Texas Department of Health
Bureau of HIV & STD Prevention

HIV/STD ANNUAL REPORT
2001

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Acknowledgements

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I. EXECUTIVE SUMMARY

From the beginning of the Human Immunodeficiency Virus (HIV) epidemic in the early 1980s to the end of 2000, over 54,447 acquired immunodeficiency syndrome (AIDS) cases have been reported in Texas. A total of 119,385 sexually transmitted disease (STD) cases excluding HIV/AIDS were reported in Texas in 2000. While reported cases of syphilis declined, chlamydia, gonorrhea and pelvic inflammatory disease (PID) increased. Young people aged 15 to 24 years accounted for over 66 percent of all reported STDs, with adolescents aged 15 to 19 accounting for over 34 percent of these cases.

The total operating budget for HIV and STD programs, Bureau of HIV and STD Prevention, Texas Department of Health (TDH), for fiscal year (FY) 2001 was $113,621,989. The Bureau distributed almost $41 million to regional and local health departments and community-based organizations throughout the State in 2001.

HIV prevention efforts focused on the high risk target populations identified through community planning activities. A total of 123,816 initial prevention counseling sessions were reported in 2000; 96 percent of initial counseling sessions included an HIV test, and this testing yielded a positivity rate of 1.3 positives per 100 tests. Over 10,000 HIV positive clients received publicly funded medical support services in FY 2001. Prevention activities provided by STD programs resulted in the location, counseling, and testing of 1,968 HIV sex/needle sharing partners of HIV positive individuals. Disease Intervention Specialists (DIS) also interviewed and managed 1,380 syphilis cases in Texas in 2000. A total of 433 new cases of syphilis were identified and referred for treatment by DIS.

HIV counselors were trained at locations across Texas; some counselors receiving customized training specific to the individual needs of their programs. The Texas HIV/STD InfoLine, which provides a telephone link between the people of Texas and the TDH, received over 2,561 calls during FY 2001.

The Texas HIV Medication Program worked with 238 participating Texas pharmacies and distributed over $42.9 million dollars of antiretrovirals and other HIV prophylactic medications in FY 2001. The medications help delay the onset of symptomatic disease and prevent opportunistic infections in persons living with HIV disease. The Texas HIV Medication Program also distributed STD medications and supplies to 52 sites statewide in 2001.*

Note. The Annual Report for 2001 is based on the previous fiscal year, September 2000 – August 2001. Due to time constraints in collecting and reporting research and epidemiological data, sections of the report containing this information may be based on the previous calendar year, January 2000 – December 2000.

II. BUREAU OF HIV & STD PREVENTION

The Texas Department of Health (TDH), Bureau of HIV and STD Prevention (Bureau) consists of three Divisions: the HIV/STD Health Resources Division; the Epidemiology Division; and the Clinical Resources Division **(Figure 1)**. The HIV/STD Health Resources Division is responsible for policy and planning, field operations, monitoring, training and technical assistance, grants, and contract development. The Epidemiology Division includes surveillance, epidemiologic assessment, research and evaluation, data management and other technical functions. The Clinical Resources Division supports all medication programs across the department including the Texas HIV Medication Program. Additionally, the Clinical Resources Division provides expertise, technical assistance, and policy direction on all clinical issues.

Mission Statement

Our mission is to prevent, treat, and/or control the spread of HIV, STD, and other communicable diseases to protect the health of the citizens of Texas. In keeping with this mission, we procure, allocate, and manage fiscal and human resources so that we may:

Provide HIV/STD education and information,
Collect, interpret, and distribute data relating to HIV and STD,
Provide guidance to those who oversee, plan for, or provide HIV and STD services, and
Provide medication and supplies to prevent, manage, and treat communicable diseases.

In pursuit of this mission, we will make every effort to assure that the citizens of Texas receive quality services.

The Bureau is dedicated to preventing the spread of HIV and other STDs and minimizing complications and costs. This is achieved primarily through education, prevention counseling, screening and testing, partner elicitation and notification, and the provision of medical and social services. The TDH provides some of these services directly, but most often through contracts with local agencies to provide community-based services when appropriate. This report documents many of the activities and accomplishments of the Bureau in 2000 and provides an epidemiologic assessment of HIV, AIDS, and STDs in Texas.

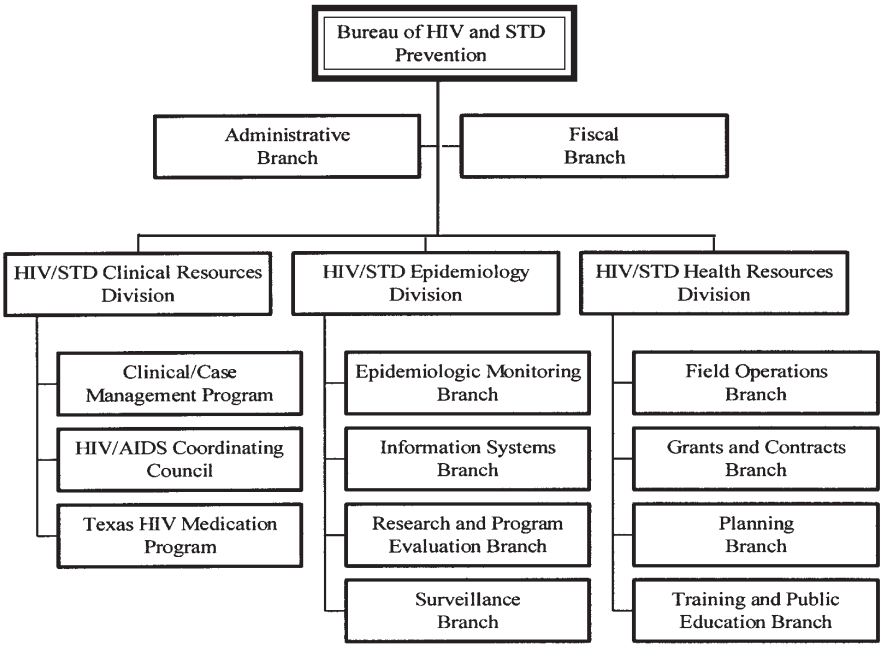
Bureau of HIV and STD Prevention Strategic Plan

The Bureau's Strategic Plan Steering Committee was reconvened in February 2000, to discuss an optimal mechanism to monitor progress on the strategic plan. The discussion resulted in the proposal to utilize prioritized initiatives as a basis for a revised strategic plan. The strategic plan will be used to more clearly define the Bureau's scope of work and as a tool to monitor progress towards goals and objectives. An initiative-based format is intended to more strongly support staff collabo-

ration, promote the Bureau's mission and provide a natural framework for progress reports. The prioritized initiatives in the revised strategic plan will then serve as a basis for assigning milestones, timelines and staff responsible for the Strategic Operational Plan for September 1, 2001 – August 31, 2002.

The Bureau's process to revise the strategic plan began in July 2001 with the formation of a core group of staff members including the Bureau senior managers and central office senior administrative staff. Planning Branch staff facilitated the discussions and documented the results. Before writing the plan, the core group members discussed how the strategic plan would be used and monitored or assessed. The Bureau's vision and mission statements were reviewed and reaffirmed. Other considerations by the group included the development of definitions, philosophy and guiding principles, the role of and impact on regional staff and why most strategic plans fail. Guiding documents were identified and discussed. These included: the Health and Human Services Commission Strategic Plan (1999-2003), the TDH Strategic Plan (2001-2005), the Center for Disease Control and Prevention (CDC) HIV Prevention Strategic Plan (2001-2005), Healthy People 2010, Institutes of Medicine (IOM) Reports on STD and HIV prevention, Health Resources and Services Administration (HRSA) principles, HRSA Ryan White Reauthorization, CDC's "A Serostatus Approach to Fighting the HIV/AIDS Epidemic (SAFE) Initiative" and the Bomer Report.[1] Currently, the core group is developing a list of initiatives and outcome measures for each initiative. With numerous competing priorities, the challenge remains selecting a limited number of initiatives on which to focus the Bureau's attention and staff efforts. A timeline was developed and agreed upon which proposes a finalized strategic plan document by December 31, 2001.

Figure 1. Bureau of HIV and STD Prevention Organizational Chart



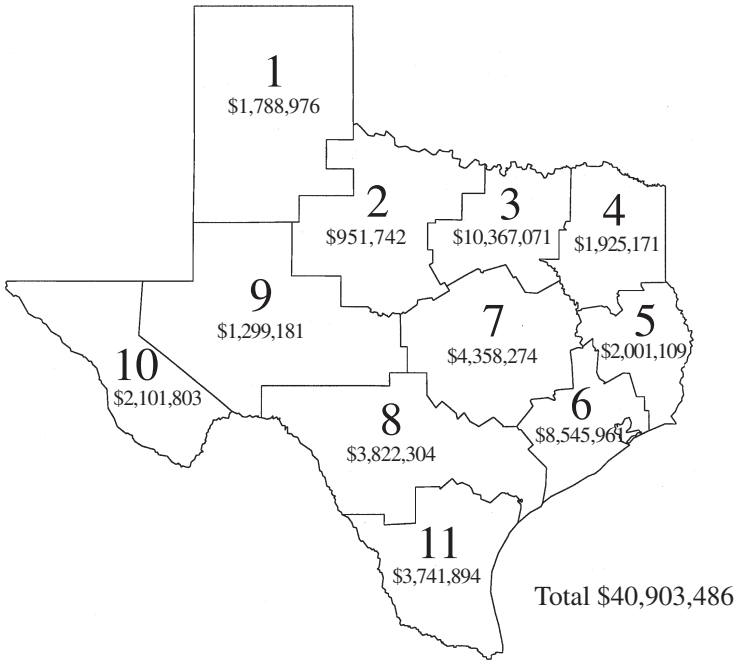
[1] Texas Department of Health Business Practices Evaluation, August 31, 2001.

III. FUNDING – FISCAL YEAR 2001

The total operating budget for HIV and STD programs for FY 2001 was $113,621,698. Almost three-quarters of the budget, $84,565,969, was provided by federal HIV and STD grants, and the remainder, $29,055,729 by State funds. The HIV and STD funds were allocated as follows: $23,423,274 (21%) for prevention; $34,075,616 (30%) for services; $50,352,144 (45%) for medication; and $5,770,664 (5%) for surveillance. The 2001 budget represented a 12% increase over the 2000 budget, most of the increase being allocated to the medication program for purchase and distribution of the new anti-HIV drugs, the protease inhibitors.

Almost $41 million, more than 35% of the total HIV and STD prevention and services resources were distributed to regional and local health departments and other contracted community-based agencies through prevention and services contracts **(See Figure 2)**. Approximately 44% of the total HIV and STD resources were spent providing HIV and STD medications throughout Texas. Other Bureau expenditures included training and public education, regional and central office administrative costs, laboratory costs, travel to support training, technical assistance, and monitoring, supplies and equipment, and public health promotion. Administration encompasses activities such as program planning and development, program evaluation, quality control and technical assistance to contractors, contract monitoring, grants management, and related programmatic and support services. The Bureau also supports the Funding Information Center (FIC) with HIV funds. The FIC researches and disseminates HIV/AIDS-related funding information to the Texas public.

Figure 2. HIV Prevention and Services Contracts Awarded by Public Health Region State and Federal Funds



IV. EPIDEMIOLOGIC ASSESSMENT OF HIV, AIDS, & STDS IN TEXAS

HIV/AIDS

Acquired immunodeficiency syndrome (AIDS) is the late stage of infection with the human immunodeficiency virus (HIV) and is characterized by severe immunosuppression and co-infection with other opportunistic agents. HIV specifically infects and depletes a subgroup of white blood cells (lymphocytes) called helper T-lymphocytes. These cells are also called CD4+T-cells, which is a term based on laboratory tests that identify these cells by the presence of a specific cell surface marker, CD4. The decline in the number of CD4+T-cells is an indicator of HIV disease progression.

The CD4+ T-cell count became an important part of the AIDS surveillance case definition that the Centers for Disease Control and Prevention (CDC) revised in 1993. The new case definition of AIDS includes all HIV-infected persons with CD4+ T-cell counts fewer than 200 per microliter of blood, or less than 14% of total lymphocytes. Before this change, the case definition relied on a confirmed positive HIV test and the identification of one of several indicator diseases that commonly occur among immuno-compromised HIV-infected patients.

Viral load tests[2] have been developed that quantify the level of HIV virus circulating in the bloodstream, and are used in conjunction with CD4+ T-lymphocyte counts to determine status of disease. Viral load tests are a sensitive measure of the HIV nucleic acid in the peripheral blood and other body systems. The level of viral nucleic acid has clinical significance: in a 1999 study, patients with greater than 100,000 HIV RNA copies/mL (plasma level) within 6 months of seroconversion, were 10 times more likely to progress to AIDS during the next 5 years than those who had less than 100,000 copies/mL in the first 6 months. Viral load testing is used to evaluate newly diagnosed disease, to monitor disease status, to establish a baseline value prior to antiretroviral treatment, and to monitor health status during treatment. In January 2000, the Texas Department of Health began mandatory HIV viral load reporting. This occurred because the surveillance case definition for HIV was updated by the CDC in December of 1999, to include a detectable viral load as an independent criterion for HIV infection and the HIV reporting law in Texas uses the CDC HIV case definition.

Like many states, Texas has recently experienced a decline in AIDS cases. Along with the decline in AIDS cases, the current trend extends to a decline in AIDS deaths. The decrease in AIDS deaths, like the decrease in progression to AIDS, has been generally attributed to the use of triple drug therapy, which delays the progression from HIV infection to AIDS. Although treatment with the triple drug combination is receiving the credit for the decline, other preventive strategies have

[2] Viral load tests measure the amount of HIV-RNA in a blood sample.

also entered into the equation: HIV positive individuals are being treated at earlier stages; a variety of therapeutic interventions to prevent secondary infection are available; specific targeting to high-risk groups for early testing and preventive education has increased; and the wider variety of medications to choose from have all created a more favorable prevention strategy.

In Texas, AIDS deaths decreased 26% during the first 6 months of 2000 compared with the first six months of 1999. During the first six months of 1999, AIDS deaths declined only 2% when compared to 1998. The 2000 decline in deaths was seen among men of all racial/ethnic groups, however African American women did not see as great a decrease in deaths as Hispanic and White women **(see Table 1)**.

