

The HIV/AIDS Epidemiologic Profile for the District of Columbia 2004



Government of the
District of Columbia
Anthony A. Williams, Mayor



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EXECUTIVE SUMMARY

The Department of Health HIV/AIDS Administration (DOH/HAA) through Centers for Disease Control and Prevention (CDC) guidelines are authorized to compile, interpret, and summarize an Epidemiologic Profile from data collected on HIV/AIDS in the District of Columbia. The following report not only provides an in-depth description of the populations affected by AIDS, but also serves as an effective tool for local public health workers, planners, educators, health care providers, and community representatives for developing, implementing, and evaluating AIDS prevention and health care services in the District of Columbia.

Through a federal cooperative agreement, The District of Columbia, Department of Health (DC/DOH) participates in the CDC HIV/AIDS surveillance activities. Using established epidemiological methods, standardized data collection forms, and computer software developed by the CDC, the HIV/AIDS Administration, Surveillance and Epidemiology section monitors longitudinal and periodic trends in HIV/AIDS-related morbidity and mortality, assesses the need for health care services, and guides the public health response to the epidemic. Foremost, HAA/Surveillance and Epidemiology has the responsibility of ensuring the confidentiality and security of collected information.

Highly Active Antiretroviral Therapies (HAART), widely available since 1996, has significantly impacted the progression of HIV to AIDS locally. As has been seen nationally, AIDS cases and deaths due to AIDS have declined. More recently, in 2002, diagnosed AIDS cases have increased, both in the District and nationally. It has been estimated nationally that the number of HIV cases continues at 40,000 new cases per year.

Residents of the District of Columbia with AIDS represent approximately 2.13% of total AIDS cases reported nationwide during the two-year period 2001 through 2002. Cumulatively, the District represents about 1.8% of all AIDS cases reported in the United States through 2002. In 2002 the rate of reported AIDS cases in the District was 162.4 per 100,000 compared to 14.8 per 100,000 for the United States. This is indicative of the disproportionate impact of the epidemic in the District of Columbia. In a local study of AIDS cases reported in year 2001, comparing the District of Columbia to cities with populations larger than 500,000, it was found that the District of Columbia has the highest rate, 119 cases per 100,000, of all cities included. This rate was the highest rate for AIDS in the nation for 2001. The District was followed closely by Baltimore, with 117 cases per 100,000. San Francisco, New York and Philadelphia were ranked third, fourth and fifth with 67, 64, and 58 cases per 100,000 respectively. The District's high rate of reported/diagnosed cases may be due to numerous underlying causes. These may include the District's significant MSM population, injection drug using population, as well as a number of sociodemographic conditions that contribute to the spread of HIV/AIDS. The link between these socioeconomic conditions and HIV/AIDS requires additional analysis and study.

As of December 31, 2002, 15,132 cumulative AIDS cases, (14,943 adult/adolescent and 189 pediatric,) were reported among residents of the District of Columbia. Of the adult/adolescent cases, 20% are females and 80% are males, while 54% are living and 46% are deceased. African-Americans or Blacks comprised 75% of the District AIDS cases, Whites comprised 20%, Latinos or Hispanics comprised 3%, and Asian/Pacific Islanders and Native Americans comprised less than 1% of the reported adult/adolescent cases. Blacks represent the overwhelming majority of the cases and continue to be disproportionately affected by the HIV/AIDS epidemic in the District of Columbia.

Among male adult/adolescent AIDS cases reported from 1998 to 2002, the predominant modes of HIV transmission were men who have sex with men, MSM, (32%), injection/intravenous drug use, IDU, (24%), and heterosexual contact (23%), as compared to the previous interval of cases reported from 1990 to 1995 when MSM transmission represented 63%, IDU represented 24%, and heterosexual contact represented 5%. Among the MSM cases reported from 1998 to 2002, almost two-thirds of the cases reported were among Blacks (65%), over one-fifth among Whites (21%), and 5% among Hispanics.

In the District of Columbia for the period 1998-2002, females accounted for 29% of the AIDS cases compared to 16% for the period 1990-1995. This represents a significant rise, 13%, in the number of cases among women. Since 1998, the number of cases among women has leveled off, representing about 30% of diagnosed cases in recent years. The significant increase in cases among women and lack of a decline in recent years may be indicative of an HIV/AIDS problem within this population. The number of diagnosed AIDS cases among males continues to decline, however, this trend should not translate to less of a focus on certain male populations. Although MSM cases continue to decline overall, Black/African-American MSM continues to represent an overwhelming majority of the MSM cases.

The inevitability of using epidemiologic data for advancing the state of prevention and for allocating resources for HIV/AIDS services is here. It is no longer enough to conceptualize and develop culturally competent responses to the HIV/AIDS challenge, but rather, HAA must stay ahead of the HIV/AIDS epidemic by implementing new methodologies that can be used for prevention and care. The District of Columbia began collecting HIV surveillance data in 2001. This data will allow the HIV/AIDS Administration to better determine trends of HIV infection in the District. Additionally, in the upcoming year, the District of Columbia hopes to receive additional funding for the monitoring of recent HIV infections. These additional resources will help us to determine the populations in which new HIV infections are occurring. In this vein, the District of Columbia, Department of Health will remain at the forefront of prevention for HIV/AIDS. This epidemiologic profile provides data that describes the overall population of the District of Columbia, as well as the past and present state of HIV/AIDS.

INTRODUCTION

The occurrence of HIV/AIDS in the District of Columbia has been documented as far back as 1979, however, AIDS surveillance in the District began in July of 1983, when reporting was mandated under the Preventive Health Services Administration of the Commission of Public Health. In 1987, active and passive surveillance strategies were then implemented to collect data and conduct epidemiological investigations for the determination of AIDS incidence trends and to characterize risk behaviors. In 2001 HIV surveillance was mandated through changes made to the current regulations. Providers such as hospitals, physicians, clinics, laboratories, counseling and testing programs, etc. are required to report HIV infection cases to the Department of Health for surveillance purposes. It became important to obtain HIV infection data to better monitor the entire epidemic not just the clinical manifestations of the latter stages of the disease. Historically, estimates of the future direction and impact of the epidemic were made through the use of diagnosed AIDS data. The availability of HAART as a treatment option delayed the progression of the disease to AIDS and to death. Therefore, strictly using AIDS data to determine the extent and direction of the epidemic is not a long-term viable option for surveillance purposes.

The number of sources of report for AIDS cases in the District of Columbia increased over time as the epidemic spread. With this spread, providers of health care, became more familiar with the reporting system, resulting in more timely and efficient reporting. In the beginning of the AIDS crisis, reporting of AIDS cases was largely dependent upon passive surveillance practices or health care provider initiated efforts. Today in the District of Columbia, most cases are identified through active surveillance or surveillance program-initiated efforts. The major target sites for active surveillance efforts include public and private hospitals, clinics (community and hospital-based), physicians, laboratories, registries (communicable diseases including TB and STDs, and cancer), death certificates, medical examiners offices, and special studies.

Sexually transmitted diseases such as syphilis, Chlamydia and gonorrhea are surrogate indicators of HIV infection. STD trends are also presented in this report. The District of Columbia ranks among the cities in the United States with some of the highest STD morbidities. Syphilis is not only mandated to be reported, it is aggressively tracked, and vigilantly surveilled. Syphilis is highly contagious and is an ulcerative STD, signifying increased risk for HIV transmissibility. In fact, the presence of all STDs increases the transmissibility of HIV and the susceptibility to HIV.

This report not only assesses the distribution of infection/disease in relationship to time and geography, but also defines persons who are at risk for becoming infected with HIV for prevention purposes. Per the Centers for Disease Control and Prevention (CDC) guidelines, this epidemiologic profile addresses three key questions:

1. What are the sociodemographic characteristics of the general population?
2. What is the scope of the HIV/AIDS epidemic in the District of Columbia?
3. What are the indicators of risk for HIV/AIDS infection in the District of Columbia?

Methodology

Data Sources, Collection, and Organization

Some of the data used in this report come from secondary data sources such as sexually transmitted disease (STD) clinic reports and population estimate data. AIDS surveillance data are the only HIV/AIDS related data consistently available nationwide. Hence, the majority of the data for this profile was collected from routine HIV/AIDS surveillance activities. Data were collected, compiled, organized and summarized by geographic area and political jurisdiction (Wards), gender, age, and race/ethnicity. Where possible, behavioral risk categories are presented in the form of figures (epidemic curves, line graphs, pie charts, etc.) and tables. Most numerical comparisons are reported as percentages.

Data Issues

AIDS surveillance data have been the only HIV-related data consistently available on a population-wide basis in all states by race/ethnicity, gender, age, and exposure category. The extensive surveillance network in place since the early years of the epidemic has yielded a relatively complete and reliable database. The criteria or case definition used for diagnosing an AIDS case has become less applicable as treatment relies more and more on laboratory findings of encroaching immunodeficiency and detecting viral load instead of outward signs and symptoms. For example, an individual can be asymptomatic and meet the CDC criteria for AIDS, and after treatment seemingly revert to a non-AIDS stage. However, once an individual meets the AIDS case definition, they will remain in that classification for surveillance purposes.

AIDS cases tend to be representative of all persons with AIDS. However, it is essential to note that AIDS cases do not reflect the majority of HIV infections but rather the extent of severe immunosuppression and related illnesses caused by HIV. Because of the long incubation period between HIV infection and the occurrence of AIDS-defining conditions, AIDS cases do not necessarily represent the characteristics of persons with more recently acquired infections or those recently tested. Additionally, recent HIV testing does not equate with recent HIV infection or transmission.

Data Limitations and Caveats

The actual 'work' of AIDS surveillance can translate into trends and have a mass effect on the data. An alteration in the case definition, technology, facility solvency, service provision, and/or treatment can change the indications, means, and influx of surveillance work. The expansion of the adult/adolescent AIDS surveillance case definition to include invasive cervical cancer, recurrent pneumonia, pulmonary TB, and laboratory findings of a CD4+ count less than 200 or 14% (the supreme example) was implemented on January 1, 1993. As expected, there were substantial increases in the number of AIDS cases diagnosed and reported in 1993, many retroactively. HIV-infected persons with opportunistic infections or conditions diagnosed before 1993 that did not previously meet

the AIDS case definition were suddenly 'reportable' once these conditions were added to the case definition. The CDC estimated early reporting effects of the new case definition to be greater than the long-term reporting effects because prevalent or retroactive as well as incident cases of immunosuppression were reported immediately following implementation of the expanded case definition. After 1994, as expected, the number of reported cases was much smaller than the surge surrounding the implementation of the expanded case criteria. This also may be demonstrated in the increase of AIDS cases in 2002 after fully implementing mandatory HIV reporting.

Caution should be taken when interpreting trends, since many groups will appear to have a declining incidence when post-1993 data are presented. Trends after 1993 reflect the true trend of the epidemic, as stabilization was reached from the immediate surging effects of the 1993 case definition. This report will present trends through 2002.

Considerations

- Almost all data have strengths and limitations and hence should be treated in the light of their purpose and characteristics.
- Small numbers and/or small changes or differences should be interpreted with caution.
- Understand the specifics of data presentation.
- Create awareness among primary health care providers and other data generators of their important role as primary data contributors.
- Always remember what the numbers represent (i.e., number of cases, rates, and percents).

All AIDS cases presented in this epidemiologic profile are based upon AIDS cases diagnosed through December 31, 2002 among persons whose residence was the District of Columbia at the time of initial AIDS diagnosis.

In the District of Columbia, policies and procedures established by the CDC for the assurance of confidentiality and security of highly personal information are strictly enforced. The HIV/AIDS Administration (HAA) has implemented a policy that requires all employees to sign legally binding statements of confidentiality annually and to receive security training to further protect the public against breaches of confidentiality and security. Additionally, all CDC-funded jurisdictions must meet the requirements and security standards set forth in the CDC-issued guidelines for the protection of HIV/AIDS surveillance confidential information and data.

Only aggregated AIDS surveillance data are released so there is nothing to suggest the identity of an individual, even inferentially. Cell sizes less than five (5) are not presented for three-way cross-tabulations of data. Data may either be suppressed or combined with other categories. Aggregation of data (i.e., combining subgroups such as Asian/Pacific Islander and American Indian/Alaskan Natives) is done so that all the data may be provided and still ensure confidentiality of persons reported with AIDS, not to undermine the importance of any one group. Additionally, analysis of AIDS cases by year of diagnosis is affected by routine delays in reporting (time between AIDS diagnosis and report to the health department). The Bureau of STD Control data are presented according to their data release policy.

