

HIV COUNSELOR TRAINER GUIDELINES



Department of Health Services
Office of AIDS
HIV Counselor Training Program

May 1992

TABLE OF CONTENTS

	Page
Statement of Purpose	1
Goals and Objectives	1
Overview	2
Trainer Commitments and Prerequisites	2
Training Roles of DHS/OA Staff	3
State Training Coordinator	3
Regional Training Coordinator	3
Regional Field Office Listing	4
State Training Staff	4
Training Guidelines	5
Co-Trainer vs. Solo-Trainer	5
Training Class Size	5
Pass or Fail Policy	5
Attendance.	5
Evaluation Material Processing	6
Letter of Completion	6
Audit Status	6
Criteria for Training Selection	7
Weekend Training	7
Grandfathering	7
RDL Enterprises, Inc.	8
Mentor Project	8
Supplemental Spanish Training	9
Remedial Development/Re-evaluation	10
 <u>Appendices:</u>	
I: Trainer Checklist - Scheduling Training	11
II: Trainer Checklist - Materials for Class	13
III: Trainer Checklist - Classroom Setting	14
IV: Trainer Checklist - After the Training Session	14

HIV COUNSELOR TRAINER GUIDELINES

STATEMENT OF PURPOSE

Our ultimate end in the process of having a training curriculum, trainers, and trained counselors, is to provide a high standard for pre/post-test counseling in the Department of Health Services, Office of AIDS (DHS/OA), funded Alternative Test Sites (ATS), and Confidential Testing programs. This high standard for counseling includes providing accurate, current information relevant to the individual we are counseling. It incorporates active listening and empathic responses to the client's needs and concerns with compassion and care.

A good beginning counselor must demonstrate; strong attending and reflecting skills, an ability to assess larger client needs relevant to HIV and related matters, an empathic attunement to these needs, an understanding that as an antibody test counselor he or she must respond to those needs with appropriate interventions.

GOALS AND OBJECTIVES

GOAL: To train and develop a statewide cadre of sensitive, skilled and informed HIV counselors to provide high quality pre/posttest counseling in the OA funded testing programs.

OBJECTIVES:

1. To provide trainees with a training program capable of enhancing existing skills and developing new ones.
2. To provide trainees with basic and advanced HIV/AIDS information that will support and direct the counseling messages provided.
3. To provide trainees with skills to communicate effectively with clients of diverse backgrounds, of different sexual orientations, of different races and/or gender, and with various language and/or physical capabilities.
4. To support trainees with continuing education and consultation opportunities.
5. To encourage annual on site supervision and evaluation of trainees.
6. To encourage trainees to expand their counseling expertise through ongoing HIV trainer development and networking.

OVERVIEW

The basic HIV Counselor Training Program (HIV/CTP), has grown out of a commitment to provide a high standard for pre/posttest counseling in the DHS/OA funded ATS and Confidential Testing programs. Without a viable vaccine against human immunodeficiency virus (HIV) infection, education and counseling become primary tools in stopping, or at the very least, slowing down the spread of HIV. To insure consistent and effective education and counseling, HIV counselors need to receive the best training available.

The DHS/OA, HIV Testing Unit has continued to meet its objective of providing statewide HIV pre/posttest counselor training to both the ATS and the state funded Confidential Testing programs. Because the HIV counselor training demands have been far greater than originally anticipated, DHS/OA has set up the following criteria for selection of candidates for the three day HIV/CTP: 1) All trainees must be involved with face to face, one on one, pre/posttest HIV counseling. 2) All trainees must be employed by or volunteer in an agency which provides this one to one counseling in an DHS/OA funded testing program. The following programs meet this requirement:

- A. The ATS Program
- B. The Confidential Testing programs under contract with the Family Health and Primary Rural Health Divisions (to include family planning and community primary care clinics and Indian Health Programs).
- C. The confidential testing activities in local health jurisdiction programs pursuant to the Local Assistance Block Grant Program.
- D. The HIV Education in Sexually Transmitted Disease (STD) Clinics Program implemented in local health jurisdictions.
- E. The confidential testing and counseling activities in programs under contract with the Department of Alcohol and Drug Programs.

TRAINER COMMITMENTS AND PREREQUISITES

In order to be eligible to serve as an DHS/OA trainer, individuals must meet/adhere to the following:

- 1. Successfully complete the three day HIV/CTP sponsored by DHS/OA.
- 2. Possess a minimum of one year's experience in HIV Ab pre/posttest counseling, or other approved equivalency.

3. Commit to participate in a minimum of two "area-wide" trainings which may be outside of the trainer's county/city each year.
4. Acknowledge commitment to attend the quarterly HIV Counselor Trainer meetings.
5. Demonstrate willingness to work harmoniously with a co-trainer.
6. Adhere to DHS/OA curriculum and policy.
7. Show willingness to assist in arranging the scheduling of a training class. This includes locating and reserving the training room, arranging for appropriate audio visual equipment, and providing maps for the trainers and participants.
8. Work with the DHS/OA State Training Coordinator and the consultant services contract representatives in the selection and scheduling process for classes.

TRAINING ROLES OF DHS/OA STAFF

DHS/OA State Training Coordinator:

The DHS/OA State Training Coordinator (STC) is responsible for the overall coordination of the training program. The STC will assist the Regional Training Coordinator with the coordination of local training when requested.

The STC prepares and distributes the monthly training calendar; monitors trainer performance and participant evaluations; provides consultation and technical assistance to new trainers; reviews class rosters and oversees the issuance of Letters of Completion. The STC also acts as lead on training related projects and coordinates and facilitates the bi-monthly DHS/OA trainer meetings.

DHS/OA Regional Training Coordinator:

DHS/OA Regional Training Coordinator (RTC), serves as the local coordinating entity for each of the six DHS/OA regional area's training needs. It is the responsibility of the RTC to: 1) assess training demand; 2) schedule training; 3) locate and reserve the training room; 4) screen and select training applicants; 5) mail out pre-reading packets; 6) arrange for appropriate audio-visual equipment; 7) provide training materials for both the trainers and the trainees (assemble and provide trainee manuals); and, 8) prepare all related participant follow-up correspondence, including

maps (directions) to training sites and information on hotel accommodations, parking and nearby restaurants (please refer to the "Regional Training Coordinator's Checklist" and the "Trainer's Material Checklist", pages 13 and 15).

The RTC will also be responsible for the coordination and monitoring of re-evaluation requirements as necessary (please refer to "Remedial Development/Re-evaluation" on page 12).

