

# HIV/AIDS

# Epidemiology Report

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*An annual report*

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## 1. Executive Summary

Overall, the State of California has the second highest number of acquired immunodeficiency syndrome (AIDS) cases in the United States and San Diego County has the third highest number of AIDS cases in the State of California. There have been 10,636 AIDS cases reported in San Diego County as of December 31, 2000. Highlights of this report are summarized here.

- While white men constitute the largest bulk of new cases, and have so from the beginning of the epidemic, the percent of new cases made up by Hispanics, African Americans, and Asian/Pacific Islanders increases every year.
- African Americans have had the highest yearly rate of AIDS in San Diego since 1986.
- Hispanic cases contribute the second largest number of new cases each year and have the second highest rate of AIDS per year.
- Female cases make up 7% of total cases. Since there is so much fluctuation between years, it is difficult to ascertain if the upward trend experienced nationally is occurring in San Diego County.
- “Men who have sex with men” (MSM) continues to be the primary mode of transmission for men with an increase in injection drug use and heterosexual contact. For women, however, the primary mode of transmission is heterosexual contact, followed by injection drug use.
- The Central Region of San Diego County is the most frequent area of residence at the time of AIDS diagnosis. There has been a shift over time with more cases coming from the South Region and less from the North Central Region.

## 2. Overall AIDS Case Data

As of December 31, 2000, there were 119,900 acquired immunodeficiency syndrome (AIDS) cases reported in California. A total of **10,636** of those cases were reported among San Diego County residents. **Four hundred seventy-five (475)** of the 10,636 cases were reported in year 2000, making San Diego County the 3<sup>rd</sup> largest contributor of AIDS cases in California, following Los Angeles and San Francisco. **Three hundred forty-four (344)** of these new cases were also diagnosed in year 2000. The additional 131 cases reported were diagnosed years earlier but due to delays in reporting did not show up in the database until year 2000. Additional AIDS cases diagnosed in year 2000 are expected to be reported throughout 2001 and into 2002. Refer to Appendix II for more information on what constitutes an AIDS case, how they are reported, and delays in reporting.

The first cases of AIDS in residents of San Diego County (2) were diagnosed in 1981. During 1993, 1148 cases were diagnosed among residents of the County (*Figure 1*).

With the implementation of the expanded AIDS Surveillance Case Definition in 1993, reported cases now reflect conditions that occur earlier in Human Immunodeficiency Virus (HIV) disease. The peak in AIDS cases is likely the result of changes in the case definition. **Delays in reporting and changes in the AIDS case definition distort observed trends.**

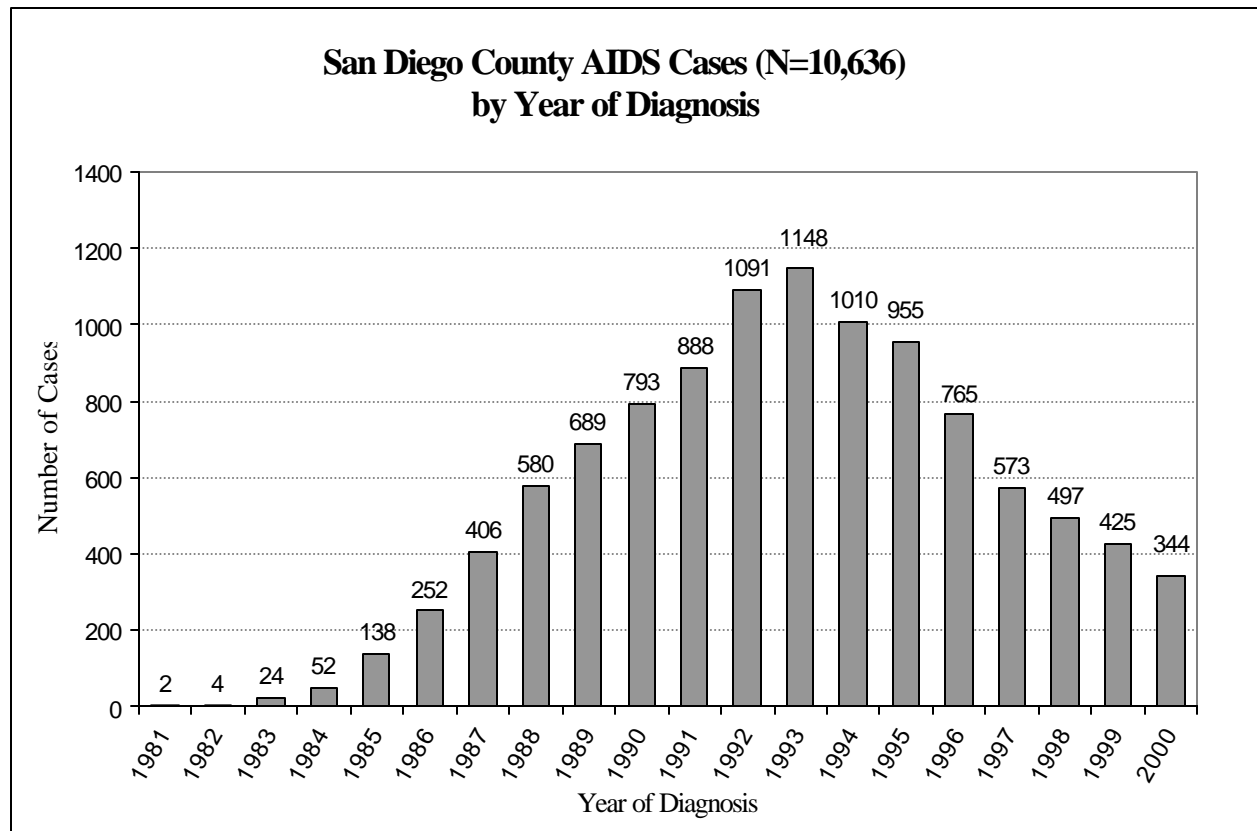


Figure 1

### 3. Demographic Variables

The demographics of AIDS cases have remained relatively stable over time, with the largest shift being in ethnic breakdown, as well as smaller shifts in place of residence at time of diagnosis, and a gradual move to an older age at time of diagnosis.

#### 3.1 Gender

The first female case occurred in 1984 and female cases have been reported in every year since. Female cases continue to constitute less than 10% of the cumulative cases. There have been 9908 (93%) male cases and 728 (7%) female cases as of December 31, 2000. Of the most recent cases, females made up 11% of the total cases reported (year 2000). The pattern for female cases has not been consistent over time. While the percent of females in year 2000 was relatively high, they made up only 7% of the cases in 1999 and 10% of the cases 1998. There seems to be an increase in the proportion of female cases nationwide, and a more gradual increase statewide, however, the number of female cases in San Diego County is too small to distinguish a trend.

#### 3.2 Race/Ethnic Group

Nationally and locally, whites continue to make up the largest number of cases. At the end of 1999, whites made up 43% of all cases in the United States and over 60% of California and San Diego County cases. By December 31, 2000, white cases constituted 60% of total cases in California and two-thirds of all cases (66%) in San Diego County. Twenty percent of all San Diego County AIDS cases were Hispanic, which is close to its proportion both statewide and nationally. The proportion of African American cases in San Diego County is 12%, which is smaller than both the state and national level. At the state level African Americans constitute 17% of AIDS cases (12/31/00) and at the national level, 37% (as of 12/31/99).

Analyzing recent cases show that the proportional breakdown changes and the role that African American and Hispanic cases play is much larger. When comparing the racial/ethnic breakdown of San Diego County's population to cumulative and, especially recent AIDS cases, some race/ethnic groups are over-represented in the AIDS data. Hispanics make up a larger percent of recent AIDS cases than they are seen in the population and the proportion of AIDS cases that are African American is almost three times larger than the proportion of the population made up by African Americans (*Figure 2*).

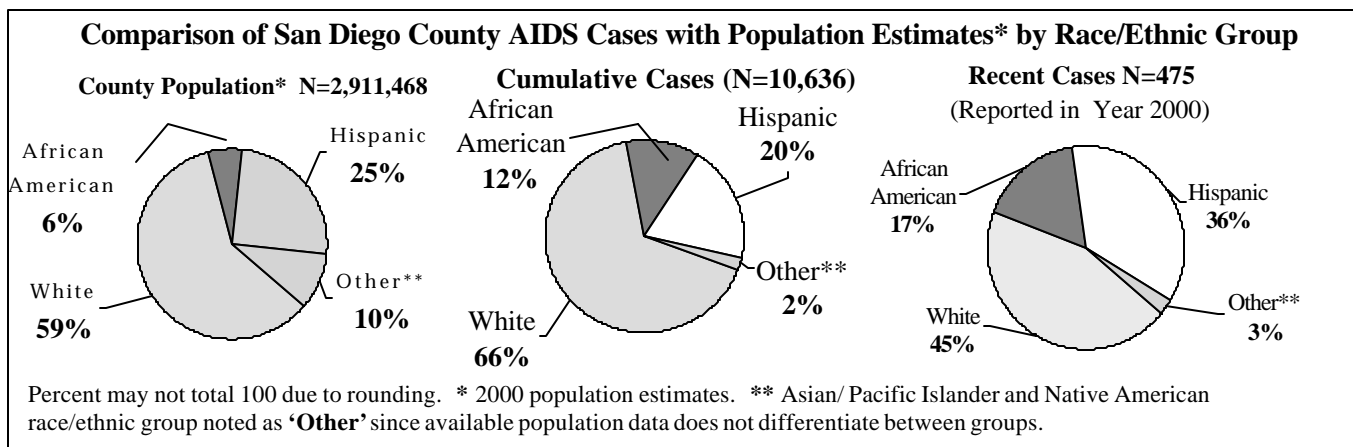


Figure 2

For a more complete breakdown of Hispanic and Asian/Pacific Islander cases, please see Appendix III.

For the most recent cases (year 2000), 55% of all cases were reported in minorities. As can be seen in Figure 3, the proportion of cases made up by people of color has been increasing over time.

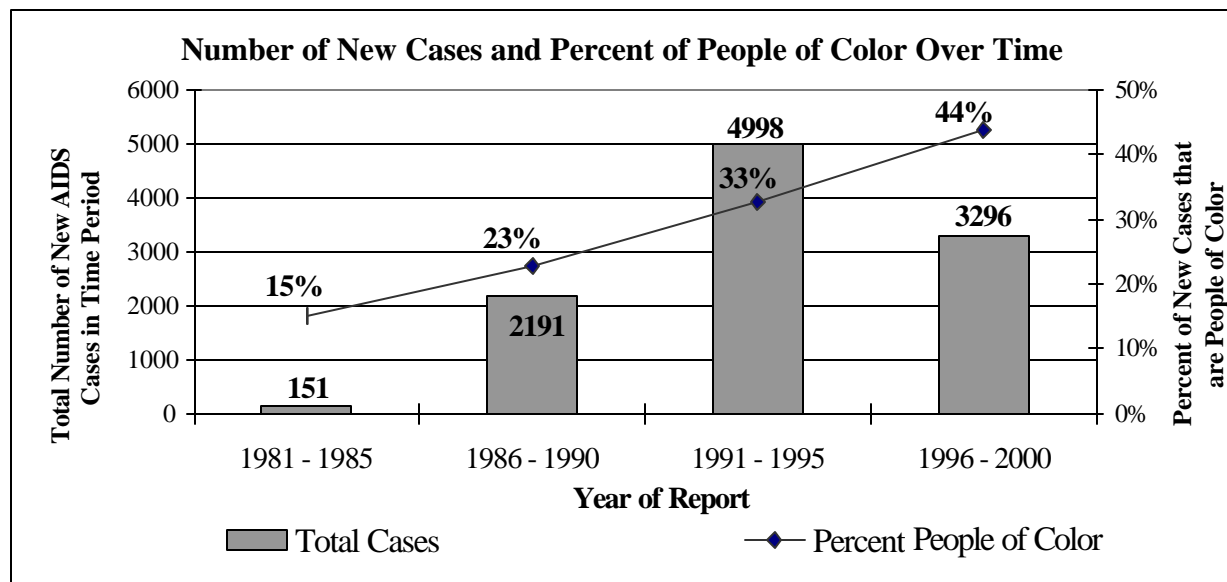


Figure 3

Rates by race/ethnic group were computed by dividing the number of individuals with AIDS from a particular race/ethnic group by the number of those people in the population at large. As was shown earlier in Figure 2, the population sizes for each racial/ethnic group in San Diego are different. Since computing rates takes the number of people in the population into consideration, it allows groups of different sizes to be compared.

In year 2000, San Diego County had a rate of 12 AIDS cases per 100,000 persons living in the county. Healthy People 2010 estimated that there were 19.5 AIDS cases per 100,000 adolescent and adults in the United States in 1998 and set a goal of no more than 1 new case per 100,000 persons. While San Diego County has not yet met that goal, there is a lower rate of AIDS than the national estimate for year 1998.

When rates by race/ethnic group are computed, however, the picture of AIDS in San Diego looks quite different than it does when examining the cumulative rate or raw numbers of those groups alone. Since 1986, African Americans have had the highest rate of AIDS in San Diego County. In the most recent year, there was a rate of 31 new cases per 100,000 persons in the African American Community. This is much higher than the 1989 baseline of 19.5 per 100,000 persons (year 2000). The rate of Hispanics surpassed that of whites in 1996 and has remained the second highest rate since (Figure 4). In year 2000, Hispanics had a rate of 19 cases per 100,000 persons and whites had a rate of 8 cases per 100,000 persons. Rates for Asian/Pacific Islanders and Native Americans were not computed due to their small numbers.

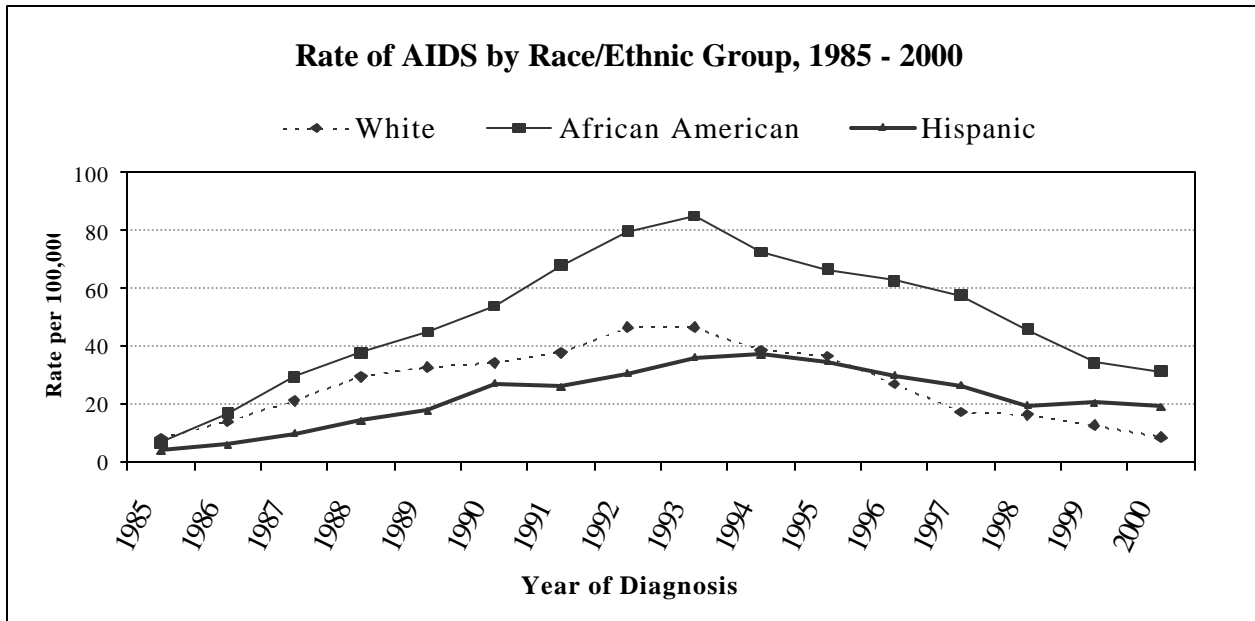


Figure 4

### Age 3.3

The age group most frequently diagnosed with AIDS is the 30 - 39 year old age group, followed by the 40 - 49 year old age group and then the 20 - 29 year old group. The breakdown of age group has been consistent over time (Figure 5). This trend is very similar to what was seen nationally (1999) and statewide (2000). By December 31, 2000 in the State of California, 47% of all cases were diagnosed in individuals in the 30 - 39 year old age group, 25% were in the 40 - 49 age group, and 17% were in the 20 - 29 year old age group.

While the average age is 37 years old, it has been slowly creeping up over time within the 30 - 39 year old age group. When age is broken down by race, Hispanics have had an average age of diagnosis consistently lower than that of whites or African Americans (Table 1).

