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Texas Department of Health Bureau of HIV & STD Prevention

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HIV/STD ANNUAL REPORT 1998

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UNIVERSITY OF TEXAS PAN AMERICAN
EDINBURG, TEXAS 78539-2999

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TABLE OF CONTENTS

List of Figures	ii
List of Tables	ii
Acknowledgments	ii

FY 1998 HIV AND STD ANNUAL LEGISLATIVE REPORT

I. Executive Summary	1
II. Bureau of HIV and STD Prevention	2
III. Funding - FY 1998	4
IV. Epidemiologic Assessment	5
V. HIV Prevention and Services	19
VI. STD Prevention and Services	30
VII. Training and Public Education	34
VIII. HIV/STD Clinical Services	39
IX. Medication Program	41
X. Appendix	49

List of Figures

1.	Bureau of HIV and STD Prevention Organizational Chart	1
2.	HIV Prevention and Services Contracts Awarded	4
3.	AIDS Cases by Year of Report, 1981 - 1998	5
4.	Adult-Adolescent AIDS Cases Reported in 1998	8
5.	AIDS Cases by Public Health Region	10
6.	Primary and Secondary Syphilis Rates by Race/Ethnicity	12
7.	Syphilis Rates, Texas 1972 - 1998	13
8.	Chlamydia Rates for Females, Texas 1991 - 1998	14
9.	Gonorrhea Rates by Sex, Texas 1991 -1998	15
10.	Selected STDs by Age Group	18
11.	Percentage of HIV Tests and Percentage of Positive HIV Tests by Sex and Ethnicity	23
12.	Percentage of Tests and Percentage of Positive Tests by Sex and Mode of Exposure	25
13.	The Disease Intervention Process	32
14.	Texas HIV Medication Program	41

List of Tables

1.	TX AIDS Deaths, Comparison by Race and Sex	6
2.	AIDS Cases Reported in 1998 by Sex and Race	9
3.	HIV Medication Allocations by Region	43

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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 1998, over 48,800 acquired immunodeficiency syndrome (AIDS) cases have been reported in Texas. A total of 103,323 sexually-transmitted disease (STD) cases were reported in Texas in 1998. While reported cases of syphilis declined, chlamydia, gonorrhea and pelvic inflammatory disease (PID) increased. Young people aged 15 to 24 years accounted for over 65% of all reported STDs, with adolescents aged 15 to 19 accounting for over 34%.

The total operating budget for HIV and STD programs for fiscal year (FY) 1998 was \$72,180,124. The Bureau of HIV and STD Prevention distributed \$32,486,783 to regional and local health departments and community-based organizations throughout the State in 1998. In addition, over \$26 million were spent to provide HIV and STD medications to Texas residents in 1998.

HIV prevention efforts focused on the high risk target populations identified through community planning activities. A total of 130,188 initial counseling sessions were reported in 1998; 99% of initial counseling sessions included an HIV test, and 1.1% of those tested were identified as HIV positive. Prevention activities provided by STD programs resulted in an estimated \$30,000,000 savings in medical costs related to STDs and \$18,000,000 savings related to HIV. STD clinics across Texas reported more than 110,000 clinic visits in 1998. Disease Intervention Specialists (DIS) interviewed and managed 1,699 reported syphilis cases in Texas in 1998. A total of 882 contacts for syphilis were referred by DIS and provided preventative therapy, resulting in the prevention of 265 cases of syphilis.

By December 31, 1998, over 600 HIV counselors were trained in 68 courses at locations across Texas. The Texas HIV/STD InfoLine, which provides a telephone link between the people of Texas and the Texas Department of Health (TDH), received 3,000 calls per month in 1998. The 1998 Texas HIV/STD Conference held in Austin May 12-13, 1998, attracted over 1,100 HIV/STD health professionals.

The Texas HIV Medication Program distributed over \$26 million dollars of antiretrovirals and other prophylactic medications in FY 1998, a two-thirds increase over 1997 levels. The medications help delay the onset of symptomatic disease and prevent opportunistic infections in persons living with HIV disease. The Medication Reimbursement Initiative paid deductibles and co-insurance payments in the amount of \$34,910, for 1780 prescriptions worth \$505,744 in client benefits. The Texas STD Medication Program distributed \$337,972 in STD medications and related supplies to 52 sites statewide in 1998.

II. BUREAU OF HIV & STD PREVENTION

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

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 of HIV and STD Prevention (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 1998 and provides an epidemiologic assessment of HIV, AIDS, and STDs in Texas. Because the Pharmacy Division primarily serves other programs, it is not discussed in this report.

Development of a Strategic Plan

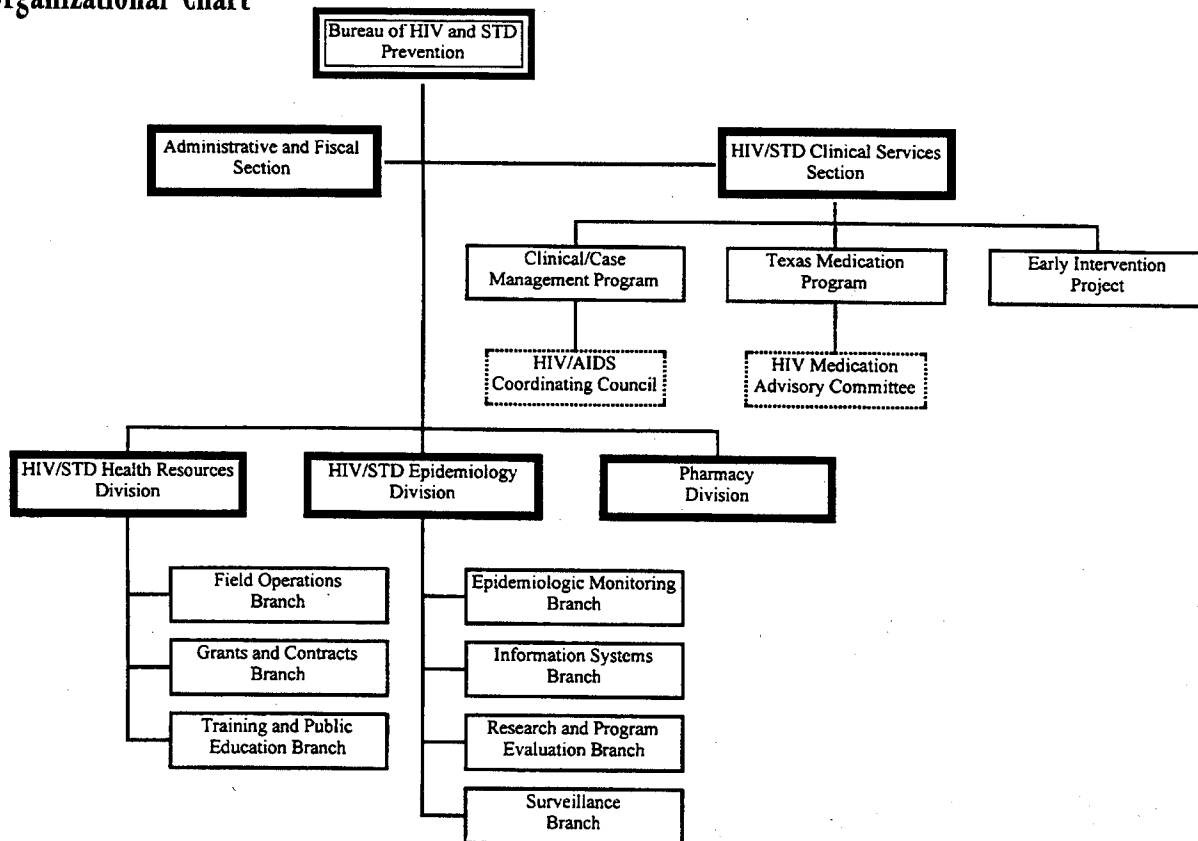
In late 1996, the Bureau formed a Strategic Planning Steering Committee (SPSC) to develop a strategic plan for the succeeding three-year period that would set priorities and guide the Bureau's response in meeting the challenges of a continually changing environment.

During 1997, the 24 member SPSC, composed of representatives from the Central Office, regional staff and external customers, developed criteria for the selection of strategies and identified the following six unique issues to be addressed by the Plan:

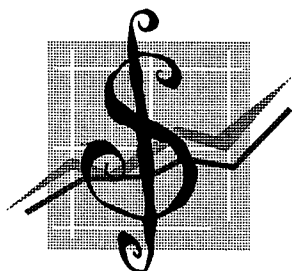
- *The capacity of contractors to perform at consistent levels.*
- *Early access to quality care.*
- *Integration of HIV and STD prevention and services.*
- *Increased emphasis on STD prevention and treatment.*
- *Increasing the comprehensiveness and utilization of HIV/STD surveillance and data.*
- *Increasing the capacity of TDH staff to excel at its tasks and effectively respond to change.*

Throughout 1997, strategy work groups addressed each issue, with SPSC members taking on the responsibility for recruiting a mix of internal and external customers to lend expertise to strategy development. The Strategic Plan was completed and adopted March 1998. The Plan will be monitored on an ongoing basis by the SPSC in order to revisit the strategies and make appropriate changes in response to major funding, legislative, and policy changes.

FIGURE 1
Organizational Chart

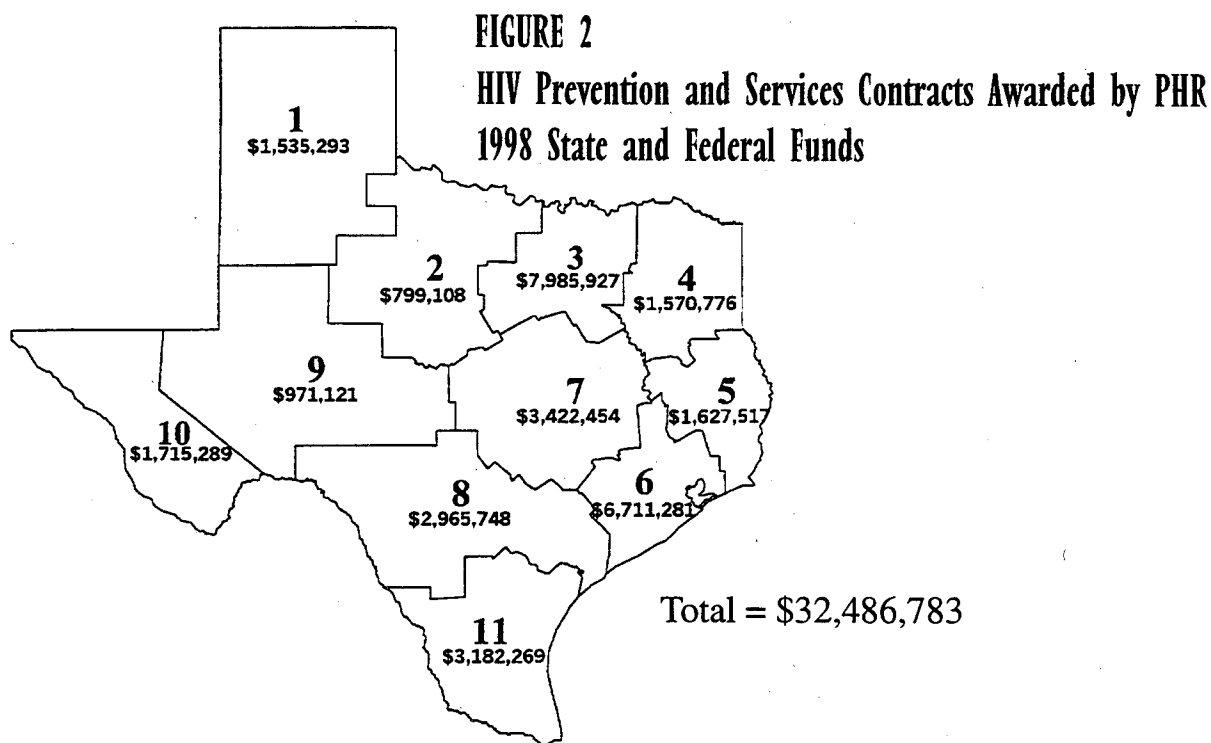


III. FUNDING - FY 1998



The total operating budget for HIV and STD programs for FY 1998 was \$72,180,124. Slightly over three-quarters of the budget (\$53,568,281) was provided by federal HIV and STD grants, almost one-quarter (\$18,611,843) by State funds. The HIV and STD funds were allocated as follows: \$18,384,671 (25%) for prevention; \$22,428,161 (31%) for services; \$26,821,591 (37%) for medication; and \$4,545,702 (6%) for surveillance. The 1998 budget represented close to a 9% increase over the 1997 budget, most of the increase being applied to the medication program for purchase and distribution of the new anti-HIV drugs, the protease inhibitors.

Over \$32 million, more than 45%, of the total HIV and STD prevention and services resources were distributed to regional and local health departments or other contracted community-based agencies through prevention and services contracts (See Figure 2). Over 37% of the total HIV and STD resources were spent providing HIV and STD medications in Texas. Other Bureau expenditures included training and public education, regional and central office administrative costs, laboratory costs, travel, supplies and equipment, and public health promotion. Administration encompasses activities such as program planning and development, quality control and technical assistance to contractors, contract monitoring and 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.



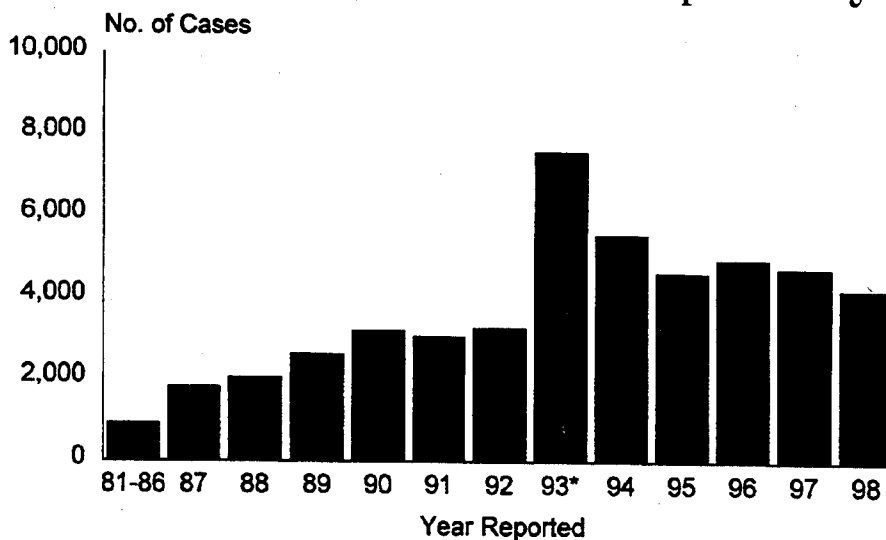
IV. HIV, AIDS AND STDS IN TEXAS - EPIDEMIOLOGIC ASSESSMENT

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 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 AIDS case definition relied on a confirmed positive HIV test and the identification of one of several indicator diseases that commonly occur among immunocompromised HIV-infected patients.

FIGURE 3
AIDS Cases by Year of Report, 1981-1998
48,907 Cumulative Cases Reported through 12/21/98



*Expanded AIDS surveillance definition implemented
AIDS database 01/22/99

Currently Texas, like many states and cities throughout the world, is experiencing a decline in AIDS cases (Figure 3). Texas AIDS data is reported in terms of the year the case was reported to TDH, not the year the person was diagnosed with AIDS. Although from 1996 to 1998 the number of AIDS reports decreased only slightly, preliminary analyses indicate that around 10% fewer people were diagnosed with AIDS in 1997 and 1998.

