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BRIEFING BOOK

CHICAGO

November 14, 1997

FACSIMILE

PHOTOCOPY PRESERVATION

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

808 17th Street NW, Suite 820
Washington, DC 20006

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

TO:	Sandra Thurman (c/o Mark Ishaug)
FAX NUMBER:	(312) 922-2916
FROM:	Todd Summers
DATE:	November 6, 1997
PAGES:	13 (including cover sheet)
COMMENTS:	

Nelson H. Carter
5900 Gilstrap Mill Road
Murrayville, Ga. 30564
Ph: 770-983-9782
Fax: 770-983-0491

To Sandra L. Thurman Director

COMPANY NAME. Office of National Aids Policy

FAX NUMBER: 202 / 632-1096

TELEPHONE NUMBER: 202 / 632-1090

FROM: Nelson H. Carter

SUBJECT: PERSONAL

TIME 10:40 P.M. DATE 11-4-97

NO. OF PAGES INCLUDING COVER SHEET 1

COMMENTS: Sandy,

Barbara said she thought you were going to be out of town or the country for a couple of weeks so I'm not surprised I haven't heard back from you. Checking to see if you got fax of 10-28-97

I'll be in Chicago and return on the 9th (evening) — I'll be in town for a week and then to FL for a few days.

Do you want your stuff sent to office or home. Need an address. If I don't hear from you in another week I'll give Jennifer a call. Happy Day ☺

Thanks, Nelson

P.S. I have a new grandson — 5# 4oz. that makes 3 - #4 in Dec.

TABS

1 **Background Overview**

-- statistics
-- funding
-- major organizations
-- summary of recent Chicago newspaper articles

2 **Statistics (detailed)**

-- health department
-- Epidemiological profile/trends

3 **Organizations**

-- Howard Brown Health Center
-- Project VIDA

4 **Medicaid 1115 Waiver Article**

5 **Chicago Tribune Article "AIDS Before Beauty" focusing on Sandy Thurman**

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1

Divider Title: _____

Background Information
Chicago, Illinois

Chicago Mayor: Richard Daley

City of Chicago Health Commissioner: Shelia Lyne

EMA populatioin estimate: 7.5 million people

Target Population for CARE Act Services (FY 96):

66% White
19% Black
11% Hispanic
3% Asian and Pacific Islander

Chicago has 81% of AIDS cases within the EMA.

Illinois State Capital: Springfield

1996 Statistics:

- According to the local health department, for the first time since the beginning of the epidemic, the number of AIDS cases attributed to Intravenous drug use (including partners and children) equaled that for men who have sex with men.
- AIDS death rate fell 20% in Chicago in 1996 compared to 1995. Some 777 Chicagoans died of AIDS in 1996, compared to 968 in 1995. (5,717 since 1990 alone.)
  - -- down 40% for Whites, 22% for Hispanics, and only 4% for Blacks
  - -- death rates were down 22% for Males, but **UP** 9% for Females, and **UP** 28% for Black Females.
- HRSA estimates some 22,000 persons living with HIV in the Chicago EMA, including the approximate 4,000 persons living with AIDS. Chicago estimates that 11% of its IDU are HIV+.

Exposure Category		**Age**		**Race/Ethnicity**	
MSM	44%	**20 - 29**	**14%**	Black	64%
IDU	35%	**30 - 39**	**41%**	White	21
MSM/IDU	4%	**40 - 49**	**32%**	Hispanic	14%
Heterosexual	9%	**Over 50**	**13%**	Other	1%

AIDS Cases by Specific Communities within Chicago (Per 100,000)

Uptown	227	Edgewater	150
Lake View	147	East Garfield Park	142
Loop	130	Near West Side	128

Ryan White Funding Levels for Chicago EMA (FY 96 estimates)

With Medicaid/Medicare

Total Ryan White Funding: $15,741071
- Title I Formula ~~$8,244,897~~
- Title I Supplemental $7,516,174

ADAP (state total) $5,427,222 (No waiting list reported)

HOPWA Funding $3.8 million

CDC Prevention Funding (1997 estimate): 10.5 million

- Seven Chicago Department of Health HIV Primary Care Community Health Centers serve indigent HIV+ clients who do not have alternative options for care:

  -- Uptown -- Southside -- Lake View -- West Town
  -- Englewood -- Mile Square -- Roseland Christian Health Center

Major AIDS Prevention/Service Organizations:

-- South Side Help Center* (Black youth, prevention, substance abuse counseling)
-- Teen Living Program* (runaway and homeless youth)
-- Cook County Hospital*
-- AIDS Foundation Chicago (policy advocates)
-- Howard Brown Clinic
-- Testing and Awareness Network
-- Project VIDA* (Hispanic focused prevention)
-- Erie Family Health Center (community health center)

* Patsy Fleming visited these organizations during her regional briefing tour in Chicago in June 1996.

ILLINOIS DOES NOT HAVE HIV REPORTING. Chicago Health Department offers anonymous AND confidential HIV counseling and testing.

-- The State of Illinois currently has an 1115A Medicaid managed care waiver from HCFA -- which it has yet to implement. According to "State Health Watch," Illinois may abandon the 1115 waiver and design their own mandatory Medicaid managed care program as allowed under the new Federal Budget agreement. State Democrats have criticized the Department of Public AID for not having implemented the approved plan.

RECENT ARTICLE/EDITORIALS

Chicago Tribune

- published 500+ HIV-related items in 1996, and more than 300+ so far in 1997.

11/2/97 Articles on the Elderly and HIV, RENT (the play), and FDA's new policy for inclusion of women in clinical trials.

10/28/97 Articles on a call to end the AIDS clinical trial in Africa, on how the Chicago School District will no longer screen applicants for HIV based on a law suit by the Lambda Legal Defense Fund, and on the planned mass testing of an HIV vaccine in Thailand.

10/26/97 Article on HIV in the National Hockey League and how the NHL has been slow to respond to the epidemic. Chicago's Hockey team is the Black hawks.

9/7/97 "AIDS Before Beauty" -- Article on Sandy Thurman's appointment describing her as someone who looks as she should head up the Junior League.

4/3/97 Article on the State expansion of the drug formulary to include all four Protease Inhibitors. Some 1,500 individuals are enrolled in the ADAP program

3/8/97 **EDITORIAL** on AIDS death rates. Attributes decline in death rates to success of safer sex message, especially for the young gay male population, but more importantly to Protease Inhibitors. Discusses caveats of death rates, especially how not all populations are benefiting equally. **Editorial says that "prevention is key, but we must experiment with new approaches" such as needle exchange.**

3/26/96 Article on HMO's not necessarily covering all the necessary drugs needed by PWA's

Chicago Sun-Times

11/3/97 Article on cost of AIDS cocktails and the State prison system being overwhelmed. Cost of AIDS drugs has gone from "$30,000 to $300, 000 per month over the past couple of years." 633 state prisoners have AIDS out of 38,000 total prisoners. 10 prisoners died from AIDS last year, 173 over the past 10 years.

10/16/97 Article on the decline in AIDS deaths in the Chicago area.

Numerous other articles including a "Dear Rhonda" (Dear Abby-like column) which highlighted a letter on someone newly diagnosed.

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2

Divider Title: _____

2. EPIDEMIOLOGICAL PROFILE DEMONSTRATING SEVERE NEED

a. The Local HIV/AIDS Epidemic and Comparison to the National Epidemic

Populated by nearly 7.5 million people across approximately 5,000 square miles, the Chicago EMA spans Cook, DeKalb, DuPage, Grundy, Kane, Kendall, Lake, McHenry, and Will Counties. Chicago's population of over 2.7 million comprises 37% of the EMA, but represents approximately 82% of the EMA's 16,441 cumulative AIDS cases, as well as 82% of cases reported in the period April 1995 to March 1997. An additional 11% of the EMA's AIDS cases are reported in suburban Cook County, leaving 7% of all reported cases spread throughout the remaining eight counties (Tables 1 and 2). A map depicting the geographic distribution of reported AIDS cases within the Chicago EMA is included as Attachment 1. The 4.7 million persons who reside outside the City of Chicago (63% of the EMA's population) represent urban, suburban and rural communities. As a whole, the EMA is racially and ethnically diverse, with 66.2% white, 19.0% African American, 11.4% Latino/a, 3.3% Asian American, and 0.2% Native American residents.

Since the first case of AIDS was reported to the Chicago Department of Health in 1981, over 16,000 cases have been reported to local health departments across the EMA. In the two-year period ending March 1997, nearly 3,500 new cases were reported in the nine-county area (21% of the cumulative total). Cumulative numbers for prior periods will continue to be revised, as additional cases are documented. Several approaches, using independent methodologies to estimate HIV seroprevalence, generate estimates of people infected with HIV ranging from 19,000 to 36,000 within the EMA. The standardized approach recommended by HRSA yields an estimate of 22,000 persons living with HIV in the EMA, including those living with AIDS (Table 3). This relatively conservative seroprevalence estimate was first used by the Planning Council in its quantitative assessment of HIV service needs for FY 1997. This estimate was adjusted to 25,000 persons during the FY 1998 needs assessment process to reflect the current target population for Title I services (see Attachment 7 and Section C below, pp. 31-33).

The population of people currently living with HIV and AIDS looks very different from those first affected by the epidemic in the EMA. Women, African Americans, heterosexuals and injecting drug users continue to experience disproportionate increases in the number of AIDS cases reported each year, while the proportion of cases attributed to whites, males and homosexual / bisexual contact continues to decrease. The proportion of pediatric cases in the Chicago EMA has

remained comparatively low, accounting for approximately one percent of all cases reported in the last two year period. Anecdotal reports, however, indicate that pediatric AIDS cases may be under reported in the Chicago EMA. The percentage of AIDS cases among women continues to rise, from 12% of cases during the first fourteen years of the epidemic to nearly 19% of cases in the past two years. Similarly, heterosexual risk was reported in 8% of cases from 1981 to 1995, but in over 10% of cases reported in the past two years (although recent data on misclassification of transmission mode indicate that these percentages exaggerate real heterosexual risk).

Population Group	Total EMA Population	AIDS Cases 1981-1995	AIDS Cases 1995-1997
White/Anglo	66%	42%	28%
African American	19%	44%	57%
Latino/a	11%	13%	13%
Women		12%	19%
Injecting drug users		29%	36%
Men who have sex with men		60%	45%
Heterosexuals		8%	10%

Injecting drug users (including male IDUs who also report risky sex with other males) account for 36% of cases in the past two years, up significantly from 29% in the first fourteen years. African Americans, who accounted for 44% of cases through 1995, make up more than 57% of cases reported in the past two years. The proportion of cases among non-Latino/a whites in the same two periods has declined from 42% to 28%.

Local seroprevalence estimates outlined in Table 3 and updated in Attachment 7 illustrate growing trends in the epidemic. Compared to AIDS case data reported in Tables 1 and 2, estimates of people living with HIV across the EMA show even greater impact of the epidemic among women, African Americans, heterosexuals and injecting drug users. Moreover, updated estimates developed during the FY 1998 needs assessment process show changing patterns in the level of acuity of HIV disease among people living with HIV overall. Recent data show proportionally more HIV-positive persons at Level II of HIV disease (between 200 and 500 CD4 cells/ml)

compared to Level I (CD4 count above 500/ml). This trend reflects the reality that an increasing number of people are living with comparatively advanced HIV disease (33% now at Level II, up from 24% in FY 1997) and consequently are likely to need more services.

While more people living with HIV are experiencing some symptoms of disease, many are living longer as a result of new anti-retroviral therapies, and fewer are progressing to end-stage disease. The change from last year's Table 3 data to Attachment 7 (showing a growth in overall HIV prevalence from 22,000 to 25,000) actually illustrates a very hopeful trend for people living with HIV. While the incidence of HIV (new infections) has stabilized in the Chicago EMA, a significant decline in annual AIDS deaths (from approximately 1,000 per year in 1993-1995 to 777 in 1996) has resulted in increased prevalence. The good news is that fewer people are dying from HIV disease. The bad news for the service delivery system is that the target population for HIV services continues to grow.

Analysis of epidemiological data by sub-population and community area uncovers several disturbing trends. While overall numbers among those who report homosexual or bisexual contact as a risk factor are rising less rapidly than among other groups, African American and Latino men who have sex with men continue to be disproportionately represented among new cases. Examination of local Latino/a AIDS cases by mode of transmission and nationality (as of September 1996) shows very different epidemics in the Mexican American and Puerto Rican communities, with AIDS incidence rates of less than 30 per 100,000 population among Mexican Americans and over 100 per 100,000 among Puerto Ricans (compared to approximate rates of 50 for non-Latino/a whites and 95 for African Americans). The cumulative impact on the Puerto Rican community is heavier and shows 56% of cases associated with injecting drug use, while the annual rate of increase among Mexican Americans is somewhat higher but includes only 16% of cases among IDUs. Finally, regional data over a six-year period indicate disproportionate growth in AIDS cases on the South and West Sides of the city, where health care and social services are least available.

National estimates of living AIDS cases distributed by HRSA show a prevalence rate of 67.2 per 100,000 for the nine-county Chicago EMA, compared to an average rate of 113.7 among all Title I EMA regions. However, with 82% of living cases in the EMA and only 37% of the population, the prevalence rate for living AIDS cases within the city of Chicago exceeds 157 per 100,000. Cumulative data paint an even more striking picture -- compared to the United States as a whole, Chicago shows a cumulative AIDS case rate more than double that of the national average

(445 per 100,000 compared to 220 per 100,000) reported through June 1996. Attachment 3 illustrates average *annual* AIDS incidence by community area across the city of Chicago, highlighting eight community areas where more than 100 AIDS cases per 100,000 population were reported *per year* between 1994 and 1995.

