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Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
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Lattoma -

Here is the

file on the meeting that PSF had w/ Richard Burzynski at ICASD.

Do you want to keep this info? If not pass back to me ASD. PSF wanted to send a congrats ltr. →

(See memo)

Can you draft a letter and see if she still wants to send something?

Let me know.

Thanks - Daniel

Estimates of the Effects of the House Republican Medicaid Plan on States, 2002 and 1996 - 2002
(Dollars in Millions, Federal Spending, Fiscal Years)

As of 6/30/95 Persons Living wit

S	2002				1996-2002						
	Baseline Spending (1)	Proposed Spending (2)	Federal Savings	Percent Reduction	Baseline Spending (1)	Proposed Spending (2)	Federal Savings	Percent Reduction	HIV cases	AIDS cases	TOTAL
Total	$176,931	$124,077	($52,855)	-30%	$954,338	$771,972	($182,366)	-19%			
Alabama	$2,485	$2,112	($373)	-15%	$13,823	$12,668	($1,155)	-8%	3,704	1,449	5,153
Alaska	$373	$219	($154)	-41%	$2,001	$1,447	($554)	-28%	-	141	141
Arizona	$2,436	$1,921	($515)	-21%	$12,903	$11,575	($1,328)	-10%	2,393	1,351	4,144
Arkansas	$2,084	$1,353	($731)	-35%	$11,081	$8,117	($2,964)	-27%	1,299	864	2,163
California	$17,955	$13,050	($4,905)	-27%	$95,663	$76,971	($18,693)	-20%	-	28,791	28,791
Colorado	$1,521	$1,025	($497)	-33%	$8,163	$6,210	($1,953)	-24%	5,133	2,018	7,151
Connecticut	$2,345	$1,643	($702)	-30%	$12,990	$10,845	($2,145)	-17%	86	3,091	3,177
Delaware	$323	$199	($124)	-38%	$1,728	$1,313	($415)	-24%	-	589	589
District of Columbia	$846	$537	($308)	-36%	$4,511	$3,548	($963)	-21%	-	3,148	3,148
Florida	$7,691	$5,119	($2,573)	-33%	$40,720	$30,189	($10,531)	-26%	-	19,697	19,697
Georgia	$4,900	$3,267	($1,633)	-33%	$26,050	$20,274	($5,776)	-22%	-	5,759	5,759
Hawaii	$508	$369	($139)	-27%	$2,732	$2,288	($443)	-16%	-	587	587
Idaho	$545	$400	($145)	-27%	$2,933	$2,358	($575)	-20%	278	120	398
Illinois	$6,207	$4,423	($1,784)	-29%	$33,242	$27,108	($6,135)	-18%	-	5,891	5891
Indiana	$4,317	$2,398	($1,919)	-44%	$23,100	$15,813	($7,287)	-32%	2,487	1,491	3,988
Iowa	$1,440	$1,107	($333)	-23%	$7,807	$6,871	($936)	-12%	-	349	349
Kansas	$1,079	$939	($140)	-13%	$5,962	$5,829	($133)	-2%	-	532	532
Kentucky	$3,455	$2,230	($1,225)	-35%	$18,353	$13,374	($4,979)	-27%	-	586	586
Louisiana	$6,147	$4,504	($1,642)	-27%	$33,991	$28,722	($5,269)	-16%	5,625	2,865	6,490
Maine	$1,092	$780	($312)	-29%	$5,999	$5,146	($853)	-14%	-	313	813
Maryland	$2,532	$1,717	($815)	-32%	$13,478	$10,962	($2,516)	-19%	-	5,020	5,020
Massachusetts	$4,717	$3,223	($1,493)	-32%	$25,516	$21,277	($4,239)	-17%	-	3,1686	3,1686
Michigan	$5,992	$4,496	($1,496)	-25%	$32,153	$27,900	($4,253)	-13%	2,444	2,334	6,178
Minnesota	$2,701	$1,914	($787)	-29%	$14,665	$12,592	($2,072)	-14%	2,005	1,033	3,038
Mississippi	$2,342	$1,814	($527)	-23%	$12,640	$10,702	($1,938)	-15%	2,855	901	3,7560
Missouri	$2,625	$2,448	($177)	-7%	$14,871	$15,193	$321	2%	3,280	2,595	5,834
Montana	$636	$401	($235)	-37%	$3,409	$2,467	($943)	-28%	-	169	169
Nebraska	$822	$534	($287)	-35%	$4,448	$3,496	($952)	-21%	-	260	260
Nevada	$540	$376	($163)	-30%	$2,899	$2,219	($680)	-23%	1,868	1,007	2,875
New Hampshire	$631	$631	$0	0%	$3,728	$4,165	$437	12%	-	276	276
New Jersey	$5,100	$3,182	($1,918)	-38%	$28,038	$21,006	($7,032)	-25%	9,519	9,349	18,868
New Mexico	$1,147	$876	($271)	-24%	$6,066	$5,164	($902)	-15%	-	468	468
New York	$22,034	$14,382	($7,652)	-35%	$119,527	$94,939	($24,588)	-21%	-	26,911	26,911
North Carolina	$5,406	$3,290	($2,116)	-39%	$29,014	$20,418	($8,596)	-30%	5,419	2,405	7,824
North Dakota	$457	$319	($138)	-30%	$2,491	$1,979	($511)	-21%	52	240	76
Ohio	$7,508	$5,260	($2,248)	-30%	$40,586	$32,642	($7,944)	-20%	1,924	2,526	4,450
Oklahoma	$2,060	$1,329	($731)	-35%	$11,074	$7,839	($3,235)	-29%	1,502	951	2,453
Oregon	$1,649	$1,195	($454)	-28%	$8,884	$7,288	($1,596)	-18%	-	1,264	1,264
Pennsylvania	$7,102	$5,519	($1,583)	-22%	$38,448	$35,315	($3,133)	-8%	-	2,840	5,840
Rhode Island	$1,004	$580	($424)	-42%	$5,465	$3,827	($1,638)	-30%	-	580	580
South Carolina	$2,756	$2,290	($466)	-17%	$15,252	$13,736	($1,516)	-10%	5,260	2,271	7,631
South Dakota	$442	$323	($119)	-27%	$2,380	$2,003	($378)	-16%	137	38	175
Tennessee	$4,587	$3,027	($1,560)	-34%	$24,576	$18,153	($6,424)	-26%	2,955	2,088	5,043
T	$11,358	$9,089	($2,270)	-20%	$61,167	$54,166	($7,001)	-11%	181	13,303	13,484
Utah	$960	$669	($291)	-30%	$5,128	$4,012	($1,116)	-22%	765	464	1,229
Vermont	$366	$240	($127)	-35%	$1,982	$1,581	($401)	-20%	-	103	103
Virginia	$2,434	$1,604	($830)	-34%	$13,022	$9,723	($3,300)	-25%	5,508	2,693	8,201
Washington	$3,381	$1,934	($1,447)	-43%	$18,203	$12,769	($5,434)	-30%	-	2,629	2,629
West Virginia	$2,591	$1,493	($1,098)	-42%	$13,723	$9,264	($4,460)	-32%	333	210	543
Wisconsin	$3,066	$2,183	($883)	-29%	$16,484	$13,549	($2,935)	-18%	1,774	1,033	2,807
Wyoming	$236	$146	($90)	-38%	$1,269	$964	($305)	-24%	56	46	102

Notes: Based on the Commerce Committee's formula as of September 18,1995.

(1) From The Urban Institute's I Expenditure Growth Model

(2) From the General Accounting Office's estimates of the spending by state under the proposal.

U.S. DHHS

20-Sep-95

State-by-State Impact of House Republican Medicaid Cuts of $182 billion

The House Republican Medicaid plan is designed to cut federal Medicaid spending by $182 billion below the Congressional Budget Office's projected Medicaid spending over the next seven years. The state-by-state allocation of federal spending -- and the cut below the baseline -- is based on an extraordinarily complex formula in the bill.

To assess the impact on states, it is necessary to compare two estimates: estimated federal Medicaid spending under the current law baseline, and estimated spending under the proposed plan. Pending further review and assessment of the just-released formula, this impact analysis is based on two publicly-released projections:

- Baseline spending estimate: the Urban Institute's projection of baseline Medicaid spending state-by-state was published in May and has been in public use since then.

- Spending under the plan: the General Accounting Office estimated the allocation of federal funds to states under the House Republican formula on September 19, 1995.

The difference between the two provides a preliminary estimate of the state impact. It shows:

- The plan achieves the target of $182 billion in cuts in federal spending over seven years -- 19 percent below the seven-year baseline, and 30 percent below projected spending in 2002.

- The range of state impact is extraordinary:

  - By the year 2002, one state -- New Hampshire -- has no cut. All the rest of the states are cut below their baseline estimate.

  - Five other states, however, suffer cuts of more than 40 percent below their 2002 baseline: Alaska (-41 percent); Indiana (-44 percent); Rhode Island (-42 percent); Washington (-43 percent); West Virginia (-42 percent).

- Financially, the greatest dollar impact is in the largest states -- New York and California.

  - New York is cut by $24.6 billion below its seven-year baseline estimate -- and 35 percent below its baseline estimate for the year 2002.

  - California is cut by $18.7 billion below its seven-year baseline estimate -- and 27 percent below its baseline estimate for the year 2002.

  - One-half of the total cut of $182 billion comes from eight states: California, Florida, Indiana, New Jersey, New York, Ohio, North Carolina, and Texas.

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Table 3. AIDS cases by age group, exposure category, and sex, reported July 1993 through June 1994, July 1994 through June 1995;1 and cumulative totals, by age group and exposure category, through June 1995, United States.

Adult/adolescent exposure category	Males				Females			
	July 1993-June 1994		July 1994-June 1995		July 1993-June 1994		July 1994-June 1995	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex w/men	38,504	(55)	32,448	(52)	-	-	-	-
Injecting drug use	17,468	(25)	14,728	(24)	6,343	(45)	5,421	(39)
Men who have sex w/men and inject drugs	4,765	(7)	3,609	(6)	-	-	-	-
Hemophilia/coagulation disorder	583	(1)	430	(1)	19	(0)	23	(0)
Heterosexual contact:	2,914	(4)	2,974	(5)	5,685	(40)	5,204	(38)
Sex w/injecting drug user	1,004		903		2,299		1,893	
Sex w/bisexual male	-		-		441		346	
Sex w/person w/hemophilia	3		6		61		57	
Sex w/transfusion recipient w/HIV infection	61		65		82		57	
Sex w/HIV-infected person, risk not specified	1,846		2,000		2,802		2,851	
Receipt of blood transfusion, blood components, or tissue3	468	(1)	382	(1)	361	(3)	305	(2)
Other/risk not reported or ident4	4,745	(7)	7,414	(12)	1,734	(12)	2,885	(21)
Adult/adolescent subtotal	69,447	(100)	61,985	(100)	14,142	(100)	13,838	(100)

Adult/adolescent exposure category	Totals2 July 1993-June 1994 No.	(%)	July 1994-June 1995 No.	(%)	Cumulative total No.	(%)
Men who have sex w/men	38,504	(46)	32,448	(43)	244,235	(52)
Injecting drug use	23,811	(28)	20,149	(27)	118,694	(25)
Men who have sex w/men and inject drugs	4,765	(6)	3,609	(5)	31,024	(7)
Hemophilia/coagulation disorder	602	(1)	453	(1)	3,872	(1)
Heterosexual contact:	8,600	(10)	8,178	(11)	35,683	(8)
Sex w/injecting drug user	3,303		2,796		17,118	
Sex w/bisexual male	441		346		1,999	
Sex w/person w/hemophilia	64		63		299	
Sex w/transfusion recipient w/HIV infection	143		122		692	
Sex w/HIV-infected person, risk not specified	4,649		4,851		15,575	
Receipt of blood transfusion, blood components, or tissue3	829	(1)	687	(1)	7,128	(2)
Other/risk not reported or identified4	6,479	(8)	10,301	(14)	29,652	(6)
Adult/adolescent subtotal	83,590	(100)	75,825	(100)	470,288	(100)

Pediatric (<13 years old)

exposure category	Males July 1993-June 1994 No.	(%)	Males July 1994-June 1995 No.	(%)	Females July 1993-June 1994 No.	(%)	Females July 1994-June 1995 No.	(%)
Hemophilia/ coagulation disorder	16	(3)	11	(2)	1	(0)	-	-
Mother with/ at risk for HIV infection4	443	(92)	419	(88)	478	(95)	462	(92)
Injecting drug use	153		120		160		136	
Sex w/injecting drug user	74		70		71		69	
Sex w/bisexual male	5		10		5		10	
Sex w/person w/hemophilia	1		1		-		1	
Sex w/transfusion recipient w/HIV infection	3		1		1		3	
Sex w/HIV-infected person, risk not specified	70		91		85		89	
Receipt of blood transfusion, blood components, or tissue	12		2		10		5	
Has HIV infection, risk not specified	125		124		146		149	

Receipt of blood

transfusion, blood components, or tissue	17	(4)	23	(5)	13	(3)	14	(3)
Other/risk not reported or identified4	6	(1)	24	(5)	13	(3)	24	(5)
Pediatric subtotal	482	(100)	477	(100)	505	(100)	500	(100)
Total	69,929		62,462		14,647		14,338	

Pediatric (<13 years old) exposure category	July 1993-June 1994 No.	(%)	Totals2 July 1994-June 1995 No.	(%)	Cumulative total No.	(%)
Hemophilia/ coagulation disorder	17	(2)	11	(1)	226	(3)
Mother with/ at risk for HIV infection4	921	(93)	881	(90)	5,925	(90)
Injecting drug use	313		256		2,471	
Sex w/injecting drug user	145		139		1,107	
Sex w/bisexual male	10		20		120	
Sex w/person w/hemophilia	1		2		24	
Sex w/transfusion recipient w/HIV infection	4		4		27	
Sex w/HIV-infected person, risk not specified	155		180		676	
Receipt of blood transfusion, blood components, or tissue	22		7		140	
Has HIV infection, risk not specified	271		273		1,360	
Receipt of blood transfusion, blood components, or tissue	30	(3)	37	(4)	359	(5)
Other/risk not reported or identified4	19	(2)	48	(5)	101	(2)
Pediatric subtotal	987	(100)	977	(100)	6,611	(100)
Total	84,577		76,802		476,899	

1See Technical Notes for a discussion of the impact of the 1993 AIDS surveillance case definition for adults and adolescents (implemented January 1, 1993) on the number of cases reported in the two most recent 12-month reporting periods.
2Includes 4 persons whose sex is unknown.
3Thirty-three adults/adolescents and 2 children developed AIDS after receiving blood screened negative for HIV antibody. Ten additional adults developed AIDS after receiving tissue, organs, or artificial insemination from HIV-infected donors. Three of the 10 received tissue, organs, or artificial insemination from a donor who was negative for HIV antibody at the time of donation. See N Engl J Med 1992;326:726-32.
4See Table 11 and Figure 6 for a discussion of the "other" exposure category. "Other" also includes 25 persons who acquired HIV infection perinatally but were diagnosed with AIDS after age

13. These 25 persons are tabulated under the adult/adolescent, not pediatric, exposure category.

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Table 17. Male adult/adolescent HIV infection cases (not AIDS) by exposure category and race/ethnicity, reported July 1994 through June 1995, and cumulative totals through June 1995, from states with confidential HIV infection reporting1.

