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Lesbian & Gay Youth

Care & Counseling

Caitlin Ryan Donna Futterman

COLUMBIA UNIVERSITY PRESS
NEW YORK

As published in
**ADOLESCENT
MEDICINE: STATE
OF THE ART
REVIEWS**, *the*
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the Section on
Adolescent Health
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Contents

Part I: Experiences and Needs

Adolescent Health Challenges
Identity Development
Experiences, Vulnerabilities and Risks
Confidentiality and Legal Issues

Part II: Primary Care and Prevention

Health Concerns of Lesbian and Gay Adolescents
Special Populations
Transgender Youth
Mental Health Concerns
Family Interventions and Anticipatory Guidance
Medical Assessment, Treatment and Prevention
Mental Health Assessment and Treatment

Part III: HIV/AIDS

HIV Infection in Adolescents, Including Lesbians and Gay Males
HIV Counseling and Testing for Adolescents
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Steven E. James, PhD, *Society for the Psychological Study of Lesbian, Gay and Bisexual Issues Newsletter*, a division of the *American Psychological Association*

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Lesbian & Gay Youth

Care & Counseling

Caitlin Ryan, MSW & Donna Futterman, MD

COLUMBIA UNIVERSITY PRESS

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About the Authors:

CAITLIN RYAN is a clinical social worker, educator and researcher who has worked on lesbian and gay health and mental health issues for more than 20 years. Her work has been acknowledged by many organizations and groups, including the National Association of Social Worker's "Social Worker of the Year" in 1988.

DONNA FUTTERMAN is an adolescent medicine specialist, Associate Professor of Pediatrics at Albert Einstein College of Medicine and Director of the Adolescent AIDS Program at Montefiore Medical Center. She has worked on lesbian and gay health issues since the 1970s.

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David S. Buckel, *Staff Attorney, Lambda Legal Defense and Education Fund, attorneys in the Jamie Nabozny anti-gay school violence case in Wisconsin*

U.S. INTERNATIONAL STRATEGY ON HIV/AIDS

INTERNATIONAL ORGANIZATIONS MEETING

JULY 28, 1998

MEETING AGENDA

INTRODUCTION

1. Overview of new strategy

- Aims to discuss progress since 1995 strategy and remaining challenges, highlighting developing countries' success stories, i.e. Thailand and Uganda, others?

2. Target audience

- Host countries (U.S. missions and embassies will serve as information conduit)
- International organizations
- Non-governmental organizations
- Developing countries

3. General Objectives

- Raise awareness of the issues and (not in order of priority)
- Enhance collaboration between federal and international agencies/organizations
- Increase affordability/accessibility of treatment in developing countries by enhanced international collaborations/public/private partnerships
- Increase political and economic commitment by foreign leaders
- Foster greater involvement by NGO's and industry in AIDS policy and program formulation
- Encourage efforts of UNAIDS and other international organizations
- Consider human rights implications of HIV/AIDS
- Highlight women and HIV/AIDS issues

4. Specific Issues

- Prevention
- AIDS-Orphans
- Complex issues surrounding treatment equity
- vaccine research

- behavioral research/behavioral change interventions
- microbicide development

DISCUSSION: Enhanced coordination/collaboration between USG and international organizations/donors in HIV/AIDS programs

5. Program Priorities/Programs for 1998-2000

6. Issues/Concerns



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

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

June 25, 1998

Dear Colleague:

We would like to call your attention to the attached article that is being released in tomorrow's *Morbidity and Mortality Weekly Report*. The article documents the substantial progress made in the control and prevention of syphilis in the United States. From 1990 to 1997, syphilis rates declined 83 percent in the United States and are at their lowest level since reporting began in 1941. We are very pleased about this. However, this isn't the whole story. A closer look reveals that despite the overall declines, syphilis continues to be a serious problem in the southern United States and in a small number of urban areas outside the South. In fact, 85 percent of all cases were reported from only 6 percent of the counties in the United States. The author emphasizes the fact that this is a great opportunity, while the disease is highly focused, to make a major impact toward the elimination of syphilis in the United States. Essential to further control or elimination of this disease will be a strong, concentrated effort with diverse organizations, public health professionals, the private medical community, and other partners in STD and HIV prevention working together.

I hope you find this information useful. As always, if you have any questions, please don't hesitate to call any of us in the NCHSTP Office of Communications at 404-639-8890.

Sincerely,

Melissa Shepherd
Associate Director for Communications
Director, Office of Communications
National Center for HIV, STD, and TB Prevention



June 26, 1998 / Vol. 47 / No. 24



MORBIDITY AND MORTALITY WEEKLY REPORT

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Primary and Secondary Syphilis — United States, 1997

Syphilis is an acute and chronic sexually transmitted disease (STD) caused by infection with *Treponema pallidum*. The disease is characterized by skin and mucous membrane lesions in the acute phase (primary and secondary [P&S] syphilis) and lesions of the bone, viscera, and cardiovascular and neurologic systems in the chronic phase. Because syphilis enhances transmission of human immunodeficiency virus (HIV), prevention of syphilis is important for controlling HIV (1). During 1986–1990, an epidemic of syphilis occurred throughout the United States (2). Syphilis rates began to decline in 1991 and have declined each year since that time. To determine whether this decline is reflected in changes in the epidemiology of syphilis, CDC analyzed notifiable disease surveillance data for 1997. This report summarizes the findings of the analysis, which indicate that reported P&S syphilis cases declined 84% from 1990 to 1997, that syphilis remains substantially more common in non-Hispanic blacks than in other racial/ethnic groups, and that it continues to be concentrated in the Southern region of the United States.

Summary data for syphilis cases reported to state health departments for 1997 were sent quarterly and annually to CDC. Data from states included the total number of syphilis cases by county, sex, stage of disease, racial/ethnic group, and 5-year age group. Data on reported cases of syphilis in the P&S stages were analyzed for this report because those cases best represent incident cases (i.e., newly acquired infections within the evaluated time period). P&S syphilis rates were calculated per 100,000 persons using population denominators from the Bureau of Census (2).

In 1997, the incidence of P&S syphilis in the United States was 3.2 per 100,000 population (Figure 1). Rates of P&S syphilis were higher in the South (6.6 per 100,000 population) than in the Midwest (2.0), Northeast (1.1), and West (1.0).^{*} The South is the only region that has not achieved the revised national health objective for 2000 (HP2000) of four cases per 100,000 population (objective 19.3) (2). In 1997, a total of 41 (82%) states had P&S syphilis rates below the HP2000 objective, and 21 states

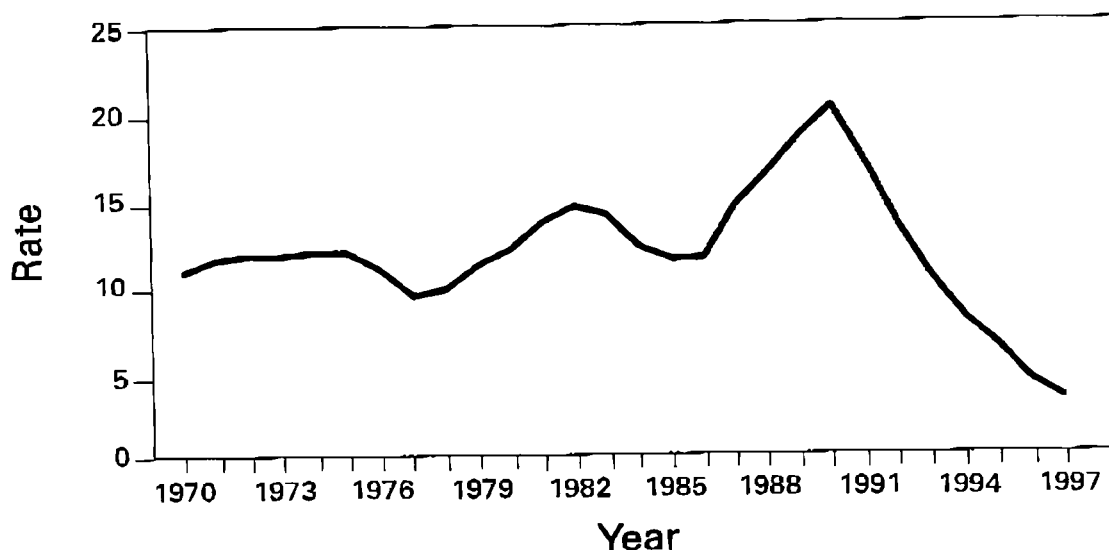
^{*} *Northeast*—Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest*—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South*—Alabama, Arkansas, Delaware, District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

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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*Primary and Secondary Syphilis — Continued***FIGURE 1. Primary and secondary syphilis rates*, by year — United States, 1970–1997**

*Per 100,000 population.

(42%) reported 10 or fewer cases of P&S syphilis (Table 1). Montana, New Hampshire, North Dakota, Vermont, and Wyoming reported zero cases of P&S syphilis. No cases of P&S syphilis were reported in 1997 from 2324 (75%) of 3115 counties. Rates of P&S syphilis were below the HP2000 objective in 2698 (86%) counties. A total of 31 (1.0%) counties accounted for 50% of P&S syphilis cases, and 186 (6%) counties accounted for 85% of all reported P&S syphilis cases (Figure 2).

P&S syphilis rates for blacks remained substantially higher than those for non-Hispanic whites and Hispanics. In 1997, the P&S syphilis rate for blacks was 22.0 per 100,000, compared with 1.6 for Hispanics and 0.5 for non-Hispanic whites. The overall male-to-female P&S syphilis rate ratio was 1.2; this rate ratio was higher for Hispanics (2.1) than for blacks (1.3) and non-Hispanic whites (1.2). P&S syphilis rates were highest for Hispanic women aged 15–19 years (2.7), for black women aged 20–24 years (47.9), and for non-Hispanic white women aged 25–39 years (1.2). P&S syphilis rates were highest for Hispanic men aged 25–29 years (5.5) and for black and non-Hispanic white men aged 35–39 years (50.6 and 1.2, respectively).

From 1990 to 1997, P&S syphilis rates declined 84% in the United States, in all regions (95% in the Northeast, 91% in the West, 80% in the South, and 73% in the Midwest), and in all but two states (Indiana and Kentucky). Rates in Indiana and Kentucky peaked in 1993 and have declined steadily since that time. Rates of P&S syphilis were below the revised HP2000 objective in 86% of all counties in 1997, compared with 69% in 1990.

P&S syphilis rates have declined for all racial/ethnic groups; the largest decline occurred among Hispanics (90%) followed by blacks (85%) and non-Hispanic whites (81%). The P&S syphilis male-to-female rate ratio has remained stable for all races.

Reported by: Div of Sexually Transmitted Diseases Prevention, National Center for HIV, STD, and TB Prevention, CDC.

*Primary and Secondary Syphilis — Continued***TABLE 1. Reported primary and secondary syphilis rates*, by state and sex — United States, 1997**

State	Male	Female	Total	State	Male	Female	Total
Alabama	11.1	8.2	9.6	Nebraska	0.4	0.2	0.3
Alaska	0.3	0	0.2	Nevada	0.5	0.8	0.6
Arizona	4.3	1.7	3.0	New Hampshire	0	0	0
Arkansas	5.8	7.9	6.9	New Jersey	2.4	1.4	1.9
California	1.7	0.7	1.2	New Mexico	0.5	0.6	0.5
Colorado	0.5	0.3	0.4	New York	0.9	0.6	0.8
Connecticut	2.3	1.5	1.9	North Carolina	10.3	9.4	9.8
Delaware	3.4	2.7	3.0	North Dakota	0	0	0
Florida	2.4	1.8	2.1	Ohio	2.2	1.8	2.0
Georgia	9.0	5.1	7.0	Oklahoma	4.0	3.1	3.5
Hawaii	0.2	0	0.1	Oregon	0.5	0.1	0.3
Idaho	0.2	0	0.1	Pennsylvania	1.2	0.8	1.0
Illinois	4.2	3.2	3.7	Rhode Island	0.2	0.2	0.2
Indiana	2.4	2.7	2.6	South Carolina	11.5	9.0	10.2
Iowa	0.2	0.3	0.2	South Dakota	0.3	0	0.1
Kansas	1.4	0.8	1.1	Tennessee	14.7	13.5	14.0
Kentucky	3.7	3.3	3.5	Texas	3.8	3.3	3.5
Louisiana	8.4	8.3	8.4	Utah	0.3	0.2	0.2
Maine	0.2	0.2	0.2	Vermont	0	0	0
Maryland	19.8	15.4	17.6	Virginia	3.8	3.3	3.5
Massachusetts	1.5	1.0	1.3	Washington	0.3	0.3	0.3
Michigan	1.8	1.4	1.6	West Virginia	0.1	0	0.1
Minnesota	0.5	0.2	0.3	Wisconsin	1.6	1.9	1.7
Mississippi	14.5	14.2	14.4	Wyoming	0	0	0
Missouri	2.1	2.2	2.1	Total	3.6	2.9	3.2
Montana	0	0	0				

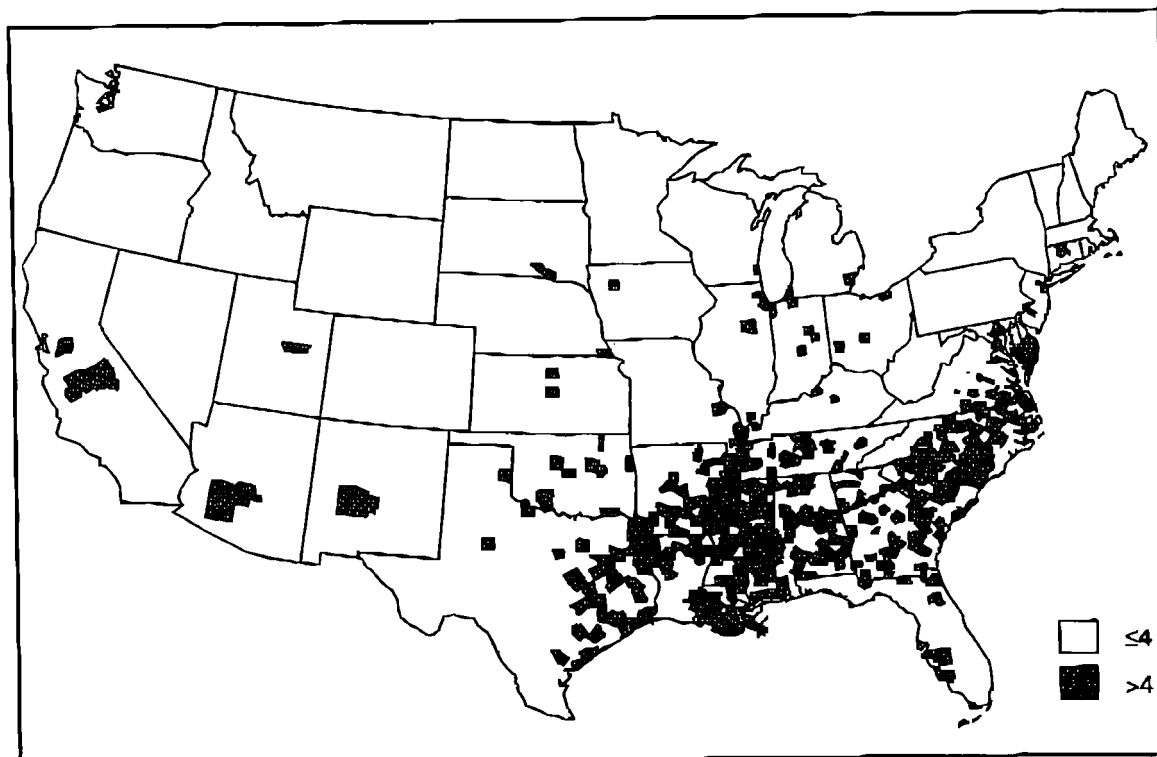
* Per 100,000 population.

