NEEDS ASSESSMENT ON THE IMPACT OF HIV/AIDS ON THE COMMUNITIES OF LOWER MANHATTAN, NEW YORK CITY

INTRODUCTION AND OVERVIEW OF IMPACT ON THE CITY OF NEW YORK

Consistent with the entire 20+ year history of this epidemic, HIV/AIDS continues to have a profound and disproportionate impact on the City of New York (NYC). According to the Centers for Disease Control and Prevention (CDC), as of December 31, 2000, there were 774,467 persons with AIDS in the United States. In both 1999 and 2000, New York City – which ranked first on the national scale of annual cumulative AIDS cases and rates in metropolitan areas with population of 500,000 or more – represented approximately 19% of the national total.[1]

Recent data indicate that in 2001, NYC reported 118,803 AIDS cases.[2] As of December 31, 2000, the City's AIDS case rate was 56.6%, compared with a national rate of 18.9%. Adult and adolescent cases in NYC represented about 18.5% of AIDS cases nationwide, while cases among New York City's children (<13-year-olds) represented about 26% of cases nationwide.[3] Through June 2000, New York State represented 18% of the national total of cumulative AIDS cases, with NYC representing 86% of the total state caseload.[4]

Of the five boroughs, Manhattan is the most seriously affected by the epidemic, reporting 39% of all AIDS cases among men and 24% of all cases among women. In 2001, with a reported AIDS caseload of 42,205, Manhattan represented 36% of NYC's total cases of AIDS. In 2001, women represented 15.7% of the borough's total AIDS cases.[5] The cumulative AIDS case rate (3,088/100,000 adults) is the highest among the boroughs and 1.8 times higher than the city average.[6]

At the end of December 2000, the New York City Department of Health (NYCDOH) reported 42,758 adult/adolescent female AIDS cases in Manhattan, with 1,239 cases diagnosed in 2000 (34% of the city's total of 3,613, representing an 8% increase from 1999. Manhattan represented 25% of new pediatric AIDS cases diagnosed Citywide in 2000, with a cumulative number of 360 cases, or 18% of the total reported Citywide.[7]

Overview of Impact on Lower Manhattan

Lower Manhattan (LM) is the southernmost portion of Manhattan island, and is comprised of several neighborhoods, including Chelsea/Clinton, the Lower East Side, Greenwich Village/SoHo, and Gramercy Park/Murray Hill. Lower Manhattan represents a significant portion of Manhattan's AIDS cases. Lower Manhattan currently has a reported 15,410 cumulative AIDS cases and 5,710 people living with AIDS (PLWAs). Lower Manhattan represents 37% of Manhattan's 42,758 cumulative AIDS cases and 15,440 PLWAs (cumulative cases minus people known to be dead). Thirteen percent of New York City's cumulative AIDS cases are attributed to Lower Manhattan. One in twenty-one residents of Lower Manhattan are HIV-positive.[8]

The following data (with the exception of pediatric cases) are reported by the United Hospital Fund (UHF) neighborhoods. These UHF neighborhoods comprise the major portion of the catchment areas served by the Lower New York Consortium for Families with HIV/AIDS. These

data briefly highlight seroprevalence and surrogate markers in the communities served by the Lower New York Consortium. The data are described and discussed more fully throughout the remainder of this Needs Assessment.

- *Children in Lower Manhattan:* Community Districts 1, 2, 3, and 4 reported 28 living pediatric cases by mid-2000.
- *Young People in Lower Manhattan (LM):* One percent of PLWAs in LM are 13-19-year-olds. (It should be noted that the figure for adolescents might be low because HIV infection often becomes AIDS during adulthood)
- *Race/Ethnicity:* Fifty-one percent of PLWAs in LM are white, 21% are Black, 20% are Hispanic, and 2% are Asian. The cumulative case rate distribution is 55.5% white, 18% Black, 25% Hispanic and 1.5% Asian and others.
- *Age Distribution:* Twelve percent of PLWAs in LM are 20-29; 46% are 30-39; 30% are 40-49; 9% are 50-59 and 2% are over 60.
- *Gender Breakdown*: Women comprise 11% of cumulative AIDS cases and 10.5% of PLWAs in LM.

Details on Impact within Lower Manhattan's Various Communities

To further demonstrate the impact of HIV/AIDS on the catchment areas served by the Lower New York Consortium for Families with HIV/AIDS, the following subsections provide specific data on the various NYC Community Districts (CD) within the Consortium's service jurisdiction.

Chelsea/Clinton: This community is comprised of United Hospital Fund (UHF) neighborhoods represented by zip codes 10001, 10011, 10019, and 10036. CD 4 reports that it is "home to the largest percentage of people with AIDS nationwide."[9] Data indicate that this community has the highest number of individuals diagnosed with AIDS (PWAs), the highest cumulative case rate (6,174/100,000), and the highest number of PLWAs (2,612) in NYC (people living with AIDS = total diagnosed cases minus persons known to be dead).[10] These figures indicate that roughly one in 13 individuals in Chelsea/Clinton is HIV-positive.[11]

Through December 2000, 6,894 cumulative cases of AIDS were reported among adults and adolescents in Chelsea/Clinton. Using the 2000 Census of 116,651 residents, the rate of AIDS for adults per 100,000 is 6,174, which ranks first in Manhattan and NYC. [12] Chelsea/Clinton has more people living with AIDS than 32 U.S. states.[13] With 29% of Lower Manhattan's population, Chelsea/Clinton has 45.7% of the PLWAs—a total of 2,199 men and 199 women.[14]