While three community areas hit particularly hard early in the HIV epidemic (Lakeview, Uptown, and Edgewater) continue to experience some of the highest average annual incidence rates shown in Attachment 3, all 77 official community areas in Chicago now report cases of AIDS each year. Graphics showing AIDS incidence rates by community area, developed by the Epidemiology Division of CDOH for use in the Planning Council's regional town meetings on HIV service needs, were used to show how the epidemic grew in six years from five community areas on the North Side reporting case rates over 50 per 100,000 in 1988 to 32 community areas spanning the North, West and South Sides of the city by 1994. Additional visual overlays illustrate how these high-impact areas mirror those most affected by poverty, injection drug use, sexually transmitted diseases, teen pregnancy, and heterosexual transmission of HIV.

Outside the city, the impact of AIDS on the rest of the EMA is increasing as well. While the proportion of suburban and rural AIDS cases has not approached its percentage of the EMA's overall population (63%), cases reported outside the city during the most recent two-year period account for nearly 18% of total AIDS cases in the EMA, up from 10% seven years ago. The majority of suburban and rural residents reported between April 1995 and March 1997 as living with an AIDS diagnosis report their history of risk exposure as men having unprotected sex with other men (45%) or injection drug use (26%). As in Chicago and the rest of the nation, ethnic and racial minorities are affected in numbers disproportionate to their population in the suburban and rural portions of the EMA. Not surprisingly, communities with relatively higher rates of poverty, drug use and homelessness report higher incidence of AIDS cases than their more affluent neighbors.

Various aspects of the local HIV epidemic, including growing numbers of multiply diagnosed persons, exploding treatment costs and limitations of the existing health care system, combine to exacerbate unmet HIV service needs in the Chicago EMA. Trends in local epidemiology outlined here indicate growing needs for services both in new geographic areas and among new populations. Regions of the EMA with the highest growth in AIDS and HIV are the same areas with fewest health care and social service resources. Further, most populations

currently hit the hardest (injecting drug users, men of color who have sex with men, and homeless persons) are the same populations that historically have been most neglected by both public and private health systems. Special needs of these and other sub-populations also are examined separately in Table 8 (pp. 91-121). Service capacity of existing health care and social service providers is unable to keep pace with rapidly growing and changing needs for HIV-related services across the EMA. Finally, costly new HIV therapies and ongoing changes in public and private health care financing present major challenges to HIV service coordination and effective use of limited resources.

b. HIV and Co-morbidities

Sources of Information: Data of variable reliability and scope are available on different HIV co-morbidities in the Chicago EMA. For example, due to good reporting and strong coordination of certain key public health services, solid quantitative data are available on HIV and tuberculosis (TB) and HIV and sexually transmitted diseases (STDs). Extensive information also is available on HIV and substance abuse, as well as HIV and homelessness, although these data generally reflect co-morbidities of people living with HIV already receiving some kind of health care or social service. Data on HIV and severe mental illness are the weakest, including mostly site-specific data on co-morbidity reported by Title I service providers. Because data on different co-morbidities are not directly comparable – i.e. not all information may be extrapolated for the entire HIV/AIDS population – data are outlined in narrative format, rather than presented in a table.

Quantitative Data: While TB has reached an all-time low in Chicago, due in large part to the city's aggressive implementation of directly observed therapy, co-incident cases of HIV and TB remain a serious public health concern. The number of newly diagnosed TB cases fell in 1996 to 592, down from approximately 800 new cases per year in 1992 and 1993. However, the proportion of TB cases with an AIDS diagnosis has increased over time. In a recent four-year period, a total of 458 co-incident cases of AIDS and TB were identified in Chicago by health surveillance staff at CDOH. The proportion of co-incident cases increased from 8% (52 of 685 cases of TB) in 1989 to over 15% (122 of 799 cases of TB) in 1993. Pulmonary TB was the sole AIDS-defining illness for 77 (17%) of the 458 co-incident cases, while 381 (83%) had TB and other AIDS-defining illnesses.

More recent data for the period 1993 to 1996, collected by the CDOH Epidemiology Division and TB Control Program, show that approximately 20% of persons with newly diagnosed

TB in Chicago are HIV-positive (333 out of approximately 1,600 TB cases). Further, nearly 18% of these co-incident cases (59 of the 333) were found to be unreported in the official AIDS/HIV case registry, demonstrating serious under reporting of AIDS among TB patients. Overall, these findings highlight the overlapping effects of the two epidemics and suggest a growing need for coordinated HIV care, preventive TB therapy, and case finding. Results of a recent project to evaluate counseling and testing of TB patients for HIV infection further illustrate the overlap between AIDS and TB. Recent outbreaks of multiple drug resistant tuberculosis (MDRTB) in Chicago between July 1994 and June 1996 show startling co-incidence of HIV and MDRTB: 20 of 23 outbreak related cases studied show documented co-infection with HIV. Complete data for 1996 show a total of 592 cases of TB reported to CDOH, over half of which occurred among African Americans, who now experience TB case rates four times higher than non-Latino/a whites.

Sexually transmitted diseases represent another group of co-morbidity factors that exacerbate local needs for both HIV care and prevention activities. Like recent efforts to combat TB in Chicago, local public health initiatives to reduce incidence of gonorrhea and syphilis have begun to yield results. Over the period 1980 to 1994, incidence rates for gonorrhea dropped nearly 45% in Chicago, from 959 to 532 per 100,000. Rates for primary and secondary syphilis during the same period dropped 40% from 39 to 23 per 100,000. These general 14-year trends, however encouraging, mask annual variations in incidence rates and rates affecting communities of color. Gonorrhea incidence in the African American community, for example, exceeded 2,400 per 100,000 in 1989 and remained nearly three times the city average in 1994. Likewise, incidence of syphilis surged in African American communities to over 150 per 100,000 in 1991 and 1992 and remained near 60 or three times the city average in 1994. Elevated rates of STDs in communities of color are associated with dramatically higher incidence of HIV and AIDS.

Unlike syphilis and gonorrhea, the incidence of chlamydia in Chicago rose dramatically in all communities between 1988 and 1994. Average annual incidence jumped 175% in six years from 140 to 385 per 100,000 population, with Latinos/as (nearly 300 per 100,000) and African Americans (over 560 per 100,000) disproportionately affected.

New evidence published in November 1996 by the National Center for HIV, STD and TB Prevention confirms the link between HIV and other STDs. There is now strong population-based and biological evidence that the presence of other STDs increases the likelihood of both transmitting and acquiring HIV. Prospective epidemiological studies have shown over time that, in

TABLE 9: TITLE I FUNDING IN THE CONTEXT OF OTHER PUBLIC FUNDING

EMA: CHICAGO

Services	Amount and Percent of Public Funding, by Source								
	Ryan White Title I*		Other Federal Funds		State Funds		Local Funds		TOTAL FUNDS
	(1) $	(2) %	(3) $	(4) %	(5) $	(6) %	(7) $	(8) %	
Home- and Community-Based Support Services	5,959,743	18.0	5,711,301	17.3	15,363,421	46.4	6,052,600	18.3	33,087,065
Ambulatory/Outpatient Medical Care	4,795,587	13.1	4,300,875	12.0	26,980,379	73.5	635,000	1.3	36,711,841
AIDS Drug Assistance Program	0	0	49,138,000	50.6	47,938,000	49.4	0	0	97,076,000
Other Outpatient/ Community-based Health Care Services	4,599,536	8.3	6,398,756	11.6	44,158,828	79.9	130,828	0.2	55,287,948
Inpatient Medical Care Services	0	0	15,372,500	44.4	15,372,500	44.4	3,857,000	11.1	34,602,000
Grantee Administrative Costs, Planning Council Support, Program Support Service Activities	901,815	62.5	295,000**	20.4	0	0	245,000	17.0	1,441,815
TOTAL	16,256,681	6.3	81,216,432	31.5	149,813,128	58.0	10,920,428	4.2	258,206,669

*Title I figures include actual dollars for eleven month supplemental project period

**FY 1998 estimated dollars for AETC program

AIDS Chicago

Third Quarter, 1997 AIDS Surveillance Report

City of Chicago
Richard M. Daley, Mayor
Department of
Public Health

Sheila Lyne, RSM
Commissioner

Anne Meegan
Acting Director
HIV/AIDS Public Policy
and Programs

AIDS Chicago is
prepared by the
AIDS Surveillance
and Epidemiology
Programs
(312) 747-9810

The Demographics of Recent AIDS Mortality Trends in Chicago

In early 1997, New York City health officials reported a 30% decline in AIDS deaths in 1996. At the same time, CDC reported a 13% decline in a comparison for the entire United States of the first halves of 1995 and 1996, and later reported a 23% decline when full-year data became available. Reports of declining mortality continued to be issued from high morbidity states as the year progressed, ranging from 12% to 29%. Several weeks ago, the Chicago Department of Public Health (CDPH) conducted an analysis of Chicago's AIDS mortality data and released the news to the press. With the story being carried in local newspapers (and *USA Today* as well), many readers may already be aware that AIDS mortality in Chicago fell 20% in 1996 compared to 1995. In this issue, we examine mortality trend data in more detail. We also examine trends in incidence (new AIDS cases) and prevalence (living AIDS cases).

Seventeen years into the epidemic, 1996 was the first year to show a significant decline in the AIDS death toll in Chicago. A 20% decline in mortality is certainly encouraging news and demonstrates that new anti-retrovirals, protease inhibitors, combination therapies with new drugs and those that have been around for a while, and increased prophylaxis are making an impact in the battle against HIV. However, these recent gains are tempered by the demographic differentials which suggest that only certain groups are benefiting from HIV therapies. For stratification of the data by specific demographic categories, we employed a three-year average of 1993-1995 deaths to compare with 1996 deaths since numbers get smaller in these more specific categories. Among racial/ethnic groups, the greatest change was seen among non-Hispanic White people with a decline in mortality of 40% (Table A). This was followed by a 22% decline in HIV-related mortality for Hispanic people, and little decline (4%) for non-Hispanic Black people. Differentials

Table A. Number of Deaths Due to HIV/AIDS, Chicago, 1990 - 1996 By Gender and Race/Ethnicity

	1990	1991	1992	1993	1994	1995	1996	% Change (1993-95) to 1996
Gender								
Female	46	64	72	120	103	121	125	9%
Male	544	650	704	841	828	847	652	-22%
Race/Ethnicity								
Non-His Black	249	317	369	471	471	536	471	-4%
Non-His White	262	310	290	331	325	315	194	-40%
Non-His Other	1	5	5	7	6	2	9	80%
Hispanic	78	82	112	152	129	115	103	-22%
Total	590	714	776	961	931	968	777	-18%

existed by gender as well with mortality declining among males by 22% while females experienced an *increased* mortality of 9% (Table A).

The picture becomes even more complex when stratified by gender-specific racial/ethnic groups and modes of transmission. Mortality among non-Hispanic White males declined by 42%, and mortality among non-Hispanic White men who have sex with other men (MSM) was also cut nearly in half (45%, Table B). In contrast, mortality among non-Hispanic Black females continues to rise, increasing 28% during this period. Increases were also seen for non-Hispanic Black females in both predominant transmission groups, injection drug use (IDU) (+11%) and heterosexual contact (+45%) (Table B). The other group experiencing an increase in mortality was non-Hispanic Black male IDUs (+9%).

Table B. Number of Deaths Due to HIV/AIDS
Chicago, 1993-95 and 1996
by Gender Specific Race/Eth. and Transmission Modes

	Number of Deaths		
	Average (93-95)	1996	% Change
Males			
Non-H Black All Modes	419	376	-10%
Non-H Black MSM	*240*	*193*	*-19%*
Non-H Black IDU	*125*	*136*	*9%*
Non-H White All Modes	301	176	-42%
Non-H White MSM	*258*	*142*	*-45%*
Non-H White IDU	*21*	*17*	*-19%*
Hispanic All Modes	114	91	-20%
Hispanic MSM	*52*	*50*	*-4%*
Hispanic IDU	*42*	*29*	*-31%*
Females			
Non-H Black All modes	74	95	28%
Non-H Black IDU	*47*	*52*	*11%*
Non-H Black Hetero.	*20*	*29*	*45%*
Non-H White All Modes*	22	18	-18%
Hispanic All Modes*	18	12	-33%

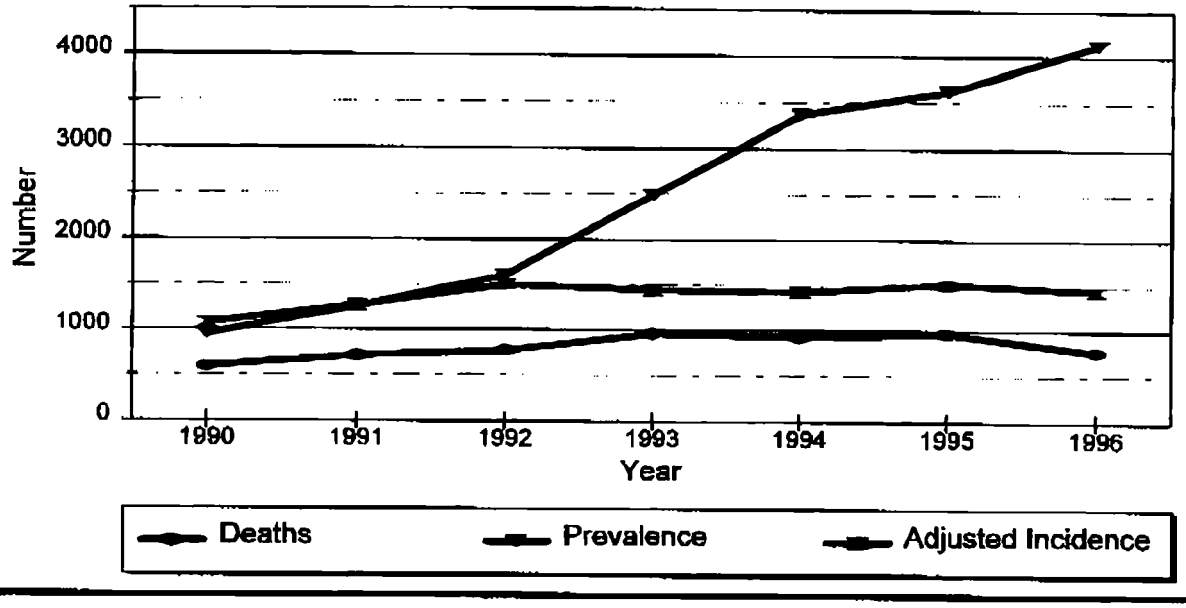
*Data for non-H White and Hispanic female transmission categories not displayed due to small numbers.