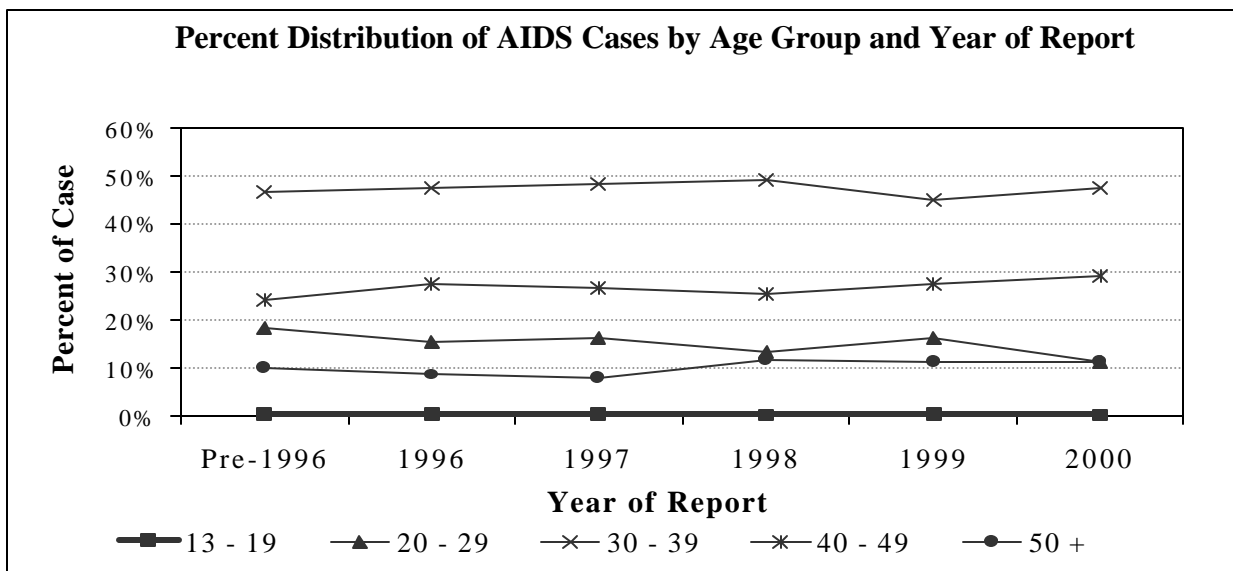


Figure 5



**Age-Related Measurements by Race/Ethnic Group Over Time**

Time Period	Age Related Measurement	Race / Ethnic Group*			
		White	African American	Hispanic	Asian/ Pacific Islander
Prior to 1996	Mean Age	38	35	34	36
	Range in years	88	71	75	69
	Youngest Case	Birth	Birth	Birth	Birth
	N	5,666	864	1320	137
1996	Mean Age	39	37	36	35
	Range in years	55	61	58	21
	Youngest Case	20	2	13	24
	N	447	105	185	24
1997	Mean Age	39	38	37	35
	Range in years	51	66	75	41
	Youngest Case	21	5	Birth	21
	N	286	98	172	15
1998	Mean Age	39	39	36	39
	Range in years	51	34	46	35
	Youngest Case	20	23	18	21
	N	274	79	132	9
1999	Mean Age	40	39	36	**
	Range in years	59	67	55	**
	Youngest Case	18	Birth	20	**
	N	214	60	143	**
2000	Mean Age	41	38	37	**
	Range in years	52	33	72	**
	Youngest Case	22	23	6	**
	N	145	54	137	**

Note: Percentages may not add up to 100% due to rounding.

\* Native Americans not included due to small cell size by year.

\*\* Less than 10 cases in time period

Table 1

### 3.4 Place of Residence

Keep in mind that the place of residence at the time of AIDS diagnosis does not represent the place of residence at the time of HIV diagnosis or acquisition of HIV infection. The Health and Human Services Agency geographically divides the County of San Diego into 6 Health Service Area (HSA) regions. For more information about the Health Service Areas, please see Appendix IV.

Since the beginning of the epidemic, the Central region of San Diego has been the place of residence for the majority of new AIDS cases. The Central region has consistently hosted 55% – 60% of the newly diagnosed cases. The main shift over time has been a decrease in percent of cases living in the North Central region and an increase in cases residing in the South region at the time of diagnosis (*Table 2*).

**Health Service Area of Residence at Time of Diagnosis by Time Period**

HSA of San Diego	Time Period				Cumulative Cases
	1981 - 1985	1986 - 1990	1991 - 1995	1996 - 2000	
Central	55%	61%	60%	57%	59%
East	6%	7%	7%	7%	7%
North Central	23%	15%	14%	11%	14%
North Coastal	8%	6%	8%	8%	7%
North Inland	5%	4%	5%	4%	5%
South	3%	6%	7%	13%	8%
Number of Cases	220	2720	5092	2604	10636

Note: Percentages may not add up to 100% due to rounding.

Table 2

Place of residence can be further broken down to city of residence within San Diego County. Cumulative cases by the city of residence in San Diego County at the time of diagnosis are displayed in Appendix V.

### 3.5 Place of Origin

Not all of the AIDS cases diagnosed nationally were individuals born in the United States. Statewide, more than half of Asian/Pacific Islander cases (59.3% of 2,284 cases) and 47.4% of Hispanic cases (n=21,419) were born in foreign countries (reported to the state of California by June 30, 1999). In San Diego County, there is a similar breakdown in that 12% of the total cases were born in foreign countries and 1% were born in a United States dependency. Most of those who were foreign-born were either Hispanics or Asian/Pacific Islanders. Native Americans have no cases born outside of the United States while over half of Hispanic and Asian/Pacific Islander cases were born outside of the United States. White and African American cases fall in between with 98% of white cases and 96% of African American cases being US-born.

The County of San Diego does not collect data on the length of time a person resided in the United States or fluency of English, so those who arrived in the United States shortly after birth cannot be differentiated from those who are newly arrived.

An analysis of Asian/Pacific Islander and Hispanic cases by time period and gender shows that a larger percent of females are foreign-born and that an increasing percent of Hispanics, in general, are foreign-born (*Table 3* and *Table 4*). Male and female Hispanic cases show a relatively similar pattern for place of birth over time. Asian/Pacific Islander cases show a larger percent of female AIDS cases being foreign-born. The percentages shown for Asian/Pacific Islander cases should be interpreted with caution, however, due to the small numbers. Most of the foreign-born Hispanics (89%) were born in Mexico and a majority of foreign-born Asian/Pacific Islanders (70%) were born in the Philippines.

**Hispanic AIDS Cases by Gender and Place of Birth by Time Period**

Gender	Place of Birth	Time Period				Cumulative
		1981 – 1985	1986 – 1990	1991 – 1995	1996 - 2000	
Male	US born	47%	53%	53%	41%	48%
	US Dependency born	5%	4%	2%	2%	2%
	Foreign Born	47%	43%	45%	58%	49%
	<b>Number in Time Period</b>	19	325	864	697	1905
Female	US born	*	55%	41%	43%	45%
	US Dependency born	*	6%	4%	1%	3%
	Foreign Born	*	39%	55%	56%	52%
	<b>Number in Time Period</b>	*	31	80	72	184

Note: Percentages may not add up to 100% due to rounding.

\* Less than 10 cases in time period.

Table 3

**Asian/Pacific Islander AIDS Cases by Gender and Place of Birth by Time Period**

Gender	Place of Birth	Time Period*			Cumulative
		1986 - 1990	1991 - 1995	1996 - 2000	
Male	US born	39%	54%	47%	48%
	US Dependency born	6%	5%	4%	5%
	Foreign Born	55%	41%	49%	47%
	<b>Number in Time Period</b>	33	78	47	159
Female	US born	**	32%	18%	25%
	US Dependency born	**	5%	0%	6%
	Foreign Born	**	64%	82%	69%
	<b>Number in Time Period</b>	**	22	11	36

Note: Percentages may not add up to 100% due to rounding.

\* There were less than 10 cases in each gender for time period 1981 – 1985.

\*\* Less than 10 cases for that gender and time period.

Table 4

#### 4. Mode of Transmission

Mode of transmission has remained relatively stable over time with “men who have sex with men” (MSM) consistently contributing the largest number of cases. Early in the epidemic, recipients of blood products (transfusion, transplants, and hemophilia) played a larger role than now. Since 1987, however, the proportions of cases attributed to Injection Drug Use (IDU), and to a lesser extent Heterosexual transmission, have been growing. In the following figure (*Figure 6*) the distribution of transmission mode is presented by year of diagnosis.

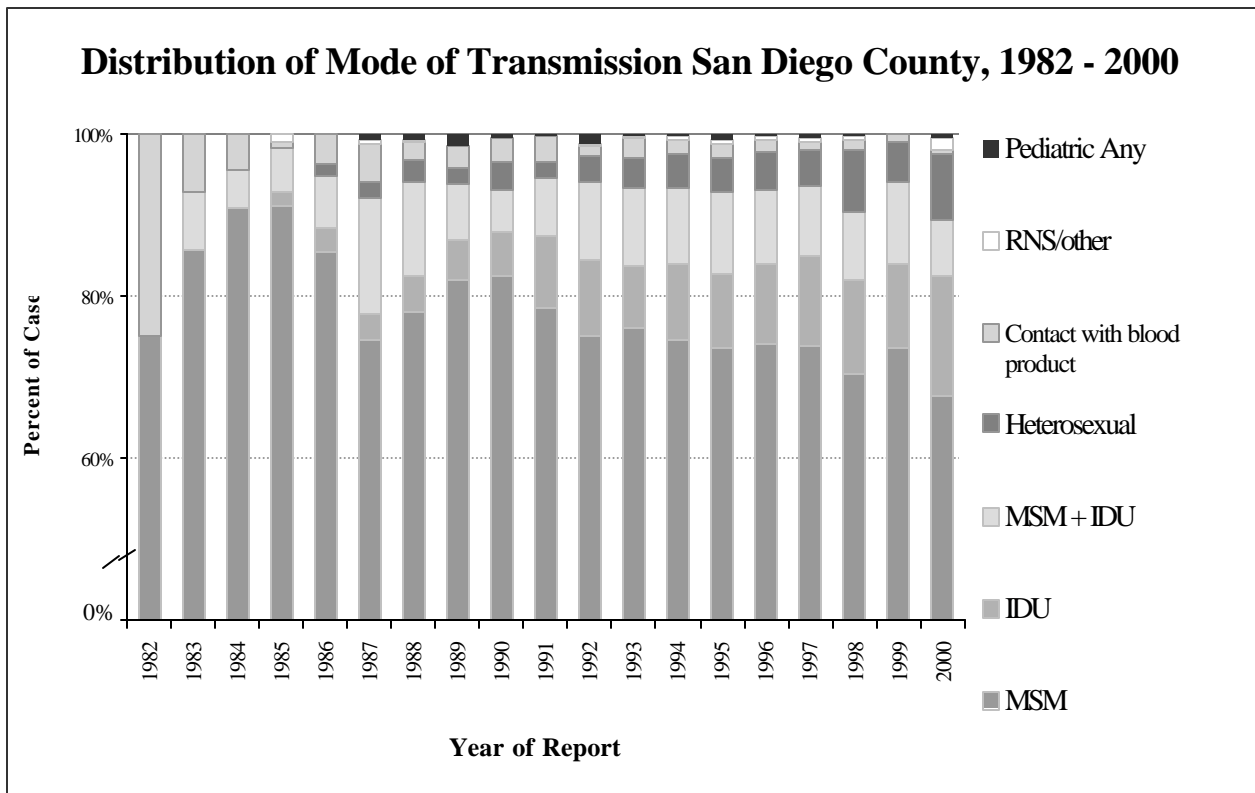


Figure 6

Cumulatively, MSM constitutes 76% of the AIDS cases, followed by both IDU (injection drug use) and the combined category, MSM and IDU at 9% each. Broken down over time and by gender (*Table 5*), the slow decrease in MSM and the gradual increase of IDU as transmission modes for men is presented. Heterosexual transmission for men is proportionally highest in 2000, compared with the last 5 years. For women, Heterosexual transmission has been attributed to more than 50% of cases each year for the last 3 years.

## AIDS Cases by Gender, Mode of Transmission, and Year of Report

Gender	Mode of Transmission	Time period					Cumulative	
		Prior to 1996	1996	1997	1998	1999		2000
Male	Adolescent/Adult: Homosexual / Bisexual (MSM)	82%	80%	81%	78%	79%	76%	81%
	Injection Drug Use (IDU)	5%	8%	8%	10%	8%	12%	6%
	MSM + IDU	10%	10%	9%	9%	11%	8%	10%
	Heterosexual	1%	0%	1%	2%	1%	3%	1%
	Transfusion/Transplant/Hemophiliac	2%	1%	1%	0%	1%	1%	1%
	Risk Not Specified/Other	0%	0%	0%	0%	0%	1%	0%
	Pediatric (0 – 12 years):							
	Transfusion/Transplant/Hemophiliac	0%	0%	0%	0%	0%	0%	0%
	Perinatal	0%	0%	0%	0%	0%	0%	0%
	<b>Number in Group</b>	6893	870	721	483	517	424	9908
Female	Adolescent/Adult: Injection Drug Use (IDU)	37%	35%	45%	31%	41%	41%	38%
	Heterosexual	44%	57%	46%	56%	59%	53%	48%
	Transfusion/Transplant/Hemophiliac	13%	3%	3%	10%	0%	0%	9%
	Risk Not Specified/Other	2%	3%	2%	2%	0%	6%	2%
	Pediatric (0 – 12 years):							
	Transfusion/Transplant/Hemophiliac	1%	0%	0%	0%	0%	0%	1%
	Perinatal	4%	3%	5%	2%	0%	0%	3%
<b>Number in Group</b>	447	72	65	52	41	51	728	

Note: Percentages may not add up to 100% due to rounding.

Table 5

When Mode of Transmission is broken down by race/ethnic group and gender (Table 6), there is a similar pattern among males, with MSM constituting the largest transmission mode. The second largest mode of transmission, however, varies among male cases by race/ethnic group. African American and Hispanic cases have the second largest portion of their cases attributed to IDU. MSM plus IDU is the second largest category for white, Asian/Pacific Islander, and Native American cases. Heterosexual contact, as a mode of transmission, is highest for Hispanic men (3%) and is attributed to 1% or less for all other males.

Unlike males, heterosexual contact is the primary mode of transmission for women in general, followed by Injection Drug Use. When race/ethnic groups are broken out, heterosexual contact remains the primary mode of transmission for African American, Hispanic and Asian/Pacific Islander cases while the primary mode of transmission for white cases is Injection Drug Use. Both African American and white female cases have more than 40% of their cases attributed to injection drug use. The second most frequent mode of transmission for Asian/Pacific Islander cases is blood contact (transfusions). There have been too few Native American female cases to really extrapolate a trend.

**Cumulative AIDS Cases by Gender, Mode of Transmission, and Race/Ethnic Group**

Gender	Mode of Transmission	Race / Ethnic Group					Total
		White	African American	Hispanic	Asian/Pacific Islander	Native American	
Male	Adolescent/Adult:						
	Gay / Bisexual (MSM)	85%	65%	78%	89%	77%	81%
	Injection Drug Use (IDU)	4%	17%	10%	3%	11%	6%
	MSM +IDU	9%	13%	8%	5%	13%	10%
	Heterosexual	0%	3%	1%	1%	0%	1%
	Transfusion/Transplant/Hemophiliac	1%	1%	2%	1%	0%	1%
	Risk Not Specified/Other	0%	0%	0%	0%	0%	0%
	Pediatric (0 – 12 years):						
	Hemophilia	.04%	0%	.16%	0%	0%	.06%
	Transfusion/Transplant/Hemophiliac	.01%	0%	.10%	0%	0%	.03%
Perinatal	.04%	1%	.47%	1%	0%	.21%	
<b>Number in Group</b>	6714	1074	1905	159	56	9908	
Female	Adolescent/Adult:						
	Injection Drug Use (IDU)	43%	44%	28%	8%	*	38%
	Heterosexual	42%	50%	51%	67%	*	48%
	Transfusion/Transplant/Hemophiliac	11%	4%	10%	19%	*	9%
	Risk Not Specified/Other	2%	1%	2%	6%	*	2%
	Pediatric (0 – 12 years):						
	Transfusion/Transplant/Hemophiliac	1%	0%	1%	0%	*	1%
Perinatal	1%	2%	9%	0%	*	3%	
<b>Number in Group</b>	318	186	184	36	4	728	

\* Too few cases to break down by percent.

Note: Percentages may not add up to 100% due to rounding.

Table 6

**5. Health Outcomes**

To have an AIDS diagnosis, it is not enough to be HIV infected. An infected person must also have one of a number of other conditions defined by the Centers for Disease Control and Prevention (CDC) to be considered an AIDS case. (Refer to Appendix II, Reporting AIDS Cases, for more information about the CDC's case definition of AIDS and how cases get reported.)

Individuals with AIDS in San Diego have experienced a number of different infections, the most common AIDS-defining infection for adolescent and adult cases is *Pneumocystis carinii pneumonia*, which was one of the original AIDS defining conditions.

In recent years, many are living not only healthier lives, they are living longer. With the introduction of new medications, many opportunistic infections that were common place at the beginning of the epidemic are less frequent in recent years. The case fatality rate, computed by dividing the number of people with AIDS who have died by the total number of people with AIDS, has also been decreasing over time.

## 5.1 Opportunistic Infections

The following two tables show the different indicator diseases experienced by San Diego residents that met the AIDS case definition, as defined by the CDC. There are some differences in how an adolescent and adult case (*Table 7*) or pediatric case (*Table 8*) can meet the definition.

Since one individual can have multiple health events, the total will exceed the number of cases.

**Frequency of Indicator Diseases\* Among Reported Adolescent/Adult AIDS Cases\*\* in San Diego**

Indicator Disease	Frequency	Percent
<i>Pneumocystis carinii</i> pneumonia	3197	30%
CD4 count <200 $\mu\text{L}/\text{mm}^3$ or <14%***	2943	28%
Wasting syndrome	1710	16%
Kaposi's Sarcoma	1472	14%
<i>Mycobacterium avium</i> complex or <i>M. kansasii</i>	1037	10%
Esophageal candidiasis	843	8%
HIV encephalopathy	758	7%
Cytomegalovirus	672	6%
Cytomegalovirus retinitis	586	6%
Cryptococcosis	544	5%
Cryptosporidiosis	430	4%
Immunoblastic lymphoma	368	3%
<i>M. tuberculosis</i> , pulmonary	302	3%
Toxoplasmosis of the brain	274	3%
Herpes simplex, invasive or chronic	271	3%
<i>M. tuberculosis</i> , disseminated or extrapulmonary	191	2%
Lymphoma, primary in brain	172	2%
Progressive multifocal leukoencephalopathy	154	1%
Pneumonia, recurrent in 12 month period	87	1%
Pulmonary candidiasis	64	1%
<i>Mycobacterium</i> , of other species or unidentified species	61	1%
Histoplasmosis	46	0%
Coccidioidomycosis	45	0%
Burkitt's lymphoma	33	0%
<i>Salmonella</i> septicemia, recurrent	25	0%
Isosporiasis	24	0%
Carcinoma, invasive cervical	1	0%

\* This list may not be a complete accounting of all the indicator conditions experienced as there is limited time to track additional opportunistic infections as disease progresses.

\*\* The sum of percentages is greater than 100 because some patients are reported with more than one AIDS indicator disease or condition.