The Community Needs Index (CNI), a composite measure of AIDS service needs determined by zip code, indicates that the Chelsea/Clinton zip code (10001), at 98.9% (high need), ranks second of 41 zip codes in Manhattan and second among New York City's 177 zip code areas. Zip code 10011, at 84.2% (high need), ranks 13th in Manhattan and 28th in New York City as a whole. Zip code 10019, at 71.8% (moderate need), ranks 19th in Manhattan and 50th in NYC. All

neighborhood zip codes rank within the top 20% in incidence (per 100,000) of male HIV discharges and men who have sex with men (MSM). Zip code 10001 ranks within the top twentieth percentile in the newborn seroprevalence rate.[15]

Lower East Side (LES): This community is comprised of neighborhoods represented by zip codes 10002, 10003 and 10009, and forms Manhattan CD 3.[16] At the end of December 2000, the LES reported a cumulative total of 5,217 adults diagnosed with AIDS (PWAs). Of these, 3,394 (65%) are known to be dead. Moreover, with 13% of Manhattan's population, the LES has 12% of individuals diagnosed with AIDS (PLWAs = total diagnosed cases minus persons known to be dead).[17] On the LES, 3.4% of the adult population (one in 30 adults) is HIV-positive.[18] Using the 2000 U.S. Census population count of 176,952, the AIDS rate for adults per 100,000 is 2,948, which is fifth for Manhattan and eighth in NYC.[19] The Lower East Side has more PLWAs than 24 U.S. states and the Virgin Islands.[20]

The CNI reports that the Lower East Side zip code area 10003, at 352/100,000, ranks within the top 29th percent of the CNI rate per 100,000 population of MSM. The same report indicates that zip code area 10009, at 78.5% (moderate need), ranks 16th among Manhattan's 41 zip code areas and 38th of New York City's 177 zip code areas.[21]

The LES has a large minority population, which has IDU and heterosexual sex as its primary risk factors. There are numerous low-income housing projects in this area, and many undocumented immigrants also reside in the LES. Data provided by the NYC Department of Health and Community Studies, Inc. indicates the majority of LES inhabitants diagnosed with HIV/AIDS are IDUs, indicating a high need for prevention and harm reduction for active substance users in this neighborhood. [22]

Greenwich Village/SoHo: This area is comprised of UHF neighborhoods 10012, 10013, and 10014, forming Manhattan's CD 2 (bounded by 14th Street on the north, Canal Street on the South, the Bowery on the east and the Hudson River to the west.[23] At the end of December 2000, Greenwich Village/SoHo reported a cumulative total of 3,299 adults diagnosed with AIDS. Of these, 2,199 (66.6%) were known to be dead. Using the year 2000 U.S. Census population count of 77,684, the AIDS rate for adults is 4,246 per 100,000, which is third highest ranking in NYC and Manhattan. Greenwich Village/SoHo has more diagnosed cases of AIDS than 21 U.S. states and the Virgin Islands.[24] In Greenwich Village/SoHo, 4.6% of the adult population (one in 22 adults) are HIV sero-positive.[25]

According to the CNI, zip code 10013, at the 56.5 percentile (low need), ranks 27th among Manhattan's 41 zip code areas, and 77th among New York City's 177 zip code areas. Zip code 10014, at the 55.9 percentile (low need), ranks 28th in Manhattan and 78th in NYC. Zip code 10012, at the 41.8 percentile (low need), ranks 31st in Manhattan and 103rd in NYC.[26]

Gramercy Park/Murray Hill (GP/MH): This neighborhood is part of CD 6, which encompasses the East Side of Manhattan from 14th to 59th Streets, from the East River to Lexington Avenue and farther west to include all of GP/MH, represented by zip codes (and Lower NY Consortium catchment areas) 10010 and 10016. At the end of December 2000, GP/MH reported 3,112 adults diagnosed with AIDS, with a cumulative rate of 2,724/100,000 (based on a total population of 114,253), approximately eight percent of Manhattan's total caseload. Of these, 1,993 are known

to be dead. In 2000, 117 cases were reported, about a 24% increase over the reported 1999 caseload.[27]

According to the CNI, GP/MH zip code 10016 is at the 73.4 percentile (moderate need) of the CNI, with an AIDS case rate of 309/100,000, ranking 18th of 41 Manhattan zip codes. While the majority of AIDS cases are MSM, female HIV infection/illness rates based on hospital discharges is 713/100,000, suggesting women in GP/MH continue to be at significant risk for HIV. Moreover, substance abuse in the community ranks high within risk indicator rates, with 2,517/100,000 cocaine hospital discharges and 1,498/100,000 "opioid" discharges.

Zip code 10010 is at the 57.1 percentile, ranking 26th of 41 Manhattan zip codes. Again, while MSM rank the highest among AIDS case rates in this area, female HIV hospital discharges, at 578/100,000, suggest high risk for HIV/AIDS among this population. [28]

Lower Manhattan The neighborhood of Lower Manhattan is the southern most part of Manhattan, primarily a financial business district, and includes zip codes 10038 and 10280. At the end of December 2000, Lower Manhattan reported 448 adults diagnosed with AIDS, with a cumulative rate of 1,895/100,000 (based on a total population of 23,640). Of these, 273 are known to be dead. In 1999 and 2000, differences between caseload numbers were insignificant.[29]