	White, not Hispanic			
	July 1994-June 1995		Cumulative total	
Exposure category	No.	(%)	No.	(%)
Men who have sex with men	2,615	(57)	15,135	(60)
Injecting drug use	559	(12)	2,274	(9)
Men who have sex with men and inject drugs	283	(6)	2,103	(8)
Hemophilia/coagulation disorder	48	(1)	308	(1)
Heterosexual contact:	117	(3)	598	(2)
Sex with an injecting drug user	36		179	
Sex with person with hemophilia	-		4	
Sex with transfusion recipient with HIV infection	-		16	
Sex with HIV-infected person, risk not specified	81		399	
Receipt of blood transfusion, blood components, or tissue	17	(0)	168	(1)
Risk not reported or identified2	942	(21)	4,642	(18)
Total	4,581	(100)	25,228	(100)

	Black, not Hispanic			
	July 1994-June 1995		Cumulative total	
Exposure category	No.	(%)	No.	(%)
Men who have sex with men	1,715	(28)	7,883	(31)
Injecting drug use	1,403	(23)	5,646	(22)
Men who have sex with men and inject drugs	210	(3)	1,272	(5)
Hemophilia/coagulation disorder	10	(0)	72	(0)
Heterosexual contact:	472	(8)	2,064	(8)
Sex with an injecting drug user	139		558	
Sex with person with hemophilia	2		5	
Sex with transfusion recipient with HIV infection	7		30	
Sex with HIV-infected person, risk not specified	324		1,471	
Receipt of blood transfusion, blood components, or tissue	33	(1)	141	(1)
Risk not reported or identified2	2,226	(37)	8,247	(33)
Total	6,069	(100)	25,325	(100)

	Hispanic	
	July 1994-	Cumulative

Exposure category	June 1995 No.	(%)	total No.	(%)
Men who have sex with men	265	(29)	1,132	(35)
Injecting drug use	306	(33)	964	(30)
Men who have sex with men and inject drugs	27	(3)	203	(6)
Hemophilia/coagulation disorder	1	(0)	8	(0)
Heterosexual contact:	46	(5)	163	(5)
Sex with an injecting drug user	14		61	
Sex with person with hemophilia	-		-	
Sex with transfusion recipient with HIV infection	-		2	
Sex with HIV-infected person, risk not specified	32		100	
Receipt of blood transfusion, blood components, or tissue	2	(0)	18	(1)
Risk not reported or identified2	281	(30)	749	(23)
Total	928	(100)	3,237	(100)

Asian/Pacific Islander

Exposure category	July 1994-June 1995 No.	(%)	Cumulative total No.	(%)
Men who have sex with men	16	(47)	74	(50)
Injecting drug use	3	(9)	14	(10)
Men who have sex with men and inject drugs	1	(3)	3	(2)
Hemophilia/coagulation disorder	-	-	3	(2)
Heterosexual contact:	1	(3)	6	(4)
Sex with an injecting drug user	1		3	
Sex with person with hemophilia	-		-	
Sex with transfusion recipient with HIV infection	-		-	
Sex with HIV-infected person, risk not specified	-		3	
Receipt of blood transfusion, blood components, or tissue	1	(3)	3	(2)
Risk not reported or identified2	12	(35)	44	(30)
Total	34	(100)	147	(100)

American Indian/Alaska Native

Exposure category	July 1994-June 1995 No.	(%)	Cumulative total No.	(%)
Men who have sex with men	17	(38)	150	(49)
Injecting drug use	10	(22)	51	(17)
Men who have sex with men and inject drugs	6	(13)	47	(15)
Hemophilia/coagulation disorder	-	-	4	(1)
Heterosexual contact:	2	(4)	10	(3)
Sex with an injecting drug user	1		2	
Sex with person with hemophilia	-		-	
Sex with transfusion recipient with HIV infection	-		-	
Sex with HIV-infected person, risk not specified	1		8	
Receipt of blood transfusion, blood components, or tissue	-	-	3	(1)
Risk not reported or identified2	10	(22)	44	(14)
Total	45	(100)	309	(100)

Cumulative totals3

Exposure category	July 1994-June 1995 No.	(%)	Cumulative total No.	(%)
Men who have sex with men	4,675	(39)	24,611	(44)

Injecting drug use	2,296	(19)	9,028	(16)
Men who have sex with men and inject drugs	529	(4)	3,655	(7)
Hemophilia/coagulation disorder	61	(1)	400	(1)
Heterosexual contact:	644	(5)	2,869	(5)
Sex with an injecting drug user	193		811	
Sex with person with hemophilia	2		9	
Sex with transfusion recipient with HIV infection	7		48	
Sex with HIV-infected person, risk not specified	442		2,001	
Receipt of blood transfusion, blood components, or tissue	53	(0)	339	(1)
Risk not reported or identified2	3,637	(31)	14,761	(27)
Total	11,895	(100)	55,663	(100)

1See Table 16 for states with confidential HIV infection reporting.
2For HIV infection cases (not AIDS), "risk not reported or identified" refers primarily to persons whose mode of exposure was not reported and who have not been followed up to determine their mode of exposure, and to a smaller number of persons who are not reported with one of the exposures listed above after follow-up. See Technical Notes.
3Includes 1,417 men whose race/ethnicity is unknown.

Estimates of the Effects of the House Republican Medicaid Plan on States, 2002 and 1996 - 2002
(Dollars in Millions, Federal Spending, Fiscal Years)

States	2002				1996-2002			
	Baseline Spending (1)	Proposed Spending (2)	Federal Savings	Percent Reduction	Baseline Spending (1)	Proposed Spending (2)	Federal Savings	Percent Reduction
Total	$176,931	$124,077	($52,855)	-30%	$954,338	$771,972	($182,366)	-19%
Alabama	$2,485	$2,112	($373)	-15%	$13,823	$12,668	($1,155)	-8%
Alaska	$373	$219	($154)	-41%	$2,001	$1,447	($554)	-28%
Arizona	$2,436	$1,921	($515)	-21%	$12,903	$11,575	($1,328)	-10%
Arkansas	$2,084	$1,353	($731)	-35%	$11,081	$8,117	($2,964)	-27%
California	$17,955	$13,050	($4,905)	-27%	$95,663	$76,971	($18,693)	-20%
Colorado	$1,521	$1,025	($497)	-33%	$8,163	$6,210	($1,953)	-24%
Connecticut	$2,345	$1,643	($702)	-30%	$12,990	$10,845	($2,145)	-17%
Delaware	$323	$199	($124)	-38%	$1,728	$1,313	($415)	-24%
District of Columbia	$846	$537	($308)	-36%	$4,511	$3,548	($963)	-21%
Florida	$7,691	$5,119	($2,573)	-33%	$40,720	$30,189	($10,531)	-26%
Georgia	$4,900	$3,267	($1,633)	-33%	$26,050	$20,274	($5,776)	-22%
Hawaii	$508	$369	($139)	-27%	$2,732	$2,288	($443)	-16%
Idaho	$545	$400	($145)	-27%	$2,933	$2,358	($575)	-20%
Illinois	$6,207	$4,423	($1,784)	-29%	$33,242	$27,108	($6,135)	-18%
Indiana	$4,317	$2,398	($1,919)	-44%	$23,100	$15,813	($7,287)	-32%
Iowa	$1,440	$1,107	($333)	-23%	$7,807	$6,871	($936)	-12%
Kansas	$1,079	$939	($140)	-13%	$5,962	$5,829	($133)	-2%
Kentucky	$3,455	$2,230	($1,225)	-35%	$18,353	$13,374	($4,979)	-27%
Louisiana	$6,147	$4,504	($1,642)	-27%	$33,991	$28,722	($5,269)	-16%
Maine	$1,092	$780	($312)	-29%	$5,999	$5,146	($853)	-14%
Maryland	$2,532	$1,717	($815)	-32%	$13,478	$10,962	($2,516)	-19%
Massachusetts	$4,717	$3,223	($1,493)	-32%	$25,516	$21,277	($4,239)	-17%
Michigan	$5,992	$4,496	($1,496)	-25%	$32,153	$27,900	($4,253)	-13%
Minnesota	$2,701	$1,914	($787)	-29%	$14,665	$12,592	($2,072)	-14%
Mississippi	$2,342	$1,814	($527)	-23%	$12,640	$10,702	($1,938)	-15%
Missouri	$2,625	$2,448	($177)	-7%	$14,871	$15,193	$321	2%
Montana	$636	$401	($235)	-37%	$3,409	$2,467	($943)	-28%
Nebraska	$822	$534	($287)	-35%	$4,448	$3,496	($952)	-21%
Nevada	$540	$376	($163)	-30%	$2,899	$2,219	($680)	-23%
New Hampshire	$631	$631	$0	0%	$3,728	$4,165	$437	12%
New Jersey	$5,100	$3,182	($1,918)	-38%	$28,038	$21,006	($7,032)	-25%
New Mexico	$1,147	$876	($271)	-24%	$6,066	$5,164	($902)	-15%
New York	$22,034	$14,382	($7,652)	-35%	$119,527	$94,939	($24,588)	-21%
North Carolina	$5,406	$3,290	($2,116)	-39%	$29,014	$20,418	($8,596)	-30%
North Dakota	$457	$319	($138)	-30%	$2,491	$1,979	($511)	-21%
Ohio	$7,508	$5,260	($2,248)	-30%	$40,586	$32,642	($7,944)	-20%
Oklahoma	$2,060	$1,329	($731)	-35%	$11,074	$7,839	($3,235)	-29%
Oregon	$1,649	$1,195	($454)	-28%	$8,884	$7,288	($1,596)	-18%
Pennsylvania	$7,102	$5,519	($1,583)	-22%	$38,448	$35,315	($3,133)	-8%
Rhode Island	$1,004	$580	($424)	-42%	$5,465	$3,827	($1,638)	-30%
South Carolina	$2,756	$2,290	($466)	-17%	$15,252	$13,736	($1,516)	-10%
South Dakota	$442	$323	($119)	-27%	$2,380	$2,003	($378)	-16%
Tennessee	$4,587	$3,027	($1,560)	-34%	$24,576	$18,153	($6,424)	-26%
Texas	$11,358	$9,089	($2,270)	-20%	$61,167	$54,166	($7,001)	-11%
Utah	$960	$669	($291)	-30%	$5,128	$4,012	($1,116)	-22%
Vermont	$366	$240	($127)	-35%	$1,982	$1,581	($401)	-20%
Virginia	$2,434	$1,604	($830)	-34%	$13,022	$9,723	($3,300)	-25%
Washington	$3,381	$1,934	($1,447)	-43%	$18,203	$12,769	($5,434)	-30%
West Virginia	$2,591	$1,493	($1,098)	-42%	$13,723	$9,264	($4,460)	-32%
Wisconsin	$3,066	$2,183	($883)	-29%	$16,484	$13,549	($2,935)	-18%
Wyoming	$236	$146	($90)	-38%	$1,269	$964	($305)	-24%

Notes: Based on the Commerce Committee's formula as of September 18,1995.

(1) From The Urban Institute's Medicaid Expenditure Growth Model

(2) From the General Accounting Office's estimates of the spending by state under the proposal.

Source: U.S. DHHS

20-Sep-95

Projected Number of Medicaid Beneficiaries, 2002

State	Baseline
United States	**45,663,533**
Alabama	737,918
Alaska	97,306
Arizona	568,256
Arkansas	514,584
California	6,525,073
Colorado	422,676
Connecticut	453,199
Delaware	98,028
District of Columbia	142,580
Florida	2,796,542
Georgia	1,519,989
Hawaii	161,525
Idaho	150,705
Illinois	1,737,408
Indiana	704,941
Iowa	380,793
Kansas	315,549
Kentucky	856,134
Louisiana	1,081,591
Maine	227,286
Maryland	591,654
Massachusetts	1,054,057
Michigan	1,432,950
Minnesota	531,194
Mississippi	706,300
Missouri	822,420
Montana	111,338
Nebraska	217,171
Nevada	132,513
New Hampshire	108,264
New Jersey	1,082,880
New Mexico	355,684
New York	3,576,932
North Carolina	1,575,219
North Dakota	88,124
Ohio	1,854,988
Oklahoma	549,455
Oregon	497,541
Pennsylvania	1,612,660
Rhode Island	261,101
South Carolina	752,963
South Dakota	96,529
Tennessee	1,265,375
Texas	3,545,644
Utah	226,308
Vermont	107,648
Virginia	929,016
Washington	886,075
West Virginia	548,958
Wisconsin	582,023
Wyoming	68,467

SOURCE: The Urban Institute Medicaid Expenditure Growth Model, 1995

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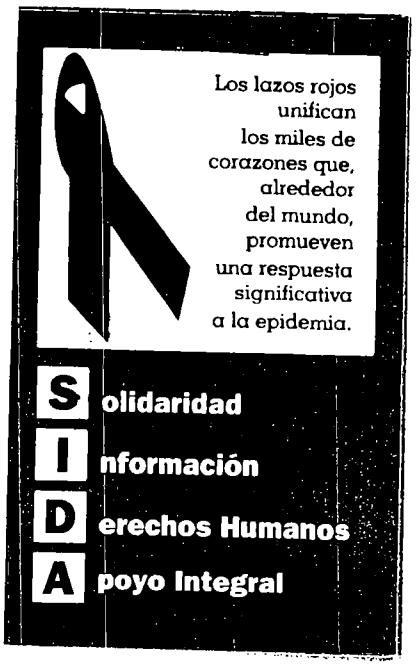
Table 5. Female adult/adolescent AIDS cases by exposure category and race/ethnicity, reported July 1994 through June 1995, and cumulative totals, through June 1995, United States.