ORGANIZATION OF THE PROFILE

Question 1: What are the Sociodemographic characteristics of the general population in the District of Columbia? Orients the reader to the overall demographic and sociodemographic characteristics of the general population of the District of Columbia.

Question 2: What is the scope of the HIV/AIDS epidemic in the District of Columbia? Examines the effect of the HIV/AIDS epidemic on a number of population groups in the District to help planners focus prevention and care services.

Question 3: What are the indicators of risk for HIV/AIDS infection in the District of Columbia? Provides a detailed look at high-risk populations. Examines direct measures of risk behaviors associated with HIV transmission and indirect measures that may serve as indicators of high-risk behavior.

**Question 1. What are the Sociodemographic
Characteristics of the general population
in the District of Columbia?**

This section provides information on the demographic and sociodemographic characteristics of the District.

Summary

Population: The U.S. Census Bureau reported in 2000 that the District of Columbia is comprised of 572,059 persons. The sixty-nine square miles that make up the District are divided into eight wards. Each ward has approximately equal number of residents and elects a political representative to serve on the City Council. Ward 6 has the smallest population with approximately 68,035 persons, and Ward 4 has the largest with about 74,092 persons. The population size of each ward can be seen for comparison in Table 1.

Demographic Composition: The District overall is made up of about 60% African American/ Black, about 30% White, about 8% Hispanic and less than 5% Asian/Pacific Islander and Native American/ Alaskan Native. The racial makeup of each ward varies widely across wards. African Americans are concentrated in Wards 5, 7, and 8, with 57% of the District's entire African American population living in these three wards. Greater than 90% of the total population of Wards 7 and 8 is African American. In contrast, 60% of the District's White population lives in Wards 2 and 3. Ward 1 is the most diverse with a population that is 45.7% African American/Black, 31.7% White, 13.9% Hispanic/Latino, 3.6% Asian/Pacific Islander, less than 1% American Indian, and 4.5% of more than one race. Ward 7 is the least diverse with 96.8% of the residents being African/American Black, 1.4% White, 0.3% Hispanic/Latino, 0.2% American Indian, 0.2% Asian Pacific Islander, and 1.0% of more than one race. This racial distribution by ward can be seen in Table 3. The District varies widely with respect to race and socioeconomic factors.

Age and Sex: In 2000, the median age of District residents was 35 years. About 20% of the population was younger than 18 years of age; 12% of the population was 65 or older. Approximately three quarters or 75% of the District's youth are African American. In contrast, only 11% of the White population, about 9% of the Hispanic population, about 5% of mixed race persons, and 1.5% of the Asian/Pacific Islander population are less than 18 years of age. More than 50% of the District's youth under 18 live in Wards 4, 7 and 8. Approximately 36% of the total population of Ward 8 is under 18, the highest percentage of youth in a ward. In comparison, 8% of the total population of Ward 2 is under 18, the lowest percentage of youth in a ward. The proportion of females in the overall population was slightly higher than the proportion of males (53% vs. 47%).

Poverty, Income, and Education: Approximately 109,000 District residents were below the federal poverty level in 1999, according to the U.S. Census Bureau. This was approximately 20% of the population surveyed, compared to 13% nationally. In this same year, the median household income was \$40,127, and the per capita income was \$28,659. Persons 25 years and older with a high school education made up approximately 78% of the population in 2000.

Unemployment and Insurance Status: The overall unemployment rate for 2001 was 6.4 percent, versus 3.5 percent for the Washington, DC Metro area and 5.8 percent for the country. Approximately 17 percent or greater than 66,000 adults (19-64 years) were uninsured between 1999 and 2000. Ten percent of the population was on Medicaid.

Demographics

Table 1. Percentage Distribution of the Population, by Gender, Washington, DC, 2000

Age Group (years)	Male, % (N=269,366)	Female, % (N=302,693)	Total Population, % (N=572,059)
0-4	6.1%	5.3%	5.7%
5-17	15.4%	13.6%	14.4%
18-24	12.3%	13.1%	12.7%
25-34	18.5%	17.2%	17.8%
35-44	16.3%	14.4%	15.3%
45-64	21.6%	22.1%	21.9%
65 and older	9.9%	14.3%	12.2%

Source: Census 2000, U.S. Bureau of the Census, and D.C. Office of Planning/State Data Center

The overall population of the District declined by 5.7% since 1990. There are about 33,000 or 6% more women than men according to the 2000 Census. The largest proportion of the population was 25-44 years old (34.8% males, 31.6% females, 33.1% overall). Women between the ages of 18 – 24 and 45-64 years made up a slightly greater proportion of total women than men. By age group, women older than 65 years made up a significantly larger percentage of the population than men. Women older than 65 years were one and a half times the number of men in this age group.

Table 2. Percentage distribution of the population, by race/ethnicity and sex, Washington, DC 2000

Race/ethnicity	Male, % (N=269,366)	Female, % (N=302,693)	Total Population, % (N=572,059)
White, not Hispanic	29.4%	26.5%	27.8%
Black, not Hispanic	57.2%	61.5%	59.4%
Hispanic	8.8%	7.0%	7.9%
American Indian	0.2%	0.2%	0.2%
Asian/Pacific Islanders	2.5%	2.8%	2.7%
More than one race	2.0%	2.0%	2.0%

Source: Census 2000, U.S. Bureau of the Census, and D.C. Office of Planning/State Data Center

In 2000 the U.S. Bureau of the Census made a revision to the self-reported category of race; allowing respondents to include their ethnicity as well as race and in the case of more than one race, this distinction. The District's primary make up by race is African American/Black, 60%, followed by White, 28%, followed by Hispanic, 8%. Although relatively small in number, the proportion of multiple race individuals in the District is larger than the proportion of American Indians and nearly as large as Asian/Pacific Islanders.

Table 3. Percentage distribution of the total population of the District by race/ethnicity and ward, 2000

Ward	Race/ethnicity						Total Population
	White, not Hispanic	Black, not Hispanic	Hispanic	American Indian	Asian/Pacific Islander	More than one race	
1	31.7%	45.7%	13.9%	0.5%	3.6%	4.5%	73,364
2	65.4%	19.9%	3.8%	0.3%	7.8%	2.8%	68,869
3	83.6%	5.8%	2.0%	0.2%	5.8%	2.6%	73,718
4	17.7%	70.7%	7.2%	0.3%	1.0%	3.1%	74,092
5	9.4%	86.7%	1.2%	0.3%	0.9%	1.6%	72,527
6	31.6%	62.7%	1.2%	0.3%	2.0%	2.1%	68,035
7	1.4%	96.8%	0.3%	0.2%	0.2%	1.0%	70,540
8	5.3%	92.4%	0.5%	0.2%	0.5%	1.1%	70,914
Total	30.8%	60.0%	3.8%	0.3%	2.7%	2.4%	572,059

Source: Census 2000, U.S. Bureau of the Census, and D.C. Office of Planning/State Data Center

In January 2001, the boundaries for each ward in the District of Columbia were redrawn. The populations of each ward shown in the above table reflect these new ward boundaries. Ward 7 has the largest number of non-Hispanic Black residents, 96.8%, followed by Ward 8. Ward 3, with the second to the highest population, has the highest proportion of non-Hispanic Whites. The ward having the largest number of residents, Ward 4, has about 71% non-Hispanic Blacks and about 18% non-Hispanic Whites.

Table 4. Percentage distribution of the District's total population by ward, percentage increase from 1990, percentage under 18 years of age, male to female ratio of adults, number of persons per square mile.

Ward	2000 Population				
	Distribution by Ward, % (572,059)	Increase since 1990 Census, %	Persons under 18 years old, %	Male to Female Ratio Among Adults	Population/ square mile
1	12.8	2.0	17.9	1 : 0.99	29,234
2	12.0	2.6	8.0	1 : 0.96	11,808
3	12.9	0.7	12.0	1 : 1.29	7,735
4	13.0	-4.5	21.2	1 : 1.15	7,935
5	12.7	-13.1	21.1	1 : 1.14	7,940
6	11.9	-4.4	17.1	1 : 1.00	6,546
7	12.3	-11.5	27.5	1 : 1.28	11,453
8	12.4	-14.3	35.9	1 : 1.23	8,127
	100.0	-5.7	20.1	1 : 1.12	9,316

Source: Census 2000, U.S. Bureau of the Census, and D.C. Office of Planning/State Data Center

Population Size and Density

Although there are just over 74,000 people living in Ward 4, the most highly populated ward in the District, there is nearly four times the number of persons per square mile in Ward 1. This ward is the most dense with over 29,000 persons per square mile compared to Ward 4 where there are about one fourth of this number. The high concentration of persons living in one area of a city is not necessarily an indicator of wealth, economic activity, and services. Ward 3 has the lowest rate of unemployment, highest median household income, but also a moderate density per square mile.

Population Growth/Decline

The 2000 Census indicated that the District as a whole lost 5.7% of its population. Ward 8 lead the District in population decline, (-14.3%), followed by Ward 5, (-13.1%), and Ward 7, (-11.5%). Wards 4 and 6 lost roughly the same percentage of people, -4.5% and -4.4% respectively. Along with the largest number of persons leaving, Ward 8 also had the highest rate of unemployment, 12.8% and the lowest 1998 median household income, \$27,937.

Percent Population under 18

While 20.1% of the District's population overall is under eighteen years of age, the proportion of the population in this age group varies considerably across Wards. The largest percentage of a ward's population under 18 years of age is found in Ward 8, 35.9%, followed by Ward 7, 27.5%. In contrast, Ward 2 (8.0%) and Ward 3 (12.0%) have the smallest proportions. Wards 1 and 6 are slightly less than the District's overall proportion with 17.9% and 17.1% respectively. The remaining wards, Ward 4 and Ward 5 approximate the District's overall percentage.

Male to Female Ratio Among Adult Residents

This ratio is used as an indicator of single-head households in the area. This is especially important when looking at poverty levels in wards such as Ward 7 and Ward 8 versus Ward 2. There are about 1.3 females for every male in Wards 3, 7, and 8. The ratio is slightly less in Wards 4 and 5 where there are 1.15 and 1.14 females for every male respectively. The ratio is nearly one to one in Wards 1, 2, and 6.

Population per Square Mile (Population Density)

Ward 1 is by far the most densely populated Ward in the District with 29,234 people per square mile, compared to the District's overall population density of 9,316 people per square mile. In contrast, the ward with the lowest density, Ward 6, contains only 6,546 people per square mile.

Table 5. Selected Sociodemographic Factors: Unemployment, Median Household Income, Per Capita Income, and Poverty level

Ward	Unemployment ¹ (%)	Median Household Income ²	Per Capita Income ²	Persons for whom poverty is measured ²	Percent below poverty level ²
1	6.3	\$36,902	\$23,760	68,531	22.0%
2	5.6	\$44,742	\$42,660	60,238	18.7%
3	2.3	\$71,875	\$58,584	68,528	7.4%
4	6.5	\$46,408	\$27,057	73,377	12.0%
5	8.8	\$34,433	\$19,173	67,587	20.0%
6	7.8	\$41,554	\$28,636	64,522	21.1%
7	7.9	\$30,533	\$16,959	69,869	24.9%
8	12.8	\$25,017	\$12,630	69,003	36.0%
D.C.	6.4	\$40,127	\$28,659	541,657	20.2%

¹ Twelve-month average for 2001, U.S. Bureau of the Census, D.C. Office of Planning/State Data Center

² D.C. Office of Planning/State Data Center, 1999

Unemployment in the District

The unemployment rate for the District of Columbia has remained steady between 6 to 7 percent in the past year for which data was available. It is important to note that although the unemployment rate hasn't gone much below 6% and not much over 7%, the District's unemployment is consistently higher than the national average (5.7% in April 2002, 6.2% in March 2003). In addition, the District's unemployment rate is nearly twice as high as the Washington Metro areas unemployment rate (3.5% April 2002, March 2003).

