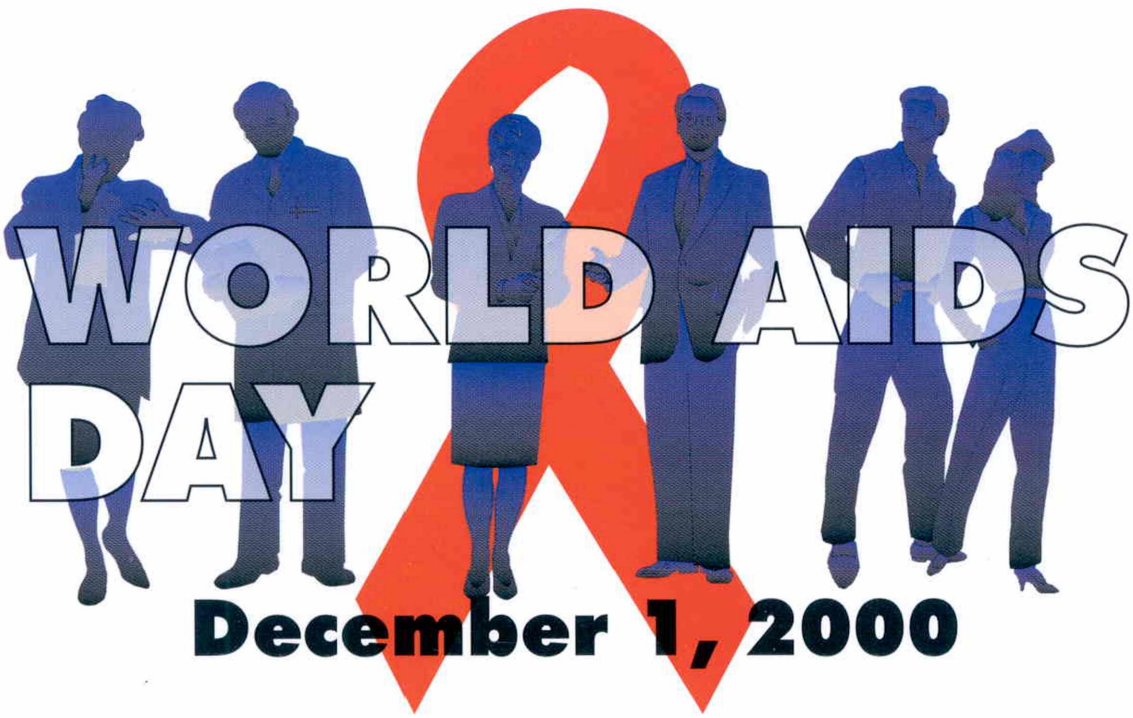
YOU can make a difference



December 1, 2000

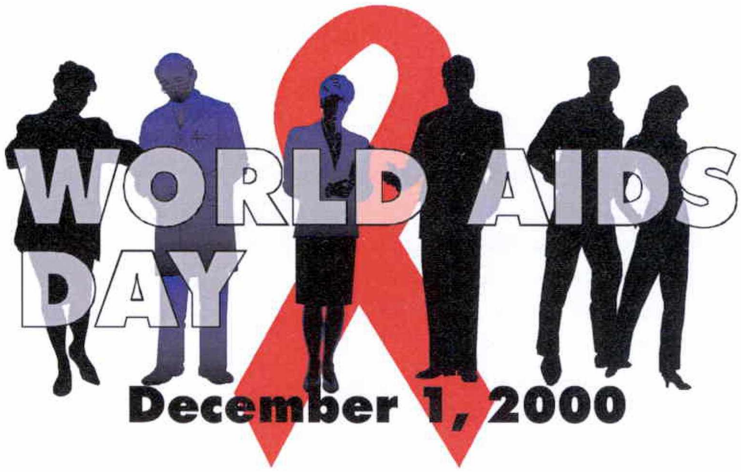
"POSITIVE LIVING WITH HIV"

December 1, 2000

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

NCHSTP
National Center for HIV, STD & TB PREVENTION

About our Panel Members



Terje Anderson

Terje Anderson is the Executive Director of the National Association of People with AIDS (NAPWA) in Washington, D.C. In addition to his position at NAPWA, he serves as a member of the Presidential Advisory Council on HIV/AIDS; a Co-Chair of the Health Resources and Services Administration AIDS Advisory Committee; and Co-Chair of National Organizations Responding to AIDS (NORA), a coalition of more than 175 national organizations. As a person living with HIV, a former injection heroin user, former sex industry worker, and a gay man, he brings a wealth of personal experience in addition to his professional background.

Prior to moving to Washington in 1998, Terje served as Executive Director of the Southern Colorado AIDS Project, worked for the Vermont Department of Health, and was the founding Executive Director of the Vermont Committee for AIDS Resources, Education and Services (Vermont CARES). While in Colorado he served as a member of the Governor's AIDS Council and as a member of the HIV Prevention Community Planning Group. In Vermont, he served as Co-Chair of the HIV Prevention Community Planning Group and as Co-Chair of the Title II CARE Consortium.

Ken Bell

Ken Bell grew up in Atlanta just around the corner from CDC's main campus. He graduated with a degree in Biology from Furman University in Greenville, South Carolina. Ken's interest in medicine and health led to work at CDC during summers and holidays while in college and, later, as a Public Health Advisor for STD control in Cleveland, Ohio, and Ft. Lauderdale, Florida. While in Florida, he trained and supervised some of the first people to offer voluntary HIV counseling and testing services. In 1990, Ken moved to Atlanta to join the HIV/AIDS Surveillance Branch, which at that time was part of the National Center for Infectious Diseases. He currently serves as a team leader in the Prevention Services Research Branch, Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, CDC.