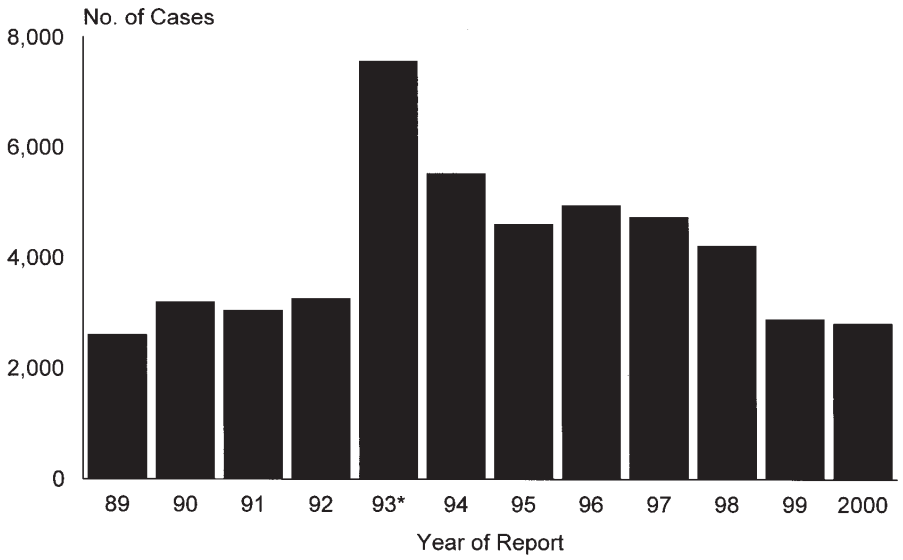
Table 1. Texas AIDS Deaths, 1998-2000

	Jan-June 1998	Jan-June 1999	Jan-June 2000	% Change (1999-2000)
Males				
White	206	175	137	-21.7
African American	145	145	99	-31.7
Hispanic	96	109	75	-31.2
All Others	1	1	1	0.0
Females				
White	17	22	14	-36.4
African American	49	52	47	-9.6
Hispanic	15	16	10	-37.5
All Others	0	0	1	0.0
Total	529	520	384	-26.2

2000 Texas AIDS/HIV Statistics

By the end of the year 2000, 54,447 persons with AIDS were reported in Texas since the start of the epidemic in the early 1980s. Consistent with national trends, Texas AIDS cases have decreased each year from 1996 through 2000 **(see Figure 3)**. The decrease in new AIDS cases has generally been attributed to the use of highly active antiretroviral therapy (HAART) to slow the progression of HIV to AIDS. The number of new HIV cases in Texas appears to be increasing, but because the Texas named HIV reporting system was only implemented in January, 1999, it is probably too early to define HIV trends at this time.

Figure 3. AIDS Cases by Year of Report, 1989-2000

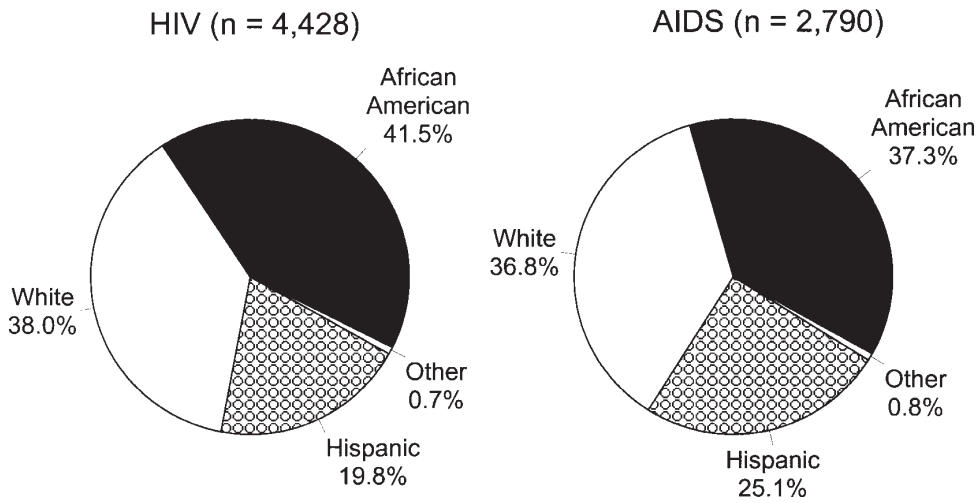


54,447 Cumulative Cases Reported Through 12/31/00.
*Expanded AIDS surveillance definition implemented.

Rates by Sex and Race/Ethnicity

Texas ranked fourth highest in the US with 2,790 reported AIDS cases in 2000. The AIDS rate for Texas in 2000 was 13.7 cases per 100,000 population. In addition, there were 4,428 HIV (not AIDS) cases reported in Texas in 2000, for an overall state rate of 21.8 cases per 100,000 population. Males in Texas constituted 80% of reported AIDS cases and 72% of reported HIV cases in2000. The AIDS rate for Texas males in 2000 was 22.1 cases per 100,000 and the HIV rate was 31.5 per 100,000. The female AIDS rate was 5.5 cases per 100,000 and the HIV rate was 12.2 per 100,000. Because HIV data represents more recent infections than AIDS data, the increase in

Figure 4. HIV and AIDS Cases by Race/Ethnicity, 2000



rates seen among females with HIV compared to those with AIDS is an indicator of the increasing spread of new infections among females. This pattern is also evident among the African American population in Texas.

The racial/ethnic distribution of AIDS cases reported in Texas in 2000 was divided fairly equally across Whites (37%), African Americans (37%) and Hispanics (26%) **(see Figure 4)**. However, the rate of reported AIDS cases in 2000 among Texas' African Americans (45.3 per 100,000 population) was more than four times higher than the rates for Whites (9.2 per 100,000) or Hispanics (11.1 per 100,000) **(see Table 2)**. The racial/ethnic distribution among HIV cases reported in 2000 was 42% African American, 38% White, and 20% Hispanic **(see Figure 4)**. The rate of reported HIV cases in 2000 among African Americans (79.3 per 100,000) was more than five times higher than the rate for Whites (15.1 per 100,000) or Hispanics (13.9 per 100,000) **(see Table 3)**.

Table 2. Texas AIDS Cases Reportd by Race/Ethnicity and Sex, 2000

	Cases	%	Rates (cases per 100,000 population)
Males	2,219		22.1
White	892	40	16.4
African American	704	32	63.3
Hispanic	607	27	19.0
All Others	16	<1	5.1
Females	571		5.5
White	134	23	2.4
African American	338	59	28.1
Hispanic	94	16	3.0
All Others	5	<1	1.6
Total	2,790		13.7

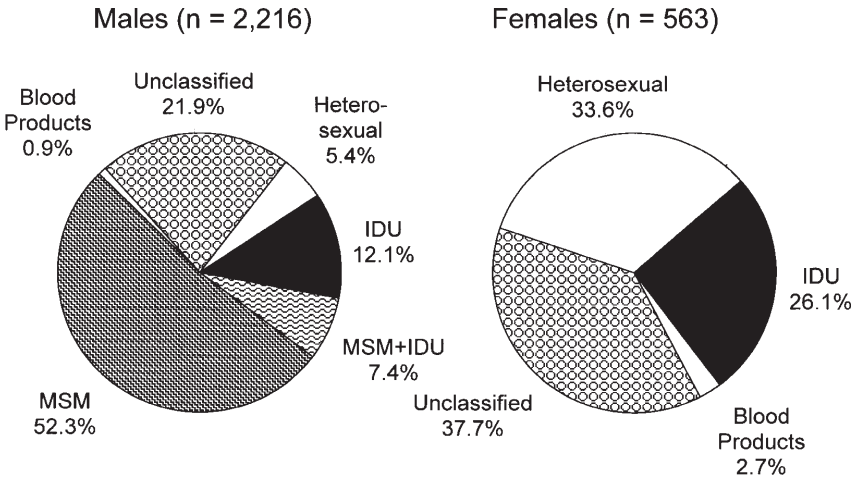
Table 3. Texas HIV Cases, 2000

	Cases	%	Rates (cases per 100,000 population)
Males	3,169		31.5
White	1,393	44	25.7
African American	1,082	34	97.3
Hispanic	667	21	21.2
All Others	27	<1	8.7
Females	1,259		12.2
White	288	23	5.1
African American	754	60	62.7
Hispanic	211	17	6.8
All Others	6	<1	1.9
Total	4,428		21.8

Modes of Exposure

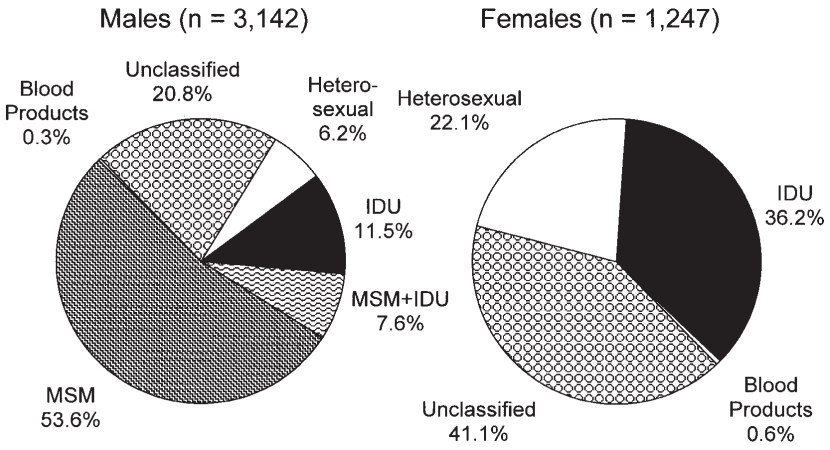
The Men Who Have Sex with Men (MSM) exposure category constituted about half (53%) of the 2000 AIDS cases among Texas males. Injecting drug use was the next most frequently cited mode of transmission at 12% of cases and about 5% of cases were attributed to heterosexual contact. Among females, heterosexual exposure made up 34% of 2000 AIDS cases and injecting drug use was the mode of exposure for 26% of cases. A large percentage of cases among both females (38%) and males (22%) had an unclassified mode of exposure **(see Figure 5)**. For HIV infections, the MSM exposure category constituted 54% of cases among Texas males, injecting drug use was the mode transmission for 12% and heterosexual transmission was reported for 6%. Among females, heterosexual exposure was identified for 36% and IDU exposures constituted 22%. As with AIDS cases, a large percentage of HIV cases among females (41%) and males (21%) had an unclassified mode of exposure **(see Figure 6)**.

Figure 5. Adult-Adolescent* AIDS Cases by Mode of Exposure and Sex, 2000



*Age 13 or older at time of diagnosis.

Figure 6. Adult-Adolescent* HIV Cases by Mode of Exposure and Sex, 2000



*Age 13 or older at time of diagnosis.

Geographic Distribution

Most AIDS cases in Texas continue to be reported from metropolitan areas. The largest number of cases reported in 2000 were from Houston/Harris County (725), followed by Dallas (599), Ft. Worth/Tarrant County (187), Austin/Travis (176), San Antonio/Bexar (164), and El Paso (81) cities/counties. Ranking these counties by rate changes the order somewhat. Dallas County demonstrated the highest rate (27.1), followed by Travis County (Austin) at 26.9/100,000. Harris County rate was lower at 21.8, followed by Tarrant (12.1), Bexar (11.9), and El Paso County at 10.5 cases per 100,000 population. The Texas Department of Criminal Justice reported 4.4% of all 2000 AIDS cases (123). In 2000, 121 counties, (out of the 254 in Texas), reported at least one AIDS case. Although still centered mainly in the metropolitan areas of the State, the HIV epidemic continues to spread to more rural areas, requiring all counties to face the challenges of providing prevention education, health care, and services.

Reports of HIV cases in Texas are also predominantly from metropolitan areas. These case reports may be skewed, however, since some areas of the State were more prepared than other areas to begin reporting HIV cases at the inception of HIV case reporting in 1999. The largest number of cases reported in 2000 were from Houston/Harris County (1270), followed by Dallas (896), San Antonio/Bexar (283), Ft. Worth/Tarrant (274), Austin/Travis (247), and El Paso (55) cities/counties. Ranking these counties by rate changes the order somewhat. Dallas County demonstrated the highest HIV rate, (40.6/100,000), followed by Harris (38.2), Travis (37.8), and Bexar (20.5) counties. The rates for Tarrant and El Paso Counties were 17.7 and 7.1 cases per 100,000 population, respectively. In 2000, 136 counties,(out of the 254 in Texas), reported at least one new HIV case. The Texas Department of Criminal Justice reported 7.4% of all 2000 HIV cases (329).

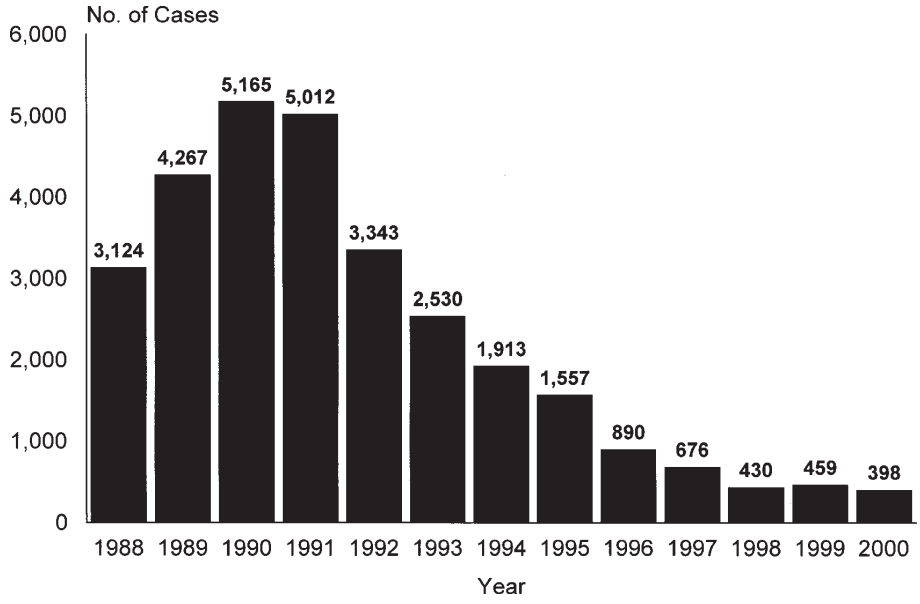
Sexually Transmitted Diseases

Primary and Secondary Syphilis

The spirochete *Treponema pallidum* causes syphilis. Primary and secondary (P&S) syphilis, the acute form of the disease, is characterized by primary lesions (an ulcer or chancre at the site of infection) followed by secondary infection (manifestations that include rash, mucocutaneous lesions, and adenopathy). Untreated P&S syphilis progresses into a chronic disease with long periods of latency. Statewide, 398 cases of P&S syphilis were reported in 2000. This represents a 13% decrease from cases reported in 1999 and continues the general downward trend for syphilis in Texas over the past nine years, the only exception being the minor increase seen from 1998 to 1999 **(see Figure 7)**. The number of P&S syphilis cases reported in 2000 was one-tenth the number reported in 1991. The age distribution of P&S syphilis cases was fairly even across the three age groups of most common occurrence; 15 to 24 (25%), 25 to 34 (29%), and 35 to 44 (32%) years of age. Men accounted for 62% of reported cases in 2000, a proportion similar to what has been seen in recent years. Three major metropolitan counties, Dallas, Harris, and Bexar, accounted for nearly 60% of all P&S syphilis cases reported.

