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Neighborhoods and Vulnerability:

The Contours of AIDS

in

Post-Industrial Pittsburgh

A Report of the History and Policy Project Course
Department of History
Carnegie Mellon University

Fall 1997

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Kris Kersey
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Volume 1

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Acknowledgements

Special thanks are due to many people who helped make our research possible. Joel Hersh, Director of the Pennsylvania Bureau of Epidemiology, authorized release of the AIDS case data we analyzed; he and William Smith, Director of the Divison of Sexually Transmitted Diseases and AIDS, Allegheny County Health Department, provided the data itself in response to numerous requests for yet more data in yet more forms. Both also met with us to discuss their work in collecting and managing AIDS case data and answer innumerable questions. Bruce Dixon, M.D., Director of the Allegheny County Health Department, also authorized release of the AIDS case data we anlayzed.

Stuart Fisk, Pennsylvania AIDS Training and Education Center, University of Pittsburgh Graduate School of Public Health, and Linda Ogden met with us to discuss various aspects of HIV epidemiology, outreach and prevention, as well as clinical aspects of AIDS. Karen Gibson, CMU Department of History, advised us on interpreting census data.

Tammy Frech and Rich Cummings of the Pittsburgh AIDS Task Force provided access to materials at the PATF library and answered many questions about the agency's work. Sabira Bushra of the Minority AIDS Working Group and Terri Baltimore of the Hill House Collaborative gave their time in interviews about their respective organizations.

Anthony Silvestre and Matthew Moyer of the Pitt Men's Study, Annette Green of the Pittsburgh Foundation, Burnell Sims of the University of Pittsburgh Medical Center, and Gary Gates of the H. John Heinz III School of Public Policy and Management provided the instructors with advice.

Rebecca Campbell wrote the history of Pittsburgh's public health infrastructure, helped develop production software guidelines, and, as a member of the map team, instructed others in using the mapping software.

Daniel Green worked on the AIDS case team and analyzed AIDS in McKeesport and other Mon Valley communities.

Kris Kersey wrote the history of European migration and neighborhood formation and worked on the neighborhood team.

Frank Ligons wrote the history African American migration and the Hill District analysis; he was the leader of the neighborhood team.

Michael Lobick, a member of the AIDS case team, analyzed AIDS cases in East Liberty, Homewood and Wilkinsburg. He also collaborated on the discussion of AIDS in the Pittsburgh media.

Melissa Murello, a member of the neighborhood team, wrote the history of local structures of government and the conclusion.

Sravan Narayan, a member of the AIDS case team, provided case rates and ratios for all data categories as well as developing the comparative analysis of AIDS in Philadelphia.

Joseph Nunez, a member of the neighborhood team and the map team, wrote the history of schools' response to AIDS, and developed maps and other visuals as needed for individual chapters.

Kristofer Peterson, leader of the AIDS case team, analyzed AIDS in North Side neighborhoods and developed many of the graphs in the appendix.

Jason Reinsch, a member of the AIDS case team and the map team, collaborated on the discussion of AIDS in the Pittsburgh media.

Rosalyn Rice, a member of the neighborhood team, wrote the chapter on neighborhood vulnerability and the Hil House as well as the chapter on the Minority AIDS Working Group.

Vincent Sonson, a member of the neighborhood team, wrote the section on the epidemiology of AIDS.

Richard Svinkin, a member of the AIDS case team, wrote the chapter on the history of the Pittsburgh AIDS Task Force. He also analyzed all the AIDS case data and developed the cluster breakdown based on zip code demographic and AIDS case patterns.

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I

Introduction

by
Jason Reinsch

Neighborhoods and Vulnerability: The Contours of AIDS in Post-Industrial Pittsburgh represents the hard work of thirteen History and Policy students at Carnegie Mellon University during fifteen weeks of diligent research. This composition was drafted for the History and Policy Project Course, a collaborative research course that is the capstone of the History and Policy curriculum. The course utilizes real world problems to allow students the opportunity to effectively exercise their research and analytical skills, experience collaborating with peers on an extended project, and formulate policy recommendations for contemporary issues. In addition to yielding effective educational benefits, the course also grants an opportunity to conduct research that is helpful to the surrounding community.

Neighborhoods and Vulnerability... focuses on the epidemiological pattern of AIDS in Pittsburgh. It aims to link this pattern to Pittsburgh as a particular place with a particular history. The research proceeded along three tracks. First, a careful analysis of AIDS case data for Pittsburgh that was provided by the State Bureau of Epidemiology and the Allegheny County Health Department. This data represents all the cases of AIDS that have been diagnosed since 1981 in 42 zip codes, comprising the city of Pittsburgh and several communities along the Monongahela River: Braddock, Rankin, Duquesne, and McKeesport, as well as McKees Rocks and a few others. The AIDS case data was broken down by age, race, gender, and mode of transmission of HIV, the virus that causes AIDS. Seeing where patterns of cases fell within specific zip codes revealed a great deal about the spatial and social geography of AIDS in Pittsburgh.

A second track of the research focused on neighborhoods as contexts for infectious disease. What neighborhood characteristics confer health and strength; what characteristics are markers of vulnerability? Looking at AIDS case data in conjunction with neighborhood social and economic characteristics unveiled the kinds of resources neighborhoods need to protect themselves against infectious disease, and what kinds of problems create circumstances in which a pathogen like HIV can flourish.

The research found that AIDS in Pittsburgh represents an important local story. Although AIDS case rates for Pittsburgh and the surrounding region are low compared to other American metropolitan regions, this does not mean Pittsburgh has an evenly dispersed, acceptably low rate of AIDS cases. Rather, there are concentrations within specific neighborhoods, and within specific social and racial groups that present targets for intervention. Moreover, the pattern of AIDS cases in our region reflects Pittsburgh's own history. The contours of AIDS in Pittsburgh reflect our local history of deindustrialization, of neighborhood formation and change, and of residential and employment-sector racism that has selectively disadvantaged African Americans.

An examination of Pittsburgh's response to AIDS formed the final focus of the research-- from city and county government, from the school system, and from the community at large. The researchers accomplished this by analyzing a variety of organizations such as the Pittsburgh AIDS Task Force and the Minority AIDS Working Group. These two organizations, in particular, portray the contrast in activist energy and resources mounted by a politicized gay community focused on a single, devastating challenge and the paucity of resources as yet directed toward AIDS in the African American community in Pittsburgh. It is hoped that the findings contained in the following two volumes can help target HIV prevention strategies by highlighting places and groups that present significant risks of HIV infection.

1

Chain Migration and Kinship Networks: Patterns of Neighborhood Formation in Pittsburgh's Ethnic Communities

By
Kris Kersey

Pittsburgh's explosive industrial and financial growth of the late nineteenth century made it a popular destination for European immigrants. Between 1880 and 1900, the city's population doubled to over 451,000 residents with the Polish and Italian communities comprising nearly one-third of the city's foreign-born population.[1] Occupational imperatives and patterns of chain migration affected where Polish, Italian, and Slovak immigrants settled. Immigrants performing similar work resided in ethnic clusters that often eased the burdens of settlement and assisted families and individuals in adjusting to their new life. Kinship networks established these clusters and provided the model for chain migratory patterns. For all three groups, the church played a vital role in transforming these clusters into Pittsburgh's distinct and permanent ethnic neighborhoods. Concurrent increases in population diversity and economic changes, which tested the persistence of Poles, Italians, and Slavs, increased homogeneity in certain neighborhoods. An understanding of Pittsburgh's evolving cityscape and pre-existing neighborhoods provides insight into the geographic restrictions and openings awaiting the European immigrants.

During the mid-1870s, the Pittsburgh elite, mostly native-born manufacturers and bankers of Scotch-Irish or German ancestry, established exclusive residential neighborhoods. By 1900, they dominated two areas within the city's boundaries: Allegheny City, which is now the North Side on Ridge, Western, and Lincoln avenues; and the East End. Leaving downtown in the 1880s and 1890s, German, Irish, and English middle-class residents set up neighborhoods in close proximity to lines along Pittsburgh's new streetcar system. Eastern lying Oakland, Squirrel Hill, Shadyside, and Wilkinsburg, Allegheny City to the north, and Mt. Washington and Mt. Oliver to the south comprised the new streetcar suburbs. Moderate single-family dwellings several miles from the large industry of the city characterized streetcar suburbs. Also beginning in the 1880s, the older homes of the Hill District and other areas adjacent to the core, or downtown, became blue-collar clusters.

Although they contained large numbers of blacks and recent immigrants, these new blue-collar areas were not homogeneous. Neighborhoods developed along the flood plains by the mills, and once row houses filled those narrow strips of land, homes began to climb the hillsides along the banks of the Mononagahela and Allegheny rivers. Recent immigrants

filled those hillside homes. Before generalizations can be made about the formation of blue-collar ethnic neighborhoods, an understanding of "chain migration" patterns becomes necessary. A case study of Slovak migration patterns offers an insight into kinship networks, the importance of the church, and explanations to the geographical spread of ethnic neighborhoods with the same perceived heritage.

According to June Alexander in Staying Together: Chain Migration and Patterns of Slovak Settlement in Pittsburgh Prior to World War I, the case study of the simultaneous emergence of several different Slovak communities in Pittsburgh explains this seemingly contradictory phenomena. The common perception is that immigrant groups settle into one or two neighborhoods thus creating places similar to New York's "Little Italy" section of Manhattan. Yet, Slovak immigrants from Hungary did not identify themselves as necessarily Hungarian. Village identity pervaded in Pittsburgh's history. Indeed, the fact that Slovaks from northern Hungary settled in five different sections of Pittsburgh seemingly defies logic. But, Slavs from the same village settled in those five respective areas, thus Pittsburgh did not have an exclusively Slovak neighborhood. Consequently, Old World origins and New World destinations "must be considered within the broad context of the Slovak immigration movement."[2] Combined cultural and economic forces influenced Slovak migration to America beginning in the late 1870s. Temporary and seasonal migration patterns in Hungary reinforced emigration as a viable option to provide for families. The importance of families cannot be overemphasized in the context of Slovak, or for that matter Polish and Italian, immigration. Seasonal migration patterns became vital to families socially and economically. Sons emigrated to America and sent back for relatives or betrothed. As children enjoyed success, parents followed their offspring's lead. This history of seasonal inter-village migration within Hungary extended kinship ties. As men and women from different villages wed, kinship networks extended into other villages. According to Alexander, "the tendency for Slovaks to follow family and friends to America was one factor that ultimately influenced Slovak settlement patterns in Pittsburgh."[3] Once here, Slovaks set about to build communities.

Churches played an important role in community development for Slovak immigrants. The ties between villages, occupations, and churches become evident as settlement patterns reveal Slovak immigrants choosing different locations within Pittsburgh. The construction of four different Slovak Catholic Churches indicates that while the Slovak populations were spread into different areas of Pittsburgh, each area was distinctly Slovak. Further investigation of these areas through church marriage, birth, and burial records indicate that each settled residents of geographic area represented a village back in Hungary. The power of kinship networks and the role they played on the longevity and stability of Pittsburgh's ethnic neighborhoods require examination.

As immigrants settled into one area, obtained work, and then acted as recruiters to bring fellow villagers to the same area, those areas became more homogeneous down to the village level. Thus, the chain migration into Pittsburgh did not rest solely on conditions in Hungary; on the contrary, the availability of work coupled with the hiring practices of Pittsburgh industry encouraged chain migration. Pittsburgh factories relied on foremen for hiring decisions who, in turn, relied on worker as intermediaries to find labor. These workers sought out family, kin, and then villagers. Because of the importance of the church in Slovak culture, these new arrivals set out to build churches to service the spiritual and social needs of their respective areas. Churches served a variety of social functions, not the least of which was to give permanency to the newly settled neighborhoods. The willingness of Slovaks to establish neighborhood churches indicates the immigrants' intentions to remain in a neighborhood. This permanency allowed for further homogeneity as Slovaks continued their chain migration patterns of linking their respective neighborhoods with their respective villages in Hungary. The tendencies for Slovaks to chain migrate and settle in different sections of Pittsburgh provide significant implications for understanding the immigration experiences of other ethnic groups.

Around 1900, the Polish, Italian, and Slovak contingents of European immigrants tended to settle in ethnic clusters close to the mills and factories along the riverbanks and near the central business district. Journey-to-work was a primary concern for these new arrivals who lacked the resources, time, and energy to use public transportation or to walk long distances after a long day of work. Russian Jews settled near established German sections of the Lower Hill around Centre Avenue. Hungarians, Croatians, and other eastern Europeans settled into small enclaves near the Jones and Laughlin mill in Hazelwood (15th ward), in company homes along "Painter's Row" on the South Side, and in the industrial satellite communities of Homestead and Braddock.[4]

The Italian immigrants first settled in Virgin Alley on Oliver Avenue in 1880, but by 1910, the Virgin Alley colony shifted to the already extensive Lower Hill. Later Italian arrivals opened new neighborhoods in Bloomfield (8th ward), and East Liberty (12th ward). A small dense cluster also settled in the hollow in Schenley Park.

The Polish entered Pittsburgh in successive waves with 12,000 within in the city by 1900 from provinces under German, Prussian, and Austrian control. Seeking almost exclusively industrial work, they settled in close proximity to the riverbank factories. The earliest Poles came from Prussia and, because of their familiarity with the language, settled in the predominately German Strip District. In the 1880s, Poles established neighborhoods on the steep north slopes of Herron Hill (6th ward, Polish Hill), and on the South Side (16th and 17th wards). By the turn of the century, Russian Poles displaced the older German and Irish workers in the Strip District and in Lawrenceville (6th and 9th wards).[5] Austrian Poles from Galicia joined the larger German and Russian communities. By the turn of the century, Polish and Italian neighborhood, formation and community development were underway.

Formation of fraternal associations followed by the building of churches fostered loyalties which provided a permanent community foundation. The ethnic church acted as a major unifying element in neighborhoods as its mere construction symbolized a group's intention on settling in an area. The short time between immigrant settlement and the erection of impressive and expensive structures attests to the importance of the church in immigrants' lives. The immigrants' weak economic position to construct such structures illustrates the immigrants' perception of the importance of the church.

The church was an all-encompassing functional unit that affected immigrants from birth through burial. One church function was to protect family interests while preserving the ethnic culture in a foreign, and sometimes hostile, society. Church leaders acted as information agents to aid in the adjustment to Americanized life for both young and old immigrants. The Polish church and its community role bear a striking resemblance to the Italian church.

As the first Poles arrived in the Strip District in the 1870s, they donated their time, services, and in some cases money to erect a small chapel at 21st and Smallman Streets. Upon completion of the chapel, community leaders began to plan for constructing a larger church to meet the demands of the rapidly growing Polish population. By 1891, this poor community of blue-collar workers replaced the old structure with a large $100,000 Romanesque-style church. Poles establishing settlements further east and on the South Side between 1900 and 1910 built churches quickly after settlement. Within ten years of their arrival on Polish Hill, immigrants erected the imposing Immaculate Heart of Mary Church that dwarfed the houses. This symbolism, prevalent throughout Pittsburgh, clearly indicates the importance of the church in Polish Hill.[6]

Polish priests became " the dominant and unifying force in each community"[7] presiding over every function of an immigrant's life. Priests solicited funds for school support and school construction while holding supreme authority in the operations of those schools. The role of the Italian church paralleled that of the Polish church.

The increase in the number of Italian Catholic priests from one in 1900 to eleven in 1906 reflects their importance to the growing Italian population. According to John Bodnar, the Italian Catholic Church served "as a social center, a charity agency, an employment

bureau, an Americanization center, a friendship center and a home."[8] Whether members engaged in physically constructing a building, rehearsing for a play, or in food preparation for a festival, the church became the focal point for the entire community. Fellow countrymen from a variety of villages, unlike the early Slav example, now represented a single ethnic background and community. These shared experiences both inside and outside the church's realm contributed greatly to the community creation process. Three other factors supplemented the work of religious institutions in that process: The development of fraternal and social organizations; the publication of local newspapers, and the success of small business districts.

Polish and Italian social and beneficial organizations, newspapers, and businesses all worked to reinforce the ethnic church's role in strengthening neighborhood unity. Polish "national" singing groups and other organizations frequently competed against each other in sporting, music, and other events. By competing as geographic neighborhood units, they bonded their respective communities. Similarly, constructed Italian groups did the same for their respective neighborhoods. Structurally organized differently, the Polish and Italian newspapers did not necessarily grow out of their communities; however, these centralized papers carefully and frequently spoke to the needs of their constituencies, and in so doing, played important roles in community development.

Perhaps the most physically evident sign of community development, the growth of the local ethnic business district also played a vital role. To struggling immigrants, the self-employed businessman, and the status he enjoyed, symbolized the "American Dream" that they all sought. Their willingness to extend credit often made them the immigrant's only hero in hard times. Entrepreneurial businesses evolved into meeting places for the local community. They were a place to gossip and exchange ideas. While Poles enjoyed some success in business, Italian businesses were much more successful. Both, however, served primarily local populations because of their neighborhood locations. The Italian businesses in East Liberty became so large and successful the area became a distinctly Italian "colony."[9] Pittsburgh's dynamic economy failed to affect the efficacy of the established kinship networks.

Stagnant labor conditions in Pittsburgh directly influenced any would-be migrant's decision. Yet, in these instances, the persistence of kinship networks became obvious. If settled immigrants supplied relatives and friends with information about job opportunities, they also supplied warnings when those opportunities disappeared. This process contributed to the stability of Pittsburgh's ethnic neighborhoods by virtually ensuring a certain level of employment for the community and thus a certain standard of living. It protected against further overcrowding. During this period, 1910 through 1930, Pittsburgh experienced tremendous outward migration of its native-born white population. This movement altered the city's spatial patterns and led to increased homogeneity of the inner city neighborhoods. Local newspapers advertised over eight new blue-collar communities outside the city limits. Some areas even offered a year's free transportation to induce settlement.[10] The development of industrial towns along the Ohio and Monangahela rivers and the relocation of the Westinghouse plant from East Liberty to the Turtle Creek Valley all lured workers from the city. In conjunction with the development of Aliquippa, Ambridge, Clairton, Duquesne, and Glassport, the street railway network and the opening of new highways altered the demographic profile of the city. By the beginning of World War I, the street railway system carried an estimated 67,000 riders, most of them white-collar, over its 583 miles of track every day.[11] The construction of Bigelow Boulevard and the Boulevard of the Allies provided direct access to the eastern residential areas of Oakland and Squirrel Hill. Tunnel construction in 1926 and the subsequent opening of the Liberty Bridge in 1928 spurred the development of a half dozen suburban communities in the South Hills. Between 1920 and 1933, the number of miles of improved roads in the Pittsburgh area more than doubled from 511 to 1,300 and provided access to suburban living in all directions from downtown.[12] Not surprisingly, the city's population shifted outward. The previously dense residential districts near downtown all lost population. Trolley and automobile transportation provided residents

who could afford them with residential alternatives. Indeed, Squirrel Hill had the highest percentage of homes over $10,000 and the highest automobile ownership rate in the country. The interrelationship between wealth and transportation alternatives contributed to the increasing homogeneity of Pittsburgh's neighborhoods. While the poor and working class immigrants remained near the city, the affluent built homes in the suburbs.

These intra-city and inner city migrations affected the population densities of the city, yet they increased the concentration of ethnic groups in certain areas. The reason for this was that as higher income residents vacated the inner city neighborhoods, eastern Europeans and blacks replaced them. This further ingrained the ethnic identities of Pittsburgh's neighborhoods. In 1910, the Italian population was disproportionally represented in fourteen areas including the central business district, the lower hill, Bloomfield, East Liberty, Larimer, Hazelwood, and Homewood areas. By 1930, the great majority of the city's Italians crowded into three Italian districts: the lower hill, Bloomfield, and East Liberty. As the number of Italians increased, the number of non-Italians in each neighborhood decreased. [13] Polish migrants also maintained the patterns of chain migration established at the turn of the century.

The increasingly commercial Strip District continued to lose population while both the Polish Hill – Lawrenceville and South Side sections attracted new residents. By 1930, both sections became synonymous with Poland in Pittsburgh. More than 75% of the residents of Polish Hill were of Polish extraction. The proportion reached 100% on some streets.[14]

After 1930, few ethnic neighborhoods received newcomers. Yet during the next thirty years, the neighborhood Catholic churches and schools, fraternal associations, local business establishments, newspapers, and other organizations flourished while providing assistance, comfort, and leisure activities to two generations of residents. Because the previous generations successfully obtained steady work and decent living conditions, the community enjoyed stability. Without the foundations of the first generation, the ethnic neighborhoods of the 1930s and 1940s would have been in disarray.

During that period, other communities, especially the black community, failed to achieve high persistence rates. Persistence is the ability for a person or, in this instance, a group to persevere through difficult times and stay put. While the institutions erected by the first generation did not cause stability and persistence, they provided the apparatus for support.

Church activities remained a significant force in the Polish and Italian neighborhoods. The focus of the Polish Catholic Church had always been the neighborhood parish. Parish priests continued their tradition of officiating at everything from birth to burial. Indicative of both the increased concentration of ethnic populations and of its continuing importance, membership increased in both the Polish and Italian neighborhood churches. Even more revealing, religious financial contributions remained steady during the depression and increased substantially thereafter. An Italian mother illustrates this role when she was urged by a social worker to move to a better neighborhood that had an American Catholic Church. Protesting that she preferred her present neighborhood with Italian Catholic Church and priests, she explained, "I want my own religion for the children."[15] Church-affiliated schools supplemented the community-based activities and helped cement neighborhood stability.

Local scouting groups, holy-name societies, and innumerable athletic teams helped to maintain community identity. Inter-neighborhood competition was often fierce, and the local teams received wide support from the adult members of the community. Young people dominated the neighborhoods in the 1930s and 1940s. Young families under forty years old, with small children, lived in each community. By 1940, second-generation Poles and Italians almost totally replace their foreign-born parents. Consequently, schools took priority as large educational structures, containing twelve or more classrooms, were erected. Illustrating this youth movement in the ethnic communities was the proliferation of family church outings and youth socials. As the youth movement molded the neighborhoods, many

organizations offered recreation and educational facilities and economic assistance for the community. Because of this, the fraternal associations adapted their functions to better serve the needs of the changing community.

Although their functions changed, fraternal associations retained their importance in the ethnic neighborhood. Originally formed as beneficial societies, social brotherhood and political action became important by the mid-1930s. Members continued to pay for and receive sickness and death benefits, but other functions received equal treatment and attention. Building to house "nests" of Polish Falcons, local colonies of the Polish Alliance, Sons and Daughters of Italy, or provincial organizations such as the Ateleta club sprang up in every ethnic community. Nearly all had a social-gathering place that included gaming tables and, after prohibition, bars.[16] The expansion of fraternal associations allowed them to play a continued role in the lives of first and second-generation residents. Polish and Italian neighborhood organizations, now nearly 30 years old, buttressed the familial and work ties around which the immigrant children organized their lives.

The incidence of multiple-family living in the Polish, and to some extent, Italian households and its absence of black residences continued the pattern of adjustment related to kin networks. Both Poles and Italians depended upon their children to assist in the income-producing activities of the family. A report by the superintendent of schools in the Bloomfield district indicated that Italian parents continued to urge their male offspring to forsake school for work as soon as possible. Many immigrant children lived in the same home as their parents, often dividing the dwelling into two or more apartments. Such assistance was invaluable, especially because few immigrant children could afford housing outside the city or in more affluent neighborhoods. The Polish Hill, Bloomfield, and East Liberty neighborhoods all contained numerous examples of multiple residences built on single lots. In fact, this tendency to divide households proved so widespread that many realtors would not sell to Polish or Italian families in more affluent neighborhoods by the 1950s for fear of disrupting higher priced single-family areas. The strong interfamilial dependence among Polish and Italian groups and the location of their work induced many second-generation migrants to settle within the community of their youth.

The journey-to-work issue continued to influence residential choices until 1930. Family and kinship ties and the social and economic services provide by one's community, together with the perceived sense of belonging, exercised an increasingly powerful force on a choice of residence. Persistence of the Poles and Italians within the city increased during each decade after 1930. Almost none of the Polish or Italian families from the 1930 neighborhoods left the city after 1940. Many had resided in the same neighborhood for thirty or more years, and attractions from other locations were not strong enough to induce them to leave Pittsburgh. Nearly 50% of the surveyed Poles and Italians remained in the same house each decade from 1930 through 1960. Those who did move did not go very far. The typical mover went down the street a few houses or around the block. Nearly half of those who moved within the metropolitan area during each decade stayed in the same census-tract neighborhood. The next largest group left the tract but stayed within the ward. The pull of ethnic neighborhood and the services it provided obviously remained strong. Even the so-called attractions of the suburbs and the threat of a black incursion that supposedly caused many to flee the city in the 1950s failed to lure the second-generation immigrant from his neighborhood. Most remained in the neighborhood, often within the same house, until both spouses had died. Most revealing was that 20% of the household heads on a street in Polish Hill in 1960 were widows. Homes in most families subsequently passed on to offspring. In fact, the proportion of household heads remaining in their parents' homes exceeded those moving to the suburbs by nearly 50% in each decade.[17] Therefore, second-generation Poles and Italians like their parents before them, made adjustments and created institutional associations to ease their lives in industrial Pittsburgh. These adjustments and associations, in turn, contributed to their remarkable residential stability.

When Poles and Italians first entered Pittsburgh in significant numbers, limited skill positions were proliferating in to the city's expanding iron and steel industry. Fortunately for the immigrants, foremen prized them over blacks as potential employees and allowed the Europeans to establish friend and kinship networks in the work place. Nevertheless, the changing nature of Pittsburgh's economy during the first two decades of this century cannot alone explain the initial occupational and residential targets of newly arrived laborers. Each group brought similar and distinctive premigration experiences with them that shaped these initial attachments to the "steel city." Italian expectations for small entrepreneurial opportunities and their widespread acquaintance with supplemental skills in Italy caused them to stress the acquisition of a trade rather than formal education. Poles expected less upon arrival in Pittsburgh and were satisfied to obtain the industrial unskilled and semiskilled work they received. They generally thought prolonged schooling was simply an unnecessary delay in establishing their inevitable foray into industrial work. While the groups revealed strong familial associations before and during movement to the city, the behavior of respective family groups in Pittsburgh differed and did not remain unaffected by urban forces of racism, limited opportunity, and the economic structure of the city. Families, in short, were malleable and were altered but not eradicated by social change.

The consequence of this interaction between urban forces and tradition was not only disparate occupational courses for each group, but significantly different patterns of community building. Immigrants, able to obtain job stability and homeownership, established functional neighborhoods in Bloomfield, Lawrenceville, and the South Side. For Poles, who were always landowners in Europe, homeownership was a high priority. But their quest for homeownership in Pittsburgh resulted not only from their past but also from economic pressures in Pittsburgh to gain a modest form of stability, and to provide assistance and living space for kin in subsequent generations. Italians, while having somewhat less familiarity than Poles in owning European real estate, also recognized the need to secure a hedge against economic uncertainties and a shelter for themselves and relatives in a city continually short of housing and in area with crucial services and neighbors of similar cultural backgrounds. The entire community-building process for both Italians and Poles was facilitated tremendously by their ability to create kinship-occupational systems in the Pittsburgh economy.

After the 1920s Pittsburgh's industrial economy offered fewer opportunities, and many employers left the city itself. Second-generation Poles and Italians, on the other hand, were beneficiaries of solid, urban bases that provided adequate housing, established institutions, and secured vital entry into specific occupational sectors. During the 1930s, Poles and Italians were occupationally stagnant. After 1940, Italians did make gains into skilled and small entrepreneurial areas. Poles, however, remained largely in blue-collar work, although more entered skilled and supervisory roles. The Depression of the 1930s, World War II, and the events of the postwar 1950s all influenced life in the Polish and Italian neighborhoods. Unemployment during the Depression halted the occupational progress of some groups; discrimination by employers and union leaders limited job opportunities for others. Urban redevelopment destroyed one neighborhood and changed several others. Educational opportunities provided by the GI bill, the widespread use of the automobile, and the growth of suburbia all tested the strength and vitality of the ethnic neighborhood. In the end, the things that characterize Pittsburgh's past and present are its distinct neighborhoods.

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[1] John Bodnar, Roger Simon, and Michael P. Weber, Lives of Their Own: Blacks, Italians, and Poles in Pittsburgh, 1900-1960 (Chicago: University of Illinois Press, 1982) 20.

[2] June Granatir Alexander, "Staying Together: Chain Migration and Patterns of Slovak Settlement in Pittsburgh Prior to World War I," in Emigration and Immigration: The Old World Confronts the New, ed. George E. Pozzetta (New York: Garland Publishing, 1991) 4.

[3] June Granatir Alexander, "Staying Together: Chain Migration and Patterns of Slovak Settlement in Pittsburgh Prior to World War I," in Emigration and Immigration: The Old World Confronts the New, ed. George E. Pozzetta (New York: Garland Publishing, 1991) 5.
[4] John Bodnar, Roger Simon, and Michael P. Weber, Lives of Their Own: Blacks, Italians, and Poles in Pittsburgh, 1900-1960 (Chicago: University of Illinois Press, 1982) 24.
[5] Ibid. 25.
[6] Ibid. 76.
[7] Ibid. 76.
[8] Ibid. 77.
[9] Ibid. 81.
[10] Ibid. 192.
[11] Ibid. 193.
[12] Ibid. 193.
[13] Ibid. 195.
[14] Ibid. 196.
[15] Ibid. 201.
[16] Ibid. 202.
[17] Ibid. 219.

2

Black Migration to Pittsburgh: The Tenets of Black Life That Confound Efforts to Combat Disease

Frank Ligons

As AIDS and HIV rates increase in the African-American population of Pittsburgh, we are forced to look deeper into the tenets of black life which may be responsible and may give us clues on how to help. Research which discerns fact from fiction and gives insight into the black community, its fears, ambitions, motivations and perspectives, gives us the information we need to better serve this marginalized segment of Pittsburgh's population. Top down policy decisions that do not take into account such factors are doomed to fail. Failure in this case literally costs lives. The stakes are high, and therefore merit an analysis which highlights the salient trends in the black experience in Pittsburgh which have led to the current attitudes and behavior which put the black community in such great peril. Careful analysis of the past 100 years of Pittsburgh's black history brings us closer to being able to confront AIDS/HIV more successfully. What should we do? There is no simple answer. However, this research has distilled a web of factors from historical research which shed a lot of light on the issue. The sad reality is that, given the dynamics of the black experience in Pittsburgh, it is not hard at all to see why the black community is being disproportionately affected by AIDS/HIV and a host of other socio-medical problems. Everything from poor education and information networks to institutional reproach has kept blacks, especially in the Pittsburgh area, amongst the dregs of American society.

The difficulty in explaining the situation of blacks in Pittsburgh is in attempting to dissect the interlocking grid of factors which have culminated in the present situation. In 1850 the status of the black community was seemingly easily appraised as "small, impoverished and victimized."[1] As is often the case, *looks can be deceiving*. The pre-civil war community benefited from the establishment of two black churches, the African Methodist Episcopal Church (AME), and AME Zion. AME Zion alone ran four benevolence societies, a private school, militia, temperance society and a cemetery.[2] Early leaders of this church-based black community knew the value of education and put great emphasis on it. Some of these same men became the first blacks to graduate with medical degrees in the United States. They stressed "culture, gentility..and education."[3] They were ambitious and resourceful, and when, for example, their

children were turned down by local public schools, they simply founded their own. Blacks in this period were a minority, but a self-sustaining and innovative community that took care of their own and would eventually comprise the black upper-class in Pittsburgh.[4]

By 1900, the older generation of pre-civil war blacks had built up quite a refuge in the midst of racial conflict and chaos. Clustered together, they had formed fraternal associations which eventually led to the foundation of churches. "The black church in Pittsburgh permeated all facets of black life."[5] And so it did, providing various employment, health and educational services to a segment of the population that had no other support. The older milieu, which dominated the church and the fraternal society scene, supported a wide range of social and cultural clubs, societies and organizations which were all directed at informing and supporting the community. Such clubs frequently hosted events featuring distinguished lecturers, authors and musicians.[6] All of this organization was made possible through the support of black-owned and run businesses which prospered in this period. One count of black-run establishments in 1909 yielded 85 such businesses, some of which were major operations.[7]

Despite their respectability, the black community's settlement in the Hill District stimulated a mass migration of native-born whites from that area which reduced their percentage from 60% to 10% between 1887 and 1900.[8] This "white flight" was only the beginning of the abandonment of so-called "black areas" that would characterize Pittsburgh over the next 100 years. But even so, all things considered, this was a good time to be black in Pittsburgh. Blacks lived in a small and unified community, ran successful businesses, developed extensive support networks, and did not yet have to face the insidious overcrowding, racist occupational and housing practices, and general fragmentation of the black community which would really begin around 1910.

The decade starting with 1910 saw a 47.2% increase in the black population in Pittsburgh.[9] This period marked the beginning of the degeneration of all aspects of black community life. Housing was scarce even before 1910, but as more blacks flooded the city, housing became horrendous. Because blacks were not welcome in most sections of the city, they were all funneled into the Hill District and progressively Homewood-Brushton and East Liberty, with a few heading off to the North Side. Times were tough. A study in 1918 revealed that 95% of black industrial workers were in unskilled positions.[10] This of course meant low wages and concomitant poverty, poor housing, malnutrition and little to no education. Another tabulation in 1910 found one-third of black males in domestic positions, and four-fifths of black industrial workers "at the bottom of the occupational hierarchy."

The steel industry in this time period was the most prosperous, but only around 11% of the black population (with 10.8% of the total being northern born; being northern born and an "old" Pittsburgh black entitled one to special privileges) had such jobs.[11] As a result, blacks "received the least desirable land - that with the highest density, that with the oldest and most deteriorated housing, or that located on the most formidable terrain."[12] Life for the recent migrant in particular was very difficult. The average migrant in this period barely made enough money to live, and the money he did make got him little more than a dilapidated shack and the most basic nutritional sustenance.

World War I brought in blacks, literally by the trainload. Between 1910 and 1930, somewhere between 500,000 and 1,000,000 blacks migrated from the south to the northern industrial centers, beckoned by the prospect of guaranteed employment, good wages and better treatment. It is estimated that 25,000 came to Pittsburgh in this period, bringing the total in 1920 up to 38,000 black Pittsburgh residents.[13] Wartime production, especially of steel and iron products, skyrocketed. Pittsburgh was the leading steelmaker in the world, having the highest volume of sales and possessing all the cutting edge technology. For these reasons, Pittsburgh became one of the main cities to respond to the new demand for iron and steel. Many positions opened up in the factories, due to the increased production demand, loss of the white work force which went off to war and the legislation which began restricting European immigration.[14]

Black migrants found jobs, but they also found an older, more established black community that did not welcome them with open arms. Northern-born blacks looked down on these new "backwater" migrants who were largely uneducated, uncivilized and were simply unacculturated. In this period we begin to witness a stratification which manifested itself in several ways. By 1930, there were 45 churches in the Hill District alone.[15] Some of these churches were from the older era and had a membership which was wealthier, well connected and very active in community development. On the other hand were "storefront" churches which were hastily constructed venues catering to the new migrant population. They were for the poorer, less educated and more recent migrants who had only recently reached Pittsburgh, and who were not welcomed by the established black community.[16]

Two-thirds of the 55,000 blacks in Pittsburgh in 1930 were newcomers. One-half of these came from rural areas. One third of the newcomers came straight from agricultural work in the South.[17] As far as the old black community was concerned, these people were inferior to them, in education, manners and dignity. Native-born blacks started to move away from their new neighbors. As recent migrants poured into the Hill, wealthier blacks moved to Homewood-Brushton in hopes of preserving their elite community. The problem was that 85% of the city's black population arrived after 1917, so it was hard to escape the deluge of new faces.[18] It was clear that a schism was opening up in the black community, one that would only widen with the arrival of a third wave of migrants that would show up after the Great Depression.

Living conditions in 1930 were "unsanitary, indecent and inadequate."[19] Unsatisfactory wages, racist employment policies and general employment instability made blacks "unable to uphold even the minimum standards of living necessary for health and physical well being.[20] One way in which this problem manifested itself was through the disproportionate prevalence of tuberculosis in the black community. Tuberculosis attracted so much attention that the Negro Health League was founded and conducted a study of TB exclusively in the early 1930s.

What they found was that blacks were being infected at much higher rates than their white counterparts, and were dying more too. In 1933, 4.4% of white deaths were due to TB, where 17.7% of black deaths were.[21] Members of the Negro Health League were concerned because "Negroes showed consistently higher rates both in relation to death from all causes and deaths from specific diseases."[22] The findings of the study were significant, and give us a glimpse into the aspects of black life in Pittsburgh which made them more susceptible to TB. Interestingly,

many of the same factors still contribute, albeit in some cases more indirectly, to the spread of AIDS/HIV in the black community today.

Doctors found that "Death rates were invariably higher where there were impure water supplies, unsanitary toilets, lack of private toilets, overcrowding, and inadequate light and ventilation."[23] Clearly, blacks suffered from "deplorable living conditions" that resulted from the economic stagnation following the WWI industrial boom, combined with racial discrimination which is easily and accurately summed up by the phrase *last-hired, first fired.*[24] Ironically, the jobs that blacks fought so hard for and did manage to get, were hazardous not only in the immediate sense, but were in factories where the conditions themselves led to illness and death.[25] And because employment was erratic and scarce, baseline nutritional requirements were not being met. Certain vitamin and mineral deficiencies which were common due to the average black working family's diet, greatly reduced their bodies' resilience in the face of disease. If that were not enough, the Hill District at this time had 4 times the city's average person per acre. "Black areas," especially around the Hill District were easily distinguished by their poor housing, high population density, dilapidated structures and proximity to "noxious industries."[26] All of these terrible hardships of the black experience cultivated a "fatalistic attitude" which confounded the medical community's attempts at education and prevention.[27] It is perhaps this same attitude which pervades the black community today and reduces the effectiveness of education which assumes that you want to protect yourself and that you actually **want to live**. Laurence Glasco sums up the horror and hopelessness of the black experience in his contribution to City At The Point by explaining:

> Blacks were housed in hastily constructed dormitories, confined to the hottest, dirtiest, and most physically demanding jobs, paid inadequate wages, harassed by prejudiced foremen and police, and excluded from most public accommodations. They became sick from the acid fumes, fainted from the intense heat, caught pneumonia in the drafty housing, and suffered accidents at a much higher rate than white workers."[28]

The Health League concluded their study with several suggestions which they believed would decrease the incidence of TB. Some of these same suggestions would be useful in the black community today in combating AIDS/HIV. The conclusions were that facilities for case identification and treatment were sadly lacking, far away or inhospitable to the black population. Without case identification, people who did not even know that they were infected (because TB has early stages which, like HIV, are asymptomatic.), were infecting others. Better treatment would save lives. Living conditions were also a big factor. In this category was everything from the crowded, unsanitary housing, to the malnutrition which doctors found significantly reduced

the body's ability fight off **any** type of infection. Educational programs were cited as one of the main initiatives. It was believed, even then, that by informing people about the disease and its modes of transmission, that you could reduce incidence. They also recommended that a separate branch of the health department be dedicated to TB exclusively, which would coordinate all efforts to fight the disease.[29]

New migrants, who were disconnected from the established black community, lacked access to better education (if only informal), facilities and support. Fragmentation of the black community along class and color lines cost all blacks the political solidarity necessary to force local government to respond to their needs. "Mini-ghettoes," which divided older migrants from the more recent and the middle class from the laboring masses, hindered the black community's hopes of leveraging benefits or services from a nearly apathetic government apparatus.[30] This political weakness offended one writer of the *Pittsburgh Courier* so much that he wrote that Pittsburgh blacks were "the most backward Negroes to be found in any large city."[31] Poor political and civic participation and organization would haunt the black population of Pittsburgh for the rest of the century as new issues of unemployment, housing, urban renewal and disease would go insufficiently addressed. The writer to the *Courier* may have been right, but for reasons he did not fully understand.

Many factors contributed to the disunification of the black community. One was the prejudice which pre-civil war black families felt towards a group which they believed (and in some sense they were correct) ruined their status and credibility, and overall drained the black community's resources. Trying to teach, support and acculturate so many "backward" migrants was simply too much for the city's black leadership.

A second, and less understood issue, is that of the new migrants' general apathy. Migrants coming from the South were used to a life of self-reliance. They were accustomed to not having the government's support in the problems they faced. And they knew, at least in the South, that political demands were either ignored or violently rebuffed. These downtrodden people brought that mentality with them, and it was hard to change a perspective on the world that was so deeply ingrained over so many years. Even as black leadership was trying to encourage the new migrants to take advantage of the different, and supposedly, better situation here in Pittsburgh, blacks were still being treated poorly by almost every institution which they came in contact with in their daily lives. Restaurants, department stores, clubs, theaters and hotels all regularly turned blacks away, or at best, treated them with condescension and suspicion. These experiences only galvanized the southern black's philosophy of apathetic disconnection from anything that may seem "uppity." It also heightened their anxieties about white public service institutions like hospitals, police stations and welfare agencies, which still operate today to keep them away.[32] Black agencies, particularly the Urban League "extended practical assistance, but often with a condescending attitude."

> "The conflicting impulses to welcome and to guard against the migrants - exemplified in the social welfare program of the Urban League of Pittsburgh -

> curtailed elite blacks' gatekeeping role in southern blacks' settlement."[33]

In short, black migrants could not, and often did not, trust anyone who was trying to help. From the medical standpoint, this perspective on life can be deadly.

Thirdly, the distribution of the black population around geographical barriers such as hills and rivers, prevented a fluid transfer of citizens and ideas.[34] Black communities became an "amalgamation of geographic areas rather than unified neighborhoods."[35] And even when blacks were grouped together, their community was hardly identifiable because of the domination of other ethnic groups, either in sheer numbers or in organization. In this sense, there were no true "black" neighborhoods until after World War II when segregation along race lines became the standard.

To sum up, just about everything kept blacks from getting the services they needed. Racism, economic stagnation and decline, geographic dispersal and socio-economic differences within the black community all kept blacks as a people from the successful organization required to defend their rights and protect their interests.[36] This situation has not improved much over the years, and is largely responsible for the lack of institutional response which in the case of AIDS/HIV, is costing lives.

The Great Depression years in Pittsburgh were especially rough for the black population. By 1935, only 23% of the Hill District's housing was classified in "good condition," with the other 75% being either "livable," "in need of repair," or plainly "unfit for habitation."[37] Migrants found themselves living in everything from converted railroad cars to boathouses. Between 33 and 40% of black adults were unemployed, and therefore with adequate food, shelter or service.[38] It was in these conditions that TB thrived.

Laurence Glasco points out that the falling off of the steel industry actually began after WWI. So, in fact, most migrants were coming after jobs that would not last anyway.[39] The deindustrialization following WWII especially devastated the black working class. Blacks found themselves in a bad spot. When everyone else was buying homes and building up equity, blacks were still almost exclusively renters.[40] The modestly-sized home owning community that existed in the Hill District was being uprooted by urban renewal projects.[41] Over 1500 families were pushed from their own homes with virtually no organized protest. Most of these families moved into other black neighborhoods such as Homewood-Brushton and East Liberty, which triggered another wave of abandonment, now from those areas, by middle class whites **and** blacks.[42]

In this period the third strata of the black community materialized. Composed of "transient casual day laborers, river boat hands, indigents, drifters, and the physically or emotionally handicapped."[43] As if that were not enough, they were uneducated, recent arrivals from rural backgrounds. They, more than even the now semi-established migrant community, met with scorn, both from the established black community and the white institutional infrastructure. Divisions were so palpable and contentious that the *Courier* wrote a piece urging people to "tolerate" the new black migrants.[44]

After World War II, blacks had no choice but to try to make the transition into non-manufacturing industries such as construction, transportation and sales. A small black middle-class started to develop. Migration from the south came almost completely to a halt.[45] School segregation emerged as a method through which to keep the black population in "its own areas."[46] Other than that, things did not change much. As recently as 1987, a national study found that the economic disparity between blacks and whites in Pittsburgh ranked 41st of 48 major metropolitan areas. This assessment reveals the shortcomings of attempts at black political organization in the area. Over 100 years after the first black community was established, the average black family makes only half what the average white family makes and suffers from an unemployment rate which is 3.5 times higher than their white counterparts.[47]

Many factors stifled the growth and well-being of the black community. "The unified institutional infrastructure that aided in neighborhood creation for other groups, failed to materialize for blacks."[48] Life was further complicated by low wages and scarce and erratic employment. This led to difficulties in trying to meet and maintain adequate housing and nutritional standards. To make matters worse, the black establishment was, at best, tentative in their efforts to show these new migrants the way to security, health and prosperity. As a result, political solidarity was a dream that could never be realized, and costed the black community jobs, housing and public services that they desperately needed.

All of these factors have culminated in a fatalistic attitude towards life in many of the city's black neighborhoods which makes it difficult to motivate people in ways that would improve their quality of life, or save it, in the case of AIDS. As for turning to help outside of the black community, there is still a distinct residue from past experience which makes the average black citizen hesitant to approach a "white" institution. This web of misfortune, racism, division and disorganization is partly responsible for the AIDS/HIV epidemic in the black community. And only through learning from the past, do we have a chance at effectively reaching these communities in ways that secure their future.

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21. Negro Health Survey of Pittsburgh, Pg. 10.

22. Negro Health Survey of Pittsburgh, Pg. 8.

23. Negro Health Survey of Pittsburgh, Pg. 65.

24. Glasco, Lauren. "Double Burden: The Black Experience in Pittsburgh." Pg. 79.

25. Bodnar, et al, Pg. 90.

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3

The Hill District

Rosalyn Rice

Urban renewal efforts, despite the intentions to improve the economic conditions of the community, often facilitate deterioration within some communities. The Hill District provides a noteworthy example of the negative impact of urban redevelopment on a neighborhood. To explain how urban redevelopment adversely affected the Hill District necessitates the discussion of psychiatric and psychological research. Secondly, a model explaining the relationship between neighborhoods sources of support and health- related variables also illustrates the harm caused by urban redevelopment. Finally, providing an analysis of the chronological stages that characterize the Hill District and especially the Hill House depicts the effects of urban redevelopment on the Hill District.

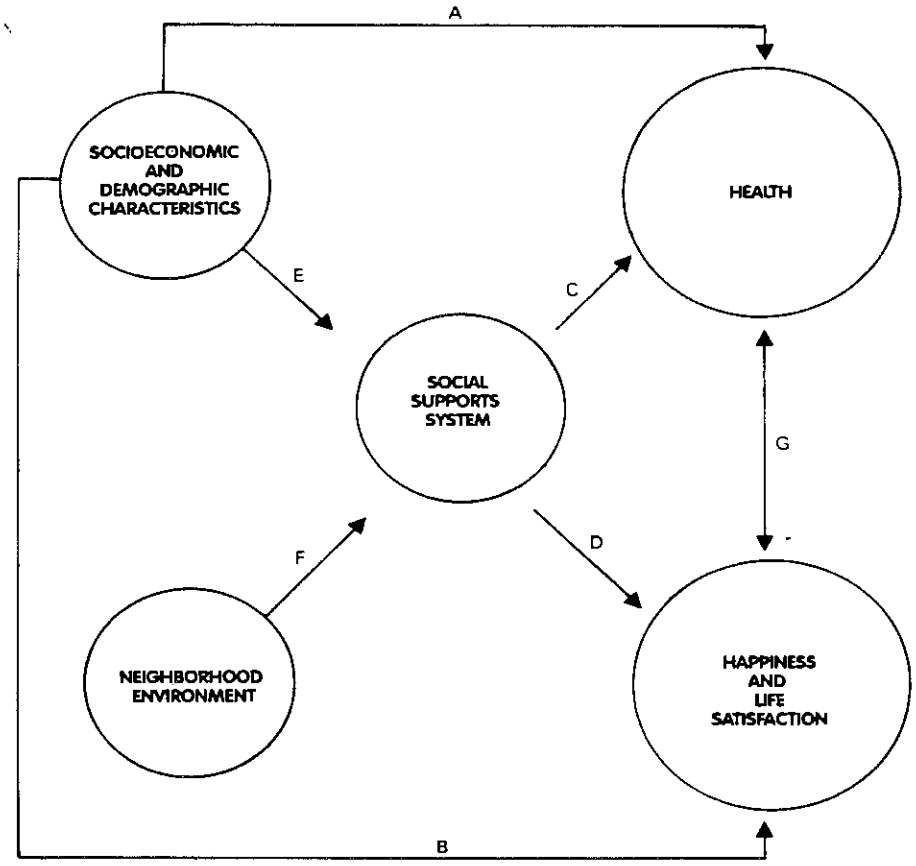
Interesting psychiatric research provide the theoretical concepts mentioned above concerning neighborhood and place. Noted psychiatrist and mental health advocate, Dr. Mindy Thompson Fullilove describes displacement as a "rupture off familiarity, attachment, and identity of space resulting in disorientation, nostalgia and alienation (and) concluding in an undermined state of mental and physical health".[i] She also advocates that neighborhoods provide their own resources and support networks that help the neighborhood inhabitants cope with the many changes and hardships that they encounter. Neighborhood stability also provides the necessary social fibers for a sense of community and strength. If these neighborhoods are destroyed and their inhabitants are displaced, the chances of rebuilding the same cultural, economic and social networks within other neighborhoods are slim. Moreover, the added stresses of being displaced furnish a higher unlikelyhood of success within a new area.

Psychological studies have also found that major social problems such as the spread of AIDS, drug use, violence and teen pregnancy are disproportionately large among the uprooted urban masses.[ii] Many urban communities consists of high unemployment rates, low educational attainment and higher incidences of impoverished neighborhoods. These factors contribute to the crippling of many urban neighborhoods by the social problems listed above.

According to these two bodies of theory, the burden of many social problems stems from the displacement of neighborhood inhabitants from their home. These studies show that "marginal' people (for example , those who have undergone frequent occupational transitions) as being more susceptible to disease.[iii] Neighborhoods provide critical resources such as community, economic and social networks. Marginal people need those resources even more because these populations have more to deal with. In contrast, marginal people also have less resources to draw from at a time of need. An established neighborhood equip marginal people with the support needed to survive and ultimately achieve success.

As the psychiatric and psychological factors influence a community's stability, sources of support and health-related variables also impact a neighborhood's persistence after enduring redevelopment efforts. The characteristics of the individual, the neighborhood environment and the social support system influence a person's physical and emotional health. Of particular interests is the relationship between neighborhood sources of support and health-related variables. Social supports include those individuals to whom a person can turn for interpersonal aid or assistance, as well as neighborhood institutions which do or at least could provide a variety of services.[iv]

There is a model that serves as a framework for this and helps to explain the relationship between neighborhoods sources for support and health-related variables. It specifies that certain aspects of a person's health and attitudes about life are influenced by socioeconomic factors of the person (links A and B) and by the characteristics of the social supports system (links C and D), including whether or not it is based in a wider community. The features of the social support system are, in turn, influenced by some of the socioeconomic and demographic attributes of the person (link E) and by some of the characteristics of the neighborhood environment (link F). There is also a direct link between happiness and life satisfaction and health (link G). (see model)



Many urban renewal efforts created dislocation for urban neighborhood inhabitants. The high incidence of dislocation destroyed innumerable neighborhoods and stripped away

those very resources that the community relied upon to survive and succeed. Such was the case in the Hill when urban redevelopment depleted its vitality.

People use both the neighborhood and the wider community to meet their needs. However, for some groups of people, the neighborhood is much more important than it is for others. For instance, age, income, family composition and race makes a difference. One of the main reasons why these characteristics create a vast difference is because of the lack of mobility that accompanies them. Older people, those with less income and African-Americans are more dependent upon their neighborhoods than other groups of people. These populations depend more upon their neighborhoods because of the security it provides for them. These marginalized populations must endure the many changes imposed by outside forces.

One conclusion drawn from this data is that people need a place to belong; a geographic center, site, situation, or location for events. "Place is understood as the sum of resources and human relationships in a given location. Place can also be defined as the provision of space for human interactions occurring in a given location." Human survival depends on having a location that is good enough to support life. Although place entails the external realities within which people shape their existence and the object of human thought and action Affiliation with a place provides a person with a conscious sense of identity to that particular community. Thus, place sets the conditions for human consciousness. It also provides the physical structures with which human relationships develop.[v]

At the heart of the experience of displacement is the sense that one is without a place of residence and lacks a place of belonging. The reconstitution of order depends on the re-establishment of a health-promoting habitat and affirmation of each person's sense of belonging to that place. Success in accomplishing these tasks can be measured by the following criteria:

1. People live in a "good enough" place
2. People feel settled in home , neighborhood and region.
3. People contribute to caretaking of the personal and shared portions of the environment.
4. People know their neighborhoods and interact with them to solve communal problems. (M. T. Fullilove. Psychiatric Implications of Displacement: Contributions from the Psychology of Place. American Journal of Psychiatry. 153: 12. Dec. 1996. 1521.)

Fullilove explains that to achieve these goals, a series of steps are required, a strategy called "empowerment collaboration". Empowerment collaboration provides the key tool for addressing each of the three areas: reestablishing familiarity, repairing attachment to place, and stabilizing place identity. At the onset people must conduct a detailed assessment of the environment. On the basis of that assessment, they can create a list of priorities to guide the assignment of resources. Where displaced people lack sufficient resources of their own, negotiations with unaffected communities should be initiated. Secondly, people must start working together on rebuilding activities of all kinds. While the rebuilding progresses, people must also attend to emotional needs of mourning the lost place and to bond to the new place. Essential for the survival in a new place, the incorporation of rituals from the old place into the rituals of the new place provides continuity and assimilation.[vi]

Finally, the evolution of the Hill District described in four stages illustrates how urban redevelopment harmed this community. The creation and duration of the Kaufmann Settlement House from 1895 to 1920 characterizes the first stage. Secondly, the Hill District Black Renaissance from 1920 to 1955. The third stage 1960 to 1990 represents the Hill District's deterioration due to the consequences of urban renewal in the next stage. The last historical phase represents the present which symbolizes new hope for the Hill District through community empowerment.

The Irene Kaufmann Settlement located in the Pittsburgh's Hill District, 1895-1920 provided social, civil health, recreational and educational activities for the Pittsburgh and especially the Hill District community. The settlement founders intended to alleviate the overwhelming burden that confronts many immigrants such as learning a new language and often new occupations. The settlement also provided low-cost or no cost health care, such as vaccinations and medical checkups, to the immigrants of Pittsburgh. Although the settlement founders planned to help Jewish immigrants, within fourteen years the settlement expanded both physically and financially.[vii] The settlement expanded because of the Great Migration of African-Americans to Pittsburgh from 1917-1920. The Great Migration permanently altered the racial make-up of the Hill District. The Kaufmann settlement soon began to serve the African-American community. Although the Irene Kaufmann settlement granted a generous proportion of services to the African-American population, much of it of an almost pioneer nature did not freely admit African Americans on equal terms of opportunity.[viii]

The 1920's symbolized a change for the Hill District .As the racial composition of the Hill District transformed, so did the organization of the Kaufmann Settlement. The Irene Kaufmann Settlement evolved into the Hill House and began to serve its predominately African-American community. About 45 percent of the African -American population lived in the Hill District at that time.[ix] The Pittsburgh's Black Renaissance began in the Hill District which enabled the Hill District community and its inhabitants to become the vibrant center of Pittsburgh.