Lisa Lynch

Lisa Lynch, 25, is a native New Yorker and the mother of two – a son, Darnell, and a daughter, Lila. Since learning of her HIV status after the death of her partner of 3 years, Lisa has been a strong advocate for people infected and affected by HIV disease. She is also a peer educator and an inspiration to young adults with HIV disease. One of only a few young adults who have been willing to discuss their HIV-positive status publicly, Lisa chose to work with youth because she "...understands youth issues and psychosocial aspects of HIV on young people." She has appeared on national talk shows to tell her story, including "The Jenny Jones Show," "The Mark Walberg Show," and "The Rolonda Show," and has been featured in *Jet* and *Essence* magazines. In addition, Lisa enjoys going to local high schools, colleges and universities, churches,

community centers, and health clinics to tell her story to other young people and educate them about how they can protect themselves from HIV infection.

Lisa was employed by NAPWA as the Youth Speakers Bureau Associate from 1995-1997. She served as a coordinator for the National Ryan White Youth Conference on HIV/AIDS for 2 years and is a certified American Red Cross HIV/AIDS instructor. She is currently a medical assistant and full-time mother. She still works closely with NAPWA as well as with the Howard University Dental School in its HIV prevention workshops and with national conference workshops for discordant couples.

Martín J. González Rojas

Martín González Rojas is a Latino gay man living with AIDS, who works for CALOR, a division of Anixter Center, as a Manager of Prevention Services and representative to the Men of Color in HIV/AIDS 2000 Coalition (MOCHA 2000). He is the current community co-chair for the City of Chicago HIV Prevention Planning Group (HPPG), as well as the Secretary/Treasurer for the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS). Martín acts as a liaison between HPPG and the Ryan White Planning Council. In 1999 he represented HPPG on the State of Illinois HIV Prevention Community Planning Group. Since 1997, he has participated in AIDS Watch and more recently in the CAER Coalition. In July 2000, Martín was selected as one of the three CDC Price Fellowship recipients. Martín has collaborated with many national organizations on a variety of HIV/AIDS-related workgroups. He continues to do many of the front-line activities and admits to getting most of his energy from the participants of the support group for Latino gay men living with HIV/AIDS that he co-facilitates whenever he is able.

Ina A. Wilson

Ina Wilson, who lives in Chicago, Illinois, is an advocate for persons living with HIV as well as the parent of an HIV-infected person. She is a retired banker who has been married for 45 years and has three sons and one daughter.

In addition to extensive community work, Ina has participated in a video and presentations by All God's Children, a community-based organization in Chicago, and has worked on behalf of HIV-infected persons in California and Illinois. She also has served as treasurer and trustee of her church for 14 years.

About Our Moderator...

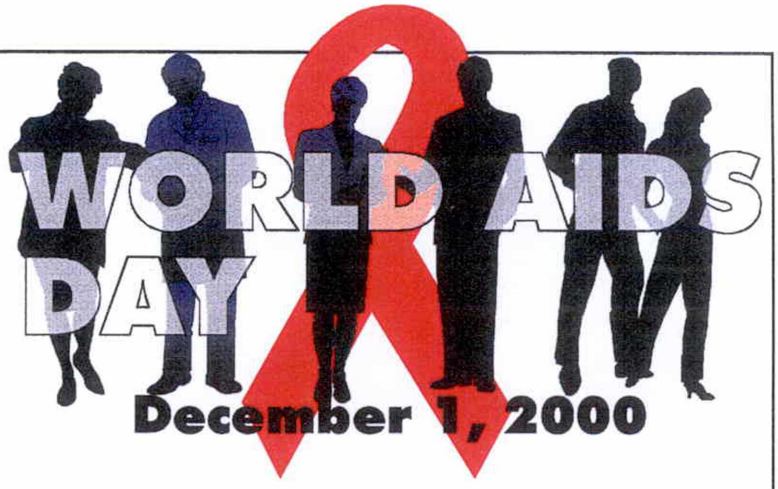
Ronald O. Valdiserri, M.D., M.P.H.

Dr. Valdiserri is the Deputy Director of the National Center for HIV, STD, and TB Prevention at CDC. He joined CDC in 1989 as Director of the Division of Laboratory Systems in the Public Health Practice Program Office. Since then, Dr. Valdiserri has served as Deputy Director for HIV in the former National Center for Prevention Services and played a key role in guiding the national implementation of HIV Prevention Community Planning – an innovative approach to improving the targeting, cultural relevance, and scientific underpinnings of publicly funded HIV prevention activities.

Prior to entering public service, Dr. Valdiserri was on faculty at the University of Pittsburgh Schools of Medicine and Public Health for nearly a decade. In addition to working with various community groups in Pittsburgh, he served as a co-investigator for two National Institutes of Health AIDS research projects. He has written numerous scholarly articles on the scientific and policy aspects of HIV/AIDS prevention and has authored a textbook on the design, implementation, and evaluation of AIDS prevention programs, which was published in 1989. In May 1994, Dr. Valdiserri published a book of essays on AIDS, "Gardening in Clay."

