PREFACE

Summary

During 1998, 250 previously unreported AIDS cases were reported to the Nevada State Health Division. This number represents a sharp 46% decrease from the 546 AIDS cases reported during 1997. Factors effecting this reduction are as follows: 1) The intensive surveillance effort referred to in the last "Nevada HIV/AIDS Surveillance Summery" ended at the first of the year when the Las Vegas Metropolitan Area qualified for Ryan White Title I funding. This substantial effort artificially raised the numbers reported in the second half of 1997 and may have lowered the numbers reported in the first half of 1998. 2) New efforts have been initiated in 1998 to identify and eliminate duplicate reports from the data system. 3) New treatments and greater access to these treatments are delaying the progression of HIV to AIDS. 4) HIV prevention programs could be taking effect.

Those involved and concerned about HIV prevention in Nevada have reason to celebrate, however we must all keep in mind that the risk of contracting HIV during risky behavior is as great now as ever and that we can not afford to relax our prevention efforts. We must also recognize that the news is not equally good for all of Nevada's population groups. The proportion of reported AIDS cases in women has increased from 11% of total cases reported through 1997, to 12% through 1998. African-Americans also continue to be disproportionately effected, accounting for 19% of reported cases in 1998 while making up only 7% of Nevada's population. The following two articles address this problem from a national prospective.

The article "HIV/AIDS Pandemic Is Worsening" reminds us that HIV continues to be devastating in many parts of the world.

Eyes Shut, Black America Is Being Ravaged By AIDS"

New York Times 6/29/98 P. Al; Stolberg, Sheryl Gay

Despite comprising about 13 percent of the population in the United States, African-Americans account for 57 percent of new HIV infections, according to the Centers for Disease Control and Prevention. Additionally, data from 25 states taken between January 1994 and June 1997 showed that 63 percent of HIV cases occurred among African-Americans in the 13 to 24-year-old age group. The AIDS mortality rate is dropping in the general population, but the disease has become the leading cause of death among African-Americans aged 25 to 44. Surgeon General David Satcher said, "I don't think there is any question that the epidemic in this country is becoming increasingly an epidemic of color." With the decrease in cases among whites and the increase in cases among African-Americans, many worry that the AIDS problem will become a marginalized. Many experts are also concerned about the lack of emphasis placed on HIV education and advocacy by some civil rights groups and African-American ministers. Neither of the two largest African-American civil rights groups in the nation, the Urban League and the National Association for the Advancement of Colored People, will address the AIDS problem at their annual national conventions this summer. According to an African-American AIDS advocate, Rev. Kwabena Rainey Cheeks, one reason for the lack of emphasis on AIDS by the African-American community has to do with taboos concerning homosexuality and drug use. The stigma attached to the disease has caused many to keep their infections secret. Despite preconceptions about drug use and homosexuality in conjunction with HIV, heterosexual

transmission is the primary route of spread among African-American women. Furthermore, prevention efforts face a number of problems. Dr. Satcher notes that many of the grants for HIV prevention go to larger groups organization--which may reach more minorities--have difficulty gaining adequate funding. President Clinton has created a plan to try and eliminate racial

disparities in HIV treatment by the year 2010; the government proposed a community program model with a $400 million budget, with some of the money devoted to AIDS programs.

"WHAT You Need to Know About AIDS in Minority Groups"

AIDS Alert--AIDS Guide for Health Care Workers Supplement (01/99) Vol. 14, No. 1, P. 1

President Clinton recently unveiled a $156 million initiative focusing on HIV/AIDS among minorities. The campaign, intended to develop HIV-prevention programs and increase access to drug treatment programs, among other things, was established because AIDS is "hitting hardest in areas where knowledge about the disease is scarce and poverty is high," Clinton said. The Centers for Disease Control and Prevention currently provides $253 million in funding to state and local health departments for HIV prevention programs. The agency, which also directly funds various organizations that have HIV prevention programs geared to high-risk individuals in specific minority groups, has been allotted an extra $4 million this year for community-based HIV-prevention organizations focusing on African-Americans and Hispanics. While minorities only made up about one-quarter of the total U.S. population in 1997, over half of all AIDS cases were among racial and ethnic minorities that year. Nearly 50 percent of all new AIDS cases in the United States were among African-Americans in 1997, while Hispanics now account for

almost one-quarter--22 percent--of new AIDS cases. The rise of HIV among young Hispanics is especially worrisome. The National Institute of Allergy and Infectious Diseases noted in a report that minorities "bear a disproportionate burden of sickness and disease," including tuberculosis.