	White, not Hispanic			
	July 1994-June 1995		Cumulative total	
Exposure category	No.	(%)	No.	(%)
Injecting drug use	1,238	(40)	6,739	(43)
Hemophilia/coagulation disorder	15	(0)	78	(1)
Heterosexual contact:	1,167	(38)	5,786	(37)
Sex with injecting drug user	455		2,639	
Sex with bisexual male	142		934	
Sex with person with hemophilia	41		211	
Sex with transfusion recipient with HIV infection	26		229	
Sex with HIV-infected person, risk not specified	503		1,773	
Receipt of blood transfusion, blood components, or tissue	117	(4)	1,596	(10)
Risk not reported or identified1	535	(17)	1,371	(9)
Total	3,072	(100)	15,570	(100)

	Black, not Hispanic			
	July 1994-June 1995		Cumulative total	
Exposure category	No.	(%)	No.	(%)
Injecting drug use	3,119	(40)	17,601	(50)
Hemophilia/coagulation disorder	5	(0)	25	(0)
Heterosexual contact:	2,664	(34)	11,767	(33)
Sex with injecting drug user	892		5,891	
Sex with bisexual male	127		717	
Sex with person with hemophilia	10		37	
Sex with transfusion recipient with HIV infection	20		105	
Sex with HIV-infected person, risk not specified	1,615		5,017	
Receipt of blood transfusion, blood components, or tissue	125	(2)	834	(2)
Risk not reported or identified1	1,934	(25)	5,145	(15)
Total	7,847	(100)	35,372	(100)

	Hispanic			
	July 1994-June 1995		Cumulative total	
Exposure category	No.	(%)	No.	(%)
Injecting drug use	1,030	(37)	6,043	(45)
Hemophilia/coagulation disorder	3	(0)	13	(0)



Los lazos rojos unifican los miles de corazones que, alrededor del mundo, promueven una respuesta significativa a la epidemia.

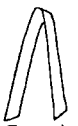
S olidaridad

I nformación

D erechos Humanos

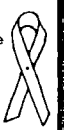
A poyo Integral

Cómo confeccionar tu lazo rojo:



Deja colgar la cinta roja sobre el dedo indice, las dos bandas tienen que quedar iguales.

Cruza la banda izquierda sobre la derecha, más o menos a una pulgada por debajo del dedo.



Sujeta con una gasilla o con alfiler parte donde se cruza la cinta. Coloca el lazo rojo en la solapa o sobre la camisa.

Un lazo rojo en tu pecho es signo de Esperanza... Esperanza de que muy pronto se logre una cura y termine la epidemia...

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Managua, Nicaragua
Telef.: 278 0028 - Fax: 278 6534

Heterosexual contact:	1,330	(47)	5,846	(44)
Sex with injecting drug user	531		3,341	
Sex with bisexual male	68		297	
Sex with person with hemophilia	5		20	
Sex with transfusion recipient with HIV infection	8		69	
Sex with HIV-infected person, risk not specified	718		2,119	
Receipt of blood transfusion, blood components, or tissue	55	(2)	436	(3)
Risk not reported or identified1	391	(14)	955	(7)
Total	2,809	(100)	13,293	(100)

Exposure category	Asian/Pacific Islander July 1994-June 1995 No.	(%)	Cumulative total No.	(%)
Injecting drug use	13	(22)	59	(18)
Hemophilia/coagulation disorder	-	-	1	(0)
Heterosexual contact:	24	(40)	144	(44)
Sex with injecting drug user	7		43	
Sex with bisexual male	5		41	
Sex with person with hemophilia	1		3	
Sex with transfusion recipient with HIV infection	2		15	
Sex with HIV-infected person, risk not specified	9		42	
Receipt of blood transfusion, blood components, or tissue	8	(13)	68	(21)
Risk not reported or identified	15	(25)	53	(16)
Total	60	(100)	325	(100)

Exposure category	Asian/Pacific Islander July 1994-June 1995 No.	(%)	Cumulative total No.	(%)
Injecting drug use	13	(22)	59	(18)
Hemophilia/coagulation disorder	-	-	1	(0)
Heterosexual contact:	24	(40)	144	(44)
Sex with injecting drug user	7		43	
Sex with bisexual male	5		41	
Sex with person with hemophilia	1		3	
Sex with transfusion recipient with HIV infection	2		15	
Sex with HIV-infected person, risk not specified	9		42	
Receipt of blood transfusion, blood components, or tissue	8	(13)	68	(21)
Risk not reported or identified	15	(25)	53	(16)
Total	60	(100)	325	(100)

Exposure category	American Indian/Alaska Native July 1994-June 1995 No.	(%)	Cumulative total No.	(%)
Injecting drug use	15	(47)	84	(49)
Hemophilia/coagulation disorder	-	-	-	-
Heterosexual contact:	14	(44)	63	(36)
Sex with injecting drug user	7		36	
Sex with bisexual male	4		8	
Sex with person with hemophilia	-		2	
Sex with transfusion recipient with HIV infection	-		-	
Sex with HIV-infected person, risk not specified	3		17	
Receipt of blood transfusion, blood components, or tissue	-	-	10	(6)
Risk not reported or identified	3	(9)	16	(9)

Prácticas de Riesgo

- Penetración (coito) en el recto (ano), sin usar condón **(muy peligroso)**.
- Penetración (coito) sin usar el condón **(muy peligroso)**.
- Compartir juguetes sexuales (dildos).
- Relaciones sexuales bajo influencia del alcohol o la droga.
- Contacto de la lengua o la boca con el recto (ano).
- Semen u orina en la boca.
- Meter varios dedos en el ano.
- Contacto con la sangre.

PROTEJAMOS EL AMOR, PREVENGAMOS EL SIDA, LAS ENFERMEDADES DE TRANSMISION SEXUAL (ETS) Y LOS EMBARAZOS NO DESEADOS.

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KAMASUTRA DE BOLSILLO

Prácticas Sexuales Seguras

- Masajes eróticos, abrazos, caricias.
- Rozarse, frotarse, bailar pegadito.
- Masturbación: mutua o simultánea.
- Besos secos y besos con la lengua.
- Mirar y dejarse mirar en la intimidad.
- Compartir fantasías, cuentos y fotos eróticas.

Prácticas Seguras cuando se hacen bien

- Penetración (coito) en la vagina o en el recto (ano), usando adecuadamente un condón de látex.
- Relación oro-genital (mamar), sin entrar en contacto con el semen.
- Relación oro-vaginal (lamer), si no hay sangre de la menstruación.

Total	32	(100)	173	(100)

Exposure category	Cumulative totals2 July 1994-June 1995 No.	(%)	Cumulative total No.	(%)
Injecting drug use	5,421	(39)	30,573	(47)
Hemophilia/coagulation disorder	23	(0)	117	(0)
Heterosexual contact:	5,204	(38)	23,633	(36)
Sex with injecting drug user	1,893		11,964	
Sex with bisexual male	346		1,999	
Sex with person with hemophilia	57		273	
Sex with transfusion recipient with HIV infection	57		420	
Sex with HIV-infected person, risk not specified	2,851		8,977	
Receipt of blood transfusion, blood components, or tissue	305	(2)	2,945	(5)
Risk not reported or identified	2,885	(21)	7,554	(12)
Total	13,838	(100)	64,822	(100)

1See Figure 6.
2Includes 89 women whose race/ethnicity is unknown.

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CDC HIV/AIDS Surveillance Report, Vol. 7, No. 1.

Mid-Year Edition
U.S. HIV and AIDS cases reported through June 1995

Report Description

The U.S. HIV and AIDS case data presented below are extracted from the "HIV/AIDS Surveillance Report," published each quarter by the Division of HIV/AIDS Prevention, National Center for HIV/AIDS, STD, and TB Prevention, Centers for Disease Control and Prevention, Atlanta, GA, 30333. In addition to the data presented here, the printed copy of the report contains maps and figures. Single copies of the printed report are available from:

CDC National AIDS Clearinghouse
P.O. Box 6003
Rockville, MD 20849-6003

(800) 458-5231 or (301) 217-0023
(800) 243-7012 (TTY/TDD)

Suggested citation:

Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 1995;7(no.1).

About this report

Through June 1995, nearly half a million (476,899) persons have been reported with AIDS. The expanded AIDS surveillance case definition (implemented on January 1, 1993) continues to influence the pattern of AIDS diagnosis and reporting. In the first half of 1995, 37,142 AIDS cases were reported. Although this number exceeds the 23,896 cases reported in the first half of 1992, before the case definition was expanded, it is less than the 61,887 and 40,457 cases reported in the first halves of 1993 and 1994, respectively. Trends in reporting of AIDS cases are expected to continue to stabilize gradually over the next several reporting periods as the surge in cases caused by the expanded definition continues to wane.

Analysis of the absolute numbers of cases reported each year, as presented in this report, continues to provide valuable information on the magnitude of the epidemic in affected communities. The data provide an important profile of young (13 to 24 years) men and women with HIV infection and AIDS, and demonstrate the need for prevention strategies appropriate for these age groups (see Tables 7 and 20). They also profile the characteristics of children with HIV and AIDS, in whom nearly all recent HIV infections occurred perinatally, and emphasize that, to prevent HIV in children, prevention programs need to assist women

in reducing their risk of acquiring HIV infection by reducing high risk drug-injection or sexual activities (see Tables 6 and 19). These data will assist states in monitoring the impact of current recommendations to reduce HIV transmission to children through counseling, voluntary testing, and prenatal care services for women.

The expansion of the case definition artifactually distorted the AIDS epidemic curve. Fluctuation in the number of reported cases in recent years has complicated the interpretation of trends in the absolute number of reported cases. However, comparing proportions and relative rates over time permits trends to be monitored. For example, in the two most recent 12-month periods, about 10 percent of persons with AIDS were residents of small metropolitan areas (50,000 to 500,000 population), and about 6 percent were residents of non-metropolitan areas (see Table 2). These percentages are consistent with those reported for 1992 (10 percent and 6 percent, respectively), before the case definition was expanded. They not only reflect the emergence of AIDS outside large metropolitan areas (500,000 or more population), but also illustrate that the epidemic remains disproportionately concentrated in large metropolitan areas, where AIDS incidence rates are consistently 2 to 3 times higher than in small metropolitan areas, and about 5 times higher than in non-metropolitan areas.

To monitor trends in the incidence of AIDS-defining opportunistic illnesses (AIDS-OIs), CDC is using analytic methods that adjust for the case definition expansion by using comparable definitions over time. The estimated number of persons with AIDS-OIs diagnosed in 1994 (64,300) increased approximately 6 percent over the estimated number in 1993 (see Table 13). In addition, previously reported trends continued: the South and the Northeast accounted for the majority of the estimated number of persons with AIDS-OIs, and blacks and Hispanics accounted for a growing proportion of persons with AIDS-OIs (see Table 14). Although men who have sex with men accounted for the largest proportion of AIDS-OIs, the rate of growth has slowed; persons infected through injecting drug-use and their heterosexual partners accounted for an increasing proportion of persons with AIDS-OIs (see Table 15).

AIDS surveillance data can detect recent shifts in the epidemic: because AIDS develops in a substantial number of HIV-infected persons within a year or two of infection, their characteristics are soon reflected in the surveillance data. For example, emerging trends among women, black and Hispanic minorities, persons in moderate- and small-sized metropolitan statistical areas and in the rural South, persons infected through heterosexual contact, minority homosexual/bisexual men, and young men who have sex with men have all been detected through AIDS surveillance. In addition, timely data from 25 states on characteristics of adults/adolescents with HIV infection (not AIDS) have documented the impact of the epidemic among sexually active and drug-using adolescents at early stages of HIV disease and have highlighted the need for appropriate prevention interventions in these populations (see Table 20).

National population-based HIV/AIDS surveillance data can be used to guide allocation of resources for HIV/AIDS prevention and control. State and local health departments provide surveillance information to assist prevention planning in local communities. Together with data from seroprevalence surveys, behavioral surveys, and vital statistics, HIV/AIDS surveillance data can assist communities in developing HIV needs assessments, health care planning, and community profiles for implementing and evaluating prevention interventions.

Suggested Reading

CDC. AIDS among racial/ethnic minorities - United States, 1993. MMWR 1994;43:644-47,653-55.

CDC. Update: trends in AIDS diagnosis and reporting under the expanded surveillance definition for adolescents and adults - United States, 1993. MMWR 1994;43:826-31.

CDC. Update: acquired immunodeficiency syndrome - United States,

1994. MMWR 1995;44:64-67.

CDC. Update: AIDS among women - United States, 1994. MMWR 1995;44:81-84. Erratum: MMWR 1995;44:135.

CDC. Update: trends in AIDS among men who have sex with men - United States, 1989-1994. MMWR 1995;44:401-04.

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Originator: aidsnews@cdcnac.aspensys.com
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Precedence: bulk
From: ghmcleaf{CONTRACTOR/ASPEN/ghmcleaf}%NAC-GATEWAY.ASPEN@ace.aspensys.com
To: jlevi@oash.ssw.dhhs.gov
Subject: CDC HIV/AIDS Surveillance Report, Part 1
X-Listprocessor-Version: 6.0c -- ListProcessor by Anastasios Kotsikonas
X-Comment: CDC National AIDS Clearinghouse
content-length: 0

Table 15. Estimated AIDS-opportunistic illness incidence, by age group, sex, exposure category, and year of diagnosis, 1990 through 1994, United States1

	Year of diagnosis				
Male adult/adolescent exposure category	1990	1991	1992	1993	1994
Men who have sex with men	25,200	28,300	30,000	29,600	31,300
Injecting drug use	8,700	10,100	12,000	12,700	13,400
Men who have sex with men and inject drugs	3,200	3,500	3,800	3,600	3,500
Hemophilia/coagulation disorder	340	380	440	440	420
Heterosexual contact	1,100	1,500	2,100	2,600	3,100
Receipt of blood transfusion, blood components, or tissue	440	460	440	380	440
Risk not reported or identified	360	380	440	400	280
Male subtotal	39,300	44,700	49,200	49,700	52,400
Female adult/adolescent exposure category	1990	1991	1992	1993	1994
Injecting drug use	3,000	3,600	4,300	4,600	4,900
Hemophilia/coagulation disorder	10	20	10	20	20
Heterosexual contact	2,200	2,900	3,800	4,800	5,700
Receipt of blood transfusion, blood components, or tissue	320	320	320	340	400
Risk not reported or identified	120	190	200	150	110
Female subtotal	5,700	7,000	8,600	9,900	11,100
Pediatric (<13 years old) exposure category2	1990	1991	1992	1993	1994
	800	830	990	970	850
Total3	45,800	52,500	58,800	60,600	64,300

1Estimates are adjusted for delays in the reporting of AIDS cases and anticipated redistribution of cases initially reported with no identified risk, but not for incomplete reporting of cases. Adult/adolescent and total estimates of less than 200, 200 to 499, 500 to 999, and 1,000 or more are rounded to the nearest 10, 20, 50, and 100, respectively. Pediatric estimates are rounded to the nearest 10. Opportunistic illness refers to AIDS-defining opportunistic illnesses included in the 1993 AIDS surveillance case definition. See Technical Notes.
2Estimates are based on cases diagnosed using the 1987 definition,

adjusted for reporting delays. The 1993 AIDS surveillance case definition affected only adult/adolescent cases, not pediatric cases.