According to the Community Needs Index (CNI), Lower Manhattan zip code 10280 is at the 5.6% percentile (low need) of the CNI, with an AIDS of 44/100,000. While the majority of AIDS cases are MSM, substance abuse risk indicators are evident, given cocaine and "opioid" hospital charges, at respective rates of 25/100,000 and 50/100,000. Sexually transmitted diseases, 20/100,000 are also a high-risk indicator for this community. Zip code 10038 is at the 61.0 percentile (moderate need), with an AIDS rate of 186/100,000, ranking 22nd of 41 Manhattan zip codes. In this community, injection drug use (IDU) appears to be the prevalent risk factor, as determined by cocaine and "opioid" hospital discharges, at respective rates of 1,156/100,000 and 1,152/200,000. Female HIV hospital discharges, at a rate of 811/100,000, highlights the impact of AIDS on women in this community.[30]

SERO-PREVALENCE AND SURROGATE MARKERS

This subsection highlights the most recent data associated with the prevalence of AIDS in Lower Manhattan (LM), particularly its impact on women, children, youth (adolescents), and people of color. The data presented below clearly demonstrate the continued and expanding need for services in the catchment areas served by the Lower New York Consortium for Families with HIV.

Women

Women comprise 10% of individuals living with AIDS in the Lower East Side. The primary risk factors for this neighborhood are injection drug use (IDU) and heterosexual transmission.[31] AIDS cases among women of color in NYC as a whole have rapidly increased since the first cases of AIDS were identified. In 2000, 1,844 AIDS cases reported in the city were among women (30% of the 2000 total). Women comprised 23% of cases (27,750) reported through December 2000.[32] NYC's cumulative cases through December 2000 represent 21% of the nation's total (134,441) through the same time period.[33]

From 1987 to 1999, the cumulative number of women living with AIDS in NYC rose exponentially from 716 cases to over 11,000 cases. In 1999, 53% of women living with AIDS were African American and 34% were Latina. Although African American and Latina women make up approximately 21% of the population, they account for over 85% of the AIDS cases reported among women. Forty-three percent of AIDS cases among women in Manhattan are attributed to injection drug use.[34]

Although the number of AIDS deaths in women is declining (as is true for the population overall in the U.S.) AIDS remains the fourth-leading cause of death among women ages 25 to 44 in the US. Nationwide, 30% of new infections each year are among women. An estimated 75% of these women are infected through heterosexual sex; 25% are infected via IDU. Of the new cases, 64% are Black, 18% are Hispanic, and 18% are white.[35] For African American women and Latinas, AIDS is the second- and third-leading cause of death, respectively, among this age group. [36]

Children

At the end of March 2000, 360 pediatric AIDS cases were reported in Manhattan. This represents 19% of cumulative pediatric AIDS cases in New York City. At 196 cases per 100,000, Manhattan has the second highest pediatric case rate in the city.[37] As of mid-2000, Lower Manhattan (Community Districts 1,2, 3, and 4) had 28 reported living AIDS pediatric cases, representing 22% of Manhattan's living pediatric AIDS cases and 3% of living pediatric AIDS cases within New York City as a whole.[38] It should be noted that LM medical providers of comprehensive pediatric AIDS care, provide service to residents from all boroughs of NYC. At Bellevue and St. Vincent's, less than 50% of pediatric AIDS cases served are Manhattan residents, with the remainder residing in the other four boroughs of NYC. Further, NYC has experienced a decline in pediatric AIDS cases, in part due to advances in medical treatment of pregnant women, reducing the risk of perinatal transmission because of effective prophylaxis during pregnancy.

Fifty-six percent of young children under the age of 13 diagnosed with AIDS in NYC are African American; 36% are Latino. These cases are evenly distributed between males and females. Fewer than 37% (678) of these 1,844 children are still alive. Ninety-six percent of pediatric AIDS cases in NYC were infected via maternal transmission. Sixty-seven percent of these mothers are injecting drug users (IDU) or the sexual partners of IDUs.[39]

According to the NYCDOH semi-annual Surveillance Update of NYC Children Perinatally Exposed to HIV, 7,980 children were born to HIV-infected mothers in NYC as of March 2001. Of that number, 2,013 were known to have AIDS, while another 1,231 were HIV-infected, but in a non-AIDS category. These numbers, while significant, represent a decline since 1999, attributable in part to mothers' pursuit of medical treatment and prenatal anti-retroviral therapies to prevent HIV transmission to their offspring. This in turn demonstrates the importance and value of continuing to provide comprehensive accessible services to HIV-infected mothers in order to further reduce the transmission of HIV infection and AIDS to the children of New York City.[40]

Youth (Adolescents)

Lower Manhattan is home to 32% of all adolescents living with AIDS in the borough of Manhattan.[41] Many sexually active adolescents from throughout NYC and other parts of the Metropolitan area gravitate to certain lower Manhattan neighborhoods, including Greenwich Village, Union Square, and SoHo. Downtown Manhattan is seen as a "mecca" for many adolescents, particularly runaways, homeless youth, youth involved in the sex industry and lesbian/gay/bisexual/transgender (LGBT) youth. There are many reasons for this appeal, including the presence of nightclubs, bars and other social spots where youth can gather; the existence of gay-friendly organizations and institutions; the presence of the West Side Highway piers, sex clubs and other "stroll" areas where the exchange of sex for money or drugs is commonplace; and the presence of parks and other public areas where young people can congregate and socialize. The young people who flock to these neighborhoods do not necessarily reside there. They make the trip to find a comfortable place where they can meet others like themselves.[42] While "hanging out" is not necessarily indicative of high-risk sexual activity or drug use, it is likely that a large percentage of the group described herein engage in behavior that puts it at risk for HIV infection.