Median Household Income

The District's median household income reported by the US Census Bureau for 1999 declined by \$2,884 from previously released figures in 1998. The median household income reported for 1999, of \$40,127, means that half of all households in the District had incomes above this amount and half of all households were below. The above table highlights the disparity among wards in the District, with Ward 3 having a median household income more than twice that of Ward 8.

Per Capita Income

This measure provides an estimate of the income per person in each ward and for the District as a whole. Ranging from \$12,630 to more than \$58,000, the above table again shows the disparity in income by ward in the District of Columbia. These figures closely resemble those figures for median household income.

Poverty Level

Of the 541,657 persons for whom poverty was measured, 20.2% or 109,415 persons were below the federal poverty level in the District. Not surprisingly, Ward 3, with the highest median household income and per capita income also had the lowest number of persons living below poverty. By contrast, Ward 8, with the lowest median household income and the smallest per capita income also had the highest percentage of persons living below the poverty level.

Table 6. Percentage Distribution of Persons Living Below Poverty in 1999, by Sex and Age Group in the District of Columbia

Age group (years)	Below poverty, %	
	Males, % (N=205,997)	Females, % (N=226,160)
less than 25	27.0	25.0
25-44	38.8	34.6
45-64	23.8	25.3
65 and over	10.4	15.1

Source: Census 2000, U.S. Bureau of the Census, and D.C. Office of Planning/State Data Center

The highest proportion of persons living below the poverty level was between the ages of 25-44 years. A slightly higher percentage of males in the 25-44 year-old age group were below the poverty level than females. In adults between the ages of 45 and 64 years old, slightly more women than men were below the poverty level. This was also true among older adults, aged 65 years and above; where 15.1 percent of women were below the poverty level versus 10.4 percent among men.

Educational Attainment

In the District, approximately 73% of persons 25 years and over had graduated from high school and approximately 33% of these persons had graduated from college. Five out of eight wards had percentages of high school graduates lower than the District's average. This was true in Ward 1, Ward 5, Ward 6, Ward 7, and Ward 8. Only Ward 3 had a percentage of college graduates that was nearly as high, with 70.1 percent of persons 25 years and older with a college degree. Ward 2, with a relatively high percentage of high school graduates at 81.4 percent, had just above half or 52.3 percent of individuals 25 years and older. The greatest contrast to these two wards is seen in Ward 8, where 61.3 percent of persons 25 years and older had high school degrees and only 8.0 percent had college degrees.

Table 7. Percentage Distribution of the Population 25 years or Older Who Have Graduated from High School and College.

Ward	Persons 25 years and over	High School Graduates, %	College Graduates, %
1	54,614	67.6	35.6
2	52,940	81.4	52.3
3	57,808	94.1	70.1
4	56,539	73.5	24.8
5	50,657	65.6	19.4
6	50,952	71.0	31.8
7	46,839	64.3	11.6
8	38,782	61.3	8.0
District	409,131	73.1	33.3

Source: Census 2000, U.S. Bureau of the Census, and D.C. Office of Planning/State Data Center

Health Insurance Coverage

In a survey conducted in 1999-2000, 17.3% of the men and women aged 19-64 years reported that they did not have health insurance coverage. Medicaid covered approximately 9.9 percent of these adults; while the majority of persons surveyed were covered by their employer and about 8.3 percent were covered by private non-group insurance or public insurance, which includes Medicare and insurance through the military.

Table 8. Percentage Distribution of Non-elderly Adults 19-64 years old, by Health Insurance Coverage, Washington, D.C. 1999-2000

Population of Nonelderly Adults	Distribution by Coverage, %			
	Employer	Medicaid	Other	Uninsured
382,267	64.5	9.9	8.3	17.3

Source: 2001 Current Population Survey, Kaiser Commission on Medicaid and the Uninsured

Question 2. What is the scope of the HIV/AIDS epidemic in the District of Columbia?

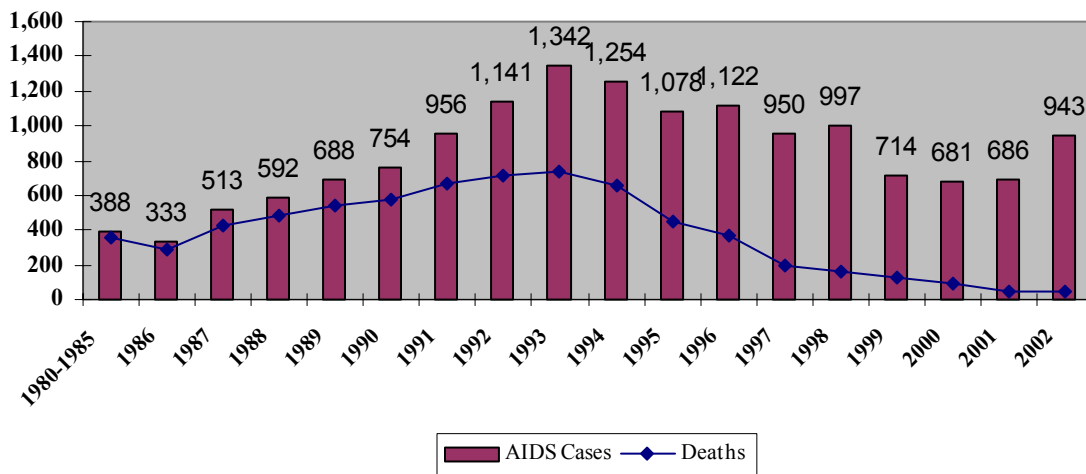
This section provides a comprehensive look at the impact of HIV/AIDS on the residents of the District. Trends within populations most effected are discussed as well as the risk associated with HIV infection in these populations. This section describes cases that were diagnosed through December 31, 2002 and reported through September 30, 2003. The HIV/AIDS reporting system or HARS was used as the primary source of data for all tables and graphs presented.

AIDS Case Numbers and Deaths

AIDS cases in the District of Columbia increased annually through 1993 when a peak of 1,342 cases was reported. Case numbers began to decline in 1994 (1,254 cases), and leveled off in 1999, 2000, and 2001. In 2002, there were 943 cases reported which accounts for a 37% increase from 2001 when there were 686 reported AIDS cases. National figures show a 3.2% increase of reported cases in 2002 compared with 2001. Locally the increase in AIDS cases in 2002 may be due to the implementation of mandatory HIV case reporting.

On January 1, 1993 the CDC expanded the AIDS surveillance case definition to include all HIV-infected persons who have less than 200 CD4+ T-lymphocytes/uL, or a CD4+ T-lymphocyte percentage of total lymphocytes of less than 14. This expansion included the addition of three clinical conditions, pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer and retained the 23 clinical conditions in the AIDS surveillance case definition that were published in 1987. The expansion of criteria for AIDS caused a peak in the number of diagnosed and reported cases in 1993. HIV-infected individuals with opportunistic infections or conditions diagnosed before 1993, who previously had not met the AIDS case definition, were suddenly reportable once the above conditions were added to the case definition.

**Figure 1. Adult and Adolescent AIDS Cases and Deaths
Diagnosed through 12/02 entered through 9/30/03**



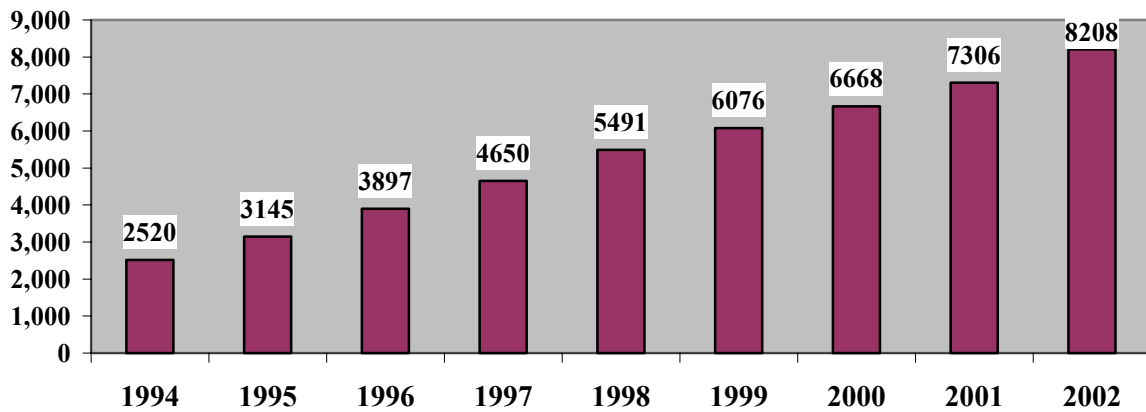
Nationally as well as locally, the number of deaths from AIDS has been declining since the mid 1990's. From 1998-2002 the Centers for Disease Control and Prevention (CDC), reported a 14% decline in the estimated number of deaths among persons with AIDS (HIV/AIDS Surveillance Report, Vol. 14). Locally for this same period, there was a 74% decrease in the number of reported deaths from AIDS. There were 156 deaths reported in 1998 and 41 deaths in 2002. AIDS deaths peaked in 1993, when 742 individuals were reported to have died. The largest one-year percentage change in the number of deaths occurs between 1996 and 1997 when there was a decline of 47% (Table 9).

As a result of the wide use of HIV/AIDS antiretroviral therapy (HAART), persons who were diagnosed with AIDS, live longer without dying from complications due to the disease. This is reflected in figure 2, which shows AIDS prevalence, or the number of persons living with AIDS, increasing. The CDC has reported a similar trend nationally, with an estimated 384,906 persons known to be living with AIDS at the end of 2002. Although the number of persons living with AIDS in the District of Columbia has been rising, the percentage increase from one year to the next has been falling since 1996, when there was a 20% increase from the previous year. Figure 2 shows the rising numbers of persons living with AIDS from 1994 to 2002. Table 9 shows the percentage rise in living cases as well as the percentage decline in diagnosed cases and deaths.

Table 9. Diagnosed AIDS Cases, Deaths, and Living AIDS Cases in the District of Columbia and Percent Change by Year of Diagnosis

Year of Diagnosis or Death	AIDS Cases	% change from previous year	Deaths of person reported with AIDS	% change from previous years	Persons Living with AIDS	% change from previous years
1984	110	-	103	-	8	-
1985	222	+102	198	+92	27	+238
1986	333	+50	284	+43	52	+93
1987	513	+54	431	+52	82	+58
1988	592	+15	487	+13	105	+28
1989	688	+16	541	+11	147	+40
1990	754	+10	575	+6	179	+22
1991	956	+27	668	+16	288	+61
1992	1,141	+19	708	+6	433	+50
1993	1,342	+18	742	+5	600	+39
1994	1,254	-7	660	-11	594	-1
1995	1,078	-14	453	-31	625	+5
1996	1,122	+4	370	-18	752	+20
1997	950	-15	197	-47	753	+0.1
1998	997	+5	156	-21	841	+12
1999	715	-28	130	-17	585	-30
2000	681	-5	89	-32	592	+1
2001	686	+1	48	-46	638	+8
2002	943	+37	41	-15	902	+41

Figure 2. Number of Persons Living with AIDS in Washington, D.C. by Year, 1994 - 2002



HIV/AIDS was the third leading cause of death among men aged 25 to 44 years from 1990 through 1996. In 1997 and 1998, homicide replaced HIV/AIDS as the third leading cause among men in this age range. HIV/AIDS continues to be one of the top five leading causes of death among men age 25 to 44 (Figure 3). Among women aged 25 to 44 years, heart disease has been and continues to be the leading cause of death, as it is among men in this age group. Cancer and cerebrovascular disease are the next two leading causes of death respectively among women, and HIV/AIDS is the seventh leading cause of death (Figure 4).

