

HIV/AIDS

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Agencies and Information Sources

Santa Cruz County (SCC) Health Services Agency - <http://www.santacruzhealth.org/>

The Health Services Agency (HSA) exists to protect and improve the health of the people in Santa Cruz County. The Agency provides programs in Environmental Health, Public Health, Medical Care, Substance Abuse Prevention and Treatment, and Mental Health.

California Department of Health Services - <http://www.dhs.ca.gov/default.htm>

To Protect and Improve the Health of All Californians

See: <http://www.dhs.ca.gov/hisp/chs/OHIR/Publication/publicationindex.htm>

California Health Interview Survey - <http://www.chis.ucla.edu/index.html>

The California Health Interview Survey (CHIS) is the largest state health survey conducted in the United States. Every two years, CHIS plans to collect information on the health and health care needs of California's diverse population.

Centers for Disease Control and Prevention - <http://www.cdc.gov/default.htm>

CDC's Mission is to promote health and quality of life by preventing and controlling disease, injury, and disability.

CDC's HIV/AIDS specific web site - <http://www.cdc.gov/hiv/pubs/facts.htm>

Santa Cruz County Health Services Agency HIV/AIDS, Hepatitis and STD Web Links

<http://www.santacruzhealth.org/resources/categories/3hiv aids.htm>

Overall

National

Deaths Annually: **14,478 (2000)**

Death Rate: **5.3 deaths per 100,000 population (2000)**

Number of Cases: **19,094 (January-June 2001)**

Hospital Discharges for Patients with HIV Diagnosis: **173,000 (2000)**

Number of Days of Care for Patients with HIV Diagnosis: **1,257,000 (2000)**

Average Length of Hospital Stay: **7.3 days (2000)**

<http://www.cdc.gov/nchs/fastats/aids-hiv.htm>

CA/Santa Cruz County. CA's Dept of Health Services reported California 1999-2000 reported a HIVD Death crude death rate of 4.2/ 100,000 in 2000 which represented an 8.7% decrease from the 1999 crude death rate of 4.6.

In SCC in 2002: 2,557 HIV tests were performed by Santa Cruz HSA throughout the community.

There were 14 positive tests: the risk is as follows: 5 Men who have sex with men; 2 injection drug users; 1 men who have sex with men and inject drugs; 1 partner of an HIV+ person; 1 heterosexual person with multiple sex partners; 4 unknown risk or no risk documented.

In 2002:252 Hepatitis C tests were performed to high risk individuals throughout the community. 69 of those tested positive, or 27%.

CA HIV Seroprevalence Annual Report 2000 <http://www.dhs.ca.gov/AIDS>

HIV/AIDS In Santa Cruz County

A report summarizing HIV/AIDS local data and trends through 2002



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Executive Summary of the 2002 HIV/AIDS Report

The number of persons living with AIDS was at an all-time high going into the year 2002. There were more persons who became AIDS-diagnosed than who died during 2002, continuing a trend of many years' standing.

Men who have sex with men continue to represent most persons diagnosed with AIDS in recent years, but exposure to HIV via heterosexual activity is a growing concern, now accounting for over 12% of cases in the past several years. Injection drug use continues to be the second-most reported manner of contracting HIV.

Because persons with AIDS are living longer, probably due to the newer therapies, there are more and more persons who have AIDS in addition to other chronic diseases associated with older age such as diabetes, heart disease, and diseases of the liver, such as hepatitis C associated cirrhosis.

The California State Office of AIDS has published a county-by-county estimate of the plausible numbers of persons with HIV infections. Using the State figures for calculation and comparison, the Health Services Agency estimates that there are between 571 and 672 persons with HIV in Santa Cruz County, of whom 100 or more are unaware of their serostatus. There may be 25 new infections per year occurring in Santa Cruz County.

Santa Cruz County New AIDS Cases by Year Diagnosed and Cases Alive at End of Year 1983 - December 31,2002

The bar graph on the facing page depicts the number of persons whose primary residence was in Santa Cruz County and, who in each of the years from 1983 through 2002, were diagnosed with AIDS. The range is from one person diagnosed in 1983 to 73 persons diagnosed in 1992.

In 2002, 13 persons who claimed residence in Santa Cruz County were diagnosed with AIDS.

The line graph is a cumulative count of persons who, among those enumerated in the bar graph, were living on December 31 in each of the years from 1983 through 2002.

