maryland, Virginia, and West Virginia. State or metropolitan area data tabulations are based on the person's residence at first positive HIV-antibody test result for HIV infection cases and residence at diagnosis of the first AIDS-indicator condition(s) for AIDS cases.

Estimates of AIDS-opportunistic illness (AIDS-OI) incidence (tables 13, 14, and 15), estimated deaths (tables 16, 17, and 18), and estimated persons living with AIDS (tables 19, 20, and 21) are not counts of actual numbers of persons reported to the surveillance system. The estimates are adjusted for delays in reporting of cases and deaths and are based on a number of assumptions (for example, see "Estimated AIDS-opportunistic illness" *infra*). While these tables use the best estimates currently available, there is inherent uncertainty in these estimates. Therefore, the estimates in this report are rounded. Other analyses (J.M. Karon, Estimating the number of AIDS-defining opportunistic illness diagnoses from data collected under the 1993 AIDS surveillance definition, *J Acquir Immune Def Syndr*, in press) suggest that the uncertainty in these estimates is at least one percent. Therefore, the rounding is to one percent of the upper limit within arbitrarily chosen ranges. State and local surveillance staff are encouraged to adopt similar

rounding conventions when presenting estimates. As is standard computational practice, changes in the estimates of the AIDS-OI incidence, estimates of deaths, and estimates of persons living with AIDS should be computed from unrounded numbers, rather than from rounded numbers. That is, an estimate, such as the percent change in annual incidence, should not be computed from the rounded estimates of AIDS-OI incidence. An estimate of change computed from rounded numbers is especially unreliable if the annual estimates are relatively small.

Exposure categories

For surveillance purposes, HIV infection cases and AIDS cases are counted only once in a hierarchy of exposure categories. Persons with more than one reported mode of exposure to HIV are classified in the exposure category listed first in the hierarchy, except for men with both a history of sexual contact with other men and injecting drug use. They make up a separate exposure category.

"Men who have sex with men" cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact). "Heterosexual contact" cases are in persons who report specific heterosexual contact with a person with, or at increased risk for, HIV infection (e.g., an injecting drug user).

Adults/adolescents born, or who had sex with someone born, in a country where heterosexual transmission was believed to be the predominant mode of HIV transmission (formerly classified as Pattern-II countries by the World Health Organization) are no longer classified as having heterosexually acquired AIDS. Similar to case reports for other persons who are reported without behavioral or transfusion risks for HIV, these reports are now classified (in the absence of other risk information which would classify them into another exposure category) as "no risk reported or identified" (*MMWR* 1994;43:155-60). Children whose mother was born, or whose mother had sex with someone born, in a Pattern-II country are now classified (in the absence of other risk information which would classify them into another exposure category) as "Mother with/at risk for HIV infection: has HIV infection, risk not specified."

"No risk reported or identified" cases are in persons with no reported history of exposure to HIV through any of the routes listed in the hierarchy of exposure categories. Risk not identified cases include persons who are currently under investigation by local health

department officials; persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow-up; and persons who were interviewed or for whom other follow-up information was available and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified into the appropriate exposure category. In general, investigations and follow up for modes of exposure by state health departments are conducted routinely for persons reported with AIDS and as resources allow for those reported with HIV infection. Therefore, the percentage of HIV infected persons with risk not reported or identified is substantially higher than for those reported with AIDS. As HIV infected persons with risk not reported or identified are diagnosed and reported with AIDS, they are assigned higher priority for follow-up to determine the mode(s) of exposure.

Estimated AIDS-opportunistic illness

In 1993, the AIDS surveillance case definition was expanded to include a laboratory measure of severe immunosuppression ($CD4^+$ T-lymphocyte count of less than 200 cells/ μ L or a percent of total lymphocytes less than 14) and three additional clinical conditions (pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer). Before 1993, the surveillance definition included only opportunistic illnesses, and trends in the incidence of AIDS were evaluated by examining the number of AIDS opportunistic illnesses (AIDS-OIs) diagnosed per year or quarter, adjusted for reporting delays. Because most HIV-infected persons become severely immunosuppressed before the onset of AIDS-OIs, the addition of the $CD4^+$ criteria has temporarily distorted observed trends in AIDS incidence. To examine trends over time, additional adjustments are required to estimate when an AIDS-OI will develop in persons who were reported based on the $CD4^+$ criteria. CDC has developed a procedure to estimate the incidence of AIDS-OIs among persons reported with AIDS based on the $CD4^+$ criteria. Estimates of trends in AIDS-OIs are displayed in tables 13, 14, and 15. Annual estimates are through the most recent year for which reliable estimates are available.

The estimated AIDS-OI incidence is the sum of incidence in two groups. Cases in both groups are adjusted for delays in case reporting. The first group is persons reported to AIDS surveillance with AIDS-OIs.

The second group is persons reported with AIDS based on a $CD4^+$ count or percent. Most of these persons will eventually have an AIDS-OI diagnosed. CDC

has estimated the number of persons who had or will have an AIDS-OI diagnosed after the date of the reported $CD4^+$ count or percent, by month of AIDS-OI diagnosis. To do this, CDC used data from the Adult Spectrum of Disease Project (*JAMA* 1992; 267:1798-1805) to estimate the probability distribution of the time interval between a $CD4^+$ count in a particular range (e.g., 0 to 29 cells/ μ L, 30 to 59 cells/ μ L, etc.) and the diagnosis of an AIDS-OI, taking into account the possibility of death before an AIDS-OI diagnosis. This probability distribution is the proportion of persons with a $CD4^+$ count in a given range who will have an AIDS-OI diagnosed 1 month, 2 months, etc., after the reported $CD4^+$ count. The expected number of persons with an AIDS-OI diagnosed in each later month among persons whose $CD4^+$ count was in a particular range during a given month is the product of the number of these persons and the proportion expected to have an AIDS-OI diagnosed in this later month. The estimate of the number of AIDS-OI diagnoses in a particular month among persons reported with AIDS based on the $CD4^+$ criteria is the sum, over all combinations of $CD4^+$ ranges and previous months, of the number of persons expected to be diagnosed with an AIDS-OI in the month for which the estimate is made.

There is uncertainty in these estimates of AIDS-OI incidence. Some uncertainty is the result of the need to adjust for delays in reporting of AIDS cases. Other persons reported with AIDS based on the $CD4^+$ criteria have an unreported AIDS-OI diagnosis by the date of the $CD4^+$ determination; the estimation procedure counts their contribution to AIDS-OI incidence later than it should. However, preliminary analyses show that this source of bias changes estimated AIDS-OI incidence by only a few percentage points.

Recently reported AIDS cases are more likely to be reported with risk not reported or identified (NIR). Recent AIDS incidence in some exposure categories, therefore, will be underestimated unless an adjustment is made. The adjustment of NIR adult/adolescent cases is based on the sex-, race-, and region-specific exposure category redistributions of cases diagnosed from 1989 through 1995 that were initially assigned to the NIR category but have subsequently been reclassified. Similar adjustment of NIR pediatric cases are based on exposure category redistribution of all cases diagnosed between 1989 through 1995 and subsequently reclassified. See *J Acquir Immune Def Syndr*, 1992;5:547-55 and *J Acquir Immune Def Syndr*, 1997;14:465-74.

The regions of residence included in table 13, 16, and 19 are defined as follows. Northeast: Connecticut,

Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; Midwest: Indiana, Illinois, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; South: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; West: Alaska, Arizona, California, Colorado, Idaho, Hawaii, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming; Territories: Guam, Puerto Rico, the U.S. Virgin Islands, and the U.S. Pacific Islands listed on page 33.

Reporting delays

Reporting delays (time between diagnosis of HIV infection or AIDS and report to CDC) may vary among exposure, geographic, racial/ethnic, age and sex categories, and have been as long as several years for some AIDS cases. About 50 percent of all AIDS cases were reported to CDC within 3 months of diagnosis, with about 20 percent being reported more than 1 year after diagnosis. Among persons with AIDS, estimates in delay of reporting of deaths show that approximately 80 percent of deaths are reported within 1 year. Reporting delay for HIV infection cases is being evaluated.

Reporting delay adjustments to tables 13 through 21 were estimated by a maximum likelihood statistical procedure, taking into account differences in reporting delays among exposure, geographic, racial/ethnic, age, sex, and vital status at diagnosis categories, but assuming that reporting delays within these groups have not changed over time (*Lecture Notes in Biomathematics* 1989;83:58-88).

Rates

Rates are calculated for 12-month period per 100,000 population for AIDS cases only. Rates are not calculated for HIV infection reports because case counts for HIV infection are believed to be less complete than AIDS case counts. Population denominators for computing AIDS rates for the 50 states and the District of Columbia are based on official postcensus estimates from the U.S. Bureau of Census. Denominators for U.S. dependencies and possessions and associated independent nations are linear extrapolations of official 1980 and 1990 census counts. Each 12-month rate is the number of cases reported during the 12-month period, divided by the 1995 or 1996 population, multiplied by 100,000. The denominators for computing race-specific rates (table 10, year-end edition only) are based on 1996 census estimates published in U.S. Bureau of Census publication PE-101PL-57, "U.S. Population Estimates by Age, Sex, Race, and Hispanic Origin: 1990 to 1996." Race-specific rates are the number of cases reported for a particular racial/ethnic group during the preceding 12-month period divided by the projected population for that race/ethnicity, multiplied by 100,000.

Case-fatality rates are calculated for each half-year by date of diagnosis of AIDS. Each 6-month case-fatality rate is the number of deaths ever reported among cases diagnosed in that period (regardless of the year of death), divided by the number of total cases diagnosed in that period, multiplied by 100. Reported deaths are not necessarily caused by HIV-related disease. Caution should be used in interpreting case-fatality rates because reporting of deaths is incomplete (*Am J Public Health* 1992;82:1500-05 and *Am J Public Health* 1990;80:1080-86).

DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Public Health Service
Centers for Disease Control
and Prevention (CDC)
Atlanta, GA 30333

Official Business

Penalty for Private Use \$300

Return Service Requested

FIRST CLASS MAIL
POSTAGE & FEES PAID
PHS/CDC
Permit No. G-284

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

YOUTH

Divider Title: _____

YOUTH

Dangerous Inhibitions:

How America Is Letting AIDS Become an Epidemic of the Young

by Chris Collins
UCSF AIDS Research Institute (ARI)
and
The Center for AIDS Prevention Studies (CAPS)
University of California, San Francisco

February 1997

Table of Contents

Preface

Executive Summary

I. Introduction

II. An Epidemic Getting Younger

Charting Risk

Do young people protect themselves?

A Sexual Epidemic

Young men

Young women

Ethnicity

Region

Targeting Resources

III. Understanding Risk

The Personal and Interpersonal Context of Sex

Vulnerable groups

Discovering sex

Older partners

Coercion and force

Communication

The Territory of Being Young

What do my friends think? What do they do?

It can't happen to me (or my lover)

Knowledge and condoms

Drugs, alcohol and situations

IV. Rethinking the Message

Getting the Word Out

Some Key Lessons Learned

Less Risk or Better Sex?

Selling better sex

Related lessons

Social Marginalization and HIV Prevention

Social Marketing

V. What Is Standing in the Way?

Public and Private Education

Government

The Private Sector

The Research Community

Reassessing Goals

A new paradigm of prevention is needed to fight an epidemic in youth which increasingly affects the poor and people of color. We need to build on the foundations of our HIV prevention efforts — provision of information and skills training — to include an emphasis on addressing the myriad external forces challenging young people, and to instilling self-value in those young people who are most vulnerable in society. HIV prevention must be delivered in a way which reaches adolescents in the context of their daily lives.

Simply counseling abstinence or rational sexual behavior won't stop the epidemic amongst young people. Most young people choose to have sex. Those at greatest risk — young men who have sex with men, young women, young people of color, homeless and runaway youth — must confront an array of personal and external social factors in order to protect themselves.

It is increasingly apparent that for a young person who becomes infected with HIV, the social problems of racism, homophobia, sexism, and poverty are also deeply personal experiences which can affect self-esteem, the ability to talk about sex openly, and the confidence to insist on personal protection.

Young people living on the street, perhaps the group at highest risk, lack fundamental security in their lives. Many are forced to trade sex for money or shelter. Significant numbers of young people have been sexually abused or coerced, and a history of these experiences is associated with increased unsafe sex.

We can decrease new HIV infections by providing prevention education that enhances a sense of belonging for young gay men and lesbians, and empowers young women to assert their needs, and by providing housing and counseling to those children who have been forced to live on the streets. As well, we must address the sexual coercion of children and teens.

Teaching self respect — particularly to those young people in the most vulnerable groups — is just as important as demonstrating condom use. We need the courage to talk more openly about sexuality: gay sex, straight sex, and specifics of how to use, and insist upon a condom.

Better prevention demands the creation of more culturally appropriate interventions, and increased emphasis on targeted funding to those young people most at risk. Yet we fail to effectively target resources and our laws and policies often serve to cut off the young people most affected by the epidemic. One recent example is the 1996 Welfare Reform Bill incentive for abstinence-only curricula — in the face of research that indicates the clear limits of abstinence-only approaches.

Government AIDS prevention efforts are burdened by financial and political constraints. Public schools are a center of controversy over issues involving sexuality education. Yet the expectation that the public sector can fund, develop and implement effective prevention programs has masked the urgent need for private sector expertise and resources in the battle against HIV among youth.

Each day, young people are deluged with advertising, movies, and music that promote sex without addressing the possible consequences of unprotected sex or providing education on safer sex skills. Private sector media professionals — with extensive knowledge about how to reach young people, and access to the channels that communicate to youth — are largely absent from fighting the epidemic.

Health promotion has not caught up with a new generation that is exposed to ever expanding media influences. Community based organizations have made valiant efforts to reach young people with effective prevention messages, but they, too, have been hampered by inadequate funding and other constraints.

Behavioral research should be pointing the direction toward more effective prevention interventions. Yet there remains an enormous communication gap between behavioral research in the academy and prevention interventions on the street. And much of prevention research is founded on behavioral theories which assume accurate perception of risk will lead to self-protection. Too often, interventions evaluated by researchers take a cognitive approach to health promotion with the age group which most typifies cognitive dissonance. Relatively limited attention is paid to the external forces which influence decisions around safer sex. Government and private sector research funders have not provided the resources to adequately focus on the prevention needs of young people of color.

An Epidemic Getting Younger

A recent study from the National Cancer Institute warns that, "while the rate of new AIDS cases reported among people born before 1960 appears to be reaching a plateau, the rate among younger Americans [born after 1960] continues to escalate." One in four new HIV infections in the United States occur in people under the age of 22; one-half of all infections occur in people under age 25. AIDS is already the sixth leading cause of death among 15 to 24 year olds in the United States and the leading cause of death among 25 to 44 year olds.