In the United States, 20,000 teenagers become infected with HIV every year.[43] Indeed, HIV infection is increasing most rapidly among young people. Half of all new infections in this country occur in people below the age of 25. From 1994 – 1997, 44% of all HIV infections among young people aged 13-24 occurred among females, and 63% among African-Americans. While the number of new AIDS cases is declining among all age groups, there has yet to be a comparable decline in the number of new HIV infections among young people.[44]

Teenagers who drink or use drugs are more likely to have sex at a younger age and with more partners. Moreover, teenagers who are 14 years of age or younger and who drink, are twice as likely to have sex than those in the same age group who do not drink. Sixty-three percent of teenagers who drink alcohol have had sex, versus about 26% in teens who do not drink. In addition, 72% of teenagers who use drugs reported having sex, as compared to 36% among those who do not take drugs.[45]

A recent report released at the U.S. Conference on AIDS in Atlanta has found that despite indications that young people are taking fewer sexual risks and are using condoms on a regular basis, HIV rates remain steady among teenagers. Each year, 50% of new HIV infections in the U.S. occur in young people aged 13-14, with African Americans and Hispanics comprising 70% of new AIDS cases in this age group. While cases among men who have sex with men (MSM) have declined over the years, MSM still accounts for 60% of new infections within this age group each year in the U.S. [46]

People of Color

In Lower Manhattan, 21% of PLWAs are Black and 20% Hispanic. This is significant because in New York City and throughout New York State, people of color are among the most affected – disproportionately so – by the AIDS pandemic. In 1999, Blacks were the highest number of reported AIDS cases in NYC, with a total of 2,340 (52%). In 2000, this same group represented 47% of NYC's total caseload.[47]

People of color in New York State remain disproportionately impacted by AIDS. As of September 30, 1999, 42% of the more than 136,000 reported AIDS cases were in African

Americans and 31% in Hispanics, totaling nearly three-fourths of all cases.[48] According to a 2000/2001 report of the NYS AIDS Advisory Council, "AIDS affects people of color even more disproportionately in New York State than in the U.S. as a whole, with 73% of New York State AIDS cases in African Americans and Hispanics, compared to 55% in the entire country."[49] Through June 2000, 41.7% of adult/adolescent AIDS cases were among Blacks and 29.4% among Hispanics, both at rates higher than the totals for the same groups nationwide.[50]

Overall, AIDS rates among people of color in Lower Manhattan and NYC as a whole are consistent with national trends. As the New York Times has reported, "In the United States, the impact of HIV/AIDS in the African American community has been devastating. Representing only an estimated 12% of the total U.S. population, African Americans make up almost 37% of all AIDS cases reported in this country."[51] The Latino population is also heavily affected by the HIV/AIDS epidemic. In 1998, Latinos represented 13% of the US population, but accounted for 20% of the total number of new U.S. AIDS cases reported that year.[52]

Trends and Risk Factors

HIV infection in Lower Manhattan is typically associated with the factors itemized below. IDU is the primary cause of infections among women; MSM the major constituency among youth. HIV infection among young children is typically transmitted perinatally, though the frequency of this occurrence has declined over the years, in part due to medical advances for women during pregnancy, and the success of programs ensuring access to perinatal prophylaxis for pregnant women.

- *Injection drug use* (IDU): Twenty-six percent of PLWAs and 30% of cumulative cases in LM are presumed to be injection drug users. IDU's accounted for 53,643 (46%) of cumulative AIDS cases in NYC.[53]

- *Heterosexual transmission:* Five percent of PLWAs and 3% of cumulative cases in LM are presumed to be the result of heterosexual transmission. According to a report entitled AIDS in New York City: Update 2001, "Heterosexual sex is a significant route of HIV transmission for U.S. women, accounting for 40% of U.S. female adult/adolescent AIDS cases reported through 1999."[54]

- *Men who have sex with men* (MSM): Fifty-five percent of PLWAs and 61% of cumulative cases in LM are presumed to be men who have sex with men. LM has the highest proportion of both cumulative and living MSM cases in all NYC neighborhoods. The 2000 NYC Community Need Index (CNI) reported 260/100,000 MSM in New York County. While the incidence of AIDS has decreased among MSM, this risk, according to the CNI, "still accounts for 60% of new infections each year in the United States." According to a CDC report, the number of new HIV infections is growing fastest among young gay blacks, particularly adolescents. HIV incidence for gay men between 23 and 29 is 14.7% among blacks, 2.5% among whites, and 3.5% among Latinos.[55]

Marker Diseases Demonstrating Risky Behavior(s)

The prevalence of certain diseases (and/or behaviors classified as diseases) among HIV/AIDS populations exacerbates HIV's impact. This complex intersection of health problems is quite

entrenched among PLWAs living in Lower Manhattan. The following data underscore how these marker diseases influence the risk for and/or control of HIV/AIDS in the Consortium's catchment areas.