The Hill District modeled Harlem in many ways throughout the 1920's to 1955. First, the Hill District was also categorized as the "Little Harlem" of Pittsburgh. Paved with jazz clubs and restaurants, Wylie Avenue was the center of activity, harboring great music, art, and literature. African-American owned institutions such as the Pittsburgh Courier, political offices and African -American based sociopolitical organizations such as the Pittsburgh Urban League and the NAACP Pittsburgh Chapter until the late 1950's.[x] The plans for construction of the Pittsburgh Civic Arena in 1955 marked the decline of the Hill District role as Pittsburgh's cultural hub. Although the construction of the Pittsburgh Civic Arena was a portion of new urban renewal plan, the demolition a large portion of the Hill District destroyed the community's vitality as well. Urban redevelopment devastated the African-American community. It literally knocked down the Hill District's economic base and displaced thousands of residents.

Over thirty years of more than one third of the area's housing units had undermined community structure and altered individual lives. Many residents lost their homes and all have lost what their communities used to be. In addition, the Hill District changed from one of the most charming and dynamic sections of Pittsburgh to one of the poorest within thirty years. Poverty, now a major condition, pervades the Hill District. This is true with regard to housing and recreational facilities. Services tend to be proportionality less available rather than more available in proportion to the need. This naturally leaves African-Americans with less assistance, less medical care, less social work services and less group work facilities.

This comparison is noteworthy because the end results of urban renewal that occurred in Harlem mirror those that occurred in the Hill District. This proposition is supported by a finding in a study of displacement in the Harlem section of New York City (M.T. Fullilove and R.E. Fullilove, 1996). This predominately African American communities that was noted for their contributions to sports, art and politics yet deteriorated significantly due to the effects urban renewal had upon their communities. Similarly, Pittsburgh's Hill District, a once vibrant cultural hub, shattered as redevelopment efforts took over.

Community housing within the African-American community is a major aspect of the dominant social problems. Moreover, the problems with public housing within the Hill District described the most concentrated and lowest standards recorded by The Real Property Inventory. (See Table 1)

Condition of Sample Units in Four Selected Areas of Pittsburgh

Place	Total Units	In Good Condition*	In Need of Minor Repairs*	In Need of Major Repairs*	Unfit*	Condition Not Reported*
Mt.Washington	6,145	38.5	46.3	12.7	2.4	0.1
Hill District	13,942	23.3	42.9	24.7	9.0	***
East Liberty	8,169	35.4	49.3	13.5	1.8	***
Homewood	9,783	50.4	41.6	7.2	0.8	***

*percent of units in each area which were public housing units
Source: The Real Property Inventory

The table shows that the largest African-American populations four neighborhoods, of which the Hill District comprises one of the poorest groups.[xi] Affordability of housing and the quality of the environment motivate African-Americans to live within these neighborhoods. African-Americans experienced the effects of housing market discrimination which , until the last decade, had restricted their mobility. In addition, African-Americans have also been forced to move by factors over which they had little control such as the construction of the Pittsburgh Civic Arena over a large portion of the Hill District.

Urban renewal in Pittsburgh destroyed several African-American neighborhoods and necessitated the movement of thousands of African American households. Many families were forced out of their homes by the Redevelopment project in 1963. Redevelopment was intended to be an experiment to create private housing in neighborhoods where new construction was stagnant.[xii] Usually , only residential buildings were demolished and other "substantial" buildings such as churches, were left alone. However, the Planning Commission plans indicated otherwise. Out of the six areas targeted in the renewal plans, only two were specified for residential purposes, the Lower Hill District east if Grant Street and Area #3 on the south of Bluff Street.[xiii]

Numbers illustrate that most of the displaced population was African-American as a direct result of the Redevelopment Project. In the 1960's, four African-American families for every white family were forced out of their homes and relocated. As a result, most of the areas used as part of the Redevelopment Project were mostly African-American. For example, the Lower and Upper Hill alone contained 68% of Pittsburgh's African-American population. In addition, half of the city's African-American residents lived in public housing units. [xiv]

Through redevelopment, more expensive homes were built, which drove African-Americans out of certain areas. With an average price of an African-American owned house being $9,000 in 1955,[xv] the lack of housing within an adequate price range led to an increased population of African-Americans in public housing.

In the book, *Neighborhoods, People and Community*, Roger Ahlbrandt Jr. beaks down Pittsburgh neighborhoods into three categories: high, moderate and low income. The Upper Hill District fell in the lower moderate income range whereas the middle and lower Hill districts fell in the lower-income range. Ahlbrant described these neighborhoods as primarily renter neighborhoods (homeownership for this group is 39 percent) with a low

level of resident satisfaction. The mean length of time lived in these neighborhoods is one year more than the city -wide average.

Neighborhood	% satisfied with neighborhood *a*	Average number of years in neighborhood *c*	% of home ownership	% of African American s
Hill District-Upper	79	26	70	76
Hill District-Middle	37	27	51	98
Hill District Lower	50	26	54	92

a Percentage of persons rating the neighborhood a good or excellent place to live
Source: *Neighborhoods, People and Community*

These statistics display that the Middle and Lower Hill District neighborhoods are those with the least internal social strength due to their dissatisfaction of their respective neighborhoods, have the lowest income, least homeownership, and the lowest average tenure within their neighborhoods. These neighborhoods are unusual to a certain extent. The Middle and Lower Hill District are predominately public housing communities. Large amounts of property acquisition for commercial use and demolition or residential properties has occurred as a result of urban renewal programs. Consequently, the internal dynamics and social fabric of each neighborhood have been influenced by the actions of an external force.

The Hill House leadership and community activists outside of the Hill House leadership understood that community empowerment provided the key for enabling the Hill District to become the community it once resembled. Numerous community leaders saw the need for stability within the Hill. Community activists and the Hill House decided to work together to combat the social ills that plagued their community. The Hill House created and supported programs that responded to the needs of the Hill District. The programs ranged from support to teenage mother, occupational skills training courses to literacy courses for adults and peer mentor partnerships between school-aged children within the Hill District and minority college-aged students within Pittsburgh.

An example of one agency that uses this strategy is the Hill District Community Collaborative. This agency is one of several agencies based within the Hill House. The Hill District Community Collaborative, designed to assist in fostering a healthy community, advocates and plans for policies and services that strengthen families. The goal of this particular agency is to reduce substance abuse, increase school achievement , and the overall enhancement of the health and well being of residents of the Hill District community.[xvi]

The Hill District Community Collaborative began in 1992. The United Way convened a series of meeting with social service agencies in the Hill District, Homewood-Brushton and McKeesport to strategize around the findings of two portfolio studies-one on the prevention of school failure and the other on substance abuse. The link between the two studies were apparent, but the methods for addressing them were not so evident. However, one thing was certain, the traditional ways of delivering services to the affected population was incomplete. The United Way asked each of the communities to develop creative,

nontraditional approaches to providing to serving substance abusing women and their families. Each community developed its own model for collaboration, identified a lead agency and submitted a proposal. The proposals were funded in 1992.

With the input and support of affiliated organizations and institutions, the Hill Collaborative strives to offer services in a sensitive, organized and cost effective manner. Instead of focusing on what individual agencies could offer the participants, the Collaborative emphasizes the positive outcomes which could occur when social service providers work collectively to assist participants.

Some agencies that are partners with the Collaborative are:[xvii]

Allegheny County Health Department
Center City Health Center
Pittsburgh Housing Authority
Families Facing the Future
Mercy Hospital
St. Francis Hospital
Pittsburgh Coalition Against Substance Abuse/Minority AIDS Working Group
Pittsburgh Aids Task Force

These agencies work together to service the collaborative participants as well as participants within other agencies within the Hill House. This system of collaboration is key because it indicates one agency alone cannot support the different needs of a community. Community inhabitants have different needs and these needs can be serviced in different levels by different agencies.

Pittsburgh urban renewal efforts severely devastated the Hill District. Both psychiatric and psychological theories and studies explores the negative impact of redevelopment. Furthermore, a model describing the relationship between sources of support and health-related variables illustrates such an effect. Finally, four historical stages illustrate the deterioration endured by the Hill District. Despite historical and current struggles agencies such as the Hill House and Hill District Community Collaborative have given this community renewed strength and hope through community empowerment.

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[vi] Fullilove, MT: Psychiatric Implications of Displacement: Contributions From the Psychology of Place. American Journal of Psychiatry 1996; 153-1516-1523.
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[xiv] Ibid.
[xv] Jacqueline Welsh Wolf, "The Changing Pattern of Residence of the Negro in Pittsburgh, Pennsylvania, With the Emphasis of the Period 1930-1960," diss., University of Oxford, 1964,65.
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4

A History of Public Health and Sanitation in Pittsburgh

Sravan Narayan, Rebecca Campbell

4.1 Introduction

Because of its rapid growth during the industrial age, Pittsburgh was plagued with the problem of providing for sanitation in a quickly changing environment. With the growth of industry, Pittsburgh became known as the "Smoky City." A visitor walking outside at midday commented, "still the daylight makes little progress; which we excuse on the ground that it has much to contend with in Pittsburg."[1] It has been seen as a filthy place, not a good place to live, and even an unhealthy place. Pittsburgh has recently turned this image around, but not without many years of struggle.

Cleanliness and public health were not always high on Pittsburgh's list of priorities. Being an industrial city, Pittsburgh did not want to hinder its economic development and concentrated on developing industry rather than keeping its residents healthy. When a choice had to be made between investing in development and investing in public health, further development usually won out.

Although the Board of Health attempted to control public health in Pittsburgh, it did not exert enough influence to make a real difference. Government funds went to areas of higher importance to the public.[2] Because of this, Pittsburgh was slow to adopt sanitation technology. It was not until 1907 that the city built a water filtration system. When it was built, typhoid rates sharply declined.[3] A sewer treatment system was not put to use in Pittsburgh until 1959.[4]

One author said that the problems of street cleaning, sewerage, water supply and garbage removal grew like baobobs. She explains, "A baobob is something you will never, never be able to get rid of if you attend to it too late. It spreads over the entire planet. it bores clean through it with its roots. And if the planet is too small, and the baobobs are too many, they split it in pieces."[5]

In Allegheny County and in the city of Pittsburgh, there has been a consistent discrepancy between the diseases which took the highest toll in human life and those which received the most attention by the Board of Health.[6] In the 19th Century infectious disease was defined as small pox, scarlet fever, cerebo-spinal fever, measles, whooping cough, diphtheria, and typhoid fever. However, consumption, pneumonia, bronchitis and other often diseases which caused more deaths were omitted.[7]

Tuberculosis, pneumonia, diphtheria, typhoid fever, and bronchitis killed more people than cholera or small pox, but people did not fear them. They were considered to be normal, and were only a cause for concern when the death tolls were much greater than usual. In Pittsburgh, historically, health officials had a crisis mentality toward disease control and reacted only to immediate needs.[8]

3.2 Evolution of Disease Theory

For most of the nineteenth century there was a belief that disease was caused by gases in the atmosphere. These gases were created when decaying organic matter was left in the environment. The gases, called miasmas, were thought to seep into homes and make the inhabitants ill. It was stated that "infectious diseases were caused by emanations, gaseous or otherwise, from decaying matter..." and that everything dirty or nauseous would cause sickness. However, this believe begged the question, why did filthy areas of the city often escape disease while relatively clean areas were afflicted.[9]

Public health officials in Pittsburgh at this time based their policies on a belief in "Filth theory." This theory stated that bad health came not from contact with those who were infected but from one's environment. One author wrote that Pittsburgh suffered from "crowded tenement districts, chronic health problems, billowing smoke, polluted waterways, and mounds of putrefying garbage."[10]

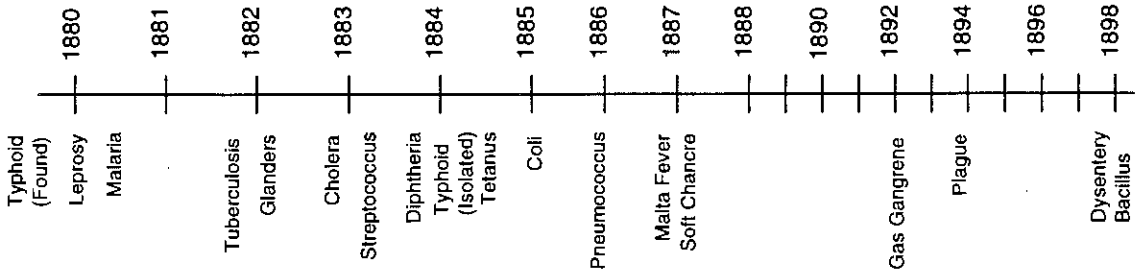
Officials believed that unsanitary conditions, filth and dampness were the cause of the spread of diphtheria. Sudden outbreaks of diphtheria in areas without adequate sewerage seemed to back up this belief.[11] In 1851, the Board of Health was devoted to removing all objects which may have tendency to endanger the health of the citizens.[12] They stressed "municipal cleanliness as the alternative to epidemics of disease."[13] Many believed that "Cleanliness of man makes a good man, and cleanliness of city makes a good city."[14]

Experience encouraged the belief that dirt caused disease in Pittsburgh, because death rates were high in areas with poor sanitary conditions. Because of this, health officials dedicated their funds to the improvement of drainage and sewers, the need for a satisfactory water supply and the removal of garbage and other nuisances.

The environment was also believed to affect the moral behavior of the working class and immigrants. People believed that environmental betterment meant moral betterment. There was a belief that filth and immorality were the primary causes of disease.[15] There was a belief that affliction with cholera was due to personal wrongdoing. Officials felt a need for city parks and playgrounds, so that citizens would have a place for recreation.[16] There was also a great concern over the amount of smoke present in the city. It caused a layer of grime and killed much of the vegetation.[17]

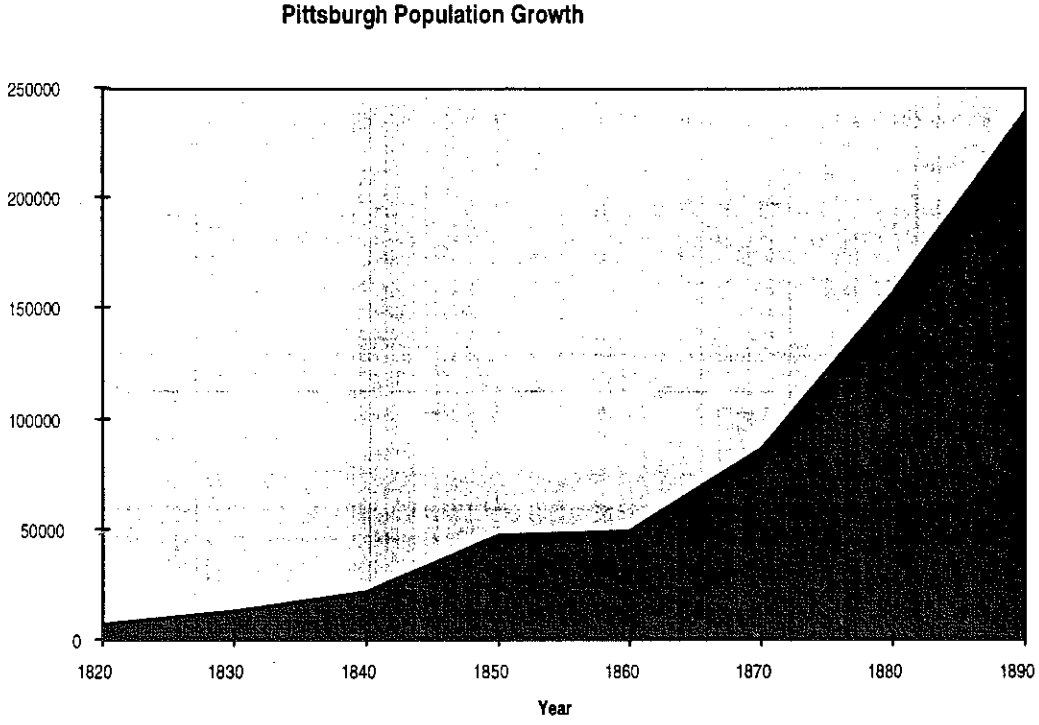
Even as the science of bacteriology made progress, actual practice was slow to catch up. It was in the late 19th century that scientists discovered microscopic organisms which caused disease and realized that the cause did not lie with miasmas.[18] The following chart shows the dates when the specific organisms which caused diseases were identified.

Figure 4.1: Timeline of Disease, 1880-1900



In 1895, the city of Pittsburgh created a division of bacteriology within the Board of Health. However, physicians still had difficulty discarding the miasma theory. They believed that until the bacteriologists had complete success, the health of mankind would be best preserved by observing the rules of good living. These were "good air, good food, good clothing and good habits." They also felt that officials should continue to execute "intelligent quarantine and rigid isolation." So, during the transition from one theory to another, the bacteriologists and sanitarians co-existed.[19]

Figure 4.2: Pittsburgh's Population Growth



4.3 Water Sanitation

During the period from 1800 to 1851, the growing population meant a growing need for water, and the city sponsored projects in an attempt to secure abundant supplies

of water.[20] Also, the increase in usage of water meant an increase in waste water. This was often tossed into gutters, cesspools, alleyways, or yards. This increase in the amount of waste water caused pools of stagnant water to form around the city.[21] However, because waste removal did not bring in revenue the way water supply did, the government left it up to the private citizen.

For many years waste was put into cesspools and privy vaults and removed by paid scavengers who then dumped it in nearby streams and rivers. Wastes were often carried through the city during the working day, and many citizens complained that the wastes would spill causing foul odors in the city.[22]

The Board of Health instituted a law stating that privy vault owners would be charged a $20 fine if their vault caused an odor. There were also laws regulating the construction of privy vaults. These were intended to help reduce the chance of leaks.[23]

In the 1830's the water closet was introduced. Because it used water to remove human wastes from the interior of a dwelling, it increased the problem of waste disposal. Privy vaults would quickly overflow, because they were not designed to hold the large amounts of water produced by a water closet. The waste water would saturate yards, flood cellars, and contaminate ground water used for drinking.[24]

The storm sewers at this time were used for all sorts of waste, because people believed that rainfall would carry away anything that was placed there. Slaughter houses would use the sewers to dispose of animal remains and wastes. The sewers were often built of the cheapest material available which was usually wood, and would deteriorate quickly. The hilly topography of Pittsburgh caused debris from hills to be washed into sewers. Because of these factors and because the sewers were not flushed regularly, filth was allowed to accumulate and the sewers were often too clogged to flow properly.[25]

Water supply and waste removal became interdependent with population growth. Because improper disposal of waste contaminated water supply, and increased water usage added to the amounts of waste to be disposed of, each problem was intensified by the other.[26] The various sewer and water problems in 19th century Pittsburgh allowed diseases to thrive.

4.3 19th Century Diseases

4.4.1 Cholera The first diseases with public significance in Pittsburgh were cholera and smallpox. Cholera is another water-borne, bacterial disease (*Vibrio Cholerae*), which symptoms include severe vomiting and diarrhea. Cholera is endemic to tropical Asian populations like India, and periodically causes epidemics in temperate climates. In 1832, a cholera epidemic hit coastal cities of Europe and the US and spread rapidly inland. The *Pittsburgh Gazette* first reported the dangers of Asiatic cholera on June 22, 1832, listing precautionary procedures used in Paris to slow the epidemic. The city of Pittsburgh spent nearly $8,000 on removal of garbage and street cleaning. Fortunately, the city was spared the 1832-4 epidemic levels of mortality that struck elsewhere, but in 1849, under less scrutiny and anticipation than in 1832, cholera struck Pittsburgh. Recently opened Sisters of Mercy Hospital (1847) immediately became a "pest house," and was a source of public backlash.[27] The 1849 epidemic caused the city of Pittsburgh to create its Board of Health in 1851 to control infectious diseases.[28] In

1854, a cholera epidemic reached its highest mortality rates in Pittsburgh. The crisis reached the point at which the city burned piles of bituminous coal in the streets in hopes of cleaning the air.[29] Ironically, earlier that year, an English physician, John Snow, determined that cholera was water-borne, however his findings were not widely accepted.[30] Since the Board of Health was just recently created, accurate mortality statistics had not been kept in the city of Pittsburgh at the time.[31] The threat of cholera rose once again in 1891. In response to the 1854 epidemic, the city rapidly took action: the Bureau of Health doubled the size of its "sanitary force;" medical officers met arriving trains and escorted diseased persons, to a special diseased camp outside city limits; a special laboratory was created to carefully review all cases of cholera; plans were made for additional hospitals around the city; for the first time in Pittsburgh history, the Chamber of Commerce saw an adverse effect on business, and took an active role in public health. Deaths due to cholera were not listed in the 1891-92 Bureau of Health statistics, but the city was spared from another cholera epidemic.[32]

4.4.2 Smallpox Although the medical history of smallpox is different than cholera, Pittsburgh's panic driven public health policies, as demonstrated with cholera, remained. Smallpox is a viral disease, characterized by rashes and high fevers. Smallpox was first treated in Pittsburgh in 1828 with quarantine, and non-mandatory vaccination. After a major smallpox epidemic in 1871-72, smallpox vaccines were given to the public at no cost, and the city increased its sanitation measures. An 1872 law required all physicians to report all cases of smallpox, diphtheria, scarlet fever, typhoid, yellow fever, cerebro-spinal fever, and cholera. When notified, the city would send "sanitary police" to guard the house, and ensure that the house was thoroughly fumigated and disinfected.[33] In 1877 however, the Bureau of Health faced budget constraints and subsequently cut back on smallpox vaccines, causing the 1877-78 smallpox epidemic in Pittsburgh. Following another smallpox epidemic in 1882, the Bureau of Health asked for another $10,000 for vaccinations. Finally, in 1895 smallpox vaccines were made compulsory.[34] Despite this law, smallpox "became an epidemic again in 1902, 1903, and 1904, its origin at that time being traced to the camps of Negro laborers brought from the South for construction of the Wabash railroad."[35] The Board of Health subsequently ordered a house-to-house vaccination program, which, by 1912, effectively stopped smallpox in Pittsburgh.

4.4.3 Typhoid When dealing with a common water-borne bacteria like typhoid (*Salmonella typhi*) it is crucial to trace the water supply. By the late 19th century, Pittsburgh's water supply came from three sources, the Allegheny River, the Monongahela River, and wells and springs. The Allegheny River supplied excellent quality water according to the Board of Health. The water from the Monongahela, and from the wells and springs provided water to the poorer, South Side section of Pittsburgh. The water for the Monongahela was from small dams erected to catch water, which also collected filth and waste. The increase in typhoid in 1887 was traced to these sources, subsequently many wells and springs were ordered closed in 1889.[36] A medical study commissioned to examine the water supply to the South Side returned with an astonishing economic argument concerning the water supply. They estimated that each life was

worth $1,275, for 260 lives, add nursing expenses, burial expenses, lost days work due to sickness, and other miscellaneous expenses, and typhoid fever cost $480,916 per year, nearly 1/6 the total budget for the city.[37] Primarily due to it's appalling sanitation of water Pittsburgh could boast of statistics as those shown on the following page in table two.

Figure 4.3: Average Death Rates from Typhoid, 1890-1898[38]

City	Deaths per 100,000
Pittsburgh	130.0
Allegheny	104.4
Washington	59.0
Philadelphia	54.7
Baltimore	35.3
San Francisco	30.5
New York	18.2
Vienna	5.2
Berlin	4.2

Finally, in 1907 certain sections of the city had access to filtered water, and by 1909 the South Side was provided with filtered water. The city reported that with filtered water the typhoid mortality rate dropped nearly 100 points.[39]

4.3.5 Diphtheria Diphtheria follows a similar pattern of infection as typhoid. Diphtheria is also caused by *Corynebacterium diphtheria.* Table 1 shows large numbers of deaths to diphtheria, which fell on deaf government ears. Crosby Gray, a Health Officer on the Board of Health, reported in 1877, following the first large outbreak of diphtheria in Pittsburgh , "from the most reliable information and data available it [diphtheria] was due in great measure to improper and insufficient drainage and sewerage. This matter is not considered of sufficient importance by the public or by the city authorities. Although theoretically it is a subject which has engaged the attention of the Board of Health for a number of years, yet practically it has done and could do little more than recommend. These recommendations I regret to say were not always upheld, much to the detriment of public health."[40] Diphtheria struck the poor South Side communities, and young children disproportionately, therefore was not worthy of the funds of the city.

4.5 The Unsanitary Environment

In the later Nineteenth Century, the adoption of water closets by large numbers of people caused an increased strain on waste removal methods.[41] Because of the belief in

filth theory and because the city lacked adequate sanitary systems, engineers and physicians joined forces to lobby for increased sanitation.[42]

In the 1850's, the measures taken by public health officials to alleviate unsanitary conditions included disinfecting privies, sprinkling lime in streets and in gutters, and burning fires in infected districts. Fines were also instituted for failing to obey nuisance abatement. These ranged from $20 to $200.[43]

In 1866 it was evident that conditions had worsened after the Civil War. There were hundreds of filthy cellars, kitchens, yards and stables throughout the city.[44] In 1881, there were 6,500 water closets in the city of Pittsburgh, but only 1,500 of these were connected to sewers. Most of the others were connected to insufficient privy vaults or cesspools.

At this time, there were new sources of revenue for the building of street sewers. An improvement tax was adopted in 1850. Also, it was decided that abutting property owners should pay for lateral sewers, while all those in the area served paid for the main sewers[45]

The street sewers, to this point, had not been well planned. Several examples can be found of poor planning. The Twenty-first Street sewer on the Southside had several curves were it connected to other streets, these curves caused obstructions as waste was unable to make the sharp turn of the sewer. On Washington Street the sewer was too large and wasted money which could have been used for improvements elsewhere. The Forty-eighth Street sewer had the opposite problem. It was built too small and often overflowed. Because there were no topographical maps of the city until 1870, sewers built before this time were not often well planned with regard to easiest path of flow.[46] Pittsburgh's rugged topography also added to the cost of building a sewage system in the city.[47]

Because the sewers were not cleaned filth accumulated in them, often several feet deep. The sewers were filled with animal debris and other organic matter causing nauseating odors. This debris also choked the sewers making it impossible for them to work properly.[48]

Smoke was also a constant problem in Pittsburgh. In 1868, one author wrote, "Every street appears to end in a huge cloud, and there is everywhere the ominous darkness that creeps over the scene when a storm is approaching."[49] However, one Pittsburgh native defended his city. "He insists, however, that the smoke of bituminous coal kills malaria, and saves the eyesight."[50]

Because of economic limitations and the low value placed on sanitation, conditions continued to worsen in Pittsburgh. Although laws were instituted in an attempt to better the sanitary conditions of the city, there was a great discrepancy between the law and actual conditions. There was a large amount of resistance to sanitary laws. Because people were used to conditions of lower density, they did not understand the need for these regulations, and resistance ranged from apathy to hostility toward the laws. There was also the problem that different classes held different standards of cleanliness. What was perfectly acceptable to a working class immigrant might be highly offensive to a middle class housewife. Because people did not fully understand the need for sanitation, wells providing drinking water for large numbers of people were often located right next to privy vaults.[51]

The sanitary condition worsened with the increased population from 1870-1900. The population increase was caused by greater industrialization. The low paid industrial workers lived in crowded, unsanitary tenements. The residents of these areas failed to realize the necessity of cleanliness and often refused to abate nuisances. Poor sewerage along with inadequate water and drainage often led to disease.[52]

For many years, rather than building a new sewer system the city simply extended old sewers and built new ones in a haphazard, unplanned manner. One commentator noted that Pittsburgh was 50 years behind other American cities, and that it needed a well planned sewer system which was paid for by the city.[53]

In 1887, the city built a garbage furnace on Hill Street in an attempt to alleviate some of the refuse removal problems. However, this furnace was inadequate and there was no funding to increase capacity. Also, the city could not compete with industry for the use of natural gas. This shows how sanitation often came second to industry in Pittsburgh.[54]

The upperclasses did not always have the best sanitary conditions. Suburbs grew very rapidly, but because of this rapid growth the city could not keep up with building sewers to connect these neighborhoods to waste removal. Also, the higher usage of water closets among the upper class caused an even greater strain on waste removal in these areas.[55]

4.6 Comparing Regions of Pittsburgh

As it became apparent that an improved sewage system was necessary, officials in Pittsburgh began a debate over the use of combined storm and sanitary sewers versus the use of separate sewers for the two uses. Although many believed that a separate sewer would be more cost effective, others felt that combined sewers would solve both problems at once and meet more of the city's needs.[56]

Pittsburgh eventually built a combined sewer system. In 1888, the city banned the construction of cesspools in any area of the city where the sewer system was available. Later, laws were passed that required installation of water closets were they could be connected to the public sewer and banned connection of water closets to privy wells.[57]

At this time sewers still discharged directly into streams and rivers because of the belief that streams were capable of self purification if allowed to flow for a certain distance.[58]

Reports were made by sanitary inspectors detailing the sanitary condition in their districts. The following information is from the reports of 1875, but is similar to other years. Because the reports did not differ greatly from year to year we know that little was changed in response to the findings of these inspectors.[59]

The first district was bounded by Thirtieth Street, Liberty, Smithfield, the Monongahela and the Allegheny. This district contained the point which was one of the dirtiest areas of the city, as it was used as a dumping ground for the city's refuse. Also, the public market was a problem area, because it was difficult to convince merchants of the necessity of clean streets and gutters. Another problem in this district was privy vaults which were to shallow and often overflowed.[60]

The second district was bounded by Smithfield, Liberty, the Pennsylvania Railroad, Neville, and the Monongahela. This district was partially rural and the main problem reported was tenement houses which were too small and poorly ventilated.

The third district, which is defined by Morningside Road, the Pennsylvania Railroad, Thirtieth Street, and the Allegheny, was the location of many slaughter houses These slaughter houses caused problems due to animal waste. Also, vacant lots were often used by residents as dumping grounds for garbage. Other problems included inadequate drainage, unpaved streets, improper privy vaults, stables, and manure.[61]

The fourth district, bounded by Haights Run on the Allegheny, the city line, the Monongahela, Four-mile run, Neville, and Liberty. This district also contained many slaughter houses, which caused similar problems to those in the third district. Also, there were many unpaved and undrained streets and the district had no sewers.[62]

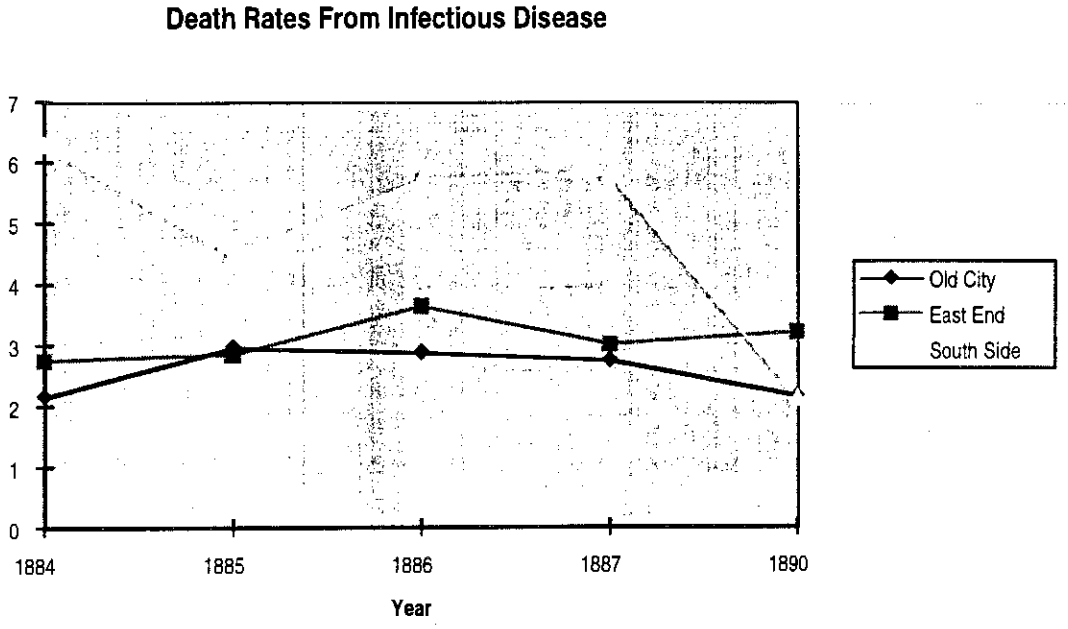
The fifth district was defined by the Monongahela, St. Clair Township, and Beltzhoover. Drainage and dumping of garbage were reported as major problems here. There was also insufficient water for operation of existing sewers and many areas had no sewers at all.[63]

The sixth district which consisted of the southwest portion of the city. Here the street were unpaved and the tenements were said to be a disgrace. The inspector said that those living in the tenements were compelled to "inhale the fumes from loathsome disease." This district also suffered from a lack of water closets.[64]

The reports of this year and subsequent years stressed problems associated with inadequate sewers, inadequate and impure water supply, and inability to contend with increasing amounts of garbage.[65] However, there is little evidence that changes were made in response to these reports.

The following chart shows the death rates in various areas of the city. The old city included the first through twelfth wards, the east end was the thirteenth through twenty-third wards and the Southside contained the twenty-fourth through thirty-sixth wards. Note that mortality rates were higher in the Southside until 1890, when the sewer system had been extended to this area.[66] Because of its inadequate and unsanitary water supplies, Pittsburgh led the nation in rates of typhoid fever deaths.

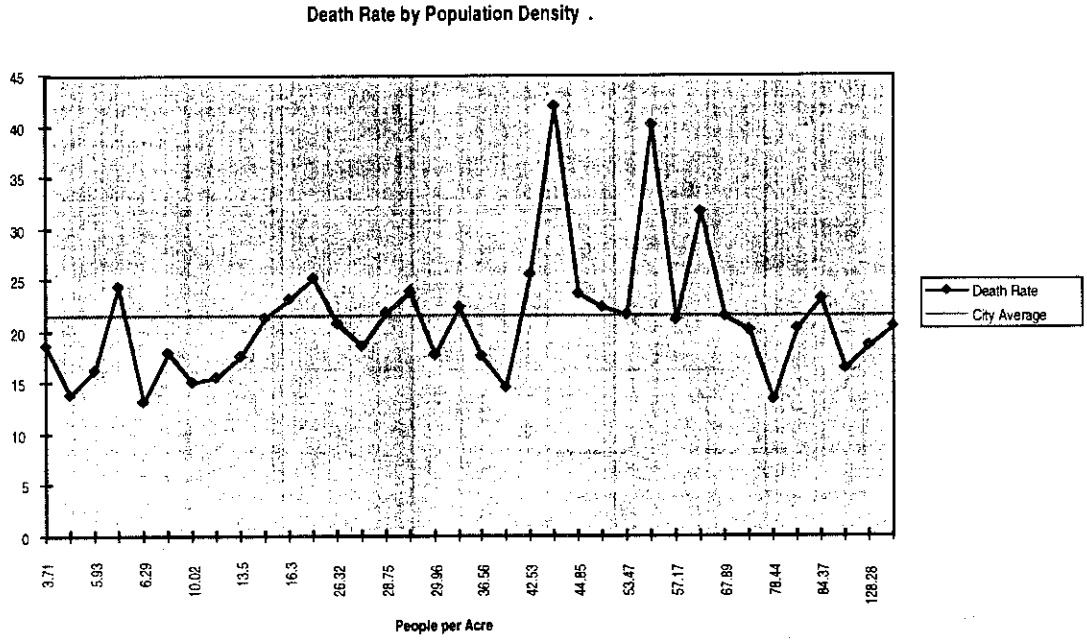
Figure 4.4: Comparative Death Rates in Pittsburgh, 1884-1890



Before 1890, death rates in the Southside were consistently high despite a lower population density. The Southside had less than one half the density of the old city, however this area was plagued by inadequate sewers and an unhealthy water supply. There was also a correlation between employment and health. Those who worked in industrial jobs had higher mortality rates. Also at high risk were those living in tenement areas and those living in low marshy areas.[67]

Although many believed that dense areas were most often afflicted with disease, population density did not always have a direct relationship to mortality rates.[68] This is shown in the chart below.

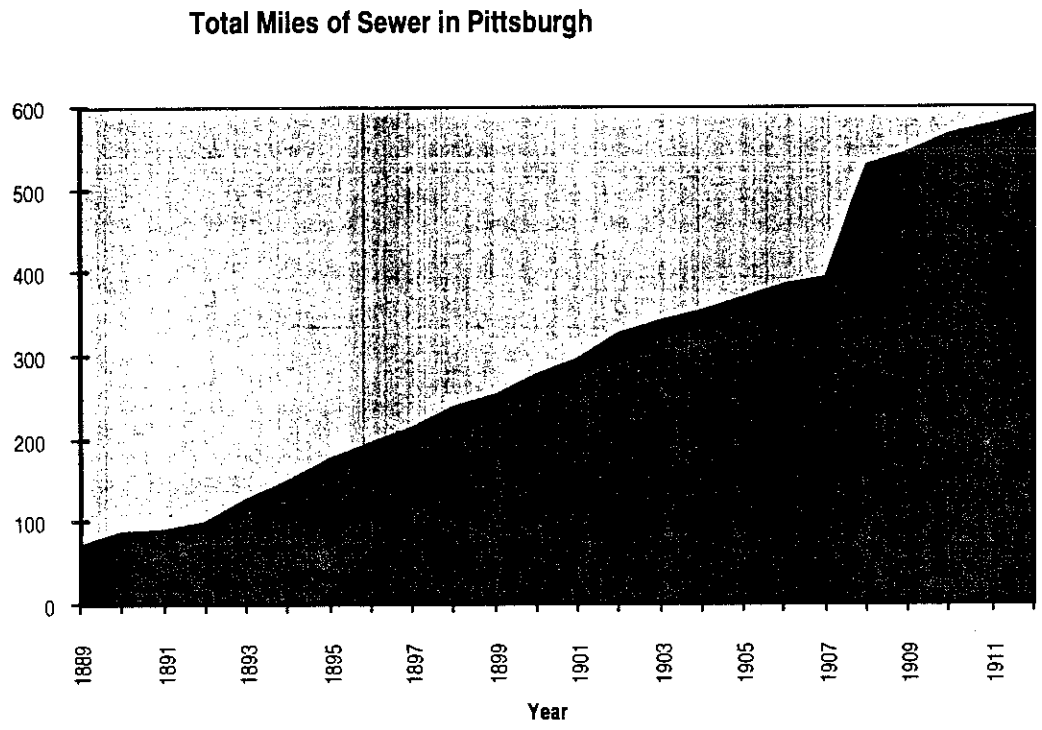
Figure 4.5: Death Rates by Population Density in Pittsburgh



Working class areas of the city were very poorly supplied. In 1872, the City Water Commission ruled that the size of a pipe laid must correspond to it's potential to bring in revenue.[69] There was an uneven distribution of sewer service in Pittsburgh because of the requirement that abutting property owners pay for sewer service to an area.[70]

The following chart shows Pittsburgh's progress at building sewers. Most of these were combined sewers with only a few miles of separate sanitary or storm sewers. The jump in mileage between 1907 and 1908 is due to the annexation of Allegheny City on the Northside. Numbers for 1908 reflect the additional sewers already existing in Allegheny City.

Figure 4.6: Total Miles of Sewerage in Pittsburgh, 1889-1911



Conditions are much better in Pittsburgh today. The city no longer suffers from filthy streets and homes. Garbage collection has become a standard practice, and street cleaning is also provided on a regular basis. Water lines and sewer lines run throughout the city, serving all neighborhoods. All of these services are now expected by citizens in every city.

4.7 Tuberculosis

Clean water and sewer lines don't solve all problems of disease in the 19th or 20th century context. The case of consumption, or tuberculosis as it is known in the 20th century highlights the difference between water-borne diseases and other "industrial" diseases. There was some understanding concerning mode of transmission and control of diphtheria and typhoid. Consumption was a completely different case; consumption was not considered highly contagious by physicians, they did not acknowledge the fact that the conditions created by emerging industrial society created the conditions which consumption would thrive under. The similarities to typhoid and diphtheria occurred in the effected groups. The poor, living in over-crowded, under-ventilated, poor lit areas were the primary target of the disease. In 1934, a Negro Health Survey was undertaken determining the poor conditions, and the lack of milk intake which encourages tuberculosis. It determined that although African-Americans accounted for 1/12 of the population, it accounted for 1/3 of tuberculosis deaths. It wasn't until the late 1930's and then after World War II that Pittsburgh had adequate facilities to treat and contain

tuberculosis, with more X-ray services for diagnosis, streptomycin for treatment, and better housing conditions.

4.8 Summary of Disease in the 19th Century

Disease in Pittsburgh was curtailed in the early 20th century, and finally lethal infectious diseases were severely reduced around the time of World War II with the wide spread introduction of antibiotics. Upon analyzing Pittsburgh, the social reactions to infectious disease in the 19th century, and government actions two conclusions are easily drawn. First, Pittsburgh's experience of smallpox and cholera demonstrated its reactive nature. Only in the face of sheer panic, in the case of cholera in 1832, and again in 1891, did Pittsburgh take proactive measures. Secondly, Pittsburgh showed a benign neglect for endemic diseases, like diphtheria, consumption, and typhoid, even when they killed greater numbers than smallpox and cholera. Perhaps the greatest irony concerning endemic disease is that if Pittsburgh adequately dealt with the problem of a sanitary water supply, the deaths due to cholera would have been lessened as well. It is evident that the economic, racial, and age based demographics of those affected by the endemic diseases played a significant part in the lack of government action, a pattern which would be dangerous if continued in the AIDS context.

4.9 Disease in the 20th Century

Most of the diseases discussed in earlier sections were water-borne diseases, and subject to the whims of sanitation experts. AIDS is a blood-borne disease, and therefore not immediately preventable by government action. AIDS transmits through sexual contact, either homosexual or heterosexual, and through sharing of needles. Therefore in studying AIDS in Pittsburgh it is useful to study diseases with similar modes of transmission. This section will look at hepatitis for exposure through needle sharing, and syphilis for transmission through sexual contact in the late 1960's and early 1970's. This time period is significant in epidemiological history for the emergence of the "hippie" counter culture with more liberal ideas about sex and drug use. Important factors to look at are the ethnicity and life-style of those infected, and the similarities to AIDS.

4.9.1 Syphilis It is believed that the modern origins of syphilis as a disease were in 1493, when Columbus brought the disease back from the new world to Europe. By 1905, the bacterial spirochete *Treponema pallidum* was isolated as the cause of syphilis. By 1909, an effective treatment for syphilis was available, and in 1943 it was discovered that penicillin was effective to combat syphilis. It makes sense that since the disease has been isolated and treated for an extended period of time that it would be a target of eradication. But there is no worldwide program to eradicate syphilis as there was for smallpox, there is no free penicillin for syphilis suffers. This lack of community response on any level, is due to the pleasure seeking activities which contract syphilis. Syphilis reached a peak of 106,000 reported infected in 1947, and steadily declined to 25,000 by 1975. The number of those inflicted with syphilis has steadily increased since 1975. In

Allegheny County, the numbers of those infected with syphilis has increased since the early 1960's.[71]

Early in the century, the reaction to venereal diseases in Pittsburgh was very conservative. In the 1910's, a Morals Efficiency Committee was appointed to take a look at the problem. In the 1930's, women and minors over sixteen who contracted venereal diseases were appointed a physician and a nurse, and would be forced to attend Morals Court. A great steps forward were taken in 1935, as the Social Security Act mandated that clinics be set up for treatment of venereal disease, and again in 1948, when the Public Health Services determined that the venereal disease clinics were inadequate, and the clinic services were reorganized.[72] The treatment of syphilis went from an out-patient care, to an in-patient service as more lethal antibiotics were developed.

The bulk of statistical work done on syphilis in Allegheny County was done in Estimation of the Incidence of Syphilis and Some Considerations on its Epidemiology in Allegheny County, Pennsylvania by Mamidanna Rao. Two important AIDS related conclusions are drawn from this data. First, the movement of syphilis from the white population to the non-white population. Second, the decreasing average age of those contracting syphilis.

Rao emphasizes a consistent and important disclaimer when dealing with syphilis data, the issue of non-reporting. Private physicians are technically required to report all cases of syphilis, however, a majority of cases go unreported. In public clinics, all cases are reported. These facts mean that those who are financially able to see a private physician are more likely to not be reported to the county authorities. The data therefore appears to be skewed towards higher non-white rates of syphilis, and higher rates for younger age groups, since the poor population of Allegheny County is disproportionately non-white, and since adolescents and young adults don't have the financial means to visit a private physician.

Syphilis took a demographic turn in the late 1960's in Allegheny County. As shown on the following page in figure 4.7, the percent of non-white reported cases overtook the number of white reported cases. In 1968, the single largest reported case group is non-white females, a reversal of earlier periods.

Figure 4.7: Race-Sex of Reported Cases of Syphilis in Allegheny County, 1966-1968.[73]

Year	Race-Sex	Number	Percentage
1966	White Male	197	27.4
	Non-White Male	19	26.7
	White Female	180	25
	Non-White Female	150	20.9
	Total	719	100
1967	White Male	135	19.1

	Non-White Male	267	37.8
	White Female	95	13.4
	Non-White Female	210	29.7
	Total	707	100
1968	White Male	117	14.1
	Non-White Male	297	35.9
	White Female	114	13.8
	Non-White Female	300	36.2
	Total	828	100

The pattern described in both clinics and private physicians is the trend towards occurrence in lower age groups. In 1966, the percent of patients below 1966 was 37.3%, in 1967, it jumped to 47.9%, and in 1968, it rose to 50.2%. This rise is due to both changing patterns of syphilis contraction, and selective reporting of older patients. When race and overall population is added to the equation, the data becomes even more startling. As shown on the following pages in figure 4.8, and in figures 4.9 and 4.10, the highest rates of reported syphilis occur in the 20-24 year old nonwhite males and females, all rates per age group for non-white males and females are higher than the highest rates for white males and females.[74]

Figure 4.8: Age-Race-Sex of Reported Cases of Syphilis in Allegheny County, 1968.[75]

Age Group		Males		Females		Total
		White	Non-White	White	Non-White	
15-19	Population	45,323	4,578	49,687	5,144	104,732
	Cases	4	16	3	31	54
	Rate	8.8	349.4	6.0	602.6	51.6
20-24	Population	33,993	3,335	42,159	4,252	83,739
	Cases	9	51	9	59	128
	Rate	26.5	1,529.2	21.3	1,387.6	152.9
25-29	Population	39,658	3,662	42,159	4,389	89,868
	Cases	5	51	3	35	94
	Rate	12.6	1,392.7	7.1	797.4	104.6
30-34	Population	49,573	4,316	52,699	5,144	111,732
	Cases	6	42	5	26	79
	Rate	12.1	973.1	9.5	505.4	70.7
35-39	Population	52,405	4,447	57,216	5,075	119,143
	Cases	9	22	-	6	37

	Rate	17.2	494.7	-	118.2	31.1
40-44	Population	51,697	3,858	56,463	4,458	116,476
	Cases	9	25	1	14	47
	Rate	13.5	648.0	1.8	314.0	40.3
45-49	Population	48,864	3,858	51,946	4,047	108,715
	Cases	3	10	1	4	18
	Rate	6.1	259.2	1.9	98.8	16.6
50-54	Population	42,491	3,531	44,418	3,566	94,006
	Cases	2	7	-	2	11
	Rate	4.7	198.2	-	56.1	11.7
All Ages	Population	364,004	31,585	396,747	36,075	828,411
	Cases	45	224	22	177	468
	Rate	12.4	709.2	5.5	490.6	56.5

Figure 4.9: Age of Reported Syphilis Cases, White Male vs. Female

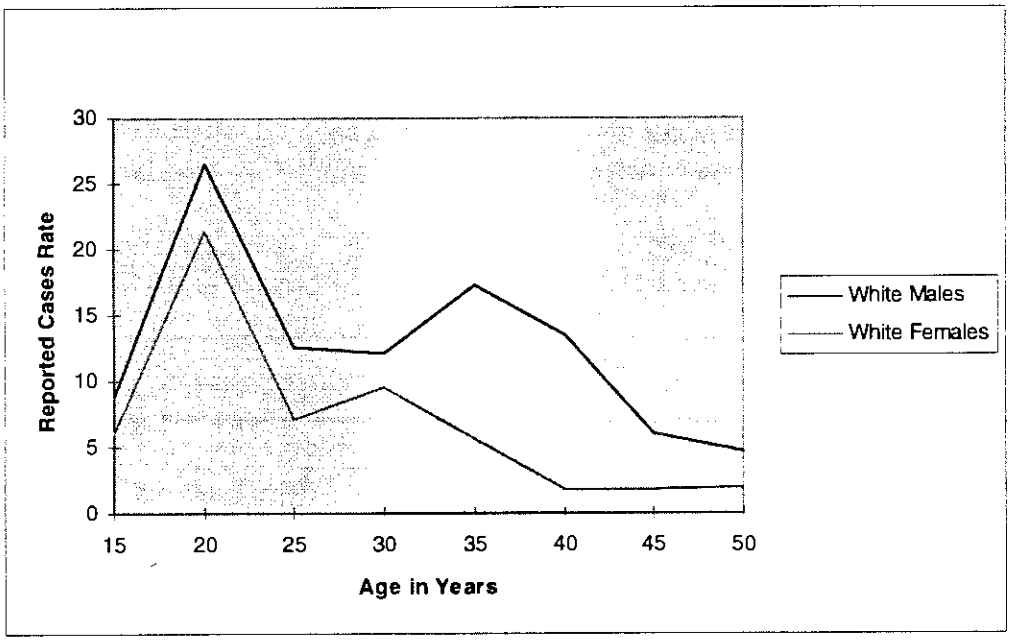
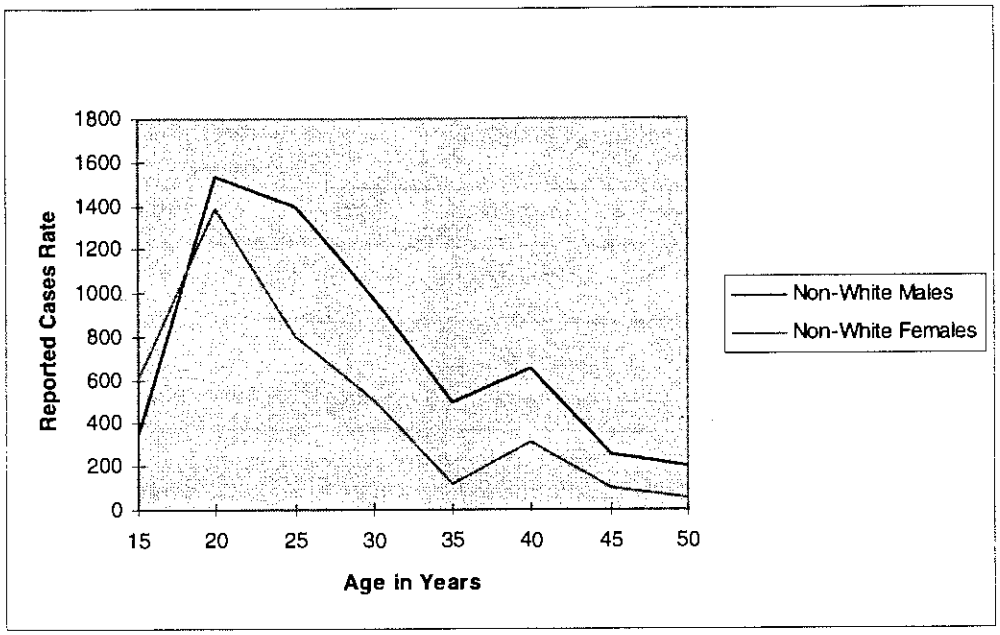


Figure 4.10: Age of Reported Syphilis Cases, Non-white male vs. female



4.9.2 Hepatitis B The case of syphilis shows the characteristics and problems associated with a disease primarily transmitted through sexual contact. The case of hepatitis B in Allegheny County demonstrates the case of a blood-borne disease transmitted through sharing needles. Although hepatitis B is also transmissible through sexual contact it is far more rare. Once again, the research done in the late 1960's and early 1970's is particularly significant due to the emerging "hippie" or "street-people" culture.[76] In comparison to the rest of the U.S., Allegheny County mirrors the trends of the U.S. but in higher numbers, as shown below in figure 4.11.

Figure 4.11: Percentage of Hepatitis reported as Type B, United States, Pennsylvania, and Allegheny County, 1966-1971.[77]

	1966	1967	1968	1969	1970	1971
United States	-	5.4	7.0	10.0	12.0	12.0
Pennsylvania	-	5.0	5.5	6.3	13.0	18.0
Allegheny County	2.0	7.0	8.5	9.0	16.0	21.0

Drug usage has also increased in the younger populations, and therefore, hepatitis B prevalence has increased in youth. This characteristic mirrors AIDS and syphilis, although no data is available on the ethnicity of hepatitis B infected persons in Allegheny County. Figure 4.12 below shows the disproportionate prevalence of hepatitis B among the 15-24 population.

Figure 4.12 Hepatitis Cases Related to Drugs in Allegheny County, 1968-1971.[78]

Year	Total Cases	All Ages, Drug Related		15-24 Year Old, Drug Related	
		Number	Percent	Number	Percent
1968	284	90	32	75	82
1969	462	169	37	140	82
1970	469	176	38	142	81
1971	581	246	42	212	86

Due to public marginalization of intravenous drug users (IDU's), the incidence of hepatitis B among the Allegheny County population, and in particular its youth has continued to grow. Piggybacking on programs designed combat AIDS, community based programs to slow the spread of hepatitis B have be enacted recently. Hepatitis B garners less attention than AIDS, due to its relatively low lethality, however the lessons that should be learned from hepatitis B are clear; Allegheny County as a community and the government must take serious measures to stop the spread of infectious diseases in intravenous drug users.

The public health history of Pittsburgh and Allegheny County is not a model for other cities. It is not a commendable litany of organized community and government response. The actions of Allegheny County in the realm of public health have certainly not been blind to ethnicity and socio-economic status. Due to its low HIV seroprevalence and wave 1 situation, Allegheny County and the city of Pittsburgh has an opportunity with AIDS to become a model region in the realm of public health.

It is crucial that Allegheny County learn the lessons provided by the 19th century epidemics and endemic diseases. Pittsburgh's panic stricken, inconsistent plans prevent the city from enacting any well planned programs for decades, which would have reduced the mortality rates from not only the quiet endemic diseases, but the raging epidemics as well.

4.10 Conclusion

The faulty reasoning used in the context of syphilis and hepatitis B are even more important to the future of AIDS in Allegheny County and Pittsburgh. The state, county, and local organizations must act to demarginalize alienated segments of the population. The community must reach out the intravenous drug using population with appropriate measures, and not neglect the IV drug using population as they did in hepatitis. The community must stop the trend of infection in younger and poorer communities. If

anything, considering past and present transgressions, a veritable affirmative action in public health policy is in order for Allegheny County. Allegheny County can not allow its public health history to repeat itself with AIDS.

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5

Structures of Local Government

Melissa Murello

The Pittsburgh city council lacks direct control over health policy. In Pittsburgh, unlike many cities, the county controls the health department, not the city which explains why the city council lacks authority over Aids and HIV policy. To understand why the Pittsburgh city council lacks direct influence over health policy requires a historical summary of the local government in Pittsburgh.