- Twenty-five percent of sexually active adolescents get a sexually transmitted disease (STD) in any given year.
- In young people more than any other group, HIV is spread sexually. Two groups of young people at risk for

- Over the last decade, prevention providers have learned important lessons to guide prevention programming, including:
 - skills training in condom use and negotiation skills, in addition to provision of basic HIV prevention information, is critical;
 - the earlier HIV prevention efforts begin in a person's life, the more likely they are to be successful;
 - peer education approaches show particular promise at reaching youth;
 - proper "dosing" (length or duration of the intervention) is an important factor in delivering effective prevention;
 - successful school-based HIV prevention interventions have common characteristics which should be used to guide programming;
 - tailored interventions for specific groups are essential, including programs for gay youth, African-American and Latino/a youth, and homeless and runaway youth;
 - interventions that address compelling needs in addition to HIV prevention can be particularly effective;
 - training young people to "decode" portrayals of sexuality in the media can help them better understand their social environment.
- Social marketing attempts to utilize the expertise of advertising and marketing to motivate behavior change and can also contribute to controlling the epidemic among adolescents.

What Is Standing in the Way?

Most Americans support efforts to inform young people about how to protect themselves from HIV, and to give them the skills and tools to do so. But numerous policies set by schools, television stations, the U.S. Congress and federal agencies impede HIV prevention efforts.

Are we misplacing efforts by focusing primarily on governmental reforms which may not come? As an alternative, some of our focus should be on tapping private sector expertise, resources, creativity, and access to communication channels in a way that can radically improve our ability to prevent HIV among youth.

Public and Private Education

- **Limits on school-based education/sex education:** Thirteen states do not require schools to provide either sexuality or STD/HIV education, including several southern states where many new HIV infections in young people are occurring. Even when HIV education is presented in classrooms, it often neglects essential issues, such as condom use. State sex education curricula tend to emphasize abstinence even though research shows abstinence-only programs have limited impact.
- **Limits on school-based education/homophobia in the classroom:** Eight states require or recommend teaching that homosexuality is not an acceptable lifestyle.
- **Limits on school-based education/condoms:** Only a small minority of high schools make condoms readily available to their students. Because some of the young people at highest risk have dropped out of school, we must also find alternative and creative ways to reach these youth with condoms and prevention messages.
- **Access to Testing:** Many young people at higher risk for HIV do not have ready access to HIV testing and counseling.

Government

- **Missing the point:** Government-sponsored HIV prevention media has often failed to directly address key at-risk groups and provide information on condom use. AIDS education must not simply address the biology of transmission, but also engage young people in thinking about vulnerability factors — including power relationships with partners and societal status — which can put them at higher risk for infection.
- **Missing the populations:** Continued failure to target funding to groups of young people most affected by the epidemic has greatly damaged the effectiveness of HIV prevention efforts.
- **Research that informs prevention:** The public prevention enterprise still has much to learn from private sector marketing research. Marketers track trends, attitudes, values and channels of communication. They place a premium on up-to-the-minute information which can help them reach youth.
- **Needle exchange:** The ban on federal funds for needle exchange programs remains in place even though six government-sponsored reports have concluded that needle exchange programs help reduce HIV infection and do not lead to increased drug use.

The Private Sector

- **Doing what government can't (or won't) do:** Government cannot fight the HIV epidemic among young people on its own. Private sector media professionals have valuable expertise which must be partnered with government's resources to more effectively fight HIV. Churches, local TV stations, supermarkets, health care

failing to reach too many young people at high risk for HIV.

Our society has a moral responsibility to do better. The public and private sectors must work together to use the resources and expertise at their disposal to fight the HIV epidemic among youth. But to do this, we must be honest about the realities of the epidemic and the lives of young people in America.

We must develop new approaches to prevention education which are culturally relevant and which arm young people to deal with the power dynamics in relationships that make demanding safer sex feel like an enormous risk. Fresh messages and marketing ideas that speak to the needs of youth need to be developed. And existing obstacles — from policies about condom availability and the content of health education in schools, to prohibitions on what is shown on the airwaves — need to be removed.

This report presents an update on the epidemic of HIV among America's young people. For purposes of the report, "youth" is defined as people in early adolescence through early adulthood, ages 11 through 24. Where noted, the discussion will frequently focus particularly on adolescents aged 13 to 19. The report takes a close look at what epidemiology can tell us about the changing nature of the epidemic, including who is getting infected, and what factors are involved in sexual risk taking among the young. It surveys some of the lessons learned from prevention programs targeted to young people. Finally, it proposes a new thematic approach to reach beyond traditional prevention efforts to those at highest risk, and provides a list of policy impediments that must be overcome.

This report on HIV and young people does not attempt to present all the facts, raise all the questions, or suggest all the potential improvements which could advance our efforts against HIV. It does try to lay out some of the key national issues which must be confronted in order to end the HIV epidemic among the young.

II. An Epidemic Getting Younger

"You need a condom the first time, but not after. Once you get comfortable with each other, the responsibilities for birth control shift to the woman."

"I don't use condoms if I feel secure that there are not extra activities going on. If I have complete trust, honesty."

- Charting Risk
- A Sexual Epidemic

Charting Risk

Experimentation defines adolescence. During their teen years, each new generation of Americans sets lifetime records for itself in overall numbers of sexual partners and incidence of sexually transmitted diseases. Sex is a normal step in the human development process, a step which is most often first taken during adolescence. Today, more than any time in memory, there are real risks associated with these first steps.

The centrality of risk in the lives of youth has even spawned its own government tracking network, the Youth Risk Behavior Surveillance (YRBS) system, which biannually measures everything from bicycle-helmet use to sexual activity to attempted weight loss. The 1995 YRBS tells us that in the last 30 days one in four high school students has smoked marijuana, one in five carried a weapon to school, half used alcohol, and one in three have been in a car with a driver who was drinking. Over the last year, one-quarter of high school students has seriously considered suicide.⁶

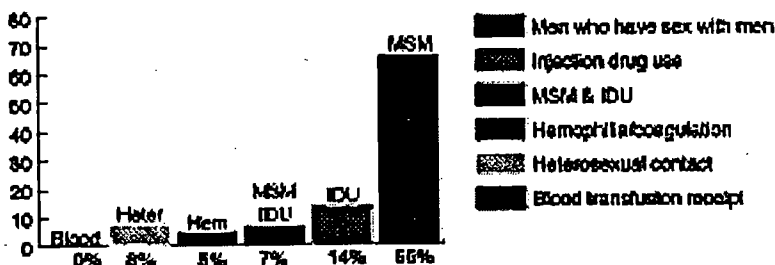
More young people are having sex in their teen years than ever before. In the mid-1950's, just over a quarter of women under 18 had had sexual intercourse. In 1968, 35% of young women and 55% of young men had had sexual intercourse by age 18. Twenty years later, these numbers were 56% of young women and 73% for young men.⁷ And as the Sexuality Information and Education Council of the United States (SIECUS) points out, "almost all adolescents participate in sexual activity of some kind. Overall, 90% have kissed...72% have participated in touching 'above the waist...'"⁸

Percentage of Young men and Women Who have Sex by Age 18

AIDS cases among young men are among young gay men. Heterosexual injection drug users represented 14% of cases and heterosexual contact accounted for 8% of cases among men. While HIV incidence has fallen dramatically among older gay men, many young gay men continue to put themselves at risk. According to researcher Susan Kegeles, "various studies report that 33% to 43% of young gay men report unprotected anal intercourse in the past two to six months."17

Table 1

**U.S. AIDS Cases Among Men 20 - 24 years old
in One Year (July 95 - June 96)**



	#	%	Cases with Reported Risk Factor
Men who have sex with men	844	57%	66%
Injection drug use	174	12%	14%
MSM & IDU	94	6%	7%
Hemophilia/coagulation	68	5%	5%
Heterosexual contact	97	7%	8%
Blood transfusion receipt	7	0%	0%
Risk not reported	208	14%	--
Total	1,492	100%	100%

source: "HIV/AIDS Surveillance Report," CDC, vol. 8, no 1

Young women

The rate of HIV infection is growing faster among young women than any other group. The proportion of young women among U.S. adolescent (ages 13-19) AIDS cases has tripled from 14% in 1987 to 46% of the reported cases in the year preceding July 1996. Heterosexual sex accounts for three-quarters (75%) of cases in young women ages 20-24 (Table 2).18 Forty-one percent of women in this age group who were infected heterosexually identified the risk category of their partner; 79% percent of them were injection drug users (IDUs). Injection drug use was the risk factor in 23% of reported AIDS cases among women in this age group. Heterosexual sex represents an increasing percentage of the epidemic among young women, while injection drug use is falling as a share of cases.

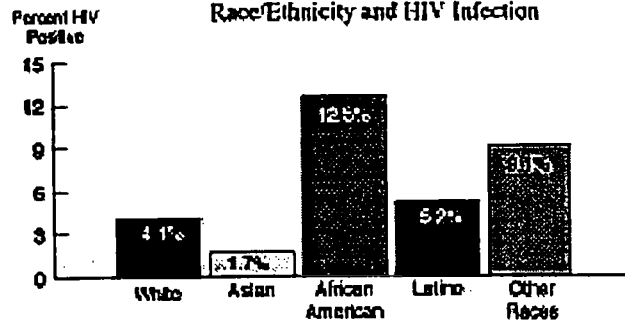
Some of these young men and women, gay or straight, are also homeless, which substantially increases their risk for acquiring HIV. Estimates of seroprevalence among homeless and runaway youth range from 5.4% to 7%.19

Table 2

**U.S. AIDS Cases Among Women 20 - 24 years old
in One Year (July 95 - June 96)**

Seroprevalence was more than seven times greater among African-Americans than among whites.²³

Table 4
Young Men's Survey, 1994-1995
Race/Ethnicity and HIV Infection



Region

The epidemic is also geographically dynamic. Initially, HIV was concentrated in large metropolitan areas. Yet more recently the epidemic has been moving into smaller communities, especially in the South. A CDC publication from 1995 notes that,

Comparing two recent reporting periods, 1988-90 and 1991-93, shows significant changes in the geography of AIDS cases reported among young MSM. AIDS cases in rural areas increased about 6% over the two periods. The largest increase — 13% — occurred in metropolitan statistical areas (or MSAs) with populations of 250-499,000. The increases in these two areas (rural and metropolitan) were mostly caused by large jumps in cases reported among African-Americans in the South — cases rose 79% among African-American MSMs in Southern rural areas and 67% in cities of 250-499,000 in the South...²⁴

The picture is similar among young women. Scott Holmberg of the CDC reported that a, "worrisome sub-epidemic involving young heterosexual women — and in parallel but less evident, heterosexual men — is emerging...particularly in the Southeast..."²⁵ The Job Corps study of young women noted above also found that "seroprevalence was higher among those entering from the South and Northeast."²⁶

The 1995 survey of HIV infection rates among teenagers attending health clinics around the country found that median HIV infection rates were 0.2% overall; 0.3% in correctional facilities; and 0.5% in STD clinics. The study also found that the "highest rates among young men reporting sex with men. Excluding men who identified themselves as having sex with other men, "rates in women were similar or somewhat higher than rates in men."²⁷

Susan Sugarman and colleagues have drawn on a variety of sources to provide seroprevalence rates among different populations which reveal the class effect of HIV-prevalence: 0.2% among college students, 0.34% for teenage youths applying for military service, 0.41% among Job Corps entrants (who are generally poorer than military recruits); and, as noted above, 5.4% to 7% among homeless and runaway youth. ²⁸ Within these groups, HIV seroprevalence differs widely by race. In white military applicants the rate is 0.17 per 1000, while among African-Americans it is 1.0/1000. Among gay youth, the rate for whites is 81/1000 and 212/1000 among African-Americans.²⁹

Targeting resources

Anyone *can* get AIDS, as national education campaigns have been telling us for over a decade. Yet the statistics make it clear that the AIDS epidemic has different contours in young people, those among us living through the riskiest time of their lives. While HIV infection rates stabilize or decrease in older populations, "the rate (of AIDS) among younger Americans continues to escalate."³⁰

The epidemic is gaining a foothold in specific population groups; race and economic status are importantly associated with risk exposure. Two groups — young women infected through heterosexual sex and young gay men — account for roughly three-quarters of the adolescent epidemic in youth (based on reported AIDS cases among 20-24 year olds in the year preceding July 1996).

The pattern of infection among American youth is consistent with the evolving global epidemic. Jonathan Mann and Daniel Tarantola have written that, "in each society, those people who were marginalized, stigmatized and discriminated against — before HIV/AIDS arrived — have become over time those at highest risk of HIV infection." ³¹

Of course, if we were to dedicate prevention resources only to these groups, we would miss many infections, and risk epidemic accelerating elsewhere. There is also the danger that by focusing our attention on the populations most severely affected by the epidemic, we will risk stigmatizing individuals in those populations and give others an excuse to protect themselves from HIV. But it is equally true that if we don't improve our ability to focus resources and

anal intercourse were more likely to be poor."⁴¹ Poverty is also listed as a primary risk factor for alcohol and drug problems by the Center for Substance Abuse and Prevention.⁴²

Work is another obvious high-risk activity in which it may be difficult for young people to take precautions against and other STDs. One-quarter of runaway youth in New York City have said they have engaged in trading sex for or drugs.⁴³ Other vulnerable populations, such as emotionally disturbed adolescents, are likely at increased risk and should also receive appropriate, targeted prevention interventions.⁴⁴

Love

The traditional view is that sex should be an outgrowth of a loving relationship. Yet, in the absence of strong self-protection instincts, love (or the desperate need for it) can sometimes disable a young person's willingness to insist on safer sex. Many adolescents in the groups most affected by HIV share a common outlook on sex as a means to gain love, affection, or respect. Multiple, complex needs are brought to relationships, and these needs can complicate a young person's ability to insist on safer sex.