Positive Living With HIV—

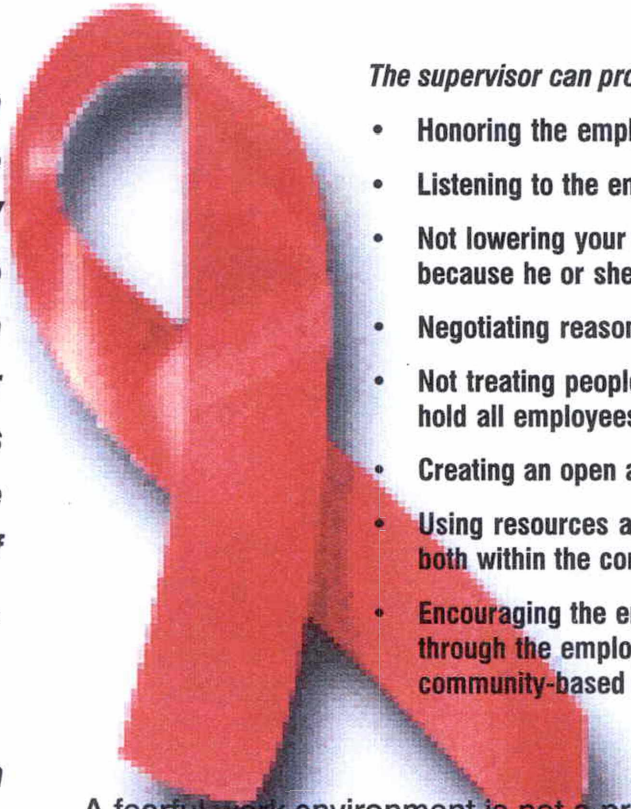
You Can Make a Difference



What You Can Do as a Supervisor

The decision to disclose one's HIV status to either a supervisor or co-workers is the prerogative of the individual.

Once an employee has elected to disclose his/her HIV status, the supervisor is obligated to keep this matter strictly confidential.



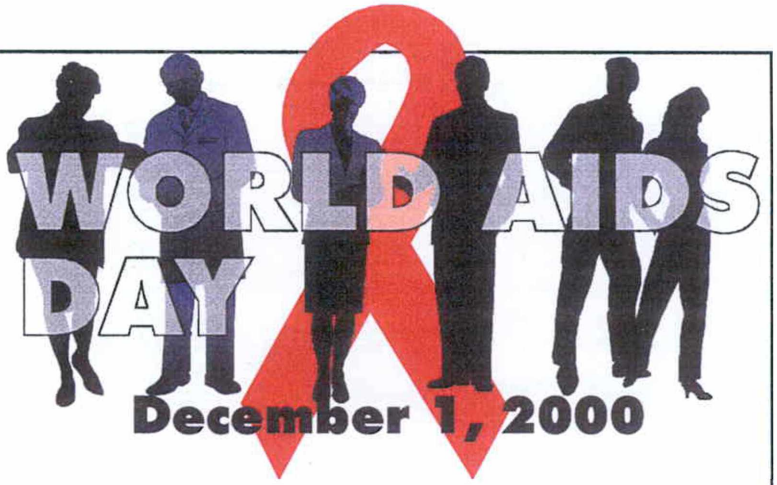
The supervisor can provide support to the employee by:

- **Honoring the employee's request for confidentiality**
- **Listening to the employee**
- **Not lowering your expectations of an employee because he or she tells you he or she is living with HIV**
- **Negotiating reasonable accommodations with employee**
- **Not treating people who are HIV positive differently, hold all employees accountable for their work**
- **Creating an open and supportive atmosphere**
- **Using resources and support structures available – both within the company and outside of the company**
- **Encouraging the employee to seek counseling either through the employee's counseling program, a community-based organization, or a support group**

A fearful work environment is not a productive work environment. If the HIV-positive employee chooses to disclose his or her HIV status, a supervisor may need to address myths or misinformation about HIV transmission or co-worker attitudes. Dealing with this issue directly can dispel unwarranted fears others may have about working with an HIV-positive person. The leadership and support displayed by the supervisor can set clear examples of how staff members will be expected to respond.

For information, please contact Business Responds to AIDS here at the National Center for HIV, STD, and TB Prevention. You can download materials from their Web site at www.brta-lrta.org or you can speak with a workplace specialist by calling 1-800-458-5231.

Local Community-Based HIV/AIDS Prevention Programs



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Outreach, Inc.

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Planned Parenthood of Georgia

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Cobb Center Manager
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HIV Prevention

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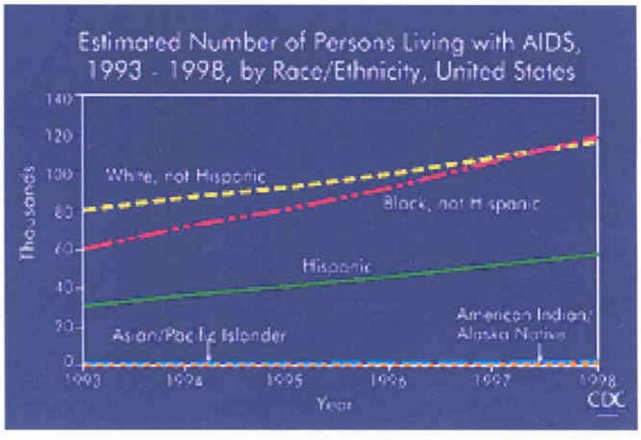
HIV/AIDS Among African Americans

In the United States, the impact of HIV and AIDS in the African American community has been devastating. Through December 1999, CDC had received reports of 733,374 AIDS cases–of those, 272,881 cases occurred among African Americans. Representing only an estimated 12% of the total U.S. population, African Americans make up almost 37% of all AIDS cases reported in this country.

Researchers estimate that 240,000-325,000 African Americans–about 1 in 50 African American men and 1 in 160 African American women–are infected with HIV. Of those infected with HIV, it is estimated that almost 118,000 African Americans were living with AIDS at the end of 1998.



In 1999, more African Americans were reported with AIDS than any other racial/ethnic group

- 21,900 cases were reported among African Americans, representing nearly half (47%) of the 46,400 AIDS cases reported that year.
- Almost two-thirds (63%) of all women reported with AIDS were African American.
- African American children also represented almost two-thirds (65%) of all reported pediatric AIDS cases.
- The 1999 rate of reported AIDS cases among African Americans was 66.0 per 100,000 population, more than 2 times greater than the rate for Hispanics and 8 times greater than the rate for whites.