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 also entered into the equation: HIV-positive individuals are being treated at earlier stages, a variety of therapeutic interventions to prophylax for 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 declined 45% during the first six months of 1997 compared with the first six months of 1996. Additionally AIDS deaths decreased 20% during the first six months of 1998 compared with the first six months of 1997. The 1998 decline in deaths among men was demonstrable across all races; however, for women, Hispanics, and African Americans did not demonstrate a decline in deaths (Table 1).

TABLE 1
Texas AIDS Deaths Comparison by Race and Sex*

	January through June 1997 - Deaths	January through June 1998 - Deaths	% Difference in Deaths
Males			
White	282	206	-27
African American	155	145	-7
Hispanic	130	96	-26
All Others	5	1	-80
Females			
White	33	17	-49
African American	45	49	+8
Hispanic	8	15	+47
All Others	0	0	0
Totals	658	529	-20

* 1997 deaths based on AIDS database 01/28/98 and 1998 deaths based on AIDS database 1/22/99.

By the end of 1998, 48,907 AIDS cases had been reported in Texas, since the epidemic began in the early 1980's. Texas ranked fourth highest in the U.S., with 4,201 AIDS cases reported in 1998 (Figure 3). The overall rate was 21.4 AIDS cases per 100,000 population. In 1998, AIDS no longer ranked in the top ten causes of deaths (overall, male or female), in Texas. For males in the 25 to 34 age group, however, AIDS remained the fourth leading cause of death, and fell to the fifth leading cause of death among the 35 to 44 age group. For Texas males, the 1998 AIDS rate, (36.3/100,000 population), remained much higher than the female AIDS rate (6.8/100,000).

The number of Texans living with AIDS as of the end of 1998, (21,641), has more than doubled in the past four years. New drug therapies account in part for this increase. However, these new therapies also mask the full impact of HIV infections on health care services if only the number of AIDS cases are considered. New drug treatments now available to HIV-infected patients delay the decline of CD4+T-cell counts and the progression to an AIDS-defining condition for these individuals. People with AIDS are living longer and people with HIV need earlier treatment (Figure 4). It remains a challenge to meet the need for HIV/AIDS services.

HIV Prevalence Estimates

Based on World Health Organization estimates, the prevalence of HIV is higher than ever before (over 29.4 million children and adults infected). Despite the recent decline in AIDS cases and deaths, HIV cases appear to be unhampered and the drug combinations do not work for everyone. Texas is currently unable to provide reliable HIV prevalence data. There are no reliable data sources to draw upon for any estimates in Texas at this time. What has been demonstrated, however, is that the most recent data, (1997), from the Survey of Childbearing Women, (SCBW), demonstrates an HIV prevalence rate of 1.05 per 1,000 women, which is similar to the rate that was found in the 1995 SCBW, (.93 per 1,000 women). If data from childbearing women, statewide, can be generalized for the remaining population of Texas, then it would appear that the HIV prevalence is fairly stable at this time. However, such a generalization is questionable, given the limits of the available data.

HIV Reporting

The time from initial infection with HIV until a person develops an AIDS-defining condition may span years; therefore, AIDS case reports do not include those recently infected. HIV infection reports tend to identify more recently infected individuals than do AIDS case reports. For health professionals to follow the current trends of HIV disease and to develop prevention strategies, prompt identification and reporting of HIV infections is essential.

HIV reporting is critical to the accurate and timely assessment of disease trends. As mentioned earlier, new drug treatments now available to HIV-infected patients delay the decline of CD4+T-cell counts and delay the progression to an AIDS-defining condition for these individuals. These developments will reduce the usefulness of AIDS case data for analyzing the epidemic and increase the need for better HIV reporting. The CDC has been encouraging all states to develop reliable HIV surveillance systems because the AIDS case reporting system is no longer adequate to track the HIV/AIDS epidemic. In 1998, Texas initiating discussions in the community regarding the implementation of an HIV surveillance system for statewide reporting to enable the State to begin better tracking of HIV incidence, prevalence and trends. The hope is that this will enable the State to provide more timely services to HIV-infected persons and more effective preventive education.

Ethnicity, Age and Gender Rates

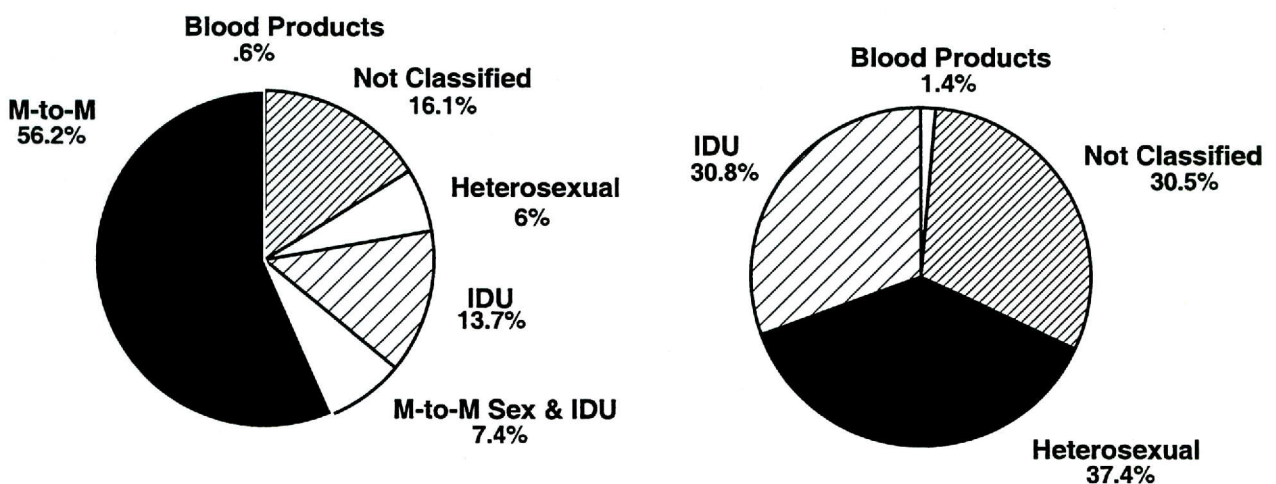
During 1998, the rate of reported AIDS cases among African Americans (68.5 per 100,000 population) was more than four times higher than rates for whites (15.6) or Hispanics (15.8). Among females, the case rate was 6.8 cases per 100,000 population. In the African-American female population, however, the rate was significantly higher at 34.5 cases per 100,000. The Hispanic and the white female rates were lower: 3.9 and 2.8, respectively. The 1998 AIDS rate for males (36.3 per 100,000 population) was much higher than that for females (6.8). The African-American male population had the highest rate, 105.2, followed by white males at 28.9, and Hispanic males at 27.4 AIDS cases per 100,000 population (Table 2). Of the AIDS cases reported in 1998, 16% were among women, compared with only 9% in 1992. In 1997 Hispanics composed 18.6 % of AIDS cases. In 1998 this increased to 22.1%. During this time, the African-American cases decreased from 40.6% in 1997 to 36.7% of the total AIDS cases in 1998. These shifts indicate that AIDS is spreading among women and Hispanics.

The 20 to 44 year-old age group demonstrated the highest AIDS rate in 1998, at 42 cases per every 100,000 Texans. The 45+ year-old age group exhibited the next highest rate at 15 cases per 100,000 Texans. As of 1997, the teenage group, (15 to 19 year-old age group), has a lower AIDS rate, at less than 2 cases per 100,000 Texans.

These data imply, however, that the teenage group is at high risk of acquiring the HIV infection, since it usually takes 5 to 10 years to develop AIDS following HIV infection. STD incidence (new cases of disease in a given time frame - year), is highest in these teen years.

A cumulative total of 2,670 AIDS cases in those age 15 through 24 had been reported to TDH by the end of 1998. Of these cases, 173 were reported in 1998 alone. The ethnic profile of AIDS cases in the 15 through 24 age group has shifted over the past nine years. In 1988 the composition was 56% white, 19% African American, and 25% Hispanic. In 1998 the composition was 23% white, 54% African American, and 23% Hispanic.

FIGURE 4
Adult-Adolescent* AIDS Cases Reported in 1998
Mode of Exposure by Gender



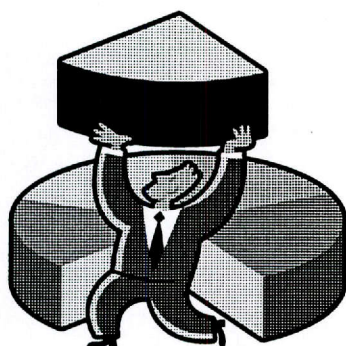


TABLE 2
AIDS Cases Reported in 1998 by Race and Sex*

Sex/Race	Cases	%**	Cases per 100,000
Males			36.3
White	1,553	44	28.9
African American	1,137	32	105.2
Hispanic	815	23	27.4
All Others	18	<1	—
Females			6.8
White	159	23	2.8
African American	403	59	34.5
Hispanic	113	17	3.9
All Others	3	<1	
—Total Cases	4,201	100.0	21.4

*The category, All Others, includes any racial/ethnic group not listed as well as those cases not specifying race. Therefore, a rate is not calculated.

**Percentages may not add up due to rounding..

Mode of Exposure

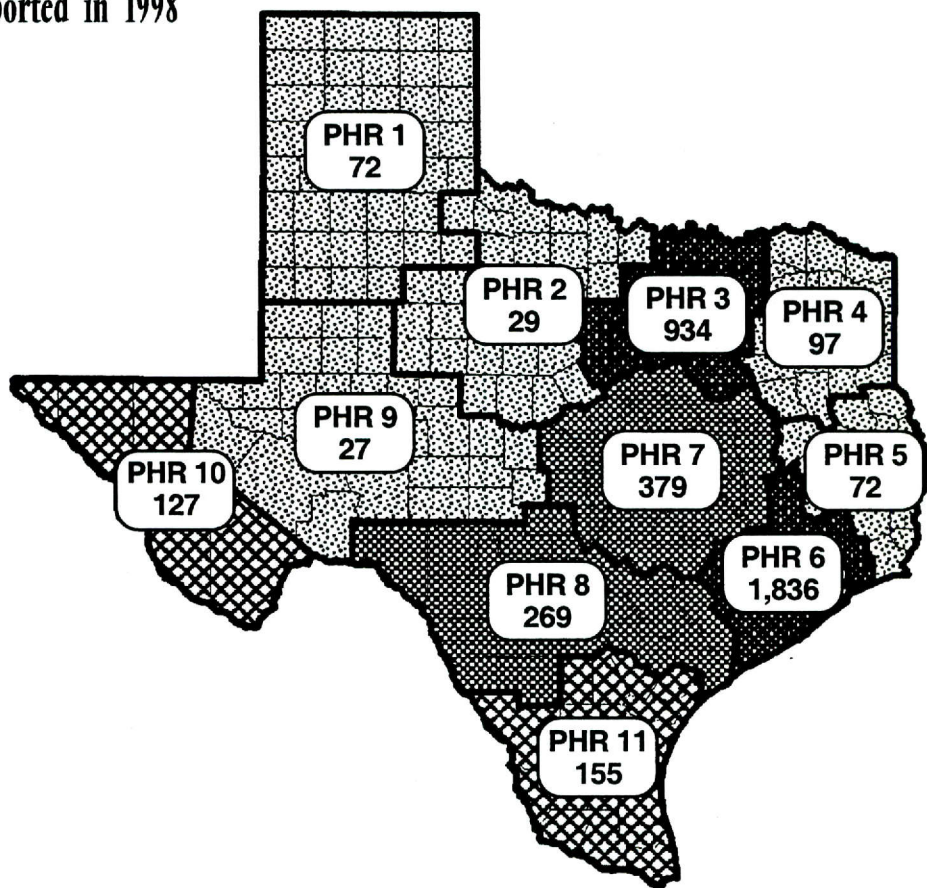
Although lower than in previous years, the exposure category of male-to-male-sex constituted the highest proportion (56%) of AIDS cases among men (Figure 5). Injecting drug use was the second most likely route of transmission (14%) for men reported with AIDS in 1998. Among women, 37% were infected through heterosexual contact and 31.0% through the use of injecting drugs. A higher percentage of cases among women (30%) than men (16%) were initially left unclassified as to mode of exposure. For both sexes, the percentage of cases that remain unclassified will decrease as the investigations of risk are completed and cases are reclassified into other categories.

Perinatal HIV transmission has declined dramatically (70%) since 1993 when 915 cases were reported. In 1997, only 278 perinatal HIV cases were reported to TDH. While this number is still too high, the downward trend is very encouraging.

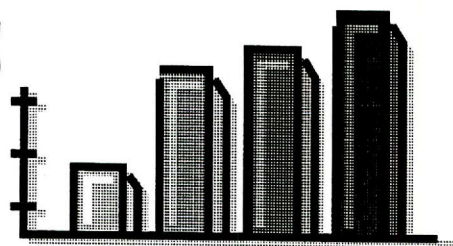
Geographic Distribution

Most AIDS cases in Texas continue to be reported from metropolitan areas, but AIDS has reached all regions in the State (Figure 5). The largest number of cases reported in 1998 was from Houston/Harris County (1,605) followed by Dallas (617), Austin/Travis (265), San Antonio/Bexar (228), Ft. Worth/Tarrant (210), and El Paso Counties (126). Ranking these counties by rate slightly affects the order. Harris County had the highest rate (49.9 per 100,000 population) followed by Travis (41.4), Dallas (28.9), and El Paso Counties (17.1). The rates for Bexar and Tarrant Counties were 17.0 and 14.3 cases per 100,000 population, respectively. Only 29 of the 254 counties in Texas have never reported an AIDS case. The Texas Department of Criminal Justice reported 5.6% of all 1998 AIDS cases. 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. Especially now, when the early aggressive treatment of HIV-infected populations has proven to substantially increase longevity, outreach to high-risk populations is extremely important.

FIGURE 5
AIDS Cases by Public Health Region
Number of Cases Reported in 1998



SEXUALLY TRANSMITTED DISEASES



Primary and Secondary Syphilis

Infection with the spirochete *Treponema pallidum* results in syphilis. Primary lesions (ulcer or chancre at the site of infection) followed by secondary infection (manifestations that include rash, mucocutaneous lesions, and adenopathy) characterize the acute form of syphilis. Untreated syphilis progresses into a chronic disease with long periods of latency. Statewide, 430 cases of primary and secondary (P&S) syphilis were reported in 1998. This 37% decrease from cases reported in 1997 continues a downward trend. The number of P&S syphilis cases reported in 1998 was one-tenth the number reported in 1991. The overall State rate in 1998 for P&S syphilis was 2.2 cases per 100,000 population—the lowest rate since the late 1950's. Officials at the CDC are calling for the elimination of syphilis altogether from the U.S., while the national rates are extremely low. CDC officials believe this is a possibility within the next five years.

African Americans continue to account for the majority (67%) of P&S syphilis cases reported in Texas. The rate of P&S syphilis among African Americans was 12.9 cases per 100,000 population in 1998, less than one-fourth the 1995 rate of 53.2 per 100,000 population (Figure 7). Nonetheless, the rate for African Americans remained extremely high compared with other ethnic groups (Figure 6). The case rate for Hispanics was 1.1 cases per 100,000 population, for whites 0.4 case per 100,000 population, and for other ethnic groups (excluding cases with race unspecified) 1.2 cases per 100,000 population. Among African-American females, those aged 20 to 24 had the highest rate at 31.3 cases per 100,000 population. The highest rate for African-American men was found among those aged 20 through 24 with 41.0 cases per 100,000 population. The extremely high case rate for both sexes indicates the continuing severity of the problem of P&S syphilis among young African Americans in Texas.