3The sum of the exposure category estimates may not equal the subtotal and total annual estimates because of rounding.

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To: jlevi@oash.ssw.dhhs.gov
Subject: CDC HIV/AIDS Surveillance Report, Part 2
X-Listprocessor-Version: 6.0c -- ListProcessor by Anastasios Kotsikonas
X-Comment: CDC National AIDS Clearinghouse
content-length: 10651

Table 22. Persons reported to be living with HIV infection (not AIDS) and with AIDS, by state and age group, reported through June 19951.

State of residence (Date HIV reporting initiated)	Living with HIV (not AIDS)2 Adults/ adolescents	Children <13 years old	Total
Alabama (Jan. 1988)	3,673	31	3,704
Alaska	-	-	-
Arizona (Jan. 1987)	2,768	25	2,793
Arkansas (July 1989)	1,279	20	1,299
California	-	-	-
Colorado (Nov. 1985)	5,107	26	5,133
Connecticut (July 1992)4	-	86	86
Delaware	-	-	-
District of Columbia	-	-	-
Florida	-	-	-
Georgia	-	-	-
Hawaii	-	-	-
Idaho (June 1986)	275	3	278
Illinois	-	-	-
Indiana (July 1988)	2,475	22	2,497
Iowa	-	-	-
Kansas	-	-	-
Kentucky	-	-	-
Louisiana (Feb. 1993)	3,585	40	3,625
Maine	-	-	-
Maryland	-	-	-
Massachusetts	-	-	-
Michigan (April 1992)	2,382	62	2,444
Minnesota (Oct. 1985)	1,985	20	2,005
Mississippi (Aug. 1988)	2,820	35	2,855
Missouri (Oct. 1987)	3,203	36	3,239
Montana	-	-	-
Nebraska	-	-	-
Nevada (Feb. 1992)	1,849	19	1,868
New Hampshire	-	-	-
New Jersey (Jan. 1992)	9,224	295	9,519
New Mexico	-	-	-
New York	-	-	-
North Carolina (Feb. 1990)	5,374	45	5,419
North Dakota (Jan. 1988)	52	-	52
Ohio (June 1990)	1,911	13	1,924
Oklahoma (June 1988)	1,493	9	1,502
Oregon	-	-	-
Pennsylvania	-	-	-
Rhode Island	-	-	-
South Carolina (Feb. 1986)	5,189	71	5,260
South Dakota (Jan. 1988)	132	5	137
Tennessee (Jan. 1992)	2,918	37	2,955
Texas (Feb. 1994)4	-	181	181

Utah (April 1989)	760	5	765
Vermont	-	-	-
Virginia (July 1989)	5,453	55	5,508
Washington	-	-	-
West Virginia (Jan. 1989)	331	2	333
Wisconsin (Nov. 1985)	1,752	22	1,774
Wyoming (June 1989)	56	-	56
Subtotal	66,046	1,165	67,211
Guam	-	-	-
Pacific Islands, U.S.	-	-	-
Puerto Rico	-	-	-
Virgin Islands, U.S.	-	-	-
Total	66,046	1,165	67,211

State of residence (Date HIV reporting initiated)	Living with AIDS3 Adults/ adolescents	Children <13 years old	Total
Alabama (Jan. 1988)	1,431	18	1,449
Alaska	140	1	141
Arizona (Jan. 1987)	1,343	8	1,351
Arkansas (July 1989)	849	15	864
California	28,622	169	28,791
Colorado (Nov. 1985)	2,010	8	2,018
Connecticut (July 1992)4	3,016	75	3,091
Delaware	585	4	589
District of Columbia	3,086	62	3,148
Florida	19,202	495	19,697
Georgia	5,688	71	5,759
Hawaii	583	4	587
Idaho (June 1986)	120	-	120
Illinois	5,805	86	5,891
Indiana (July 1988)	1,477	14	1,491
Iowa	345	4	349
Kansas	569	3	572
Kentucky	578	8	586
Louisiana (Feb. 1993)	2,820	45	2,865
Maine	308	5	313
Maryland	4,889	131	5,020
Massachusetts	3,623	63	3,686
Michigan (April 1992)	2,706	28	2,734
Minnesota (Oct. 1985)	1,022	11	1,033
Mississippi (Aug. 1988)	882	19	901
Missouri (Oct. 1987)	2,580	15	2,595
Montana	63	1	64
Nebraska	247	3	250
Nevada (Feb. 1992)	996	11	1,007
New Hampshire	273	3	276
New Jersey (Jan. 1992)	9,102	242	9,344
New Mexico	466	2	468
New York	26,240	671	26,911
North Carolina (Feb. 1990)	2,363	42	2,405
North Dakota (Jan. 1988)	26	-	26
Ohio (June 1990)	2,496	30	2,526
Oklahoma (June 1988)	946	5	951
Oregon	1,260	4	1,264
Pennsylvania	5,725	115	5,840
Rhode Island	575	5	580
South Carolina (Feb. 1986)	2,248	23	2,271
South Dakota (Jan. 1988)	36	2	38
Tennessee (Jan. 1992)	2,044	14	2,058
Texas (Feb. 1994)4	13,174	129	13,303
Utah (April 1989)	458	6	464
Vermont	102	1	103
Virginia (July 1989)	2,623	70	2,693
Washington	2,618	11	2,629
West Virginia (Jan. 1989)	208	2	210
Wisconsin (Nov. 1985)	1,024	9	1,033
Wyoming (June 1989)	46	-	46

Subtotal	169,638	2,763	172,401
Guam	4	-	4
Pacific Islands, U.S.	-	-	-
Puerto Rico	5,851	153	6,004
Virgin Islands, U.S.	134	7	141
Total	175,627	2,923	178,550

State of residence (Date HIV reporting initiated)	Cumulative totals Adults/ adolescents	Children <13 years old	Total
Alabama (Jan. 1988)	5,104	49	5,153
Alaska	140	1	141
Arizona (Jan. 1987)	4,111	33	4,144
Arkansas (July 1989)	2,128	35	2,163
California	28,622	169	28,791
Colorado (Nov. 1985)	7,117	34	7,151
Connecticut (July 1992)4	3,016	161	3,177
Delaware	585	4	589
District of Columbia	3,086	62	3,148
Florida	19,202	495	19,697
Georgia	5,688	71	5,759
Hawaii	583	4	587
Idaho (June 1986)	395	3	398
Illinois	5,805	86	5,891
Indiana (July 1988)	3,952	36	3,988
Iowa	345	4	349
Kansas	569	3	572
Kentucky	578	8	586
Louisiana (Feb. 1993)	6,405	85	6,490
Maine	308	5	313
Maryland	4,889	131	5,020
Massachusetts	3,623	63	3,686
Michigan (April 1992)	5,088	90	5,178
Minnesota (Oct. 1985)	3,007	31	3,038
Mississippi (Aug. 1988)	3,702	54	3,756
Missouri (Oct. 1987)	5,783	51	5,834
Montana	63	1	64
Nebraska	247	3	250
Nevada (Feb. 1992)	2,845	30	2,875
New Hampshire	273	3	276
New Jersey (Jan. 1992)	18,326	537	18,863
New Mexico	466	2	468
New York	26,240	671	26,911
North Carolina (Feb. 1990)	7,737	87	7,824
North Dakota (Jan. 1988)	78	-	78
Ohio (June 1990)	4,407	43	4,450
Oklahoma (June 1988)	2,439	14	2,453
Oregon	1,260	4	1,264
Pennsylvania	5,725	115	5,840
Rhode Island	575	5	580
South Carolina (Feb. 1986)	7,437	94	7,531
South Dakota (Jan. 1988)	168	7	175
Tennessee (Jan. 1992)	4,962	51	5,013
Texas (Feb. 1994)4	13,174	310	13,484
Utah (April 1989)	1,218	11	1,229
Vermont	102	1	103
Virginia (July 1989)	8,076	125	8,201
Washington	2,618	11	2,629
West Virginia (Jan. 1989)	539	4	543
Wisconsin (Nov. 1985)	2,776	31	2,807
Wyoming (June 1989)	102	-	102
Subtotal	235,684	3,928	239,612
Guam	4	-	4
Pacific Islands, U.S.	-	-	-
Puerto Rico	5,851	153	6,004
Virgin Islands, U.S.	134	7	141
Totals	241,673	4,088	245,761

1Persons reported with vital status "alive" as of the last update.
2Includes only persons reported from states with confidential HIV reporting. Excludes 1,553 adults/adolescents and 26 children reported from states with confidential HIV infection reporting whose state of residence is unknown or are residents of other states.
3Includes 225 adults/adolescents and 2 children whose state of residence is unknown.
4Connecticut and Texas have confidential HIV infection reporting for pediatric cases only.

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To: jlevi@oash.ssw.dhhs.gov
Subject: CDC HIV/AIDS Surveillance Report, Part 2
X-Listprocessor-Version: 6.0c -- ListProcessor by Anastasios Kotsikonas
X-Comment: CDC National AIDS Clearinghouse
content-length: 4970

Table 21. HIV infection cases (not AIDS), by sex, age at diagnosis, and race/ethnicity, reported through June 1995, from states with confidential HIV infection reporting1.

Male Age at diagnosis (years)	White, not Hispanic No.	(%)	Black, not Hispanic No.	(%)	Hispanic No.	(%)
Under 5	116	(0)	321	(1)	63	(2)
5-12	74	(0)	59	(0)	19	(1)
13-19	558	(2)	712	(3)	51	(2)
20-24	3,744	(15)	3,546	(14)	415	(13)
25-29	6,579	(26)	5,477	(21)	833	(25)
30-34	6,041	(24)	5,703	(22)	813	(24)
35-39	3,975	(16)	4,759	(19)	571	(17)
40-44	2,199	(9)	2,831	(11)	322	(10)
45-49	1,100	(4)	1,180	(5)	137	(4)
50-54	546	(2)	607	(2)	46	(1)
55-59	239	(1)	254	(1)	21	(1)
60-64	131	(1)	133	(1)	17	(1)
65 or older	116	(0)	123	(0)	11	(0)
Male subtotal	25,418	(100)	25,705	(100)	3,319	(100)

Male Age at diagnosis (years)	Asian/Pacific Islander No.	(%)	American Indian/ Alaska Native No.	(%)	Total2 No.	(%)
Under 5	2	(1)	3	(1)	511	(1)
5-12	-	-	2	(1)	161	(0)
13-19	4	(3)	8	(3)	1,363	(2)
20-24	26	(17)	59	(19)	7,977	(14)
25-29	41	(28)	95	(30)	13,353	(24)
30-34	31	(21)	69	(22)	12,998	(23)
35-39	18	(12)	40	(13)	9,607	(17)
40-44	14	(9)	22	(7)	5,521	(10)
45-49	7	(5)	8	(3)	2,516	(4)
50-54	3	(2)	5	(2)	1,243	(2)
55-59	2	(1)	2	(1)	532	(1)
60-64	-	-	1	(0)	287	(1)
65 or older	1	(1)	-	-	266	(0)
Male subtotal	149	(100)	314	(100)	56,335	(100)

Female Age at diagnosis (years)	White, not Hispanic No.	(%)	Black, not Hispanic No.	(%)	Hispanic No.	(%)
Under 5	115	(3)	291	(3)	65	(6)

5-12	21	(0)	51	(0)	16	(1)
13-19	252	(6)	930	(8)	52	(5)
20-24	816	(19)	1,924	(17)	149	(14)
25-29	1,047	(24)	2,462	(22)	271	(25)
30-34	931	(21)	2,406	(21)	255	(24)
35-39	590	(14)	1,678	(15)	122	(11)
40-44	264	(6)	883	(8)	80	(7)
45-49	158	(4)	332	(3)	35	(3)
50-54	53	(1)	148	(1)	15	(1)
55-59	45	(1)	100	(1)	13	(1)
60-64	22	(1)	50	(0)	5	(0)
65 or older	51	(1)	60	(1)	1	(0)
Female subtotal	4,365	(100)	11,315	(100)	1,079	(100)
Total3	29,784		37,022		4,398	

Female Age at diagnosis (years)	Asian/Pacific Islander No.	(%)	American Indian/ Alaska Native No.	(%)	Total2 No.	(%)
Under 5	2	(4)	6	(6)	491	(3)
5-12	1	(2)	1	(1)	93	(1)
13-19	1	(2)	10	(9)	1,264	(7)
20-24	10	(22)	19	(18)	2,960	(17)
25-29	16	(35)	18	(17)	3,888	(23)
30-34	9	(20)	20	(19)	3,689	(21)
35-39	1	(2)	22	(20)	2,452	(14)
40-44	3	(7)	9	(8)	1,264	(7)
45-49	2	(4)	2	(2)	546	(3)
50-54	1	(2)	1	(1)	222	(1)
55-59	-	-	-	-	160	(1)
60-64	-	-	-	-	79	(0)
65 or older	-	-	-	-	118	(1)
Female subtotal	46	(100)	108	(100)	17,226	(100)
Total3	195		423		73,577	

1See Table 16 for states with confidential HIV infection reporting.
2Includes 1,430 males and 313 females whose race/ethnicity is unknown.
3Includes 16 persons whose sex is unknown.