Sexually Transmitted Diseases (STDs): In 2000, the rate of all reported STDs in LM increased from the rates of the previous year. In 2000, the rate of gonorrhea increased by 3% (from 130.2 in 1999 to 134.4/100,000); the rate of chlamydia increased by 5% (from 341 in 1999 to 359/100,000); and the rate of primary and secondary syphilis increased by 405% (from 1.9/100,000 in 1999 to 5.8/100,000). Despite a reported decrease in NYC's overall primary and secondary (P&S) syphilis rates in 2000, Manhattan's rates increased. In LM neighborhoods (Chelsea/Clinton, Greenwich Village/SoHo, Union Square/Lower East Side, and Lower Manhattan), P&S syphilis has increased at an alarming rate. Rates in Chelsea/Clinton grew at a rate of up to 15.2/100,000 in 2000, from the 1999 rate of 4.8/1000, an increase of 217%, representing the highest syphilis rate in NYC in 2000. Increased rates also occurred in Greenwich Village (32%) and Union Square/Lower East Side (50%).[56]

Tuberculosis (TB): With 63 cases, the UHF neighborhood of Union Square/LES had the highest number of TB cases in Manhattan in 1999, 19% of the reported 331/100,000 cases noted in the CNI.[57] Manhattan represented 21% of the total cases reported in all five boroughs (328/100,000 population), ranking third among the five boroughs for TB rates.[58] Nearly one-third of all TB cases was among HIV sero-positive individuals.[59] TB increased by 40% in 2000 among NYC's immigrant population as well.[60] New York City leads the nation's one hundred metropolitan cities in terms of TB cases, with 12% of the total reported cases nationwide. [61]

Substance Abuse (Alcohol and Other Drugs/AOD): IDUs accounted for 53,643 (46%) of cumulative AIDS cases in NYC. Twenty-six percent of people diagnosed with AIDS in Lower Manhattan have IDU as their primary risk factor. Racial and ethnic minority populations in the U.S. are most heavily affected by IDU-associated AIDS. In 1999, IDUs accounted for 37% of all AIDS cases among both African-American and Hispanic adults and adolescents, compared with 22% of all cases among white adults/adolescents.[62] IDU-associated AIDS accounts for a larger proportion of cases among women than among men. Since the epidemic began, 59% of all AIDS cases among women have been attributed to IDU or sex with partners who are IDU, compared with 31% of cases among men.[63]

Non-injection drugs (such as crack cocaine) also contribute to the spread of the epidemic when users trade unprotected sex for drugs or money or engage in risky sexual behaviors that they might not engage in when sober. One CDC study of more than 2,000 young adults in three inner-city neighborhoods found that crack smokers were three times more likely to be infected with HIV than non-smokers.[64] The Office of Alcoholism and Substance Abuse Services (OASAS) estimates that 8.8% of NYC's adolescents (aged 12-17) are chemically dependent and are in need of treatment.[65]

THE SOCIAL CONTEXT OF HIV/AIDS

There are numerous social, racial/ethnic, and economic factors affecting the communities served by the Lower New York Consortium for Families with HIV/AIDS. The data below clearly underscore the complexities and obstacles encountered by the populations the Consortium

serves. It also points to the need for an array of targeted, accessible services in order to help overcome the myriad obstacles to appropriate HIV/AIDS services.

Homelessness

Lower Manhattan Community Districts (CD) 1, 2, 3, 4 and 6 all note the increasing prevalence of the homeless in their communities, noting the need for additional services and shelter/housing needs. CD 1, for example, listed homelessness as first on its list of primary concerns; 60% of the community classify homelessness as a high priority. In CD 2, homeless youth have become prevalent in the West Village, on the piers and surrounding neighborhood, and in Washington Square Park. According to the report on Community District Needs "This population, predominantly 16 to 21 in age, which includes a significant number of lesbian and gay young people, lives dangerously in a street life dominated by rounds of prostitution and drug use. To help these young people, there is an urgent need for additional outreach services, 24-hour drop-in centers, and most importantly, transitional, short-term emergency housing." CD 4 notes the need for social services—drug treatment and mental health—for the homeless population. CD 6 reports homelessness as one of its primary issues, noting that existing formal shelters (such as Bellevue, the 30th Street Shelter, and the Women's Shelter at East 45th Street) as well as informal shelters (at churches and synagogues that open their doors to the homeless) are over-extended and operating well beyond their current capacities.[66]

According to national studies, homelessness and AIDS are interconnected in ways that exacerbate HIV's impact on already hard-hit communities and individuals.[67] In NYC, there are approximately 14,000 homeless PLWAs, with an additional 12,000 who would be homeless were it not for public assistance. Emergency short-term housing for homeless PLWAs is often available on a nightly basis in commercial single-room occupancy (SRO) hotels. Most housing facilities are not city-developed; most are shelters operated through contracts with non-profit groups and private organizations. [68]

In Manhattan, housing is a primary concern for PLWAs. Specific subpopulations in need of housing include women (particularly women of color), children, domestic violence survivors, immigrants, and IDUs. [69] Decent housing is a fundamental requirement for health maintenance and effective health care, particularly for people with chronic life-threatening conditions such as HIV/AIDS. "Without stable housing," observes a report by Housing Works, "it's impossible to maintain complex medical and medication regimens, keep appointments for doctors and public assistance, eat properly, care for children, or carry out many other tasks."[70] According to the NYC Department of Homeless Services, in November 2001, the average daily census of homeless people in the municipal shelter system in was 30,417 – approximately 27% more than the November 2000 rate (24,835), and 32% higher than the November 1999 rate (23,040). This steady increase strongly suggests a need for additional provision of services to address the problem of homelessness among New Yorkers in general and people living with HIV/AIDS in particular.[71]

In fall 2000, AIDS Housing of Washington (AHW) issued a fact sheet highlighting the links between AIDS and homelessness. AHW reported that homeless women, children and adolescents face a high risk for HIV infection. Homeless adolescents are at risk due to higher rates of sexual abuse and exploitation and it has been estimated that 70% -- 85% of homeless adolescents abuse substances. Single homeless women are more likely to be victims of domestic

violence and sexual abuse, both of which have been linked to HIV infection. Homeless women have special added barriers to health care. Homeless mothers, in particular, have been found to subordinate their own health care needs to the needs of their children.[72]