Editorial Note: The findings in this report document substantial progress in the control and prevention of infectious syphilis in the United States. P&S syphilis is at its lowest level since reporting began in 1941. Although syphilis remains an endemic disease in parts of the South, rates in this region have declined 80% since 1990. The South has had the highest syphilis rates since the 1940s, in part because of limited access to health care in many parts of the South. Despite substantial declines in P&S syphilis in all racial/ethnic groups, syphilis continues to disproportionately affect blacks. Reporting of syphilis has presumably been biased toward over-reporting of infections in persons of minority races/ethnicities who attend public STD clinics; the degree to which this bias influences disease rates across racial/ethnic groups is unknown. Reasons for these reported racial disparities require further investigation.

At least four factors may have contributed to the recent decline in syphilis. First, after recognition of the epidemic in the mid-1980s, increased state and federal resources were invested in syphilis control programs (3). These resources were used for both traditional (e.g., partner notification and clinical services) and nontraditional (e.g., community-based screening and outreach and risk-reduction counseling) activities (3). Second, since the mid-1980s, a variety of HIV prevention activities have been implemented throughout the United States. Although these activities probably contributed to declines in all STDs, it is unknown how these activities contributed to the prevention of specific bacterial STDs. Third, a decline in crack cocaine use (4) may have resulted in a decline in the incidence of syphilis. Use of crack cocaine and exchange of sex for drugs were major contributors to the recent syphilis epidemic (5). Finally, the presence of acquired immunity in the population at risk following the epidemic may have contributed to the decline (6,7).

Primary and Secondary Syphilis — Continued

FIGURE 2. Counties with primary and secondary syphilis rates above or at the national health objective for 2000 of four cases per 100,000 population — United States, 1997



A concerted effort while rates are low and disease is focal could contribute to the possible elimination of domestic transmission of syphilis in the United States (8). In 1996, the Council of State and Territorial Epidemiologists proposed that syphilis surveillance systems be evaluated and strengthened, that treatment and prevention efforts be enhanced in areas of substantial ongoing transmission, that a national workgroup be convened to evaluate the possibility of elimination of domestic syphilis transmission, and that ongoing support for syphilis control be maintained or enhanced until domestic syphilis is eliminated. A recent Institute of Medicine report on STDs in the United States suggests that STD surveillance systems use new information technology, be accurate and timely enough to identify national and local trends in STD incidence, and provide the data necessary to direct local activities (9). CDC is working toward improving syphilis surveillance on a national level by encouraging state and local health departments to discontinue aggregate syphilis reporting and to collect, analyze, take action on, and report line-listed case reports of syphilis electronically to CDC. These line-listed data will provide an opportunity to analyze case reports at the county level by a variety of demographic characteristics and other potential risk factors for STD.

Syphilis is increasingly manifested as an epidemic rather than an endemic disease in the United States; focal outbreaks are still occurring (5). Optimal combinations of several different prevention and control strategies may be useful for areas with

Primary and Secondary Syphilis — Continued

different levels of morbidity (i.e., to prevent importation into those areas without disease and to intensify detection and control in those areas with substantial morbidity). Several state and local health departments have developed enhanced syphilis control and elimination plans (e.g., California, Florida, Massachusetts, and San Diego County). Components of such a plan could include an evaluation and enhancement of the surveillance system, a review of the epidemiology of syphilis in the local area and development of targeted interventions if applicable, and enhancement of screening for syphilis in high-risk populations (e.g., correctional and drug-treatment facilities and emergency departments).

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State-Specific Pregnancy Rates Among Adolescents — United States, 1992-1995

In the United States during 1985-1990, the pregnancy rate for persons aged 15-19 years increased 9% (1). From 1991 to 1992, however, the rate declined substantially in 31 of the 42 states* for which data were available (2); from 1992 through 1995, the birth rate declined steadily (3), and state-specific abortion rates decreased annually (4,5). This report presents estimated state-specific pregnancy rates for 1992-1995† for adolescents aged ≤19 years by age and race and the percentage change in state-specific pregnancy rates for persons aged 15-19 years for 1992 to 1995. The findings indicate a downward trend in pregnancy rates for persons aged 15-19 years during 1992-1995 for all 43 states for which data were available.

Number of pregnancies was estimated as the sum of live births, legal induced abortions, and estimated fetal losses (i.e., spontaneous abortions and stillbirths) among

*The word "state" in this report includes the District of Columbia except where explicitly noted.

†State-specific adolescent pregnancy rates for 1992 were previously reported by CDC (2). Data for 1992 are reported here because of the inclusion, for the first time, of estimated fetal losses in the calculation of pregnancy rate. Adolescent pregnancy rates published by CDC before this report should not be used together with those reported here in time series analyses because of this change in methods.

Pregnancy Rates — Continued

adolescents aged ≤ 19 years. Data about live-born infants were obtained from birth certificates and were reported by the mother's state of residence. Because abortion data by residence were not available for all states, abortions were reported by state of occurrence.[§] Estimates of fetal loss were based on sample survey data of women aged 15–44 years from the 1988 and 1995 National Survey of Family Growth (NSFG). A national estimate of fetal loss for all adolescents aged 15–19 years was derived from NSFG data and was used to create annual estimates of fetal losses based on the number of live births and legal induced abortions in a given year (CDC, unpublished data, 1998). Denominators were obtained from postcensal population estimates provided by the Bureau of the Census (6).

Rates were calculated as the number of pregnancies per 1000 females aged 15–17, 18–19, or 15–19 years. Because most pregnancies (98% of live-born infants and 94% of legal induced abortions) among persons aged <15 years occur among those aged 13–14 years (CDC, unpublished data, 1995; 7), the number of persons aged 13–14 years was used as the denominator when the rate was calculated for the <15 -year age group. Legal induced abortions for which mother's age or race was unknown were included in categories based on the distribution of mothers with known age or race. Changes in pregnancy rates for persons aged 15–19 years from 1992 to 1995 were tested for statistical significance at $p < 0.05$.

Although abortion totals were available for all states, age-specific data were only available from 43 states for 1992–1995; abortion data stratified by age and race were available from 37 states for 1992–1995. Because adequate age and Hispanic ethnicity data for women who had abortions were available for only 19 states in 1992, 21 states in 1993 and 1995, and 22 states in 1994, pregnancy rates by ethnicity are not included.

Pregnancy rates for persons aged 15–19 years ranged from 63.3 (Wyoming) to 126.0 (Georgia) in 1992[¶]; from 62.0 (Minnesota) to 122.0 (Georgia) in 1993; from 57.1 (North Dakota) to 119.0 (Texas) in 1994; and from 56.3 (North Dakota) to 117.1 (Nevada) in 1995 (Table 1). In each year, the rate was highest for persons aged 18–19 years and lowest for those aged <15 years. During 1992–1995, the pregnancy rate for persons aged 15–19 years decreased in each of the 43 states for which age-specific data were available. Declines ranged from 2.8% (Arkansas) to 20.1% (Vermont); all but one of these decreases were statistically significant.

Rates declined for persons aged 18–19 years in all 42 reporting states from 1992 to 1995. However, pregnancy rates increased for those aged <15 years in nine of 40 states for which data were available and for those aged 15–17 years in two of 42 states. Rates for persons aged 15–19 years were, in most cases, higher for blacks than for whites among states for which data were available (Table 2). However, in 24 of the 26 states for which data were available, the decline in pregnancy rate for blacks was greater than for whites from 1992 to 1995.

From 1992 to 1995, abortion and birth rates declined for persons aged 15–19 years. Of 43 states for which data were available, 40 reported a decreased adolescent

[§]For 47 reporting areas during 1992–1994 and for 48 areas in 1995, the number and characteristics of persons who obtained legal induced abortions were provided by the central health agency (state health departments and the health departments of New York City and the District of Columbia). For five areas during 1992–1994 and for four areas during 1995, data about the number of abortions were provided by hospitals and other medical facilities.

[¶]District of Columbia is not included in these comparisons because its pregnancy rates were higher than for any state, in part because of large numbers of abortions among nonresidents.

Pregnancy Rates — Continued

abortion rate (CDC, unpublished data, 1992, 1995), and birth rates declined in 50 of 51 states (2,3). Relative decreases in abortion rates generally exceeded declines in birth rates.

Reported by: Behavioral Epidemiology and Demographic Research Br and Statistics and Computer Resources Br, Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The findings in this report indicate a downward trend in adolescent pregnancy rates during the first half of the 1990s. Adolescent pregnancy rates declined in states with high and with low rates, suggesting the potential for all states to achieve lower adolescent pregnancy rates.

The estimation of adolescent pregnancy rates was limited by the lack of age-specific data for eight states and adequate race-specific abortion data for 17 states. The lack of age-specific abortion data by ethnicity in most states also limited this analysis because the ethnic composition of state populations is an important determinant of state variations in pregnancy rates.

Legal induced abortions reported to CDC may undercount the true number of abortions. Use of abortion data by state of occurrence rather than by state of residence may have overestimated the abortion rate in states with large metropolitan areas that might draw from adjoining states, such as New York City and the District of Columbia. Estimates of fetal loss are subject to underreporting, especially because of unrecognized early fetal losses; fetal loss estimates are based on small numbers of adolescent pregnancies. Therefore, pregnancy totals based on births, legal induced abortions reported to CDC, and fetal loss estimates may underestimate the actual pregnancy rate. However, underreporting probably remains relatively constant from year to year and is unlikely to affect the trends in this report substantially.

Sexual experience, sexual activity, and effective contraceptive use are important determinants of changes in pregnancy rates. After increasing in the 1980s, the estimated proportion of adolescent females aged 15–19 years who were sexually experienced (i.e., ever had sexual intercourse) and the percentage who were sexually active (i.e., had had sexual intercourse within 3 months of interview) stabilized from 1988 to 1995 (8). The proportion of adolescents who reported having used contraception at first intercourse increased from 1988 to 1995 (3) but little change was found in the proportion of persons aged 15–19 years who reported using a contraceptive method within 1 month of interview (9). Among those who reported using a contraceptive method within 1 month of interview, use of oral contraceptives declined from 1988 to 1995, and use of condoms and long-acting contraceptive methods increased.

Sexual experience and contraceptive use may be influenced by motivation to avoid pregnancy, access to health-care services, income, education, and other factors. Sustaining the downward trend in adolescent pregnancy will require solutions that address complex individual and community-level factors that can affect adolescents' sexual and reproductive behavior. Programs designed to reduce adolescent pregnancy that address an array of risk factors (e.g., socioeconomic disadvantage, poor educational and employment opportunities, or lack of social support) in addition to specific skills to postpone sexual experience and increase contraceptive use may be more effective in reducing adolescent pregnancy than programs focusing exclusively on changing sexual beliefs or behavior (10). Additional characteristics of effective programs are strong educational components, messages tailored to the needs of

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Pregnancy Rates — Continued

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June 26, 1998

TABLE 1. Pregnancy rates* for adolescents aged ≤19 years, by age group and state†, and percentage changes in rates for 15-19-year-olds — United States, 1992-1995 — Continued

State	1992				1993				1994				1995				% Change in rate for 15-19-year-olds from 1992 to 1995‡
	<15	15-17	18-19	15-19	<15	15-17	18-19	15-19	<15	15-17	18-19	15-19	<15	15-17	18-19	15-19	
Alabama	10.8	71.7	164.4	109.9	11.6	72.8	158.3	108.1	10.6	75.5	160.6	110.1	10.1	71.1	158.2	106.3	-3.3
Arizona	6.5	76.0	192.4	122.1	5.6	73.9	187.3	118.4	6.7	74.7	183.7	117.1	6.3	70.5	164.4	108.2	-11.4
Arkansas	8.2	66.1	166.4	107.0	7.7	64.0	161.6	103.7	8.1	68.8	166.8	108.3	8.4	68.1	158.3	104.1	-2.8
Colorado	5.5	61.4	144.0	94.2	5.0	58.1	134.4	88.0	4.9	56.3	130.2	85.1	4.2	54.2	121.0	80.4	-14.7
Connecticut	7.7	63.6	135.5	92.8	7.4	63.5	130.3	90.2	5.6	62.5	122.1	85.8	5.0	53.8	114.7	77.3	-16.8
District of Columbia	36.1	†	†	245.7	28.4	†	†	278.1	41.3	†	†	267.3	26.0	†	†	229.6	-6.6
Georgia	12.5	82.0	188.6	126.0	12.3	81.9	181.1	122.0	12.4	80.0	175.3	117.5	11.9	79.2	172.4	115.6	-8.3
Hawaii	7.8	66.5	149.3	101.9	5.6	64.5	153.4	102.1	6.4	68.4	152.9	103.7	7.3	58.5	139.4	92.3	-9.4
Idaho	2.3	38.5	119.9	70.4	2.3	39.2	110.1	67.3	2.7	35.8	99.9	61.2	2.9	35.1	105.6	63.4	-9.9
Indiana	4.8	50.0	136.4	85.2	4.2	48.3	132.8	82.6	5.1	49.8	133.6	83.4	4.8	49.9	132.0	82.4	-3.2
Kansas	5.8	63.3	164.0	102.6	6.6	63.1	164.4	102.6	5.3	60.5	154.5	96.9	7.1	59.6	150.7	94.9	-7.5
Kentucky	7.1	61.4	148.1	96.4	6.7	61.7	142.7	94.3	6.6	59.7	144.8	93.5	5.8	55.9	138.0	88.6	-8.1
Louisiana	10.3	73.3	162.5	109.2	9.9	73.2	158.4	107.6	9.6	71.4	156.7	105.6	8.2	63.7	149.9	98.2	-10.1
Maine	2.5	37.6	104.4	65.1	2.8	36.9	103.3	63.4	2.6	33.0	102.2	60.0	2.7	36.3	94.2	58.7	-9.8
Maryland	8.5	60.5	134.2	90.7	8.8	61.3	129.3	88.4	8.4	57.6	129.6	85.8	7.0	54.9	123.3	81.4	-10.2
Massachusetts	5.7	50.0	125.3	82.0	6.0	49.1	138.4	86.1	5.5	47.9	127.9	80.2	4.3	44.3	113.1	71.8	-12.5
Michigan	6.0	56.7	148.1	94.0	5.7	55.9	139.1	89.2	5.7	53.0	137.4	86.1	5.3	50.1	128.9	80.6	-14.2
Minnesota	3.7	37.4	107.9	65.1	3.5	35.9	102.9	62.0	3.5	34.4	100.8	59.8	2.7	34.0	92.9	56.4	-13.3
Mississippi	12.9	83.9	169.5	118.8	13.2	77.7	167.9	114.2	11.6	73.9	156.0	106.8	10.8	73.4	147.8	103.1	-13.2
Missouri	5.5	55.5	147.0	92.0	6.0	52.7	137.6	86.3	5.6	51.0	138.5	85.0	5.2	46.7	131.0	79.3	-13.8
Montana	4.2	51.2	132.6	82.8	3.2	48.6	127.5	79.1	3.6	43.1	123.1	73.7	2.7	43.9	118.6	72.8	-12.0
Nebraska	3.9	41.7	124.1	74.7	3.8	40.4	119.9	72.5	3.8	42.3	120.6	73.6	3.1	38.9	103.5	64.6	-13.5
Nevada	8.6	77.3	195.9	125.0	7.4	75.8	184.7	118.8	6.8	76.1	180.4	116.6	6.7	74.6	185.1	117.1	-6.3
New Jersey	6.8	51.9	126.9	82.2	6.8	52.1	117.1	78.0	6.3	49.6	116.7	75.9	5.0	46.3	112.8	72.0	-12.4
New Mexico	5.8	78.9	182.8	120.0	5.9	77.6	179.5	117.6	6.8	74.2	167.3	110.1	6.7	70.2	164.4	106.8	-11.0
New York	10.1	76.4	169.0	113.9	9.3	77.2	168.2	113.8	8.7	76.1	165.9	111.9	7.8	70.0	160.0	105.8	-7.1
North Carolina	10.0	80.5	183.5	123.4	9.5	79.1	178.4	119.7	10.3	80.4	175.2	118.4	9.6	75.4	168.5	112.4	-8.9
North Dakota	**	31.6	115.5	63.9	**	30.7	112.9	62.3	**	27.4	104.8	57.1	**	30.8	97.0	56.3	-11.8
Ohio	5.3	52.2	140.0	88.0	5.6	54.3	140.2	89.0	5.4	53.1	136.1	86.0	4.8	51.5	132.4	83.3	-5.4
Oregon	4.8	57.6	156.0	95.5	4.9	58.5	151.0	94.3	5.0	59.2	146.7	93.0	5.4	58.2	146.9	92.5	-3.2
Pennsylvania	7.4	54.9	127.2	84.6	6.8	54.6	124.7	82.9	6.5	48.8	118.7	76.4	5.6	44.4	113.9	71.6	-15.3
Rhode Island	7.3	58.5	166.6	103.9	5.9	63.6	171.6	107.7	7.5	61.4	162.2	101.1	5.3	54.1	154.4	93.5	-10.1
South Carolina	8.9	68.1	153.7	103.8	9.0	65.0	147.1	98.9	8.5	68.8	143.1	99.0	8.8	64.8	142.0	96.0	-7.5
South Dakota	**	42.6	113.3	70.1	1.9	38.1	104.9	64.2	**	35.1	102.5	61.2	1.8	34.0	99.0	59.5	-15.1