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To: jlevi@oash.ssw.dhhs.gov
Subject: CDC HIV/AIDS Surveillance Report, Part 9
X-Listprocessor-Version: 6.0c -- ListProcessor by Anastasios Kotsikonas
X-Comment: CDC National AIDS Clearinghouse
content-length: 0

Table 8. AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through June 1995, United States

Male Age at diagnosis (years)	White, not Hispanic No.	(%)	Black, not Hispanic No.	(%)	Hispanic No.	(%)
Under 5	401	(0)	1,593	(1)	630	(1)
5-12	288	(0)	270	(0)	193	(0)
13-19	649	(0)	468	(0)	288	(0)
20-24	6,054	(3)	4,641	(4)	2,735	(4)
25-29	29,889	(14)	16,854	(14)	10,851	(16)
30-34	49,941	(23)	27,096	(22)	16,750	(24)
35-39	47,371	(22)	28,321	(23)	15,311	(22)
40-44	34,274	(16)	20,518	(17)	10,332	(15)
45-49	20,271	(10)	10,877	(9)	5,608	(8)
50-54	10,900	(5)	5,863	(5)	2,923	(4)
55-59	6,082	(3)	3,236	(3)	1,677	(2)
60-64	3,514	(2)	1,746	(1)	908	(1)
65 or older	2,911	(1)	1,397	(1)	668	(1)
Male subtotal (100)	212,545	(100)	122,880	(100)	68,874	

Male Age at diagnosis (years)	Asian/Pacific Islander No.	(%)	American Indian/ Alaska Native No.	(%)	Total1 No.	(%)
Under 5	15	(1)	9	(1)	2,651	(1)
5-12	8	(0)	1	(0)	761	(0)
13-19	18	(1)	13	(1)	1,437	(0)
20-24	99	(3)	48	(5)	13,599	(3)
25-29	384	(13)	210	(21)	58,268	(14)
30-34	646	(22)	272	(27)	94,836	(23)
35-39	630	(22)	199	(20)	91,986	(22)
40-44	509	(17)	142	(14)	65,883	(16)
45-49	281	(10)	63	(6)	37,156	(9)
50-54	154	(5)	30	(3)	19,899	(5)
55-59	90	(3)	15	(1)	11,128	(3)
60-64	42	(1)	11	(1)	6,230	(2)
65 or older	49	(2)	7	(1)	5,040	(1)
Male subtotal (100)	2,925	(100)	1,020	(100)	408,874	

Female Age at diagnosis (years)	White, not Hispanic No.	(%)	Black, not Hispanic No.	(%)	Hispanic No.	(%)
Under 5	406	(3)	1,606	(4)	596	(4)

5-12	121	(1)	289	(1)	147	(1)
13-19	140	(1)	482	(1)	119	(1)
20-24	980	(6)	2,217	(6)	910	(6)
25-29	2,825	(18)	5,885	(16)	2,488	(18)
30-34	3,695	(23)	8,692	(23)	3,412	(24)
35-39	3,043	(19)	8,140	(22)	2,766	(20)
40-44	1,850	(11)	5,085	(14)	1,663	(12)
45-49	953	(6)	2,208	(6)	852	(6)
50-54	565	(4)	1,166	(3)	479	(3)
55-59	445	(3)	660	(2)	303	(2)
60-64	326	(2)	422	(1)	151	(1)
65 or older	748	(5)	415	(1)	150	(1)
Female subtotal (100)	16,097	(100)	37,267	(100)	14,036	
Total2	228,644		160,148		82,910	

Female Age at diagnosis (years)	Asian/Pacific Islander		American Indian/ Alaska Native		Total1	
	No.	(%)	No.	(%)	No.	(%)
Under 5	9	(3)	9	(5)	2,634	(4)
5-12	6	(2)	-	-	565	(1)
13-19	4	(1)	1	(1)	747	(1)
20-24	16	(5)	18	(10)	4,146	(6)
25-29	36	(11)	36	(20)	11,280	(17)
30-34	70	(21)	44	(24)	15,936	(23)
35-39	61	(18)	35	(19)	14,075	(21)
40-44	50	(15)	19	(10)	8,676	(13)
45-49	28	(8)	8	(4)	4,054	(6)
50-54	16	(5)	4	(2)	2,233	(3)
55-59	10	(3)	4	(2)	1,424	(2)
60-64	16	(5)	3	(2)	918	(1)
65 or older	18	(5)	1	(1)	1,333	(2)
Female subtotal (100)	340	(100)	182	(100)	68,021	
Total2	3,265		1,202		476,899	

1Includes 630 males, 99 females, and 1 person with unknown sex whose race/ethnicity is unknown.
2Includes 4 persons whose sex is unknown.

October 29, 1996

MEMORANDUM FOR LAHOMA ROMOCKI/FILE

FROM: Daniel Montoya

SUBJECT: Meeting w/ Richard Burzynski/Donna Rae Palmer on International Council on AIDS Service Organizations

PSF wants to send a congratulations letter to:

Lic. Rita Arauz
Fundacion Nimehuatzin
Apartado A-262
Managua, Nicaragua

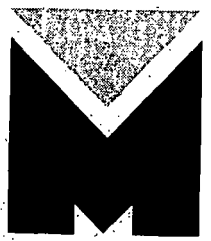
for pushing for and passing legislation entitled, "Promotion, Protection and Defence of Human Rights in the Face of AIDS" in Nicaragua.

PSF suggested that a coordinator for all groups working on access to drugs needs to be established. Also said to make sure that GNP+ (Jairo Pedraza) was included as one of the groups.

RICHARD BURZYNSKI
ICASO - Central Secretariat

INTERNATIONAL COUNCIL OF AIDS SERVICE ORGANIZATIONS
Canadian AIDS Society
400-100 Sparks St.,
Ottawa, Ont., CANADA K1P 5B7

Tel.: 1-613-230-3580 Fax.: 1-613-563-4998
E-mail: icaso@web.apc.org



Mobilization Against AIDS

584-B Castro St.
San Francisco, CA
94114-1465
tel 415-863-4676
fax 415-863-4740
mobilization@out.org

Donna Rae Palmer
Executive Director

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FOLDER TITLE:
International Council on AIDS Service Organizations (ICASO)

2007-1550-F
kc1263

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[001] 5

PERSONAL RESUME

15 September 1995

Name:	:	*Warren H. Lindner*
Current Position	:	*Executive Director* *Centre for Our Common Future* *(On Sabbatical)*
Home Address	:	*Chalet le Fort* *30933 Route de la Barliette* *74300, Les Carroz* *France*
Telephone	:	*(3350) 90 36 12*
Fax	:	*(3350) 90 03 21*
E-Mail	:	*Compuserve: 101376,3300* *Internet: 101376.3300@CompuServe. Com*
Personal Data	:	*Citizen of the U.S.A.,* (b)(6) (b)(6) *with four children, ages 24, 23, 18, and 16; Height: 5'10'; Weight: 170 lbs.*

****

PROFESSIONAL EXPERIENCE

April 1988 to Present

Executive Director, the Centre for our Common Future, a Swiss charitable foundation, founded in April 1988 to mark the first anniversary of the issuance of the report of the World Commission on Environment and Development (the 'Brundtland Commission'), 'Our Common Future'.

Since its inception its principle missions have been (i) to act as a non-partisan information exchange mechanism and a global information clearinghouse on sustainable development initiatives, (ii) to further public participation in the search for sustainability, (iii) to foster inter-sectoral dialogue on key issues related to sustainability and (iv) to build and service networks of groups from different sectors of society and different regions of the world for the creation of new working partnerships for sustainable development.

Over the past eight years, the Centre has been instrumental in preparing and packaging key information on sustainable development and servicing thousands of organisations and institutions around the world which have committed themselves to furthering the principle of sustainable development. It now has more than 265 'Working Partner' organisations and institutions in more than 70 countries that work with it and a database of more than 85,000 organisations and institutions working on sustainable development in over 200 countries. These organisations represent all sectors of society, including environment and development groups; women's organisations; government agencies and ministries; international organisations; indigenous peoples; youth groups; the scientific and academic community; trade unions; business and commerce; the legal profession; and the media.

outcome of three years of fact-finding and consultation conducted in public in all the regions of the world, with the aid of governments, institutions and citizens groups.

As Secretary of the Commission, was responsible for the management and operational aspects of the Commission's activities world-wide, including: its official meetings and visits to 16 countries; the public hearings it held in 10 countries; and the presentation of its final report 'Our Common Future' to heads of governments and ministers from over 100 countries.

Was also responsible for the daily management and direction of the Commission's secretariat in Geneva [15 senior professional staff and 10 support staff from 14 countries], for overseeing its press and public information programme and for the financial management of the Commission, including the establishment and control of its budget [approximately $8 million] as well as for all fundraising efforts for the Commission.

August 1982 - August 1984

Director of the Energy Department with Société Générale pour l'Energie et les Ressources [Sogener] a publicly quoted Swiss energy and merger/acquisition company located in Geneva, Switzerland, which until 1982 was a 42% owned subsidiary of Tosco Corporation. During this period, worked closely with, and primarily for, the company's principal shareholder, Maurice F. Strong [former Chairman of the Board of Petro-Canada, Chairman of the Board of Canada Development Investment Corporation, principal shareholder of Tosco Corporation, former Secretary General of the Stockholm Conference in 1972, Under-Secretary General of the United Nations, and Secretary General of the Rio Earth Summit].

In this capacity represented and acted on behalf of Mr. Strong in the conduct of his international business activities including the disposition of his controlling interest in a publicly traded Swiss holding company, Credit Immobilier, to Tosco Corporation and the reacquisition of that company from Tosco by a group of international investors and its on-sale to a Geneva investment group.

Also acted on behalf of Sogener, Credit Immobilier and their principal shareholders in the acquisition and disposition of various investment interest and when needed provided general legal advice in respect of their activities particularly in the U.S. Also served as a consultant to Sogener's merger/acquisition subsidiary Interfinexa S.A.

November 1980 - August 1982

Deputy Director General of the WorldWide Fund for Nature (formerly the World Wildlife Fund), an international charitable conservation foundation based in Gland, Switzerland [with 26 affiliate organizations on five continents] whose main objective is the raising of funds for allocation to conservation and development projects around the world.,

During this period, served as Deputy Director General at WWF's International Headquarters, with primary responsibility for the administration of the International Secretariat, and representation of the Director General and the institution at high level meetings.

Was also responsible for the management of divisional directors' activities and the activities of and relations with, the foundation's Board of Trustees, which included, among others, his Royal Highness the Duke of Edinburgh, Dr. Anton Rupert, Chairman of the Rupert Group of Companies, Mr. John Loudin, former Chairman of the Board of the Royal Dutch Petroleum Company, Mr. David Ogilvy, founder of Ogilvy & Mather, Sir Arthur Norman, Chairman of the Confederation of British Industry, Mr. Joseph Cullman, Chairman of the Executive Committee of Philip Morris and Sir Peter Scott.

others, Vice-President of the Freshman Class; President of the Sophomore Class; two terms as President of the Student Body; local President and National Vice-President of Inter-Collegiate Knights (National honorary and service organisation); delegate to White House National Student Leadership Conference; member of Omicron Delta Kappa, national academic and service organisation; member of Lambda Chi Alpha fraternity; and only student in University's history to receive its highest leadership award, 'The Chancellor's Special Award for Leadership".

College preparation at Mount St. Joseph Preparatory School, Baltimore, Maryland.

Languages: Fluent French

ASSOCIATIONS:

Previously,: member of the International Advisory Board of Globe '90 and Globe '92; member of the International Advisory Board of Earth Day, 1990 and 1991; Vice-President of Gulf International Corporation; Member of the Board of Trustees of the North South Roundtable and Gaia Foundation; Treasurer of the North South Roundtable.

Currently member of: the Editorial Board of Tomorrow Magazine; the Advisory Board of Gallup International; the Policy Advisory Board of the Earth Council; the World Commission on Financing the United Nations; The Gensis Facility; and a member of the Board of the Panos Institute.

REFERENCES

Gro Harlem Brundtland,
Prime Minister of Norway

Maurice Strong,
Senior Advisor, World Bank,
former Under-Secretary
General, United Nations

Klaus Schwab,
President, World Economic Forum

Gus Speth,
Executive Director, United
Nations Development Program

Emil Salim,
Chairman, World Commission on Forestry
Former Minister of Population, Indonesia

Mansour Khalid, President,
African Centre for Environment,
former Minister of Foreign Affairs, Sudan

Executive Director's Open Letter To Readers

The following is the text of a letter sent by the Centre's Executive Director, Mr. W.H. Lindner, to the Centre's Working Partners, donors, and institutional and individual friends. He would now like to share its contents with the readers of *The Network.*

Dear Readers,

The Centre has now entered its eighth year of operations. Overall, I believe, we have made a significant contribution to furthering the debate on sustainable development and extending the concept of public participation.

Our information and publications now reach thousands of institutions throughout the world. Our database continues to grow and expand. Our new training programme is proving a great success. And our productions of 'popular versions' of international agreements have been extraordinarily well received.

Personally, I am very proud of what the Centre's team has achieved and pleased to have played a role in directing the Centre's activities during that period.

In recent months, however, I have given a great deal of thought to the Centre's future and the role that I, as its founder, should play in the months and years ahead. And after much consideration I have decided that the time has now come for me to change my position within the Centre by moving into a more policy, public and advisory role and relinquishing day-to-day responsibility for its management. I should like, therefore, to advise that, subject to final approval of our Board , as from the 15th of June, 1995, I shall no longer be functioning as the Centre's Executive Director, but instead shall become its new president and an *ex-officio* member of its Board of Trustees.

There are several reasons which have brought me to this decision. Firstly, for some time, I have believed that the Centre was too identified with me as an individual; and that this was an impression that would only change if my role within the Centre were to change. Additionally, I am convinced that the challenges of the post-Rio agenda require new thinking and new approaches. The Centre must adjust to these new realities and to do that, I believe, will also require new executive direction.

It has also become important for me to change my role within the Centre for personal health reasons. For more than eight years now, I have been HIV positive. While throughout that whole period I have been free of symptoms and in good health – and remain so today – it is only realistic to expect that the status of my health could change in the future. An orderly transition of executive direction should, therefore, now be made.

Again subject to the Board's final approval, as from the 15th of June, 1995 (and for as long as is decided by the Board in the context of the Centre's restructuring), Sarah Adams, the Centre's Assistant Executive Director, will assume day-to-day responsibility for managing the Centre. Sarah has not only my and the Board's full support and endorsement in assuming this role, but that of all the Centre's staff. She will be assisted by a newly created 'Strategic Task Force' of senior staff members and a recently constituted Advisory Group formed from the Centre's Working Partners.