DHS/OA Regional Field Offices and Regional Training Coordinators:

<u>Region</u>	<u>Address</u>	<u>Staff</u>
I/Northern	Office of AIDS P.O. Box 942732 Sacramento, 95824-7320	CATHERINE BAKER 916/327-3245 FAX: 916/323-4642
II & IV/Bay Area	2151 Berkeley Way, Room 719A Berkeley, 94704	IVY WAGNER 510/540-2317 FAX: 510/540-3233
III/Monterey Coast	344 Salinas Street, Suite 203 Salinas, 93901	DAVID V. BANDA 408/443-3139 FAX: 408/443-3130
V & VI/L.A., San Bernardino, Riverside, Orange	10370 Commerce Center Dr Suite 140 Rancho Cucamonga, 91730	LAURA RIOS 714/483-1625 FAX: 714/483-1628
VII/San Diego	1700 Pacific Coast Hwy. Room 107 San Diego, 92101	MICHAEL BURSAW 619/236-3130 FAX: 619/236-2506
VIII/Central Valley	3374 E. Shields, Room C-14 Fresno, 93726	TIFFINIE JONES 209/421-5837 FAX: 209/488-4255

DHS/OA State Training Staff:

DHS/OA State Training Staff serve as co-trainers in all DHS/OA HIV/CTP. As a representative of the DHS/OA, it is the responsibility of the DHS/OA trainer to insure that the training curriculum is followed, and that all registration and evaluation documents are submitted to the Regional Training Coordinators in a timely manner.

TRAINING GUIDELINES

As DHS/OA HIV Counselor Trainers, you represent the State. As a DHS/OA representative, it is imperative that you conduct yourself in a professional and courteous manner. Bear in mind that this training program is constantly under scrutiny by public and private health officials, along with a myriad of other interested policy makers. Anything but exemplary performance is sure to be subjected to criticism.

CO-TRAINER vs. SOLO-TRAINER

The HIV/CTP is designed as a two trainer format. Therefore, two trainers will always be scheduled when setting up trainings. Solo-training may be approved, but the request for training must be submitted in writing and approved by the Chief, HIV Testing Unit. Areas where solo-trainings may be appropriate are in rural settings where small class sizes (less than 12 people) are often the norm.

TRAINING CLASS SIZE

The HIV/CTP was designed for group participation. The ideal number of trainees should be 20 people. The minimum number of trainees should be no less than 6 people. The maximum number of trainees should be no more than 24 people. There may be an occasion for exceptions. However, any training that exceeds the maximum class size must receive prior approval from either the Chief of the HIV Testing Unit.

PASS OR FAIL POLICY

HIV/CTP trainers bear the responsibility of determining the trainee pass/fail status. If the answer to the questions, "Would this person be capable of giving a positive test result?" or "Would I feel comfortable if a loved one received counseling from this trainee?" is anything other than "yes", DHS/OA recommends that the trainer exercise her/his prerogative. Trainers will be fully supported by DHS/OA in any decision they reach pertaining to the pass/fail status of a trainee.

ATTENDANCE

Attendance should be monitored at all trainings. Every participant is expected to attend the full twenty-four hours. However, because personal or job related emergencies/situations may arise, DHS/OA will provide a four hour exception. To successfully complete the course, a trainee must attend a minimum of 20 hours of training.

EVALUATION MATERIAL PROCESSING

A finalized roster and evaluation materials are to be sent to the RTC within two weeks upon completion of each HIV/CTP by the DHS/OA trainer. Evaluation forms should be submitted for each counselor trainee participating in the class. Separate evaluations for each trainer should also be evaluated. These evaluation materials are to be used for quality assurance and will also serve as documentation of performance.

LETTER OF COMPLETION

Letters of Completion for HIV Counselor Training will be provided to all participants who successfully complete HIV/CTP. This document verifies that a trainee has satisfactorily met and completed the HIV/CTP requirements i.e., attendance at a minimum of 20 hours, a posttest score of 90% or above, and successful completion of the counseling application (posttest positive role play). The letter of completion will be sent out after the completion of every HIV/CTP.

Prior to September 1, 1990, DHS/OA issued Certificates of Training to all counselors who met the requirements and completed the HIV/CTP. This was replaced by the Letter of Completion. The Letter of Completion wields no statutory authority. Health and Safety Code, Chapter 23, Section 1632 (a), statutes of 1986, (AB 488), only mandates that DHS/OA provide training -- not a Letter of Completion or certification. Essentially, the intent of the certificates, and now the Letter of Completion, was to serve as a "token of appreciation" to the trainee. This should be kept in mind when responding to participant's questions about the Letter of Completion.

Trainers should not provide their own certificates. Litigation is a distinct possibility in the event that somebody presented themselves to an agency as a "certified State HIV Counselor". Certification does not, in of itself, insure employment, nor should it be used as a condition of employment, in either the private or public testing programs.

AUDIT STATUS

HIC/CTP is available for participants who are not employed by agencies which provide State funded counseling and testing services, on a space available basis. Auditors will receive Letters of Completion to acknowledge attendance.

CRITERIA FOR TRAINING SELECTION

No person may participate in the HIV/CTP unless he/she is currently (or will be) employed by an agency that is providing HIV counseling and testing services funded by the DHS/OA Testing Unit. Please refer to the Overview Section, Page 4 for a description of the types of agencies which meet this criteria.

A newly hired employee has a grace period of ninety days, from date of hire, before he or she is expected to attend a HIV/CTP.

No trainee shall be allowed in a class without prior approval from the RTC.

All HIV/CTPs must be approved, in advance, by the DHS/OA STC. The RTC will schedule trainings based on regional need. As the State funded agencies inform their respective Regional Field Office of training needs, the RTC will notify the STC of the training schedule. Local trainers may utilize the current counselor training curriculum to fulfill training requests from agencies, providers, and programs that do not receive DHS/OA testing funds. However, trainers may not endorse any such training as being DHS/OA sponsored. These trainings need to remain separate from DHS/OA training and can not be used to substitute for DHS/OA training requirements. All costs for outside training must be assumed by the local agency providing the training.

WEEKEND TRAINING

Weekend trainings may be authorized providing that: 1) Prior written approval is received from the Chief, HIV Testing Unit. 2) A DHS/OA trainer is available. And, 3) the three day training is completed within a five week period. Agencies requesting the weekend training, must submit a letter to the STC substantiating the need. Since a DHS/OA trainer will be utilized, the STC must be contacted at least one month of the training.

GRANDFATHERING

The practice of grandfathering professionals into the HIV/CTP is at present, a mute issue. In November of 1988, approximately 450 counselors were grandfathered into the ATS test sites. Since then, only a few individuals (less than 12/year), have received grandfathering approval. In the present program year (1991-92), there have been two people who sought grandfathering status. In both cases the petitioner was requested to provide a letter detailing their reasons for being considered for grandfathering status. One case was approved the other was denied.

The DHS/OA feels anybody who is considering HIV pre/posttest counseling can and will benefit from taking the three day HIV/CTP. HIV/AIDS knowledge and experiential or clinical background can be enhanced by attending this inter-active class. Additionally, the psychosocial, legislative and medical knowledge regarding transmission, intervention and treatment of HIV/AIDS continues to evolve over time.

Therefore, as a guideline to be followed regarding grandfathering, an individual always has the right to petition for grandfathering status. He or she can do this by submitting a written request to the Chief, HIV Testing Unit, include any supportive documentation and reasons for exemption. It should be understood that the chances of successfully petitioning the grandfather status is remote at best.

RDL ENTERPRISES, Inc.