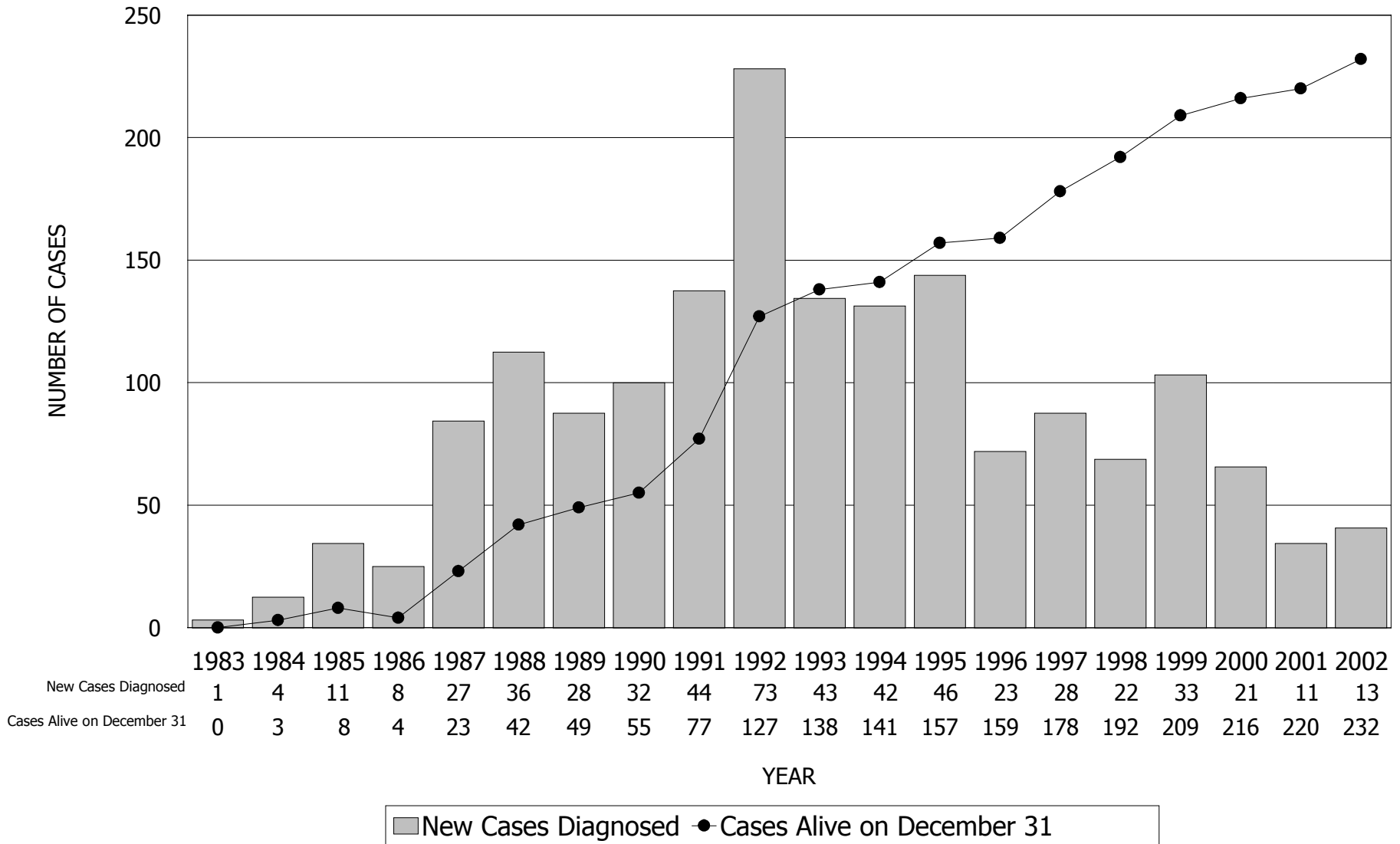
The line graph follows the state trend of ever-increasing annual numbers of persons who are living with AIDS. As of December 31, 2002, 232 persons diagnosed with AIDS sometime in the past were alive, per the county database.

The bar graph depicts 1992 as the year with the most ever reported new local AIDS cases counted. This matches the data in most California counties as well as the cumulative state count for California. In the years since 1992, annual new case counts have not followed a predictable trend. In some years cases dropped, as between 1995 and 1996, only to rise again, as between 1998 and 1999. This uneven year-to-year experience is also seen in some other California counties. The state overall has seen a slow, rather steady decline in new cases, often attributed to persons with HIV initiating therapy that delays the onset of an AIDS-defining event.

Since 549 persons (3 children and 546 adolescents/adults) had ever been counted in the Santa Cruz database as local residents with AIDS, the 232 survivors represent approximately 42% of persons ever diagnosed with AIDS.

The Health Services Agency estimates that there are between 571 and 672 local persons with HIV infection (this figure includes the 232 persons living with AIDS) in Santa Cruz County.

SANTA CRUZ COUNTY NEW AIDS CASES BY YEAR DIAGNOSED AND CASES ALIVE AT THE END OF YEAR 1983 - December 31, 2002



Adult/Adolescent New AIDS Cases by Year, Gender, Mode of Transmission, Race/Ethnicity, and Age, Santa Cruz County, 1983 - December 31, 2002

The facing chart refers to the annual tallies of AIDS cases for persons ages 13 and older in each of the years since 1983. The total number of persons ever diagnosed with AIDS in this chart is 546. The chart excludes 3 children who had AIDS diagnosed in the past, all of whom died. The children were infected perinatally. There was a boy and two girls.

In all years, the number of new cases of AIDS among men exceeds the number of new cases in women. In 1999, the cases among women accounted for a larger share of all cases than in any prior year, with males accounting for nearly 82% of new cases.

The most common mode of transmission is sexual contact between men. This is true statewide. In Santa Cruz County, the trend follows the state trend of male-to-male sexual transmission accounting for a smaller share of transmissions as the years go by, while still remaining the most commonly reported transmission route. In 1999, male-to-male sexual transmission accounted for less than half of transmissions in new cases for the first time since the AIDS case registry was instituted. Persons who cited injection drug use without male-to-male sexual activity is the transmission category that accounted for four of the 13 newly diagnosed cases. Infections associated with injection drug use are accounting for larger shares of cases in many jurisdictions in California. The other mode of transmission that has been increasing in California has been heterosexual exposure (with no documentation of injection drug use), and in 2002, one of the 13 local cases fit this category.