"HIV/AIDS Pandemic Is Worsening"

World Watch (03/99-04/99) Vol. 12, No. 2, P. 31; Halweil, Brian

Nearly 50 million people have contracted HIV since the virus was first recognized, with over 14 million people dying from AIDS. An estimated 34 million people currently live with HIV, 6 million of whom contracted the virus last year. Sub-Saharan Africa has been hit particularly hard, accounting for 70 percent of the world's infections and 90 percent of AIDS deaths. At least one-tenth of the population of 12 African nations carry HIV, with one-quarter of adults in Zimbabwe and Botswana infected with the virus. The incidence of HIV infection in Asia is still relatively low but is rapidly increasing. Although India has an estimated 4 million HIV-positive individuals, the country has a low infection rate considering its large populations. The Eastern European HIV populations has increased seven-fold since 1994, with the collapse of health care systems and increased drug use accounting for many new infections in the former Soviet Union. AIDS deaths have declined in the United States and Western Europe largely due to anti-HIV medication, although risky behaviors still persist. The epidemic has predominantly affected young adults--the economic backbone of a nation--and the disease may have significant ramifications on economic development. Additionally, there are already 9 million AIDS orphans worldwide, with the number expected to increase. Treatment for HIV is expensive, and many developing nations are not able to provide the drugs to infected constituents. However, strong prevention programs--such as those implemented in Senegal, Tanzania, Thailand, and Uganda--have been determined to have an impact on the spread of HIV.

"Needle Stick Risk"

Washington Post--Health (08/11/98) P. 10; Phalen, Kathleen F.

The Centers for Disease Control and Prevention estimates that approximately 800,000 U.S. health care workers will be injured by patient needles this year; and about 2,000 of those workers will test positive for new infections of hepatitis C, 400 will get hepatitis B, and 35 will

contract HIV. Public health officials believe more than 4 million Americans have been infected with the hepatitis C virus, which is 10 times more likely to be transmitted than HIV. Among the cited causes for needle stick injuries are worker inattention and a lack of safety needles. Some safe needles blunt during use, have protective sheaths, or retract; and according to the CDC could prevent injuries up to 76 percent of the time. Hospital officials are calling on the manufacturers of the safety products to lower their costs since safety needles cost twice as much as the conventional hollow bore needles; however, manufacturers say the issue is one of supply and demand, and that the prices will come down as more of the safe needles are produced.

New HIV Reporting Requirement

On February 12, 1999 the Nevada State Board of Health approved new HIV reporting regulations that require life insurance companies to report positive laboratory findings to the State Health Division. This new regulation enhances HIV surveillance in Nevada and helps the health authorities ensure that infected individual have the opportunity to receive appropriate care and support services. As with all reported confidential information these reports are protected by confidentiality laws will remain secure and confidential. Questions regarding confidentiality and security standards that protect HIV/AIDS reported information can be directed to Bill Hill, Bureau of Disease Control and Intervention Services, (775) 684-5924.

Technical Notes

Much of the statistical information in this report is extracted from the Nevada HIV/AIDS Reporting System (HARS). HARS is a highly confidential computerized database developed by the Centers for Disease Control and Prevention (CDC). Its purpose is to provide the CDC, HIV prevention and care planners, and resource allocation decision makers with crucial epidemiological information. Statistical data is also provided to educators and others involved in HIV/AIDS awareness efforts so that the public can be apprised of the magnitude of the HIV problem in Nevada. ***The data provided to the CDC and others will never contain information that could identify a specific individual.***

Accurate and useful information depends on the consistent and conscientious reporting of HIV and AIDS cases by health care providers, laboratories and others. The HARS database is continually updated and evaluated for accuracy and completeness. Although all reported cases are checked for duplication before they are entered into HARS, not all reporting duplications are initially detected, especially those that are reported in other states. Due to the continual refining of data and the pursuit of missing information, data provided in this report should be considered provisional. As such, the numbers may not always be 100% consistent with previous surveillance reports.