\*\*\* Defined as a CD4+ T-lymphocyte of less than 200  $\text{mL}/\text{mm}^3$  or a percentage less than 14% in adult/adolescents who meet the AIDS surveillance case definition.

*Table 7*

**Frequency of Indicator Diseases\* Among Reported  
Pediatric AIDS Cases\*\* in San Diego**

Indicator Disease	Frequency	Percent
Wasting syndrome	25	46%
Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	18	33%
<i>Pneumocystis carinii</i> pneumonia	18	33%
HIV encephalopathy	17	31%
Esophageal candidiasis	14	26%
Cytomegalovirus	11	20%
<i>Mycobacterium avium</i> complex or <i>M. kansasii</i>	11	20%
Pulmonary candidiasis	6	11%
Cytomegalovirus retinitis	4	7%
Cryptosporidiosis	4	7%
Immunoblastic lymphoma	4	7%
Recurrent/multiple bacterial infections	4	7%
<i>M. tuberculosis</i> , disseminated or extrapulmonary	2	4%
Progressive multifocal leukoencephalopathy	2	4%
Herpes simplex, invasive or chronic	1	2%
Lymphoma, primary in brain	1	2%
<i>Mycobacterium</i> , of other species or unidentified species	1	2%

\* This list may not be a complete accounting of all the indicator conditions experienced as there is limited time to track additional opportunistic infections as disease progresses.

\*\* The sum of percentages is greater than 100 because some patients are reported with more than one AIDS indicator disease or condition.

A CD4+ T-lymphocyte of less than 200  $\text{mL}/\text{mm}^3$  or a percentage less than 14% in a pediatric patient does not meet the CDC AIDS case definition.

Table 8

## 5.2 Mortality Status

In 1993, a change in the definition of AIDS created a spike in the number of AIDS cases reported. Since this time, the number of new cases per year has been steadily dropping (*Figure 7*). There were 17% fewer cases diagnosed in 1999 than 1998 (*Table 9*). Year 2000 numbers are still tentative and will change as more cases diagnosed in 2000 are reported in 2001.

The number of AIDS deaths has also been dropping thus the case fatality rate decreases every year. As of December 31, 2000, a total of 5996 deaths have been reported with a case fatality rate of 56%. In the State of California, where there have been 119,900 AIDS cases, there is a slightly higher case fatality rate (61%).



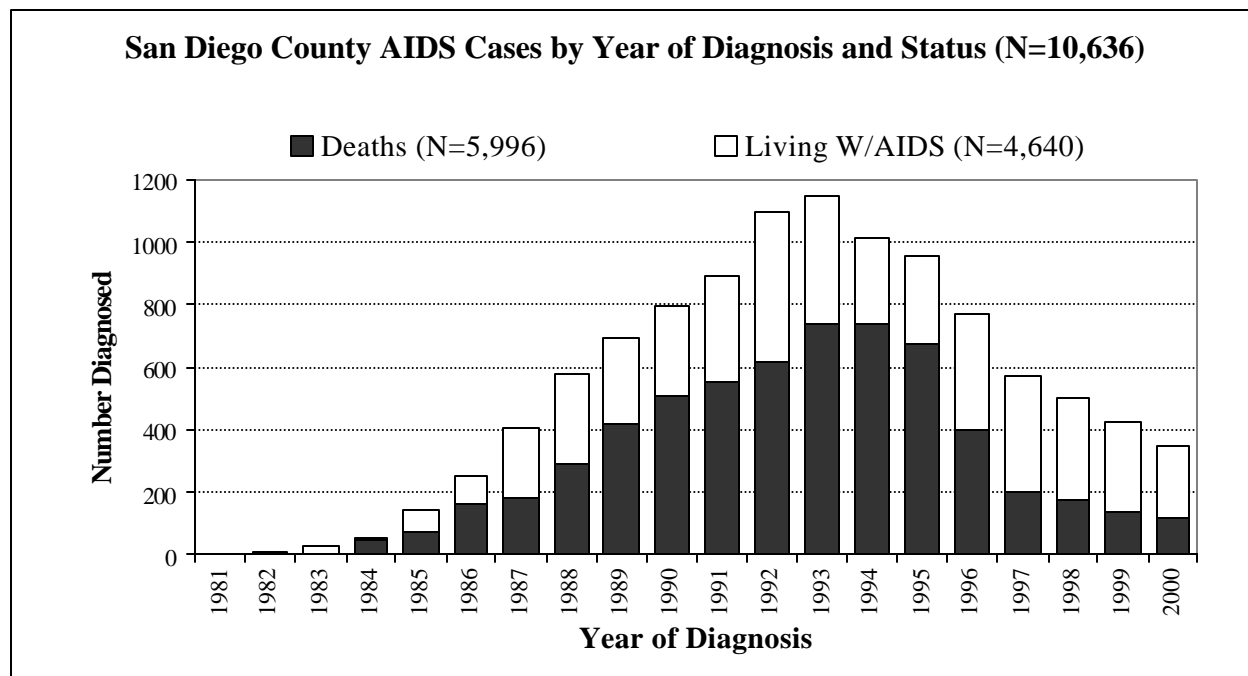


Figure 7

**San Diego County AIDS Cases, Deaths, and Fatality Rate over time**

Number of Cases, Deaths and Fatality Rate	Time Period					
	Prior to 1996	1996	1997	1998	1999	2000
New Cases	8032	765	573	497	425	344
Percent Change	*	-25%**	-34%	-15%	-17%	-24%
Number of Deaths	4977	400	198	175	133	113
Percent Change	*	-68%**	-102%	-13%	-32%	-18%
Cumulative Cases	8032	8797	9370	9867	10292	10636
Cumulative Deaths	4977	5377	5575	5750	5883	5996
Case Fatality Rate	62%	61%	59%	58%	57%	56%

\* Cumulative Data

\*\* Compared to 1995 data

Table 9

## **6. HIV in San Diego County**

Since HIV, unlike AIDS, is not currently a reportable condition, not as much is known about the HIV positive population. There are several sources of data that can help give us some idea of the basic demographics of the HIV positive community, although each source has its limitations. Keep in mind that none of the data used or described here are linked to an individual by an identifier, such as a name or social security number in order to protect confidentiality, and thus may contain duplicate records.

### **6.1 HIV and Local Data**

#### ***Counseling and Testing Data***

Local HIV counseling and testing data, most of which is conducted by the California Department of Health Services through contracts with the County of San Diego, can give us some information about those aged 12 and older who voluntarily seek HIV testing. On average, the County provides between 15,000 and 18,000 counseling and testing services each year. These tests are provided at no cost, either anonymously (no name is ever given) or confidentially (a name is given, but the name is not entered into any database). Most of the counseling and testing data analyzed here describes service utilization rather than those who tested HIV positive, primarily because the number who test HIV positive each year for sub-groups (like women, children or youth) is so small. One limitation of this data source is that each case is not unique since many individuals test repeatedly within a year. Also, those who voluntarily seek testing probably differ in important ways from those who don't. Because testing data is not required to be reported, HIV tests performed at private clinics or hospitals are not included in this database. See the appendix VII for an explanation of the risk groups as determined by the California Department of Health Services.

#### ***Research and Clinic Data***

Local research studies and clinics enroll and/or case-manage individuals who are HIV positive. Each clinic or study has its own unique set of qualifiers or self-selection criteria and often a relatively small sample size, prohibiting the generalization of characteristics to the local HIV positive population. However, for subsets of the HIV positive population, for example pediatric cases, clinic/research may be the best source of data. Some sources could be combined, such as data from Ryan White Care Act Clinics, to produce larger and more meaningful numbers. This data source has not been traditionally analyzed and reported to the public in a systematic way, at least partly due to concerns about confidentiality. By protecting confidentiality (not including identifiers and reporting the data in an aggregate manner), this data source is being explored for inclusion in regular reports.

#### ***Seroprevalence Data***

Seroprevalence data generally refers to studies or programs that regularly collect blood for various tests. Sometimes the specific aim is an HIV test, while other times individuals come in for another test requiring a blood sample and after the samples are stripped of all identifiers, they are tested for HIV. For example, all blood and plasma donations are tested for HIV and all military and Job Corps applicants are tested for HIV. Alternatively, one month a year at local health department STD (sexually transmitted disease) clinics, serum from individuals testing for

any STD other than HIV are stripped of identifiers and tested for HIV as a way of estimating the prevalence of HIV in that population. Again, this seroprevalence data is not without limitations. Individuals attending a STD clinic are likely to be at higher risk for HIV than the general population. Conversely, blood and plasma centers employ a protocol intended to screen out individuals thought to be at high risk for HIV or HIV positive, so one would expect very low rates of positivity. Those who are aware they are HIV positive or suspect it may also be more aware that programs such as the military screen applicants for HIV, and may be less likely to apply as a result. Also, all of the participants in these programs are self-selected and are likely to be different from the population as a whole. Much of this data is not currently available by gender, race/ethnicity, or age at the county level.

### ***Needs Assessment Data***

The County Office of AIDS Coordination conducts a biannual needs assessment of between 1,000 and 1,500 adults or youth living with HIV or AIDS. This consumer survey provides valuable information on the demographics and service needs of this population in San Diego County. Since the primary interest here is HIV, the number of completed surveys is not always large enough for analysis. For example, during the 2000 needs assessment, 406 and 82 HIV positive men and women, respectively, were surveyed and are described in the section on gender; however, too few youth ages 13-19 were surveyed (5) for analysis.

## **6.2 HIV Data and Demographics**

While not much is known about HIV positive individuals locally, even less is known about certain subgroups such as women, youth, children and some race/ethnic groups. Sometimes demographic data is not collected and where there is data on these groups, often there are small numbers. Small numbers make it difficult to distinguish between random variation and real differences between groups or over time. Also, small numbers can mean some groups may not be represented in the data at all. This is especially true for some race/ethnicities, age groups, and transgender populations.

Certain parameters are used here to define gender, race/ethnicity, youth and children. Women are defined as those who self-report as female or pregnant female, men as those who self-report as male (transgender male to female and transgender female to male are rare in the data and have been excluded from most analysis here). Race/ethnicity is generally self-reported but also reflects the available methods and categories used by organizations to collect the data. Youth are those aged 13-19 and children are those under 13 years of age.

## **6.3 Gender**

### ***Counseling and Testing Data***

The majority of individuals seeking HIV counseling and testing services in San Diego County are men: about 65% male and 35% female in the year 2000. The proportion utilizing services by gender has been relatively stable over time (*Figure 8*). Similarly, men have traditionally had a much higher positivity rate (1.3% in 2000) compared to women, although the rate for men appears to be decreasing (*Figure 9*). In general, men coming in for services are older and less diverse than women in any particular year but this is changing. More Hispanic and African American men are testing and fewer white men, with a general trend towards older testers. Like

men, the trend for women has been an increase in older age groups and a growth in the proportion of Hispanic and African American clients (*Figures 10-13*).

The top 5 risk groups for men receiving HIV counseling and testing services has changed only slightly in the last 6 years. The top ranking risk group is ‘Multiple Partners’ (meaning multiple heterosexual partners), and then next is ‘Men who have Sex with Men’. Over the last few years, ‘No Reported Risk’ has been bumped to last by ‘Partners with Multiple Partners’ and ‘Intravenous Drug User’ (*Figure 14*). Nearly 70% of men coming in for services had tested at least once before according to year 2000 data. In year 2000, 177 tests were confirmed HIV positive; 144 (81%) of these were to men.

The top 5 risk groups for women has remained stable over the last five years with ‘Multiple Partners’ and ‘Partners with Multiple Partners’ constituting the largest proportion of testers. While remaining in the top 5, “Multiple Partners’ and ‘No Reported Risk’ categories have decreased in size and proportion over time. Other risk groups have increased slightly but not enough to threaten the stability of the top 5 (*Figure 15*). Like men, the majority of testers had been tested previously: about 67% of women in 2000 had tested at least once before. Of the 177 HIV positive tests in 2000, 32 were to women. This number is too small to further analyze by race/ethnicity, age group or geographic region. Where large enough numbers exist for analysis, patterns and trends for San Diego County parallel California state HIV counseling and testing patterns and trends.