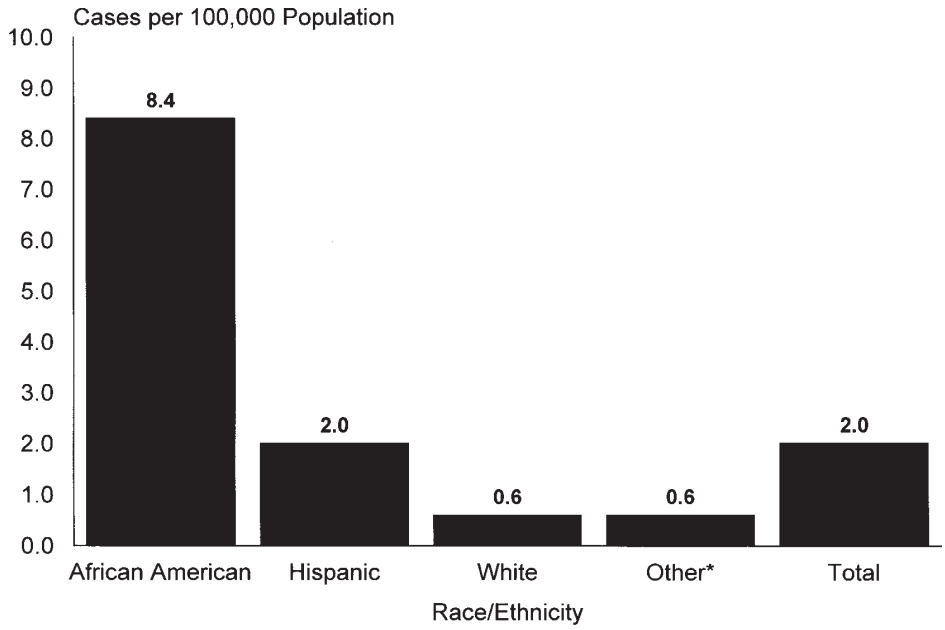
The overall State rate in 2000 for P&S syphilis was 2.0 cases per 100,000 population. African Americans continued to account for the largest proportion (49%) of P&S syphilis cases reported in Texas in 2000: the rate of P&S syphilis among African Americans was 8.4 cases per 100,000 population. Although less than one-sixth the 1995 rate of 53.2, the rate for African Americans remained extremely high compared with rates for Hispanics (2.0 cases per 100,000 population) and Whites (0.6 cases per 100,000) **(see Figure 8)**. Among African American women, those aged 20

Figure 7. Primary and Secondary Syphilis Cases, Texas 1988-2000



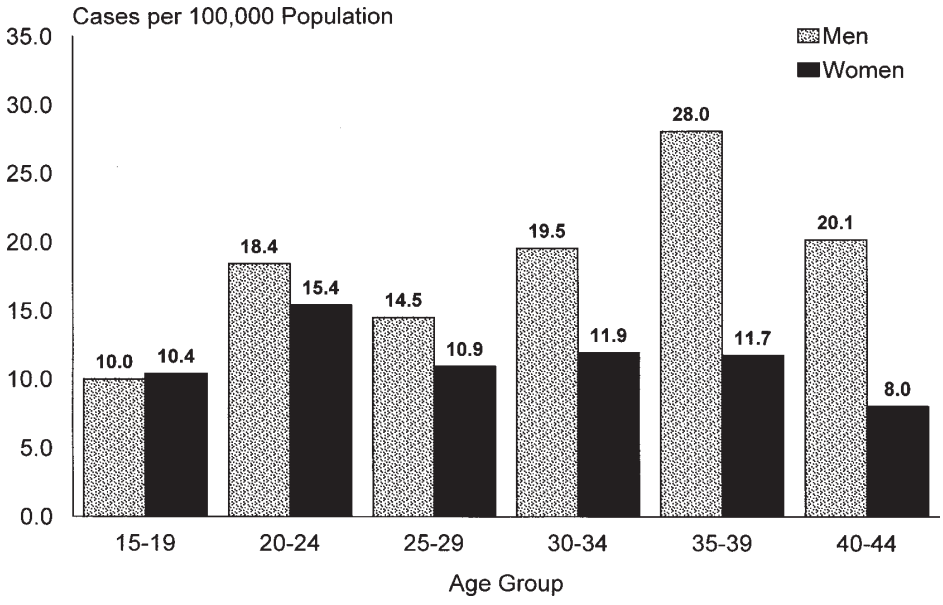
to 24 had the highest rate at 15.4 cases per 100,000 population. The highest rate for African American men was found among a slightly older age group, those aged 35 to 39, at 28.0 cases per 100,000 **(see Figure 9)**. The extremely high case rate for both sexes indicates that P&S syphilis continues to be a significant problem some among African American communities in Texas.

Figure 8. Primary and Secondary Syphilis Case Rates by Race/Ethnicity, Texas 2000



* Excludes cases of unspecified race/ethnicity.

Figure 9. Primary and Secondary Syphilis Rates Among African Americans by Age Group and Sex, Texas 2000

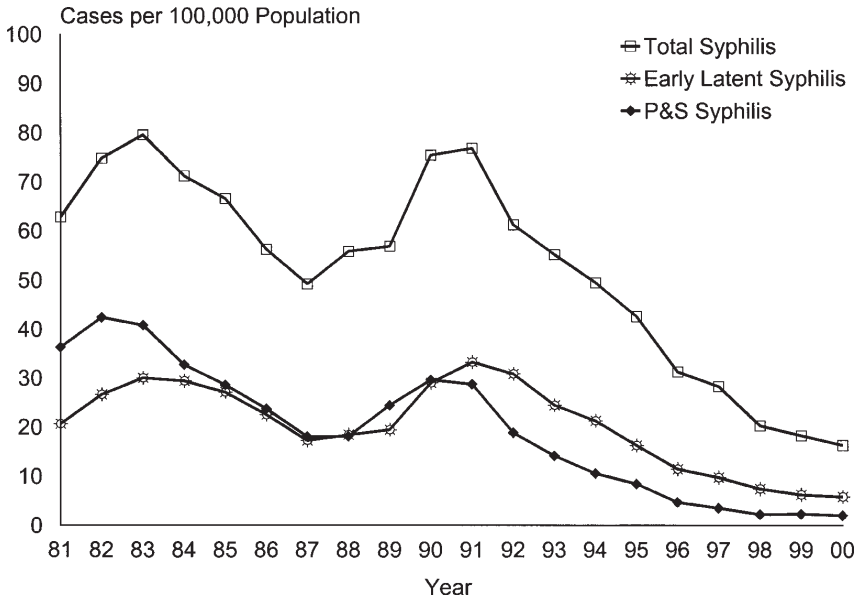


Early Latent Syphilis

Latent syphilis is defined as those periods after infection with *Treponema pallidum* when patients are sero-reactive[3], but demonstrate no other evidence of disease. Patients who have latent syphilis and who acquired the infection within the preceding year are classified as having early latent syphilis; untreated cases of more than one year's duration are classified as late latent. Tertiary syphilis is symptomatic late disease that may include neurologic and cardiovascular sequelae. The late latent and tertiary stages of syphilis are not discussed separately in this article because those individuals contracted the disease many years prior to their cases being diagnosed and reported, and syphilis is not as likely to be transmitted in these late stages. Thus, there are limited public health implications to these diagnoses.

In 1990 slightly over 5,000 cases of P&S and early latent syphilis were reported with similar rates of 30.4 and 29.9 cases per 100,000 population, respectively **(Figure 10)**. While the rate of P&S syphilis generally declined from 1990 to 2000, the early latent syphilis rate increased in 1991 and since then has decreased more slowly than the rate of P&S syphilis. This delayed decline of early latent syphilis rates is typical of periods of decreasing syphilis morbidity. Although both P&S syphilis and early latent syphilis cases were considerably lower in 2000 compared with 1990, the number of early latent syphilis cases (1,175) was nearly three times the number of P&S syphilis cases. The overall rate of early latent syphilis in 2000 was 5.8 cases per 100,000 population. The incidence rate for early latent syphilis among African Americans was 25.5 cases per 100,000, compared to 6.3 among Hispanics and 1.6 among Whites.

Figure 10. Syphilis Case Rates, Texas 1981-2000



[3] Shortly after the body becomes infected with *Treponema pallidum* the body produces antibodies that can be detected through blood analysis. A syphilis test is sero-reactive when the test is positive, or antibodies are present in the blood sample.

Congenital Syphilis

Congenital syphilis, one of the most serious forms of the disease, can cause abortion, stillbirth, or premature delivery, or may lead to other severe complications in the newborn. In 2000, 71 cases of congenital syphilis were reported (down from 92 cases in 1999), marking the seventh year of decline. Harris County had the highest number of congenital cases with 29, a fairly large decrease from the 47 cases reported from that county in 1999. No other county had more than 7 cases of congenital syphilis reported in 2000. Statewide, 56% of congenital cases were among Hispanics, 38% among African Americans, and 3% among Whites. Based on 1999 live birth numbers (2000 birth data was unavailable), the estimated rate of congenital syphilis in 2000 was 20 cases per 100,000 live births, down from 30 cases per 100,000 in 1999.

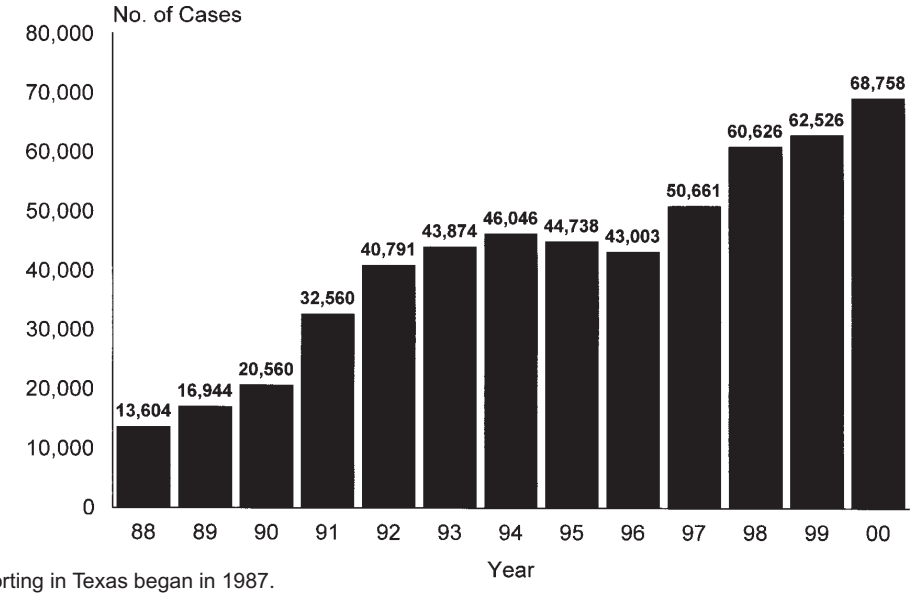
Total Syphilis

The term 'total syphilis' refers to all reported syphilis cases regardless of the stage of the disease. Included in this total are congenital, P&S, early latent, late latent, and tertiary syphilis. In 2000, 3,303 cases of total syphilis were reported, for a statewide rate of 16.2 cases per 100,000 population. This marks the ninth straight year of decline in total syphilis numbers, closely paralleling the decreases seen among P&S and early latent syphilis **(see Figure 10)**.

Chlamydia

The bacteria *Chlamydia trachomatis* is one of the most common causes of sexually transmitted infections. Chlamydia infection in women can result in serious complications such as pelvic inflammatory disease and ectopic pregnancy. After chlamydia became reportable in 1987, the number of

Figure 11. Chlamydia Cases, Texas 1988-2000*



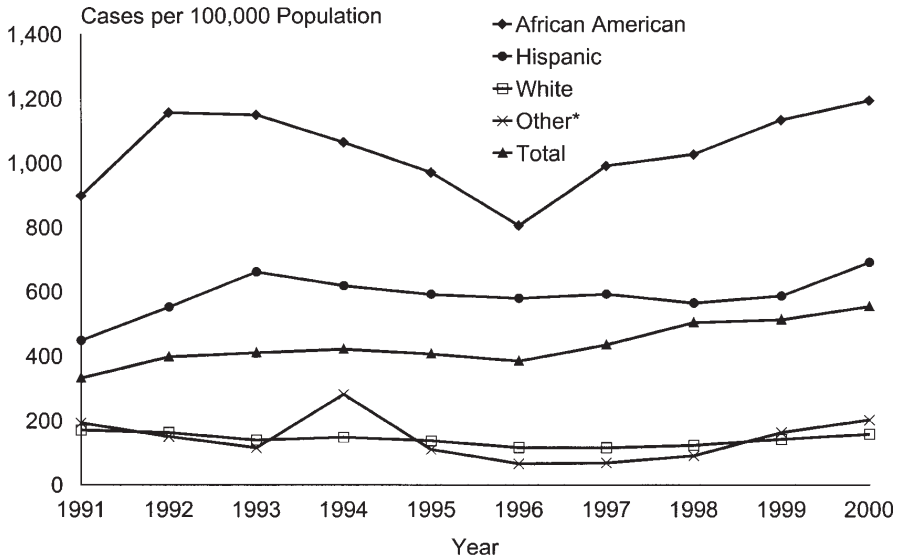
*Chlamydia reporting in Texas began in 1987.

cases soared; this likely reflected increased testing, not necessarily increased disease. Reports of chlamydia in 2000 totaled 68,758, a 10% increase from the previous year's total of 62,526 **(see Figure 11)**. In 1997 and 1998, Texas experienced similar increases in chlamydia reports that were attributed to the state-wide implementation of new morbidity surveillance software, Sexually Transmitted Disease Management Information System (STD*MIS). The leveling out of chlamydia numbers in 1999, following the establishment of STD*MIS, supported that theory. The explanation for increased chlamydia reports in 2000 is less clear, but possible factors include improved reporting from several specific high-volume clinics, the transition to amplified chlamydia testing technology by some private health care providers, and a true increase in chlamydia incidence.

Of the total chlamydia cases reported in 2000, 83% were among women. Women are more likely to be screened for chlamydia than men because they are often screened during clinical exams for family planning, prenatal care, and routine Pap smear testing. Because of the increased risk of severe outcomes, including the potential for pelvic inflammatory disease and the possibility of infecting a newborn child, chlamydia screening programs almost always focus on women. Men are often asymptomatic and do not seek treatment; thus underdiagnosis is a major problem in the male population. Given that men make up such a small proportion (17%) of chlamydia cases reported, the true incidence of chlamydia in the Texas population cannot be estimated. Improved outreach, education, and screening among males is needed.

Because women accounted for the vast majority of chlamydia reports, rates for each sex are examined separately. The 2000 case rate for women in Texas was 552 cases per 100,000 population, with African American women having the highest rate (1,192 cases per 100,000), followed by Hispanic and White women (689 and 158 cases per 100,000 population, respectively) **(see Figure 12)**. Men showed a similar racial/ethnic distribution, but with far lower rates. However, equal target

Figure 12. Chlamydia Case Rates Among Women by Race/Ethnicity, Texas 1991-2000



* Excludes cases of unspecified race/ethnicity.

ing of men for screening and testing would likely result in a higher incidence than is suggested by case reports.

Over 74% of all reported chlamydia patients were 15 to 24 years of age. This amounts to over 43,000 cases reported for women aged 15 to 24 alone. The rates for chlamydia among women aged 15 to 19 and 20 to 24 were 3,115 cases and 2,786 cases per 100,000 population, respectively.