Figure 3. Leading Causes of Death Among Men, Age 25-44 years, Washington, D.C, 1989 - 2001 (Rate per 10,000)

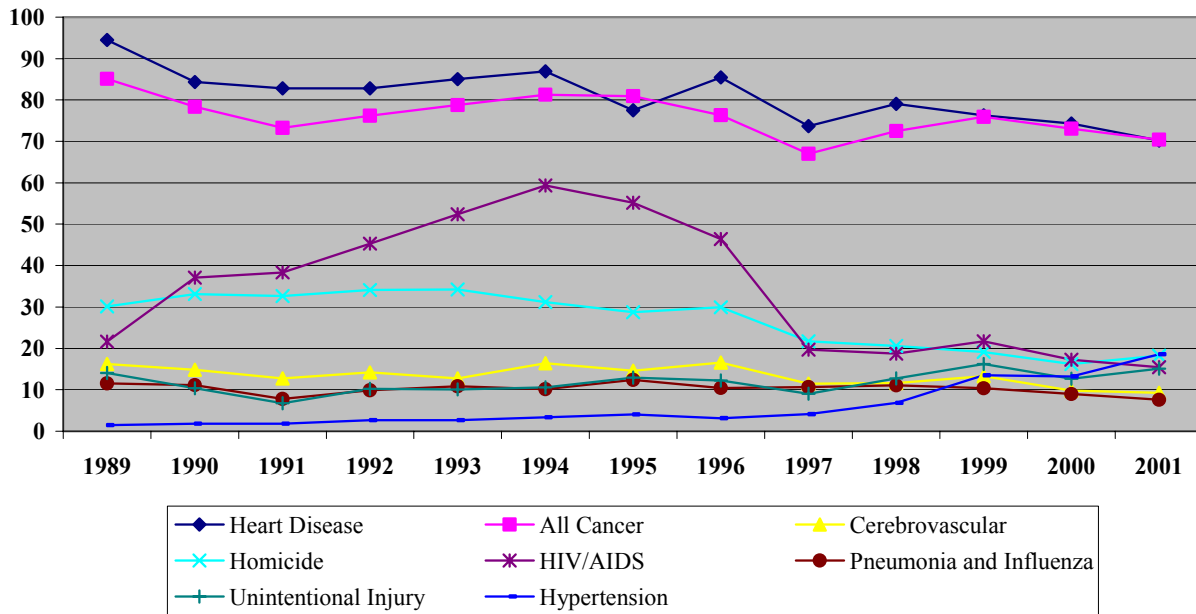
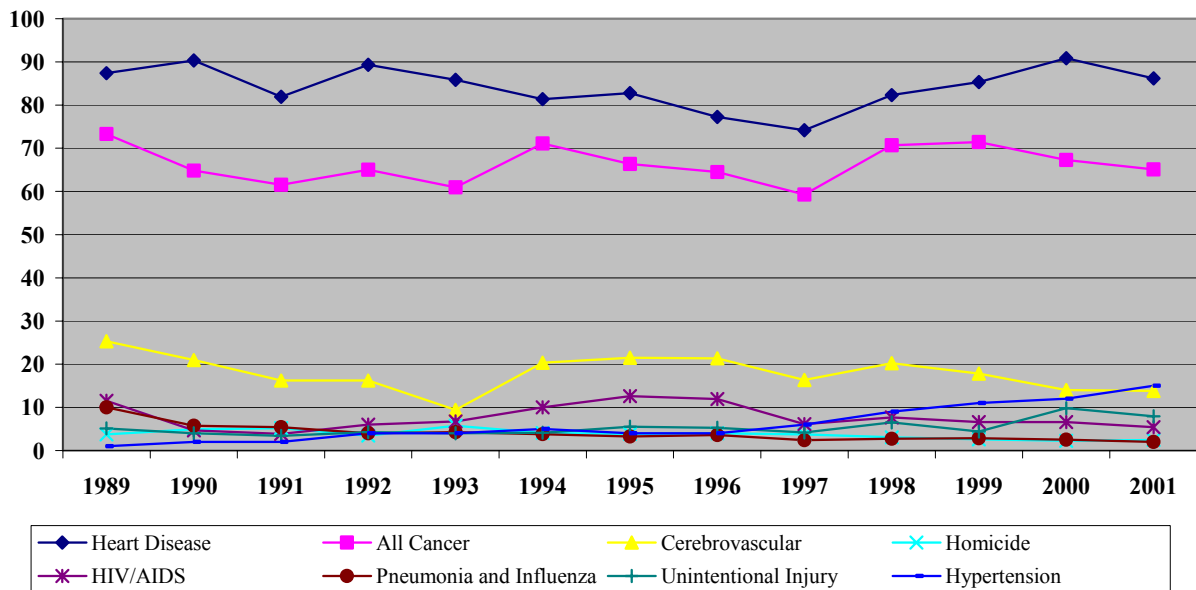


Figure 4. Leading Causes of Death Among Women, Age 25 - 44 years, Washington, D.C., 1989 - 2001 (Rate per 10,000)



Of the 15,132 cumulative AIDS cases diagnosed in the District of Columbia, 12,098 (80%) were male and 3,034 (20%) were female (Table 11). Female cases as a percent of all adult/adolescent cases have risen over time, from 9% in 1985-1990 to 15% in 1995, 19% in 2000 and 20% for AIDS cases diagnosed in 2002. The CDC has reported (Surveillance Report Year End Edition, Vol.13, No. 2) that females make up 18% of cumulative adult/adolescent cases reported between 1981 and 2001, but 26% of adult/adolescent cases reported in 2001 alone. District of Columbia closely mirrors these national trends in terms of the increasing percentages of women with AIDS.

AIDS Cases by Gender

AIDS Cases Among Adult and Adolescent Women

Since 1993, AIDS cases reported among women have grown at a faster rate than among men. Adult/adolescent women with diagnosed AIDS in the District of Columbia account for 20% (3,034) of the cumulative cases reported through December 31, 2002, and 29% of recently reported cases between 1998 and 2002 (Table 11). The number of reported cases among African-American/Black women has been steady since 1998, making up about 30% of total cases among African American/Blacks. Representing the overwhelming majority (90%) of women reported with AIDS in the District, African-American/Black women have surpassed the number of reported cases among White men since 1994. Among African American/Black female AIDS cases diagnosed between 1998 and 2002 45% were through heterosexual contact and about 33% were through injection drug use (IDU). A significant percentage, about 21% of AIDS cases among African American/Black females do not have risk information.

The number of women living with AIDS makes up about one fourth of total living cases (Table 10). For the period 1996 – 2002, the number of women living with AIDS grew to 28% of all living cases compared to 25% of cumulative living cases. As was discussed previously, the number of cases diagnosed in women has been increasing. Women make up a larger percentage of diagnosed living cases than men among adolescents age 13-19 years, 53% in women and 47% in men (Table 10). Among 20-29 year olds, female cases make up 29% of living cases while men make up 71% in this age group.

AIDS Cases Among Adult and Adolescent Men

Adult/Adolescent men diagnosed with AIDS in the District of Columbia account for 80% (12,098) of the cumulative cases reported through December 2002, and 75% of living AIDS cases. African-American/Black men make up 56% of cumulative AIDS cases. More recently in 2001, African American/Black men made up 54% of reported cases compared to White men who made up 7% of cases, Hispanic men who made up about 4%, Asian/Pacific Islander men and Native American men who made up less than 1% of cases for that year. Men having sex with men (MSM) make up about 32% of AIDS cases diagnosed between 1998 and 2002. Injection drug users made up about 24% of cases and heterosexual contact represented about 23% of cases reported diagnosed between 1998 and 2002. About 16% of AIDS cases among men do not have risk information. The number of cases reported/diagnosed in men has been decreasing over time.

Table 10: Persons Living with AIDS in the District of Columbia

Characteristic	Living with AIDS						Newly-diagnosed AIDS Cases 1996 - 2002	
	Male		Female		TOTAL		TOTAL	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
SEX								
Male	6,173 (75%)						3,621 (72%)	
Female	2,028 (25%)						1,442 (28%)	
AGE AT DIAGNOSIS (years)								
<13	53	(<1)	43	(2)	96	(1)	34	(<1)
13-19	26	(<1)	29	(1)	55	(<1)	35	(<1)
20-29	836	(14)	342	(17)	1,178	(14)	636	(13)
30-39	2,502	(41)	820	(40)	3,322	(41)	1,931	(38)
40-49	2,004	(33)	610	(30)	2,614	(32)	1,739	(34)
50 +	752	(12)	184	(9)	936	(11)	688	(14)
RACE/ETHNICITY								
White	1,106	(18)	76	(4)	1,182	(14)	518	(10)
African American/Black	4,548	(74)	1,799	(89)	6,347	(77)	4,003	(79)
Hispanic	270	(4)	35	(2)	305	(4)	193	(4)
Asian/Pacific Islander	29	(<1)	8	(<1)	37	(<1)	23	(<1)
American Indian/AK Native	<5	(<1)	<5	(<1)	<5	(<1)	1	(<1)
Unknown	219	(4)	108	(5)	327	(4)	325	(6)
HIV EXPOSURE								
MSM	3,251	(53)	0	(0)	3,251	(40)	1,721	(34)
Injection Drug Use (IDU)	1,437	(23)	813	(40)	2,250	(27)	1,313	(26)
IDU & MSM	278	(5)	0	(0)	278	(3)	113	(2)
Heterosexual Contact	658	(11)	883	(44)	1,541	(19)	1,176	(23)
Transfusion/hemophilia	27	(<1)	24	(1)	51	(<1)	24	(<1)
Mom at risk/with HIV	52	(<1)	43	(2)	95	(1)	34	(<1)
Unknown	470	(8)	265	(13)	735	(9)	682	(14)
TOTAL CASES	6,173		2,028		8,201		5,063	

Modes of HIV Exposure

Modes of exposure are ways of classifying HIV/AIDS cases, by describing the behavior(s), which led to the transmission of HIV from one person to another. A CDC determined hierarchy of exposure modes based upon risk behaviors determines these categories. These modes of exposures based upon the hierarchy are Men Who Have Sex with Men (MSM), Injection Drug Use (IDU), Men Who Have Sex with Men and Injection Drug Use (MSM/IDU), Heterosexual, Transfusions/Blood to Blood, etc. For heterosexual transmission, an additional category was added to further define a secondary exposure mode based upon the at risk behavior of the person with which heterosexual activity occurred. No Identified Risk (NIR) is a classification that is used when exposure modes are not identified in medical records or case report forms for surveillance purposes. This category has been increasing rapidly in recent years. Representing 11% of cases in 1998, NIR's have increased to 23% of cases diagnosed in 2002. This growing number of AIDS cases without risk information may distort recent trends of infection.

An analysis of AIDS trends in District of Columbia by mode of exposure, shows a decline in the proportion of cases among MSM and MSM/IDU from 80% of total diagnosed AIDS cases in 1989 to 52% of total diagnosed in 2002 (Figure 5). The most notable increase of AIDS cases by risk category has been among heterosexuals who have had sexual contact with an injection drug user.

The trend of declining numbers among MSM and MSM/IDU AIDS cases and rising numbers among heterosexual contact cases can be seen in Figure 5. Tables 12 and 13 describe in greater detail the risk information for the quickly growing numbers of heterosexual contact AIDS cases.