Other AHW findings include [all bulleted items below are quoted directly from source]:[73]

- People living with HIV/AIDS are at higher risk of becoming homeless.
- The homeless population has a median rate of HIV prevalence at least three times higher — 3.4% versus 1% — than the general population.
- One study found that AIDS was the diagnosis made in 17% of hospital admissions for homeless patients, and that mental illness and/or AIDS was the diagnosis in three-quarters of the cases where a homeless person was hospitalized for more than 60 days.[74]
- Homeless people living with HIV are thought to be sicker than domiciled PLWAs.
- Homeless shelters expose homeless people living with HIV to infectious diseases.
- More than two-thirds of those who are homeless suffer from chronic or infectious diseases, yet 55% of homeless lack health insurance, and 24% said they needed to see a doctor in the last year but were unable to do so, according to a 1999 HUD study.
- Many homeless individuals are excluded from primary care, specialty care, respite care and case management.
- Other barriers to care for the homeless include inadequate transportation, lack of comprehensive and/or culturally appropriate services, lack of awareness of services and resources, poor provider attitudes, and concerns about confidentiality.

Uninsured/Unemployed

Given the socioeconomic, health, and demographic indicators in the LM catchment areas the Consortium serves, it can be stated with certainty that a significant percentage of the populations served lacks health insurance or receives Medicaid (currently undergoing a shift to managed care). Overall data about the health insurance levels within NYC supports this assertion, and points to the need for advocacy and outreach services that help uninsured PLWAs gain access to the medical care and assistance they require.

In a Commonwealth Fund Issues Brief entitled "Health Care in New York City," it was noted that the number of uninsured persons in New York City is growing. Twenty-eight percent of the city's working-age adults (ages 18–64) are uninsured – more 1 million men and women, a rate 50% higher than that of New York State or the nation as a whole. According to the Commonwealth Fund, NYC has the seventh-largest percentage of uninsured non-elderly residents (age 64 and younger) in the nation's 85 largest urban areas. Worse still, the number of uninsured people is growing more rapidly in NYC than in the rest of the country. [75]

Other key points on the intersections between the growing number of uninsured New Yorkers and HIV/AIDS-related issues are as follows:

- Most uninsured New Yorkers are from low-income, working families, 42% of whom live below the federal poverty level, with another third surviving at incomes ranging between poverty level and 250% above poverty level.[76] In the 16 LM catchment areas the

Consortium serves, a cumulative average of 15% of the total population lives below poverty level.[77]

- Working New Yorkers are much less likely to have employer-sponsored insurance than their counterparts nationally: 44 percent of working-age adults in NYC have employer coverage, compared with 63 percent nationally.[78] Given that, it is safe to assume that the unemployed are not likely to have any health insurance. In the Consortium's catchment areas, a cumulative average of 7% of the total population is unemployed.[79]

- Department of Labor December 2001 estimated the rate of unemployment for New York State at 5.8%, slightly below the 7.8% rate in New York City during the same time period. [80]

- The city's immigrant population is another factor in NYC's high rate of uninsured persons. Fifty-six percent of the city's residents were born in foreign countries or are the children of foreign-born parents, and nearly a third of the state's 3.2 million uninsured residents are not citizens. Statewide, 46% of non-U.S. citizens were uninsured in 1996, compared with 15% of U.S. citizens. Minority adults in NYC are 50% more likely to be uninsured than the city's white, non-Hispanic adults.

- Lack of insurance and access to care is especially burdensome for patients in large metropolitan areas who bear a large portion of urban health and social problems. This is especially true in NYC, which has high rates of chronic diseases, including HIV/AIDS and tuberculosis, along with high rates of substance abuse and homelessness.

- High rates of substance abuse contribute to the prevalence of infectious diseases such as HIV/AIDS. NYC remains a national epicenter for HIV/AIDS, with 17% of the nation's AIDS cases but only 3% of the nation's population.

Substance Users

Injection Drug Use (IDU) accounts for 53,643 (46%) of cumulative AIDS cases in NYC as of 2000. Twenty-six percent of people diagnosed with AIDS in Lower Manhattan have IDU as their primary risk factor. In the specific UHF catchment areas covered in this Needs Assessment, HIV infections resulting from IDU and other forms of substance use were described as follows:

- *Chelsea/Clinton:* 25% are attributed to IDUs.[81]

- *Greenwich Village/SoHo*: 18% are attributed to IDU.[82]

- *Lower East Side:* 42% of AIDS cases are attributed to IDUs.[83]

- *Gramercy Park/Murray Hill:* Based on NYCDOH data reported through June 1999, IDU contributed to the majority of AIDS cases among women—138 cases or 64% of the community's total caseload. Twenty-six percent of male AIDS cases were related to IDU. [84]

- *Lower Manhattan (financial district):* Based on NYC DOH data reported through June 1999, IDU contributed to the majority of AIDS cases among women—58 cases or 70% of the community's total caseload. Thirty-seven percent of male AIDS cases were related to IDU. [85]