Questions as to what information is required to be reported in Nevada, or what confidentiality safeguards have been established, can be addressed to Bill Hill, HIV/AIDS Surveillance Coordinator, Bureau of Disease Control and Intervention Services, (775) 684-5924.

Table 1. Reported AIDS cases in the United States: known cases through June 30, 1998.*

Total Cumulative Cases	665,357	
Males	557,324	84%
Females	108,032	16%

Deaths	401,028	60%

Cases By Race/Ethnicity

White, not Hispanic	296,435	45%
Black, not Hispanic	240,927	36%
Hispanic	120,484	18%
Asian/Pacific Islander	4,786	1%
American Indian/Alaskan Native	1,848	<1%
Unknown	877	<1%

Cases By Exposure Category

Adult/Adolescent Cases

Homosexual/Bisexual Men	317,862	48%
Injecting Drug User (IDU)	168,008	26%
Homosexual/Bisexual IDU	42,093	6%
Hemophiliac	4,781	1%
Heterosexual Contact	62,599	10%
Transfusion With Blood/Products	8,311	1%
None of the Above/Other	53,423	8%
Adult/Adolescent Total	657,077	100%
Percentage of Total Cases		99%

Pediatric Cases

Hemophiliac	234	3%
Parent at Risk/Has HIV/AIDS	7,512	91%
Transfusion With Blood/Products	375	5%
None of the Above/Other	159	2%
Pediatric Total	8280	100%
Percentage of Total Cases		1%

**Includes dependencies, possessions and associated nations.*

Table 2. Top Ten States/Territories incidence rates (AIDS cases per 100,000 population)

for cases reported 1/1/98 through 12/31/98 vs same period 1997.

RESIDENCE	1998	RANK	1997	RANK
District of Columbia	189.1	1	188.2	1
New York	47.9	2	72.3	3
Puerto Rico	44.3	3	53.2	4
Florida	36.5	4	41.2	5
Maryland	31.9	5	36.3	8
U.S. Virgin Islands	29.6	6	83.8	2
New Jersey	26.3	7	40.1	6
Delaware	23.4	8	31.3	10
Louisiana	21.8	9	25.0	11
Connecticut	20.3	10	37.4	7
Nevada	14.8	17	35.0	9
United States	17.6		22.1	

Figure 1. Top Ten States/ Territories.

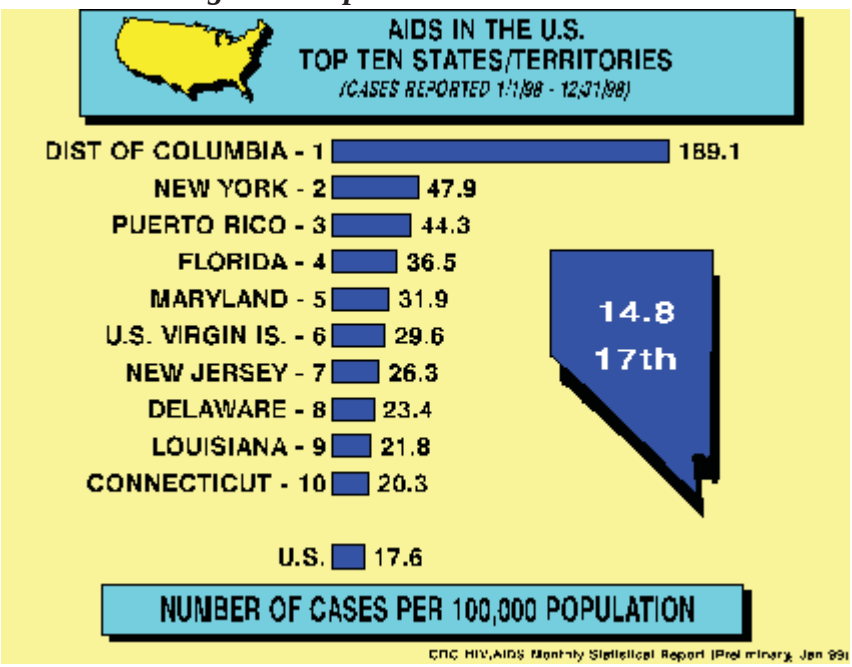


Table 3. Reported AIDS cases in Nevada.