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Tennessee	9.3	69.4	170.2	110.9	8.5	66.6	167.8	107.5	9.0	68.0	170.5	107.3	7.7	64.1	167.1	104.5	-5.8
Texas	7.7	77.4	189.0	122.3	7.7	77.2	185.4	120.8	7.6	78.0	180.9	119.0	7.3	76.6	176.7	118.3	-4.8
Utah	3.0	37.2	110.8	65.6	2.4	36.6	104.4	62.9	2.2	35.0	96.5	59.1	2.2	34.3	92.7	58.1	-11.5
Vermont	3.4	45.5	132.1	81.0	3.0	44.0	124.9	76.2	3.2	41.2	118.8	71.6	3.4	36.7	109.3	64.7	-20.1
Virginia	7.2	58.0	141.3	93.2	7.1	58.4	135.9	89.6	6.7	56.0	136.8	89.2	6.2	54.4	127.8	84.2	-9.6
Washington	5.0	64.1	155.8	100.4	5.3	62.2	153.2	98.2	5.3	59.4	142.5	91.9	5.2	56.8	137.0	88.2	-12.1
West Virginia	3.8	45.9	125.2	78.0	4.9	46.5	121.3	76.7	3.5	45.8	115.2	73.5	3.7	43.7	117.4	73.3	-6.0
Wisconsin	4.5	41.6	118.1	71.7	4.7	39.7	109.3	67.2	4.1	37.4	101.4	62.4	4.1	36.2	95.5	59.2	-17.4
Wyoming	**	31.8	114.5	63.3	**	34.6	109.0	63.2	2.5	31.0	105.3	59.1	**	30.7	102.7	58.0	-8.4

*Per 1000 females in age group (per 1000 females aged 13-14 years for the <15-year age group).

†Pregnancy rate could not be calculated for the following states because they did not provide abortion data by age for 1992-1995: Alaska, California, Delaware, Florida, Illinois, Iowa, New Hampshire, and Oklahoma.

‡All percentage changes except for Arkansas were statistically significant at $p < 0.05$.

§Pregnancy rate could not be calculated because the state did not provide abortion data for certain age groups.

**Pregnancy rate was not calculated for groups with <20 pregnancies or <1000 adolescent females.

TABLE 2. Pregnancy rates* for adolescents aged 15–19 years, by race† and state‡ and percentage change in rate — United States, 1992–1995 — Continued

State	1992		1993		1994		1995		% Change in rate from 1992 to 1995	
	White	Black	White	Black	White	Black	White	Black	White	Black
Alabama	86.5	158.8	84.9	156.9	85.6	161.0	84.9	146.8	-1.8	-7.6
Arizona	120.6	177.6	116.8	168.2	116.3	152.5	109.0	113.4	-9.6	-36.2
Arkansas	90.5	168.2	88.5	158.4	91.5	168.3	88.3	158.6	-2.4	-5.7
Colorado	¶	¶	¶	¶	¶	¶	¶	¶	—	—
Georgia	93.9	192.1	92.1	182.4	88.9	174.4	90.2	165.6	-3.9	-13.8
Hawaii	76.3	**	75.2	**	73.6	**	51.7	80.0	-32.2	—
Idaho	70.0	**	66.6	**	60.7	**	63.3	**	-9.7	—
Indiana	74.2	184.8	72.4	178.1	74.1	169.6	74.1	158.4	-0.2	-14.3
Kansas	91.7	249.9	92.0	232.6	88.5	210.7	85.9	210.7	-6.3	-15.7
Kentucky	89.1	176.8	87.4	171.3	86.4	171.8	82.2	156.4	-7.7	-11.5
Louisiana	77.0	157.7††	73.7	157.4††	73.7	152.0††	71.6	136.1††	-6.9	-13.7††
Maine	64.8	**	62.6	**	59.1	**	57.6	**	-11.1	—
Maryland	60.2	161.7	58.7	153.4	58.2	146.6	58.1	132.3	-3.4	-18.2
Minnesota	55.8	257.2	52.9	227.5	51.3	213.9	47.1	215.1	-15.6	-16.4
Mississippi	84.8	159.4	77.7	157.2	73.2	146.7	72.7	137.7	-14.3	-13.6
Missouri	71.9	219.4	69.0	197.3	69.6	183.1	66.4	161.0	-7.6	-26.6
Montana	72.9	**	70.4	**	66.5	**	65.5	**	-10.3	—
Nevada	120.2	201.9	115.3	180.4	114.4	163.0	117.7	141.5	-2.0	-29.9
New Jersey	48.6	211.9	48.4	211.0	46.1	200.3	46.4	177.5	-4.5	-16.2
New Mexico	120.6	118.9	116.4	126.7	109.5	103.8	106.8	99.6	-11.4	-16.2
New York	91.2	207.4	89.6	211.9	88.9	203.9	85.4	186.0	-6.3	-10.3
North Carolina	98.2	183.2	95.2	177.9	95.2	172.1	92.5	157.8	-5.8	-13.9
North Dakota	56.4	**	55.3	**	50.7	**	49.6	**	-12.1	—
Ohio	¶	¶	¶	¶	70.9	185.4	69.2	173.4	—	—
Oregon	93.6	214.3	92.4	218.2	90.5	206.4	90.5	184.7	-3.4	-13.8
Pennsylvania	63.1	249.4	61.6	246.6	56.8	224.9	53.7	208.1	-15.0	-16.6
Rhode Island	92.0	249.8	95.7	240.4	90.6	225.0	83.5	197.2	-9.2	-21.1
South Carolina	80.9	141.1	78.9	130.7	78.2	131.6	78.6	123.3	-2.8	-12.6
South Dakota	54.8	**	51.2	**	50.3	**	48.7	**	-11.1	—
Tennessee	91.3	191.6	88.1	186.0	88.5	181.8	87.3	170.5	-4.3	-11.0
Texas	115.8	175.5	115.7	166.0	115.0	157.0	114.3	142.2	-1.3	-19.0

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Utah	64.0	**	61.5	**	57.7	**	56.6	**	-11.5	—
Vermont	80.6	**	75.9	**	71.6	**	65.4	**	-19.0	—
Virginia	74.2	164.4	72.2	153.3	72.9	148.4	68.5	139.0	-7.7	-15.5
Washington	¶	¶	¶	¶	¶	¶	¶	¶	—	—
West Virginia	76.2	137.4	75.0	135.1	71.5	138.8	71.1	137.6	-6.7	0.2
Wisconsin	53.4	267.6	51.2	239.3	48.2	212.3	46.5	194.9	-13.1	-27.2

* Per 1000 adolescent females aged 15–19 years in each racial group. Rates were not calculated for some states according to the following hierarchy: 1) abortion data by age and race were not reported by state; 2) <20 pregnancies or <1000 adolescent females were in the group; and 3) for >15% of the abortion data, age or race of the woman was unknown.

† Pregnancy rate for adolescents of races other than white or black are not presented because the composition of this category varied widely by state and because abortion information was not available on the race breakdown of "others" for each state.

‡ Pregnancy rate could not be calculated for the following states because they did not provide abortion data by age and race for 1992–1995: Alaska, California, Connecticut, Delaware, District of Columbia, Florida, Illinois, Iowa, Massachusetts, Michigan, Nebraska, New Hampshire, Oklahoma, and Wyoming.

¶ Pregnancy rate was not calculated because race information was missing for >15% of females who had had an abortion.

** Pregnancy rate was not calculated for groups with <20 pregnancies or <1000 adolescent females.

†† Rate and percentage change is for all races other than white.

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different groups of adolescents, and youth development approaches that seek to strengthen self-esteem and planning for the future (10).

In 1995, CDC funded 13 Community Coalition Partnership Programs for the Prevention of Teen Pregnancy to demonstrate how communities can mobilize resources in support of community-wide, sustainable efforts to prevent initial and repeat adolescent pregnancies. Rigorous evaluation of adolescent pregnancy prevention measures is an essential component of these community demonstration programs. The identification of effective strategies will assist state and local agencies in implementing successful approaches to continuing the downward trend in adolescent pregnancy.

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Progress Toward Poliomyelitis Eradication — Europe and Central Asian Republics, 1997–May 1998

In 1988, the World Health Assembly resolved to eradicate poliomyelitis globally by 2000 (1). In 1995, the World Health Organization (WHO) European Region (EUR), comprising 51 member states (including Israel and the Central Asian Republics), accelerated efforts toward polio eradication. Improvements in status have been reported previously (2–4). This report summarizes progress toward polio eradication during 1997–1998*, demonstrating that polio incidence has decreased to seven cases in 1997 and two cases in 1998, and surveillance has improved substantially.

Supplemental vaccination activities. Since 1995, National Immunization Days (NIDs)[†] were conducted in 18 contiguous countries of the WHO Eastern Mediterranean (eight countries: Afghanistan, Iran, Iraq, Jordan, Lebanon, Pakistan, Palestine,

*The report contains data reported to EUR through May 30, 1998. Surveillance data for 1997 have been updated (2).

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and Syria) and European regions (10 countries: Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Russian Federation, Tajikistan, Turkey, Turkmenistan, and Uzbekistan) as part of Operation MECACAR (Eastern Mediterranean, Caucasus, and Central Asian Republics). Reported coverage levels were >95% in 1997 with two doses of oral poliovirus vaccine (OPV), similar to levels achieved during previous years (2). Beginning in the autumn of 1997 with "mopping-up" vaccination,[‡] coordinated activities in countries of the two regions continued as "Operation MECACAR Plus"; NIDs were conducted in April and May 1998, but final results are not available. Additional coordinated NIDs and "mopping-up" vaccination will continue through 2000 in selected countries, depending on the quality and results of local acute flaccid paralysis (AFP) surveillance.

Surveillance. AFP surveillance and virologic testing of stool specimens from AFP cases is a key strategy recommended by WHO for polio eradication. By 1998, a total of 17 countries where polio is endemic or was recently endemic have established AFP surveillance; in addition, 18 countries where polio is not endemic also report AFP surveillance data (Table 1). From January 1997 through May 1998, three countries (Albania, Belarus, and Kyrgyzstan) consistently achieved the minimum AFP reporting rate indicative of a sensitive surveillance system (at least one nonpolio AFP case per 100,000 children aged <15 years annually); reported rates for the Russian Federation in 1997 and 1998 and for Ukraine in 1997 are difficult to interpret because of the inclusion of cases of isolated facial paralysis. In addition, 13 other countries are close to achieving or have provisionally achieved the minimum reporting rate in 1998. The overall rate of collection of two adequate stool samples[¶] from persons with reported AFP cases increased to approximately 70% in 1997 and in 1998 (Table 1). During 1997–1998, few countries consistently achieved the WHO-recommended target of two adequate stool specimens collected from at least 80% of AFP cases. Beginning in 1998, a total of 29 of 35 countries are reporting case-based AFP surveillance data weekly to the WHO regional office. Completeness of reports received for weekly reporting is 83%; for the six countries still reporting aggregate counts of AFP cases monthly, completeness is 69%.

EUR laboratory network. The EUR polio laboratory network consists of 35 laboratories: 30 national laboratories, two subregional reference laboratories, and five regional reference laboratories (two of which are national laboratories) (5). WHO accreditation of national laboratories based on six objective criteria (5) is being implemented; 20 laboratories have received full accreditation. Four laboratories received provisional accreditation pending further experience or improvements in specific areas. Based on the status of accreditation, of the 1596 AFP cases reported in 1997, a total of 448 (28%) stool specimens were processed for virus isolation in fully accredited laboratories.

[‡]Mass campaigns over a short period (days to weeks) in which two doses of OPV are administered to all children in the target age group, regardless of previous vaccination history, with an interval of 4–6 weeks between doses.

[§]Focal mass campaign in high-risk areas over a short period (days to weeks) in which two doses of OPV are administered during house-to-house visits to all children in the target age group, regardless of previous vaccination history, with an interval of 4–6 weeks between doses.

[¶]Two stool specimens collected at an interval of at least 24 hours within 14 days of onset of paralysis. WHO recommends that ≥80% of patients with AFP have two adequate specimens collected (4).