In Santa Cruz County, AIDS has become over time, a disease that involves a larger share of the non-white population. This is true statewide. Non-Hispanic whites, the largest racial group in Santa Cruz, accounted for the largest raw number of cases. In 2002, whites accounted for 8 of the 13 cases, (62%). Non-Hispanic whites account for nearly 75% of the general county population. Latinos account for approximately 27% of the general population, and accounted for about a 30% proportion of new AIDS cases in 2002. The African American population has had a disproportionate share of AIDS cases over the years. The total of 24 ever-reported African American cases represents over 4% of all cases; African Americans represent about 1% of the general county population.

AIDS is often not diagnosed until a person has been infected with HIV for as many as 10 years. Therefore, the age at time of AIDS diagnosis may be interpreted as a decade after the age at which infection occurred. In Santa Cruz, the AIDS diagnosis is most common among persons in their thirties and forties. However, there are in each year those in their twenties who are diagnosed with AIDS, which indicates that infection is occurring among teenagers.

Six persons who had ever received an AIDS diagnosis died in 2002.

Adult/Adolescent New AIDS Cases by Year, Gender, Mode of Transmission, Race/Ethnicity and Age, Santa Cruz County, 1983-December 31st, 2002

Gender	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	TOTAL
Male	1	4	11	8	26	35	27	29	40	66	39	40	43	22	24	20	27	19	11	11	503
Female	0	0	0	0	1	1	1	3	4	7	4	2	3	1	4	2	6	2	0	2	43
TOTAL	1	4	11	8	27	36	28	32	44	73	43	42	46	23	28	22	33	21	11	13	546
Mode of Transmission																					
Men Who Have Sex With Men (MSM)	1	4	7	4	24	30	22	25	29	45	29	29	34	15	19	15	15	12	5	7	371
Injection Drug Users (IDU)	0	0	0	0	1	3	2	4	5	13	4	4	6	3	4	2	9	4	2	4	70
MSM/IDU	0	0	3	3	1	2	2	2	5	7	6	6	2	2	0	0	0	2	3	1	47
Heterosexual Exposure	0	0	0	0	1	1	0	1	3	6	3	2	1	3	2	4	5	3	0	1	36
Transfusion Recipient	0	0	0	1	0	0	1	0	2	0	0	0	0	0	1	0	0	0	0	0	5
Coagulation Disorder	0	0	0	0	0	0	0	0	0	1	1	1	0	0	1	0	0	0	0	0	4
Risk Not Reported/Other	0	0	1	0	0	0	1	0	0	1	0	0	3	0	1	1	4	0	1	0	13
TOTAL	1	4	11	8	27	36	28	32	44	73	43	42	46	23	28	22	33	21	11	13	546
Race/Ethnicity																					
White	1	3	9	8	21	31	19	25	35	63	35	34	33	15	23	15	18	12	8	8	416
Latina/o	0	1	1	0	5	3	7	6	3	5	4	6	9	6	3	5	10	6	3	4	87
African American	0	0	1	0	1	1	1	1	3	5	2	0	1	1	0	2	3	2	0	0	24
Asian Pacific Islander	0	0	0	0	0	0	1	0	1	0	0	1	3	0	0	0	1	0	0	0	7
American Indian/Alaska Native	0	0	0	0	0	0	0	0	2	0	2	1	0	1	2	0	1	0	0	1	10
Other/Unknown	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	2
																					0
TOTAL	1	4	11	8	27	36	28	32	44	73	43	42	46	23	28	22	33	21	11	13	546
Age Category																					
13-19	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
20-29	0	2	1	2	6	8	4	3	1	16	8	4	9	5	8	4	4	2	1	3	91
30-39	0	2	6	2	8	24	12	17	25	33	18	25	19	11	8	9	13	14	5	3	254
40-49	0	0	4	3	11	4	7	9	15	14	15	8	11	6	7	6	10	3	2	5	140
Over 49	1	0	0	1	2	0	5	3	3	10	2	4	7	1	5	3	6	2	3	7	60
TOTAL	1	4	11	8	27	36	28	32	44	73	43	42	46	23	28	22	33	21	11	13	546
Number of Deaths																					
	1	1	6	12	8	17	22	26	22	23	32	40	30	20	9	7	16	10	9	6	317

Deaths Occurring During the Calendar Year in Santa Cruz County, 1983-December 31st, 2002

Adult/Adolescent New AIDS Cases by Year and Zip Code at Time of Diagnosis, Santa Cruz County, 1983 - December 31, 2002

The table on the next page is a year-by-year review of where (by zip code) persons with AIDS resided within Santa Cruz County in the year in which they were diagnosed.

Persons with AIDS have lived in every part of the county, but the distribution has never been homogenous. The largest concentration of persons with AIDS has been in and around the City of Santa Cruz (including Live Oak), comprising about 190 (48%) persons with AIDS diagnosis since 1983, and 75 (59%) persons diagnosed since 1977.

The mid-county area of Capitola, Soquel, and Aptos has accounted for about 20% of ever diagnosed adolescents/adults, and 18 (14%) of those diagnosed since 1997.

The southern area of the county defined as Freedom, Watsonville and Aromas, has about 15% of ever diagnosed adolescents/adults, and 23 (18%) of those diagnosed since 1997.

The San Lorenzo Valley communities of Scotts Valley, Felton, Ben Lomond, Brookdale and the Summit area account for about 16% of ever diagnosed adolescent/cases and 10 (8%) of those diagnosed since 1997.

Three (0.5%) of persons diagnosed between the period 1983 and 2002 had unknown zip codes, two of which (1.6%) were diagnosed in the last 6 years.