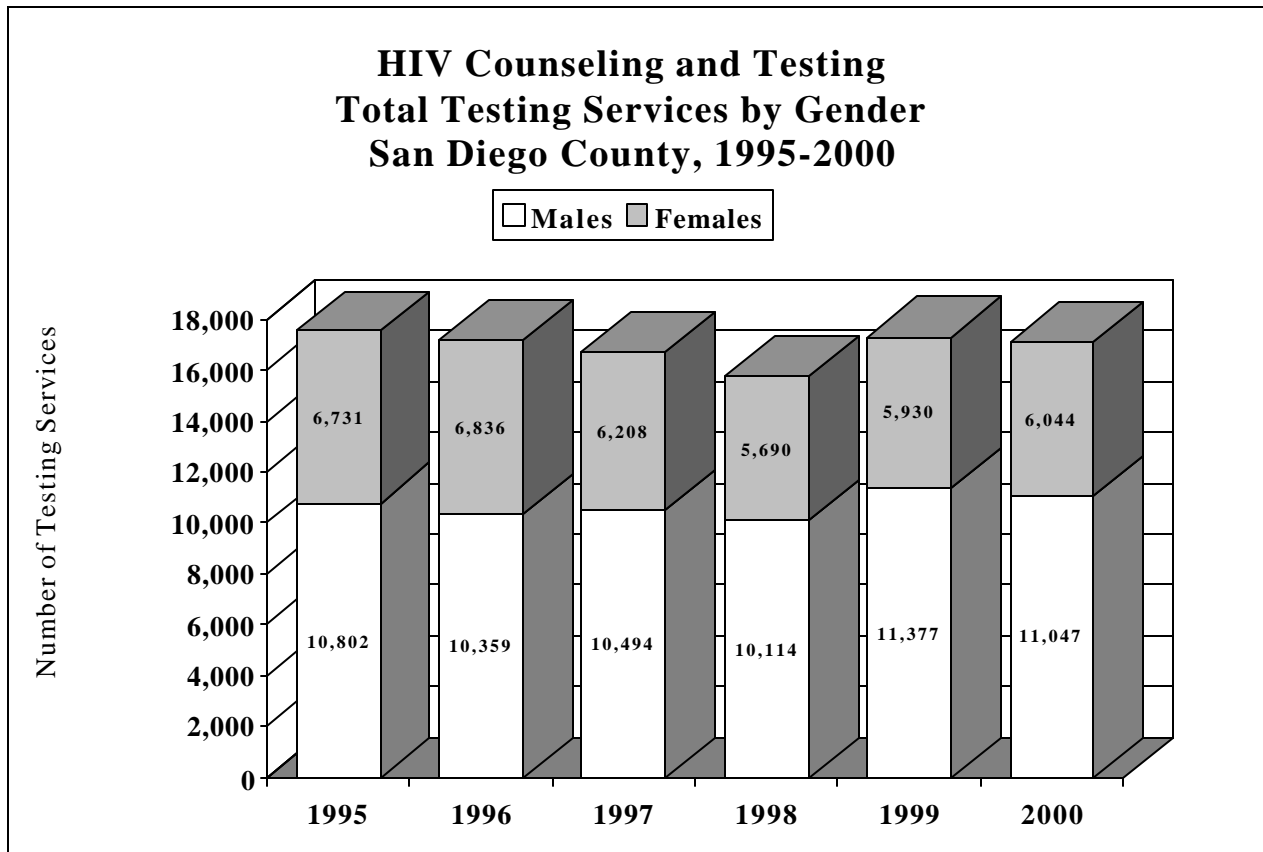


Figure 8

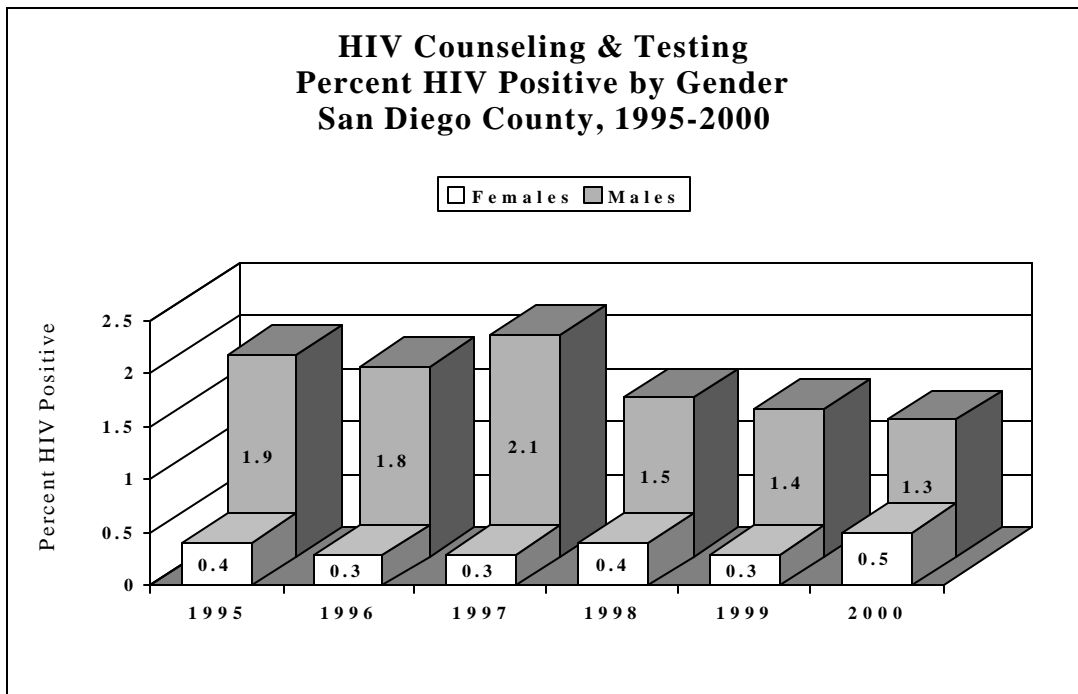


Figure 9

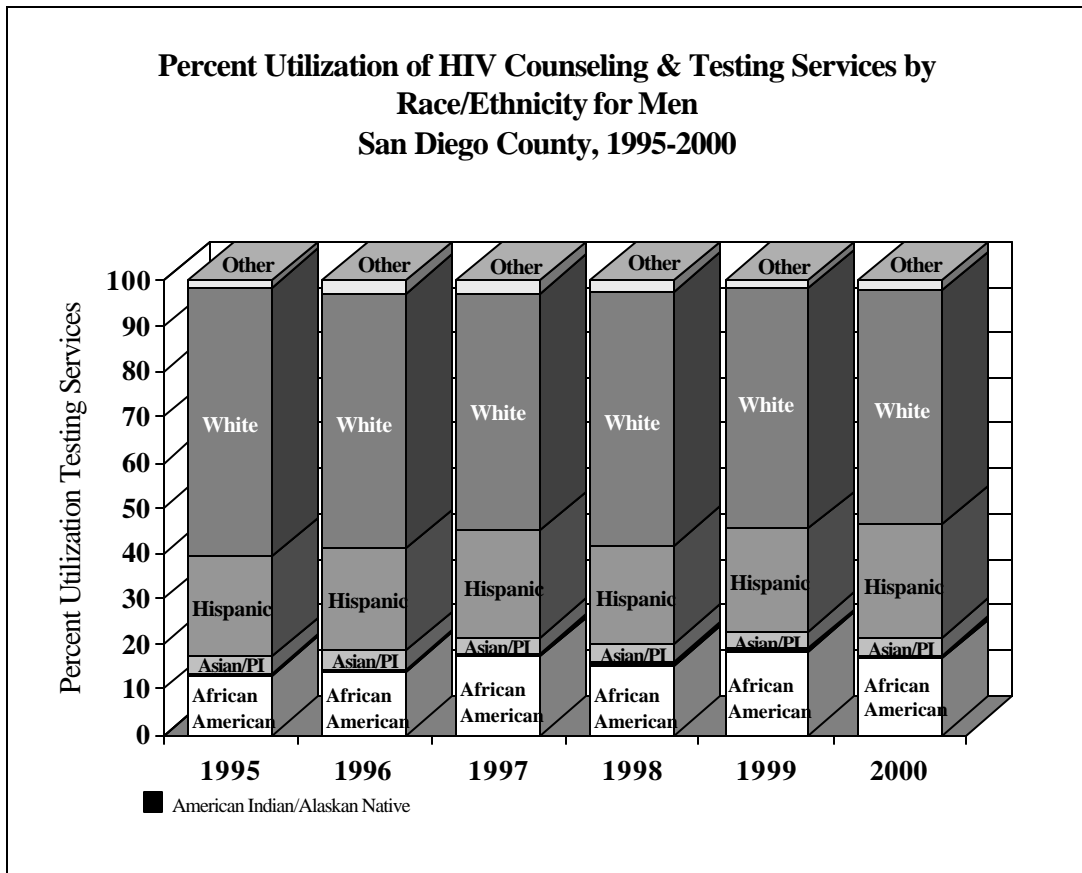


Figure 10

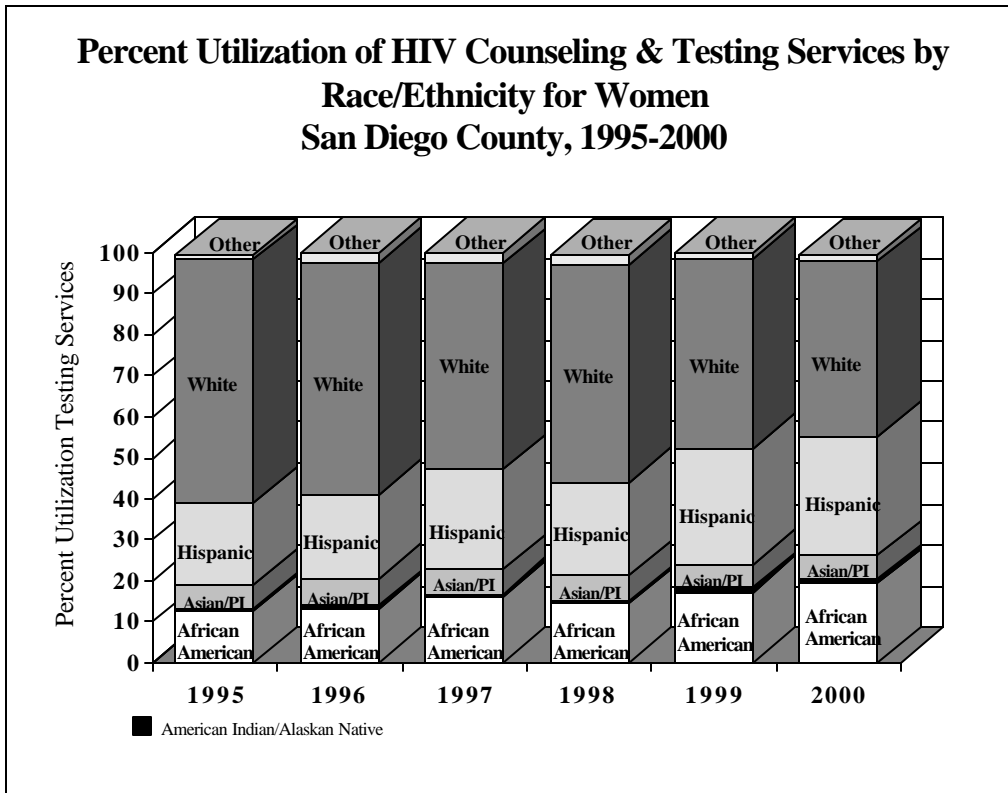


Figure 11

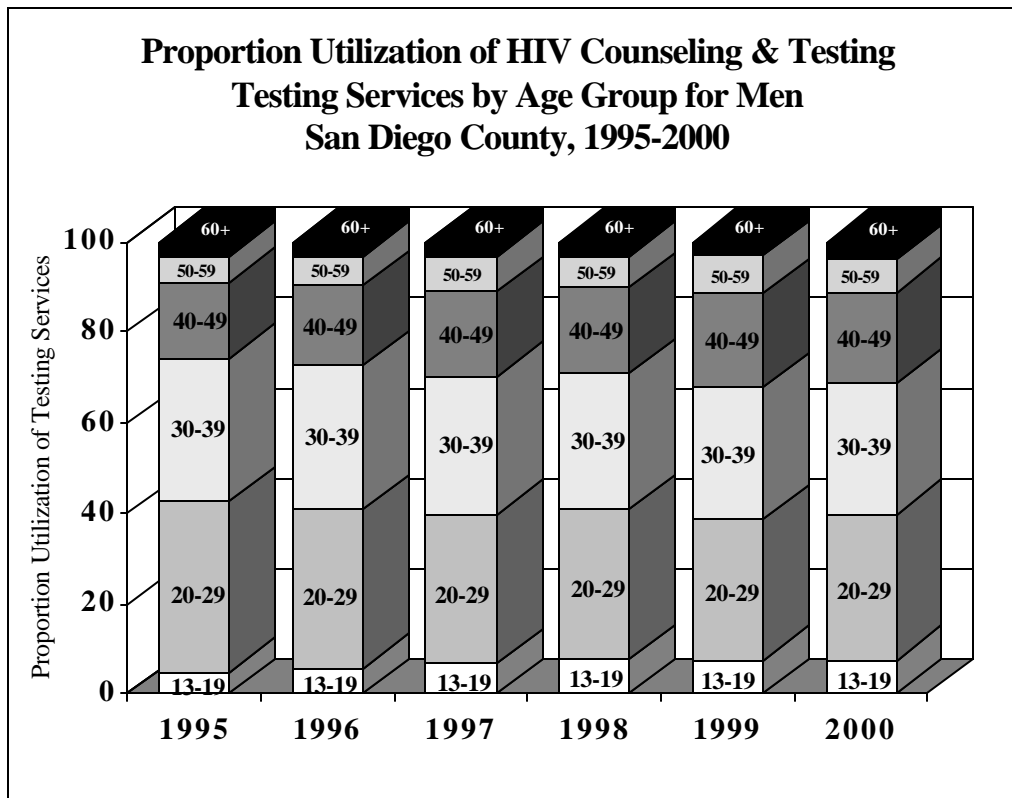


Figure 12

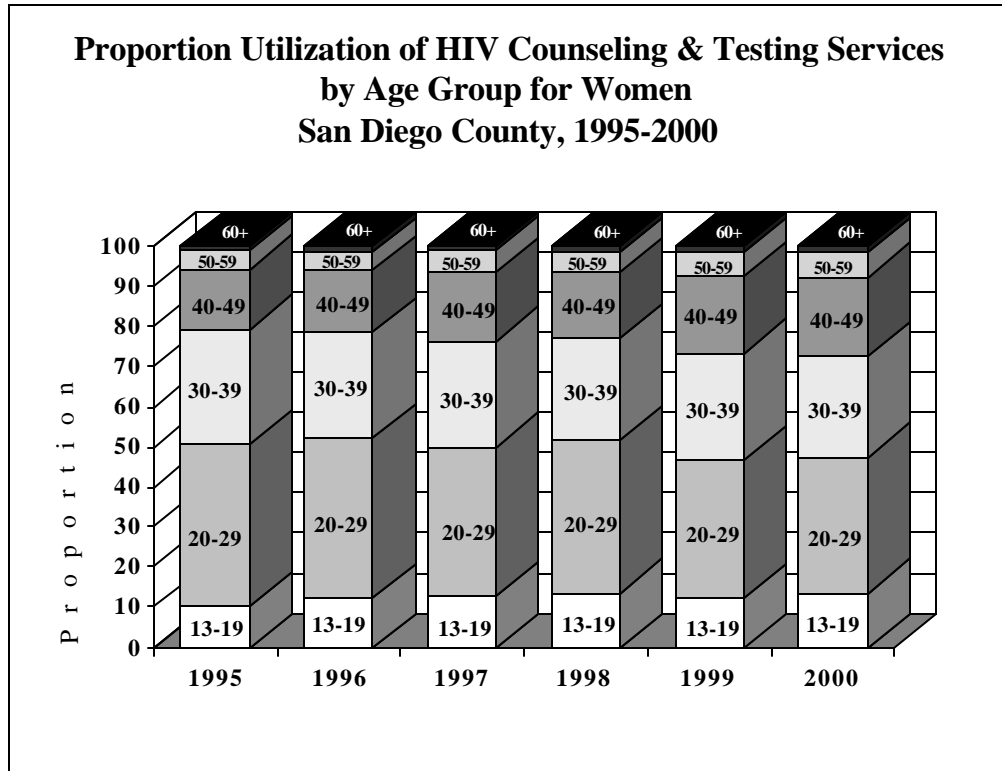


Figure 13

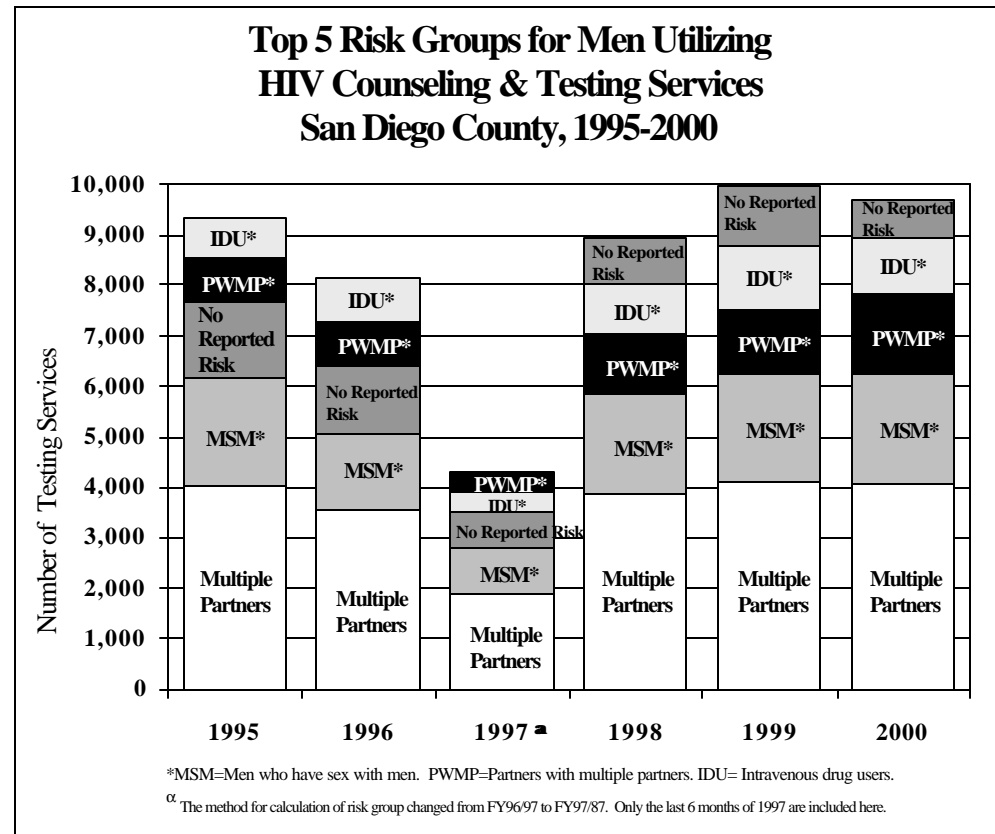


Figure 14

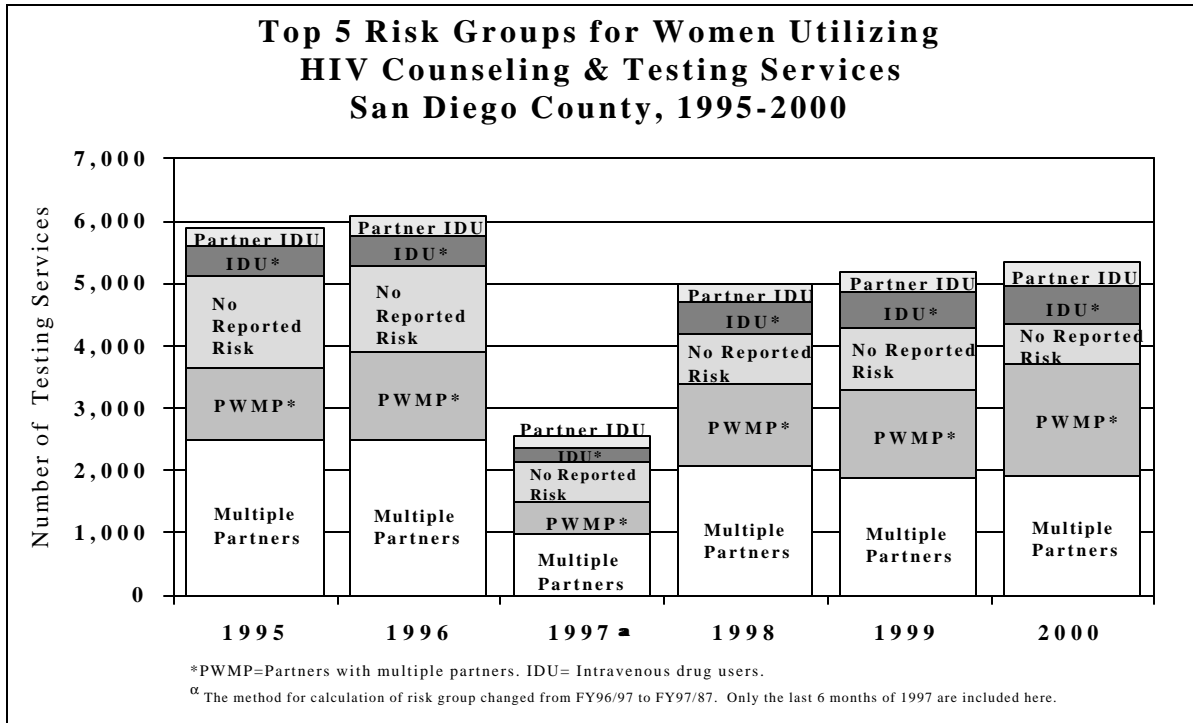


Figure 15

Between 100 and 150 pregnant women seek HIV counseling and testing services each year and most of these women are ages 20-29. Because the numbers are small, the percent of pregnant testers by race/ethnicity fluctuates from year to year. However, in all years pregnant Hispanic women are the majority race/ethnicity, representing between 36% and 57% of all pregnant testers (Figure 16). Between 1995 and 2000, only 1 pregnant woman tested positive for HIV. Also, in that same time period, fewer pregnant testers are first-time testers. In 1995, 55% of the women were first-time testers, but in 2000 only 35% were first-time testers.

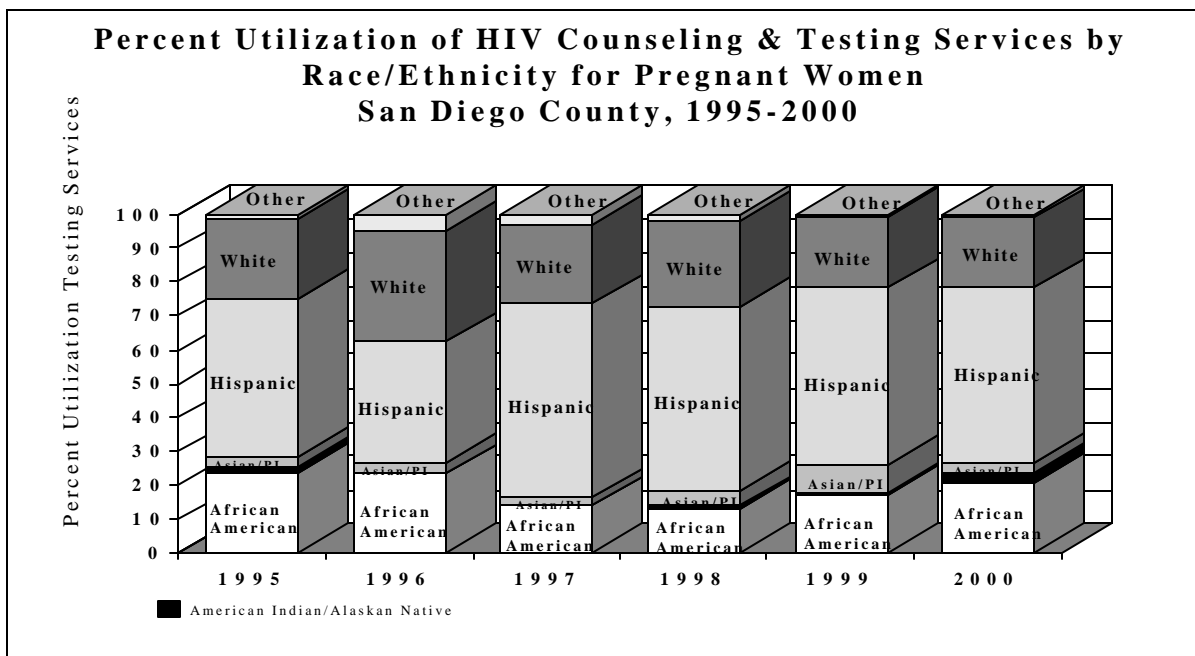


Figure 16



**Seroprevalence Data**

At this time there is very little current data by gender for seroprevalence. The California Department of Health Service’s Survey of Childbearing Women (SCBW) began in 1988 and was discontinued in 1995, then replicated again in 1998. During those years, unlinked testing was conducted on blood samples taken from hospital live births for the third quarter of each year or between 9,000 and 12,000 births per year in San Diego County. The rate of HIV seropositivity in the county ranged from .3 to .9 per 1,000 births (or .03% to .09%), having close to the same levels as the state (*Figure 17*). For the county, this rate translates to between 4 and 11 HIV positive mothers, numbers too small to further analyze by race/ethnicity or age.