Statewide the total number of clients screened for chlamydia through public funding decreased 13% from 337,832 in 1999 to 294,706 in 2000; the number of positives resulting from these screenings decreased 19% from 26,145 in 1999 to 21,222 in 2000.

Gonorrhea

The bacteria *Neisseria gonorrhoeae* causes gonorrhea. Left untreated, gonorrhea may lead to sterility in men and pelvic inflammatory disease, ectopic pregnancy, and sterility in women. The 32,895 cases of gonorrhea reported in 2000 represent less than a 1% increase from the number of cases reported in 1999 **(see Figure 13)**. As with chlamydia, gonorrhea numbers increased substantially in both 1997 and 1998 prior to leveling off in 1999. The conversion to STD*MIS surveillance software was likely responsible for this trend. However, while chlamydia saw another jump in 2000, gonorrhea reports remained stable. The Texas rate for gonorrhea was 162 cases per 100,000 population in 2000, which is virtually unchanged from the rate in 1999. The rate among women in 2000 (164 cases per 100,000) was only slightly higher than the rate for men (158 cases per 100,000) and both rates have been nearly the same since 1996.

The gonorrhea rate for African Americans (758 cases per 100,000) was nearly 8 times higher than the rate for Hispanics (95 cases per 100,000) and over 20 times higher than the rate for Whites (34 cases per 100,000) **(Figure 14)**. African American men had the highest rate of all race/ethnicity-sex groups at 836 cases per 100,000 population. Gonorrhea cases among African Americans aged 15 to 24 accounted for the greatest share of African American cases (64% of those reported); they also represented 36% of all cases reported regardless of race/ethnicity or age.

Among age groups, the highest rate for women was found in those aged 15 to 19 (906 cases per 100,000) followed by those aged 20 to 24 (772 cases per 100,000). Men in these age groups also had higher rates at 437 cases per 100,000 for the 15 to 19 age group and 637 per 100,000 for those 20 to 24. Gonorrhea among young women aged 15 to 24 comprised 73% of all cases in women; young men in this age group accounted for 52% of all gonorrhea cases among men.

Statewide the total number of publicly-funded screenings decreased 12% from 338,181 in 1999 to 295,969 in 2000; at the same time the number of positive results from these tests decreased 16% from 15,611 in 1999 to 13,066 in 2000.

Figure 13. Gonorrhea Cases, Texas 1972-2000

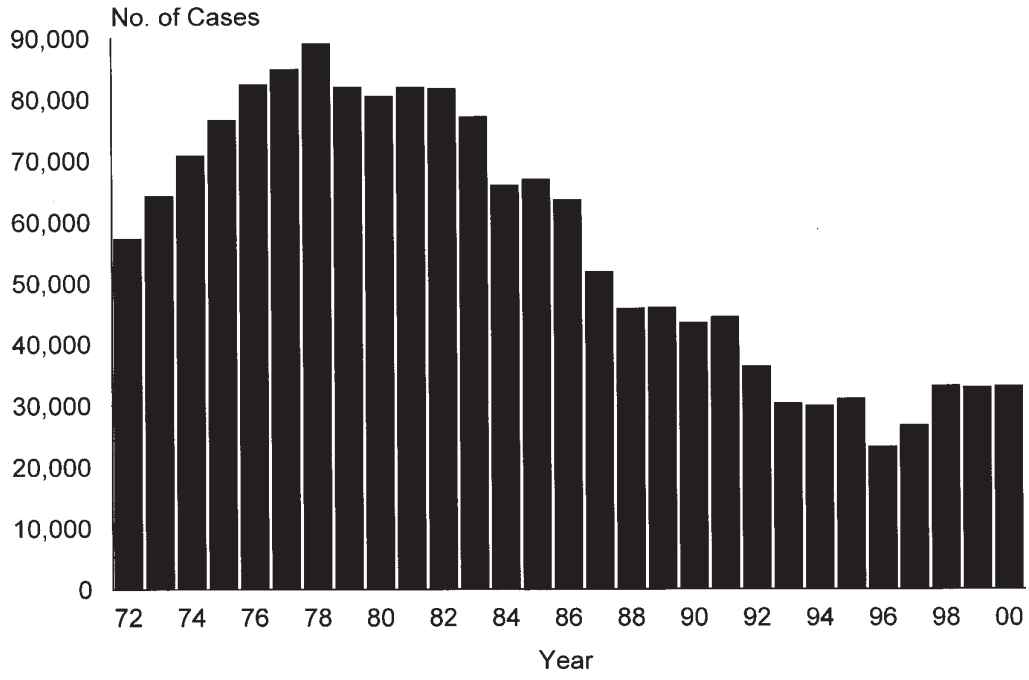
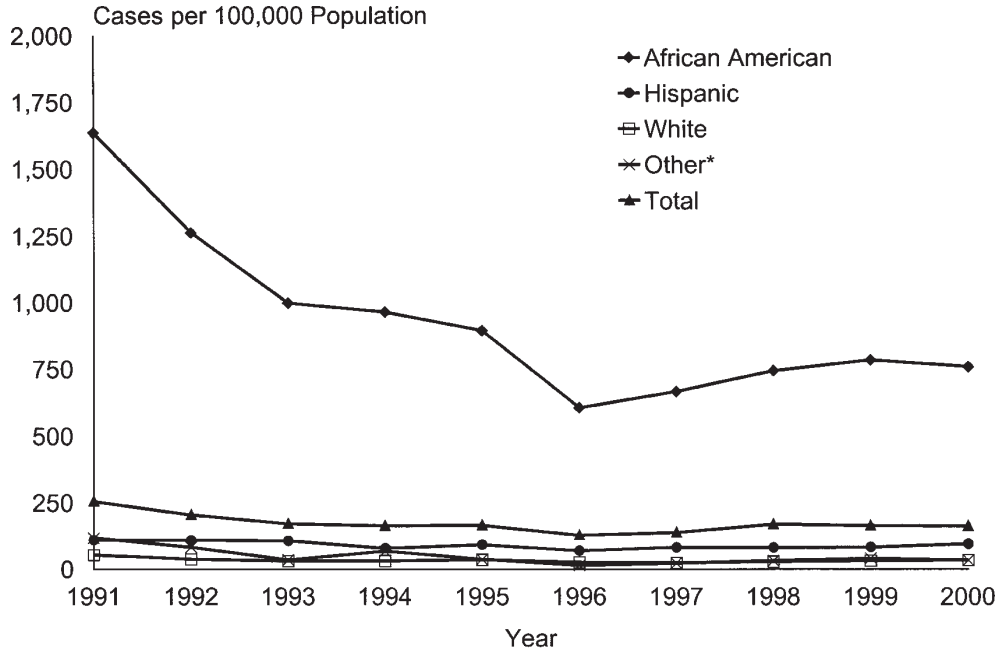


Figure 14. Gonorrhea Case Rates by Race/Ethnicity, Texas 1991-2000



* Excludes cases of unspecified race/ethnicity.

Pelvic Inflammatory Disease (PID)

PID is a serious, sometimes life-threatening complication of untreated chlamydia and gonorrhea in women. Acute PID caused by chlamydia and gonorrhea increases a woman's risk of recurrent PID, chronic pelvic pain, ectopic pregnancy and infertility. In 2000, 1,910 cases of PID were reported, an 8% increase from the 1,766 cases reported in 1999. PID cases attributed to chlamydia or gonorrhea accounted for 52% of the cases reported in 2000, 42% were cases of unknown etiology. Chlamydial PID case reports rose from 531 in 1999 to 675 in 2000, gonococcal PID case reports decreased from 391 in 1999 and 318 in 2000. The racial/ethnic breakdown of PID resembles that of other STDs with African American women accounting for 40% of all cases, Hispanic women for 37% and White women for 19%. Young women aged 15 to 24 accounted for 64% of all PID cases in 2000.

Sexually Transmitted Diseases Among Adolescents

Compared to older adults, adolescents (10 to 19 year-olds) and young adults (20 to 24 year-olds) are at significantly higher risk for acquiring STDs for a number of reasons: they may be more likely to have multiple (sequential or concurrent) sexual partners rather than a single, long-term relationship; they may be more likely to engage in unprotected intercourse; and they may select partners who are at higher risk. In addition, for some STDs such as *Chlamydia trachomatis*, adolescent women may have a physiologically increased susceptibility to infection due to increased cervical vulnerability. During the past two decades, the age of initiation of sexual activity has steadily decreased and age at first marriage has increased, resulting in increases in premarital sexual experience among adolescent women and in an enlarging pool of young women at risk.

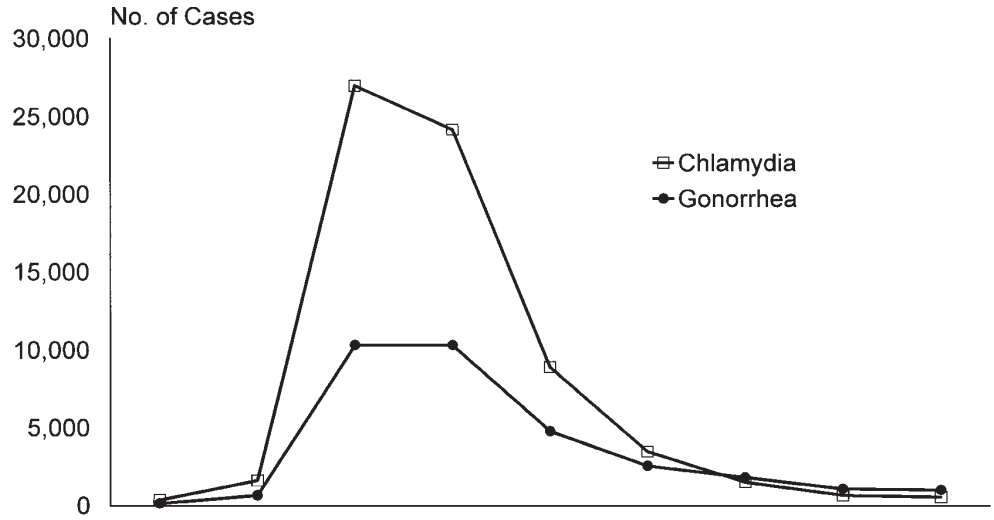
The total burden of STDs is estimated at 15 million new infections annually in the United States. Studies indicate that people are two to five times more likely to become infected with HIV when other STDs are also present because the open lesions associated with STD infections allow portals of entry for the HIV virus. Generally, about one quarter of all STD infections in the US occur among teens. Prevalence studies in various clinic populations and large-scale screening projects have consistently demonstrated that younger women have higher positivity rates of chlamydia than older women.

Of the 119,385 cases of STDs reported in Texas in 2000, excluding HIV/AIDS, 66% were among those 15 to 24 years old, 34% were among adolescents aged 15 to 19 **(see Figure 15)**. Minority youth make up a disproportionate share of these STD cases. Among 2000 STD case reports that included ethnicity information for those aged 15 to 19, 37% were African American, 30% were Hispanic, and were 15% White. The STD case rate for African Americans aged 15 to 19 was nine times higher than the rate among Whites, and the rate for Hispanic adolescents was more than twice the rate among Whites.

Gonorrhea cases reported in 2000 among those aged 15 to 19 numbered 10,316 and accounted for 31% of all gonorrhea cases. The case rates for this age group was 2,840 cases per 100,000 population for African Americans, 344 per 100,000 for Hispanics, and 155 per 100,000 for Whites. Chlamydia cases reported in 2000 numbered 26,962 for this age group and accounted for over 30% of all cases reported. The chlamydia case rates for those aged 15 to 19 were 3,961 cases per 100,000 population among African Americans, 1,641 per 100,000 for Hispanics, and 610 per 100,000 for Whites. The true incidence of chlamydia may be much higher because it is usually asymptomatic and detected only by the screening of those seeking medical care for other reasons.

Although young people have a greater risk of being infected with an STD other than HIV, these "traditional" STDs receive less attention than HIV. Prevention methods for both HIV and STDs overlap, but teaching adolescents to recognize the symptoms of traditional STDs and to seek treatment early may prevent more severe forms of the diseases from developing. Educational programs and preventive messages need to be developed and delivered by parents, teachers, religious leaders, youth leaders, professionals working with adolescents, peers, media, and role models. Young people themselves, serving as peer educators, should be enlisted and relied upon as an important part of all STD prevention efforts.

Figure 15. Chlamydia and Gonorrhea Cases Reported By Age Group, 2000



	0-09	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45+
Chlamydia	369	1,631	26,962	24,133	8,890	3,462	1,503	662	549
Gonorrhea	148	661	10,316	10,305	4,778	2,545	1,796	1,079	1,006

V. HIV PREVENTION AND SERVICES

The three components of the HIV Prevention program are Health Education and Risk Reduction (HERR), Prevention Counseling and Partner Elicitation (PCPE), and Public Information. All components of the prevention program are planned through a community planning initiative mandated by the CDC in 1993.

Community Planning

Community planning is the process that enables local communities to identify, plan, and determine HIV/STD prevention priorities within their regions. Community planning in Texas has evolved from a single decision-making body heavily influenced by TDH, to a body of ten HIV Prevention Community Planning Groups (CPGs), to a partnership with six CPGs that represent the geographic and cultural diversity of Texas. The CPGs are responsible for determining community priorities and intervention strategies based on local and regional needs assessment. The CPGs and the TDH jointly develop a comprehensive HIV prevention plan that identifies populations with the highest rates of HIV infection and prioritizes interventions and strategies to prevent HIV infection in identified populations. The TDH uses this plan to allocate HIV prevention funds through a competitive Request for Proposal process.

The goal for each CPG is to include members who represent the unique profile of affected populations within its jurisdiction. An open nomination process for membership ensures parity, inclusion and representation from those most affected by HIV, such as those who are affected, infected and at highest risk for HIV infection; persons with expertise in social and behavioral science and epidemiology; and local HIV prevention workers. Members of the CPGs represent the cultural, ethnic and other diversities of the Texas population most affected by HIV and AIDS within each CPG jurisdiction.

The CPGs completed a two-year planning cycle (1997-1998) in September of 1998. During this planning cycle, the CPGs reviewed epidemiologic and needs assessment data, behavioral science literature on prevention interventions, and completed a priority setting process to develop the Regional Action Plans. The 1999 Comprehensive HIV Prevention Plan submitted to the CDC in October of 1998 for implementation years 1999 through 2002 is a compilation of the ten Regional Action Plans.

Throughout 2000 and into 2001 the six Community Planning Groups began the process of the development of new plans that will be submitted to CDC in the fall of 2002 and will be implemented in January 2003. These plans reflect a new format with more specific prevention intervention selection for at risk populations, a result of improved use of behavioral data in decision-making processes.

Accomplishments

- TDH increased technical assistance to CPGs to improve the ability and capacity to produce locally representative HIV prevention plans. The technical assistance included training in infrastructure development, assistance in analysis of epidemiologic data, guidance in applying behavioral science theory to prevention interventions, and needs assessment data collection methods.