The DHS/OA has entered into a contract with RDL Enterprises, on January 1, 1991, for the purpose of scheduling, monitoring and reimbursing local trainers into the HIV/CTP. Each new local trainer will receive from RDL; 1) a consultant contract, 2) W-9 forms, 3) an explanation of procedures for scheduling, and 4) an explanation of the reimbursement policy following the State guidelines for per diem and travel reimbursement. RDL can be contacted by either writing or telephoning:

Diana Novak or Linda R., Begbie
RDL Enterprises, Inc.
509 L Street
Sacramento, CA 95814
916/443-0728
FAX: 916/443-0728

MENTOR PROJECT

The purpose of the mentor project is to provide individualized instruction, review and assessment to beginning and experienced HIV counselor trainers. DHS/OA has contracted with the University of California San Francisco, AIDS Health Project (UCSF/AHP), to provide mentorship training for DHS/OA training staff. Training staff will be randomly selected to enter into the mentor trainings each program year.

Trainers will be observed by UCSF/AHP trainers (mentors) during the facilitation and production of the three day HIV/CTP. Mentors will provide the trainers with feed-back regarding training expertise. This analysis will involve a constructive review of the trainer's knowledge level, presentation skills, processing skills and ability to engage the class in the learning process.

Prior to an assignment to a mentor training, involved trainers will work with the mentors to identify and develop individual goals and areas for enhancement. The critique process will also be agreed upon prior to class; it can take place during breaks, at the beginning or end of the training day, or at any time scheduled and agreed to by the involved staff.

SUPPLEMENTAL SPANISH TRAINING

In response to the increasing incidence of HIV infection among Latinos and Latinas in California, the DHS/OA has developed a one and one half day Supplemental Spanish Language Training for HIV counselors. The goal of the training is to enhance the skills of the bilingual counselor who works with monolingual/monocultural Spanish clients and to ensure that adequate and appropriate HIV prevention information is conveyed. The training focuses on the basic elements of HIV counseling and addresses the cultural and linguistic needs of these clients.

Eligibility criteria for the Spanish class is as follows:

1. Currently employed as an HIV pre/posttest counselor in an agency that is receiving DHS/OA testing funds.
2. Have successfully completed the OA's three day HIV/CTP.
3. Works with monolingual Spanish speaking clientele and is able to demonstrate verbal and written fluency (counselors with marginal Spanish language skills may be admitted with prior review and approval coordinated by the RTC).

Training is scheduled according to demand by the RTC and all training is subject to final approval by the STC and all training is subject to final approval by the STC and the Chief, HIV Testing Unit. Only one Spanish training per month may be scheduled for an area. A maximum of twenty participants may be enrolled in each class. The ideal class size should be 15-18 trainees.

All trainees must be approved in advance by the RTC. Prior to placement in the class, training candidates must submit a training application to the RTC. Applicants may be contacted and screened by designated DHS/OA staff, in order to verify Spanish fluency. Agencies seeking to verify fluency in advance of enrollment may contact the RTC for approval. Once screened, the agency will be notified of the results and applications will be processed accordingly.

Unlike the HIV/CTP, this training does not include a formal evaluation. Agencies seeking informal feedback regarding skill levels demonstrated by their participants should contact the RTC prior to the class, so that evaluation materials can be prepared.

REMEDIAL DEVELOPMENT/RE-EVALUATION

It is seldom that training participants do not successfully complete the HIV/CTP. If an unsuccessful participant is employed by an DHS/OA funded HIV testing agency that is willing to provide the participant with individualized instruction and support, the DHS/OA will monitor and endorse the remedial development and become involved in subsequent re-evaluation the trainee.

The remedial development and re-evaluation of any trainee is a collaborative effort that may occur only through the cooperation of the trainee, the trainee's supervisor/agency administrator, the trainer conducting the initial evaluation and the RTC (sometimes with the added support of a local non DHS/OA trainer). The RTC is responsible for assuring that remedial support and re-evaluation activities are appropriately designed, approved, and carried out.

Additional information on the policies and procedures in working with an unsuccessful candidate can be obtained from the RTC in your area. Ask for, "Elements of the Re-evaluation Process and Development Plan: A Manual."

APPENDICES

I. Trainer Checklist - Scheduling Trainings:

- A. Assess the need for training in the area.
1. Contact testing programs, either through telephonic communication or an actual visit to the agency, on an ongoing basis.
 2. Have the agency designate a contact person who can identify who needs to be trained, or contact the applicants supervisor.
- B. Develop a tentative scheduling of trainings.
1. Schedule trainings for a six or twelve-month period. The dates of these training sessions should be documented on a schedule for training.
 2. Forward schedule to DHS/OA headquarters staff at the following address:
- State Training Coordinator
Department of Health Services
Office of AIDS
P. O. Box 942732
Sacramento, CA 94234-7320
- C. Contact state funded agencies approximately six weeks prior to the training session to begin the enrollment of participants in the training session.
1. Get the agency to identify the individual(s) they plan on enrolling.
 2. If they are unable to name a participant, get the agency to commit to a number that they plan on sending to the training session. Indicate that you will contact them in about two weeks (if you haven't heard from them) for the names of those they intend on sending to the training session.
 3. Allow a maximum of two slots per agency if demand is high.
 4. If an agency is willing to host a training session (provide a classroom), consider giving this agency the opportunity to send an additional participant.
 5. In the event that demand exceeds the capacity of the training class, an effort should be made to establish another training as soon as it is feasible to provide the training. If persons employed in non-OA funded testing programs request training, waiting lists should be established and training may be provided as slots become available. Agencies should then be on a priority basis.

6. Each candidate for training must complete an application form and it should be sent to the nearest office.
- D. Limit total enrollment to no more than 20-24 participants.
- E. About three weeks prior to the training session, confirm, with the agencies, that there are no changes and they are committed to sending the previously named individuals to the training session.
 1. Determine whether the pre-reading packets are to be sent directly to the participant or to the contact person at the agency.
 2. Request that the agency notify the area office of any cancellation before the training session.
 3. If a cancellation occurs, call agencies on the waiting list and offer additional slots.
- F. Mail out pre-reading material two weeks prior to the training session to each individual attending the session.
Included in the packet:
 1. A letter confirming their participation in the training session.
 2. Pre-reading material.
 3. The location of the training session and a map.
 4. Names and phone numbers of the trainers.
 5. Days and hours of the training session.
 - a) The training session will begin at 8:00am and will end at 5:00pm each day.
 - b) The need to be on time for the training sessions.
 6. The importance of having read the required pre-reading material prior to the training session.
 7. Include a list of parking facilities, hotels and restaurants in the area.
- G. At least three weeks prior to the training session, forward a tentative training roster to DHS/OA headquarters.
- H. Reserve a meeting room large enough for 24 participants and two instructors.
 1. The room must be large enough for the main group to break into several different smaller groups.
 2. If possible, obtain another room for the afternoon of the last day for the role play evaluations.
 3. The room must be available for the full three days.
- I. Reserve a VCR and monitor.
- J. Approximately one month prior to training, co-trainer should

be selected by DHS/OA training coordinator. Do not assume that your co-trainer has read the guidelines or checklist; it is important to go through the list yourself. It is important to communicate with your co-trainer the responsibilities and follow through.

II. Trainer Checklist - Material for Class

This checklist has been developed to guide all trainers in preparing for HIV/CTP.