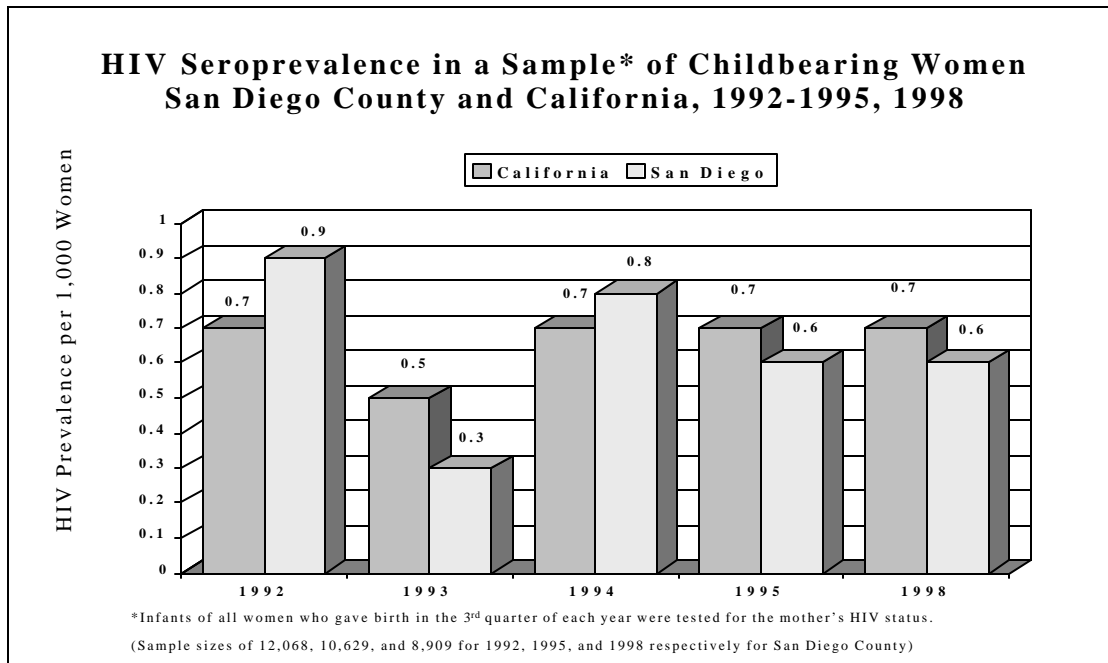


Figure 17

Another serosurveillance project, the survey of adults attending STD (sexually transmitted disease) clinics has been conducted at 12 California health departments, including San Diego County, since 1989. To be included, a client must be visiting for a STD (other than HIV) that requires a blood sample. Eligible clients are consecutively sampled during one month, up to 500 samples, that are then stripped of identifiers and tested for HIV. The seroprevalence for women attending STD clinics in San Diego County during 2000 was 0.7% (1 positive woman out of 148 tested), but over time it has ranged from 0.0% to .6%. This compares to a seroprevalence of 6.0% (21 men out of 352 tested) for men during 2000, with a range of 3.0% to 6.3%. From 1990 to 2000, the trend is not entirely clear (*Figure 18*). For example, the difference between the 3% in 1996 for men and the 6% in 2000 for men looks significant but it is not statistically different because the figures are based on small numbers.

Blood and plasma donation data does not consistently include gender at the county level, and even if it did, the number HIV positive is very small: 5 out of 106,037 units of blood tested in 1999 (.005%), and 8 out of 187, 216 units of plasma tested in 1999 (.005%). Military applicant screening does include data on gender but again the numbers are very small. In 1998, 3,492 civilians applied for military service and were screened for HIV. Of that number 1 person tested positive for HIV, resulting in a prevalence rate of .03%.

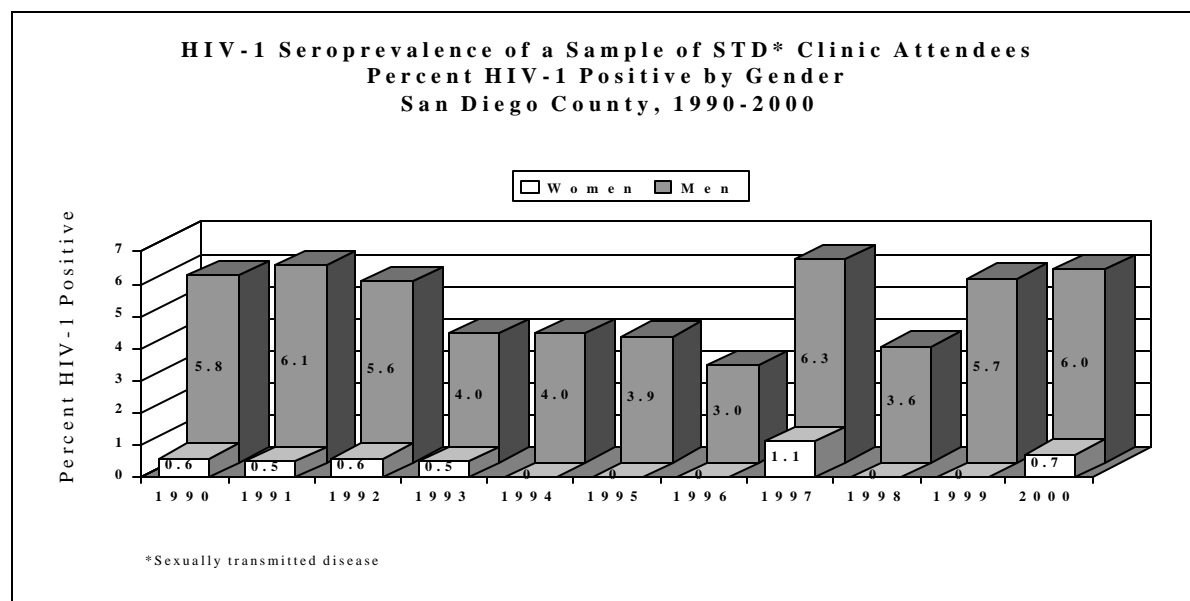


Figure 18

### ***Needs Assessment Data***

During the 2000 HIV/AIDS Needs Assessment, 406 men and 82 women in San Diego County who were HIV positive completed a survey. For men, ages of participants ranged from 19 to 80, with the largest share of men falling between ages 30-39 (39.4%). Most of the men reported their race/ethnicity as white (56.1%), with 22.9% reporting Hispanic, 15.1% African American, 2.9% Asian/Pacific Islander, 2.0% Native American, and 1.0% other. The vast majority of men self-identified as gay (77.0%), with 14.6% heterosexual, and 8.4% bisexual. Almost 13% of the men reported a chronic mental illness, 22% reported drinking regularly/often, and 21% reported using illegal drugs in the last 6 months. About 18% of the men reported being in recovery for past substance abuse problems.

Most of the men had a high school education or better (86.8%) and just over half (53.9%) were unemployed. The median monthly income for these men was \$813 with the median rent being \$402. Almost 5% of the men were homeless at the time of the survey, and another 5% felt at risk of being homeless within the next 30 days.

Of the 82 female participants, ages ranged from 18 to 62, with the age group 30-39 having the largest proportion (36.6%) of women. African American and Hispanic women made up the majority (37.5% and 36.3% respectively), with white at 21.3%, Asian/Pacific Islanders at 3.8% and Native Americans at 1.3%. When asked about sexual orientation, 92.4% of the women indicated heterosexual. A few women reported sex work/prostitution or injection drug use (4 and 3 women respectively).

Just over half (51.2%) the women had a high school education or better and most (70.7%) were unemployed. The median monthly income for these women was \$692 while the median monthly rent was \$387. About 9% of the women were homeless at the time of the survey, and an additional 6% felt at risk of homelessness in the next 30 days. Also, over half the women (56.1%) were raising at least one child or teen under the age of 18, caring for a total of 79 children. Fourteen of these children were HIV positive as well.

## 6.4 Risk Group

### *Counseling and Testing Data*

When a client comes in for HIV testing, a counselor asks about specific risk behaviors. The State Office of AIDS calculates a hierarchy of risk based on those behaviors and on the epidemiology of HIV transmission. The fifteen risk groups in order of highest to lowest risk for HIV transmission are: Men who have sex with Men (MSM), Bisexual, Intravenous Drug Users (IDU), Gay/Bi IDU (men only), HIV+ Partner, Partner Bisexual, IDU Partner, Sex for Drugs/Money, Blood Transfusion <1985, Multiple Partners (heterosexual only), Partners with Multiple Partners (heterosexual only), Occupational Exposure, Child at Risk (perinatal transmission), No Reported Risk, and Unknown. For a more in-depth description of this hierarchy, please see Appendix VII.

The largest share of those who come in for testing fall into the Multiple Partners risk group—about 35% in 2000. The distribution of testers by risk group has stayed remarkably stable over the last 6 years with the exception of a growth in Partners with Multiple Partners and IDU, and a decrease in No Reported Risk, Blood Transfusion <1985, and Occupational Exposure (*Table 10*).

During the year 2000, 82% of HIV positive tests fell into one of five groups: MSM (46%), Multiple Partners (13%) and IDU (11%), Bisexual (6.8%) and IDU Partner (5.1%) (*see Figure 19*). Over time the distribution of the top 5 risk groups for HIV positive tests has changed. MSM continues have the largest share of HIV positive tests; however, Multiple Partners and IDU have pushed Bisexual to a smaller share. The highest rate of those testing HIV positive was among MSM and HIV+ Partner (3.7% and 3.6% respectively in 2000). Since 1995 many of the highest risk groups have experienced a decrease in the rate testing HIV positive, including MSM, Bisexual, and Gay/BI IDU (*Table 11*). The other groups have remained fairly stable or have such small numbers that trends are not clear.

HIV Counseling and Testing Services, Distribution of All Testers by Risk Group San Diego County, 1995-2000												
Risk Group	1995		1996		1997		1998		1999		2000	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
MSM	2,157	12.3	1,512	8.8			2,003	12.6	2,120	12.2	2,183	12.7
Bisexual	859	4.9	938	5.5			686	4.3	759	4.4	801	4.7
IDU	1,273	7.2	1,347	7.8			1,511	9.5	1,854	10.7	1,707	9.9
Gay/Bi IDU	189	1.1	269	1.6			211	1.3	217	1.3	187	1.1
HIV+ Partner	310	1.8	278	1.6			241	1.5	225	1.3	196	1.1
Partner Bisexual	173	1.0	159	0.9			215	1.4	209	1.2	193	1.1
IDU Partner	543	3.1	546	3.2			540	3.4	713	4.1	737	4.3
Sex for Drugs/Money	153	0.9	683	4.0			89	0.6	161	0.9	125	0.7
Blood transfusion <1985	127	0.7	122	0.7			34	0.2	31	0.2	5	0.0
Multiple partners	6,512	37.1	6,068	35.3			5,945	37.5	6,042	34.8	6,009	35.0
Partners with multiple partners	2,047	11.7	2,294	13.3			2,483	15.7	2,691	15.5	3,380	19.7
Occupational exposure	109	0.6	123	0.7			38	0.2	58	0.3	40	0.2
Child at risk	0	*	2	*			0	*	0	*	0	*
No reported risk	2,983	17.0	2,711	15.8			1,715	10.8	2,153	12.4	1,424	8.3
Unknown	128	0.7	156	0.9			125	0.8	118	0.7	169	1.0
Total	17,563	100.0	17,208	100.0			15,836	100.0	17,351	100.0	17,156	100

*Table 10* No percents calculated for fewer than 5 events. Percents may add to slightly more or less than 100 due to rounding. Risk Group was calculated differently in the first half of 1997 than the last half; data from 1997 not included here.

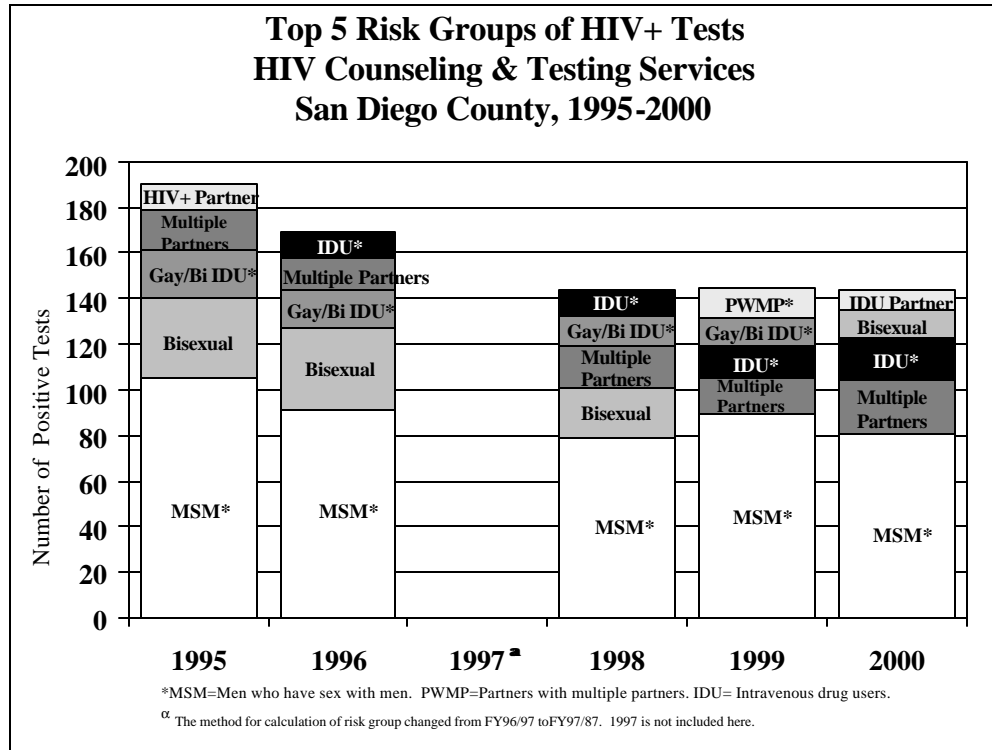


Figure 19

HIV Counseling and Testing Services Number and Percent HIV Positive by Risk Group San Diego County, 1995-2000																		
Risk Group	1995			1996			1997			1998			1999			2000		
	No. HIV+	No. Testers	Percent HIV+	No. HIV+	No. Testers	Percent HIV+	No. HIV+	No. Testers	Percent HIV+	No. HIV+	No. Testers	Percent HIV+	No. HIV+	No. Testers	Percent HIV+	No. HIV+	No. Testers	Percent HIV+
MSM	105	2,157	4.9	91	1,512	6.0				79	2,003	3.9	89	2,120	4.2	81	2,183	3.7
Bisexual	35	859	4.1	36	938	3.8				22	686	3.2	8	759	1.1	12	801	1.5
IDU	9	1,273	0.7	12	1,347	0.9				11	1,511	0.7	14	1,854	0.8	19	1,707	1.1
Gay/Bi IDU	21	189	11.1	17	269	6.3				14	211	6.6	13	217	6.0	4	187	*
HIV+ Partner	12	310	3.9	9	278	3.2				6	241	2.5	5	225	2.2	7	196	3.6
Partner Bisexual	0	173	*	1	159	*				0	215	*	0	209	*	0	193	*
IDU Partner	7	543	1.3	3	546	*				4	540	*	5	713	0.7	9	737	1.2
Sex for Drugs/Money	0	153	*	3	683	*				0	89	*	1	161	*	2	125	*
Blood transfusion <1985	2	127	*	1	122	*				0	34	*	0	31	*	0	5	*
Multiple partners	18	6,512	0.3	14	6,068	0.2				18	5,945	0.3	16	6,042	0.3	23	6,009	0.4
Partners with multiple partners	8	2,047	0.4	5	2,294	0.2				10	2,483	0.4	13	2,691	0.5	8	3,380	0.2
Occupational exposure	0	109	*	0	123	*				0	38	0.0	0	58	*	1	40	*
Child at risk	0	0	*	0	2	*				0	0	*	0	0	*	0	0	*
No reported risk	11	2,983	0.4	11	2,711	0.4				6	1,715	0.3	10	2,153	0.5	8	1,424	0.6
Unknown	4	128	*	1	156	*				0	125	*	1	118	*	3	169	*
<b>Total</b>	<b>232</b>	<b>17,563</b>	<b>1.3</b>	<b>204</b>	<b>17,208</b>	<b>1.2</b>				<b>170</b>	<b>15,836</b>	<b>1.1</b>	<b>175</b>	<b>17,351</b>	<b>1.0</b>	<b>177</b>	<b>17,156</b>	<b>1.0</b>

No percents calculated for fewer than 5 events. Percents may add to slightly more or less than 100 due to rounding. Risk Group was calculated differently in the first half of 1997 than the last half; data from 1997 not included here.