Two themes pervade early Pittsburgh politics and government. First, a sense of community has persisted despite the organization of parties for the purposes of mobilizing electoral coalitions. It was not that the "spirit of party" was extinct, but rather that Pittsburgh depicted a one-party city throughout the nineteenth century. Democratic-Republican strongholds in the rural areas of Allegheny County and Western Pennsylvania surrounded Pittsburgh during the nineteenth century. Candidates assumed rather than stressed party ties in Pittsburgh electoral campaigns while prominent federalist citizens chose to serve public office more from a sense of civic duty than a mode of initiating party or personal organization. Secondly, Pittsburgh officeholders used the city government to promote and aid the city's best economic interest. Pittsburgh voters expected that wealthy men would work as public officials to advance economic interest which also illustrates the sense of community, the existence of a mutual set of values, and the ordinary citizen's faith in the wealthy to promote and articulate their ideas and values.[i]

In spite of these persistent themes in local politics, several changes occurred in the structure of the city government between 1794 when the legislature approved an act organizing the city government and 1832 when the office of mayor became popularly elected and Pittsburgh adopted a ward system for election to the bicameral city council. The 1794 act provided for the annual election of two burgesses and four assistant burgesses. The resulting committee of six served as a collective executive while the town meeting retained legislative authority. An act in 1804 provided for the election of one burgess and granted legislature authority to a town council of twelve. Then, in 1816, another act vested legislative power in the Select and Common Councils. These councils congregated at a joint secession to select a mayor from among the twelve aldermen appointed by the governor.[ii]

Although these acts increased the number of public officials, the same basic sense of community and shared values that fueled Pittsburgh politics since the 1790s persisted. All elections remained as citywide affairs, with no separate representation for specific areas of the city. The 1820s voters often elected the city's "economic dominates." In 1828, the city council composed of 21% of men from various occupations while merchants and professionals comprised of 58% of the council which indicates that many ordinary citizens in Pittsburgh voted for men of property and exceptional social standing for public office.[iii]

However, as the economy transformed, the population grew and the city expanded, Pittsburgh subareas became distinct from each other and its politics reflected this shift of geographical and social detachment. The war of 1812 created an increasing demand for

manufacturing. Consequently, Pittsburgh shifted from a commercial city to a manufacturing city. The expansion of the city's manufacturing industry influenced to dissolving the earlier commercial consensus that united patricians and artisans and served as a linchpin for public policy.[iv]

The shift toward manufacturing caused discord in the local government. First, Pittsburgh abandoned at large scale elections of city council and adopted a ward system of representation. In 1833, voters elected to divide Pittsburgh into four wards. Each ward possessed its own representatives in the Select and Common Councils which diminished the sense of community as conflicting interests emanated. Secondly, the emerging group of manufacturing leaders challenged the control of the old elite of the city government which played a key role in electoral politics during the 1830s.[v]

By the 1850s, Republicans replaced the Whig party which also illustrates the changes in the city's economic function. The Whigs represented Pittsburgh's older economy, commercialization while the Republicans depicted Pittsburgh's new economy of industrialists. In the 1850s the completion of railroads that linked Pittsburgh to larger transportation networks destroyed the city's role as a transshipment center. Thus, as the merchant's role lessened in the Pittsburgh economy, these Whig party members lost their power in the local government.[vi]

At other levels, the political turmoil of the 1840s and 1850s reflected conflicts arising due to the increasing diversity of the local population. By 1850, immigrants composed of a third of Pittsburgh and an even larger percent of the voting age population. Threatened by the influx of immigrants, Natives formed exclusive groups to reinforce their identity.[vii] In 1847, citizens organized the Native American Party to protest their unemployment due to the competition of the cheap laboring immigrants. As the economy slumped in the 1840s and the population increased, problems arose. People expecting jobs traveled to Pittsburgh only to discover lay-offs and wage cuts. Consequently, as labor strikes occurred and anti- immigrant sentiment pervaded the city, social tension increased.[viii]

The voting shift among the mass public mirrored the changes among councilmen and party candidates. The groups that constituted the Republican voting coalition shared a common view-an evangelical disposition that clashed with distinctively ritualistic or liturgical thinking of the city's Catholic voters. As the Republicans advocated such measures as the "Protestanization" of public schools, social and political conflicts intensified between these two groups.[ix]

The 1850s brought about changes in transportation which altered patterns of residential areas. Distinct upper, middle and lower-class areas emerged. As the population increased, the demands for city services grew and the urgency for development finance and construction to serve the needs of the population increased. This geographical separation created a heightened sense of social differences, leading residents within a community to seek councilmen that represented their own interests.[x]

Pittsburgh had been a Republican city since the 1860s. Republican support increased when the depression hit in the 1840s. While Pittsburgh's mean Republican percentage in presidential and state elections between 1876 and 1890 had been 53 percent, the city returned 67% for the Republican candidate for state treasurer in 1893; and 70 percent for McKinley in 1896. Once the excitement of the 1890s died, Republican voting decreased, but party margins over Democrats remained larger and more secure than it had been in the 1870s and 1880s.[xi]

Newly formed Republican hegemony evolved from shifts in the working-class wards that had previously voted Democratic. Before the depression, Democratic candidates received only a minority of the city's working-class votes. The depression and sectional candidacy of William Jennings Bryan essentially obliterated the slightest amount of support. As a result, instead of polling the usually 30 or 40 percent of the citywide vote as they had in the 1870s and 1880s, only 25 percent of Pittsburgh voters supported Democratic candidates.[xii]

After the turn of the century, exclusive membership groups greatly influenced Pittsburgh policy. Two factors converged to create this shift. First, as a consequence of the political explosion of the 1890s, electoral competition between the city's major parties was almost eliminated. Thus, grass root interests and values could not be organized and represented significantly through the implementation of party competition for elected office. Secondly, many concerns that drove people into action around the turn of the twentieth century lacked the geographical foundation of organization. For example, concern for the spread of disease cut across geographical sub divisions. Public health officials called for citywide solutions, as they perceived the city's ward based system of government as an obstacle threatening public health.[xiii]

In 1911, reformers attacked the city ward system and succeed in replacing it with a city council that Pittsburgh elected as a whole. This change in government centralized decisions making by shifting it up and separating it from public organizations at the community level. Groups organized geographically while dominating wards were no longer assured representation on the city council or of control over public institutions that operated in their neighborhoods. Moreover, citywide elections changed the social character of representatives. Members of the upper class pervaded the new centralized agencies of government while lower and middle classes lacked representation.[xiv]

Although the growing of centralization of power and authority in urban government occurred in many cities, Pittsburgh appears to go further in extent of centralization in political representation.[xv] Pittsburgh represented one of the few cities in which citywide election fully replaced the ward system.[xvi] Pittsburgh's success of urban redevelopment in the mid twentieth century illustrated this institutional centralization. Under the leadership of a body composed of the city's largest and most powerful corporate leaders and elected officials of the city and county, Pittsburgh undertook a massive physical reconstruction of selected parts of the city, most significantly in its older, central sections. This committee carried out, independent of elected bodies, their plan with autonomy and power of high domain and subsidized those who could complete new construction. Many attributed the success of this project to the unique degree of cooperation between corporate elite and government officials.[xvii]

Two tendencies appeared in the twentieth century which counteracted some elements of centralization. One arose from the zealous resistance of outlying communities to consolidation with the city in a larger, metropolitan structure of government. For many years, in the nineteenth century, the city government absorbed new communities through consolidation. As time passed, communities on the periphery, less anxious to join, began opposing consolidation. Pittsburgh leaders continued their drive for bigger government in the 1920s as they proposed a larger metropolitan government which voters rejected repeatedly.[xviii] Outlying boroughs and townships reclaimed their authority and autonomy from the state government which granted political independence from the city and enabled them to resist Pittsburgh's expansive inclination. Consequently, a shift in government from a city to a countywide focus evolved as larger scale administration established for public health, sewage disposal, water supply, mass transit, redevelopment and airport management. The new administration of centralized jurisdiction and relatively independent authority molded the longer term standard of centralization of government as a persistent theme in Pittsburgh political history.[xix]

After WW II, urban communities moved toward a larger role in public affairs. Nurtured by the rise of political consciousness in the black community in the 1960s, the shift toward the larger role of urban communities in public affairs resulted from the destruction of black residential and commercial areas during redevelopment. Despite demands for more community autonomy in City Council, until 1986, the council lacked black members.[xx]

The history of the local government in Pittsburgh explains why the 1997 City Council has no direct legislative authority over Aids/HIV policy. As Pittsburgh shifted

from a commercial city to an industrial city in the early nineteenth century and ties dissolved between the patricians and artisans, tension in local government arose. Thus, in 1833, voters divided Pittsburgh into four wards to ensure the representation of various interests. Each ward with its own representatives diminished the sense of community in Pittsburgh. Moreover, political and social tension increased between Natives and immigrants and among the various economic and social classes as the influx of immigrants threatened job security in the middle of the nineteenth century and the development of transportation in the 1850s altered patterns of residential areas. Consequently, residents sought councilmen that represented their own interests. After the turn of the twentieth century, exclusive membership groups greatly influenced local politics as the concerns such as public health that drove citizens into action cut across geographical lines and called for citywide resolutions. As a result, in 1911, voters replaced the city ward system with a city council elected by Pittsburgh as a whole which centralized decision-making by shifting it up and isolating it from public organizations at the community level. Finally, as communities on the periphery resisted consolidation in the twentieth century, Pittsburgh government transferred from a city to a countywide focus and established departments for public health, sewage disposal, water supply, mass transit, redevelopment and airport management. The changes in structure of the local government in each decade reflects the needs and concerns of that specific era. Thus, as twentieth century voters perceived such issues as public health as calling for countywide attention, Pittsburgh local government moved toward a countywide focus.

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[xviii] Hayes, Samuel P. City at the Point. 391-392.

[xix]Hayes, Samuel P. City at the Point. 392.
[xx]Hayes, Samuel P. City at the Point. 392.

6A

The Evolution of AIDS Epidemiology in the United States

Vincent A. Sonson II

In 1981, scientists encountered a mysterious syndrome that compromised the immune system of previously healthy, young men who had no genetic disposition to immunodeficiency. The disease appeared to manifest itself only in male homosexuals. Epidemiologists immediately set forth to determine what factors led to the spread of the syndrome. Thus began the history of AIDS epidemiology. This essay traces the evolution of AIDS epidemiology from its earliest days to the present. The multifactoral model used by many epidemiologists to dissect the cause of the disease is discussed. Also, the critical role that epidemiologists play in the containment of a disease with no known cure is explored.

AIDS Epidemiology in the United States: From "Gay Plague" to Universal Threat

Epidemiologists often attribute several, complimentary factors to the spread of an epidemic disease. This multifactoral disease model, or "web of causes," is a convenient tool for these scientists. The model allows the epidemiologist to "incorporate many possible explanatory variables whose putative causal connections with a given disease may be plausible for a number of reasons- scientific, logical, historical, experimental, and so forth."[i] The liberties afforded epidemiologists by the multifactoral model evoke a certain problem-solving creativity that researchers in other fields might not enjoy. This freedom, however, can be perilous. "Variables may be drawn in (or left out) as a function of the social values of the scientist, the working group, or the society. When included in the model, embraced by the professionals, and published in the scientific press, such value judgments appear to be objective, well-grounded scientific statements."[ii] In the early 1980s, epidemiologists attempting to uncover the causal factors of what would later be known as AIDS disguised their own value judgments in the mask of scientific objectivity to place blame for this new epidemic specifically on the shoulders of homosexual men and, to a lesser extent, recreational drug users.

Between October 1980 and May 1981, Dr. Michael Gottlieb of Los Angeles, California reported to the Center for Disease Control (CDC) that five young, homosexual men had been treated for *Pneumocytosis carinii* (PCP) in local hospitals. Shortly thereafter, Dr. Linda Laubenstein of New York University, and Dr. Alvin Friedman-Klein, who trained at the National Institutes of Health (NIH), reported several cases of *Kaposi's sarcoma* (KS) among young, homosexual men in New York City. PCP and KS had previously been observed exclusively in elderly patients, those with genetically defective immune systems, or persons taking immunosuppressive drugs (e.g., after transplant surgery). The appearance of PCP and KS in young men with no predisposition to immune system failure grabbed the attention of the CDC. In the absence of a biological determinant

for this immune system dysfunction, epidemiologists set out to piece together the puzzle of the emerging epidemic. The CDC appointed Dr. Wayne Shandera, of the Epidemic Investigation Service (EIS), to work closely with Dr. Gottlieb analyzing this new disorder. Dr. Shandera later published his findings in the *Morbidity and Mortality Weekly Report (MMWR).*[iii] In the *MMWR* issue where Dr. Shandera's comments appeared, an editorial note claimed that "the fact that these patients were all homosexuals suggests an association between some aspect of a homosexual lifestyle or disease acquired through sexual contact and *Pneumocytosis* pneumonia in this population."[iv] This value-laden "life-style" hypothesis forced responsibility for the disorder, and susceptibility to the disorder, upon the homosexual community. This misconception would not persist very long in the scientific community, however, as an important finding was on the horizon.

In July 1982 three cases of AIDS were reported to the CDC among persons with hemophilia A. These cases would refute the notion that AIDS was a "gay" disease. Dr. William Foege, then Director of the CDC, spoke at a July 1982 conference on the syndrome, and he addressed the new findings.

> Dr. William Foege...was giving a five-minute presentation on the infectious etiology hypothesis for AIDS. Six or seven other people were also to speak on other hypotheses about etiology- semen from many different men, nitrites, drug abuse, and homosexuality itself. Dr. Foege spoke first and reported that descriptions of these three new cases in hemophiliacs... strongly pointed toward a viral etiology for AIDS because the men had received blood products from many thousands of donors. Each speaker who followed changed his or her talk to a cofactor talk spontaneously, because Dr. Foege's evidence was so convincing to everybody working in the field.[v]

Dr. Foege's assertion of a viral source of AIDS effectively changed the way scientists thought of the disease.

The discovery of hemophiliac AIDS cases was followed closely by the disclosure of other, non-homosexually transmitted instances of AIDS. In the January 7, 1983, issue of *MMWR*, Drs. Gerry Friedland and Neil Streigbegel, and other researchers at Montefiore Hospital in New York City reported several cases that occurred among women who were female sex partners of men with AIDS. 1983 also witnessed the first cases of infantile AIDS, including the first baby with transfusion-associated AIDS. Although a specific pathogen had not yet been isolated as the biological transmitter of AIDS, the notion that AIDS was strictly a "gay plague" had effectively been dismissed in the epidemiological community.

Any lingering doubt as to the viral nature of the disease was supplanted by Drs. Francoise Barre-Sinoussi and Luc Montagnier in 1983, and by Dr. Robert Gallo in 1984. These men, in a laboratory setting, successfully isolated the virus responsible for triggering AIDS in the human body. In light of their pioneering efforts, successive researchers have built upon their work to develop a more thorough understanding of the AIDS virus.

Human immunodeficiency virus (HIV) is a retrovirus, which inactivates the immune system and destroys its ability to produce certain immunocytes, specifically CD4 T cells. A depleted immune system renders the body helpless against a plethora of infections that healthy persons can easily combat. These have been designated opportunistic infections. A syndrome of such infections constitutes AIDS. We also know that AIDS is a blood-borne disease. HIV infection occurs when an infected person's blood or other body fluid (semen, plasma) enters another person's bloodstream. The virus has been isolated in saliva and tears, but the amount is miniscule, and there have been no reported cases of infection via these sources.

The predominant modes of transmission of the AIDS virus became evident by 1995, as explained by William Rushing in his book The AIDS Epidemic.. "The most efficient mode of transmission is the entry of a large amount of infected blood into the bloodstream, as in a blood transfusion. However, the most common transmission mode is through sexual intercourse... Sex between males is the most frequent mode of transmission

in industrialized countries; sharing of contaminated syringes by drug users is the second most common mode."[vi]

As we learn more about the AIDS virus, it becomes increasingly obvious that AIDS is not transmitted casually. It is not air-borne, it is not transmitted through physical touch, it is not carried by insects. In essence, "It almost always requires the active participation of an individual in activity in which body fluid is exchanged with one or more persons."[vii]

Although scientists have made great strides in the discovery of HIV and its modes of transmission, they have been unable to provide a cure for the disease. Armed with an advanced understanding of the virology and transmissibility of AIDS, and an awareness that a cure has yet to be uncovered, AIDS epidemiologists set forth to devise a method to minimize the spread of the disease.

Risk Groups or Risk Behaviors?

One of the earliest efforts by epidemiologists to check the spread of AIDS in this country involved the labeling of certain groups as high-risk cohorts for contracting the disease. Three groups labeled as such by the CDC were homosexual men, injection drug users, and persons who receive blood transfusions and blood products. The designation of such groups allowed for appropriation of resources to those in greatest need of assistance.[viii] But the identification of groups as high-risk also had negative implications. High-risk groups became stigmatized as posing a threat to the rest of the population, and thus were victims of prejudice and misunderstanding. Such labeling also led those who were not members of said groups to believe they were not vulnerable to AIDS.

Reaction to the limitations of referring to groups as high-risk forced a change in vocabulary among epidemiologists. *Risk behaviors* replaced *risk groups* as the fashionable terminology, and "By 1988 it had become an axiom that risk for HIV comes not from who you are, but from what you do."[ix] While this simple amendment has served to de-stigmatize AIDS, it has unfortunately shifted appropriation of resources away from those who need them most. It is apparent that members of certain groups are more likely to contract AIDS, and "Failure to recognize that, in some instances, the use of the term 'risk group' may be valuable is a major barrier to assigning appropriate priorities in health promotion actions."[x] Clearly the stigmatization of groups is an evil that has no place in our society. However, if referring to certain groups as high-risk directs appropriate resources in their direction, epidemiologists should continue to employ the language and simultaneously reject attempts to marginalize an individual based upon group membership.

In the end, it is an individual's behavior, not group membership, that makes the transmission of the virus possible. Accordingly, many prevention resources are allocated to educating the public about the disease and how it is spread. Acknowledging that certain individuals have a greater risk of contracting AIDS based on the group, or groups, they associate with (because members of those groups tend to engage in particularly risky behaviors) can direct funding and resources in the proper direction.

Patterns of Transmission: The "Wave" Discussion

It has become common to think of the AIDS epidemic in this country in terms of "Wave I" and "Wave II." The first wave refers to the infection of white, affluent homosexual males in the early 1980s. Wave II represents a shift in AIDS infection away from homosexual males to socioeconomically disadvantaged injection drug users (IDU) and heterosexual women. Although this trend can be traced in a very general sense in the US, many epidemiologists warn that characterizing the AIDS epidemic in two, broad waves oversimplifies the matter. First of all, the shift from wave I to wave II implies that

because the focus of the epidemic has moved away from homosexual men, this group is no longer of concern for this group. "Unfortunately, describing the epidemic in waves has led some to believe that, since the epidemic wave has 'peaked' in the homosexual community and is now accelerating in the disenfranchised injection drug using community, we no longer have to worry about HIV infection in the homosexual community."[xi]

Another danger of thinking of the epidemic in terms of two distinct waves is that we might wrongly assume that cohorts of the two waves cannot exist simultaneously in the same community. In reality, separate epidemics *can* exist side by side in the same community at the same time, with little or no interaction between them. In New York City, for example, two separate epidemics of HIV have been documented, with little social contact between them.[xii]

> The first is among men who have sex with men, who are primarily white, but which includes a growing proportion of African-Americans and Hispanics. The second epidemic has occurred among IDUs and their sexual partners and children who live primarily in racially segregated, poverty-stricken, inner-city neighborhoods. As a result, AIDS case rates vary several-fold between different postal districts, reflecting the heterogeneity of risk in New York's diverse economic, ethnic, and social context.[xiii]

This example illustrates the complex task of characterizing AIDS in New York City, and it highlights the flaws of the two-wave model of the disease. The New York case study also bears a strong resemblance to the picture of AIDS in Pittsburgh, which will be discussed later in this publication.

A further pitfall in the two-wave model is that it renders traditional risk groups static. We tend to portray wave I victims as exclusively being white, affluent homosexual males. The New York data from the example above, and the data we have collected on Pittsburgh, suggest that a growing number of AIDS cases among homosexual males are surfacing in African-American men. A study conducted in San Francisco and Berkeley, California, found that HIV seroprevalence among 16-22-year-old African-American gay men in that region to be 40 percent, nearly four times higher than in white gay men of the same age group.[xiv] Discussion of the AIDS epidemic in terms of wave I and wave II periods is convenient but problematic, for the above reasons. Epidemiologists, therefore, tend not to subscribe to this model.

Charting the Spread of AIDS: The United States Today

As of 1993, homosexual men accounted for 57 percent of all AIDS cases in the US. Injection drug users accounted for 23 percent, while heterosexual transmission occurred in seven percent of all cases. Transfusion recipients and hemophiliacs combined for three percent of AIDS cases in the same year.[xv] Geographically, New York, New Jersey, Florida and California have the highest case rates for males, while New York, New Jersey, Connecticut and Florida have the highest rates for females. According to Blattner, et al., "The highest rates for the country are observed in the District of Columbia for both males and females, and detailed analysis of this site documents a typical urban minority injection drug use and emerging heterosexual epidemic superimposed on an earlier epidemic among homosexual men." The District of Columbia represents another region where separate epidemics exist side by side.

In men, the proportion of homosexual cases decreased through 1991 as the proportion of IDU cases rose substantially. Among women there has been a major upward trend in the number of cases transmitted through heterosexual contact. Through 1990, the major peak for AIDS incidence in homosexuals, heterosexuals and IDUs occurred between the ages of twenty and forty. As of 1993, 84 percent of all AIDS cases occurred in males.

The racial breakdown of AIDS cases in the United States today provides more insight into the state of the epidemic.

> Recent surveillance data reveal that US blacks account for 35.7 percent of all AIDS cases and Hispanics for 17 percent, while these groups compose only 12 percent and 6 percent, respectively, of the US population. Women represent a higher proportion of infected blacks and Hispanics (52 percent and 20 percent, respectively) than do white women... This results because heterosexual transmission of HIV is occurring in blacks and Hispanics disproportionately to whites.

Socioeconomically, the disadvantaged are becoming more susceptible to the AIDS virus. For example, parenteral drug users are often socially and economically disadvantaged, and their injection drug usage makes them highly susceptible to the AIDS virus. Also, persons of lower socioeconomic status are increasingly responsible for cases of heterosexual AIDS transmission.[xvi]

Conclusion

From this complex web of social phenomena, epidemiologists have constructed explanations for the spread of AIDS in this country. In the absence of a biological cure for the disease, epidemiologists have played a critical role in the development of strategies to curtail the epidemic. Their multifactoral models are certainly not flawless; certain groups have been unjustly marginalized as a result of some initial epidemiological findings on the disease. However, until a cure is found, our only defense against the expansion of the epidemic is a clear understanding of all the factors that allow it to flourish. The epidemiologists "web of causes" sheds light upon these factors, and facilitates the coordination of methods to prevent the proliferation of AIDS.

The current state of AIDS in Pittsburgh reflects many of the complexities we have discussed thus far. Separate epidemics do exist side by side. For example, the epidemic among injection drug users in the Hill District coexists with the epidemic of homosexual males on the North Side. And prevention resources are not reaching the highest-risk groups in this city, evidenced by the lack of attention given to homosexual black males who account for a large portion of total AIDS cases in Pittsburgh. The following submissions will shed more light upon these and other matters regarding the AIDS landscape in Pittsburgh.

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[ii] Oppenheimer, 269.

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6.b
Introduction

Kristofer Peterson

Our project focused on the epidemiological pattern of AIDS in Pittsburgh. We wanted to link this pattern to Pittsburgh as a particular place with a particular history. Our research proceeded along two tracks. We analyzed AIDS case data for Pittsburgh that was provided by the State Bureau of Epidemiology and the Allegheny County Health Department. This data represents all the cases of AIDS that have been diagnosed since 1981 in 4x zip codes, comprising the city of Pittsburgh and several communities along the Monongahela River: Braddock, Rankin, Duquesne, and McKeesport, as well as McKees Rocks and a few others. The AIDS case data was broken down by age, race, gender, and mode of transmission of HIV, the virus that causes AIDS. By seeing where patterns of cases fell within specific zip codes, we learned a great deal about the spatial and social geography of AIDS in Pittsburgh.

We found that AIDS in Pittsburgh represents an important local story. Although AIDS case rates for Pittsburgh and the surrounding region are low compared to other American metropolitan regions, this does not mean Pittsburgh has an evenly dispersed, acceptably low rate of AIDS cases. Rather, there are concentrations within specific neighborhoods, and within specific social and racial groups that present targets for intervention. Moreover, the pattern of AIDS cases in our region reflects Pittsburgh's own history. The contours of AIDS in Pittsburgh reflect our local history of deindustrialization, of neighborhood formation and change, and of residential and employment-sector racism that has selectively disadvantaged African Americans.

This chapter of the paper endeavors to explain that story. It begins with an in depth analysis of AIDS and Demographic data by clusters of Zip codes. These clusters pull out a variety of patterns in AIDS cases across the city, most importantly the vast disparity in the impact of AIDS on the white and African American communities. From there we move into detailed analyses of several zip codes. First, there is an analysis of Allegheny, Observatory, and Killbuck which along with the analysis of East Liberty, Homewood, and Wlkinsburg attempts to use demographic data to explicate the complicated patterns of AIDS in these zip codes. Then , there is a discussion of McKeesport, which represents the most stereotypically wave II area in and around Pittsburgh. This discussion incorporates ideas about the decline of the steel industry as well as demographic data to explain McKeesport's extraordinary AIDS pattern. Finally, we see a comparison of Mt. Oliver to Allegheny, in an attempt to explain the Mt. Oliver's resistance to AIDS despite its demographic similarities to Allegheny. This paper now moves into the discussion of zip code data by clusters.

6C

Analysis of AIDS Case Data and Population Data for the Forty-Two Zip Code Sample

Richard Svinkin

Introduction

In order to gain an indepth understanding of the multitude of AIDS case data presented in this project, a decision was made to include a zip code by zip code analysis, of the various Case totals, modes of exposure by Race and gender, and produced rates per 100,000 for various data types and categories. Once population characteristics were analyzed a clearer picture of AIDS in Pittsburgh presented itself. AIDS did have discernable patterns in Pittsburgh, even though the cases are indeed quite spread out for some areas, and bunched together in others. A population relationship between the size of the African-American community and the White community in each respective zip code was established, and proved to be a sufficient point of entry into the AIDS story in Pittsburgh.

Five clusters or groupings of zip codes produced 5 stories, different in more detailed terms, but all primarily sharing the same basic principle. Every zip code that included at least 1 case of an African-American with AIDS in the 42 zip code sample, except Kilbuck (15233) and Squirrel Hill (15217), also included a % of total cases within the African-American community that was actually higher than the % of African-Americans in the zip codes. In Bellevue (15202) for example, African-Americans account for 28% of all AIDS cases in 15202, but only 2.51% of the total population. It was thought that some zip codes would produce similar relationships between African-American population % and the % of African-American AIDS cases in the zip code, while others would produce vastly different results. The analysis did not show that dichotomy. Throughout the city, in zip codes where there exist at least 1 African-American AIDS cases, African-Americans consistently accounted for a higher % of AIDS cases than the % of African-American residents in the zip code. A new strategy was necessary to help paint the AIDS picture, namely the cluster strategy.

It became more profitable to breakdown the AIDS landscape in Pittsburgh by population percentages than by AIDS cases and percentages alone. Here are the population descriptions of the 5 clusters utilized in this analysis.

1) Cluster I - 17 zip codes make up cluster I, wherein African-Americans make up less than 20% of the over all population of each zip code. For the entire cluster African-Americans make up 6.79% of the population, but a striking figure of 21.34% of all AIDS cases in Cluster I. Cluster I zip codes are primarily not in the most populated areas and the high rates and % of African-American AIDS cases show that impoverished urban areas are not the only places where African-Americans bear the brunt of the epidemic
2) Cluster II - 5 zip codes in which all include an African-American population that accounts for more than 20% of the population, but still is in the minority. For the cluster, African-Americans make up 28.57% of the total population while comprising 43.08% of all AIDS cases in the cluster. Cluster II zip codes, Rankin, Duqeusne, Bloomfield, Mt. Oliver, and Observatory, are mostly redential areas with higher

average population size than cluster I, and a substantially higher number of injection drug use cases, though not a substantially higher proportion of male sex white male exposure cases within the Cluster II case totals. Cluster I AIDS cases for African-Americans are mainly of the male sex with male exposure type, while Clusters II, III, and IV are more diverse for the African-American community.

3) Cluster III - All 5 zip codes in Cluster III, include more than 50 total cases of AIDS, but still an African-American minority. The cumulative African-American population in Cluster III is 30.38% of the over all population in the 5 zip codes, but African-Americans comprise 45.11% of the total AIDS cases in the cluster.
4) Cluster IV - The 3 zip codes in Cluster IV, represent the only zip codes in the 42 zip code sample where African-Americans comprise the majority of the population in each zip code, and a majority of the total population of the cluster. African-Americans comprise 72.22% of the total Cluster population while still comprising a higher percentage of the total AIDS cases in the cluster with 76.27% of the AIDS cases in cluster IV being African-American.
5) Cluster V - This cluster is different from the other clusters in that each zip code is already a member of another cluster. This cluster represents those 7 zip codes which combined account for almost 66% of all cases of injection drug use exposure in the entire 42 zip code sample. Not surprisingly, with the absurd injection drug use portion, a high proportion of the sample's male sex with male exposure cases also fall within the cluster's 7 zip code boundaries, with 42.25% of all male sex with male cases existing in Kilbuck, Allegheny, Uptown, Homewood, Wilkinsburg, McKeesport, and East Liberty.

Throughout every cluster, African-Americans not only make up a higher % of total cases than their % of the population, but many times the individual modes of transmission such as male sex with male exposure, injection drug use exposure, and heterosexual exposure, produce similar results. Not every individual mode of exposure for African-Americans produce a disproportionate result in comparison to the over all population percentages, but where they do makes for significant analysis. For individual examples of these phenomena a thorough zip code by zip code analysis, including the various categories of data we have compiled are run through for every zip code in the 42 zip code sample.

To set the stage for the section describing each zip code a few principle findings will now be reported. For the entire sample, African-Americans make up 28.03% of all cases of male sex with male exposure, and 15.50% of the population. The injection drug use picture is more severe, with 78.08% of all injection drug use cases being African-American. The heterosexual picture is also severely skewed towards African-Americans and the zip code by zip code analysis will reveal more interesting locations of heterosexual exposure than originally postulated.

The gender situation in Pittsburgh is clear. White males make the majority of cases, followed by African-American males, African-American females, and far behind are White female AIDS cases. For a more thorough description see the charts created for each cluster. What follows is a zip code by zip code analysis of AIDS case data, including all major modes of exposure, racial and gender analysis as well as the outlining of some specific zip code characteristics that tie them together across demographic and geographic lines. *Charts showing much of the data in this chapter in graphic form can be found in Appendix 6.C.*

Cluster I - Zip codes with small African American Populations yet high various African-American AIDS statistic

These zip codes lay credence to the notion that an African-American community doe not have to be bound by a "ghetto" in order to be afflicted by high levels of AIDS. 15132 - McKeesport. In terms of African-American population size, McKeesport is a somewhat atypical zip code, even though it still qualifies as a cluster I zip code. 22,927 or 82.76% of the residents are

White, while 4,519 or 16.31% are African-American, the second highest total African-American population in cluster I just behind the 15235 - Penn Hills zip code. What makes McKeesport one of the hardest hit zip codes in the cluster is that 28 of the 37 or 75.68% of the reported AIDS cases are African-Americans. Whites comprise 9 of 37 cases or 24.32 % of the total AIDS cases in 15132.

McKeesport, on the surface, appears to be a zip code where AIDS presents no significant threat. The large population size coupled with the only the 15th highest AIDS case rate of the 41 zip code sample, 137.174 per 100,000, gives the impression that McKeesport does not have a significant AIDS problem over all. Breaking McKeesport down by Race has already thrown doubt on that assumption, and looking at the AIDS cases by gender in addition to race furthers the analysis.

2 of the 9 White AIDS cases are females in 15132. The large White population reduces the AIDS case rate for White females to 16.014, which in comparison to other zip codes in the cluster or even in the larger sample is a relatively high rate. African-American females also endure a relatively high rate of AIDS. 11 of the 37 cases or 29.73% of all cases in 15132 are females and African-American. The rate for African-American females for 15132 is 454.170, 3rd highest in the entire sample. Even more upsetting is the fact that this rate is higher than the average African-American rate, (male and Female) for the entire 41 zip code sample, higher than the 268.542 average National rate for African-American females, and almost 29 times the 16.014 rate for White females in 15132. These are especially striking pieces of data because only 8.74% of the population in McKeesport are African-American females, whereas White females comprise 45.08% of the population. While there is no way of knowing exactly what mode of exposure category each African-American female case fits into, we can arrive at an assumption for which cells have substantial African-American female cases.

Of the 28 African-American cases, 6 were exposed through the male sex with male mode of exposure. The resultant rate for African-American male sex with male exposure cases is 286.123, not especially high for the cluster or the sample. Discounting the 6 male sex with male cases from our African-American female analysis, 18 cases of injection drug use as the mode of exposure gives McKeesport the 3rd highest total for cases of AIDS resulting from injection drug use, and the second highest rate of African-American Injection drug exposures, 398.318 per 100,000, in the entire sample. There is also 1 case of exposure through heterosexual contact for African-Americans in 15132, with a resulting rate of 22.129. Since there are 11 African-American females with AIDS in 15132, it is possible that a substantial number of African-American females were infected with AIDS through Injection drug use.

African-American males also face injection drug use exposure in McKeesport. Since only 6 of the 17 African-American male cases reported the male sex with male type exposure, it is also probable that a large number of African-American males were exposed through injection drug use. If we include the 2 White injection drug use exposure cases into the analysis, then we find that McKeesport is tied for 3rd in the city with 20 cases in that category of exposure.
The African-American male AIDS case rate is also unusually high in comparison to the 41 zip code sample. With a rate of 810.682 for African-American males, McKeesport ranks 9th for all zip codes in the larger sample.

In comparison to the Pittsburgh average for African-American males, McKeesport includes a rate higher than the Pittsburgh average rate of 709.305 cases per 100,000. There is a significant AIDS problem for African-American males in 15132 in addition to the extremely high rates for African-American females. Over all 15132 includes the 2nd highest Black to White ratio for AIDS cases with a figure of 15.784. Not only is that ratio extremely high for Pittsburgh, it also exceeds the 4.855 Black to White ratio for the country.

McKeesport presents itself as a multiply challenged zip code for the AIDS epidemic. What sets McKeesport apart from the rest of the 17 codes of the first cluster is that it exhibits very typical Wave II characteristics, with 20 of the 38 cases being injection drug use related, while more typical Wave I characteristics, such as male sex with male exposure fall far below the injection drug use category, comprising only 10 of the 38 cases. The way that McKeesport is typical of the cluster, and of the sample in general, is that surprisingly African-American male sex with male exposures

exceed White totals and rates for most of the zip codes in the cluster and the city. McKeesport has significant troubles for African-Americans while Whites far out populate African-Americans in 15132.

15201 - Arsenal. As opposed to McKeesport Arsenal is more typical of the first cluster and less extreme in its over all picture. Whites account for 88.51% of the population with a total of 13,640 residents, while accounting for 18 of the 21 AIDS cases or 85.71% in 15201. All the White cases are male, 15 of those being of the male sex with male mode of exposure. The over all rates for White males and White male sex with male are not extremely high for the city, although the 243.625 White male sex with male exposure rate is higher than the Pittsburgh average of 206.308, and just over the Pittsburgh White male rate of 230.232.

The African-American picture is not so dissimilar except for the proportion of AIDS cases to the over all African-American population, as is characterized for all zip codes of the first cluster. With no African-American female cases in the Arsenal zip code, 15201 is one of only 6 zip codes in the 17 zip code sample with no African-American female cases.

While African-American males comprise only 4.52% of the population in 15201, the 3 African-American male cases, 2 exposed through male sex with male and 1 through injection drug use, account for 14.28% of all AIDS cases in the Arsenal zip code. Even though White males account for 15 of the 17 cases of AIDS exposed through male sex with male exposure type, the African-American male sex with male rate per 100,000 is higher, 286.944 to 243.625. While Arsenal exhibits low Injection Drug totals in comparison to the rest of the 41 zip code sample, the area does exhibit significant male sex with male cases for African-Americans as far as the rate per 100,000 in comparison to the over all population of African-Americans in Arsenal, and in comparison to the White male sex with male rate despite the 15 to 2 ratio of White cases to African-American cases.

15202 - Bellevue. Bellevue is one of the most alarming zip codes of the first cluster because of the extremely high African-American male and female total cases and rates, while the African-American is so extremely small next to the White population in Bellevue. African-Americans comprise a miniscule percentage of the population, only 563 African-Americans reside there totalling 2.54% of the population, while accounting for 7 of the 25 AIDS cases or 28%. Bellevue also exhibits extremely high rates for African-Americans at 1,243.339 per 100,000, the second highest in the 41 code sample behind Sharpsburg. African-American males are hit by a 1,898.734 rate in 15202, the second highest in the sample, and in the cluster also behind Sharpsburg.

The over all rate for Bellevue is only 112.648, 19th in the larger sample ranking. The extreme majority of Whites in 15202, makes the zip code rate seem insignificant, while a simple race breakdown shows a different world all together. Fitting the same patterns, African-American male sex with males also comprise a disproportionate part of the AIDS picture for African-Americans, with 5 of 6 cases of African-American male exposure. African-American males comprise a remarkably low 1.4% of the over all 15202 population, but 28% of all cases.

The African-American female picture is also skewed with respect to population totals, but not as strongly as the African-American male picture. African-American females account for 247 of the residents in 15202, only 1.41% of the population and 4% of the over all cases, 1 of 25 total. The female rate is also high for Bellevue with a rate of 404.858 per 100,000 for African-American females, while there are no cases of White females with AIDS in the Bellevue zip code. The 404.858 African-American female rate is the 5th highest of all zip codes with cases of African-American females with AIDS, and is almost double the over all National rate for African-American females, 268.542 being that figure. Bellevue represents a huge policy challenge considering the astounding African-American male rates and proportion of cases considering the absolute minute percentage of the population they comprise.

15203 - Carson. Carson is one of the few zip codes where there are male sex with male AIDS cases, but no injection drug use exposure or heterosexual contact cases. Of the 28 total cases, 24 are White male sex with male with a comparatively high 481.541 rate, 6th highest in the 41 zip code sample. The African-American male sex with male rate is even higher at 833.333,

comprising only 2 of 26 cases of male sex with male category. The 224 African-American male residents of Carson comprise only 2.01% of the over all population of 11,146. Yet African-American AIDS cases, true for all zip codes of the 17 zip code cluster, exceed the percentage of the population of African-Americans, with 2 cases out of 28 total or 7.14%. Even though Carson compares favorably in its working class composition to other zip codes in the first cluster, it exhibits no cases of injection drug use related modes of exposure. Carson does include 1 White female case, with a rate of 17.575 comparatively low to zip codes where there are White females, but of course higher than those zip codes where there are not White female cases at all.

The Carson zip code does of course include the East Carson street commercial district, where many young Pittsburgh professionals congregate at and live in, and where the gay community of Pittsburgh does comprise a part of the "scene". The famed night-life of East Carson street may play a part in bringing significant numbers of White gay males into the same social network, but does not necessarily prescribe that one needed to enter into the East Carson street social scene to be exposed to AIDS.

The high working class composition DATA NEEDED HERE, may simply express the idea that being gay does not mean being affluent in the Carson zip code, or that all classes of people could be exposed to AIDS in multiple ways. Carson may be exhibiting a high rate of male sex with male exposure to AIDS for both Whites and African-Americans because a high level of unprotected male sex with male contact exists in the zip code, and not because of any specific demographic characteristics to support the practice of un-safe sex. More research needs to be done for this zip code since it does not include more typical Wave II characteristics, and because it still includes the 8th highest rate of AIDS per 100,000 in the 41 zip code sample with a figure of 251.211.

15204 - Corlis. Whites in Corlis make up 60% of the cases, and 88.97% of the population. African-Americans, true to form for cluster 1, make up 40% of the AIDS cases and a far smaller 10.52% of the over all population. African-American males account for 30% or 3 of 10 cases, while their membership of the population is a far smaller 4.68%. African-American females also share the brunt of the percentage breakdown, with 10% or 1 of 10 of the cases, yet only 5.84% of the population.

Upon examining the breakdown of cases by mode of exposure, an analysis of 15204 reveals that a very infrequent relationship exists between the number of cases of injection drug use and heterosexual contact as modes of exposure. Corlis is one of the few zip codes where the number of heterosexual contact mode of exposure cases exceeds the number of AIDS cases where injection drug use was reported as the mode of exposure. 2 of the 10 cases or 20% of the 10 AIDS cases in Corlis resulted from the heterosexual contact type exposure while only 1 of the 10 cases or 10% of the cases resulted from exposure to injection drug use.

A further breakdown by race produces expected results for characteristic cluster I zip codes, but also some unexpected results. An analysis of the 6 cases of the 10 total AIDS cases in Corlis yields a 66.622 rate per 100,000 for Whites, male and female. White males account for 4 of 10 cases, yielding a rate of 98.642, while comprising 40.89% of the population. All 4 White male cases were exposed through the male sex male mode of exposure, yielding the same 96.622 rate. African-American AIDS cases of male sex male exposure account for 2 of the 4 African-American cases, and an over all rate of 421.941, not significantly high in comparison to the other 40 zip codes in the larger sample, and not unusually high for cluster I.

2 White female cases were reported in Corlis, yielding a hefty 41.093 rate, the 2nd highest among all zip codes with White female cases. With 1 heterosexual contact mode of exposure for Whites, it is possible that that case is a female, regardless the heterosexual contact rate of 11.104 is ranks 4th out of the 14 zip codes with White AIDS cases exposed through heterosexual contact. The over all National heterosexual rate of exposure is 16.755, not significantly higher than the White Hetero-sexual rate in Corlis. The African-American heterosexual rate is 93.897, also calculated from 1 African-American case of AIDS through heterosexual contact, yields a much higher figure than the National rate for all races in the country. The 93.897 rate for African-American heterosexual mode of exposure is the 2nd highest figure of the 41 zip code sample, out of

15 zip codes with AIDS cases of African-American heterosexual mode of exposure. As a zip code Corlis seems to have escaped disproportionate rates of Injection drug use, while suffering from an advance in the heterosexual form of exposure, even though the total number of cases (2) is not an exceedingly high figure. But 2 of 10 cases or 20% provides a significant percentage when examining the 15204 zip code.

15205 - Crafton. For most data groups Crafton presents a straightforward example of a cluster I zip code. 23 of 28 AIDS cases, or 82.14% are White, 22 males and 1 female. 5 of 28 or 17.86% of the AIDS cases in 15205 are African-American, 4 males and 1 female. There are no cases of heterosexual contact cases in Crafton, and only 4 of the 28 reported injection drug use as their mode of exposure. What sets Crafton apart from most zip codes in the 41 zip code sample and cluster I, is that within the African-American cases, more cases were reported for the injection drug use mode of exposure than the number of male sex with male exposure cases in Crafton. The 4 injection drug use cases for African-Americans yields a 120.736 rate, which is lower than the 132.805 rate for the 41 zip codes in the sample. The African-American male sex with male rate is 75.586, which is the lowest rate per 100,000 out of all the zip codes in the larger sample where African-American male sex with male exposure cases exist.

Crafton also presents an atypical statistic for the 41 zip code sample, but not necessarily for cluster I, in that the percentage of African-American females, 8.01% of the population, is actually higher than the % of African-American female cases; only 1 of the 28 cases is an African-American female. Even though the typical pattern of population percentage vs. Case percentage does not occur in 15205 for African-American females, the rate for African-American females is still greater than the rate for White females, 50.251 to 8.821. African-American females and White females comprise the same percentage of cases in 15205, 3.57%, but White females make up 45.61% of the population of 24,859, while African-American females comprise only 8.01%. Perhaps the low case percentage can be accounted for since the total population of African-Americans is relatively high for a cluster I zip code.

15207 - Hazelwood. On the surface Hazelwood appears to have a low rate of AIDS compared to the city and the nation. Yet again a deeper analysis considering race and gender yields a different picture according to those demographic characteristics that tie the cluster zip codes together. Of the 16 total cases of AIDS in Hazelwood, ranking 15207 only 20th in the 41 zip code sample according to total AIDS cases, 9 are White and 7 are African-American. Whites comprise 56.25% of the cases while making up 84.07% of the population. African-Americans comprise a relatively high 14.95% of the population, but an extremely high 43.75% of the 16 cases in 15207.

Hazelwood, like Crafton, includes a higher total number of cases of African-American injection drug use exposure cases than African-American male sex with male cases. 4 cases of injection drug use exposure were reported as opposed to 3 male sex with male cases for African-Americans in Hazelwood. What is different from Crafton, is that the African-American male sex with male rate per 100,000 is higher than the African-American injection drug use rate, 294.406 to 175.285. African-American male sex with male exposure cases comprise 3 of 8 or 18.75% of the White and African-American male sex with male cases in Hazelwood. The Injection drug use category yields a different result. Of the 6 cases of injection drug use exposure in 15207, 4 or 66.66% of all injection drug use cases. This set of data relationships represents a larger trend for Pittsburgh, even African-Americans comprise a higher percentage of the total male sex with male AIDS cases than would be expected, White case totals are far greater in total number and percentage of most individual zip codes. The flip side is not true for injection drug use exposure cases. African-Americans tend to disproportionately feel the brunt of exposure to AIDS through injection drug use, especially African-American males.

In one other way, Hazelwood and Crafton are very similar, both zip codes exhibit lower percentages of African-American females for AIDS cases than for over all population percentage. In Hazelwood, African-American females total 8.20% of the population, but only 6.25% or 1 of 16 AIDS cases. One research question to answer would be why do these zip codes with lower total AIDS cases in proportion to over all African-American female population not suffer from similar

rates and case percentages of other zip codes with similar population percentages for race and gender in cluster I?

15211 - Mt. Washington. Mt. Washington's low over all population, 13,388 people, should produce a comparably low AIDS case rate per 100,000. The assumption holds little weight, since 15211 includes the 11th highest over all case rate at 209.143, but only the 32nd highest total zip code population. While only 2 total AIDS cases exist in the Mt. Washington African-American community, the resultant rates per 100,000 are relatively high for their percentage of the population. While only 3.57% of all cases in15211 are African-American males and an equivalent 3.57% of all cases being African-American females, the fact that only 212 African-American males or 1.58% of the population, and 246 African-American females, 1.84% of the population, live in the Mt. Washington zip code, forces the over all rates for African-Americans by gender to higher levels than the case totals should produce. The combined gender African-American rate per 100,000 is 436.681, 12th highest in the 41 zip code sample. The African-American rate is still higher at 471.698, putting Mt. Washington in roughly the same position among African-American male ranked zip codes. What is astounding is the fact that the African-American female rate is 406.504, (calculated for 1 case out of 28 total AIDS cases), almost as high as the African-American male rate, and 4th over all for those zip codes where African-American female AIDS cases exist.

For the White population, Mt. Washington presents a zip code hit relatively hard for White male sex with male exposures, with a subsequently less rate, percentage, and proportion of White injection drug use exposures. While 20 of 28 cases were reported as White male sex with male, only 3 cases were reported that were White injection drug use type exposures. The White male sex with male rate is not extremely high, holding roughly the same position across different ranking categories for the cluster and the larger sample. What is unusually high is the rate of White injection drug use per 100,000, a figure of 23.332 which is the 2nd highest White rate in the 41 zip code sample. Mt. Washington on the surface looks like the stereotypical Wave I zip code with high AIDS case totals for White male sex with male exposure to AIDS. A closer look at white injection drug use totals reveals that Mt. Washington may be vulnerable to more cases in this area, than perhaps even for African-Americans as a whole.

15215 - Sharpsburg. At first glance the 8 total AIDS cases, 25th in the larger sample, and the AIDS case rate of 62.676, ranking 33rd over all, would make Sharpsburg a zip code with a relatively insignificant AIDS presence, in comparison to the nation and the city. Whites make up a standard 87.5% of the AIDS cases with a total of 7 cases. African-Americans make up only 12.5% of the cases with only 1 African-American male case to speak of. There is one problem which makes that 1 case quite significant. There are only 71 African-Americans, 38 males or .298% of the population and 33 females or .26% of the residents in the entire zip code, where 12,764 people live. The African-American AIDS case rates are absolutely through the roof as a result of the fact that only 71African-Americans reside in the Sharpsburg zip code area. The over all African-American rate per 100,000 is an absurd 1,408.451, easily the highest in any sample in the report and far greater than the National rate for African-Americans. The same results occur when analyzing the African-American male rate which blows up to 2,631.579 per 100,000. What does bring the analysis back down to reality is the fact that the African-American case is a male, exposed through male sex with male type exposure.

The situation for whites is far more grounded. White case rates for 15215 are 56.270 over all, and 122.915 for males. What is interesting is that there is one case of a heterosexual contact case in Sharpsburg, yielding a rate of 8.039. While that figure in and of itself does not present a significant puzzle, the fact that the case is not a woman, and there are no female cases at all in 15215 does present a question. Do a substantial number of people in Sharpsburg visit other parts of the city for more social entertainment that may lead them into sexual situations where unprotected sex will occur? Or does the 1 heterosexual case represent a newly placed contingent in Sharpsburg wherein the heterosexual case moved in? These questions can not be answered by any acceptable method, but for this level of policy analysis, it is helpful to consider the transience issue more thoroughly than one would at first glance at 15215.

15216 - South Hills. The South Hills area is considered to be a relatively affluent residential area in the city of Pittsburgh, and with a relatively affluent residential community comes the stereotypically high rate of White male sex with male exposure case totals and rates, which is true for the South Hills. 29 white males of the 36 cases were exposed through the male sex with male exposure type. 4 of the 36 cases are however injection drug use related in their form of exposure to AIDS. 3 of the injection drug use AIDS cases are white, yielding a relatively high white injection drug use mode of exposure rate per 100,000, the figure being 11.519. Of all zip codes in the larger sample where white injection drug use as a form of exposure exists, 15216 places 9th out of 20 zip codes with injection drug use AIDS cases.
The African-American situation is quite different, with only 1 male injection drug use mode of exposure AIDS case reported. The African-American male rate is quite high at 540.541, despite the low case total. The rate can once again be explained because of the fact that only 185 African-American males or .69% of the total population reside in the South Hills zip code. Since the 1 case was reported as a cases of exposure through injection drug use, the rate per 100,000 is relatively high at 222.717. The African-American injection drug use AIDS rate places 5th among zip codes with at least 1 case of an African-American injection drug use exposure to AIDS.

Unless there exists a level of transience for the South Hills, or simply that injection drug use may lead an individual to many different places throughout a city to find and use injection drugs, it is possible that a significant level of contact exists between White injection drug users and African-American injection drug users. Stereotypical assessments of illicit drug users would propose that contact between races would most likely be minimal in an urban center like Pittsburgh, where African-Americans have historically felt a disproportionate brunt of most social, economic, and political ills, and continue to suffer from economic, social, and political isolation and marginalization. Perhaps the South Hills represents an area where at least some regular contact exists between illicit drug users of the two races.

15217 - Squirrel Hill. Squirrel Hill is almost identical to the South Hills zip code in terms of its AIDS case distribution. 35 of 37 cases or 94.59% are White, and Whites comprise 93.17% of the population. 30 of those cases were exposed through the male sex with male type exposure, while 3 cases of injection drug use exposures were reported for Whites. While the White male sex with male exposure rate is slightly higher than the rate for South Hills, 254.022 to 239.788, the injection drug use exposure to AIDS rates are almost the same, 11.754 for Squirrel Hill, and 11.519 for the South Hills zip code. As far as ranking the total number of white cases in comparison to the 41 zip code sample, Squirrel Hill ranks 5th with 35 cases, while 15216 ranks 6th. The African-American male case in Squirrel Hill was exposed through the male sex with male mode of exposure, resulting in a 312.500 rate per 100,000. Squirrel Hill does hold true to the pattern of African-American male percentage of population versus percentage of cases for cluster I. The 320 African-American males who reside in Squirrel Hill make up 1.17% of the population, while the 1 African-American AIDS case accounts for 2.70% of the total AIDS cases in 15217.

15218 - Swissvale. The 15218 zip code presents a more striking AIDS picture in terms of race, but also presents a chilling picture of rates for both Whites and African-Americans. Whites comprise 92.36% of the 16,434 residents. The White totals by gender include 6,872 males and 8,305 females, males account for 41.82% of the population and females account for 50.54% of the total Swissvale zip code population. While White males account for 18 of 28 cases, with relatively normal rates of White males per 100,000 and a similarly usual White male sex with male rate, White females account for 2 of the 28 cases, resulting in the 7th highest rate in the 41 zip code sample. While the White heterosexual contact exposure rate is only 6.589, with 1 case, there exists no cases of White AIDS exposure through injection drug use.

The African-American contingent in the AIDS case totals is extremely significant and worrisome. Despite the fact that African-Americans comprise 6.71% of the population, 7 African-American males and 1 African-American female are 28.57% of the total AIDS cases.
The 7 African-American male cases or 25% of the total cases far out total the 3.1% African-American male portion of the 15218 population. The over all African-American rate per 100,000 is 725.295, is almost double the Pittsburgh rate of 392.979, and is also higher than the National rate

of 558.772. The African-American rate is 1,375.246 placing 4th among the 41 zip code sample, and far above the 709.305 Pittsburgh average, and 849.003 National figure.

While the African-American female rate is not as striking at 168.350 per 100,000, and the African-American injection drug use as mode of exposure rate not especially significant at 181.324, the rate of heterosexual contact and male sex with male modes of exposure are especially noteworthy. Although only 1 heterosexual case of exposure to AIDS exists in the African-American community in 15218, the 90.662 rate places Swissvale 4th on the over all ranking chart for African-American heterosexual contact mode of exposure to AIDS. The African-American male sex with male rate of exposure to AIDS is a large 982.318, placing Swissvale 5th on the over all African-American male sex with male chart for the 41 zip code sample. The high rates for different African-American categories as compared with very low African-American populations, makes Swissvale one of the leading representatives of cluster I, where African-Americans represent less than or equal to 19.78% of the population, and where there exists less than 50 cases of AIDS.

15220 - Wabash. Wabash presents a very difficult AIDS picture to analyze. The 20 AIDS cases reported in Wabash rank 15220 18th over all, right around the middle of the pack. The rate per 100,000 is also comparatively low at 104.932 also around the middle of the pack, ranking Wabash at the 21st position. Whites make up 92.67% of the population and 90% of cases in the zip code. 17 White male cases were reported 16 of which reported the male sex with male mode of exposure. 8,410 white males live in the Wabash zip code, while White males account for 85% of the AIDS cases in Wabash. There is one White female with AIDS in Wabash, and 1 report of a heterosexual exposure. This may imply that the woman was exposed through heterosexual contact, but it does not mandate this interpretation.

What is especially interesting about Wabash, is that even though their is a high total of AIDS cases with the male sex with male type exposure, there are no cases of injection drug use as mode of exposure for either African-Americans or Whites. Of the two African-American cases 1 is male reporting the male sex with male exposure, while the 1 African-American female reported the heterosexual contact mode of exposure, accounting for the highest rate for African-American heterosexual exposure in the 41 zip code sample, with a rate of 107.759. Once again the rate may be inflated because of the low African-American population, totaling 928 residents. But the fact that these zip codes with extremely low African-American populations, and yet consistently higher rates of AIDS sensitive to specific exposure modes or gender, must point to a substantial AIDS problem in those neighborhoods like Wabash, where African-Americans no matter what their size, feel the brunt of the epidemic disproportionately when considering the percentage of AIDS cases versus the percentage of African-American populations.