- A. Participant material
- B. Ground rules for the training sessions should be written out and posted in the classroom prior to the beginning of the training session.
- C. Easel
- D. Butcherblock paper
 - 1. Butcherblock blank paper
 - 2. For those exercises that require headings at the top of the butcherblock paper, complete these prior to the training session.
 - a) 12 questions about HIV
 - b) Language and terms
 - c) Cultural sensitivity
- E. Felt tip and erasable markers
- F. Videos - refer to the training manual and other videos that are felt appropriate for the training session
- G. Material to be distributed during the training session
 - 1. Handout packets of various reading materials, (including legal updates and a directory of local resources).
 - 2. Local, State and National statistics
- H. Masking tape
- I. A supply of pencils
- J. Name tags
- K. Sign in rosters
- L. Xeroxed copies of training role plays, (enough of each role play for each small group).

- M. Evaluation materials
- N. All materials should be broken down by day
 - 1. Pretest Questionnaire
 - 2. Posttest Questionnaire
 - 3. Overall Evaluation
 - 4. Trainer Evaluation (one for each of the trainers)
 - 5. Certification Summary Forms
 - 6. Counselor Evaluation Forms
 - 7. Copies of roster sign-in sheet
- O. All materials should be broken down by day.
- P. Candy (peppermints and candy kisses), for the guided imagery session in the afternoon of the second day.

III. Trainer Checklist - Classroom Setting

- * Arrive one hour prior to start of training on Day One
- A. Day before training, call and confirm room, VCR and monitor.
- B. Arrive 60 minutes prior to class, in order to set up tables, chairs, class materials, etc.
- C. Pick up the VCR and monitor.
- D. Post butcher block paper for exercise.
- E. Post welcome sign in front of training site for "lost souls".
- F. Inform trainees who are nurses about CEU credit (20 hours of CE), to indicate their license number on the sign in roster as well as the Certification Summary Form (upper right-hand corner).
- G. (Optional): Consider discussing with trainees, the possibility of a pot-luck during lunch on the final day, (this is also a good time for viewing videos).

IV. Trainer Checklist - After the Training Session

- A. Discuss evaluations with co-trainer.
- B. DHS/OA trainer submits all evaluation forms, class roster (sign-in sheet) within two weeks of the completion of the class.

HIV INCIDENCE AND PREVALENCE IN SAN FRANCISCO IN 1992:

SUMMARY REPORT FROM AN HIV CONSENSUS MEETING

**SURVEILLANCE BRANCH, AIDS OFFICE
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
FEBRUARY 12, 1992**

I. EXECUTIVE SUMMARY

This report summarizes estimates of the incidence and prevalence of HIV infection in San Francisco for 1992. These estimates are based upon an HIV Consensus Meeting held on September 11, 1991, which was sponsored by the San Francisco Department of Public Health AIDS Office.

It is estimated that 28,000 men, women and children are currently living with HIV infection in San Francisco, representing almost 4% of the City's population. San Francisco has the highest number of HIV-infected persons per capita of any major city within the United States. Almost 3% of the estimated one million persons living with HIV infection in the U.S. reside in San Francisco.

It is also estimated that more than 1,000 men, women and children will become newly-infected with HIV during 1992 alone. This number is higher than previous predictions for 1992 and is driven primarily by data suggesting a "second wave" of HIV infection among gay and bisexual men.

Based on the large body of research conducted in San Francisco in the past decade, it is estimated that the vast majority of persons currently infected with HIV in San Francisco are either gay and bisexual men, injection drug users, or sexual partners of gay and bisexual men or injection drug users. In addition, the data suggest that the incidence of HIV infection among other risk populations is extremely small, and both parallels, and is driven by, the incidence among those populations at highest risk. The data suggest no evidence of significant HIV transmission within low-risk populations in San Francisco.

The current state of the HIV/AIDS epidemic in San Francisco provides a unique opportunity to re-emphasize prevention efforts within those populations at highest risk. This would prevent both transmission of HIV within the high-risk populations and would prevent further transmission to other populations where the prevalence of HIV infection is currently low.

The data suggest that focused prevention campaigns have been very successful in San Francisco when targeted to populations at high risk. The data indicate that comprehensive community-based prevention efforts among gay and bisexual men were primarily responsible for the dramatic reductions in the incidence of HIV infection among gay and bisexual men in the early to mid-1980s. These programs were designed and coordinated by persons within the gay/bisexual communities. The key aspects of these programs included a balance between grass-roots efforts, media campaigns, self-help groups, and a strategy of empowerment and support for persons at risk. Likewise, the data suggest that comprehensive street- and community-based programs designed for injection drug users have been successful in slowing the epidemic among injection drug users in San Francisco in recent years. The key to success in both instances was the use of comprehensive community-based prevention efforts and the commitment among those at risk to change their behavior.

These data also suggest that current prevention programs must continue to be supported in order to maintain the recent changes in behavior and to reach new generations at risk. To sustain behavior change over long periods of time, prevention messages need to be repeated frequently and through a variety of channels. The inadequate Federal fiscal commitment to programs targeting gay and bisexual men in the late 1980's may have contributed to the development of a "second wave" of HIV infection among gay and bisexual men. It is critically important that existing resources not be diverted from programs for injection drug users or their sexual partners now that the data suggest a slowing of the epidemic within this

community in San Francisco. There needs to be continued advocacy for funding at the Federal level for a significant expansion of prevention activity.

Given scarce resources for the prevention of HIV infection, and the expense of waging strong grass-roots, community-based prevention campaigns in several risk populations, the most effective prevention strategy for addressing the HIV epidemic would be to focus the vast majority of new resources for prevention on those populations at highest risk: gay and bisexual men (especially young men and gay/bisexual men of color), injection drug users, and their sexual partners. The benefits from successful prevention efforts among those at highest risk would also spill over to other populations where the risk was much lower.

State and Federal agencies must realize that the robbing of prevention funds to pay for AIDS care programs will only perpetuate future waves of HIV infection. Instead of specifying target populations for localities, these agencies must permit local jurisdictions the flexibility to address needs based on local data.

The SFDPH AIDS Office will be seeking the cooperation of existing contractors to emphasize the highest-risk populations of young gay and bisexual men, gay and bisexual men of color, injection drug users, their sexual partners, and the issue of relapse in program development and planning. Contractors who currently target the general community will be assisted in focusing their programs to address the above.

The following points highlight the key findings from this report. These are followed by a table (Table 1) which summarizes the principal findings:

1. **An estimated 28,000 men, women and children are currently living with HIV infection in San Francisco, representing almost 4% of the City's population.**
2. **More than 1,000 men, women, and children will become newly-infected with HIV during 1992 alone. This number is higher than previous predictions for 1992 and is driven primarily by data suggesting a "second wave" of HIV infection among gay and bisexual men.**
3. **Approximately 25,000 gay and bisexual men (including gay and bisexual injection drug users) are currently living with HIV infection in San Francisco, with an additional 650 men expected to become infected in 1992. The men currently becoming infected are increasingly young men (25 years and under), and men of color, who may not have received the prevention messages of the first wave of the epidemic. These infections, together with new infections among some older gay and bisexual men who have relapsed to unsafe sexual behaviors, represent a "second wave" of HIV infection among gay and bisexual men.**
4. **An estimated 1,700 injection drug users (IDUs) other than gay/bisexual males are currently living with HIV infection in San Francisco and more than 200 are expected to become infected with HIV in 1992. The data suggest that the prevalence of HIV infection has stabilized since 1987 among both street-based and in-treatment IDUs in San Francisco. The current data, however, may underestimate the true prevalence and incidence of HIV infection.**
5. **More than 1,100 women are currently infected with HIV in San Francisco and it is estimated that 180 additional women will become infected with HIV in 1992. Most of these women were infected with HIV through injection drug use or through sexual contact with a male partner at risk for HIV. The**

prevalence of HIV infection has appeared to stabilize among women in recent years, a trend which parallels the stabilization of the HIV epidemic among injection drug users in San Francisco.