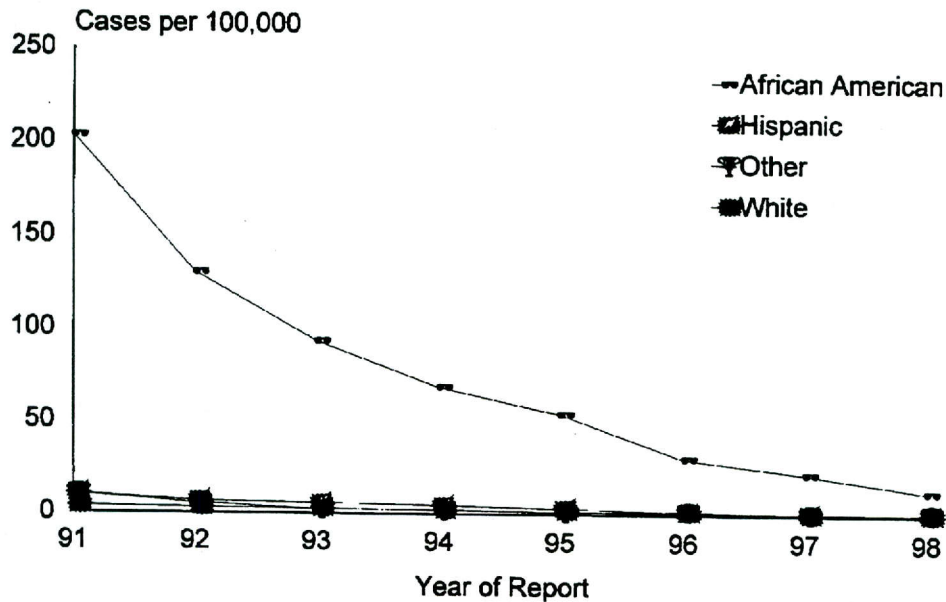
As in 1997, about one-third of the patients with P&S syphilis were aged 15 to 24 years. The number of cases in men and women were almost equal: women accounted for 177 cases (41% of the total) compared with 253 cases among men. In 1998 there were only 48 (11%) cases of P & S syphilis among those age 15 to 19 years. Despite the fact that the numbers have steadily declined in recent years, there is still significant racial/ethnic disparity in P & S syphilis prevalence.

Early Latent Syphilis

Latent syphilis is the stage in which no observable clinical signs or symptoms are present to suggest infection, yet the serologic tests for syphilis (STS) are reactive. All cases of syphilis are latent at some time during the course of an untreated infection.

FIGURE 6

Primary and Secondary Syphilis Rates by Race/Ethnicity: Texas, 1991-1998



The *early* latent stage of syphilis is defined as latent disease within the first year after infection. These periods can occur between the primary and secondary stages, between secondary relapses, and after the secondary stage. In early syphilis, any period during which primary or secondary symptoms are absent is classified as latent.

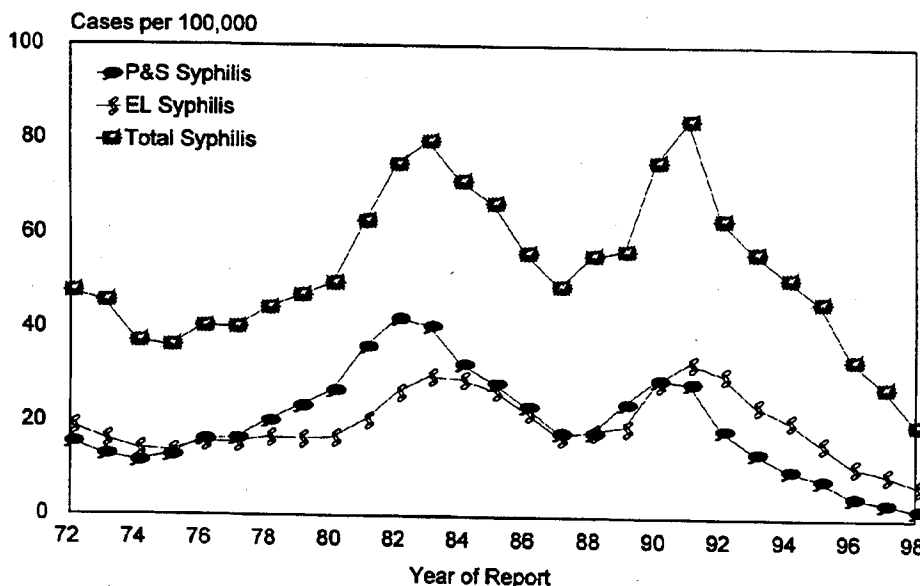
When more than a year has passed since the patient became infected and there are no signs of disease, the case is classified as a *late latent* case. The reason for separating latent stages into early and late is that secondary relapses generally do not occur following the first year and that early latent disease is treated with a single dose of benzathine penicillin (vs. three doses for late latent disease). The diagnosis of latent syphilis is made on the basis of a confirmed positive serologic test.

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, respectively. Since that time, the rate of P&S syphilis has steadily declined. However, the early latent syphilis rate increased in 1991 and since then has decreased more slowly than the P&S syphilis rate (Figure 8). 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 1998 compared with 1990, the number of early latent syphilis cases (1,460) was almost three times the number of P&S syphilis cases. The 1998 overall rate of early latent syphilis was 7.4 cases per 100,000 population. The case rates (cases per 100,000 population) for early latent syphilis by race/ethnicity were as follows: African Americans, 39.4; Hispanics, 5.7; whites, 1.3.

In 1998 African Americans constituted 61% of all early latent syphilis cases, followed by 10% whites and 23% Hispanics. Women aged 15 to 24 years made up 37% of all females with early latent syphilis while men in this age group accounted for only 18% of all cases in males.

FIGURE 7

Syphilis Rates: Texas, 1972-1998



Congenital Syphilis

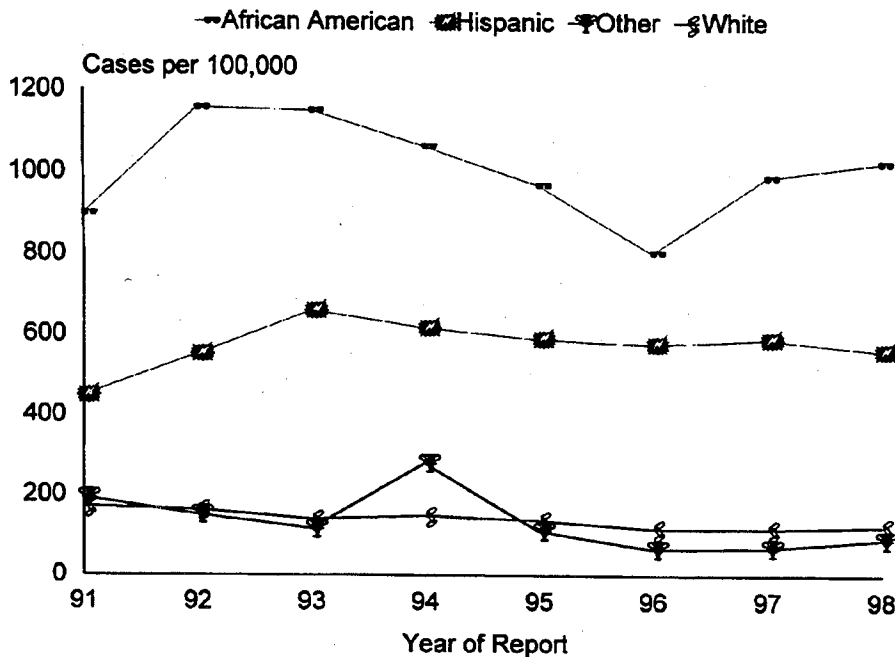
Congenital syphilis, one of the most serious forms of the disease, may cause spontaneous abortion, stillbirth, or premature delivery, as well as numerous severe complications in the newborn. In 1998, 99 cases of congenital syphilis were reported, marking the sixth straight year of decline. The lower number of congenital syphilis cases in 1998 represented a 38% decrease from 1997. With 51 cases in 1998, Harris County had the highest number of congenital cases, much less than the 108 cases reported in 1997. Dallas County had the second-highest numbers with 23 cases. Statewide, 55% of congenital syphilis cases were in African Americans; 39% among Hispanics; and 2% in whites.

Chlamydia

Infections caused by the bacteria, *Chlamydia trachomatis*, are the most common of all sexually transmitted diseases. Chlamydia infection in women can result in serious complications such as pelvic inflammatory disease, ectopic pregnancy and infertility. After chlamydia became reportable in 1987, the number of cases soared, reflecting increased testing but not increased disease. Reports of chlamydia in 1998 totaled 60,626, a 20% increase from the previous year's total of 50,661.

Statewide, the total number of clients screened by public funding decreased slightly (from 354,889 in 1997 to 349,517 in 1998); the number of positives resulting from those screenings decreased by 401 (from 24,108 to 23,707 positives). Of the total chlamydia cases reported in 1998, 83% were in

FIGURE 8
Chlamydia Rates for Females: Texas, 1991-1998



females. Women are more likely to be screened for chlamydia during clinical exams for family planning, prenatal care, and routine pap smear testing. Because of the increased risk of severe outcomes (including the potential to infect a newborn child), chlamydia screening programs focus on women. Males are often asymptomatic and therefore do not seek treatment. Given that men are not targeted for testing and thus make up such a small proportion (less than 17%) of chlamydia cases reported, it is not possible to estimate the true incidence of chlamydia in the Texas population. Due to the overwhelming proportion of cases among women, rates of chlamydia infection for each sex should be examined separately. The 1998 case rate for females was 504 cases per 100,000 population with African American women having the highest rate (1,026) followed by Hispanic women (563) and whites (123 cases per 100,000 women). Examination of the case rate in men demonstrated the same racial/ethnic distribution as women but with far lower rates. However, if males were equally targeted for screening and testing, incidence among males would be higher than suggested by case reports.

Over 40% of all reported chlamydia patients were aged 15 to 19 years of age. Seventy-six percent of chlamydia cases in women in 1998 were among those 15 to 24 years of age. With nearly 38,000 cases reported for females ages 15 to 24 alone, the rates for chlamydia among young women age 15 to 19 years and 20 to 24 years were 2,994 cases and 2,431 cases per 100,000 population, respectively.

Gonorrhea

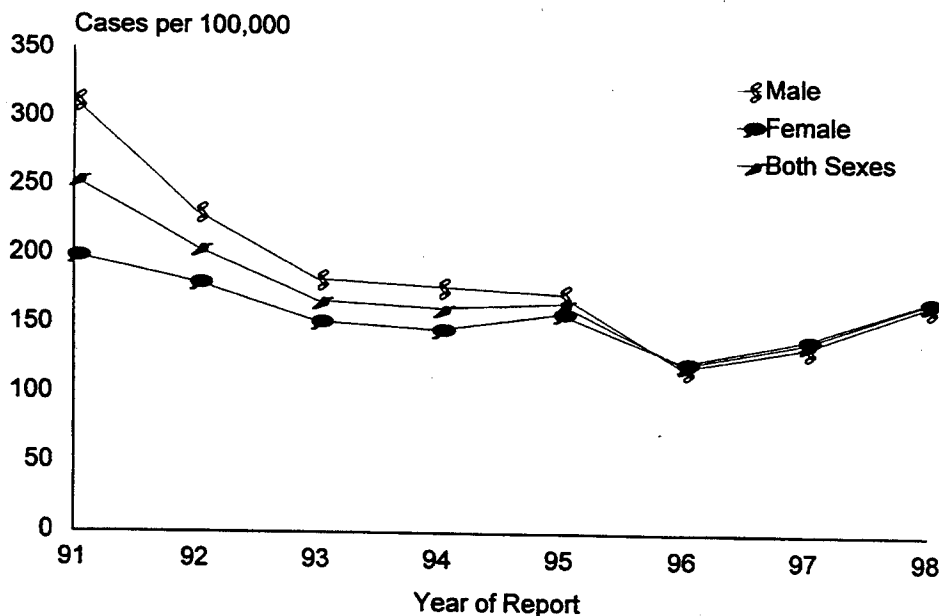
Infection with the bacteria, *Neisseria gonorrhoeae*, results in clinical gonorrhea. Left untreated, gonorrhea may lead to sterility in men and pelvic inflammatory disease, ectopic pregnancy, and sterility in women. The 32,934 gonorrhea cases reported in 1998 represent a 24% increase from the number of cases reported in 1997 and the second year in a row of increased incidence. In Texas, the rate of gonorrhea had been steadily decreasing since 1978, when it reached a peak of 683 cases per 100,000 population.

The 1998 overall rate for gonorrhea was 168 cases per 100,000 population, the highest since the 1995 rate (165). The female rate at 169 was slightly higher than the male rate at 165 cases per 100,000 population. Among age groups, the highest rate for females was found in females aged 15 to 19 years (944 cases per 100,000 population) followed by those aged 20 to 24 years (744 cases per 100,000 population). Males in these age groups also had higher rates than did males in other age groups. Gonorrhea among females aged 15 to 24 years comprised 71% of all cases in females; males of the same age group accounted for 52% of all gonorrhea cases among males.

As noted for chlamydia, increased screening may be responsible for some of this rise. Statewide the total number of publicly funded screenings decreased 2% (from 357,317 in 1997 to 350,643 in 1998); the number of positives resulting from these screenings dropped 5% from 14,689 to 13,930 between 1997 and 1998.

FIGURE 9

Gonorrhea Rates by Sex: Texas, 1991-1998



The rate for African Americans (756 cases per 100,000 population) is nearly 10 times greater than that for Hispanics (77 cases per 100,000 population) and 26 times higher than the rate for whites (29 cases

per 100,000 population). African-American men had the highest rate of all race-sex groups with 874 cases per 100,000 population. As was seen for the entire population, African Americans aged 15 to 24 years accounted for the greatest share of African-American cases (63% of those reported); they also represented 32% of all cases reported, regardless of race or age.

The highest rates of gonorrhea occurred in eastern Texas. This is not surprising considering that African Americans have a high rate of gonorrhea and that more African Americans live in east Texas than in other areas of the State. The lowest rates of reported gonorrhea occurred along the border with Mexico.

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 1998, 1,861 cases of PID were reported, a 39% increase from the 1,341 cases reported in 1997. PID attributed to cases of known etiology (chlamydial or gonococcal) demonstrated the largest increase for 1998, while the 1997 increase was attributed to cases of unknown etiology.



Chlamydial PID case reports rose from 281 in 1997 to 487 in 1998; gonococcal PID case reports more than doubled from 190 in 1997 to 399 in 1998. New surveillance software (STD*MIS) is the most likely explanation for the increase in the total number of cases. STD*MIS may also have resulted in the increase in cases with the etiologic agent identified because of the data capture method. Regardless of the improvements in data capture, PID most likely remains vastly under-reported making analysis of trends difficult.

The racial/ethnic occurrence of PID resembles that of other STDs: African-American women accounted for 44% of all cases, Hispanic women for 29% and white women for 19%. Young women aged 15 through 24 accounted for 59% of all cases.

Sexually Transmitted Diseases Among Adolescents

Adolescents are at high risk for acquiring a wide array of STDs for several reasons: they may be more likely than others to have multiple sexual partners rather than a single, long-term relationship; more likely to engage in unprotected intercourse; and more likely to select partners at higher risk of having STDs. During the past two decades, the age of initiation of sexual activity has steadily decreased.

U.S. and Texas Adolescent Statistics

The total burden of STDs is estimated at 12 million new infections annually in the United States. Of these, 3 million occur among teenagers. In this country, STDs are the most common reportable diseases and recently several studies have linked HIV transmission to the presence of STDs. There is now strong evidence that other STDs increase the risk of HIV transmission, and conversely, STD treatment reduces the risk of acquiring HIV. Studies indicate that people are two to five times more likely to become infected with HIV when other STD's are also present. The open lesions of herpes and syphilis allow a portal of entry for HIV viruses, while the inflammatory and mucopurulent nature of gonorrhea and chlamydia provide numerous target cells (CD4 cells) for increasing susceptibility. About two-thirds of all STD infections generally occur among persons under 25 years of age and predominantly among minority populations. 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 103,323 cases of all STDs reported in Texas in 1998, over 65% were among those aged 15 through 24 years old (Figure 10). Over 34% of these cases were from adolescents 15 to 19 years old. Minority youth make up a disproportionate share of these STD cases. The 1998 STD case reports that included ethnicity information for those aged 15 through 19 were comprised of 48% African American, 34% Hispanics, 18% white, and <1% other ethnicities. The STD case rate for African Americans was almost two times higher than the Hispanic rate, and almost three times higher than the white rate.