Figure 5. Percentage of Diagnosed AIDS Cases by Mode of Exposure, 1986 - 2002

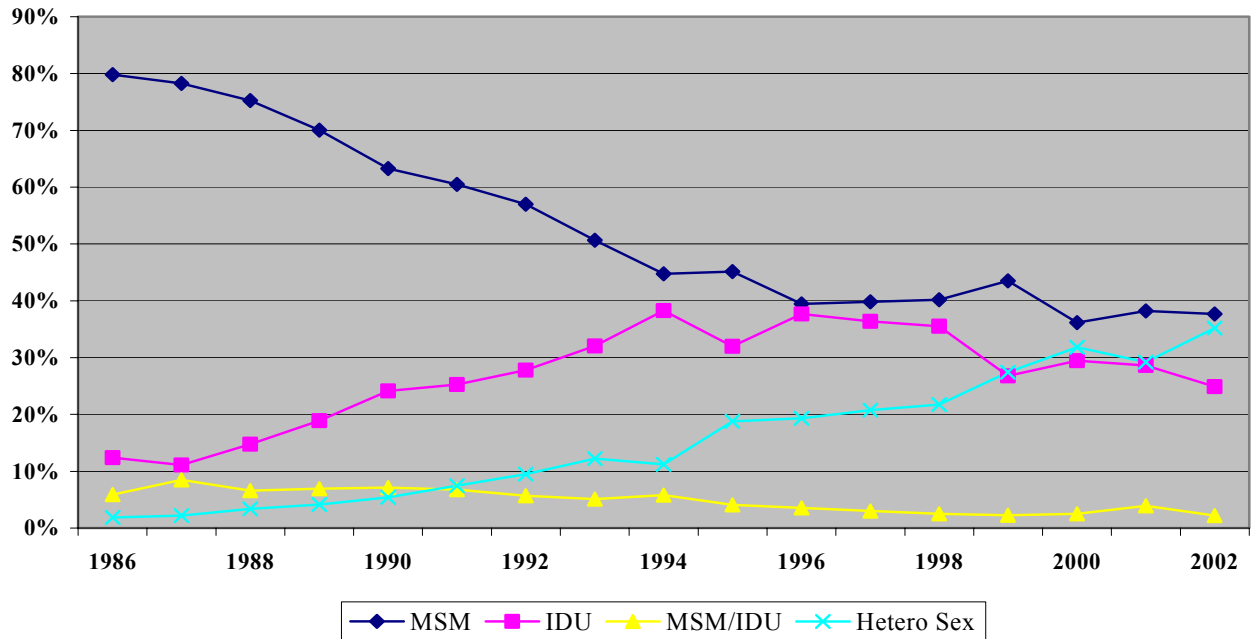


Figure 6. Percent Distribution of Adult and Pediatric AIDS Cases by Gender, 1983 - 2002

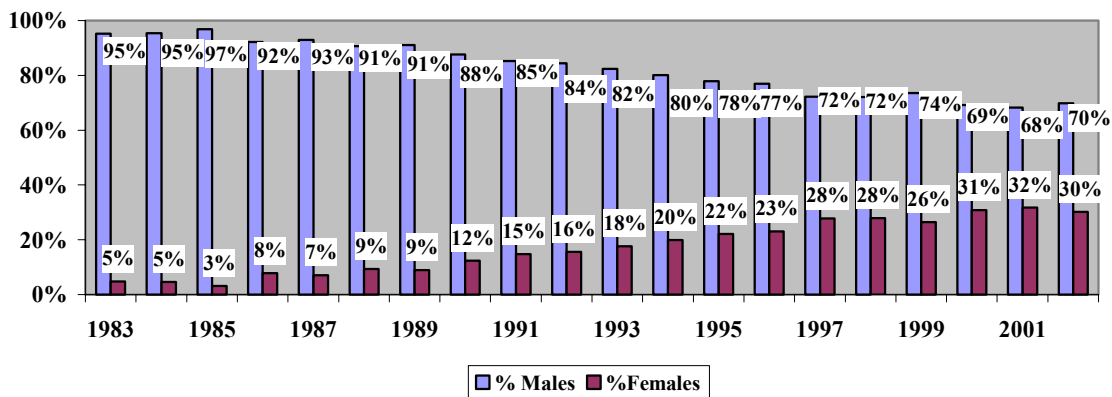


Table 11. AIDS in Washington, DC: Diagnosed through December 2002 and reported through 9/30/03

Category	Cases diagnosed in 1998		Cases diagnosed in 1999		Cases diagnosed in 2000		Cases diagnosed in 2001		Cases diagnosed in 2002		Cumulative cases diagnosed 1980 - 2002	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
TOTAL CASES	997		715		681		686		943		15,132	
SEX	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Male	719	72%	526	74%	471	69%	468	68%	658	70%	12,098	80%
Female	278	28%	188	26%	210	31%	218	32%	285	30%	3,034	20%
RACE/ETHNICITY												
White, not Hispanic	112	11%	88	12%	68	10%	59	9%	46	5%	2,962	20%
Black, not Hispanic	837	84%	591	83%	562	83%	567	83%	584	62%	11,286	75%
Hispanic	42	4%	27	4%	32	5%	28	4%	22	2%	485	3%
Asian, Pacific Islander	<5	<1%	5	<1%	<5	<1%	<5	<1%	<5	<1%	48	<1%
Am. Indian/AK Native	0	0%	0	0%	0	0%	<5	<1%	0	0%	6	<1%
Unknown	<5	<1%	<5	<1%	15	2%	29	4%	289	31%	345	2%
AGE AT DIAGNOSIS (yrs)												
<13	8	<1%	<5	<1%	0	0%	<5	<1%	<5	<1%	179	1%
13-19	8	<1%	<5	<1%	7	1%	<5	<1%	8	<1%	71	<1%
20-29	120	12%	89	12%	89	13%	75	11%	85	9%	2,248	15%
30-39	395	40%	265	37%	253	37%	235	34%	319	34%	6,327	42%
40-49	330	33%	249	35%	231	34%	251	37%	347	37%	4,575	30%
50-59	107	11%	83	12%	78	11%	94	14%	149	16%	1,363	9%
60+	29	3%	20	3%	23	3%	26	4%	32	3%	369	2%
HIV EXPOSURE*												
MSM	353	35%	268	38%	200	29%	195	28%	271	28%	7,204	48%
Injection Drug Use (IDU)	312	31%	165	23%	163	24%	146	21%	179	19%	3,939	26%
IDU & MSM	22	2%	14	2%	14	2%	20	3%	16	2%	673	4%
Heterosexual contact	191	19%	169	24%	176	26%	149	22%	253	27%	2,095	14%
Hemophilia	0	0%	0	0%	0	0%	0	0%	<5	<1%	22	<1%
Transfusion/transplant	<5	<1%	<5	<1%	<5	<1%	<5	<1%	<5	<1%	104	<1%
Mother with HIV	8	<1%	<5	<1%	0	0%	<5	<1%	<5	<1%	172	1%
Undetermined/other	108	11%	90	13%	126	19%	172	25%	219	23%	923	6%
Deaths During Period	156		130		89		48		41		6,932	

In the District of Columbia, the percentage of cases diagnosed among men who have sex with men have been steadily falling, from 35% of total cases in 1998 to 28% of cases in 2002. The number and percentage of cases by heterosexual contact, however, have been steadily on the rise, similar to national trends. This rise is shown both in Figure 5 and Tables 12 and 13.

Transmission modes by gender and race/ethnicity for cumulative AIDS cases diagnosed since 1980 (Tables 12 and 13) indicate that among male AIDS cases, although 60% of cases overall were diagnosed in men who have sex with men, the proportion of cases varies by race/ethnicity. As is shown in Table 12, White MSM's are about 36% of cumulative numbers, Black MSM's are about 59%, and Latino MSM's are about 4% of total diagnosed MSM cases. The differences between races within modes of exposure are even more pronounced when looking at AIDS cases where transmission was through injection drug use (IDU). The overwhelming majority of IDU AIDS cases are among African American/Blacks, representing 95% of cumulative cases in this population. White IDU cases are about 3% of overall cases and Hispanic/Latino cases are about 1%. Although less pronounced, African American/Black men who have sex with men and inject drugs (MSM/IDU) are 82% of cumulative cases in this risk category. White MSM/IDU are about 15% of total and Latino men make up about 3%.

Table 12 indicates that among men, heterosexual contact cases are about 7% of total diagnosed cases. Not surprisingly, the racial differences are also prominent in the heterosexual category of exposure. The sum of the three heterosexual categories for African American /Black men total 777 cases or 91% of total cases among heterosexual cases. Hispanic heterosexual male cases make up slightly higher percentage, about 5%, than White cases, 4%.

Table 12. AIDS Cases in Adult Males by Race/Ethnicity and Mode of Transmission, Washington, D.C., 1980 – 2002

Males	African American/Black		White		Hispanic/Latina		Total ¹	
	#	%	#	%	#	%	#	%
MSM	4,212	45.6%	2,561	89.2%	300	62.1%	7,110	56.3%
IDU	2,399	26.0%	81	2.8%	37	7.7%	2,519	19.9%
MSM/IDU	546	5.9%	102	3.6%	17	3.5%	665	5.3%
Het. Sex w/IDU	270	2.9%	7	0.2%	12	2.5%	289	2.3%
Het. Sex w/PWHA	498	5.4%	25	0.9%	33	6.8%	556	4.4%
Het. Sex w/Recipients Blood Prod.	9	0.1%	2	0.1%	0	0.0%	11	0.1%
Heterosexual total	777	8.4%	34	1.2%	45	9.3%	856	6.8%
Blood/Blood Products	40	0.4%	20	0.7%	3	0.6%	65	0.5%
No Identified Risk	485	5.3%	39	1.4%	36	7.5%	561	4.4%
Total	9,236	100.0%	2,871	100.0%	483	100.0%	12,632	100.0%

¹ Total includes 42 cases of Asian/PI and Indian race

Table 13. AIDS Cases in Adult Females by Race/Ethnicity and Mode of Transmission, Washington, D.C., 1980 – 2002

Females	African American/Black		White		Hispanic/Latina		Total ¹	
	#	%	#	%	#	%	#	%
IDU	1,285	34.6%	57	34.8%	7	9.3%	1,352	34.1%
Het. Sex w/IDU	311	8.4%	7	4.3%	3	4.0%	322	8.1%
Het. Sex w/Bi Male	30	0.8%	6	3.7%	5	6.7%	42	1.1%
Het. Sex w/Recipient Blood Prod.	5	0.1%	3	1.8%	0	0.0%	8	0.2%
Het. Sex w/PWHA	709	19.1%	27	16.5%	25	33.3%	765	19.3%
Heterosexual total	1,055	28.4%	43	26.2%	33	44.0%	1,137	28.7%
Blood/Blood Products	46	1.2%	6	3.7%	0	0.0%	52	1.3%
No Identified Risk	269	7.3%	15	9.1%	2	2.7%	289	7.3%
Total	3,710	100.0%	164	100.0%	75	100.0%	3,967	100.0%

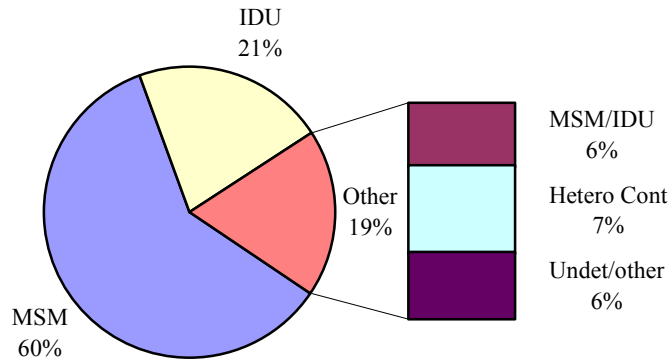
¹ Total includes 12 cases of other races

In the District of Columbia, Table 11 shows the number of diagnosed AIDS cases increasing in 2002. Again this may be due to the implementation of mandatory HIV reporting. A closer review of Table 11 reveals that there is a steady decline in the percentage of cases diagnosed among men and steady rise in the percentage of cases among women. By race/ethnicity, AIDS cases among African American/Blacks have remained steady with the exception of cases diagnosed in 2002. This apparent decline among African American/Black cases, however, cannot be definitive until all cases with unknown race are investigated. The 289 cases with an unknown race in 2002 make up 31% of the total.

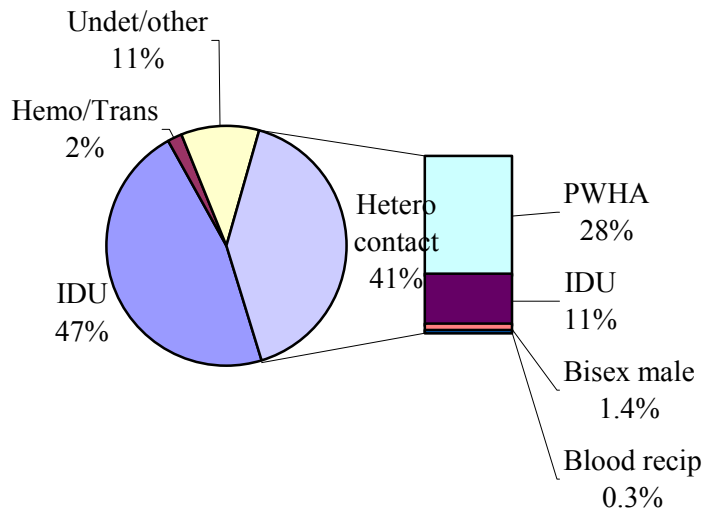
Heterosexual contact cases among women made up approximately 40% of total diagnosed AIDS cases. Of these, a majority of 93%, were among African American /Black women. White women made up about 4% of total cases while Hispanic/Latina women made up about 3% of total cases. It should be noted that the majority of cases with no identified risk were reported within the last two years, i.e. 2001 and 2002.