6. An estimated 250 non-injection drug-using heterosexual men are currently infected with HIV in San Francisco, and about 50 men will become infected with HIV in 1992. The prevalence of HIV infection has appeared to stabilize among both hetero- sexual men and women, a result of the slowing of the HIV epidemic among injection drug users in San Francisco. If the prevalence of HIV infection remains stable among injection drug users, relatively few new infections would be expected for women and heterosexual men in the future.
7. Approximately 8 to 20 infants will be born each year with antibodies to HIV, but only about 5 per year will eventually be determined to be infected with HIV. The incidence of HIV infection among infants has stabilized in recent years. Perinatal transmission will continue to be a relatively small problem in San Francisco.

TABLE 1

ESTIMATED HIV INCIDENCE AND PREVALENCE IN SAN FRANCISCO: 1992

<u>RISK GROUP</u>	<u>POPULATION SIZE</u>	<u>HIV PREVALENCE</u>		<u>ANNUAL HIV INCIDENCE</u>	
		<u>N*</u>	<u>PERCENT</u>	<u>N**</u>	<u>PERCENT</u>
<u>Gay/Bisexual Men:</u>					
Non-IDUs					
Young (17-25)	5,000	600	12%	200	4.0%
Older (26+)	50,000	22,500	45%	415	1.5%
IDUs	3,000	1,900	63%	35	3.5%
SUBTOTAL	58,000	25,000	43%	650	2.0%
<u>Injection Drug Users:</u>					
Heterosexual Men	8,500	1,200	14%	150	2.0%
Women	4,500	500	11%	80	2.0%
SUBTOTAL	13,000	1,700	13%	230	2.0%
<u>Other Adults/Adolescents:</u>					
Women	315,000	630	0.2%	100	0.03%
Heterosexual Men	253,000	250	0.1%	50	0.02%
SUBTOTAL	568,000	880	0.15%	150	0.025%
<u>Infants and Children:</u>	85,000	85	0.1%	5	0.03% (of births)
<u>TOTAL</u>	724,000	27,665	4%	1,035	0.15%

* Total number of persons living with HIV infection

** Number of new infections per year

II. PURPOSE AND GOALS

This report is a summary of the HIV Consensus Meeting that was coordinated by the San Francisco Department of Public Health AIDS Office and held on September 11th, 1991. The purpose of this meeting was to provide a forum where researchers could discuss their data and generate best estimates on the direction of the HIV/AIDS epidemic in San Francisco. The results of this meeting were intended to guide prevention efforts in the fight against HIV infection. The goals of this meeting were: 1) to assemble together AIDS researchers and epidemiologists to present their data on HIV infection among various risk populations in San Francisco, and 2) for these researchers to provide their scientific opinions on the direction of the epidemic so as to arrive at a consensus on the best estimate of HIV prevalence and incidence in San Francisco.

III. METHODS

The morning and early afternoon sessions of the meeting were devoted to presentations on the current knowledge of HIV infection in San Francisco among various risk populations. During the afternoon session, participants were asked to vote on the estimates of HIV prevalence and incidence for each risk group. Votes were tabulated and the merits of the final tally were discussed by the participants. The prevalence of HIV was defined as the proportion of the total risk population infected with HIV at a specified time interval. The incidence of HIV was defined as the proportion of the susceptible (uninfected) population becoming infected with HIV per year. The voting was limited to the following risk groups: gay/bisexual men, gay/bisexual male injection drug users, male and female injection drug users, and women and heterosexual men. The current knowledge of HIV infection in San Francisco comes from many research collaborations and projects. The methods used in these studies included probability samples of San Francisco neighborhoods, long-standing cohort studies of gay and bisexual men, studies of young men who frequented gay-identified bars and dance clubs, clinic-based unlinked serosurveys, studies of women in the sex industry, surveys of childbearing women, studies of heterosexual partners, street-based samples of injection and non-injection drug users, and screening of blood donors. The results from specific surveys could not be generalized to the population as a whole but were illustrative of the communities from which the samples were obtained.

Estimates of the size of the risk populations in San Francisco were revised subsequent to the consensus meeting. Estimates of the number of gay/bisexual men were obtained from a randomized telephone survey conducted by Communication Technologies in 1989 for the San Francisco Department of Public Health and the San Francisco AIDS Foundation. Estimates of the number of gay/bisexual injection drug users were obtained from both the Communication Technologies survey and from a survey of gay and bisexual men of color conducted in 1990 by Fairbank, Bregman, and Maullin, Inc. in collaboration with the Mission Neighborhood Health Center, Filipino Task Force on AIDS, the American Indian AIDS Institute, the University of California at San Francisco, and the San Francisco Department of Public Health.

Estimates of the number of injection drug users were calculated by two methods. First, estimates of the percentage of recent and lifetime users were obtained from several population-based surveys of risk behavior sponsored by the San Francisco Department of Public Health. These percentages were then applied to 1990 census data to generate estimates for the City. The second method utilized treatment data generated by Community Substance Abuse Services of the San Francisco Department of Public Health. An unduplicated count of IDUs (San Francisco residents only) utilizing drug treatment facilities in San Francisco in 1990-91 (current users) or

in 1988 to 1990 (recent users) was inflated by the ratio of total IDUs to those in treatment. Ratios of users to those in treatment were obtained from data on street-based samples in 1991, provided by the Urban Health Study, and from household studies (AMEN Cohort) conducted by the University of California, San Francisco, in 1989.

Estimates of the numbers of other adults and adolescents at risk were obtained by subtracting the number of gay and bisexual men and injection drug users from total population estimates from the 1990 census. The estimated numbers of infants and children were based on the 1990 census data.

IV. DETAILED FINDINGS

A. RISK POPULATION: GAY AND BISEXUAL MEN

Nancy Hessel provided an update on the City Clinic Cohort Study. This cohort of gay and bisexual men was initially recruited from the San Francisco City Clinic, a sexually transmitted disease clinic, between 1978 and 1980 for studies of hepatitis B. All unused serum samples, both from the initial screenings and from the vaccine trials, were frozen and stored. In 1983, epidemiological studies of AIDS were initiated in this cohort. The incidence of HIV infection was assessed among cohort members who agreed to participate in AIDS follow-up studies. In addition to the City Clinic Cohort, Michael Samuel provided an update on a separate cohort study of gay and bisexual men, the San Francisco Men's Health Study. This cohort has been followed since 1984, when a population-based random sample of 1034 single men 25 to 54 years of age was recruited from 19 census tracts in San Francisco with the highest cumulative AIDS incidence. Serum samples were initially obtained between June 1984 and January 1985, and thereafter through twice-yearly follow up. Dr. George Lemp presented data from the Young Men's Survey (YMS), a survey of 258 young gay and bisexual men who frequented gay-identified bars and dance clubs during the Spring of 1991. Male San Francisco residents under the age of 25 years were recruited outside seven gay-identified bars and/or dance clubs in San Francisco. Structured interviews were conducted and blood specimens were drawn in an RV parked near the club.