Known Cases	Cumulative as of 12/31/98	1998

Total Cases	**3,875**		**250**	
Males	3,427	88%	209	84%
Females	448	12%	41	16%
Deaths	1,935	50%	27	11%
Cases By Race/Ethnicity				
White, not Hispanic	2,625	68%	145	58%
Black, not Hispanic	744	19%	54	22%
Hispanic	440	11%	43	17%
Asian/Pacific Islander	41	1%	5	2%
American Indian/Alaskan Native	24	1%	2	1%
Unknown/Not Reported	1	<1%	1	<1%
Cases By Exposure Category				
Adult/Adolescent Cases				
Homosexual/Bisexual Men	2,401	62%	146	59%
Injecting Drug User (IDU)	687	18%	35	14%
Homosexual/Bisexual IDU	346	9%	14	6%
Hemophiliac	12	<1%	1	<1%
Heterosexual Contact	257	7%	23	9%
Transfusion With Blood/Products	37	1%	0	--
None of the Above/Other	111	3%	30	12%
Adult/Adolescent Total	3,851	100%	249	100%
Percentage of Total Cases		99.4%		99.6%
Pediatric Cases				
Parent at Risk/Has HIV/AIDS	22	92%	1	100%

Transfusion With Blood/Products	2	8%	0	--
Pediatric Total	24	100%	1	100%
Percentage of Total Cases		0.6%		0.4%

AIDS IN NEVADA - CUMULATIVE REPORTED CASES THROUGH 12/31/98

3,875 KNOWN CASES

Table 4. Reported cases by year diagnosed and known deaths through 12/31/98.

Year Case Diagnosed	No. Cases	Known Deaths	Fatality Rate
1981-90	708	622	88%
1991	341	246	72%
1992	436	302	69%
1993	438	259	59%
1994	424	197	46%
1995	506	151	30%
1996	424	80	19%
1997	364	50	14%
1998	234	28	12%
Total	**3,875**	**1,935**	**50%**

Table 5. Reported cases by sex and age group through 12/31/98.

Age Group	Males	Females	Total
Under 5	11	10	21
5 - 12	0	3	3
13 - 19	4	4	8
20 - 29	565	92	657
30 - 39	1533	194	1,727
40 - 49	915	90	1,005
Over 49	399	55	454
Unk	0	0	0
Total	3,427	448	3,875

Table 6. Reported cases by Nevada county of residence through 12/31/98.

Carson City	124	3%
Churchill	16	<1%
Clark	3,032	78%

Douglas	24	1%
Elko	12	<1%
Lyon	16	<1%
Nye	17	<1%
Washoe	617	16%
White Pine	9	<1%
Others*	9	<1%

*Counties with less than 5 cases are not listed for privacy purposes.

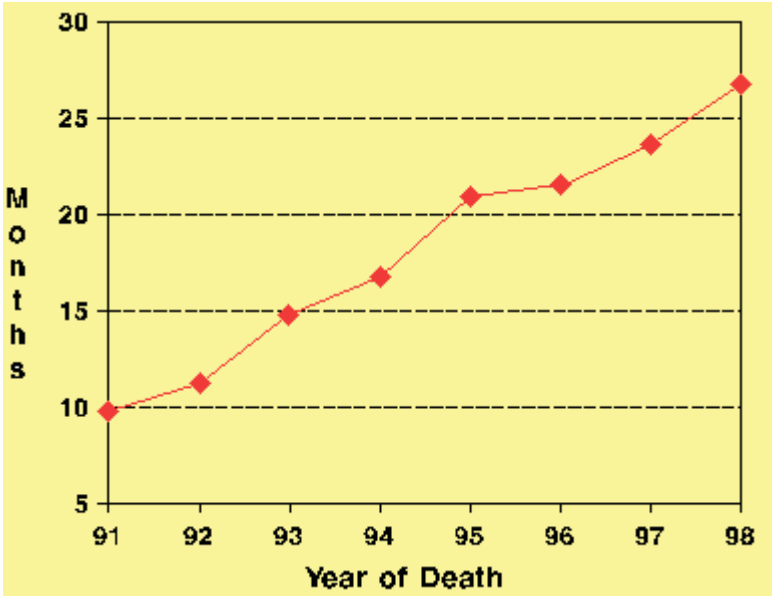
Note: Esmeralda county has not yet reported an AIDS Case.

Table 7: Reported Nevada AIDS incidence rates (cases per 100,000 population) by race/ethnicity, 1990 – 1998.