Adult/Adolescent New AIDS Cases by Year and Zip Code at
Time of Diagnosis, Santa Cruz County, 1983-December 31, 2002

	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
95001	0	0	0	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
95003	0	0	0	3	5	2	0	4	6	6	4	7	3	2	2	2	1	4	0	0
95004	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
95005	0	0	0	1	0	3	1	0	3	3	3	2	1	0	0	0	0	0	0	0
95006	0	1	0	0	2	1	0	1	6	5	4	5	2	1	0	0	0	0	0	0
95007	0	0	0	0	0	1	0	1	0	0	1	0	0	0	0	0	1	0	0	0
95010	0	0	2	0	0	2	2	1	2	11	1	0	0	1	2	0	0	1	0	1
95018	0	0	2	0	1	3	0	1	2	2	1	1	1	0	2	1	2	1	0	2
95019	0	1	0	0	0	0	0	0	1	1	2	0	1	0	0	0	0	0	1	1
95030	0	0	0	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0
95060	0	2	2	1	6	9	9	10	9	18	13	6	16	8	13	9	18	7	4	6
95061	0	0	0	0	2	0	0	0	0	1	0	2	0	1	1	0	0	0	0	1
95062	1	0	1	1	4	6	4	6	7	11	9	5	10	3	4	3	3	3	1	0
95064	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0
95065	0	0	0	2	1	0	0	0	0	2	0	1	0	0	0	0	0	0	0	1
95066	0	0	1	0	0	2	1	0	0	2	2	2	2	0	0	1	0	0	0	0
95073	0	0	0	0	2	3	2	2	2	3	1	5	1	3	1	0	2	0	1	1
95076	0	0	3	0	3	2	8	4	4	8	2	5	9	4	3	5	4	5	4	0
UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0	0	0
TOTALS	1	4	11	8	27	36	28	32	44	73	43	42	46	23	28	22	33	21	11	13

City of Santa Cruz		Mid-County		South County		San Lorenzo Valley	
Santa Cruz	95060, 95061, 95062, 95064, 95065	Capitola	95010	Freedom	95019	Scotts Valley	95066
		Soquel	95073	Watsonville	95076	Felton	95018
		Aptos	95003, 95001	Aromas	95004	Ben Lomond	95005
						Boulder Creek	95006
						Brookdale	95007
						Los Gatos/Summit	95030
50.4% of total cases		20.0% of total cases		15.0% of total cases		15.9% of total cases	

The 100 Most Recently Reported Adult AIDS Cases by Ethnicity/Race, Mode of Transmission, and Gender Within Age Groups, Santa Cruz County, January 1, 1998 - December 31, 2002

The table on the facing page is meant to display a closer look at the 100 most recently AIDS-diagnosed persons. These 100 persons are divided into four categories based on age at time of diagnosis. Within the age range, there is a further breakdown into race/ethnicity, mode of transmission and gender. This group could be representative of those who are most recently enrolled in care and treatment programs at the various local agencies serving clients.

The table displays that the 12 women who have been diagnosed with AIDS since mid-1998 are more likely to be younger than the men. Five of the 12 women were in their twenties; 9 of the 88 men were in their twenties.

The 12 women had the following modes of transmission: 3 are counted as injection drug users, and 9 are counted as persons who were infected through heterosexual contact.

Across all age categories men who have sex with men account for most infections.

Injection drug use accounted for the second most common mode of transmission, with 10 of the 21 IDUs documented as white, four as African American, six Latino, and one Native American.

Note: The following graph has abbreviations that are being used for the first time within this report.

- * Het = Heterosexual Contact
- * Adult Hemo = Adult Hemophiliac
- * Trans Recip = Transfusion or Transplant Recipient
- * NIR = No Identifiable Risk

**The 100 Most Recently Reported Adult AIDS Cases by Ethnicity/Race, Mode of Transmission and Gender
Within Age Groups, Santa Cruz County, January 1, 1998-December 31, 2002**

Age 20-29	MSM		IDU		MSM/IDU		Het		Adult Hemo.		Transf.Recip.		NIR		TOTAL
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
White	2	0	0	0	1	0	1	3	0	0	0	0	0	0	7
African American	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Latina/o	3	0	1	1	0	0	0	0	0	0	0	0	1	0	6
Asian/Pacific Islander	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
American Indian/Alaska Native	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Other Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	5	0	1	1	1	0	1	4	0	0	0	0	1	0	14
Age 30-39	MSM		IDU		MSM/IDU		Het		Adult Hemo.		Transf.Recip.		NIR		TOTAL
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
White	15	0	4	1	3	0	0	1	0	0	0	0	1	0	25
African American	1	0	1	0	0		2	0	0	0	0	0	0	0	4
Latina/o	8	0	3	0	0	0	0	2	0	0	0	0	2	0	15
Asian/Pacific Islander	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
American Indian/Alaska Native	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	24	0	8	1	3	0	2	3	0	0	0	0	3	0	44
Age 40-49	MSM		IDU		MSM/IDU		Het		Adult Hemo.		Transf.Recip.		NIR		TOTAL
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
White	12	0	3	1	2	0	0	1	0	0	0	0	0	0	19
African American	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2
Latina/o	1	0	0	0	0	0	0	0	0	0	0	0	2	0	3
Asian/Pacific Islander	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
American Indian/Alaska Native	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Other Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	14	0	6	1	2	0	0	1	0	0	0	0	2	0	26
Age=>49	MSM		IDU		MSM/IDU		Het		Adult Hemo.		Transf.Recip.		NIR		TOTAL
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
White	9	0	1	0	0	0	0	0	0	0	0	0	0	0	10
African American	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Latina/o	2	0	1	0	0	0	1	0	0	0	0	0	0	0	4
Asian/Pacific Islander	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
American Indian/Alaska Native	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Unknown	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
TOTAL	11	0	3	0	0	0	1	1	0	0	0	0	0	0	16
GRAND TOTAL	54		21		6		13		0		0		6		100

**Adult AIDS Cases by Ethnicity/Race, Mode of Transmission and Gender Within
Age Groups,
Santa Cruz County, 1983 - December 31, 2002**

The facing tables provide another display of the 546 Adolescent/Adult AIDS cases ever diagnosed and counted in the local database. The table on top shows the race/ethnicity versus the mode of transmission, which is further divided between males and females.