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*Poliomyelitis — Continued***TABLE 1. Number of reported cases of nonpolio acute flaccid paralysis (AFP), nonpolio AFP rate*, and percentage of persons with reported AFP with two stool specimens, by year and country — European Region (EUR), World Health Organization, 1997 and 1998†**

Country	1997			1998		
	No. nonpolio AFP cases	Nonpolio AFP rate	% of persons with AFP with two stool specimens‡	No. nonpolio AFP cases	Nonpolio AFP rate	% of persons with AFP with two stool specimens‡
Albania	12	1.11	83%	3	1.11	33%
Armenia	15	1.46	93%	4	0.91	75%
Azerbaijan	13	1.08	77%	1	0.24	100%
Belarus	34	1.53	100%	20	2.13	40%
Bosnia and Herzegovina	1	0.20	100%	1	1.16	100%
Bulgaria	9	0.61	100%	9	1.28	38%
Croatia	3	0.32	67%	0	0	
Czech Republic	9	0.49	78%	10	1.28	50%
Estonia	3	1.03	33%	1	0.82	0
Georgia	7	0.55	86%	4	0.77	75%
Greece¶	—	—	—	0	0	
Hungary**	—	—	—	5	0.65	20%
Israel	17	1.02	18%	6	0.85	17%
Italy	55	0.65	36%	30	0.83	33%
Kazakhstan	35	0.69	60%	10	0.61	80%
Kyrgyzstan	24	1.39	63%	8	1.42	88%
Latvia	0	0	0	0	0	
Malta††	3	3.61	0	1	2.85	100%
Netherlands	10	0.35	0	5	0.50	0
Poland	49	0.59	55%	11	0.31	36%
Portugal	0	0	0	0	0	
Republic of Moldova	8	0.68	88%	9	1.82	56%
Romania	39	0.89	100%	31	1.67	81%
Russian Federation	889	4.07	71%	223	4.08	92%
Slovak Republic	3	0.25	100%	2	0.40	0
Slovenia	0	0		0	0	
Spain‡‡	5	0.46	100%	23	0.83	52%
Switzerland	15	1.18	7%	1	0.19	0
Tajikistan	6	0.25	71%	2	0.20	100%
Former Yugoslav Republic of Macedonia	4	0.67	75%	1	0.39	100%
Turkey	135	0.62	65%	98	1.07	50%
Turkmenistan	9	0.56	56%	5	0.74	80%
Ukraine	149	1.76	79%	23	0.64	87%
Uzbekistan	14	0.15	86%	22	0.58	91%
Federal Republic of Yugoslavia	14	0.62	64%	17	1.95	65%
Total	1589	1.12	69%	586	1.83	70%

*Per 100,000 children aged <15 years. The rate for 1998 is annualized.

†Data reported to EUR through May 30, 1998.

‡Two stool specimens collected at an interval of at least 24 hours within 14 days of onset of paralysis and adequately shipped to the laboratory.

¶AFP surveillance began in early 1998.

**AFP surveillance began in January 1998.

††AFP surveillance began in July 1997.

‡‡AFP surveillance began in autumn 1997.

Poliomyelitis — Continued

Incidence of polio. From 1991 through 1996, the number of confirmed polio cases** reported annually in EUR ranged from 177 to 297; in 1997, only seven cases from two countries (Tajikistan and Turkey) were reported. Wild poliovirus type 1 was isolated in six cases in one southeastern province of Turkey during July–December 1997 (3). To date, Turkey has reported two cases of polio from an adjoining province; one case had onset of paralysis in January and the other in April 1998. All recent isolates of wild poliovirus type 1 in Turkey are related to a single Middle East genotype. Because of inadequate stool specimen collection from some AFP cases in which there was residual paralysis, death, or loss to follow-up, 19 polio-compatible cases were reported in 1997 from seven countries.

Certification process. The European Regional Commission for the Certification of Poliomyelitis Eradication has begun reviewing comprehensive documentation on the vaccination and surveillance activities of EUR countries. All member countries have been asked to form national certification committees to objectively review country vaccination, laboratory, and epidemiologic surveillance data and submit relevant documentation to the regional commission. Documentation from the countries of Europe in which there has been an absence of reported cases for >8 years will be sought in 1998, followed by review for the other countries through 2000.

Reported by: Communicable Diseases and Immunization Unit, World Health Organization Regional Office for Europe, Copenhagen, Denmark; Expanded Program on Immunization, Global Program for Vaccines and Immunization, World Health Organization, Geneva, Switzerland. Respiratory and Enteric Viruses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Vaccine Preventable Disease Eradication Div, National Immunization Program, CDC.

Editorial Note: Polio transmission has been interrupted in most EUR countries where polio was previously endemic; this status is attributed to improvements in routine vaccination coverage and the successful implementation of NIDs through Operation MECACAR. In addition, surveillance activities in most EUR countries have improved. The quality of surveillance and laboratory performance in many areas of the region needs further improvement, particularly in all areas where polio was recently endemic, to ensure that indigenous transmission has been interrupted and that any transmission secondary to imported poliovirus is promptly detected.

WHO staff and consultants are assessing AFP surveillance systems and laboratory performance in 15 countries to determine how further improvements can be made; this is in anticipation of needing to provide definitive AFP and virologic surveillance data supporting the certification process. The incidence of facial paralysis has been unexpectedly high in some countries, possibly attributed to a high incidence of borreliosis. Reporting of facial paralysis has obscured the sensitivity of some surveillance systems monitoring paralytic illnesses more consistent with clinical polio. With the collection of information about individual AFP cases, future monitoring of AFP surveillance will provide more homogeneous data across EUR.

Southeastern areas of Turkey adjacent to Syria, Iran, and Iraq remain at high risk for wild poliovirus transmission; wild polioviruses have been isolated from AFP cases throughout 1997 in Iran and Iraq (4). Most areas of Tajikistan, Turkmenistan, and

**A confirmed case of polio is defined under the virologic scheme of classification as AFP with laboratory-confirmed wild poliovirus infection; in countries where virologic surveillance is inadequate, clinical cases have either residual paralysis at 60 days, death, or no follow-up investigation at 60 days. Most countries in EUR use the virologic scheme of classification of AFP cases, for which some AFP cases with residual paralysis at 60 days, death, or no follow-up investigation may be considered as polio-compatible cases.

Poliomyelitis — Continued

Uzbekistan remain at risk for polio because of confirmed ongoing poliovirus transmission in Afghanistan (4). Importation of wild poliovirus or continuing low-level indigenous transmission may not be detected because of weak surveillance and/or laboratory deficiencies. Interregional and intercountry efforts are ongoing to coordinate surveillance and supplementary vaccination activities in these key high-risk border areas. Supplemental vaccination activities will continue to be organized through 2000 under Operation MECACAR Plus to interrupt any remaining chains of poliovirus transmission. Mopping-up campaigns will be conducted in October and November 1998 in the high-risk areas that border countries of the Eastern Mediterranean Region where polio is endemic or was recently endemic.

EUR priorities toward polio eradication by 2000 include 1) strengthening AFP surveillance systems throughout the region (including accreditation of all laboratories), particularly in the Caucasus, Turkey, and the Central Asian Republics; 2) ensuring that high-quality NIDs or sub-NIDs are conducted through Operation MECACAR Plus in selected countries with persistent high risk for wild poliovirus circulation caused by low vaccination coverage, weak surveillance, and/or administrative problems; 3) implementing coordinated supplemental vaccination activities among key border area populations; 4) maintaining and strengthening the political commitment of governments for polio eradication and certification; 5) consolidating the support of donor governments and partner agencies to ensure sufficient financial and human resources; and 6) progressing in the formal process of certification.

Polio eradication efforts in EUR have been supported by the governments of countries where polio is endemic or was recently endemic, WHO, United Nations Children's Fund (UNICEF), Rotary International, U.S. Agency for International Development, CDC, and through contributions from Canada, Denmark, European Union, Finland, France, Germany, Greece, Hungary, Italy, Japan, Luxembourg, Monaco, Netherlands, Norway, Switzerland, and the United Kingdom.

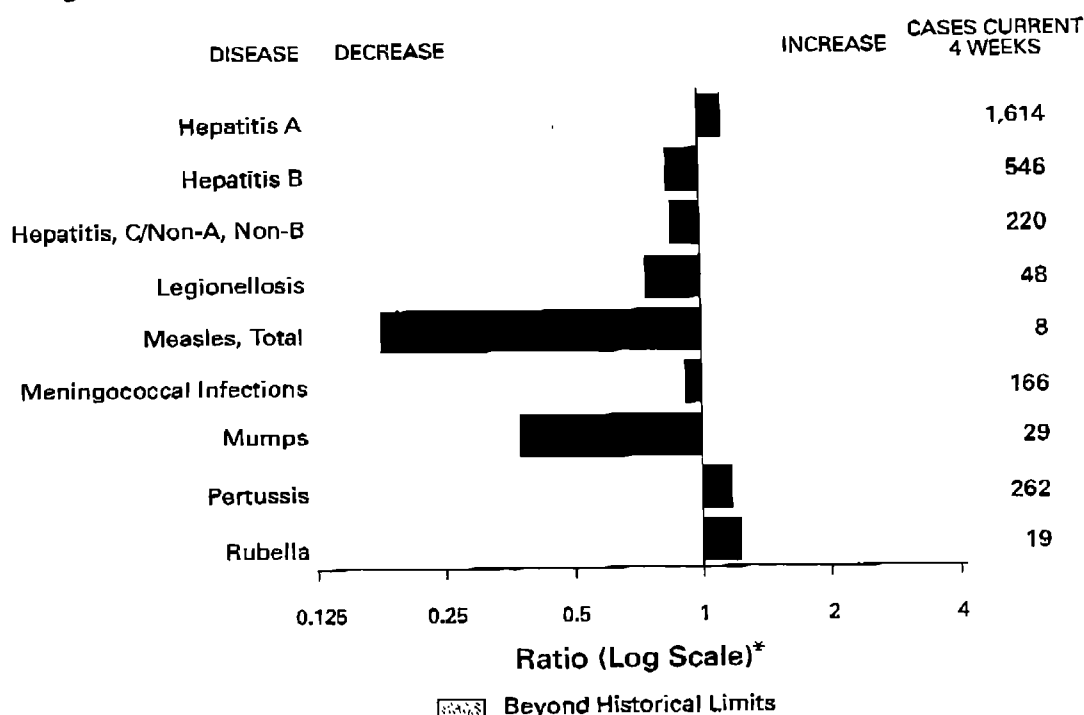
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FIGURE 1. Selected notifiable disease reports, comparison of provisional 4-week totals ending June 20, 1998, with historical data — United States

*Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE 1. Summary — provisional cases of selected notifiable diseases, United States, cumulative, week ending June 20, 1998 (24th Week)

	Cum. 1998		Cum. 1998
Anthrax	-	Plague	2
Brucellosis	31	Polio-myelitis, paralytic†	-
Cholera	3	Psittacosis	20
Congenital rubella syndrome	2	Rabies, human	-
Cryptosporidiosis*	814	Rocky Mountain spotted fever (RMSF)	68
Diphtheria	1	Streptococcal disease, invasive Group A	1,066
Encephalitis: California*	2	Streptococcal toxic-shock syndrome*	33
eastern equine*	-	Syphilis, congenital**	128
St. Louis*	-	Tetanus	11
western equine*	-	Toxic-shock syndrome	63
Hansen Disease	54	Trichinosis	6
Hantavirus pulmonary syndrome*	4	Typhoid fever	130
Hemolytic uremic syndrome, post-diarrheal*	14	Yellow fever	-
HIV infection, pediatric†	108		

-: no reported cases

*Not notifiable in all states.

† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).

‡ Updated monthly to the Division of HIV/AIDS Prevention—Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update May 21, 1998.

§ One suspected case of polio with onset in 1998 has been reported to date.

**Updated from reports to the Division of STD Prevention, NCHSTP.

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TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending June 20, 1998, and June 14, 1997 (24th Week)

Reporting Area	AIDS		Chlamydia		<i>Escherichia coli</i> O157:H7		Gonorrhea		Hepatitis C/NA, NB	
	Cum. 1998*	Cum. 1997	Cum. 1998	Cum. 1997	NETSS [†]	PHLIS [‡]	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997
UNITED STATES	20,034	25,974	236,084	225,050	606	305	138,335	128,357	1,827	1,589
NEW ENGLAND	640	897	8,701	7,943	84	60	2,297	2,678	19	30
Maine	13	25	419	427	5	-	25	25	-	-
N.H.	21	14	424	355	12	16	42	56	-	-
Vt.	10	18	179	186	1	3	13	24	-	1
Mass.	275	416	3,874	3,279	47	30	920	1,012	18	26
R.I.	58	70	1,153	948	3	1	172	216	1	3
Conn.	263	354	2,652	2,748	16	10	1,125	1,345	-	-
MID. ATLANTIC	5,695	8,265	28,966	26,631	61	10	18,020	16,156	186	158
Upstate N.Y.	710	1,336	N	N	39	-	2,781	2,797	140	123
N.Y. City	3,153	4,138	15,749	13,890	3	5	6,757	6,149	-	-
N.J.	993	1,783	4,626	4,706	19	4	2,631	3,336	-	-
Pa.	839	1,010	8,591	8,035	N	1	3,851	3,874	46	35
E.N. CENTRAL	1,518	1,809	40,052	33,354	106	60	26,758	19,779	239	305
Ohio	281	394	11,395	10,171	26	11	6,752	6,255	6	7
Ind.	293	328	3,288	3,991	25	20	2,083	2,717	3	9
Ill.	610	602	11,444	6,018	29	-	8,995	2,940	11	50
Mich.	252	394	9,898	8,235	26	13	7,324	5,816	219	221
Wis.	82	91	4,027	4,939	N	16	1,604	2,051	-	18
W.N. CENTRAL	351	520	13,981	14,494	75	38	6,805	6,372	108	32
Minn.	56	83	2,016	3,019	30	20	708	1,050	5	2
Iowa	20	88	2,010	2,149	17	-	638	580	11	15
Mo.	176	254	5,375	5,353	10	12	3,928	3,418	88	4
N. Dak.	4	4	290	392	1	1	29	24	-	2
S. Dak.	9	2	765	583	1	1	125	57	-	-
Nebr.	36	48	1,020	802	7	-	346	324	2	2
Kans.	50	63	2,505	2,116	9	2	1,031	919	2	7
S. ATLANTIC	5,037	6,477	49,873	40,021	41	18	39,972	38,291	94	104
Del.	57	111	1,172	612	-	1	637	524	-	-
Md.	571	742	3,794	3,366	11	4	4,194	5,397	5	3
D.C.	413	469	N	N	1	-	1,629	1,886	-	-
Va.	368	552	4,623	5,205	N	7	2,759	3,607	5	10
W. Va.	47	38	1,298	1,400	N	1	370	440	4	8
N.C.	335	363	10,324	7,722	11	3	8,622	7,512	12	28
S.C.	318	295	8,650	5,657	1	-	5,586	5,115	1	24
Ga.	608	856	11,394	4,428	4	-	9,341	5,728	9	-
Fla.	2,320	3,051	8,618	11,633	12	-	8,834	8,082	68	31
E.S. CENTRAL	788	807	16,987	15,572	39	11	16,040	15,348	70	172
Ky.	101	112	2,834	3,016	10	-	1,810	1,912	11	7
Tenn.	272	354	5,934	5,823	20	10	6,024	4,792	56	105
Ala.	233	196	4,564	3,716	9	-	5,718	5,210	3	6
Miss.	182	145	3,660	3,017	U	1	3,688	3,434	U	54
W.S. CENTRAL	2,473	2,590	35,058	22,058	42	6	19,926	15,094	507	186
Ark.	81	96	1,442	1,297	1	1	1,128	2,113	3	5
La.	415	493	5,872	3,671	-	1	4,800	3,444	9	96
Okla.	134	138	4,846	3,349	6	3	2,530	2,115	2	4
Tex.	1,843	1,863	23,098	13,741	35	-	11,468	7,422	493	81
MOUNTAIN	725	751	8,007	13,358	59	41	2,953	3,500	226	145
Mont.	13	18	556	470	4	-	23	20	4	10
Idaho	14	22	874	658	6	1	78	47	86	23
Wyo.	2	13	301	255	1	-	15	25	37	36
Colo.	127	194	-	2,770	19	11	1,054	823	13	19
N. Mex.	111	66	1,772	1,865	9	6	329	418	51	30
Ariz.	288	188	3,534	5,180	N	9	1,296	1,654	3	17
Utah	57	60	717	785	13	8	66	110	19	3
Nev.	115	190	253	1,375	7	6	92	403	13	7
PACIFIC	2,807	3,858	34,454	51,619	99	66	7,584	11,139	378	457
Wash.	203	287	4,967	4,197	23	22	858	896	10	14
Oreg.	88	144	2,584	2,154	27	23	348	320	2	2
Calif.	2,463	3,377	25,060	43,858	47	18	6,010	9,510	311	359
Alaska	12	22	875	635	2	-	152	185	1	-
Hawaii	41	28	968	775	N	3	185	228	54	82
Guam	-	2	8	193	N	-	2	27	-	-
P.R.	834	760	U	U	-	U	187	298	-	61
V.I.	17	35	N	N	N	U	U	U	U	U
Amer. Samoa	-	-	U	U	N	U	U	U	U	U
C.N.M.I.	-	1	N	N	N	U	7	16	-	2

N: Not notifiable U: Unavailable - : no reported cases C.N.M.I.: Commonwealth of Northern Mariana Islands

*Updated monthly to the Division of HIV/AIDS Prevention-Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, last update May 24, 1998.