It is my intention to remain with, and to be located at, the Centre after the 15th of June so as to provide regular and ongoing policy advice and guidance, working closely with Sarah Adams and the other members of staff. I also plan, before then and thereafter, to represent the Centre at international meetings and gatherings, and to do more writing and lecturing on issues related to sustainable development under the name of the Centre.

I hope that I will also now be able to devote some of my time to issues related to HIV and AIDS so as to make whatever contribution I can to a greater understanding and awareness of the disease and the inequities surrounding it, particularly as regards the disparities between the North and South in access to medication and treatment.

I am personally convinced that the Centre has made an important contribution to sustainable development and that it has a continuing and significant role to play in the post-Rio period.

Nevertheless, we are now at an important crossroad. Consultations on our continuing role are currently in the process and our Board will meet shortly to consider our long-term future. Achieving that future, however, will depend, to a great extent, on the support and assistance we can expect to receive from our Working Partners, our donors and our 'friends'.

I certainly plan to contribute my time and efforts to ensuring that the Centre achieves its full potential and hope that we can count on your continuing support and co-operation.

Sincerely yours,

W.H. Lindner
Executive Director

PROJECT PROPOSAL FOR THE INTRODUCTION OF NORTH/SOUTH AND EQUITY ISSUES INTO THE PROGRAMME OF THE 12TH WORLD AIDS CONFERENCE TO BE HELD IN 1998 IN GENEVA, SWITZERLAND

Submitted by David Cooper, President, International Aids Society, Lars Kallings, Secretary general, International Aids Society, and Bernard Hirschel, Conference Chairman on behalf of

The International Aids Society,

PROJECT PROPOSAL FOR THE INTRODUCTION OF NORTH/SOUTH AND EQUITY ISSUES INTO THE PROGRAMME OF THE 12TH WORLD AIDS CONFERENCETO BE HELD IN 1998 IN GENEVA, SWITZERLAND

Principal Objectives of the Project

Working in close collaboration with UNAIDS, the International Aids Society and the Swiss Government, other co-sponsors of the Conference, the Conference Chairman, and the Committes organizing the 1998 Conference **(henceforth collectively called the « Organizers »):**

To use the Conference preparations, and the Conference itself, to foster:

- broader political and public understanding and visibility of the North/South and equity dimensions of the AIDS pandemic;
- broader developing country participation in the preparations and conduct of the conference, from governments, from the scientific community, from the public health field, and, in particular, from NGOs and civil society at large;
- the organization and funding of a 'scholarship program' to ensure access to the Conference for persons from lesser developed countries;
- a closer partnership between the scientific community, public health structures, civil society and the pharmaceutical industry relative to equitable access to drugs and treatment in the lesser developed countries; and
- greater international press focus on the North/South and equity issues and much greater participation of press and journalists from the developing countries in the lead up to the '98 Conference and at the conference itself.

Duties and Responsibilities of Project Manager (PM)

Working under the overall responsability and the direct surpervision of the International Aids Society, the Project Manager shall serve in the capacity of a Senior Advisor to the Conference Chairman, with the following specific duties and responsibilities:

1. In consultation with IAS and UNAIDS , to ***design and implement a 'North/South and public participative' stream*** into the main programme of the Conference, which stream will address, among others, issues of equity, particularly as they relate to access to health care, drugs and treatment;

2. As a member of the Organizing Committee of the Conference in an advisory, non-voting capacity, to ***work closely with IAS and UNAIDS in planning, designing and implementing such a stream***;

3. To ***inform, mobilize and encourage the involvement of the institutions and organizations which have participated in recent UN multilateral conferences to participate in the Conference***, the purpose of such participation being the inclusion in the conference of people and organizations which are both familiar with, and concerned about, the issues, particularly those from the South;

4. To ***form a broadly inter-sectoral planning group of 15 representatives*** to assist in setting the agenda of the 'North/South' stream; ***additional funds have been made available by the Government of Geneva for special projects of this kind***;

5. To explore in cooperation with foundations and the bilateral and multilateral aid agencies the feasibility of ***establishing a financial mechanism that would ensure broad participation from the developing countries*** in the planning and conduct of the Conference - [a part of this effort would involve ***the organization and funding of a 'scholarship programme'***, see Principal Objectives];

6. To work during the period leading up to the Conference ***to broaden public and political visibility in the developing countries of the Conference programme, its agenda and its purposes***, working closely in the fulfilment of these tasks with various bodies; and to write regular 'op ed' pieces on the Conference and the North South issues related to the pandemic;

7. To explore ***the feasibility of organizing a 'special plenary' at the Conference on the 'North/South agenda'*** with the participation of political figures, representatives of civil society, the medical profession and the pharmaceutical industry;

8. To explore with industry groups, such as the World Economic Forum, the World Business Council on Sustainable Development, and the pharmaceutical industry ***the feasibility of holding a special plenary session(s) within the Conference on the role, responsibilities and opportunities of the pharmaceutical industry*** in the context of the North/South dimensions of the pandemic;

9. On request, to ***represent IAS at conferences and symposia*** being held in preparation for the Conference;

10. ***To provide ongoing advice and input to the Organizers during the planning cycle for the Conference.***

11. After the Conference, ***write a final report on « North/South issues and public participation »,*** for guidance in future conferences.

W.H. Lindner, candidate for the post of Project Manager

W. H. Lindner is the former Executive Director of the Centre for our Common Future. He has a vast professional experience gained over the last 15 years during his association with the Worldwide Fund for Nature, the Brundtland Commission, the Rio Earth Summit and the Centre for our Common Future.

Being HIV seropositive himself for almost eight years now, W.H. Lindner would like to devote energy and time to issues related to Aids, particularly in the context of the 1998 World Aids Conference to be held in Geneva and with specific emphasis on the North/South dimensions of the pandemic, the issue of equity and the need for public participation in policy setting related to the disease.

His curriculum vitae is enclosed with this proposal.

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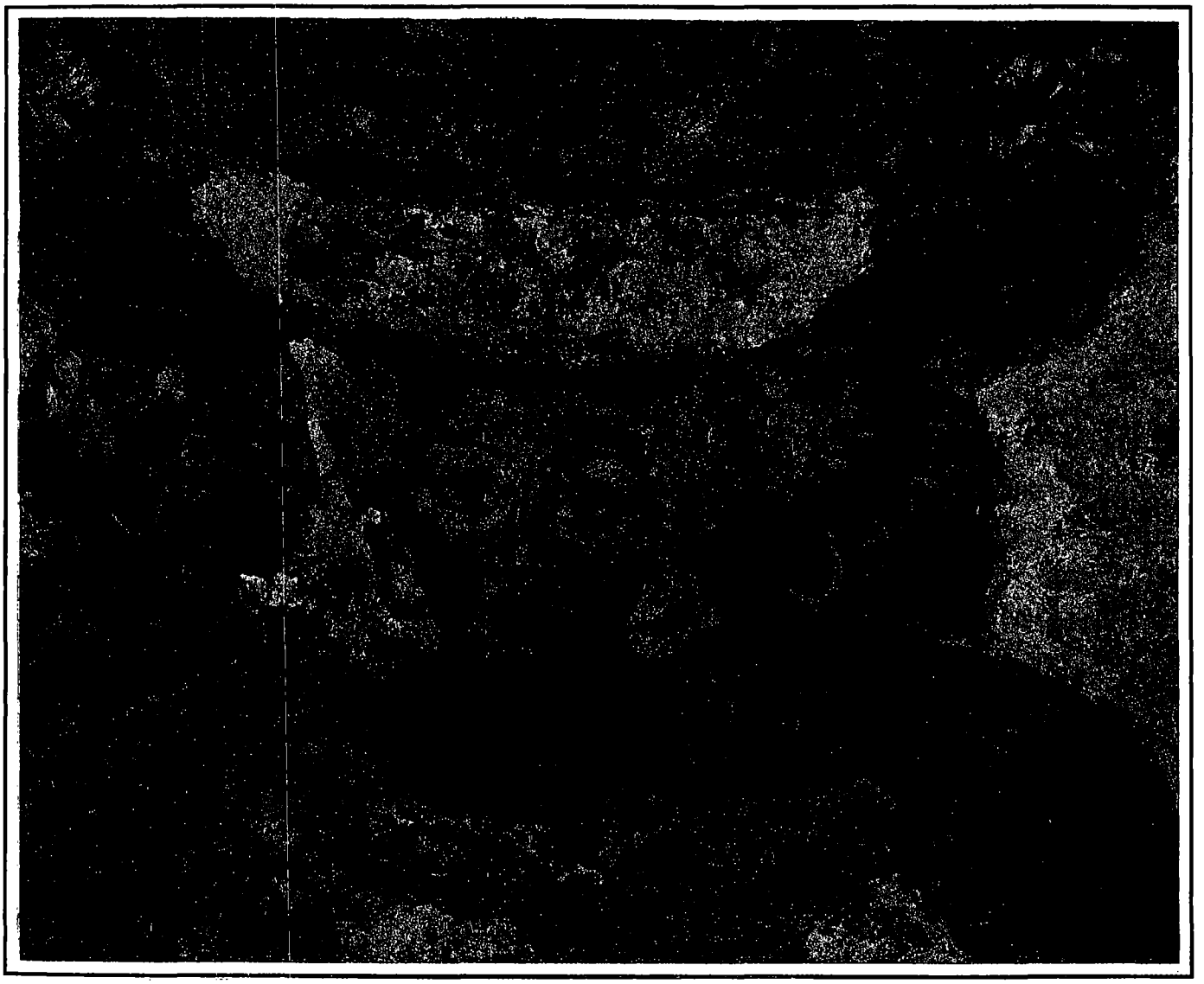
DeSida

Revista
de la
Fundación
Nimehuatzin

NÚMERO 3 | 13 CÓRDOBAS | ABRIL 1996



NICARAGUA: ¿Por qué una ley sobre el SIDA? • Proyecto de ley de Derechos Humanos ante el SIDA • VIDEO: "Cuando florezcan los jazmines" • Cumbre de París: un año después

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S P E C I A L R E P O R T

The Legacy of the Paris AIDS Summit

Prepared by the International Council of AIDS Service Organizations

J U L Y 1 9 9 6

What was Accomplished in Paris?

On World AIDS Day, December 1, 1994, heads of government (or their representatives) from 42 countries attended a summit on AIDS in Paris, France. The summit was organized by the Government of France and the World Health Organization. All 42 countries signed a Declaration reaffirming the need for *"political leaders to make the fight against AIDS a priority"* by undertaking in their national policies to *"make available necessary resources to better combat the pandemic, including adequate support for people infected with HIV/AIDS (PHAs), nongovernmental organizations (NGOs) and community-based organizations (CBOs) working with vulnerable populations."*

The Declaration has Three Major Segments:

1. Statements of principle.
2. Commitments regarding national policies and programmes.
3. Global initiatives.

At the National Level, the Governments Undertook to:

- Promote and protect the rights of individuals, particularly people living with HIV/AIDS;
- Involve NGOs and CBOs in the development and implementation of public policies;
- Intensify prevention efforts, particularly among youth and women; and
- Strengthen primary health care systems and better integrate HIV/AIDS into these systems.

The Declaration Promised Increased International Cooperation Through:

- The greater involvement of people living with HIV/AIDS.
- More international and national partnerships in research.
- Stronger international collaboration for blood safety.
- The development of a global care initiative.
- Support for initiatives to reduce the vulnerability of women.

(For the full text of the Declaration, see page 5.)

United Nations' Secretary General, Boutros Boutros-Ghali, said publicly that the U.N. would work to get other countries to sign the Declaration.

Have any other countries signed the Declaration?

What impact has the Declaration had on national policies and programmes in the countries that did sign it?

How has the Declaration affected awareness and understanding of HIV/AIDS issues?

How has the Declaration been used to improve the response to the pandemic?

How can CBOs and NGOs use the Declaration to further their objectives?

This Special Report attempts to provide some of the answers to these questions. In the first half of 1996, ICASO undertook a survey on the impact of the Declaration. The resulting report entitled, "**A Study on the Influence of the Paris Summit Declaration at the National Level**", focussed on national policies and programmes. The findings are included in many of the articles in this Special Report.

CONTENTS

Defiende tus Derechos

en el trabajo, en la calle, en tu vida privada,
en la cárcel, en los centros de estudio,
en los hospitales y centros de salud o en cualquier lugar.

En caso de violaciones, quejas o dudas, llama, escribe o visita:

Fundación NIMEHUATZIN
Managua, Nicaragua.
Telf: 278 0028
Fax: 278 6534

Programa Nacional de Prevención y Control de ETS, VIH/SIDA
Tel.: 289 4402

CEP-SIDA
Tel.: 278 0028

Centro Nicaragüense de Derechos Humanos
Tels.: 266 8940 - 266 8405

Asociación Nicaragüense Pro Derechos Humanos
Tels.: 266 8062 - 266 8063

Comisión Permanente de Derechos Humanos
Tels.: 222 3800 - 266 2226

Centro de Derechos Constitucionales
Tel.: 266 9715

"Si los derechos del individuo son negados, el derecho de todos está amenazado y esto significa en el caso del SIDA: Que no es un problema de los derechos de un individuo vs. el derecho de la mayoría, sino que la protección del derecho de unos pocos es necesaria para la protección de la salud de todos".

Jonathan Mann
(Ex-Director Programa Mundial de SIDA-OMS)

SI VIVES CON VIH O SIDA EN NICARAGUA ESTOS SON TUS DERECHOS FUNDAMENTALES

1. La Ley protege a todos los individuos por igual; en consecuencia, no debes sufrir discriminación de ningún tipo.

2. No estás obligado a someterte a la prueba de anticuerpos del VIH ni a declarar que vives con VIH o que has desarrollado SIDA. Si de manera voluntaria decides hacerte la prueba, tienes derecho a que ésta sea realizada en forma anónima y que los resultados de la misma sean conservados con absoluta confidencialidad y con la garantía de un apoyo psicológico, médico y social.

3. Nadie puede hacer referencia a tu estado de salud pasado, presente o futuro sin tu consentimiento, de lo contrario está violando tu derecho a la privacidad.

4. En ningún caso puedes ser objeto de detención forzosa, aislamiento, marginación social o familiar por vivir con VIH o haber desarrollado SIDA.

5. No pueden impedirte el libre tránsito dentro o fuera del territorio nacional por vivir con el VIH o haber desarrollado SIDA, cualquiera que sea tu raza, lengua, nacionalidad, religión, sexo o preferencia sexual.