A Kaiser Family Foundation survey of teens found significant differences between young men and women in their perceptions of love as a reason to have sex. Twenty-eight percent of young men and 45% of young women named love as often a reason to have sex.⁴⁵ Another survey of American teens found that 71% of high school girls said they were "in love" with their last sexual partner, while only 45% of boys described themselves as being in love with their last partner.⁴⁶

In the paper, "What Leads to Sex," Stephen Eyre and Susan Millstein also found significant differences in what attracts 16 to 20 year-old men and women to a potential sexual partner. "Arousal" was the chief antecedent to attraction for both African-American and white heterosexual young men. (For African-Americans, arousal was significantly associated with finding the potential partner "attractive," while for white men arousal was linked with "drinking.") African-American young women, on the other hand, named the following factors as leading toward sex with a potential partner: the person respects me, is intelligent, has a sense of humor, is good looking, or has a nice body. The main reason to have sex named by these young women was "you love/care about the person."⁴⁷

A 1996 government report found that, "Many women at risk for STDs use contraceptive methods that offer no protection from the diseases...Of the...women who reported having a main partner, 56% said that they had not used condoms the last time they had intercourse. Among the ...women with a casual partner, 29% said they had not used condoms the last time they had intercourse."⁴⁸

In their study of young gay men, Robert Hays and colleagues found that young men engaged in high-risk sex were more likely to have a boyfriend or lover than men who do not engage in high risk sex. And the authors note that, "Engaging sex as a way to attract a partner or gain affection must also be addressed [in prevention efforts]. As one HIV-positive respondent wrote, 'gay youths are...incredibly in need of love and attention. I have a lot of bitterness over the fact that as a gay teenager all I wanted was to be loved and all I got was dick up the butt and the HIV infection.'"⁴⁹

Sex that occurs in the context of a loving relationship presents special challenges in HIV prevention. The same researchers found that a safer sex intervention they implemented among young gay men in Eugene, Oregon, "led to a sizable decline in unprotected anal intercourse with casual partners, but risk-taking behavior with lovers remain[ed] at unacceptably high levels."⁵⁰ It is certainly possible that someone will choose to have unprotected sex because of an accurate assessment that his or her partner is HIV negative and that the relationship is mutually monogamous. But the finding that only approximately one quarter of HIV positive young gay men know their HIV status complicates this risk assessment process.⁵¹

The need to prove love — or not risk losing it — can lead some young people toward greater risk. So much is invested in relationships, it feels dangerous to put that connection at risk. In her study of homeless and runaway youth, Susan Sugerman found that 26% of those surveyed said it was important not to use a condom with a sexual partner in order to prove you love and trust him or her.⁵²

Discovering Sex

Young people need to know about sex before they engage in it. Though HIV education is essential at all stages of young adulthood, research shows that the earlier young people are reached in their sexual careers, the better the results. Janet St. Lawrence found that among African-American young people, those who used a condom at first intercourse were more likely to be consistent condom users.⁵³

For young gay men, many of whom have been bottling up their sexual desires for years, there are special risks associated with the discovery period of sex. In their sample of predominantly white gay men in San Francisco, Ron Stallings found that among gay men under 30, shorter length of residence in San Francisco was correlated with risk-taking behavior, suggesting that the initiation period into a relatively open gay environment is a particularly dangerous time for young gay men.⁵⁴ Young gay men who participated in PMI focus groups noted that they were less likely to

"What do my friends think? What do they do?"

Many young people feel as if they are putting themselves at *social* risk when they take steps to protect themselves from risk for HIV. Young people do not use condoms because they are embarrassed to buy them, use them, or ask their partner to use them (and because they may not be readily accessible). Concern with peer approval is the great barrier in condom use among youth — gay and straight. George Lemp found that, "a lack of peer support for safe sex is the strongest predictor of unprotected anal intercourse," among young gay and bisexual men in the San Francisco Bay Area. Ralph DiClemente reported that "perceived peer norms ...supporting condom use" was one of the most significant factors in condom use among African-American adolescents living in "high-risk urban environments."⁷⁰ Peer pressure is also an important factor in drug use. An October 1996 survey by the National Center on Addiction and Substance Abuse reports that "the main reason teens use drugs is because their friends do."⁷¹

"It can't happen to me (or my lover)"

Accurate perception of risk is not a hallmark of youth. This is particularly true in the case of risk for HIV infection. It is a testimony to the power of denial that adolescents of color and gay adolescents — two of the groups at highest risk for HIV — can identify AIDS as "someone else's" problem. Researchers have concluded that, "in comparison with their white peers, minority adolescents report less perceived vulnerability to AIDS, perhaps because they tend to view AIDS as a disease affecting white gay men."⁷²

Many young gay men assume that AIDS is an "older man's disease," and hence they can be less cautious when they have sex with others their own age.⁷³ At the center of the HIV epidemic, many gay men seem to have developed a code of limited accuracy for managing and interpreting risk. In a study of gay men aged 18 to 39, Eva and Ross found that "there is not a close match between what is epidemiologically accepted as risk behavior and what respondents regarded as risk behavior." They also found that gay men relied upon several external factors to make a determination about their partners' risk, such as age, appearance, diction, and HIV knowledge, and whether they were the insertive partner.⁷⁴

Faith in a partner's lack of risk is equally dangerous. Overby's study of high-risk female minority adolescents found that "most participants perceived themselves to be at low personal risk owing to current monogamy, lack of intravenous drug use, and implicit trust in their partner's safety."⁷⁵ In a study on sexual anticipation and practice in adolescents, Kim Miller notes that "adolescents with one (steady) partner...may discount safe sex or HIV prevention messages because they may feel safe in what they think is a monogamous relationship." She also points out that 72% of these adolescents with a steady partner are female.⁷⁶ Leslie Clark reported at the 1996 International AIDS Conference that among adolescents, "confidence in one's ability to determine a potential partner's HIV status was significantly related with lack of condom use."⁷⁷

A lack of faith in a partner's safety is all the more troubling when you consider that many of these partners, regardless of their intention to tell others about their HIV status, do not know that status themselves. As noted earlier, in a San Francisco Bay Area survey, only approximately one quarter of HIV positive young gay men knew their HIV status.⁷⁸ A paper by the AIDS Policy Center for Children, Youth, and Families in Washington, D.C. reports that relatively few young people have ever taken the HIV antibody test and that, "in a study of publicly funded test sites, only 45% of all teenagers who were tested for HIV returned to learn their results."⁷⁹

Knowledge and condoms

Knowledge about HIV is the essential first step to protecting oneself. DiClemente's review of the literature includes a study finding that AIDS knowledge is associated with condom use.⁸⁰ The 1995 Youth Risk Behavior Surveillance report tells us that 86% of all high school students had been taught about AIDS in school. Nearly two thirds (63%) of all high school students nationwide had talked about AIDS or HIV with a parent or other adult family member.

But superficial knowledge can be a risk factor in itself. Like knowledge about the dangers of tobacco or drinking and driving, education alone does not solve the problem. Ralph Hingson found, "little relation between adolescents' knowledge about HIV infection and risky sexual practices primarily because most adolescents knew the principal modes of HIV infection."⁸¹ In a study of African-American youth, Stevenson found that "those teenagers who perceived themselves as highly knowledgeable scored lower on reliable AIDS Knowledge and Prevention Beliefs measures."⁸²

Drugs, alcohol and unplanned sexual encounters

If experimentation with drugs and alcohol is part of many people's adolescent years, so are rushed and unplanned sexual encounters. Both make safer sex more difficult to prepare for and negotiate. A CSAP article notes that, "...adolescents and young adults may be novices at both drinking and sexual activity....their risky behavior may reflect the limited knowledge and experience of beginners in any endeavor."⁸³ One-quarter of all high school students report combining sex and drugs or alcohol. White males have by far the highest rates (36%) while African-American young women have the lowest (11%).⁸⁴ In their survey of gay adults, Lowy and Ross reported that "respondents complained that alcohol and drugs, often integral features of a central city gay social lifestyle, accounted for some of the difficulty in maintaining safe sex standards."⁸⁵ ⁸⁶

surveyors asked teachers responsible for HIV education of students about the actual subject matter covered in classes, the results were alarming. Among teachers of courses that focus primarily on health education topics, 87% taught the basic facts about HIV/AIDS, 83.8% taught how HIV is and is not transmitted, and 78% taught "reasons for choosing sexual abstinence." But only 37% of these teachers taught the correct use of condoms and only 56% taught information on HIV testing and counseling. 91 Maybe this is part of the reason why a 1996 survey found that nearly 47% of teens say they want more information about how to prevent AIDS or other STDs.⁹²

Ability to tailor health education to the realities of young people is not unique to HIV prevention. An article in the *New York Times* reported that the school based antidrug DARE program — used in almost 75% of US school systems — "employs trained police officers to come to classrooms and teach students how to resist drugs. The system has pleased teachers, parents and police officers, but academic researchers say the program does not make a lasting impact on students' behavior..."⁹³

HIV prevention strategies for young people are often similarly mismatched with the target population. Much of youth-focused HIV prevention is fear based, even though young people are known for believing themselves to be invincible and for thinking on short time lines. It often urges teens to avoid risk, when risk and disobeying helpful advice are the currency of youth. It takes a cognitive approach to health promotion with the age group which most typifies cognitive dissonance. And it ignores the multiple motivations for sex and the external forces which can affect whether someone insists upon safer sex.

Why the strategic mismatch? The most obvious explanation is fear of dealing openly and honestly with teen sexuality in its myriad forms: the multiple healthy motivations for sex, the urge of some young people to be with older partners, the coercion and power dynamics that often plays a role in sex, attraction to same-sex partners, even the very fact that young people have sex at all. For over a decade, HIV prevention has been disabled by these constraints, both in its message, and in its ability to put the tools of prevention — most notably condoms — into the hands of more teens. Profound discomfort about adolescent sexuality is one of the most basic and important impediments to more effective HIV prevention efforts.

There are many examples of HIV prevention programs which have transcended these restraints and honestly addressed adolescent HIV prevention needs. By and large, they share the characteristics of being intense, sustained over time, providing necessary skills training, and being carefully designed to match the specific cultural, age, sex role, and sexual preference characteristics of the populations targeted. To improve our HIV prevention efforts to adolescents we need to expand and build upon the high quality prevention programs already implemented. But we also need to consider new thematic approaches to prevention for young people, and address specific policy roadblocks to improved prevention efforts. First, a review of findings which can help inform a new generation of HIV prevention messages to

Some Key Lessons Learned

Following is a brief review of some of the key lessons learned from quality adolescent HIV prevention programming.

- **Information is just part of the picture:** HIV educators know that young people need to learn skills — such as condom use and assertiveness — in addition to basic information about AIDS. Ross and Rosser have noted that education without skills training or modification of attitudes, beliefs, or situational determinants of risky behavior is not sufficient for behavior change among adolescents.⁹⁴
- **Early and often:** In a comprehensive review article, Kyung-Hee Choi and Thomas Coates found that provision of "explicit HIV prevention programs prior to the time that adolescents are sexually active can have greater impact than programs initiated after the initiation of sexual activity."⁹⁵ Successful interventions must be sustained and intense in nature.
- **Peer education:** Use of peers to deliver prevention messages is often noted as an important ingredient of successful prevention efforts. Peer-directed interventions can help change the perception of social norms around condom use, and peers may be able to deliver messages which are more readily accepted by young people.⁹⁶
- **Dosing:** Like a medication, "proper dosing" is an important factor in effective HIV prevention. A summary paper published by the Office on AIDS, National Institute of Mental Health, observes that, "There is a threshold which varies according to group, below which significant change is unlikely to occur." Among homeless runaway youth, 10 to 14 intervention sessions emerged as a full dose. In an intervention among gay men, 12 session programs produced "substantive behavioral change."⁹⁷
- **Specific populations; young African-Americans:** There has been a dearth of research on HIV prevention focusing on young African-Americans. But a few studies of programs that integrate knowledge and skills in a culturally appropriate manner have demonstrated success. St. Lawrence found that an eight-week intervention combining education with behavior skills training — including "correct condom use, sexual assertion, refusal, information provision, self-management, problem solving, and risk recognition" was effective in helping African-American adolescent participants lower their risk for HIV infection.^{98 99}
- **Specific populations; young gay men:** A review paper prepared by Robert Hays notes that, "The myth that the gay community has been saturated with AIDS prevention services is in serious need of debunking. New

themes which can reach a diverse and constantly changing audience.

Related lessons

• lessons from the first decade and a half of HIV prevention can readily inform a revitalized message:

- **Addressing other real needs:** Information and skills are the foundation of HIV prevention, but to reach many high-risk youth, these tools must address self-perceived individual needs and be presented in a way that allows them to be integrated into the cultures in which people live. For example, interventions offered in the context of social events or community mobilizations may reach many young people who would be uninterested in an educational session on HIV.
- **Young men, young women:** Janet St. Lawrence has proposed that because young men and women have different levels of knowledge and different attitudes about sex, intervention programs should be tailored differently for each group. For young men, "content that conveys girls' expressed preference for contraception may help make condoms more acceptable by 'normalizing' their use, taking the onus off the boy." Young women, on the other hand, need, "skills building interventions that promote self-expression, assertiveness in sexual situations, problem-solving, and 'empowerment' in relationships..."¹⁰⁶
- **Media savvy:** Even the media-savvy generation may benefit from help in decoding the sex-laden messages being sent their way. In his review of youth-oriented prevention programming, Douglas Kirby observed that, "effective programs included activities that address social or media influences on sexual behaviors...for example, how sex is used to sell products and how television shows often suggest that characters have unprotected intercourse but don't experience the consequences."¹⁰⁷

Social Marginalization and HIV Prevention

We should never expect simple provision of information and skills to end an epidemic when social marginalization plays an important role in transmission. Society's homophobia, racism and sexism all express themselves on the individual psychological level, and as they do each becomes a factor in disease transmission. AIDS education must not simply address the biology of transmission, but also engage young people in thinking about vulnerability factors — including power relationships with partners and societal status — which can put them at higher risk for infection. Individuals who can anticipate some of these risk dynamics may have a greater chance to be able to insist upon safer sex. And to deliver this message, youth-oriented prevention funding must be targeted to young people from sub-populations most profoundly affected by the epidemic.

ing self-respect — particularly to those young people in the most vulnerable groups — is just as important as strating condom use. Part of achieving personal satisfaction in sexual experiences is being able to navigate the motivations involved in sex. Each issue identified in the "Understanding Risk" section has corollaries here. If is your goal in being sexual, then you need to think about distinguishing love from being forced to risk your health for someone else's pleasure. If you prefer older partners, you should be prepared to negotiate the sometimes challenging power dynamics of the situation. Young women need to be urged to think clearly about satisfying their own needs. Young gay men need to be taught that they are not pariahs. All young people need to be encouraged to make personal choices based on valuing themselves, and to understand and anticipate the risk involved in not valuing their own needs.

Social Marketing

The advertising industry knows about motivating young consumers, and spends \$1 billion annually to reach children.¹⁰⁸ This investment produces annual teen expenditures of \$65 billion in the United States.¹⁰⁹ These marketing efforts ultimately do more than sell products; they play a pivotal role in the culture of adolescence in the 1990's. Peter Zollo, a marketing researcher who specializes in reaching young people, says that, "teenagers look to advertising for what's cool." Zollo's assertion that advertising actually *defines* popular culture for many young people may overstate the case. But it is certainly true that there is a powerful synergy of youth culture and advertising which helps define the world for young people.