Data on HIV and AIDS diagnoses in 25 states with integrated reporting systems show these trends are continuing. In these states, during the period from January 1996 through June 1999, African Americans represented a high proportion (50%) of all AIDS diagnoses, but an even greater proportion (57%) of all HIV diagnoses. And among young people (ages 13 to 24), 65% of the HIV diagnoses were among African Americans.

Prevention Efforts Must Focus on High-Risk Behaviors

Adult/Adolescent Men. Among African American men with AIDS, men who have sex with men (MSM) represent the largest proportion (37%) of reported cases

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since the epidemic began. The second most common exposure category for African American men is injection drug use (34%), and heterosexual exposure accounts for 8% of cumulative cases.

Adult/Adolescent Women. Among African American women, injection drug use has accounted for 42% of all AIDS case reports since the epidemic began, with 38% due to heterosexual contact.

Interrelated Prevention Challenges in African American Communities

Looking at select seroprevalence studies among high-risk populations gives an even clearer picture of why the epidemic continues to spread in communities of color. The data suggest that three interrelated issues play a role – the continued health disparities between economic classes, the challenges related to controlling substance abuse, and the intersection of substance abuse with the epidemic of HIV and other sexually transmitted diseases (STDs).

- ***Substance abuse is fueling the sexual spread of HIV in the United States, especially in minority communities with high rates of STDs.*** Studies of HIV prevalence among patients in drug treatment centers and STD clinics find the rates of HIV infection among African Americans to be significantly higher than those among whites. Sharing needles and trading sex for drugs are two ways that substance abuse can lead to HIV and other STD transmission, putting sex partners and children of drug users at risk as well. Comprehensive programs for drug users must provide the information, skills, and support necessary to reduce both injection-related and sexual risks. At the same time, HIV prevention and treatment, substance abuse prevention, and sexually transmitted disease treatment and prevention services must be better integrated to take advantage of the multiple opportunities for intervention.

- ***Prevention efforts must be improved and sustained for young gay men.*** In a sample of young men who have sex with men (ages 15-22) in seven urban areas, researchers found that, overall, 7% were infected with HIV (range, 2%-12%). A significantly higher percentage of African American MSM (14%) than white MSM (3%) were infected.

It is clear that the public sector alone cannot successfully combat HIV and AIDS in the African American community. Overcoming the current barriers to HIV prevention and treatment requires that local leaders acknowledge the severity of the continuing epidemic among African Americans and play an even greater role in combating HIV/AIDS in their own communities. Additionally, HIV prevention strategies known to be effective (both behavioral and biomedical) must be available and accessible for all populations at risk.

For information about national HIV prevention activities, see the following CDC fact sheets:

* *CDC's Role in HIV and AIDS Prevention*
* *Linking Science and Prevention Programs – The Need for Comprehensive Strategies*

For more information...

CDC National AIDS Hotline:
1-800-342-AIDS
Spanish: 1-800-344-SIDA
Deaf: 1-800-243-7889

CDC National Prevention Information Network:
P.O. Box 6003
Rockville, Maryland 20849-6003
1-800-458-5231

Internet Resources:
NCHSTP: http://www.cdc.gov/nchstp/od/nchstp.html
DHAP: http://www.cdc.gov/hiv
NPIN: http://www.cdcnpin.org

HIV Prevention

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HIV/AIDS Among Hispanics in the United States

The United States has a large and growing Hispanic population that is heavily affected by the HIV/AIDS epidemic. In 1999, Hispanics represented 13% of the U.S. population (including residents of Puerto Rico), but accounted for 19% of the total number of new U.S. AIDS cases reported that year (9,021 of 46,400 cases). The AIDS incidence rate per 100,000 population (the number of new cases of a disease that occur during a specific time period relative to the size of the population) among Hispanics in 1999 was 25.6, more than 3 times the rate for whites (7.6) but lower than the rate for African Americans (66.0).

Proportion of U.S. AIDS Cases Reported in 1999 Among Selected Hispanics by Exposure Category and Place of Birth

	U.S.	Mexico	Puerto Rico
MSM	31%	50%	14%
IDU	28%	7%	46%
Hetero-sexual	13%	12%	26%

Hispanics in the United States include a diverse mixture of ethnic groups and cultures. As shown in the chart at left, HIV exposure risks for U.S.-born Hispanics and Hispanics born in other countries vary greatly[1], indicating a need for specifically targeted prevention efforts.

Trends in AIDS Cases Among Hispanics in the U.S.

Between 1992 and 1998, the number of persons *living* with AIDS increased in all groups, as a result of the 1993 expanded AIDS case definition and, more recently, improved survival among those who have benefited from the new combination drug therapies. During that 6-year period, the characteristics of persons living with AIDS were changing, reflecting an expansion of the epidemic, particularly in minority populations. In 1992, 17% of those estimated to be living with AIDS were Hispanic, while in 1998, 19% were Hispanic. In comparison, non-Hispanic whites represented 49% of people estimated to be living with AIDS in 1992, but only 39% in 1998.

Cumulatively, males account for the largest proportion (81%) of AIDS cases reported among Hispanics in the United States, although the proportion of cases among women is rising. Women represent 19% of cumulative AIDS cases among Hispanics, but account for 22% of cases reported in 1999 alone. Fifty-seven percent of Hispanics reported with AIDS in 1999 were born in the U.S.; of these 43% were born in Puerto Rico.

From the beginning of the epidemic through December 1999, 107,867 Hispanic men have been reported with AIDS in the United States. Of these cases, men who have sex with men (MSM) represent 43%, injection drug users (IDUs) account for 36%,

[1] See Table 20, *HIV/AIDS Surveillance Report,* 1999 Year-end Edition, Vol. 11, No. 2.