[†]National Electronic Telecommunications System for Surveillance.

[‡]Public Health Laboratory Information System.

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TABLE II. (Cont'd.) Provisional cases of selected notifiable diseases, United States, weeks ending June 20, 1998, and June 14, 1997 (24th Week)

Reporting Area	Legionellosis		Lyme Disease		Malaria		Syphilis (Primary & Secondary)		Tuberculosis		Rabies, Animal
	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	Cum. 1998*	Cum. 1997	Cum. 1998
UNITED STATES	466	382	2,204	1,655	494	641	3,035	3,961	3,438	9,058	3,179
NEW ENGLAND	23	27	843	402	19	31	36	77	146	197	620
Maine	1	1	1	3	3	1	1	-	U	15	101
N.H.	2	4	13	7	3	2	1	-	2	5	33
Vt.	1	4	3	3	-	2	3	-	1	3	30
Mass.	9	8	125	55	11	16	22	39	119	109	200
R.I.	4	5	31	43	2	2	-	1	24	13	35
Conn.	6	5	470	291	-	8	9	37	U	51	221
MID. ATLANTIC	100	66	1,221	947	126	184	99	197	244	1,375	686
Upstate N.Y.	28	15	684	122	33	27	16	20	U	191	486
N.Y. City	19	3	3	76	60	110	22	36	U	714	U
N.J.	4	11	193	288	19	35	18	86	244	283	86
Pa.	49	37	361	481	14	12	43	55	U	187	114
E.N. CENTRAL	143	141	34	30	46	69	409	349	230	809	42
Ohio	63	62	32	12	3	6	74	109	5	148	33
Ind.	19	24	2	9	3	7	66	75	U	70	-
Ill.	14	5	-	2	15	30	157	36	225	423	2
Mich.	29	31	-	7	24	17	89	58	U	122	6
Wis.	18	19	U	U	1	9	23	70	U	48	1
W.N. CENTRAL	34	26	21	20	30	19	70	76	116	228	330
Minn.	3	1	9	11	13	5	3	13	U	64	63
Iowa	4	7	9	-	3	6	-	3	U	20	73
Mo.	12	2	-	7	10	5	54	39	80	91	17
N. Dak.	-	2	-	-	2	-	-	-	U	5	64
S. Dak.	-	1	-	-	-	-	1	-	13	4	54
Nebr.	12	10	1	1	-	1	4	1	5	8	2
Kans.	3	3	2	1	2	2	8	20	18	38	57
S. ATLANTIC	60	51	197	160	118	109	1,279	1,603	662	1,390	1,005
Del.	7	5	4	32	1	2	15	14	-	14	17
Md.	12	11	136	102	41	40	306	448	132	136	245
D.C.	4	3	4	6	7	7	36	61	53	46	-
Va.	5	10	14	2	19	26	84	130	118	140	317
W. Va.	N	N	4	-	-	-	2	3	24	24	41
N.C.	6	6	9	7	8	7	353	326	193	172	136
S.C.	5	2	1	1	4	7	148	197	142	113	72
Ga.	1	-	2	1	15	13	231	283	U	260	81
Fla.	19	14	23	9	23	7	104	141	U	485	96
E.S. CENTRAL	19	19	23	35	13	15	523	858	160	561	121
Ky.	11	6	6	5	1	4	58	72	U	80	19
Tenn.	5	6	8	12	8	4	265	355	U	208	70
Ala.	3	2	9	4	4	4	121	222	160	181	32
Miss.	U	5	U	14	U	3	79	209	U	92	U
W.S. CENTRAL	16	5	10	10	17	7	389	526	53	1,146	103
Ark.	-	-	5	3	1	1	52	87	53	98	21
La.	1	1	-	1	4	4	134	185	-	85	-
Okla.	6	1	-	2	2	2	24	56	U	87	82
Tex.	9	3	5	4	10	-	179	198	U	876	-
MOUNTAIN	29	25	3	5	24	35	87	84	194	245	74
Mont.	1	1	-	-	-	2	-	-	12	6	26
Idaho	-	2	1	-	3	-	-	-	4	5	-
Wyo.	1	1	-	1	-	2	1	-	2	2	39
Colo.	5	5	1	2	7	16	7	2	U	48	1
N. Mex.	2	1	-	-	9	5	12	4	27	17	-
Ariz.	4	7	-	1	4	4	62	69	92	111	7
Utah	15	5	-	-	1	2	3	3	28	10	1
Nev.	1	3	1	1	-	4	2	6	29	46	-
PACIFIC	42	22	52	46	101	172	143	191	1,633	3,107	198
Wash.	4	6	1	1	9	8	9	6	17	128	-
Oreg.	-	-	8	9	9	10	2	4	U	88	-
Calif.	37	15	43	36	82	148	132	179	1,520	2,778	181
Alaska	-	-	-	-	-	3	-	1	20	42	17
Hawaii	1	1	-	-	1	3	-	1	76	91	-
Guam	-	-	-	-	-	-	-	3	-	13	-
P.R.	-	-	-	-	-	3	109	101	46	88	27
V.I.	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	-	-	-	-	1	7	8	-	-

N: Not notifiable U: Unavailable - : no reported cases

*Additional information about areas displaying "U" for cumulative 1998 Tuberculosis cases can be found in Notice to Readers, MMWR Vol. 47, No. 2, p. 39.

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TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending June 20, 1998, and June 14, 1997 (24th Week)

Reporting Area	<i>H. influenzae</i> , invasive		Hepatitis (Viral), by type				Measles (Rubeola)					
	Cum. 1998*	Cum. 1997	A		B		Indigenous		Imported†		Total	
			Cum. 1998	Cum. 1997	Cum. 1998	Cum. 1997	1998	Cum. 1998	1998	Cum. 1998	Cum. 1998	Cum. 1997
UNITED STATES	526	562	10,113	12,822	3,538	4,260	-	23	1	13	36	72
NEW ENGLAND	30	32	128	300	50	78	-	-	-	1	1	10
Maine	2	3	13	41	-	5	-	-	-	-	-	-
N.H.	5	4	7	17	9	5	-	-	-	-	-	1
Vt.	2	2	10	7	1	3	-	-	-	-	-	-
Mass.	19	20	38	148	15	35	-	-	-	1	1	8
R.I.	2	2	9	26	26	8	-	-	-	-	-	-
Conn.	-	1	51	61	-	22	-	-	-	-	-	1
MID. ATLANTIC	74	69	636	1,123	511	645	-	9	-	2	11	16
Upstate N.Y.	29	6	152	137	143	116	-	2	-	-	2	4
N.Y. City	13	22	174	495	132	262	-	-	-	-	-	5
N.J.	28	25	140	168	90	125	-	7	-	1	8	2
Pa.	4	16	170	325	146	142	U	-	U	1	1	5
E.N. CENTRAL	82	65	1,249	1,382	351	722	-	9	1	3	12	7
Ohio	34	42	159	192	33	41	-	-	1	1	1	-
Ind.	24	8	73	141	26	52	U	2	U	1	3	-
Ill.	23	24	218	340	66	140	-	-	-	-	-	5
Mich.	-	11	713	608	210	225	-	7	-	1	8	2
Wis.	1	-	86	103	16	264	-	-	-	-	-	-
W.N. CENTRAL	39	27	828	926	155	249	-	-	-	-	-	11
Minn.	25	18	60	86	16	18	-	-	-	-	-	2
Iowa	1	3	365	133	26	19	-	-	-	-	-	-
Mo.	8	3	325	500	86	187	-	-	-	-	-	1
N. Dak.	-	-	3	9	4	1	-	-	-	-	-	-
S. Dak.	-	2	8	13	1	-	-	-	-	-	-	8
Neb.	-	1	15	38	7	8	-	-	-	-	-	-
Kans.	5	-	52	147	15	16	-	-	-	-	-	-
S. ATLANTIC	111	97	886	666	505	498	-	2	-	5	7	3
Del.	-	-	2	13	-	3	-	-	-	1	1	-
Md.	34	40	162	110	79	75	-	-	-	1	1	1
D.C.	-	-	28	14	6	21	-	-	-	-	-	1
Va.	12	6	124	87	51	57	-	-	-	2	2	-
W. Va.	4	3	1	6	3	8	-	-	-	-	-	-
N.C.	13	16	48	103	82	108	-	-	-	-	-	1
S.C.	4	3	16	64	3	57	-	-	-	-	-	-
Ga.	23	20	236	120	82	47	-	-	-	1	1	-
Fla.	21	9	269	139	199	122	-	2	-	-	2	-
E.S. CENTRAL	31	36	171	320	187	315	-	-	-	-	-	1
Ky.	4	4	10	36	22	19	-	-	-	-	-	-
Tenn.	20	22	117	194	134	205	-	-	-	-	-	-
Ala.	7	8	44	49	31	32	-	-	-	-	-	1
Miss.	U	2	U	39	U	59	U	U	U	U	U	-
W.S. CENTRAL	29	26	1,986	2,554	598	496	-	-	-	-	-	4
Ark.	-	1	40	119	34	34	-	-	-	-	-	-
La.	13	6	40	106	45	57	-	-	-	-	-	-
Okla.	14	17	269	789	31	17	-	-	-	-	-	-
Tex.	2	2	1,637	1,540	488	388	-	-	-	-	-	7
MOUNTAIN	65	64	1,606	1,901	396	409	-	-	-	-	-	-
Mont.	-	-	51	49	3	5	-	-	-	-	-	-
Idaho	-	1	126	76	17	14	-	-	-	-	-	-
Wyo.	-	1	23	19	2	14	-	-	-	-	-	-
Colo.	14	9	123	219	46	80	-	-	-	-	-	-
N. Mex.	5	6	82	147	161	139	-	-	-	-	-	-
Ariz.	38	23	1,025	871	107	84	-	-	-	-	-	5
Utah	4	3	108	331	37	48	-	-	-	-	-	-
Nev.	6	21	68	108	23	25	U	-	U	-	-	2
PACIFIC	65	128	2,623	3,660	785	838	-	3	-	2	5	13
Wash.	3	2	556	251	61	34	-	-	-	1	1	-
Oreg.	29	22	194	189	53	55	-	-	-	-	-	-
Calif.	27	97	1,839	3,125	660	732	-	3	-	1	4	10
Alaska	1	1	11	22	6	11	-	-	-	-	-	-
Hawaii	5	4	23	73	6	6	-	-	-	-	-	3
Guam	-	-	-	-	-	3	U	-	U	-	-	-
P.R.	2	-	23	172	245	660	-	-	-	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	5	-	1	7	25	U	-	U	-	-	1

N: Not notifiable U: Unavailable -: no reported cases

*Of 122 cases among children aged <5 years, serotype was reported for 66 and of those, 30 were type b.

†For imported measles, cases include only those resulting from importation from other countries.

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TABLE III. (Cont'd.) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending June 20, 1998, and June 14, 1997 (24th Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997	1998	Cum. 1998	Cum. 1997
UNITED STATES	1,404	1,896	3	224	323	52	1,940	2,445	2	242	58
NEW ENGLAND	67	115	-	-	7	4	322	524	-	32	-
Maine	4	11	-	-	-	-	5	6	-	-	-
N.H.	4	11	-	-	-	2	27	61	-	-	-
Vt.	1	2	-	-	-	1	31	164	-	-	-
Mass.	32	62	-	-	2	1	250	271	-	6	-
R.I.	3	8	-	-	4	-	3	12	-	-	-
Conn.	23	21	-	-	1	-	6	10	-	26	-
MID. ATLANTIC	139	194	-	15	34	3	249	186	1	111	13
Upstate N.Y.	36	46	-	3	5	3	120	63	1	104	2
N.Y. City	15	33	-	4	1	-	4	45	-	2	11
N.J.	37	37	-	1	6	-	5	11	-	4	-
Pa.	51	78	U	7	22	U	120	67	U	1	-
E.N. CENTRAL	202	281	-	39	36	8	182	231	-	-	3
Ohio	83	103	-	19	13	5	71	68	-	-	-
Ind.	25	33	U	3	4	U	48	27	U	-	-
Ill.	47	82	-	1	8	-	14	30	-	-	-
Mich.	26	38	-	16	10	1	32	31	-	-	-
Wis.	21	25	-	-	1	-	17	75	-	-	3
W.N. CENTRAL	116	137	-	20	8	9	153	139	-	13	-
Minn.	19	23	-	10	3	7	86	88	-	-	-
Iowa	16	27	-	6	4	2	38	8	-	-	-
Mo.	48	64	-	3	-	-	12	22	-	2	-
N. Dak.	-	1	-	1	-	-	-	2	-	-	-
S. Dak.	6	4	-	-	-	-	4	3	-	-	-
Nebr.	4	4	-	-	1	-	5	3	-	-	-
Kans.	23	14	-	-	-	-	8	15	-	11	-
S. ATLANTIC	248	315	1	32	36	4	121	195	1	6	17
Del.	1	4	-	-	-	-	1	-	-	-	-
Md.	22	31	-	-	1	-	25	74	-	-	-
D.C.	-	5	-	-	-	-	1	2	-	-	-
Va.	22	31	-	4	4	-	6	19	-	-	1
W. Va.	7	13	-	-	-	-	1	4	-	-	-
N.C.	34	55	-	7	7	-	42	46	-	3	10
S.C.	37	38	-	4	9	-	13	9	-	-	6
Ga.	55	60	-	1	5	1	4	6	-	-	-
Fla.	70	78	1	16	10	3	28	35	1	3	-
E.S. CENTRAL	103	134	1	1	19	-	48	44	-	-	1
Ky.	16	35	-	-	3	-	18	11	-	-	-
Tenn.	40	43	1	1	3	-	17	15	-	-	-
Ala.	47	39	-	-	6	-	13	12	-	-	1
Miss.	U	17	U	U	7	U	U	6	U	U	-
W.S. CENTRAL	155	187	-	31	40	1	124	70	-	62	3
Ark.	22	25	-	-	-	-	16	4	-	-	-
La.	35	33	-	2	11	-	1	11	-	-	-
Okla.	26	23	-	-	-	-	13	8	-	-	-
Tex.	72	106	-	29	29	1	94	47	-	82	3
MOUNTAIN	83	114	-	21	44	16	435	660	-	5	4
Mont.	2	7	-	-	-	-	1	7	-	-	-
Idaho	4	7	-	3	2	1	177	429	-	-	1
Wyo.	3	1	-	1	1	-	7	4	-	-	-
Colo.	19	31	-	4	3	5	85	159	-	-	-
N. Mex.	15	19	N	N	N	2	84	32	-	1	-
Ariz.	28	26	-	4	27	7	68	15	-	1	3
Utah	9	11	-	3	6	1	22	4	-	2	-
Nev.	3	12	U	6	5	U	11	10	U	1	-
PACIFIC	291	419	1	65	99	9	306	396	-	13	17
Wash.	38	51	-	5	12	5	136	177	-	9	3
Oreg.	55	85	N	N	N	-	17	23	-	-	-
Calif.	193	280	1	45	71	4	147	185	-	2	7
Alaska	1	1	-	2	5	-	2	2	-	-	-
Hawaii	4	2	-	13	11	-	4	9	-	2	7
Guam	-	1	U	-	1	U	-	-	U	-	-
P.R.	4	9	-	1	4	-	2	-	-	-	U
V.I.	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	U	-	4	U	-	-	U	-	-