Social marketing attempts to bring advertising and marketing expertise to motivate healthy behavior change. It has been used to discourage smoking, promote low fat foods, and urge pregnant women to seek prenatal care. If social marketing can reach the young people most affected by HIV with highly effective messages, it can also contribute to controlling the epidemic among adolescents.

Social marketing has the potential to turn the tables on traditional health education efforts. It also offers an excellent opportunity to develop the sex-positive messages that have been so effective with gay adults. One of the first steps in developing a social marketing campaign is determining what target audience members think they need, and then creating a campaign that promotes a product as meeting that need. Critical to the success of this approach is starting with an understanding of the consumer; what he or she wants, what he or she thinks is important.

lation Services International, which has developed numerous social marketing campaigns for developing

Below is a short list of public and private sector actions which could make HIV prevention more effective. It is, of course, only a partial list, one that focuses on broad areas of education and health policy.

Public and Private Education

Limits on school-based education: sex education

Approximately nine out of ten parents want their children to have sex education in school.¹¹⁴ A 1996 Kaiser survey of Americans found overwhelming support for school-based AIDS education. Thirteen percent of those interviewed said this education should be begin at ages 7 to 9; 49% felt it should begin at ages 10 to 12 ; and 25% would begin AIDS education at ages 13 to 15.¹¹⁵ Education policy should not be set simply by polling data, but it is important to note when the public sector may not be taking an opportunity to provide sex ed even with broad agreement that this education is needed. SIECUS reports that 13 states do not require schools to provide either sex or STD/HIV education,¹¹⁶ including several southern states where many new HIV infections in young people are occurring. And, as noted earlier, when HIV education is presented in classrooms, it often neglects essential issues, such as condom use.

It is sometimes argued that, in the name of good values and disease control, the primary goal of sex education in the schools should be to encourage abstinence as the only acceptable option. Yet Kirby's review of school-based programs concluded that, "abstinence programs do not have a positive impact upon delaying the onset of intercourse."¹¹⁷ At least one study has found that an "abstinence only" program *increased* the level of sexual activity in young people.¹¹⁸ Even so, a 1993 SIECUS study found that, "state curricula emphasize abstinence."¹¹⁹ The organization further reports that, "of the 26 states that require abstinence instruction, only 14 also require the inclusion of other information on contraception and pregnancy and disease prevention."¹²⁰

Neither research nor public sentiment support these restrictive policies. In 1995, the North Carolina State Legislature enacted a law requiring public schools in the state to restrict classroom discussion of sex to "abstinence only." The American Social Health Association then commissioned a poll of state residents, and found that 65% of voters believed schools should educate students about condoms as a way to prevent STDs.¹²¹

Recommendation: All children should be offered honest, age-appropriate sex and STD/HIV education as a part of their schooling. This education should include information on condoms and other tools necessary to protect oneself from HIV and other STDs and include themes addressed elsewhere in this report, including acceptance of homosexuality, and issues concerning power dynamics in relationships. State legislatures should revise state law as appropriate to ensure that this education is provided. Equally important is providing opportunities for parents to improve their ability to talk with young people about sexuality and self protection.

Limits on school-based education: Homophobia in the classroom

Of all the insults young people use against each other, "fag" and "dyke" are among the most potent. Good public health practice would have schools attempt to counteract the damaging effects of homophobia. After all, to avoid HIV, young gay men need to be able to accept their sexuality and understand the need to protect themselves. And, as noted earlier, internalized homophobia in young gay men is associated with HIV infection. (page 16)

Yet eight states require or recommend teaching that homosexuality is not an acceptable lifestyle,¹²² and SIECUS found that the topics least likely to be covered in state sex education curricula are sexual identity and orientation.¹²³ The federal Center for Substance Abuse and Prevention warns that, "Although [gay, lesbian and bisexual youth and adults] ...comprise more than 10% of people at risk for problems, alcohol and other drug programs generally do not address their prevention needs."¹²⁴

Recommendation: School-based sexuality curriculum should present gay, lesbian and bisexual sexual preferences as healthy and valid identities. Young people should learn that homophobia, like other forms of bigotry, has severe human costs.

Limits on school-based education: condoms

Many Americans support condom availability in high school. A 1991 national survey found that "65% of the American adult population supports condom availability in schools to prevent the transmission of HIV."¹²⁵ A 1996 Kaiser study titled Americans and AIDS/HIV found that 46% of adults agreed that condoms should be provided in high schools.¹²⁶ According to the study, 62% of 18 - 29 year olds support condoms in high schools.

Despite this widespread support for condom availability, today it is easier for many young people to get drugs than it is to get condoms. A September 1996 *New York Times* article reported that, "teenagers from inner-city, working-class and suburban neighborhoods said marijuana can be as easy to buy as beer or cigarettes, often from schoolmates... 'It takes a phone call,' said Matt, a 16-year old in Gloucester, Mass."¹²⁷

Missing the Populations

We are spending too many prevention dollars on low risk populations, while ignoring the urgent need for culturally appropriate, targeted messages to young people at higher risk. In a 1996 article on federal HIV prevention spending, *Wall Street Journal* noted that, "The emphasis on the broad reach of disease has virtually ensured that precious dollars won't go where they are most needed."¹³⁷

— course, political concerns often stand in the way of effectively targeting resources. But as a society, we must find a way to overcome these concerns and target culturally appropriate prevention where it is urgently needed.

Recommendation: CDC, working with local prevention planning groups must ensure that prevention spending more equitably addresses needs of young men who have sex with men, African-Americans, Latinos, and young women at higher risk of infection.

Research that informs prevention

Government agencies have excelled at providing essential information on the national epidemiology of AIDS. The Youth Risk Behavioral Survey and annual HIV/STD epidemiologic reports are prominent examples. Yet the public prevention enterprise still has much to learn from private sector marketing research. Marketers track trends, attitudes, values and channels of communication. They place a premium on up-to-the-minute information which can help them reach youth. They don't just count consumers, but try to understand their targets. They also seek to continually renew that understanding.

The CDC's PMI is an example of new public initiatives that seek to understand what motivates young people in order to produce more effective prevention campaigns. Private sector marketers have worked with government officials and researchers to make PMI a unique and promising endeavor. More of this kind of collaboration is urgently needed. Projects like PMI need further reach and adequate funding to produce interventions on a timely basis.

Recommendation: Collaborative projects like the Prevention Marketing Initiative — which seek to gain in-depth knowledge of young people's values, concerns and attitudes — should comprise an increased share of CDC educational efforts.

Needle Exchange

Young people who are at risk for HIV through needle use suffer from the ban on federal funds for needle exchange programs. This ban remains in place even though six government-sponsored reports have concluded that needle exchange programs help reduce HIV infection and do not lead to increased drug use.¹³⁸ Young people also need access to youth-friendly substance abuse programs.

Recommendation: The Department of Health and Human Services should follow the advice of government-funded reports and fund needle exchange programs.

The Private Sector

Doing What Government Can't (or Won't) Do

Government cannot fight the HIV/STD epidemic among young people on its own. It faces constraints in the areas of politics, marketing knowhow, and financing. The private sector has a moral responsibility to be more actively involved in HIV prevention among youth. Private sector media, advertising, marketing, and public relations professionals have valuable expertise which must be partnered with government's resources to more effectively fight HIV. Other areas of the private sector have important opportunities to help prevent HIV in youth, for example:

- local TV producers can air more HIV prevention spots, particularly segments which address young people in high risk groups, including young men who have sex with men;
- TV writers and producers can make condoms more visible in youth-oriented programs;
- supermarkets and pharmacies can ensure that condoms are easy to purchase and that the young people who do purchase them are not harassed;
- all businesses can agree to sponsor or support community-based HIV prevention activities, and to make HIV prevention literature visible and available;
- more churches can provide HIV prevention services which are sensitive to the needs of young people;
- physicians, nurses and other health care personnel can deliver prevention messages to their young (and old) clients.

Recommendation: The private sector has a responsibility to offer its expertise in research, campaign design, and media production to improve our society's HIV prevention efforts. Government and the private sector must work together in a manner that enhances our ability to gain in-depth understanding of young peoples' knowledge, attitudes

center of the epidemic, we need to tailor our interventions to their needs rather than to the needs of adults. To give young people the information and tools they need, we must undo policy impediments created to appease a minority of the population. And, one to one, parents, teachers, and friends must be willing to talk honestly with young people about their sexual concerns and desires.

References

- 1 In this report, most decimals have been rounded.
- 2 Rosenberg, P., et al, "Declining Age at HIV Infection in the United States," letter in *New England Journal of Medicine*, March 17, 1994, vol. 330, p.789.
- 3 Centers for Disease Control and Prevention, "Adolescents and HIV/AIDS," fact sheet, Dec. 1995.
- 4 Quoted from press release, "National Cancer Institute Study Fact Sheet: New Study Refines Estimates of HIV in the United States: Reveals Sobering Trend for Young Americans," National Cancer Institute, Nov. 1995; based on the article, "Scope of the AIDS Epidemic in the United States," by Rosenberg, P, *Science*, Nov. 24, 1995, vol. 270, p. 1372-1375.
- 5 Committee on Prevention and Control of Sexually Transmitted Diseases, Institute of Medicine, *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*, National Academy Press, Washington, D.C., 1996.
- 6 Centers for Disease Control and Prevention, "Youth Risk Behavior Surveillance — United States, 1995," published in *Morbidity and Mortality Weekly Report*, CDC Surveillance Summaries, Sept. 27, 1996, vol. 45, no. SS-4, p. 8-19.
- 7 The Alan Guttmacher Institute, *Sex and America's Teenagers*, The Alan Guttmacher Institute, New York and Washington, D.C., 1994, p. 20.
- 8 Sexuality Information and Education Council of the United States, "Adolescence and Abstinence," Fact Sheet on SIECUS web site.
- 9 Centers for Disease Control and Prevention, "Youth Risk Behavior Surveillance — United States, 1995," published in *Morbidity and Mortality Weekly Report*, CDC Surveillance Summaries, Sept. 27, 1996, vol. 45, no. SS-4, p. 64.
- 10 Centers for Disease Control and Prevention, "Youth Risk Behavior Surveillance — United States, 1995," published in *Morbidity and Mortality Weekly Report*, CDC Surveillance Summaries, Sept. 27, 1996, vol. 45, no. SS-4, p. 67.
- 11 The Alan Guttmacher Institute, *Sex and America's Teenagers*, The Alan Guttmacher Institute, New York and Washington, D.C., 1994, p. 38.
- 12 Centers for Disease Control and Prevention, "Youth Risk Behavior Surveillance — United States, 1995," published in *Morbidity And Mortality Weekly Report*, CDC Surveillance Summaries, Sept. 27, 1996, vol. 45, no. SS-4, p. 19.
- 13 Division of STD Prevention, "Sexually Transmitted Disease Surveillance, 1995," Centers for Disease Control and Prevention, Sept. 1996, Atlanta.
- 14 Jemmott, JB, Jemmott, LS, Fong, GT, "Reductions in HIV Risk-Associated Sexual Behaviors Among Black Male Adolescents: Effects Of An AIDS Prevention Intervention," *American Journal of Public Health*, March 1992, vol. 82, no 3, p. 372.
- 15 The average ten year lag between infection with HIV and development of clinical symptoms of AIDS makes it difficult to track the epidemic. AIDS cases are reported to the CDC, but they represent infections occurring approximately a decade before, not where the epidemic is today. To protect confidentiality, 22 states do not require reporting of HIV infection itself. Even if they did, the large number of individuals who are not tested until they become ill would make these figures of dubious value. Still, by looking at current AIDS reporting and comparing it with previous years, we can get a sense of where the epidemic is concentrated and where it is heading.
- 16 These and other epidemiological figures are from the Centers for Disease Control and Prevention, "HIV/AIDS Surveillance Report. U.S. HIV and AIDS Cases Reported Through June 1996," Centers for Disease Control and Prevention, midyear edition, 1996, vol. 8, no.1.
- 17 Kegeles, SM, Hays, RB, Coates, TJ, "The Mpowerment Project: A Community-Level HIV Prevention Intervention Among Gay Men," *American Journal of Public Health*, August 1996, vol. 86, no 8, p.1129.

Youths: Associations with School Problems, Running Away, Substance Abuse, Prostitution and Suicide," *Journal of Consulting Clinical Psychology*, 1994; vol. 62, p. 261-269; quoted in, *Advocates for Youth*, "Adolescent Males: Sexual Attitudes and Behavior," fact sheet, *Advocates for Youth*, Washington, D.C. , Aug. 1995.

Communication Sciences Group, Results of Phase Two Formative Research in Phoenix, Arizona, Oct. 10, 1995, p. 6.

Platner Associates Inc., Audience Research for HIV Prevention Planning, Newark, 1996, p. 33.

40 Romer, D, Kim, S, "Health Interventions for African-American and Latino Youth: The Potential Role of Mass Media," *Health Education Quarterly*, May 1995, vol. 22, no 2, p. 176.

41 Peterson, JL, "High-Risk Sexual Behavior and Condom Use among Gay and Bisexual African-American Men," *American Journal of Public Health*, Nov 1992, vol.82, no.11, p. 1490.

42 Center for Substance Abuse Prevention, "Risk Factors," fact sheet from CSAP web site.

43 Susan Tucker Sugerman found that 19% of runaway and homeless youth at a shelter in Houston, Texas had practiced sex work. Sugerman, ST, "Acquired Immunodeficiency Syndrome and Adolescents," *American Journal of Diseases of Children*, April 1991, vol 145, p. 431.

44 Athey, JG, "Emotionally Disturbed Adolescents and AIDS: An Introduction," in Woodruff, JO., ed., *Troubled Adolescents and HIV Infection*, CASSP Technical Assistance Center, Georgetown University Child Development Center, Washington, D.C., October 1989, p. 5.

45 Kaiser Family Foundation, "The 1996 Kaiser Family Foundation Survey on Teens And Sex: What They Say Teens Today Need to Know, And Who They Listen To," Kaiser Family Foundation, Menlo Park, CA, June 1996, p. 14.

46 Roper Starch, Teens Talk About Sex: Adolescent Sexuality in the 90's: A Survey of High School Students, commissioned by Rolanda in association with Sexuality Information And Education Council Of The United States, p. 6.

47 Eyre, SL, (UCSF), and, Millstein, SG, "What Leads to Sex? Adolescent Preferred Partners and Reasons for Sex," in press.

48 Centers for Disease Control and Prevention, "Contraceptive Method and Condom Use Among Women at Risk for Infection and Other Sexually Transmitted Diseases — Selected US Sites, 1993-1994," *Morbidity And Mortality Report*, Sept 27, 1996.

Hays, RB, Kegeles, SM, Coates, TJ, "High HIV Risk-Taking Among Young Gay Men," *AIDS*, 1990, vol. 4, no. 9, p. 556.