These inequities in mortality trends become more urgent when viewing the concomitant trends in incidence and prevalence of AIDS cases in Chicago (Figure A). The incidence of new AIDS cases has been relatively stable over the past several years, at about 1,500 new cases annually. This has exceeded the deaths by approximately 500 a year, and more so recently as the number of deaths drops off sharply. What this means is that the number of people *living* with AIDS in Chicago is rising sharply, up to over 4,000 in 1996 from just 1,000 in 1990. The implications of this are far-reaching, impacting the areas of both treatment and prevention. With more and more people living with AIDS, there is clearly a need for more care. Simultaneously, as more and more people living with AIDS are living more healthily, efforts need to continue in earnest to prevent new infections.

Methodological Notes

1) As we have discussed before (First Quarter, 1996; Third Quarter, 1996), the 1993 expansion of the definition of AIDS necessitates that the data be arranged to take the change of definition into account. Since time trends are the essence of our understanding of the epidemic, some arrangement must be made that will allow us to employ consistent definitions over time. In 1996, CDC released computer software called the HARS/PRODAS Reporting Delay and Adjusted Incidence Programs that adjusts the data with a sophisticated estimation model that shows how many cases would be diagnosed each year if a consistent definition were employed. This, in turn, allows us to examine trends that are consistent and thus

Figure A. AIDS Deaths, Prevalence, and Incidence by Year
Chicago, 1990-1996



understand how the epidemic is proceeding. In order to accomplish this in *AIDS Chicago*, we employ the following process. In each issue, the actual number of cases, as well as the adjusted numbers, are reported in Table 1. Tables 2 - 5 depend upon percentages, not numbers or rates, and thus remain based upon diagnosed (as opposed to adjusted) cases, as they have always been. The community area data presented in Table 6 are too small to make reliable adjustments, and they too are left in their original format. Notably, all of the figures (numbers 1 - 4) are generated employing the CDC software, thus presenting consistent time trend data. The details of how the calculations are implemented have been described by CDC and OAS would be pleased to provide a copy of the relevant documentation to anyone who is interested.

2) Some of the graphs presented are based upon rates--the number of cases divided by the relevant population of the group. This employment of rates enables the direct comparison of different groups while taking into account the varying population sizes. For these data, case rates per 100,000 population are employed. For example, a rate of 200 per 100,000 means there are 200 cases for every 100,000 people in the referent population. The Chicago population data are derived from the 1990 census of the United States population.

Chicago's AIDS Data

Table 1 displays the number of known AIDS cases in Chicago by diagnosis year. As noted in the Methodological Notes, we present both diagnosed as well as adjusted cases for each year. The adjusted numbers are the ones to employ when examining time trends. The cumulative number of cases has reached 13,976. The number of new cases, or incidence, was essentially stable between 1992 - 1996 at roughly 1,500 cases each year.

Any understanding of the nature of the epidemic will depend upon our ability to study its characteristics as they change over time. Figure 1 presents the incidence rate per 100,000 population by year of diagnosis for males and females. As described in the Methodological Notes, these rates are

adjusted by CDC software. The incidence for males, which had remained relatively constant between 1992 and 1995, fell slightly in 1996. For females, incidence has continued to rise. Nonetheless, the 1996 male case rate is still nearly five times that of the female rate.

Figure 2 presents the incidence rates for non-Hispanic Black people, non-Hispanic White people, and Hispanic people. (The CDC software utilized for the adjustments in this graph is not yet capable of generating separate data for Puerto Ricans and Mexicans.) The epidemic, which predominantly existed in the White community in the earliest years, has shifted dramatically. The last year that Whites had the highest annual incidence rate was 1989. Since 1990 Blacks have had the highest rate. Interestingly, in 1996 the increasing rate for Hispanic people exceeded the declining rate for White people, at around 40 per 100,000 population. Both of these rates are still less than half of the Black rate. When Hispanic subgroup information was analyzed without employing CDC software projection estimates (see *AIDS Chicago*, Third Quarter, 1994; *J. AIDS*, Vol. 11, p. 83-87, 1996), it was found that Puerto Ricans have experienced an incidence of AIDS even higher than that of Black people.

Table 1. Actual and Projected AIDS Cases in Chicago as of 9/26/97

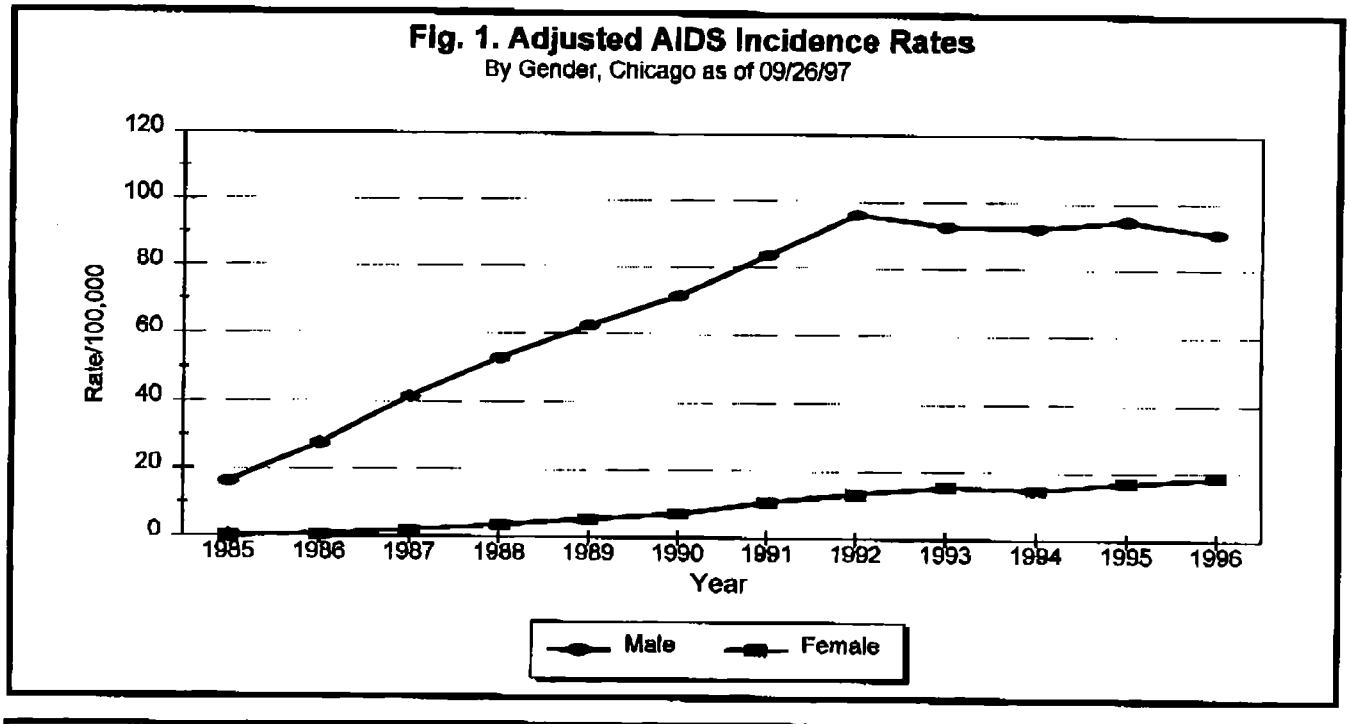
Diagnosis Year	Actual Cases	Percent Increase	Adjusted Cases	Percent Increase
1980	1		0	
1981	4	300%	0	—
1982	16	300%	18	—
1983	41	156%	47	161%
1984	111	171%	109	132%
1985	222	100%	223	105%
1986	373	68%	377	69%
1987	606	62%	582	54%
1988	766	26%	760	31%
1989	905	18%	913	20%
1990	1,133	25%	1,059	16%
1991	1,400	24%	1,274	20%
1992	1,713	22%	1,484	16%
1993	1,912	12%	1,461	-2%
1994	1,782	-7%	1,453	-1%
1995	1,477	-17%	1,515	4%
1996	1,096	-26%	1,484	-2%
1997	418	—	—	—
Not yet adjusted	—	—	1,217	—
Total	13,976		13,976	

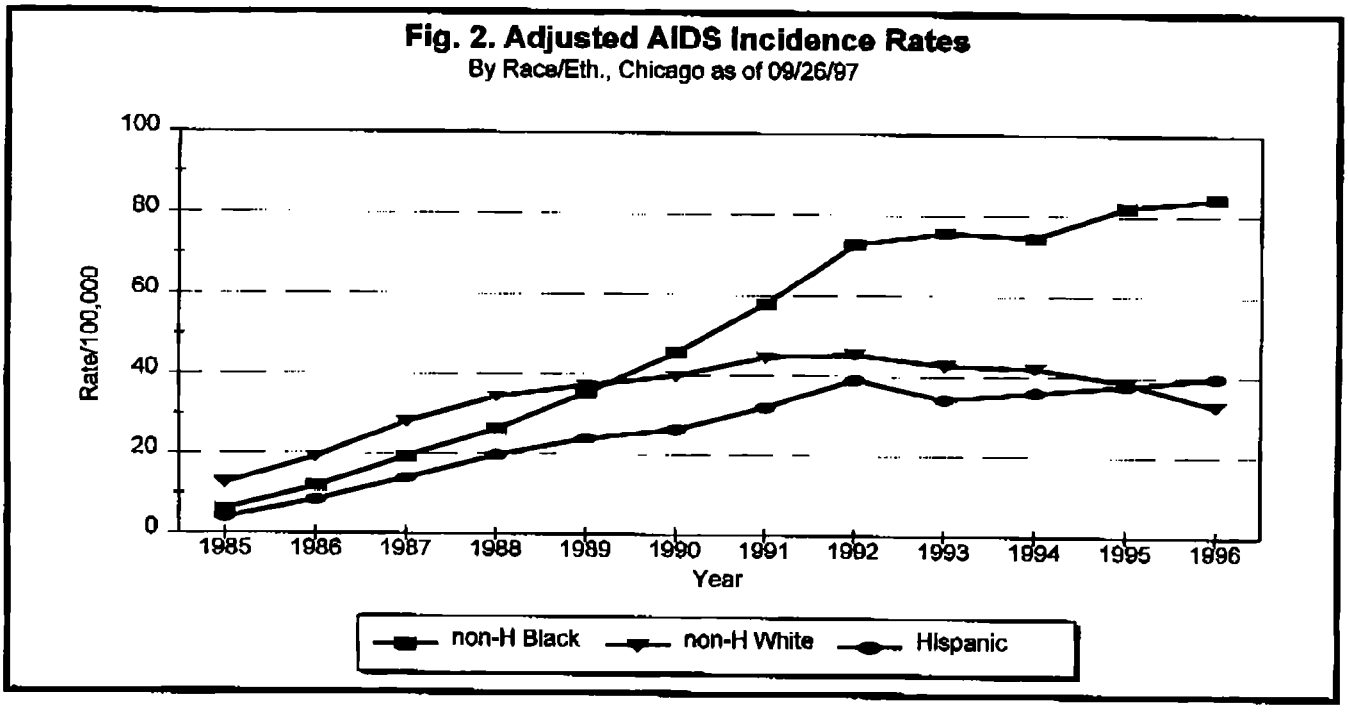
Characteristics of AIDS Cases

Table 2 contains time trend data for selected characteristics of AIDS cases, including gender, race/ethnicity, mode of transmission, and age at diagnosis for the diagnosis years 1988-1996. It can be seen that the proportion of cases among females has almost tripled from 7% in 1988 to 19% in 1996. The race and ethnicity data include estimates of the proportion of cases from the two largest Hispanic subgroups in Chicago. Notable changes have occurred in the race and ethnicity characteristics over this period of time as well. In 1990 the proportion of cases occurring among Black people surpassed the proportion of cases occurring among White people, and since 1992 more than half of the cases annually have occurred among Black people (1987 was the last year Whites comprised over 50% of the cases). The proportion of 1996 cases among Blacks is 64%. By mode of transmission, the distribution over time has shown a decreasing proportion of cases among men who have sex with men (MSM). In 1996 only 44% of the cases were in this category. Concomitant to this annual decline in percentage among MSM cases, there has been a substantial increase in the proportion of cases among injection drug users (IDU). As referenced in the second quarter 1997 lead story, all transmissions associated with injection drug use are referred to by the collective term "IDU-Related Transmission" and have also been increasing substantially

in recent years. IDU-related transmission accounted for 43% of all cases diagnosed in 1996. This percentage is derived by adding together the modes of IDU (35%), MSM/IDU (4%), and nearly half of the heterosexual transmissions (4%) from partners with known risks (see *AIDS Chicago*, Third Quarter, 1995). Heterosexual contact remains the third largest transmission group and has more than doubled as a percentage of total cases since 1988.