This table shows that of all female injection drug users, 15 are white and 1 is Latina, whereas heterosexual women include Whites, Latinas, and a Native American. Women account for 25 of the 36 cases attributed to heterosexual contact.

In the second table, the display of age categories indicates that those who were older at the time of diagnosis with AIDS were more likely to be men who have sex with men. Thirty nine percent of those 40 years of age or older are men who have sex with men, while approximately 61% of those under 30 years of age are men who have sex with men.

Note: The following graph uses the abbreviations below.

- * Het = Heterosexual Contact
- * Adult Hemo = Adult Hemophiliac
- * Trans Recip = Transfusion or Transplant Recipient
- * NIR = No Identifiable Risk

Adult AIDS Cases by Ethnicity/Race, Mode of Transmission and Gender Within Age Groups, Santa Cruz County, 1983-December 31, 2002

Ethnicity/Race	MSM		IDU		MSM/IDU		Het		Adult Hemo.		Transf.Recip.		NIR		TOTAL
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
White	293	0	37	15	35	0	4	20	3	1	3	0	5	0	416
African American	11	0	7	0	3	0	3	0	0	0	0	0	0	0	24
Latina/o	60	0	8	1	3	0	3	3	0	0	1	1	7	0	87
Asian/Pacific Islander	5	0	0	0	1	0	0	0	0	0	0	0	1	0	7
American Indian/Alaska Native	2	0	2	0	4	0	1	1	0	0	0	0	0	0	10
Other Unknown	0	0	0	0	1	0	0	1	0	0	0	0	0	0	2
TOTAL	371	0	54	16	47	0	11	25	3	1	4	1	13	0	546

Age Category	MSM		IDU		MSM/IDU		Het		Adult Hemo.		Transf.Recip.		NIR		TOTAL
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
13-19	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
20-29	52	0	6	6	9	0	3	10	1	0	1	0	3	0	91
30-39	175	0	26	8	30	0	3	6	1	0	0	0	5	0	254
40-49	104	0	14	2	8	0	2	5	0	1	1	0	3	0	140
Over 49	40	0	8	0	0	0	3	4	0	0	2	1	2	0	60
TOTAL	371	0	54	16	47	0	11	25	3	1	4	1	13	0	546

**Adult/Adolescent HIV Non-Name Code Reporting Cases by Gender,
Age, Ethnicity/Race, and Mode of Transmission,
Santa Cruz County, July 1, 2002 - December 31, 2002**

The Santa Cruz County Health Services Agency, in compliance with the State Department of Health Services, began data collection of positive HIV tests as of July 1, 2002, and continues to update and maintain this data through the HIV/AIDS Reporting Surveillance System. Surveillance reporting prior to July 1, 2002, has consisted of AIDS cases only, determined by a low CD 4 or T-cell count and/or the presence of an HIV positive status in conjunction with one of the 26 AIDS related opportunistic (immune compromising) infections.

The data on the facing page reflects the HIV positive statistics from July 1, 2002 through December 31, 2002. The majority of the data reflects prevalent HIV positive tests. HIV positive tests prior to July 1, 2002 are considered prevalent and have not advanced to the status of an AIDS diagnosis. Most are aware of their HIV positive serostatus. Approximately 3 of the 77 submitted cases were new HIV diagnoses within the calendar year of 2002.

Since HIV positive data was not reportable until July 1, 2002, the prevalent case data was drawn from as far back as 1983, and accurate information as to the first date of a positive HIV diagnosis was often not available. Many prevalent cases are recorded with a date of diagnosis in 2002 when reporting began.

**Adult/Adolescent HIV Non-Name Code Reporting Cases by Gender,
Age, Ethnicity/Race and Mode of Transmission, Santa Cruz County,
July 1,2002 - December 31,2002**

Gender	
Male	61
Female	16
TOTAL	77
Age	
13-19	1
20-29	11
30-39	20
40-49	24
Over 49	21
Unknown	0
TOTAL	77
Race/Ethnicity	
White, Not Hispanic	57
Black, Not Hispanic	1
Hispanic	16
Asian/Pacific Islander	1
American Indian/Alaska Native	0
Unknown	2
TOTAL	77
Mode of Transmission	
Men Who Have Sex With Men (MSM)	47
Injection Drug Use (IDU)	7
MSM/IDU	4
Hemophilia/Coagulation Disorder	0
Heterosexual Contact	13
Receipt of blood, components, or tissue	1
Risk not reported/Other	5
TOTAL	77

Anonymous HIV Testing for the Santa Cruz County Health Services Agency HIV Testing Program, 1992 - December 31, 2002

Each year the Health Services Agency offers anonymous testing for HIV infection to persons who provide demographic information, but who are not identifiable by name. The number of tests varies. In 2002, there were 1,201 such tests. It is possible for a person to be tested more than once; therefore the 1,201 on the following page represents tests rather than individuals.