Figure 7 shows the percent distribution of cumulative diagnosed AIDS cases among males and females. Of the total AIDS cases diagnosed among men (n=12,098), about 60% are among MSM while 21% are among IDU's. This picture is very different for women, where 47% of all diagnosed cases (n=3,034) are from injection drug use and 41% are from heterosexual sex, of which sex with an injecting drug user makes up 11%.

Figure 7. Adult/Adolescent AIDS Cases Diagnosed in Washington, D.C. through 2002 by Gender and Mode of Exposure



MALES (N=12,098)



FEMALES (N=3,034)

Race/Ethnicity of AIDS Cases

African American/Black AIDS cases comprise 75% of cumulative AIDS cases in the District of Columbia (Table 11). The epidemic in the District of Columbia was primarily a disease concentrated among White men who have sex with men, but has not been concentrated among the White population since 1985 when cases among Whites outnumbered African American/Blacks for the last time in a calendar year. Since 1986, when AIDS cases among African American/Blacks made up approximately 54% of total diagnosed cases, the percentage among communities of color, including Latino/as and Asian/Pacific Islanders has been increasing at a steady rate. In 1990 the percentage of cases among African American/Blacks and Latinos made up 72% of total cases diagnosed that year. This percentage rose to 84% among these two racial groups in 1994 and has risen to as high as 91% in 2001.

Although sixty percent of the estimated 572,052 people who live in the District are African American/Black, there are a disproportionate number of cases among this racial group. Figure 8 illustrates more clearly the diverging trend of increasing proportion of African American/Black cases versus White cases and somewhat level cases among all other racial groups. Table 6 indicates differences among males and females by racial/ethnic categories.

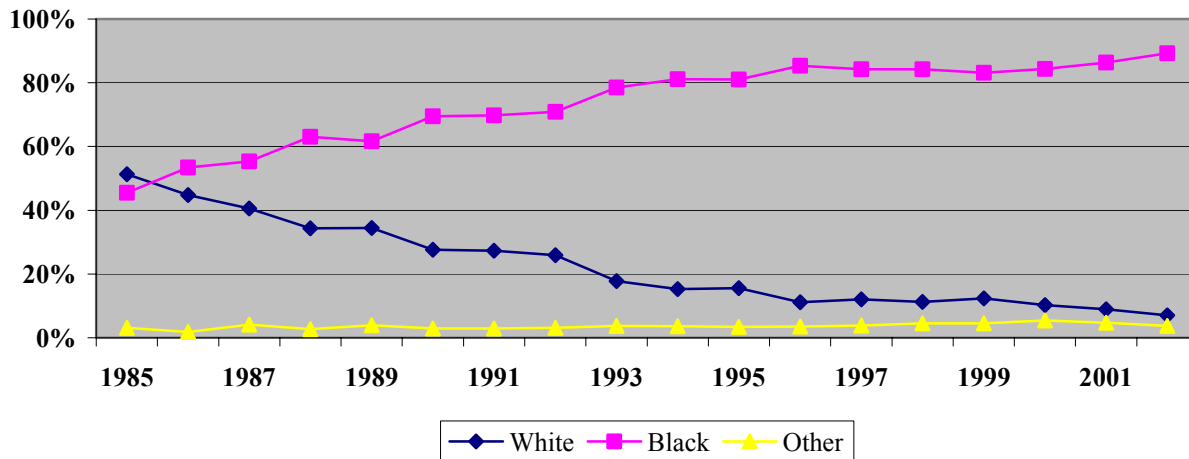
National figures also show a marked disproportionate burden of AIDS among persons of color. African Americans make up about 12% of the population and about 37% of cumulative cases. Hispanics total about 9% of the population but are about 18% of cases nationally. Table 14 shows the average annual rate of cases diagnosed between 1999 and 2001 by race/ethnicity and gender for the District of Columbia. It is interesting to note that the average rate for these three years, 1999, 2000, and 2001, in African American/Black women exceeds the average rate in White males. The disease has shifted populations in the District.

Table 14. Diagnosed AIDS Cases in Washington, DC, 1999-2001 and Average Annual Rates per 10,000

R	MALE		FEMALE		TOTAL	
	No.	Rate	No.	Rate	No.	Rate
White, not Hispanic	192	7.3	23	0.9	215	4.1
Black, not Hispanic	1,163	24.9	557	9.9	1,720	16.7
Hispanic	72	10.1	15	2.3	87	6.5
Asian/Pacific Islander	8	3.9	<5	1.2	11	2.4
American Indian/ Alaskan Native	<5	4.1	0	0.0	<5	1.9
T CES						

* Rates for this table were calculated by summing cases diagnosed during the three-year period, from 1999 to 2001, divided by the sum of population estimates for each racial/ethnic group. Population estimates were taken from the 2000 U.S. Census.

Figure 8. AIDS Cases Diagnosed in Washington, DC in 1999 - 2001 and Average Annual Rates per 10,000 population by Race/Ethnicity



HIV/AIDS Cases by Age Groups

By age group, the District of Columbia AIDS cases among pediatric (less than 13 years of age) and 13 to 19 year old populations as remaining steady, making up less than 1% of total cases in the past five years. Nationally the CDC reports that diagnosed AIDS cases decreasing among children and in the age group 25-34 years. CDC reports an increase in all other age groups. Although broken out slightly differently in Table 2, the District of Columbia data demonstrates that AIDS cases in the 20 - 29 year-old age group have remained steady. The percentages in the remaining age groups have remained steady for the five-year period, 1998 – 2002, (Table 15).

Historically, AIDS has affected persons who are relatively young. Persons aged 30-39 years old at the time of diagnosis make up about 43% of cumulative diagnosed cases. About 30% were slightly older, between 40-49 years old, and 15% were between the ages of 20-29 years (Table 15). In all age groups, except for 13-19 year olds, male cases outnumbered female cases.

The breakdown by race/ethnicity and age group shows a similar picture across race, although in very young cases there are an overwhelming number of cases among African American/Blacks, 90% of cases in the 13-19 year old age group. Cases among Whites average about 20% across ages and cases among Hispanic/Latinos range from 3-4%.

It is important to note that out of the 72 cases among youth, age 13-19 years, over half were cases due to heterosexual contact. The number of cases transmitted through heterosexual contact falls precipitously in all other age groups, averaging about 15% overall. MSM is the predominant mode of transmission among 20-29 year olds and 30-39 year olds. Among 40-49 year olds, injection drug use or IDU makes up 36% of all cases. This percentage falls slightly in the 50 years and older age group, where MSM cases make up about 42 percent of the total.

Table 15. Age at Diagnosis by Sex, Race/Ethnicity, and Mode of Exposure, for Adult/Adolescent AIDS Cases, 1990 - 2002

Category	13-19 years	20-29 years	30-39 years	40-49 years	50+ years
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
SEX					
Male	31 (43)	1,820 (77)	5,344 (81)	3,799 (81)	1,491 (84)
Female	41 (57)	540 (23)	1,249 (19)	867 (19)	281 (16)
RACE/ETHNICITY					
White	<5 (1)	454 (19)	1,429 (22)	946 (20)	337 (19)
African American/Black	65 (90)	1,772 (75)	4,811 (73)	3,457 (74)	1,293 (73)
Hispanic	<5 (3)	96 (4)	224 (3)	127 (3)	51 (3)
Asian/Pacific Islander	0 (0)	8 (<1)	19 (<1)	16 (<1)	6 (<1)
Am. Indian/AK Native	0 (0)	<5 (<1)	<5 (<1)	<5 (<1)	<5 (<1)
Missing/unknown	<5 (6)	28 (1)	108 (1)	119 (3)	12 (3)
HIV EXPOSURE					
MSM	18 (25)	1,353 (57)	3,499 (53)	1,973 (42)	749 (42)
Injection drug use (IDU)	<5 (3)	280 (12)	1,566 (24)	1,667 (36)	479 (27)
MSM/IDU	<5 (1)	125 (5)	346 (5)	187 (4)	56 (3)
Heterosexual contact	39 (54)	446 (19)	820 (12)	525 (11)	276 (16)
Transfusion/hemophilia	0 (0)	20 (1)	42 (<1)	29 (<1)	35 (2)
Unknown	12 (17)	136 (6)	320 (5)	285 (6)	177 (10)
TOTAL	72	2,360	6,593	4,666	1,772

Pediatric AIDS Cases

Pediatric AIDS cases are those cases representing individuals who were less than 13 years of age at the time of AIDS diagnosis. Those individuals age 13 years and above are classified as an adolescent/adult case.

Of the cumulative pediatric AIDS cases diagnosed since 1983, 54% are living and 46% have died. Of the living cases slightly more are males than females. The majority of living cases are among African American/Blacks, 92% of living, while White and Hispanic pediatric AIDS cases combined make up less than 5%. About 60% of cumulative cases were diagnosed within the first year of life. The predominant mode of exposure, about 95%, in all diagnosed cases is perinatal transmission, from mother to child. Of the remaining cases, 4% acquired HIV from a transfusion of blood or blood products, less than 1% acquired HIV from transfusion, and less than 1% of cases are of unknown exposure (Table 16).

Table 16: Pediatric (Age < 13 years) Living AIDS Cases, Deaths, and Cumulative, 1983 – 2002

Category	Living Pediatric AIDS Cases		Pediatric AIDS Deaths		Cumulative cases diagnosed 1983 - 2002	
	No.	%	No.	%	No.	%
TOTAL CASES	103		86		189*	
SEX	No.	%	No.	%	No.	%
Male	58	56%	38	44%	96	51%
Female	45	44%	48	56%	93	49%
RACE/ETHNICITY						
White, not Hispanic	2	2%	2	2%	4	2%
Black, not Hispanic	95	92%	80	93%	175	93%
Hispanic	2	2%	3	3%	5	3%
Asian, Pacific Islander	0	0%	0	0%	0	0%
Am. Indian/AK Native	0	0%	0	0%	0	0%
Unknown	4	4%	1	1%	5	3%
AGE AT DIAGNOSIS (yrs)						
0-1	51	50%	59	69%	110	58%
2-3	25	24%	12	14%	37	20%
4-6	12	12%	11	13%	23	12%
7-8	7	7%	0	0%	7	4%
9-10	<5	1%	<5	4%	<5	2%
11-12	<5	1%	0	0%	<5	<1%
Adult diagnosis >13	7	7%	0	0%	7	4%
HIV EXPOSURE*						
Mother with HIV	95	92%	80	93%	179	95%
Pediatric transfusion/transplant	<5	3%	5	6%	8	4%
Pediatric hemophilia	<5	1%	0	0%	<5	<1%
Pediatric undetermined	<5	4%	<5	<1%	<5	<1%

* Cumulative cases include 7 cases, which were perinatally infected with HIV but were diagnosed and reported after 13 years of age.

Figure 9. Trend of Diagnosed Pediatric AIDS cases, District of Columbia, 1983 - 2002

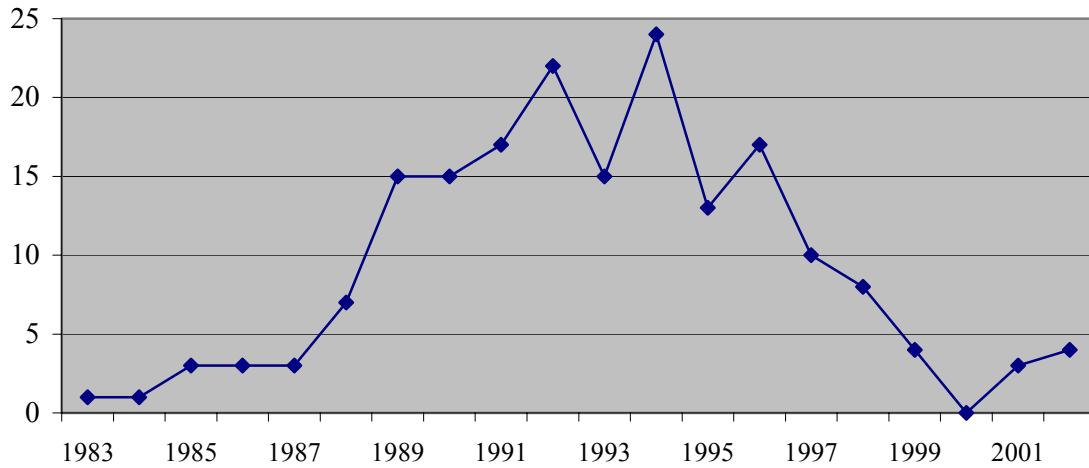


Figure 9 indicates the trend of diagnosed pediatric AIDS cases since the first reported case in 1983. Similar to national trends, the number of pediatric diagnosed AIDS cases has gradually declined after a peak in 1993. The decline in cases is likely associated with the implementation of the Public Health Services recommendation in 1995 for universal counseling and voluntary HIV testing of pregnant women. In addition, Public Health Services made strong recommendations for the use of antiretroviral therapy in pregnant women and newborn infants in 1995. The District reported no new cases of AIDS in children less than 13 years of age in 2000. However, the number of cases in 2001 and 2002 show a slowly rising trend.