Table 11

## 6.5 Race/Ethnicity

### *Counseling and Testing Data*

Through the first half of 1997, clients of HIV counseling and testing services had 6 mutually exclusive race/ethnic categories to choose from: African American, American Indian/Alaskan Native, Asian/Pacific Islander, Hispanic, white, and other. Beginning in fiscal year 97/98, clients had the same categories but could choose two different race/ethnicities if they desired. Since then, between 2% and 3% of testers choose more than one race/ethnicity. For purposes of analysis, only the first race chosen is used to assign race/ethnicity. The majority of testers self-report as white, about 48% in 2000; however, there are proportionately more African Americans and Hispanics receiving services each year (*Figure 20*). As shown in table 12, the largest share of positive tests are to whites, but that share has been decreasing as it has increased in African Americans and Hispanics. African Americans have traditionally had the highest rates for testing HIV positive and this is still true in 2000, although as in most race/ethnic groups, the rate appears to be decreasing over the last six years (*Figure 21*).

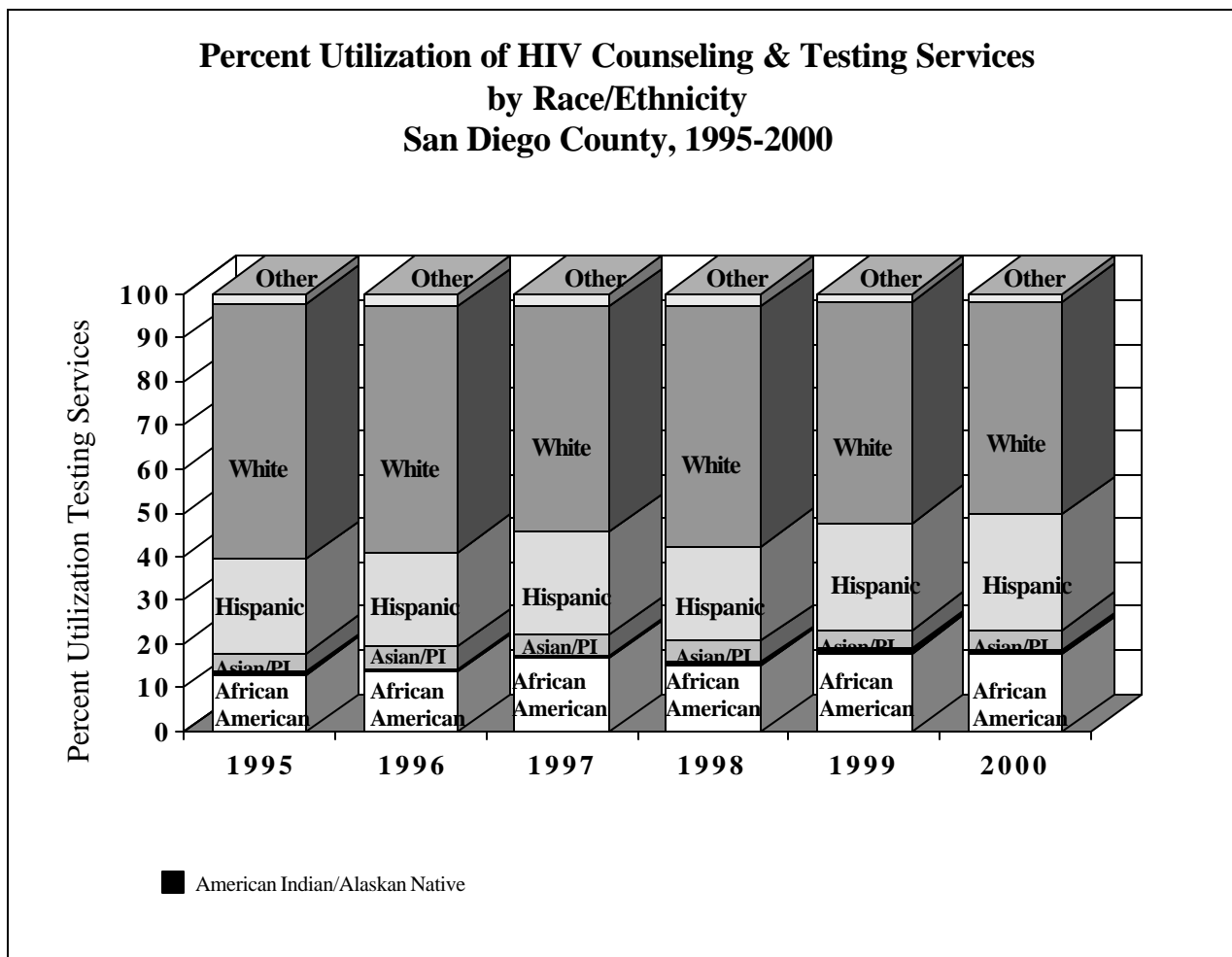


Figure 20

HIV Counseling and Testing Services												
Distribution of HIV+ Tests by Race/Ethnicity												
San Diego County, 1995-2000												
Race/Ethnicity	1995		1996		1997		1998		1999		2000	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
African American	41	17.7	41	20.1	66	27.4	38	22.4	49	28.0	41	23.2
American Indian/Alaskan Native	0	*	1	0.5	1	*	1	0.6	2	1.1	0	*
Asian/Pacific Islander	9	3.9	7	3.4	7	2.9	6	3.5	5	2.9	6	3.4
Hispanic	66	28.4	51	25.0	61	25.3	54	31.8	53	30.3	56	31.6
White	109	47.0	100	49.0	103	42.7	67	39.4	64	36.6	70	39.5
Other	3	*	2	1.0	3	*	4	2.4	2	1.1	2	1.1
Missing	4	*	2	1.0	0	*	0	*	0	*	2	1.1
Total	232	100.0	204	100.0	241	100.0	170	100.0	175	100.0	177	100.0

Table 12

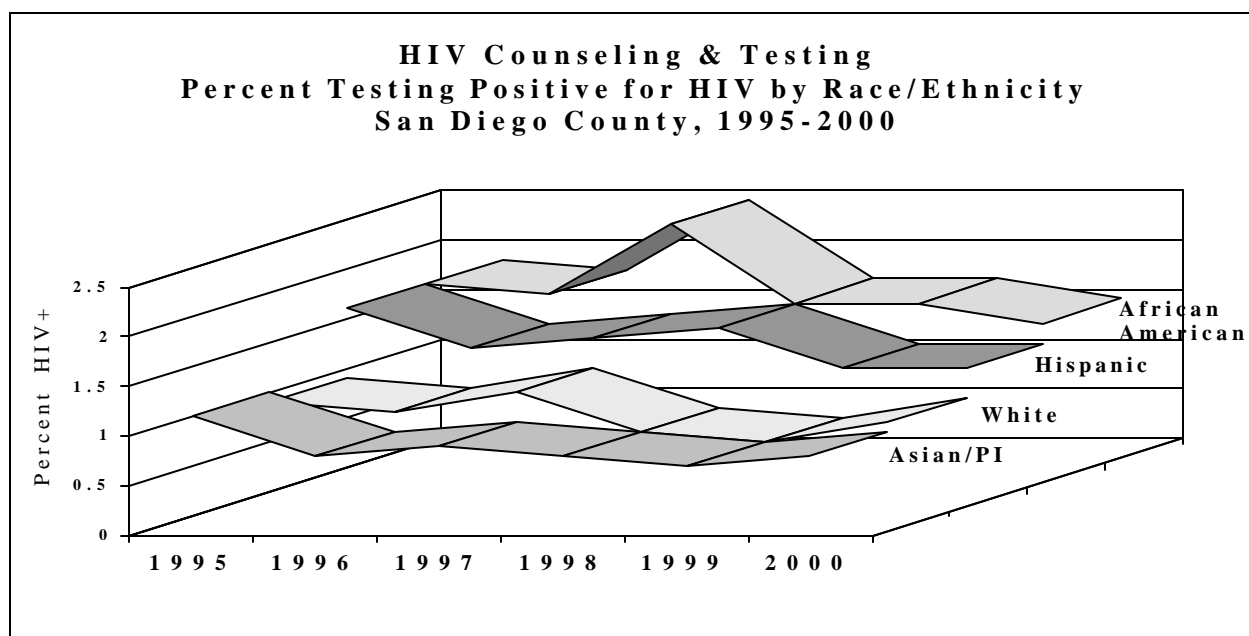


Figure 21

## 6.6 Youth

### Counseling and Testing Data

Most of the data available on youth comes from the county's HIV counseling and testing data. Each year over 1,000 youth aged 13-19 come in for HIV testing, and each year since 1995 has seen an increase in the number of youth tested (*Figure 22*). Of those aged 13-19 who tested in 2000, about 51% were girls and 49% boys. This appears to be a gradual change from 1995 when a larger majority of testers were girls. When compared by race/ethnic makeup, youth have more Hispanics and fewer whites testing than adults, but like adults, the trend in youth testing is even fewer whites and more Hispanics (*Figure 23*).

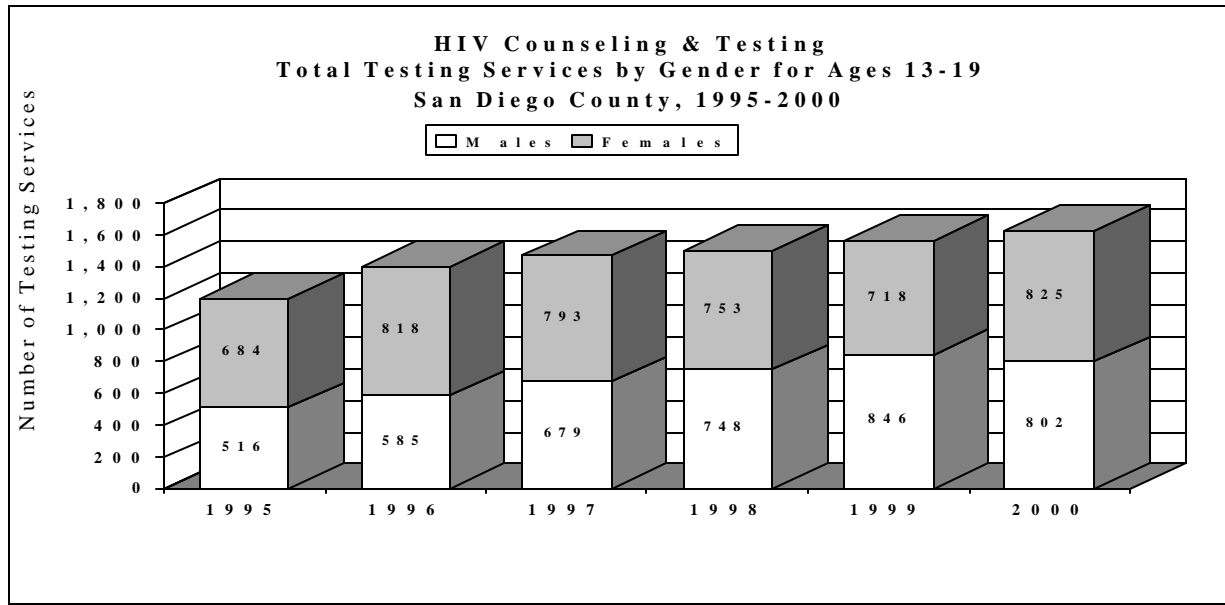


Figure 22

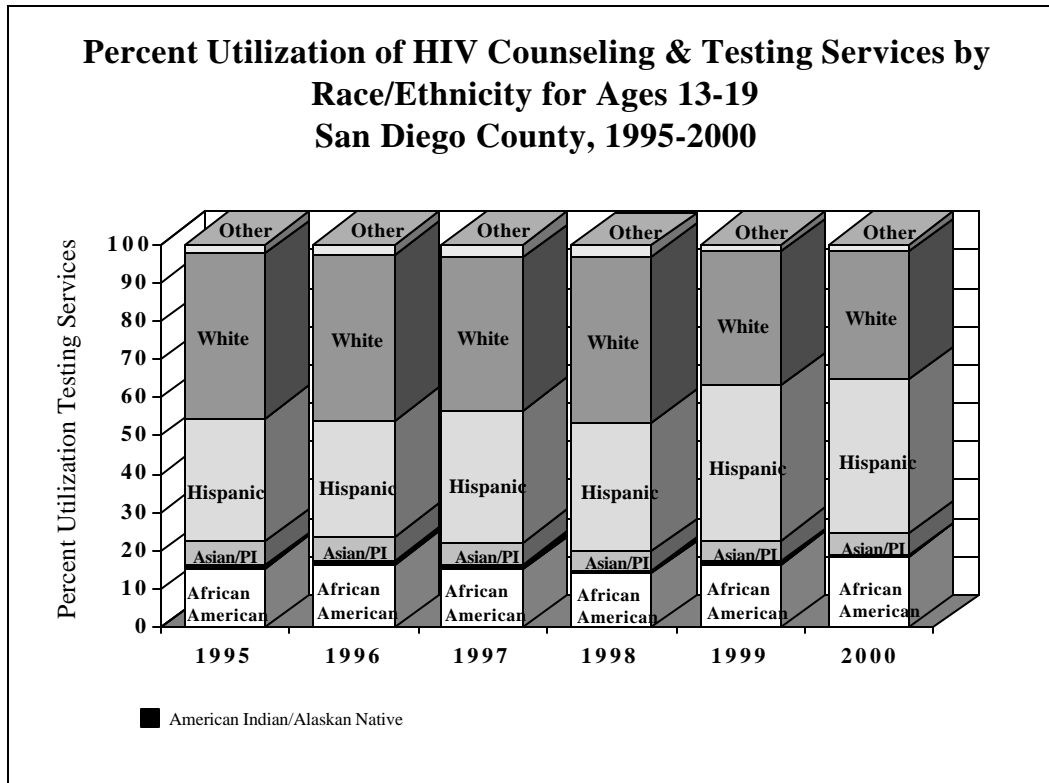


Figure 23

The rate of HIV infection in youth testers 13-19 is much lower than the overall rate, about 0.1% or 2 testers out of 1,608 in 2000. Since 1995, the percent of testers who are HIV positive has fluctuated from a low of 0.1% to a high of 0.4% (Figure 24). This probably has more to do with small numbers and random variation than actual differences between years. Similarly, the small number of youth testing positive each year (between 1 and 5) precludes further analysis by race/ethnicity.

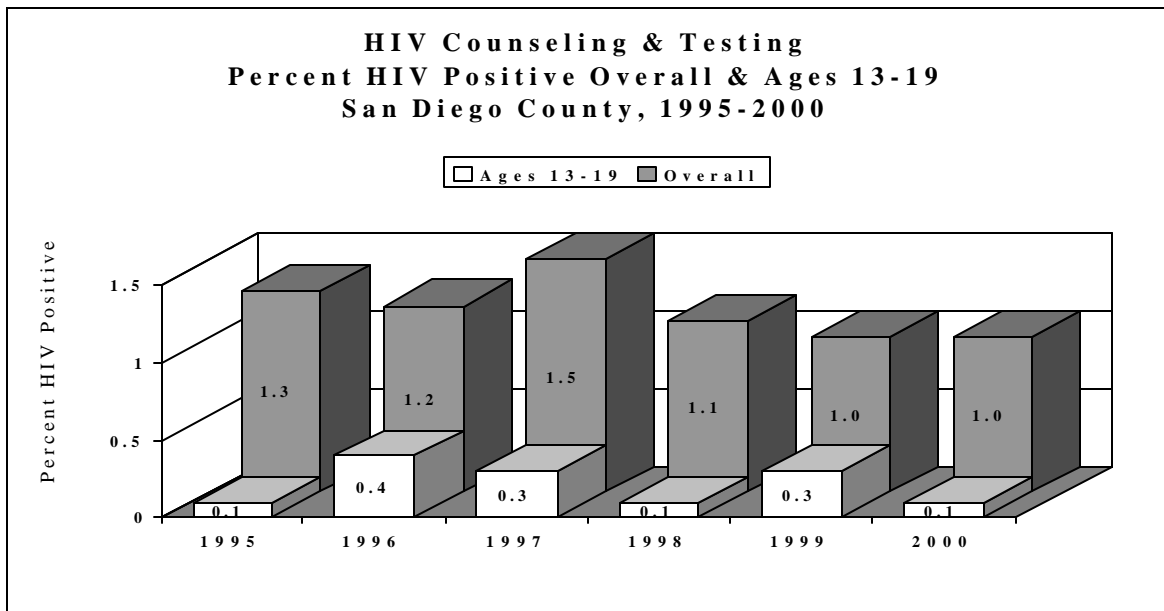


Figure 24

Like women, the vast majority of youth testers fall into the ‘Multiple Partners’ risk group, then either ‘Partners with Multiple Partners’ or ‘No Reported Risk’. Over the last couple of years, the two remaining top 5 risk groups seem to be changing from IDU-related risk groups to ‘MSM’ and ‘Bisexual’ risk groups (Figure 25). Unlike older testers, about 64% of youth had never tested before. Patterns of youth testers by race/ethnicity, risk group and HIV infection rates appear to be very similar to California youth testers.