Dr. Andrew Zolapa provided data on HIV infection among homeless gay and bisexual males in San Francisco. In addition, Dr. Eve Golden provided data on gay and bisexual men from the AMEN cohort study, a probability sample of households in 16 census tracts within three multi-ethnic neighborhoods in San Francisco. Also, data was presented on HIV infection among young gay and bisexual men from an unlinked seroprevalence survey at the San Francisco City Clinic. Finally, Ricardo Bermudez provided data on homeless and runaway gay youth seeking shelter and services at two youth centers.

City Clinic Cohort:

- * The prevalence of HIV infection within the overall cohort was estimated to be 76% in 1990. Among a subset of patients who were enrolled in hepatitis B vaccine trials, the prevalence of HIV was 53% (n=359) in 1990. The prevalence of HIV among living cohort participants was estimated to be 40%.
- * Three participants with unprotected oral intercourse as their only risky behavior seroconverted during 1990-91.
- * The incidence of new HIV infection in this cohort has been between 1% and 2% per year since 1986.

San Francisco Men's Health Study:

- * The incidence of HIV infection in 1989/90 in this cohort of gay/bisexual men was estimated to be about 1% per year, but due to the small number of seroconversions, the confidence intervals surrounding this estimate are wide.
- * The prevalence of HIV among living gay/bisexual cohort members is estimated to be 48%.
- * Of the men infected between 1985 and 1990, 98% practiced unprotected oral receptive intercourse, 61% practiced anal receptive intercourse, and 43% practiced unprotected anal intercourse, in the interval preceding infection.

Young Men's Survey (YMS):

- * Of 258 men enrolled and tested, 12% were found to be HIV infected. Of men between the ages of 17 to 19, 14.3% (n=21) were HIV infected. Among those 20 to 22 years of age, 14.0% (n=93) were HIV infected. And among 23-to 25-year-olds, 10.4% (n=144) were HIV infected.
- * Among white men, 10.9% (n=138) were HIV infected, among African-American men, 22.9% (n=35) were HIV infected, and among Latino men, 14.3% (n=49) were HIV infected. Of the 33 Asian/Pacific Islander men surveyed, none were infected.
- * Sixty-one percent of those infected with HIV reported that their first high-risk sexual encounter or use of injection drugs occurred between 1984 and 1990.
- * This study suggests that the incidence of HIV infection may be higher for younger gay/bisexual men when compared with older men. The incidence of HIV infection for young gay/bisexual men was estimated to be 4% per year.

Other studies:

- * Among homeless gay and bisexual men sampled from SRO (Single Room Occupancy) hotels and homeless shelters in San Francisco, 40% were found to be HIV infected.
- * Among gay/bisexual men sampled in the AMEN cohort, 32% were infected with HIV (n=113), and among gay and bisexual men who inject drugs, 59% (n=43) were HIV infected.
- * Among gay and bisexual men attending the City Clinic in 1989, 50.7% (n=446) were HIV seropositive. Among gay and bisexual injection drug users, 68.9% were HIV seropositive (n=119). Among gay and bisexual men between 20 to 24 years of age, 41.9% (n=62) were HIV positive.
- * Among homeless and/or runaway gay and bisexual male youth (24 years and younger) seeking services at two youth centers, 40.7% (n=59) were infected with HIV.

After considerable discussion, the consensus of the participants was that the prevalence of HIV infection among non-injection drug-using gay and bisexual men in San Francisco is between 40% and 44%. The incidence of new infections is estimated to be between 1.5% and 2.0% per year, although several participants suggested that the incidence may be higher. The lack of consensus on incidence reflects opinions that the incidence is higher for younger gay and bisexual men (estimated to be 4% per year) than for older men, and that the observed rates in the City Clinic Cohort and San Francisco Men's Health Study may be minimum estimates. Among injection drug-using gay and bisexual men, the prevalence of HIV is estimated to be between 60% and 64%, with an estimated incidence between 3.0% to 3.9% per year.

To determine the number of gay and bisexual men currently living with HIV, and also the number becoming infected each year, we combined estimates of the size of the populations at risk with the estimates of incidence and prevalence.

Assuming an estimated population size of 55,000 non-injection drug-using gay and bisexual men [including 5,000 young (17 to 25 years) and 50,000 older (26+ years) gay men] and 3,000 injection drug-using gay and bisexual men, the following estimates can be made:

	POPULATION SIZE	HIV PREVALENCE		ANNUAL HIV INCIDENCE	
		N	PERCENT	N	PERCENT
<u>Gay/Bisexual Men:</u>					
Non-IDUs					
Young (17-25)	5,000	600	12%	200	4.0%
Older (26+)	50,000	22,500	45%	415	1.5%
IDUs	3,000	1,900	63%	35	3.5%
SUBTOTAL	58,000	25,000	43%	650	2.0%

These estimates suggest that the number of living HIV-infected gay and bisexual men in San Francisco is about 25,000, and that the number of men becoming infected with HIV per year is approximately 650. A significant proportion of the newly-infected men are expected to be 25 years of age or younger.

B. RISK POPULATION: INJECTION DRUG USERS (IDUs)

HIV prevalence and incidence data were presented on various injection drug-using populations in San Francisco, including data from street-based samples (Dr. John Watters, Urban Health Institute), surveys of IDUs in drug treatment clinics (Dr. Robert Gorter, UCSF), street-based samples of "crack" cocaine users in the Bayview and Sunnysdale neighborhoods (Dr. Benjamin Bowser, Bayview Foundation), and data from the AMEN cohort study of households in 16 census tracts within 3 multiethnic neighborhoods of San Francisco (Bayview, The Western Addition, and The Mission). (Dr. Eve Golden, CAPS, UCSF).

Urban Health Study:

- * The prevalence of HIV among street-recruited IDUs in San Francisco by half-year is as follows: 1988(2) 13%; 1989(1) 12%; 1989(2) 14%; 1990(1) 12%; 1990(2) 14%; 1991(1) 11%.

- * HIV seroprevalence may have increased among Latino users, but the sample size is very small. African-Americans may also be at elevated risk.
- * HIV incidence rates may be as high as 4%.
- * Behavior changes reported by heterosexually-active participants in the past year include: condom usage has increased by 30% among males; by 1990, syringe exchange was the primary source of syringes for 40% of participants; injectable cocaine users are being replaced by "crack" smokers.