Year	White	Black	Hispanic	Asian Pacific Islander	Native American	Total
1990	**15.1**	**36.6**	**12.9**	**5.6**	**5.7**	**15.8**
1991	**20.1**	**52.4**	**14.9**	**7.7**	**5.2**	**21.0**
1992	**17.6**	**61.7**	**14.3**	**4.8**	**4.8**	**19.5**
1993	**38.5**	**104.3**	**40.0**	**11.2**	**13.5**	**41.7**
1994	**22.5**	**91.3**	**30.9**	**8.4**	**12.6**	**27.3**
1995	**24.6**	**95.6**	**30.5**	**6.3**	**8.5**	**29.3**
1996	**21.8**	**84.1**	**33.3**	**16.9**	**17.0**	**27.9**
1997	**25.0**	**111.8**	**38.7**	**15.5**	**19.3**	**35.0**
1998	**10.2**	**42.2**	**17.8**	**8.9**	**7.1**	**14.8**

The above table contains the incidence rates for AIDS cases for the various ethnic groups living in Nevada during the past nine years. The rates are based on reported cases/year and race/ethnicity estimates based on the 1990 census and information provided by the Nevada State Demographer's Office.

Figure 2: Average number of months from date of AIDS diagnosis to date of death for Nevada deaths reported between 1991 and 1998.



The above graph shows that HIV infected individuals in Nevada who have been defined as having AIDS are living longer.

REPORTED HIV IN NEVADA

Figure 3. Reported Nevada HIV infections by gender and by calendar half year – 1/1/93 through 12/31/98.*

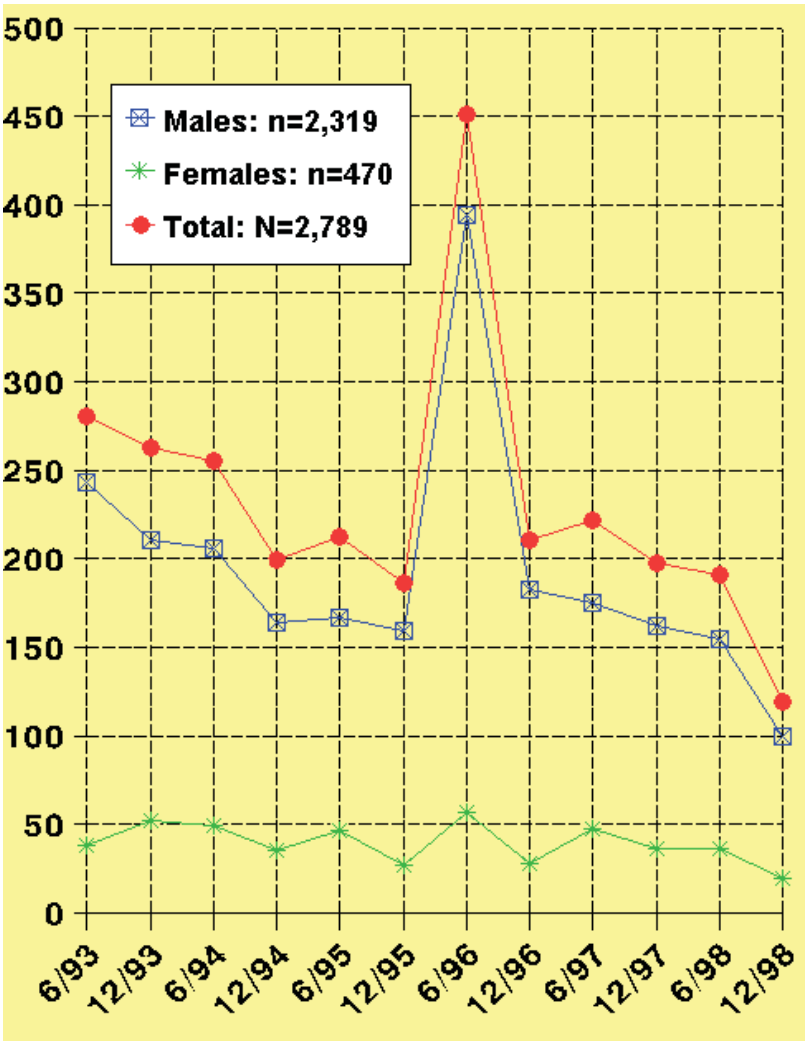


Figure 4. Year first reported positive for Nevada HIV infections by gender and by calendar half year – 1/1/93 through 12/31/98.