Figures 3 and 4, also based upon CDC adjusting software, depict the number of cases by selected transmission modes for males and females. It can be seen from Figure 3 that the majority of cases occurring among males falls in the two main transmission groups, MSM and IDU, with the former





declining over the past three years and the latter remaining relatively constant. The number of cases among males attributed to heterosexual contact and for all the remaining transmission modes, aggregated as "Other," remains relatively small. Figure 4 presents transmission group information for females. These patterns are somewhat unstable since the numbers are comparatively small for the CDC adjusting procedures. Nonetheless, we can see that the predominant transmission modes for females over time have been injection drug use and heterosexual contact, with both rising over time, and particularly sharply in recent years.

Table 2. Case Percentages by Selected Characteristic
Chicago, 1988-1996

Characteristic	Diagnostic Year 1988	1989	1990	1991	1992	1993	1994	1995	1996
Gender					**Percent**				
Male	93	91	91	87	86	85	84	82	81
Female	7	9	9	13	14	15	16	18	19
Race/Ethnicity					**Percent**				
Black, Non-Hispanic	36	41	46	49	53	55	55	61	64
White, Non-Hispanic	48	44	40	37	32	30	30	24	21
Other, Non-Hispanic	1	<1	1	<1	1	1	1	1	1
Hispanic	14	15	14	13	15	14	15	13	14
Mexican*	4	6	5	5	5	5	6	6	6
Puerto Rican*	9	7	6	6	7	6	6	6	7
Transmission Group					**Percent**				
Male sex w/ Male	71	67	64	59	53	51	51	45	44
Injection Drug Use	16	19	21	25	32	33	33	34	35
MSM and IDU**	4	5	5	6	5	5	4	4	4
Hemophiliac	1	1	1	<1	<1	1	<1	1	0
Heterosexual	4	3	4	6	6	6	7	9	9
Transfusion	1	2	1	1	<1	<1	<1	<1	<1
Perinatal Transmission	1	2	2	1	1	1	1	1	1
Other/Undetermined	2	2	2	2	2	3	4	5	8
Age Group					**Percent**				
Less than 13	1	3	2	1	1	1	1	1	1
13 - 19	1	<1	<1	<1	<1	<1	1	<1	<1
20 - 29	21	20	16	16	17	14	14	13	14
30 - 39	45	46	47	44	45	46	45	42	41
40 - 49	20	21	25	27	26	29	29	31	32
50+	11	11	10	11	12	10	10	12	13
Total Number of Cases	766	905	1,133	1,400	1,713	1,912	1,782	1,477	1,096

Note: Groups may not total to 100% due to rounding.
*Estimated subgroup proportions are included in "Hispanic"
**Men who have sex with men and inject drugs

Fig. 3 Adjusted AIDS Incidence

Male Cases by Mode, Chicago as of 09/26/97

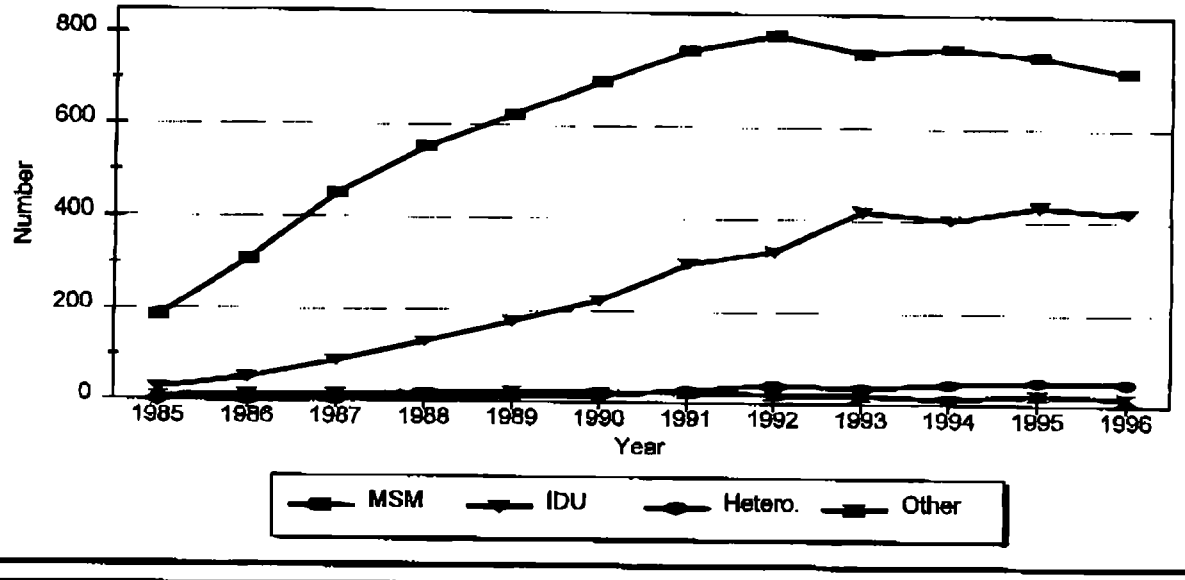


Fig. 4 Adjusted AIDS Incidence

Female Cases by Mode, Chicago as of 09/26/97

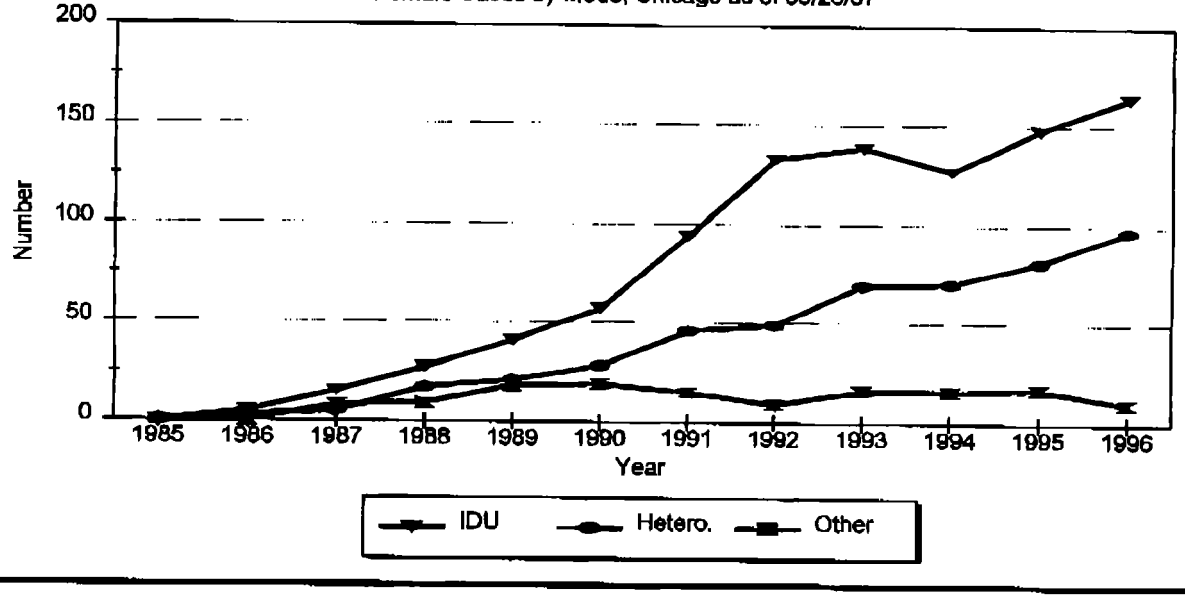


Table 3 presents the characteristics of recently diagnosed cases, aggregated for cases after 1993, for each transmission group by gender and race/ethnicity for adult (≥ 13 years of age) cases. For example, for recent adult cases diagnosed in Chicago, almost half of the Black and Hispanic male cases have been among men who have sex with men compared to 81% for White men. We can also note that 38% of the cases among Black males have occurred among injection drug users compared to 10% of the White male cases and 32% of the Hispanic male cases. The Hispanic subgroup data details the large proportion of IDU cases among Puerto Rican adult males. Overall, the image of the recent epidemic among women is very different, with a majority of the cases attributed to injection drug use (54%), followed by

heterosexual contact (32%). In contrast, note that for Mexican and Puerto Rican females these categories are reversed with the larger proportion of cases attributed to heterosexual contact. Furthermore, when comparing Mexican females to Puerto Rican females, we see that the overwhelming majority of cases for the former is attributable to heterosexual contact while the cases in the latter group are somewhat equally distributed between IDU and heterosexual contact.

Pediatric AIDS Cases

Table 4 presents selected characteristics of pediatric (< 13 years of age) AIDS cases. It can be seen that cumulatively 94% of the 165 pediatric AIDS cases are due to perinatal transmission, that is transmission between an infected mother and her offspring. Additionally, it can be calculated that 69% of the pediatric cases are Black, 9% are White, and 21% are Hispanic.

Table 3. Recently Diagnosed Adult Case Characteristics
Chicago, Cases Diagnosed in 1994-1997 as of 9/26/97

	Race/Ethnicity					Hispanic Sub-Group*		
Characteristic	**Black**	**White**	**Hisp.**	**Other**	**Total**	**Mex**	**P. Ric.**	**Oth. H**
Male Groups			**Percent**					
Male sex w/ Male	47	81	48	69	57	63	30	56
Injection Drug Use	38	10	32	11	29	12	53	16
MSM and IDU**	5	4	3	3	4	2	5	0
Hemophiliac	<1	<1	<1	0	<1	1	0	0
Heterosexual	4	1	6	3	3	6	4	11
Transfusion	<1	<1	<1	0	<1	0	0	4
Other/Undetermined	5	3	11	14	6	17	7	13
Total Number of Male Cases	2,231	1,085	563	35	3,914	195	178	55
Female Groups			**Percent**					
Injection Drug Use	56	67	34	50	54	13	44	20
Heterosexual	30	25	51	30	32	70	50	60
Transfusion	2	0	2	0	1	3	0	0
Other/Undetermined	13	8	13	20	12	13	6	20
Total Number of Female Cases	582	110	109	10	811	30	48	5

Note: Groups may not total to 100% due to rounding.
*Proportions based only on known subgroup cases.
**Men who have sex with men and inject drugs

AIDS Deaths

Table 5 shows that there have been 9,214 known deaths among AIDS cases thus far in Chicago. It is important to recognize that these deaths may include individuals with AIDS who died of other causes. The proportion of people with AIDS that is known to have died, often called the "case fatality rate" (CFR), is also presented. For the earlier years, when the numbers are small and the CFR is less than 100%, this may be because some of the people are still alive or because some have been lost from our reporting system. (This may happen, for example, if a person with AIDS moves to another state and that state does not realize that the person was diagnosed in Chicago.) The cumulative CFR is 66%.

Table 4. Pediatric Case Characteristics
Chicago, Cumulative through 9/26/97

Characteristic	Race/Ethnicity Black	White	Hisp.	Other	All
Gender			**Percent**		
Male	40	60	60	100	47
Female	60	40	40	0	53
Transmisison Group			**Percent**		
Perinatal Transmission	96	93	86	100	94
Hemophiliac	2	0	9	0	3
Transfusion	2	7	6	0	3
Other/Undetermined	0	0	0	0	0
Total Cases	114	15	35	1	165

Note: Groups may not total to 100% due to rounding.

Table 5. AIDS Cases and Death
Chicago, Cumulative through 9/26/97

Diagnosis Year	Cases	Living	Dead	CFR*
1980	1	0	1	100%
1981	4	0	4	100%
1982	16	1	15	94%
1983	41	3	38	93%
1984	111	8	103	93%
1985	222	16	206	93%
1986	373	34	339	91%
1987	606	53	553	91%
1988	766	75	691	90%
1989	905	114	791	87%
1990	1,133	167	966	85%
1991	1,400	235	1,165	83%
1992	1,713	409	1,304	76%
1993	1,912	650	1,262	66%
1994	1,782	885	897	50%
1995	1,477	928	549	37%
1996	1,096	820	276	25%
1997	418	364	54	13%
Total	13,976	4,762	9,214	66%