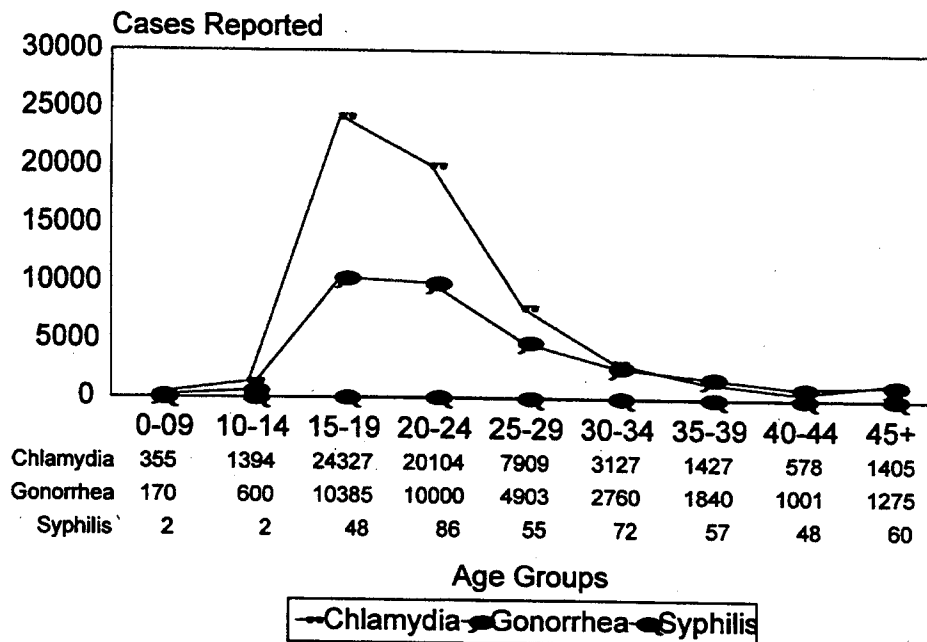
Gonorrhea cases reported in 1998 among those aged 15 through 19 numbered 10,385 and accounted for 32% of all gonorrhea cases. The case rates for this age group by race/ethnicity per 100,000 population were African American: 2,654, Hispanics: 282, and whites: 143.

Chlamydia cases reported in 1998 numbered 24,327 for this age group (15 to 19 year old) and accounted for over 40% of all cases reported. The case rates for this age group per 100,000 population were African American: 3,407, Hispanics: 1,353, and whites: 501. 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. Also, women are more likely to be screened than men; 83% of all cases reported in 1998 were among women.

Primary and secondary syphilis cases reported in 1998 numbered 48 among those aged 15 through 19 and accounted for 11% of all primary and secondary syphilis cases. The case rate for African Americans (17.5 per 100,000 population) in this age group, was 13 times higher than the Hispanic case rate (1.3) and 25 times higher than the white case rate (.7).

The annual cost of STD treatment and related services is estimated at over 10 billion dollars annually. For Texas, the cost of treating uncomplicated STDs for those 15 through 19 years of age in 1998 was at least \$2.5 million. Every dollar spent in Texas for the prevention of STDs saves ten dollars in medical costs.

FIGURE 10
Selected STD's by Age Group: Texas 1998



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.

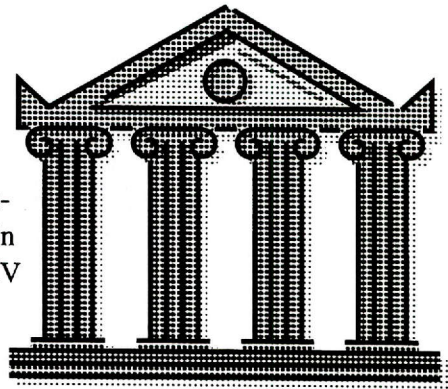
V. HIV PREVENTION AND SERVICES

HIV PREVENTION

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. Over \$7.6 million were awarded directly to local health departments and community-based organizations providing prevention services to their communities in 1998.

Community Planning

Community planning is the process which enables local communities to identify, plan, and determine prevention priorities within the regions. The TDH will use the priorities identified by the HIV Regional Planning Coalitions in the establishment of future HIV Cooperative Agreements with the CDC. The TDH, in partnership with the ten HIV Prevention Regional Planning Coalitions (Coalitions), instituted major initiatives in the community planning process in 1998.



Community planning in Texas has evolved from a single decision-making body heavily influenced by TDH to a partnership with ten community planning groups that represent the geographic and cultural diversity of Texas. The Coalitions are responsible for determining community priorities and intervention strategies based on local and regional needs assessment. The Coalitions 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.

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

The HIV Prevention Regional Planning Coalitions are in a two-year planning cycle (1997-1998). During this planning cycle, the Coalitions will review epidemiological and needs assessment data, behavioral science literature on prevention interventions, and complete a priority setting process to develop the Regional Action Plans. The 1999 Comprehensive HIV Prevention Plan to be submitted to the CDC in October of 1998 for implementation years 1999, 2000, and 2001 will be a compilation of the ten Regional Action Plans.

Accomplishments

- The ten Coalitions, in partnership with the TDH, completed the *1998 Comprehensive HIV Prevention Plan*. The targeted subpopulations were categorized in one of three Behaviorally-Defined Target Populations (BDTP): persons at highest risk of HIV infection or reinfection through male with male sexual activity (M/MMS); persons at highest risk of HIV infection or reinfection through injecting drug use (IDU); and persons at highest risk of HIV infection or reinfection through unprotected heterosexual sex (UHS).
- TDH used a variety of communication sources to educate the general public on community planning, such as sample brochures, public notices and other informational materials. The TDH HIV/STD Prevention web page contains information on HIV prevention community planning, the roles and responsibilities of community planning groups (also known as CPGs or HIV Prevention Regional Planning Coalitions), frequently asked questions regarding community planning and contact information for the CPG Co-chairs.
- At the regional level, the Coalitions marketed the community planning concept and solicited membership through varying methods, which included soliciting participation from organizations; conducting town meetings; distributing informational materials, such as brochures and newsletters; and distributing promotional materials, such as tee shirts and magnets.
- All CPGs were provided with data on subpopulations and interventions to be addressed by TDH prevention contractors to include as part of their resource inventory for their next Regional Action Plan. Several Coalitions collected resource inventory data on organizations that were not funded by the TDH. CPGs were encouraged to collect resource inventory information on a continuous basis, updating their inventories as they became aware of new providers of prevention services and other regional resources.
- TDH increased technical assistance to Coalitions to improve their ability and capacity to produce regionally representative HIV prevention plans. The technical assistance included training in infrastructure development, assistance in analysis of epidemiological data collection, guidance on applying behavioral science theory to prevention interventions, and data collection methods.
- Each CPG began drafted a Regional Action Plan (RAP) for implementation years 1999, 2000 and 2001. The RAPS include priority subpopulations and interventions based on the needs assessment data and the priority setting process conducted in 1997.
- The following regional issues were addressed in 1998. The Co-chairs will decide at a later date the methodology for resolution of the issues. In addition, it was decided that two issues,

PIR and Prevention Evaluation, will be addressed in a work group. The 1998 regional issues are as follows:

1. Membership
 2. PIR
 3. Community Planning Structure
 4. Clarification of Collaboration
 5. Priority Setting.
- In May 1998, TDH and the HETCAT consultants, with the assistance of the Coalitions, developed and administered an evaluation of the community planning process to determine which processes are working well and which need to be strengthened.
 - The CPGs and TDH redesigned the structure of local planning regions to assure effective implementation of community planning and to assist rural CPGs in maintaining representation in the process.

Future Plans

During the next twelve months, the Community Planning Program will conduct the following activities: revise existing by-laws; implement a new planning structure for HIV and STD prevention; integrate STD prevention interventions into the HIV Comprehensive Plan; and transition the implementation of the community planning program to a contractor.

Health Education and Risk Reduction

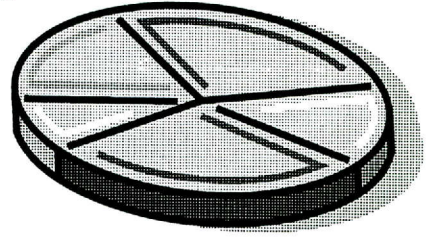
The goal of the Health Education and Risk Reduction (HERR) component is to educate persons at high risk for HIV about disease transmission, assist them in establishing realistic and personalized risk reduction plans, and to provide them with the skills needed to remain HIV free. During 1998, TDH staff developed and managed a competitive application and review process for selecting HERR contractors who will provide these services for their communities beginning January 1, 1999. This competitive application was based on plans developed by the 10 community planning groups, using the process outlined in the previous section.

In 1998, both local health departments and community-based organizations provided HERR services. These contractors targeted one or more of the specific populations named in their region's HIV Prevention Plan (e.g., African-American injection drug users, gay men, women at risk through heterosexual transmission) 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 served¹, 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, schools, local health department clinics, and other local agencies.

¹ 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.

TDH staff also provide technical and programmatic assistance, as well as conduct monitoring of HERR contractors. In addition, TDH staff provide technical 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 over 200,000 educational contacts to gay men, injection drug users, and high-risk heterosexuals in a variety of community-based settings. Contractors exceeded targeted contacts in all categories of behaviorally-defined target populations.
- HERR contractors dispensed over 4 million condoms throughout the State.
- TDH staff and staff at the AIDS Prevention Project at the University of Texas Southwestern Medical Center at Dallas completed development of a system for reporting contacts made during HERR activities. This data and reporting system was piloted in 1998.

Future Plans

- TDH will continue to direct HERR contractors to provide HERR interventions in outreach settings and to have peers of the targeted population providing these interventions. Peer outreach will be conducted in locations identified in regional prevention 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.
- TDH will continue to provide guidance and technical assistance to ensure that HERR contractors reach their targeted populations.
- TDH will implement the new HERR data collection systems to enhance efforts to monitor and improve programs.

Prevention Counseling and Partner Elicitation

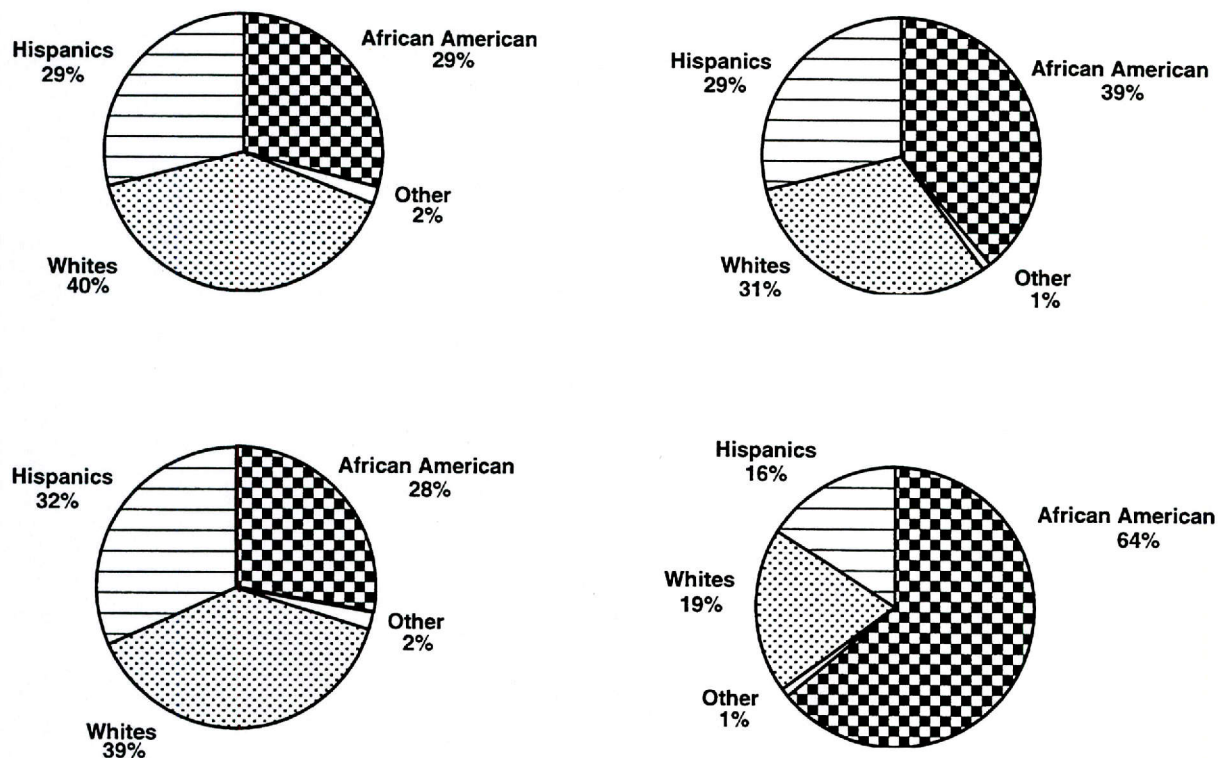
TDH provides Prevention Counseling and Partner Elicitation (PCPE) services throughout the State through contracts with local health departments and community-based organizations. Prevention Counseling is client-centered, interactive and responsive to individual client needs. The focus of prevention counseling 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, which includes assessing and supporting client readiness for testing and coping with the results.

When clients return to learn their test results, they always 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. The PCPE staff provide referrals to link HIV positive clients with medical, psychological and social services. They also elicit 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. These notifications can be handled either by the clients or by trained Disease Intervention Specialists at local health departments. 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 to contractors and monitor contracts to ensure compliance with objectives and appropriate use of program funds. Additionally, the PCPE component maintains 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

FIGURE 11
Percentage of HIV Tests and Percentage of Positive HIV Tests
By Sex and Ethnicity, Texas 1998



fills out a standard machine-scannable bubble form that contains demographic and mode of exposure² information about the client, as well as information about the counseling session (e.g., date, if 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 forwarded to the CDC in Atlanta.

In 1998, contractors reported 130,188 initial counseling sessions. Fifty-one percent (51%) of these sessions were with male clients, and 49% with females—the first time since TDH began tracking HIV counseling that more men than women were counseled.