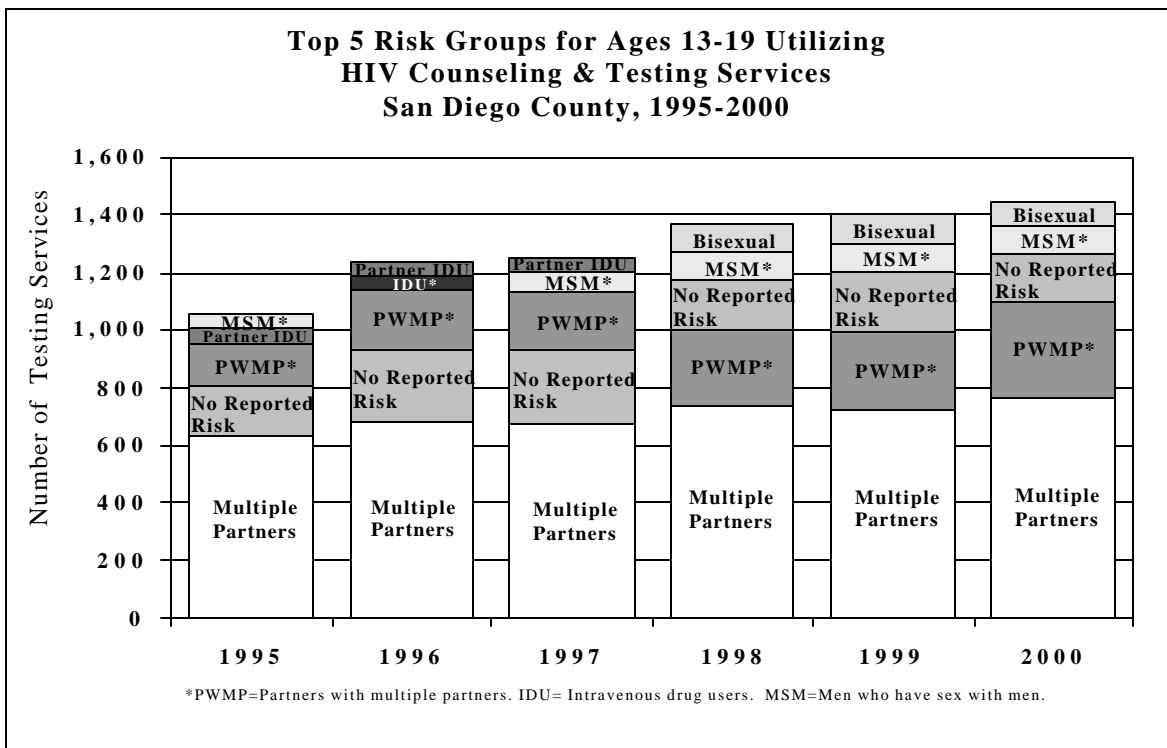


Figure 25



### ***Research and Clinic Data***

There is limited available data from research and clinics, and the following data comes from one local program. During the year 2000, this program provided services for 25 HIV positive youth aged 13-19. Of these, 10 were boys and 15 were girls. The race/ethnic composition was 15 Hispanic, 6 white, 2 Asian/Pacific Islander, 1 African American, and 1 unknown/refused. Although Hispanics seem over-represented, these numbers are very small and more data is required to determine the significance. Seventeen of the youth were infected perinatally (transmission from an HIV positive mother during pregnancy, childbirth or breastfeeding), 5 by transfusion, and 1 each from hemophilia, injection drug use, and heterosexual sex.

## **6.7 Children**

### ***Counseling and Testing Data***

Counseling and testing services are offered to those ages 12 and up without parental permission. However, on average only about 3 children aged 12 seek these services per year. This number is too small for analysis.

### ***Research and Clinic Data***

Very little information is available on children who are HIV infected. The following data comes from one local program. During calendar year 2000, 50 HIV positive children ages 0-12 received services through the program. Of these, 26 were boys, 24 were girls. The race/ethnic composition of these children was: 13 African American, 28 Hispanic, 8 white, and 1 unknown race. All the children in this program acquired HIV perinatally.

## **6.8 Geographic Areas**

### ***Counseling and Testing Data***

The County of San Diego's Health and Human Services Agency (HHSA) divides San Diego County into six zip code based geographic regions: North Coastal, North Inland, North Central, Central, East and South. When analyzed by the HHSA regions, HIV counseling and testing data clearly shows that the largest share of clients come from the Central Region, 46% in 2000 (*Table 13*). Other than where zip code is missing, the Central region also shows the highest rate of HIV positive tests (1.4%) as well as the largest share of HIV positive tests (63%). The South region is next, with a 1.3% rate of HIV positive tests, and 16% of the total HIV positive tests. While this data may reflect a higher risk by region, it may also be the result of testing locations, outreach programs or access to healthcare. Some regions had fewer than 5 HIV positive tests, therefore, no percents were calculated.

HIV Counseling and Testing, Test Result by HHS Region San Diego County, 2000						
HHS Region			Test Result			Total
			Positive	Negative	Inconclusive	
North Coastal Region	Number	2	1,035		1,037	
	Row percent	*	99.8		100.0	
	Column percent	*	6.2		6.1	
North Inland Region	Number	2	498		500	
	Row percent	*	99.6		100.0	
	Column percent	*	3.0		3.0	
North Central Region	Number	17	3,247	3	3,267	
	Row percent	0.5	99.4	0.1	100.0	
	Column percent	9.6	19.4	37.5	19.3	
Central Region	Number	112	7,717	3	7,832	
	Row percent	1.4	98.5	<0.1	100.0	
	Column percent	63.3	46.2	37.5	46.3	
East Region	Number	9	1,581	1	1,591	
	Row percent	0.6	99.4	0.1	100.0	
	Column percent	5.1	9.5	12.5	9.4	
South Region	Number	29	2,236	1	2,266	
	Row percent	1.3	98.7	<0.1	100.0	
	Column percent	16.4	13.4	12.5	13.4	
Missing	Number	6	404		410	
	Row percent	1.5	98.5		100.0	
	Column percent	3.4	2.4		2.4	
Total	Number	177	16,718	8	16,903	
	Row percent	1.0	98.9	<0.1	100.0	
	Column percent	100.0	100.0	100.0	100.0	

Table 13

## 6.9 Summary

Overall, where enough data exists to examine trends, the rate of HIV infection appears to be decreasing, especially among the highest risk groups. Disparities continue in HIV infection rates by race/ethnicity although the gap is decreasing. Low rates of HIV infection exist among heterosexual risk groups, women, youth and children; however, the rates among some of these groups have shown no decline. Finally, current data sources are not appropriate for describing prevalence among the general population.

Sources: San Diego County HIV Counseling and Testing Data  
 State of California, Department of Health Services, Office of AIDS  
 Epidemiology Profile and Projections of HIV/AIDS in San Diego County, 1998, County of San Diego, HHS, Community Epidemiology  
 2000 HIV/AIDS Needs Assessment, San Diego County, County of San Diego, HHS, Office of AIDS Coordination  
 California HIV Counseling and Testing Annual Reports, State of California, Department of Health Services, Office of AIDS, HIV Prevention Research and Evaluation  
 California HIV Seroprevalence Annual Reports, State of California, Department of Health Services, Office of AIDS, HIV/AIDS Epidemiology Branch  
 Results of HIV-1 and HIV-2 Testing in California Blood Banks and Plasma Centers, Semi-annual reports, State of California, Department of Health Services, Office of AIDS, HIV/AIDS Epidemiology Branch.

## **7. Conclusion**

During the 19 years of this epidemic, 10,636 residents of San Diego County have become infected with HIV and have gone on to develop AIDS. Every community in San County is represented in the AIDS cases – young, old, minorities, whites, men, women, children, heterosexual, homosexual, the list goes on.

In the early 1980s, it was primarily young, gay, white males who were AIDS cases. In recent years, minorities made up a larger percent of the cases than whites. Indeed, African Americans have the highest rate of AIDS in San Diego, followed by Hispanics. ‘Men who have sex with men’ is still the most frequent mode of transmission for men, but the percent of cases with this risk factor has been slowly creeping down and is being replaced by an increase in the percent of cases from injection drug use and, to a lesser extent, heterosexual contact.

Female cases, while still less frequent than male cases, are consistently being reported and, with them, a few pediatric cases. Heterosexual contact followed by injection drug use are the primary sources of HIV infection for females. The small number of female cases in San Diego County per year results in greater fluctuation between years, making it difficult to distinguish trends. In the nation, and to a lesser degree the state, the proportion of female cases has definitely increased but it is unclear at this time if San Diego is experiencing the same trend. What is clear is that the number of female cases drives the number of pediatric cases. Advances in treatment during pregnancy have drastically decreased transmission to the infant resulting in few pediatric cases.

Injection drug use, and HIV infection from those individuals, is a particular problem in different communities in San Diego County.

The Central region of San Diego County continues to be the most impacted by AIDS.

## 8. Data Sources, Reliability and Limitations

AIDS cases are required to be reported to the Health and Human Services Agency (HHSA) pursuant to California Code of Regulations, Health & Safety Statutes, Title 17, Section 2500. Reports come from physicians, health care providers, hospitals and clinics via confidential morbidity reports. A San Diego County AIDS case is an individual diagnosed with AIDS, while residing in San Diego County. **HIV infection, without an AIDS defining condition, is NOT reportable in California.**

Active verification of cases and internal tests of the data increase the reliability of the data.

The AIDS data used to generate reports have several limitations as listed below:

**1. Under-reporting of cases** - The number of diagnosed AIDS cases for which notification of the Office of Public Health does not occur is called “under-reporting”. Delays in reporting are graphically obvious in recent (1999 and 2000) years. It is likely that cases diagnosed in 2000 will continue to be reported in 2001.

**2. Diagnosis date versus report date** - Reporting delays impact the available data. Those cases **diagnosed** in 1995, for example, may not be **reported** to the Health and Human Services Agency until 1997 or later. See *glossary* for the definition of Date of Diagnosis and Date of Report.

**3. Collection tools** - While information on a variety of variables is collected, it is still limited. Data on an individual income or specific drug of choice is **not** collected, for example. The data collected is limited and reflects of the quality of data submitted by the reporting facility.

**4. Non-resident AIDS cases** - Persons with AIDS diagnosed elsewhere and relocating to San Diego County after diagnosis, are NOT represented in AIDS case data for the county. Persons receiving medical care or other services in San Diego County while residing outside the county, are not reflected in this data in any way.

**5. Asian/Other Category** - Available population estimates combines Asian/Pacific Islander and Native American racial/ethnic groups into one category: **Asian/Other**.

**6. Confidentiality** - Charts and graphics with small cell sizes (under 3) may not be described in detail where identification of persons may occur.

**7. Changes in CDC Criteria for AIDS Case Definition** - Since 1981, the Centers for Disease Control and Prevention (CDC) have changed the AIDS Case definition to include more diagnostic criteria. These changes in definition distort observed trends. The peak in AIDS cases is likely the result of the 1993 change in the case definition.

## 9. Appendices

### Appendix I Glossary

The following are summary definitions and explanations of a number of terms which you may encounter in this report. Terms may be added for clarification in subsequent reports.

**Acquired Immune Deficiency Syndrome** – End stage HIV disease where the immunological system is severely disabled by HIV, resulting in an increased susceptibility to opportunistic infections and rare cancers. To be considered an AIDS case, one must be HIV+ and have one of a number of specific conditions (for example, of Kaposi's Sarcoma).

**Adult/Adolescent Cases** – AIDS cases who were at least 13 years of age at time of diagnosis.

**AIDS** – See Acquired Immune Deficiency Syndrome.

**Case Definition** – A set of standard criteria for deciding whether a person has a particular disease or health-related condition. In the case of AIDS, the Centers for Disease Control lists specific conditions (opportunistic infection or a level of immunosuppression) a person must have in order to be classified as an AIDS case.

**Case Fatality Rate** – The proportion of individuals with a specific disease who die within a certain period of time.

**Centers for Disease Control and Prevention (CDC)** - The lead federal agency for protecting the health and safety of people - at home and abroad, providing credible information to enhance health decisions, and promoting health through strong partnerships.

**CDC** – See Centers for Disease Control.

**Epidemic** – The spread of an infectious disease through a population or geographic area.

**Epidemiology** – The study of factors associated with health and disease and their distribution in the population.

**Health and Human Services Agency (HHSA) Regional Services Areas** - Service areas defined by zip codes. See Appendix IV for a breakdown of the zip codes for the 6 areas.

**HHSA** – See Health and Human Services Agency Regional Services Areas

**Heterosexual transmission** – Transmission of HIV via sexual contact sex with any member of the opposite sex. This category can be further broken down to investigate the behavior of the sexual partner, such as sex with an intravenous/injection drug user, bisexual male (for females only), person with hemophilia/coagulation disorder, transfusion/transplant recipient with documented HIV infection, or a person with AIDS or documented HIV infection.

**HIV** – See Human Immunodeficiency Virus.

**Human Immunodeficiency Virus (HIV)** - A retrovirus that destroys the immune system eventually causing AIDS.

**IDU** – See Injection Drug User.

**Injection Drug User (IDU)** – Someone who at some time has injected drugs.

**Incidence** – The total number of new cases of a disease occurring within a specified period of time.

**Incidence Rate** – The number of cases of a disease per specified time period divided by the population at risk, often expressed per 100,000 population. Incidence rates are useful for comparison of selected factors to demonstrate the severity of the epidemic among individuals of different ages, gender and race/ethnic group.

**Mode of Transmission** – The way in which a disease was passed from one person to another. In describing HIV/AIDS cases, identifies how an individual may have been exposed to HIV, such as injecting drug use, men who have sex with men, and heterosexual contact. (Also known as **exposure categories**)

**Men having Sex with Men (MSM)** – A mode of HIV transmission , men who have same sex contact (bisexual or homosexual).

**MSM** - See Men having Sex with Men.

**NIR** - See No Identified Risk.

**No Identified Risk (NIR)** – An AIDS case that lacks mode of transmission information to determine the person’s risk for acquiring HIV infection.

**Pediatric Cases** – AIDS cases who were newborns to children 12 years of age at time of diagnosis.

**Public Health Surveillance** – An ongoing, systematic collection, analysis, and use of data regarding specific health conditions and diseases, in order to monitor these health problems, such as the Centers for Disease Control and Prevention surveillance system for AIDS cases.

**Risk not Specified (RNS)** - An AIDS case that lack mode of transmission information to determine the person’s risk for acquiring HIV infection.

**RNS** - See Risk not Specified.

**Year of Diagnosis** – The year in which a case met the CDC criteria for AIDS and was diagnosed with AIDS.

**Year of Report** – The year in which an AIDS case is reported to the Office of Public Health.

## Appendix II – Reporting AIDS Cases

### *Who is responsible for reporting AIDS cases?*

AIDS is a condition listed in California's disease reporting regulations. (California Code of Regulations, Health & Safety Statutes, Title 17, Section 2500). The statute reads: "Every health care provider knowing of or in attendance on a case or suspected case of a disease/condition in Section 2500 is required to make a report. Health care facilities or other settings where more than one health care provider may be caring for a case should establish administrative procedures to assure that reports are made to the local health department without duplication. When a health care provider is not in attendance on a case, any individual having knowledge of a person with one of the reportable diseases or conditions is required to notify the local health department."

### *When is AIDS Reported?*

When an individual is diagnosed with one or more of the AIDS defining conditions listed below, their HIV care providers are required to report the case to the local health department within 7 days of the diagnosis: (For HIV infected individuals, definitive or presumptive)

- \* CD4+ T-lymphocyte count <200  $\mu\text{L}/\text{mm}^3$  or <14% of total T-lymphocytes
- \* Candidiasis of the bronchi, trachea, or lungs
- \* Candidiasis, esophageal
- \* Cervical cancer, invasive
- \* Coccidioidomycosis, disseminated or extrapulmonary
- \* Cryptococcosis, extra-pulmonary
- \* Cryptosporidiosis, chronic intestinal
- \* Cytomegalovirus disease
- \* Cytomegalovirus retinitis
- \* Encephalopathy, HIV-related

- \* Herpes simplex: chronic ulcers or bronchitis pneumonitis or esophagitis
- \* Histoplasmosis, disseminated or extrapulmonary
- \* Isosporiasis, chronic intestinal
- \* Kaposi's Sarcoma
- \* Lymphoma, Burkitt's
- \* Lymphoma, immunoblastic
- \* Lymphoma, primary in the brain
- \* Mycobacterium avium complex or M kansasii, disseminated or extrapulmonary
- \* Mycobacterium tuberculosis, any site
- \* Pneumocystis carinii pneumonia
- \* Pneumonia, recurrent
- \* Progressive multifocal Leukoencephalopathy
- \* Salmonella septicemia, recurrent
- \* Toxoplasmosis of the brain
- \* Wasting syndrome due to HIV

The pediatric AIDS case definition (for HIV infected children <13 years of age) includes all of the above mentioned indicator diseases **with the exception** of pulmonary Mycobacterium tuberculosis, cervical cancer and CD4+ T-lymphocyte counts <200  $\mu\text{L}/\text{mm}^3$  or <14% of total T-lymphocytes.

**In addition, recurrent bacterial infections (at least two episodes within a two year period) and lymphoid interstitial pneumonia/pulmonary lymphoid hyperplasia (LIP/PHL) are AIDS defining conditions for HIV infected children.**

The original case definition of AIDS was established by the Centers for Disease Control (CDC) in 1981. Additional conditions and diseases were added in 1985, 1987 and 1993. All case definitions and revisions are published in the CDC's publication entitled 'Morbidity and Mortality Weekly Report' (MMWR).

***What information is required to be reported?***

Reports of AIDS cases to the local health department shall include, but are not limited to, name, address, phone, ethnic group, gender, date of birth, transmission information, diagnosis and date of diagnosis and the name, address and phone of the person or facility making the report.

The AIDS Epidemiology Unit is required by law to protect the privacy of any individual reported with AIDS. HIV infected individuals, without a diagnosis of AIDS, are not required, at this time, to be reported in the State of California.

***How should a report be made?***

Providers can submit a confidential case report form available from County of San Diego, Health and Human Services Agency. Forms can be sent to:

**Lyn Cardoza**  
Health and Human Services Agency  
Community Epidemiology  
P.O. Box 85222  
San Diego, CA 92186-5222

Providers also have the option of reporting cases by phone. For a reporting kit or any additional information, call the AIDS Epidemiology Unit @ **(619) 515-6675**.

***Why is reporting necessary?***

Law requires reporting of diagnosed AIDS cases. California's disease reporting regulations not only specify what, when, where and how to report cases, but also include descriptions of monetary penalties to be imposed for failure to comply with these laws.

Timely and accurate AIDS case reports provide this county with a better understanding of our local epidemic. Epidemiologists can monitor trends in populations being effected by HIV infection, project future numbers of AIDS cases and provide information for those responsible for planning for future health care needs and prevention and educational activities.

Failure to report in a timely manner may have an impact on current and projected funding needs. Funding formulas using data which represents under-reporting of AIDS cases may translate into under funded programs and services for those with HIV infection.