50 Kegeles, SM, Hays, RB, Coates, TJ, "The Mpowerment Project: A Community-Level HIV Prevention Intervention for Young Gay Men," *American Journal of Public Health*, August 1996, vol. 86, no 8, p.1135. The researchers reported that 44.7% of those in the study self-reported unprotected anal intercourse with a boyfriend after the intervention (p.1133).

51 McFarland, W, et al, "HIV Seroprevalence Among Young Men Who Have Sex with Men in the San Francisco Bay Area: The Young Men's Survey III," San Francisco Department of Public Health, Santa Clara Valley Health and Hospital Systems, Alameda County Health Care Services agency, and Division of HIV/AIDS, Centers for Disease Control and Prevention, presented January, 1997.

52 Sugerman, ST, et al, "Acquired Immunodeficiency Syndrome and Adolescents," *American Journal of Diseases of Children*, April 1991, vol. 145, p. 433.

53 St. Lawrence, JS, "African-American Adolescents' Knowledge, Health-Related Attitudes, Sexual Behavior, and Contraceptive Decisions: Implications for the Prevention of Adolescent HIV Infection," *Journal of Consulting and Clinical Psychology*, 1993, vol. 61, no.1, p. 108.

54 Stall, Ron, "A Comparison of Younger and Older Gay Men's HIV Risk-Taking Behaviors: The Communication Technologies 1989 Cross-Sectional Survey," *Journal of AIDS*, 1992, vol. 5, p. 682-687.

55 DiClemente, RJ, "Psychosocial Determinants of Condom Use Among Adolescents," in DiClemente, RJ, ed, *Adolescents and AIDS*, Sage Publications, Newbury Park, 1992, p. 48.

56 *Advocates for Youth*, "Adolescent Pregnancy and Childbearing," Fact Sheet, *Advocates for Youth*, March 1996, quoting from, *Facts at a Glance*. Washington, D.C.: Child Trends, 1996; and, Males M. "School-age Pregnancy: Why Prevention Worked?" *Journal of School Health*, 1993; vol. 63, p.429-432.

77 Clark, LF, et al, "Confidence in HIV Risk Assessments as a Barrier to Adolescent Condom Use," International Conference on AIDS, Vancouver, July 1996.

78 McFarland, W, et al, "HIV Seroprevalence Among Young Men Who Have Sex with Men in the San Francisco Bay Area: The Young Men's Survey III," San Francisco Department of Public Health, Santa Clara Valley Health and Hospital Systems, Alameda County Health Care Services agency, and Division of HIV/AIDS, Centers for Disease Control and Prevention, presented January, 1997.

79 AIDS Policy Center for Children, Youth and Families, "Position Statement: Youth and HIV Testing," AIDS Policy Center for Children, Youth and Families, Washington, D.C., April 1996, p. 2.

80 DiClemente, RJ, "Psychosocial Determinants of Condom Use Among Adolescents," in Adolescents and AIDS, DiClemente, RJ., ed, Sage Publications, Newbury Park, 1992, p. 38.

81 Hingson, R, Strunin, L, "Monitoring Adolescents' Response to the AIDS Epidemic: Changes in Knowledge, Attitudes, Beliefs, and Behaviors," in DiClemente, RJ., ed, Adolescents and AIDS, Sage Publications, Newbury Park, 1992, p. 24.

82 Stevenson, HC, et al, "HIV Prevention Beliefs Among Urban African-American Youth," *Journal of Adolescent Health*, April 1995, vol. 16, no. 4, p. 316-23.

83 Center for Substance Abuse Prevention, "AIDS," Prevention Primer, on CSAP world wide web site.

84 Centers for Disease Control and Prevention, "Youth Risk Behavior Surveillance — United States, 1995," published in Morbidity And Mortality Weekly Report, CDC Surveillance Summaries, Sept. 27, 1996, vol. 45, no. SS-4, p. 67.

85 Lowy, E, Ross, MW, "It'll Never Happen to Me': Gay Men's Beliefs, Perceptions and Folk Constructions of Sexual Risk," AIDS Education and Prevention, 1994, vol. 6, no. 6, p. 467-482, p.478.

86 Drug use was identified as a risk factor for seroconversion in the HIVNET Vaccine Preparedness Study among gay men. Buchbinder, SP., et al, "The Feasibility of Conducting Preventive HIV Vaccine Trials in Homosexual Men in the United States," *Journal of Infectious Diseases*, 1996, vol. 174, p. 954-961.

87 Hingson, R, Strunin, L, "Monitoring Adolescents' Response to the AIDS Epidemic: Changes in Knowledge, Attitudes, Beliefs, and Behaviors," in DiClemente, RJ, ed, Adolescents and AIDS, Sage Publications, Newbury Park, 1992, p.24.

Blatner Associates, Inc., Audience Research for HIV Prevention Planning, Newark, Centers for Disease Control and Prevention, 1996, p.xi

89 Horatio Alger Association, The Mood of American Youth, Horatio Alger Association, Virginia, 1996, p.51.

90 Reported condom use during last sexual encounter rose from 46% in 1989 to 54% in 1995..

91 "School-Based HIV-Prevention Education — United States, 1994," *Morbidity And Mortality Weekly Report*, Sept. 6, 1996.

92 Kaiser Family Foundation, "The 1996 Kaiser Family Foundation Survey on Teens And Sex: What They Say Teens Today Need to Know, And Who They Listen To," Kaiser Family Foundation, Menlo Park, CA, June 1996, p.7.

93 Kolata, G, "Experts Are at Odds on How Best to Tackle Rise in Teen-Agers' Drug Use," *New York Times*, Sept. 18, 1996, p. A17.

94 Ross, MW and Rosser, BRS, "Education and AIDS Risks: A Review," *Health Education Research*, 4, p. 273-284.

95 Choi, K, Coates, TJ, "Prevention of HIV Infection," AIDS, 1994, vol 8, no 10, pgs. 1380, 1384.

96 Coates, T, and Greenblatt, R., "Behavioral Change Using Interventions At The Community Level," in Holmes, K, et al (Eds.) Sexually Transmitted Diseases (2nd ed.), 1990, New York: McGraw-Hill, p. 1075-1080; DiClemente, Ralph, "Confronting the Challenge of AIDS Among Adolescents, Directions for Future Research," *Journal of Adolescent Research*, 1993, vol. 8, no. 2, p. 156-166.

97 Office on AIDS, National Institute of Mental Health, and NIMH Consortium on HIV Prevention Research, "AIDS Prevention Strategies that Work: A Review of NIMH-Sponsored Research," 1995.

St. Lawrence, JS, et al, "Cognitive-Behavioral Intervention to Reduce African-American Adolescents' Risk for HIV Infection," *Journal of Consulting and Clinical Psychology*, 1995, vol. 63, no 2, p. 221-237.

- 121 American Social Health Association, "ASHA Poll: Most NC Voters Favor Condom Education in Schools," *STD News*, American Social Health Association, Fall 1996.
- 122 Sexuality Information And Education Council Of The United States, "Sexuality Education in the Schools: Issues \nswers," Fact sheet
Sexuality Information And Education Council Of The United States, "Adolescence and Abstinence," Fact sheet on b site.
- 124 Center for Substance Abuse Prevention, "Gay, Lesbian and Bisexual Youth/Adults," Prevention Primer on web cite.
- 125 Roper Organization, Inc, "AIDS: Public Attitudes And Education Needs," New York, 1991; quoted in Kirby, D, et al, "School-Based Programs to Reduce Sexual Risk Behaviors: A Review of Effectiveness," *Public Health Reports*, May-June 1994, vol 109, no 3, p. 341.
- 126 Kaiser Family Foundation, "The Kaiser Survey on Americans and AIDS/HIV," March 1996, p. 10.
- 127 Wren, CS, "Youths Confide Buying Drugs as Easy as Beer," *New York Times*, Sept. 10, 1996.
- 128 Kirby, DB, Brown, NL, "Condom Availability Programs in U.S. Schools," in *Family Planning Perspectives*, September/October 1996, p.196.
- 129 Advocates for Youth, "School Condom Availability," fact sheet, May 1995.
- 130 "A Resurgence for Condoms?," *Supermarket Business*, August, 1996, p. 74.
- 131 Kaiser Family Foundation, "The 1996 Kaiser Family Foundation Survey on Teens And Sex: What They Say Teens Today Need to Know, And Who They Listen To," Kaiser Family Foundation, Menlo Park, CA, June 1996, p. 6.
- 132 McFarland, W, et al, "HIV Seroprevalence Among Young Men Who Have Sex with Men in the San Francisco Bay Area: The Young Men's Survey III," San Francisco Department of Public Health, Santa Clara Valley Health and Hospital Systems, Alameda County Health Care Services agency, and Division of HIV/AIDS, Centers for Disease Control and Prevention, presented January, 1997.
IDS Policy Center for Children, Youth and Families, "Position Statement: Youth and HIV Testing," AIDS Policy er for Children, Youth and Families, Washington, D.C., April 1996, p. 2-3.
- 133 Wolf, RC, et al "Enough Already: Reevaluating the Future of the U.S. Government's AIDS Awareness Campaign," poster presentation, International Conference on AIDS, Vancouver, 1996.
- 135 A study by Lynn Miller compared the self-identified goals of at-risk women with the key messages in HIV prevention media. It found that, "those goals mentioned most often in AIDS-prevention messages were not particularly relevant to high risk women." Miller, L, et al, "Selling Safer Sex: Do AIDS Messages Fit the Everyday Goals of High Risk Women?," International AIDS Conference, Vancouver, 1996.
- 136 Austin, EW, "Reaching Young Audiences," in Maiback, E and Parrott, RL, eds., *Designing Health Messages: Approaches form Communication Theory and Public Health Practice*, Sage Publications, 1995.
- 137 Bennett, A and Sharpe, A, "AIDS Fight Is Skewed By Federal Campaign Exaggerating Risks," *Wall Street Journal*, May 1, 1996, p. A-1, col.6
- 138 Lurie, P, Drucker, E, "An Opportunity Lost: Estimating the Number of HIV Infections Due to the US Failure to Adopt a National Needle Exchange Policy," presented at the International Conference on AIDS, Vancouver, 1996.
- 139 Kaiser Family Foundation, "The Kaiser Survey on Americans and AIDS/HIV," March 1996, p.10.
- 140 Kaiser Family Foundation, "Emerging Issues in Reproductive Health," fact sheet, June 24, 1996.
- 141 Based on conversation with Allen Carrier of AIDS Project Los Angeles; this experience is consistent with that of Dana Van Gorder and David Weisman when they requested air time for HIV prevention spots on network affiliates in the San Francisco Bay Area.
- 142 Based on conversation with Centers for Disease Control and Prevention staff.
Quoted in, "Information for HIV Prevention Community Planning Groups, #2, HIV/AIDS Among Young Gay and xual Men," Centers for Disease Control and Prevention, September 1995.

Developing Health Skills for a Lifetime: CDC's Role in Preventing HIV Infection Among Young Americans

HIV Is the Leading Cause of Death for Americans Ages 25 to 44

It is estimated that half of all new HIV infections in the U.S. are among people under 25, and the majority of them are infected sexually. HIV-related death has the greatest impact on young and middle-aged adults, particularly racial and ethnic minorities. HIV is the leading cause of death for Americans between the ages of 25 and 44. In 1994, 1 in every 3 deaths among African-American men in this age range was due to HIV. And 1 in every 5 deaths among African-American females the same age was HIV-related.

Among all men in the next younger cohort, 13- to 24-year-olds, 55% of reported AIDS cases in 1995 were among young MSM (men who have sex with men); 10% were among injection drug users (IDUs); and 6% were among young men infected heterosexually. Among young women the same age, 51% were infected heterosexually, and 17% were IDUs.

Surveys of HIV infection among young people are limited, but suggest that prevalence may be stabilizing overall. With sustained, targeted prevention for each group entering adolescence and young adulthood, it is possible to further reduce the toll AIDS takes on young Americans. To do that, more information is needed about the range of adolescent sexual behavior to help develop interventions that are targeted to young people, work within the context of adolescent sexual behavior, and focus on individual, social, and community-level change.

Assessing the Diverse Prevention Needs of Young People

To better understand adolescent behaviors and the impact of selected family, social, and cultural factors on those behaviors, CDC researchers conduct broad-based surveys of the extent of risk behaviors among young people, as well as focused studies of the factors contributing to risk and behavioral intent among specific groups of adolescents.

Surveys of risk behavior among young people suggest that prevention programs have helped increase condom use among adolescents who are sexually active, without increasing the level of sexual activity among young people. Five-year trends from the Youth Risk Behavior Survey (YRBS) show both a leveling of sexual risk behavior rates and increased condom use among sexually active young people. From 1990 through 1995 the percentages of high school students who reported ever having had sex, having four or more partners, or having intercourse in the 3 months prior to the survey all remained steady. In contrast, overall condom use at last intercourse was up significantly, from 46% in 1990 to 53% in 1995. Female and African-American students posted the largest increases in condom use. While increased condom use is encouraging, YRBS findings indicate that more must be done to help young people delay initiation of sexual activity and reduce risky sexual behavior.

Other CDC research also suggests that new approaches to prevention may be needed to build upon success in increasing condom use, and to reduce the level of sexual activity among young people. In a recent survey of a group of 14-16 year old adolescents and their mothers, researchers found that the traditional definitions of "sexually active" and "not sexually active" may mask important behavioral intentions and sexual practices. Even adolescents who might traditionally be defined as not sexually active are actually engaging in or intend to engage in a range of sexual behaviors that could place them at risk for HIV infection. Of the adolescents in the survey, 99% could be classified into one of five categories: delayers (no intention to initiate intercourse); anticipators (intend to initiate in the next year); one-timers (has sex once, and not again); steadies (have intercourse with one partner); and multiples (have intercourse with multiple partners). Vital differences were found among the typology groups. For example, one-timers and steadies were significantly older than multiples when they first had intercourse. One-timers were significantly more likely to use condoms than were steadies or multiples. And only multiples reported having had a sexually transmitted disease.

The researchers also looked more closely at adolescent females in the study group and found that in addition to other risk factors, the age of a young woman's first sexual partner may be related to her level of risk. Young women whose first sexual partner is 3 or more years older may be at greater risk of HIV infection. Older men present a greater risk for HIV transmission because they are more likely to have had multiple partners and to have had more varied sexual and drug use experiences. The young women whose first partners were older were also less likely to use condoms. Power differences are greater between older and young partners, likely contributing to riskier behaviors young women report with older partners. All these differences must be taken into account as HIV prevention programs are developed and implemented.

Reaching Young People through Effective School-Based and Community Programs

The foundation of all CDC's HIV prevention programs is that those closest to the problem are best able to solve it, equipped with needed tools. CDC's role is to provide those tools. In 1987, CDC launched a national program to help schools and other

youth-serving agencies deliver effective HIV-prevention health education. CDC provides financial support and translates biomedical and behavioral research into practical interventions, so that schools and other agencies serving youth can implement effective HIV prevention education for youth.