Immigrants/Non-English Speaking New Yorkers

One in four New Yorkers was born outside of the United States. Known immigrants living with AIDS account for 11% of PLWAs in NYC. The AIDS case rate among immigrants in NYC is 575/100,000. While immigrants living with AIDS come from many parts of the world, nearly 66% represent three regions: the Caribbean (40%), Central America (13%), and South America (12%). Two-thirds of immigrants living with AIDS in NYC originate from 16 countries – all of which, with the exception of Italy and Germany, fall within these same three regions. These countries include: Haiti, Dominican Republic, Jamaica, Mexico, Colombia, Cuba, Trinidad/Tobago, Ecuador, Honduras, Brazil, Guyana, Venezuela, Panama, Italy, Peru, and Germany. [86]

Lower Manhattan has significant enclaves of Central American, South American and Mexican immigrants who do not speak English and may not have access to services. There is also a significant Chinese immigrant population, which may be underestimated because of documentation gaps.[87] In the catchment areas the Consortium serves, commonly spoken languages include Spanish and Asian/Pacific Islander. A larger group of people live in what is termed as "linguistically isolated households," or a "household in which no household member age 14 or over speaks English only and no household member age 14 years or over speaks English 'very well.'" This is particularly evident in zip code areas 10002, 10013, 10038, 10001, 10005, 10006,10012, and 10009.[88] Language barriers often prevent non-English speaking New Yorkers from obtaining services which could help to prevent and/or treat HI/AIDS, a significant problem in Lower Manhattan.

THE HIV SERVICE DELIVERY SYSTEM

This subsection describes the services currently available to the children, youth, and women living with HIV/AIDS (as well as their families) in Lower Manhattan. It also itemizes and describes the major care providers in the target region, including key services such as medical care, dental care, substance abuse treatment services, etc. A discussion of federal and other governmental funding is included as well. Barriers to care are outlined and explained, gaps in services described, and recent changes in the health care system locally – and their impact on the target populations – are discussed in detail. Last but not least, information sources and methods for ensuring accuracy and currency of information included in this Needs Assessment are listed and described.

Major Providers of Care in the Target Area

The Lower Manhattan region has a number of medical and social service programs targeting people living with HIV/AIDS, including children, youth, women and men, and their families. This array of services is supported in large measure by Ryan White resources (Titles I, II, III & IV) and by the New York State Department of Health AIDS Institute. These medical, case management, and care coordination services are described below.

Medical: Ryan White Title I supports a variety of ancillary services in medical outpatient settings, including nutrition services, mental health counseling, substance abuse treatment, medication adherence support, psychiatric evaluation and social work services. In addition to primary care visits, several outpatient medical programs offer specialty services such as gynecology, dermatology, ophthalmology and complementary therapies. Throughout the Lower Manhattan region, Ryan White Title I supports outpatient medical care at Bellevue Hospital, St. Vincent's Hospital, Cabrini Medical Center, Gouverneur Diagnostic & Treatment Center, Callen-Lorde Community Health Center and Daytop Village.[89]

Ryan White Title III supports early intervention services in Lower Manhattan at the following sites: Callen-Lorde, Care for the Homeless, Community Healthcare Network, Greenwich House, Project Renewal, St. Vincent's Medical Center, and the Lower New York Consortium for Families with HIV/AIDS.[90]

NYS AIDS Institute supports 33 Designated AIDS Centers (DACs) statewide, with seven DACs in LM. These State-certified, hospital-based, multi-disciplinary programs are designed to provide high quality care for people living with HIV/AIDS through Medicaid reimbursable services.[91] However, while all DACs provide specialized HIV care for adults, most do not have a specialization in pediatric AIDS care.

Case Management: Ryan White Title I and NYSDOH AIDS Institute support case management programs in medical and social service settings that ensure access to and coordination of services for people living with HIV/AIDS. Several case management programs offer harm reduction, support groups, individual and family counseling, housing placement assistance, treatment education, referrals and escorts. Throughout the Lower Manhattan region, Ryan White Title I supports case management services at African Services Committee, AIDS Service Center (ASC), AIDS Treatment Data Network, American Indian Community House, Asian Pacific Islander Coalition on HIV/AIDS (APICHA), Bailey House, Care for the Homeless, Exponents, Fortune Society, Gay Men's Health Crisis (GMHC), and Planned Parenthood of NYC. In addition, there are twelve Manhattan-based COBRA AIDS Case Management Programs, providing intensive, family-centered programs for Medicaid-eligible people living with HIV/AIDS, and supported through Medicaid fee-for-service billing.[92]

In addition, the NYSDOH AIDS Institute supports Community Service Programs, Multi-Service Agencies and Community Development Initiatives that provide comprehensive HIV prevention, advocacy and direct support services for individuals and families living with HIV/AIDS. These organizations include Asian Pacific Islander Coalition on HIV/AIDS (APICHA), AIDS Service Center (ASC), American Indian Community, House, Black Leadership Commissions on AIDS, Hispanic AIDS Forum, Housing Works, Latino Commission on AIDS, Musica Against Drugs, and NENA Comprehensive Health Center.

Care Coordination: While the Lower Manhattan region has substantial coverage of medical and social services for people living with HIV/AIDS, there are, however, only a small subset of service providers with specialization and expertise in serving women and families. For example, Bellevue Hospital treats approximately 150 HIV-infected children each year, and St. Vincent's Medical Center treats approximately 50 HIV-infected children annually. While Community

Districts 1-4 in Lower Manhattan had 28 reported living AIDS pediatric cases in mid-2000, families from all over NYC travel to these premiere family-centered programs to obtain medical and social services for their HIV-infected children.