*Case Fatality Rate

AIDS Cases in Community Areas

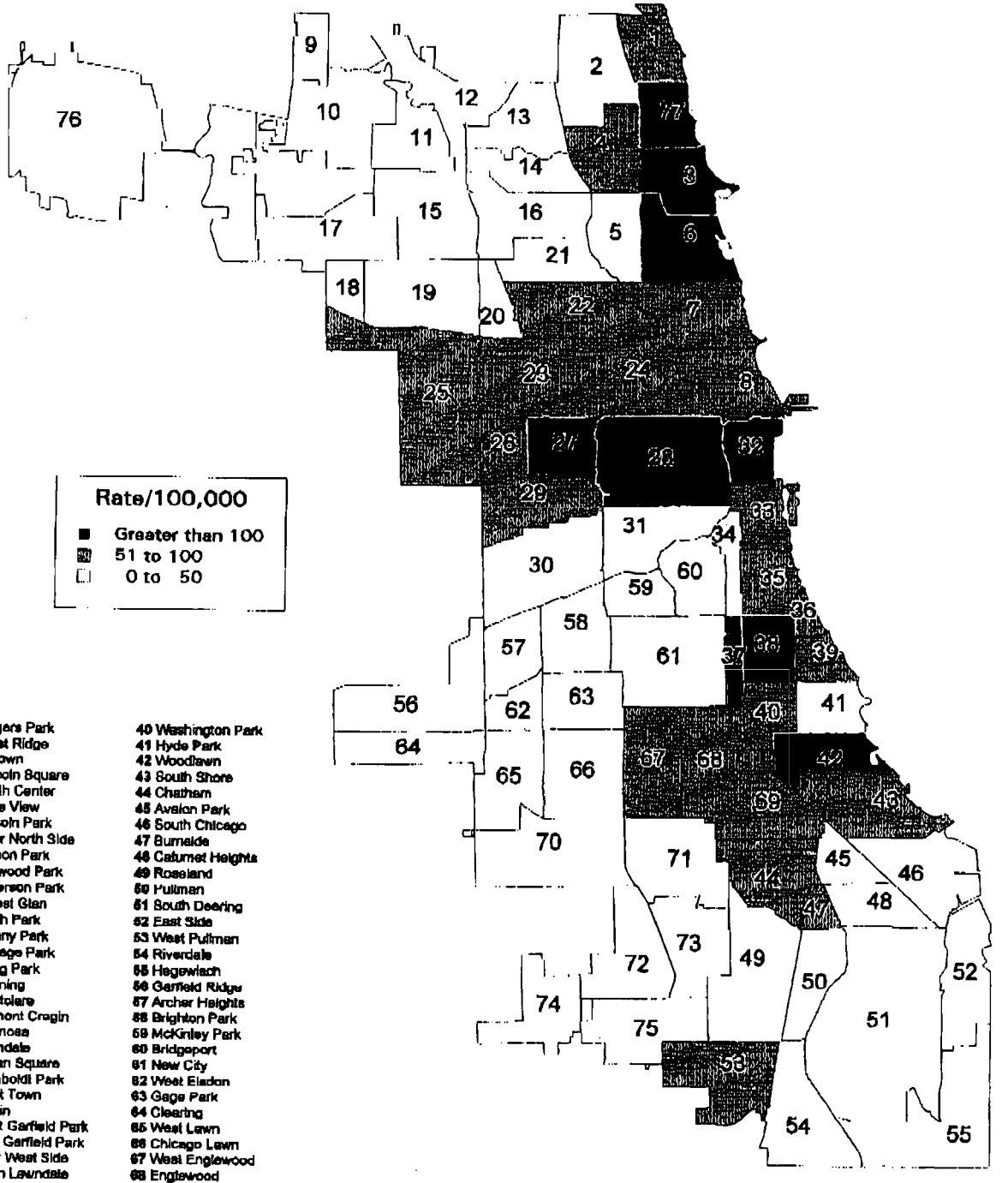
Table 6 exhibits by community area the total number of cumulative AIDS cases reported, the number of cases thought to be living, and the number and two-year average annual case rate for cases diagnosed in 1994 - 1995. This table reflects the fact that the AIDS epidemic has affected, and will likely continue to affect, every community in the city (but of course it will not affect every community equally). The table depicts not only the cumulative morbidity experienced by the various community areas, but also shows which communities are currently experiencing the highest average annual incidence. For example, three of the community areas associated with the epidemic early on, Uptown, Edgewater, and Lake View, continue to experience some of the highest average annual incidence rates. However, as Table 6 and Figure 5 indicate, many other community areas, including several on the South and West sides, have elevated rates. It is important to remember that cases will continue to be added as they are reported. Thus, the current value of the community area rates are minimum estimates.

Table 6. AIDS Cases by Community Area
Cumulative, Living, and Cases Diagnosed 1994-95 (Number and Average Annual Rate/ 100,000)*
Chicago, as of 9/26/97

	Community Area	Cum.	Alive	# 94-95	Rate*		Community Area	Cum.	Alive	# 94-95	Rate*
1	Rogers Park	486	179	110	91.1	40	Washington Park	157	53	37	95.2
2	West Ridge	116	38	19	14.5	41	Hyde Park	115	35	21	36.7
3	Uptown	1,319	435	290	227.1	42	Woodlawn	196	69	55	100.1
4	Lincoln Square	178	63	52	57.9	43	South Shore	384	134	88	71.5
5	North Center	147	35	20	30.3	44	Chatham	165	53	38	51.7
6	Lake View	1,569	425	268	147.2	45	Avalon Park	43	10	10	42.7
7	Lincoln Park	381	93	71	58.1	46	South Chicago	114	40	26	31.9
8	Near North Side	495	142	77	61.3	47	Burnside	15	4	4	60.4
9	Edison Park	6	3	1	4.4	48	Calumet Heights	52	14	10	28.6
10	Norwood Park	24	6	4	5.3	49	Roseland	205	70	54	47.8
11	Jefferson Park	16	7	1	2.1	50	Pullman	37	10	9	48.2
12	Forest Glen	18	1	1	2.8	51	South Deering	47	8	9	25.3
13	North Park	27	10	8	24.6	52	East Side	9	3	2	4.9
14	Albany Park	123	49	28	28.3	53	West Pullman	143	56	43	54.0
15	Portage Park	79	29	23	20.3	54	Riverdale	26	9	3	13.9
16	Irving Park	142	41	40	39.9	55	Hegewisch	10	1	3	14.8
17	Dunning	39	13	10	13.5	56	Garfield Ridge	30	6	5	7.4
	Montclare	11	5	3	14.2	57	Archer Heights	3	0	0	0.0
	Belmont Cragin	90	25	20	17.6	58	Brighton Park	37	17	8	12.4
20	Hermosa	69	28	17	36.7	59	McKinley Park	16	4	5	18.8
21	Avondale	111	40	29	40.8	60	Bridgeport	48	19	12	20.1
22	Logan Square	436	168	100	60.5	61	New City	185	64	44	41.3
23	Humboldt Park	358	131	87	64.4	62	West Elsdon	10	2	1	4.1
24	West Town	587	205	132	75.3	63	Gage Park	43	27	16	29.7
25	Austin	564	215	151	66.2	64	Clearing	27	10	4	9.3
26	West Garfield Park	141	56	44	91.3	65	West Lawn	19	5	5	10.7
27	East Garfield Park	253	105	68	141.5	66	Chicago Lawn	94	40	32	31.2
28	Near West Side	376	161	118	127.7	67	West Englewood	252	92	71	67.3
29	North Lawndale	264	79	82	86.7	68	Englewood	255	89	65	67.1
30	South Lawndale	162	79	46	28.3	69	Gr. Grand Crossing	187	55	53	68.6
31	Lower West Side	80	36	23	25.2	70	Ashburn	39	13	8	10.8
32	Loop	119	40	31	129.7	71	Auburn Gresham	215	80	52	43.5
33	Near South Side	46	19	12	87.9	72	Beverly	34	11	11	24.6
34	Armour Square	14	2	1	4.6	73	Washington Heights	105	36	29	45.2
35	Douglas	152	49	36	58.7	74	Mount Greenwood	8	2	1	2.6
36	Oakland	43	20	14	85.4	75	Morgan Park	74	17	22	41.1
37	Fuller Park	31	10	10	114.6	76	O'Hare	11	3	1	4.5
38	Grand Boulevard	260	89	86	119.8	77	Edgewater	820	293	182	149.9
39	Kenwood	114	38	27	74.3	99	Unknown	300	135	60	—
							Total	13,976	4,758	3,259	58.5

* age annual rate for the two year period 1994-95

Fig. 5. Average Annual AIDS Incidence by Community Area
1994-95 Diagnoses, Chicago 9/26/97



01 Rogers Park
02 West Ridge
03 Uptown
04 Lincoln Square
05 North Center
06 Lake View
07 Lincoln Park
08 Near North Side
09 Edison Park
10 Norwood Park
11 Jefferson Park
12 Forest Glen
13 North Park
14 Albany Park
15 Portage Park
16 Irving Park
17 Dunning
18 Montclare
19 Belmont Cragin
20 Hermosa
21 Avondale
22 Logan Square
23 Humboldt Park
24 West Town
25 Austin
26 West Garfield Park
27 East Garfield Park
28 Near West Side
29 North Lawndale
30 South Lawndale
31 Lower West Side
32 Loop
33 Near South Side
34 Armour Square
35 Douglas
36 Oakland
37 Fuller Park
38 Grand Boulevard
39 Kenwood
40 Washington Park
41 Hyde Park
42 Woodlawn
43 South Shore
44 Chatham
45 Avalon Park
46 South Chicago
47 Burnside
48 Calumet Heights
49 Roseland
50 Pullman
51 South Deering
52 East Side
53 West Pullman
54 Riverdale
55 Hegewisch
56 Garfield Ridge
57 Archer Heights
58 Brighton Park
59 McKinley Park
60 Bridgeport
61 New City
62 West Elsdon
63 Gage Park
64 Clearing
65 West Lawn
66 Chicago Lawn
67 West Englewood
68 Englewood
69 Gr. Grand Crossing
70 Ashburn
71 Auburn Gresham
72 Beverly
73 Washington Hts.
74 Mount Greenwood
75 Morgan Park
76 O'Hare
77 Edgewater

Chicago Department of Public Health
HIV Primary Care Community Health Centers

These centers are designed for indigent clients who are HIV-positive and do not have alternative options for care. These centers are Chicago Department of Public Health Early Intervention Sites (EIS), or are supported by the Chicago Department of Public Health.

Uptown
Kirby Cunningham, M.D.
John Watson, Social Work Assistant
845 W. Wilson
(312) 744-1935
Tuesday (10:00am-6:00pm)
Wednesday (8:00am-4:00pm)
Friday (9:00am-12:00pm)

Southside
Mark Zajackowski, M.D.
Jessica Martin, R.N., Case Manager
1306 S. Michigan
(312) 747-0180
Hours by appointment:
Monday (9:00am-12:00pm)

Lake View
Kirby Cunningham, M.D.
Linda Pitts, R.N., Case Manager
John Watson, Social Work Assistant
2861 N. Clark
(312) 744-2572
Monday, Thursday (8:30am-4:30pm)
Friday (1:00pm-4:00pm)

West Town
Romina Kee, M.D.
Jessica Martin, R.N., Case Manager
2418 W. Division
(312) 744-5470
Friday (8:00am-4:00pm)

Roseland Christian Health Center
William Crevier, M.D.
10248 S. Vernon
(773) 291-6050
Monday (9:00am-4:30pm)
Tuesday (9:00am-7:30pm)
Wednesday (9:00am-4:30pm)
Thursday (9:00am-7:30pm)
Friday (8:00am-Noon)

Englewood
Romina Kee, M.D. (Wednesdays)
Mark Zajackowski, M.D. (Fridays)
Denise Andrews, R.N., Case Manager
641 W. 63rd St.
(312) 747-8900 or (312) 747-5278
Wednesday, Friday (8:00am-4:00pm)

Mile Square (EIS)
Ken Pursell, M.D.
Pyrai Vaughn, Case Manager
2045 W. Washington
(312) 413-8046 or on Thursday (312) 996-5330
Thursday (8:30am-4:00pm)

Chicago Department of Public Health
Counseling, Testing, Referral, and Partner Notification Program

This program provides anonymous and confidential counseling and testing at the following sites:

Site	Days of Operation	Hours of Operation
Lake View 2861 N. Clark (312) 744-8829	Monday, Thurs., Friday Tuesday, Wednesday	8:30 am - 4:30 pm 10:00 am - 6:00 pm
Southside ** 1306 S. Michigan (312) 747-5400	Monday, Thurs., Friday Tuesday, Wednesday Saturday	8:30 am - 4:30 pm 10:00 am - 6:00 pm 8:00 am - 4:00 pm
West Town 2418 W. Division (312) 744-5464	Monday, Wed., Friday Tuesday, Thursday	8:00 am - 4:30 pm 10:00 am - 6:00 pm
Englewood 641 W. 63rd Street (312) 747-8900	Monday, Wed., Friday Tuesday, Thursday	8:30 am - 4:30 pm 10:00 am - 6:00 pm
Uptown 845 W. Wilson (312) 744-7533	Monday, Wed., Friday Tuesday, Thursday	8:00 am - 4:30 pm 10:00 am - 6:00 pm
Roseland 200 E. 115th Street (312) 747-2817	Monday, Wed., Friday Tuesday, Thursday	8:30 am - 4:30 pm 10:00 am - 6:00 pm

** Anonymous and Confidential Counseling and Testing provided on Saturdays at this site.

General AIDS Information - (312) 747-AIDS
TT/TDD (312) 744-4284

For suburban Cook County HIV Counseling and Testing please contact the **Cook County Department of Public Health - (708) 445-2437**

Statewide AIDS Information 1-800-243-AIDS

AIDS Chicago SUBSCRIPTION FORM

If you are not currently receiving ***AIDS Chicago*** and would like to receive future issues, please complete this form and return to the address below.

If you would like to purchase a copy of the new OAS publication ***A Compilation of Cover Stories from AIDS Chicago***, please complete this form and return to the address below with a check for $10.00 payable to: "Chicago Department of Public Health".

❑ Send me a copy of the new publication. A check for $10.00 is enclosed.

❑ Place me on the mailing list for ***AIDS Chicago***.

Name _____

Address _____

City/State _____ Zipcode _____

HIV/AIDS Surveillance Program
Chicago Department of Public Health
333 S. State Street, Room 2151
Chicago, Illinois 60604-3972

#46

facsimile
TRANSMITTAL

[redacted]

to: Matthew Murguia
fax #: 202.632.1096
re: AIDS Chicago 3Q 1997
date: November 3, 1997
pages: 15, including this cover sheet.

From the desk of...

James Murphy, MPH
Epidemiologist III
Chicago Department of Public Health
333 South State Street
Chicago, Illinois 60604

312.747.9611
Fax: 312.747.9663

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3

Divider Title: _____

PROJECT VIDA
2659 South Kedvale • Chicago, IL 60623
phone 773/522-4570 • fax 773/522-4573

Nov. 5, 1997

Dear Mr. Murgia:

The name of our executive director is Luule Vess. For 1997-98 we were funded by Ryan White for the following:

53,000 for Mental Health Counseling
80,000 for alternative Therapies

In January we applied to receive funds from the CDC, and although we scored very highly, we did not receive the grant. It was decided that the money would be better spent by agencies that serve primarily African-American clients.