15222 - Downtown. The first thing to note about Downtown is the small population size relative to the rest of the zip codes in the cluster and the larger sample. Only 1,704 people live in 15222, and while only 10 cases exist there, placing 24th over all, the rate per 100,000 is the 2nd highest in the city at 586.854. As with most urban centers across America, the stereotype of the depressed "downtown" environment with high rates of drug and alcohol abuse, would produce an impression that AIDS in the Downtown area would be most likely the result of injection drug use, even prostitution, or some other marginalized behavior that is associated with an American urban center. The fact is that of the 10 cases in 15222, only 1 was the result of an exposure to unsafe injection drug use. That case is an African-American male, and while African-Americans account for 2 of the 10 cases and still only 19.77% of the population, the rate per 100,000 for African-American male sex with male exposure is more than 2 times the rate for African-American injection drug use type of exposure, 602.410 to 296.736.

Of the 8 White male cases, 7 were exposed through the male sex with male exposure type, resulting in a rate of 1,348.748 per 100,000, the highest in the 41 zip code sample. One may interpret the high male sex with male rate by asserting that a number of more affluent White gay males live in the Downtown zip code, but the demographic characteristics make that less likely than an assertion that their is a significant working class, or non-affluent White gay population in the Downtown area. The same may be said for African-Americans in the Downtown zip code. Also,

Downtown is not a far distance from the Uptown zip code where a substantial number of Injection drug use cases exist, and it may be that some of the Uptown drug networks have spilled into the downtown area, or even simply that the 1 case, represents a man who lives in 15222, but uses injection drugs in the Uptown zip code area.

15235 - Penn Hills. 15235 represents the largest population in the 41 zip code sample, and the largest African-American population in the 17 zip code cluster, with 2,827 African-American males, 6.73% of the population, and 3,025 African-American females, 7.20% of the population in Penn Hills. There exist 39 cases within the boundaries of 15235, 9th over all in the 41 zip code sample. 15235 is also one of the few zip codes in the first cluster where the percentage of African-American females in the population is a higher figure than the percentage of African-American female AIDS cases. The 66.116 African-American female rate per 100,000, is the 2nd lowest rate per 100,000 of all the zip codes where there are at least 1 African-American female AIDS case.

The large population in the Penn Hills zip code contributes to the high number of cases, but also to the relatively low rates of AIDS across other demographic lines. The 26 White cases in Penn Hills places that zip code 8th on the over all list of White AIDS case totals per zip code. The White AIDS rate, however, is only 23rd on the over all White AIDS case rate list, with a figure of 72.823. Still Whites comprise 26 of 39 cases or 66.66% of all cases. There is one case of a heterosexual contact type exposure, but no cases of exposure through injection drug use, and 23 of 29 cases are White males who were exposed via the male sex with male mode.

The African-American distribution of cases does not resemble the White distribution at all. Of the 13 African-American cases in 15235, 7 are males exposed through male sex with male mode, 3 cases were exposed through the injection drug use mode, and 2 cases were exposed through unsafe heterosexual contact. The individual rates for African-Americans in Penn Hills are relatively low because of the high population totals for African-Americans with respect to the population numbers of the first cluster. Still, African-American males make up 28.21% of the AIDS cases in 15235, while only comprising 6.73% of the population. The African-American picture is more typical of a more urban zip code where higher injection drug use exposure rates and higher heterosexual exposure rates exist. 15235 presents a multiple challenge for outreach considering the multiple modes of exposures that have assaulted the African-American community there.

15236 - Pleasant Hills. Simply by looking at the population proportions of 15236, where there are 35,526 Whites and only 433 African-Americans, the logical prediction for the distribution of AIDS cases would be mainly amongst Whites, with the existence of a possibility of 1 or 2 African-American AIDS cases, as the proposed cluster I pattern has exposed for those zip codes that qualify in terms of population data. That logical prediction is actually correct, since 17 of the 19 cases are White, and all 17 White cases are male. Where Pleasant Hills goes off the standard and on to an extremely unusual tangent is in the gender distribution of African-American AIDS cases. The 2 African-American cases in Pleasant Hills are both females, causing Pleasant Hills to place number 1 on the ranking list of African-American female AIDS case rates with a figure of 816.327 per 100,000. In fact, 15236 is the only zip code in Cluster I and in the entire 41 zip code sample, where there exist cases of African-American females with AIDS but no African-American males with AIDS.

Observing the zip code map, we find that Pleasant Hills is situated at the very bottom of the outlined 41 zip codes, and borders only 3 other zip code areas in the sample, Castle Shannon (15234), Brentwood (15227), and Hazelwood (15207). Both Brentwood and Castle Shannon include no African-American AIDS cases whatsoever. Hazelwood does include 7 African-American cases out of 16 total cases, and only one African-American female case, less than the number of African-American female cases in Pleasant Hills. Although the difference between 2 cases and 1 cases may seem insignificant, the following analysis may shed some light on why we should examine 15236 more closely.

First, even if the fact that there are only 2 African-American AIDS cases in the Pleasant Hills zip code we may conclude that it is very strange that there are 2 African-American female cases in Pleasant Hills and only 1 in Hazelwood where there are far more African-Americans, and

far fewer Whites than in 15236. African-Americans comprise 1.20% of the 15236 population, only 433 people, while comprising a hefty 14.95% of the Hazelwood population, the 3rd highest African-American presence in the 17 zip code sample. The total White population in Hazelwood is the 6th lowest in cluster I, with a total of 12,829 residents. Whites in Pleasant Hills total 35,526 people. Yet African-American female case rates are higher in Pleasant Hills, and the number of cases is also higher.

What further confounds the issue is that Hazelwood has a relatively high proportion of African-American Male cases in comparison to their portion of the population, where they account for 6 cases or 37.5% of cases while only making up 6.68% of the population. Hazelwood African-American females actually account for a lesser percentage of AIDS cases than the percentage of their population, 6.25% of cases and 8.28% of 15207 residents. Pleasant Hills is in some ways the exact opposite, since there are no African-American male AIDS cases at all, and the percentage of African-American female AIDS cases, 10.53% of the total AIDS cases, far outweighs the percentage of African-American women in the over all population, .68% of all 15236 residents.

If their is no connection between Hazelwood and Pleasant Hills in terms of the gender comparison for African-Americans, or if their is, still there is the fact that the other two zip codes that border 15236, Castle Shannon and Brentwood, have no African-American AIDS cases at all, male or female. A set of questions pops up when these set of facts are proposed; what made or makes African-Americans in 15236 more vulnerable than in 15234 or 15227? What are the demographic similarities between them that further support the premise that Pleasant Hills is an uncanny trouble spot? What are the differences that make 15236 look like a freak phenomenon, or what are the distinct characteristics of African-Americans in Pleasant Hills or all people there in general that increases the likelihood of AIDS according to certain demographic factors? Or simply are the two African-American females residing in a drug rehab clinic? That question would be immediately quashed once the mode of exposure statistics are viewed, since there are no cases of African-Americans being exposed to AIDS through injection drug use, or even heterosexual contact.

All of the preceding questions meet at one specific proposition, which is that the 2 African-American females cases shouldn't be in Pleasant Hills, not that they shouldn't exist, or that they shouldn't live in Pleasant Hills while living with the disease, but that they shouldn't have been their in the first place, especially since their are no African-American male cases of AIDS in that very zip code. These questions then lead us to another point; The situation of Pleasant Hills should be examined very carefully. Pleasant Hills may be our demographic "dream" in the sense that the zip code exhibits many problems that African-Americans face in Pittsburgh, isolation, joblessness, and other factors that contribute to this anomaly of case distribution by gender and race. Even if some of the conclusions offered here are false, or some of the questions simply unanswerable, Pleasant Hills, with the highest African-American female AIDS case rate in the 41 zip code sample, a rate that simply destroys the national rate of 268.542, and the absence of African-American male cases, and the lack of crucial AIDS case and demographic connections between the zip codes that border it, could be our best point of entry into realizing helpful strategies to combat the epidemic amongst African-Americans in places like Pleasant Hills.

15237 - McKnight. The final zip code that can be characterized by the cluster I trends of 79.93% White or more, and 19.78% African-American, and less than 50 AIDS cases with at least 1 African-American case is 15237. In terms of White population size McKnight very much resembles Pleasant Hills and Penn Hills, creating a three pointed category within Cluster I, since Penn Hills is east of the City, Pleasant Hills is south of the Monogaheila river, and McKnight is north of the Allegheny river, in the area characterized the North Hills. All three have very large White populations, the three largest in the cluster and all containing more than 30,000 Whites.

McKnight has the highest total of Whites in the entire 17 zip code cluster and the highest total of Whites in the entire 41 zip code sample. Yet McKnight exhibits only the 15th highest White AIDS case total in the 41 zip code sample with a figure of 25 cases. The White case rate in 15237 is 64.805 per 100,000, only 29th of 41 zip codes in the larger sample. Like many other zip codes in the cluster and the larger sample, 25 of 26 cases are White, and 24 of 26 are White Males. In terms

of mode of exposure, 18 of 26 cases in 15237 are White males exposed through male sex with male type exposure, resulting in a rate of 99.585 for White male sex with male exposures, fairly low for the cluster and the sample. There is 1 case of a White female infected with AIDS, and 1 case of a White person exposed to AIDS through the injection drug use mode of exposure. But both rates are relatively low considering the fact that McKnight includes the highest White population in the 41 zip code sample.

The 1 African-American case, a male exposed through the male sex with male type of exposure, predictably results in a disproportionately high rate of African-American male sex with male AIDS cases per 100,000, a figure at 621.118, 7th highest in the larger sample and 5th highest in the cluster. Again, the McKnight situation expresses the idea that just because a zip code includes African-American cases does not mean that those cases can be characterized by more typical wave II exposures like injection drug use and heterosexual contact. As shown by many other sources in the project there are far more African-American cases of male sex with male exposures than there are of injection drug use exposures. Still, McKnight includes a smaller African-American population, .407%, than the percentage of African-American cases 3.85%, typical of all zip codes in cluster I.

Cluster II - Zip codes with White populations between 62.35% - 77.78%, and African-American populations between 21.53% - 37.20%

By location Rankin, Observatory, both North of Allegheny and Ohio Mt. Oliver, Duquesne, both South of Monogoheila Bloomfield interior peninsula of city.

15104 - Rankin. The first thing that jumps out about Rankin is that 7 out of 10 AIDS cases in Rankin are African American. The second and most striking fact of all, is that of those 7 African-American cases 4 are females. African-Americans make up 37.20% of the population and 70% of all cases. The over all African-American rate is relatively low, at 135.370 per 100,000, which can be attributed to the high population relative to other zip codes. Of the 13,901 people who live in Rankin, 5,171 are African-Americans. Whites account for 30% of the 10 cases, and 62.35% of the population, with a total of 8,667 residents.

The percentage of African-American female AIDS cases, at 20.898%, is just over half the percentage of African-American female AIDS cases which at 4 of 10 cases amounts to 40% of Rankin's cases. The rate, as a result of the high population of African-American females relative to most but not all zip codes in the 42 zip code sample, is only 16th out of 21 zip codes with at least 1 African-American female case. Rankin is also the only other zip code besides Pleasant Hills where the African-American female rate is higher than the African-American male rate. Pleasant Hills is of course a different case because there are no African-American male cases. The African-American male rate is only slightly lower, at 132.392, not really a very significant difference.
Within the Rankin zip code, the 4 African-American female total is higher than the White male total of 3 cases, higher than the African-American male total of 3, and of course higher than the White female total of 0. Rankin represents another area where African-American females represent a large chunk of the AIDS cases in the zip code, while White females either do not account for any cases or far fewer cases.

Rankin also represents another area where African-Americans disproportionately feel the brunt of injection drug use as a mode of exposure, when compared to their White counterparts. The only 2 cases of exposure through injection drug use are both African-American. Since the African-American population in Rankin accounts for a relatively higher percentage of cases the African-American injection drug use rate is actually quite low for zip codes with African-American AIDS cases that were exposed through that mode with a figure of 38.677. African-Americans also account for the only case of a transmission through the heterosexual mode of exposure. Only 1 case reported that mode of exposure and the resultant African-American rate is subsequently quite low, with a rate of 19.339, 3rd lowest of the 15 zip codes with at least one case of an African-American with AIDS that was exposed through heterosexual contact.

15110 - Duquesne. 15110 represents the least populated zip code in cluster II with a total of 8,525 residents. The 5,742 Whites and 2,619 African-Americans represent the smallest totals for cluster II as well. The percentage distribution is actually right in the middle of the cluster, with 67.35% Whites and 30.72% African-American. Duquesne does have similarities with Rankin, both zip codes include a higher total of African-American AIDS cases than White cases, even though Whites comprise the majority of the population. The Black to White ratio of AIDS cases per 100,000 is 5.481, 7th in the 42 zip code sample, and higher than the Pittsburgh average of 3.472, higher than the Allegheny ratio of 4.090 and higher than the U.S. ratio of 4.855. The over all African-American AIDS case rate per 100,000 is not very high, with a figure of 190.913. The White rate is much lower still with a figure of 34.381 per 100,000, one of the lowest in the sample.

Duquesne is a zip code that includes no female AIDS cases, White or African-American. Of the 8 cases in Duquesne, 5 are African-American males, and 2 are White males. The resultant African-American male AIDS case rate per 100,000 is not high for the 42 zip code sample, but is 2nd behind Bloomfield in cluster II, which includes only 5 zip codes. Both White males reported the male sex with male type exposure, while only 3 of the 5 African-American males with AIDS reported that mode of exposure. 2 African-American males with AIDS reported injection drug use as their mode of exposure, resulting in a rate of 76.365, not very high for the 42 zip code sample, but significant in that there are no White cases of injection drug use as the mode of exposure. Even though the rates are not astoundingly high, the duquesne situation supports ceertain major trends in the larger sample, including the fact that surprisingly more African-American AIDS cases were exposed through the male sex with male category than through injection drug use, and that injection drug use affects the African-American community much more than it does the larger White community. Duquesne also supports the idea that a significant number of the African-American male AIDS cases who were exposed through the male sex with male mode of exposure, are working class/poor African-Americans who do not self identify as gay, but just the same engage in the behavior, Duquesne probably supports this claim since it is a primarily a poor working class zip code over all, and sinceit is a town that was once supported by a steel mill, characteristic of most of Pittsburgh history.

15210 - Mt. Oliver. 15210 includes the highest number of Whites in cluster II, with a total of 27,577 people, and the highest number of African-Americans in cluster II as well, with a total of 7,632 people. The resultant populations percentage is actually the highest for Whites in cluster II with a 77.78% figure and lowest for African-Americans with a figure of 21.53%. In that way Mt. Oliver could be characterized as a cluster I zip code since the percentage of African-American AIDS cases, 43.24% more than doubles the percentage of African-Americans in Mt. Oliver, 21.53%. The high number of African-Americans in Mt. Oliver arguably makes it more efficient to look at it as a cluster II zip code, regardless of the high White population.

Of the 37 AIDS cases in Mt. Oliver, 20 are White and 16 are African-American. What is more striking is that while there are 16 White male cases and 4 White female cases, the African-American case distribution broken down by gender reveals 9 African-American male cases, and 7 African-American female cases. While the White female AIDs case total is the highest in the sample with 4 cases, the 7 African-American female cases is the 5th highest case total in the 42 zip code sample, and the highest case total in cluster II. The rate for White females is 27.218, 5th highest among those zip codes with at least 1 White female case, while the resultant rate per 100,000 for African-American female AIDS cases is one of the lowest among zip codes with at least 1 African-American female case, with a figure of 160.846. Yet the percantage of African-American female AIDS cases, 18.92%, is higher than the percentage of African-American females in Mt. Oliver, with a figure of 12.27%. The rate is relatively low considering that Mt. Oliver's 35,455 people rank it 6th in the 42 zip code sample in terms of population size.

The population size for Whites in 15210 also contributes to the higher rate of African-American male sex with male mode of exposure than the same mode of exposure rate for Whites, 182.927 to 116.451. White males account for 15 AIDS cases exposed through the male sex with male mode, while African-Americans account for 6 such cases. In terms of this specific mode of

exposure, the percentage of African-American cases is 6 of 15 or 40%, while African-American males only account for 9.25% of the population.

Mt. Oliver is also similar to 15110, in that the number of African-American AIDS cases exposed through injection drug use is very close to the total of male sex with male exposures for African-Americans with a total of 5 cases of exposure through injection drug use. While the 5 cases in Mt. Oliver out number the 2 cases of the same mode of exposure in Duquesne, the high population totals account for a lower rate per 100,000 of injection drug use as mode of exposure, with a rate of 65.514. Mt. Oliver is also different from Duquense in that there exist cases of Whites exposed to AIDS through injection drug use. The White rate for this exposure is also low in Mt. Oliver with a rate of 10.879 per 100,000 while accounting for 3 cases total.

Mt. Oliver provide further statistical shocks; the number of African-American AIDS cases exposed through heterosexual contact is the same total of White AIDS cases exposed through injection drug use, both categories include three cases, but the rate of African-American exposure through heterosexual contact is higher than the White exposure through injection drug use, 39.308 to 10.879. In addition, there is 1 case of a White person being exposed through heterosexual contact, resulting in the second lowest rate, 3.626 per 100,000, among the 14 zip codes with at least 1 White case of exposure through heterosexual contact.

Mt. Oliver is also a predominantly working class zip code, although it borders Mt. Washington, considered to be a more affluent area. As a result we may hypothesize that a substantial number of cases both African-American and White, that were exposed through the male sex with male exposure qualify as working class. While African-American males of the working class in Mt. Oliver who were exposed through male sex with male type exposure may not self identify as gay, their White counterparts may not necessarily exhibit the same behavior, or they may exhibit the same behvaior, either way a further analysis of how class affects the issues of self identification and racve would be relevant considering the AIDS case situation in Mt. Oliver.

15214 - Observatory. The Observatory area includes some unusual statistical The Observatory area includes some unusual statistical facts considering its membership in cluster II. The overall multiracial AIDS case rate per 100,000 for the entire zip code is 205.741, higher than the Pittsburgh average of 157.25, but still lower than the national 228.003 rate as most of the 42 zip codes are. The White male sex with male exposure rate per 100,000 is 8th among the 39 zip codes with at least one such case of exposure, with a rate of 358.974. This rate is substantially higher than the Pittsburgh average rate of 206.308 for male sex with male type exposure for White males, and higher than the Observatory rate for African-American males, highly unusual though not the only zip code with this relationship..

While the Observatory zip code is 2nd behind Mt. Oliver in terms of total African-American population, with a figure of 7,011, it ranks 2nd in the cluster with a 35.18% figure of African-American population proportion. The 41 cases in 15214 make it the hardest hit zip code in cluster II in terms of AIDS cases, and 7th among the 42 zip code sample. Of those 41 cases, 17 are African-American, making the percentage of African-American cases 41.46%, still higher than the percentage of African-American people in 15214, a figure at 35.18%. The number of African-American male cases is 11, or 26.83% of all cases in 15214, while African-American males account for 15.89% of the population. African-American females account for 6 of 41 cases or 14.63% of all cases, and 19.29% of the population, not unusual for the 42 zip code sample, though not typical either. Observatory includes 22 White male AIDS cases, tied for 10th in the 42 zip code sample, and resulting in a rate of 376.068, making 15214 the only zip code that includes a higher White male rate per 100,000 than African-American male rate per 100,000.

Observatory appears more typical of the sample when analyzing the injection drug use mode of exposure as it is distributed by race. While there are 7 cases of African-Americans being exposed to AIDS through the injection drug use mode, there are no cases of Whites being exposed through the same mode. One might conclude that since Observatory includes both a substantial number of working class Whites as well as working class African-Americans, that the injection drug use mode would be more equally distributed across racial lines. The fact is that with no White

cases exposed through this mode, that Observatory exhibits the constant trend of Pittsburgh in that African-Americans unduly bear the brunt of being exposed to AIDS through injection drug use.

The category African-Americans and Whites share a more equal responsibility for the same mode of exposure is the heterosexual contact mode of exposure. While African-Americans still, as expected, comprise the majority of cases exposed through the heterosexual contact mode, the difference between the 2 races is only 1 case. African-Americans account for 3 cases through that mode while Whites account for 2 cases. The African-American rate per 100,000 according to the heterosexual mode of exposure is of course higher considering they make up far fewer people in 15214, the two rates being 42.790 for African-Americans, and 15.721 for Whites. The African-American heterosexual contact rate is 6th among the 15 zip codes with at least 1 case of an African-American heterosexual contact exposure. The White rate for heterosexual contact exposure is 2nd among the 14 zip codes with at least 1 case of a White heterosexual contact mode of exposure.

The data presented may suggest an unusual conclusion, assuming for a moment that people in Observatory and Allegheny do not exchange a lot of "traffic". Since there are no White cases of exposure through injection drug use in 15214, and 2 cases of Whites being exposed through the heterosexual contact mode of exposure, it is possible that the African-American injection drug use case load and the White heterosexual and African-American heterosexual contact case load may be representative of substantial contact between the two races in the area of drugs, or possibly sex for drugs.

Let us consider for a moment that people in Observatory, specifically those people who comprise the AIDS case load, have insignificant contact with people in Allegheny. If in fact those two White heterosexual contact exposure cases have something to do with the 3 African-American cases of the same exposure type, and the 7 African-American injection drug use exposures, then it might be possible to conjecture that there is some contact between Whites and African-Americans in the realm of illicit drug consumption. Often times a user could be forced to sell sex to sustain their habits, and in those case many times sex will be exchanged directly for drugs. Perhaps 15214, or simply the possibilities proposed here may lead to a new understanding of unusual levels of contact between White and African-American substance abuse communities.

15224 - Bloomfield. Bloomfield, like Observatory is one of the few zip codes where the White male sex with male exposure rate per 100,000 is actually higher than the rate of African-American male sex with male exposures. The rate per 100,000 for White males exposed through the male sex with male mode is 472.122 as compared with the African-American rate of 407.451 per 100,000. The difference in cases is 21 for Whites through the male sex with male exposure and 7 for African-American males. African-American males account for 11 of the 34 cases, while White males account for 22 cases. There is one White female case, but no African-American cases, making Bloomfield and Duquesne the 2 zip codes in cluster II with no African-American female cases.

African-Americans, male and female, comprise 27.15% of the population, with a total of 3,901 residents, while African-American males account for 32.35% of all AIDS cases in15224. Even though the White male sex with male exposure rate is higher than the African-American male sex with male exposure rate, the African-American male rate of 640.279, sensitive to the 11 total African-American male cases, is higher than the White male AIDS case rate of 494.604. The White female AIDS case rate is 17.085, not one of the higher zip code rates in the 42 zip code sample, and lower than the rates for Observatory and Mt. Oliver the only other 2 zip codes in cluster II with at least 1 White female AIDS case.

African-Americans in Bloomfield account for more cases of exposure through injection drug use a common trend throughout the sample. 3 of the 4 cases of exposure through injection drug use are African-American males, a deduction made possible by the fact that there are no African-American female cases in 15224. The subsequent rate per 100,000 for African-Americans is 76.903, while the 1 White case of exposure through injection drug use creates one of the lowest rates of White injection drug use exposure of those zip codes with at least one such case, with a rate of 9.708.

The fact that both races contribute to the total case load exposed through the injection drug use mode does not necessarily point to a significant level of contact between illicit drug users of the 2 races in 15224. Bloomfield includes segmented neighborhoods that include African-Americans and Whites, and the segmentation or isolation is real for both races. Liberty avenue, around which many of Bloomfield's Whites live, houses a very commercial shopping collective, with many of the stores and restaurants owned by Italian-Americans and other predominantly White Catholic communities. A few blocks north, closer to Penn avenue, one enters into a predominantly African-American shopping district, in the Friendship residential neighborhood. While many Whites, and college students live in the area just south of Penn avenue, there exists very little contact between the two economic areas. While this may not be representative of the drug culture between the 2 neighborhoods that are placed into the same zip code, it does point to a feeling of separation and isolation between the two areas. Either way, there can be one conclusion that should hold water, both injection drug communities are from working class backgrounds, and the possibility exists that many of the males who reported the male sex with male mode of exposure, both African-American and White, also come from predominantly working class backgrounds.

Cluster III - Zip codes with more than 50 total AIDS cases, and still including an African-American minority.

That African-American minority may account for a percentage of the population more analogous to cluster I, cluster II, or even higher African-American population percentages than either cluster. The important thing is that all cluster III zip codes include more than 50 AIDS cases but still include African-American population minorities.
Also the African-American communities in Wilkinsburg, Oakland, and East Liberty are typically considered to be of the poorest in the city, while there is evidence that many African-Americans in Allegheny are more affluent, while the much of the Shadyside situation for the African-American population spills over into the East Liberty zip code without doubt.

15206 - East Liberty. 15206 is a zip code with the highest AIDS case total in the 42 zip code sample, with 159 total cases. The racial distribution of those cases paints a very distinct division between the White community in East Liberty, and the African-American community there. The White population, totaling 19,474 residents and 52.26% of the population, a percentage majority which is the smallest White percentage of 5 zip codes in cluster III. The White community seems to have endured a clearly Wave I pattern of AIDS, with 66 of the 73 White AIDS cases reporting the male sex with male exposure. The African-American male sex with male exposure total if also the highest mode of exposure for that community with a total of 46 cases, representing a significant membership in the Wave I pattern as well.

What sets the 2 races apart in 15206, is that the African-American case totals for injection drug use and heterosexual contact, in addition to the African-American male sex with male exposure category, are also the highest case totals for those modes of exposures in the 42 zip code sample, while Whites comprise very few cases for those modes of exposure relative to their African-American counterparts. East Liberty, therefore, is our best individual example of a zip code where African-Americans almost exclusively feel the brunt of the more typical Wave II spread of AIDS.

The African-American population in East Liberty is the highest total in the 42 zip code sample. There are 16,968 African-American residents in 15206, resulting in a 45.53% figure for the African-American contingent in 15206, also the highest African-American composition in any zip code in the 42 zip code sample, except those 3 zip codes in cluster IV where African-Americans actually compose the majority of the zip code population. The 83 total African-American AIDS cases are 52.20% of all AIDS cases in 15206, still a higher figure than the African-American percentage of the over all population, typical of most every zip code where there is at least 1 case of an African-American with AIDS.

African-American males account for 20.596% of the 15206 populaiton, and 7,675 residents. The number of African-American AIDS cases is also the highest total number of AIDS cases for that category in the 42 zip code sample, with a total of 68 cases, which accounts for 42.77% of all AIDS cases in 15206. The African-American male rate per 100,000 is also very high, but not the highest in the sample, with a rate of 885.993, which is higher than the Pittsburgh average rate of 709.305 for African-American males and one of the few rates in Pittsburgh where the figure is higher than the national average rate for African-American males, where the rate is 849.003. The White male rate is also higher than the national average rate, 788.288 to 212.945, and higher than the Pittsburgh rate of 230.232. With a simple analysis of bi-racial AIDS rates for males of 15206, one might conclude that the AIDS brunt is being equally shared in 15206, and shared in much the same way. Further analysis according to gender and according to modes of exposures reveals otherwise.

First off while White and African-American case totals are similar for males, the female picture is drastically different, while the 3 White female cases are high for the sample, the 15 African-American female cases is the absolute highest number of cases in the 42 zip code sample. The resultant rates are not the very highest in the sample, but they are high just the same. The African-American female AIDS case rate per 100,000 of 161.412 is higher than the Pittsburgh average rate for African-American females of 131.851, while lower than the national rate of 268.542. The White female rate of 28.318 is higher than the national rate of 17.256 and higher than the Pittsburgh average rate for White females of 10.620. All the case rate comparisons show that nationally, in the 42 zip code sample and 15206, that African-American females are feeling the brunt of the AIDS epidemic in much higher proportions than their White female counterparts.

When assessing the three main modes of exposure African-Americans account for most of the wave II spread, while still accounting for a substantial percentage of the more typical Wave I mode of exposure.

In terms of Wave II modes of exposures, the most striking statistic is the 11 Heterosexual contact mode of exposure cases for African-Americans. Coupled with the 3 White heterosexual contact exposures, 15206 represents the only zip code where the total number of heterosexual contact mode of exposure cases reaches double digits, or even as a high as 6 cases. The African-American heterosexual contact exposure cases alone account for the highest total, African-American and White, in the entire 42 zip code sample. The high populations skew the importance of the rates for these racial modes of exposures, with only a 64.828 rate for African-Americans, 5th highest of the 15 zip codes with at least 1 case of an African-American person being exposed through the heterosexual contact mode. The White heterosexual contact AIDS case rate per 100,000 is 15.405, the 3rd highest of the 14 zip codes with at least 1 case of a White person being exposed through the heterosexual contact mode.

The bi-racial breakdown of injection drug use as a mode of exposure in 15206, reveals much the same picture as the heterosexual contact realm. 25 of the 27 cases of exposure through injection drug use are African-American, making the 25 cases the highest total number of injection drug use exposure cases in the 42 zip code sample, but not nearly the highest rate per 100,000 for that specific mode of exposure for African-Americans. The White case total of 2 cases results in a comparatively small rate of 10.879, not even in the top 10 for White injection drug use total exposures to AIDS.

While African-Americans account for 78.57% of the bi-racial heterosexual contact mode of exposure case total, and 92.59% of the bi-racial injection drug use mode of exposure case total, African-Americans account for only 41.07% of all White and African-American male sex with male exposure cases. Of the 112 cases of male sex with male exposure, highest in the 42 zip code sample for the combination of Whites and African-Americans, 46 are African-American cases, and 66 are White cases. The resultant White rate is 743.243, 4th highest in the sample, and the African-American rate per 100,000 for the same mode of exposure is 599.349, only 9th in the 42 zip code sample. 6 out of the 8 zip codes above East Liberty on the African-American male sex with male exposure list, are cluster I zip codes, where very small African-American populations exist.

The real question that plagues an analysis of 15206, is not why are the case rates comparatively lower than the national rates or even low compared to the Pittsburgh lists. The most

important question is why the African-American community is facing both the Wave II and Wave I patterns of AIDS exposure, while the White community accounts for a slight minority of the cases 73 of 159 are White AIDS cases, and still a majority of the population. East Liberty is not a zip code populated with 5,000 or so residents, which could explain why the White AIDS case distribution is heavily representative of a Wave I pattern. East Liberty includes the 4th highest population of the 42 zip code sample, with 37,264 residents.

One could argue that the large size of the population for both African-Americans and Whites in 15206 is representative of the idea that Pittsburgh does not have a significant AIDS problem when considering how this zip code compares to national AIDS statistics. Even if that is true, why then are African-American male sex with male exposure cases so high, and White Wave II pattern exposures so low? Why is the African-American community singularly facing the brunt of the second major AIDS pattern, while the White community is safe under the Pittsburgh wing of insignificant AIDS case rates and totals? More research needs to be done as to why the primarily working class Whites in 15206 do not face the same difficulties that their working class African-American counterparts face in 15206.

15212 - Allegheny. Allegheny is right behind East Liberty in total AIDS cases with 133. Allegheny also has a similar total population as 15206, with 35,320 residents falling within the boundaries of 15212, the 7th highest total in the 42 zip code sample. Allegheny is also right behind East Liberty in terms of AIDS case rate per 100,000 for the whole zip code, Allegheny includes a rate of 377.305, 5th highest in the sample, while East Liberty includes a rate of 426.685, 4th highest in the sample. One area where the 2 zip codes differ greatly is the proportion of Whites and African-Americans in terms of total population. Unlike East Liberty, Allegheny includes one of the highest White populations in the 42 zip code sample, with 29,702 residents. The African-American population is remarkably low compared to the White population, with a total of 5,284 people. So while the African-American population only comprises 14.99% of the total population, 35.39% of all AIDS cases or 47 cases out of 133 are African-American in 15212.

The racial distribution according to mode of exposure is not as shockingly skewed towards an East Liberty type distribution as one might expect. Whites account for 2 cases of heterosexual contact exposure, with a rate of 15.721, the 2nd highest White heterosexual contact exposure rate of those 14 zip codes with at least 1 White heterosexual contact exposure case. The African-American heterosexual exposure case total is 3, still higher than the White case total, and the rate per 100,000 is higher than the comparative White rate in 15212, with a figure of 42.790, 6th over all among the 15 zip codes with at least 1 African-American heterosexual contact exposure case. Despite the fact that African-Americans still comprise more cases of heterosexual contact exposure in 15212, the White contingent closes the distance as compared with East Liberty.

The injection drug use exposure picture is more skewed towards African-Americans, but not as much as in East Liberty. While the 17 African-Americans reporting injection drug use as their mode of exposure, clearly presents an African-American majority in that category, the 5 White cases of exposure through injection drug use represents a substantial White presence in that category, at least for a city like Pittsburgh, where African-Americans disproportionately feel the brunt of Wave II patterns like injection drug use. The rates per 100,000 for African-Americans and Whites are relatively high for injection drug use as a mode of exposure. The White rate is right behind East Liberty, at the 6th position, with a rate of 16.834 cases per 100,000, while the African-American rate is higher than East Liberty's, since the African-American population in Allegheny is much smaller, with a figure of 321.726, a figure more like a rate for the male sex with male exposure category. Both rates are higher than the Pittsburgh average rates, of 6.240 for Whites, and 132.805 for African-Americans.

Even the gender breakdown of AIDS cases in Allegheny reveals a different picture than East Liberty. While African-American females comprise 11 cases and White females comprise 3 cases in East Liberty, African-American females account for 5 cases in Allegheny while White females account for the same case total of 3. While the White female rate in Allegheny is about the same as East Liberty with a rate of 19.068 cases per 100,000, the African-American female rate per 100,000 is actually higher than the East Liberty rate for African-American females, with a figure of

173.370. Compared with East Liberty, Allegheny which includes the second highest case total in the 42 zip codes sample, is actually more evenly distributed than East Liberty, in term of Wave II type exposure cases, although not that evenly distributed in terms of respective racial population breakdowns.

Allegheny is more closely related to East Liberty when considering the racial breakdown of the male sex with male exposure category. The 2 zip codes have different case totals according to race and the specific mode of exposure, but both include African-American AIDS case distribution which results in the African-American male sex with male exposure category being the modal category for the zip code. The 27 African-American male sex with male exposure cases in 15212 produce a rate of 1,125.000 cases per 100,000, the 4th highest African-American male sex with male exposure rate in the 42 zip code sample. The rate is so much higher than the rate for East Liberty because the African-American population in Allegheny is so much smaller. The size of the White population, on the other hand, produces the 5th highest rate in the sample, with a figure of 522.586 cases per 100,000. The 73 cases in Allegheny does however represent the largest White male sex with male case total in the 42 zip code sample.

Considering the high number of cases in Allegheny, 2nd highest total in the sample, Allegheny includes a very strange proportion of African-Americans and Whites. Although Allegheny has the highest White male AIDS case total, the rate per 100,000 is not the highest in the sample with a figure of 579.855, but the rate is much higher than the national rate of 212.945 for White males and the average Pittsburgh rate of 230.232. The African-American male AIDS case rate of 1,750.000 cases per 100,000 exceeds the national rate of 849.003, and also exceeds the Pittsburgh rate of 709.305. The comparably high African-American rate should represent a zip code like Sharpsburg where the African-American population is very small and the case total also low relative to zip codes like East Liberty. The high White population in 15212 does settle the various rates per 100,000, but the African-American population coupled with the high number of African-American AIDS cases sounds a loud alarm for the Allegheny zip code.

15221 - Wilkinsburg. 15221, on the surface appears to be enduring less of a brunt of AIDS than other neighborhoods of its size and location, like East Liberty or Allegheny. Wilkinsburg does have the 2nd highest population of any zip code in the sample, with 39,743 residents, 2nd only to Penn Hills (15235). In addition Wilkinsburg does have the 3rd highest total number of AIDS cases with 99, but only the 9th highest over all zip code AIDS case rate per 100,000, with a figure of 249.100, just over the national average rate of 228.003, unlike East Liberty and Allegheny the 2 zip codes with higher case totals and substantially higher rates than the national average. Perhaps a racial breakdown by cases and population will help us gain a better understanding of what sets Wilkinsburg apart from Allegheny and East Liberty in terms of their respective AIDS landscapes.

First off, 15221 is 2nd behind Allegheny in cluster III, in total White population category, with 22,793 Whites, and 2nd behind East Liberty in terms of the African-American population, with 16,691 African-Americans residing within the boundaries of 15221. The percentage of African-Americans in Wilkinsburg is 42.00%, while African-American comprise 62 of the 99 cases, or 62.63% of all AIDS cases. Here we find our first main reason for the difference between Wilkinsburg and the East Liberty/Allegheny duo. Whites in Wilkinsburg, although comprising the second highest Whitepopulation in cluster III, have more in common with their White counterparts in the South Hills or Squirrel Hill, where White case totals are about the same number. Looking at our map, a significant section of the Wilkinsburg zip code is nestled in between the Squirrel Hill zip code and the Swissvale zip code where mostly Whites reside. Only 806 African-Americans reside in 15217 (Squirrel Hill), and only 1,103 African-Americans reside in 15218 (Swissvale). Perhaps most of the 32 White cases reside in that chunk of the Wilkinsburg zip code that is sandwiched by Squirrel Hill and Swissvale, and possess similar economic, social, and political, lives to their White neighbors in both Squirrel Hill and Swissvale. In fact, one of the neighborhoods in the sandwiched 15221 bottleneck, Regent Square, is predominantly White, and share many characteristics with Squirrel Hill and Swissvale, such as the close proximity to Frick Park. Frick Park also serves as an excellent point of entry into the current discussion.

If you wanted to avoid driving through the more downtrodden areas of Wilkinsburg, as many of Pittsburgh's White residents do, and still reach Swissvale from Squirrel Hill, all you would need to do would be to drive up Forbes avenue, through the scenic road that cuts around Frick Park, until you reach Penn Avenue in Regent Square. Then turning right onto Penn, you could avoid any substantial contact with what is really considered Wilkinsburg, and head straight to the 376 highway on ramp, which is situated right in Swissvale. Regardless of the implications of the history of urban infrastructure in this area, such as the location choice of the highway, and other economic issues surrounding the Regent square area and not the rest of Wilkinsburg, what this little tangent points to is a creation of isolation, isolation of the African-American community from the economic mechanics of the Squirrel Hill, Regent Square, Swissvale connection.

Wilkinsburg also represents a zip code where the African-American male sex with male exposure case total far out numbers the African-American injection drug use exposure case load, while still representing a zip code where the African-American population is almost entirely working class. Of the 99 cases in 15221, 39 are African-American males reporting the male sex with male exposure, while there are 35 such cases for White males. While the respective rates for the 2 races for the male sex with male exposure category are not excessively high for the sample, Wilkinsburg includes the 2nd highest total African-American male sex with male exposure case total, right behind the 46 such cases in East Liberty, another predominantly working class area.

As far as Wave II type exposures, 15221 is a zip code where African-Americans exclusively bear the brunt of both the injection drug use category and heterosexual contact category of exposure. 12 African-Americans reported injection drug use as their mode of exposure, while no Whites reported that mode of exsposure. The African-American rate of AIDs for the injection drug use exposure category in 15221 is a relatively low 71.85, since the African-American population in Wilkinsburg is high. The same situation characterizes the heterosexual contact exposure category. Only 2 cases of African-Americans reported heterosexual contact as their mode of exposure, resulting in the lowest rate of such exposure in the 42 zip code sample, and the 15 zip codes with at least one such case of heterosexual contact exposure for African-Americans.

One major factor may contribute to the lower rates for the African-American community in their isolated chunk of Wilkinsburg, even though the African-American community includes the 3rd highest case total in the 42 zip code sample. The Pittsburgh AIDS Task Force, one of the major AIDS volunteer organizations in the city of Pittsburgh and in the entire 6 county metropolitan area is located there. Just the presence of that organization, as a source of information, free anonymous testing, and its role in prevention and education in the surrounding neighborhood and the sample in general, may contribute to a higher level of awareness and active behavior concerning AIDS in Wilkinsburg, giving that area an edge over East Liberty and Allegheny, even though the Pittsburgh AIDS Task Force focuses on those areas as well. Here again, geography plays a crucial role.

15213 - Oakland. One of the major demogrpahic characteristics that sets Oakland apart from other zip codes of it's size, is the fact that the University of Pittsburgh, Carlow College, and Carnegie Mellon University, are located in Oakland. While some of the students live off campus, and in other zip codes in the city, the large majority of students reside in South and North Oakland, placing an extremely large number of 18-24 year olds within variegated neighborhoods to say the least. Oakland includes the 8th largest population in the 42 zip codes sample, with 30,818 residents, and the 7th highest total number of AIDS cases with 53, just behind Shady Side and Kilbuck, both of which include 57 cases, but far fewer people.

The racial breakdown of residents in Oakland reveals that 21,265 Whites reside in 15213, or 69.00% of the total population, and 6,815 African-Americans, or 22.11% of the total population. As far as the racial breakdown of AIDS cases is concerned, the percentages are much closer to one and other, with 25 of the 53 cases being African-Americans, and the other 28 being White. African-Americans comprise 47.17% of cases while only composing 22.11% of the population. Whites account for 28 cases or 52.83% of all AIDS cases in 15213. The population proportions somewhat represent the population proportions of the larger zip code, either way, every neighborhood within 15213, whether it is South Oakland or North Oakland, the presence of off-campus student residents is clear.

In terms of mode of exposure, Whites are expected to make up the large majority of male sex with male exposure cases and African-Americans, while definitely comprising a large number of male sex with male exposure cases, are expected to bear the brunt of Wave II type exposures. Looking at the different modes of exposure according to race, we see that Whites do in fact make up the majority of male sex with male exposure cases, 25 of 28 White cases in Oakland are White males exposed through the male sex with male exposure. The African-American total for this mode of exposure is the 5th highest in the 42 zip code sample; the 17 cases of this type rank Oakland behind East Liberty, Allegheny, Wilkinsburg, and Homewood. The resultant rates are not especially high for the 42 zip code sample, the White rate for male sex with male exposure isn't close to the top 10 with a figure of 242.272. The African-American rate per 100,000 for the male sex with male type exposure is 576.662 good enough for only the 10th highest position in the 42 zip code sample for African-Aemrican male sex with male mode of exposure. The African-American male sex with male exposure category accounts for 40.48% of that category, still higher than the total percentage of the African-American population in Oakland at 22.11%.

The injection drug use mode of exposure in Oakland only accounts for 9 cases for African-Americans and Whites, the 2nd lowest total in cluster III. 6 of the cases are African-American, composing 66.66% of the injection drug use exposure cases. The 3 White cases result in only the 7th highest rate per 100,000 for White injection drug use exposure, with a rate of 14.108. The African-American rate for that category is not unusually high either with a figure of 88.041 cases per 100,000, not even in the top 15 zip codes with at least one case of an African-American case of exposure through injection drug use. In addition the only case of heterosexual contact exposure to AIDS in Oakland is African-American, and the 4 female case are all African-American as well.

What the data suggests is that even though the college populations significantly alter the demographic content of the 15213 zip code, the African-American tendency to account for the majority of Wave II type exposure, and still be disproportionately represented in the Wave I exposure of male sex with male, holds true despite the college presence. While injection drug use cases may be significantly reduced by the college presence, the percentage of African-Americans suffering from Wave II patterns of AIDS,is continuously higer than the over all percentage of African-Americans in any given zip code where there is at least 1 case of an African-American with AIDS.

15232 - Shady Side. The 15232 zip code is considered to be one of the most affluent zip codes in the 6 county metropolitan area, with some of the most expensive shopping in the city, and one of the largest White gay male populations of any zip code in Pittsburgh. According to population break down by race, Shady Side should be characterized as a cluster 1 zip code with the 9,459 Whites comprising 85.27% of the population, and the 1,083 African-Americans comprising only 9.76% of the total population in Shadyside. One would expect White male sex with male exposures to be extremely high in 15232, and African-American case totals to be somewhere around 1 or 2 cases, considering the very small population.

Shadyside does include the 3rd highest number of White male sex with male exposures, with a total of 45 cases, and the 3rd highest White male sex with male case rate in the 42 zip code sample, with a rate of 998.225 cases per 100,000. African-American males do account for 6 cases of male sex with male exposures, not close to the top numbers of that category for African-Americans in the sample, but the rate per 100,000 is the 3rd highest rate in the sample, with 1,452.785 cases per 100,000. While the fact that African-American males only make up 413 residents of the Shady Side population, or 3.72% of the over all 15232 population, the fact that 6 male sex with male cases are African-American represents a very significant dilemma since so few people should not support such a high number of cases.

Within the two main Wave II exposure categories, only 3 cases are found in Shady Side, 2 cases of injection drug use exposure, 1 African-American and 1 White, and 1 African-American case of heterosexual contact exposure. The resultant rates for the injection drug use cases are low, even for African-Americans, who endure a rate of 92.336 cases per 100,000. The 1 African-American heterosexual contact exposure case produces the same 92.336 rate per 100,000. Perhaps the fact that Shady Side is an extremely affluent neighborhood could substantiate a claim that the 3

Wave II cases are of the middle or even upper classes, or simply that the male sex with male exposure pool has contact with the small injection drug use and heterosexual contact pool.

The female AIDS picture in Shady Side is predictably low with 1 White case, and 2 African-American female cases, while neither case loads produces an unusually high rate for cases per 100,000, it is again interesting that African-Americans, despite being in the extreme minority in Shady Side, compose the majority of the female cases, the heterosexual contact exposure cases, and 1 of 2 injection drug use cases. In that way Shady Side, despite the overwhelming presence of Wave I patterns of exposure, fits into the over all patterns of Pittsburgh, even those zip codes where Wave II is increasingly significant, since African-Americans make up a far higher percentage of overall cases than they do population.

Cluster IV - Zip codes with 50+ cases where the African-American population is in the literal majority in the zip code

These 3 zip codes include Homewood (15208) Kilbuck (15233), and Uptown (15219). All three zip codes have 17 cases of injection drug use exposure or higher for African-Americans, and Homewood and Uptown have more African-American male sex with male cases than White male sex with male cases. In addition the isolation issue does seem to contribute to high case rates even for the White minorities in these zip codes.

15208 - Homewood. There are 12,182 African-Americans living in the Homewood zip code area, and 3,735 Whites. The resultant population percentages make Homewood the only zip code where African-Americans compose more than 75.00% of the population, with 75.94% of the population, while Whites make up the smallest percentage of any zip code, with 23.28% of the population. Of the 58 cases in 15208, 5th over all of the 42 zip codes in terms of total cases, 50 are African-American or 86.21% of the total AIDS cases in 15208, still in excess of their percentage of the population. African-American males account for 40 of the 50 African-American cases, with a resultant rate of 749.204 cases per 100,000, which is higher than the Pittsburgh average rate for African-American males at 709.305, and the African-American female rate in 15208 of 146.135 is also higher than the Pittsburgh average rate for African-American female rate of 131.851. Both rates are lower, however than the national rates for the respective categories.

Of those 50 African-American cases, 10 are female, accounting for the 2nd highest total of African-American female AIDS cases, and far higher than the highest female case total for Whites, in Mt. Oliver, where 4 White female cases ranks number 1 among those zip codes with at least 1 case of a White female with AIDS. The 10 African-American female cases only rank Homewood 10th among those zip codes where there is at least 1 case of an African-American female with AIDS, with a rate of 146.135 cases per 100,000. The 8 White cases in 15208 are all male.

When examining the 3 main modes of exposure categories, African-Americans are in the majority in every category, with the highest number of cases falling not in the injection drug use category as 19African-Americans reported that specific mode of exposure, but in the male sex male mode of exposure, where 22 African-Americans reported the male sex with male exposure. The resultant rate for the male sex with male exposure cases for African-American males is 412.062 cases per 100,000 not especially high for the sample, and only a few cases higher than the White rate for the same mode of exposure of 407.688. The African-American injection drug use exposure rate of 155.968 is also not especially high for the African-American injection drug use exposure category for the sample. There are no White cases of injection drug use exposure in 15208. Homewood also includes the second highest total of African-American cases exposed through the heterosexual contact mode of exposure with 4 cases in 15208. The rate per 100,000 for this specific mode of exposure is only 10th highest among those zip codes with at least 1 case of African-American heterosexual contact as a mode of exposure.

Homewood is one of the best examples in the sample, of a zip code with a high proportion of working class African-American males who reported the male sex with male exposure, even though we can not identify the exact proportion of working class African-Americans with AIDS in

15208, or the percentage of those who reported the male sex with male exposure. The high proportion of poor working class African-Americans must account for at least a substantial sum of cases in Homewood being of working class background. In addition, Whites in Homewood do not account for a disproportionate percentage of AIDS cases in comparison to their over all composition in the population.

15219 - Uptown. The Uptown zip code includes the Hill District neighborhood which is considered to be one of Pittsburgh's "worst ghettos". The word ghetto derives from a yiddish word which means divorce. Indeed, the African-American community is divorced in the 15219 zip code, isolated from economic opportunity and other safety nets against problems like AIDS. Of the 62 total AIDS cases in the Uptown zip code, 55 are African-American, while only 7 are White. African-Americans comprise 71.66% of the population with 13,779 residents, the highest African-American population in the 3 zip codes of cluster IV, while making up 88.71% of the population. Like Homewood, Uptown's White minority accounts for a smaller percentage of cases than their percentage of the population.

Uptown and Homewood also share another characteristic, there are no White female AIDS cases in either zip code. Uptown does however have fewer African-American female cases than Homewood, with 6 total African-American female cases. The number of African-American male cases is 49, good for 3rd in the 42 zip code sample for African-American males. The rate per 100,000 for African-American males is a relatively high rate of 798.176 per 100,000, higher than the Pittsburgh average of 709.305 for African-American males, but lower than the national figure of 849.003 cases per 100,000 African-American males.

In terms of specific mode of exposure, 30 of the 37 male sex with male exposure cases are African-American, while the other 7 cases are White, representing all white cases in Uptown. The injection drug use category reveals a 19 case total for African-Americans, with of course no White cases in that category, and the heterosexual contact category only includes 3 total cases, all African-American. While the rates per 100,000 for the respective modes of exposure are not relatively high for the 42 zip code sample, the fact that there are 5,197 Whites in 15219, and no White cases of injection drug use or heterosexual contact, reveals that African-Americans are receiving a terrorizing brunt of Wave II patterns of exposure. The African-American plight in terms of AIDS, and the lack of White representation in the Wave II patterns of AIDS exposure aids Uptown towards a disproportionate over all rate considering the total population size. The total population of 15219 is 19,228, only 18th in the 42 zip code sample, but the 322.446 case rate per 100,000 is 7th over all.

15233 - Kilbuck. Kilbuck includes one of the highest total case loads, tied for 6th in the sample with 57 cases, while its tiny population, one of the smallest over all populations in the larger sample with 6,093 people, only ranks 39th in the 42 zip code sample. Kilbuck also includes the highest over all rate for all races in the 42 zip code sample, with a rate of 935.500 cases per 100,000, much higher than the Pittsburgh over all average of 157.25 and also much higher than the over all national rate for AIDS cases per 100,000 of 228.003. What sets Kilbuck apart from the rest of cluster IV, is the high White composition of AIDS cases. 23 of 57 cases are White, 40.35% of all cases in 15233. The African-American case percentage, 52.63% is actually lower than the African-American population percentage of 64.19%. Kilbuck is more what one would expect when encountering the White minority and African-American majority in a zip code. For the most part it is the smaller African-American population in other zip codes that would account for a disproportionate amount of cases. Kilbuck stands alone in that regard, as the only zip code where African-Americans make up the majority of the population and a lesser percentage of cases.

Examining racial case rates further perplexies the situation. The White rate per 100,000 is a whopping 1,112.724 cases, the 3rd highest racial case rate behind the African-American rate in Sharpsburg (1,408.451), and the African-American rate in Bellevue (1,243.339). The 23 White cases present the over all analysis with a significant anomaly, since no other zip code in the 42 zip code sample looks anything like Kilbuck. Even the White male rate (1,380.176) is higher than the African-American male rate (1084.337), the only other 2 zip codes where that relationship is similar is in 15222 (Downtown) and 15214 (Observatory). Continuing the voyage into the bizarre,

the White female case rate per 100,000 is just higher than the African-American female rate, 211.416 to 211.119, even though there are 3 African-American female cases in Kilbuck and only 1 White female case. While the difference between the 2 rates is not especially significant it is significant that the White female case rate is basically equal with the African-American female rate, highly unusual for zip codes with at least one White female case and at least 1 African-American female AIDS case. The White female case is also the absolute highest White female case rate in the 42 zip code sample, with the nearest figure being 41.093 cases per 100,000, which can be found in the Corliss zip code.

Finally the surprises come to an end when examining the mode of exposure breakdown by race. 18 of the 20 White cases reported the male sex with male exposure, resulting in the 2nd highest White male sex with male exposure rate in the 42 zip code sample, behind only Dowtown, with a rate of 1,129.235, the same rate as the White male rate in Kilbuck. There are 3 injection drug use exposure cases for Whites in Kilbuck resulting in the highest rate in the 42 zip code sample for the White injection drug use category. There are no heterosexual contact exposure cases for Whites in Kilbuck, and no African-American cases of that mode of exposure.

The African-American situation is a bit more unusual. Only Kilbuck and McKeesport include more African-American injection drug use exposure cases than African-American male sex with male exposure cases, where there are more than 10 African-American injection drug use exposure cases. There are 17 cases of African-American injection drug use exposure cases, and 12 African-American male sex with male exposure cases. As a result the African-American male sex with male exposure rate is not especially high for the larger sample, with a figure of 481.928, but the African-American injection drug use exposure rate of 434.671 is the highest in the 42 zip code sample, with McKeesport running a close second with a rate of 398.318 cases per 100,000.

What Kilbuck adds to the analysis of Pittsburgh, is that it is one of the few zip codes where the 2 races at least somewhat equally share the brunt of the disease, even though Kilbuck represents another zip code where African-Americans disproportionately share the brunt of Wave II patterns of AIDS exposure. Kilbuck is also another example of a zip code where the many of the cases White and African-American, are working class. One question that could be asked for a zip code like Kilbuck, is what factors make the White population so much more vulnerable in a zip code like Kilbuck, and not in McKeesport or Homewood where Whites disproportionately escape exposure to the disease?

Cluster V - The seven zip codes that comprise 64.95% of all injection drug use AIDS cases

In the entire 42 zip code sample the combination of African-American and White cases for the injection drug use exposure category totals 214 cases. 139 of those cases, or 64.95% of those cases, can be found in just 7 zip codes. East Liberty (15206), Wilkinsburg (15221), and Allegheny (15212) are all cluster III zip codes with a White majority in the population and more than 50 total AIDS cases in each respective zip code. In those 3 zip codes, 61 of the 139 cases of injection drug use exposure are located. The 7 zip codes in cluster V include all 3 zip codes in Cluster IV, Kilbuck (15233), Homewood (15208) and Uptown (15219), all of which include more than 50 total AIDS cases and an African-American majority. The total number of injection drug use exposure cases in Cluster IV is 58 cases. The most unusual zip code to gain membership into this unfortunate club is McKeesport (15132) where there are less than 50 total cases, and a White majority characteristic of the Cluster I cut off for racial composition according to zip code population.

A helpful point of entry into the exploration of these 7 zip codes is geography. East Liberty, Homewood and Wilkinsburg all border one and other in the Eastern part of Pittsburgh. The 3 zip codes together include a total of 58 cases of injection drug use exposure, 56 of those cases being African-American. Wilkinsburg and Homewood include no White cases of injection drug use exposure, while East Liberty is one of only 4 zip codes in cluster V with at least 1 case of White injection drug use exposure, with a total of 2 White cases of that mode of exposure.