N: Not notifiable

U: Unavailable

-: no reported cases

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**TABLE IV. Deaths in 122 U.S. cities,* week ending
June 20, 1998 (24th Week)**

Reporting Area	All Causes, By Age (Years)						P&I† Total	Reporting Area	All Causes, By Age (Years)						P&I† Total	
	All Ages	>65	45-64	25-44	1-24	<1			All Ages	>65	45-64	25-44	1-24	<1		
NEW ENGLAND	508	359	92	33	11	13	35	S. ATLANTIC	1,630	1,023	375	152	46	33	87	
Boston, Mass.	119	77	27	5	5	5	13	Atlanta, Ga.	580	340	134	64	13	9	15	
Bridgeport, Conn.	41	33	5	3	-	-	1	Baltimore, Md.	211	119	51	28	10	2	25	
Cambridge, Mass.	18	14	2	2	-	-	2	Charlotte, N.C.	93	68	18	5	1	3	13	
Fall River, Mass.	29	23	4	2	-	-	-	Jacksonville, Fla.	130	84	32	8	3	3	7	
Hartford, Conn.	41	28	8	5	1	1	-	Miami, Fla.	110	82	19	5	4	-	-	
Lowell, Mass.	27	16	7	4	-	-	1	Norfolk, Va.	52	33	8	5	3	3	3	
Lynn, Mass.	13	11	-	2	-	-	-	Richmond, Va.	56	36	16	2	-	2	1	
New Bedford, Mass.	16	12	3	1	-	-	2	Savannah, Ga.	48	29	13	3	2	1	-	
New Haven, Conn.	34	27	4	2	-	1	3	St. Petersburg, Fla.	53	42	6	4	1	-	7	
Providence, R.I.	49	38	6	-	2	2	2	Tampa, Fla.	172	110	43	11	3	5	14	
Somerville, Mass.	0	0	-	-	-	-	-	Washington, D.C.	135	80	27	17	6	5	2	
Springfield, Mass.	35	18	10	2	1	4	2	Wilmington, Del.	10	2	8	-	-	-	-	
Waterbury, Conn.	25	20	3	1	1	-	3	E.S. CENTRAL	795	540	162	55	15	22	48	
Worcester, Mass.	60	42	13	4	1	-	6	Birmingham, Ala.	174	115	35	14	4	5	15	
MID. ATLANTIC	2,043	1,428	396	155	32	31	82	Chattanooga, Tenn.	66	48	13	1	3	1	5	
Albany, N.Y.	53	38	10	1	1	3	2	Knoxville, Tenn.	64	50	11	3	-	-	7	
Allentown, Pa.	18	15	2	1	-	-	-	Lexington, Ky.	64	46	13	2	-	3	4	
Buffalo, N.Y.	88	69	13	1	5	-	2	Memphis, Tenn.	178	115	32	16	7	8	11	
Camden, N.J.	28	16	7	5	-	-	3	Mobile, Ala.	87	60	22	3	-	2	-	
Elizabeth, N.J.	19	10	5	4	-	-	-	Montgomery, Ala.	38	22	9	8	-	-	2	
Erie, Pa.	35	30	5	-	-	-	-	Nashville, Tenn.	123	84	27	8	1	3	4	
Jersey City, N.J.	34	19	7	7	1	-	-	W.S. CENTRAL	1,309	842	262	128	43	34	69	
New York City, N.Y.	1,064	741	209	78	15	21	39	Austin, Tex.	75	52	15	6	1	1	6	
Newark, N.J.	60	27	17	11	4	-	1	Baton Rouge, La.	38	10	14	7	3	2	-	
Paterson, N.J.	21	13	5	2	1	-	-	Corpus Christi, Tex.	46	36	5	1	1	3	6	
Philadelphia, Pa.	200	129	42	22	4	3	11	Dallas, Tex.	174	114	26	18	10	6	7	
Pittsburgh, Pa.‡	92	64	19	6	1	2	3	El Paso, Tex.	63	42	13	5	1	2	4	
Reading, Pa.	23	19	4	-	-	-	1	Ft. Worth, Tex.	95	68	14	10	2	1	2	
Rochester, N.Y.	113	86	17	8	-	2	4	Houston, Tex.	361	214	83	48	10	6	23	
Schenectady, N.Y.	33	26	5	2	-	-	2	Little Rock, Ark.	60	33	15	7	2	3	-	
Scranton, Pa.	31	26	5	-	-	-	-	New Orleans, La.	107	67	25	15	4	6	-	
Syracuse, N.Y.	92	70	17	5	-	-	14	San Antonio, Tex.	186	140	31	7	6	2	16	
Trenton, N.J.	19	14	4	1	-	-	-	Shreveport, La.	U	U	U	U	U	U	U	
Utica, N.Y.	20	16	3	1	-	-	-	Tulsa, Okla.	106	76	21	4	3	2	5	
Yonkers, N.Y.	U	U	U	U	U	U	U	MOUNTAIN	1,038	688	188	101	30	30	60	
E.N. CENTRAL	1,950	1,313	393	151	47	43	102	Albuquerque, N.M.	113	72	24	14	1	2	4	
Akron, Ohio	38	26	12	-	-	-	-	Boise, Idaho	36	26	5	1	-	4	1	
Canton, Ohio	34	31	2	-	1	-	2	Colo. Springs, Colo.	55	32	13	7	-	3	5	
Chicago, Ill.	393	234	91	43	12	11	28	Denver, Colo.	111	75	12	12	4	8	5	
Cincinnati, Ohio	89	65	15	6	1	2	7	Las Vegas, Nev.	189	123	39	19	8	-	13	
Cleveland, Ohio	109	70	25	9	2	3	-	Ogden, Utah	24	19	2	2	1	-	4	
Columbus, Ohio	192	121	48	14	7	2	16	Phoenix, Ariz.	225	136	46	26	8	8	12	
Dayton, Ohio	120	83	23	11	2	1	5	Pueblo, Colo.	30	23	5	2	-	-	2	
Detroit, Mich.	197	119	53	13	8	3	7	Salt Lake City, Utah	112	75	20	10	3	4	6	
Evansville, Ind.	37	30	4	2	-	1	2	Tucson, Ariz.	143	107	22	8	5	1	8	
Fort Wayne, Ind.	44	38	4	1	1	-	2	PACIFIC	1,842	1,334	332	105	33	38	127	
Gary, Ind.	12	8	4	-	-	-	1	Berkeley, Calif.	16	12	4	-	-	-	-	
Grand Rapids, Mich.	62	48	7	4	1	2	7	Fresno, Calif.	108	81	16	7	3	1	-	
Indianapolis, Ind.	178	126	36	10	3	3	-	Glendale, Calif.	40	34	6	-	-	-	3	
Lansing, Mich.	47	38	8	2	1	-	5	Honolulu, Hawaii	67	49	12	2	2	2	3	
Milwaukee, Wis.	107	71	21	8	2	5	8	Long Beach, Calif.	73	51	18	3	-	1	11	
Peoria, Ill.	41	30	5	4	-	2	2	Los Angeles, Calif.	503	368	86	30	9	10	24	
Rockford, Ill.	48	28	13	6	-	1	4	Pasadena, Calif.	23	16	5	1	-	1	1	
South Bend, Ind.	53	39	6	5	1	2	2	Portland, Oreg.	100	78	11	4	4	3	9	
Toledo, Ohio	79	59	8	4	5	3	2	Sacramento, Calif.	162	119	34	8	1	-	19	
Youngstown, Ohio	70	51	8	9	-	2	2	San Diego, Calif.	145	98	31	11	2	3	13	
W.N. CENTRAL	753	536	107	49	23	28	46	San Francisco, Calif.	136	82	30	8	2	4	18	
Des Moines, Iowa	U	U	U	U	U	U	U	San Jose, Calif.	158	119	25	6	4	4	9	
Duluth, Minn.	32	24	7	-	1	-	2	Santa Cruz, Calif.	29	20	7	2	-	-	3	
Kansas City, Kans.	28	21	3	2	1	1	-	Seattle, Wash.	136	85	29	14	5	3	1	
Kansas City, Mo.	107	70	10	10	4	3	4	Spokane, Wash.	59	48	5	4	-	2	7	
Lincoln, Nebr.	43	35	8	1	1	-	3	Tacoma, Wash.	87	64	13	5	1	4	6	
Minneapolis, Minn.	188	138	26	15	3	6	11	TOTAL	11,868†	8,063	2,307	929	280	272	656	
Omaha, Nebr.	95	71	12	4	2	6	6									
St. Louis, Mo.	111	65	23	9	5	9	12									
St. Paul, Minn.	84	62	9	5	6	2	7									
Wichita, Kans.	85	50	11	3	-	1	1									

U: Unavailable - no reported cases

*Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

†Pneumonia and influenza.

‡Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

§Total includes unknown ages.

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Policy and Program Recommendations

- Encourage efforts of UNAIDS and other international organizations
- Consider human rights implications of HIV/AIDS
- Highlight women and HIV/AIDS issues

4. Specific Issues

- Prevention
- AIDS-Orphans
- Complex issues surrounding treatment equity
- vaccine research

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Assessing Risk in the Absence of Information: HIV Risk Among Women Injection-Drug Users Who Have Sex with Women

Rebecca M. Young, Gloria Weissman, and Judith B. Cohen

Introduction

Lesbian/bisexual Injection Drug Users (IDU) are women of color and white women; they are addicts as well as casual users; they are "bar dykes," women in jail, streetwalkers and call girls, teenagers, mothers, homeless, and employed. Some identify as "lesbian," "gay," "bisexual," or "straight" ("I'm not a lesbian but my lover is"), and some simply don't identify. What these women do have in common is that, by virtue of their occasional or exclusive choice of other women as their sexual partners, they are ignored, confused, mistreated, and miseducated by the vast majority of AIDS research, education, and service programs.

Women IDUs who have sex with other women fall into a number of overlapping categories in terms of demographic characteristics, sexual identity, and behaviors. The

terms "lesbian" and "bisexual" are used most appropriately to describe sexual identity or orientation, yet sexual identity is not always congruent with sexual behavior.¹ When we discuss research findings in this article, we will specify whether we are comparing groups of women according to the gender(s) of their sexual partners, or according to sexual identity, or both. However, we lack a satisfactory term to describe the entire group of women who *either* have female sexual partners *or* identify as lesbian or bisexual, or who do both. We will use "lesbian/bisexual" to refer to this group in the more general discussions and recommendations, though we consider this an imperfect solution.

This clarification of terms points to a fundamental difficulty in assessing and reducing the HIV risk of women who both inject drugs and have sex with other women: lesbian/bisexual IDUs are at risk for HIV not only because of their sexual and injection behaviors, but (at least for those who are to some extent lesbian identified) sometimes also by the protection they believe is afforded by their "low-risk" lesbian identity. Their personal perception of HIV risk is further limited by a systematic failure to gather information about lesbian and bi-

sexual women's risk. While the risk of woman-to-woman transmission appears to be lower than transmission via same-gender sex among men or sex between men and women,² it is a mistake to focus solely on woman-to-woman sexual transmission as the factor that differentiates risk among lesbian and bisexual women from risk among heterosexual women.³ Further, specific information about woman-to-woman sexual transmission is badly lacking and will continue to be obscured by current research methodologies.⁴ In the place of scientific evidence, women who have sex with other women are forced to rely on *a priori* assumptions of reduced risk.⁵ Institutional denial of the possibility of lesbian risk by researchers, policy makers, and drug-treatment as well as HIV-program staff has resulted in a stark failure to provide appropriate risk-reduction education to this group.⁶

Different subsets of women meeting a *behavioral* definition of lesbian/bisexual IDUs may be at risk in different ways and can be reached by different outreach and education strategies. Lesbian injection-drug users can be at risk because of risky injection practices; sex with female and male sexual partners, including sex for drugs or money; and, for some, because of

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Sam Friedman, NDRI - Special Editor for this issue of AIDS & Public Policy Journal

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the dismissal and/or negation of their risk by virtue of their lesbian identity. Those IDUs who self-identify as "lesbian" or "gay (women)" are susceptible to institutionally supported denial of HIV risk and the accompanying dismissal of the need for risk-reducing activities, face overt and subtle hostility from programs targeting women or IDUs in general, receive limited and often conflicting information about the risk of sexual activities in which they engage, and are not reached by or included in many research and education programs.

Those female IDUs who do *not* identify as lesbian but who do have sex with other women may be missed by programs for several additional reasons. Drug and HIV programs offer these women confusion, misinformation, and especially absence of information about what kinds of sexual behaviors with other women constitute HIV risk. These women may feel alienated (based on their sexual behavior, regardless of their sexual identity) from heterosexual drug-using, drug-treatment, and mainstream communities, and they may feel ambivalent toward and/or lack contact with lesbian and gay community programs, the only ones that have undertaken some small initiatives and produced limited materials specifically addressing HIV risks for lesbian and bisexual women. Finally, because lesbian and gay communities, like other communities, are stratified and segmented, it is likely that lesbian and gay community programs do not adequately seek and reach the injectors within their communities.