Table 17: Cumulative and Living AIDS Cases by Ward Among Males

Ward	Total Male Population	Cumulative Diagnosed AIDS	Living AIDS through 12/31/02	Rate of Living AIDS per 10,000
1	36,861	2,085	1,076	292
2	35,167	2,038	1,002	285
3	32,248	443	166	51
4	34,454	1,061	605	176
5	33,840	1,339	742	219
6	34,037	1,675	853	251
7	30,988	802	458	148
8	31,771	831	483	152
Mental		4	2	-
Homeless		480	351	-
Prison		502	338	-
Unknown		181	96	-
Total	269,366	11,441	6,172	229

Table 18: Cumulative and Living AIDS Cases by Ward Among Females

Ward	Total Female Population	Cumulative Diagnosed AIDS	Living AIDS through 12/31/02	Rate of Living AIDS per 10,000
1	36,503	397	285	78
2	33,702	270	193	57
3	41,470	34	23	6
4	39,638	276	181	46
5	38,687	388	265	68
6	33,998	348	235	69
7	39,552	380	268	68
8	39,143	472	326	83
Mental		3	2	-
Homeless		106	88	-
Prison		68	50	-
Unknown		7	6	-
Total	302,693	2,749	1,922	63

The above tables, which break down cumulative and living AIDS cases by gender and Ward, show several noteworthy points. Among men, Wards 1 and 2 have the highest number of reported AIDS cases, 2,085 and 2,038 cases respectively. Not surprisingly, these two wards also have the highest number of living cases. Ward 6 with the third highest number of AIDS cases also has the third highest rate of living AIDS cases.

Among women, Ward 8 has reported the most cases, 472 cases, followed by Ward 1 with 397 cases and Ward 5 with the third highest number of reported cases. Looking at the rate of living AIDS cases among women there is a similar but not identical ranking. Following cumulative diagnosed AIDS cases, Ward 8 and Ward 1 have the highest rate of living cases among women, 83 cases and 78 cases per 10,000, respectively. Wards 5, 6, and 7 however, have approximately the same rate of living AIDS cases among women, at 69 cases per 10,000 in these three wards.

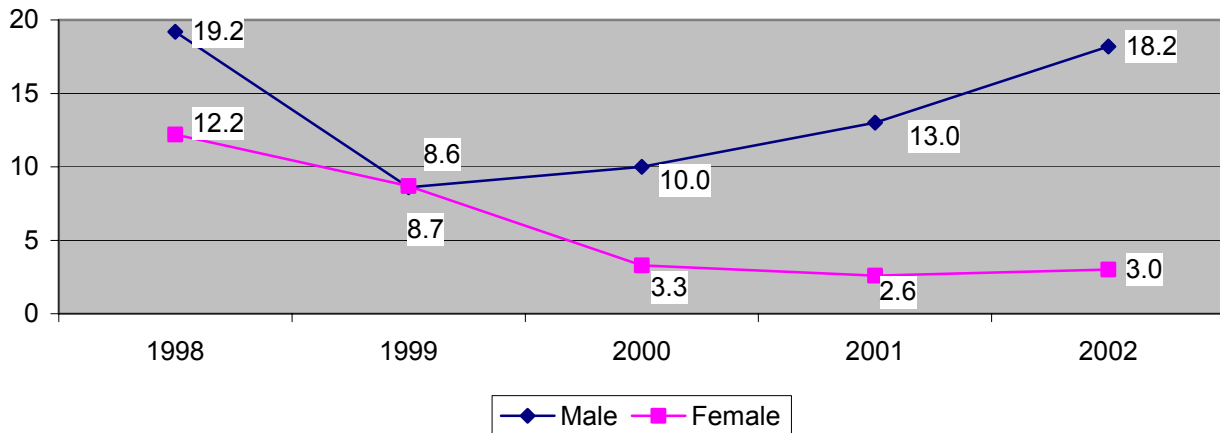
**Question 3. What are the indicators of risk for
HIV/AIDS infection in the District of
Columbia?**

Other sexually transmitted diseases (STDs), both ulcerative, (i.e., syphilis, genital herpes) and inflammatory (i.e., gonorrhea, chlamydia) increase the risk of HIV infection. As referenced in the book “The Hidden Epidemic” by the Institute of Medicine, numerous studies indicate that STDs increase susceptibility and infectivity to HIV. As a co-morbid condition to HIV it is important to know the STD trends that are occurring in the District of Columbia.

TRENDS IN STD RATES AS AN INDICATOR OF HIV RISK:

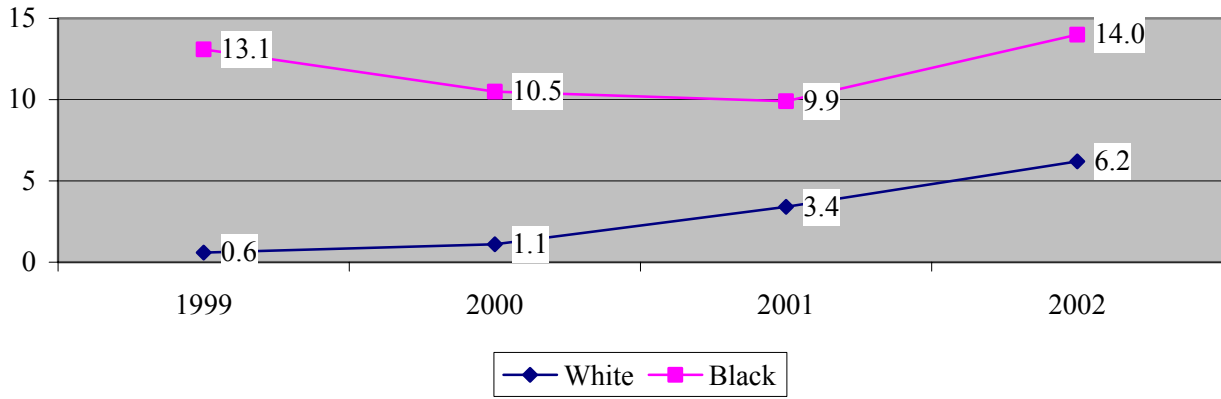
Persons in the District of Columbia most likely to become infected with HIV are those who engage in high-risk behaviors and who live in communities where HIV prevalence is high. Because HIV is classified as one type of sexually transmitted disease, (STD), other STD's can serve as indicators of high-risk sexual behavior. Indicators are ways to measure risk when direct measures are not available. Identifying persons with STD's other than HIV, such as syphilis, gonorrhea, and chlamydia, can help planning bodies interrupt the transmission of HIV. The following are trends in rates of STD's per 100,000 people.

Figure 10: Trends in Primary and Secondary Syphilis Case Rates, per 100,000, by Gender, District of Columbia, 1999 - 2002



The above rates are based upon the U.S. Census figures for 2000 for the District of Columbia. The estimated number of men is 211,446 and that for women is 245,621. The trend among women since 1997 has been a steady decline in cases, with a leveling off in 2002. Male cases, however, have been on the rise since 1999 and have risen to numbers reported in 1997. Nationally, syphilis cases have also risen to high levels in many metropolitan areas, especially among men.

Figure 11: Trends in Primary and Secondary Syphilis Case Rates, per 100,000, by Race/Ethnicity, District of Columbia, 1999 – 2002



Similar to trends in HIV infection, syphilis affects both the white the African American/black population. Although the above graph does not show the rate by gender, it can be surmised from Figure 1 that the rise in syphilis rate since 2000 is mostly among men.

Figure 12: Trends in Primary and Secondary Syphilis Case Rates, per 100,000, by Age Group, District of Columbia, 1999 – 2002

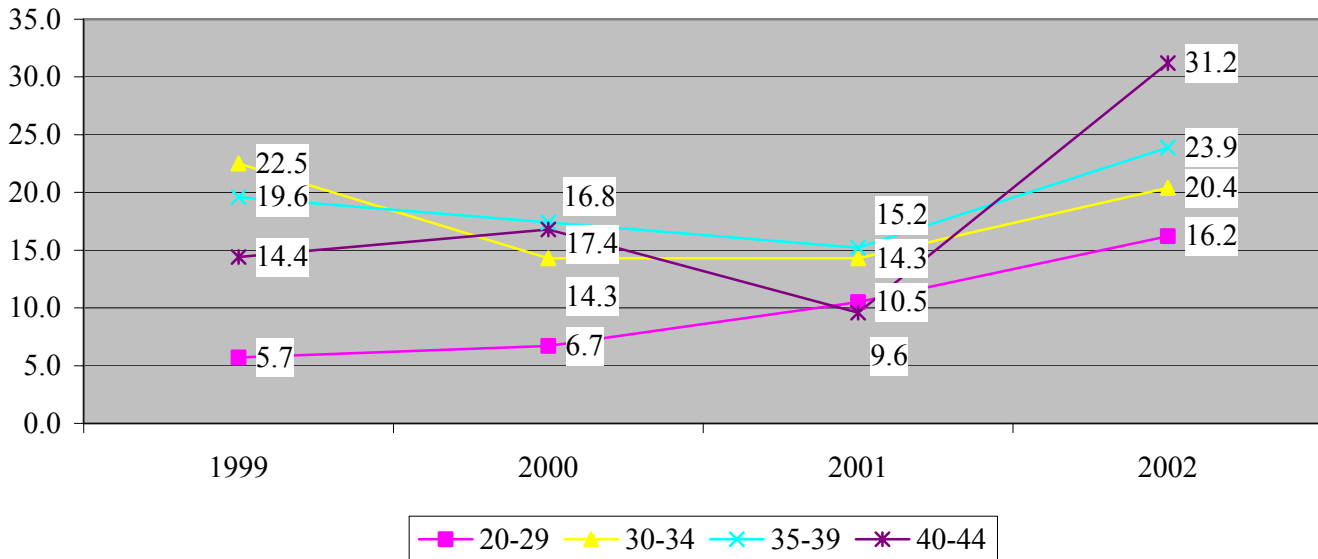
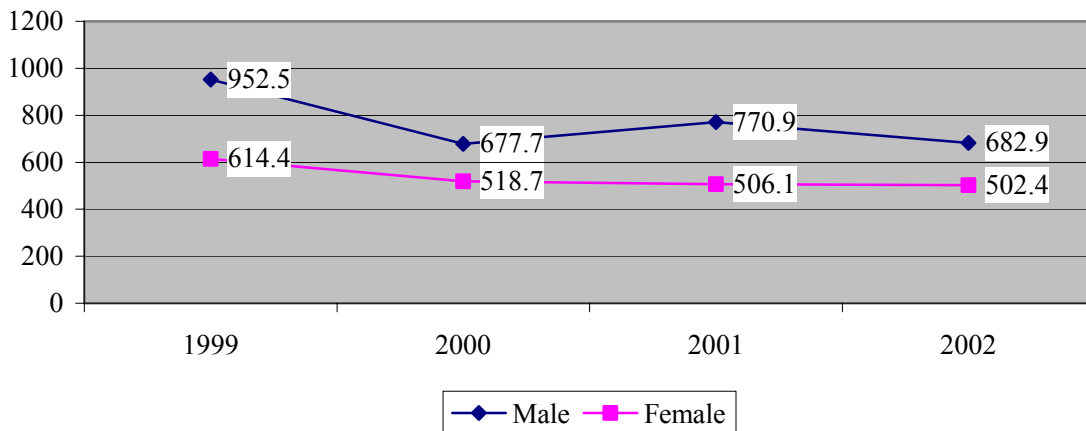