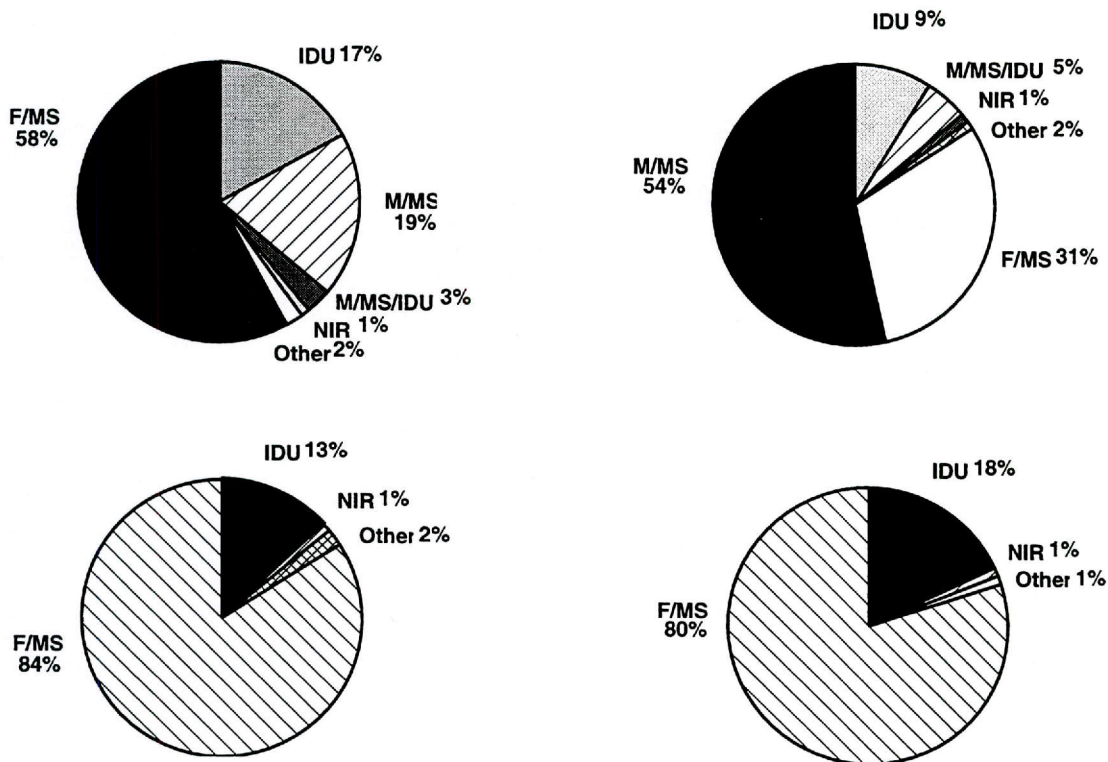
In this year, 99% of the initial counseling sessions included an HIV test. Of these tests, 41% were for clients who had never tested for HIV before. For every 100 tests performed, 1.1 were HIV- positive. This rate is the same as the positivity rate reported in 1997. The race/ethnicity and mode of exposure of the men and women who tested and who tested positive for HIV are shown in Figures 12 and 13. Positivity rates were two times higher for African Americans than other race/ethnic groups, and rates of positivity were three times higher for men compared to 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 four times higher 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 28% of the HIV tests done for women, but 64% of the positive tests among women.

Accomplishments

- Staff at TDH and at the AIDS Prevention Project at the University of Texas Southwestern Medical Center at Dallas completed the development of a new scannable record and data compilation system to provide contract monitors, contractors, and community planning groups with more detailed information about PCPE.
- PCPE contractors provided 129,617 HIV tests in 1998. Of these 1,426 of these tests were positive for HIV. This positivity rate, 1.1 positives per 100 tests, was the same as the rate for 1997.
- More than 90% 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.

² 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).

FIGURE 12
Percentage of Tests and Percentage of Positive Tests
By Sex and Mode of Exposure, Texas 1998



Future Plans

- TDH will implement the new PCPE data collection and reporting system.
- TDH will continue to provide guidance and technical assistance to ensure that PCPE contractors reach the targeted populations outlined in the regional prevention plans.
- TDH will continue to emphasize the importance of augmenting on-site, clinic-based counseling and testing services with PCPE services provided at non-traditional sites with the goal of making counseling and testing more accessible to target populations. Non-traditional sites refer to field testing that occurs in places where high-risk activities involving a targeted population takes place or where members of a targeted population congregate.
- In a further effort to expand accessibility, PCPE contractors are expected to use counselors who are peers of the targeted populations.

HIV SERVICES

Texas HIV Services projects were established in 1989 in response to *AIDS in Texas: Facing the Crisis*, the final report of the Texas Legislative Task Force on AIDS. In supporting basic treatment and health and social services to HIV-infected Texans, the Texas Legislature charged the HIV/STD Health Resources Division (Division) to:

- coordinate the use of local, federal and private HIV Services funds;
- encourage the provision of community-based HIV services;
- address needs not met by other funding sources;
- provide statewide distribution of HIV Services funds that reflect regional needs; and
- encourage cooperation among local HIV service providers (Health and Safety Code, Chapter 85, sec. 85.032).

Additionally, the reauthorized Ryan White CARE Act of 1996 mandated the development of a *State-wide Coordinated Statement of Need (SCSN)*, the purpose of which is to provide a mechanism to collaboratively identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWH/A) and to maximize coordination, integration, and effective linkages across the CARE Act Titles related to such issues. The mandate requires participation in the development of the SCSN by CARE Act recipients. Guidance for the project was developed by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (DHHS), with active participation from HIV/AIDS Program Directors, Title I and Title III grant recipients, the National Alliance of State and Territorial AIDS Directors (NASTAD), various constituent groups, and PLWH/A. The SCSN has become a multi-year, long-range project which will:

- ensure representation from consumers and all Ryan White (RW) grantees across all RW Titles, resulting in collaboration and coordination;
- include a strong emphasis on needs assessment activities;
- identify State systems and activities and services that are already in existence;
- look at how epidemiological data are currently being used at the local level;
- create a better network of local/State communication;
- facilitate capacity development of providers as it relates to HIV services; and
- provide opportunities to collaborate with peers and colleagues statewide.

Service Delivery

During 1998, the Bureau of HIV/STD Prevention, in compliance with both State and federal mandates, distributed over \$18,500,000 in HIV service contracts throughout the State.

To award HIV Service funds as extensively and equitably as possible, the Bureau divides the eleven Texas Public Health Regions into 26 HIV Service Delivery Areas (HSDAs). Each HSDA is served by a local HIV CARE Consortium made up of public and private HIV service providers, community-based organizations, HIV-infected individuals and community leaders. The Consortium determines the needs of its community and allows local providers to coordinate services. This ensures that a wide variety of medical and psychosocial services are available to the local HIV-infected population.

TDH contracts with an administrative agency designated by the Consortium members to manage the TDH award. The funds available to each HSDA are determined through a funding formula based on the population living in the HSDA (50%), the number of AIDS cases reported in the most recent 24-month period (50%), and an adjustment for the local poverty index.

Basic HIV services supported by TDH contracts with local health departments and community-based organizations include:

- * ambulatory/outpatient medical care
- * case management services
- * dental care
- * medications
- * mental health therapy
- * support services, such as direct emergency financial assistance, food bank, housing, and transportation.
- * hospice care
- * insurance assistance program
- * nutrition services
- * rehabilitation care
- * substance abuse treatment/counseling
- * home health care

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 economically devastated by the disease, many must rely on publicly funded care. Providing cost-effective HIV services benefits all Texas residents by reducing health care costs supported by taxpayers.

Accomplishments

- The HIV/STD Health Resources Division participated in the development of a training video regarding the responsibilities of nonprofit boards of directors who contract with TDH. The video entitled "Texas Department of Health Legal and Fiscal Responsibilities for Nonprofit Boards of Directors," was distributed along with an accompanying manual to all TDH nonprofit contractors in September 1998.
- The Statewide Coordinated Statement of Need Steering Committee set goals for addressing emerging trends and crosscutting issues in years two and three of the project period.
- In March 1998, the Bureau of HIV and STD Prevention adopted a three-year strategic plan. The plan identifies issues to be addressed by the Bureau and concrete strategies. The strategies are aimed at increasing the capacity of contractors to perform, increasing access to quality care, further integrating HIV and STD planning and programming, strengthening and expanding STD services, improving HIV/STD surveillance systems, and enhancing the capacity of Bureau staff to excel at work responsibilities.
- In May 1998, TDH sponsored its annual Ryan White meeting for representatives from Title I, II, III, IV, and Part F grantees. Attendees also included Title II consortia chairpersons and Title II planning council chairpersons. The meeting included sessions on a variety of topics,

including needs assessment, HRSA and TDH policies, the Texas Medication Program, the COMPIS database system, cross-title coordination, and insurance assistance.

- Ryan White Title II contractors reported positive coordination efforts at the local level with the Tuberculosis (TB) Control Programs. At the State level, the TB Elimination Division and the Bureau continue to collaborate in the areas of education, services, and reporting.
- HOPWA and HUD funding periods have been synchronized to reduce the amount of unallocated funds remaining at the end of each fiscal year; close to \$1 million in past unallocated funds were distributed.
- TDH performed a *Survey of Publically-funded Providers of Prenatal Care or HIV Testing* to determine the rate of compliance with HB1345.

Future Plans

- The Bureau of HIV and STD Prevention began a process of identifying positive and negative elements in the current system of planning for and delivering HIV services in Texas. As these issues were explored, Bureau staff recognized an opportunity to consider the HIV prevention community planning system and the need for increased planning of sexually transmitted diseases services. The Bureau began developing a White Paper on "Community Involvement in HIV/STD Planning and Administrative Services." In 1999, the Bureau will determine what measures to take to implement planning system changes and to integrate HIV/STD planning.
- In collaboration with Consortia and administrative agencies, the TDH will continue to expand and revise written policies and procedures for efficient Consortia and administrative agency operation.
- The TDH will continue to provide technical assistance to Consortia and administrative agencies to improve their working relationships and incorporate broad community input into their processes.

CASE HISTORIES

Success Story #1

A 32-year old man was referred to a community-based organization (CBO) by a physician. Married with two small children, this man had an extremely compromised immune system and needed immediate emotional, financial, and medical support. In addition to assistance with obtaining medications and medical care, the CBO staff helped the family reconnect electric and gas service and provided them assistance with their rent and their application for federal Section 8 housing. The CBO also assisted the family with food through the local food bank.

Success Story #2

An 18-year old woman became pregnant and infected with the HIV virus at the same time. Due to early diagnosis and treatment, she had a healthy baby boy. Through case management and transportation provided through a CBO, this young woman was able to keep all her medical appointments. Her son is now 16 months old, HIV negative, and scheduled for his last HIV test. The CBO looks forward to removing him from the client list.

Success Story #3

A 40-year old homeless man came to a CBO for help. So severely alcoholic that he was unable to complete his intake interview without slipping into the bathroom to drink rubbing alcohol, he soon became clean and sober with the agency's support. Case management staff enrolled him in substance abuse treatment and with Shelter Plus Care funds they also found him supervised housing. From there, he went to vocational training and graduated from welding school. He is now self-supporting and sober for over three years. He volunteers at the CBO whenever he can.

VI. STD PREVENTION AND SERVICES

Sexually transmitted diseases (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 are passed to the fetus through the mother's blood while she is carrying the child or at delivery. Others, such as gonorrhea, chlamydia and herpes, are usually 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 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.³

The goal of STD prevention and services is to prevent the spread of high priority STDs such as syphilis, HIV, chlamydia, and gonorrhea. The foundation of this effort is built on four primary components: surveillance and case detection through screening, disease intervention activities, direct client services, and training and technical resources. Three of these components are discussed below; training and technical resources efforts are addressed in the Training and Public Education section of the report.

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

³ Institute of Medicine. *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*. Washington, DC: National Academy Press, 1997, p.7.

Highly trained Disease Intervention Specialists (DIS) routinely perform syphilis and HIV counseling/interviewing, case management, and partner notification activities for individuals infected with these STDs. In certain locales where resources permit, they also perform targeted gonorrhea and chlamydia case finding. DIS also provide targeted prevention counseling to clients identified as high risk for STD. Prevention Counseling and Partner Elicitation (PCPE) activities are routinely performed with early syphilis and HIV-infected individuals. PCPE is applied to 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 and counsels him or her on ways to handle the infection or exposure and 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 14) continues with the identification of each infected partner. When a contact is notified, they are not told who identified them as a potential contact. All disease intervention activities are completely confidential.

The Bureau purchases and distributes medicines for the treatment of priority STDs to regional and local health departments and other key providers through the STD Medication Program. The STD Medication Program is highlighted later in this report. The Bureau purchases HIV/STD disease intervention services from regional and local health departments. The Bureau also funds local physicians to examine and treat STD patients exposed to syphilis, chlamydia and gonorrhea when no publicly-funded facilities are available.

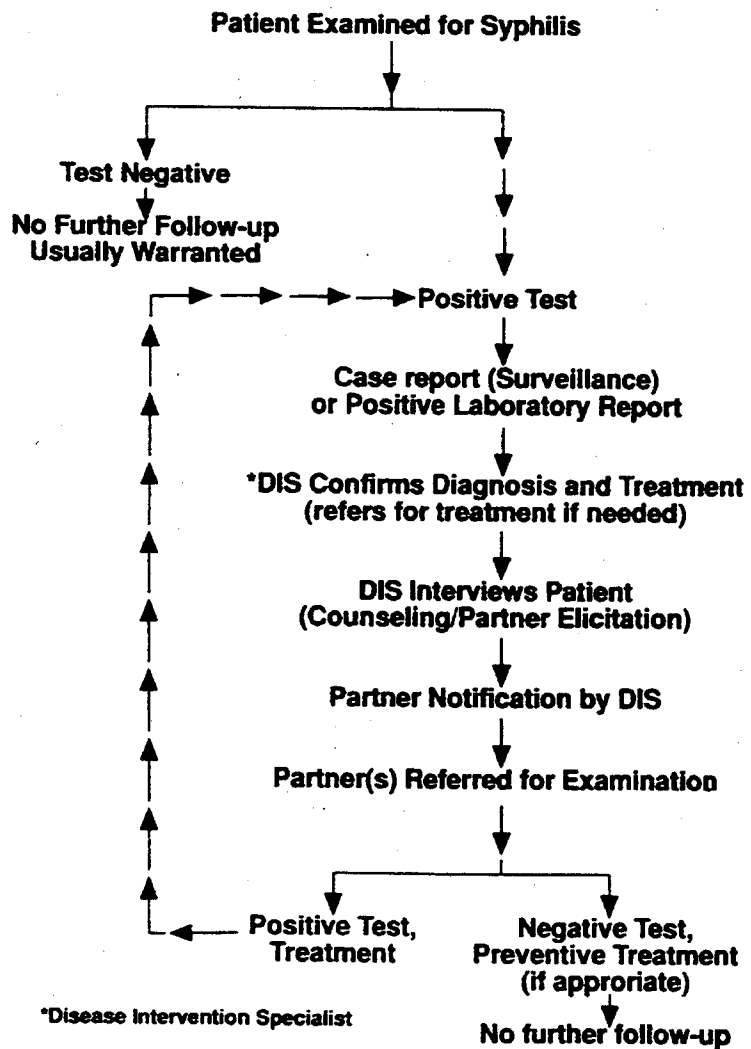
Similarly, the Bureau funds client services delivered by the Baylor College of Medicine Teen Clinic in Houston. Through a cooperative agreement, STD resources support STD examinations and treatment at three clinics. These teen clinics serve high risk adolescent females who otherwise would not seek health care. This partnership ensures that teenagers in Houston have access to needed STD services.

Accomplishments:

- Prevention activities provided by STD programs resulted in an estimated \$30,000,000 savings in medical costs related to STDs and \$18,000,000 in savings related to HIV in 1998.
- DIS referred 882 syphilis contacts for preventive therapy, resulting in the prevention of an estimated 265 cases of syphilis in 1998.
- During 1998, DIS interviewed and managed 1,699 reported syphilis cases.
- DIS provided PCPE to 940 HIV-positive individuals in 1998 resulting in the location, counseling, and testing of 1,071 HIV sex/needle sharing partners. DIS successfully referred 733 (78%) of the HIV-positive individuals to early intervention services.
- STD clinics across Texas reported more than 110,000 clinic visits in 1998.

- During 1998, the gonorrhea screening program tested 300,441 women, identified 6,788 positives (2.3%) and confirmed treatment on 6,424 (94.6%). The chlamydia screening program tested 300,352 women, identified 18,196 positives (6.1%) and confirmed treatment on 17,500 (96.2%).
- The Bureau collaborated with TDH family planning and maternity clinics and with Planned Parenthood affiliates to provide STD screening and medication to their clients.
- STD programs maintained surveillance activities with physicians, hospitals, public/private laboratories, and community health centers, including site visits to encourage STD reporting and surveillance.
- Implemented STD*MIS software in 24 surveillance sites throughout the State for morbidity reporting.