- The CPGs and TDH in partnership redesigned and implemented a new geographical structure, known as area planning jurisdictions. The purpose of restructuring CPGs was to enhance their capacity to perform multiple and complex planning processes, and to assist rural CPGs in maintaining parity, inclusion and representation in the process.

- Members of the CPGs attended several state and national meetings and conferences throughout the year in order to gain knowledge, as well as share information with other jurisdictions on innovative practices in community planning in Texas.

- CPG members participated in a workgroup to develop a standardized resource inventory tool.

- CPG members attended a series of local trainings that were used to develop and enhance their skill in the development of Area Action Plans that will be more specific for the population targeted for risk behaviors.

- TDH, with community input, redesigned the plan format to be more user-friendly for the community members compiling the plans.

- The CPGs performed the following activities to prepare for the writing and completion of Area Action Plans that are to be completed in early 2002:

    - Reviewed new HIV Epidemic Profiles that were produced by the Bureau's Research and Program Evaluation Branch
    - Identified at risk populations to survey in a targeted needs assessment process.
    - Conducted a standardized targeted needs assessment.
    - Developed and conducted a resource inventory.
    - Reviewed needs assessment and resource inventory data that has been collected during the year.
    - Reviewed prevention intervention matrices and behavioral science information to improve the selection of targeted and specific prevention interventions for each identified at risk populations.

Future Plans

The following goals were adopted for the community planning process in Texas for 1999, 2000 and 2001. In early 2002, CPGs and TDH will assess and revise these goals to reflect the desired achievements for the current planning cycle:

- Improve the needs assessment process by developing minimum standards for collecting qualitative and quantitative data on subpopulations and resource inventory data on existing programs.

- Strengthen the infrastructure of CPGs by maximizing technical assistance resources including the use of current technology.

- Collaborate with Ryan White Title I Planning Councils, Ryan White Title II Consortia, and other HIV/STD planning groups by exchanging information and by mutual participation in local planning activities.

- Integrate STD resources and expertise in the development of comprehensive HIV prevention priorities in the regional action plans.

- Adhere to the Party, Inclusion, and Representation guidelines by all CPGs.

- Restructure CPGs to ensure the effective implementation of the principles of community planning.

Health Education and Risk Reduction

The goal of the Health Education and Risk Reduction (HERR) component is to educate persons at high risk for HIV about disease transmission, assist them in establishing realistic and personalized risk reduction plans, and to provide them with the skills to prevent transmission of HIV. During 1998, TDH staff developed and managed a competitive application and review process for selecting HERR contractors who began providing these services for their communities in January 1, 1999. This competitive application was based on plans developed by the ten community planning groups, using the process outlined in the previous section. These plans will remain in place until the new planning stage, currently underway, is implemented in January 2003.

During 2000, both local health departments and community-based organizations provided HERR services. These contractors targeted one or more of the specific populations named in their Regional Action Plan (e.g., African-American injection drug users, men who have sex with other men, women at risk through heterosexual transmission, etc.), and provided these populations with educational interventions with demonstrated effectiveness that were culturally sensitive, language-

appropriate, and appropriate to the settings in which the clients are encountered. In keeping with the guidance provided by the communities' plans, the majority of the HERR direct delivery staff were peers to the populations they served[4], which helps establish and maintain the rapport necessary for effective communication. They conducted activities in a variety of sites, such as community hangouts, streets, parks, local jails, STD clinic waiting rooms, local health department clinics, and other local agencies.

TDH staff provided technical programmatic assistance, as well as conducted monitoring of HERR contractors. In addition, TDH staff provided assistance to organizations to help them evaluate their programs and demonstrate the effectiveness of their interventions. This ensures that contractors are effective in their implementation of HIV prevention interventions and that contract dollars are spent in accordance with accepted contract objectives. Another important role of this component is to provide ongoing information and HIV educational material to both contractors and non-contractors for distribution to the general public.

Accomplishments

- HERR contractors provided 178,426 educational contacts to men who have sex with men (M/MS), injection drug users (IDU), and high-risk heterosexuals in a variety of community-based settings. Contractors exceeded objectives in all categories of behaviorally-defined target populations.

- HERR contractors also provided 184,091 skills-building contacts to gay men, injection drug users, and high-risk heterosexuals in a variety of community-based settings. Contractors exceeded objectives in all categories of behaviorally-defined target populations. This represented a 20% increase in skills-development contacts in 2000 over those reported in 1999.

- HERR contractors distributed over 4.1 million condoms throughout the State.

- TDH successfully used the HERR contact reporting system to identify gaps in coverage for HIV prevention services, and issued an RFP designed to provide funding to close prevention services gaps for M/MS and IDU in areas with high numbers of living HIV and AIDS cases.

Future Plans

- TDH will continue to direct HERR contractors to provide HERR interventions in outreach settings and to have peers of the targeted population provide these interventions. Peer outreach will be conducted in locations identified in Regional Action Plans where high-risk activity takes place or where members of the populations being targeted congregate. In addition to individual level interventions, group and community level interventions will be undertaken.

[4] Peer means that the worker was either a member of the group being targeted (e.g., gay man, former injection drug user, Hispanic woman) or is sensitive to and experienced with the issues affecting that population.

- With the cooperation of the University of Texas Southwest Medical School, TDH will develop methods to evaluate HERR interventions and programs for quality improvement and to assist in demonstrating the effectiveness of activities, and monitor the outcomes associated with these programs.

- TDH will develop programs to increase the number of science-based and evidence-based HERR programs in the State.

Prevention Counseling and Partner Elicitation

TDH provides Prevention Counseling and Partner Elicitation (PCPE) services throughout the State through contracts with local health departments and community-based organizations. Prevention counseling is client-centered, interactive and responsive to individual client needs. The focus of prevention counseling is on developing prevention goals and strategies with the client rather than simply providing information. Counselors must understand the unique circumstances of each client (e.g., behaviors, sexual orientation, race/ethnicity, culture, knowledge level, social and economic status). Counselors engage clients in Test Decision Counseling, a process to help clients reach their own decisions about whether to test for HIV, that includes assessing and supporting client readiness for testing and coping with the results.

When clients return to learn their test results, they receive personal post-test prevention counseling. If the client tests negative for HIV infection, results counseling reinforces behavior changes identified by the client to keep from becoming infected. If the client tests positive for HIV, post-test counseling encompasses a range of issues including referrals to medical, psychological and social services. The counselor also elicits the names of sex and/or needle sharing partners in order to assist the client in ensuring these partners are notified of their potential exposure to HIV and offered the opportunity to receive counseling and learn their HIV status. Trained Disease Intervention Specialists at local health departments or the clients conduct these notifications. Finally, post-test counseling reinforces behavior changes the client has identified to maintain personal health and prevent transmitting the infection.

TDH staff provide technical assistance and monitoring to contractors to ensure compliance with objectives and appropriate use of program funds. TDH maintains PCPE data collection and reporting systems that provide important information for planning and implementing prevention activities. Each time an initial counseling session is done with a client, the counselor fills out a standard machine-scannable bubble form that contains demographic and mode of exposure[5] information

[5] Most PCPE clients have multiple risks for HIV. Mode of exposure is a way of categorizing clients by the risk behavior that they report that is most likely to expose them to HIV. The modes of exposures are listed in order of risk of transmission of HIV, beginning with the riskiest. The modes are: 1) male to male sex with injection drug use (M/MSIDU), 2) male to male sex (without injection drug use) (M/MS), 3) injection drug use (without male to male sex) (IDU), 4) heterosexual sex (F/MS), 5) other tissue/blood exposures (e.g., occupational exposures, transplants), and 6) no indicated risk for HIV (NIR).

about the client, as well as information about the counseling session (e.g., date, if an HIV test was performed, result of HIV test, if client returned for follow up counseling). These forms are submitted to TDH, where they are compiled and analyzed, and the data are forwarded to the CDC in Atlanta.

In FY 2000, contractors reported 123,816 initial counseling sessions. Fifty-three percent (54 percent) of these sessions were with male clients, and 46% with females.

Table 4. Publicly Funded HIV Tests and Positives by Sex and Race/Ethnicity

	Male		Female	
	Tests (%*)	Positive (%*)	Tests (%*)	Positive (%*)
White, non-Hispanic	23,776 (36.3)	387 (31.1)	19,638 (34.9)	91 (21.7)
African American, non-Hispanic	18,705 (28.5)	464 (37.3)	16,306 (28.9)	243 (57.9)
Hispanic, all races	21,755 (33.2)	374 (30.1)	19,297 (34.3)	82 (19.5)
Asian/Pacific Islander	77 (0.1)	3 (0.2)	45 (0.1)	1 (0.2)
American Indian/Native American	521 (0.8)	6 (0.5)	458 (0.8)	0 (0)
Other, multiracial	240 (0.4)	3 (0.2)	207 (0.4)	2 (0.5)
Unknown/Missing	466 (0.7)	6 (0.5)	383 (0.7)	1 (0.2)
Total	65,540	1,243	56,334	420

* Small numbers make proportions unstable.

During FY 2000, 96% of the initial counseling sessions included an HIV test. Of these tests, 41% were for clients who had never tested for HIV before. For every 100 tests performed, 1.3 were HIV positive. This rate is a slight increase over the positivity rate reported in 1999 (1.0 positives / 100 tests). The race/ethnicity and mode of exposure of the men and women who tested and who tested positive for HIV are shown in **Figures 12 and 13**. Positivity rates were nearly two times higher for African Americans than Hispanics and Whites, and rates of positivity were nearly three times higher for men compared to women (1.9 positives per 100 tests for men, 0.7 positives per 100 tests for women). Across risk groups, men who reported sex with men and using injection drugs (M/MS/IDU) and men who reported sex with men (M/MS) had positivity rates five and four times higher, respectively, than injection drug users (IDU) or men and women at risk through heterosexual sex (F/MS). The race/ethnic distribution of women testing HIV-positive is especially noteworthy: African-American women make up 29% of the HIV tests done for women, but 58% of the positive tests were among African American women.

Accomplishments

- In 2000, TDH staff assisted the City of Houston with adopting the revised scannable form for its contractors and assisted contractors with training and technical assistance in the use of the form (Note: the City of Houston receives separate funding for its HIV prevention efforts from TDH and is responsible for its own community planning process, data collection, and monitoring process).

- PCPE contractors provided 123,816 initial counseling sessions in FY 2000. Of these 1,663 were positive for HIV. This positivity rate, 1.3 positives per 100 tests, was 0.3 positives per 100 tests higher than the rate in 1999.

- More than 61% of the HIV-positive clients counseled at PCPE contractor sites who returned for their test results were successfully referred to medical care and social services for their HIV infection.

- Information derived from the initial year of use of the new scannable form created in 1999 has been used to develop a "risk profile" for use in community planning.

Table 5. HIV Tests and Positives by Sex and Mode of Exposure BDTP - Risk Since 1978 * Result of Test * Client's sex Crosstabulation Count

	Male		Female	
	Tests (%*)	Positive (%*)	Tests (%*)	Positive (%*)
M/MS/IDU	1,553 (2.4)	100 (8.0)	--	--
M/MS	11,946 (18.2)	657 (52.9)	--	--
IDU	10,344 (15.8)	126 (10.1)	6,744 (12.0)	55 (13,1)
F/MS	41,073 (62.7)	340 (27.4)	48,651 (86.4)	358 (85.2)
NIR	624 (1.0)	20 (1.6)	939 (1.7)	7 (1.7)
Total	65,540	1,243	56,334	420

* Small numbers make proportions unstable.

Future Plans

- TDH will continue to increase the proportion of those individuals receiving an HIV test who return for results counseling to learn their HIV status.

- TDH will continue to assure that those clients who test positive for HIV are successfully linked into a system of care.

- PCPE contractors will continue to use counselors who are peers of the targeted populations in order to expand accessibility.

HIV SERVICES

The reauthorized Ryan White CARE Act Amendments of 2000 made legislative changes designed to improve and expand access to care, increase accountability, and enhance service capacity in underserved urban and rural communities. Primary themes in the new legislation include:

- Improved access to care for persons living with HIV aware of their serostatus but not in care.
- Quality management and health services.
- Capacity development for planning councils, States, and CARE consortia.
- Targeting resources to meet the needs of underserved communities/populations increasingly affected.
- Coordination and linkages with other publicly-funded programs such as Medicaid, State Children's Health, Insurance Programs, Maternal and Child Health Programs, Community Health Centers, and providers of services to the homeless and substance user.

Texas initiated a three-year project in May 1997 to develop a statewide coordinated statement of need (SCSN) for HIV/AIDS service delivery throughout the State. In addition, the project promotes communication and cooperation between those who are planning the delivery of services to those affected by HIV/AIDS and the various regional CPGs. A steering committee structure has guided the implementation of the Texas SCSN planning activities. The SCSN Steering Committee includes clients and persons living with HIV and AIDS, and representatives from Ryan Care Act Titles I, II, III, IV, Part F programs, CPGs, and TDH. The 17-member steering committee also represents the cultural, ethnic, age, gender, and geographic diversity of Texas. The SCSN meets on a quarterly basis to review the progress of the project, address concerns, and identify future goals and objectives for the project.

The overarching goal of the project is to collaborate in the development of a SCSN for HIV/AIDS service delivery and infrastructure at the local and state levels of the State of Texas. This goal is based on the expectation that collaboration and coordination will strengthen the capacity of HIV/AIDS service providers to provide more efficient services while also helping to identify significant cross-cutting issues that must be addressed at the local and state levels.

Service Delivery

In FY 2001, the Bureau of HIV and STD Prevention distributed over $20.6 million in HIV services contracts throughout the State. To award HIV services funds as extensively and equitably as possible, the Bureau divides the State into 26 HIV Service Delivery Areas (HSDAs) and seven planning areas. TDH contracts with administrative agencies to manage the delivery of services. The

funds available to each HSDA are determined through a new funding formula based on three factors at the following weights:

- 50% Number of reported living cases of HIV and AIDS in the HSDA;

- 30% Number of unduplicated clients receiving at least one publicly-funded service in three non-consecutive, randomly selected months from July 1999 through June 2000;

- 20% Percent of the HSDA population that is eligible for Medicaid (indicates economic distress of a community and is highly correlated with poverty).

Basic HIV services supported by TDH contracts with local health departments and community-based organizations include: ambulatory/outpatient medical care, hospice care, case management services, insurance assistance program, dental care, nutrition services, medications, home health care, mental health therapy, substance abuse treatment/counseling, and support services such as direct emergency financial assistance, food bank, housing, and transportation.

Physical and mental health services enable HIV-infected persons to remain healthier and independent, extending the time they can care for themselves and others without support. HIV services reduce the need for expensive hospitalizations and more costly treatments by providing preventative services and less costly home-based care. Since many HIV/AIDS clients are impoverished by the disease, they must rely on publicly-funded care. Providing cost-effective HIV services benefits all Texas residents by reducing health care costs supported by taxpayers.