Available Evidence on Risky Drug-Using and Sexual Behaviors

Although limited, the existing data on HIV risks of lesbian/bisexual IDUs are extremely provoca-

tive. The Association for Women's AIDS Research and Education (AWARE) is a research program that has been assessing HIV infection risk from drug use and sexual behavior among women in San Francisco and Alameda counties. The AWARE program is one of the few large HIV research endeavors that has gathered information on both sexual identity and sexual behavior. Since 1988, 711 women have participated in the AWARE project: 69 percent are black, 21 percent are white, 6 percent are Latina, and 4 percent are other women of color—including Native Americans, Asians, and Pacific Islanders. The majority of the women (56 percent) are between 25 and 35 years of age, 17 percent are under 25, and 27 percent are more than 35 years old. The average age is 32 years. Virtually all of the women (99.7 percent) who have been a part of the research to date have used drugs, including alcohol, during the three years prior to entry, with most reporting more than one kind of drug use. Of the sample, 41 percent have injected drugs, and 32 percent have used crack cocaine. In describing themselves, 76 percent of the women said they were "exclusively heterosexual," and 3 percent described themselves as "exclusively homosexual." The remaining 21 percent described themselves as preferring some combination of partners of both genders, across a seven-point range from "mostly same-sex" to "mostly other-sex" partners.

In the AWARE sample, HIV risk practices and seropositivity rates differed by both the gender(s) of sexual partners reported and by the respondents' self-assigned sexual identity. Women who had had one or more female sexual partners since 1980 ($n = 329$) were nearly twice as likely to inject drugs during the same time period as women who had had

no female sexual partners (76 percent versus 42 percent).⁷ Women who had had at least one female sexual partner in the three years prior to entry were also much more likely to have engaged in anal intercourse with a male partner than women who had no female partners were (33 percent versus 19 percent). The difference is even more striking when the prevalence of anal intercourse is examined according to the self-described sexual identity of respondents. Twice as many women who identified as *either* exclusively homosexual or as bisexual had engaged in anal intercourse with a male partner during the last three years: 32 percent of both these groups compared with 16 percent of women who identified as *exclusively* heterosexual.

Differences in HIV infection rates again emphasize the importance of separating sexual identity and sexual behavior. Self-identified lesbians were *more* likely to be seropositive than women identifying as either bisexual or heterosexual (15 percent versus 13 percent and 11 percent, respectively). In contrast, fewer women who reported having had any female sexual partners since 1980 were HIV seropositive than were women who reported having had no female sexual partners (10 percent versus 15 percent).

The National AIDS Demonstration Research (NADR) Project, established by the National Institute on Drug Abuse in 1987 and comprising 40 grants and contracts in 59 sites around the country, represents the largest research endeavor undertaken to date to assess sexual and drug-using behavior of IDUs and their sexual partners. According to Samuel Friedman of National Development and Research Institutes, Inc. (NDRI), in an analysis of NADR data on female drug injectors from 14 US cities, women who reported having had sex with

other women in the six months prior to interview "were more likely to: use amphetamines or poppers; be homeless; inject only with illicit syringes, rent used syringes, inject at drug dealers' houses, share syringes with more people; and have sex for drugs, or for money" than women IDUs with no female sexual partners were.⁸ Most significantly, women who had had any female sexual partners were more likely to seroconvert during the six-month period: this is consistent with the higher seroprevalence reported among lesbian/bisexual IDUs in at least two other studies.⁹

Several other studies have reported that as many as half of all self-identified lesbians periodically have some sex with men.¹⁰ Although no studies to date indicate the frequency of such encounters, what information has been gathered about lesbians' actual sexual practices and the characteristics of their male partners presents troubling news about HIV risks. In a study of female sexual behavior conducted in 1987 by researchers of the Kinsey Institute, 46 percent of self-identified lesbians ($n = 262$) had had sex with men since 1980. Of this group, 32 percent were aware that the male partner was behaviorally bisexual (that is, regardless of sexual identity, these men actually had sex with both men and women). Of the women with bisexual male partners, 45 percent reported penile-anal intercourse; 88 percent of lesbians reporting sex with any men since 1980 reported penile-vaginal intercourse, and 30 percent reported penile-anal intercourse. Only 8 percent of the lesbians in this highly educated sample who practiced penile-anal intercourse always used condoms; less than 5 percent of the sample always used condoms for penile-vaginal intercourse.¹¹ Data about drug injection among these women were not available.

In a small study of IDUs in San Francisco who self-identified as lesbian, 53 percent ($n = 28$) reported sex with men in the previous five years: 25 percent for drugs or money, and 26 percent for other reasons.¹²

There is a widespread belief and some empirical evidence that lesbians are more likely than heterosexual women to abuse alcohol and other drugs.¹³ There are, however, major methodological problems with virtually all of the studies that are usually quoted to support this trend,¹⁴ including lack of comparable heterosexual control groups, sampling problems (such as drawing study subjects from patrons of gay bars),¹⁵ and "the lack of a standard and universal operational definition of sexual orientation."¹⁶ The question will not be resolved in the foreseeable future, since no substantial funding has yet been made available for research in this area.

A study of 500 lesbian/bisexual women conducted by the Lesbian Information Project, Sydney, Australia,¹⁷ revealed substantial levels of injection-drug use: 23 percent of the sample had injected drugs; of all injectors, 59 percent had injected in the last five years, and 36 percent had injected in the last year.¹⁸ Many of these women had multiple risks for HIV: of the IDUs, 90 percent had also had sex with men. Sexual identity again was shown to be an inappropriate predictor of sexual behavior: 90 percent of the sample self-identified as "lesbian," "dyke," or "gay," yet 79 percent of the sample had had sex with men.¹⁹

Increased Risk Due to Inaccurate or Unavailable Information

At the present time, we lack critical information needed to assess and reduce risk among lesbian/bisexual IDUs. Most HIV/AIDS research does not attempt to

gather information about lesbian/bisexual women,²⁰ nor does more general research on drug use or drug treatment. Equally important, much of the research conducted to date is structured in a way that makes it impossible to glean information relevant to lesbian/bisexual IDUs from the data that have been collected.²¹ For example, research instruments concerned with HIV risk often equate "sex" with "intercourse" (that is, activities that require penile penetration) and sexual identity with sexual behavior.²² Further, the US Centers for Disease Control's (CDC) AIDS case-reporting protocol utilizes hierarchical categories mixing behaviors and sexual identities, but does not include lesbian/bisexual women in the protocol.

A glaring example of how these research biases operate can be found in the National Household Sero-prevalence Pilot Survey, funded by the CDC and conducted in a representative sample of households in Dallas County and Pittsburgh in 1989 to 1990. The following introduction appears for the sexual-practices questions in this self-administered questionnaire:

For the next questions, when we ask if you "had sex" with a person, we are asking *only* if you had intercourse with that person. There are two types of intercourse:

VAGINAL INTERCOURSE is when a man's penis is inside a woman's vagina. ANAL INTERCOURSE is when a man's penis is inside his partner's anus or rectum.²³

In this survey, sex can only occur if at least one partner is a man. Far from being the exception, this definition is the rule in HIV research.²⁴ Some other surveys get one step closer to acknowledging sex between women but do not systematically follow through with appropriate phrasing of questions and response categories to capture relevant information. For example, the AIDS

Initial Assessment (AIA) and AIDS Final Assessment (AFA) questionnaires developed by the National Institute on Drug Abuse for the 40 National AIDS Demonstration Research (NADR) programs do include questions about the gender of sexual partner(s) and about use of latex barriers/dental dams for cunnilingus and anilingus.

Many of the questions about latex barriers/dental dams, however, (and initially, *all* of them) were asked and coded together with questions about use of condoms. This obscured accurate reporting in several ways: (1) Interviewer instructions for including "latex barriers/dental dams" were confusing and changed several times throughout the use of the AIA and AFA. As a result, many interviewers did not read "latex barriers/dental dams" on the questions about the use of barriers for sex but simply read "condoms." (2) The frequency of condom use is not a good predictor for the same respondent's use of latex barriers/dental dams. Including both of these items in the same question almost certainly distorted the frequency of barrier use for cunnilingus and anilingus. (3) Reasons for not using latex barriers/dental dams are very likely to be different from reasons for not using condoms, yet this information cannot be analyzed separately from the AIA or AFA. (4) Thousands of interviews were conducted *before* the questionnaire was edited to include "latex barriers/dental dams" on the questions about cunnilingus and anilingus. Prior to the change, the interviewers' instructions were to ask about frequency of these activities with and without condoms.

Another weakness is that the questionnaire collected extensive demographic information, including race/ethnicity, religion, employment, domicile, and so on, to assist in appropriately targeting educa-

tion and service programs, yet no questions were asked about sexual identity/orientation. Although nearly none of the investigators analyzing NADR data have reported on lesbian sexual behavior, those who do so (such as Friedman, *et al.*, referenced above) are forced to speculate about sexual identity based on the reported gender of sexual partners in the six months prior to interview, a method that is demonstrably unreliable for extrapolating sexual identity/orientation.²⁵ Some of these problems have been corrected in the new Risk Behavior Assessment (RBA) instrument, which NIDA has used in new programs since December 1991.²⁶ In particular, the new instrument includes a question on sexual identity, which should make future data gathered by NIDA-funded programs much more useful.

One of the most powerful single policies affecting research and program development in the AIDS epidemic has been the CDC's method of AIDS case reporting by hierarchical, identity-based, and mutually exclusive (*sic*) transmission categories. In the most complete assessment of lesbian/bisexual women's HIV risk that we have reviewed, "Lesbian Exclusion from HIV/AIDS Education: Ten Years of Low-Risk Identity and High-Risk Behavior," Rebecca Cole and Sally Cooper criticize the reporting system on many grounds.²⁷ They are especially concerned about its lack of a female-to-female transmission category and the impossibility of reporting multiple transmission routes for infected women. Cases with multiple risks are assigned to transmission categories based on epidemiological distribution of early AIDS cases in the US, with those *populations* in which the most AIDS cases are identified proxying for *transmission routes* that are then assumed to be most effective/risky.

As another critic of the policy has observed, "if you are a lesbian IVDU with an IVDU partner, the possibility of woman-to-woman transmission would be ignored and you would be counted solely as an IVDU, even if you never shared needles."²⁸

This reporting strategy distorts the picture of AIDS distribution and HIV transmission in three important ways: first, it uses labels of sexual identity as proxies for sexual behaviors; second, it disallows the recognition of multiple routes of potential exposure to HIV; and third, it is teleological, preferentially assigning cases to categories deemed as "more likely routes of transmission" (thereby inflating the number of cases in these categories), then asserting that these routes are more likely *because* of the greater numbers of cases in those categories. The categories as structured are particularly damaging to our ability to assess HIV/AIDS risk for lesbian/bisexual women or to determine how many lesbians have AIDS. For its classification purposes, the CDC identifies a lesbian as a woman "who has not had sex with a man since 1977."²⁹ The CDC's arbitrary definition of a lesbian misses the mark by a wide margin. The effect, however, is that the CDC actively seeks to *rule out* woman-to-woman transmission, while it seeks to *prove* transmission by routes that it has listed as more likely. If a woman has any other identifiable risk factor, she is not considered to be exposed by woman-to-woman sexual activity, regardless of the relative frequency or other specific details of the various activities. Fittingly enough, women infected only through sex with other women are listed in this system as "Other/unknown."³⁰ It is also relevant to note that a much higher proportion of women than men with AIDS are in this category. There is no way to determine how strongly this dis-

torts the categorical distribution of cases, but the method is fundamentally flawed.

Much of the information needed to address issues of HIV among lesbians is unavailable simply because basic HIV research has not focused adequately on the needs of women. Many critics have asserted that AIDS research and policy often cast women as "vectors" of HIV/AIDS: dangerous channels of infection who threaten men and babies, rather than individuals whose health and well being are of primary concern.³¹ Since lesbians are, mistakenly, assumed neither to be mothers nor to have sex with men, HIV research on lesbians is particularly unlikely to be done.

The strong tendency to study and describe not simply "women" but "women of reproductive age" suggests that the concern for women among many epidemiologists and policy makers is not primarily based on concern for women's own health. Instead, it reflects a primary concern for protecting men and infants, and for keeping women's reproductive abilities—that is, their potential to produce the "best quality" fetus/baby for society—intact.³² This is further reinforced by the lack of attention to HIV symptomatology and etiology in women, the lack of access to clinical trials, and the lack of development of appropriate AIDS-related services focused on women as whole beings (as opposed to actual or potential mothers or partners of men).³³ A single sentence found in a May 1989 issue of CDC's *Morbidity & Mortality Weekly Reports* is revealing:

Most heterosexually acquired cases, excluding U.S. residents born in Haiti or Africa, continue to be in women (75 percent), blacks or hispanics (70 percent), and partners of IV-drug users (71 percent). Thus, heterosexually acquired AIDS in the United States has been focused in *demographically discrete population groups* [emphasis added].³⁴

This astonishing classification of "demographically discrete population groups" can only be accomplished if one is white and male, and by the initial limitation, heterosexual.

"Demographically discrete" is a comforting phrase of limitation, and by delineating the groups thus contained, specifies who is worth being concerned about. As long as heterosexually acquired cases result from transmission to women (or racial/ethnic minorities, or the socially marginal partners of injection-drug users, who are conceived of as women in any case), then the problem is discrete and therefore limited.³⁵ Lesbians will not be studied or educated about AIDS unless this notion of women as vectors of HIV infection is challenged.

Program Bias

Lesbians and bisexual women face discrimination in many drug and alcohol treatment programs.³⁶ Drug-treatment staff generally have little or no training in sexuality,³⁷ and widespread confusion prevails about the meanings of and differences among sexual orientation, sexual identity, sexual behavior, gender orientation, and gender identity.³⁸ Although the 1973 decision by the American Psychiatric Association to remove homosexuality from its official list of mental diseases was echoed in drug-treatment programs with the recognition that *changing* sexual orientation is not a legitimate goal of drug treatment, in many programs that recognition has never been supported with even the most basic information, training, or specific counseling policies. Currently, required sexuality training is primarily AIDS related, and lesbians are addressed peripherally if at all. Although no research has been done to determine the extent of this problem, each of the

authors has information about specific instances in which lesbian and bisexual women's sexual orientation inappropriately became the focus of their drug treatment; this is corroborated by critiques of lesbians' experiences in alcohol programs.³⁹

According to Donna Marie Alexander, who spent seven years as a staff therapist for a residential drug-treatment program and who is currently Director of Counseling and Advocacy for the Washington, DC, Rape Crisis Center, such incidents are still not unusual:

Recently, I was counseling a young lady at the (Rape Crisis) Center who is a lesbian and an incest survivor. In a group session that she attends at a drug treatment program, other clients told her that she should have been able to stop the sexual abuse (at an early age), that she is a lesbian because of the abuse and that she has just never given herself a chance with men. The counselor didn't *initiate* that discussion, but he agreed with it, and certainly didn't take the opportunity to contradict any of that misinformation.

Lesbian and bisexual clients often face hostility from both staff and other clients, and, as in the anecdote cited above, often do not receive counseling for their drug problems because attention is inappropriately deflected to their sexual orientation.⁴⁰

In such a climate, it is not surprising that HIV/AIDS education and outreach programs, many of which are run by drug-treatment agencies or former drug-treatment staff, do not adequately reach lesbian and bisexual women injectors. Only a handful of NIDA's 40 NADR programs explicitly sought out lesbian/bisexual IDUs and their sexual partners for inclusion in the research and education programs, and none received special funding for these efforts. The NADR projects that were targeted just to women did work sensitively with lesbian and bisexual women and benefitted

from the formal and informal guidance and support of lesbian professionals. The Sexual Partners Outreach Program sites, in which staff made an effort to identify and address lesbian IDUs, reached a much higher proportion of women who reported sex with any female partners: 22.9 percent of the female IDUs in the programs targeting women ($n = 558$) reported at least one female sexual partner compared to 9.5 percent of female IDUs in NADR programs as a whole ($n = 11,575$).⁴¹

Lesbian/Bisexual IDUs Would Benefit from Targeted Education

Many communities that are targeted for special HIV education programs are targeted not so much because of the different nature of their risk *vis à vis* other groups, but because of their potential resistance to (or, more positively, the probable inappropriateness of) messages from/for a dominant group.