Anonymous test data provides an opportunity to identify persons who may not have AIDS but who do have HIV infection. Thus, the 99 individuals who tested positive from 1992 onward may have already been counted as an AIDS case in the preceding pages of the report (i.e. through duplication).

The positive HIV testing data parallels the AIDS data in that MSM comprise the most infections (53.5%) followed by IDU (13 %) and MSM/IDU (11.1%). If the categories of "partner at risk/HIV+", "partner has multiple sex partners", "multiple sex partners", and "heterosexual partner" are added together, and we assume that all of these may be a different way to have heterosexual transmission, then heterosexual transmission is the third most common form of transmission in anonymously tested persons.

Males account for 59 of the 99 positive tests. Whites account for 65.6% of positive tests and Latinos account for over 22% of positive tests

**HIV TESTING
SANTA CRUZ COUNTY HEALTH SERVICES AGENCY
HIV TESTING PROGRAM**

ANONYMOUS HIV TESTING, 1992-2002

YEAR	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Total
Number Tested	2,537	1,804	3,485	2,109	2,359	2,227	2,001	1,498	1,299	1,291	1,201	21,811
Number Positive	11	12	23	6	4	7	9	8	8	5	6	99
Percent Positive	0.43%	0.67%	0.66%	0.28%	0.17%	0.31%	0.45%	0.53%	0.62%	0.39%	.50%	.45%

YEAR	1992		1993		1994		1995		1996		1997		1998		1999		2000		2001		2002		TOTAL	% of Pos.		
Risk	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	T	M	F	T	M	F	T	
MSM	6		7		11		5		2		5		3		4		4			3		3		53	53.53%	
IDU	1		3		3				1		1		1		1		1						12	1	13.13%	
MSM/IDU	2						1		1		1		3		1		1	2					9	2	11.11%	
Partner HIV+/At Risk	1		1	1	2								1								1		3	4	7.07%	
Transfusion					2																		2		2.02%	
Multiple Sex Partners					1								1										2		2.02%	
Partner Has Multiple Sex Partners	1				2																		3		3.03%	
Heterosexual Contact															1				1	1			2	1	3.03%	
Risk Info. Missing					2										1							2		4	1	5.05
TOTAL	10	1	11	1	23	6	4	7	8	1	6	2	6	2	4	1	5	1	90	7	2	100%*				

YEAR	1992		1993		1994		1995		1996		1997		1998		1999		2000		2001		2002		TOTAL	% of Pos.		
RACE	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	T	M	F	T	M	F	T	
White	10	1	9		14		3		4		3		5		4	2	4	1	1	1	2	1	59	5	1	65.65%
Latina/o			2		4		2				3		2		1		2	1	2			3		21	1	22.22%
African American					2								1	1	1								4	1	5.05%	
Asian Pacific Islander			1								1												1	1	2.02%	
Native American					1		1												1				3		3.03%	
Other					2																		2		2.02%	
TOTAL	10	1	11	1	23	6	4	7	8	1	6	2	6	2	4	1	5	1	90	7	2	100%*				

* Total may not equal 100% due to rounding and/or multiple risk factors.

Estimate of Local HIV Morbidity

There are, by estimate of the Centers for Disease Control and Prevention, approximately 40,000 new HIV infections per year in the US. Given that Santa Cruz County has approximately 0.08% of the national population, it can be estimated that 32 (40,000x0.0008) new infections occur annually in Santa Cruz County. Santa Cruz County tends to have a slightly lower rate of AIDS diagnoses than the national rate, so this methodology may result in an overestimate and the actual number may be closer to 25 new infections annually.

HIV became reportable by a non-name code to the California Health Department as of July 2002. As of December 31, 2002, 77 HIV non -AIDS cases in Santa Cruz County have been reported to the California Health Services.

Various methods have been developed to estimate the number of seropositives locally. Seropositives include not only those who have HIV/AIDS and know it, but also persons who are infected and do not know their status. The total number of persons with HIV in Santa Cruz County, including those who do not know their serostatus, is the sum of (a) persons living with AIDS, who number 232, including pediatric cases, and (b) those with HIV but not AIDS.

The Health Services Agency estimates that the total number of seropositives (HIV/AIDS) is between 571 and 672.

National Center for HIV, STD and TB Prevention Divisions of HIV/AIDS Prevention

See: http://www.cdc.gov/hiv/pubs/facts/HIV-HCV_Coinfection.htm

Frequently Asked Questions and Answers About Co-infection with HIV and Hepatitis C Virus

Why should HIV-infected persons be concerned about co-infection with HCV?

About one quarter of HIV-infected persons in the United States are also infected with hepatitis C virus (HCV). HCV is one of the most important causes of chronic liver disease in the United States and HCV infection progresses more rapidly to liver damage in HIV-infected persons. HCV infection may also impact the course and management of HIV infection.

The latest U.S. Public Health Service/Infectious Diseases Society of America (USPHS/IDSA) guidelines recommend that all HIV-infected persons should be screened for HCV infection. Prevention of HCV infection for those not already infected and reducing chronic liver disease in those who are infected are important concerns for HIV-infected individuals and their health care providers.

Who is likely to have HIV-HCV co-infection?

The hepatitis C virus (HCV) is transmitted primarily by large or repeated direct percutaneous (i.e., passage through the skin by puncture) exposures to contaminated blood. Therefore, co-infection with HIV and HCV is common (50%-90%) among HIV-infected injection drug users (IDUs). Co-infection is also common among persons with hemophilia who received clotting factor concentrates before concentrates were effectively treated to inactivate both viruses (i.e., products made before 1987). The risk for acquiring infection through perinatal or sexual exposures is much

lower for HCV than for HIV. For persons infected with HIV through sexual exposure (e.g., male-to-male sexual activity), co-infection with HCV is no more common than among similarly aged adults in the general population (3%-5%).