Sincerely,

Melissa Sweeney

Melissa Sweeney
Prevention Specialist

What Is Project VIDA?

Project VIDA is a community-based HIV/AIDS service organization situated in Chicago's Little Village neighborhood. Project VIDA was founded in March 1992, in response to soaring rates of HIV infection among Latinos. The primary focus remains prevention to Latino youth in the Chicago and near-suburban areas, however Project VIDA has been branching out to respond to the many other HIV-related needs of the Latino community.

What Makes Project VIDA Such An Effective Agency?

Recognizing the importance of both peer education and community empowerment, Project VIDA utilizes the skills of young neighborhood leaders. Besides speaking to youth on the streets and in schools about HIV prevention and risk reduction issues, Project VIDA's peer educators fulfill additional duties that are often reserved for older professionals. Under the close supervision of the agency's director, they work on tasks such as compiling survey data, writing public service announcements, and operating the agency's direct service programs. Their continual success demonstrates that when teenagers and young adults are trusted with major responsibilities, they have both the ability and the desire to rise to the occasion.

In response to what we have heard the community asking for, Project VIDA has evolved programs which minister to the other prevention health care needs of the Latino population. Because of the high rate of teenage pregnancy, for example, we have created a program to educate and inform young mothers. Project VIDA always strives to be responsive to the needs of the community it serves.

What Services Does Project VIDA Offer?

- HIV testing and counseling.
- Complementary therapies (massage therapy, acupuncture, herbology, homeopathy, and energy work).
- Individual and group mental health counseling for HIV-infected and impacted individuals.
- A media campaign which uses Spanish radio, television, and newsprint to promote a variety of messages to the otherwise disenfranchised Latino population.
- Substance abuse counseling.
- Support groups and outreach to gay, lesbian, and bisexual youth in the Latino community.
- Living room groups which provide recent immigrants Spanish language information on HIV/AIDS.
- Community presentations on HIV, safer sex, and teen pregnancy in schools, churches, and other public places.
- A food pantry for disabled people with AIDS.
- A Girl's Program which seeks to empower and educate the young women of Little Village

What Other Organizations Are

HOWARD BROWN HEALTH CENTER

An innovative health and human service organization, Howard Brown Health Center is the Midwest's largest lesbian, gay and bisexual health center. Founded in 1974 as a drop-in clinic for the testing and treatment of sexually transmitted diseases in gay men, the Center has greatly expanded its services over the course of two decades. Today, Howard Brown provides comprehensive services, including primary care medical services, anonymous HIV testing, case management, individual and group counseling, prevention, education and research. The Center is recognized as the leading private provider of HIV/AIDS services in the Midwest and offers one of the nation's most comprehensive lesbian-specific health programs.

In October, Howard Brown Health Center and the lesbian and gay community celebrated an historic moment; the Center opened its new 20,000-square-foot health center at 4025 North Sheridan, the first facility built by a gay and lesbian community-service organization in Illinois.

Howard Brown Health Center
Federally Funded Projects

Chicago Prevention Research Study

This project is actually a group of studies relating to HIVNET, the network of organizations running Phase II and III trials of HIV vaccines and other prevention initiatives. It currently has two components, a Phase II vaccine trial, and a trial of an individualized behavioral intervention. These may be expanded in the next year to include a study of post-exposure prophylaxis. The Center works cooperatively on this project with the University of Illinois at Chicago which operates a women's cohort.

NIH/Abt Associates	1,493,358	9/96-12/97	Vaccine Research
NIH/Abt Associates	1,693,429	2/97-9/98	Vaccine Research
NIH/Abt Associates	188,947	7/97-12/97	Behavioral Intervention

Multi-center AIDS Cohort Study

This is the longest-running study of HIV natural history in the world and continues strong at Howard Brown. Several hundred participants are followed to monitor the progression of HIV disease.

NIH	958,983	4/97-3/98	HIV Natural History (MACS)

Awareness Intervention for Men

This study is developing a group intervention for men who have risks for HIV infection associated with drug and alcohol use.

NIDA	844,702	5/97-4/98	HIV Behavioral Intervention

Social Services

This program provides social services for people with HIV the case managers who help link clients to critical services.

AFC (Title II)	121,950	4/97-3/98	Case Management

Primary Care

This program, funded through several titles of the Ryan White CARE Act, offers comprehensive primary care services for uninsured people with HIV, including physician and nursing services and nutrition and mental health counseling. It also helps to cover pharmaceuticals that are not covered by the state's drug assistance program.

Hektoen Institute (Title II)	15,000	4/96-3/97	Primary Care
HRSA (Title III)	492,723	10/96-12/97	Primary Care
CDPH (Title I)	90,131	4/97-2/98	Primary Care
CDPH (Title I)	101,000	3/97-2/98	Pharmaceuticals

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State Health Watch

Vol. 4 No. 10 — *The Newsletter on State Health Care Reform* — October 1997

Illinois may scrap 1115 Medicaid waiver

State could develop its own managed care plan under budget act

Illinois may become one of the first states in the nation to withdraw plans to roll out a mandatory Medicaid managed care program approved under a Section 1115 waiver. A top state official said late last month that Illinois may take advantage of the recently enacted federal Balanced Budget Act giving states the flexibility to develop their own mandatory Medicaid managed care programs.

While states are required to meet national quality and consumer protection standards and to file state plan amendments with the Health Care Financing Administration (HCFA) under the Budget Act, they will be subject to substantially reduced federal oversight of program design and implementation.

It's a strategy other states may follow, in the interest of maximizing flexibility and minimizing federal intervention in their Medicaid managed care programs, said Diane Rowland, executive director of the Washington, D.C.-based Kaiser Commission on Medicaid.

Seven states, including Illinois and New York, which run two of the largest Medicaid programs in the nation, have have not yet implemented their approved 1115 waivers. Another six states have pending 1115 waiver applications. To the extent these states have no plans to alter Medicaid eligibility and expand coverage—a feature of the first wave of 1115 waiver requests—they will probably find it easier to roll out mandatory Medicaid managed care programs under the Balanced Budget Act, Ms. Rowland said.

It's little surprise that Illinois would jump at the opportunity to move ahead with a mandatory Medicaid managed care program under less federal oversight. State officials have spent the last three years in frustrating negotiations with HCFA over Illinois' MediPlan Plus program, and Illinois Governor Jim Edgar has, for several years, argued that states should have more freedom to run their Medicaid programs.

HCFA held up approval for the program until 1996 and, even then, gave a tentative go-ahead with significant conditions attached. One of the most notable conditions was required approval of all pro-

Continued on page 4

In This Issue

Wash. insurance commissioner gets tough with financially troubled doctor-run HMO

Washington State's insurance commissioner will oversee the managed care plan created by the Washington State Medical Association (WSMA) until the plan is "financially rehabilitated" and has built up its reserves to meet the state's $1 million requirement. The cooperative agreement between Insurance Commissioner Deborah Senn and Unified Physicians of Washington (UPW) replaces an earlier court action, which allowed the commissioner to seize control of the plan and to take steps to place it in receivership.

The challenges facing Unified Physicians of Washington highlight the capitalization and administration hurdles faced by other plans in California, Florida, New Jersey and elsewhere that have been launched by physicians seeking more control over how they practice medicine.

In the case of UPW, state insurance commissioner Deborah Senn moved aggressively when she became concerned about the health plan's solvency. "We wanted to be sure consumers were protected," said Jim Stevenson, spokesman for the commissioner's office.

The commissioner issued a warning to UPW this summer to build up its reserves after they were determined to be inadequate. When, after three months, the plan's financial condition worsened, Ms. Senn's office intervened.

UPW is now working to reorganize its management (its chief executive officer and chief financial officer have left), cut administrative expenses, and restructure its financial operations under the direct oversight of the Office of the Insurance Com-

Continued on page 6

Illinois may scrap 1115 waiver to gain more flexibility

Continued from page 1

gram materials, which Illinois has not yet received.

A spokesman for the U.S. Health Care Financing Administration (HCFA) said the federal agency had suggested that the state try to go ahead with a mandatory Medicaid managed care program under the Balanced Budget Act.

In Illinois, news of state officials' plans provoked an immediate outcry from state Democrats, who have criticized the Department of Public Aid for failing to implement MediPlan Plus. Any new program would need new authorizing legislation. A spokesman for Illinois House Speaker Michael Madigan promptly accused the Department of Public Aid of "bungling" and promised that no new program would be approved without proper oversight.

Public Aid director resigns

Already extremely wary of the Department of Public Aid's track record in administering the $5 billion Illinois Medicaid program for about 1.3 million members, lawmakers were hardly reassured when Director Robert Wright unexpectedly resigned only a day after making his announcement about potential major changes to the Medicaid program.

His departure was being attributed to a high-profile bribery case involving mid-level Public Aid managers and a Medicaid claims contractor. Linda Renee Baker, his top deputy, has been named acting director. Despite the executive change, a department spokesman said plans to move ahead with the reformed Medicaid managed care program are on track.

If the program is to be rolled out in January, as state officials would like, legislation will have to be introduced during the veto session at the end of October.

Almost no one wants to re-enact the political battles that accompanied the creation of MediPlan Plus in 1994. That process resulted in many uncomfortable compromises, including numerous carve-outs and special exemptions.

Among MediPlan Plus' more controversial features:

• Carve-outs were granted to community mental health agencies, alcohol and substance abuse providers, school based health clinics, Cook County Hospital, children's hospitals, and providers of care to chronically ill children. Providers could continue to bill Medicaid on a fee-for-service basis for exempted services and beneficiaries could exercise free choice in selecting providers.

• Physicians and community health centers won an any-willing-provider clause allowing them to be included in any managed care plan's network, so long as they were willing to accept the contract terms. Community health centers also won the right to be selected as a primary care provider for a Medicaid recipient.

• Provider-sponsored health plans, known as managed care community networks, were not required to set aside any capital reserves against future losses. This infuriated state-licensed HMOs, which are required to have capital reserves of $1.5 million.

Echoing a fairly widespread sentiment, Bob Berger, the executive director of the Illinois Association of HMOs, calls MediPlan Plus "the antithesis of managed care, as it should be practiced."

Some local health experts see a chance for Illinois to design a better, more rational program. "MediPlan Plus was totally unmanageable," said Michael Gelder, a health care consultant in Evanston, IL. who represented community health centers in negotiations over MediPlan Plus. "The question is, have the politics in Illinois changed sufficiently so that they can change the program design? Perhaps yes: Illinois now has a surplus, welfare rolls are shrinking, and Medicaid expenditures aren't under the same kind of attack."

But, perhaps no. "There's a political reality in what the state and the Department of Public Aid can do with Medicaid, and it's reflected in the legislation that established MediPlan Plus," said Jeff Miller, former head of the Department of Public Aid and now executive associate dean for management at Northwestern University Medical School.

Rate reductions

"A lot more is known about how to do Medicaid managed care well now than three years ago," said Hank Webber, senior lecturer at the University of Chicago. "The question is whether Illinois can use the experience of other states in a positive way: it certainly would behoove them to do so."

Illinois also has some experience of its own to rely upon. The state's growing voluntary Medicaid managed care program now serves nearly 190,000 poor women and children in Cook County. Negotiations have been underway since the beginning of the summer for a new round of two-year contracts, due to start in December. In June, the state asked for a 19% reduction in rates, to $91 per member per month from almost $113 previously. After howls of protest from HMOs, the state raised the monthly rate it's willing to pay to $103.47 per member.

It's a strategy other states may follow in the interest of maximizing flexibility and minimizing federal intervention in their Medicaid managed care programs.

—Rowland

According to former Public Aid director Wright, eight of the nine HMOs currently in the voluntary Medicaid managed care program have indicated a willingness to accept those terms.

One Medicaid HMO, American Health Care Providers, Inc., the second largest in the state, has not yet been approved to participate in the program, after an initial finding that its network was inadequate. Another new HMO has not yet received a state license but is expected to join the program.

Plans participating in the voluntary program have been anticipating a potential major boost in enrollment once the state implements a mandatory Medicaid managed care programs.

—Judy Graham

COMPREHENSIVE STATE HEALTH REFORM DEMONSTRATIONS

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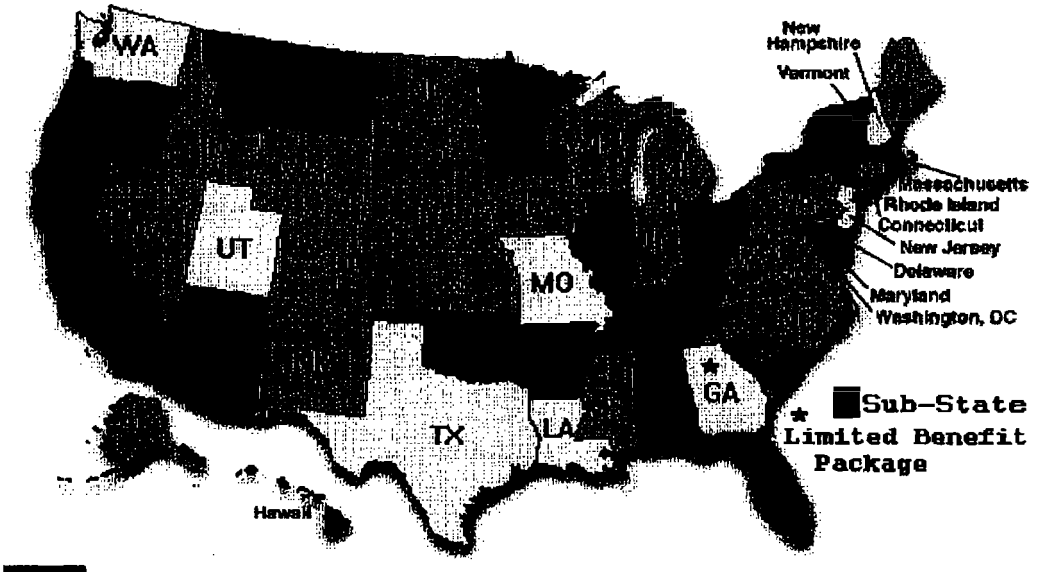

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ILLINOIS STATEWIDE HEALTH REFORM DEMONSTRATION

FACT SHEET

Name of Section 1115 Demonstration: Illinois MediPlan Plus Demonstration

Date Proposal Submitted: September 14, 1994

Date Proposal Approved: July 12, 1996

Proposed Implementation: August 1997

SUMMARY

The Health Care Financing Administration has approved Illinois' Section 1115 Medicaid demonstration proposal entitled, "Illinois MediPlan Plus Demonstration" for a 5-year period. The goal of the demonstration is to increase access and quality of health care for the State's 1.1 million Medicaid beneficiaries and limit rising costs through the increased use of managed care. Illinois intends to contract with a mix of health maintenance organizations (HMOs), managed care community networks (MCCNs), and enrolled managed care providers (EMCPs) that incorporate Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and physicians who agree to provide primary care case management services. In addition, as a transition to managed care, for a limited period, community providers who are interested in forming a MCCN will be permitted to participate as a Prepaid Health Plan (PHP) in order to gain incremental experience in operating a managed care delivery system.