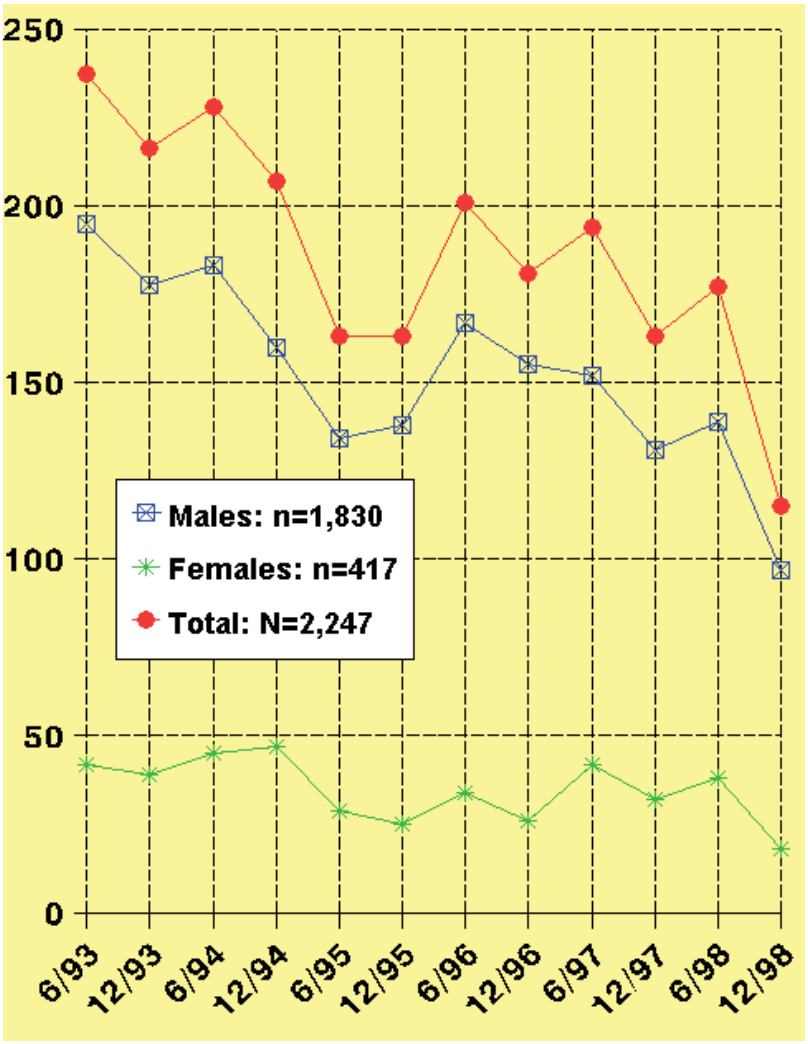
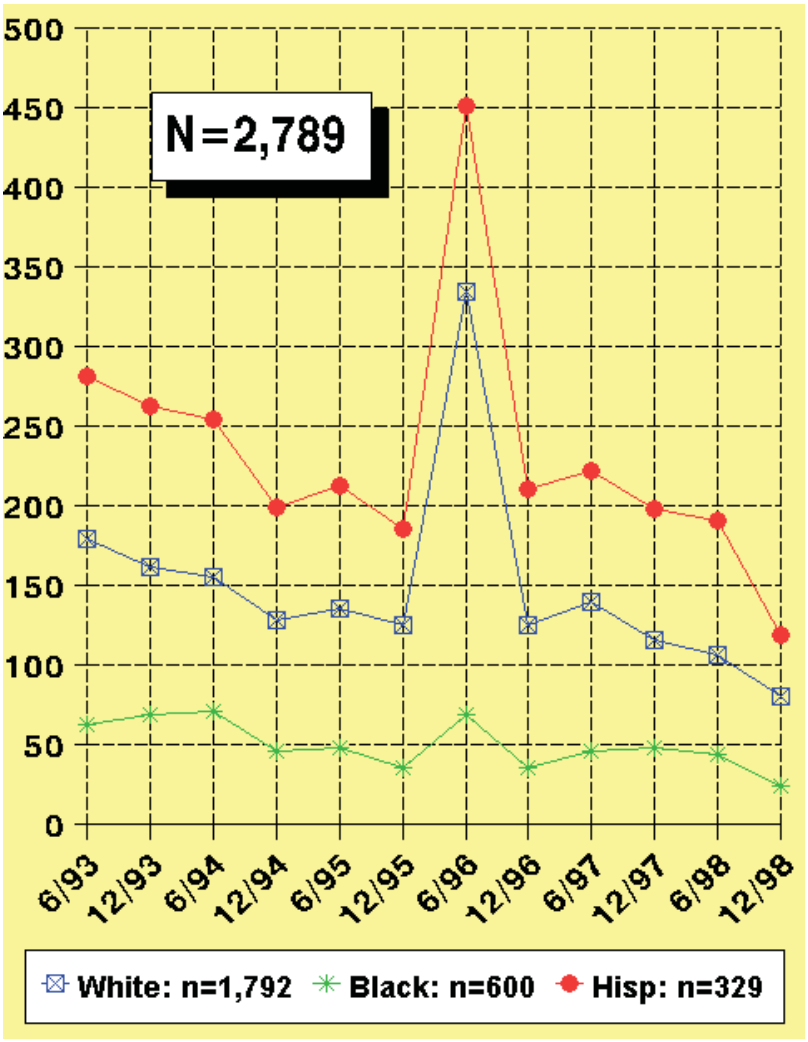