Accomplishments

- TDH began a restructuring of the planning and administration of HIV services in Texas that will assist in making these activities more manageable both in the local community and at the state oversight level. External stakeholders were involved in recommending parameters and providing suggestions for the restructuring process. During this period, the twenty-six planning areas were consolidated to seven and eight new administrative agencies selected.

- In June 2000, the SCSN Steering Committee met and approved the Spring 2000 Edition of the Guide to Conducting a Needs Assessment. This guide identifies and describes the components of a comprehensive needs assessment; recommends particular actions in planning needs assessment activities, collecting the appropriate information and data, analyzing the data collected, and using the findings through report preparation; and provides a glossary, both English and Spanish copies of a client survey instrument, and a resource inventory tool.

- TDH funded seven new Ryan White Services Projects specifically to reduce barriers and improve access to HIV health and social services for underserved and emerging populations.

- In FY 2001, TDH received $144,865 in supplemental RW funds for the federally-defined emerging community of El Paso. These funds were contracted to Centro De Salud Familiar La Fe for the following services: Medication/Drug Assistance, Health Insurance Reimbursement, Direct Financial Assistance and Dental Services.
- On July 31, 2001, TDH published a Request for Proposals (RFP) to create intensive case management systems to establish and maintain participation by minorities in the Texas HIV Medication Program (THMP). A total of $477,014 per 12-month period was earmarked for this program. The target populations to be served are African Americans, Hispanics and others with HIV in the State's two highest morbidity counties, Harris and Dallas, who are: (1) incarcerated in federal, state or local adult and juvenile institutions, or (2) recently released back into these two counties.

Future Plans

- TDH will continue to reduce the number of Administrative Agencies from the original 26 to no more than 12.
- TDH will continue to fund Ryan White Services Projects that are specifically targeted to reduce barriers and improve access to HIV health and social services for underserved and emerging populations.
- TDH will implement a program to increase minority participation in the Texas HIV Medication Program.

Housing Opportunities for Persons with AIDS (HOPWA)

The Housing Opportunities for Persons with AIDS (HOPWA) program provides emergency housing assistance and rental assistance to eligible persons with HIV/AIDS and their families. The primary objective of HOPWA is the provision of assistance to continue independent living for persons with HIV/AIDS and their families in Texas. During this reporting period, TDH received $2,529,000 in funds from the U.S. Department of Housing and Urban Development (HUD) for the HOPWA program. Twenty-five of the State's 26 HIV Services Delivery Areas (HSDA), receive HOPWA funding through an administrative agency serving the HSDAs.

The Emergency Assistance Program provides short-term rent, mortgage, and utility payments to prevent homelessness. This program enables low-income individuals with HIV that are at risk of becoming homeless to remain in their current residences for a period not to exceed 21 weeks in any 52-week period. The Rental Assistance Program provides tenant-based rental assistance, including assistance for shared housing arrangements. It enables low-income clients to pay their rent and utilities until there is no longer a need, or until they are able to secure other housing.

Accomplishments

- In FY 2001 the HOPWA program provided housing assistance to 2,863 persons with HIV/AIDS and their families.

VI. STD PREVENTION AND SERVICES

STDs are a major threat to the health of Texans. Young women and their children are especially at high risk for STDs and the resultant complications. Babies born to infected mothers are often the ones to suffer the most from STD infections. STDs such as syphilis and HIV can be passed to the fetus through the mother's blood while she is carrying the child or transmitted at delivery. Others, such as gonorrhea, chlamydia and herpes, may also be transmitted to the newborn at the time of delivery. STDs in children can lead to fetal death, retardation, crippling, blindness, deafness, pneumonia and low birth weight. STDs in women can lead to chronic debilitating pain, ectopic pregnancy, sterility, cancer and death. Adolescents are at higher risk for acquiring STDs for several reasons: a tendency to have multiple partners, to have unprotected sex, and to select partners who are at high risk. Adolescent women have a physiologically increased susceptibility to infection; furthermore, teenage women have steadily increased their number of premarital sexual encounters during the past two decades. At the same time, adolescents often encounter the most obstacles to seeking health care. STDs are a particularly significant health problem for economically disadvantaged minority populations.

For every $1 spent on early gonorrhea and chlamydia detection and treatment, $12 in associated costs could be saved. [6]

The goal of the STD prevention and services program is to prevent the spread of high priority STDs such as syphilis, HIV, chlamydia, and gonorrhea. The foundation of this effort is built on six primary components: community/individual behavior change; surveillance/data management; partner services/disease intervention; medical/laboratory services; leadership/program management; and training and professional development. Five of these components are discussed below; training and professional development activities are addressed in the Training and Public Education section of the report.

Dramatic changes in the health care industry in recent years have meant that health departments no longer serve as sole source providers of STD prevention and control services. The responsibility for STD service delivery has been increasingly spread among members of private health care systems, such as HMOs. The Bureau undertakes activities to empower communities in the identification and meeting of these needs. STD program personnel around the State participate in HIV Community Planning Groups and collaborate with community based organizations to provide outreach, screening and treatment services to at-risk populations in non-traditional settings. Of particular note are the Infertility Prevention Project and the Syphilis Elimination Project. The IPP

6 Institute of Medicine. The Hidden Epidemic: Confronting Sexually Transmitted Diseases. Washington, DC: National Academy Press, 1997, p.7.

provides resources to fourteen local health departments and Title X Family Planning Clinics for the screening and treatment of women and their partners for chlamydia and gonorrhea. The Syphilis Elimination Project funds the Dallas County, Houston and San Antonio Metropolitan Health Departments, as well as local community coalitions, for enhanced outreach and disease intervention activities.

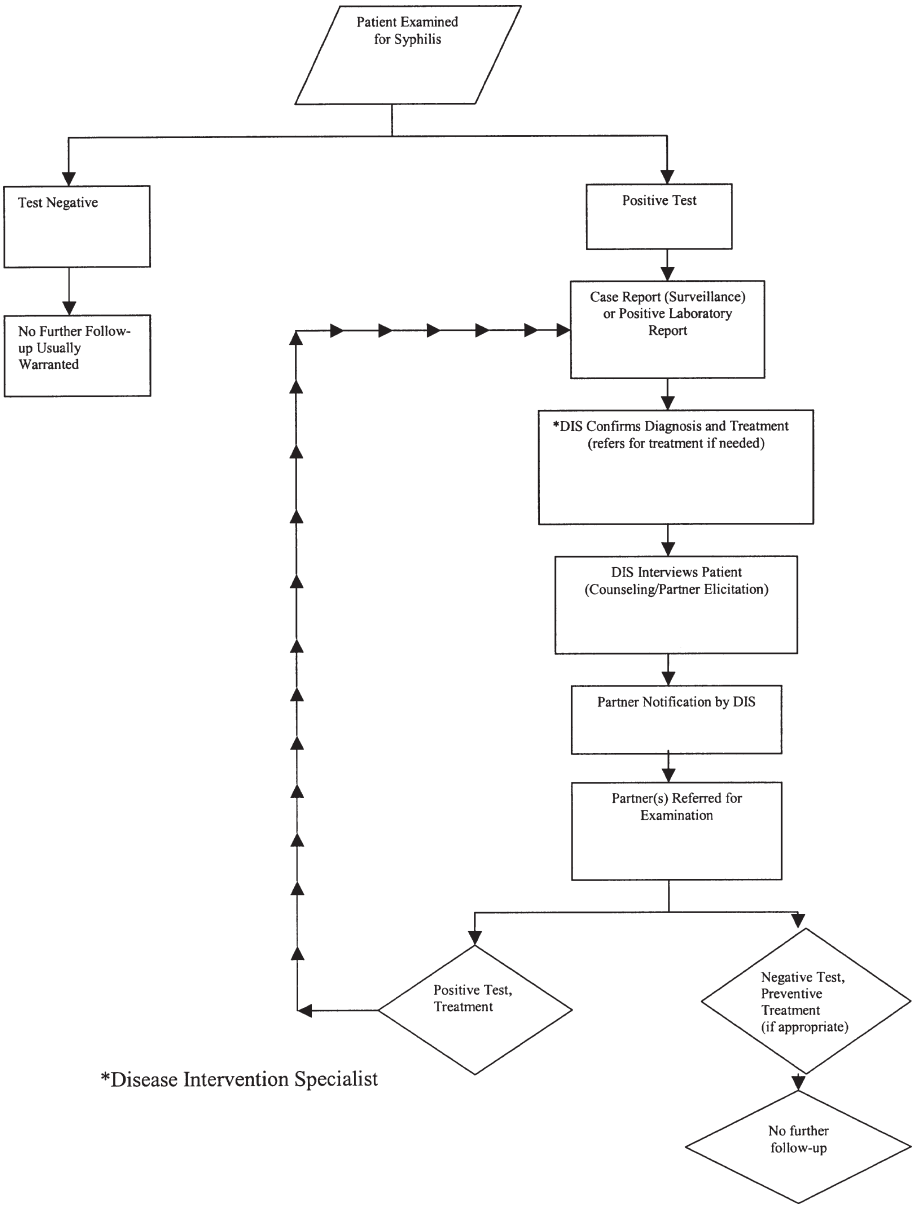
Surveillance, the collection and analysis of data about the occurrence of disease, is crucial to the success of any disease control effort. Health care providers and laboratories in Texas are required to report syphilis, gonorrhea, chlamydia, chancroid, AIDS, and HIV infections. Analyzing case reports provides information needed by TDH and local health departments to plan appropriate prevention and control activities and predict disease trends. The Bureau uses the STD Management Information System, a CDC-developed computerized morbidity surveillance system. Both TDH regional HIV/STD programs and local health department programs collect disease reports within their jurisdiction, and transmit the information to TDH. TDH monitors the extent of the statewide STD problem and changes in demographic and geographic distribution of cases. This information is used to prioritize needs, allocate program resources, and plan and direct activities to respond to changing conditions.

Highly trained DIS routinely perform syphilis and HIV counseling/interviewing, case management, and partner notification and service activities for individuals with STDs. In certain locales where resources permit, they also perform targeted gonorrhea and chlamydia case finding, as well as targeted prevention counseling, to clients identified as high risk for STDs. PCPE activities are routinely performed with infectious syphilis and HIV-infected individuals. PCPE is conducted with both gonorrhea and chlamydia clients as resources allow.

The disease intervention process usually begins when a DIS receives a report of an infected or at-risk client. The DIS locates the person, refers him/her for examination and treatment, and counsels him/her on methods to reduce the risk of acquiring or transmitting STDs and HIV in the future. The DIS elicits the names, addresses, and other locating information of sex and/or needle sharing partners, and through field investigation, locates and refers these partners for examination, treatment and/or counseling. The cycle **(see Figure 16)** continues with the identification of each infected partner. When a contact is notified, they are <u>not</u> told who identified them as a potential contact. All disease intervention activities are completely confidential. TDH funds disease intervention activities through its regional programs and through contracts with eleven local health departments.

The Bureau purchases and distributes medicines for the treatment of priority STDs to regional and local health departments and other key providers through the Clinical Resource Division's Texas HIV Medication Program, which is highlighted later in this report. The Bureau provides resources for screening high risk clients for gonorrhea, chlamydia, HIV and syphilis through the State laboratory system and ocassionally funds private physicians to examine and treat STD patients in areas where no publicly funded facilities are available. TDH also funds STD examinations and treatment at three Baylor College of Medicine Teen Clinics in Houston, which serve high risk adolescent

Figure 16. The Disease Intervention Process



females who otherwise would not seek health care. This partnership ensures that at-risk teenagers in Houston have access to needed STD services.

TDH's leadership and management keep the program focused on maintaining high standards for STD contractors around the State and acquiring the technical skills and knowledge to remain proactive in a changing health care environment. TDH has developed guidelines and established standards for STD program performance. Regional and local STD programs provide detailed reports on morbidity and progress on objectives semi-annually.

Accomplishments

- DIS interviewed and managed 1,380 syphilis cases during 2000; as a result of disease intervention activities among high risk associated individuals (i.e. partners), 433 new cases of syphilis were identified and treated, and 805 persons were preventively treated for syphilis.

- 2001 was the second year of CDC funding for the Syphilis Elimination Project, which enhances syphilis outreach, screening and surveillance in the State's High Morbidity Areas (HMAs), Dallas and Harris counties. As part of the project, TDH, as well as local STD Programs in the HMAs, developed and implemented state and local Syphilis Elimination Plans, which include Rapid Response Plans to facilitate containment of unusual increases in syphilis morbidity. Community coalitions made up of public and private organizations representative of and serving populations affected by syphilis participated in development of local plans and joined local health departments in outreach and screening activities among high risk populations.

- Screening for syphilis was increased in adult and juvenile corrections facilities in the two HMAs, as well as in Bexar County, where an unusual increase in syphilis cases began during 2000 and continued through 2001.

- DIS provided PCPE to 1,286 HIV-positive individuals in 2000, resulting in the location, counseling, and testing of 1,968 HIV sex/needle sharing partners. DIS successfully referred 1,152 (89.6 percent) of the HIV-positive individuals to early intervention services.

- During 2000, the gonorrhea screening program tested 295,969 persons, identified 13,066 positives (4.4 percent) and confirmed treatment on 12,479 (95.5 percent) of those infected. The chlamydia screening program tested 294,706 persons, identified 21,222 positives (7.2 percent) and confirmed treatment on 20,374 (96.0 percent).

- Through the CDC-funded Infertility Prevention Project, the Bureau of HIV and STD Prevention collaborated with the TDH Bureau of Laboratories, the TDH Family Planning Division and its family planning contractors to provide STD screening and medication to clients statewide.

- In 2001, TDH regional STD programs and state-funded local STD programs conducted 267 presentations to local, state, national and international audiences, reaching a total of 14,974 individuals. Of special note is a presentation by Public Health Region (PHR) 11 STD staff on STD trends, statistics and program activities in the border area to the U.S.-Mexico Border Health Association's Sister Cities Conference held May 25, 2001. As a result of the conference, workgroups were formed to explore possible bi-national cooperation in disease surveillance, treatment and prevention in the border area.

- TDH has been active in promoting the use of electronic laboratory reporting to accelerate case reporting and enhance the disease intervention process. As of 2001, ten private laboratories around the State utilize electronic laboratory reporting, making electronic reports available daily to local health departments in Dallas, El Paso, Fort Worth, Houston, San Antonio, Waco, Wichita Falls and TDH PHRs 1, 7, and 8.

- A streamlined STD Client Satisfaction Survey in both English and Spanish was provided to local STD programs to support TDH's quality assurance system.

- TDH completed the design of an instrument for the assessment of STD screening practices among private providers and selected managed care organizations in four geographical areas in the State. The Office of Survey Research at the University of Texas at Austin will conduct the survey; results from the survey will be available in 2002.

Future Plans

- Local and regional STD programs will continue to collaborate with public and private organizations such as jails, youth detention centers, homeless shelters, and neighborhood health facilities to provide outreach and screening for populations at risk for acquiring and transmitting STDs.

- Collaborative activities for 2002 will include continued exploration of additional areas for STD and HIV coordination to best utilize program resources and improve or expand delivery of services, especially regarding women offered STD screening outside of STD clinics.