FIGURE 13
The Disease Intervention Process



Future Plans

- Field STD programs will continue to establish coordinated efforts with local agencies and programs such as jails, youth detention centers, homeless shelters, and neighborhood health facilities.
- 1998 collaborative activities include exploring additional areas for STD and HIV coordination to maximize program resources and improve or expand delivery of services, especially regarding women offered STD screening outside of STD clinics.
- Implement electronic laboratory reporting (ELR) from major laboratories. ELR will enhance the surveillance system by improving the timelines and completeness of laboratory reports for reportable STDs.
- The Bureau strategic plan outlines priority issues and strategies for STD prevention during the next three years. Some of the strategies identified are:
 - strengthen and expand STD prevention education services;
 - strengthen and expand STD clinical and laboratory services;
 - improve disease and behavioral surveillance for STDs; and
 - increase public support and awareness of STD prevention and treatment.

VII. TRAINING AND PUBLIC EDUCATION

The Training and Public Education Branch (TPEB) plans, develops, conducts, and evaluates HIV and STD training for TDH, other State agencies, local health departments, and community-based organizations involved in HIV and STD activities. HIV and STD training include technical and disease information as well as administrative and managerial workshops. As part of this process, TPEB staff develop program-specific educational materials and guidelines for use in disease prevention activities. Training staff facilitate the delivery of training by:

- Providing direct training for courses as the four-day *HIV Prevention Counseling and Partner Elicitation* (PCPE) course, the 10-day *Introduction to Sexually Transmitted Disease Intervention* (ISTDI) course, and the one-day cultural competency course entitled, *The Never Ending Journey*;
- Providing *Train the Trainer* courses in which Training Branch instructors teach other State agency and community-based organization staff to present TDH approved instructional packages;
- Developing and providing customized training to individual programs to address specific needs; and
- Developing, updating, and disseminating HIV/STD curriculums, literature, audiovisuals, and other educational materials.

The Training Branch also maintains the Texas HIV Prevention Counselor Registry of all HIV counselors who have successfully completed the courses required by TDH in order to deliver HIV counseling services in Texas. The Registry includes HIV PCPE counselors trained by TDH, Texas Commission on Alcohol and Drug Abuse (TCADA), & Texas Department of Mental Health and Mental Retardation (MHMR) via an interagency memorandum of understanding. TPEB staff provide technical assistance to HIV prevention contractors and STD programs in evaluating their training needs and ensuring those needs are met. TPEB continues to receive out-of-state participants referred by the Centers for Disease Control and Prevention (CDC) for STD courses. TPEB is responsible for planning and presenting the annual Texas HIV/STD Conference. TPEB also compiles and distributes the statewide HIV/AIDS Community Resource Directory and operates the 1-800 bilingual Texas HIV/STD InfoLine. TPEB is responsible for coordinating the Bureau's staff career development needs and identifying staff training opportunities.

Accomplishments:

- The *HIV PCPE* course was offered 52 times in locations across the State of Texas. Over 650 participants were trained including five hearing-impaired participants in 1998.
- Three quality assurance reviews were conducted with PCPE trainers across the State in 1998.
- TPEB staff consulted with the staff from the TDH Osteoporosis Program and provided guidance and technical assistance on the Osteoporosis Summit, held August 1, 1998 in Austin, Texas.
- *The Never-Ending Journey*, a cultural competence training course for HIV and STD prevention workers, service providers, and managers was presented 24 times throughout the State to 499 participants.
- On March 10 and 11, 1998, 18 interagency trainers who present the TDH *HIV Prevention Counseling and Partner Elicitation* (PCPE) curriculum met in Austin to network, share expertise and discuss potential improvements to the course. Trainers represented the following agencies: TDH, Houston Health and Human Services, UT Southwestern Medical Center, the Texas HIV Connection, and TCADA.
- In recognition of National STD Awareness Month, TPEB conducted two seminars entitled, *STD Update 1998*. The seminars, presented on April 13 and 17, were open for all TDH staff to attend. Curriculum was centered around the history and structure of the STD Prevention Program, STD Case Management, reportable STDs in Texas, and the revisions of the Centers for Disease Control and Prevention's (CDC) *1998 Guidelines for Treatment of Sexually Transmitted Diseases*.
- TPEB communicated with the Texas Department of Criminal Justice - Infectious Disease (TDCJ-ID) regarding their HIV prevention counseling and counselor training programs. Currently, TDCJ-ID offers a one-day training for their prevention counselors through their Preventive Medicine Department. A copy of the TPEB's, PCPE Pre-course was sent to TDCJ-ID. An offer for select TDCJ-ID HIV prevention counselors to attend the TPEB four-day PCPE course was extended, as well as other assistance regarding HIV training for prevention counselors.
- TPEB STD Training staff assisted the CDC with revising the National STD Program Operations Guidelines. This document is utilized by STD Programs across the country for guidance.
- Copies of the TDH training curriculum, *HIV Prevention Counseling and Partner Elicitation* were shared with the Washington Department of Health, HIV Office in Olympia, Washington. The State of Washington is interested in reviewing the curriculum as Texas is one of only a few states that has incorporated partner elicitation skills into the training program for prevention counselors.

- In conjunction with National HIV Testing Day on Saturday, June 27, TPEB prepared a news release to promote the toll-free Texas HIV/STD InfoLine as a means of finding out where to get tested for HIV around the State. In addition, local HIV contractors received a National HIV Testing Day media kit to assist them in planning local promotional activities.
- The 11th Annual Texas HIV/STD Conference held in Austin, Texas on May 12-15, 1998 had a total of 960 registered participants. Approximately 24% (227) of them completed and submitted a conference evaluation packet. Of those, nearly 79 % (179) strongly agreed or agreed that the overall program goal of the conference was achieved.
- TPEB provided the National TB Center in San Francisco, California with copies of TDH's TB 101 trainer and participant manuals and accompanying videos. This curriculum provides an overview of Tuberculosis for service providers.
- The TDH HIV/STD InfoLine began the planning process for providing information on hepatitis. This bilingual, educational tape will be added to the current menu and encompass information as well as symptoms on all six known kinds of viral hepatitis.
- TPEB staff worked with the TDH Audiovisual Library to purchase 32 new videos covering a number of HIV/STD topics. These videos are offered free of charge to citizens of Texas through the TDH Audiovisual Library.
- Beverly Nolt, TPEB Manager was a contributing author for "Violence and Threats of Violence Experienced by Public Health Field-Workers" in *JAMA* (August 5, 1998-Vol 280, No. 5). The article concluded that violence directed toward public field workers is a common occupational hazard and that an assessment of what situations, clients, and locations pose the risk of violence to public health workers is needed.
- The Idaho Health Department contacted TPEB concerning a need for Partner Elicitation & Notification (PE & N) trainings. Due to the morbidity, lack of funding, and rural nature of the State, Idaho health care professionals work across program lines and are unable to attend the two week *Introduction to STD Intervention* course used to train PE & N. In October, TPEB conducted three trainings in Moscow, Boise, and Pocatello, Idaho. The trainings received excellent evaluations. The Idaho Health Department paid for all travel and per diem.
- TPEB completed the revision of the CDC curriculum, *Quality Assurance for HIV Prevention Counseling and Partner Elicitation (PCPE)*. The revised curriculum is a two-day course for supervisors of staff who deliver HIV PCPE and includes partner elicitation skills. The TDH course was piloted in March 1998. Input and suggestions for revision were incorporated into the curriculum, and the course was replicated throughout the State. To date, over 65 PCPE supervisors have been trained in the new curriculum.
- TPEB staff are working with the Surveillance Branch to develop two scripts for general information on HIV reporting; one for the HIV/STD InfoLine is geared toward clients, and one for the Communicable Disease Reporting Line is geared toward providers.

- The TDH Bureau of HIV and STD Prevention worked with the TDH Division of Communications & Special Health Initiatives to develop a news release, "Texas Talk," that encouraged Texas radio stations to cover STDs during October. The release gave brief, basic talking points about STDs and let stations know that TDH and local/regional health department representatives were available for interviews. STD staff in each public health region and major Texas city were identified to handle requests from area stations. Bilingual staff were identified to respond to requests from Spanish-language stations.
- For two weeks in September 1998, TPEB provided two customized STD courses for U.S. Army and Air Force medical staff stationed in Europe. Both courses were one week in duration and were presented at Landstuhl Regional Medical Center in Germany. The first course, entitled *STD Intervention*, had 15 participants representing members of the U.S. Army and Air Force. The curriculum concentrated on assertiveness, constructive confrontation, STD interview technique, as well as applying problem solving techniques and appropriate motivations. The second course, entitled *STD Intervention for Supervisors*, had 17 participants charged with supervision in various U.S. military clinics throughout Europe. This course focused on DIS performance assessment, accountability, and case management. Both courses received an overall rating of "excellent" on the participant evaluation forms. This collaborative effort was the result of a long-established working relationship between the State of Texas and the many military installations in Texas. All expenses were paid by the U.S. Army.
- The Public Information Unit worked with the HIV/STD Epidemiology Division in October to develop an information packet regarding name reporting for HIV in anticipation of the Board of Health's adoption of new HIV reporting rules.
- The Public Information Unit worked with the Austin-Travis County Health and Human Services Department's HIV Services Program to create a new pamphlet on HIV/AIDS for the deaf and hard of hearing community.

Future Plans

- TPEB staff will work on revising and revamping the *Texas Resource Guide for HIV/STD Education*. This will be a collaborative effort between the Texas Education Agency, the TDH School Health Program and the Bureau of HIV and STD Prevention. The guide will be a revised and updated version of the *Resource Guide for HIV/AIDS Education of School-Age Children* and the *STD Educator's Guide*. The updated guide is expected to be distributed by mid-1999.
- Planning is currently taking place by TPEB staff for the 12th Annual Texas HIV/STD Conference at the Austin Convention Center on April 6-9, 1999. Approximately 1,100 HIV/AIDS/STD health professionals are expected to attend.
- TPEB will revise the four-day PCPE curriculum and conduct training of trainer (TOT) courses for all state instructors.

- Training staff will ensure that 90% of all STD program staff are trained in prevention counseling.
- TPEB will work collaboratively with the Centers for Disease Control and Prevention (CDC), National Part III training centers as well as local and regional HIV/STD staff to assess the feasibility of merging the current two-week ISTD course with the four-day PCPE course. If merging is viable, TPEB will create a pilot curriculum, test the course and receive feedback, revise the course and begin using the new curriculum.
- TPEB staff will develop and conduct three customized trainings in response to the needs identified by the Field Operations Branch and/or HIV/STD Program Managers.

VIII. HIV/STD CLINICAL SERVICES

The HIV/STD Clinical Services Section (CSS) provides expertise, technical assistance and policy direction for all clinical issues and activities in which the Bureau of HIV and STD Prevention is involved. The Section consists of two formal programs, the HIV Medication Program and the Clinical/Case Management Program. The Medication Program provides medications which are used to treat HIV and AIDS and to prevent opportunistic infections in people with HIV disease. Individuals must meet drug specific eligibility criteria for the Program in order to participate. The Clinical/Case Management Program monitors the quality of clinical and case management services provided to clients by 30 State-funded grantees statewide. The Program conducts annual site reviews and periodic site visits, provides technical assistance when needed, develops minimum standards and clinical guidelines for the provision of clinical and case management care, promotes knowledge of and adherence to professional standards of care, and conducts investigations of allegations of client abuse and/or neglect related to clinical and/or case management services by funded providers. Increasingly, the Clinical/Case Management Program assists agencies and communities to plan and implement appropriate health and psychosocial services networks to meet the growing need for HIV services, particularly in unserved and under-served communities and infected populations.

Accomplishments

- Assumed oversight and management of the Early Intervention grant which provides services to people with HIV disease to maintain an optimum level of health and prevent worsening of existing conditions.
- As part of the Early Intervention grant review process, implemented “pre-award” site visits by Bureau staff to verify the capacity of potential grantees for clinical and psychosocial case management services to assure they can provide these services immediately upon execution of a contract with the Bureau.
- Provided on-site guidance and technical assistance to the El Paso Health Service Delivery Area, in cooperation with Health Resources Division and regional staff, to restructure the health and psychosocial services network when an administrative agency dissolved; this prevented breaks in continuity of services for almost 200 clients.
- Coordinated the development and conduct of the “Survey of State HIV/STD Contractors’s Fiscal Needs” to determine the future funding priorities and needs of grantees to serve their clients.

- Through the Clinical/Case Management Program, CSS continues to monitor all grantees on an annual basis, which has significantly improved the quality of the provision of clinical and case management services. In addition, the Clinical/Case Management Program began monitoring of sub-contractors for clinical and/or case management services in major cities in order to assure that these services also meet minimum standards.
- Initiated restructuring of the Texas Medication Program to increase efficiency in the process used to apply for medications, and to improve accounting processes within the Program.

Future Plans

- In order to begin to address the need for training for clinical providers who desire to deliver services to HIV-infected pregnant women, a growing sub-population in Texas, the HIV/STD Clinical Services Section will organize and hold the first "Clinical Conference" on HIV-related topics. As part of this conference, nationally recognized speakers will provide current clinical practice guidelines and address practice issues on perinatal transmission prevention and disease management.
- Provision of life-sustaining medical services, including access to HIV medications, to incarcerated populations within some county and local jails appears to be difficult to accomplish due to financial constraints within those agencies. Creating successful linkages to medical and psychosocial services when inmates are discharged from state, county and local jail settings is also a complex task. The CSS will begin working with Health Resources Division staff and other state agencies to improve access to services whenever possible.
- Due to increased emphasis on medical services brought about by the improvements in life-sustaining medications and the resultant need for additional clinical assistance to grantees, the CSS will hire one additional registered nurse to meet the needs of external customers.
- CSS will provide clinical expertise in health service delivery planning to the Bureau process of a major restructuring of HIV services and prevention activities across Texas.
- CSS will provide clinical expertise in health service delivery planning to the Bureau process for a major revision to the formula by which grantee agencies receive their state and federal grant funds.

IX. MEDICATION

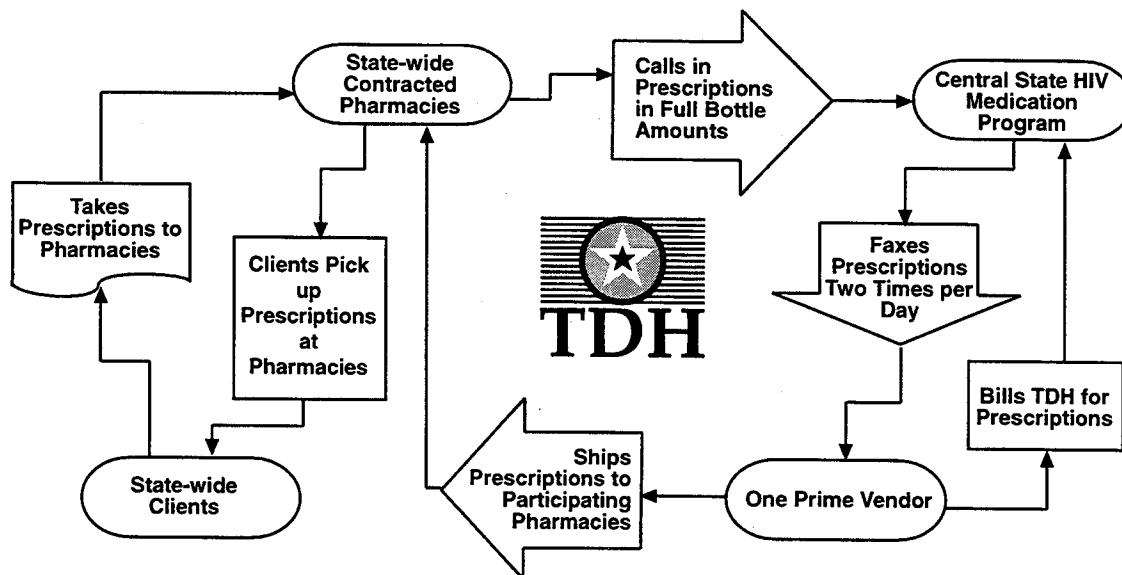
HIV MEDICATION

The Texas HIV Medication Program (Medication Program) provides medications to HIV-infected individuals who qualify for enrollment in the program across the State. Working through 243 participating Texas pharmacies, the program purchases and distributes over \$26 million annually in antiretroviral drugs and other prophylactic medications.