MediPlan Plus will be implemented statewide. In areas where MCCN access exists to serve beneficiaries, the State will be given a waiver of freedom-of-choice and exemptions from the HMO lock-in provisions and the 75/25 enrollment composition provision. In areas where there is not sufficient MCCN access, only the waivers permissible through the 1915(b) program (freedom-of-choice) will be granted.

ELIGIBILITY

There will be no eligibility expansion under the demonstration.

All current Medicaid eligibles will be covered under MediPlan Plus with the exception of the following populations who will continue to receive benefits under the traditional Medicaid program or appropriate waiver:

- persons residing in long term care facilities;
- eligibles with Medicare coverage;
- eligibles with significant third-party liability;
- certain persons eligible for medical assistance in previous months and determined ineligible for ongoing assistance;
- residents of State-operated facilities;

- recipients eligible through meeting a spenddown obligation;
- those who are eligible only through the Healthy Start program (Medicaid presumptive eligibility);
- those residing outside of the State; and
- recipients of services provided under the State's Program for All-Inclusive Care for the Elderly (PACE).

BENEFIT PACKAGE

All services available under the current Medicaid program will be offered to beneficiaries under the demonstration, but the following services will be available on a fee-for-service basis rather than a capitated basis: behavioral health services; alcohol and substance abuse services; rehabilitation services; dental, podiatric, optical, and optometric services; lead screening and laboratory services; skilled nursing services (more than 100 days); long term care services; and services provided under other waiver programs.

ENROLLMENT/ DISENROLLMENT PROCESS

Under MediPlan Plus, individuals will be given the opportunity to choose a managed care entity (HMO, MCCN, or PHP) or EMCP. Beneficiaries who do not make a choice will be assigned to an HMO or MCCN. In the case where only 1915(b) waivers have been granted, and the lock-in is six months, beneficiaries assigned to an entity will have 30 days from their effective date to change entities for any reason. In those regions where section 1115 waiver authority has been granted because MCCN access exists, and the lock-in is for a year, a beneficiary will have 60 days from the effective date to change such assignment for any reason. However, if it is determined that the percentage of individuals who change their site selection in these areas is 25 percent or greater, the period of time allotted for new enrollees to request a change without cause will increase from 60 to 90 days.

DELIVERY SYSTEM

MediPlan Plus participants will choose from a mix of HMOs, MCCNs, and EMCPs. In addition, for a limited time under the demonstration, participants may choose a PHP.

A MCCN is an entity that is owned, operated, or governed by providers of health care services within the State. The MCCN must provide or arrange for primary, secondary, and tertiary managed health care services. The MCCN will provide services exclusively to enrollees of the Illinois MediPlan Plus program.

To afford local community providers the opportunity to gain incremental experience in operating a managed care delivery system, PHPs will be included in the delivery network for a limited period. As a requirement of the special terms and conditions, PHPs will have one year of the demonstration to form a MCCN, with the exception of the Cook County Bureau of Health Services which will have two years. At the conclusion of the first year of the demonstration, PHPs will no longer be permitted to participate in the delivery network.

An EMCP is either an FQHC, RHC, or a physician who serves as a gatekeeper. A "gatekeeper" is defined as a provider who has agreed to provide, or arrange with other qualified physicians to provide, appropriate services to assigned beneficiaries on a fee-for-service basis.

QUALITY ASSURANCE

MediPlan Plus will be monitored through internal and external review to assure that cost- effective, quality care is delivered. These reviews include monitoring access, utilization practices, outcome measures, and client satisfaction, as well as establishing service standards in contracts with managed care entities.

COST-SHARING

There will be no copayments, deductibles, or cost-sharing arrangements for MediPlan Plus participants.

For more information contact Gina Clemons at (410) 786-9644

Fact Sheet Revised 12/02/96

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Editorials

Shalala punts on a crucial call

The Feb. 18 memo by Health and Human Services Secretary Donna E. Shalala, forwarding to Congress a report on the latest research on the effectiveness of needle-exchange programs in reducing HIV infections among drug users, is a triumph of pusillanimous politics and double talk over facts and sound public policy.

All the research cited in the report corroborates what already has been known for years: Needle-exchange programs reduce HIV infections and save money. They even encourage a significant percentage of addicts to seek treatment.

Yet Shalala couldn't bring herself to ask Congress to lift its 1992 ban on HHS funding of needle-exchange programs. The ban stands until the surgeon general—who reports to Shalala—vouches to Congress that such programs are safe and effective.

AIDS is spreading faster among intravenous drug users than in any other group. According to a study by the National Academy of Sciences, between 1981 and 1993 the percentage of new HIV infections due to unsafe homosexual sex dropped to 47 percent from 74 percent, while those attributable to the use of dirty needles by intravenous drug users doubled, to 24 percent.

Indeed, despite the recently reported annual decline in AIDS deaths overall, AIDS has become the leading cause of death in the African-American and Hispanic communities, primarily because of drug use and dirty needles. Most tragically, many of the victims are the babies or innocent sex partners of HIV-infected addicts.

Needle-exchange programs work. In a 1993 study by Yale University, they were shown to reduce HIV infections by a third. Another study, funded by the Centers for Disease Control and Prevention, indicated that needle exchanges even worked as a bridge for getting significant numbers of users into rehabilitation.

One of the most persuasive arguments is financial. Some 70 needle-exchange research projects, of varying sizes and uncertain funding, operate mostly in large cities, including Chicago. Their average annual budget comes to approximately $169,000—about what it costs to treat just one HIV-infected addict during the course of the disease.

None of the six studies cited in the HHS report found any basis for the fear that needle exchanges encourage drug use.

Yet the argument—largely symbolic—against these programs is that it looks incongruous for one branch of the government to "subsidize" drug use, however indirectly, while other agencies wage a multibillion-dollar war against it.

It is Shalala's responsibility to sort out facts from symbols—and fears from reality—and argue for sound, effective federal policies. By simply tossing the needle-exchange hot potato back to Congress without comment, she has failed in that role.

HIGH PROFILE: Sandra Thurman

'I have an obligation to be very honest with people about what needs to happen to stem the spread of this epidemic even if they don't want to hear it. I'm pretty feisty. I like a good fight.'

Tribune photos by Emi

'I come from an activist community and I am an activist, but I don't look like what people think an activist looks like.'

AIDS before beauty

Head of federal programs to combat HIV finds she must first overcome her Junior League image

By Monica C. Fountain
SPECIAL TO THE TRIBUNE

WASHINGTON—When people see Sandra Thurman, they don't see an AIDS activist.

With her long blond hair, tailored designer suits and Southern accent, Thurman said, people tend to think "president of the Junior League" when they meet her.

But not only is Thurman, 44, a veteran activist in the fight against AIDS, she is also President Clinton's new AIDS czar and has the responsibility of coordinating federal AIDS policy.

Thurman comes from a socially prominent, politically connected Georgia family. And although her background and appearance would indicate a socialite, Thurman has a reputation as a fierce fighter and committed activist.

"I would say she's a lion in Chanel clothing," said Todd Summers, executive director of the AIDS Housing Corporation, based in Boston.

"I come from an activist community and I am an activist, but I don't look like what people think an activist looks like," Thurman said. "I think that's such an advantage and disadvantage for me. In Congress, it's an advantage. With the community, it can be a disadvantage. They look at me and see somebody who looks like the president of the Junior League and it doesn't fit. It takes them a while to sort of get past that. The cover and the book don't necessarily jibe with people. That's the sort of image thing that I think that women have to deal with that men don't."

When she was growing up, she said, her dream was to become a veterinarian.

"I was absolutely horrible in chemistry," Thurman said with a laugh. "So I decided the next best thing was to go into some sort of human services so I would be able to help the two-legged variety of animal without having to pass chemistry."

Thurman said she became involved with AIDS in the early 1980s almost "completely by accident." In the early days when people were just starting to hear about something called acquired immune deficiency syndrome, Thurman was working as a hospice volunteer. When several of her friends started dying from this new disease, she knew she had to help.

"In the early days people were so afraid of AIDS. They were still very afraid to touch someone," Thurman said. "I got really concerned in the mid-'80s that women I knew who had been active in other charity work weren't coming to the AIDS issue."

Her friends thought she had lost her mind when Thurman started volunteering to take care of AIDS patients and eventually became head of AID Atlanta, the city's largest AIDS service organization.

"They said, 'What are you doing? You don't know anything about this disease,' " she said. Some friends would not even come to her office at AID Atlanta.

"At the beginning of the epidemic, she was someone who stepped forward boldly," said Cornelius Baker, executive director of the National Association of People with AIDS. "She's not gay. She's not male. She's not infected. She could have just lived in her nice comfortable world. She didn't just stand by while her friends died."

Baker said Thurman's appointment to the top AIDS policy post was encouraging.

"She's certainly a person who brings good skill and intelligence to the position," Baker said. "I think it can make a difference. Any of these positions in government are only as good as the person the president appoints and how much support the president gives the person."

During the announcement of her appointment April 7, Clinton assured Thurman of his personal support. "My door is open to her," he said.

That type of access will be important.

Thurman walks into her job at a time when the demand for funds to pay for AIDS treatment is growing and federal funds are shrinking.

"I could not have arrived here at a worst time," Thurman said. "It's hard and we're facing the most difficult time financially and programmatically that we've ever faced before."

The management of AIDS is more complicated. The good news is new drugs are keeping people alive longer. The bad news is the drugs are very expensive. Clinton has talked about developing a vaccine. AIDS activists sometimes assume the development of a vaccine will be at the expense of a quest for a cure or better treatment for those who already have the infection.

Before she could even unpack her boxes, Thurman said, she had to go to battle on budget matters and over activists' reaction to Clinton's announcement about the search for a vaccine.

But Thurman is ready for the fight.

As director of AID Atlanta, Thurman gained a reputation for her blunt, yet persuasive manner.

When Clinton named Thurman to be the new director of the Office of National AIDS Policy, he said: "She tells it like it is. She speaks the truth unvarnished. She won't hold back in this office."

Thurman said Southerners "have a way of communicating that says direct and indirect at same time. We have a way of polishing the hard edges off of subjects."

She described herself as "energetic, pretty blunt, pretty Southern, very straightforward.

"This is an issue that we have to be straightforward about. I have an obligation to be very honest with people about what needs to happen to stem the spread of this epidemic even if they don't want to hear it. I'm pretty feisty. I like a good fight."

Thurman is no stranger to politics and a good fight. She is the fourth generation of a family of women activists. Her mother, Marjorie, was the chair of the Democratic Party in Georgia for several years and was active in the civil rights movement. Her grandmother was an advocate for prisoners and helped to do away with chain gangs in Georgia. Her great-grandmother was an advocate for education for all children. Thurman ran Clinton's 1992 campaign for the Georgia Democratic presidential primary and was chair of his Little Rock inaugural ball this year.

She left a position she had just started as director of citizen exchange for the United States Information Agency to become Clinton's AIDS czar.

The Office of National AIDS Policy coordinates policy of all federal agencies involved in the AIDS epidemic, from the Centers for Disease Control and the National Institutes of Health to the Food and Drug Administration. The Office of National AIDS Policy reports to the president, ensures his priorities are being met and makes sure he has full information about AIDS. The office is a command center that tries to "craft a strategy that's most appropriate for the AIDS epidemic at the time," Thurman said.

Thurman plans to make the office more user-friendly and user-driven.

In the past the Office of National AIDS Policy was headed by women who had experience in government bureaucracies but not in delivering services or acting as an activist in the community.

"I bring a more political flavor to the office," Thurman said. "I want to nurture closer ties with the AIDS community and people actually working on the front lines of the epidemic. I want to make sure with all the bureaucracy that the information that's driving us is directly from the community."

The AIDS epidemic has changed from the early '80s when she first becam involved. AIDS is now household word, but Thurman said there is still a tendency in the United States for people to think AIDS is something that won't happen to them. Most people know someone who has died of AIDS, but there is still a lot of misinformation about who is at risk, Thurman said. AIDS is increasing the fastest among women, people of color and young people, Thurman said.

Although Thurman struggled with the decision to take on her new job, she said, she had too much invested in the AIDS crisis not to take it.

"I have lost so many close friends to HIV and AIDS. Much of the work I do is in their behalf," Thurman said. "I don't want anyone else to have to go through what they went through.