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and 6% of cases were due to heterosexual contact. About 7% of cases were among Hispanic men who both had sex with men and injected drugs. Among men born in Puerto Rico, however, injection drug use accounts for a significantly higher proportion of cases than male-male sex.

For adult and adolescent Hispanic women, heterosexual contact accounts for the largest proportion (47%) of cumulative AIDS cases, most of which are linked to sex with an injection drug user. Injection drug use accounts for an additional 40% of AIDS cases among U.S. Hispanic women.

Building Better Prevention Programs for Hispanics

While race and ethnicity alone are not risk factors for HIV infection, underlying social and economic conditions (such as language or cultural diversity, higher rates of poverty and substance abuse, or limited access to or use of health care) may increase the risk for infection in some Hispanic-American communities.

- ***Transmission related to substance abuse continues to be a significant problem among Hispanics living in the United States,*** especially among those of Puerto Rican origin. Studies of patients in drug treatment centers find HIV prevalence among Hispanics to be substantially higher in some regions of the country, particularly the Northeast and Midwest. Comprehensive programs for drug users must provide the information, skills, and support necessary to reduce both injection-related and sexual risks. In addition, HIV prevention and treatment, substance abuse prevention, and sexually transmitted disease treatment and prevention services must be better integrated to take advantage of the multiple opportunities for intervention.

- ***Prevention messages must be tailored to the affected communities.*** Hispanic populations need interventions that (1) are consistent with their values and beliefs and (2) include skills-building activities to facilitate changes in sexual behavior. Further, because the HIV/AIDS epidemic among Hispanics living in the U.S. reflects to a large extent the exposure modes and cultural modes of the individuals' birthplaces and communities, an understanding of these behaviors and differences is important in targeting prevention efforts. For example, some high-risk behaviors associated with drug abuse (such as use of shooting galleries) may be more predominant among Puerto Rico-born Hispanics than among other Hispanics. Therefore, for these populations, prevention strategies should emphasize (1) preventing and treating substance abuse and (2) decreasing needle-sharing and the use of shooting galleries. For Hispanics born in Mexico, Cuba, and Central and South America, CDC data indicate that male-male sex is the primary mode of HIV transmission. Messages targeted to these populations must be based on an understanding of their cultural attitudes toward homosexuality and bisexuality, which may be different from those of other populations at high risk for infection.

To improve prevention programs in Hispanic communities across the United States, in addition to addressing underlying social and economic conditions, we must apply the lessons we have already learned about the design of culturally appropriate HIV prevention efforts for each Hispanic population.

For more information...

CDC National AIDS Hotline:
1-800-342-AIDS
Spanish: 1-800-344-SIDA
Deaf: 1-800-243-7889

Internet Resources:
DHAP: http://www.cdc.gov/hiv
NPIN: http://www.cdcnpin.org

CDC National Prevention Information Network:
P.O. Box 6003
Rockville, Maryland 20849-6003
1-800-458-5231

HIV Prevention

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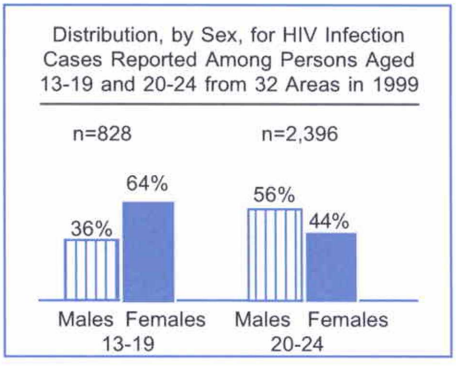
Young People at Risk: HIV/AIDS Among America's Youth

In the United States, HIV-related death has the greatest impact on young and middle-aged adults, particularly racial and ethnic minorities. In 1998, HIV was the fifth leading cause of death for Americans between the ages of 25 and 44. Among African American men in this age group, HIV infection has been the leading cause of death since 1991. In 1998, among black women 25-44 years old, HIV infection was the third leading cause of death. Many of these young adults likely were infected in their teens and twenties. It has been estimated that at least half of all new HIV infections in the United States are among people under 25, and the majority of young people are infected sexually.



In 1999, 1,813 young people (ages 13 to 24) were reported with AIDS, bringing the cumulative total to 29,629 cases of AIDS in this age group. Among young men aged 13- to 24-years, 50% of all AIDS cases reported in 1999 were among men who have sex with men (MSM); 8% were among injection drug users (IDUs); and 8% were among young men infected heterosexually. In 1999, among young women the same age, 47% of all AIDS cases reported were acquired heterosexually and 11% were acquired through injection drug use. Among both males and females in this age group, the proportion of cases with exposure risk not reported or identified (25% for males and 41% for females) will decrease and the proportion of cases attributed to sexual contact and injection drug use will increase as follow-up investigations are completed and cases are reclassified into these categories.

Surveillance data analyzed from 25 states with integrated HIV and AIDS reporting systems for the period between January 1996 and June 1999 indicate that young people (aged 13 to 24) accounted for a much greater proportion of HIV (13%) than AIDS cases (3%). These data also show that even though AIDS incidence (the number of new cases diagnosed during a given time period, usually a year) is declining, ***there has not been a comparable decline in the number of newly diagnosed HIV cases among youth.***

Scientists believe that cases of HIV infection diagnosed among 13- to 24-year-olds are indicative of overall trends in HIV incidence (the number of new infections in a given time period, usually a year) because this age group has more recently initiated high-risk behaviors. Females made up nearly half (49%) of HIV cases in this age group reported from the 32 areas with confidential HIV reporting for adults and adolescents in 1999–and in young people between the ages of 13 and 19, a much greater proportion of HIV infections was reported among females (64%) than among males (36%). Cumulatively, young African Americans are most heavily affected, accounting for 56% of all HIV cases ever reported in this age group in these 32 areas.