The Lower New York Consortium for Families with HIV/AIDS is the only Ryan White Title IV funded program dedicated to developing, implementing and coordinating care for children, youth and women with HIV in Lower Manhattan. Independent community organizations, such as the Lower East Side Family Union, Iris House, GMHC, ASC and APICHA have unique services for women and families, but apart from the infrastructure of the Lower New York Consortium, there is no coordinating mechanism in Lower Manhattan.

Federal Funds That Can be Used to Provide Services

The New York State Health Department, in coordination with the federal government, supports a variety of HIV medical service initiatives, such as the Primary Care Initiative, combining federal and state funding for 42 medical providers across NYS, expanding HIV prevention and primary care service availability.[93] Through partnership between New York State and the HIV Planning Councils of New York City, Long Island and Lower Hudson and Dutchess Counties, Ryan White Titles I and II and NYS Department of Health funds jointly support four programs for HIV Uninsured Care (ADAP, ADAP+, ADAP+ Insurance Continuation, and HIV Home Care). These programs are intended to provide access to medical services and medications for all uninsured and under-insured NYS residents with HIV/AIDS.[94] NYS AIDS Institute also supports a Substance Abuse Initiative, designed to provide co-located HIV prevention and primary care services in substance abuse treatment settings throughout NYS. This Initiative is supported by Substance Abuse and Mental Health Services Administration, as well as combined State and federal funds.[95]

Barriers Standing Between Target Groups and the Care They Need

There are numerous socioeconomic challenges and barriers facing inner-city minority men, women and families in need of access to comprehensive HIV medical and social services in LM, such as poverty, substance use, inadequate housing, domestic violence, mental illness, limited education, immigrant status, language barriers, lack of child care, lack of co-located services, transportation, etc. For inner city women of color, these challenge significantly compound their risk for HIV. It is also widely recognized that based on their traditional caregiver role, women are less likely to seek health care for themselves, even when they seek it for other family members. To adequately serve HIV-positive women, interventions must address this multitude of factors with tailored programs to help women overcome barriers to obtaining HIV treatment and maintaining treatment adherence and access to services. Such programming must also directly assist women in increasing their capacity for self-care, relapse prevention and/or harm reduction.

On another front, the changing of the service delivery system to a managed care environment for Medicaid populations, and concurrent changes in welfare laws will have devastating impacts on both legal and illegal immigrants, and low income people living with HIV. These changes will create increased demand for assistance in managing their health care with significantly reduced public resources. Impending changes in public entitlement regulations will leave many low-income people with HIV without resources and services. Moreover, it should be noted that alcohol and other drug (AOD) users are extremely difficult to engage and sustain in HIV care

services. Case management has the capacity to provide a solid, consistent support system for this population. If AOD users are denied public entitlements because of their active substance use, as has been proposed, they will not receive needed services and will most likely engage in high risk behaviors which will lead to an increase in HIV infection.

Gaps in the System of Care

In 2001, The PWA/HIV Advisory Group of the New York HIV Health and Human Services Planning Council, conducted a survey of people living with HIV throughout NYC, and generated a report of recommendations to fill service gaps and meet needed services of the HIV community. Fifty percent of survey respondents ranked housing as the top priority need and gap, resulting from poor housing conditions, no access to adequate housing, delays in receiving housing and increased recidivism due to poor housing conditions. Case management (13%), Food/Nutrition (11%), and Mental Health Services for Families (8%) followed housing in the priority needs ranking among survey respondents. Specific service gaps in these areas included women's specialized services, food pantry and produce bags, and after-school tutoring and child life programs.[96]

Recent Changes in the State and Local Health Care System

As mentioned in the subsection above, among the most significant changes on the horizon for New York City's health care delivery system is the transition to managed health care for Medicaid populations. To minimize the negative impact of this sweeping change for people living with HIV/AIDS, the NYS Health Department has supported the development of Special Needs Plans (SNPs) which are intended to provide specialized HIV care within a coordinated managed care framework through extensive partnerships between medical and social service providers.

SNPs are designed to care for the whole family, including both the HIV-positive and HIV-negative children of HIV-positive parents. While HIV-infected children with *uninfected* parents or guardians may join a SNP on their own, their parents will have to be part of a separate health plan. Conversely, if an HIV-positive parent dies, his or her uninfected children will automatically be disenrolled, and will then need to become enrolled in the health plan of the chosen guardian. These situations are likely to be extremely confusing and challenging for families, particularly during times of stress and loss.

People living with HIV/AIDS require ongoing assistance and support in overcoming the many institutional and individual barriers to accessing services, remaining in care, learning about and receiving appropriate medical therapies, and sustaining independent living for as long as possible. Recent changes in immigration and welfare laws imposing work requirements and time limits on public benefits, denying benefits to active AOD users, and denying benefits to legal and undocumented immigrants – along with the concurrent shift to Medicaid managed care for people with HIV/AIDS – are likely to adversely impact the ability of low income minority communities to access needed support and medical services in the months and years to come.

Sources of Information and Methods for Ensuring Accuracy of Information

Key sources consulted include the most recent and reliable source materials available, including the following: *Ryan White Title I Service Summary Report to the NYC Department of Health*,

MHRA (September 2000); *About the AIDS Institute*, NYS Department of Health AIDS Institute (June 2001); *NYC Ryan White CARE Act Title I Consumer Advisory Groups Funding Recommendations Report* (March 10, 2001, PWA/HIV Advisory Group, NY HIV Health and Human Services Planning Council). In addition, great care has been taken to provide detailed citations for local, state and national data cited throughout this Needs Assessment document. See below for a complete listing of source materials and citations.

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