6. Si deseas contraer matrimonio, no te pueden obligar a someterte a ninguna de las pruebas de detección de anticuerpos del VIH.

7. Vivir con VIH o con SIDA no es impedimento para el ejercicio de tu sexualidad, siempre y cuando asegures tu protección y la de los demás.

8. Cuando solicites empleo, no te pueden obligar a hacerte ninguna de las pruebas de detección del VIH. Si vives con VIH o has desarrollado SIDA, esto no podrá ser motivo para que seas suspendido o despedido de tu empleo.

9. Cualquier acción dirigida a negarte un empleo, una vivienda, un seguro o quitártelos por vivir con el VIH o con SIDA es discriminatoria y puedes denunciarlo.

10. Tienes derecho a superarte mediante la educación formal o informal que se imparta en instituciones educativas públicas o privadas.

11. Tienes derecho a asociarte o afiliarte a instituciones que tengan como finalidad la protección de los intereses de quienes viven con VIH o han desarrollado SIDA.

12. Tienes derecho a buscar, recibir y difundir información precisa y documentada sobre los medios de propagación del VIH y la forma de protegerte.

13. Si vives con VIH o has desarrollado SIDA, tienes derecho a recibir información sobre tu padecimiento, sus consecuencias y tratamientos a los que puedes someterte.

14. Tienes derecho a los servicios de asistencia médica y social que tengan como objetivo mejorar tu calidad y tiempo de vida.

15. Tienes derecho a una atención médica digna, y tu historial médico deberá manejarse de manera confidencial.

16. Tienes derecho a una muerte y servicios funerarios dignos.

(Adaptado de la cartilla mexicana de Derechos Humanos).

URGENTE

Ley de DERECHOS HUMANOS ante el SIDA

La Red de Etica, Derechos Humanos y Aspectos Jurídicos del VIH introdujo a la Asamblea Nacional, el 1 de diciembre de 1995, el Proyecto de Ley de Promoción, Protección y Defensa de los Derechos Humanos ante el SIDA con los aportes de quienes defienden los derechos humanos en sus municipios y comunidades; así como de juristas y profesionales, organismos e instituciones de prevención del SIDA y personas que viven con el VIH/SIDA. La propuesta de Ley consta de 38 artículos, divididos en cinco capítulos y se fundamenta en el derecho a la vida y a la salud; en los principios éticos de no-discriminación, confidencialidad, autonomía y solidaridad; y en los derechos humanos consignados en las Declaraciones, Pactos y Convenciones contenidas en el Artículo 46 de la Constitución Política.

Para mayor información llama, escribe o visita:

Fundación Nimehuatzin
Managua, Nicaragua
Teléfono: 2 78 00 28
Fax: 2 78 65 34

Programa Nacional
de Prevención y Control
de ETS/VIH/SIDA
Teléfono: 2 89 44 02

Colectivo de Educadores Populares
en la Lucha contra el SIDA (CEP-SIDA)
Teléfono: 2 78 00 28

Asociación Nicaragüense
Pro Derechos Humanos
(ANPDH)
Teléfono: 2 66 80 62 - 2 66 80 63

Centro Nicaragüense
de Derechos Humanos
(CENIDH)
Teléfono: 2 66 89 40
2 66 84 05

Comisión Permanente
de Derechos Humanos
(CPDH)
Teléfono: 2 22 38 00
2 66 22 26

Centro de Derechos Constitucionales
(CDC)
Teléfono: 2 66 97 15

Estos organismos forman parte de la RED DE ETICA, DERECHOS HUMANOS Y ASPECTOS JURIDICOS DEL VIH

1ra. edición: 10,000 ejemplares Fondos: AIDSCAP/FHI/USAID

los DERECHOS HUMANOS ante el SIDA

La realidad

- Según la OMS, el 90% de las nuevas infecciones por el VIH se dan en los países pobres del Sur; y de éstas el 60% son mujeres.
- En nuestro país crece de manera acelerada el número de personas infectadas con el Virus de la Inmunodeficiencia Humana (VIH) y de personas que ya tienen el Síndrome de la Inmunodeficiencia Adquirida (SIDA).
- Las mujeres están en situación de mayor riesgo, debido a su condición de subordinación; es por eso que va en aumento el número de mujeres con VIH/SIDA en Nicaragua.
- A medida que avanza la epidemia, hay más niños y niñas con VIH y SIDA; también crece el número de huérfanos de quienes murieron de SIDA.
- Además del impacto individual y en la familia, el SIDA llega a ser un obstáculo para el desarrollo humano sostenible; ya que afecta a la población productiva y reproductiva.
- Hay poca información sobre la realidad nacional de la epidemia del VIH/SIDA y sobre las formas de prevención.
- Médicos que ordenan a la mujer embarazada que se haga la prueba del SIDA, sin explicarle su trascendencia ni contar con su consentimiento.
- Profesionales a quienes les suspendieron su contrato laboral, al sospechar que eran seropositivos y empresas que exigen la prueba del SIDA como requisito para solicitar empleo.
- Acoso del personal de salud hacia personas con VIH para buscar sus contactos sexuales. Personas con VIH a quienes se les niega atención médica y personas a quienes les exigen la prueba de manera obligatoria, como condición para ser intervenidas quirúrgicamente.

Violaciones de los Derechos Humanos

- La situación antes mencionada viola los derechos humanos de las personas que viven con la infección del VIH o que ya tienen SIDA y amenaza los derechos humanos de toda la sociedad.
- La discriminación, el rechazo a las personas infectadas por el virus VIH y la violación de sus derechos humanos es un obstáculo para brindarles la atención y el apoyo que necesitan, hace imposible la necesaria comunicación con ellas y las aleja de los hospitales y centros de salud. Como resultado, en determinadas ocasiones algunas de estas personas pueden reaccionar con rabia y deseos de venganza hacia la sociedad que las estigmatiza, las rechaza y las persigue.
- Al inicio de la epidemia hay más violaciones. Esto ya se ha dado en otros países y también sucede en Nicaragua. La movilización social de personas viviendo con VIH o con SIDA, de sus familias y de toda la gente que los apoya, puede cambiar esta situación, logrando que se aborde de manera ética y profesional el trato a las personas y el manejo de la epidemia.

LA PRUEBA Y LOS DERECHOS HUMANOS

La prueba obligatoria viola los derechos humanos; es una medida de salud pública muy costosa; y es ineficaz. Un resultado negativo de la prueba sólo indica que en los tres o seis meses previos a la toma de la muestra de sangre, la persona no tenía anticuerpos del VIH; pero eso no garantiza que, desde hace tres o seis meses, esa persona no se haya infectado o que no se infectará en las próximas horas, sobre todo si no toma las precauciones necesarias.

La imposición de pruebas obligatorias como requisito para obtener empleo, aparte de violar los derechos humanos y ser una medida ineficaz para controlar la epidemia, puede propiciar una nueva fuente de corrupción como sería la venta de resultados negativos falsos amañados; amenazando de este modo la salud pública.

LEY DE PROMOCION, PROTECCION Y DEFENSA DE LOS DERECHOS HUMANOS ANTE EL SIDA

Las principales situaciones que quedarán reguladas y los derechos que quedarán protegidos por la Ley de Promoción, Protección y Defensa de los Derechos Humanos ante el SIDA, de aprobarse el proyecto actual sin cambios, son las siguientes:

- La prueba de anticuerpos al VIH o prueba del SIDA tiene que ser voluntaria, informada y con el consentimiento expreso de las personas; para donantes de sangre esta autorización es implícita a la donación (Art. 5)
- La prueba tiene que ser confidencial y personal; debe ir acompañada de consejería antes y después de realizarla (Art. 6)
- Las autoridades deben asegurar la información y acceso al uso de condones, el tratamiento de las enfermedades transmisibles por vía sexual (ETS) y todos los medios de prevención científicamente aceptados (Art. 23)
- Las medidas de salud pública tienen que respetar la autonomía de la persona, es decir, su capacidad para decidir sobre su salud, siempre que se les facilite la información necesaria (Art. 3)
- Todos los ciudadanos y ciudadanas tienen derecho a que sean respetadas su vida privada y su reputación (Art. 4)
- Las personas infectadas por el virus VIH tienen derecho al trabajo; la infección no es ningún impedimento para contratarlas ni constituye ninguna causal para despedirlas (Art. 11)
- La ley protege el derecho a la educación de las personas infectadas por el VIH y de sus hijos e hijas (Art. 13)
- Las personas viviendo con VIH+ tienen derecho a la sexualidad, utilizando las medidas adecuadas para protegerse de reinfecciones y proteger a su pareja (Art. 15)
- Las personas con la infección del VIH son iguales ante la ley y tienen responsabilidad por actos delictivos que pongan en peligro la salud de otras personas (Considerando #8)

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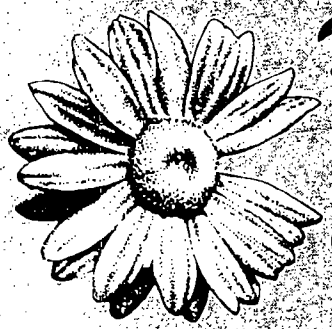

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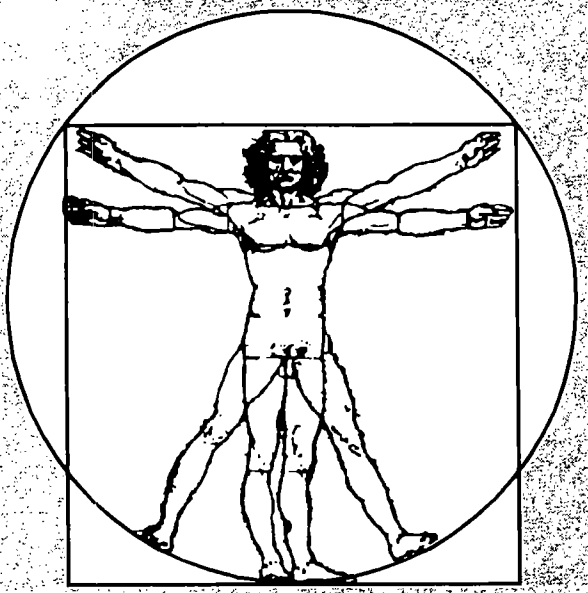
- ☐ **Para que no me corran del trabajo.**
- ☐ **Para que no me discriminen.**



La prueba del SIDA es voluntaria y confidencial

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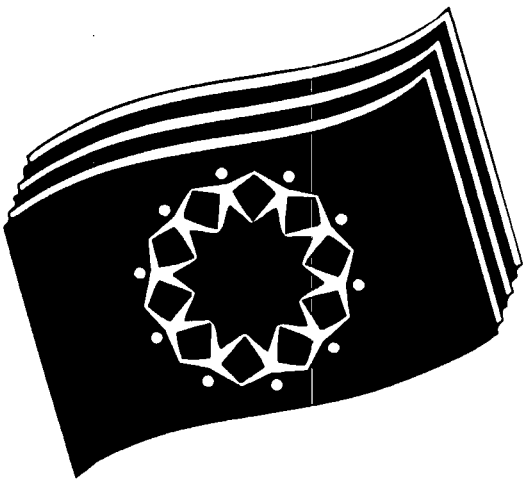

ICASO Update

International Council of AIDS Service Organizations
Special Edition Newsletter, July 1996, Issue No. 7

This special edition of the ICASO Update focuses on human rights issues.

From Africa to Asia, Latin America and the Caribbean, from Europe to North America, we continue to see the human rights of communities and people affected by HIV/AIDS abused.

Discrimination and stigmatization against people living with HIV/AIDS and against communities which were the first to be affected have contributed to the spread of HIV—obstructing education campaigns and worsening the human rights situation.

The AIDS epidemic has raised complex issues of human rights, ethical practices, the role of the law, morality, and medical ethics among others which have been neglected and left undiscussed by people, organizations and governments.

Human rights issues must be addressed and integrated into an overall approach to the epidemic that is just, humane and ethical.

Unless there is a commitment by all parties to address the human rights issues raised by HIV/AIDS, the fight will not be won.

Discriminatory policies perpetuate stigma of AIDS

Every minute of every day, 5 people become infected with HIV. These are men, women, children, co-workers, friends and relatives, migrant and mobile populations.

Appearing before the UN Commission on Human Rights in April, Patrick Levy of the European Council of AIDS Organizations (EUROCASO) spoke on behalf of the International Council of AIDS Service Organizations (ICASO) focusing on the issues of HIV/AIDS for migrant populations.

Levy stated that migrants, immigrants and refugees live a marginalized existence. At worst, they are the victims of hate by extreme right wing groups. At best, they gain only indifferent acceptance and tolerance.

Migration of rural people to urban centres, movement of truck drivers, militaries, sex workers and seasonal migration increase individuals vulnerability of exposure to HIV. These are people on the move often with little resources and no access to information, health care and support regarding how to avoid becoming infected.

In many developed countries, migrants who are HIV positive are theoretically entitled to services typically available to that country's citizens and residents. In reality, however, HIV positive migrants often do not receive the authorization necessary to allow them treatment. For example, cases have been reported in France of people dying before obtaining certificates permitting treatment.

In more than 50 countries around the world, travel restrictions continue to be applied against people living with HIV/AIDS.

In more than 50 countries around the world, travel restrictions continue to be applied against people living with HIV/AIDS. Even in countries claiming to advocate for human rights, HIV positive people are

ICASO UPDATE

International Council of AIDS Service Organizations | October 1996, Issue No. 8

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GENEVA 98 CONFERENCE: ICASO NOW A SPONSOR

ICASO has reached an agreement with the organizers of the 12th World AIDS Conference scheduled for Geneva in July 1998. In a letter addressed to Dr. Bernard Hirschel (Conference Chair) announcing the change in position, ICASO stated,

"We believe that significant progress has been made to deal with long-standing issues of partnership. The resulting framework which was finalized at the last meeting illustrates that a meaningful partnership with the community and people living with HIV/AIDS is both possible and highly desirable."