Since its inception in late 1987, the Medication Program has provided HIV medications to over 25,700 Texans. Currently, the program receives and approves more than 122,016 medication orders each year. The medications help delay the onset of symptomatic disease and prevent opportunistic infections in persons living with HIV disease. Figure 15 shows how the program operates to ensure that qualified individuals anywhere in Texas have access to needed medications in a simple and timely manner.

FIGURE 14
Texas HIV Medication Program



The program also develops and maintains confidential data files which provide valuable statistical information regarding medication usage to the Surveillance section of the HIV/STD Epidemiology Division, service providers, and lawmakers. The program 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, the program developed and maintains its own accounting systems.

In addition to its regular services, the Medication Program operates the Medication Reimbursement Initiative (MRI). This program, formerly known as the Pilot Insurance Program, is operating in its fifth year of existence. The MRI program pays the deductibles and co-insurance payments required by the insurance companies of the Medication Program's approved clients, who then receive medications directly at their homes. The MRI program affords eligible HIV-infected persons the opportunity to use their insurance pharmacy benefits 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 Medication Program services.

The Medication Program 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. To apply for MRI services, eligible applicants submit a completed regular Medication Program application and a completed client profile sheet with all the correct insurance information. Priority Pharmacy then verifies the applicant's prescription medication insurance benefits from this completed client profile. Priority Pharmacy also agrees to deliver the medications to each approved client by overnight mail at no cost to the approved applicant or TDH. They also provide a toll-free number to all approved clients, their physicians, and TDH for all communications relating to the approved applicant, their prescriptions, and access to an on-staff social worker.

Accomplishments

- The Medication Program approved 122,016 medication orders dispensed through participating pharmacies to nearly 8,087 individual clients.
- The Medication Program added the new formulations of Combivir (AZT+3TC in one pill) and Fortovase (a gelcap version of saquinavir with greater bioavailability for patients) to the formulary.
- Thirty-one pharmacies joined the statewide network, providing greater convenience for clients and reducing client loads at individual pharmacies.
- For Fiscal Year 1998, the Medication Program paid MRI deductibles and co-insurance payments in the amount of \$34,910. The MRI program served a total number of 45 approved applicants in Fiscal Year 1998.
- In January 1998, to keep up with the evolving standards of care in the treatment of HIV infection, the Medication Program began providing clients with antiretroviral combinations of up to four drugs per month in addition to the drugs for opportunistic infections that clients qualified for medically.

TABLE 3
HIV Medications Allocations by Region
Fiscal Year 1998

Region	Number of Clients Served	Amount Spent
1	145	\$443,040
2	89	\$299,369
3	2,001	\$6,125,890
4	295	\$982,963
5	183	\$511,948
6	2,683	\$7,963,158
7	1,000	\$3,723,082
8	858	\$3,050,894
9	122	\$378,224
10	332	\$1,428,132
11	379	\$1,360,133
TOTAL	8,087	\$26,266,833

- The Medication Program and the Medicaid Vendor Drug Program entered a joint arrangement in December of 1994 in which clients must fill their first three prescriptions each month using their Medicaid entitlement. Participating pharmacies will then contact the Medication Program for HIV-infected persons who need pharmacy assistance beyond the three-prescription-per-month Medicaid limit. The system has allowed clients to utilize both programs more effectively and ensures maximum utilization of the Medicaid program before TDH provides medication to Medicaid clients.
- The Medication Program initiated the new pilot program, entitled Health Options to Promote Employment (H.O.P.E.), to assist persons with HIV in returning to work. To be eligible for the program, applicants must be HIV positive Texas residents with a gross annual income at or below 500% of the current Federal Poverty Income Guidelines. The overall expectation of the H.O.P.E. Program is that persons returning to the workforce will have the opportunity to either earn an income that would eliminate their need for Medication Program assistance or obtain health insurance benefits that sufficiently cover their prescription medications. The H.O.P.E. Program began accepting orders on April 1, 1998 with 70 clients approved and 249 prescriptions processed at a cost of \$57,657. Because funding for this pilot project was contingent upon additional funds from a Dallas-based AIDS Foundation which were not provided, the Bureau has had to freeze acceptance of new applicants to the H.O.P.E. Program. The current clients are continuing to receive medication assistance through existing funding methods.

- The Medication Program has also developed and implemented the pilot program known as the Medications Plus Program (M.P.P.), which allows contractors that designate Ryan White Title II, State Services, or Early Intervention funds to purchase drugs through the Medication Program for their clients. The medications purchased through the M.P.P. will be paid for through contractor accounts set up by the Bureau of HIV and STD Prevention and will allow the participating contractors to take advantage of the Public Health Service pricing on all medications ordered through this program. Contractors participating in the new M.P.P. must designate funds to purchase drugs through their existing TDH contracts and work through pharmacies already participating in the Medication Program. The Houston Regional HIV/AIDS Resource Group has recently signed up for affiliation with the M.P.P., and hopefully other contractors will soon follow. As the program gets underway, it will be possible for some of the more expensive and frequently requested drugs not on the Medication Program formulary to be added to the M.P.P. list.

Future Plans

- The future standard of care will recommend that patients start on antiretroviral therapy with a combination of drugs earlier in the disease in order to preserve immune function. Based upon the Bureau's epidemiological research, the HIV Medication Program will continue to develop a system to accurately predict the growth of enrollees utilizing the program under these new treatment standards.
- In order to take full advantage of federal funding, the Medication Program will protect Texas eligibility status and cooperate with national organizations collecting information to document State needs. The program will also explore private funding sources and redirect all appropriate funding streams to ensure access to standard of care therapy for Texans.
- The Medication Program will develop clear clinical indicators in order to provide the new FDA-approved quadruple combination of antiretrovirals and protease inhibitors statewide.
- The Medication Program will continue to refine the prioritization of the Medication Program drug formulary to be utilized in case of a potential funding shortfall.

STD MEDICATION

The Medication Program distributed \$337,972 in STD medications, needles, and protective needle adapters to 52 sites statewide in 1998. These sites include Public Health Region Offices, 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.

Accomplishments

- The Medication Program staff continued implementation of the new statewide medication distribution and inventory control systems. The new system reduces the number of direct shipment sites statewide and centralizes medication inventory control in the local health departments and regional offices. This system ties STD morbidity to actual medication allotment in an effort to encourage more timely and more accurate reporting of STDs statewide. This relationship is also intended to help the program set realistic stock levels of STD medications for each of its shipment sites, rather than relying on less exact estimates.

Future Plans

- The Medication Program will continue the new statewide distribution and inventory control system for all STD related medications. Pending available funding, the program will provide enough medication to treat a case and two contacts each for gonorrhea, chlamydia, syphilis, and pelvic inflammatory disease.

X. APPENDIX

Texas AIDS Surveillance Report

October-December 1998

Summary of Cumulative Data

1. Disease Category	Adult/Adolescent *		Pediatric *		Total	
	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)
PCP	15870 (33)	12331 (78)	134 (37)	97 (72)	16004 (33)	12428 (78)
Other Disease w/o PCP	14059 (29)	9467 (67)	221 (62)	112 (51)	14280 (29)	9579 (67)
KS Alone	1484 (3)	1054 (71)	1 (0)	0 (0)	1485 (3)	1054 (71)
No Diseases Listed	17156 (35)	4267 (25)	2 (1)	2 (100)	17158 (35)	4269 (25)
Total	48569 (100)	27119 (56)	358 (100)	211 (59)	48927 (100)	27330 (56)

2. Age *	Cases (%)	3. Race/Ethnicity	Adult/Adolescent *	Pediatric *	Total
			Cases (%)	Cases (%)	Cases (%)
Under 5	278 (1)	White, Not Hispanic	26562 (55)	85 (24)	26647 (54)
5-12	80 (0)	Afr./Am. Not Hispanic	13017 (27)	176 (49)	13193 (27)
13-19	342 (1)	Hispanic	8760 (18)	96 (27)	8856 (18)
20-29	10792 (22)	Asian/Pacific Is.	154 (0)	1 (0)	155 (0)
30-39	22980 (47)	Am. Indian/Alaskan	63 (0)	0 (0)	63 (0)
40-49	10487 (21)	Unknown	13 (0)	0 (0)	13 (0)
Over 49	3968 (8)	Total	48569 (100)	358 (100)	48927 (100)
Unknown	0 (0)				
Total	48927 (100)				

4. Patient Groups	Adult/Adolescent Transmission Modes**		Total (%)
	Males (%)	Females (%)	
Homosexual or bisexual Men	29733 (68)	0 (0)	29733 (61)
Intravenous (IV) drug User	4748 (11)	1877 (38)	6625 (14)
Homo/Bi IV drug User	4325 (10)	0 (0)	4325 (9)
Coagulation disorder	235 (1)	10 (0)	245 (1)
Heterosexual contact	1527 (4)	2103 (42)	3630 (7)
Transfusion with blood/products	398 (1)	221 (4)	619 (1)
Risk not reported/Other	2623 (6)	770 (15)	3393 (7)
Total	43589 (100)	4981 (100)	48570 (100)

	Pediatric Transmission Modes		Total (%)
	Males (%)	Females (%)	
Coagulation disorder	22 (12)	1 (1)	23 (6)
Parent at risk/has AIDS/HIV	147 (77)	144 (86)	291 (82)
Transfusion with blood/products	20 (11)	15 (9)	35 (10)
Risk not reported/Other	1 (1)	7 (4)	8 (2)
Total	190 (100)	167 (100)	357 (100)

* Classification at time of AIDS diagnosis.

**42 patients were diagnosed with AIDS as adults but have evidence of being HIV infected as children. They are counted as adults/adolescent cases in tables 1, 2, and 3; and as Adult "Risk/Other" cases in table 4.

Texas AIDS Surveillance Report

October-December 1998

County of Residence			Cumulative 1998			County of Residence			Cumulative 1998			County of Residence			Cumulative 1998		
Reported	Deaths	To Date	Reported	Deaths	To Date	Reported	Deaths	To Date	Reported	Deaths	To Date	Reported	Deaths	To Date	Reported	Deaths	To Date
ANDERSON CO.	36	17	4	GAINES CO.	2	2	0	NEWTON CO.	6	2	0						
ANDREWS CO.	8	6	0	GALVESTON CO.	633	373	49	NOLAN CO.	12	8	1						
ANGELINA CO.	53	32	4	GARZA CO.	2	1	0	NUECES CO.	511	295	44						
ARANSAS CO.	25	14	0	GILLESPIE CO.	6	5	0	OCHILTREE CO.	3	1	1						
ARCHER CO.	4	3	1	GONZALES CO.	11	6	1	ORANGE CO.	81	49	2						
ARMSTRONG CO.	1	1	0	GRAY CO.	10	8	2	PALO PINTO CO.	13	1	2						
ATASCOSA CO.	12	7	1	GRAYSON CO.	96	48	8	PANOLA CO.	9	5	1						
AUSTIN CO.	8	2	2	GREGG CO.	148	66	25	PARKER CO.	46	18	6						
BAILEY CO.	2	1	0	GRIMES CO.	17	13	1	PARMER CO.	3	1	0						
BANDERA CO.	5	3	2	GUADALUPE CO.	28	14	2	PECOS CO.	9	7	0						
BASTROP CO.	64	31	5	HALE CO.	17	10	1	POLK CO.	52	34	1						
BAYLOR CO.	1	1	0	HALL CO.	1	0	1	POTTER CO.	243	156	32						
BEE CO.	16	11	1	HAMILTON CO.	7	2	2	PRESIDIO CO.	1	1	0						
BELL CO.	209	112	19	HARDEMAN CO.	7	2	0	RAINS CO.	4	3	1						
BEXAR CO.	3,529	1,889	228	HARDIN CO.	38	25	1	RANDALL CO.	38	30	2						
BLANCO CO.	4	1	0	HARRIS CO.	17,137	9,919	1,605	REAL CO.	1	0	0						
BOSQUE CO.	6	1	1	HARRISON CO.	49	23	4	RED RIVER CO.	6	3	2						
BOWIE CO.	113	67	13	HASKELL CO.	4	3	0	REEVES CO.	9	6	2						
BRAZORIA CO.	225	140	28	HAYS CO.	74	40	12	REFUGIO CO.	1	0	0						
BRAZOS CO.	131	82	8	HEMPHILL CO.	1	0	0	ROBERTSON CO.	16	9	1						
BREWSTER CO.	3	3	0	HENDERSON CO.	41	16	3	ROCKWALL CO.	23	12	1						
BRISCOE CO.	1	1	0	HIDALGO CO.	317	149	49	RUNNELS CO.	4	3	1						
BROOKS CO.	4	2	1	HILL CO.	23	13	3	RUSK CO.	26	15	4						
BROWN CO.	14	5	2	HOCKLEY CO.	12	9	0	SABINE CO.	7	6	0						
BURLESON CO.	11	5	1	HOOD CO.	19	7	1	SAN AUGUSTINE C	14	11	0						
BURNET CO.	20	10	2	HOPKINS CO.	20	14	4	SAN JACINTO CO.	16	10	3						
CALDWELL CO.	25	14	1	HOUSTON CO.	18	11	4	SAN PATRICIO CO.	55	39	6						
CALHOUN CO.	16	7	0	HOWARD CO.	32	23	1	SAN SABA CO.	2	2	0						
CALLAHAN CO.	5	2	0	HUNT CO.	61	33	4	SCHLEICHER CO.	3	1	1						
CAMERON CO.	291	138	33	HUTCHINSON CO.	4	3	0	SCURRY CO.	5	2	0						
CAMP CO.	6	2	0	JACK CO.	3	1	0	SHELBY CO.	33	18	3						
CARSON CO.	4	3	1	JACKSON CO.	9	8	1	SHERMAN CO.	1	1	0						
CASS CO.	20	10	2	JASPER CO.	21	15	1	SMITH CO.	186	94	20						
CASTRO CO.	3	3	0	JEFF DAVIS CO.	1	1	0	SOMERVELL CO.	3	1	1						
CHAMBERS CO.	12	9	2	JEFFERSON CO.	523	266	46	STARR CO.	18	10	2						
CHEROKEE CO.	30	13	3	JIM HOGG CO.	3	3	0	STEPHENS CO.	3	3	0						
CHILDRESS CO.	9	8	0	JIM WELLS CO.	17	13	0	STONEWALL CO.	1	1	0						
CLAY CO.	2	1	0	JOHNSON CO.	82	45	10	SUTTON CO.	1	0	0						
COKE CO.	2	2	0	JONES CO.	8	4	1	SWISHER CO.	2	2	0						
COLEMAN CO.	5	2	2	KARNES CO.	1	0	0	TARRANT CO.	2,832	1,529	210						
COLLIN CO.	202	96	34	KAUFMAN CO.	67	36	4	TAYLOR CO.	126	70	7						
COLORADO CO.	10	8	0	KENDALL CO.	11	7	0	TERRY CO.	2	1	0						
COMAL CO.	45	24	8	KERR CO.	38	20	5	THROCKMORTON	1	1	0						
COMANCHE CO.	7	4	0	KIMBLE CO.	1	0	0	TITUS CO.	17	8	2						
CONCHO CO.	3	3	0	KINNEY CO.	3	2	0	TOM GREEN CO.	72	38	5						
COOKE CO.	22	14	2	KLEBERG CO.	33	22	4	TRAVIS CO.	3,178	1,864	265						
CORYELL CO.	23	12	4	LA SALLE CO.	3	3	0	TRINITY CO.	11	4	0						
CRANE CO.	1	1	0	LAMAR CO.	20	15	2	TYLER CO.	14	9	0						
CROCKETT CO.	3	2	0	LAMB CO.	6	3	0	UPSHUR CO.	25	10	4						
CROSBY CO.	3	2	1	LAMPASAS CO.	10	7	0	UVALDE CO.	10	7	0						
CULBERSON CO.	2	1	1	LAVACA CO.	3	1	0	VAL VERDE CO.	16	11	4						
DALLAM CO.	5	2	1	LEE CO.	4	2	1	VAN ZANDT CO.	26	19	1						
DALLAS CO.	10,427	5,941	617	LEON CO.	8	1	1	VICTORIA CO.	68	37	9						
DAWSON CO.	4	2	0	LIBERTY CO.	67	36	12	WALKER CO.	50	32	5						
DE WITT CO.	9	8	0	LIMESTONE CO.	11	4	4	WALLER CO.	32	13	4						
DEAF SMITH CO.	8	3	1	LIPSCOMB CO.	1	1	0	WARD CO.	10	6	1						
DENTON CO.	339	187	25	LIVE OAK CO.	6	3	0	WASHINGTON CO.	12	8	0						
DICKENS CO.	3	3	0	LLANO CO.	8	6	1	WEBB CO.	191	102	15						
DIMMIT CO.	2	2	1	LUBBOCK CO.	250	152	29	WHARTON CO.	33	18	1						
DONLEY CO.	2	1	0	MADISON CO.	13	10	1	WICHITA CO.	164	80	8						
DUVAL CO.	6	3	0	MARION CO.	4	2	1	WILBARGER CO.	18	6	5						
EASTLAND CO.	10	5	1	MARTIN CO.	4	3	0	WILLACY CO.	6	2	1						
ECTOR CO.	130	74	8	MASON CO.	1	1	0	WILLIAMSON CO.	126	73	14						
EDWARDS CO.	2	1	0	MATAGORDA CO.	30	22	2	WILSON CO.	13	6	3						
EL PASO CO.	922	463	126	MAVERICK CO.	28	16	4	WINKLER CO.	6	5	1						
ELLIS CO.	80	45	4	MCCULLOCH CO.	8	6	1	WISE CO.	20	11	3						
ERATH CO.	15	12	2	MCLENNAN CO.	261	145	32	WOOD CO.	27	15	1						
FALLS CO.	8	6	1	MEDINA CO.	15	11	0	YOAKUM CO.	3	1	1						
FANNIN CO.	11	5	2	MIDLAND CO.	105	59	7	YOUNG CO.	10	6	0						
FAYETTE CO.	8	3	0	MILAM CO.	19	12	0	ZAPATA CO.	3	3	0						
FISHER CO.	3	1	0	MITCHELL CO.	4	1	0	ZAVALA CO.	5	4	1						
FLOYD CO.	4	2	1	MONTAGUE CO.	9	7	0	TDC CO.	1,818	674	234						
FOARD CO.	1	1	0	MONTGOMERY CO.	240	138	33	TOTAL THIS REPORT	48,927	27,330	4,201						
FORT BEND CO.	354	190	46	MOORE CO.	5	4	0	TOTAL COUNTIES REPORTING		225							
FRANKLIN CO.	1	1	0	MORRIS CO.	11	7	0										
FREESTONE CO.	9	5	1	NACOGDOCHES C	45	24	7										
FRIO CO.	4	3	1	NAVARRO CO.	37	17	8										