CDC is also working with five communities to design targeted interventions to reach high risk youth in their local area. These programs are putting HIV prevention into action within the framework of social marketing, a discipline that combines communications and behavioral science with community mobilization. CDC is providing communities with financial resources and, more importantly, along with AED, is equipping them with intensive technical assistance that supports their efforts to apply research-driven, consumer-based research to design, develop, deliver, and evaluate HIV prevention marketing programs for youth. The Prevention Marketing Initiative provides communities with a practical structure for targeted programs and its application has resulted in several key learnings, applied at both the national and local levels.

For example, research in three cities found that among 18-25 year old heterosexuals, gender and ethnic differences seemed to be more directly related to sexual risk behaviors than differences in socioeconomic status or relationship status. Young adults in this study also expressed doubt and confusion about refusing to have sex without a condom when they were in a sexual relationship with either a casual or steady partner. This information has been applied in the design of community-level prevention programs in these 5 communities and in a national public service campaign entitled, "Respect Yourself, Protect Yourself." Radio and television spots feature diverse young people modeling safer sex behaviors, including abstinence, refusing to have sex without a condom, and talking with partners about safer sex.

Through these and other practical applications of communications and behavioral theory, CDC continues to put cutting-edge science into the hands of communities to effect HIV prevention for young adults. For more information on CDC's work in this area, see any of the following presentations in Vancouver.

Youth Presentations in Vancouver

Oral

Five-Year Trends in HIV Risk Behaviors Among Youth, Janet Collins.

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

Adolescent Sexual Experience: A New Typology, Kim S. Miller.

Poster

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

Evaluating School-Based HIV/AIDS Education Efforts: A Systematic Approach to Improving Program Quality, Stephen W. Banspach.

A Pilot Study of Risk Behaviors and Condom Use among Incarcerated Adolescents, USA, Juarlyn L. Gaiter.

Setting Priorities for HIV Prevention Programs in School, Pete Hunt.

Focus Group Themes That Will Shape Participatory Social Marketing Interventions in 5 Cities, May Kennedy.

HIV Prevalence, Risk Factors, and Predictors of Unprotected Sex Among Homeless and Runaway Youth in Four U.S. Communities, Duncan MacKellar.

Reaching And Involving Youth: A Prevention Marketing Approach, Chad Martin.

Case Study Methods for Process Evaluation of Participatory Social Marketing, Laretta Pinckney, Martha Hare.

Initiation of Sexual Intercourse: Ages and Trends, Ellen Sogolow.

Research to Classroom: Selecting and Disseminating Educational Programs that Reduce HIV Risk Behaviors Among Adolescents, Susan Wooley.

Addressing the Changing Needs of the Next Generation: CDC's Role in Preventing HIV Infection Among Young Americans Through School Health Programs

Developing Prevention Skills for a Lifetime of Health

Just like their peers in other countries, young Americans lay the pattern for behaviors that will have significant impact -- positive or negative -- on their overall health for the rest of their lives. CDC works to help children and youth develop the knowledge, skills, attitudes, and behaviors that will help keep them healthy life-long.

HIV Prevention Is a Top Priority

It is estimated that half of all new HIV infections in the U.S. -- about 40,000 annually -- are among people younger than 25. Prevention activities/interventions -- beginning well before young adulthood -- are desperately needed to stem this tide. (For more information on HIV/AIDS prevention and youth, see the companion fact sheet, *Developing Health Skills for a Lifetime: CDC's Role in Preventing HIV Infection Among Young Americans*.)

In 1987, CDC launched a national program to help schools and other youth-serving agencies deliver effective HIV-prevention health education in schools and other youth-serving agencies. The impact of these efforts is assessed through applied surveillance and evaluation research, which is provided to communities to help them best address their unique local HIV/AIDS needs.

CDC puts prevention tools into the hands of education agencies in every state, the District of Columbia, American Samoa, Guam, Marshall Islands, Northern Mariana Islands, Puerto Rico, Virgin Islands, and 18 large U.S. cities. CDC provides financial support and translates biomedical and behavioral research into practical interventions, so that schools and other agencies serving youth can implement effective HIV prevention education for youth. Major activities include training teachers, developing and disseminating educational materials, and monitoring and evaluating program activities.

Local Solutions To Local Problems

The foundation of all CDC's HIV prevention programs is that those closest to the problem are best able to solve it, equipped with needed tools. CDC's role is to provide those tools. Consistent with that belief, CDC does not mandate or endorse any specific curriculum for HIV prevention. The specific scope and content of school health programs are locally determined and consistent with parental and community values. CDC's role is to identify curricula that have credible evidence of reducing health risk behaviors among youth and to provide resources to ensure that the interventions, including training, are available for those who want to use them.

To help schools develop quality locally determined HIV prevention education programs, CDC also supports 28 national organizations that are leaders in promoting school health education, 3 demonstration centers that train policymakers and program managers, and directors of training in each funded state, territory, and city. These three efforts help diffuse trained tacticians equipped with the latest behavioral and biomedical science nationwide.

CDC also supports "comprehensive school health" programs in thirteen states. A unique synthesis of state health and education departments, comprehensive school health education is a planned, sequential, approach that integrates important health topics such as HIV, STDs, unintended pregnancy, tobacco, nutrition, and physical activity for all students in kindergarten (age 6) through high school (age 18). This holistic approach to health is founded on the knowledge that health behaviors do not co-exist independently -- that a youngster's ability to resist peer pressure and social influences to smoke are integrally related to the ability to say no to risky sexual activity. Comprehensive, cohesive health education strengthens young people's health skills in all areas.

Continuous Improvement To Better Target Prevention Programs

Central to CDC's work are its continuing efforts to evaluate and improve program effectiveness and to develop surveillance systems for measuring risk behaviors among young people. In 1993, as part of the Youth Risk Behavior Surveillance System, CDC conducted a national school-based Youth Risk Behavior Survey (YRBS) among a representative sample of 16,296 high school students in grades 9-12. Data summarized from the survey are used by local communities to develop programs that target the most prevalent high-risk behaviors.

Using this and other information, CDC develops and disseminates guidelines for effective school health programs and policies. CDC staff provide technical assistance to communities in evaluating HIV/STD prevention programs and comprehensive school health programs. Evaluation assistance is available in policy assessment, curriculum assessment, staff development, student outcomes, and related health education topics to each funded state or local education agency.

Five-year trends from the YRBS show both a leveling of sexual risk behavior rates and increased condom use. From 1990 through 1995 no significant change was detected in the percentage of high school students who reported ever having had sex, having four or more partners, or having intercourse in the 3 months prior to the survey. In contrast, overall condom use at last intercourse was up significantly, from 46% in 1990 to 53% in 1995. Female and African-American students posted the largest increases in condom use. While increased condom use is encouraging, YRBS findings indicate that more must be done to help young people delay initiation of sexual activity and reduce risky sexual behavior. CDC will continue to work with national, state, and local agencies to design, develop, deliver, and evaluate community-level prevention programming.

School Health Programs Presentations in Vancouver

Oral

Five-Year Trends in HIV Risk Behaviors Among Youth, Janet Collins.

Poster

Evaluating School-Based HIV/AIDS Education Efforts: A Systematic Approach to Improving Program Quality, Stephen W. Banspach.

School Condom Availability Programs in the United States, Nancy Brener.

Building an Infrastructure in the Nation's Schools for Addressing Major Health Problems, Including AIDS, Peter Cortese.

Designing Culturally Appropriate Theory-Based Behavioral Interventions: The Antigua Schools Project, Aisha Gilliam.

Setting Priorities for HIV Prevention Programs in School, Pete Hunt.

HIV Education in the United States -- How Good Is It? Laura Kann.

Initiation of Sexual Intercourse: Ages and Trends, Ellen Sogolow.

HIV Infection and U.S. College Students: How Great is the Risk? Charles W. Warren.

Research to Classroom: Selecting and Disseminating Educational Programs that Reduce HIV Risk Behaviors Among Adolescents, Susan Wooley.

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

MARIJUANA

Divider Title: _____

MEDICAL MARIJUANA

Is It Better to Inhale? An Examination of the Medical Use of Marijuana Controversy in the United States

I. B. Corless, RN, PhD, FAAN, and H. M. Miramontes, RN, MSN, FAAN

Shortly after we discussed the need for this editorial, Jerome Kassirer (1997) spoke out in *The New England Journal of Medicine* in favor of physicians determining the medical use of marijuana. Two issues were paramount in his editorial: the right of physicians to determine their prescribing privileges and the efficacy of marijuana use in selected cases.

The issue of the effectiveness of marijuana used for medicinal purposes, however, has become conflated with the increase in the nonmedical use of marijuana by students in the eighth and tenth grades (U.S. Department of Health and Human Services, 1996). The concern of Donna Shalala, Secretary of the U.S. Department of Health and Human Services, that young people are given "the clear and unambiguous message that drugs are illegal, dangerous and wrong," has been confounded with the need to find effective medications to mitigate disease or treatment-related symptoms of patients. The individual interest is with securing relief from distressing symptoms. The societal concern is with the regulation of access to certain classes of drugs. While one might debate whether the Bill of Rights gives us the right of access to all drugs, the covenant between the individual and community is one in which freedom of access is exchanged for protection from potentially harmful substances.

The question then becomes harmful for whom? Presently, the answer is that unrestricted access to all classes of mood-altering drugs is considered harmful for the community. For example, drinking to excess is regulated so that one cannot be a public nuisance or drive while impaired (with the potential threat of injury to others). Smoking, too, was restricted when the clear linkage to subsequent illness was made manifest and the societal resources entailed for treatment became evident

as were the dangers of passive inhalation to the non-smoking public.

The debate regarding the medical use of marijuana follows this same pattern of argumentation, namely, that medical use will increase community abuse. Protection of the community is construed as necessitating limitation of the rights of the individual.

Until this point, there has been no consideration as to whether marijuana is indeed efficacious. And that is because this question, in fact, is secondary to the primary concern which is regulating access to drugs. But it is not just regulation of drugs that is at issue; it is that society has declared a "war on drugs"; it is a war that keeps many people employed. There are the drug producers, distributors, salespeople, and assorted armed personnel on the one hand, and the law enforcement officers, citizens groups, and legislators on the other. In actual practice, the commingling of individuals and resources to the financial benefit of various individuals suggests that these beneficiaries will be no more inclined to stop production and distribution than are the manufacturers of tobacco. The complexity of this worldwide problem is illustrated by the fact that drug cartels have tentacles that reach into the highest levels of government in various countries, as recent reports in newspapers indicate.

There are individuals and agencies that are devoted to preventing the harm that ensues from substance abuse. Their dedication and commitment are to be commended, and the deaths, in the line of duty, of many fine individuals, lamented. The hard work of dedicated individuals and agencies is not the issue. Rather, the question is what is the most effective way of curtailing drug abuse?

Former Surgeon General Jocelyn Elders, M.D., had the intellectual and political courage to ask whether

some other approach, including the legalization of drugs so that they might be dispensed by the government to individuals certified as addicts, might be more productive. Dr. Elders raised an important question for careful scientific and political consideration. Unfortunately, her question resulted in an orgy of invective and political grandstanding, which did not help society in winning its war on drugs. The result was to maintain the status quo if not to retard any advances in curtailing drug abuse.

In this milieu, genuine concern about the welfare of individuals sick with various diseases may be overlooked in the promotion of the vested interests of others. Dr. Donald Abrams and his colleagues have been blocked in their attempt to investigate the efficacy of a substance used to some reportedly good effect as an alternative treatment for pain, nausea, and as an appetite stimulant, by those whose commitment is with restricting access to illicit drugs. And while there has been some debate in the literature about the efficacy of marijuana's medical use, the problem to be confronted is only secondarily one of medical effectiveness, and primarily one of a clash with major political interests.

The research debate, however, is muddled by the inclusion of studies primarily concerned with long-term effects, the effects in psychotic illness and the effects on neonates none of which pertain to short-term use for nausea and vomiting in persons living with cancer or AIDS. Other uses such as for individuals with glaucoma, multiple sclerosis, and phantom limb pain, to mention a few applications noted in the literature, may entail use over various time periods in the face of which the research on long-term effects would be relevant.

A definitive analysis of the evidence is beyond the scope and the intent of this editorial. Rather, the purpose of this editorial has been to indicate how a scientific question has been absorbed into the issue of societal drug policy. The anecdotal evidence suggests, furthermore, that smoking marijuana is of greater benefit than ingesting delta 9-tetrahydrocannabinol (delta 9-THC). To answer the scientific question, studies such as that proposed by Abrams of comparing three doses of inhaled marijuana with oral delta 9-THC (dronabinol) capsules are required. Also, the establishment of a therapeutic marijuana research program, such as the one currently being considered by the Commonwealth of Massachusetts, is another promising approach to pursue. The federal investigation of laetrile, a much touted

cancer drug, provided the evidence necessary to eliminate laetrile from further therapeutic consideration. Data from clinical research studies can also provide an answer to the medical efficacy of inhaled marijuana.

Two issues remain to be addressed. One is the concern that current sufferers be required to await the results of clinical trials. This concern reflects the need for a compassionate-use-of-marijuana program. Such a program is included in the proposed Massachusetts legislation. The second issue is that legalization of the medical use of marijuana is the opening wedge to the legalization of marijuana and other drugs. The counter-argument is that marijuana like other drugs prescribed by medical personnel will be strictly regulated. Abuse of prescriptive authority would result in the loss of one's license.

The passage of legislation in California permitting physicians to "recommend" marijuana use without writing a prescription opens the door to abuse. Clearly, responsibility needs to be affixed to health care practitioners with prescriptive authority. Marijuana is not an over-the-counter drug and should not be "recommended" without the assumption of professional responsibility. At the same time, health care providers should not be threatened with incarceration when marijuana is prescribed for medically indicated purposes.

To do no harm and to promote well-being is what attracts practitioners into health care. The continual evaluation of health care practice is basic to that goal. Clinical trials as to the efficacy of the medicinal use of marijuana are necessary to advance the scientific foundation of practice. To delay such investigations is to leave the practitioner and patient adrift with hearsay information and access to questionable sources of medicinal relief for distressing symptoms. Only research can provide the answer to the question: Is inhaled marijuana the better drug for persons suffering from symptoms associated with AIDS, cancer, and other diseases? Is it, in fact, better to inhale?

References

- Kassirer, J. (1997). Federal foolishness and marijuana. *New England Journal of Medicine*, 336(5), 366-367.
- U.S. Department of Health and Human Services. (1996, December 19). Marijuana and tobacco use still rising among 8th and 10th graders. *HHS News*, p. 1.