The total population for the 3 zip codes is 93,052 residents, with East Liberty ranking 4th in the 42 zip code sample with 37,264 residents, Wilkinsburg ranking 2nd in total population with 39,743 residents, and Homewood falling behind the other 2 zip codes in this mini-cluster with only 16,042, 22nd in the 42 zip code sample. The disparity between Homewood and East Liberty/Wilkinsburg, may be attributed to the fact that Homewood covers a small geographic area, much smaller than East Liberty, with Wilkinsburg being the largest zip code of the 3 in terms of sheer land.

All 3 zip codes, East Liberty, Homewood, and Wilkinsburg have a Black to White ratio for cases per 100,000 less than the Pittsburgh average Black to White ratio of 3.472, and much less than the national ratio of 4.855. East Liberty includes the lowest Black to White ratio among the 3 Eastern Pittsburgh zip codes with a ratio of 1.305 African-American cases to every 1 White case per 100,000. East Liberty also includes the highest total of African-American cases of AIDS with 83, and the second highest White case total in the 42 zip code with 73 total cases. Subsequently East Liberty is one of only 2 zip codes (Allegheny) in cluster V where the total number of White cases is higher than the total number of African-American AIDS cases.As a result the White rate per 100,000 in 15206 is 374.859 cases much higher than the White case rate for Pittsburgh at 113.192, and higher than the national White case rate of 115.101cases per 100,00. The African-American rate per 100,000 in East Liberty is also higher than the Pittsburgh average, 489.156 to 392.979, but smaller than the national African-American rate of 558.772. The rates are very high, considering how large the White and African-American populations are in East Liberty, with 19,474 Whites and 16,968 African-Americans in residence in 15206.

Predictably the high case total for African-Americans in East Liberty includes the highest total number of cases of African-American heterosexual contact, with 11 such cases, while Whites only account for 3 cases of heterosexual contact exposure. The African-American injection drug use exposure case total is also the highest in the 42 zip code sample with 25 cases or 11.68% of the sum total of all African-American and White cases of injection drug use exposure. Only 2 White AIDS cases of injection drug use exposure exist within the boundaries of 15206. The African-American male sex with male exposure case total is also the highest number in the city with 46 cases, though not producing a comparably high rate for African-American male sex with male exposures, since East Liberty includes the highest African-American population total in the 42 zip code sample with 16,968 residents.

The White Male sex with male rate in East Liberty is actually very high, regardless of the large number of Whites living in 15206. The White rate in 15206 for the male sex with male exposure is 743.243, 4th highest in the 42 zip code sample and also the 2nd highest total number of cases of male sex with male exposure with 66 cases. Whites in East Liberty however, as is true for most of the 42 zip code sample, do not suffer from high case totals or case rates for Wave II patterns of exposure, resulting in the African-American community's singular plight in this regard. In addition, East Liberty includes the highest total number of African-American female cases, with 15, with Homewood running 3rd with 10 cases and Wilkinsburg coming in 4th with 8 total cases of African-American females with AIDS.

Wilkinsburg, the other zip code area that essentially sandwiches Homewood. Compared to East Liberty, Wilkinsburg matches up very well in terms of population size. Wilkinsburg's 22,793 Whites, the 3rd highest White population total behind Allegheny (1) and McKeesport (2), ranks above East Liberty in cluster V, and the total number of African-Americans in 15221, 16,691 ranks Wilkinsburg a close 2nd to East Liberty's 16,968 African-Americans, within the entire 42 zip code sample. However the total number of African-American cases of injection drug use exposure in Wilkinsburg is 12, less than _ the total number of African-American injection drug use exposure cases in East Liberty, the figure also makes 15221 last in cluster V for the specified category. The over all AIDS picture in Wilkinsburg is also less severe than in East Liberty, but the African-American picture is as disproportionately bad if not worse than the East Liberty African-American AIDS situation.

Of the 99 total AIDS cases in Wilkinsburg, 62 are African-American while only 36 are White. Still the Black to White ratio for AIDS cases per 100,000 of 2.352 is lower than the Pittsburgh ratio of 3.472, and lower than the national ratio of 4.855. The over all rate per 100,000

for the entire zip code is 249.100, 9th in the 42 zip code sample, and higher than both the Pittsburgh and National average rates. On the whole, Wilkinsburg reflects the same African-American Wave II dominant trend that East Liberty projects, but in an even more intense fashion.

For the male sex with male exposure category Wilkinsburg actually includes an African-American majority, with 39 total cases as opposed to the White total of 35 cases. Even though the African-American male sex with male rate per 100,000 is higher than the White rate for the same mode of exposure, the 344.285 White rate ranks 8th in the sample, while the African-American male sex with male rate of 526.032 ranks 11th in the larger sample. The injection drug use category reveals a much more disparate picture between Whites and African-Americans in 15221.

Even though the 12 case total is the lowest in the cluster for African-American AIDS cases exposed through the injection drug use mode, the fact that there are no White cases, points to the over all significance of injection drug use in Wilkinsburg. Homewood and uptown are the only other cluster V zip codes where there are no White cases of injection drug use at all, revealing the heavy Wave II price paid by African-Americans in those zip codes, and in all cluster V zip codes, while Whites either escape representation in that category all together or simply account for a few cases, showing their disproportionate lack of composition of Wave II pattern exposures. The heterosexual contact exposure category includes only 2 cases, but they are significant since once again they are both African-American. Of the 8 female cases in Wilkinsburg, all are African-American, once again representing the Wave II pattern exposure plight of African-Americans while Whites comprise none of the cases in the specific Wave II category in Wilkinsburg.

Homewood presents the most anomalous zip code of the Eastern Pittsburgh zip code triad of East Liberty, Wilkinsburg, and Homewood. The over all population in Homewood is one of the lowest in the 42 zip code sample, ranking 22nd with a total of 16,042 residents, only Kilbuck has a lower population total than Homewood in cluster V. Homewood also represents the only zip code in the Eastern Pittsburgh triad where the African-American population is actually in the majority, with 12,182 African-Americans and 3,735 Whites. The Homewood zip code also represents the highest percentage of African-Americans in the 42 zip code sample, comprising 75.94% of the population, while White comprise only 23.28% of the population.

African-Americans comprise 86.21% of all AIDS cases in 15208, while only making up 75.94% of the population, subsequently for both Homewood and Uptown, 2 of 3 zip codes with African-American majorities, the percentage of cases that are African-American is still higher than the percentage of African-Americans in the population, even though they make up the majority. Homewood includes a smaller total African-American population than does Wilkinsburg, consequently the overall African-American AIDS case rate in the 15208 zip code of 410.442 is higher than the Wilkinsburg case rate of 371.458, while the difference isn't really significant. Even though East Liberty includes a higher number of African-Americans, Homewood has a lesser African-American AIDS case rate than does East Liberty, where the rate is 489.156 cases per 100,000. The Black to White ratio in Homewood is actually higher than East Liberty's, and smaller than Wilkinsburg's, though all 3 are lower than both the Pittsburgh and national Black to White case ratio.

In terms of AIDS cases, and the 3 modes of exposure analyzed in this paper, Homewood looks more like Uptown, than either East Liberty or Wilkinsburg, even though Uptown is not a member of the Eastern Pittsburgh triad, where Homewood is located. The total number of cases in Homewood is lower than in Wilkinsburg, 62 to 99, and much lower than East Liberty's 159 AIDS cases, while Uptown only out totals Homewood by 4 cases with a total of 62 cases. Perhaps the main reason for why Homewood reflects Uptown more than the neighboring triad zip codes, other than the size of the populations in Homewood and Uptown in comparison to Wilkinsburg and East Liberty, is the fact that both Uptown and Homewood include a majority of African-Americans.

Of the 29 male sex with male cases in Homewood, 22 are African-American and the 7 White male sex with male cases constitute all but 1 White case in Homewood, the other being a heterosexual exposure case. Even though African-Americans account for 22 of 29 cases of the male sex with male exposure, the White rate per 100,000 of 407.688 cases is basically equal to the African-American rate of 412.062. The same relationship does not hold true for the injection drug use exposure rate for the 2 races. While the African-American injection drug use exposure case rate

of 71.895 is only 17th in the 42 zip code sample, where only 28 zip codes include at least 1 case of an injection drug use exposure for African-Americans, the fact that there is not 1 White case makes the 12 African-Americans seem all the more significant when considering the trend of African-American disproportionate representation for the Wave II pattern exposures. The heterosexual contact exposure situation for the 2 races is a bit different. The 1 White case in this category reduces the distance between Whites and African-Americans in this category of Wave II pattern exposures, since the resulting case rate for Whties of 26.774 is the highest White rate in the 42 zip code sample, and only a few cases behind the African-American rate of 32.835, only 10th in the sample, produced by the 4 African-American cases of heterosexual contact exposure. Regardless of the fact that the 2 rates are very similar, the fact that African-Americans make up 75.94% of the population and 80% of heterosexual contact exposure cases, 100% of injection drug use exposure cases and 75.86% of the male sex with male exposure cases, points to not only a disproportionate representation of African-Americans in Wave II categories, but also a significant representation (virtually the same as their percentage of the population) for more typically Wave I patterns of AIDS spread, while most perspectives on Wave I patterns focus on White gay males.

The AIDS picture in the uptown zip code (15219) very much resembles the AIDS landscape in the Homewood zip code (15208). Uptown includes the Hill District, thought to be the most dangerous and impoverished African-American ghettos, according to popular Pittsburgh representations, should by all stereotypical accounts out total a lesser known zip code like Homewood in terms of Wave II patterns of exposure. The fact is that the only category of exposure where the Uptown zip code includes a higher total number of cases than the Homewood zip code is the male sex male category for African-Americans. Both zip codes include 19 cases of African-American injection drug use exposure. The injection drug use exposure rate for African-Americans in 15219 is slightly lower at 137.891, 10th among the 42 zip code sample, and both zip codes include no cases of White injection drug use exposure.

The Uptown zip code actually includes 1 less case for the heterosexual contact exposure category with a total of 3 cases, also resulting in a lower rate. Uptown, however includes no cases of White heterosexual contact exposure. Where Uptown out totals Homewood is in the male sex with male category. Uptown includes 30 cases of African-American male sex with male exposure, the second highest total for that category in the 42 zip code sample, behind only East Liberty and the 46 African-American male sex with male exposure cases there. Uptown also includes the same number of White male sex with male exposure cases with a total of 7 cases. Uptown, as a result of having more African-American AIDS cases also includes a higher Black to White AIDS case ratio, with a 2.963 figure, though that case ratio is still lower than the Pittsburgh and national average ratios.

Georgaphically speaking, the Kilbuck zip code is completely surrounded by the Allegheny zip code, and the Ohio river. This fact leads the analysis to couple the 2 zip codes together within the same geographic point of entry in what is considered the city's North Side, even though the Allegheny zip code includes what is traditionally considered to bethe north side, with the multiple walking and driving bridges that connect Downtown to the 15212 zip code area. Kilbuck, by far includes the smallest population of the seven zip codes that constitute cluster V, but not the smallest case total, McKeesport (15132) includes only 38 cases in comparison to Kilbuck's 57 cases, which rank the tiny zip code, in terms of population, in a tie for 6th over all in the 42 zip code sample. Only 6,093 people reside in the Kilbuck zip code area, the 4th lowest population total in the 42 zip code sample. Other data collected for the 15233 zip code continue Kilbuck's assault on common sense.

Kilbuck is the worst trouble spot for AIDS in the entire 42 zip code sample, when considering the population size. Kilbuck is also the only zip code in the entire sample, in which the percentage of the African-American population is actually less than the African-American percentage of AIDS cases. While 64.19% of the population in 15233 is African-American, 52.63% of the AIDS cases in Kilbuck are African-American. The White situation in Kilbuck is therefore also unique in that it is the only zip code where the White population actually composes a smaller percentage of cases than their percentage of the population.

The AIDS crisis in Kilbuck also takes shape when analyzing the various demographic and exposure case rates for 15233. Of the 30 male sex with male cases in Kilbuck (African-American and White) 18, a majority of cases, are White, resulting in the second highest White male sex with male rate in the 42 zip code sample, with a rate of 1,129.235. The African-American male sex with male situation is completely bizarre. The 12 African-American male sex with male cases would be considered the main problem for Kilbuck, considering its African-American population of 3,911 residents, were it not for the fact that Kilbuck is the only zip code in the 42 zip code sample besides McKeesport where the number of African-American injection drug use exposure cases is higher than the number of African-American male sex with male exposure cases. The 17 African-American cases of injection drug use results in the highest rate of African-American injection drug use exposure in the entire sample, with a rate of 434.671, more than 300 cases higher than the 42 zip code sample average African-American rate of 132.805. The White rate, even though Whites only account for 3 cases of injection drug use exposure, second behind Allegheny's 5 White injection drug use exposure cases, but resulting in the highest White injection drug use exposure rate of 145.138.

What continues to boggle the mind about Kilbuck is that for the other major Wave II pattern exposure category, heterosexual contact, there are no cases, African-American or White, in the entire Kilbuck zip code. This fact sets Kilbuck completely apart from the rest of the zip codes in cluster V, and in terms of Kilbuck's relation to the injection drug use problem that cluster V presents. The female AIDS situation for African-Americans in 15233 is also unusual. 5 of the 6 zip codes with the highest African-American female AIDS case totals, East Liberty (15), McKeesport (11), Homewood (10), Wilkinsburg (8), and Uptown (tie-6) are all in cluster V, the 7 zip codes that account for 64.95% of all injection drug use cases in the 42 zip code sample. Kilbuck, also a zip code in cluster V, includes 1 White female case, and 3 African-American female cases. Although the population size of 15233 does reveal those cases to be significant, the White female rate is the highest in the 42 zip code sample with 211.416 cases per 100,000, the African-American female AIDS situation is not as striking in comparison to other cluster V zip codes. The 211.119 case rate per 100,000 for African-Americans is about the same rate as the White female rate, but is nowhere close to the top African-American female rates in the 42 zip code sample. Kilbuck represents a true trouble spot considering its extremely small population,yet extremely high case rates and totals for both Whites and African-Americans. Kilbuck is not, however, the most unusual member of cluster V, as the analysis of McKeesport will show after a look at the Allegheny situation, Kilbuck's big brother to the north.

Allegheny (15212) presents one of the hardest hit zip codes by AIDS for both Whites and African-Americans. The 133 total AIDS cases in 15212 rank it 2nd in the sample behind cluster V counterpart East Liberty. Allegheny also includes a large number of people, 35,250, and a fairly high rate of AIDS cases per 100,000 of 377.305. The rate becomes even more significant when considering the large population. The racial breakdown by race is more disparate, with 84 cases being White and 47 African-American. The rates include one of the greatest distances between the White and African-American, with a White rate of 282.809, fairly high for the entire sample, and 889.478 for the African-American population. The African-American rate, despite the fact that a substantial number of African-Americans live in 15212 (5,284) is the 3rd highest rate for African-Americans in the 42 zip code sample.

Once again a cluster V zip code produces high totals for African-American females, but Allegheny is somewhat different since there are a fairly high number of White female cases in 15212. The 5 African-American female cases still outnumber the 3 White female cases. The Male distribution is thus in the majority for both Whites and African Americans. Mode of exposure breakdowns produce expected results for a zip code of Allegheny's size and AIDS case total. The number of African-American injection drug use cases does actually creep close to the total number of African-American male sex male exposure cases with 17 injection drug use cases and 27 male sex with male exposure cases. Although Allegheny does include the highest number of White injection drug use cases with 5, the only mode of exposure where Allegheny actually breaks with the cluster pattern is in the heterosexual contact category. In this category Allegheny includes 3 White heterosexual contact exposures, and 2 African-American heterosexual contact exposures for

that category. This is the only zip code where there is at least 1 White cases of heterosexual contact exposure, and also at least 1 case of African-American heterosexual contact exposure, where the number of White heterosexual contact exposures is greater than the African-American total for the same exposure. Over all Allegheny follows Cluster V patterns fairly well, as it includes some of the highest figures for not only injection drug use for African-Americans but other modes of exposure, and especially high rates and cases for African-Americans broken down by gender.

McKeesport presents the most unusual case of almost any cluster in the entire 42 zip code sample. African-Americans make up less than 20% of the total population but account for 28 AIDS cases while Whites account for more than 80% of the population and only 9 total cases. The small African-American population has not prevented the zip code area from including the 3rd highest total of African-American female AIDS cases with 11, in the entire sample, and 4th highest African-American injection drug use case total with 18 cases, 4th highest in the cluster, and as a result the 4th highest in the entire sample. McKeesport is a zip code which represents cluster I, where smaller African-American communities are more spread out within the boundaries of the zip code, and where mostly African-American male sex with male exposures can be found. The fact that McKeesport includes only 6 African-American male sex with male cases and 18 injection drug use cases makes McKeesport anamolous for even cluster I. McKeesport does however show that an African-American community does not have to be in a large, impoversihed, urban "ghetto" setting to be extremely hard hit by AIDS. This concludes the cluster textual analysis for charts and graphs representing larger cluster trends concerning AIDS, see the data appendix.

6.D
Examination of Allegheny Observatory and Killbuck

Kristofer Peterson

This sub-section provides a detailed analysis of three contiguous zip codes, Allegheny (15212), Observatory (15214) and Killbuck (15233). These zip codes represent a complicated area of high variable income, education, and demographic composition. As a result, they all exhibit AIDS in a wide variety of people from a wide variety of modes of transmission.

Allegheny (15212)

The Allegheny zip code in Pittsburgh, Pa. is one of the cities largest. Both in size and in population (35,280) which ranks it as the 5th largest zip code in Pittsburgh. As a result of its size, Allegheny has wildly disparate populations within its boundaries, ranging from concentrations of extreme white and black poverty, to examples of extreme white and black wealth. Allegheny is severely affected by AIDS, with the second highest number of cases in Pittsburgh (133), and with an aggregate case rate of 377.305. In terms of Rank, it has the 5th highest case rate of any zip code in the city and the 2nd highest rate amongst zip codes of population 12,000 or more. The task of this section is to examine the AIDS case data for this zip code and relate it to demographic data, both for the zip code as an aggregate unit, and for individual census tracts in the zip code. In doing so, this section will identify the vulnerabilities that exist in the area that account for the heavy impact of AIDS and hypothesize about the types of cases that exist within this area. The first step in this effort is to examine the aggregate demographic data for the zip code, to give the reader a general picture of its population.

As can be seen in Figure 6.d.1, the Allegheny zip code has a heavily white population, with whites accounting for 84.26% of the population roughly consistent with the national average. In addition, the zip code is slightly more populated by females than males (53% females) following the national average, and fairly consistent between races. In terms of transience, the population is fairly stable with 22,257 (63%) residents residing in the same house as they did in 1985. When the category is expanded to the same Metropolitan Statistical Area as 1985 the number rises to 30,846 people and 87%. In terms of educational attainment, the white and black populations of Allegheny are roughly equivalent, each having the same population proportions in each category as can be seen in Figures 6.d.2 and 6.d.3. The disadvantage blacks face however, can be clearly seen by comparing Figure 6.d.2 and 6.d.3 with 6.d.4 (Proportion of Population in Household income Category, By Race 1990.) In this comparison, it is clear that despite similar educational attainment curves, the black population falls disproportionately within the extreme poverty income range of less than $15,000 per year. Looking more generally at data by census tract, we see that some census tracts, such as 2609.97, 2602, and 2201 are predominately white and have median incomes between 25,000 and 40,000 dollars. While tract 2717 is predominately black, and has a relatively high median income of 20,000 dollars, thought those whites that are in the tract are significant poorer than the black

populations. In addition, tracts such as 2306, 2406 and 2704 are predominately made up of poor whites and tracts 2305, 2304, and 2204 are made up of predominately poor blacks. Educational attainment follows a similar pattern with some tracts such as 2206 and 2503 having a substantial portion of educated whites and blacks and others such as 2304-6 and 2406 being made up of largely undedicated whites. Finally, 2609.98 the zip codes most populous tract is populated largely by uneducated blacks. In conclusion, the figures shown in the aggregated zip code data previously examined don't reveal the whole story of the Allegheny zip code. There are pockets of wealth and poverty, education and ignorance, blacks and whites throughout this zip code.

The Allegheny zip code has an aggregate AIDS case rate of 370.305, and a black to white rate ratio of 3.145.(Figure 6.d.5) Pittsburgh's aggregate case rate is 152.125, and its ratio of black to white case rates is 3.472. By this comparison, Allegheny as a zip code seems better off that the city as a whole. However, this disparity is easily explained, both Pittsburgh's aggregate case rate and black vs. white case rate ratio are dragged upward by a number of zip codes with very small black populations, and case rates. In fact, only 11 of the 42 zip codes in the sample are above the median ratio. Further evidence of the depth of Allegheny's problem is provided by the fact that it accounts for 10.1% of Pittsburgh's cumulative AIDS case, and only accounts for 4.2% of its population. Moving on to specifics, Figure 6.d.5 shows the breakdown of case rates in Allegheny by Race and Gender. Note the high black male and female rates, the black male rate is the 3rd highest in the city, and the Black female rate is the 10th highest in the city. As we move on to Mode of Transmission by Race we see a similar pattern. Figure 6.d.6 (6.d.7 and 6.d.8 contain the raw case totals) indicates the zip code's AIDS case breakdown by selected Modes of Transmission and Race. Here we see that blacks are very hard hit by the MSM and IDU modes of transmission. While the white modes of transmission are near the national rates, the Black MSM cases-per-100,000 rate is equivalent to 1 case for every 100 black men. Moreover, the IDU rate is the third highest in the city, and well above the city-wide rate of 132.805. Clearly, in the Allegheny Zip-code blacks are heavily effected by AIDS. This paper will now move on to discuss some hypotheses for the reasons behind this case rates.

Now that we have examined the detailed demographic make up of the Allegheny zip code, as well as the AIDS case data for that area we can make some hypotheses about AIDS in the Zip Code. Starting with the White Male Sex with Male rate, the white MSM rate is 522.86, which is fairly high. Noting the presence of large numbers of poor whites, as well as the Mexican War Streets we can assume that these cases represent a mixture of white working class gay males, and middle class gay males. The white female rate is extremely low, but represents a mixture of IDU and heterosexual context modes of transmission, though the heterosexual contact rate represents a token case. The black male rate of 1750, with its subordinate rates of 1125 for MSM behavior and 321.73 for IDU activity is very interesting. Coupled with the presence of isolated black wealth, and widespread black poverty we can theorize that the MSM cases are primarily of the MSM behavior, not self-identified as gay pattern. The high IDU rate is consistent with the poverty in the area, however the lack of a similarly high white IDU rate raise questions about what is insulating the white community. Finally the Black Female rate of 173.370 in combination with the low black heterosexual mode of transmission rate leads one to conclude that IDU activity is responsible for more cases in Allegheny's black women than heterosexual activity. This is consistent with the poverty rates amongst blacks in Allegheny, but again one wonders what insulates Pittsburgh from higher heterosexual transmission rates. In conclusion, it is fairly clear that the black community in Allegheny is more heavily effected by AIDS that the white community, both in relative frequency of cases (rates) and in terms of the spread of the problem. While the white community is only seeing AIDS in significant proportions amongst Gay Males, the black community is being hit amongst women and the IDU population as well as those engaging in MSM behaviors.

Observatory (15214)

Observatory is Pittsburgh zip code 15214. Observatory has a population of 19928. The area is predominately white and female. The exact breakdown of population by race and gender can be seen in Figure 6.d.9. In addition, Observatory has a relatively high median income of 21,786 dollars per year. Finally we see that Observatory has a very stable population, with its mean percentage of people living in the same houses as they did in 1985 at 63% and no tract having more than 13% who lived out of this Metropolitan Statistical Area center city in 1985. The relatively high median income explains to a degree Observatory's below national average AIDS rate of 205.741. However, on closer inspection of the AIDS case rate data, a disturbing rate spike appears, a rate of 156.047 for African American females the 8th highest in Pittsburgh and 5 times higher than the White female case rate. Spurred on by this detail, we now move into a detailed analysis of Observatories Case Rate data.

The AIDS case rate data for Observatory reveals several interesting features. First, looking at the Race and Gender case rate breakdown in figure 6.d.10, we see an high White Male rate of 376.068, and a low black male rate of 347.442. The White male rate is almost 150% of the Pittsburgh aggregate White Male rate, and the Black Male rate is about 40% of the aggregate black male rate for Pittsburgh. In addition, we see the Black Female rate of 156.047, which is 5 times greater than the White Female rate. Seeing this data, we must look to the Race by Mode of Transmission case rate breakdown for explanation. Figure 6.d.11 presents case rates broken down by Mode of Transmission and Race. Looking at this data we immediately see that the White Rate is consists almost entirely of MSM cases, as well as a small number of heterosexual transmission cases. The Black rate however, is made up 1/2 MSM cases and 2/6 IDU cases, with 1/6 heterosexual transmission cases. In summary, we see that the White Cases in Observatory are overwhelmingly MSM, while the Black cases are evenly split between the MSM mode of transmission and the IDU/heterosexual contact modes of transmission. We now move on to a detailed examination of demographic data at the census tract level in an attempt to develop hypotheses about AIDS in the Observatory zip code.

Looking at the Census tract level demographic data for Observatory several interesting facts come to light. First, looking at Figure 6.d.12 (Population by Race and Gender) we se that Observatory is fairly segregated. Several tracts are almost exclusively white (2602, 2612.98, 2613, and 2708), while two (2603 and 2614) are predominately Black. Looking at Figure 6.d.13 (Household Income by Race), and relating it to 6.d.12 we see that overall, Blacks have lower Median incomes than Whites. Looking deeper we also notice that Blacks living in predominately White tracts tend towards higher median incomes that Blacks living in predominately black neighborhoods. Examining Figure 6.d.14 (Educational Attainment by Race), reveals a similar trend. Blacks in White neighborhoods being more educated than blacks in predominately black neighborhoods, with blacks in general being worse off educationally than whites. Finally, looking at employment status by race (Figure 6.d.15), we see that people of all types have fairly low unemployment rates throughout Observatory. However, there are a few exceptions, black men in predominately black neighborhoods (2614 and 2509) are largely out of the labor force, indicated chronic non-employment. To summarize, people in Observatory are fairly well off, with some exceptions. There are areas of extreme wealth, and high employment rates, and there are areas of concentrated poverty and unemployment, largely among Blacks. This data provides a significant basis for hypotheses about the specifics behind AIDS cases in Observatory, to which we will now proceed.

Some hypotheses can now be generated about the types of AIDS cases that occur in Observatory. First, amongst Whites almost all of the cases are of the MSM mode of transmission. This coupled with the relative affluence of whites in Observatory leads on to

believe that these cases have resulted from stereotypical White middle-class self-identified gay behavior. With respect to the Black male cases, we see both MSM and IDU modes of transmission, this in combination with the presence of both extreme wealth and extreme poverty amongst the black community leads one to the conclusion that both self-identified gay MSM, and non self-identified MSM behaviors, in addition to IDU behavior may be occurring in Observatory. Finally, seeing that the black heterosexual rate isn't high enough to account for all of the black female cases in Observatory, we must hypothesize that IDU behavior is also responsible for some

Killbuck (15233)

Killbuck is Pittsburgh zip code 15233. It represents the highest overall case rate in Pittsburgh (In addition, Killbuck has a number of remarkable demographic and case rate features that make it worthy of study. To begin this study we will first get an overall sense of the area by looking at demographic data at the zip code level. Then, we will move on to a discussion of the AIDS case data. Finally we will take an in depth look at demographic data at the census tract level, and relate that to the AIDS data, in an attempt to form some hypotheses about the dramatic impact of AIDS in this ZIP code.

Killbuck is a predominately Black zip code (65%.) In addition, it is unusual because Black males make up the bulk (40%) of its residents. A full accounting of Killbuck's population by Race and Gender can be seen in figure 6.d.16. We also see that Killbuck has a relatively high median income of 18,011 dollars per year. None of these facts really explain Killbuck's AIDS case rate of 935.500 per 100,000 population. However, detailed analysis of the AIDS data will be helpful in understanding Killbuck's aggregate rate.

As has already been mentioned, Killbuck has Pittsburgh's highest aggregate case rate at 935.500. (AIDS case rates for Killbuck can be found in figure 6.d.17 and 6.d.18.) However, when we break that rate down by race and gender we get more insight into that rate. Killbuck's White Male case rate is 1380.176, while its Black Male rate is 1084.337. These rates are interesting, partly because the White male rate exceeds that of Black males, which is extremely unusual in Pittsburgh, and also because both rates are in the top 5 for the city. This indicates that males in Killbuck are extremely hard hit by AIDS. In addition, Killbuck's female rates are very high. The White female rate of 211.416 is the highest in the city by a factor of 500%, and the Black female rate is 7th highest in the city. All around we see that Killbuck is highly affected by AIDS. Looking at the same data, but broken down by mode of transmission and race in very informative. First looking at data for the MSM mode of transmission we see that the White MSM rate is 1,129.235 while the Black MSM rate is 481.928. This data makes it pretty clear that the overwhelming majority of the White male cases are MSM, while the Black MSM rate indicates that IDU cases make up a significant portion of the Black male rate. The complete lack of heterosexual transmission cases in Killbuck allows us to deduce that all of the female cases, Black and White were IDU cases. Having examined the AIDS case data, we now move on to a detailed analysis of demographic data at the census tract level, in an attempt to further understand the impact of AIDS in Killbuck.

In looking at census tract level demographic data for Killbuck there are tow important things to note: 1) Tract 2704 refers to Western Penitentiary, and Tract 2108.98 has a population that consists of 10 White men. However, tract 2107 is still of interest. In Killbuck, tract 2107 is predominately Black, consisting of approximately 80% Blacks. The male female split is roughly even.(Figure 6.d.19) Moving on to examine employment status by race (Figure 6.d.20) we see that the unemployment rate in tract 2107 is highest amongst Black males, while White females are the group least in the labor force. In looking at education attainment, we see that more Blacks than Whites in 2107 completed high school, while a greater proportion of Whites than Blacks attained at least an associates

degree (Figure 6.d.21.) Finally, looking at Figure 6.d.22 (Household Income by Race) However, 40% of Whites, and 52% of Blacks fall below the poverty line in this tract. This data will now provide a backdrop for some hypotheses about the occurrence of AIDS in Killbuck.

Looking at Killbuck's extremely high White MSM rate in relation to the occurrence of both poverty and wealth in the zip code's White population, we can hypothesize that both stereotypical self-identified MSM behaviors, and blue-collar MSM behaviors are extent in Killbuck. With regard to the Black MSM rate, and the Poverty of the Black community in Killbuck, we can argue, that many of the Black MSM cases fall into the pattern of Non-self-identified as Gay MSM behaviors. In addition, we can hypothesize that due to the difference in rate between Black Male cases, and Black MSM cases, that IDU mode of transmission plays a significant role amongst Black men in Killbuck. Finally, seeing the absence of Heterosexual contact as a mode of Transmission, we can argue by process of elimination, that Female IDU behavior accounts for all of the Black and White female cases in Killbuck.

6E

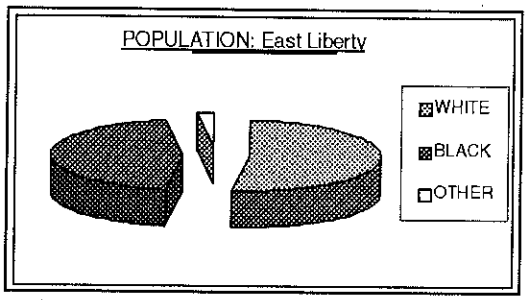
IN-DEPTH ANALYSIS:
East Liberty (15206), Wilkinsburg (15221), and Homewood (15208)

By Michael R. Lobick

East Liberty (15206)

East Liberty lies to the west of downtown Pittsburgh on the northern border of the wedge of land that is defined by the intersection of the Allegheny and Monongahela Rivers, just east of Arsenal and Bloomfield. Within the confines of its zip code boundaries, East Liberty is home to more AIDS cases, 159, than any other zip code in the city of Pittsburgh. Its diverse ethnic and racial makeup make for a challenging analysis of the area, especially when placed within the context of AIDS.

East Liberty unlike many of the zip codes within the city of Pittsburgh has an almost even racial breakdown between blacks and whites. The white population is still the majority numbering 19,474 with 52.26% of the population while the blacks total 16,968 or 45.53% of the total. Census tract analysis reveals that 9 of the 13 census tracts that comprise the 15206 zip code possess at least a 75% majority of one race. This at least partially indicates that the two races live in separate neighborhoods, although it should be noted that two other tracts have percentages nearer to 60% to 40% and two others where the percentages are nearly equal. Within these populations, the overall AIDS case rates vary by only by approximately 155 per 100,000. There is 1.305 black AIDS cases in East Liberty for every white when adjusted by rate for the relative populations. That places East Liberty's black case rate to white case rate ratio in the lowest fifth of the 30 zip codes in Pittsburgh that have both white and black AIDS cases.



The white population of East Liberty is characterized by its age, most noticeably its lack of youth when compared with the black population. Only 14.42% or 2,809 of its white inhabitants are 17 years of age or younger compared with 24.65% of the black population in the same statistic. The white population also contains 21.53% of its total in the cohort above 65 years of age compared with only 14.76% of the black population in

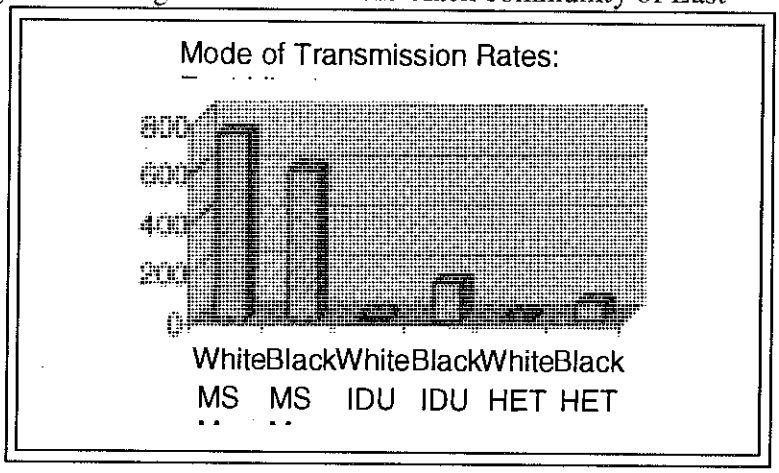
the same cohort. Its per capita income is also nearly $10,000 per year higher than the corresponding income of East Liberty's black inhabitants and in only one of the 13 census tracts is the black per capita income greater than the white (#1208). This may partially be explained by the much higher percentage of youth present in the black population (nearly 25% are 17 years of age or younger), which would correspondingly lower the per capita income of the black population. In addition, the term "working class" may accurately be used to characterize the white population. Over 45% of the white households in East Liberty earn less than $25,000 per year and fully 75.5% of the white household are under $50,000 per year in income.

The AIDS case rates within East Liberty among both white males and females are higher than the national averages, with the white male rate being drastically higher, 788.288 per 100,000 as compared to 212.945 nationally. Many of the cases occurring within the white male community can be linked to the male sex with male (MSM) mode of transmission. Of the 73 cases of AIDS reported in the white community of East Liberty, fully 70 are from white males with 66 identifying their risk behavior as MSM. Over 90% of the AIDS cases within the white population of East Liberty can be attributed to MSM behavior.

The case rates within the black community of East Liberty share similarities with their white neighbors but also demonstrate some stark differences. The overall black case rate is approximately 115 cases per 100,000 higher than the corresponding white case rate. The black MSM rate, while still very high, is lower than its white counterpart (599.349 black to 743.243 white). The gap in cases is made up by the number of black injection drug use cases (IDU) present in East Liberty. A total of 28 IDU cases exist in the area with fully 25 of them being accounted for in the black population, the highest IDU case total in any Pittsburgh zip code. This gives rise to a black IDU rate in East Liberty of 147.336 per 100,000, which is conspicuous especially when compared to the corresponding white rate which is slightly over 10.

Perhaps the most alarming statistic in East Liberty's AIDS case breakdown is the high number of heterosexually transmitted cases present in the zip code, indicating a possible evolution in the epidemic.

There are a total of 14 heterosexually transmitted cases present in the 15206 zip code. That represents 23% or nearly one quarter of all such cases reported in the entire city. This truly becomes an issue when we further realize that 11 of those cases are present within the black community, so that nearly one fifth of the heterosexually transmitted cases in the city of Pittsburgh occur within the black community of East Liberty. East Liberty has the highest rate in the city of black heterosexual cases (64.828 per 100,000) when we consider only the zip codes that have reported more than one black heterosexual AIDS case. We can infer that in fact many of these

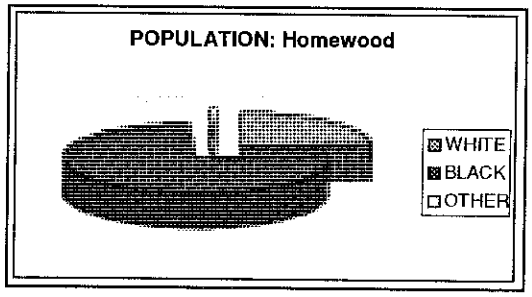


cases are present in black women, a classic flag category for the Wave II pattern of the AIDS epidemic.

Possible explanations for the much higher rates of both IDU and heterosexual cases in the black community can be seen by comparing the economic indicators of the two races in East Liberty. With 65.46% of its household incomes below $25,000 a year, the black community of East Liberty has nearly a 20% higher level of income below $25,000 than the corresponding white community. As mentioned before, the black community's per capita income is almost $10,000 less per year ($8,668 as compared with $18,602) than the corresponding white figure. We also see some variations among the educational attainment of the races. No real differences among the young people's (18 and under) educational attainment can be seen, both races have nearly equal percentages enrolled and graduating from high school, nearing 80% and 13% respectively. Rather, the differences are noted as the demographics get older. In the white population 35.19% of the population has a bachelor's degree or higher compared with just 9.34% of their black neighbors. These factors could lead to increased IDU which in turn could go a long way towards explaining the high number of heterosexual AIDS cases present in East Liberty.

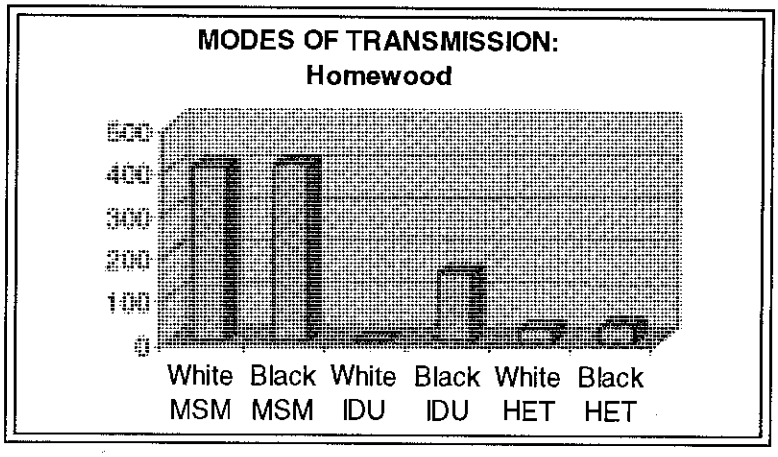
Homewood (15208)

Homewood is an area with a relatively small population (16,042) which is nestled between the much larger areas of East Liberty, Wilkinsburg, and Squirrel Hill. With 58 cases occurring within its zip code boundaries, Homewood has an overall rate of 361.551 per 100,000. That rate places it sixth highest on the list of AIDS case rates broken down by zip codes and consequently much higher than the overall Pittsburgh AIDS case rate which is 157.25 per 100,000.



The racial makeup of Homewood is predominately black (76.53%) with almost a quarter of the population being white (23.47%). This partially explains the high numbers of AIDS cases within the black community in Homewood (50) in relation to those in the white (7) but fails to address the issue of a black case rate over double that of the white population (410.442 to 187.416 per 100,000). Nearly all of the white cases are accounted for by the MSM mode of transmission while that mode of transmission only partially explains the black cases. The overall MSM rates in Homewood are strikingly similar by race. Whites have an MSM rate of 407.688 per 100,000 while the corresponding black rate is 412.062. The difference between the two populations becomes most evident when comparing the rates of IDU. Homewood has no cases of white IDU but the black community has 19, for a rate of 155.968 per 100,000. Within the zip code there are 5 cases of heterosexual origin, 4 black and 1 white. These result in corresponding case rates, which are similar, both hovering around 30 per 100,000.

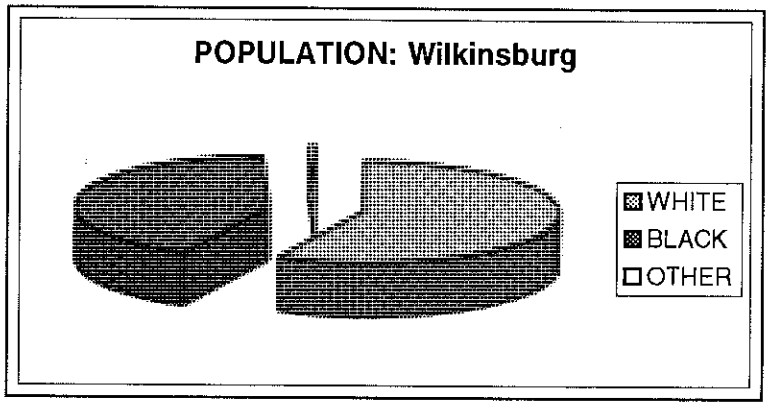
How do we account for the large numbers of IDU cases within the black population; the second highest total for any zip code in the city of Pittsburgh with the corresponding absence of cases within the white population? This may be a result of very divergent types of socioeconomic neighborhoods being lumped together into a common zip code through necessity, not demographics. The differences in per capita income are startling. White per capita income is $27,750 while the black figure is $7,711, which is a difference of over $20,000. While the black population is somewhat younger than the corresponding white population (27.72% under 17 versus 22.25% in the white community), this gap is not nearly enough to account for such a wide separation in per capita income. The argument that the two populations are vastly different gains further merit when comparing householder race by age by householder income. We see that fully 72.65% of all black households earn less than



$25,000 per year versus a white figure of 27.83%. Additionally we notice that almost half, 47.24% of the white households earn over $50,000 per year, which is striking, especially when compared to the black percentage of 7.43% for the same statistic. There is also a marked difference in educational attainment between the races, which would be expected when judged in light of the income statistics. The white population has a much greater rate of Bachelor's degrees or better with nearly 64% of its population attaining that level of academic achievement. The same statistic for the black population is only 9.33%, marking a difference between the two races of over 50% of their respective populations

Wilkinsburg (15221)

Wilkinsburg as a zip code, rests on the western edge of the city of Pittsburgh. It constitutes most of the area north of the Monongahela from Swissvale through Penn Hills. Racially a very significant black minority of 42% characterizes the area with the white majority comprising 57.35% or 22,793 of the area's 39,743 residents. The overall rate of AIDS for the region is 249.1 per 100,000 which places the neighborhood well above the all Pittsburgh rate of 157.25 and ranks the zip code ninth highest in overall AIDS rate and third highest in total number of AIDS cases.



Of the 99 cases identified in Wilkinsburg, 74 of them are through the MSM mode of transmission, 35 white and 39 black. These numbers lead to a white rate of 344.285 per 100,000 and a black rate of 526.032 for MSM within Wilkinsburg. Both of those rates are above the national MSM rate of 230.515 and the all Pittsburgh rate of 247.846. It can clearly been seen that the majority of cases in Wilkinsburg, like most other zip codes in Pittsburgh are from the MSM cohort.

Every case of the IDU mode of transmission in Wilkinsburg was reported in the African-American community. Of the 36 white cases in Wilkinsburg, none of them reported IDU as the mode of transmission, while of the 83 black cases reported there were 12 such reports in the black community or 19.35% of all black cases. Of the two heterosexual cases reported both are black, leading to a rate of 11.983 per 100,000.

Demographically, Wilkinsburg breaks down similarly to East Liberty. The per capita income of the white population is $17,145 and that of the black population is nearly half that at $9,502. The educational attainment among the racial groups is disparate, not in high school age persons, but in their older neighbors and family. In the white population, 38.4% of the population has a college degree compared with 20.85% of the black population. This level of achievement or non-achievement academically

appears to translate well to household incomes. In the black population 60.61% of the households have a yearly income of less than $25,000 while only 43.91% of white household experience the same low income levels. In addition the 23.74% of white households making over $50,000 per year isn't close to being matched by the corresponding 9.38% of black households.

Conclusions:

1. **The difference between E. Liberty and Wilkinsburg is a poorer Black population:**

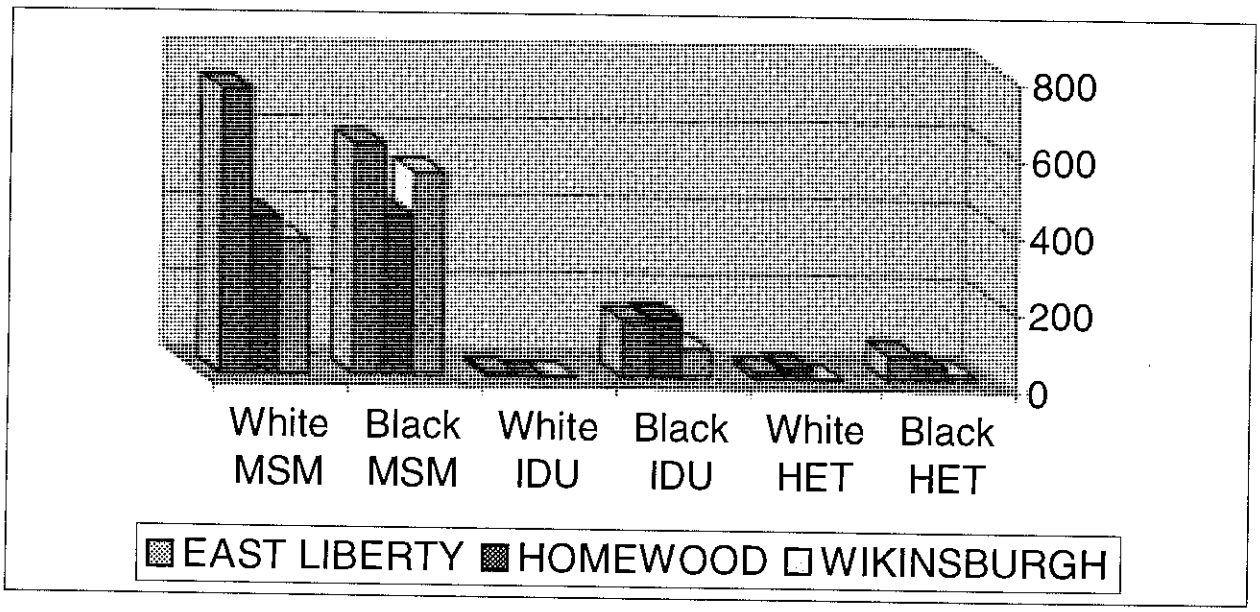
That is to say that the demographic data between the two neighborhoods are similar. This is especially true in income and educational attainment in the white communities. However, it appears that East Liberty's black population is worse off than the blacks of Wilkinsburg (i.e. lower per capita income, lower household income, lower educational attainment, etc.). One possible hypothesis for the higher black rates in East Liberty when compared to the blacks in Wilkinsburg (See Figure 6E.1) is exactly those facts.

2. **Homewood is a divided zip code:**

This conclusion was alluded to inside the paper. The white minority with demographics so unlike the surrounding, majority black communities supports the notion that there are very different white and black neighborhoods within the zip code. The black neighborhood within the zip code is depressed and very susceptible to AIDS especially IDU and Heterosexual modes of transmission.

Figure 6.E.1

Comparison of Mode of Transmission Rates



Introduction for In-Depth Zip Code Analysis

The AIDS case data in a number of the zip codes that we looked at seemed sufficiently interesting or complicated as to warrant further investigation. These areas were Allegheny, Observatory, Killbuck, Homewood, East Liberty, Wilkinsburg, Mt. Oliver, and Mckeesport. They were grouped into geographic blocks when possible and analyzed by AIDS case data and also by taking demographic statistics into account. In some cases the zip code level data was further broken down into census tract level data. By obtaining demographic data at the lowest possible level we hoped to gain a deeper understanding of the zip code and the people who live in it. With our ability to better understand the zip code we hope to develop a sense of why this locale has the risk for AIDS that it does and hopefully we can identify valuable trends, which we can apply elsewhere.

6 F

Contours of AIDS in McKeesport, Duquesne, Rankin, and McKees Rocks

Dan Green

From an initial glance, one tends to assume that McKeesport, Duquesne, Rankin, and McKees Rocks, which have similar demographics, would in turn have coinciding AIDS case statistics. These four zip codes are similar in nature, they are economically depressed areas, former centers of industrialization which have recently witnessed the dismantling of industries in each area. These similar economic patterns, so the theory may go, can be mirrored in the AIDS case figures for each community, for they demonstrate similar trends in modes of transmission and case numbers in each of the four zip codes. This would in turn lead to similar behavioral patterns which expose individuals to the HIV virus, the precursor to AIDS. However, upon closer inspection, there appears in one of these municipalities, McKeesport, an important outlying statistic that does not necessarily follow initial implications.

McKeesport

McKeesport Pennsylvania, zip code 15132, is located southeast of the city of Pittsburgh, along the Monongahela River. A former center of the industrialization which characterized much of the Pittsburgh region, McKeesport has experienced quite a devastating blow economically from the loss of industries in the Mon Valley.

Unfortunately for McKeesport, new forms of employment have not yet replaced all of the lost manufacturing jobs to the extent that they have in many other parts of the Pittsburgh area. A review of the educational, poverty, and work force levels in McKeesport indicates a high number of individuals who have not yet recovered from the de-industrialization of this area. When reviewing the AIDS case data for McKeesport, the manner of the AIDS case make-up in this zip code 15132 in large part mirrors the economic depression of the area.

The economic picture of McKeesport becomes an interesting factor when reviewing AIDS case data of the Pittsburgh region. McKeesport represents the highest rate of black AIDS cases in the entire Pittsburgh area, in particular through the use of injection drugs.

This chapter outlines the extent to which an economically depressed area can suffer from high rates of AIDS cases, brought about by the widespread use of injection drugs.

AIDS Case Data[i]

McKeesport, more specifically zip code 15132, has quite a high number of AIDS cases at 38, which gives it a rate of 137.1 per 100,000 population. Of these cases, blacks are disproportionately represented, numbering 28 of the 38 cases. To put this in another perspective, McKeesport is only 16% black, yet they make up over 73% of the AIDS cases in McKeesport. The black case rate is a whopping 619.6 cases per 100,000 population, compared to a rate of only 39.2 cases per 100,000 population for whites. Of the 38 cases in zip code 15132, 25 are male and 13 are female. Breaking this down by race, There are 17 are male and 11 are female black cases, while for whites there are 7 male and 2 female cases. In addition, there is 1 hispanic male case. The modes of transmission include 11 male sex with male (4 white, 6 black, 1 hispanic). The most common mode of transmission in McKeesport, however, is through injection drug use, which accounts for 20 cases (2 white, 18 black). There is also 1 white Adult Hemophiliac, 1 black case of heterosexual relations with an injection drug user, and 1 black who had heterosexual relations with a bisexual male. One white case was via a blood transfusion, and of the final 3 cases, 2 black and 1 white, the mode of transmission was not specified. The high number of black female cases in McKeesport seem to indicate that this zip code is firmly entrenched in wave II. Yet, upon closer inspection, this is not necessarily the case. Wave II is usually described as women, particularly black women, becoming infected with AIDS via heterosexual relations. Looking at the data more closely, however, it appears that heterosexual relations only accounted for 2 of the 13 female cases. Therefore, it appears that many of the infections for women in McKeesport resulted from injection drug use. The median age of in AIDS cases in McKeesport is 36.3 years, with the youngest case at 22 years and the oldest case at age 66. The statistic that jumps out while examining the AIDS case data for McKeesport is the very high levels of AIDS cases in the black community.

A closer look at the AIDS Case Data. In McKeesport, as is noted above, there are 38 total cases, 25 male and 13 female. Of the male cases, once again, 7 are white, 17 are black, and 1 is hispanic. Of the female cases, 2 are white and 11 are black. The first observation that stands out in these numbers are the disproportionately high numbers of black cases, who only make up 16% of the population in McKeesport, yet blacks represent almost three fourths of all AIDS cases here. This highlights a segment of the population in McKeesport which needs to be targeted in order for policy makers to examine possible prevention methods necessary for McKeesport.

Coupled with race as a significant factor in the AIDS case picture for McKeesport is modes of transmission. Male having sex with male included 4 white, 6 black, and 1 hispanic. Injection drug users entailed 2 white and 18 black, there was 1 white Adult Hemophiliac, 1 black who engaged in heterosexual sex with an injection drug user, and 1 black who engaged in heterosexual relations with a bisexual male. The tables below offer a visual perception of the breakdown of AIDS case data, and the modes of transmission figures reported for McKeesport.

Case Rates and Numbers[ii]

	Male	Female	Total
White	7	2	9
Black	17	11	28
Hispanic	1	0	1
Total	25	13	38

Figure 6F.1

Modes of Transmission[iii]

	MSM	IDU	Adult Hemo	Hetsx w IDU	Hetsx w Bi M	total
White	4	2	1	0	0	9
Black	6	18	0	1	1	28
Hispanic	1	0	0	0	0	1
total	11	20	1	1	1	38

Figure 6F.2

(Of the four missing cases, 1 white was via blood transfusion, and of the remaining 3, 2 black and 1 white, the modes of transmission were not reported.)

As can be seen in the chart above, there appears to be widespread injection drug use in McKeesport, particularly among the black community. More to the point, the activity of injection drug use in McKeesport appears to be lacking AIDS prevention methods, possibly the lack of clean needles. The black population already suffers from abnormally high rates of AIDS cases in McKeesport, and the high level of injection drug use exacerbates this problem.

Breaking this down into numbers, of the black AIDS cases viewed here, 18 out of 28, a full 64%, where infected through injection drug use. Indeed, the black case rate of injection drug users in McKeesport is the highest in Allegheny County, at 398.3 per 100,000 population. To put this into a clearer perspective, the rate of injection drug use cases among blacks in the Hill District (Uptown), which is commonly referred to as a very economically depressed black neighborhood, is 137.9 per 100,000, roughly a mere *one third* of the rate in McKeesport. With this noted, it is safe to say that the case figures coming out of McKeesport, particularly of the black community, are quite alarming.

McKeesport Demographics[iv]

Zip Code 15132, McKeesport, is located just southeast of Duquesne, along the Monongahela River. The total population is of McKeesport is 27,702. Broken down by race, there are 22,927 white, 4,519 black, and 256 of other origin. That translate into 83 percent white and 16 percent black.

The neighborhoods surrounding McKeesport offer quite different demographic pictures than you will find in McKeesport. White Oak, zip code 15133, is a predominately white, middle class neighborhood, as is zip code 15133. This zip code is officially named McKeesport as well, but is quite different than its counterpart 15132. The McKeesport of 15133 is almost exclusively white, and is mostly middle class as well. Finally, the third neighborhood bordering McKeesport is Boston, zip code 15135, and once again it is a mostly white, middle class area. Therefore, by reviewing the demographic figures for McKeesport 15132, it becomes evident that this neighborhood is a small microcosm, surrounded by very different neighborhoods.

Zip Code 15132

neighborhood name: McKeesport

location:	Southeast of Pittsburgh, on Monongahela River			
total population:	27,702			
population by race:				
white	22,927			
black	4,519			
other	256			
number of houses:	11,395			
houses by income:	Less than $5,000	1,357	$30,000 to 39,999	1,390
	$5,000 to 9,999	2,313	$40,000 to 49,999	780
	$10,000 to 14,999	1,508	$50,000 to 59,999	463
	$15,000 to 19,999	1,246	$60,000 to 74,999	215
	$20,000 to 24,000	1,027	$75,000 to 99,999	102
	$25,000 to 29,000	864	$100,000 or more	70
median income:	$16,687			
per capita income by race:	whites $9,723			
	blacks $6,536			

Figure 6F.3

A closer look at the demographics. There are 11,395 households in McKeesport, with a median income of $16,687. A full 32% of homes have reported incomes lower than $10,000.