*A summary of legislation related to the case reporting, confidentiality, penalties and surveillance activities supported in the California Code of Regulations is available by calling the AIDS Epidemiology Unit @ (619)515-6675.*



**Appendix III Expanded Ethnic Origin of Hispanic and Asian/Pacific Islander Cases****Expanded Origin of Hispanic Cases**

<b>Ethnic Origin</b>	<b>Frequency</b>	<b>Percent</b>
Mexican	1688	80.8%
Hispanic, non-specific	174	8.3%
Peurto Rican	89	4.3%
Central American	41	2.0%
South American	40	1.9%
Cuban	28	1.3%
Spain / Portugal	25	1.2%
Dominican	4	0.2%
<b>Total Hispanic Cases</b>	<b>2089</b>	<b>100.0%</b>

Table 14

**Expanded Origin of Asian/Pacific Islander Cases**

<b>Ethnic Origin</b>	<b>Frequency</b>	<b>Percent</b>
Filipino	105	53.8%
Japanese	18	9.2%
Chinese	15	7.7%
Vietnamese	12	6.2%
Guamanian Islander	10	5.1%
Hawaiian	8	4.1%
Asian, non-specific	6	3.1%
Loatian	5	2.6%
Samoan	4	2.1%
Thai	3	1.5%
Cambodian	2	1.0%
East Indian	1	0.5%
Korean	1	0.5%
Fijian	1	0.5%
Mongolian	1	0.5%
Singaporean	1	0.5%
Taiwanese	1	0.5%
Tongan	1	0.5%
<b>Total Asian/Pacific Islander Cases</b>	<b>195</b>	<b>100%</b>

Table 15

## **Appendix IV - Health Service Area (HSA) of San Diego**

San Diego County is broken down into 6 Health Service Areas by zip code. The following list shows the breakdown of each area by the zip codes contained therein. The population estimates in each of the zip codes uses SANDAG's estimates, available to the public in their web site (see Appendix VII).

### **Central Area**

Zip codes 92101, 92102, 92103, 92104, 92105, 92113, 92114, 92115, 92116, 92134, 92136, 92139, 92112, 92162, 92163, 92164, 92165, 92170, 92175, and 92176.

### **East Area**

Zip codes 91901, 91905, 91906, 91916, 91917, 91931, 91934, 91935, 91941, 91942, 91945, 91948, 91962, 91963, 91977, 91978, 91980, 92019, 92020, 92021, 92040, 92071, 91944, and 91946.

### **South**

Zip codes 91902, 91910, 91911, 91913, 91914, 91915, 91932, 91950, 92118, 92135, 92154, 92155, 92173, 92179, 91909, 91912, 92143, 91951, 91933, and 92158.

### **North Coastal**

Zip codes 92007, 92008, 92009, 92014, 92024, 92052, 92054, 92055, 92056, 92057, 92067, 92068, 92075, 92083, 92084, 92672, 92093, 92169, 92161, 92038, and 92137.

### **North Inland**

Zip codes 92003, 92004, 92025, 92026, 92027, 92028, 92029, 92036, 92059, 92060, 92061, 92064, 92065, 92066, 92069, 92070, 92082, 92086, 92127, 92128, 92129, 92259, 92390, 92536, 92592, 92046, and 92198.

### **North Central**

Zip codes 92037, 92106, 92107, 92108, 92109, 92110, 92111, 92117, 92119, 92120, 92121, 92122, 92123, 92124, 92126, 92130, 92131, 92133, 92140, 92145, 92138, 92147, 92166, 92168, 92171, 91990, 92193, and 92196.

**Appendix V City of Residence**

<b>City of residence at Time of AIDS diagnosis</b>		
<b>City of Residence</b>	<b>Cases</b>	<b>Percent</b>
San Diego	7932	74.6%
Chula Vista	314	3.0%
Oceanside	309	2.9%
El Cajon	208	2.0%
Escondido	205	1.9%
La Mesa	164	1.5%
National City	141	1.3%
Spring Valley	136	1.3%
Vista	138	1.3%
La Jolla	126	1.2%
Carlsbad	117	1.1%
San Ysidro	100	0.9%
Encinitas	79	0.7%
Imperial Beach	71	0.7%
Lemon Grove	76	0.7%
Santee	77	0.7%
San Marcos	58	0.5%
Lakeside	38	0.4%
Poway	43	0.4%
Coronado	36	0.3%
Del Mar	34	0.3%
Fallbrook	35	0.3%
Alpine	16	0.2%
Bonita	26	0.2%
Cardiff by the Sea	19	0.2%
Leucadia	19	0.2%
Ramona	23	0.2%
Rancho Santa Fe	12	0.1%
Solana Beach	15	0.1%
Valley Center	15	0.1%
Other*	54	0.5%
<b>Total</b>	<b>10636</b>	

\* The following cities had 10 or less cases: Bonsall, Boulevard, Borrego Springs, Camp Pendleton, Campo, Descanso, Dulzura, Jamul, Julian, Mount Laguna, Pauma Valley, Pine Valley, Ranchita, San Luis Rey, and Santa Ysabel.

Note: Percentages may not add up to 100% due to rounding.

Table 16

**Appendix VI - San Diego County AIDS Cumulative Cases Reported through December 31, 2000**

Acquired Immunodeficiency Syndrome (AIDS)  
Definitive and Presumptive AIDS Cases  
Surveillance Report – 12/31/2000

1. Disease Category	Adult/Adolescent*		Pediatric*		Total	
	Cases ( %)	Deaths ( %)	Cases ( %)	Deaths ( %)	Cases ( %)	Deaths ( %)
PCP	3197 ( 30)	2576 ( 81)	18 ( 33)	12 ( 67)	3215 ( 30)	2588 ( 80)
Other Disease w/o PCP	3897 ( 37)	2817 ( 72)	36 ( 67)	19 ( 53)	3933 ( 37)	2836 ( 72)
KS Alone	544 ( 5)	375 ( 69)	0 ( 0)	0 ( 0)	544 ( 5)	375 ( 69)
<u>No Diseases Listed</u>	<u>2944 ( 28)</u>	<u>197 ( 7)</u>	<u>0 ( 0)</u>	<u>0 ( 0)</u>	<u>2944 ( 28)</u>	<u>197 ( 7)</u>
Total	10582 (100)	5965 ( 56)	54 (100)	31 ( 57)	10636 (100)	5996 ( 56)

2. Age*	Cases ( %)	3. Race/Ethnicity	Adult/Adolescent*	Pediatric*	Total
			Cases ( %)	Cases ( %)	Cases ( %)
Under 5	34 ( 0)	White, Not Hispanic	7020 ( 66)	12 ( 22)	7032 ( 66)
5-12	20 ( 0)	Black, Not Hispanic	1248 ( 12)	12 ( 22)	1260 ( 12)
13-19	35 ( 0)	Hispanic	2060 ( 19)	29 ( 54)	2089 ( 20)
20-29	1847 ( 17)	Asian/Pacific Islander	194 ( 2)	1 ( 2)	195 ( 2)
30-39	4980 ( 47)	Am. Indian/Alaska Native	60 ( 1)	0 ( 0)	60 ( 1)
40-49	2671 ( 25)	<u>Unknown</u>	<u>0 ( 0)</u>	<u>0 ( 0)</u>	<u>0 ( 0)</u>
Over 49	1049 ( 10)	Total	10582 ( 100)	54 (100)	10636 (100)
<u>Unknown</u>	<u>0 ( 0)</u>				
Total	10636 ( 100)				

4. Exposure Category	Adult/Adolescent Transmission Modes		
	Males ( %)	Females ( %)	Total ( %)
Men who have sex with men	8055 ( 82)	0 ( 0)	8055 ( 76)
Injecting drug use	633 ( 6)	274 ( 39)	907 ( 9)
Men who have sex with men and inject drugs	952 ( 10)	0 ( 0)	952 ( 9)
Hemophilia/coagulation disorder	55 ( 1)	3 ( 0)	58 ( 1)
Heterosexual contact	78 ( 1)	346 ( 49)	424 ( 4)
Receipt of blood, components, or tissue	87 ( 1)	64 ( 9)	151 ( 1)
<u>Risk not reported/Other</u>	<u>21 ( 0)</u>	<u>14 ( 2)</u>	<u>35 ( 0)</u>
Total	9881 ( 100)	701 (100)	10582 (100)

	Pediatric Transmission Modes		
	Males ( %)	Females ( %)	Total ( %)
Hemophilia/coagulation disorder	3 ( 11)	0 ( 0)	3 ( 6)
Mother with/at risk for HIV infection	21 ( 78)	23 ( 85)	44 ( 81)
Receipt of blood, components, or tissue	3 ( 1)	4 ( 15)	7 ( 13)
<u>Risk not reported/Other</u>	<u>0 ( 0)</u>	<u>0 ( 0)</u>	<u>0 ( 0)</u>
Total	27 ( 100)	27 (100)	54 (100)

\*Classification at time of AIDS dx if patient met the AIDS case definition (otherwise age at first HIV report).

**Appendix VI - San Diego County AIDS Cumulative Cases Reported through December 31, 2000**

Acquired Immunodeficiency Syndrome (AIDS)  
 Definitive and Presumptive AIDS Cases  
 Surveillance Report - 12/31/2000

5. Reported Cases of AIDS and Case-Fatality Rates by Half-Year of Diagnosis.

<u>Half-Year of Diagnosis</u>	<u>Number of Cases</u>	<u>Number of Deaths</u>	<u>Case-Fatality Rate</u>
Before 1988	878	861	98%
1988 Jan - June	264	254	96%
July - Dec	316	296	94%
1989 Jan - June	305	267	88%
July - Dec	382	341	89%
1990 Jan - June	417	358	86%
July - Dec	378	335	89%
1991 Jan - June	406	334	82%
July - Dec	482	406	84%
1992 Jan - June	533	404	76%
July - Dec	558	410	73%
1993 Jan - June	642	397	62%
July - Dec	505	281	56%
1994 Jan - June	514	231	45%
July - Dec	497	218	44%
1995 Jan - June	504	136	27%
July - Dec	451	118	26%
1996 Jan - June	433	92	21%
July - Dec	332	52	16%
1997 Jan - June	325	51	16%
July - Dec	248	39	16%
1998 Jan - June	235	27	11%
July - Dec	262	29	11%
1999 Jan - June	225	32	14%
July - Dec	200	16	8%
2000 Jan - June	208	7	3%
July - Dec 31	136	4	3%
Totals	10636	5996	56%

## **Appendix VII Office of AIDS HIV Counseling and Testing Risk Group Hierarchy**

After risk behavior is entered into the database for a client, the computer program ranks the risks and assigns the client to the risk group with the *highest risk*. The following risk groups are mutually exclusive and are presented in order of epidemiologic risk from highest risk to lower risk. Most all of the behaviors have to have been performed within the last 2 years to be assigned that group (except IDU, HIV+ Partner, Partner IDU, and Blood Transfusion, and Child at Risk). Also, some categories may seem to include all of a particular risk group when they do not. For example, Gay/Bi IDU includes some men who have sex with men (MSM) who are also injection drug users (IDU). Below are the current definitions (there have been changes over the years):

**Men who have Sex with Men (MSM):** men who report having a male sex partner in the last two years, no female sex partners in the last two years, and never injection drug use.

**Bisexual:** men and women who report having both a male and female partner in the last two years.

**Injection Drug Users (IDU):** clients who report ever injecting drugs, except men who have had sex with men but no women in the last two years (they are placed in Gay/Bi IDU).

**Gay Men/Bisexual Men who are Injection Drug Users (Gay/Bi IDU):** Men who report having sex with a male, or male and female partner in the last two years and ever using injection drugs.

**HIV+ Partner:** client reports ever having a partner who is HIV positive.

**Partner Bisexual:** women only who ever report having a male partner who has sex with men.

**IDU Partner:** client reports ever having a partner who uses injection drugs.

**Sex for Drugs/Money:** client reports trading sex for drugs or money in the past two years.

**Blood Transfusion <1985:** client reports ever having a blood transfusion prior to 1985 or ever in a country where the blood is not tested for HIV.

**Multiple Partners :** men who report >1 female partner in the last year and no male partners in that time; women who report >1 male partner in the last year and no female partners in that time.

**Partners with Multiple Partners :** client reports having a partner who has had multiple partners in the last two years.

**Occupational Exposure :** client reports on the job blood exposure in the past two years (either blood to blood exposure or any exposure to known HIV positive blood).

**Child at Risk:** clients less than 12 years of age and report having an HIV positive mother.

**No Reported Risk:** client does not fall into one of the above risk categories and reports one or no sexual partners in the last year.

**Unknown:** client reports more than one sexual partner in the last year (or unknown number of sexual partners) and did not report any risk factors (client may have refused to discuss risk factors).

## Appendix VIII World Wide Web Addresses for HIV/AIDS Related Information

### **International**

WHO Global HIV/STD Surveillance Fact Sheet [www.who.int/emc-hiv/fact\\_sheets/index.html](http://www.who.int/emc-hiv/fact_sheets/index.html)  
Contains the most recent country-specific data on HIV/AIDS prevalence and incidence

### **National**

ADAP Monitoring Project [www.aidsinfonyc.org/adap/index.html](http://www.aidsinfonyc.org/adap/index.html)  
Up-to-date information on ADAPs providing medications to low income, uninsured or underinsured people with HIV in 52 States and Territories.

AEGIS [www.aegis.com](http://www.aegis.com)  
Extensive databases of newspaper and wire reports, community group publications, legal documents, statistics, and patient forums.

AIDSLINE [igm.nlm.nih.gov](http://igm.nlm.nih.gov)  
AIDSLINE is a database containing references, including abstracts to the published literature on HIV infections and AIDS.

AIDS Treatment Information Service [www.hivatis.org/atishome.html](http://www.hivatis.org/atishome.html)  
Provides information on Federally and privately approved treatment Guidelines for persons with HIV/AIDS.

AIDS Economics [www.iaen.org](http://www.iaen.org)  
Comprehensive information on economic and cost-effectiveness aspects of HIV/AIDS therapy.

AIDS Education Global Information Service [www.aegis.com/](http://www.aegis.com/)  
Roxane Laboratories, Inc.

AIDS Imaging [members.xoom.it/Aidsimaging/contents.htm](http://members.xoom.it/Aidsimaging/contents.htm)  
Clinical, radiologic, and microscopic images of infectious diseases, AIDS-related conditions and sexually transmitted diseases.

AIDSmeds.com [www.aidsmeds.com](http://www.aidsmeds.com)  
AIDSmeds.com contains complete and easy-to-read information on treating HIV and AIDS, including guided treatment lessons, information on drugs, recent news, community forums, great links, and more.

American Foundation for AIDS Research [www.amfar.org/](http://www.amfar.org/)  
Basic bio-medical & clinical research.

Antiviral Weekly [www.newsrx.net/protect/TOPIC.CGI](http://www.newsrx.net/protect/TOPIC.CGI)  
Weekly Antiviral Update information.

CDC National Prevention Information Network [www.cdcnpin.org](http://www.cdcnpin.org).  
Resources and information about education, prevention, Published materials, research funding and related trends.

CDC, Division of AIDS Prevention [www.cdc.gov/nchstp/hiv/dhap.htm](http://www.cdc.gov/nchstp/hiv/dhap.htm)  
National Centers for HIV, STD and TB prevention.

Coalition for Positive Sex [www.positive.org/home/index.html](http://www.positive.org/home/index.html)  
Web site has animation demonstrating safer sex techniques.

Gay Men's Health Crisis [www.gmhc.org/](http://www.gmhc.org/)  
New York based, non-profit organization offering support services.

- Healthweb [www.healthweb.org](http://www.healthweb.org)  
A Categorized list of all aspects of HIV/AIDS, selected by health science libraries in the Midwest.
- HIV/AIDS Treatment Information Service (ATIS) [www.hivatis.org](http://www.hivatis.org)  
Provides information in English and Spanish about federally approved treatment guidelines for HIV and AIDS.
- Journal of the American Medical Association  
HIV/AIDS Information Center [www.ama-assn.org/special/hiv/hivhome.htm](http://www.ama-assn.org/special/hiv/hivhome.htm)
- National Institute of Health, Office of AIDS Research [www.nih.gov/od/oar/oar\\_home.htm](http://www.nih.gov/od/oar/oar_home.htm)
- NIH AIDS Statistics Graphics Files [www.cdc.gov/nchstp/hiv/graphics.htm](http://www.cdc.gov/nchstp/hiv/graphics.htm)
- California**
- AIDS Project Los Angeles [www.apla.org/](http://www.apla.org/)
- California AIDS Clearinghouse [www.hivinfo.org/cac8.htm](http://www.hivinfo.org/cac8.htm)  
HIV prevention, community planning, educational materials, directory & calendar.
- AIDS Treatment News Archive [www.immunet.org/immunet/atn.nsf/homepage](http://www.immunet.org/immunet/atn.nsf/homepage)
- State Office of AIDS [www.dhs.ca.gov/AIDS/](http://www.dhs.ca.gov/AIDS/)  
The Office of AIDS has lead responsibility for coordinating state programs, services, and activities relating to HIV/AIDS. Up to date state statistics can be accessed.
- Project Inform [www.projinf.org](http://www.projinf.org)  
Non-profit Community-Based Organization.
- The Body: California AIDS Services Organization [www.thebody.com/hotlines/calif.html](http://www.thebody.com/hotlines/calif.html)  
California AIDS Services Organizations AIDS Resource by Location
- San Diego County**
- Being Alive <http://www.beingalive.org/frontpage800.shtml>  
Non-profit organization delivering quality, compassionate services to people affected by HIV/AIDS
- County of San Diego <http://www.co.san-diego.ca.us/cnty/cntydepts/health/services/epidiv aids.html>  
Listing of AIDS related Services offered by San Diego County's Health and Human Services Agency.
- AIDS Research Institute <http://www.ari.ucsd.edu/>  
University of California, San Diego, dedicated to improving health care for those with HIV.
- HIV Consumer Council <http://www.hivconsumercouncil.org/>  
Provides information regarding events that involve HIV+ people and to encourage participation of the HIV community of San Diego County in the decision making processes that affect them.
- SANDAG [cart.sandag.org/sdw](http://cart.sandag.org/sdw)  
Population estimates for San Diego County.