"I thought that I might be able in some small way to make a difference if I was here. That's why I car because I thought I cou make a difference. That's what has driven me to hold every job I've ever had, so that's how I wound up here. My friends are still thinking I'm crazy."

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AIDS FOUNDATION OF CHICAGO
PRESS RELEASE

FOR IMMEDIATE RELEASE
November 3, 1997

For More Information Contact:
Mark Ishaug at 312-922-2322

AIDS Coalition to Press for Increased Funding for STD Services

Several dozen social service organizations and members of the Chicago City Council have joined with the AIDS Foundation of Chicago to seek city Council approval for a proposed $2 million increase in Chicago Department of Public Health funding for the treatment and prevention of sexually transmitted diseases (STDs). The initiative is a response to recent research findings that show a direct link between STDs and the spread of the AIDS virus.

The federal Centers for Disease Control and Prevention (CDC) announced in September that several recent studies have determined that STDs facilitate infection with HIV, the virus that causes AIDS. Researchers found that people infected with both HIV and an STD run a greater risk of infecting others with HIV because they carry higher concentrations of the virus in their genital secretions than those infected with HIV alone. People with STDs are also more susceptible to sexual transmission of HIV because of STD-related tissue damage to the genital tract that normally acts as a barrier against HIV and other infections.

In its report of global STD reduction strategies published this year, the Institute of Medicine cites several studies supporting STD services as scientifically sound and cost-effective HIV prevention measures. A landmark community-level study conducted overseas reduced rates of HIV infection by 42% by improving access to STD treatment and prevention services. In another study, treatment for gonorrhea among HIV+ men reduced the level of HIV in their semen by over 50%.

Chicago rates for gonorrhea and chlamydia are among the highest in the nation, and Cook County has the third highest number of syphilis cases among all U.S. municipalities. Local and federal funding to combat STDs in

-- more --

Chicago has dwindled over the past five years as STD rates remain high across the city's south and west sides, which also have the highest rates of AIDS and poverty. The $2 million increase proposed by the AIDS Foundation will treat or prevent over 20,000 STD cases a year and prevent at least 1,250 cases of HIV infection, at a cost-savings of $25 million in uncompensated HIV/AIDS care.

In announcing the formation of a coalition seeking additional city resources for STD services, AIDS Foundation of Chicago executive director Karen Fishman noted that the health department is responding to recent findings by convening a conference on STD issues on November 5. "The city's health department needs additional resources to adequately respond to Chicago's on-going STD epidemic and to prevent the several thousand cases of HIV infections that we now know will likely result if those cases remain untreated," she said.

Ten aldermen -- Sam Burrell (29th Ward), Shirley A. Coleman (16th Ward), Lorraine L. Dixon (8th Ward), Barbara Holt (5th Ward), Billy Ocasio (26th Ward), Burton Natarus (42nd Ward), Terry Peterson (17th Ward), Toni Preckwinkle (4th Ward), Robert Shaw (9th Ward), and Mary Ann Smith (48th Ward) -- are currently supporting the increase. Over 25 social service organizations have also joined the effort led by the AIDS Foundation.

"I believe that the $2 million increase that the AIDS Foundation is seeking is a small price to pay for the benefit that will result from successful prevention efforts," said Alderman Preckwinkle in a recent statement. "The city must do whatever it can to ensure that these [high STD] rates decline before we face a public health disaster," she said.

City Council budget hearings for the coming fiscal year began in early October and are expected to result in a final budget ordinance by mid-November.

Established in 1985, the AIDS Foundation of Chicago is the largest source of philanthropic support for AIDS programs and services in the Midwest. The Foundation's grant making program supports HIV/AIDS projects that reach thousands of men, children, and families throughout metropolitan Chicago. Through its Service Providers Council, the Foundation coordinates the activities of more than 120 local organizations committed to AIDS care and prevention.

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Support City of Chicago Funding Increases to Combat STDs

The AIDS Foundation of Chicago, Illinois' leading advocate for people living with or at-risk for HIV/AIDS, is seeking a $2 million increase in City of Chicago funding for the prevention and treatment of sexually transmitted diseases (STDs).

A $2 Million Public Health Investment Now Could Save the City Over $25 Million per Year in HIV-Related Health Care Costs

- An additional $2 million will help Chicago Department of Public Health clinics treat and prevent over 20,000 sexually transmitted diseases (STDs) a year. It will also help prevent thousands of cases of HIV infection as a result of untreated STDs.

- The average annual cost of care for HIV-positive people is $20,000. A conservative estimate is that some 1,250 newly-infected individuals would seek HIV-related health care services from City clinics. These individuals are predominantly low-income, uninsured, and not yet eligible for Medicaid. The cost of their care would amount to nearly $25 million a year.

- A combination of federal and state grants already help nearly 1,000 of the City's poorest residents gain access to HIV-related health care services at City clinics. Dwindling federal and state support combined with the epidemic's unabated spread will increasingly shift the burden of caring for low-income HIV+ people to the City. The City can avert paying millions of dollars in future health care costs by investing in STD/HIV prevention now.

The STD Epidemic Is Creating a Public Health Crisis in Chicago

Over 30,000 cases of gonorrhea, chlamydia, and syphilis were reported in Chicago in 1996, and thousands of other cases are believed to have evaded reporting. Gonorrhea, chlamydia, and syphilis are among several dozen STDs that can cause serious life-threatening complications including cancer, problem pregnancies, infertility, stillbirths, low birth weight, neurological damage, and death.

- Although STD rates nationwide are at a 33-year record low, STD rates in Chicago are among the highest in the nation. Chicago rates for gonorrhea, chlamydia, and congenital syphilis (transmitted from mother to infant *in utero*) are three times the national average, and Cook County has the third highest number of syphilis cases among U.S. municipalities.

- Young women are at especially high risk for STDs. In 1995, 43% of all chlamydia cases in Chicago were among 15-19 year-olds, and adolescent females had the highest case rate of any other group -- 4,804 cases per 100,000 population.

Evidence Confirms That STDs Are Helping the Spread of HIV/AIDS

- People co-infected with HIV and an STD are more likely to infect others with HIV because they carry higher concentrations of the virus in their semen, vaginal secretions, and/or genital ulcers. People with STDs are also more susceptible to sexual transmission of HIV because of STD-related damage to tissue in the genital tract that normally acts as a barrier against HIV and other infections.

- Although recent treatment advances have improved survival rates for HIV positive people, a cure remains out of reach and most of those infected are expected to develop AIDS eventually and die. The established link between STDs and HIV opens a new window of opportunity to prevent new HIV infections and slow the spread of the AIDS epidemic.

All Chicago Communities Are Threatened by STDs and HIV

Over 9,000 Chicago residents have died from AIDS-related causes since 1981, and some 25,000 others are living with HIV disease. Chicago ranks sixth in the nation in cumulative AIDS cases, and HIV infection continues to escalate throughout the city.

- STDs in Chicago are highest among people of color living in low-income communities on the south and west sides of the city. These same communities account for the city's highest rates of new HIV infections.
- While Chicago's poorest communities experience epidemic rates of STDs and HIV, every single community area in the city reported cases of chlamydia, gonorrhea, and AIDS in 1996, and all but six community areas reported cases of syphilis.

STD Prevention and Treatment Services Stem the Spread of HIV/AIDS

- STD treatment and prevention services are scientifically sound and cost-effective HIV prevention measures. A landmark community-level study reduced rates of HIV infection by 42% by improving access to STD treatment and prevention services.
- According to researchers, the treatment of just one case of syphilis can prevent up to 12 cases of HIV transmission.
- Cases of chlamydia among women are especially difficult to identify and treat as the infection can remain asymptomatic for several years. Left untreated, the disease can cause serious, life-threatening complications, including high susceptibility to HIV, for the infected woman and any children she may bear.

Federal and Local Funding Cuts Undermine the Health Department's Efforts to Combat STDs

Since 1992, the federal Centers for Disease Control and Prevention (CDC) has removed over 50 full-time employees from field assignments working at Chicago STD clinics. These cuts reduced STD testing and counseling staff by 33%.

- Cost-cutting measures at the Chicago Department of Public Health (CDPH) in the last several years have meant annual 5-10% across-the-board cuts for all programs, including STD treatment and prevention. Staff and budget reductions have meant that public STD clinics in Chicago have inadequate staff to conduct appropriate outreach, education, intensive risk-reduction counseling, contact-tracing, and surveillance activities.
- Recent welfare and Medicaid cuts have led greater numbers of indigent clients with STDs to rely on city clinics for primary medical care, resulting in higher costs.

Additional City Funding Is Needed Immediately

- The health department has responded astutely to recent staff losses by ensuring that all HIV counseling and testing staff, funded primarily by the CDC, are cross-trained in STD-related client services. The department has also taken steps to integrate STD and HIV counseling and screening activities. However, the department does not have the resources available to adequately address Chicago's STD problem.
- Additional funds are needed to support STD/HIV community-based prevention programs, additional STD testing and counseling staff, more workers to conduct outreach, contact-tracing, and surveillance activities, and access to primary medical care for those individuals needing STD treatment.

In California, a statewide chlamydia screening program for women in family planning clinics **saved the state more than $60 million** in STD treatment costs over a five-year period. The CDC estimates that approximately $12 in costs associated with STD complications can be **saved** for every $1 spent on early detection and treatment.

Link Found to Spread of AIDS

By LAWRENCE K. ALTMAN

WHEN men are infected with H.I.V. and another sexually transmitted disease, like gonorrhea, their semen contains about eight times as much AIDS virus as is found in semen of men who who do not have dual infections, a new study has found.

The findings indicate that control measures used in some countries to battle AIDS are worthwhile and suggest that widespread detection and treatment programs for sexually transmitted diseases could help prevent many new H.I.V. infections, said the study's authors, from the University of North Carolina School of Medicine in Chapel Hill.

The study was carried out in Malawi, a country in southern Africa where an estimated 15 percent of sexually active adults are infected with H.I.V., the virus that causes AIDS, chiefly from heterosexual intercourse. The study was reported on June 28 in The Lancet, an international medical journal published in London.

The findings are relevant for the United States and other developed countries, said Dr. Anthony S. Fauci, the director of the National Institute of Allergy and Infectious Diseases, which is one of a number of Federal agencies that paid for the study along with the World Health Organization. Family Health International conducted the study along with the University of North Carolina researchers.

"The study has important economic and public health implications," Dr. Fauci said, "because if you can treat a sexually transmitted disease with a few doses of relatively inexpensive antibiotics, you may prevent a number of H.I.V. infections that would cost a lot more to treat."

For many years, Dr. King K. Holmes of the University of Washington, an international leader in sexually transmitted diseases, has urged that more attention be paid to such infections because of their possible role in the spread of H.I.V. infections. Many experts believe that open sores, like those from herpes and syphilis, can make it easier to transmit H.I.V. or become infected with it.

Also, many experts say that in the absence of a vaccine against AIDS, health workers need to look more to indirect ways to prevent the transmission of H.I.V. Among them are improved treatments for sexually transmitted diseases, the promotion of condom use, counseling about sexual behavior and more needle-exchange programs for intravenous drug users.

> Other diseases may raise levels of H.I.V. in semen.

Scientists believe that cells infected by sexually transmitted diseases can produce natural substances known as chemokines. One explanation for the increased risk of H.I.V. infection or transmission is that chemokines could ease the entry of H.I.V.-infected cells into semen and speed up the rate of viral replication there.

An earlier epidemiology study from another African country, Tanzania, suggested that treating other sexually transmitted diseases in people infected by H.I.V. could cut the transmission of the virus by 40 percent.

Using laboratory techniques that were developed recently, a team of American, Malawi and Swiss scientists headed by Dr. Myron S. Cohen at the University of North Carolina showed that antibiotic treatment for other sexually transmitted diseases, particularly gonorrhea, in people with H.I.V. greatly lowered the amount of the AIDS virus in the semen of H.I.V.-infected men in Malawi.

"The more virus in semen," Dr. Cohen said, "the greater the chance for transmission to someone else."

The study looked at 135 H.I.V.-infected men. Of this group, 86 suffered from pain on urination because of inflammation caused by other sexually transmitted diseases — including gonorrhea, syphilis and genital ulcers presumably caused by herpes simplex virus, chlamydia and trichomonas — and were treated for them. The remaining 49 H.I.V.-infected men did not have other sexually transmitted diseases but were treated for skin conditions.

After a week of treatment, the amount of H.I.V. dropped significantly in the semen of men with other sexually transmitted diseases. After two weeks of treatment, the amount of H.I.V. was similar to the levels seen in men who had been treated only for skin conditions.

Dr. Joseph J. Eron Jr., a co-author, said the study had been conducted in Africa because the higher rates of H.I.V. and sexually transmitted diseases there had allowed his team to get answers more quickly than would have been possible in the United States.

Information from the study suggested that more H.I.V. was present in the semen of men in Africa compared with those in this country. That raised the possibility that differences in the types of H.I.V. might account for differences in the ability of the virus to grow in semen and might help explain why the incidence of AIDS is higher in Africa than in other areas.

The National Institute of Allergy and Infectious Diseases plans to support studies to answer such questions, said Dr. Penny J. Hitchcock, an expert in sexually transmitted diseases at the institute.

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FAX Cover Sheet

Date: November 5, 1997

Attention: Ms. Sarah Holewinski
Office of National AIDS Policy

Fax No: 202-632-1096

From: David Ernesto Munar, Policy Associate
312-922-2322

I am faxing you information on AIDS Foundation's campaign to urge the Chicago City Council to raise city health department funding by $2 million for the treatment and prevention of sexually transmitted diseases (STDs). The initiative is a response to recent research finding that show that STDs are helping to spread the AIDS epidemic. Please convey the information to Sandy in preparation for her upcoming Chicago visit. Please contact me if you have any question or need any additional information.

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