Looking at education, there are high numbers of people in McKeesport who have achieved only relatively low levels of educational attainment. Of the residents of McKeesport over the age of 18, according to the 1990 Census, a full 32% did not graduate

from high school. Broken down further into different race and age brackets, the extent of the lack of education in McKeesport becomes highlighted even further.

For whites over the age of 25, a full 32% did not complete high school. Nor do 41% of blacks over 25 years of age have a high school diploma. Of those who completed 12 years of compulsory education, only 11% have gone on to eventually receive a Bachelor's degree.

There are 321 high school students who in 1989 were employed part time. Of the recent high school graduates under the age of 19 who entered the labor force, 71% have found employment. However, among those under the age of 19 who dropped out of high school, only 34% were employed.

These figures of low educational goals translate, quite expectantly, into a large number of low income households. Of white householders under the age of 25, 25% earn less than $5,000 annually. For blacks in the same age group, that of 25 years or less, a large majority of 81% of householders earn less then $5,000 per year. It is safe to say that this is an astonishing figure, and such a high percentage of extremely low incomes indicates that their incomes must be supplemented by other means, including public assistance, or possibly activity in the drug or sex trades.

For whites between the ages of 25 to 44 years, 11% earn less then $5,000. For blacks in this age group, the percentage of householders earning less than $5,000 is 34. 8.5% of whites between the ages of 35 and 44 take home less than $5,000 per year, and among blacks of this age, the figure is 16% who do not earn more than $5,000 annually.

The median income for McKeesport is noted above at $16,687. Per capita, however, the income for whites comes out to be $9,723 per year, while for blacks it is $6,536 annually. Not surprisingly, well over 14% of males ages 18 to 64 live below the poverty level. At the same time, nearly 16% of females ages 18 to 64 live below the level of poverty.[v]

Since injection drug use is the prevalent mode of transmission of AIDS in McKeesport, the accessibility of a needle exchange program is called into question. There is currently a comprehensive needle exchange program operating in Uptown (the Hill District). Unfortunately, McKeesport is quite removed from the hub of Pittsburgh, and this program may not be easily accessible to many of the injection drug users of McKeesport.

Duquesne

Duquesne, Pennsylvania, zip code 15110, is located northwest of McKeesport and lies alongside the Monongahela River. In Duquesne, there are significantly lower numbers of AIDS cases than in McKeesport. Duquesne has a much higher percentage of African Americans than does McKeesport, but the AIDS case numbers, although higher of blacks in Duquesne than for whites, in no way mirrors the situation in McKeesport, where an astronomical number of blacks were infected via injection drug use. As is shown below, the modes of transmission for blacks in Duquesne are spread equally across the spectrum, and do not focus on one key problem area.

AIDS Case Data[vi]

Duquesne, Pennsylvania, has a total number of eight AIDS cases. All of the eight cases in Duquesne are male. The overall case rate per 100,000 population is 93.8. Broken down by race, there are two white cases, five black cases, and one hispanic. Once again, a disproportionately high number of black cases is evident, for the case rate for blacks per

100,000 in 15110 is 190.9, to 34.8 for whites. (Blacks make up 30 percent of the population in 15110, but are 62.5 percent of the AIDS cases in Duquesne). For modes of transmission, all white cases are from men engaging in sex with men, while three of the five black cases were via injection drug use. Looking closer, both white cases, along with two blacks and the one hispanic case were infected with the HIV virus via men engaging in sex with men Of the final 3 black cases, two are injection drug users and the last one is from either engaging in homosexual sex or through injection drug use. Zip Code 15110 is basically a Wave I neighborhood, for AIDS cases have yet to be reported in black females, the typical victims of Wave II. The median age of cases in 15110 is 36.6 years.

Case Rates and Numbers[vii]

	Male	Total
White	2	2
Black	5	5
Hispanic	1	1
Total	8	8

Figure 6F.4

Modes of Transmission[viii]

	MSM	IDU	Homo & IDU	Total
White	2	0	0	2
Black	2	2	1	5
Hispanic	1	0	0	1
Total	5	2	1	8

Figure 6F.5

Duquesne Demographics[ix]

Looking at the demographics for Duquesne, it appears that Duquesne is not as similar as McKeesport as initially assumed. Duquesne's population total is 8,525 residents, which is approximately 19,000 less than in McKeesport. The racial breakdown in Duquesne includes 5,742 whites and 2,619 blacks. This indicates quite a large African American community within Duquesne, for blacks comprise 30.7 percent of the total population. In McKeesport, the percentage of African Americans was closer to 16 percent, roughly half the size of the black community in Duquesne. Duquesne on the whole is slightly worse off economically than McKeesport, with a median income level of $15,801 per year. This figure, as the median, includes the disheartening fact that a full 34.5 percent of homes in Duquesne have incomes lower than $15,000 per year.

Zip Code 15110

neighborhood name:	Duquesne			
location:	Southeast of Pittsburgh, on Monongahela River			
total population:	8,525			
population by race:				
white	5,742			
black	2,619			
other	164			
number of houses:	3,515			
houses by income:	Less than $5,000	464	$30,000 to 39,000	321
	$5,000 to 9,999	749	$40,000 to 49,000	281
	$10,000 to 14,999	459	$50,000 to 59,000	79
	$15,000 to 19,999	412	$60,000 to 74,999	69
	$20,000 to 24,000	345	$75,000 to 99,999	20
	$25,000 to 29,000	294	$100,000 or more	22
median income:	$15,801			

Figure 6F.6

The median income in Duquesne is $15,801 per year per household, which is the lowest median income among the towns discussed here, Rankin, McKeesport, and McKees Rocks. 13 percent of households in Duquesne earn less than $5,000 per year, as 34.5 percent of households take home less than $10,000 per year. A full 47.5 percent of households earn less than $15,000 annually.

Educational attainment For individuals in Duquesne over the age of 25 years, 12.5 percent of whites do not have any high school experience, coupled with 12.3 percent of blacks over 25 who have never attended high school. 16.9 percent of blacks over 25 had previously attended some high school before dropping out, as did 20 percent of their white counterparts. 43 percent of whites over the age of 25 received a high school diploma, as did 37.6 percent of black adults. Approximately 5 percent of blacks and whites over the age of 25 hold a bachelors degree, while 2 percent of whites and 1.6 percent of blacks in Duquesne hold a graduate degree. Thus by race, it appears that the levels of education are quite similar between the races in Duquesne, with the exception of a higher percentage of blacks in Duquesne receiving a bachelors degree.

Educational Attainment Figures-Duquesne[x]

Black		White
12.3%	Less than 9th grade	12.5%
16.9%	some high school	20%
37.6%	High School Graduate	43%
8.6%	Associate Degree	5%
4.5%	Bachelors Degree	5%
1.6%	Graduate School	2%

Figure 6F.7

Rankin

Rankin, Pennsylvania, zip code 15104, is another neighborhood along the Monongahela River southeast of the city of Pittsburgh. Rankin, like its neighbors Duquesne and McKeesport, is a former industrial town, and is just east of Homestead. The total population in Rankin is 13,915 persons. Broken down by race, there are 8,667 white residents in Rankin, and 5,171 black residents. This shows that 37 percent of the residents in Rankin are black, and this percentage will increase in the years to come. The under 25 population in Rankin has a majority of blacks with over 53 percent, thus ensuring that in years to come a drastic change in the racial balance of Rankin will ensue. Unless a significant shift in the population of Rankin occurs in the near future, the next few decades will most likely witness the black population as a whole becoming the majority race in Rankin.

AIDS Case Data[xi]

Rankin has a total of 10 cases. With a population of 13,901, that gives Rankin a rate of 71.9 cases per 100,000 population. Six of the ten cases in 15104 are male, and the remaining four cases are female. Of the male cases, three are black and three are white. All black female cases are black. It is a significant observation that 70% of the cases in Rankin are black, although blacks make up only 37% of the total population. In other terms, the black case rate is 135.3 per 100,000, to only 34.6 per 100,000 for whites. Looking at modes of transmission figures, there is one white case of Adult Hemophilia, two white and three black cases were transmitted via men engaging in sex with men, two black cases were through injection drug use, one black case was via heterosex with an injection drug user, and the final black case was male sex with an injection drug user. The median age of cases in 15104 is 38.6 years, and range quite evenly from 26 to 50 years. The exception is an infant who is not yet a year old. The cases of four black females, making up 40% of 15104's cases, indicate that this neighborhood is already well established in Wave II. Furthermore, there is an emergence of Wave III in this zip code, for one of the black female cases is that of a newborn.

Case Rates and Numbers[xii]

	Male	Female	Total
White	3	0	3
Black	3	4	7
Total	6	4	10

Figure 6F.8

Modes of Transmission[xiii]

	MSM	IDU	Adult Hemo	Hetsx w IDU	M Sx w IDU	total
White	2	0	1	0	0	3
Black	3	2	0	1	1	7
Total	5	2	1	1	1	10

Figure 6F.9

Rankin Demographics[xiv]

As with Duquesne and McKeesport, Rankin has high levels of high school drop outs among its adult population over the age of 25 years. A full 33 percent of whites over the age of 25 have not completed high school in Rankin. Of these, 65 percent of these whites without a high school diploma did not even reach the 9th grade. The black figures for Rankin are much the same, as 32 percent of black adults do not have a high school diploma or the equivalency.

48.6 percent of whites in Rankin did complete high school, and yet only 4 percent of these decided to continue their education through a four year bachelors program. For blacks, only 38. 6 percent in Rankin over the age of 25 years have a high school diploma, and likewise, only 3 percent of blacks who have graduated from high school earned a four year college degree.

Educational Attainment Figures-Rankin[xv]

Black		White
12.9%	Less than 9th Grade	13%
19.1%	Some High School	20%
38.6%	High School Graduate	48.6%
6.4%	Associate Degree	4.0%
3.0%	Bachelors Degree	4.0%
.005%	Graduate School	1.3%

Figure 6F.10

The median income in Rankin is $16,642 annually. 11.6 percent of the households in Rankin earn less than $5,000 per year. Broken down by race, these figures draw further conclusions. 27 percent of white householders ages 25-34 take home less than $10,000 annually. The black community in Rankin has an even lower income picture, for 38 percent of black householders under the age of 34 earn less than $10,000 and 37 percent of blacks ages 35-44 earn less than $10,000 per year as well. Twice as many females than males live under the poverty level in Rankin, 1,049 females to 540 males.

Zip Code 15104

neighborhood name: Rankin

location: East of Homestead

total population: 13,915

population by race:

white	8,667			
black	5,171			
other	63			
number of houses:	5,762			
houses by income:	Less than 5,000	674	$30,000 to 34,999	375
	$5,000 to 9,999	1,116	$35,000 to 39,999	309
	$10,000 to 12,499	493	$40,000 to 44,999	150
	$12,500 to 14,999	372	$45,000 to 49,999	166
	$15,000 to $17,499	344	$50,000 to 59,999	171
	$17,499 to 19,999	255	$60,000 to 74,999	24
	$20,000 to 24,999	609	$75,000 to $99,999	14
	$25,000 to 29,999	555	$150,000 or more	11
median income:	$16,642			

Figure 6F.11

McKees Rocks

McKees Rocks, zip code 15136, is not in the same geographical area as the three previous cases of McKeesport, Duquesne, and Rankin. McKees Rocks is located southwest of the city of Pittsburgh, along the Ohio River. However, McKees Rocks, as another deindustrialized region, is a possible candidate to match with these three other Mon Valley cases, and thus McKees Rocks is analyzed here to see how it matches up with the other three zip codes. When we look at the demographic picture of McKees Rocks, we find some surprisingly similar and also some strikingly different characteristics. For example, education levels are similar in McKees Rocks, and yet the annual median income in McKees Rocks is nearly $10,000 higher per year than in its Mon Valley counterparts. Furthermore, a key factor is that although the three neighborhoods of Rankin, Duquesne, and McKeesport all contained sizable African American communities, McKees Rocks is almost exclusively white.

AIDS Case Data[xvi]

There are a total of fifteen cases of AIDS in McKees Rocks. Of these fifteen cases, only three are of females, compared with twelve males. The existence of these three females indicates that McKees Rocks is already entering Wave II. Of the male cases, nine were white, two were black, and the final case was an hispanic. Modes of transmission in McKees Rocks contained eight white men who had sex with men, as well as one black and one hispanic engaging in homosexual sex. Of the remaining five cases, two were black injection drug users, one was a white homosexual and injection drug user, one white who engaged in heterosexual relations with an injection drug user, and the final black case was unspecified. Once again, blacks are disproportionately represented. Blacks only comprise approximately 5 percent of the population in McKees Rocks, and yet they make up over 26 percent of the AIDS cases in McKees Rocks.

Case Rates and Numbers[xvii]

	Male	Female	Total
White	9	1	10
Black	2	2	4
Hispanic	1	0	1
Total	12	3	15

Figure 6F.12

Modes of Transmission[xviii]

	MSM	IDU	Homo & IDU	Hetsx w IDU	Not specified	Total
White	8	0	1	1	0	10
Black	1	2	0	0	1	4
Hispanic	1	0	0	0	0	1
Total	10	2	1	1	1	15

Figure 6F.13

McKees Rocks Demographics[xix]

McKees Rocks, population wise, is the second largest of the communities discussed in this chapter. The total population in McKees Rocks is 25,232 persons. However, McKees Rocks is only 5 percent black, for it contains only 1,209 blacks within its borders.

The educational picture for McKees Rocks is quite similar to McKeesport, Duquesne, and Rankin. Almost 29 percent of white adults with more than 25 years have no high school diploma, as do 38 percent of blacks adults. In fact, 13.2 percent of whites and 10 percent of blacks have less than a 9th grade education. An interesting anecdote is that although 10 percent more blacks in McKees Rocks than whites do not have any have any high school diploma, a higher percentage of blacks than whites graduated from high school. 48 percent of blacks in McKees Rocks completed high school, as did 41.6 percent of whites. An approximately equal number of blacks and whites obtained an associate degree, 5 percent of each. However, a significant finding is that not one African American over the age of 25 in McKees Rocks has completed a four year bachelors program, while 8 percent of whites have graduated from college.

Educational Attainment Figures-McKees Rocks[xx]

Black		White
10%	Less Than 9th Grade	13.2%
28%	Some High School	15.6%
48%	High School Diploma	41.6%
5.0%	Associate Degree	5.6%
0%	Bachelors Degree	8.0%
0%	Graduate Degree	1.3%

Figure 6F.14

The median income in McKees Rocks is $24,092 per year, almost $10,000 higher than the three neighborhoods in the Mon Valley examined in this chapter. Of the households in McKees Rocks, only 9 percent earn less than $5,000 per year, while 24 percent earn less than $10,000 per year.

Zip Code 15136

neighborhood name: Rankin

location: Southwest of Pittsburgh

total population: 25,232
white 23,904
black 1,209

number of houses: 10,233

houses by income:

Less than $5,000	894	$30,000 to 34,999	822
$5,000 to 9,999	1446	$35,000 to 39,999	628
$10,000 to 12,499	415	$40,000 to 44,999	610
$12,500 to 14,999	448	$45,000 to 49,999	415
$15,000 to 17,499	619	$50,000 to 59,999	614
$17,500 to 19,999	510	$60,000 to 74,999	624
$20,000 to 24,999	957	$75,000 to 99,999	284
$25,000 to 29,999	814	$100,000 or more	133

median income: $24,092

Figure 6F.15

Most of the lower incomes in McKees Rocks tend to be black. Of black householders under the age of 25 in McKees Rocks, none earn more than $15,000 per year. Furthermore, 75.3 percent of black householders under the age of 25 earn less than $10,000 per year. This trend continues at a disturbing pace. For black householders ages 25 to 34 years, 100 percent, or 70 households, earn less than $5,000 per year. This trend continues up the age bracket, indicating high levels of poverty among the black residents in McKees Rocks.

Conclusion

From an initial glance one might assume that all four of these zip codes, McKeesport, Duquesne, Rankin, and McKees Rocks would contain similar AIDS case statistics. This belief stems from the assumptions that the demographic pictures, and the economic situations of each community are similar, thus leading to similar behavioral patterns which expose individuals to the HIV virus, the precursor to AIDS. Although there are a few inconsistencies concerning the make up of each community, with the exception of McKeesport's black injection drug use problem, these communities do paint a similar picture. There is a significant outlier with McKeesport, however, with injection drug use rates, specifically black injection drug use rates, which are quite high.

The educational backgrounds are quite similar in each neighborhood, with both whites and blacks usually experiencing the same levels of education. This trend is evident in each of the four areas. Furthermore, the economical situations in each of the four zip codes examined in this chapter show quite similar results. McKeesport, Rankin, and

Duquesne all have approximately the same median income. McKees Rocks does have a higher median income, but the significant levels of poverty, especially black poverty, brings McKees Rocks back into the same situations as Rankin, Duquesne, and McKeesport.

Aside from these similarities, however, there are inconsistencies between McKees Rocks, Rankin and Duquesne on the one side, and McKeesport on the other. The first problem lies in the different racial breakdowns of each community. Rankin is 37 percent black, Duquesne is 30 percent black, McKeesport is 16 percent black, and McKees Rocks is only 5 percent black. It is true that, with the exception of McKeesport, where black injection drug use rates are extremely high, the case rates for African Americans in the other three towns, McKees Rocks, Duquesne, and Rankin, are similar, hovering around 140 per 100,000 population (McKeesport is 619). However, the introduction of McKeesport indicates that the communities are different, in that injection drug use is not so prevalent in McKees Rocks, Duquesne, or Rankin as it is in McKeesport.

If the similar economic patterns lead to certain risk behaviors, then either all of these places would have a injection drug problem like McKeesport, or none of them would. The fact is that McKeesport, although similar to the other three municipalities in many demographic aspects, has a widespread injection drug problem that is not found elsewhere. This factor indicates that McKeesport must be treated as a unique case, if any policy decisions are to be successful.

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[i] Allegheny County Health Department, HIV-AIDS Reporting System
[ii] Allegheny County Health Department, HIV-AIDS Reporting System
[iii] Allegheny County Health Department, HIV-AIDS Reporting System
[iv] 1990 Bureau of the Census, U.S. Department of the Treasury
[v] 1990 Bureau of the Census, U.S. Department of the Treasury
[vi] Allegheny County Health Department, HIV-AIDS Reporting System
[vii] Ibid.
[viii] Ibid.
[ix] 1990 Bureau of the Census, U.S. Department of the Treasury
[x] Ibid.
[xi] Allegheny County Health Department, HIV-AIDS Reporting System
[xii] Ibid.
[xiii] Ibid.
[xiv] 1990 Bureau of the Census, U.S. Department of the Treasury
[xv] Ibid.
[xvi] Allegheny County Health Department, HIV-AIDS Reporting System
[xvii] Ibid.
[xviii] Ibid.
[xix] 1990 Bureau of the Census, U.S. Department of the Treasury
[xx] Ibid.

6G

Comparison of Allegheny and Mt. Oliver

by
Jason Reinsch

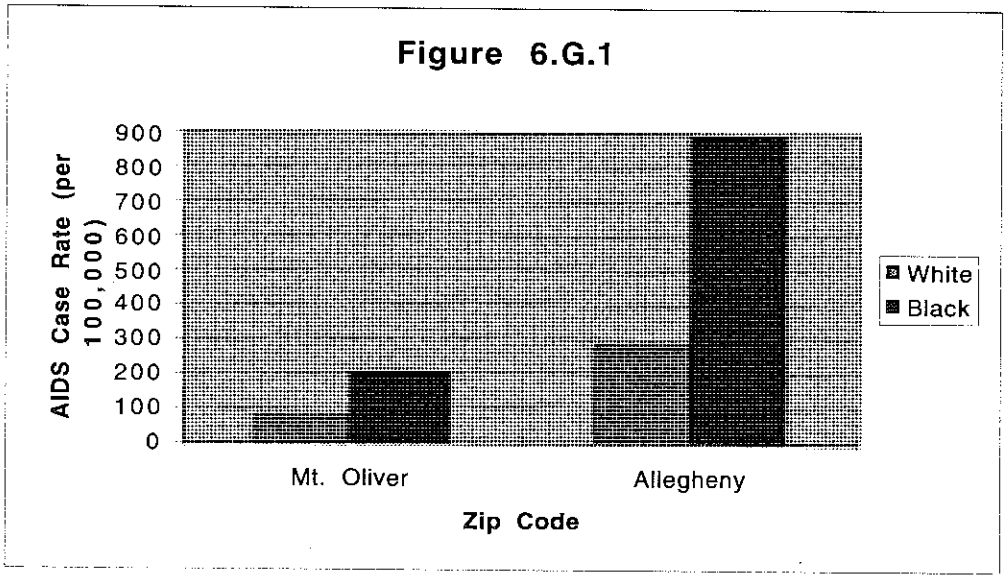
The Mt. Oliver and Allegheny zip codes offer similar demographic profiles, yet strikingly different AIDS case rates. An examination of the two areas lends credence to the idea that intangible neighborhood factors affect the spread of AIDS. This section compares these two areas that, while appearing so similar, exhibit major differences in this apparent vulnerability to AIDS. The results here lend support to the analytical model developed in the report's examination of the Hill District zip code.

AIDS Case Rates

Given the quite similar demographic data one might assume that there would be similar AIDS case rate data. This is not the case. To start broadly, consider the overall case rates for the zip codes. Allegheny features a much higher case rate, 377.305 per 100,000 residents (the fifth highest rate of the 42 Pittsburgh zip codes.) In contrast, Mt. Oliver has a moderate case rate, 104.36 per 100,000.

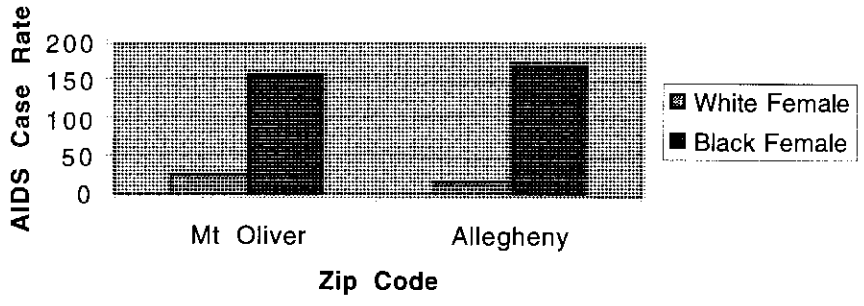
As for the AIDS case rate breakdowns of blacks and whites, Allegheny is much higher by nearly a factor of four in both cohorts. In fact, as seen in Figure 6.G.1, the lowest rate in Allegheny, whites, is still larger than Mt. Oliver's largest case rate, blacks.

Figure 6.G.1



The difference in case data as seen so far raises interesting questions given Allegheny's substantial case rate. Examination of the specific rates, which are divided by race versus sex or race versus mode of transmission, reveals that discrepancies in black MSM and IDU rates as well as white MSM rates largely account for the overall rate difference. However, breaking the data down by sex uncovers an interesting result. For males, the expected comparatively large rates are found for Alleghney, but to an even greater degree. However, this is offset by the interesting data for females. The rate data for females are very similar between the zip codes. In fact the white female rate is actually higher in Mt. Oliver (see Fig 6.G.2.) Given such a disparity between the male rate of the zip codes, the similar female rates are a mystery. Perhaps certain modes of transmission for males can account for the large discrepancy in overall case rate.

Figure 6.G.2



For the white MSM rate, somewhat expected numbers are found given the overall rate proportion between the two zip codes. Allegheny has a much higher AIDS case rate, 522.5 (73 cases) compared to the Mt. Oliver rate, 116.5 (15 cases.) They differ by a factor of ~4.5. However, we see a major change with the black MSM rates of the two zip codes. The rate in Mt. Oliver is one of the lowest in the city for black MSM, only 182.9 (6 cases.) On the other hand the black MSM rate for Allegheny is 1125.0 (27 cases), one of the highest in the city. With regards to IDU rates, a similar pattern is found.

The comparison of white IDU rates reveals that the two zip codes are somewhat similar. With only 5 cases in Allegheny for a rate of 16.8 and 3 cases in Mt. Oliver for a rate of 10.9 it is apparent that with such low case numbers and a much smaller ratio compared to the overall rate ratio, the white IDU cohort is quite limited. However, as with black MSM, black IDU rates differ drastically. With only 5 cases in Mt Oliver for a rate of 65.5, this area is currently affected to a much lesser degree than Allegheny. Allegheny contains 17 cases of black IDU cases for a rate of 321.7. The ratio between the two areas is a little less than 5.

With regards to heterosexually transmitted AIDS, little can accurately be inferred from the low case numbers. A total of 4 cases is present in Mt. Oliver and only 5 cases in Allegheny. Perhaps this magnifies the importance of the discrepancies between the zip codes in the cohorts of black MSM transmitted AIDS and black IDU transmitted AIDS.

Demographic Data

Population and Racial breakdown. Similar population and racial breakdown were the initial similarities that led to a closer examination of these two zip codes. The population of

each neighborhood is large for the Pittsburgh area, 35,455 for Mt. Oliver and 35,250 for Allegheny. Additionally, both neighborhoods have a similar racial breakdown or, more importantly, an African-American population comparable to the national average. Mt. Oliver's black population is slightly larger with 21.53% of the residents being black compared to 14.99% of Allegheny. Despite these comparable racial components of the population, Allegheny has a much higher case rate than Mt. Oliver.

Age. The next similarity is the age cohort between 18 and 64 years old. The percentages of these populations in the zip codes are very close, 57.3% and 58.2% for Mt. Oliver and Allegheny, respectively. This similarity is significant because it is between these ages that the majority of AIDS cases appear. There are only slight differences in the other age cohorts 17 or younger and 65 and above. Mt. Oliver has a slightly larger percentage of 17 or younger, 25.23% versus 20.71% for Allegheny. Thus, one can reason that Allegheny will have a larger 65 and older population, 21.09% compared to 17.47% in Mt. Oliver.

Education attainment. The level of educational attainment for a universe of 18 and over residents between the two zip codes is very close. Allegheny has a slightly higher percentage of the people without a diploma, 33.76%. Mt. Oliver follows closely behind with 32.54% not obtaining a diploma or equivalent.

Joblessness. Joblessness is a very important factor in determining general neighborhood vulnerability. In the instance of Mt. Oliver and Allegheny, it is apparent the degree of joblessness (in the universe of 16 and older persons) is nearly identical for whites although there is a noticeable difference between the rates of blacks. White males have a 40.47% rate of joblessness in Mt. Oliver and 40.04% in Allegheny. For white females, there is only a slight difference: 53.98% in Mt. Oliver and 55.94% in Allegheny. There is a larger degree of distinction between joblessness rates in the black population. Black males shoulder a larger burden of joblessness in Mt. Oliver with 59.56% as opposed to 54.69% in Allegheny. An even larger disparity exists for black females; 68.35% in Mt. Oliver and 58.54% in Alleghney. Being more specific with regard to the component factors of the joblessness rate, unemployment and not in the workforce, the components are nearly equal as a proportion of the individual joblessness rates.

School enrollment. With regards to a universe of 16 to 19 year olds, Allegheny is able to boast a higher percentage of school enrollment. In fact, Allegheny's lowest enrolled cohort, whites, is larger than Mt. Oliver's highest enrolled cohort, blacks. The enrollment percentages in Allegheny are 85% for blacks and 79.31% for whites. In Mt. Oliver, 77.66% of the blacks are enrolled and 73.20% of whites are enrolled.

Median income. The median income, which could be a powerful indicator of economic disparity, only lends itself to further indicate the similarity between the targeted zip codes as the values are very close. The median income for Allegheny is $19,967 compared to approximately $19,500 in Mt. Oliver.

Poverty status. With regards to the poverty status of residents in Mt. Oliver and Allegheny, the percentages are nearly equal. In Allegheny, 21.19% of the population dwells below the poverty line. Similarly, 21.54% of the Mt. Oliver residents live below the poverty line.

Occupational status. Occupational status, though more overtly than poverty status, is also an indicator of a poorer population because service oriented jobs tend to pay much less than non-service oriented jobs. However, there appears to be no discernible difference

between the two zip codes with 20.53% of Mt. Oliver jobs and 20.85% of Allegheny jobs being service based.

Per Capita Income. There is a bit of a discrepancy between the two zip codes with respect to per capita income. Both exhibit the well-documented disparity between black and white income. As for the overall values, Allegheny exhibits greater per capita income than Mt. Oliver. Whites in Allegheny have a per capita income of $11,701 and those in Mt. Oliver have a per capita income of $10,268; a difference of about $1,500. The per capita income for blacks in Allegheny is $7,168 and $5,609 in Mt. Oliver; also a difference of about $1,500.

Transience. Transience can be a measure of the number of persons (5 years and older) who live in either the same house or the same Metropolitan Statistical Area (MSA) compared to five years earlier. As residents live in an area for extended amount of time it is reasonable that they will begin to take a greater interest in the activity of their area because of either financial motivation or concern for various social networks that have been formed. Thus, this data can be considered and indirect measure of the community's stability. When comparing the two zip codes it appears that Mt. Oliver has a slightly higher number of its residents that have lived in the same house for the past five years. 66% of Mt. Oliver residents live in the same house, compared to 63% in Allegheny. Furthermore, 23% of Allegheny residents compared to 24.3% of Mt Oliver residents have moved to a different house within their current MSA and 4.5% of Allegheny residents compared to only 2.6% of Mt. Oliver have moved to the area from another MSA.

Demographic implications. As one can see in the above depiction of the two zip codes it is not clear that Allegheny exhibits such a high AIDS case rate in comparison to Mt. Oliver. Discrepancies found in three categories, joblessness for blacks, school enrollment, and per capita income, are worthy of remark. Mt. Oliver exhibits a higher degree of joblessness for blacks, a higher percentage of school enrollment, and a lower per capita income. These discrepancies indicate that Mt. Oliver might be expected to have a higher AIDS case rate. If anything, the numbers suggest that Mt. Oliver might be more susceptible to an AIDS outbreak. So far this has not been the case. Clearly, while economic and demographic conditions affect neighborhood health on a general level, AIDS transmission involves additional factors. These factors are discussed in more detail in chapter 8.

Overall Implications

The fact that the AIDS case rates for the zip codes differ so dramatically poses a complex mystery. A mystery attributed to no clear, single cause. Unfortunately, possible explanations escape the usefulness of quantitative data. So what possible causes exist though not seen in the demographic and AIDS case data? First of all, Allegheny lies adjacent to Killbuck, the worst AIDS case rate of any zip code in Pittsburgh. Zip codes are not closed microcosms so interaction between the surrounding areas presents a definite factor in the susceptibility of an area to AIDS. Similarly, Allegheny is closer to downtown Pittsburgh. This is important because when the police patrol the downtown area for prostitution, sex workers often travel across the bridges to Allegheny and Killbuck thus adding another vector for AIDS transmission[1]. Also Mt Oliver is geographically isolated from the IDU cluster described in Richard Svinkin's earlier piece, chapter 6.C, whereas Allegheny resides within that cluster, which constitutes about 65% of Pittsburgh's IDU cases. A second possible explanation is a greater degree of social stability in Mt Oliver shown through transience data and ethnic communities. Finally, Allegheny is a much more diverse community. This diversity skews the zip code's demographic data, concealing the

vulnerability of some neighborhoods within the zip code. Even some of the "well off" areas in Allegheny like the Mexican War Streets, which contains a significant population of affluent homosexuals, pose a greater risk for AIDS transmission though not visible in the demographic data. In conclusion, the AIDS case and demographic data shed little light on the cause of the radically different AIDS case rates. This emphasizes the importance of intangible factors such as familial and community support networks that can lead possible outbreak of AIDS.

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[1] Linda Ogden, Lecture, CMU History and Policy Project Course, Fall 1997.

7

The Philadelphia Story

Sravan Narayan

7.1 Introduction

W.C. Fields' tombstone reads, "I'd rather be here than in Philadelphia." Nobody is quite sure what the noted humorist objected to in Philadelphia. Perhaps it was the pollution, or the poverty, or maybe he couldn't stand to be that close to New Jersey. Or maybe Fields was far ahead of his time and predicted the AIDS epidemic that would engulf Pennsylvania's largest city. As an aggregated AIDS case Philadelphia is an excellent foil to Pittsburgh, not only to frame the rates in Pittsburgh, but also to point out patterns which one or both of the cities exhibit.

7.2 Wave I and Wave II

One of the distinctions which makes Philadelphia a useful comparison to Pittsburgh is the wave I-wave II framework. Pittsburgh is usually classified as a wave I situation, a city in which the gay white male is the primary victim of AIDS. Most would also argue that Pittsburgh has wave II characteristics in combination with the wave I pattern. Philadelphia acts as a foil in this situation as it appears to be a city in wave II of the AIDS epidemic. Philadelphia therefore not only acts as a comparative tool for rates in Pittsburgh, but also a potential situation which Pittsburgh may soon find itself in.

7.3 Comparing Rates

Over 3.5% of the 19107 zip code has AIDS according to the Pennsylvania Department of Health. No zip code or census tract in the Pittsburgh can boast of such a dubious feat. Unfortunately this figure is not outrageous for Philadelphia. When comparing the overall rates between Pittsburgh and Philadelphia we see that the ratio of the AIDS case rates in the cities is 1:4 respectively; the overall AIDS case rate for Pittsburgh is 157.250 and the rate for Philadelphia is 634.883. This makes a bit more sense of the 3631.541 rate exhibited by 19107, as the rate for Killbuck (15233) is 935.500, and when that figure is multiplied by four, the result is 3742.000, a comparable figure to 19107. Figure 7.1 below shows the top 15 zip codes, sorted by AIDS case rate for both Pittsburgh and Philadelphia (the actual analysis included 42 Pittsburgh Zip Codes and 48 Philadelphia Zip Codes. Full listings of data is available in the appendix.)

Figure 7.1: Pittsburgh and Philadelphia Zip codes, sorted by AIDS case rate.

Pittsburgh Zip Code	AIDS Case Rate	Philadelphia Zip Code	AIDS Case Rate
15233	935.500	19107	3,631.541
15222	586.854	19102	2,382.407
15232	513.838	19106	1,967.121
15206	426.685	19123	1,789.168
15212	377.305	19130	1,704.888
15208	361.551	19103	1,642.630
15219	322.446	19146	1,536.284
15203	251.211	19133	1,471.267
15221	249.100	19132	1,254.174
15224	236.621	19121	1,237.251
15211	209.143	19147	1,230.680
15214	205.741	19122	1,135.079
15213	171.977	19140	1,048.225
15218	170.378	19139	910.174
15132	137.174	19104	855.586

What should be noted from the above figure is not only the high rates for the top cases in Philadelphia, but also the number of zip codes with very high rates. The AIDS case rates for Pittsburgh descend rapidly to the 100 per 100,000 range, while the Philadelphia rates are still in the 800 per 100,000 after the top 15 zip codes. This indicates that the AIDS picture in Philadelphia is far less concentrated in a few areas in Philadelphia than in Pittsburgh.

7.3 Race

During the analysis of Pittsburgh, one of the most significant factors which jumped out is the issue of race and AIDS. For a wave I city, the burden of AIDS should not fall on a minority, as the primary target is the white homosexual male. Then why is it that the Black AIDS case rate is 3.472 times the white AIDS case rate in Pittsburgh. The wave I-wave II framework would predict a more disproportionate ratio for the wave II example, Philadelphia; however, the ratio in Philadelphia is only 3.180 to 1. This figure means if the black and white populations were equal, there would be 3.180 black AIDS cases for every one white case in Philadelphia. Clearly, AIDS cases in Pittsburgh are more disproportionate than in Philadelphia.

It is important not to over-stress the importance of race when dealing with AIDS. As figure 7.2 demonstrates for Philadelphia, and as 7.3 demonstrates for Pittsburgh, there appears to be a trend towards higher rates in zip codes with a greater percentage of minority population; however in both cases there are numerous outliners. These outliners detract from the strength of the correlation between race and high AIDS case rates. In both cities the zip codes with the highest minority populations have only near average AIDS case rates.

Figure 7.2: Percent of Zip Code a minority vs. AIDS Case Rate for Philadelphia

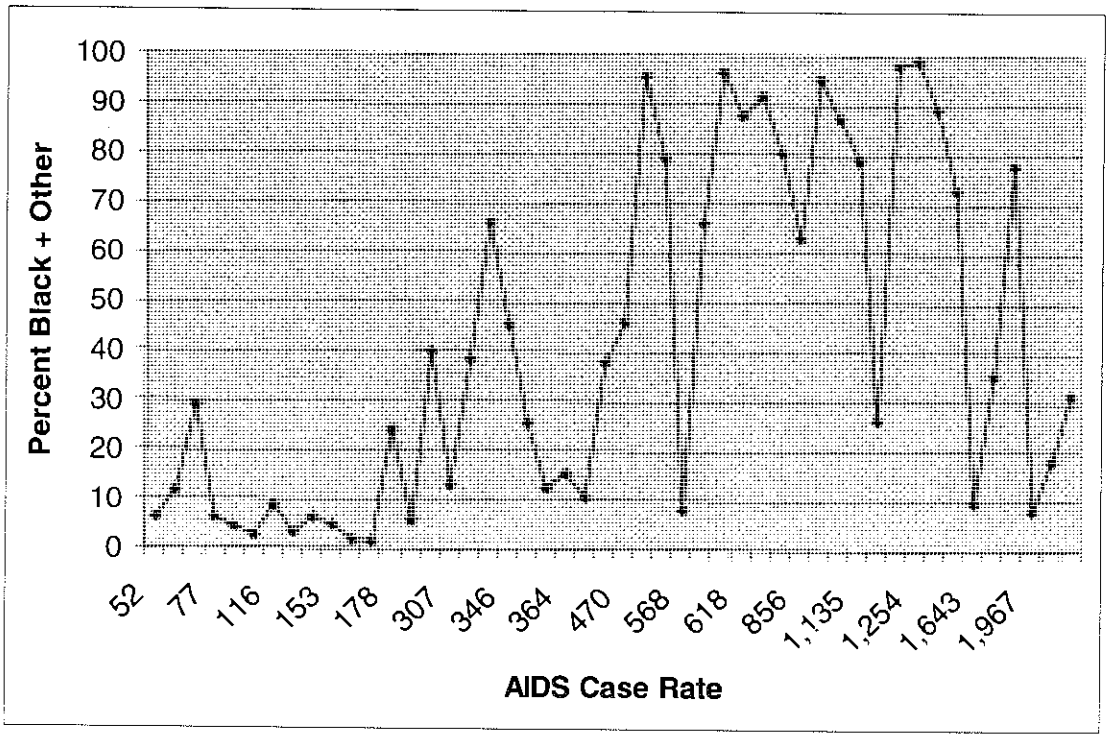
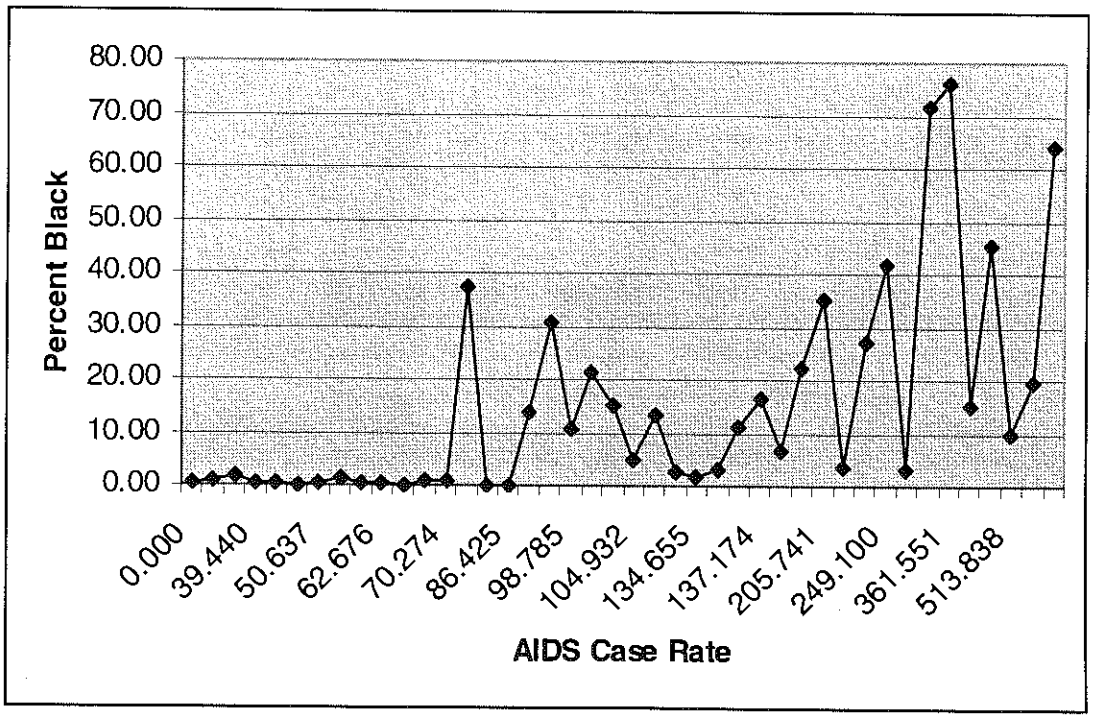


Figure 7.3: Percent of Zip Code which is black vs. AIDS Case Rate for Pittsburgh



7.4 Gender

Section 7.3 established Pittsburgh as a wave II city with concerns to race. A second aspect of the wave I-wave II comparison is gender. As wave I patterns push to wave II patterns, typically, the gender gap in the black population narrows dramatically, as the gap in the white population may slightly decrease.

Figure 7.4: Ratio of AIDS case rates, black female to white female.

Pittsburgh	12.416
Philadelphia	14.165

As figure 7.4 shows, Pittsburgh already has a comparable black female to white female ratio, another sign of a wave II pattern.

7.5 Mode of Transmission

Another important piece of the wave I-wave II comparison is in the mode of transmission. In the wave I-wave II framework, the wave II area is typically characterized by higher rates of injection drug use and heterosexual contact, with a decline in the percentage of male–sex with male transmission. Figure 7.5 below shows that the Philadelphia-Pittsburgh comparison supports this hypothesis.

Figure 7.5: Percentage of AIDS case by Mode of Transmission

	MSM	IDU	Heterosexual Contact
Pittsburgh	72.16%	16.64%	4.35%
Philadelphia	51.76%	34.97%	10.16%

After adding the race element to the above data, several interesting statistics about Pittsburgh stand out, as figure 7.6 below demonstrates.

Figure 7.6: Ratio of Black AIDS Case Rate to White AIDS Case Rate, by Mode of Transmission

	MSM	IDU	Heterosexual Contact
Pittsburgh	2.198	21.283	10.422
Philadelphia	1.877	4.170	9.779

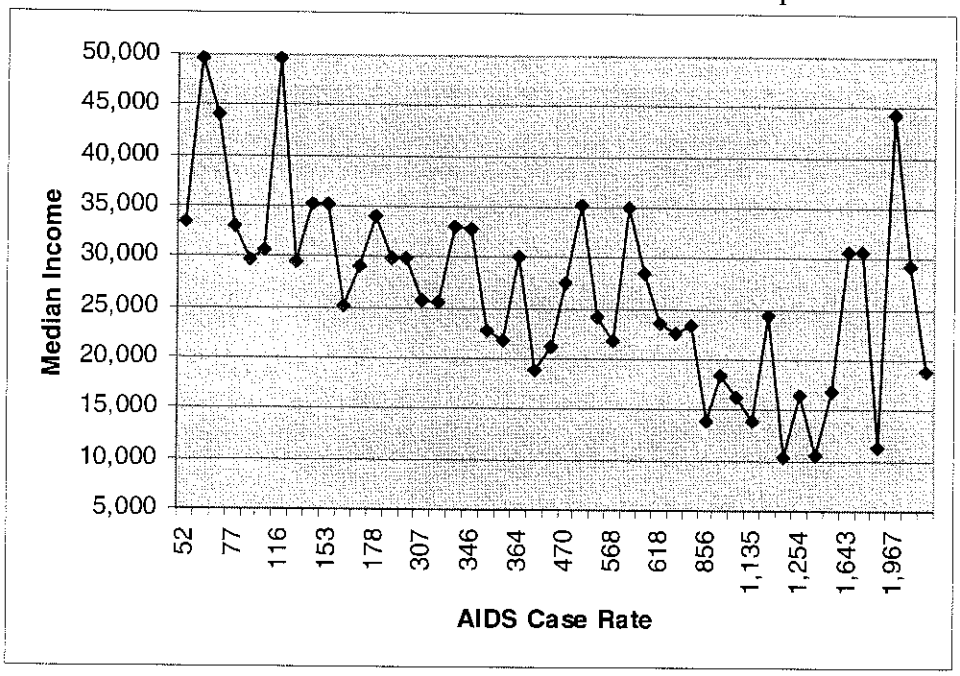
The data in figure 7.6 indicates two primary conclusions. First, 21.283 to 1 ratio indicates that if the black and white populations were equal in Pittsburgh there would be 21 black injection drug use AIDS cases for every 1 white injection drug use AIDS case. This figure reinforces the notion that the black injection drug use community bears a disproportionate burden of AIDS. Even the disproportionate 4.170 to 1 ratio in Philadelphia does not compare to the Pittsburgh IDU figure. Secondly, the data points to a rather subtle point concerning MSM. In both cities the black to white AIDS case rate ratio for MSM is around 2 to 1. This statistic highlights one of the understudied and

hidden causes of AIDS, black MSM, which is further discussed in several other sections of this book. From a quick glance at figure 7.6 one would think that the to figures would be Philadelphia, and the bottom would be Pittsburgh, but once again the wave I-wave II framework is contradicted.

7.6 Income Effects

Another factor which has been extensively studied, and has been studied in this class as well are the income effects; is there a strong correlation between poverty and disease. Chapter 3 argues that throughout the history of Pittsburgh public health there has been a correlation between disease and poverty, from impure water, to poor living conditions. Similar to the last section on race, there appears once again to be a trend, but not enough to be a strong correlation. Figure 7.7 below demonstrates this finding.

Figure 7.7: Median Income vs. AIDS Case Rate for Philadelphia



For both Pittsburgh and Philadelphia it seems that the question of the complexities remains. For Philadelphia, geography appears to provide a beginning to an explanation.

7.7 Location

The twelve zip codes with the highest rates have one thing in common in Philadelphia, location. All twelve zip codes are located between the Schuylkill and Delaware Rivers in the central area of Philadelphia. The map in the appendix(figure 7.9) demonstrates this fact. The map also shows that there are several zip codes which are predominantly minority populated, and some which are both poor and have high minority population, but they do not have the highest rates (some of these zip codes have high rates

compared to Pittsburgh rates (see appendix) but do not have the highest rates in Philadelphia.) The cluster of 12, as they are seen on the map, are from north to south: 19132, 19133, 19121, 19122, 19130, 19123, 19103, 19102, 19107, 19106, 19146, 19147. After high AIDS case rates, and a similar location the similarities end in this cluster. Some of the starker differences are shown in figure 7.8.

Figure 7.8: Comparison of Zip Codes amongst the Cluster of 12.

Zip Code	19106	19107	19121	19132	19102
AIDS Case Rate	1967.121	3631.541	1237.251	1254.174	2382.407
Median Income	$44,193	$18,795	$10,231	$16,380	$29,295
Percent Black	8%	31%	98%	99%	18%
Educational Attainment (% college educated)	75.3%	57.0%	6.8%	6.6%	62.4%

I believe that location is the single most important factor in Philadelphia in the transmission of AIDS. What remains to be seen is if location will become the most important factor in Pittsburgh. We might ask whether the complexities suggested by the Philadelphia data, which as an aggregate falls under a wave II pattern, means that in Pittsburgh we must closely analyzed geographically localized patterns to help explain the AIDS epidemic.

7.8 Conclusion

In summary, there are a few very basic and salient conclusions on Philadelphia and its comparison to Pittsburgh. First, as was pointed out in section 7.7, given the data analyzed, location appears to be the most important factor in the spread of AIDS in Philadelphia. As a corollary to the previous point, race and income are not always determining factors. The contradiction between this finding, and the prediction that the wave I-wave II framework of AIDS is not at all surprising. As mentioned in previous chapters, the model is too simplistic to adequately explain all factors, and therefore can be contradicted fairly easily this suggest further complexities that policymakers must take into account, many of which will be further discussed in our presentation. Finally, if Philadelphia does indeed represent this wave II condition, towards which Pittsburgh may be progressing, I would argue that in some areas, Pittsburgh is clearly there, the case of black females; and in the case of transmission to black injection drug users, Pittsburgh is comparatively ahead of Philadelphia.

relatively low overall rates exist in the context of concentrations of cases within racial and class groups and in specific neighborhoods, as well as a dispersed pattern of some cases in almost all neighborhoods. This combination of factors, we believe, constitutes a call to action to increase HIV prevention work and prevent further progress toward a Wave II pattern.

8

Hill District Case Study

Frank Ligons, Kris Kersey, Melissa Murello, Rosalyn Rice, Joseph Nunez, Vincent Sonson

The 15219 zip code, commonly referred to as the "Hill District,", is comprised of seven neighborhoods: Bluff, Bedford Dwellings, Crawford-Roberts, Middle Hill, Polish Hill, Terrace Village and the Upper Hill.[1] Much of the narrative concerning the history of the "Hill" and Polish Hill was laid out in earlier sections of this report. However, the overarching challenge of this project is to connect the problem of AIDS in Pittsburgh to a historical narrative. This is attempted with an eye to both explaining the unique historical context which has culminated in the present AIDS situation, and to uncover clues which will assist those concerned with AIDS in Pittsburgh in their quest for better data, better analysis, and ultimately, better guidance.

We have chosen the Hill District as the focus of a case study to build on our more general scholarship, in hopes of facilitating a deeper insight into what is currently one of the "hot spots" for AIDS in Pittsburgh. The Hill District is of particular interest for several reasons: 1) It is a neighborhood, which in terms of AIDS case rates, is close to the mean for the city. This fact suggests a statistical typicality to the area, which makes it a good place to launch an in-depth analysis on a local level. 2) It is a predominantly black and working class community. These are two attributes that are becoming increasingly correlated with AIDS cases in Pittsburgh. 3) Its history provides us with a historical context that illuminates the "hows" and "whys" of AIDS in a particular area.

Vulnerability

To pursue this exploration of the local picture, we have developed a conceptual framework to assist in assessing a neighborhood's vulnerability to AIDS. This idea of "vulnerability" is a complex one, essentially an aggregation of all aspects of community life: social, cultural, economic and institutional. Our historical research, manifested particularly in the earlier reports on black migration to the Hill and chain Migration to Polish Hill, has

revealed patterns of settlement which we believe have culminated in contrasting degrees of vulnerability.[2]

As is evident from the earlier sections of this report, the Hill has been a place which, since its beginnings, has undergone tremendous hardship. Economic, social, institutional, cultural and political constructs have served to reduce the once prosperous community to a rubble of destroyed and decaying buildings, all glaring remnants of a once celebrated community. One may easily witness this on a quick drive through the area. What is difficult to see is the erosion of the social, political and economic infrastructure. These *intangible* weaknesses, while not as immediately apparent as the boarded-up houses, are the engines of the Hill's downfall and communal **vulnerability**.

The issue of "vulnerability" is an important one when discussing AIDS or any social, economic or medical ill. Rosalyn Rice's contribution to this report highlights the psychological, emotional, and ultimately, physical ramifications of living in a uprooted and disrupted community. As she points out, marginalized populations are dependent on their "neighborhood."[3] A neighborhood, in this sense, is not only a geographical area, but rather a web of social, economic and institutional supports. This "web" has been compromised in most neighborhoods within the Hill by social schisms within the black community, urban renewal projects and deindustrialization. All of these factors have resulted in a disruption of the mental, emotional and economic health of the citizens in these areas. This has impacted not only their physical health, but continues to confound the situation by contributing to the perceived, and in some cases, real necessity of drug use and prostitution, which bear a great deal of the responsibility for the prevalence of AIDS in the community.[4]

However, not all of the Hill District has undergone the same trauma. Polish Hill, a predominantly white community settled by Polish immigrants, underwent a very different immigration experience. The contrast between the neighborhoods in the Hill, which are almost entirely black, as opposed to Polish Hill, which is almost entirely white, sheds light on the quantitative intangibles which affect a community's ability to mitigate social, economic and even medical disasters. In the case of AIDS, we notice the relative paucity of white AIDS cases in general, with the conspicuous absence of any white female or white IDU(injection drug use) cases. Clearly, there has to be some mechanism, some combination of factors, which account for this striking disparity in AIDS cases, as the tangible demographic data does not. One of the keys in unlocking the mystery of this disparity is in understanding how the conceptual framework of "vulnerability" plays out in real life. Embedded in the earlier sections of this report on the black experience in the Hill District and the white immigration experience are signs of vulnerability, and the lack of them. One feature of a neighborhood (in not only the physical sense, but in the more holistic sense) which has a great influence on its vulnerability, is the church.

For both the black and the white communities within the Hill District the church played an important role. The first wave of black migrants established and cultivated a powerful church, which provided not only spiritual support, but community outreach, in the form of educational, social, employment and health services. Similarly, European immigrants settling in Polish Hill founded churches as the center of not only spiritual matters, but all matters concerning the community. In both cases, the church was an important mitigater of much of the adversity that faced its congregations. From the earlier work in this report, we know that the consolidation of spiritual and social affairs within the black community in the Hill began to

crumble as successive waves of migrants overwhelmed the established church and its members with distaste, distrust, resentment and sheer numbers.

Progressively, cracks in the foundation of the black community became chasms, chasms which would at length separate those who could afford to give help from those who were in the most desperate need of it. Recent black migrants needed the outreach of the older, established black community to teach, direct, inform, train, socialize and employ them. But, history reveals that the new migrants did not receive that support.[5] This history has culminated in a situation where depressed, urban, black communities within the Hill District are still largely disconnected from the umbrella of outreach, social service and institutional lifelines that would make the difference, in the case of AIDS, between life and death. This disconnection is the very essence of "vulnerability" in the Hill.

Conversely, immigrants to Polish Hill maintained their solidarity. Earlier work in this report indicates that "chain migration" to the Hill District was a successful mechanism. It was successful because it managed to preserve and enhance the bonds within the community that would reduce its vulnerability. Unlike their black neighbors, Polish residents did not suffer the socio-economic fragmentation that eroded the black community. They built an ethnic haven in which the church was the center of all community life. In the church, residents found the assistance they needed in adapting to life in Pittsburgh. They found employment opportunities, lessons on "Americanization," and all the outreach activities that the first and well-established black churches had also engaged in. To this day, the church in Polish hill physically towers over the community as a reminder of its dominance in day-to-day life there. Its dominance has been, and continues to be, important in reducing Polish Hill's vulnerability to AIDS, and other ills. Conceptually, this makes good sense. The question is: How does vulnerability in this case play out or not? The answer is complex. But, there are some meaningful patterns that may be readily distilled.