The AIDS education motto, "It's not who you are, it's what you do," is absolutely true in the most literal sense. Nonetheless, the now standard procedure of "targeting" certain population groups for education and services reflects an understanding that "who you are" may strongly influence what you do and in what context you do it: it also determines to a large degree what information and services will reach you to affect your future behavior and health. In fact, while behavior determines whether or not one becomes infected, so do other factors, such as the prevalence of HIV among one's network of sexual and needle-sharing partners, and the norms, expectations, and resources of the groups to which individuals belong. Researchers must improve understanding of both behavior and identity as crucial components in strategies for stemming the epidemic.

In spite of the increased risk behavior and demonstrated high seroprevalence of lesbian IDUs, to our knowledge there has not been a single program in the US that specifically targets them for AIDS prevention. Lesbian IDUs are told (usually implicitly or by omission) that they are *not* at risk for HIV/AIDS because of their status as lesbians. Yet, at the same time, they are told that they *are* at risk by virtue of their drug use. Messages for the female sexual partners of women IDUs are even more confusing. On the one hand they are told flatly that one should avoid sex with IDUs and always practice safer sex; on the other hand, they are given risk-reduction guidelines that are irrelevant for their sexual behavior, such as "always use condoms" (which categorically defines "IDU sexual partner" as male). Further, most programs provide no images that make it appear safe to disclose lesbian sexual behavior to risk-reduction counselors or outreach staff.

An interesting (though speculative) possibility, which at least some providers of lesbian health services suggest, is that lesbian-identified IDUs are at increased risk because they feel protected from HIV by their lesbian identity.⁴² The strong denial that is so often a major coping mechanism for the drug user may enable them to believe that being lesbian (and the reduced sexual risk that they believe that this conveys) "cancels out" their drug-injection risks. An alternate interpretation of the data on increased lesbian/bisexual risk is that same-sex activity among women IDUs is an indicator of marginality: this may be the subset of female injectors who are most likely to take risks, least likely to be reached by education and health programs, and least receptive to the programs that do reach them. Both hypotheses should

be tested in programs specifically targeting lesbian/bisexual IDUs.

Lesbians (as well as heterosexuals of both genders, bisexuals, and gay men) participate in many behaviors that have nothing to do with their sexual identity but which place them at risk for HIV (and other diseases). Further, the other identities that lesbians "wear" are often hostile or oblivious to the realities of lesbian existence. As Rebecca Cole and Sally Cooper observed:

All lesbians belong to racial and ethnic communities, but their particular experience of being a lesbian in those communities may not be reflected in the communities' culturally-appropriate HIV/AIDS prevention strategies. The degree of invisibility and isolation that lesbians confront in the racial, ethnic, and religious communities from which they come, and in the health fields, has put lesbians with [and, we would add, at risk for] AIDS and HIV infection in tremendous crisis.⁴³

Recommendations

Although the NADR programs were not looking for lesbian/bisexual IDUs, nearly one in ten of the women injectors reached by these studies reported at least one female sexual partner. The proportion of lesbian/bisexual women in the NADR study therefore represents a *minimum* estimate of female IDUs who have sex with other women, and lesbian/bisexual IDUs are a significant at-risk group. We know from experience that marginalized groups cannot be reached adequately through more generalized efforts. This recognition has led to targeted programs for people of color, for IDUs and their sexual partners, for incarcerated populations, etc. We must apply this lesson to lesbian/bisexual IDUs—triply marginalized as women, IDUs, and lesbians/bisexuals, or *quadruply* marginalized, for the many lesbian/bisexual IDUs of color—if we are to reduce their

HIV risks. In order to provide this population with the information and support necessary to reduce their substantial HIV risks, the following steps will be necessary:

1. The CDC should collect and report transmission data by *behavior-based* categories only, rather than the mixture of behavior and identity categories that are now used.
2. The CDC should alter its reporting protocol to encourage collection and reporting of *multiple* risk behaviors, rather than the mutually exclusive hierarchical categories now used.
3. Future studies of HIV infection risk must consciously seek to collect relevant information about lesbians, especially lesbian IDUs. At a minimum, this would include asking unbiased questions about sexual behavior that would allow an accurate reflection of lesbians' sexual activities, with both female and male partners; gathering information about both sexual behavior and sexual identity, adding questions about the sexual orientation and behaviors of subjects' partners; consulting with lesbian sexuality professionals or others who are familiar with and comfortable with lesbian sexuality about the design of research and education programs; and providing sensitivity training about lesbians and bisexual women for all of the staffs of these programs. The success of the AWARE project (as well as the small San Francisco Lesbian IDU Project) in reaching lesbian/bisexual IDUs and gathering relevant data about their sexual and drug-using risks suggests that targeted programs can identify and work with this group.
4. Programs for IDUs must develop materials that explicitly address lesbian and bisexual IDUs, stressing the data that suggest increased HIV risk and the importance of reducing risk from both drug-using and sexual behaviors.
5. Targeted ethnographic research must be undertaken that is specifically designed to describe and assess the HIV risk behaviors in which lesbian IDUs engage. This should include questions about: self-described sexual orientation; drug-using and equipment-sharing behaviors; drug-using and equipment-sharing networks; perception of and experience with drug-treatment programs, AIDS outreach and education programs, and AIDS service providers; sexual behavior and risk-reduction activities; information on sexual partners, including the partners' gender, sexual orientation, drug-using behavior, known HIV risk or infection, and networks; level of knowledge regarding HIV transmission from sexual and drug-using behaviors; self-perception of HIV risk and measures of perceived (in)vulnerability; contact with and efficacy of other HIV risk-reduction counseling and education programs; and lesbian group identity among female injectors who have sex with other women.
6. Research on the drug-treatment experience of lesbian clients must be systematically funded and implemented. The vast anecdotal evidence of discriminatory, inappropriate treatment of lesbian clients must be tested in a rigorous manner. This research should include, at a minimum: a comparison of lesbian, bisexual, and heterosexual female clients on meas-

ures of treatment outcome, clients' perception of the program's efficacy, drug history at admission, clients' support systems after treatment, and identification with staff as role models; a comparison of lesbian clients in conventional treatment programs versus clients in lesbian and gay programs such as Pride Institute and in women-only programs; assessment of programs' capability to assist lesbian clients, including availability of appropriate family counseling, knowledge and attitudes of treatment staff on a range of sexuality issues, and policies and practices regarding employment of lesbian and gay staff; and an assessment of the resources and support available to programs to improve their ability to serve lesbian clients, including what relevant training is offered, what training is delivered, and what training is required on relevant sexuality issues.

Summary

A pattern of increased HIV infection risk among women IDUs who have sex with other women is emerging from a number of recent studies. HIV infection risk may differ according to both the gender of sexual partners and self-reported sexual identity. Increased risk is evident in spite of standard HIV research practices that obscure and fail to collect information relevant to lesbian/bisexual IDUs, and in spite of the powerful myth of lesbian invulnerability to HIV/AIDS. While lesbian/bisexual IDUs appear to be at greater risk for acquiring HIV, this group is not adequately reached by HIV programs targeting either women or IDUs in general, and currently there are no programs focusing on this group.

At this time, there is no excuse for continuing to ignore lesbian/bisexual IDUs in HIV research and education.

NOTES

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- 2 P.D. Drotman and M. Mays, "AIDS and Lesbians: IV-Drug Use Is the Risk" (paper presented at the Fourth International Conference on AIDS, Stockholm, Sweden, June 1988).
- 3 S.Y. Chu, J.W. Buchler, P.L. Fleming, and R.L. Berkelman, "Epidemiology of Reported Cases of AIDS in Lesbians, United States 1980-89," *American Journal of Public Health* 80, no.11 (1990): 1380-81.
- 4 Z. Leonard, "Lesbians in the AIDS Crisis," in *Women, AIDS, and Activism*, ed. C. Chris and M. Pearl (Boston: South End Press, 1990).
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- 7 The sample size for items comparing groups of women according to the gender of their partners is smaller than the total size of the sample. This is because many items about same-sex partners were skipped during interviews, and rather than assume that the skips all accurately reflected "non-applicable" or "no" to questions regarding same-sex partners, these interviews were excluded from the analysis.
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- 12 P. Case, M. Downing, B. Fergusson, et al., "The Social Context of AIDS Risk Behavior Among Intravenous Drug Using Lesbians in San Francisco" (paper presented at the Fourth International Conference on AIDS, Stockholm, Sweden, June 1988).
- 13 R. Jazwinski, "The Research on Alcohol Use Among Lesbians," (paper distributed at the 13th National Lesbian and Gay Health Foundation Conference, New Orleans, 27 July 1991); M.T. Saghir, E. Robbins, B. Walbran, and K. Gentry, "Homosexuality: IV. Psychiatric Disorders and Disability in the Female Homosexual," *American Journal of Psychiatry* 127, no.2 (1970): 147-54.
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- 15 P.M. Nardi, "Alcoholism and Homosexuality: A Theoretical Perspective," *Journal of Homosexuality* 7, no.46 (1982): 9-25.
- 16 Jazwinski, "The Research on Alcohol Use Among Lesbians."
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- 21 R.M. Young, "Shadow Boxing? Lesbians and the AIDS Epidemic," unpublished manuscript, Columbia University, New York City, May 1992.
- 22 *Ibid.*
- 23 Centers for Disease Control (hereafter, CDC), *National Household Seroprevalence Survey* (Atlanta, GA: CDC, OMB 0920-0235).
- 24 One case in point is the multi-country study of drug injectors and HIV risk currently operating under the auspices of the World Health Organization, which gathers no information about woman-to-woman sex. Another is the fact that the recently revised CDC AIDS-case reporting form still does not include questions about woman-to-woman sex in the behavioral history.
- 25 Reinisch, Sanders, and Ziemba-Davis, "Self-Labeled Sexual Orientation," 222-23.
- 26 C. Gordon, NOVA Research Company. Telephone conversation with the authors, 22 June 1992.
- 27 For other clear criticisms of the CDC reporting categories, see N. Reyes, "Invisible Science: Lesbians and AIDS," in *Women, AIDS, and Activism: Essays by the ACT UP/New York Women and AIDS Book Group*, ed. C. Chris and M. Pearl (Boston: South End Press, 1990); Leonard, "Lesbians in the AIDS Crisis," 115; and R. Denenberg, "What the Numbers Mean," in *Women, AIDS, and Activism*. All of these criticisms are strong, though the ACT UP essays call for further identity-based categories, which would include lesbians. We think this part of the critique is mistaken, and we would rather see all categories reflect behaviors.
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- 29 Drotman and Mays, "AIDS and Lesbians"; Chu, Buchler, Fleming, and Berkelman, "Epidemiology of Reported Cases of AIDS," 1380-81.
- 30 *Ibid.*, 1381.
- 31 P.A. Triechler, "AIDS, Gender, and Biomedical Discourse: Current Contests for Meaning," in *AIDS: The Burden of History* ed. E. Fee and D. Fox (Berkeley, CA: University of California Press, 1988); S. Watney, *Policing Desire: Pornography, AIDS, and the Media*, 2nd ed., (Minneapolis, MN: University of Minnesota Press, 1989).
- 32 For example, the discussion of HIV-antibody counseling and testing of women in *A Physician's Guide to AIDS: Issues in the Medical Office* (New York: New York State Department of Health, 1988), 5-6, is written entirely in the context of preventing maternal transmission. Even in the context of pregnancy, the issue here and in all other sources reviewed was maternal transmission, while the possible negative consequences of pregnancy for an HIV-infected woman's health was never addressed. See also CDC, *Morbidity & Mortality Weekly Report: AIDS and Human Immunodeficiency Virus Infection in the United States: 1988 Update* 38, no. S-4 (12 May 1989, supplement): 6-9; American Medical Association, *Information on AIDS for the Practicing Physician* (Chicago: American Medical Association, 1987), especially an entry by W. Ledger, "AIDS and the Obstetrician/Gynecologist," 5; and *A Guide to HIV Counseling and Testing* (New York: New York State Department of Health, February 1990).
- 33 An especially disturbing example of the lack of attention to women in clinical trials is the fact that studies conducted by the Burroughs-Wellcome Company demonstrated significant incidence of vaginal cancer in rats and mice during testing of zidovudine (AZT), which was reported in Appendix I, "Results of Studies Conducted by the Burroughs-Wellcome Company of

Zidovudine Carcinogenicity Involving Animals," *Morbidity & Mortality Weekly Report* (26 January 1990). Of the female mice in the study, 10 percent developed vaginal tumors; the study was undertaken to determine the efficacy of AZT in interrupting maternal-fetal transmission of HIV. According to an ACT UP briefing document distributed at the National Conference on Women and HIV Infection, 13-14 December 1990, "An 'independent' review panel, comprised of Burroughs-Wellcome employees, AIDS Clinical Trials Group 076 investigators, and NIAID officials, determined that the potential benefits to the fetus outweighed the risks for the mother," *What NIAID Won't Tell You about Women in Clinical Trials* (New York: ACT UP, 1990). AZT received FDA approval prior to any clinical trials involving women: R. Deneberg, "Treatment Trials," *Women, AIDS, and Activism* (Boston: South End Press, 1990), 75.

34 CDC, *Morbidity & Mortality Weekly Report: AIDS and Human Immunodeficiency Virus Infection in the United States: 1988 Update* 38, no. S-4 (12 May 1989, supplement): 1-38.

35 A. Juhasz, "The Contained Threat: Women in Mainstream AIDS Documentary," *Journal of AIDS Research* 27, no.1 (1990).

36 B.B. Mills and M.B. Nelson, "Perspectives in the Treatment of Drug-Dependent Lesbians," in *Treatment Services for Drug Dependent Women*, vol. 2, ed. B.G. Reed, G.M. Bescher, and J. Mondanaro (Rockville, MD: NIDA, 1987): 443-76.

37 J. Mondanaro, M. Wedenoja, J. Densen-Gerber, J. Elahi, et al., "Sexuality and Fear of Intimacy as Barriers to Recovery for Drug-Dependent Women," in *Treatment Services for Drug-Dependent Women*, Vol. 2 ed. B.G. Reed, G.M. Bescher, and J. Mondanaro (Rockville, MD: NIDA, 1987), 303-78.

39 S. Potter, "Social Work, Traditional Health Care Systems and Lesbian Invisibility," *Journal of Social Work and Human Sexuality*, 3, no.2/3 (Winter 84/Spring 85): 62.

40 Mills and Nelson, "Perspectives on Treatment of Drug Dependent Lesbians."

41 Peggy Young, NOVA Research Company. Memorandum to the authors, 1 July 1992.

42 Amber Hollibaugh, Director of the Lesbian AIDS Project of the Gay Men's Health Crisis in New York City, calls this the "Lesbianism as Condom" phenomenon and maintains that this myth is nearly as pervasive among health professionals as among at-risk clients. Telephone conversation with the author, 6 May 1992.

43 Cole and Cooper, "Lesbian Exclusion from HIV/AIDS Education," 19.

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