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Improving HIV Prevention for Young People

CDC research has shown that early, clear communications between parents and young people about sex is an important step in helping adolescents adopt and maintain protective sexual behaviors. In addition, a wide range of activities must be implemented in communities to reduce the toll HIV infection and AIDS takes on young Americans.

- **School-based programs are critical for reaching youth before behaviors are established.** Because risk behaviors do not exist independently, topics such as HIV, STDs, unintended pregnancy, tobacco, nutrition, and physical activity should be integrated and ongoing for all students in kindergarten through high school. The specific scope and content of these school health programs should be locally determined and consistent with parental and community values. **Research has clearly shown that the most effective programs are comprehensive ones that include a focus on delaying sexual behavior *and* provide information on how sexually active young people can protect themselves.** Evidence of prevention success can be seen in trends from the Youth Risk Behavior Survey conducted over an 8-year period, which show both a decline in sexual risk behaviors and an increase in condom use among sexually active youth. The percentage of sexually experienced high school students decreased from 54.1% in 1991 to 49.9% in 1999, while condom use among sexually active students increased from 46.2% to 58.0%. These findings represent a reversal in the trend toward increased sexual risk among teens that began in the 1970s and point to the success of comprehensive prevention efforts to both delay first intercourse among teens and increase condom use among young people who are sexually active.
- **Efforts to reach out-of-school-youth are made by community-based programs.** Addressing the needs of adolescents who are most vulnerable to HIV infection, such as homeless or runaway youth, juvenile offenders, or school drop-outs, is critically important. For example, a 1993 serosurveillance survey of females in four juvenile detention centers found that between 1% and 5% were HIV infected (median 2.8%).
- **Prevention efforts for young gay and bisexual men must be sustained.** Targeted, sustained prevention efforts are urgently needed for young MSM as they come of age and initiate high-risk sexual behavior. Ongoing studies show that both HIV prevalence and risk behaviors remain high among young MSM. In a sample of young MSM ages 15-22 in seven urban areas, researchers found that, overall, 7% were infected with HIV, with higher prevalence among young African American (14%) and Hispanic (7%) men than among young white men (3%).
- **We must address sexual and drug-related risk.** Many students report using alcohol or drugs when they have sex, and 1 in 50 high school students reports having injected an illegal drug. Surveillance data from the 32 states with integrated HIV and AIDS reporting systems suggest that drug injection led to at least 5% of HIV diagnoses reported among those aged 13-24 in 1999, with an additional 49% attributed to sexual transmission (both heterosexual and MSM).
- **STD treatment must play a role in prevention programs for young people.** An estimated 12 million cases of STDs other than HIV are diagnosed annually in the United States, and about two-thirds of those are among people under the age of 25. Research has shown that biological factors make people who are infected with an STD more likely to become infected with HIV if exposed sexually; and HIV-infected people with STDs also are more likely to transmit HIV to their sex partners. Expanding STD treatment is critical to reducing the consequences of these diseases and helping to reduce risks of transmitting HIV among youth.
- **Evaluation of factors influencing risk behavior must be ongoing.** Both broad-based surveys of the extent of risk behaviors among young people and focused studies of the factors contributing to risk and behavioral intent among specific groups of adolescents must be conducted and analyzed.

For young people, it is critical to prevent patterns of risky behaviors before they start. HIV prevention efforts must be sustained and designed to reach each new generation of Americans.

For more information...

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HIV Prevention

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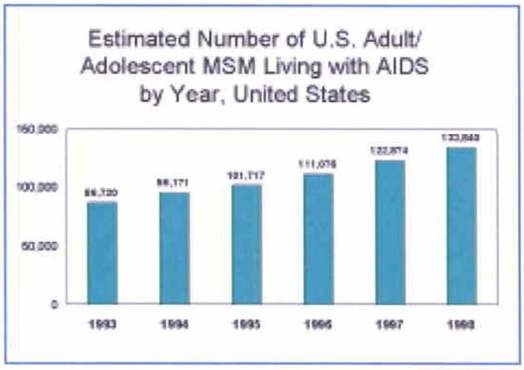
Need for Sustained HIV Prevention Among Men Who Have Sex with Men

In the United States, HIV-related illness and death historically have had a tremendous impact on men who have sex with men (MSM). Even though the toll of the epidemic among injection drug users (IDUs) and heterosexuals has increased during the last decade, MSM continue to account for the largest number of people reported with AIDS each year. In 1999 alone, 15,464 AIDS cases were reported among MSM, compared with 10,138 among IDUs and 7,139 among men and women who acquired HIV heterosexually.



Overall, the number of MSM of all races and ethnicities who are *living* with AIDS has increased steadily, partly as a result of the 1993 expanded AIDS case definition and, more recently, improved survival. *(See chart at right.)*

Continuing Risk Among Young MSM

Abundant evidence shows a need to sustain prevention efforts for each generation of young gay and bisexual men. We cannot assume that the positive attitudinal and behavioral change seen among older men also applies to younger men. Recent data on HIV prevalence and risk behaviors suggest that young gay and bisexual men continue to place themselves at considerable risk for HIV infection and other sexually transmitted diseases (STDs).