Legalizing medicinal marijuana

By Steve Michael
and Wayne Turner

People suffering from AIDS, cancer, glaucoma and other serious or terminal illnesses sometimes turn to marijuana on the advice of their doctors when other treatments fail. The District of Columbia's Initiative 57 would protect these patients, their doctors and immediate caregivers from criminal prosecution in the use of marijuana in medical treatment.

The tightly worded measure requires that medical marijuana be restricted to use under the supervision and care of a licensed physician. Initiative 57, proposed by the local AIDS activist group ACT UP Washington, firmly established that medical decisions are best determined within the doctor-patient relationship, not by politicians or prosecutors. Volunteers have until December to gather approximately 16,700 signatures of D.C. registered voters to place Initiative 57 on the D.C. ballot.

Under current law, the seriously ill who turn to marijuana for its possible therapeutic effects are subject to arrest, criminal prosecution and incarceration. Politicians use this issue to look tough on drugs, jailing sick and dying patients in the name of public safety.

Caregivers have no other option but to enter dangerous open-air drug markets to purchase the marijuana that might provide some comfort to loved ones in their final days. Physicians who even discuss the possible benefits of marijuana with their patients have been targeted by federal prosecutors.

Many AIDS patients have found

that marijuana eases severe nausea and vomiting and helps counter the loss of appetite and weight loss of deadly AIDS wasting syndrome. Expensive new triple-combination therapies hold little promise for those AIDS sufferers who are unable to hold their pills down.

Cancer patients enduring the side effects of radiation and chemotherapy sometimes find relief in marijuana. Some people with glaucoma, one of the leading causes of blindness among Americans, have been successfully treated with marijuana for over 20 years.

For those sick and dying patients who use marijuana to ease their suffering, marijuana is hardly a recreational drug. Initiative 57 simply provides legal protection to these patients, their physicians and caregivers from prosecution under D.C.'s Uniformed Controlled Substances Act. The D.C. initiative is much tighter than measures passed by voters in California and Arizona.

Under the provisions of Initiative 57, nonmedical use of marijuana is explicitly prohibited. Use of medical marijuana, like other prescription medicines, cannot defend against any other crime, such as driving while intoxicated. Authors have included a parent consent clause, Section 9, which prohibits the distribution of medical marijuana to any person under the age of 18 for the treatment of a minor's medical condition without the informed, written consent of a parent or legal guardian for the use of marijuana.

The marijuana sold by drug dealers on the streets is sometimes laced with drugs or other contaminants. Initiative 57 would allow legal, non-profit corporations or cooperatives to ensure a safe supply of marijuana to patients, taking drug dealers out of the equation. Patients are limited under Initiative 57 in the quantities they are permitted to possess.

The local petition effort is drawing national attention from those who

have shown little interest in the well-being of the people of D.C. The campaign for Initiative 57 is turning into the first Republican primary of the 2000 presidential election. Billionaire publisher and former presidential candidate Steve Forbes has loudly launched a big-money media campaign against Initiative 57, calling the AIDS activists sponsoring the measure "twisted drug predators." William Bennett, the failed drug czar under President Bush, is directing opposition to Initiative 57 through his group Empower America. Representatives from the Family Research Council, headed by Reagan administration domestic policy adviser Gary Bauer, tried to block Initiative 57 at the D.C. Board of Elections and Ethics, but they were unable to find a D.C. voter to oppose the initiative.

Reacting to pressure, drug czar Gen. Barry McCaffrey has weighed in, opposing the petition drive in a letter sent to D.C. officials. Gen. McCaffrey's office says they have not yet reviewed the legislative text of Initiative 57.

Meanwhile, amid the grandstanding of presidential aspirants, open-air drug markets and crack houses in Washington continue to flourish. The Drug Detox Center at D.C. General Hospital is overflowing. Waiting lists for drug treatment slots grow as funding for these lifesaving programs has been eliminated. Drug kingpins continue to import crack cocaine for sale in our city and at the Lorton prison complex. Yet these pressing problems, so apparent to Washington residents, have failed to grab the attention of political grandstanders, much like Nero fiddling while Rome burned.

By supporting D.C. Initiative 57, the people of the District can free those suffering from AIDS, cancer and other serious illnesses from the threat of prosecution and imprisonment if their doctor recommends marijuana as a medication of last resort.

Steve Michael and Wayne Turner are founders of ACT UP, the AIDS Coalition to Unleash Power, in Washington. Mr. Michael, who is HIV-positive, is the proposer of Initiative 57.

Washington Times

8/7/97

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

FUNDING

Divider Title: _____

AIDS FUNDING

THE WHITE HOUSE

WASHINGTON

REVISED

Statement by
Patricia S. Fleming
National AIDS Policy Director
on
President Clinton's FY 1998 Budget

President Clinton's fiscal 1998 budget maintains the strong Federal commitment to fighting the epidemic of HIV and AIDS. There are increases for virtually all AIDS programs despite the enormous pressure of balancing the Federal budget.

At a time of great optimism in the global response to HIV/AIDS, the President makes important investments in research, prevention, treatment, and housing. Discretionary spending for AIDS in the Department of Health and Human Services will rise 3 percent in FY 1998. The President's budget also maintains the vital safety net for Medicaid and Medicare.

When he took office in 1993, the President identified combatting AIDS as a priority of his Administration. With these new budget proposals, total spending for AIDS programs during the President's term in office will have increased by 70 percent. These funding increases, along with other actions taken by the Administration, have helped to spur scientific advances and translate those findings into better care for people living with HIV and AIDS.

Highlights of the President's FY 1998 budget include:

- \$1.04 billion for the Ryan White CARE Act, an increase of \$40 million, or 4 percent. Included is \$167 million that is earmarked for the AIDS Drug Assistance Program. ADAP funding has increased by 221 percent in the last two years;
- \$1.54 billion for AIDS research at the National Institutes of Health, an increase of \$38 million, or 2.6 percent. Included is a substantial increase in funding for research into AIDS vaccines. AIDS research funds would be appropriated directly to the Office of AIDS Research, which would distribute those funds to the various institutes;
- \$634 million for AIDS prevention and surveillance programs at the Centers for Disease Control and Prevention, an increase of \$17.5 million, or 2.8 percent. The new funds will be targeted at intravenous drug users and their sexual partners; and
- \$204 million for the Housing Opportunities for People with AIDS (HOPWA) program at the Department of Housing and Urban Development, an increase of \$8 million, or 4.1 percent.

The President's budget also includes an important reform in disability policy that will allow people who leave the Social Security disability programs (SSI and SSDI) to return to work to retain their Medicaid or Medicare benefits. As improved treatments restore the health of people living with HIV/AIDS, it is imperative that government policies also adjust to the needs of those individuals. This reform will allow people to go back to work without leaving their health insurance behind.

The President is also asking Congress to restore welfare and Medicaid benefits for legal immigrants who are in need of assistance. These individuals work hard, pay taxes, and deserve the support of their government and their communities.

This is the final budget presented during my tenure as National AIDS Policy Director. I am proud of the increases in resources we have achieved and made available to fight the war on AIDS. Today's budget will advance our united effort to put an end to the epidemic.

#

AIDS Discretionary Spending
(in millions)

Program	FY96	FY97	FY98 (proposed)	FY97-98
FDA	\$73	\$73	\$73	0%
HRSA	\$762	\$1001	\$1,041	+4.0%
Ryan White CARE	(\$757)	(\$996)	(\$1,036)	+4.0%
Title I	(\$392)	(\$450)	(\$455)	+1%
Title II	(\$261)	(\$417)	(\$432)	+4%
Title IIIB	(\$57)	(\$70)	(\$85)	+22%
Title IV ^a	(\$29)	(\$36)	(\$40)	+11%
Other RWCA	(\$19)	(\$24)	(\$25)	+4%
Other HRSA	(\$25)	(\$5)	(\$5)	0%
IHS	\$3	\$4	\$4	+4%
CDC	\$583	\$617	\$634	+3%
NIH	\$1,411	\$1,501	\$1,540	+3%
SAMHSA	\$54	\$66	\$67	+2%
AHCPR	\$6	\$4	\$1	-73%
OHAP	\$0.5	\$0.5	\$0.6	+3%
Total HRSA (discretionary)	\$1,498	\$1,770	\$1,865	+5%
Total	\$191	\$195	\$204	+4%

^aThe HRSA pediatric demonstration projects were not incorporated into Title IV until FY94 at \$22 million.

^bThis includes an earmark of \$167 million for the AIDS Drug Assistance Program

AIDS Spending
Other Departments & Agencies
(in millions)

Department/Agency	1996	1997	1998
AID	\$111	\$117	\$117
Defense	\$103	\$98	\$100
HUD/HOPWA	\$171	\$196	\$204
Justice/Prisons	\$6	\$7	\$8
Labor	\$1	\$2	\$2
OPM	\$226	\$241	\$253
Veterans	\$337	\$350	\$358

Entitlement Spending
(in millions)

Program	FY96	FY97	FY98
Medicaid (Federal Share)	\$1,600	\$1,800	\$1,900
Medicare	\$1,100	\$1,300	\$1,400
Social Security (SSI)	\$280	\$310	\$320
Social Security (DI)	\$696	\$760	\$843



F A C T S H E E T

HIV/AIDS BUREAU • DIVISION OF SERVICE SYSTEMS • AUGUST 1997

Title I Ryan White CARE Act

The CARE Act

On August 18, 1990, Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Reauthorized in 1996, the CARE Act is designed to improve the quality and availability of care for individuals and families affected by HIV disease. The HIV/AIDS Bureau, Health Resources and Services Administration (HRSA), administers CARE Act programs. Title I is administered by the Bureau's Division of Service Systems.

The CARE Act includes the following major program components:

- **Title I:** funding to eligible metropolitan areas hardest hit by the HIV/AIDS epidemic;
- **Title II:** formula funding to States and territories to improve the quality, availability, and organization of health care and support services for people living with HIV disease;
- **Title III:** funding to public and nonprofit entities for outpatient early intervention services;
- **Title IV:** funding to public and private nonprofit entities for demonstration projects to coordinate services to, and improve access to research for, children, youth, women and families; and
- **Part F:** support for Special Projects of National Significance (SPNS) Program, the Dental Reimbursement Program, and AIDS Education and Training Centers (AETCs).

Eligible Services

Title I funds may be used to provide a wide range of community-based services, including the following:

- **Outpatient health care**, including medical and dental care and developmental and rehabilitative services;

- **Support services** such as case management, home health and hospice care, housing and transportation assistance, nutrition services, and day/respite care; and
- **Inpatient case management services** that expedite discharge and prevent unnecessary hospitalization.

Providers may include public or nonprofit entities; private for-profit entities are eligible only if they are the only available provider of quality HIV care in the area.

In 1995, an estimated 300,000 people received services from Title I providers.

Title I Eligibility

Title I provides emergency assistance to eligible metropolitan areas (EMAs) most severely affected by the HIV/AIDS epidemic. To be eligible, an area must:

- Have more than 2,000 cumulative AIDS cases reported during the past 5 years; and
- Have a population of at least 500,000. This provision does not apply to any EMA designated and funded prior to Fiscal Year (FY) 1997.

Grantee

Grants are awarded to the Chief Elected Official (CEO) of the city or county that administers the health agency providing services to the greatest number of people living with HIV in the EMA. The CEO usually designates an administrative agent (most often the local health department) to select service providers and administer contracts. The CEO or grantee establishes intergovernmental agreements with other political subdivisions within the EMA that provide HIV services and include 10 percent or more of the EMA's total AIDS cases.

When the first Title I grants were awarded in FY 1991, 16 EMAs were identified. In FY 1997, there were 49 EMAs in 19 States, Puerto Rico, and the District of Columbia.



Ryan White CARE Act Title I Grant Awards

EMA	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Atlanta GA	\$2,123,775	\$3,111,666	\$5,490,571	\$7,488,801	\$9,091,331	\$9,208,162	\$12,632,117
Austin TX	N/E	N/E	N/E	N/E	2,124,274	2,398,671	3,337,861
Baltimore MD	N/E	1,898,561	3,250,343	3,923,438	4,715,150	8,364,074	10,033,688
Bergen-Passaic NJ	N/E	N/E	N/E	2,019,121	2,847,639	3,369,095	4,292,593
Boston MA	2,236,267	2,823,768	4,154,744	6,955,035	7,079,242	8,360,436	9,033,443
Caguas PR	N/E	N/E	N/E	N/E	902,928	1,064,876	1,431,210
Chicago IL	3,229,799	4,327,603	7,390,763	9,625,451	12,099,865	13,164,930	15,741,071
Cleveland-Lorain-Elyria OH	N/E	N/E	N/E	N/E	N/E	1,384,956	1,877,513
Dallas TX	1,379,434	3,119,688	4,542,034	6,935,644	8,176,385	7,820,653	8,129,583
Denver CO	N/E	N/E	N/E	3,375,884	3,092,041	3,549,707	4,668,572
Detroit MI	N/E	N/E	2,091,739	2,849,559	2,406,902	4,405,380	6,087,121
Dutchess Co. NY	N/E	N/E	N/E	N/E	609,583	581,761	776,847
Ft. Lauderdale FL	1,807,299	3,065,827	4,591,215	6,814,599	5,091,994	6,584,204	8,312,185
Ft. Worth-Arlington TX	N/E	N/E	N/E	N/E	N/E	2,255,398	1,902,232
Hartford CT	N/E	N/E	N/E	N/E	N/E	3,048,467	2,661,473
Houston TX	3,710,210	5,803,011	7,820,319	10,133,592	10,233,981	10,312,524	10,768,697
Jacksonville FL	N/E	N/E	N/E	N/E	2,418,868	2,725,251	3,762,713
Jersey City NJ	1,562,728	2,181,853	3,618,220	4,140,141	3,770,366	3,767,874	4,600,103
Kansas City MO	N/E	N/E	N/E	2,655,564	2,726,195	2,514,291	2,884,537
Los Angeles CA	7,848,314	9,788,087	19,190,269	25,441,211	31,037,580	26,313,561	30,227,298
Miami FL	3,044,301	5,923,065	9,716,264	15,258,563	19,195,347	15,156,078	18,863,208
Middlesex-Somerset-Hunterdon NJ	N/E	N/E	N/E	N/E	N/E	2,198,883	1,919,076
Minneapolis-St. Paul MN	N/E	N/E	N/E	N/E	N/E	1,370,726	1,990,700
Nassau-Suffolk NY	N/E	N/E	2,012,809	2,886,968	3,895,849	3,683,885	4,697,795
Newark NJ	4,111,603	5,363,563	3,542,848	7,009,180	11,791,405	9,725,848	11,612,530
New Haven CT	N/E	N/E	N/E	2,136,872	2,711,634	4,002,182	5,336,678
New Orleans LA	N/E	N/E	1,796,972	3,243,332	3,503,009	2,087,199	4,727,682
New York NY	33,457,519	35,894,688	44,469,219	100,054,267	93,587,184	92,241,697	92,459,373
Oakland CA	N/E	2,123,466	2,602,816	3,929,287	4,148,299	4,741,595	5,905,961
Orange County CA	N/E	N/E	1,839,726	2,627,947	3,175,288	3,492,993	4,401,330
Orlando FL	N/E	N/E	N/E	2,715,587	3,194,835	3,599,489	4,319,349
Philadelphia PA	2,323,850	3,571,035	4,729,230	7,374,936	9,836,096	10,345,478	13,465,328
Phoenix AZ	N/E	N/E	N/E	2,217,471	2,447,784	2,901,602	3,380,053
Ponce PR	N/E	N/E	1,280,364	1,176,793	1,908,071	1,685,036	2,183,463
Portland OR	N/E	N/E	N/E	N/E	2,402,734	2,688,924	3,472,480
Riverside-San Bernardino CA	N/E	N/E	N/E	2,402,010	2,656,331	4,687,432	5,986,979
Sacramento CA	N/E	N/E	N/E	N/E	N/E	2,463,814	2,038,827
St. Louis MO	N/E	N/E	N/E	2,248,247	2,581,330	2,587,364	3,506,350
San Antonio TX	N/E	N/E	N/E	N/E	1,731,222	2,396,426	3,014,191
San Diego CA	1,460,205	2,778,724	3,761,979	5,233,574	5,628,252	6,592,104	8,198,109
San Francisco CA	12,713,831	12,713,831	18,944,229	27,217,076	39,210,400	35,172,274	37,194,634
San Jose CA	N/E	N/E	N/E	N/E	N/E	2,275,044	1,992,602
San Juan PR	1,681,081	3,579,982	4,679,777	8,456,057	10,269,416	8,199,506	10,550,845
Santa Rosa-Petaluma CA	N/E	N/E	N/E	N/E	1,207,605	1,142,456	1,330,630
Seattle WA	N/E	N/E	2,824,570	3,233,903	4,048,484	4,289,545	5,481,431
Tampa-St. Petersburg FL	N/E	N/E	2,265,553	3,304,312	4,231,119	4,610,201	6,548,952
Vineland-Millville-Bridgeton NJ	N/E	N/E	N/E	N/E	340,644	454,338	677,001
Washington DC	3,392,784	5,127,184	7,447,578	9,328,712	10,713,183	12,763,696	15,838,868
West Palm Beach FL	N/E	N/E	N/E	3,582,542	3,770,641	3,390,914	5,122,618
TOTALS	\$86,083,000	\$119,426,000	\$182,326,998	\$319,989,000	\$349,370,000	\$372,141,000	\$429,377,900