Figure 5. Reported Nevada HIV infections by race/ethnicity* and by calendar half year – 1/1/93 through 12/31/98.



** Thirty-six Asian and 30 Native American infections were reported over this period. Two infections were reported with race/ethnicity "unknown."*

Table 8. Reported Nevada adult/adolescent HIV infections by exposure category and gender: January 1, 1993 through December 31, 1998

Exposure Category	Males	(%)	Females	(%)	Total	(%)
Homosexual/Bisexual Males	1,499	65%	na		1,499	54%
Injecting Drug User (IDU)	242	10%	130	29%	372	13%
Homosexual/Bisexual IDU Males	209	9%	na		209	8%
Heterosexual Contact	71	3%	210	45%	281	10%
Transfusion	8	<1%	8	2%	16	1%
Hemophiliac	7	<1%	0	--	7	<1%
Risk not reported/Unknown	270	12%	108	24%	378	14%
Total	2,306	100%	456	100%	2,762	100%

Table 9. Reported Nevada HIV pediatric infections by exposure category and gender: January 1, 1993 through December 31, 1998

Exposure Category	Males	(%)	Females	(%)	Total	(%)
Parent at risk/has AIDS/HIV	13	100%	14	100%	27	100%
Hemophiliac	0	--	0	--	0	--
Transfusion	0	--	0	--	0	--
Risk not reported/Unknown	0	--	0	--	0	--
Total	13	100%	14	100%	27	100%

Table 10. Reported Nevada HIV infections by age group, gender, and race/ethnicity: January 1, 1993 through December 31, 1998

	White		Black		Hispanic		Other/Unk		Total	
Age Group	M	F	M	F	M	F	M	F	M	F
Under 5	6	5	5	8	2	0	0	0	13	13
5 - 12	0	0	0	0	0	0	0	0	0	0
13 - 19	10	6	6	11	3	0	0	0	19	17
20 - 29	482	75	105	56	103	16	19	2	709	149
30 - 39	666	92	188	66	130	11	26	8	1,010	177
40 - 49	288	34	82	37	40	8	6	3	416	82
Over 49	113	14	23	12	11	4	2	1	149	31
Unknown	1	0	0	1	1	0	1	0	3	1
Subtotal	1,566	226	409	191	290	39	54	14	2,319	470
Total	1,792		600		329		68		2,789	

Table 11: Reported Nevada HIV incidence rates(infections per 100,000 population) by race/ethnicity: 1992 – 1998.