- Ongoing studies show that both HIV prevalence (the proportion of people living with HIV in a population) and risk behaviors remain high among some young MSM. In a sample of MSM 15-22 years old in seven urban areas, CDC researchers found that, overall, 7% already were infected with HIV. Higher percentages of African Americans (14%) and Hispanics (7%) were infected than were whites (3%).
- In the 32 states with confidential HIV reporting, data show that substantial numbers of MSM still are being infected, especially younger men. In 1999, 46% of reported HIV diagnoses among adolescent males aged 13-19 and 51% of cases among men aged 20-24 were attributed to male-to-male sexual contact.
- Research among gay and bisexual men suggests that some individuals are now less concerned about becoming infected than in the past and may be inclined to take more risks. This is backed up by reported increases in gonorrhea among gay men in several large U.S. cities between 1993 and 1996. Despite medical advances, HIV infection remains a serious, usually fatal disease that requires complex, costly,

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These data highlight the need to design more effective prevention efforts for gay and bisexual men of color. The involvement of community and opinion leaders in prevention efforts will be critical for overcoming cultural barriers to prevention, including homophobia. For example, there remains a tremendous stigma to acknowledging gay and bisexual activity in African American and Hispanic communities.

Need to Combat Other STDs

Studies among MSM who are treated in STD clinics have shown consistently high prevalence of HIV infection, ranging from nearly 4% in Seattle to a high of almost 36% in Atlanta. (See CDC's *National HIV Prevalence Surveys, 1997 Summary,* Table 1.) Some studies have shown that the likelihood of both acquiring and spreading HIV is 2-5 times greater in people with STDs, and that aggressively treating STDs in a community may help to reduce the rate of new HIV infections. Along with prompt attention to and treatment of STDs, efforts to reduce the behaviors that spread STDs are critical.

Prevention Services Must Reach Both Uninfected and Infected

Research has shown that high-risk behavior is continuing in some populations of MSM, including those who are infected with HIV. Because HIV-infected gay and bisexual men are living longer and healthier lives, greater efforts must be made to reach them with behavioral interventions that can help them protect their own health and prevent transmission to others.

For information about national HIV prevention activities, see the following CDC fact sheets:

* *CDC's Role in HIV and AIDS Prevention*
* *Linking Science and Prevention Programs—The Need for Comprehensive Strategies*

For more information...

CDC National AIDS Hotline:
1-800-342-AIDS
Spanish: 1-800-344-SIDA
Deaf: 1-800-243-7889

CDC National Prevention Information Network:
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Internet Resources:
NCHSTP: http://www.cdc.gov/nchstp/od/nchstp.html
DHAP: http://www.cdc.gov/hiv
NPIN: http://www.cdcnpin.org

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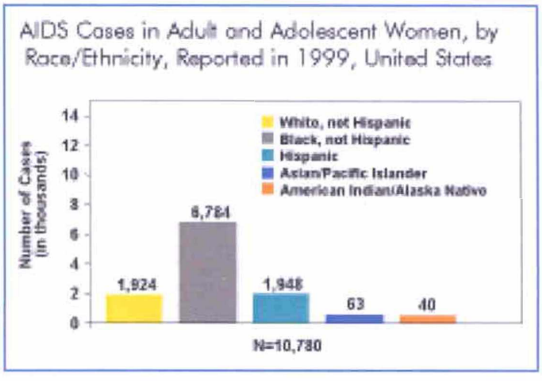
HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk

HIV infection among U.S. women has increased significantly over the last decade, especially in communities of color. CDC estimates that, in the United States, between 120,000 and 160,000 adult and adolescent females are living with HIV infection, including those with AIDS.

Between 1992 and 1998, the number of persons living with AIDS increased in all groups as a result of the 1993 expanded AIDS case definition and, more recently, improved survival among those who have benefited from the new combination drug therapies. During that 6-year period, a growing proportion of women were living with AIDS, reflecting the ongoing shift in populations affected by the epidemic. In 1992, women accounted for 14% of adults and adolescents living with AIDS – by 1998, the proportion had grown to 20%.

In just over a decade, the proportion of all AIDS cases reported among adult and adolescent women more than tripled, from 7% in 1985 to 23% in 1999.



The epidemic has increased most dramatically among women of color. African American and Hispanic women together represent less than one-fourth of all U.S. women, yet they account for more than three-fourths (77%) of AIDS cases reported to date among women in our country. In 1999 alone *(see chart above)*, women of color represented an even higher proportion of cases.

While AIDS-related deaths among women were decreasing as of 1998, largely as a result of recent advances in HIV treatment, HIV/AIDS remains among the leading causes of death for U.S. women aged 25-44. And among African American women in this same age group, AIDS was the third leading cause of death in 1998.

Heterosexual Contact Now Is Greatest Risk for Women

Sex with drug users plays large role

In 1999 most women (40%) reported with AIDS were infected through heterosexual exposure to HIV; injection drug use accounted for 27% of cases. In addition to the direct risks associated with drug injection (sharing needles), drug use also is fueling the heterosexual spread of the epidemic. A large proportion of women infected heterosexually were infected through sex with an injection drug user. Reducing the toll of the epidemic among women will require efforts to combat substance abuse, in addition to reducing HIV risk behaviors.

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Prevention Needs of Women

- ***Pay attention to prevention for women.*** The AIDS epidemic is far from over. Scientists believe that cases of HIV infection reported among 13- to 24-year-olds are indicative of overall trends in HIV incidence (the number of new infections in a given time period, usually a year) because this age group has more recently initiated high-risk behaviors–and females made up nearly half (49%) of HIV cases in this age group reported from the 32 areas with confidential HIV reporting for adults and adolescents in 1999. Further, for all years combined, young African American and Hispanic women account for about three-fourths of HIV infections reported among females between the ages of 13 and 24 in these areas.
- ***Implement programs that have been proven effective*** in changing risky behaviors among women and sustaining those changes over time, maintaining a focus on both the uninfected and infected populations of women.
- ***Increase emphasis on prevention and treatment services for young women and women of color.*** Knowledge about preventive behaviors and awareness of the need to practice them is critical for each and every generation of young women – prevention programs should be comprehensive and should include participation by parents as well as the educational system. Community-based programs must reach out-of-school youth in such settings as youth detention centers and shelters for runaways.
- ***Address the intersection of drug use and sexual HIV transmission.*** Women are at risk of acquiring HIV sexually from a partner who injects drugs and from sharing needles themselves. Additionally, women who use noninjection drugs (e.g., "crack" cocaine, methamphetamines) are at greater risk of acquiring HIV sexually, especially if they trade sex for drugs or money.
- ***Develop and widely disseminate effective female-controlled prevention methods.*** More options are urgently needed for women who are unwilling or unable to negotiate condom use with a male partner. CDC is collaborating with scientists around the world to evaluate the prevention effectiveness of the female condom and to research and develop topical microbicides that can kill HIV and the pathogens that cause STDs.
- ***Better integrate prevention and treatment services for women*** across the board, including the prevention and treatment of other STDs and substance abuse and access to antiretroviral therapy.