Surveys of IDUs in Drug Treatment Clinics:

- * HIV prevalence among IDUs in methadone treatment by year is as follows: 1985 10%; 1986 13%; 1987 13.5%; 1988 8%; 1989 7.5%.
- * Among African-Americans, the prevalence of HIV by year is as follows: 1985 18.5%; 1986 26.5%; 1987 28.1%; 1988 18.1%.
- * Among Latinos, the prevalence of HIV by year is as follows: 1985 16.7%; 1986 13.5%; 1987 14.8%; 1988 2.5%
- * Unlinked HIV seroprevalence surveys of IDUs entering methadone treatment from 1989-1991 show a prevalence of 8.6%. In this survey, males and females have similar prevalence estimates, 8.4% and 4.2%, respectively.
- * These data suggest a stabilized HIV prevalence of about 8% - 10% among in-treatment IDUs.

Bayview Foundation Surveys of Street Youth:

- * Among 335 street-recruited youth aged 18 to 29 years from the Bayview and Sunnydale neighborhoods, 6 (1.8%) were HIV positive. Among 188 "crack" users, 5 (2.7%) were HIV positive.
- * The prevalence of syphilis markers (VDRL) was 6.6% (22/335). 35% reported an STD in the previous 12-months. 45% reported never using condoms. 41% indicated that they had been tested for HIV prior to the survey.

UCSF Surveys of IDUs In Treatment:

- * By 1990, the prevalence of HIV infection among in-treatment IDUs had stabilized at a level between 8.5% and 9.0%. Since in-treatment surveys may underrepresent HIV infection among all IDUs, the true prevalence of HIV infection may be higher.
- * Between 1985 and 1990, the average HIV seroconversion rate among IDUs in treatment was 2.3% per year. The trend of HIV incidence by 2-year periods is estimated as follows: 1985-86 4.3%; 1987-88 1.9%; 1989-90 1.9%. Seroconversions are occurring at a higher rate among women than men (2.3% vs 1.5%), and at a higher rate among African-Americans than Latinos or whites (3.5%, 1.8%, and 1.1% respectively). It is estimated that 200 new infections are occurring per year among IDUs.

- * Risk factors associated with recent seroconversion are more often sexually related, and not drug related, with women at higher risk than men, especially "crack"-using women. Also, long-term enrollment in a treatment program (>12-months) may be protective against HIV infection.

AMEN Cohort Study:

- * Among 131 heterosexual IDUs recruited in this study, 5 (3.8%) were HIV seropositive. The prevalence was 5% among males (3/60) and 3% among females (2/71).

Although the prevalence of HIV infection has appeared to stabilize among both street-based and in-treatment IDUs, the participants concluded that, for a variety of reasons, the current data may underestimate the true prevalence and incidence of HIV infection. First, methadone treatment facilities may underrepresent the "crack-using" population. With the recent increases in "crack" use and with the association between the use of "crack" cocaine and HIV infection, methadone treatment facilities may increasingly underestimate the prevalence of HIV infection among IDUs. Second, recent household surveys suggest that many persons within San Francisco neighborhoods with a high incidence of injection drug use may have moved to other counties in the Bay Area where there is a lower cost of living. An outmigration of HIV-infected IDUs would mask a rise in HIV prevalence. Finally, HIV-infected IDUs who have progressed to later stages of HIV infection and who receive care in acute care settings may no longer utilize methadone treatment programs or be available for street-based surveys. Exclusion of IDUs with significant manifestations of HIV infection would result in an underestimate of the number of prevalent infections in San Francisco.

Although adequate data are not currently available, the participants unanimously concluded that the incidence of HIV infection among IDUs is between 2% and 2.9% per year. The participants did not reach a consensus regarding the prevalence of HIV infection among IDUs, but suggested that HIV prevalence may range from 10 to 19%.

Assuming that the population of IDUs is approximately 13,000 persons (8,500 heterosexual men and 4,500 women), then the following estimates can be made:

	POPULATION SIZE	HIV PREVALENCE		ANNUAL HIV INCIDENCE	
		N	PERCENT	N	PERCENT
<u>Injection Drug Users:</u>					
Heterosexual Men	8,500	1,200	14%	150	2.0%
Women	4,500	500	11%	80	2.0%
SUBTOTAL	13,000	1,700	13%	230	2.0%

These estimates suggest that approximately 1,700 injection drug users are living with HIV infection in San Francisco and that approximately 230 IDUs are becoming infected per year. Among heterosexual males, the estimated number currently infected is about 1,200 persons, and the estimated number becoming infected per year is estimated at 150. Among women, approximately 500 are currently infected with HIV and about 80 new infections are expected per year.

C. RISK POPULATION: OTHER ADULTS/ADOLESCENTS AND INFANTS AND CHILDREN

Estimates of HIV infection among other adults/adolescents and infants and children in San Francisco were presented from several studies including: the screening surveys of childbearing women (Dr. Mary Jess Wilson, CDHS Office of AIDS), clinic-based HIV seroprevalence surveys of women attending a family planning clinic and an abortion clinic (Tim Kellogg, AIDS Office), surveys of women who self-identified as sex workers in San Francisco (Dr. Judith Cohen, UCSF, Project AWARE), an update on the heterosexual partners study (Dr. Nancy Padian, UCSF, CAL-Partners), a probability sample of heterosexuals recruited in multiethnic neighborhoods in San Francisco (Dr. Eve Golden, CAPS, AMEN cohort), heterosexuals attending a sexually transmitted disease (STD) clinic (Dr. Gail Bolan, City Clinic), and screening surveys of blood donors and recipients (Susan Samson, Irwin Memorial Blood Centers). Each study's estimate of HIV prevalence is presented below:

- * **SURVEYS OF CHILDBEARING WOMEN:** Approximately 99.7% of the live births that occurred in San Francisco during each 3-month survey period were included in the surveys. During the 1988 survey, the prevalence of HIV among women giving birth was 0.195%, or 1.95 HIV infections per 1,000 women giving birth. During 1989, the prevalence of HIV was 0.157%, or 1.57 HIV infections per 1,000 women giving birth. And during 1990, the prevalence of HIV was 0.082%, or 0.82 HIV infections per 1,000 women giving birth. Approximately 8 to 20 newborns will test positive for HIV antibodies per year in San Francisco, but only 2 to 6 will eventually become HIV infected.
- * **SURVEYS OF FAMILY PLANNING AND ABORTION CLINIC CLIENTS:** Unlinked seroprevalence surveys have been conducted in a family planning clinic since 1989 and in an abortion clinic since 1990. The prevalence of HIV among family planning clients by year are as follows: 1989 0.32%, or 3.2 HIV infected women per 1,000 women tested; 1990 0.15%, or 1.5 HIV infected women per 1,000 tested; and 1991 0.24%, or 2.4 HIV infected women per 1,000 tested. Among abortion clinic clients, the overall prevalence was 1.07%, or 11 HIV infected women per 1,000 tested. The abortion clinic is a referral site for HIV infected women seeking abortions.
- * **PROJECT AWARE - FEMALE SEX WORKERS:** The ethnic distribution of study participants was as follows: 70% African-American, 10%-15% Latina, and 10%-15% white. During 1989, the prevalence of HIV infection among the study group was 13.9%. During 1990/91, the prevalence of HIV was also 13.9%. Among "crack" cocaine users, prevalence of HIV infection was 18%; among IDUs it was 12%; and among those who used both injection drugs and crack, it was 14%. Six of 10 HIV-infected sex workers in 1990/91 were African-American.
- * **HETEROSEXUAL PARTNERS STUDY:** Among discordant heterosexual partners (one HIV + /one HIV -), the transmission rate was 20% from male-to-female, and 1% from female-to-male.
- * **STD CLINIC ATTENDANTS:** An unlinked HIV seroprevalence survey among heterosexuals seeking evaluation and/or treatment for an STD was conducted during 1989 and 1990. Among heterosexual males, 70 of 2670 (2.6%) were HIV infected, and among heterosexual females, 28 of 1103 (2.5%) were infected with HIV. The prevalence was highest among African-American clients (3.0%).