What are the effects of co-infection on disease progression of HCV and HIV?

Chronic HCV infection develops in 75%-85% of infected persons and leads to chronic liver disease in 70% of these chronically infected persons. HIV-HCV co-infection has been associated with higher titers of HCV, more rapid progression to HCV-related liver disease, and an increased risk for HCV-related cirrhosis (scarring) of the liver. Because of this, HCV infection has been viewed as an opportunistic infection in HIV-infected persons and was included in the 1999 USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus. It is not, however, considered an AIDS-defining illness. As highly active antiretroviral therapy (HAART) and prophylaxis of opportunistic infections increase the life span of persons living with HIV, HCV-related liver disease has become a major cause of hospital admissions and deaths among HIV-infected persons.

The effects of HCV co-infection on HIV disease progression are less certain. Some studies have suggested that infection with certain HCV genotypes is associated with more rapid progression to AIDS or death. However, the subject remains controversial. Since coinfecting patients are living longer on HAART, more data are needed to determine if HCV infection influences the long-term natural history of HIV infection.

How can co-infection with HCV be prevented?

Persons living with HIV who are not already coinfecting with HCV can adopt measures to prevent acquiring HCV. Such measures will also reduce the chance of transmitting their HIV infection to others.

Not injecting or stopping injection drug use would eliminate the chief route of HCV transmission; substance-abuse treatment and relapse-prevention programs should be recommended. If patients continue to inject, they should be counseled about safer injection practices; that is, to use new, sterile syringes every time they inject drugs and never reuse or share syringes, needles, water, or drug preparation equipment.

Toothbrushes, razors, and other personal care items that might be contaminated with blood should not be shared. Although there are no data from the United States indicating that tattooing and body piercing place persons at increased risk for HCV infection, these procedures may be a source for infection with any bloodborne pathogen if proper infection control practices are not followed.

Although consistent data are lacking regarding the extent to which sexual activity contributes to HCV transmission, persons having multiple sex partners are at risk for other sexually transmitted diseases (STDs) as well as for transmitting HIV to others. They should be counseled accordingly.

How should patients coinfecting with HIV and HCV be managed?

General guidelines

Patients coinfecting with HIV and HCV should be encouraged to adopt safe behaviors (as described in the previous section) to prevent transmission of HIV and HCV to others. Individuals with evidence of HCV infection should be given information about prevention of liver damage, undergo evaluation for chronic liver disease and, if indicated, be considered for treatment. Persons coinfecting with HIV and HCV should be advised not to drink excessive amounts of alcohol. Avoiding alcohol altogether might be wise because the effects of even moderate or low amounts of alcohol (e.g., 12 oz. of beer, 5 oz. of wine or 1.5 oz. hard liquor per day) on disease progression are unknown. When appropriate, referral should be made to alcohol treatment and relapse-prevention programs. Because of possible effects on the liver, HCV-infected patients should consult with their health care professional before taking any new medicines, including over-the-counter, alternative or herbal medicines.

Susceptible coinfecting patients should receive hepatitis A vaccine because the risk for fulminant hepatitis associated with hepatitis A is increased in persons with chronic liver disease. Susceptible patients should receive hepatitis B vaccine because most HIV-infected persons are at risk for HBV infection. The vaccines appear safe for these patients and more than two-thirds of those vaccinated develop antibody responses. Prevacination screening for antibodies against hepatitis A and hepatitis B in this high-prevalence population is generally cost-effective. Postvaccination testing for hepatitis A is not recommended, but testing for antibody to hepatitis B surface antigen (anti-HBs) should be performed 1-2 months after completion of the primary series of hepatitis B vaccine. Persons who fail to respond should be revaccinated with up to three additional doses. HAART has no significant effect on HCV. However, coinfecting persons may be at increased risk for HAART-associated liver toxicity and should be closely monitored during antiretroviral therapy. Data suggest that the majority of these persons do not appear to develop significant and/or symptomatic hepatitis after initiation of antiretroviral therapy.

Treatment for HCV Infection

A Consensus Development Conference Panel convened by The National Institutes of Health in 1997 recommended antiviral therapy for patients with chronic hepatitis C who are at the greatest risk for progression to cirrhosis. These persons include anti-HCV positive patients with persistently elevated liver enzymes, detectable HCV RNA, and a liver biopsy that indicates either portal or bridging fibrosis or at least moderate degrees of inflammation and necrosis. Patients with less severe histological disease should be managed on an individual basis. In the United States, two different regimens have been approved as therapy for chronic hepatitis C: monotherapy with alpha interferon and combination therapy with alpha interferon and ribavirin. Among HIV-negative persons with chronic hepatitis C, combination therapy consistently yields higher rates (30%-40%) of sustained response than monotherapy (10%-20%). Combination therapy is more effective against viral genotypes 2 and 3, and requires a shorter course of treatment; however, viral genotype 1 is the most common among U.S. patients. Combination therapy is associated with more side effects than monotherapy, but, in most situations, it is preferable. At present, interferon monotherapy is reserved for patients who have contraindications to the use of ribavirin.