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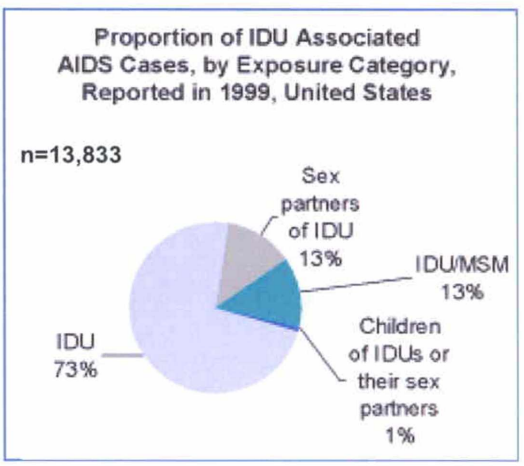
Drug-Associated HIV Transmission Continues in the United States

Sharing syringes and other equipment for drug injection is a well known route of HIV transmission, yet injection drug use contributes to the epidemic's spread far beyond the circle of those who inject. People who have sex with an injection drug user (IDU) also are at risk for infection through the sexual transmission of HIV. Children born to mothers who contracted HIV through sharing needles or having sex with an IDU may become infected as well.



Since the epidemic began, injection drug use has directly and indirectly accounted for more than one-third (36%) of AIDS cases in the United States. This disturbing trend appears to be continuing. Of the 46,400 new cases of AIDS reported in 1999, 13,833 (30%) were IDU-associated.

Racial and ethnic minority populations in the United States are most heavily affected by IDU-associated AIDS. In 1999, IDUs accounted for 33% of all AIDS cases among African American and 35% among Hispanic adults and adolescents, compared with 23% of all cases among white adults/adolescents.

IDU-associated AIDS accounts for a larger proportion of cases among women than among men. Since the epidemic began, 58% of all AIDS cases among women have been attributed to injection drug use or sex with partners who inject drugs, compared with 31% of cases among men.

Noninjection drugs (such as "crack" cocaine) also contribute to the spread of the epidemic when users trade sex for drugs or money, or when they engage in risky sexual behaviors that they might not engage in when sober. One CDC study of more than 2,000 young adults in three inner-city neighborhoods found that crack smokers were three times more likely to be infected with HIV than non-smokers.

Strategies for IDUs Must Be Comprehensive

Comprehensive HIV prevention interventions for substance abusers must provide education on how to prevent transmission through sex.

Numerous studies have documented that drug users are at risk for HIV through both drug-related and sexual behaviors, which places their partners at risk as well. Comprehensive programs must provide the information, skills, and support neces-

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sary to reduce both risks. Researchers have found that many interventions aimed at reducing sexual risk behaviors among drug users have significantly increased the practice of safer sex (e.g., using condoms, avoiding unprotected sex) among participants.

Drug abuse treatment is HIV prevention, but drug treatment slots are scarce.

In the United States, drug use and dependence are widespread in the general population. Experts generally agree that there are about 1 million active IDUs in this country, as well as many others who use noninjection drugs or abuse alcohol. Clearly, the need for substance abuse treatment vastly exceeds our capacity to provide it. Effective substance abuse treatment that helps people stop using drugs not only eliminates the risk of HIV transmission from sharing contaminated syringes, but, for many, reduces the risk of engaging in risky behaviors that might result in sexual transmission.

For injection drug users who cannot or will not stop injecting drugs, using sterile needles and syringes only once remains the safest, most effective approach for limiting HIV transmission.

To minimize the risk of HIV transmission, IDUs must have access to interventions that can help them protect their health. They must be advised to always use sterile injection equipment; warned never to reuse needles, syringes, and other injection equipment; and told that using syringes that have been cleaned with bleach or other disinfectants is not as safe as using new, sterile syringes.

Having access to sterile injection equipment is important, but it is not enough.

Preventing the spread of HIV through injection drug use requires a comprehensive approach that incorporates several basic principles:

- ensure coordination and collaboration among all providers of services to IDUs, their sex partners, and their children,
- ensure coverage, access to, and quality of interventions,
- recognize and overcome stigma associated with injection drug use, and
- tailor services and programs to the diverse populations and characteristics of IDUs.

Strategies for prevention should include:

- preventing initiation of drug injection,
- using community outreach programs to reach drug users on the streets,
- improving access to high quality substance abuse treatment programs,
- instituting HIV prevention programs in jails and prisons,
- providing health care for HIV-infected IDUs, and
- making HIV risk-reduction counseling and testing available for IDUs and their sex partners.

Better integration of all prevention and treatment services is critically needed.

HIV prevention and treatment, substance abuse prevention, and sexually transmitted disease treatment and prevention services must be better integrated to take advantage of the multiple opportunities for intervention—first, to help the uninfected stay that way; second, to help infected people stay healthy; and third, to help infected individuals initiate and sustain behaviors that will keep themselves safe and prevent transmission to others.

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