- * **AMEN COHORT:** A probability sample of 16 census tracts in 3 multiethnic neighborhoods (Bayview, Western-Addition, and The Mission) yielded a total of 1,770 participants. Of the 1,770, 78% agreed to a blood draw. Among male heterosexuals that participated, 0.9% (4/463) were HIV infected, and among female participants, 0.2% (1/632) were infected with HIV.
- * **HIV AMONG BLOOD DONORS:** In the first half of 1991, only 2 donors were screened HIV-positive out of 44,300 donations, or 5 HIV-positives per 100,000 donations.

The consensus of the participants was that the prevalence of HIV among non-injection drug-using women in San Francisco is between 0.10% and 0.25%. It was estimated that approximately 600 women are currently living with HIV infection, and that 100 women are becoming infected per year. Based on the 1990 census we estimate that approximately 315,000 women live in San Francisco, therefore the incidence of HIV infection is approximately 0.03% per year, or 30 infections per 100,000 women-years. Many of these infections are expected to be from sexual contact with a male partner at risk for HIV.

The participants suggested that the number of HIV-infected heterosexual males is approximately 40% that of women. This is estimated to yield approximately 250 HIV-infected men. Assuming that the sexual transmission of HIV from female-to-male is less efficient than from male-to-female, then the number of new infections occurring per year among men should be less than that estimated for women. The participants estimated that 50 heterosexual men are infected per year in San Francisco.

Data from the survey of childbearing women suggest that the number of babies being born in San Francisco with antibodies to HIV is approximately 8-20. It is currently estimated that approximately 33% of infants with HIV antibodies will eventually become infected with HIV. Therefore, the consensus of the participants was that approximately 5 babies will become infected with HIV per year.

Based on the preceding assumptions, we make the following estimates:

	POPULATION SIZE	HIV PREVALENCE		ANNUAL HIV INCIDENCE	
		N	PERCENT	N	PERCENT
<u>Other Adults/Adolescents:</u>					
Women	315,000	630	0.2%	100	0.03%
Heterosexual Men	253,000	250	0.1%	50	0.02%
SUBTOTAL	568,000	880	0.15%	150	0.025%
<u>Infants and Children:</u>					
	85,000	85	0.1%	5	0.03%
(of births)					

V. CONCLUSIONS

- * It is estimated that 28,000 men, women, and children are currently living with HIV infection in San Francisco, or about 4% of the population of San Francisco. Also, it is estimated that approximately 1,000 men, women and children will become infected with HIV during 1992.
- * Approximately 25,000 gay and bisexual men are living with HIV infection in San Francisco. The number of gay and bisexual men becoming infected per year is estimated to be 650 persons, which reflects an annual seroconversion rate of 2.0%. The men currently becoming infected are increasingly young men (25 years and younger) who may have missed the prevention messages of the first wave of the AIDS epidemic. Also, gay and bisexual men of color, especially African-American men, may represent a larger proportion of the "second" wave of HIV infection among gay and bisexual men.
- * The number of living HIV infected heterosexual injection drug users in San Francisco is estimated to be 1,700, of whom approximately 29% are women. The HIV infection rate is estimated to be about 2.0% per year, or approximately 230 IDUs who will become infected per year.
- * It is estimated that more than 1,100 women are currently infected with HIV in San Francisco, for a prevalence of 3.5 per 1,000 women (based on the 1990 census). It is also estimated that 180 women will become infected with HIV in 1992. Among male heterosexuals, it is estimated that about 250 non-injection drug-using men are currently infected with HIV in San Francisco, and about 50 men will become infected per year. Finally, it is estimated that approximately 8 to 20 babies will be born each year with antibodies to HIV, but only about 5 will eventually be determined to be infected with HIV.

VI. ACKNOWLEDGMENTS

The San Francisco Department of Public Health AIDS Office wishes to thank all the researchers who participated in this meeting, especially those who took the time to present their data. We also thank Al Abramowitz, Community Substance Abuse Services; Craig Chaffee, State Department of Alcohol and Drug Programs; and Dr. John Watters (Urban Health Institute, UCSF) and Dr. John Newmeyer (Haight-Ashbury Free Medical Clinics) for provision of data on the numbers of IDUs in San Francisco. We would also like to thank the San Francisco AIDS Foundation for the use of their conference room, and the Filipino AIDS Task Force for the use of their overhead projector. We also acknowledge Nellie Rose, Gloria Posadas, and Sylvia Herrera for their logistic support. Finally, we wish to thank Drs. George W. Rutherford and Donald Francis of the California Department of Health Services for their efforts in moderating this meeting. A list of presentations and presentors follows:

Current Findings from the City Clinic Cohort - Nancy Hessel, AIDS Office, SFDPH

Current Findings from the San Francisco Men's Health Study - Warren Winkelstein and Michael Samuel, U.C. Berkeley

HIV Infection Among Young Gay/Bisexual Men: Findings from the Young Men's Survey - George Lemp, AIDS Office, SFDPH

HIV Among Out-of-Treatment IDUs - John Watters, Urban Health Institute

HIV Infection Among IDUs in Methadone Treatment - Robert Gorter, UCSF

HIV Seroconversion Among IDUs - Andrew Moss, UCSF

HIV Infection Among "Crack" Users - Benjamin Bowser and Carl Word, Bayview Foundation

HIV Infection Among Women of Childbearing Age: Survey of Neonates, Family Planning Clients and Women Seeking Abortions - Mary Jess Wilson, CDHS Office of AIDS, and Tim Kellogg, AIDS Office, SFDPH

HIV Infection Among Women in the Sex Industry - Judith Cohen, UCSF

HIV Infection Among Female Sex Partners of Men at Risk, and a BAYPAC Update - Nancy Padian, UCSF

HIV Infection in Multiethnic Neighborhoods: Findings from the AMEN Cohort - Eve Golden, Center for AIDS Prevention Studies (CAPS), UCSF

HIV Infection Among Blood Donors and Blood Recipients - Susan Samson, Irwin Memorial Blood Centers

HIV Infection Among Heterosexuals Attending an STD Clinic - Gail Bolan, City Clinic, SFDPH

HIV Infection Among the Homeless in San Francisco - Andrew Zolopa, UCSF

HIV Infection Among High-Risk Adolescents - Ricardo Bermudez, Special Programs for Youth (SPY), SFDPH

Moderators - Drs. George Rutherford and Donald Francis