Studies thus far, although not extensive, have indicated that response rates in HIV-infected patients to alpha interferon monotherapy for HCV were lower than in non-HIV-infected patients, but the differences were not statistically significant. Monotherapy appears to be reasonably well tolerated in coinfecting patients. There are no published articles on the long-term effect of combination therapy in coinfecting patients, but studies currently underway suggest it is superior to monotherapy. However, the side effects of combination therapy are greater in coinfecting patients. Thus, combination therapy should be used with caution until more data are available. The decision to treat people coinfecting with HIV and HCV must also take into consideration their concurrent medications and medical conditions. If CD4 counts are normal or minimally abnormal (> 400/ul), there is little difference in treatment success rates between those who are coinfecting and those who are infected with HCV alone.

Other Treatment Considerations

Persons with chronic hepatitis C who continue to abuse alcohol are at risk for ongoing liver injury, and antiviral therapy may be ineffective. Therefore, strict abstinence from alcohol is recommended during antiviral therapy, and interferon should be given with caution to a patient who has only recently stopped alcohol abuse. Typically, a 6-month abstinence is recommended for alcohol abusers before starting therapy; such patients should be treated with the support and collaboration of alcohol abuse treatment programs.

Although there is limited experience with antiviral treatment for chronic hepatitis C of persons who are recovering from long-term injection drug use, there are concerns that interferon therapy could be associated with relapse into drug use, both because of its side effects and because it is administered by injection. There is even less experience with treatment of persons who are active

injection drug users, and an additional concern for this group is the risk for reinfection with HCV. Although a 6-month abstinence before starting therapy also has been recommended for injection drug users, additional research is needed on the benefits and drawbacks of treating these patients. Regardless, when patients with past or continuing problems of substance abuse are being considered for treatment, such patients should be treated only in collaboration with substance abuse specialists or counselors. Patients can be successfully treated while on methadone maintenance treatment of addiction.

Because many coinfecting patients have conditions or factors (such as major depression or active illicit drug or alcohol use) that may prevent or complicate antiviral therapy, treatment for chronic hepatitis C in HIV-infected patients should be coordinated by health care providers with experience in treating coinfecting patients or in clinical trials. It is not known if maintenance therapy is needed after successful therapy, but patients should be counseled to avoid injection drug use and other behaviors that could lead to reinfection with HCV and should continue to abstain from alcohol.

Infections in Infants and Children

The average rate of HCV infection among infants born to women coinfecting with HCV and HIV is 14% to 17%, higher than among infants born to women infected with HCV alone. Data are limited on the natural history of HCV infection in children, and antiviral drugs for chronic hepatitis C are not FDA-approved for use in children under aged 18 years. Therefore, children should be referred to a pediatric hepatologist or similar specialist for management and for determination for eligibility in clinical trials.

What research is needed on HIV-HCV coinfection?

- Many important questions remain about HIV-HCV coinfection:
- By what mechanism does HIV infection affect the natural history of hepatitis C?
- Does HAART affect the impact of HIV on the natural history of HCV infection?
- Does HCV affect the natural history of HIV and, if so, by what mechanism?
- How can we effectively and safely treat chronic hepatitis C in HIV-infected patients?
- How can we distinguish between liver toxicity caused by antiretrovirals and that caused by HCV infection?
- What is the best protocol for treating both HIV and chronic hepatitis C in the coinfecting patient?

The following sources may also be helpful in understanding HCV and HCV/HIV coinfection.

Publications

Centers for Disease Control and Prevention. Recommendations for prevention and control of hepatitis C virus (HCV) infection and HCV-related chronic disease. MMWR 1998;47(No. RR-19):1-39. Available on the Internet at: <ftp://ftp.cdc.gov/pub/Publications/mmwr/rr/rr4719.pdf>

Centers for Disease Control and Prevention. 1999 USPHS/IDSA guidelines for the prevention of opportunistic infections in persons infected with human immunodeficiency virus: U.S. Public Health Service (USPHS) and Infectious Diseases Society of America (IDSA). MMWR 1999;48(No. RR-10):32-4. Available on the Internet at: www.cdc.gov/mmwr/preview/mmwrhtml/rr4810a1.htm.

National Institutes of Health. Chronic hepatitis C: current disease management (NIH Publication No. 00-4230). DHHS, 1999. (See web version below).

Sulkowski MS, Mast EE, Seeff LB, Thomas DL. Hepatitis C virus infection as an opportunistic disease in persons infected with human immunodeficiency virus. Clinical Infectious Diseases 2000 Apr;30 Supplement 1:S77-S84.

Internet Resources

Division of HIV/AIDS Prevention, CDC: www.cdc.gov/hiv

Division of Viral Hepatitis, CDC: www.cdc.gov/hepatitis

National Institutes of Health: www.niddk.nih.gov/health/digest/pubs/chrnhepc/chrnhepc.htm

CDC National Prevention Information Network: www.cdcnpin.org
Expert Perspectives: Strategies for the Management of HIV/HCV Coinfection:
www.projectsinknowledge.com/lnit/hiv-hcv/*

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CARE Team

180 clients each month who are HIV+ are cared for by the Santa Cruz County CARE Team. About 90 of these clients are on the State programs and have a Nurse and Masters level SW working with them. The others usually have a nurse who assists them as needed. Working closely with the Santa Cruz AIDS Project the CARE Team keeps clients in housing and as healthy as possible. Hospitalizations continue to decrease each year. Compliance with HIV drugs is less of a problem today because medications have advanced to the stage where clients only have to take them once or twice daily. The CARE Team's special Program for Prevention for the high risk HIV+ clients has progressed and now serves both English and Spanish speaking clients with continued focus upon medication compliance, education, prevention, advocacy with the medical providers, and working closely with other organizations in the County who serve those with HIV.