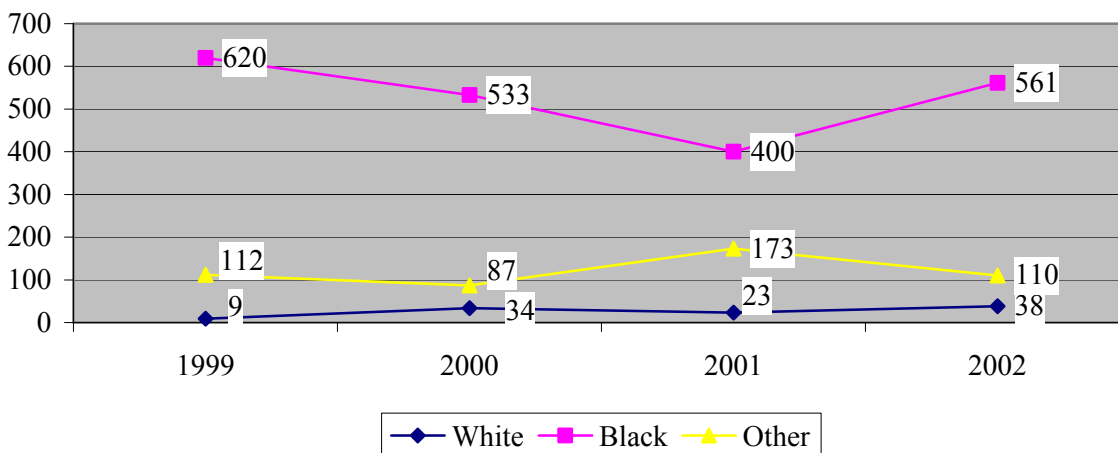
Figure 3 shows that since 1999, there has been an overall increase in all age groups. The most dramatic increase is among persons age 40 – 44 years. The spike in 2002 from 2001 in this age group is reflective of a reemergence of syphilis nationally in white men who have sex with men. Among young adults age 20 - 29 years there has been a steady rise. Similarly in the 30 - 34 year old and 35 - 39 year old age groups. Nationally, the syphilis case rate has risen from 2.2 per 100,000 in 2001 to 2.4 per 100,000 in 2002.

Figure 13: Trends in Gonorrhea Case Rates, per 100,000, by Gender, District of Columbia, 1999 – 2002



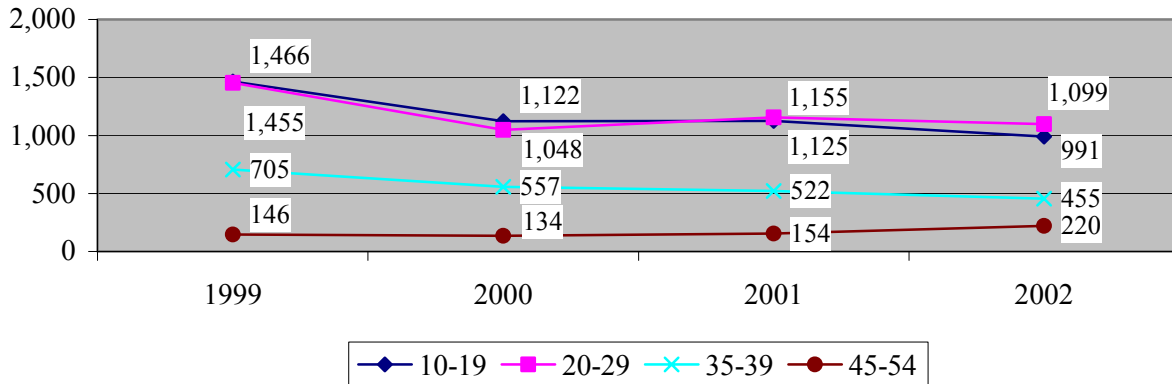
The national rate among women decreased from 128.2 cases per 100,000 to 123.7 cases per 100,000, from 2001 to 2002. Among men, the national rate declined as well from 128.4 per 100,000 to 124.2 per 100,000 persons. The slight decrease in District cases from 2001 to 2002, shown above, thus approximates national trends.

Figure 14: Trends in Gonorrhea Case Rates, per 100,000, by Race/Ethnicity, District of Columbia, 1999 – 2002



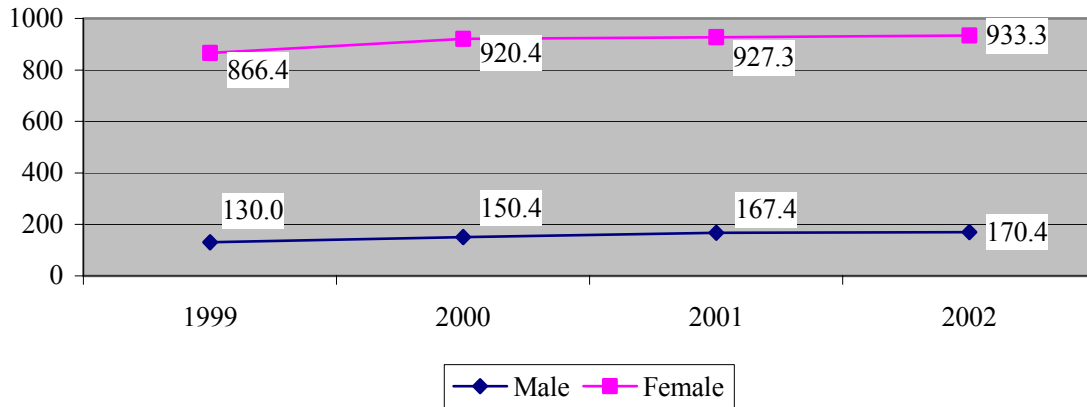
The “Other” category in figure 5 includes cases classified by race/ethnicity as Hispanic, Asian Pacific Islander, and Native American/Alaskan Native. These cases combined produce a rate higher than among whites but not as high as the rate among African American/Blacks. As with syphilis, the African American/Black population is disproportionately affected.

Figure 15: Trends in Gonorrhea Case Rates, per 100,000, by Age Group, District of Columbia, 1999 – 2002



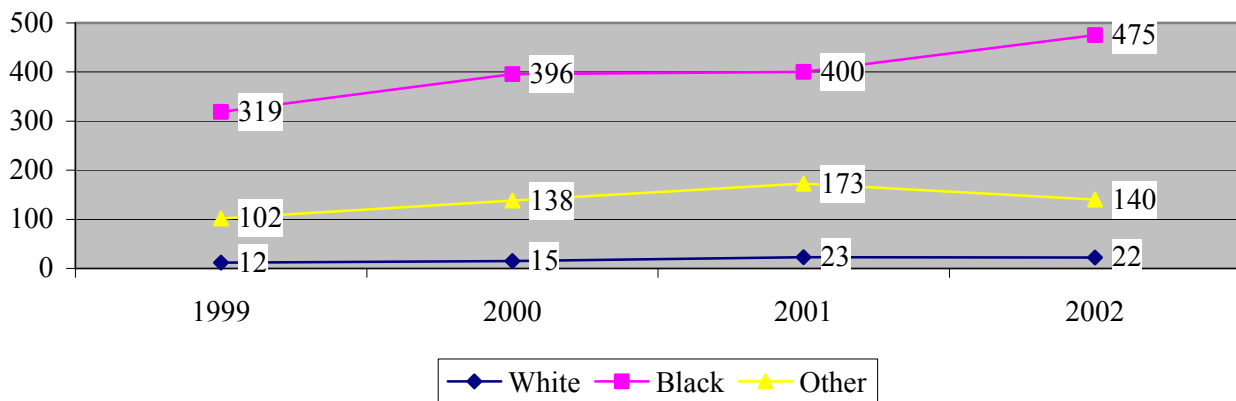
The rate of gonorrhea cases per 100,000 in the District in 2002 is two and a half times as high as the national rate. Per 100,000 persons the District reported 537 cases of gonorrhea. Nationally the figure reported by the CDC is 220.2 per 100,000 persons, in 2002, down from 227.8 per 100,000 reported in 2001. Among persons age 10 – 19 years the District’s rate is almost twice the national average, 991 per 100,000 in the District versus 503 per 100,000 nationally. In persons age 20 – 29, the District more closely mirrors national figures although still higher, 1099 cases per 100,000 in the District versus 879 per 100,000 nationally. In persons age 35 – 39 years figure 6 shows a gradual decline since 1999. This is also seen nationally in this age group. There is a slight increase in rate among 45 – 54 year olds. This slight rise is also recorded nationally.

Figure 16: Trends in Chlamydia Case Rates, per 100,000, by Gender, District of Columbia, 1999 – 2002



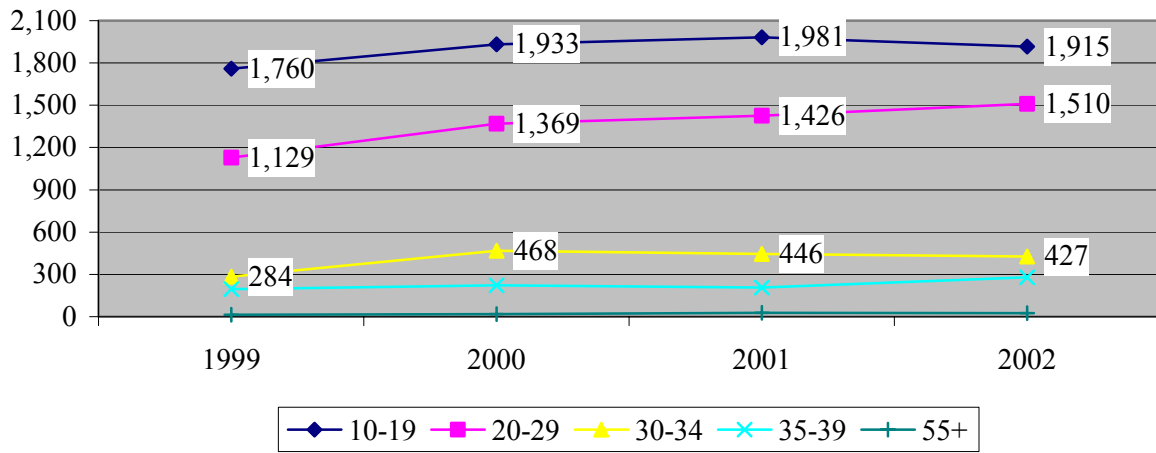
The number of chlamydia cases per 100,000 among women in the District of Columbia is more than twice the national rate. In 2002 the CDC reported 455.4 cases of chlamydia per 100,000 persons among women. The District’s rate among women in 2002 is nearly twice the national rate. The rate among men nationally in 2002 was 130.1 cases per 100,000. The District’s rate in this same year among men is slightly higher. The gradually increasing trends since 1999 among women and men are reflective of national trends among women and men for chlamydia.

Figure 17: Trends in Chlamydia Case Rates, per 100,000, by Race/Ethnicity, District of Columbia, 1999 – 2002



Similar to figure 5 illustrating gonorrhea, the “Other” category in figure 8 includes cases classified by race/ethnicity as Hispanic, Asian Pacific Islander, and Native American/Alaskan Native. Then case rate among “other” races outnumber cases among whites but do not equal the rate among African American/Blacks. In 2002 the rate of chlamydia among African American/Blacks was more than three times the rate among the other category and twenty-one times the rate per 100,000 among whites.

Figure 18: Trends in Chlamydia Case Rates, per 100,000, by Age Group, District of Columbia, 1999 – 2002



In 2002 the CDC reported that among persons age 10 – 19 years the rate per 100,000 was 1,558. The District’s rate in this age group is slightly higher. Unlike gonorrhea, the District’s rate is not two and a half times as high as the national rate. In persons age 20 – 29, the District’s rate is below the national rate of 2211 cases per 100,000 for cases reported in 2002. This difference, however, is seen in the 30 – 34 year age group where the national rate in 2002, 245.4 per 100,000, is almost twice the District’s rate. In persons age 35 – 39 years figure 9 shows a gradual increase since 1999, which is also seen nationally in this age group. There is a slight increase in rate among persons diagnosed older than 55 years. The CDC reports slight increases in this age group nationally as well.