Demographics[6]

For the purpose of this section, Crawford-Roberts, Middle Hill, Upper Hill, Bedford Dwellings and Terrace Village are referred to as the "Hill." These are all the neighborhoods in the 15219 zip-code, excepting Polish Hill. Demographically, Polish Hill and the Hill are similar. There are only two outstanding exceptions, racial composition and school enrollment. The Hill is comprised of neighborhoods that are between 96% and 99% black, with one exception. The Upper Hill is 86% black. Polish Hill is 85% white. (Figure 8.1) School enrollment is of persons ages 16 to 19 are significantly lower for residents of Polish Hill. About half as many Polish Hill adolescents in this age cohort are enrolled in school, compared with their black counterparts in the Hill. (Figure 8.2) As for the other demographics that we examined, there are no major differences between Polish Hill and the Hill.

The age breakdown reveals no significant differences. (Figure 8.3) Aside from Bluff, which is influenced by the large college student population there, Polish Hill and the other neighborhoods are characterized by approximately 50-60% of their populations being between the years of 18 and 64. Between 15% and 25% of the residents are 65 and over. And approximately this same percentage of people are 17 and under.

Joblessness is high all across the board. (Figure 8.4) The average for the whole zip code is about 59%. There are particularly high rates in Bedford Dwellings and Terrace Village

(reaching as high as 80%), but the average is lower, with the lowest average rate found in the Upper Hill around 50%, with Polish Hill close behind. Standing back, it is clear that both Polish Hill and the Hill suffer from staggering joblessness rates.

Roughly 50% of the employed people in the Hill District over the age of 16 are in blue-collar jobs. (Figure 8.5) This figure coupled with the joblessness data reveals that, on average, over 75% of the people in any given neighborhood in the Hill District are either not in the labor force, unemployed or working in a blue-collar capacity.

Educational attainment is low for all of the 15219 zip code, excepting Bluff once again. (Figure 8.6) The average percentage of the neighborhood's population without a diploma is 41%. All of the neighborhoods hover closely around this average. Once again, there are no significant differences between Polish Hill and the Hill.

After all of the above, it comes as no surprise that the Hill District suffers from very high poverty rates. (Figure 8.7) The average percentage of the neighborhood population living below the poverty line in the 15219 zip code is 43%. In the Upper Hill, 13% of the population lives below the poverty line. On the other extreme, Terrace Village has 75% of its residents living below the poverty line. Once again, the poverty rates for Polish Hill vis-a-vis the Hill are very similar. Through all of these measures, it is apparent that there are no significant demographic or socio-economic differences between Polish Hill and the Hill.

Crime Data[7]

Scholarship confirms that these conditions lead to higher crime rates; of most concern in this case are crimes involving drugs and prostitution. This is certainly true in the case of the Hill, but it does not hold for Polish Hill. The Hill District comprises 8% of the total city offenses. (Figure 8.9) 74% of that 8% of the city's total offenses take place in the Middle Hill, Bluff and Terrace Village. The Hill District is cited as being responsible for 31% of the entire city's drug violations. (Figure 8.10) Polish Hill itself is only responsible for .2% of the city's drug violations. 89% of the Hill District's drug violations are attributed to the Middle Hill, Bluff and Terrace Village neighborhoods. Polish Hill had (1993) no prostitution offenses and only 5 drug violations. The rest of the Hill District had 111 prostitution offenses and 803 drug violations. Clearly, almost all of the crime in the 15219 zip code takes place outside of Polish Hill. Crimes within the Hill District involving prostitution and drugs are occurring almost exclusively outside of Polish Hill. (Figure 8.11)

How can this striking disparity be explained? It does not come through in the demographic or socio-economic data. It cannot be reliably correlated with race. And the crime data from 1993 is not an anomaly. What is left to consider? We posit that there are other reasons for both the lower crime rates and the relative scarcity of white AIDS cases. The supposition propelled to the fore by juxtaposing the crime rates and AIDS case rates of the black communities within the Hill with their white Polish Hill neighbors, is that the prevalence of AIDS, particularly a wave 2 pattern, is directly correlated with the extent to which the community has been stripped of its defenses and left **vulnerable.**

Our research reveals that the black portions of the Hill are caught in much the same socio-economic nightmare that haunted their ancestors starting with the Great Migration. Low rates of home-ownership, short tenure, poor housing stock, overcrowding, malnutrition and unstable and inadequate employment opportunities still cripple the already hobbling

community. These same conditions that were referred to in an earlier section of this report as characterizing the Hill in the 1920s are still uncomfortably valid today. Again, it is difficult to calculate the impact psychologically, emotionally, or physically of these conditions. But it is not unreasonable to suggest that they contribute to the ability of AIDS to infiltrate their community. Whether it be through the despair which leads one to become an injection drug user, the economic necessity which forces one to become a sex worker or the relative lack of concern with what is for many an abstract and highly stigmatized medical entity, AIDS is thriving in the Hill and will continue to do so without informed and aggressive intervention.

AIDS In The Hill District

There are 30 black cases of AIDS due to MSM (male sex with male) within the 15219 zip code. Because there are so few workers with white collar jobs (20% of all those of working age) and the median income is so low in this zip code ($10971), we can statistically suppose that there is a significant black working class population within the Hill that engages in MSM behavior. However, these men do not identify themselves in ways which are consistent with the white, middle-class gay male population that has already carved out for itself a considerable social, political and organizational niche in this city. In fact, some of these men probably do not self-identify as gay at all. This disconnection from the empowered gay population of Pittsburgh has consequences.

For one, there are race and class tensions which compound the already existing dilemmas and complexities of being a gay male in American society. Being black, working class and gay makes things that much more difficult, as race and class norms operate to ostracize, excommunicate and disconnect "dissident" members from their community. It has been difficult, even for agencies interested in assisting and protecting this population (such as the Pittsburgh AIDS Task Force), to recruit black volunteers and advisers. Many would-be volunteers are plagued by a lack of time, as they use all their energy just trying to meet *their* day to day needs. Coupled with the social stigma associated with AIDS and homosexual behavior in the black community, these factors have prevented PATF from enlisting the help they need from this segment of the population. The negligence, and often hostility, on the community level is only reinforced by the lack of organizational entities that identify with and target the black working class gay community. All of this results in a web of marginalization that keeps these men on the fringes of society, social services and medical treatment.

It is impossible to make definitive statements as to where the white AIDS cases fall on the neighborhood level. But the demographics suggest that the gay white population is also working class, and therefore suffers too from the homophobia, which is perhaps worse in working class communities than in more affluent areas.[8] Similarly, they are disconnected, although only by class, from their more affluent gay counterparts with whom they do not identify. This disjunction in the gay community leaves an unknown portion of its population without the organizational, social, medical and political support that is required to combat AIDS. It is noteworthy that there are no reported white cases in which injection drug use or heterosexual sex is the mode of transmission. This is most likely attributable to the social control which is more successfully implemented in Polish Hill. Social control is exercised through the neighborhood's social strength, cultural homogeneity, the influence of the church

and the nature of living arrangements in which it is not uncommon for several generations to live under one roof.

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[1] There are a few other neighborhoods whose borders cross over into 15219. Our project has ruled out these neighborhoods on the basis of statistical and geographical insignificance.

[2] Kersey, Kris. "Chain Migration and Kinship Networks: Patterns of Neighborhood Formation in Pittsburgh's Ethnic Communities." Chapter 1.

Ligons, Frank. "Black Migration to Pittsburgh: Tenets of Black Experience Confounding Efforts to Combat Disease." Chapter 2A.

[3] Rice, Rosalyn. "The Hill House." Chapter 2B.

[4] Gutnick, Todd. "Hill Resident Brace for Uncertain Future." *Pittsburgh-Tribune Review*. July 27, 1997.

[5] Glasco, Lauren. "Double Burden: The Black Experience in Pittsburgh." In City at the Point. Samuel P. Hayes. Ed. Pittsburgh: University of Pittsburgh Press, 1989.

[6] United States Bureau of Census. 1990.

[7] City Of Pittsburgh, Department of Public Safety, Bureau of Police. "Statistical Report." 1993.

[8] Gravity@newsavanna.com. "Sexism, Patriarchy and Homophobia". 1995.

9

Pittsburgh's Response to AIDS

Jason Reinsch, Michael Lobick, Joe Nunez, Dan Green, Melissa Murello, Vincent Sonson

This chapter will examine the Pittsburgh community's response to the AIDS virus. Michael Lobick and Jason Reinsch characterize the reaction of the populus to the epidemic via media releases concerning the issues. Joe Nunez explores the sentiment in the public schools and the policy decisions that emerge. Finally, Dan Green and Melissa Murello monitor the actions of local government in the wake of the burgeoning AIDS scare.

Pittsburgh Residents Fight Against AIDS: Climate of Opinion During AIDS Brief History

Michael Lobick and Jason Reinsch

Because there is no medical cure for AIDS, it is imperative that proper policies be formulated so that a battle against this disease may be waged. In order to formulate such a policy, a great deal of information is required. One of the most important types of information to the policy makers is an accurate understanding of the climate of opinion in a given area. This information is the basis for any policy because any attempts to curb behaviors must compliment the overall outlook of the disease. This climate of opinion is invaluable information for tailoring an area's AIDS-prevention and containment policy.

Unfortunately, determining such with any degree of certitude is not as simple as one might think. One accurate way of obtaining such information lies in the activities that residents participate in. One's actions are the best way to determine how someone feels on a certain subject matter. The following pages give a narrative account of Pittsburgh resident's participation in various AIDS related activities during the course of the AIDS epidemic in the context of larger, national events. This information may be analyzed to determine the public opinion with a large degree of accuracy and will prove to be the foundation of a well thought, properly prescribed AIDS prevention policy. The language in this piece reflects the attitudes of the mainstream through the mass media.

Early Pittsburgh Exposure: 1981 to 1984. Though the scare of AIDS had begun and was gaining public awareness in larger cities such as San Francisco and New York, Pittsburgh remained relatively unaware of the budding epidemic. This remained true until mid-1982 when the first signs of the disease surfaced in Pittsburgh. On August 29, 1982,

a headline in the Pittsburgh Press read, "Mysterious Gay Plague Afflicts 2, Kills 1 in county." Though there were most definitely many unreported and undetermined cases of AIDS in the area, the announcement that AIDS had officially reached Pittsburgh marks the beginning of the local battle. County Health officials had revealed that two local homosexual men, one of whom had already died, had apparently contracted AIDS. The paper reported that the "gay plague" crippled one of the men's immune system eventually led to three different viral infections that were the actual cause of his death. The overall content of the article is evidence as to the limited knowledge of AIDS in the Pittsburgh area at the time. Word choice such as "Gay Plague" demonstrates that the community, like most other communities, was not yet aware that AIDS was not only a homosexual disease. In addition, the paper states that "County officials report concern about AIDS among Pittsburgh's homosexual population, which is keeping informed about the disease through gay publications," (Frederick). This also shows that health officials, like the rest of the population, saw AIDS as an exclusively gay disease. With such minimal exposure to the disease, the public had not begun to take any sort of stance on the issue. In the first four years alone a total of 17 cases had been reported, (Allegheny County). AIDS remained a relatively small issue in the Pittsburgh region for these initial four years.

First Sign of Community Involvement: 1985 to mid-1986. One of the first notable periods of Pittsburgh community involvement spanned from 1985 to the mid-1986. By 1985 the number of nationally reported cases had reached 10,000 in just four short years. This increase in number was influential in that the more cases of AIDS, the more likely one was to know or come in contact with someone with AIDS; however this fact was greatly over shadowed by the death of Rock Hudson due to complications from AIDS.

Rock Hudson's 1985 acknowledgment that he was being treated for AIDS was a critical moment in the evolution of the public opinion about AIDS. Even this event was heavily laced with images of Hudson's emaciated condition and references to Hudson's "secret life and the gay subculture," (Pollock, p.444).

Upon his death on October 2, 1985, little emphasis was placed on his cause of death in the papers, and most of the media coverage presented standard obituaries detailing his career and accomplishments. The *Pittsburgh Post Gazette* ran only on article obtained from the *New York Times News Service*, which only briefly mentioned the cause of his death as AIDS, "a mysterious and usually fatal illness that primarily afflicts male homosexuals, intravenous drug users, and recipients of contaminated blood transfusions."

The October 2nd public announcement made by the then President Ronald Reagan curiously omitted the well-known cause of his death:

"Nancy and I are saddened by the news of Rock Hudson's death. He will always be remembered for his dynamic impact on the film industry, and fans all over the world will certainly mourn his loss. He will be remembered for his humanity, his sympathetic spirit, and well-deserved reputation for kindness. May God rest his soul," (Perez, p.21).

Rock Hudson brought AIDS into America's living room, but his death did not have a lasting impact on how AIDS was perceived in the U.S. nor did it spur increased AIDS education.

Regardless, AIDS was becoming more of an issue in Pittsburgh. This is revealed in the emergence of several public concerns about the epidemic. A medical information service maintained by the district's Health Education Center allowed callers to phone in and listen to tape recorded messages on more than 300 health subjects. According to a September 17, 1985 article in the Pittsburgh Post Gazette, AIDS with upwards of 200 Pittsburgh residents calling every month took the lead as the most requested information tape, (Pierce, "AIDS queries..."). Though Pittsburgh residents were beginning to display an interest in the disease researchers were discouraged by a relatively low turnout for federally financed HIV testing. Testing was performed by eight county health centers in the surrounding area with

only 33 total participants showing up. Allegheny County accounted for 16 of those tests during the three-week period. Dr. Charles Rinaldo, AIDS researcher at the University of Pittsburgh, said that there were many social, legal and psychological explanations for the low turnout. Because of the social stigmata attached to the disease, "Even walking through the door of a clinic can brand you as a homosexual or a drug user," (Warner).

One of the most intriguing early instances of community action originated in the Unitarian Church. In early 1986, the Unitarian Church began an educational program geared towards both children and adults. Jean Williams, the communications director of the 22-denomination Christian Associates of Southwest Pennsylvania, noted that the program was the first of its kind in the Pittsburgh area. The program stressed caring, friendship and understanding to those afflicted with the disease. The majority of the program is aimed at young adults and children so that this important age group may be educated with the most recent scientific and religious information. The program was also aimed at refuting the idea that AIDS was actually a punishment from God sent on homosexuals and drug users to punish them for their sinful ways. One part of the packet for young children tells a story of a young boy who learns that one of his homosexual neighbors had become very ill. His parents inform the boy that, indeed, their neighbor had developed AIDS, which is a serious disease that has no cure. The boy's parents reassure him that he can visit the neighbor without contracting the disease, which he promptly decides to do, (Sharpe).

Heterosexual AIDS Outbreak:1986 to 1987. As the years passed since initial outbreak of the disease, more Pittsburgh residents fell victim to the deadly disease. The increased number of cases and the advent of an experimental drug treatment called AZT would spur more public involvement and participation, but to a large extent the disease was still seen as the "gay plague." Public disdain for homosexuals maintained a stratification between the homosexuals and heterosexuals, thus, the "it's THEIR problem" attitude prevailed. This was changed in late-1986 when a women infected with the disease was found in Pittsburgh. On October 25, 1986, a Pittsburgh Post Gazette article titled "One heterosexual transmitted AIDS case found here" was published. The article told of a Pittsburgh woman who contracted the disease while engaged to a bisexual man on the East Coast. She had come to Pittsburgh in the hope of undergoing treatment. This was just the finding necessary to substantiate fears of heterosexual spread of AIDS that resulted from sexual contact between women and bisexual males, (Pierce, "One heterosexual..."). The public also looked to prostitutes as a possible threat due to their high-risk behavior.

On July 13, 1987, another article declaring the presence of heterosexual AIDS in Pittsburgh was published. This article reported that a woman who had sexual contact with an intravenous drug user who carried HIV had developed full-blown AIDS. There was a second case of a man who admitted to having sex with an overseas prostitute, (Moushey). These two cases differed from the first woman because these diseases developed and, in one case, was contracted here.

As heterosexual cases of AIDS were found, the public not only expressed more concerns about contracting the disease, more community projects began forming to help battle the disease through education, fundraising, and compassionate assistance. "Slowly but surely we're coming to recognize AIDS isn't someone else's problem" proclaimed the Rev. William Doubleday at the Calvary Episcopal Church, (Seebacher). The occasion was a forum held at the church by Doubleday in order to convey his message of compassion and caring to the nearly 100 listeners.

Another instance of public action was television's first national AIDS education and prevention campaign. KDKA-TV and its Group W sister stations launched their ambitious program on October 19, 1987. The series of programs titled "AIDS Lifeline" was a composition of specials, AIDS news reports, and public service announcements. The program also distributed various videotapes and pamphlets in the area. The first night of "AIDS Lifeline" featured a press conference by Surgeon General C. Everett Koop. Koop

warned the viewers, "The only weapons in our arsenal are information and education," (Vancheri, "Group W..."). On the national front Koop was making headlines for his straitforward dealings with AIDS.

Koop maintained that he wasn't going to engage in the conservatively driven "exercise in moral censure," (Perez, p.23) he felt was being requested by members of the administration. His report would present facts about health and disease prevention honestly and on target. As Koop wrote:

> I knew that telling the truth about AIDS, the whole truth and nothing but the truth would not be well received in some places. ... A large portion of the president's constituency was anti-homosexuality, anti-drug abuse, anti-promiscuity, and anti-sex education; these people would not respond well to some of the things that would have to be said in a health report about AIDS, (Perez, p.24).

The thirty-six-page report written personally by the Surgeon General was publicly released at a press conference. It covered the signs and symptoms of the disease, how it was transmitted, groups and behaviors at risk, and the methods of prevention. It employed language that was considered unusually candid and frank for a government publication. In the "Forward" to the *Surgeon General's Report*, Koop insisted that the report would be clinically compassionate, which is to say that the report would contain only "Current and timely information" collected from "the best medical and scientific experts this country can offer,"(Perez, p.24).

The clinical compassion of the Surgeon General's Report can also be found in sections that deal with more controversial proposals such as compulsory blood testing, the use of quarantine, and requiring a visible identification sign for AIDS carriers. Koop saw these proposals as unnecessary, ineffective, "unmanageable and cost prohibitive," and likely to provide a "false sense of security." He saw AIDS a disease that could infect anyone and said it shouldn't be used as "an excuse to discriminate against any group or individual," (Perez, p.26).

The report also focused much attention about the collective ignorance that the American people possessed concerning AIDS. "Many of the controversial issues surrounding the disease have arisen and will continue to be debated largely because of a lack of knowledge about AIDS, how it is spread, and how it can be prevented," (Perez, p.25). Thus, the report placed a large emphasis on the education of the American people so that they would be able to make informed decisions about AIDS.

Substantial media attention surrounded the release of the report. Much of it praised Koop and the positions he had taken in the report while recognizing that some of his stands were bound to be controversial considering the intense emotions surrounding AIDS. He was praised by the *San Francisco Chronicle* for dealing with the AIDS crisis "in a straight forward, non-political way,"(Perez, p.27). Specific elements of the document were also singled out for praise. Many reports placed emphasis on Dr. Koop's statement that "We are fighting a disease, not people."

The release of the report, with its frank and direct approach about sexual behavior, intravenous drug use, and the necessity of education concerning the disease and the media attention that followed its release brought a new level of attention to AIDS. The report "served to alter irreversibly the socio-political environment in which the AIDS crisis was discussed, while simultaneously contextualizing Reagan's silence as a lack of leadership on this important issue," (Perez p.30).

AIDS spreads to more groups: 1988 to 1990. Between 1988 and 1990 the AIDS epidemic continued its projected increase, now to over 100 new cases a year in Allegheny County. Not only did the disease increase in number, the disease continued to grow in various heterosexual groups. In 1988, AIDS cases among women accounted 8% of cases in the United States. In 1989, 29% of all AIDS victims reported intravenous drug

use as a risk factor. Adding to the concern of AIDS being more prevalent in various groups was concern over the increasing cost of AIDS care. The average cost of caring for a person living with AIDS reached $38,000 per year. This cost coupled with more than 3,000 new cases every month in the United States led Pittsburgh residents to even more community action and participation in the battle against AIDS.

One of the most noted manifestations of public action was the Pittsburgh AIDS Task Force, an organization which is discussed in greater detail in a chapter written by Richard Svinkin. Pittsburgh residents also showed increased support of the AIDS education and prevention by taking part in AIDS Quilt cerernonies in that were held the weekend of July 22, 1989. The AIDS Quilt began as a project by the NAMES Foundation in order to recognize the thousands of people who had died of the disease. When 2,600 of the AIDS Quilt panels visited, 100 panels were added to symbolize the number of deaths related to AIDS in the Pittsburgh area. Though only 80 were present at the opening ceremony, the promoters estimated 30,000 visitors that weekend, (Guo).

During this time of spreading HIV infection, two other examples of community action stand out. The first example was continued participation in the annual candlelight memorial. The night of May 21, 1990, was the eighth year the event had taken place. 150 people gathered to show their concern for the disease by reading poetry, stories, and songs inspired by AIDS. The hope of the participants was to raise the awareness of both the public and the government so that lives would be saved, ("150 gather for..."). Another example of action to raise public consciousness occurred on a college campus in Pittsburgh. On March 3, 1990, the Pittsburgh Tribune Review featured an article about two women from the University of Pittsburgh who were selling special condoms door-to-door everywhere on campus from the dorms to fraternities and sororities to the student center. The special high quality condoms were decorated with school colors and the Panther mascot. The two organizers ventured into the business in the hopes that they would provide a fun way to raise awareness that the chances of contracting the HIV virus is substantially reduced when a condom is used properly, ("Women sell novelty...").

Superstar with AIDS: 1991 - 1993. On Thursday, November 7th, 1991, Earvin "Magic" Johnson announced to the world that he was infected with HIV. Mr. Johnson, one of the greatest basketball players of all time and still in the prime of his career at age 32, indicated that he would retire from the Los Angeles Lakers immediately. His announcement caused a public uproar and triggered a media frenzy surrounding both AIDS and his personal battle with it.

In both its "loudness" and public appeal, Magic Johnson's announcement defined a critical moment in the evolution of the public's opinion about AIDS. Although virtually no empirical evidence exists to corroborate the point, it is certainly plausible to assume that within a few days of his announcement an unusually high proportion of the public had learned of Mr. Johnson's condition, regardless of whether they were sports fans. Thus, in the economic, racial and ethic barriers the announcement cut across, the intensity of its exposure was immense.

More important, the fact that Johnson's link to the virus was clearly a heterosexual one flew in the face of the commonly believed AIDS and homosexuality connection. This link had persisted for some time, at least in the public consciousness; despite increasing evidence that AIDS was on the rise in other groups. It was now not a stretch to state that virtually everyone in America knew someone with AIDS or at least infected with HIV.

Along with the press praising his courage in his announcement, Magic Johnson was greeted warmly by AIDS activists who welcomed his pledge to be a crusader for their cause. "'If you tried to come up with the perfect person to carry the message of AIDS awareness to the people it ought to reach,' said New York AIDS activist Rodger McFarlane, 'you couldn't do better than Magic Johnson,'" (Leerhsen p.59). "' He [Johnson] can address the issue better than anyone I can think of,' says Bart Casmir, who

works for the San Francisco AIDS-education group. 'God couldn't have picked a better spokesman,'" (Kantrowitz, p.69). Gay activists had long complained that heterosexuals with AIDS commanded more sympathy than homosexuals with AIDS. While that probably was true, Mr. Johnson's lack of self-pity seemed to have eased their bitterness over the double standard. Many longtime activists were saddened that it took someone of Johnson's stature to drive home the message that AIDS can strike anyone.

It was precisely the message of AIDS's lack of discrimination that Magic brought into the living rooms of America. Heterosexuals could no longer dismiss AIDS as a disease of the poor, gay and drug addicted. At the time of Johnson's announcement, according to the Centers for Disease Control, about 6% of the 196,000 Americans with AIDS (of whom 125,000 had died) contracted it through heterosexual sex. In the previous year however, heterosexual AIDS cases had increased by 40% while overall AIDS cases rose by 12%, (The new face..., p. 31). The increase was particularly dramatic among inner city blacks and Hispanics, groups over which Magic was thought to have greater influence than previous patients did. Blacks alone, while making up only 12% of the nation's population in 1991, accounted for 25% of its AIDS patients, (Iyer, p.27).

In Pittsburgh the reaction to Magic Johnson's announcement was similar to the shock that ran through the entire country. The following day, November 8, 1991, *The Pittsburgh Post Gazette* responded by offering a large 4-5 page section dedicated to the Magic Johnson story and the reaction to his announcement. While most of the coverage was pulled from national sources, there were two locally written articles concerning the reaction of teenagers in the city to the announcement, and the potential of Mr. Johnson to reach out to the black community of Allegheny County.

In "City teens sobered by the news," Staff writer Tony Norman interviewed several teenagers from around the Pittsburgh area. Comments like "It made me realize that anyone could get it" and "When I heard that Magic Johnson had [the AIDS virus], it seemed like a big brother or a close friend" were judged representative by the author. Perhaps the most telling and encouraging comment was made by Travis Jemison, a seventh grade student at Milliones Middle School. After conceding that he didn't know much about the AIDS virus Jemison added, "All I want to know is how not to get it."

The *Post Gazette* Science Editor Bryon Spice brought up potential local benefits of the announcement in his piece "Possible benefit is seen." Mr. Spice saw the local black community as having the potential to become more aware of the crisis after Johnson's announcement. The black population of Allegheny County made up 24% or 139 of 568 county AIDS cases as of November 1, 1991, according to Dr. Bruce Dixon of the Allegheny County Health Department. The article also noted an increase, even after one day, of requests for information on AIDS, and a rise in requests for HIV testing throughout the city, booking up all appointments through the next week.

In addition to the two articles, the *Post Gazette* also ran an editorial entitled "One-on-one with AIDS" which echoed the sentiments of many that Mr. Johnson had a unique ability to reach many people previously unable or unwilling to be confronted with the epidemic.

Five weeks after the announcement by Magic Johnson that he was in fact HIV positive, *The Pittsburgh Press,* a now defunct daily newspaper, ran an article entitled "Requests for AIDS testing rise sharply in county" that described the continued increasing trend of requests for information about AIDS and HIV and requests for appointments to be tested within Allegheny County. The article stated that 518 tests were performed in November, 1991, up from 267 the previous year. Requests were reported to be up significantly among blacks and heterosexuals, two groups to which Johnson's announcement may have held extra significance.

1993 to present: The Countdown to Extinction. In the past few years Pittsburgh residents have made numerous attempt to educate the population and prevent the spread of AIDS through various community activities. One program which is stationed in Northview Heights and Garfield communities features volunteers who are trying to educate women by holding Safer Sex Parties. These parties teach women the necessity of safe sex through activities such as condom races, a fun event designed to lower the participants' guard and stimulate questions and conversation. One of the focuses has been tackling the myth of "Black Genocide...there are some who (believe) that this is a ploy to reduce the number of Black babies coming into the world," says project coordinator Charles Mikell, (Hamm). They also report that one of the keys to the success has been members of the community volunteering for the project. This is important because it is important to convey messages of this sensitive matter through friends as opposed to strangers. Other citizens participate in certain activities to relieve the pain and anxiety of those suffering from the disease. Some organize Christmas parties for mothers and their children suffering from AIDS. The Hazelwood Church of the Good Shepherd sponsors such a party with the hope of lessening the social burdens of the disease by allowing a social atmosphere composed of similar individuals, (Perlmutter). One unique example of public attempts to lessen the suffering of AIDS patients is targeted at lessening the effects of AIDS wasting syndrome, substantial weight loss due to loss of appetite. Wesley Light has given away free brownies that are baked with a special ingredient - marijuana. "The use of marijuana to induce the "munchies" and assist with weight gain is a common practice among AIDS patients, says Dr. Martin Seltman, a family physician who treats many people with AIDS," ("City activist's baked..."). Light's activity did not suffer any police harassment. One last example of public participation in local events to show their support for the war against AIDS is the recent PATF AIDS Walk. Begun in 1995, the program has enjoyed immediate success. The first year of the event, the PATF raised over $175,000 through corporate and public donations. The money was used to fund a variety of local AIDS awareness programs, (Pollastrini). The second annual event raised approximately $250,000 and the third year there was an expected donation of $300,000, (Heltzel). The PATF plans to continue the event in the hopes of raising public awareness about the disease as well as giving Pittsburgh residents the opportunity to show their support of those with AIDS.

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AIDS Education in the Allegheny Public School Districts

Joseph L. Nuñez

The subject of AIDS is never an easy one for any particular group of people. There is, however, a hierarchy of populations where the topic of AIDS is handled much easier than others. Elementary and secondary school students are perhaps at the very bottom of this system. For former public secondary education students, many can recall the fact that AIDS was practically prohibited in schoolroom discussions. The fact was that parents were highly uncomfortable in exposing their innocent children to such real-world complexities as AIDS. Parents in the 1990's still feel the same way. As children progress beyond elementary education, they get closer to the discussion of sex and venereal diseases. During the sixth grade, some students in the United States discuss sex for the very first time since some of them are in the beginning stages of puberty. Beyond the sixth grade, it is left to local schools to teach students any further.

AIDS has dramatically changed the face of public sex education among elementary and secondary school students in a number of ways. Before the onset of the AIDS epidemic, sex education was quite conservative and very minimal. Sex education was not allowed to condone sexual contact among teenagers but neither did it strictly enforce abstinence. As one observer indicates, sex education changed because up until the introduction of AIDS, sexual intercourse wasn't necessarily a life and death situation (venereal diseases for the most part do not kill its victims as AIDS does)[1].

Description of the County School Districts. Before jumping into the discussion of AIDS education policy in Allegheny County, it is important to describe the county and the number of school districts that it consists of. Besides looking at the number of districts and students that exist within the county, it is necessary to describe some of the characteristics of the families whose children attend these schools. For this, we will use data collected from the Quality Education Data Company (QED) for the 1996-97 school year. As evident in the comparative table of county school districts (see Appendix A), there is some (albeit small) diversity in regards to ethnicity, dollars spent per student, and college bound percentages.[2]

Allegheny County, Pennsylvania consists of forty-three school districts ranging as far west as the Moon school district (located near the Pittsburgh International Airport) to the Plum school district (located east of the Pennsylvania Turnpike). Among these forty-three school districts, there are 172,927 students enrolled in 245 elementary schools, 69 middle schools, 62 high schools, and 20 special education schools (such as alternative learning centers and vocational education schools).

The ethnicity of the school districts in Allegheny County is mostly homogenous. That is, all but three of the school districts are predominately white. At one extreme is the Allegheny Valley school district whose students are 99% white and 1% black. Some other school districts in this extreme include the Deer Lakes, Hampton, Pine-Richland, Shaler, and South Allegheny school districts (each district is 98% white). A small minority of school districts lie at the opposite end of this spectrum. These districts include the Duquesne (25% white, 74% black), Pittsburgh (45% white, 53% black), and Wilkinsburg (3% white, 96% black) school districts

Other characteristics of Allegheny County public school students include a modestly high percentage of college-bound students, a high percentage of students' families whose average income is above the national poverty line, and a high amount of discretionary dollars spent per pupil in comparison to other counties. Of the schools that reported their college-bound percentages, exactly half (20) of them reported college-bound percentages below 60%. Some of the lower percentages come from such districts as the Avonworth, Keystone Oaks, North Allegheny, and Plum school districts. Districts such as North Allegheny, Fox Chapel, Mt. Lebanon, and Steel Valley reported high college-bound percentages (85% or higher).

Some important areas to look at when considering AIDS education policy are those districts that have a low percentage of students' families whose average income is above the poverty line. Although these percentages are relatively high for the county, there are a few areas whose percentages dip below the 80% mark. These districts include the Clairton City, Duquesne, Pittsburgh, Sto-Rox, and Wilkinsburg school districts. Of the remaining districts that are above the 80% mark, the Upper St. Clair school district has the highest percentage, 99% (For a more comprehensive analysis, see Appendix A).

Looking for Case Studies. When the discussion of AIDS finally fell upon the ears of local school students, school district officials were left in debate as to how they would prevent their students from contracting the AIDS virus. Although the main task of preventing the spread of AIDS in Allegheny County was left to the County Public Health Department, school district superintendents realized their duty in informing their students on how to prevent themselves from infection.[3] This debate began in the mid 1980's and has continued to the present date.

The goal of this discussion is to explain the Pittsburgh school district's response to AIDS awareness and education among its students from the mid 1980's to the present. Although the Pittsburgh school district is large (it consist of approximately 42,086 students), it is not totally representative of the forty-three school districts that exist in Allegheny County. It does however, possess great influence over all of the other districts. This is reflected by the lack of public policy guidelines adopted by the independent school districts in reference to AIDS education.[45] Therefore we must use information on the Pittsburgh school district's AIDS education policy as our main guide. Of course, no area school district will treat AIDS education in the *exact* manner as Pittsburgh does.

To help us get a better understanding of the school setting, a focus on the Central Pittsburgh school district area will be provided later. This area serves the greater Hill District area that is within the 15219 zip code. This analysis will also add to a better picture of the Hill District community as a whole

The origins of AIDS education in Pittsburgh. AIDS awareness in Pittsburgh public schools began in 1985 for two different reasons. First, because knowledge of the disease was sparse and research was still an ongoing process, parents (as well as the American population as a whole) were scared for the safety of their children.[6] At best, schools could only offer lessons on personal hygiene that began in kindergarten. As knowledge of both the virus and methods of transmission increased in the later part of the 1980's, parental fears dissipated.

The second catalyst in AIDS awareness in the classroom was an event that occurred in the fall of 1985. During a press conference that fall, Allegheny County Health Director N. Mark Richards inadvertently announced that a teacher in one of the school districts in Allegheny County had the AIDS virus. Richards, when questioned further, refused to disclose the identity of the teacher. This incident and the responses of many parents prompted the Pittsburgh school district to devise a policy on AIDS. The policy allowed a teacher or student to continue their activities as long as they did not pose a health hazard to others. Such health hazards included an infected student biting other students or being incontinent.[7,8,9,10]

Although no formal AIDS education policy erupted from this event, it became the foundation for further education among public school students. In 1986, school officials began the difficult process of incorporating AIDS into sex education curriculum after a Pennsylvania law required that AIDS education be taught in public schools. The city school district began this process by creating an educational pamphlet aimed at all students from grades kindergarten to 12th grade. For elementary school students, the pamphlet and its accompanying lesson expanded on its discussion of proper hygiene by adding that students should avoid contact with their classmates' blood and other bodily secretions. Middle and high school students received much more detailed instructions. In addition to the guidelines given to elementary school students, some of these recommendations included abstinence, no sex until marriage, casual sexual contact, intravenous drug use, or use of inhalant nitrites.[11]

If sex and AIDS awareness was now evident, opposition was even more so. The topic of condoms was hotly debated in the Pittsburgh school district. During this time, C. Everett Coop

was the presiding U.S. Surgeon General and his policy regarding AIDS involved a heavy emphasis on condom use. In Allegheny County, the Pittsburgh school district was not the only district that feared outraged parents who might accuse the district of condoning adolescent sex.

The Allegheny County Health Department in November of 1986 reported that there were no cases of AIDS among Pittsburgh public school students.[12] This fact led many to believe that AIDS was still a disease that had no relevance to school-age children. Although the Surgeon General strongly urged educators throughout the nation to begin teaching children about AIDS as early as possible with "frank, open discussion about sexual practices - homosexual and heterosexual"[13], his recommendations were not followed through in Pittsburgh. School officials, such as Fran Rifugiato of the Pittsburgh school district and Myles Stepanovich of the McKeesport school district, were much more concerned about what type of reaction their schools might get from parents.[14] Therefore, the guidelines focusing mostly on abstinence and no sex until marriage remained the norm.

AIDS education enters a new phase. On December 22, 1987, Pittsburgh School District Superintendent Richard Wallace announced that a student with AIDS was attending one of the district's schools.[15] With this announcement came the concern that AIDS was beginning to affect more school-age children, specifically adolescents. Kerry Stoner, executive director of the Pittsburgh AIDS Task Force commented that "the presence of the disease among Pittsburgh high school students was inevitable"[16]. Although a policy that allowed a student with AIDS to attend classes was already set forth previously, there was still debate with bigger questions. This incident coincided with the national war against AIDS after it was revealed that the AIDS virus was spreading much faster than ever before. The fact that more people were dying from AIDS at this time than during any other period also fueled the desires of school leaders to teach AIDS prevention.[17]

National statistics on teenagers at this time began to indicate that more of them were becoming more sexually active than in years before. These statistics also indicated that a large minority of them did not use contraceptives. The fact that teens were having sex was finally acknowledged. The Surgeon General's advice on the use of condoms was beginning to be (although reluctantly) accepted around the nation.[18] The Pittsburgh school district, however, was being pulled in two different directions. Although the school district did not condone teenage sex, the closest it came to stressing "moral" behavior was by stating that the only sure way of avoiding AIDS is sexual abstinence and avoidance of illegal intravenous drug use.[19]

In May of 1988, the federal government began distribution of a new brochure on AIDS prevention. This was the first time in its history that the government attempted to inform every known citizen of the country about a sexually transmitted disease. Initially, school leaders feared that such information would create more curiosity about sex among children and teenagers. Many accused the brochure of being blunt with its references to the vagina, penis, rectum, anal sex, oral sex, and masturbation. But once the brochures were distributed, school leaders such as Pittsburgh Public Schools spokeswoman Pat Crawford, were in favor of more AIDS education. In an article dated May 5, 1988, Crawford explained that the school district's AIDS education program began in the fifth grade. From then on, students would learn about AIDS once in middle school and once again in high school.[20]

The fight against condoms still raged on, however. With the three major television networks at this time rejecting condom advertising, a precedent for local advertising was set. Affiliate stations such as KDKA, WTAE, and WPXI in addition to the Pittsburgh Press declined to accept condom advertisements.[21] Since condoms and their rates of effectiveness were still not being addressed in local schools at this time, students could only obtain information from health care facilities or elsewhere. In fact, in 1991, Dr. Bruce Dixon concluded that the best way for people to find out about condoms was through news stories and talk shows.

Since the onslaught of AIDS in the mid 1980's, teaching safe sex among teenagers has had two opposing sides. Originally, the majority of school parents in Pittsburgh in the 1980's opposed discussion of contraceptives. But once it was revealed that teenagers were engaging in sexual intercourse at unprecedented rates, parents began to change their positions, slightly. By 1997,

48% of Pittsburgh parents surveyed (a bit lower than a previous national survey) indicated that they were in favor of both teaching students more about condoms and distributing them in high school.[22]

The current AIDS education policy. Between 1992 and 1996, national statistics indicated that AIDS among high school students was increasing.[2324] In 1992, the statistics stated that more than half of all high school students were sexually active but that many schools refused to teach safe sex practices. The Pittsburgh school district was still among the many districts that refused to condone pre-marital sex. During this period, school districts around the county began to change their policy regarding safe-sex education. Although a small minority of school districts have begun to distribute or at least have condoms readily available to students, many are beginning to tackle safe-sex and AIDS prevention with the use of contraceptives in the classroom.[2526] In fact, a report issued in 1997 by two California research groups estimated that only 4,000 out of 16,000 of the nation's school districts are using abstinence-only curriculum with the remaining majority opting for comprehensive sexuality education. Comprehensive sexuality education consists of discussions about safe-sex, biological hormone changes through puberty, and homosexuality in addition to regular sex education.[27]

The Pittsburgh school district does not use comprehensive sexuality education nor abstinence-only sex education at the current moment. It does not discuss contraceptive use in the classroom but it also does not strictly enforce abstinence. A student can get information on contraceptives by asking a teacher or being referred to a community health clinic. Sex education policy still requires that the disclaimer, "only abstinence is the sure-proof way of avoiding AIDS" be taught to adolescents. The arguments against abstinence-only education are that the disease is affecting teenagers so much that morality is a secondary concern (similar to the argument for clean needle exchange programs for drug users[28]) and that the no sex until marriage rule does not apply to homosexuals who cannot get married by law.[2930]

Informing school-age children about the AIDS virus and how it is spread has become a separate discussion. At the present time, school districts like Pittsburgh are taking a positive stance in teaching children more about AIDS at earlier ages. The Pittsburgh school district is following examples set forth by local private schools and neighboring school districts to teach children as young as eight-years old the basics of AIDS education.[31] In 1994, the Pittsburgh AIDS Task Force, in conjunction with the school district, began outreach programs aimed at teaching young children about AIDS. Although the programs do not discuss sexuality, Dave Tucci of the PATF feels that AIDS should be framed as a public health issue, not a moral or religious one.[32]

The Pittsburgh school district has also increased the amount of AIDS instruction it gives out after elementary school. Students now receive AIDS education every year in middle school and twice more in their high school education. There are a number of news articles that report the benefits of extensive AIDS instruction in public education.

The future of AIDS education in Pittsburgh. Clearly and as indicated previously, AIDS education in the Pittsburgh school district has two components. First, there is general AIDS education that now begins early in a student's career. This education is science-driven and does not address issues such as morality and safe-sex practices. The second component to AIDS education is sex education, something that has existed much longer. With sex education lies many topics that have total relevance to AIDS such as contraceptives and homosexuality. Although some larger city public school districts might discuss these subjects fully, school leaders feel that Pittsburgh's AIDS crisis is not large enough to warrant more discussion.[33]. Until it *does* warrant more talk, the best method of AIDS education in Pittsburgh will be to seek outside help from outreach programs and organizations.[3435]

Variations on AIDS Education. As mentioned earlier, the Pittsburgh school district is only one (although the largest) district among forty-three in Allegheny County. When the superintendent issues policy guidelines, other superintendents are not forced to do likewise. In fact, many superintendents in the more affluent suburban communities outside of Pittsburgh have usually chosen not to address the issue of AIDS as strongly as in Pittsburgh.[36] These are the districts that are more likely to accept an abstinence-only policy regarding sex and AIDS education.

Parents and educators in these areas tend to believe that the behavior patterns associated with AIDS infection such as intravenous drug-use and homosexual practices do not occur in their districts, but rather somewhere further like in Pittsburgh.[37]

Although all school districts in Pennsylvania are required to offer AIDS education, local districts can choose what topics to handle and which to ignore. Unfortunately, no school district, including Pittsburgh is required to provide the public with an official policy on AIDS education. We do know however of earlier attempts from educators in the more affluent districts who have in the past pushed for more detailed AIDS education, specifically regarding sex, only to face a number of angry and outraged parents.[383940] Using school problems such as gang violence and truancy, we can correctly assume that AIDS education varies among districts according to its seriousness.

The Central Pittsburgh School District. The Central Pittsburgh School District (also known as the East Central Area district) consists of 10 elementary, 6 junior high, and 2 high schools. Some of the noteworthy schools are Arsenal Middle School, Milliones Middle School, Peabody High School, and Schenley High School. A large proportion (if not all) of the students in this area come from the Hill District community. Arsenal Middle School is located on Butler Street in the Lawrenceville community and has approximately 662 students. Milliones Middle School is located on Centre Avenue in the middle of the Hill District community and has approximately 671 students. Peabody High School is located on North Highland Avenue (in Highland Park) and services 851 students. Schenley High School is located on Bigelow Boulevard (in West Oakland) and services 1,290 students. During the 1991-92 school year, the Central Pittsburgh district experienced a 70% college-bound rate and a 7.7 dropout rate, the second highest rate among all Allegheny county school districts that school year (more current statistics for each individual area within the Pittsburgh school district are not publicly available).[41]

AIDS and sex education is just one concern out of a number of other concerns for the district. For years, there have been numerous reports of drug use, misconduct, and gang violence within secondary schools. To combat these problems, a number of programs, task forces, and special meetings have been created over recent years.[42] One interest within the area schools that has existed since the early '80's (if not earlier) has been teen pregnancy. In 1986, it was estimated that 4 out of 10 American teen-age girls will become pregnant. According to observers in this area, this statistic is much higher for the Pittsburgh school district. Studies from Johns Hopkins University and the Guttmacher Institute at this time indicated that students who have had education in topics such as contraceptives and safe sex practices were both less likely to become (or remain) sexually active and become pregnant. These findings, in addition to other factors, led to the creation of a task force dedicated to understand teenage pregnancy and to possibly create health clinics within those schools that have severe pregnancy rates.[43]

This proposal came under vehement attack for various reasons. The most salient argument against the clinics was that they were attempting to target poor, black schools and communities. Schools in the Central Pittsburgh school district such as Arsenal and Milliones were on the top of a list of schools experiencing severe teenage pregnancy problems. The remainder of the list consisted of only primary black urban schools in the entire Pittsburgh school district. A year later, in 1987, the proposal was dismissed, but not without creating an unfavorable reputation among the Central Pittsburgh area middle and high schools.[4445]

In terms of actual AIDS cases within the Hill District, it is apparent that the majority of the people suffering from AIDS come from the 25 to 35 years of age bracket which means that infection could have occurred between 5 to 10 years earlier. Given the previous history that Central Pittsburgh area schools have experienced, in addition to the current image they have, it would not be surprising to see AIDS task forces and activists target the district again in the (possibly near) future.

Conclusion. Since the spread of the disease to local teachers and students, school district officials have supported AIDS education in the classroom. During the latter half of the 1980's, the superintendent only enforced dispensing basic AIDS information to students. This was primarily because little was known about the disease and its transmission. As knowledge increased (as well

as reported AIDS cases), school officials decided to increase curriculum to the discussion of sexual transmission and prevention.

Sex education has always been a tricky subject in Allegheny County. Clearly AIDS is being brought to the awareness of every public school student at every age level. This type of proactive campaign has eliminated hysteria among students and parents as well as stir compassion towards the AIDS victim community. But when it comes to teaching students how to be sexually responsible, the district has remained conservative.

Presently, state legislation to teach abstinence-only sex education is being finalized. This means that school districts will only receive state aid if they avoid discussion of contraceptives and promote abstinence in the classroom. Although this will not change sex and AIDS education for the majority of the Allegheny county school districts since they have stayed quite conservative, school districts like Pittsburgh's might bear the consequences of such ideal versus real-life ideology. The fact that teenage pregnancy has been a prevalent issue in the Pittsburgh school district since the mid '80's attests to the fact that teenagers are having (most likely unprotected) sex.

The implications of these findings can go both ways. The lack of data supporting outbreaks of both teenage pregnancy and AIDS infection for the county as whole and the fact that abstinence-only sex education has already been agreed upon in Pennsylvania suggests that Allegheny county can continue its conservative mentality (In fact, even in 1997 a recent survey conducted by Mansfield University indicates that 79% of the parents sampled support abstinence-based sex education.[46]) Yet, like with many situations, when one focuses on a specific area like the Hill District, it is apparent that a significant problem exists. It will take this sort of investigating to create a more suitable sex and AIDS education policy.

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[1] *Ibid.*

[2] *QED State School Guide - 14th Edition (1996 -97) PA*, Quality Education Data (Denver: 1997).

[3] "City School AIDS Policy Is Adopted", Pittsburgh Post-Gazette, Nov. 23, 1985

[4] *Ibid.*

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10

Funding Infrastructure for Community-Based Agencies

Kristofer Peterson

An important part of the fight against AIDS is the work of community based organizations (Community Based Organizations). These organizations sprung up before the government reaction to AIDS, advocating for the belated governmental response, and caring for the sick and dying. As the government has begun to act in response to AIDS, community based organizations continue to play a critical role. In Pittsburgh, the Pittsburgh Aids Task Force (PATF) provides case-management, anonymous testing, and life support services such as transportation that governmental organizations, for various reasons, can not provide. In addition, other Community Based Organizations provide services such as nutritional, social and mental health support. Furthermore, Community Based Organizations have the flexibility to utilize volunteers, bringing in diverse individuals with diverse skills, as well as community support. Despite the differences between Community Based Organizations and government, the two are closely linked. First, governments are dependent on Community Based Organizations to provide a variety of services, e.g. anonymous testing. Second, Community Based Organizations are dependent on grant money they receive from the government in exchange for providing these services. The purpose of this section is to explicate these relationships. To that end, it will examine major sources and recipients of government funding, and explain the process by which these grants are made, and the services to be provided are chosen. In addition, it will analyze the distribution of grant money in several ways including: by city/rural, by organization, by type of service, and public organizations vs. Community Based Organizations .

In this effort, this section will first present a brief history of the Ryan White Care Act, the primary source of federal funding for AIDS services. It will then describe the features of the most important Titles of the Care act, Titles I and II, with special attention to Title II which provides funding to Pittsburgh organizations. In addition it will look at Titles IIIb and V which also fund AIDS organization in Pittsburgh. The section will then go on to look at state funding from line item 106, which funds similar activities to Ryan White. It will then move on to examine HOPWA money, which is used to provide housing for people with AIDS (PWA). Then, it will take a look at the activities of Allegheny County and its activities. It will then examine miscellaneous programs such as the State Pharmaceutical Assistance Program (SPAP) which do not fall neatly under other funding categories. The section will then examine the method by which regional needs are assessed, grant proposals are issued, and funding decisions are made. Finally, the section will address some of the issues affecting AIDS service funding nationally and in the region, and make some policy recommendations in accordance with them.Ryan White CARE Act

The Ryan White Comprehensive AIDS Resources Emergency Act is the major source of funding for AIDS service organizations in the United States. As a result, an examination of the act is an important part of any look at funding of AIDS service organizations.

History. President George Bush signed the Ryan White CARE Act Saturday August 18, 1990. The act was named in memory of Ryan White, an adolescent

hemophiliac who contracted AIDS from a transfusion, and with his family courageously fought the discrimination associated with AIDS in his attempt to attend school. The Act was designed to provide emergency aid to cities hard hit by the HIV virus as well as support for other cities in providing services to people with AIDS and their families. Between 1990 and 1996 funding for Ryan White increased consistently , with additional areas being certified for title I funds as the epidemic spreads. (see Figure 10.2.) However since 1994, as the number of EMAs has increased the average funding for each EMA has fallen. (See Figure 10.2) In 1996, the CARE act was re-approved despite attempts by Jesse Helms to gut it.[1] However, in the new environment of a Republican congress, growth of the funding has slowed. (see Figure 10.3) The shrinkage in funding can also be seen in chart 4, which displays funding levels for the Pittsburgh AIDS Task Force (PATF) in fiscal years 1994-96. Clearly, PATF is constantly receiving less funding than it requires. In addition, the shortfall has increased since 1994's conservative congress. As a result organizations such a PATF have had to organize major fundraising drives, and extensively utilize volunteers. It remains to be seen how the CARE act, and the broader funding programs will fair in the future.

Title I. Title I of the Ryan White CARE Act provides automatic emergency aid to Eligible Metropolitan Areas (Eligible Metropolitan Areas) with either, 2,000 AIDS cases in the five years preceding the grant application, or an AIDS incidence of .0025 in the grant year. As a result, Pittsburgh is ineligible to receive Title I funds. However, a brief description of the title is appropriate here. The purpose of Title I is to,

1) In general.--The chief elected official shall use amounts received
under a grant under section 2601 to provide direct financial assistance to
entities described in paragraph (2) for the purpose of delivering or enhancing HIV-related--
A) outpatient and ambulatory health and support services, including
case management and comprehensive treatment services, for individuals
and families with HIV disease; and
(B) inpatient case management services that prevent unnecessary
hospitalization or that expedite discharge, as medically appropriate, frominpatient facilities.[2]
While the Title I does not apply to Pittsburgh because Pittsburgh does not meet the 5 year case total of 500 cases, or the morbidity rate level of .0025 to qualify for Title I, the competitive grants offered under Title II
are for the provision of these services.

Title II. Title II of the Ryan White Care act is the major source of AIDS care funding in Pittsburgh. Last year it amounted to ~70% of the regions public funding. Thus, Title II grants are important to the region.
Title II, much like Title I is focused on AIDS care services. Specifically it funds; outpatient and ambulatory health and support services, including case management and comprehensive treatment services, for individuals and families with HIV disease as well as inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from
inpatient facilities. In addition, Title II funds support auxiliary life-support services such as; transportation, nutrition, mental heath services, and advocacy. In addition, Title II dictates that 15% of the funds granted be directed towards women an children, reflecting some acknowledgment of the spreading effects of the epidemic. It also requires that the state add matching funds totaling 33% of the federal grant. It should also be noted that Title II does not fund prevention and outreach activities, furthermore in both the 1990 and 1996 versions of the act there is a specific prohibition on funding needle exchange programs.

It is clear that Title II provides support for a wide range of AIDS care services. As a result of its broad support, it also shapes the planning and administration carried out by

regional organizations. Most importantly, Ryan White requires a regional planning consortium made up of one or more public or non-profit AIDS service organizations. The responsibilities of this consortium are to, engage in the planning development and delivery of such services as are listed above. The purpose of this coordination is to result in more effective treatment of the PWA population.[3] In Pittsburgh, the South Western Pennsylvania AIDS Planning Coalition (SWPAPC) which predates Ryan White serves in this role. It's importance will be highlighted later in a discussion of the funding process.

Title IIIb. Title IIIb also brings grant money into Pittsburgh, however it is much more narrow that Title II. Title IIIb money is a yearly competitive grant, which can only be used for outreach to vulnerable populations. In Pittsburgh this means that title IIIb is used for outreach to minorities, funding the Allegheny County Health Department (ACHD) in its efforts. It is also used to reach women who are at risk, again Title IIIb funds the work of the ACHD.[4] While Title IIIb is small, bringing in less than 100,000 dollars per year, it goes to reduce the spread of HIV in the most vulnerable populations, and is consequently quite valuable.

Title V. Title V of the Ryan White Care Act is used for practitioner training. It establishes Education & Training Centers (ETCs) in EMAs for the education of doctors and nurses. In Pittsburgh the ETC is located at the University of Pittsburgh School of Public Health. The staff at this center go out into outlying communities in the SWPAPC planning district and educate practitioners. Specifically, they educate practitioners about new treatments for HIV and AIDS, and equally importantly about needs and rights of patients. Again the funds under Title V are quite small, but the education they support is invaluable to PWAs living in rural parts of South Western Pennsylvania.

State Funding

In Pennsylvania, state funds for AIDS service organizations come from budget line item 106, which is an appropriation for the State Department of Health added to the budget in 1990. In the last year, state funding was about 900,000 dollars. However funding levels over the last 8 years have varied widely. The state provides matching funds for Ryan White Title II, as well as additional support for other services. The state funds go to the same services as Ryan White Title II funds, home health care, case management, in and out patient treatment, and life support services. In addition, some state funding goes towards prevention efforts, such as those of the Minority AIDS Working group. State funds are very helpful in the fight against AIDS, there is major policy question associated with them. The question is, What is the formula used by the State Department of Health in distributing these moneys. Until that is known, state funding will always have an air of uncertainty about it.

HOPWA. The Housing Opportunities Program for People With AIDS program provides housing assistance and supportive services for low-income persons with HIV/AIDS and their families. Grants are provided: (1) by formula allocations to States and metropolitan areas with the largest number of cases and incidence of AIDS; and (2) by selection through a national competition of projects proposed by State and local governments and nonprofit organizations. Grantees are encouraged to develop community-wide comprehensive strategies and form partnerships with area nonprofit organizations to provide housing assistance and supportive services for eligible persons. As with the CARE Act Pittsburgh does not qualify for title I grants. However it does receive money under Title II, both in the category of Projects of National Significance (trying to establish pilot programs) and under the HIV Multiple Diagnoses program which tried to help homeless PWAs with drug and alcohol abuse problems. HOPWA can primarily be seen as a tenant based rental assistance program, that is a program which takes applications from individual PWAs and assists with their rent.[5] HOPWA money used to move through the Jewish Healthcare Foundation as Ryan White and state money do, however the program is

now run through the Senior Care Management division of Presbyterian Hospital. In addition, a small amount of funding goes to the Corpus Christi residence. While HOPWA does not fund a wide variety of services, it does an effective job of funding housing. It has relieve PATF of the need to provide rent assistance, and the overall funding level for housing has risen from less than 150,000 in 1994-95 to more than 400,000 in 1996-97.