- TDH will continue to urge high volume laboratories around the State to institute electronic laboratory reporting, including the TDH laboratory, which serves many local and regional STD programs.

- TDH will continue implementation of its Syphilis Elimination Plan, responding rapidly to increased syphilis morbidity by working with affected communities to enhance outreach, screening, and disease intervention activities.

- TDH will study the feasibility of adopting amplified DNA technologies for chlamydia and gonorrhea testing, which is expected to increase the detection of morbidity of these diseases in the short term, and lead eventually to enhanced disease prevention and intervention.

VII. TRAINING AND PUBLIC EDUCATION

The overall mission of the Training and Public Education Branch (TPEB) is to develop and provide accurate, specialized HIV/STD information and training to diverse audiences using effective and appropriate methods of communication and education. To accomplish its mission TPEB collaborates with programs across TDH, other State agencies, local health departments, and community based organizations involved in HIV and STD prevention activities.

Specific TPEB activities include providing training courses such as the four-day HIV/STD/Viral Hepatitis *Prevention Counseling/Partner Elicitation* (PCPE) course, the 10-day *Introduction to Sexually Transmitted Disease Intervention* (ISTDI) course, the two-day course *STD Facts and Fallacies*, and the one-day cultural competency course entitled, *The Never Ending Journey*.

Accomplishments

- TPEB provided training for the Centers for Disease Control and Prevention (CDC) Options research project October 16-20, 2000 in conjunction with the University of California, San Francisco. The Options research project is an epidemiological and clinical intervention study of persons with recent HIV infection.

- Two trainers from TPEB planned, developed and piloted a peer counselor development workshop within the Gatesville Women's Prison. This project, a collaboration between AIDS Foundation Houston (AFH), Texas Department of Criminal Justice (TDCJ) and TDH, resulted in five days of skills building facilitated by the TPEB trainers, September 24 – 29, 2000.

- The Prevention Training Center III (PTC-III) grant application for continued funding was completed and renewed. The contract period is from April 1, 2001 through March 31, 2002. The grant was initially received by TDH, HIV/STD Health Resources in April 2000. The continued funding allows TDH to continue to sub-contract with the Dallas County Health and Human Services and the University of Texas Health Science Center at San Antonio, School of Nursing to provide partner services training to the southeastern quadrant of the United States (a total of 13 states).

- A one-day HCV Prevention Counseling training was delivered to all 20 HCV pilot testing sites during October 2000. In response to demand, additional trainings were given in PHRs 6 and 3 during January 2001. TPEB has also made all course materials available online for trainers around the nation.

- TPEB developed and delivered training materials for the integration of HCV counseling and testing into existing HIV counseling and testing activities. These training materials include a self-paced study module, demonstration videos, and a one-day workshop with lecture, role plays and other activities.

- TPEB staff received approximately $60,000 in Syphilis Elimination funding to be used for developing educational media. Approximately $20,000 was spent on the Spanish translation and printing of two pamphlets describing the partner notification process, “What About Your Partners?” and “What If I’ve Been Exposed to an STD?” The remaining $40,000 was spent developing and producing a poster and matchbook-style condom folder to be used in neighborhoods affected by a syphilis outbreak. These materials will only be used in areas affected by an elevated incidence of syphilis.

- TPEB staff answered approximately 920 public information requests (PIRs) during FY 2001, not including requests taken through the HIV/STD InfoLine. The majority of PIRs included requests for HIV/STD educational materials, community resource directories, HIV/AIDS/STD surveillance and seroprevalence data, conference information, and administrative information (policies/rules/guidelines).

- The Bureau held the 13th Texas HIV/STD Conference at the Hyatt Regency on Town Lake in Austin, Texas on April 16-20, 2001. Just over 1,000 health professionals from Texas and around the country attended the conference. The four-day conference featured over 150 speakers presenting topics ranging from HIV prevention and treatment to syphilis elimination and hepatitis C. The conference website can be found at www.tdh.state.tx.us/hivstd/educate/conf/2001.

- During 2001, TPEB staff added a Spanish language educational tape on Chlamydia to the Texas Department of Health HIV/STD Info Line. A total of 2,561 calls were routed to an attendant during the first 9 months of 2001. Of all the calls answered by an attendant, approximately 98% were from English-speaking callers and approximately 2% were from Spanish-speaking callers. Types of requests included HIV testing (36%), risk assessment (13%), signs and symptoms (7%), community resource directory requests (0%), social services (5%), statistics (1%), treatment (1%), infection control (1%), educational materials (3%), STDs (26%), Hepatitis (1%), Other (6%).

- TPEB staff facilitated 14 video teleconferences (VTCs) during 2001. TPEB’s VTC program is designed to provide health professionals with ongoing, up-to-date information on prevention, intervention, treatment, and related news on HIV, AIDS, STDs, other infectious diseases and related public health topics.

VIII. HIV/STD CLINICAL RESOURCES

The Clinical Services Section was officially reorganized on April 1, 2000, to become the HIV/STD Clinical Resources Division (CRD). The CRD is composed of three programs: the Texas HIV Medication Program (THMP), the Clinical/Case Management and Administrative Compliance Program and the Early Intervention Program (EIP). The CRD is also responsible for managing the HIV/AIDS Interagency Coordinating Council.

The primary mission of the CRD is to enhance the lives of individuals with HIV disease by providing life-sustaining medications, and ensuring quality clinical and case management services are available and accessible.

THMP:

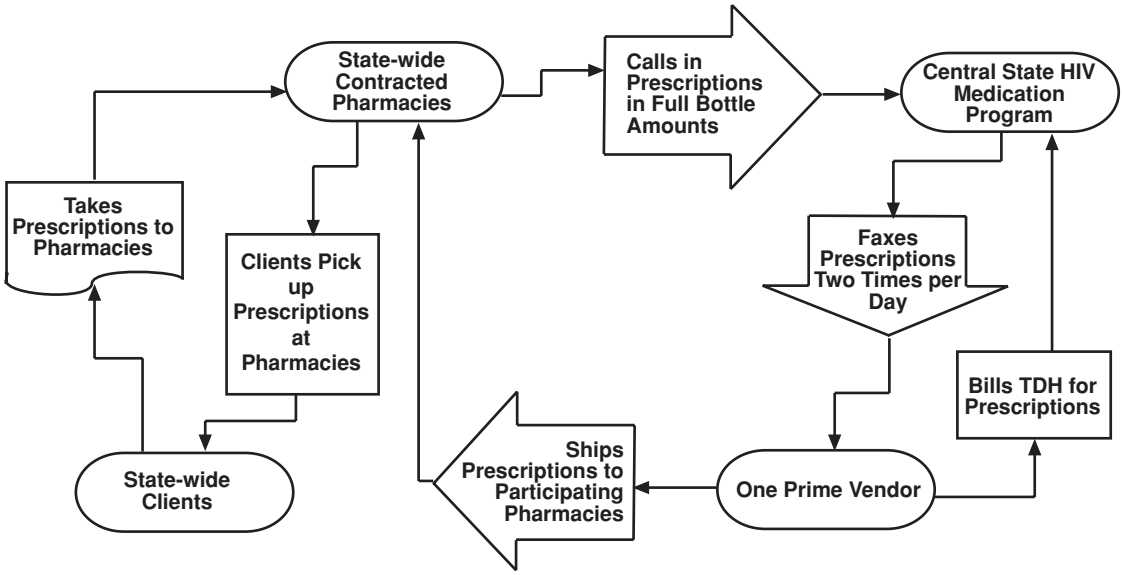
THMP is responsible for the purchase and distribution of medications for the treatment of HIV disease and other sexually transmitted diseases. THMP also provides medications for the treatment of opportunistic infections for people with HIV disease. Medications for the treatment of HIV disease are provided to clients through a network of pharmacies statewide. The HIV Medication Advisory Committee is also managed by THMP.

THMP is the official AIDS Drug Assistance Program (ADAP) for the State of Texas. THMP provides medications to HIV-infected individuals qualifying for enrollment in the program through 238 participating Texas pharmacies across the State. To qualify for enrollment the individual, spouse, and children residing in the home under the age of 18 must have an adjusted gross income that falls at or below 200% of the current federal poverty income guidelines. THMP purchases and distributes over $42.9 million annually in antiretroviral drugs and other prophylactic medications.

Since its inception in late 1987, THMP has provided HIV medications to over 30,000 Texans. Currently, the program receives and approves more than 176,000 medication orders each year. The medications help delay the onset of symptomatic disease and prevent opportunistic infections in persons living with HIV disease. **Figure 17** shows how the program operates to ensure that qualified individuals anywhere in Texas have access to needed medications.

THMP develops and maintains confidential data files that provide valuable statistical information regarding medication usage to the Surveillance section of the HIV/STD Epidemiology Division, service providers, and lawmakers while preserving client confidentiality. THMP also collaborates with the Medicaid Vendor Drug Program to ensure optimum service delivery and avoid duplication of services. In order to maximize its medication purchasing flexibility and utilization of funds, THMP developed and maintains its own accounting systems.

Figure 17. The Texas HIV Medication Program



In addition to its regular services, THMP operates the Medication Reimbursement Initiative (MRI). This program, formerly known as the Pilot Insurance Program, is operating in its sixth year of existence. The MRI program pays the deductibles and co-insurance payments required by the insurance companies of approved clients, who then receive medications directly at their homes. The MRI program affords eligible HIV-infected persons the opportunity to use the prescription benefits on their insurance policies while keeping the State support costs to a minimum by utilizing private sector funds. Persons with insurance benefits that provide for prescription medications would otherwise be disqualified from receiving regular THMP services.

THMP has contracted with Priority Pharmacy in San Diego, California to provide MRI medications. Priority Pharmacy has specialized in home delivery pharmacy services to HIV patients since 1987.

STD Medication

The THMP distributes STD medications, needles, and protective needle adapters to approximately 52 sites statewide. These sites include TDH PHRs, county health departments, and local health departments. These sites then deliver treatment directly to STD clients or supply the medications to the community providers who treat the clients.

Clinical, Case Management and Administrative Compliance Program

This Program is responsible for conducting quality assurance reviews of State and federally funded grantees that provide clinical and/ or case management services to individuals with HIV disease. To accomplish this, THMP staff conduct annual site reviews, provide technical assistance by telephone and on-site as needed, develop and distribute minimum clinical and case management standards and conduct investigations into allegations of client abuse and neglect. The Program also provides consultation regarding HIV disease and other STDs to health care professionals and the general public as requested.

Early Intervention Program (EIP)

Early intervention is a strategy of service delivery to persons with HIV that focuses on delaying the onset of life-threatening symptoms and diseases. Services provided through the EIP include clinical care, health maintenance activities, prevention of acute and chronic illness, and support services. The EIP in Texas was initiated in 1992 to provide health care and psychosocial services to Texans who have tested positive for HIV. The intent of initial funding was to provide services that would delay the onset of AIDS. Recent advances in medical and pharmacological protocols have shown that early intervention effectively reduces the levels of virus in the body. Since its inception, the Texas EIP has evolved from a program focused only on HIV infected people, to a program that aims to promote and maintain optimum health at all stages of the disease, including AIDS. Currently there are eight EIP projects funded Statewide.

HIV/AIDS Interagency Coordinating Council

The HIV/AIDS Interagency Coordinating Council was established by the Legislature to facilitate communication between agencies and associations involved in providing HIV/AIDS services to individuals, families and communities. The Council is also responsible for coordination of agency programs relating to the prevention of HIV/AIDS and the provision of services to people infected with HIV/AIDS, and for submitting an annual report to the Governor with recommendations and plans regarding coordinated activities to address issues and problems affecting this population.

Accomplishments

- THMP added three new participating pharmacies to the program to distribute antiretrovirals and other medications to individuals who qualify for ADAP assistance.

- Citing the fact that more needs to be done to eliminate health disparities, the TDH released an RFP to increase minority participation in the ADAP.

- THMP staff is coordinating efforts with the TDCJ and the Texas Council on Offenders with Mental Impairments to improve linkages to HIV medical services and the Texas ADAP for TDCJ inmates being returned to the community.

- TDH staff facilitated the development of an implementation plan for unit cost reimbursement of HIV medical and psychosocial support services by establishing and convening workgroups on the topic.

- From April 1, 2001 through September 30, 2001, THMP approved 105,589 medication orders dispensed through participating pharmacies to 9,951 clients.

- The HIV/AIDS Interagency Coordinating Council has expanded its focus to include activates related to the HCV epidemic.

Future Plans

- CRD will continue efforts to improve linkages to clinical care and medications for minority populations, with specific emphasis on people with HIV who are being released from prisons/jails and from substance abuse treatment centers.

- THMP will continue to increase public awareness of its existence and outreach to potential clients statewide, with an emphasis on under served and hard-to-reach client populations.

- CRD will continue to enhance the capacity of HIV Administrative Agencies and services providers to provide quality HIV services.

- CRD will continue to ensure that the local care systems and plans promote equal access to HIV services to all persons living with HIV/AIDS.

IX. APPENDIX

Texas AIDS Surveillance Report

Reported AIDS Cases, January – December 2000

HIV & AIDS: Residence Data	Jan - Dec 2000							
	HIV (Non-AIDS)			AIDS				
Residence County	Cumulative Reported Cases*	Cases Reported in 1999	Jan - Dec 2000	Cumulative Reported Cases*	2000 Rate***	Cases Reported in 1999	Jan - Dec 2000	Persons Living with HIV / AIDS
Region 1	***147***	***46***	***96***	***803***	***10.1***	***76***	***78***	***479***
Lubbock Co.	69	36	30	323	14.1	44	32	213
Potter\Randall Co.	61	7	53	339	15.1	23	33	196
Other	17	3	13	141	3.9	9	13	70
Region 2	***90***	***30***	***58***	***483***	***3.4***	***34***	***18***	***321***
Taylor Co.	22	6	15	145	8.0	9	10	90
Wichita Co.	31	15	15	177	0.8	13	1	118
Other	37	9	28	161	2.5	12	7	113
Region 3	***2,067***	***716***	***1,302***	***15,986***	***16.0***	***758***	***881***	***9,345***
Dallas Co.	1,452	531	896	11,526	27.1	535	599	6,604
Denton Co.	53	18	33	383	6.2	20	26	235
Tarrant Co.	408	124	274	3,143	12.1	133	187	1,861
Other	154	43	99	934	5.2	70	69	645
Region 4/5N	***303***	***118***	***182***	***1,376***	***8.5***	***151***	***112***	***977***
Angelina Co.	26	10	16	72	10.7	11	8	59
Bowie Co.	22	11	11	133	14.1	8	12	80
Gregg Co.	42	10	32	187	20.3	17	22	151
Smith Co.	38	16	22	221	9.4	18	16	151
Other	175	71	101	763	6.2	97	54	536
Region 6/5S	***2,553***	***923***	***1,494***	***21,065***	***17.7***	***766***	***882***	***11,361***
Galveston Co.	49	10	36	694	20.0	19	47	339
Harris Co.	2,218	830	1,270	18,490	21.8	676	725	9,909
Jefferson Co.	129	33	92	580	16.2	20	38	403
Montgomery Co.	33	5	27	262	4.6	11	11	145
Other	124	45	69	1,039	6.3	40	61	565
Region 7	***563***	***174***	***371***	***4,928***	***13.2***	***359***	***267***	***2,775***
Bell Co.	38	10	28	253	11.7	19	25	169
Brazos Co.	37	11	25	161	11.5	17	14	101
Mclennan Co.	52	23	29	289	6.7	14	13	177
Travis Co.	367	107	247	3,602	26.9	251	176	1,961
Other	69	23	42	623	4.7	58	39	367
Region 8	***472***	***152***	***314***	***4,303***	***9.0***	***232***	***190***	***2,455***
Bexar Co.	417	132	283	3,888	11.9	205	164	2,221
Victoria Co.	8	2	3	72	4.9	1	4	39
Other	47	18	28	343	3.4	26	22	195
Region 9/10	***168***	***65***	***97***	***1,577***	***8.5***	***123***	***117***	***948***
El Paso Co.	111	52	55	1,089	10.5	89	81	680
Midland Co.	15	6	9	127	10.0	10	13	77
Other	42	7	33	361	4.9	24	23	191
Region 11	***292***	***98***	***185***	***1,744***	***7.0***	***129***	***121***	***1,149***
Cameron/Hidalgo Co.	160	43	114	720	6.8	55	60	559
Nueces Co.	58	27	27	586	11.6	41	37	322
Webb Co.	52	16	35	218	9.6	11	18	158
Other	22	12	9	220	1.8	22	6	110
TDCJ ‡	699	370	329	2,148		231	124	2,066
Statewide Total	**7,354**	**2,692**	**4,428**	**54,413**	**6.9**	**2,859**	**2,790**	**31,876**

* Cumulative HIV data includes pediatric HIV infections reported since 1994 and adult/adolescent HIV infections reported since 1999

** Cumulative AIDS data includes all cases reported since 1980, including cases originally reported as HIV which have progressed to AIDS.