"N/E" means "not eligible." The EMA was not eligible to receive funding in that fiscal year.



FACT SHEET

HIV/AIDS BUREAU • DIVISION OF SERVICE SYSTEMS • AUGUST 1997

Title II Ryan White CARE Act

The CARE Act

On August 18, 1990, Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Reauthorized in 1996, the CARE Act is designed to improve the quality and availability of care for individuals and families affected by HIV disease. The HIV/AIDS Bureau, Health Resources and Services Administration (HRSA), administers CARE Act programs. Title I is administered by the Bureau's Division of Service Systems.

The CARE Act includes the following major program components:

- **Title I:** funding to eligible metropolitan areas hardest hit by the HIV/AIDS epidemic;
- **Title II:** formula funding to States and territories to improve the quality, availability, and organization of health care and support services for people living with HIV disease;
- **Title III:** funding to public and nonprofit entities for outpatient early intervention services;
- **Title IV:** funding to public and private nonprofit entities for demonstration projects to coordinate services to, and provide enhanced access to research for, children, youth, women and families; and
- **Part F:** support for the Special Projects of National Significance (SPNS) Program, the Dental Reimbursement Program, and AIDS Education and Training Centers (AETCs).

Grants

Title II base and supplemental grants are awarded on a formula basis to States, the District of Columbia, Puerto Rico, and eligible U.S. territories to provide health care and support services for people living with HIV disease. Grants are awarded to the State agency

designated by the governor to administer Title II, usually the health department.

States with more than one percent of the total AIDS cases reported nationally during the previous 2 years must contribute their own resources to match the Federal grant, based on a yearly formula. Under Title II, States receive earmarked funds to support AIDS Drug Assistance Programs (ADAPs). ADAPs provide medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid, in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam. States also may use Title II base funds for their ADAP Programs.

Eligible Services

Title II funds may be used to support a wide range of services:

- **Home and community-based health care and support services;**
- **Continuation of health insurance coverage,** through a Health Insurance Continuation Program (HICP);
- **Pharmaceutical treatments,** through the ADAP Program;
- **Local consortia** that assess needs, organize and deliver HIV services in consultation with service providers, and contract for services; and
- **Direct health and support services.**

States are required to spend a portion of their Title II award to provide medications to treat HIV disease, including drugs for the prevention and treatment of opportunistic infections. States also must document their progress in making therapeutics available to eligible people with HIV disease.



Ryan White CARE Act Title II Grant Awards

STATE	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997 FORMULA	FY 1997 ADAP	FY 1997 TOTAL
ALABAMA	483,388	\$636,291	\$938,176	\$1,421,000	\$1,349,942	\$2,756,823	\$2,838,265	\$1,329,706	4,167,971
ALASKA	100,000	100,000	100,000	100,000	100,000	288,443	250,000	112,917	362,917
ARIZONA	653,285	687,616	751,528	1,855,383	1,759,313	2,260,259	2,045,462	1,450,752	3,496,214
ARKANSAS	276,192	440,564	528,077	821,978	753,038	1,369,814	1,395,995	654,013	2,050,008
CALIFORNIA	12,953,753	15,559,171	17,183,378	28,172,762	27,867,193	36,282,354	31,548,137	26,371,892	57,920,029
COLORADO	727,458	832,808	937,655	1,794,570	1,980,699	2,509,154	2,127,037	1,607,932	3,734,969
CONNECTICUT	763,464	915,334	1,068,399	2,246,095	2,404,858	3,651,778	3,330,036	2,790,394	6,120,430
DELAWARE	151,980	173,168	229,208	515,066	585,604	1,259,006	1,322,724	619,686	1,942,410
DIST. OF COLUMBIA	1,094,364	1,385,438	1,441,594	2,155,767	2,532,524	3,332,588	2,877,431	2,613,341	5,490,772
FLORIDA	7,397,516	9,856,630	11,228,316	16,361,686	17,780,752	25,220,349	23,416,364	17,898,632	41,314,996
GEORGIA	2,366,100	2,885,813	3,124,415	4,527,285	4,731,696	7,394,151	7,214,630	5,125,509	12,340,139
HAWAII	329,429	366,974	371,756	545,494	499,350	1,180,678	1,158,830	542,903	1,701,733
IDAHO	100,000	100,000	100,000	130,115	138,867	285,657	250,000	112,917	362,917
ILLINOIS	2,289,116	2,829,336	3,598,455	5,363,921	5,577,650	7,260,236	6,606,747	5,427,222	12,033,969
INDIANA	621,522	728,781	753,940	1,394,908	1,536,770	2,762,555	2,928,889	1,372,162	4,301,051
IOWA	110,588	164,436	215,475	333,799	333,360	613,264	624,726	292,680	917,406
KANSAS	245,985	256,907	324,039	605,134	568,263	1,050,840	997,168	568,196	1,565,364
KENTUCKY	299,687	406,244	467,575	641,709	643,697	1,344,978	1,415,277	663,046	2,078,323
LOUISIANA	1,308,109	1,672,504	1,844,076	2,494,411	2,785,044	4,080,447	4,252,105	2,717,224	6,969,329
MAINE	118,205	136,527	121,410	205,421	228,492	536,845	489,755	229,446	719,201
MARYLAND	1,554,569	2,027,034	2,130,393	3,625,966	4,684,012	6,521,685	5,923,285	5,025,239	10,948,524
MASSACHUSETTS	1,454,614	1,793,707	1,837,845	3,501,905	3,776,077	4,836,051	4,217,542	3,310,714	7,528,256
MICHIGAN	1,046,092	1,213,083	1,486,048	2,874,019	2,675,943	3,897,084	3,405,961	2,408,285	5,814,246
MINNESOTA	357,781	417,361	501,656	970,420	973,550	1,249,617	1,037,082	841,003	1,878,085
MISSISSIPPI	488,542	590,409	546,105	900,115	954,192	1,868,450	1,879,965	880,749	2,760,714
MISSOURI	1,043,394	1,330,744	1,459,224	2,716,091	2,504,335	3,131,126	2,620,796	1,965,652	4,586,448
MONTANA	100,000	100,000	56,197	100,000	100,000	129,912	136,900	64,137	201,037
NEBRASKA	100,000	117,188	146,689	292,135	267,083	506,277	499,395	233,963	733,358
NEVADA	330,545	443,483	531,149	924,894	964,174	2,049,946	2,043,859	957,533	3,001,392
NEW HAMPSHIRE	100,000	104,655	102,372	160,060	175,763	332,092	314,204	214,993	529,197
NEW JERSEY	4,215,417	4,711,438	4,505,948	6,650,657	8,958,831	13,135,111	11,931,930	9,448,859	21,380,789
NEW MEXICO	203,312	254,732	259,454	485,763	479,074	882,641	805,975	377,593	1,183,568
NEW YORK	13,802,740	16,909,338	17,618,806	26,126,095	29,093,044	38,324,520	34,972,364	29,381,796	64,354,160
NORTH CAROLINA	986,337	1,253,338	1,366,064	1,996,053	2,414,668	4,810,589	4,803,070	2,250,201	7,053,271
NORTH DAKOTA	100,000	100,000	19,872	100,000	100,000	107,243	100,000	24,390	124,390
OHIO	1,117,823	1,373,30	1,476,544	2,519,172	2,623,138	4,668,106	4,739,289	2,577,208	7,316,497
OKLAHOMA	393,500	490,547	512,925	1,133,726	1,050,786	1,656,387	1,554,105	728,066	2,282,191
OREGON	513,063	658,551	675,020	1,170,946	1,300,587	1,684,631	1,601,172	1,148,136	2,749,308
PENNSYLVANIA	2,241,191	2,536,697	2,849,791	4,421,998	5,177,510	7,991,467	7,686,648	5,258,299	12,944,947
PUERTO RICO	4,716,952	5,681,717	6,121,433	7,521,643	7,682,087	9,376,181	7,605,266	5,315,209	12,920,475
RHODE ISLAND	173,200	194,400	210,219	452,600	554,753	1,083,242	1,054,708	494,123	1,548,831
SOUTH CAROLINA	688,747	795,067	763,896	2,091,875	2,679,771	4,516,376	4,509,988	2,112,895	6,622,883
SOUTH DAKOTA	100,000	100,000	100,000	100,000	100,000	112,536	100,000	38,843	138,843
TENNESSEE	605,992	737,498	905,045	1,675,354	1,846,877	3,757,915	3,906,471	1,830,152	5,736,623
TEXAS	5,731,924	7,329,198	7,078,303	11,813,825	12,636,414	16,132,517	14,636,207	11,061,308	25,697,515
UTAH	199,022	234,917	304,258	511,096	428,266	810,043	852,251	399,273	1,251,524
VERMONT	100,000	100,000	100,000	100,000	103,727	279,529	250,000	92,140	342,140
VIRGINIA	970,120	1,351,047	1,430,800	2,403,511	2,642,609	5,365,718	5,235,047	2,881,631	8,116,678
WASHINGTON	1,025,356	1,322,995	1,270,740	2,262,586	2,310,797	3,154,250	2,830,277	2,067,728	4,898,005
WEST VIRGINIA	127,689	153,234	135,148	173,904	184,768	446,290	492,843	247,513	740,356
WISCONSIN	354,601	459,433	481,719	1,069,752	1,063,650	1,840,433	1,755,689	823,839	2,579,528
WYOMING	100,000	100,000	44,037	100,000	100,000	113,650	100,000	37,940	137,940
VIRGIN ISLANDS	38,397	27,019	36,048	68,703	0	197,360	191,525	N/A	191,525
GUAM	2,954	4,323	3,379	3,379	2,902	4,970	11,608	N/A	11,608

TOTALS	77,474,015	\$95,151,000	\$102,394,599	\$162,705,300	\$174,766,500	\$250,405,164	\$230,895,000	\$167,000,000	\$397,895,000
---------------	-------------------	---------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

*Did not request funding

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

WOMEN

Divider Title: _____

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 fastest 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 combining 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%.*

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

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.

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

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

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

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>.



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

Back to Top

© 1997, San Antonio Express-News
E-mail the editors with any questions or comments.

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.

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.



Photo by Gloria Ferniz
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.

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.

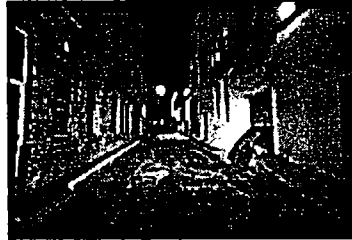


Photo by Gloria Ferniz
Concerned that police will see his open beer, container, Randy Willey - who has AIDS - hides it in a downtown alley before looking for a place to relieve himself.

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."

Back to Top

© 1997, San Antonio Express-News
E-mail the editors with any questions or comments.

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.

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



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

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."

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."



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.

Back to Top

© 1997, San Antonio Express-News
E-mail the editors with any questions or comments.

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 occasionally 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 shelter 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."

Back to Top

© 1997, San Antonio Express-News
E-mail the editors with any questions or comments.

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.

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."



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

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 heads for 'the freeway' after a man stole his money promising a nonexistent 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 important 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."

Back to Top

© 1997, San Antonio Express-News
E-mail the editors with any questions or comments.

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 and homeless, 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.

Back to Top

© 1997, San Antonio Express-News
E-mail the editors with any questions or comments.

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 prophecies.

"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, he's 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 warning: 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."

Back to Top

© 1997, San Antonio Express-News
E-mail the editors with any questions or comments.

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."

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.

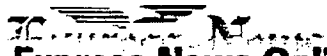
Later, in the dark hallway outside Ed's room, Goldenberg says that most terminal- AIDS residents prefer to spend their last days in the Ambassador rather than a hospice.

"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.

Back to Top

© 1997, San Antonio Express-News
E-mail the editors with any questions or comments.



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 amount 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. 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.

Back to Top

© 1997, San Antonio Express-News
E-mail the editors with any questions or comments.

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 count 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.

Back to Top

© 1997, San Antonio Express-News
E-mail the editors with any questions or comments.

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

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

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

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

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)