Texas STD Surveillance Report

January-December 1998

Table 1: Reported Chlamydia and Gonorrhea Cases

Residence County	Chlamydia				Gonorrhea			
	1997	1997 Rate	Jan-Dec 1997	Jan-Dec 1998	1997	1997 Rate	Jan-Dec 1997	Jan-Dec 1998
Region 1	2,530	332	2,530	3,127	952	125	952	1,280
Lubbock Co.	1,037	455	1,037	1,181	491	215	491	671
Potter/Randall Co.	743	362	743	956	313	153	313	403
Other	750	228	750	990	148	45	148	206
Region 2	1,077	202	1,077	1,542	501	94	501	597
Taylor Co.	263	211	263	530	136	109	136	205
Wichita Co.	483	380	483	490	267	210	267	235
Other	331	117	331	522	98	35	98	157
Region 3	12,642	254	12,642	15,697	9,226	185	9,226	12,014
Dallas Co.	7,990	388	7,990	8,920	6,645	323	6,645	7,444
Denton Co.	433	121	433	493	144	40	144	208
Tarrant Co.	2,402	173	2,402	4,138	1,759	126	1,759	3,331
Other	1,817	155	1,817	2,146	578	58	578	1,031
Region 4/5 N	1,734	136	1,734	2,865	814	63	814	1,624
Angelina Co.	42	58	42	121	71	97	71	121
Bowie Co.	143	166	143	312	137	159	137	276
Gregg Co.	248	232	248	282	51	48	51	81
Smith Co.	454	280	454	638	167	103	167	381
Other	847	100	847	1,512	388	46	388	765
Region 6/5 S	13,535	288	13,535	15,058	8,726	185	8,726	9,761
Galveston Co.	789	346	789	683	587	257	587	659
Harris Co.	10,756	347	10,756	11,575	6,606	213	6,606	7,237
Jefferson Co.	934	391	934	966	1,034	433	1,034	965
Montgomery Co.	11	5	11	184	5	2	5	72
Other	1,045	115	1,045	1,650	494	54	494	828
Region 7	6,147	324	6,147	7,284	3,017	159	3,017	3,836
Bell Co.	939	461	939	1,313	386	189	386	527
Brazos Co.	282	229	282	331	135	110	135	208
McLennan Co.	954	499	954	1,275	562	294	562	710
Travis Co.	2,977	480	2,977	3,017	1,531	247	1,531	1,797
Other	995	131	995	1,348	403	53	403	594
Region 8	6,008	303	6,008	7,264	2,139	108	2,139	2,287
Bexar Co.	4,838	372	4,838	5,939	1,751	135	1,751	1,873
Victoria Co.	321	410	321	409	172	220	172	204
Other	849	141	849	916	216	36	216	210
Region 9/10	3,062	240	3,062	3,238	585	45	585	728
El Paso Co.	1,439	206	1,439	1,698	155	22	155	256
Midland Co.	386	321	386	453	143	119	143	209
Other	1,237	271	1,237	1,087	287	63	287	263
Region 11	3,885	246	3,885	4,547	635	40	635	805
Cameron/Hidalgo Co.	1,967	252	1,967	2,022	168	22	168	178
Nueces Co.	986	317	986	1,220	351	113	351	448
Webb Co.	328	200	328	438	28	17	28	51
Other	604	188	604	867	88	27	88	128
Tx. Dept. of Criminal J.	6		6	4	1		1	2
Statewide Total **	50,675	267	50,675	60,626	26,612	140	26,612	32,934

* Rates per 100,000 population ** Includes 49 chlamydia & 16 gonorrhea cases in 97 with unknown residence.

Texas STD Surveillance Report

January-December 1998

Table 2: Pelvic Inflammatory Disease and Chancroid

Residence County	Pelvic Inflammatory Disease								Chancroid		
	Chlamydia		Gonorrhea		Other/Unspecified		Total PID		1997	Jan-Dec 1997	Jan-Dec 1998
	Jan-Dec 1997	Jan-Dec 1998	Jan-Dec 1997	Jan-Dec 1998	Jan-Dec 1997	Jan-Dec 1998	Jan-Dec 1997	Jan-Dec 1998			
Region 1	27	14	20	10	1	3	59	27	0	0	0
Lubbock Co.	16	3	16	2	1	0	33	5	0	0	0
Potter/Randall Co	2	3	1	3	0	0	6	6	0	0	0
Other	9	8	3	5	0	3	20	16	0	0	0
Region 2	15	59	20	41	2	0	51	100	0	0	4
Taylor Co.	0	22	10	17	0	0	23	39	0	0	0
Wichita Co.	12	18	7	15	2	0	21	33	0	0	4
Other	3	19	3	9	0	0	7	28	0	0	0
Region 3	69	122	60	134	347	562	476	818	20	20	6
Dallas Co.	8	75	38	102	338	473	384	650	18	18	6
Denton Co.	11	2	4	4	2	0	17	6	0	0	0
Tarrant Co.	17	1	0	0	1	67	18	68	1	1	0
Other	33	44	18	28	6	22	57	94	1	1	0
Region 4/5 N	2	8	1	3	0	0	3	11	0	0	0
Angelina Co.	0	1	0	0	0	0	0	1	0	0	0
Bowie Co.	0	0	0	0	0	0	0	0	0	0	0
Gregg Co.	1	0	0	0	0	0	1	0	0	0	0
Smith Co.	0	0	0	1	0	0	0	1	0	0	0
Other	1	7	1	2	0	0	2	9	0	0	0
Region 6/5 S	6	59	12	115	0	267	378	441	25	25	19
Galveston Co.	2	2	5	5	0	0	8	7	0	0	0
Harris Co.	1	46	6	105	0	259	362	410	23	23	19
Jefferson Co.	0	1	0	0	0	1	0	2	0	0	0
Montgomery Co.	0	0	0	0	0	0	0	0	0	0	0
Other	3	10	1	5	0	7	8	22	2	2	0
Region 7	50	68	44	60	25	16	121	144	3	3	0
Bell Co.	4	1	2	0	0	0	6	1	0	0	0
Brazos Co.	2	0	1	0	0	0	3	0	0	0	0
McLennan Co.	4	1	2	0	11	0	17	1	3	3	0
Travis Co.	25	52	28	53	1	3	54	108	0	0	0
Other	15	14	11	7	13	13	41	34	0	0	0
Region 8	25	7	16	5	0	6	41	18	0	0	0
Bexar Co.	10	4	9	1	0	0	19	5	0	0	0
Victoria Co.	2	0	1	1	0	0	3	1	0	0	0
Other	13	3	6	3	0	6	19	12	0	0	0
Region 9/10	29	36	14	23	79	66	124	125	4	4	4
El Paso Co.	0	2	2	2	0	0	4	4	2	2	4
Midland Co.	10	11	8	12	22	11	40	34	0	0	0
Other	19	23	4	9	57	55	80	87	2	2	0
Region 11	46	114	6	8	11	55	75	177	0	0	0
Cameron/Hidalgo Co.	21	34	2	1	0	28	44	63	0	0	0
Nueces Co.	5	45	3	5	11	4	21	54	0	0	0
Webb Co.	6	7	1	1	0	9	10	17	0	0	0
Other	14	28	0	1	0	14	0	43	0	0	0
Tx. Dept. of Criminal J.	0	0	0	0	0	0	0	0	0	0	0
Statewide Total **	269	487	193	399	465	975	1328	1861	53	53	33

* Chlamydia and Gonorrhea PID cases are also included in Table 1: Reported Chlamydia and Gonorrhea Cases

** Includes 1 chancroid case for '97 with unknown residence.

Texas STD Surveillance Report

January-December 1998

Table 3: Reported Syphilis Cases

Residence County	Congenital			Primary/Secondary				Early Latent			Total Syphilis		
	1997	Jan-Dec 1997	Jan-Dec 1998	1997	1997 Rate	Jan-Dec 1997	Jan-Dec 1998	1997	Jan-Dec 1997	Jan-Dec 1998	1997	Jan-Dec 1997	Jan-Dec 1998
Region 1	0	0	0	5	1	5	5	14	14	16	55	55	52
Lubbock Co.	0	0	0	2	1	2	2	2	2	2	15	15	12
Potter/Randall Co.	0	0	0	1	0	1	0	9	9	5	18	18	14
Other	0	0	0	2	1	2	3	3	3	9	22	22	26
Region 2	0	0	0	3	1	3	5	5	5	0	23	23	25
Taylor Co.	0	0	0	0	0	0	0	3	3	0	3	3	9
Wichita Co.	0	0	0	0	0	0	4	0	0	0	5	5	10
Other	0	0	0	3	1	3	1	2	2	0	15	15	6
Region 3	19	19	26	196	4	196	153	524	524	561	1,085	1,085	990
Dallas Co.	4	4	23	148	7	148	124	306	306	405	718	718	752
Denton Co.	0	0	0	1	0	1	1	0	0	3	3	3	8
Tarrant Co.	12	12	3	39	3	39	22	192	192	119	305	305	171
Other	3	3	0	8	1	8	6	26	26	34	59	59	59
Region 4/5 N	4	4	4	97	7	97	50	130	130	167	259	259	294
Angelina Co.	0	0	0	15	21	15	6	11	11	26	27	27	33
Bowie Co.	2	2	0	6	7	6	8	10	10	11	20	20	21
Gregg Co.	0	0	0	23	22	23	16	11	11	12	36	36	32
Smith Co.	0	0	0	11	7	11	5	17	17	24	32	32	30
Other	2	2	4	42	5	42	15	31	31	94	144	144	178
Region 6/5 S	115	115	59	241	5	241	133	717	717	481	2,328	2,328	1,638
Galveston Co.	0	0	0	13	6	13	5	56	56	22	87	87	29
Harris Co.	108	108	51	180	6	180	96	528	528	357	1,944	1,944	1,400
Jefferson Co.	4	4	3	19	8	19	15	72	72	41	138	138	85
Montgomery Co.	0	0	0	5	2	5	1	14	14	7	21	21	10
Other	3	3	5	24	2	24	16	47	47	54	138	138	114
Region 7	1	1	0	49	2	49	42	85	85	73	256	256	204
Bell Co.	0	0	0	4	2	4	11	7	7	7	24	24	32
Brazos Co.	0	0	0	11	9	11	3	18	18	20	32	32	29
McLennan Co.	0	0	0	14	7	14	4	9	9	6	48	48	25
Travis Co.	0	0	0	8	1	8	15	33	33	18	98	98	57
Other	1	1	0	12	1	12	9	18	18	22	54	54	61
Region 8	5	5	5	31	1	31	33	114	114	72	348	348	280
Bexar Co.	4	4	4	27	2	27	26	96	96	61	309	309	242
Victoria Co.	0	0	0	1	1	1	2	8	8	3	14	14	10
Other	1	1	1	3	0	3	5	10	10	8	25	25	28
Region 9/10	5	5	1	6	0	6	5	39	39	20	176	176	177
El Paso Co.	5	5	0	3	0	3	2	34	34	14	115	115	84
Midland Co.	0	0	0	0	0	0	1	0	0	3	1	1	5
Other	0	0	1	3	0	3	2	5	5	3	60	60	88
Region 11	14	14	4	13	0	13	3	77	77	66	319	319	303
Cameron/Hidalgo Co.	11	11	2	6	1	6	1	47	47	33	208	208	182
Nueces Co.	1	1	1	2	1	2	0	6	6	13	23	23	26
Webb Co.	1	1	1	1	1	1	1	11	11	10	45	45	35
Other	1	1	0	4	1	4	1	13	13	10	43	43	60
Tx. Dept. of Criminal J.	0	0	0	35		35	1	158	158	4	544	544	12
Statewide Total **	164	164	99	676	4	676	430	1,863	1,863	1,460	5,397	5,397	3,975

* Rates are per 100,000 population

** Total Syphilis includes all reported cases of syphilis, regardless of stage.

** Includes 1 Congenital & 4 Total Syphilis cases for '97 with unknown residence.

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