*** Rates are cases per 100,000 population

‡ Texas Department of Criminal Justice

Texas STD Surveillance Report

Table 1. Chlamydia and Gonorrhea Cases, January – December 2000

Chlamydia and Gonorrhea: Residence Data					Jan - Dec 2000			
	Chlamydia				Gonorrhea			
Residence County	1999 Rate	2000 Rate	Jan - Dec 1999	Jan - Dec 2000	1999	2000 Rate	Jan - Dec 1999*	Jan - Dec 2000
Region 1	***418***	***425***	***3,220***	***3,297***	***198***	***198***	***1,522***	***1,534***
Lubbock Co.	578	590	1,308	1,343	354	327	801	744
Potter\Randall Co.	400	440	858	962	193	220	414	480
Other	320	320	1,054	992	93	94	307	310
Region 2	***281***	***277***	***1,500***	***1,478***	***116***	***157***	***619***	***838***
Taylor Co.	442	383	550	478	229	182	285	227
Wichita Co.	308	388	394	500	144	337	184	434
Other	198	178	556	500	53	63	150	177
Region 3	***289***	***316***	***15,531***	***17,367***	***211***	***208***	***11,333***	***11,419***
Dallas Co.	431	452	9,358	9,979	344	331	7,474	7,317
Denton Co.	124	164	496	686	37	57	147	238
Tarrant Co.	247	273	3,729	4,215	185	180	2,783	2,785
Other	151	188	1,948	2,487	72	81	929	1,079
Region 4/5N	***291***	***282***	***3,789***	***3,694***	***175***	***147***	***2,281***	***1,924***
Angelina Co.	243	283	180	211	205	162	152	121
Bowie Co.	506	543	429	462	433	423	367	360
Gregg Co.	346	391	374	423	176	181	190	196
Smith Co.	481	416	809	707	341	240	574	408
Other	231	217	1,997	1,891	115	96	998	839
Region 6/5S	***294***	***333***	***14,460***	***16,629***	***175***	***167***	***8,608***	***8,356***
Galveston Co.	292	365	681	857	265	227	619	533
Harris Co.	320	368	10,473	12,218	181	178	5,914	5,917
Jefferson Co.	439	444	1,036	1,044	444	407	1,048	957
Montgomery Co.	152	157	358	380	61	64	143	155
Other	202	221	1,912	2,130	94	83	884	794
Region 7	***440***	***442***	***8,764***	***8,938***	***223***	***205***	***4,438***	***4,139***
Bell Co.	912	946	1,933	2,026	338	390	717	835
Brazos Co.	520	474	631	578	361	230	438	280
Mclennan Co.	623	570	1,202	1,102	428	360	825	696
Travis Co.	426	477	2,756	3,120	238	234	1,542	1,531
Other	275	253	2,242	2,112	112	95	916	797
Region 8	***347***	***356***	***7,201***	***7,505***	***120***	***128***	***2,485***	***2,693***
Bexar Co.	417	427	5,668	5,880	151	167	2,055	2,301
Victoria Co.	456	514	367	418	158	105	127	85
Other	183	186	1,166	1,207	48	47	303	307
Region 9/10	***225***	***311***	***3,042***	***4,285***	***33***	***56***	***451***	***774***
El Paso Co.	251	287	1,896	2,226	21	27	155	209
Midland Co.	193	313	247	408	62	108	79	141
Other	192	349	899	1,651	46	90	217	424
Region 11	***297***	***322***	***5,019***	***5,565***	***56***	***70***	***943***	***1,218***
Cameron/Hidalgo Co.	299	300	2,563	2,648	27	25	233	220
Nueces Co.	359	478	1,133	1,523	166	243	524	774
Webb Co.	231	267	420	503	17	20	31	38
Other	271	263	903	891	47	55	155	186
Statewide Total	313	338	62,526	68,758	163	162	32,680	32,895

* Rates are cases per 100,000 population

Texas STD Surveillance Report

Table 2. Pelvic Inflammatory Disease and Chancroid Cases, January – December 2000

Pelvic Inflammatory Disease and Chancroid: Residence Data											Jan - Dec 2000
	Pelvic Inflammatory Disease (PID)								Chancroid		
	Chlamydia		Gonorrhea		Other/Unspecified		Total PID				
Residence County	Jan - Dec 1999	Jan - Dec 2000	Jan - Dec 1999	Jan - Dec 2000	Jan - Dec 1999	Jan - Dec 2000	Jan - Dec 1999	Jan - Dec 2000	1999	Jan - Dec 1999	Jan - Dec 2000
Region 1	***7***	***32***	***9***	***20***	***6***	***22***	***22***	***74***	-	-	-
Lubbock Co.	3	2	5	2	4	3	12	7	-	-	-
Potter\Randall Co.	2	13	-	5	1	14	3	32	-	-	-
Other	2	17	4	13	1	5	7	35	-	-	-
Region 2	***23***	***35***	***14***	***22***	***1***	-	***38***	***57***	-	-	***1***
Taylor Co.	13	21	6	13	-	-	19	34	-	-	-
Wichita Co.	6	1	5	2	1	-	12	3	-	-	1
Other	4	13	3	7	-	-	7	20	-	-	-
Region 3	***145***	***138***	***155***	***110***	***488***	***517***	***788***	***765***	***8***	***8***	***11***
Dallas Co.	86	79	129	84	456	496	671	659	4	4	6
Denton Co.	7	3	4	-	2	-	13	3	1	1	-
Tarrant Co.	-	2	2	-	3	7	5	9	2	2	2
Other	52	54	20	26	27	14	99	94	1	1	3
Region 4/5N	***3***	***3***	***3***	***2***	-	***1***	***6***	***6***	-	-	-
Angelina Co.	-	0	-	1	-	-	-	1	-	-	-
Bowie Co.	-	0	-	-	-	-	-	-	-	-	-
Gregg Co.	-	0	1	-	-	-	1	-	-	-	-
Smith Co.	-	1	-	-	-	-	-	1	-	-	-
Other	3	2	2	1	-	1	5	4	-	-	-
Region 6/5S	***91***	***54***	***90***	***54***	***243***	***202***	***424***	***310***	***7***	***7***	***3***
Galveston Co.	45	18	27	23	2	-	74	41	-	-	-
Harris Co.	40	30	58	26	235	200	333	256	7	7	3
Jefferson Co.	1	0	-	-	-	-	1	-	-	-	-
Montgomery Co.	1	2	-	1	2	1	3	4	-	-	-
Other	4	4	5	4	4	1	13	9	-	-	-
Region 7	***54***	***59***	***63***	***42***	***9***	***3***	***126***	***104***	-	-	***1***
Bell Co.	4	8	3	3	-	-	7	11	-	-	-
Brazos Co.	5	1	4	1	-	-	9	2	-	-	-
Mclennan Co.	6	11	6	9	-	-	12	20	-	-	1
Travis Co.	28	22	36	23	1	-	65	45	-	-	-
Other	11	17	14	6	8	3	33	26	-	-	-
Region 8	***12***	***25***	***10***	***16***	***13***	***15***	***35***	***56***	-	-	***2***
Bexar Co.	6	16	8	14	11	11	25	41	-	-	1
Victoria Co.	-	1	-	-	-	1	-	2	-	-	-
Other	6	8	2	2	2	3	10	13	-	-	1
Region 9/10	***18***	***41***	***14***	***15***	***6***	***5***	***38***	***61***	-	-	***1***
El Paso Co.	3	4	3	3	1	-	7	7	-	-	1
Midland Co.	8	6	6	2	5	3	19	11	-	-	-
Other	7	31	5	10	-	2	12	43	-	-	-
Region 11	***178***	***288***	***33***	***37***	***10***	***41***	***221***	***366***	***1***	***1***	-
Cameron/Hidalgo Co.	65	108	7	1	-	22	72	131	-	-	-
Nueces Co.	48	100	13	28	10	13	71	141	1	1	-
Webb Co.	23	27	-	1	-	2	23	30	-	-	-
Other	42	53	13	7	-	4	55	64	-	-	-
Statewide Total	531	675	391	318	776	806	1,698	1,799	16	16	19

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Table 3. Syphilis Cases, January – December 2000

Syphilis: Residence Data								Jan - Dec 2000					
	Congenital			Primary/Secondary				Early Latent			Total Syphilis		
Residence County	1999	Jan - Dec 1999	Jan - Dec 2000	1999 Rate	2000 Rate	Jan - Dec 1999	Jan - Dec 2000	1999	Jan - Dec 1999	Jan - Dec 2000	1999	Jan - Dec 1999	Jan - Dec 2000
Region 1	***-***	***-***	***1***	***0.3***	***0.3***	***2***	***2***	***7***	***7***	***14***	***32***	***32***	***33***
Lubbock Co.	-	-	1	0.4	0.9	1	2	2	2	1	8	8	8
Potter\Randall Co.	-	-	-	0.5	-	1	0	1	1	4	4	4	6
Other	-	-	-	-	-	-	0	4	4	9	20	20	19
Region 2	***8***	***8***	***-***	***1.7***	***0.7***	***9***	***4***	***11***	***11***	***4***	***53***	***53***	***41***
Taylor Co.	-	-	-	-	0.8	-	1	-	-	1	2	2	2
Wichita Co.	1	1	-	5.5	2.3	7	3	8	8	3	29	29	15
Other	-	-	-	0.7	-	2	0	3	3	-	22	22	24
Region 3	***7***	***7***	***11***	***3.3***	***2.3***	***178***	***141***	***457***	***457***	***489***	***888***	***888***	***882***
Dallas Co.	4	4	7	7.0	4.5	152	100	380	380	361	691	691	588
Denton Co.	-	-	-	0.2	1.0	1	4	1	1	6	3	3	14
Tarrant Co.	3	3	4	1.3	1.4	20	22	64	64	80	171	171	192
Other	-	-	-	0.4	1.1	5	15	12	12	42	23	23	88
Region 4/5N	***4***	***4***	***5***	***4.1***	***1.4***	***54***	***19***	***135***	***135***	***111***	***256***	***256***	***193***
Angelina Co.	1	1	-	9.4	6.7	7	5	23	23	13	35	35	25
Bowie Co.	-	-	-	2.4	1.2	2	1	6	6	6	10	10	10
Gregg Co.	-	-	-	1.8	2.8	2	3	6	6	20	10	10	29
Smith Co.	1	1	-	8.9	1.2	15	2	22	22	22	45	45	27
Other	2	2	5	3.2	0.9	28	8	78	78	50	156	156	102
Region 6/5S	***50***	***50***	***33***	***2.7***	***1.7***	***132***	***115***	***408***	***408***	***302***	***1,451***	***1,451***	***1,160***
Galveston Co.	1	1	-	0.4	0.4	1	1	42	42	23	47	47	30
Harris Co.	47	47	29	2.1	2.1	70	70	240	240	135	1,102	1,102	849
Jefferson Co.	-	-	-	6.8	6.0	16	14	31	31	21	87	87	63
Montgomery Co.	1	1	3	0.8	0.4	2	1	10	10	10	23	23	19
Other	1	1	1	4.5	3.0	43	29	85	85	113	192	192	199
Region 7	***1***	***1***	***-***	***1.6***	***0.3***	***32***	***21***	***78***	***78***	***62***	***310***	***310***	***177***
Bell Co.	-	-	-	1.9	1.4	4	3	3	3	6	23	23	18
Brazos Co.	-	-	-	0.8	1.6	1	2	10	10	6	17	17	14
Mclennan Co.	-	-	-	1.6	0.5	3	1	2	2	6	22	22	17
Travis Co.	-	-	-	2.8	1.2	18	8	23	23	27	61	61	59
Other	1	1	-	0.7	0.8	6	7	40	40	17	187	187	69
Region 8	***5***	***5***	***5***	***1.9***	***3.6***	***39***	***75***	***78***	***78***	***110***	***254***	***254***	***322***
Bexar Co.	4	4	4	2.3	4.9	31	67	71	71	103	227	227	286
Victoria Co.	-	-	-	5.0	3.7	4	3	2	2	3	8	8	10
Other	1	1	1	0.6	0.8	4	5	5	5	4	19	19	26
Region 9/10	***1***	***1***	***2***	***0.7***	***0.5***	***10***	***7***	***13***	***13***	***12***	***182***	***182***	***215***
El Paso Co.	1	1	2	1.2	0.8	9	6	9	9	11	79	79	92
Midland Co.	-	-	-	-	-	-	0	2	2	-	16	16	4
Other	-	-	-	0.2	0.2	1	1	2	2	1	87	87	119
Region 11	***23***	***23***	***14***	***0.2***	***0.8***	***3***	***14***	***53***	***53***	***71***	***221***	***221***	***280***
Cameron/Hidalgo Co.	22	22	11	0.2	1.2	2	11	36	36	51	129	129	170
Nueces Co.	-	-	-	0.3	0.3	1	1	9	9	3	20	20	10
Webb Co.	-	-	2	-	0.5	-	1	5	5	14	19	19	48
Other	1	1	1	-	0.3	-	1	3	3	3	53	53	52
Statewide Total	99	99	71	2.3	2.0	459	398	1,240	1,240	1,175	3,647	3,647	3,303

* Rates are cases per 100,000 population

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Bureau of HIV and STD Prevention
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