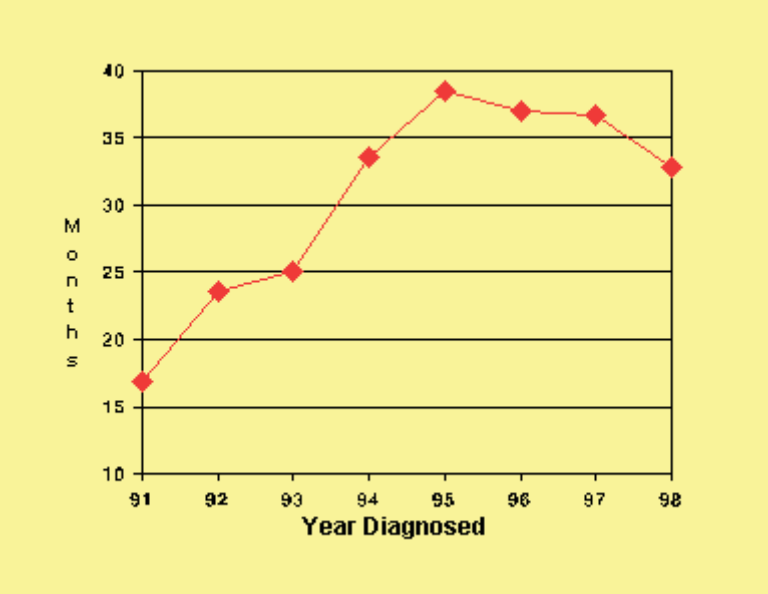
Year	White	Black	Hispanic	Asian Pacific Islander	Native American	Total

1992	106.4	469.6	118.7	16.7	14.5	136.6
1993	31.4	144.0	38.0	8.9	5.9	39.4
1994	24.2	118.7	28.3	4.2	16.7	30.9
1995	21.5	77.8	24.5	10.6	8.5	25.5
1996	35.2	87.7	42.3	16.9	12.8	38.8
1997	19.8	80.5	28.1	11.6	23.7	24.7
1998	13.1	53.1	17.0	14.4	14.4	16.4

The above table contains the incidence rates for HIV infections for the various ethnic groups living in Nevada during the past seven years. The rates are based on reported infections/year and race/ethnicity estimates based on the 1990 census and information provided by the Nevada State Demographer's Office.

Reporting of HIV infections became mandatory in 1992, and therefore the disproportionately high incidence rates reported in that year reflect infections testing positive prior to 1992.

Figure 6: Average number of months from first HIV positive confirmation to date of AIDS diagnosis for Nevada cases reported between 1991 and 1998.



The above graph is an attempt to measure the success of Nevada's HIV prevention programs in accomplishing the early identification of HIV infections. Recognizing that the time interval reflected here is impacted by advances in HIV care, there is evidence of a need to reinforce outreach and testing programs in an effort toward earlier identification and treatment of infections.

RESOURCE INFORMATION

Nevada, as well as other states and the USPHS (CDC), maintain local and toll-free telephone numbers which provide interested persons confidential access to current HIV/AIDS information and referrals. Callers to these numbers are able to speak with an individual who can answer

their questions about HIV infection and AIDS and/or provide appropriate referrals to meet the caller's needs. State, local, and CDC numbers are:

State

Nevada AIDS Hotline: 1-800-842-AIDS (8am - 10pm, 7 days a week),
e-mail: nvhotline @aol.com
http://www.thebody.com/cgi/safeans.html

Clark County

Clark County Health District: (702) 383-1393
Aid for AIDS of Nevada: (702) 382-2326
American Red Cross (Clark County Chapter): (702) 791-3311
Nevada Association of Latin Americans, Inc.: (702) 382-6252

Washoe County

Washoe County District Health Department: (775) 328-2400
Nevada AIDS Foundation: (775) 329-2437
Nevada Hispanic Services: (775) 786-6003
American Red Cross (Sierra Nevada Chapter): (775) 856-1000

National

National AIDS Hotline: 1-800-342-AIDS (24 hours)

Educational and other information (including bi-lingual materials) about HIV/AIDS are also available to health care professionals, educators, and the public upon request from the previously listed agencies and health districts as well as state and national agencies. A current edition of the State HIV/AIDS Services and Information Resource Directory is also available at no cost from the State HIV/AIDS Program Office. State and CDC addresses are:

Nevada:

Bureau of Disease Control and Intervention Services
HIV/AIDS Program Office
505 E. King St., Rm 304
Carson City, NV 89701-3701
(775) 684-5900 (8am - 5pm, Mon - Fri, PST)

National:

CDC National AIDS Clearinghouse
PO Box 6003
Rockville, Maryland 20858
1-800-458-5231 (9am - 7pm, Mon - Fri, EST)