ALLEGHENY COUNTY

Allegheny County funds AIDS services through its Health Department. It funds ACHD's confidential funding program. Partially funds several outreach efforts to minorities, Intravenous Drug Users (Injection Drug Users) and women. (these programs are also funded with State 106 and Ryan White IIIb moneys). The county's biggest funding action however, is to redirect about 50,000 dollars to PATF to fund anonymous testing. The county does this because regulations prevent them from doing anonymous testing themselves. In conclusion, while Allegheny county plays a small part in funding AIDS programs, the fill an important niche, providing outreach and risk reduction education as well as anonymous testing.

Medicaid. Pennsylvania's state Medicaid program is an important source of funding for AIDS services. Not because it spends a lot of money funding services, but rather because it frees many other service dollars from providing medical care. Pennsylvania's Medicare system is very good at providing AIDS benefits. It pays for case management, primary care, hospitalization, and home health services associated with AIDS. Thus, Medicare saves many dollars that would otherwise have gone to basic medical needs, and allows them to be spent on other services such as mental health, testing and supplementary life support services. In addition, this effect is amplified by the high number of AIDS patients eligible for Medicare in Pittsburgh as compared to other areas.[6]

In addition, Barbara Feige described Pennsylvania's State Pharmaceutical Assistance Program (SPAP).[7] This program, also run by the State Department of Welfare provides generous assistance in purchasing AIDS related Pharmaceuticals. Specifically the program covers all approved AIDS treatment drugs,[8] as well a two psychotropic drugs for mental health needs. The program provides free drugs for those with incomes under $30,000 and subsidizes them for those with higher incomes. Again this is a program that takes some of the burden off of service organizations, allowing them to provide other important programs.

Drug and Alcohol Abuse Related Funding

Finally, it should be mentioned that the Ryan White CARE Act, as well as the state fund small AIDS service programs through the area's Drug and Alcohol treatment programs. These programs provide HIV testing and counseling for those in treatment programs. While these programs are not major, they do provide important services to the Injection Drug User population, some of whom might not be otherwise tested.

Funding Process. The funding process begins with the state of Pennsylvania and the Department of Health and Human Services. These two organizations use their formulae to determine how much money comes into the Southwestern AIDS Planning Region. From there, grant moneys come to the Jewish Health Care Foundation, the fiscal agent for the region. The responsibilities of the fiscal agent are as follows: to make a determination of the region's priorities for service (in conjunction with SWPAPC), to request proposals to fit these needs, in conjunction with the regional allocation board to select sub-contractors to provide services in the priority areas.[9] Fiscal agency began in Pittsburgh in 1992 when Ryan White money first came to the region, because SWPAPC which predated Ryan White lacked the facility to administer funds. At that time, the Pittsburgh Foundation served as fiscal Agent, with Dana Philip's administering funds. In 1993, Dana Philip's left the

Pittsburgh Foundation and came to the Jewish Health Care Foundation, fiscal agency came with her. Soon after, Barbara Feige came to be the administrator.

The regional AIDS planning coalition, SWPAPC does the priority setting for the region. The do this through a process of meetings for major areas of AIDS policy, for example, life support issues, and drug and alcohol issues.[10] Each of these representatives from Community Based Organizations set priorities at each of these meetings and pass them on to the main coalition. From there a final report is issued and sent back to the Jewish Healthcare Foundation.

Upon receiving this report, the fiscal agent issues requests for proposals (RFPs) from organizations to fulfill the regions priorities. Organizations such as PATF and ACHD then file grant proposals with JHF. To make decisions about allocation of funds fulfilling these grant applications JHF then convenes an Allocation Committee. The Allocation Committee's composition is very specific. It is made up of 10 members, who vary from year to year. The first three are members of the regional planning coalition (SWPAPC), three members selected by JHF, there are also three members from outside the regional planing area (to prevent conflicts of interest), and finally there is a designated seat for a consumer of AIDS services. Usually there are 2-3 consumers on the board. In addition consumers are involved in the rest of the process. The allocation board then makes decisions about which applications to accept, and JHF then contracts with the grantee organizations to provide the required services.

Policy Issues

Over the course of studying AIDS service and prevention funding in the SWPAPC region, several policy issues came to light. The first, and most critical is that funding both public and private is off. Ryan White Grants are falling, AIDS walks nationally are making less money,[11] volunteer hours are dropping. This is most likely the result of the new perception that AIDS is a beaten disease, and it hurts Community Bases Organizations severely. Organizations such as PATF are incredibly resourceful, utilizing volunteers to get around funding decreases, however changing public perception may soon reduce volunteerism to critical levels. The new drug cocktails with their treatment effectiveness are leading to this perception. However, AIDS is not beaten, infections are still climbing nationally, and the cocktails don't work for as many as 40% of patients. These facts must be publicized, and funding and donations must be encouraged.

Second, federal programs need to fund prevention. Money for AIDS prevention is not included in the Ryan White Act, and prevention is a critical part of fighting diseases. Most practically, prevention is always cheaper than a cure. In addition, morbidity rates are climbing in minority and marginalized communities. It will take public funding to reach communities such as Injection Drug Users were outreach is costly and difficult.

Finally, with the Advent of effective treatment, e.g. the cocktails, people are taking much longer to progress to AIDS from HIV infection. Given the current formulae to calculate regional grants, this will lead to a steep drop in funding. Grants are calculated based on the number of AIDS cases in a region. As fewer HIV patients progress into AIDS, funding will drop. However individuals with HIV still need services, particularly medical to prevent their deterioration. As a result two things must happen. First, HIV must be made reportable. It is the only sensible way to collect data. HIV seroprevalence data represents a much more current picture of the epidemic (as compared to AIDS data), and thus can be used for planning. In addition, HIV data is resistant to the effects of the cocktails, thus ensure accurate case data. Second, funding formulae must be changed so that funding is based on HIV seroprevalence rather than AIDS cases. In this way appropriate funding levels will be maintained. Otherwise, as AIDS funding drops with the number of cases, and the number of patients stays level or increases, all patients health will suffer.

In conclusion, three things must happen. The public must be informed that AIDS is not a beaten disease, that their money and time are more critical than ever. This will encourage continued volunteerism, as well as spur donations. In addition, Ryan White must be expanded to cover prevention and outreach. Finally HIV must be made reportable, and Federal and State funding formulae must be changed to fund based on HIV infections rather than AIDS cases.

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[2] CARE Act, 1990 p. 7
[3] Ryan White 1996 p. 10
[44] Interview, Barbara Feige 09-29-97
[5] ibid.
[6] interview with B. Feige

[7] ibid.

[8] it must be noted that Pennsylvania is very effective in moving newly approved drugs into the program.

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[10] Drug and Alcohol Abuse issues were added in 1996

[11] ibid.

11

The Pittsburgh AIDS Task Force - The Pittsburgh Response to AIDS Through Volunteer Organizations

Richard Svinkin

In March of 1991, Michael Carbine, director of the Bureau of HIV/AIDS in the Pennsylvania State Health Department, addressed the members and volunteers of the Pittsburgh AIDS Task Force, or PATF, at their annual meeting with the following declaration, "When the history of the epidemic is written, it will say that these organizations formed the backbone of our response to AIDS."[1] In accordance with this declaration, the following case study depicts the history of Pittsburgh's response to the HIV/AIDS epidemic through the eyes, ears, programs, clients services, and prevention efforts of the volunteer dominated, non profit 501(c)(3) organization known as PATF.

Historical Analysis

In 1984, members of the Community Advisory Board to the Pitt Men's Study realized that existing health and social services lacked adequately trained personnel, substantial non financial resources, and efficient methods of information exchange to meet the evolving needs of people with AIDS in Pittsburgh.[2] Combined with forces from the Gay community, the Advisory board drew up plans for a volunteer organization that would address specific needs that were realized through the study, and other needs that the machinery at the University of Pittsburgh could not offer to people with AIDS. The general feeling of the Advisory board was that health and social service providers were already overtaxed and undereducated pertaining to issues within the realm of treatment, and to the out of hospital environment of living with AIDS. PATF was designed to service non-medical needs for Pittsburgh's victims of AIDS.

In the time between the meeting of the Advisory board and March of 1985, when the Pittsburgh AIDS Task Force was formed, volunteers created the Three Rivers PAL Project (Personal Active Listening), a program that to this day provides buddies for people with AIDS.[3] Volunteers also managed to begin the raising of public awareness of AIDS in Pittsburgh, and spread the word about the coming organization. By the time that PATF was formed, the gay community had already begun the work designed by the Advisory Board.

For much of the early history of the epidemic in Pittsburgh, the main focus of PATF was on people with AIDS, the great bulk of whom were members of the Gay community. Consequently much of the case work performed by volunteers at PATF focused on Pittsburgh's gay community, with most of PATF's actual clients being White, gay, and male. As the history

of the epidemic wore on in Pittsburgh, volunteers at PATF were faced with a new challenge, the rising tide of AIDS in the African-American community, especially among males who were exposed through the male sex with male mode of exposure, but would not self identify as gay.[4]

The existence of this new category of clients posed a great problem for mainly White gay volunteers and program coordinators who were experienced in the fight for gay rights, so much of which invlovled the acceptance of a persons sexuality. These quasi cultural conflicts and other social issues have framed the history of PATF and present a satisfactory point of entry into the analysis of this paper, specifically how PATF has fared in combating AIDS in the gay community in Pittsburgh, and how they have fared in fighting the epidemic in the African American community.

One of the first concepts arrived at during the early days of PATF, was the added stigmatization of AIDS on an already stigmatized community. Volunteers quickly sought ways to reduce the stress of that stigma, and since most of the volunteers were gay, PATF had a decisive advantage over existing Health and Social service providers.

PATF also had an advantage of tardiness. The AIDS epidemic became a known menace in Pittsburgh after other cities had already gone through the first stages of the epidemic. In that sense PATF was able to look at the experience of Task Forces in other cities, such as New York or San Fransisco.[5] Since most organizations in those cities also dealt with victims from the mainly White gay community, as a result volunteers at PATF had helpful resources of information collection and a model from which to create a structure of the organization. But Pittsburgh is different from more populated cities in America, and had its own specific range of social, political, economic, and cultural obstacles to hurdle.[6]

As far as the gay community was concerned, PATF became a vessel for that segment of Pittsburgh's population, and PATF was instrumental in providing that segment with a functional network of support and a service infrastructure that helped spread information and educate people who were at risk for contracting the disease because of certain risk behaviors they engaged in. As PATF grew, so did the scope of their efforts and effectiveness, reaching all segments of the population, whether through education programs, or transportation services, or answering AIDS questions through their AIDS information hotline, which lasted until 1992, when a state run hot-line was instituted.[7] PATF became more than a service organization for a specific community, it became the leader of the fight against AIDS in Western Pennsylvania.

The same advantages PATF enjoyed in fighting the epidemic in the early years, have not carried over to the new AIDS landscape in Pittsburgh. As the AIDS case data section of the project will show, African-Americans bear a disproportionate brunt of the over all case total, and account for the great majority of cases exposed through injection drug use and heterosexual contact. (See Chapter 6) Unfortunately, the African American community does not enjoy the same economic advantages as the gay community, since many Pittsburgh members of the gay community happen to be White and middle class, and as the section on the Minority AIDS Working Group will show (See Chapter 6) do not possess the same economic resources that helped fuel PATF as it grew in the mid 1980's.

Economics however, is not the only factor that separated the two demographic groups. The engine of any organization like PATF is volunteerism. Tammy Frech, volunteer at PATF and former editor of Update, PATF's newsletter, and Rich Cummings, present director of the

Three Rivers PAL project and a former PAL buddy, have both pointed out the relative lack of African-American volunteerism at PATF presents many difficulties when considering the growing number of African-American clients that PATF volunteers service and support.[8] Both have argued that AIDS, despite the fact that African-Americans make up 15.50% of the population and 38.77% of all AIDS cases in the 42 zip code sample (See Chapter 6), is much lower on an African-American's priority of life list than say a White gay male. The reasons for that assessment are not hard to fathom.

Unlike any other ethnic or racial group in Allegheny county, the African-American community has felt the brunt of poverty, homelessness, joblessness, exploitation, drug abuse, racism, teen age pregnancy and a whole host of major social, political, and economic difficulties in this region. According to this general assessment, AIDS is viewed as just another problem, consequently the threat does not warrant supreme and undivided attention.[9] If an individual's mind is focused on solving, or at least trying to solve, any one of the major problems that an African-American individual faces on a daily and life long basis, it becomes easier to comprehend why many (but not all) African-Americans do not volunteer their "spare" time and participate at organizations like the PATF in a similar proportion as other racial and gender specific communities in Pittsburgh. Volunteers at PATF have taken certain steps towards mobilizing higher levels of participation among African-Americans in Pittsburgh and the surrounding areas, results do continue to be limited.

For many of the same reasons that prevent higher levels of African-American volunteerism in the fight against AIDS, the volunteer body at PATF has included more and more White, middle class, middle age women wince the inception of PATF. In 1993, 500 active volunteers devoted over 25,000 hours to PATF. Of those 500 or so people, 85% were estimated to be Caucasian, while it was estimated that 14% of the volunteer body was African-American. What is more striking, is that 51% of the volunteer body were women, and 49% men.[10] Since men make up a great majority of AIDS cases in the 42 zip code sample assembled in Chapter 6, the high level of women volunteers at PATF represents the changing face of volunteerism at PATF, going from a volunteer body representing the community hit hardest by the epidemic in the early years, to the racial/gender specific segment of the population, among Whites and African-Americans, that does not represent the major segments hit hard by the epidemic.

White middle age, middle class women, many of whom have families, have a more secure economic background than their African-American counterparts, and have more time to devote to volunteerism as a result. While this fact represents promising participation in over all volunteer efforts in Pittsburgh, PATF desperately needs more African-Americans to participate if they are going to be as effective as possible for that community. While efforts at servicing and programming may seem grim, PATF has achieved substantial things within the African-American community, in terms of prevention and education, while caring and supporting the numerous and growing African-American client body that utilize PATF services. An over view of the numerous and diverse programs and services will provide a more in depth look at the history of the organization, and the history of Pittsburgh's response to the AIDS epidemic.

The Three Rivers PAL Project. The Three Rivers PAL (Personal Active Listening) Project continues to recruit and train buddies, on a volunteer basis, to engage in one on one relationships with people with HIV or AIDS. One of the needs that the project services is the

day to day psychological and practical support of people living with HIV or AIDS.[11] Buddies go through an extensive training course designed by volunteers of PATF, which instructs prospective buddies on the list of responsibilities they may have to fulfill, and exposes them to the type of world they will encounter when dealing with a person with HIV or AIDS on a regular basis. The PAL project is one of the many successful programs at PATF, and seeks to greatly improve or simply maintain a clients quality of life.

A buddy fulfills many practical functions that a client may be unable to perform, or simply needs to devote their energies to other matters. Throughout the history of the program, which started in 1985, buddies have helped clients with housekeeping, shopping, and the securing of transportation, all of which revolve around the issue of basic day to day practical survival.[12] Buddies helped clients keep to the rigorous medication schedule, and funneled information back to their clients about new drugs and helped them adjust to new perscriptions. Clients could count on their buddies to help them make medical appointments, or referring them to other programs at PATF that might help them in other ways.[13]

The role of the buddy has extended far outside the realm of practical support. The most complex part of the buddy training process relates to the psychological aspects about being a buddy. Since the beginning of the PAL project when prospective buddies underwent a 12 hour training program, buddies were prepared for the more stressful process of Active Listening.[14] The Active Listening skill translates into the building of a confidential friendly relationship with a client so that the relationship is open enough for the client to reduce his/her own stress or pain by confiding their experiences to their buddies. These exchanges of personal matters covers the full scope of AIDS dialogue, from death to depression, even happiness and survival. Buddies needed to be prepared, and still need to be prepared for the traumatic psychological relationship they were volunteering for.[15]

Regardless of the content of the dialogue, the main benefit was the connection established between buddy and client. So many times being diagnosed with AIDS or HIV can lead to ostracization and otherwise destruction of a persons social life. Buddies helped clients resocialize, even if only with the buddy, or sometimes with the larger PATF family.[16] That socialization has begun to change as the history of the program progresses.

In the early days of the PAL project, most of the clients were White, and were exposed through the male sex with male exposure mode. Most of the volunteers were also White and male, and many of them were themselves members of the gay community.[17] Sometimes a buddy was even themselves infected with HIV or AIDS, but at a less advanced stage, or simply entered into a buddy network where group support was provided in a collective manner. A more significant change in recent years resulted from the life lengthening drugs that have been extending the life of clients and thus the life of the client buddy relationship.

One way the volunteers of the PAL project and PATF responded in 1996 was to design the format of the buddy team. Buddies requested some direct form of relief as a result of the strenuous tenure a buddy client bond could become. While a support group had been instituted a few years before, in which buddies met with each other and talked about their experiences and helped each other through the struggle, buddies requested a more direct form of assisstance.[18]

The buddy team concept aims to reduce the stress on buddies by teaming buddies together to take on a client or clients together. This signifies another change in the nature of the

program and the nature of the disease in the recent history of Pittsburgh. By 1996, a buddy team was assigned to a family devastated by AIDS, revealing the new landscape of AIDS in Pittsburgh, in which multiple family members may be infected with HIV/AIDS.[19] No individual buddy could be asked to support an entire family by themselves, but throughout the history of the program buddies have done exactly that, since so many times their support extends to the family of the client, even if they themselves are not afflicted.

The buddy team format incidentally is also a very effective use of the buddy "resource". The level of volunteerism in the history of the program has been astounding. The number of volunteers has consistently outnumbered the number of client requests for the buddy program. Even as far back as 1986, 22 referalls were received by the volunteers of the PAL project, all of whom were paired with buddies, and 65 buddies completed the training course in that year. Most of the buddies who were not paired with a client stayed on at PATF in some other capacity.[20] During fiscal year 1993-1994, 64 clients were paired with buddies, and more than 75 buddies were trained for the program.[21] What is even more amazing is that in the cumulative years 1981-1990, 425 individuals had been diagnosed with AIDS in Allegheny county, 95 of those were directly serviced by the PAL project.[22]

As 1995 approached, members and volunteer at PATF and PAL realized the ever growing number of African-Americans living with AIDS in Allegheny county and in the region. Recruiting within the African-American community formally began in 1994, for the purposes of finding buddies from the same demographic background as the growing number of PAL clients from the African-American community. The level of success acheived has been lees than expected. Rich Cummings and the other volunteers and staffers in the PAL project responded with an unusual choice of action.

The PATF Today

This year, members of the PAL team decided to avoid direct recruitment by traditional recruiters at PAL. Finding volunteers from the African-American community was hard enough, but recruitment by an organization that has been stereotyped as a White gay organization presented an almost insurmountable challenge. A new strategy was attempted. An Afro-Centric brochure produced exclusively by African-Americans using PATF resources was published in the last few months.[23] While it is still too early to tell the effectiveness of such a move, the policy change represents a new strategy concerning African-Americans. Instead of trying old strategies involving direct recruitment by the primarily White organization, volunteers at PATF essentially offered their resources to a small group of African-Americans who produced the document, and let them design the brochure they wanted to design.

The brochure represents a positive push towards acheiving new goals. By including or even offering African-Americans the chance to work behind the scenes and command authority as to the content of programs that are aimed at their communty, PATF has yet again led the way for other AIDS organizations in the region. The contextual reality of the diverse and extensive plight of African-Americans in the region has influenced the mechanics of the organization, and thefuture of the PAL projects depends on the ability of PATF to adjust to the changing face of

AIDS in Pittsburgh. PATF's ability to adjust to the changing environment of AIDS in Pittsburgh has marked their history, and hopefully will mark their future.

Case Management. Begining in 1989, PATF organized a case management team, designed to provide one on one case assessment for each client of PATF.[24] By 1991, 2 full time staff and 11 "paraprofessional volunteers" created a link network, where clients can acess health and social service information from their case managers.[25] Case managers also assist clients in utilizing various PATF programs. To be sure, case management provides an invaluable service for clients considering that the public health system landscape is so decentralized, muddled, and hard to understand at least clients can call one phone number and talk to one person, in trying to figure out what is available to them.

The case management program also trains local health and social service workers, and holds information sessions with the various health and social service providers in Pittsburgh. In 1992, 45 social workers from 15 area hospitals attended a PATF sponsored information session dealing with issues of discharge and resource information within PATF and other organizations in the city. PATF thus links up with the various and diverse components of the health infrastructure in Pittsburgh, as well as connecting with clients, providing a bridge on what seems to clients to be a chaotic and hard to comprehend set of issues and needs.[26]

PATF utilizes the case management program also in an effort to de-stigmatize institutional health and social services in the minds of its clients. Another major obstacle in the African-American community is a general distrust of any service provided by the government or simply an organized White institution bent on entering into the African-American community and offering input on how that community should utilize services. Needless to say, the African-American perspective on American institutions is somewhat grounded in reality since the record of public institutions within the African American community is filled with racism and discrimination much like any other facet of social existence African-Americans have faced in their history. That's not to say that public institutions or organizations, even like PATF, are out to get African-Americans utilizing the offer of "help" as a vessel for furthering the plight of the African American community. Obviously we can not sign away every program developed by an institution as mal intended, but we can see that African-American cynicism considering their history is a major obstacle to slowing the spread of AIDS in their community. The gay community reports a similar cynicism along discrimination lines, and PATF has attempted to bridge the gap between public health institutions and the gay community as well.

PATF has tried to include clients in their own health care, in an effort to service those clients, and help them survive. Other committees within PATF such as the legal committee and the advocacy committee have attempted to utilize legal channels to fight for the rights of people with HIV or AIDS, and many times throughout PATF's history those clients have been African-American. What case management aims to do is provide an introduction and maintain a relationship with clients as long as they utilize PATF services. The case management program has at least made the link between clients and service providers, and hopefully the future will bring some sort of reconciliation between public health and the African-American community.[27]

The Emergency Fund. One of the programs that a case manager may refer a client to is the Emergency Fund. In 1986, PATF volunteers quickly realized the financial strain placed upon people with AIDS. While the Fund mainly provided clients with funds for out of hospital

expenses, such as emergency money for rent, food, transportation, and other basic survival needs, the fund also provided money for clients for in hospital requests such as financial assitance for the use of hospital phones and in-room TV charges.[28]

In that year, almost $1,300 was distributed to clients, with almost $10,000 raised for the fund from mainly private contributions made by members of the Pittsburgh gay and lesbian community.[29] 5 members of the Fund Review Committee reveiwed emergency fund requests in 1986, and an 8 member committee over saw the $49,207 distributed by the fund in fiscal 1991-1992.[30] By 1995, expenses covered by the emergency fund had changed significantly. In that year 146 requests were granted with a total of $18,372 distributed. The actual decrease in funding to client emergency needs represents a diversifacation of direct financial assistance by the fund. 1995 marked the creation of the food pantry, a seperate function of PATF, where in local food donations are available for clients in need. PATF also provided nutritional supplements free of charge, and distributed transportation vouchers to its clients.[31] Before the creation of these seperate client services programs, clients acquired such services through the emergency fund. Transportation was however provided by the van service since 1991, when Dan Gamble donated tens of hours a week driving the PATF van for clients in need of transportation to and from medical appointments, and other basic transportation requests.[32] The diversifacation of expenses were diverted to the new programs and as a result direct requests to the Emergency Fund reduced in size.

The fund represents 2 major points about the nature of the epidemic in social terms. First, people across the nation who were diagnosed with the disease found themselves ostracized from social life but also found themselves out of work, and denied access to vital services they required. The emergency fund provides assisstance to those people in Pittsburgh suffering from the loss of income or general financial support. What the fund also represents, for both African-Americans and Whites, is a large composition of working class people living with HIV and AIDS in Pittsburgh. Even if relating this point to the gay community, the analysis begs us to realize the high % of working class people in Pittsburgh, and working class people with AIDS in the city.

The very existence of the fund, represents an aknowledgement of the fact thata significant number of people who have developed the disease, through either unsafe male sex with male type exposure, injection drug use, or another mode of exposure, and are either African-American or White, and male or female, arise out of the working class sectors of Pittsburgh society. This realization challenged the stereotype that all gay men in Pittsburgh are middle class or rich, and that PATF exclusively focuses on White gay males of the middle class. The over all effectiveness of the fund, in providing basic needs and covering basic costs of living for clients in dire need, shows that Pittsburgh not only has an AIDS problem along racial lines, but also along class lines, diversifying the AIDS landscape in Pittsburgh overall.

Public Education - The Speakers' Bureau. In the area of pro-active education, PATF responded quickly by forming the Speakers' Bureau in 1986. Through the Speakers' Bureau, PATF provided AIDS experts to address a variety of HIV/AIDS related issues to community groups, local universities, professional health care programs and centers, crisis intervention teams, churches, schools, and public service employees in the Pittsburgh area.[33] All speakers particapted on a volunteer basis, and came from every part of the HIV/AIDS spectrum, including prevention, education, services, client management, community outreach, and client advocacy.[34]

PATF volunteer speakers attend community meetings, and educate youth in schools, but have also spoken in less typical forums. In 1988, PATF was asked to provide experts for a panel discussion on the CBN (Christian Broadcasting Network). The panel included Ralph Williamson, a person with AIDS, Fr. John Federman, an episcopal priest, and Dr. Paul Rogers of Veterans Hospital in Oakland, Pittsburgh. Dr. Rogers was a former staffer of Dr. Robert Gallo, the famous AIDS researcher, at the National Institute of Health. PATF staff also participated in the show, with Kerry Stoner, the executive director and two staff members, Barbara McCully, and Cyndee Klemanski.[35] This forum was unusual since many Christian organizations in the media have very negative stances on AIDS and victims of AIDS. The forum represents PATF's historic committment to educate any group or individual who requests education about HIV/AIDS.

Throughout the history of PATF, the Speakers' bureau has been one of the most sought after programs by many different sources in the larger community. Most churches and schools requested experts from PATF, to talk to students and congregations about how a person could be exposed to the disease, and what tests wereavailable. The Speakers' Bureau provided speakers and experts that informed the various community groups on mode of transmission issues, and reported on the PATF anonymous testing program, which since it's inception, has tested and provided counseling to any one who utilized the service at PATF. The confidentiality of the program, has made PATF's HIV testing division the most successful in the region, and by 1995, over 95% of PATF clients who were tested at PATF returned for their results, the highest return rate in the region.[36] The two programs and the over all structure of PATF make it possible for one program to advocate another or the whole of the programs at PATF, one of the basic requirements of a successful and effective volunteer organization.

By fiscal 1991-1992, the Speakers' Bureau reached over 9,500 people in direct education programs, and made 289 presetations. As the years have progressed, the Speakers' Bureau has provided more education and presentations in the African-American community, many times by African-American speakers, either from the local area, or from outside Western Pennsylvania.[37] By fiscal 1993-1994 a Speakers' Bureau program, "Personal Perspectives", which educated people about living with HIV/AIDS presented Speakers' Bureau experts, many of whom were people living with HIV or AIDS, to many different community sources.[38] The Speakers' Bureau thus included volunteers afflicted with HIV or AIDS, continuing a pattern throughout PATF history.

PATF has made it possible for people who have been afflicted with HIV or AIDS to participate in it's programs as active members of the fight. Many people in the PATF family have donated their time and energy to PATF programming and servicing, even though they were themselves victims of the disease. These people like the PATF executive director from 1986 to 1992, Kerry Stoner, and Vince Bluett, hotline coordinator until 1992, both died of AIDS in 1992.[39] Without an organization like PATF, many people such as Vince and Kerry would not have had the opportunity to participate in their own fight in the community, and would not have been able to function as a part of an organization, which is one of the best ways to improve the quality of life a person with AIDS can acheive.

The Speakers' Bureau and other public information campaigns, such as the AIDS information hotline which ran until 1992, and the PATF Newsletter Update which brings updates on all PATF program and other AIDS news to thousands of people each year, and the

Information Library housed in the PATF offices in the Wilkinsburg neighborhood in Pittsburgh, all provide notn only information to the community, but also invitations to the communty to join the fight. This also marks another characteristic of a volunteer organization. Every program, must not only provide the specified service, but simultaneously promote PATF and invite members of the community to join the fight. This characteristic is a direct result from the limited funding picture a community based volunteer organization can expect in this day and age.

Prevention and Outreach - Project Lifework. The first target group for PATF prevention in 1986 was the gay and bisexual male population in Pittsburgh. The education committee decided that a targeted strategy was needed to spread the word throughout that segment of the population, and also acheive prevention goals for a population segment which at the time was by far the hardest hit part of Pittsburgh society. Prevention efforts began with advertising in the regions only gay publication, OUT magazine.[40] The advertisements, like the 5,000 brochures and pamphlets and 200 posters produced by PATF volunteers, stressed the importance of safe sex for the gay and bisexual male community, and promoted general AIDS awareness.[41] By 1987, prevention became even more direct for the gay and bisexual male community in Pittsburgh.

In 1987 PATF launched the Project Lifework program. Volunteers visited area bars and social clubs patroned by gay and bisexual males, and brought prevention to the fore front. Bar and Club staff wee trained by PATF volunteers to distribute safe sex information, and hand out condoms and safe sex kits, which included condoms and information packets. These visits were met with great success, with thousands of men reached in the first few visits, and many times prevention helped spread the word about the various programs and services at PATF.[42]

Volunteers and people targeted by outreach responded to PATF and called for more programs in the realm of prevention. PATF responded by creating safer sex workshops within the construct of Project Lifework. In the early days of the safer sex workshops, mainly safe sex information was funneled to participants in a group setting. By 1988, safer sex kits produced by Project Lifework volunteers were distributed to over 1,000 people in outreach settings, and 250 gay and bisexual males in the safer sex workshop setting, held twice a month in 1988.[43] The years following the creation of these programs would bring about many changes in the content and presentation of such workshops.

In 1989, PATF volunteers within the realm of Project Lifework responded to community requests and needs once again. In the safer sex workshops, one of the major particapnt complaints about safe sex was the fact that safer sex was purely less pleasureable than unprotected sex, and that it was hard to ignore the difference. Tim Cline and Don Freeman spent over 600 hours in the first half of 1989 creating the "Eroticizing Safer Sex Workshop", which stressed the dangers of unsafe sex, pointed out the need for safer sex, and provided a three and a half hour program that explores many pleasureable opitions within safer sex. Their program also met with great success, and the new workshop became a main stay for years at PATF.[44] In the years following the new program within Project Lifework the AIDS environment in Pittsburgh changed again.

By fiscal 1991-1992, substance abuse issues and negotiating training became a part of Project Lifework community outreach and workshops. Workshops addressed new issues within the world of substance abuse and the role drugs play in sexual environments, as well as pointing

out the dangers of letting one's guard down through drugs and forgetting to negotiate safer sex. The African-American picture was also presented in these workshops. Workshop facilitators helped participants explore the culturally sensitive realm of African-American gay males in Pittsburgh.[45]

Unfortunately, accessing the great number of African-American males who engage in male sex with male intercourse, but did not self identify as gay still posed great difficulties for PATF and Project Lifework. Much of Project Lifework's history deals directly with "openly" gay and bisexual males. It is almost impossible to clearly identify the community of African-American males who engage in the male sex with male intercourse realm, but do not identify as gay, and are many times hesitant to participate in functions or activities that might stigmatize them in the community. Acessing this segment of the African-American population remains a troubelsome issue for volunteers of Project Life Work and PATF over all.

Project Lifework volunteers responded to the over all problem of reaching all males who engage in the male sex with male behavior, White and African-American, but were not a part of the open and active gay community in Pittsburgh. That characterization was based on a few basic themes, one fo which were those men who engaged in male sex with male behaviors but did not patron gay bars. Volunteers of Project Lifework created the sticker program, wherein stickers promoting PATF's anonymous testing service, and general AIDS awareness were placed in areas where the targeted group of males do frequent, such as public parks.[46]

During fiscal year 1993-1994, over 28,600 condoms, 9,500 lubricant packages, and 1,795 safe sex brochures were distributed through the various workshops and outreach efforts of Project Lifework.[47] By 1995, Project Lifework had extended the area of outreach by not only focusing on gay bars, gay events, and public parks, but also distributed information at adult bookstores in hopes of reaching the men who engage in sanie sex intercourse but do not self identify as gay. In that year, 31,000 condoms were distributed, with Tammy Frech, PATF staff member leading the way.[48]

By fiscal 1991-1992, PATF and Project Lifework began conductin information sessions aimed at the women of Pittsburgh. New safer sex workshops were designed for women, called SexWISE, or Women Interested in Safer Eroticism. PATF volunteers conducted 8 such workshops for women in fiscal 1991-1992, reaching 72 women through SexWISE. The workshops also stressed safe sex, eroticizing safer sex, and the acquisition of negotiating skills. PATF's leadership in targeting women for prevention and outreach was a welcome addition to their programming.[49]

The extensive and effective record of Project Lifework points to one conclusion; the success of PATF and Project Lifework of creating a network of support and a service infrastructure targeting not only people with AIDS, but also those men in the gay and bisexual community that have benefited from the prevention and outreach activities of Project Lifework. The challenge ahead will be outreach targeting African-American males who engage in same sex intercourse but do not self-identify as gay, and have been hesitant to participate in outreach activities that target gay and bisexual men. While the cultural gap between White gay males and the African-American male contingnet who do not self identify as gay but still practice same sex intercourse is wide and hard to bridge. PATF is faced wit an enormous challenge, that perhaps only a completely Afro-centric organization can begin to deal with. None the less, Project

Lifework represents one of the most successful programs at PATF, and has succeeded in becoming a fixture in gay life in Pittsburgh.

Substance Abuse and Youth - The "SAY" Project - Adolescent Outreach. In 1990, PATF established this project in an effort to educate other agencies within public health on the connection between substance abuse and HIV/AIDS, and the high risk youth face in this regard.[50] Volunteers and staff at PATF reported that in 1990, nearly 40% of people living with HIV/AIDS who turned to PATF had a history of substance abuse. PATF utilized certified staff specialists who provided information and training to 2,893 staff and 613 clients in agencies that deal with substance abuse issues. This work was not only done in the Pittsburgh area, but also in substance abuse centers and organizations in 11 counties in southwestern Pennsylvania.[51]

In 1990, the SAY project launched a media campaign to get the message out to teens that drugs and AIDS are connected. Local TV and radio stations participated and even MTV aired PATF's "AIDS it kills everything" public service announcement in 1990.[52] This move and others like it within the scope of the SAY project were direct responses to trends and facts arising out of PATF's client pool. In fiscal 1991-1992, close to 50% of persons who requested PATF services had a history of substance abuse, almost a 10% increase over the previous fiscal year period.[53]

While, that figure does not represent the proportion of injection drug use exposure cases in the 42 zip code sample presented in the data section, it does represent an increase of people infected with HIV who became aware of PATF's work on substance abuse and AIDS. In that sense the SAY project did more than just outreach and prevention, for it could be argued that public exposure for PATF programs including substance abuse case work related to HIV/AIDS, and direct information provision, allowed people to realize that in one specific way, PATF was more than just a White gay male organization. If PATF is going to acheive the same success in the future it must work towards diversifying their image, and the SAY project certainly began that work in 1990.

In 1993, the SAY project reduced in exposure at PATF, and a separate program targeting Adolescents was formed. The goal of the project was to "maintain the low incidence of HIV infection among Adolescents in Allegheny County."[54] Adolescent outreach initially focused on training adolescent serving professionals to educate young people about the dangers and realities of the HIV/AIDS epidemic. In fiscal 1993-1994, the Adolescent Outreach Project, distributed information to more than 4,500 adolescents, and presented to over 1,700 adolescent service professionals and parents. The focus then shifted towards the schools.[55]

In that year, PATF and the Adolescent Outreach project began developing a pilot program for a local school district including AIDS education curricula. Three organizations joined forces with PATF, including the Red Cross, the Allegheny County Health Department, and the Allegheny Intermediate Unit, to form the "AIDS Prevention Alliance".[56] The alliance aided the school district in refining their AIDS curricula and general teaching methods, as well as providing specific training for HIV and human sexuality issues. In this forum, schools could educate their own kids, and PATF was a big part of the process.[57] By 1995, all 46 school districts in Allegheny county participated in the pilot program.[58] This fact was an exceptional acheivement, since many schools in the education system in Pittsburgh have had difficulties approving any

AIDS education that went beyond discussing abstinence throughout the early history of the epidemic in Pittsburgh, as well as the first few years of PATF.[59]

Minority Initiatives. Volunteers and staff members of PATF have been struggling with the African-American AIDS question since 1986, when the "People of Color" committee was implemented.[60] The first need the committee adressed was the building of relationships with African-American community leaders in public health circles and larger focused community groups, such as the African-American church network, and African-American businesses.[61] The mountain in front of the committee must have looked impassable. While some African-American churches responded, and some African-Americans began to participate in PATF programs directly, volunteers and staff members at PATF began to realize that they had a vastly different community to deal with.[62]

First PATF had to convince the African-American community that AIDS was not simply a White Gay problem. By 1987, a partnership with the Alma Illery Center helped to spread the word in the Hill District and throughout the African-American community in Pittsburgh. Plans were made for an AIDS education/information project for the African-American community in the Pittsburgh area.[63] The project was modeled on a program of community outreach and education, and was to spread the word about other services PATF provided. The education/information project provided Project Lifework materials, and began a campaign in the African-American media, promoting the PATF hot line. By 1989, 1/3 of the calls received by the hotline were from African-Americans.[64] Things were certainly looking promising.

By fiscal 1991-1992, the Jewish Health Care Foundation became the primary funding source of PATF's minority initiatives. PATF continued to build partenrships with African-American community leaders, and PATF's information distribution program within the African-American community reached more than 4,700 individuals.[65]

By fiscal 1992-1993, the Minority Business Outreach (MBO) division of PATF's minority initiatives program began to reap results. More than 30 Minority owned businesses distributed Project Lifework safer sex kits, and brochures describing the AIDS crisis and PATF's response. Minority business owners distributed 4,000 condoms and 2,500 brochures to their customers.[66] PATF continued to work with the African-American media, and built a relationship with PCASA, or the Pittsburgh Coalition Against Substance Abuse, an African-American organization responsible for the creation of MAWG, or the Minority AIDS working group.[67]

In fiscal 1993-1994 PATF expanded their minority initiatives again by providing information tables at African-American community events such as the Black Expo, Malcolm X celebrations, African-American health fairs, and African-American church functions. PATF also continued work with African-American female clients through the establishment of a peer support group for African-American females with AIDS.[68]

Despite all the reports of success and improvement of African-American initiatives throughout PATF's history, one necessary element of effective African-American prevention and outreach is still largely missing, volunteers. Rich Cummings reports that the PAL project needs African-American volunteers for the growing number of clients that are African-American. That is not to say that pairing a White person and an African-American person is an impossibility, but most volunteer organizations in recent years have accepted that many times the best facilitator of programs or the best distributer of information for a specific community, is a member of that

community, whether it be a White gay male providing outreach at gay locations, or an African-American buddy providing support to an African-American client.[69] A description of funding in the concluding section of this paper will shed more light on the pressing African-American question.

Conclusion

In the last few years federal and state funding has been decreasing as a percent of PATF's total budget. The fact that Federal and State funding do not provide money for prevention and outreach programs puts the stress on PATF to provide for these programs through the allocation of funds from mainly private donations, and charitable contributions such as the grant issued by the Jewish Health Care foundation. PATF has always managed to provide funds for prevention and outreach, in fact prevention and outreach were mainly the two primary expenses for PATF, until 1996, when case management actually accounted for more expenditures than did prevention and outreach. (See PATF Appendix.)

If Federal and State funding are actually decreasing as a % of PATF's budget, then private funds will have to start easing the stress on other programs such as case management and client services. Prevention and outreach, the two primary weapons used to fight the disease in the African-American community by PATF, will struggle in the future to maintain their level of effectiveness.

One factor that enabled PATF to spend money on prevention and outreach was the amazing level of volunteerism they have received from the larger community. Volunteers through the devotion of dozens of hours a month, and tens of thousands of hours a year, have enabled PATF to spend money where it was most needed. The same primary community that offered private donations were, in the early history of PATF, from the same community most affected by the disease, the White gay male community.

As African-Americans make up more and more of the client pool at PATF, and as white gay men make up less and less, there is no guarantee that similar private donations from the African-American community will come pooring in. There simply is not the same level of financial resources in the African-American community as their is and was in the White gay community. That is not to say that more established sources of private donations will stop giving, but the conceptual structure is clear. A White gay male victim pool translated into a White gay volunteer explosion, and a White gay funding source for prevention and outreach. An increasing African-American client pool has begun showing signs of an increasing level of African-American volunteerism, though the proportion of African-American volunteers relative to the proportion of African-American clients is still low.

African-Americans did donate 900 hours through volunteerism at PATF in 1996, but considering the 25,000 total volunteer donated hours in 1993, the 1996 African-American total for volunteer hours is not even 1/25 of the 1993 total for volunteers of all races. That statistical relationship becomes even more an issue when considering that African-Americans make up 38.77% of all AIDS cases in the 42 zip code sample provided in Chapter 6. African-Americans only make up 15.50% of the total population in the same 42 zip code sample. A similar

relationship can be drawn between the proportion of African-American volunteers at PATF still relatively lower than the proportion of African-American clients.[70]

The Minority initiatives program at PATF has begun to make head way, and the level of volunteerism from the African-American community has slightly increased at PATF. Perhaps other organizations, those exclusively African-American have been having considerably more success in recruiting African-American volunteers. The report featured in Chapter 12 might reveal just that for the Minority AIDS Working Group. But the African-American AIDS picture in the 42 zip code sample is at best grim. Much more needs to be done on all sides if the epidemic can be slowed to reasonable proportions for that community. PATF has proven an effective organization for the gay community. PATF has built a network of service for the gay community and provided an invaluable infrastructure of support. The same needs to be done for the African-American community. PATF has already taken steps towards achieving that and result are starting to come back. PATF has, however, led the way towards supporting African-American organizations in their own quest to stop the epidemic. Perhaps the future will bear benefits for all organizations and victims involved. But it's going to take enormous resources and a significant level of volunteerism for the fight against the epidemic to be successful.

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12

The Minority AIDS Working Group: A Case Study

Rosalyn Rice

In 1991, The Minority AIDS Working Group (MAWG) was created from a collaborative effort of Primary Health Care Services, Pittsburgh Coalition Against Substance Abuse, the Pittsburgh AIDS Task force and the Allegheny County Outreach Project. MAWG's establishment was a direct response to the steadily increasing cases of AIDS in the African-American community. "Working to Save a People from Extinction" is The motto of the Minority Aids Working Group . The motto reflects the agency's focus on HIV prevention and education and targeting African Americans through empowerment. MAWG is primarily funded through the Pittsburgh Coalition Against Substance Abuse (PCASA) because PCASA saw a strong relationship between HIV and substance abuse. In addition, there were no effective HIV/AIDS services that targeted African-American communities.

The Minority AIDS Working Group has collaborated with numerous government and non-government agencies on HIV prevention programs. These agencies include the Southwestern Pennsylvania AIDS Planning Coalition and the Pennsylvania Department of Health for Prevention Education. MAWG also holds an outreach subcontract with the Allegheny County Health Department for HIV-antibody testing.

The Minority AIDS Working Group is comprised of forty-five African American men and women representing grass-roots organizations and drug and alcohol service providers. Ten members are certified by the American Red Cross as HIV/AIDS educators. The Minority AIDS Working Group has three paid staff: coordinator, administrative assistant and peer educator and a small core of adult volunteers. Sabira Bushra serves as the coordinator for the Minority AIDS Working Group. She has extensive experience in HIV prevention education geared towards minority populations. Bushra is also a member of the Board of Directors of the Southwestern Pennsylvania AIDS Planning Coalition (SWPAPC), the regional Title II Ryan White CARE Act Consortium. Bushra is also the chair of the Coalition's Membership Committee.

Opposition to Conventional Outreach

It took two years to see positive results from MAWG's street outreach efforts. MAWG volunteers were often attacked by the people in the community. Historically, the African American community has a bad relationship with public health institutions. From the very beginning of the AIDS epidemic, the United States response to AIDS was negative. Public attitudes reflected by the media condemned those who were infected with the disease and used them as scapegoats. Since HIV/ AIDS primarily affected homosexuals and intravenous drug users, these populations became even more marginalized. African-American communities viewed street outreach as an invasion. A common sentiment about

AIDS was that it did not affect their communities. When mainstream agencies began doing outreach in those communities the typical response to their efforts was negative. "If you approached African-American communities about HIV/AIDS the typical response would be 'You think I'm a dope fiend or a faggot!'", because the media implied that only homosexuals and intravenous drug users can only be infected with HIV. Additionally, some commentators implied that the only reason homosexuals and intravenous drug users contracted HIV was because of their "immoral" actions. The distribution of AIDS prevention information was complicated by this negative moral implication.

Additionally, HIV/AIDS is still perceived as "just another problem" for the African-American community to deal with. African-American communities, especially those with low-incomes face disproportionate rates of teenage pregnancy, drug and alcohol abuse, unemployment, and violence in their communities and AIDS must contend with these other problems for immediate attention. The Minority AIDS Working Group tries to portray the dangers HIV infection when paired other problems within the African-American community. The information is given in terms that these populations understand and by people whom they can relate to.

Future Projects: The Rise Up Peer Education Project

An assessment done by MAWG indicated that the strengths of African-American communities have been overlooked by prevention planners and in prevention messages to the youth. The message that is currently projected to African-American youth is that of hopelessness, powerlessness and the negative aspects of the history of African-Americans. The emphasis must be on the determination, progress, and success of African-American people. the strength and resiliency of African-Americans enabled them to survive slavery and ongoing racism. This knowledge must be relayed to the youth. MAWG has planned a program that will address the needs of African-American youth while providing HIV/AIDS prevention and education skills. The program is called the **Rise Up Peer Education Project**. This program's goal is to encourage youth to learn that life is worth living and their role is pivotal in society. Empowered youth will play an important role in the continued survival of their community.

The Rise Up Peer Education Project will be an extension of the HIV prevention activities of the Minority AIDS Working Group. The Project will incorporate culturally protective factors existing in the African-American community by promoting positive sexual health and the development of decision-making, negotiating and risk avoidance skills among youth by training a core team of peer educators.

The project is designed to reach out to youth who are not accessing social service and health care systems and have difficult or nonexistent relationships with traditional educational systems. Many of these youth are on the streets, and are at grave risk for HIV infection. The situation is fueled by high unemployment rates and school drop-out rates in the targeted neighborhoods. These problems encourage drug and criminal activity. The economic constraints place these youth at risk for involvement with drugs and consequently for HIV and other types of sexually transmitted disease (STD) infection.

The target population for the program is young people from the ages of 13 to 24, from six African-American neighborhoods in Pittsburgh and the borough of Wilkinsburg who are at risk for HIV infection and other sexually transmitted diseases. African-American youths living in these designated areas are at risk for becoming the primary population of second wave AIDS diagnoses. Bushra points out that " [On a national level i]n every demographic category, African Americans constitute the largest rising group of diagnosed AIDS cases. African Americans make up 12.5% of the population whereas they represent 44% of all AIDS cases. African American youths are disproportionately represented in the reported sexually-transmitted disease cases in [Allegheny] county as well."

The Rise Up Peer Education Project will encourage the enlistment of youth educators from the target neighborhoods of East Liberty, Fairywood-Westgate, Garfield,

the Hill District, Homewood-Brushton/East Hills, Lincoln/Larimer and Wilkinsburg. The peer educators will work for MAWG to develop a multi-faceted, youth-driven prevention/intervention program for each neighborhood. The peer educators will also comprise the core planning team for the development of intervention strategies that promote increased understanding of human sexuality, HIV and STD infection, knowledge of specific behavior that places a person at risk for HIV infection, correct and consistent use of condoms and other protective sexual barriers and how to access primary health centers, family planning and substance abuse services.

The peer educators are trained to assist youth in preventing or reducing behaviors that place them at risk for HIV and STD infection by developing a comprehensive, culturally based youth peer education program. The peer educators increase the youth participants' knowledge base of HIV and STD prevention and promote positive sexual health through interactions with them in targeted neighborhoods. The peer educators also assist the newly recruited peer educators in developing and implementing a culturally based HIV/AIDS street and community outreach strategy for their own neighborhoods. Further goals include developing linkages and resources and providing technical assistance to sustain a peer education team in targeted neighborhoods.

Strengths and Weaknesses

The Minority AIDS Working Group possess several strengths and weaknesses. One of the strengths of MAWG is that it is an agency that serves populations that were not originally served by HIV/AIDS agencies. It was born of the Pittsburgh Coalition Against Substance Abuse (PCASA), an agency that responded to the abuse of drugs and alcohol in the African-American community. PCASA saw the correlation between substance abuse and rising HIV infection in the African-American Community and sought to do something about it. Another strength is that MAWG is comprised of people who are from the neighborhoods and populations the agency serves. Many of the ideas for outreach are planned by the targeted neighborhood inhabitants which provides a strong link between the community and the agency. Furthermore, MAWG utilizes straightforward and culturally influenced outreach strategies within their projects. These tactics empower the participants to make positive choices about heir own lives.

An important weakness of MAWG is their low level of funding. MAWG is primarily funded by PCASA. MAWG wants to expand its services; however the current funding the agency currently receives is not enough. MAWG is involved in fundraising activities and has several events planned in the near future to help the agency reach its goal.

There are agencies within Pittsburgh, such as the Pittsburgh AIDS Task Force (PATF), that can help MAWG monetarily. This agency has been in existence longer than MAWG. Although the Task Force's outreach strategies are primarily geared towards gay males who are mostly white, it possesses the resources to provide effective treatment and preventive programs. The needs of the gay community are different than those of the African-American community. For PATF to adjust their outreach strategies to the needs of African-American communities is a challenge. However, if PATF and MAWG collaborate, PATF can use their extensive background in AIDS outreach in connection with MAWG's strategies to help African-Americans communities. The Pittsburgh AIDS Task force can provide help by assisting MAWG in the planning of fund raisers. The Task Force can also assist The Minority AIDS Working groups by subcontracting outreach money to the Minority AIDS Working Group to do outreach in neighborhoods where the Task Force is lacking.

Section IV

Conclusion

Melissa Murello

Drawing from our extensive historical and statistical research regarding the biological and the social epidimeology of AIDS in Pittsburgh, we can conclude that three major factors greatly influence the outcome of a community's battle with AIDS. These factors include networks, negotiation skills and specific demographic and historical characteristics of a neighborhood.

First, networks have played a key role in AIDS outreach especially in the white homosexual community. Those who identify as gay have networks that have provided opportunities for reaching them. Such networks occur in part through owners of clubs or bars that cater to homosexuals. These Pittsburgh business owners, leaders within gay networks, have assumed a major role in involving their patrons in AIDS outreach. In addition, the Pittsburgh AIDS Tasks Force's Project Life Work has developed sex workshops and programs discussing negotiation skills through white gay male networks. However, this outreach misses those who do not identify themselves as gay, but still engage in sex with other men. This outreach also overlooks those who are disengaged from networks. Often, the working class and African Americans are among those that outreach through such networks misses. Networks also influence the spread of AIDS in the pattern of isolated clusters. Isolation can work for or against a group. If a network of gay men or injection drug users contains no individuals who are HIV positive, that network may avoid infection. However, the introduction of an HIV-infected individual into a network of people who engage in risky behavior, HIV may then spread through that network.

Secondly, one's negotiation skills can influence one's chances of contracting the disease. The knowledge about preventing HIV transmission already exists. However, preventing transmission depends on the nature of communication during drug using behaviors and sexual encounters, and the levels of experience that bring one to feeling comfortable talking about safe sex issues during sexual activities. Moreover, negotiation skills may also prevent relapse, the reversion to HIV-risky behaviors. Thus, negotiation skills especially in the cases of youth, appear quite significant in Aids outreach.

Finally, demographic and historical features of a neighborhood affect the outcome of the community's fight against AIDS. Cases rates in the Hill District are not as high as in other areas. Killbuck's black injection drug use rate is 3 times that of the Hill. Historical influences that have strengthened the Hill and are less present in Killbuck may help explain this difference. A sense of neighborhood cohesion lingers in the Hill, a once vibrant community while remnants of the earlier infrastructure of black groups exists. For example, the Hill House represents 35 agencies. The Hill House plays a significant role in determining which agencies work out of the Hill House. The Hill House Consensus Group also rejects or accepts proposals by groups such as developers and city government that would affect the Hill. This neighborhood, although shattered, has renewed strength.

In contrast, the Northside lacks the black infrastructure necessary for self help institutions that pervade the Hill District.

In the Hill, the churches represent an opportunity for raising consciousness about the impact of AIDS on African Americans in Pittsburgh. If churches address public health issues, they may pave the way for communicating the specific taboo behaviors that transmit HIV and effective prevention for African Americans. These behaviors, when they transmit HIV, threaten working-age adults and children which makes this an issue for churches.

Despite the presence of positive characteristics in the Hill, a prevalence of factors that contribute to vulnerability pervades this community. The 1960s urban redevelopment targeted six residential areas in the Hill, but only rebuilt two as residential areas. As a result, four African American families were displaced for every white family displaced. Moreover, African Americans, limited by racist housing policies, searched unsuccessfully for homes in many neighborhoods. Consequently, many blacks concentrated in public housing or in distant African American middle class neighborhoods.

Based on our conclusions regarding the importance of networks and negotiation skills and the factors that influence a neighborhood vulnerability to Aids, we have devised various policy recommendations. First, the disproportionate numbers of African Americans who have contracted Aids suggests that African American volunteers be funneled to The Pittsburgh AIDS Task Force, and the resources for the Minority Aids Working Group must increase. Secondly, the patterns of black cases attributed to injection drug use and male sex with males suggest the need for research in these networks. In addition, to prevent the spread of AIDS through injection drug use, we recommend some combination of needle exchange, decriminalization of syringe possession, and the availability of syringes in pharmacies. Finally, the importance of negotiation skills suggests that education about negotiation and conflict resolution will be effective in fighting the spread of AIDS. This can be articulated in a school context that doesn't necessarily address sex or drugs. However, separate programs outside of schools and targeted at specific social networks may present similar material with the relevant sex and drug behaviors as topics of the role playing and skill building.

Our suggestions for further research include the existence of HIV infection data, not just AIDS case data. This would allow us to flag the spread of the disease at an earlier stage. Secondly, yearly time series data would have allowed us to track new cases by mode of transmission over time to disentangle the various epidemic patterns. New cases per year by age, race, gender and mode of transmission would have been very useful. Thirdly, we would have liked to evaluate HIV data for individual neighborhoods rather than zip codes to better examine neighborhood characteristics. However, issues of confidentiality severely limited this research. Furthermore, greater communication with community workers would have enhanced our understanding arising from the data-based research.

Further research and better theoretical approaches are also necessary to understand the intersections of race, class and male homosexual behavior specifically in understanding black and working class homosexual behavior in the contexts of gay identity and heterosexual identity. Such research should examine network structures as they reflect race and class divisions, or illustrate the links between those divisions.

In addition, ethnographic studies of drug using behaviors and their social contexts have already illustrated that network structures affect HIV transmission through shared injection equipment. Drawing from these studies, further research of the local scene should evaluate network structures and drug using behavior. Another issue for further research may be the application of epidemiological studies of HIV in Pittsburgh to determine rates like HIV seroprevalence among injection drug users.

In the past, Pittsburgh has been slow to respond to public health problems. Currently, comparatively low AIDS case numbers, and recent success in combating syphilis in Allegheny County, may lead to a sense that AIDS is not a serious problem in Pittsburgh. Research in other cities has shown that prevention must begin when case rates are still low to prevent a take-off into overwhelming numbers of cases. Pittsburgh's