At the Annual General Meeting of ICASO's CMC held in Ottawa (May 1996), it was decided that ICASO would not be a sponsor of the next international AIDS conference. Citing the need to work in full and equal partnership, ICASO in a letter to the conference organizers explained their belief that at the time, an equal partnership among all conference sponsors did not exist. Despite our decision, ICASO kept the door open and continued communicating with the International AIDS Society (IAS), and our partners, the Global Network of People Living with HIV/AIDS (GNP+), the International Community of Women Living with HIV/AIDS (ICW) and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

Meetings were held in Geneva, 3-4 September, to discuss the Conference. In attendance from ICASO were Richard Burzynski (ICASO CS), As Sy (AfriCASO), and Jean-Jacques Thorens (EuroCASO Development Officer). A pre-meeting was held between ICASO, GNP+, ICW, and local Swiss Community Groups to identify common ground regarding the International Conference and the place of community in the programme. At the full meeting of the sponsors, it was agreed that a new model would be adopted which sees the conference program developed by two committees of equal standing: the Scientific Program Committee (dealing primarily with the abstract format) and the Community Program Committee. On a CMC teleconference call to report that the meetings went extremely well, an agreement for ICASO participation in Geneva 98 was finalized.

While remaining optimistic about the new model which has been long overdue, ICASO added,

"We will undoubtedly have more discussions and struggles as we develop the conference programme and incorporate the new . . . model. However, we are committed to working together with you, the local Geneva team, and the other cosponsors . . . "

As Sy will be the primary ICASO contact to the Conference Committee with Jean-Jacques Thorens as the secondary ICASO representative.

POST SCRIPT:

At a meeting in Vancouver during the XI International Conference on AIDS, ICASO agreed to work closely with the GNP+ and ICW to develop a discussion document explaining how the partnership would need to be implemented to be meaningful. This draft document was discussed at a September 5 meeting between the IAS, GNP+, ICW, UNAIDS and ICASO. It outlines the principles of cooperation and partnership between the stakeholders of the international conference and was well received. A next draft, incorporating input from all the partners, will be discussed again at the next Geneva '98 meeting. When finalized, each organization will be requested to officially endorse it.

A NOTE ABOUT VANCOUVER

With limited resources and staff, ICASO was able to coordinate an impressive presence at the Vancouver Conference with a booth in BC Place, an office at the VTCC and the Community Wall displayed in Robson Square.

The ICASO booth was located in a high traffic spot which ensured that most participants were able to pass-by and either speak to ICASO representatives or collect material on display. Because of the high number of ICASO COR attending the conference the booth generally had representatives from two or more of the regions present. Another site which saw heavy traffic and soon became the drop-in and say hello spot was the ICASO office located at the Vancouver Trade and Convention Centre (VTCC). The computer equipment provided by the Conference organizers was put to good use by community people. For others, the office was a place to stop and rest, chat to a colleague and catch up on conference news and gossip.

ICASO also made an effort to reach the general public of Vancouver by setting up a display of the Community Wall in Robson Square. A key project of ICASO and Enda T.M., the Community Wall was constructed for, and first displayed at, the Yokohama Conference in 1994. It is an impressive public outreach tool that provides people with a view of the community response globally. For the first two days, the Wall was displayed at the Community Forum site and received positive comments from participants. It was then transported to Robson Square in downtown Vancouver for the remainder of the Conference.

There had been some discussion before the conference regarding a possible COR meeting to be held sometime during the week. Because of the lack of time, resources (finances and personnel), an informal reception was held in the free meeting room (provided for sponsoring organizations). It was an opportunity for people to meet, reconnect and for some be introduced for the first time to ICASO. The atmosphere was casual and for many it was a chance to converse face-to-face for the first time since Yokohama.

HEALTH & HUMAN RIGHTS PRESENTATION

Dede Oetomo (Gaya Nusantara/ APCASO COR member) will attend the 2nd International Conference on Health & Human Rights, organized by the François Xavier Bagnoud Center for Health & Human Rights, Harvard School of Public Health, on October 3-5.

He will be making a presentation at the round table on Sexual Orientation: Health & Rights with a focus into the dilemma between gender and sexual behaviour, orientation and identities in terms of human rights and health services in Indonesian society.

Dede explains that "while gay-identified men and transgendered people, for example, are small in number, non-identifying MSMs and men who have sex with transgendered people are much larger in number. This brings up the question whether identity politics is relevant in the Indonesian context. Another issue is how the introduction of an identity labelling may change the situation on the ground. The facade of tolerance that Indonesian society shows to transgendered and gay men in day-to-day life is not accompanied by the same tolerance when it comes to provision of health services."

SECOND CONSULTATION ON HIV/AIDS AND HUMAN RIGHTS

Following the first United Nations (UN) consultation on HIV/AIDS and Human Rights in 1989, a second consultation was held from 23-25 September 1996 (Geneva) organized jointly by UNAIDS and the UN Centre for Human Rights. Thirty-five persons from around the globe gathered in Geneva over three days to discuss and adopt *Guidelines on HIV/AIDS and Human Rights* which would assist policy-makers in the formation of HIV/AIDS-related policy and legislation.

Among the many present were several persons involved with ICASO-related activities. These included Ken Morrison (Canada), As Sy (Senegal) Edgar Carrasco (Venezuela), Babes Ignacio (Philippines). Other representatives included Shaun Mellors (GNP+), David Chipanta (ANP+) and Isabelle Defeu (ICW).

The document, *Guidelines on HIV/AIDS and Human Rights*, is scheduled to be completed and released in November 1996. Meanwhile, ICASO and its regional offices are in the process of investigating ways to help community organizations to effectively use the guidelines.

AFRICASO - AFRICA

The grant from the European Commission coordinated by AfriCASO, will allow a greater involvement of people living with HIV to participate in AIDS conferences, attend workshops and improve networking through better communication. The International Conference in Vancouver was identified as the most important event this year, and four people from different networks of PLWA's were sent with the EC grant: Dorothy Onyango (ICW), Richard Constant Okou (GNP+), David Chipanta (NAP+), and Jeanne Kouamé (AfriCASO). These four people were able to attend both the community forum, the conference and also participate in the meeting held by the European Commission through the Aids Task Force. The meeting was held on July 11th 1996 and provided an opportunity for participants to speak of the implementation of the projects in the regions.

The agenda included: Report from the Paris meeting and on the decision making process; Report on the implementation in each region for 1996; Guidelines for the intermediate report for the EC; and Proposals for the follow-up of the report of the project in 1997.

APCASO - ASIA/PACIFIC

Teresita Marie "Bai" P. Bagasao has resigned from the Kabalikat ng Pamilyang Pilipino Foundation, Inc. as Executive Director, and consequently as APCASO COR Secretariat. Effective September 1, 1996, she officially takes up the position of Programme Development Officer (Asia and Pacific) with UNAIDS based in Geneva for two years. As a personal message:

"While I may appear to have 'crossed over to the other end' to work with other stakeholders from governments, UN agencies and other private sectors, I see this as part of the same continuum that is moving towards the same goal. I hope that in this new role, I would continue to contribute further to the creation of safe and supportive spaces for our communities to undertake sustained action."

Kabalikat remains as the regional secretariat until a new host organization is identified. Dede Oetomo of Gaya Nusantara (Indonesia) and COR for Southeast Asia will be the interim member to the ICASO COR Management Committee (CMC). At the APCASO COR Meeting held last June in Manila, it was decided to identify National Focal Points (NFPs) to help strengthen local organizations/networks. Through them, community issues could be gathered and regional and global issues disseminated to communities for appropriate action. The COR members will serve as the focal points of the NFPs in each subregion. A general call for nomination was sent out to identify NFPs and the deadline was set for the end of September. Some criteria were also set for the selection of the NFPs, and their roles and functions were defined.

The COR confirmed APCASO's participation in the 4th Regional AIDS Conference in Manila next year as a member of the International Advisory Committee to be represented by Dede Oetomo.

The first meeting of positive women will be held in Manila, Philippines on October 28 to November 1, 1996. The meeting is sponsored by APCASO and the International Community of Women Living with HIV/AIDS (ICW). The meeting is being organized in response to the need for women with HIV/AIDS from Asia Pacific to consolidate and strengthen the fragile network that exists within the region. The meeting specifically aims to build capacity and strengthen networks (including ICW) at the local, national, regional and global levels; enable positive women from the region, for the first time, to share experiences and information, and have involvement outside of their countries; provide an opportunity to develop skills, and increase knowledge of running support groups and networks locally, regionally and nationally; organize income generating projects and develop strategies to communicate and work with AIDS organizations, CBOs, NGOs and government agencies; and, further develop the ICW Reproductive Rights project.

Kabalikat formally served notice at the COR meeting last June 1996 that it is stepping down as the APCASO Secretariat host as soon as possible but not later than December 1996. The APCASO COR brainstormed on the process and options for moving the Secretariat. Some criteria for selection were identified, including capable management skills; credibility within its own community; reputation for integrity among "other organizations"; good English across the organization; accessibility; technology; and, compatible organizational culture with APCASO, including non-discriminatory policy.

Agreement was reached that the process of transition would involve transfer of APCASO knowledge and the capacity building of the new host organization. To initiate the process, a call for nomination was sent out and deadline for nominations was set for the end of August. It is hoped that the new host would be identified by early October.

EUROCASO - EUROPE

The European Commission Funding for support of the EuroCASO Secretariat has finally arrived.

EuroCASO is ready to begin strengthening the network after a year of limited activity. Based at the Netherlands Institute for Alcohol and Drugs (NIAD) in Utrecht, Holland, the staff includes Franz Trautmann (coordinator), Julietta Tiemeyer and Daan van der Gouwe (staff members), and Danielle Branderhorst (administrative).

Apart from organizing the usual activities (Working Committee meetings, regional workshops), it is the aim of the secretariat to focus more on HIV/AIDS and drug use. It is estimated that in Southern Europe about 75% of the people with HIV/AIDS became infected via unsafe drug use. This trend is also beginning to appear in Eastern Europe.

Report of the Working Committee Meeting Amsterdam, 20-22 September 1996

As soon as the good news arrived, a WCM was arranged. Due to the lack of money, EuroCASO's activities of last year had been kept quite low profile. Issues discussed included: the planning of activities (workshops, meetings, newsletter), additional fundraising and the structure of EuroCASO. The current Working Committee consists of the following people.

Southern European Region: *Patrick Levy, Davide Austin, Jean-Jacques Thorens*

Eastern European Region: Zdenek Kurka

Northern European Region: *Anette Fournais, Jeannine van Woerkom*

In the next twelve months five regional issue focused workshops will be organised.

* The Southern European Workshop (financed by Levi Strauss), will be held in Italy in early 1997. The agenda is not finalized.
* The Eastern European Workshop will be organised together with GNP+/ICW, and will take place in Warsaw, Poland at the end of this year. A possible focus of the workshop will be access to treatment, nutrition and medical care for PWAs.
* The Northern European Workshop agenda is not yet confirmed. Possible issues include the ECOSOC meeting, euthanasia, prisons, migrants, lobbying the government, etc.
* One of the two Self-help workshops will focus specifically on drug use and peer support. The NIAD will play a important role in preparing this workshop. The workshop is to be held in South Eastern Europe at the end of this year.
* The other Self-help workshop scheduled for 1997 will probably focus on womens issues. Other subjects might be fundraising.
* The next working committee meeting will probably be held in Israel in January of 1997.

Development Officer: The role of the development officer will be different from what it used to be, since some tasks have been taken over by the secretariat. The development officer will focus more on twinning projects and initiating/ developing/supporting HIV- organisations (NGO's) throughout Europe.

LACCASO - LATIN AMERICA & THE CARIBBEAN

The LACCASO Secretariat held a Latin America and the Caribbean Networks Planning Meeting in Santafé de Bogotá, Colombia (September 1996). The meeting was done in collaboration with the Liga Colombiana de Lucha cotra el SIDA, GNP+, ICW and the Panamerican Association of PWAs.

The Secretariat also worked on the Action Plan submitted to ICASO as part of the collective ICASO request for funding to UNAIDS for the period July 1996 / August 1997.

Several presentations were made by representatives of LACCASO at the XI International Conference on AIDS in Vancouver, BC, Canada. Most noticeable was the relevant presence through the establishment of LACCASO through its booth in the exhibition area. The booth provided participants a choice of publications /materials from Latin America including REDES, the LACCASO newsletter. The LACCASO Director also worked on a paper, which was presented jointly with the ICASO Central Secretariat at the Trinational Symposium (Mexico/USA/Canada) in Vancouver.

A second draft has been completed on the redefinition of the project "Latin America and the Caribbean Network on Human Rights, Law and Ethics" in collaboration with UNDP and UNAIDS.

NACASO - NORTH AMERICA

NACASO's efforts to expand are bearing fruit. Two organizations have asked to join--the Interagency Coalition on AIDS & Development (ICAD) and Mobilization Against AIDS-- and others are considering NACASO's request for their participation.

A joint meeting of the North American members of ICASO, GNP+, and ICW was organized by NACASO in Vancouver. This meeting focused on joint activities between the three networks. ICW and GNP+ appealed to ICASO members for assistance in obtaining the resources required to undertake their work.

NACASO has agreed to begin a formal process to explore fiscal sponsorships, resource sharing, and joint fundraising between the members of the three networks in North America.

At this same meeting the selection process for the North American PWA/NGO positions on the UNAIDS PCB was discussed. All participants expressed strong concern that these positions be filled and that a formal process be established to do this.

NACASO is also holding workshops addressing global AIDS issues--including one addressing specifically global networks-- at the National AIDS Skills Building Conference to be held in Washington October 10-13, 1996.

CALL FOR NOMINATIONS TO UNAIDS PCB

Please find below a letter from the NGO/CBO/PHA Representatives to the Programme Coordinating Board (PCB) to the Joint United Nations Programme on HIV/AIDS (UNAIDS) regarding the selection of new representatives to this NGO/CBO/PHA Liaison Committee.

Dear Friends,

While the UNAIDS began to operate officially January 1 this year, its Programme Coordinating Board (PCB), in which the Community participates as members, have been meeting since July 1995. This ten member group is often referred to as the NGO/CBO/PHA Liaison Committee to the PCB - or the NLC.

The group consists of one main representative from each of five regions (Africa, Asia/Pacific, Latin America/Caribbean, Europe, North America) plus one alternate representative from each of the regions, totalling ten people in all. One delegate from each region is supported to attend each PCB meeting. We believe we are making-in roads to the way the UN is responding to HIV/AIDS. Our presence also serves as a constant reminder about the issue that we face. As of June this year, however, our main and alternate members from North America as well as our alternate member from Latin America have resigned. And in September 1996, our main member from Asia Pacific will also be stepping down. As agreed upon in the earlier meetings, the NGO/PHA members are tasked with agreeing on the process to find replacements not only for these 4 vacancies but also for replacement when our terms of office are up.

It should be noted that all of the seats currently vacant were previously filled by women, including a woman living with HIV, which now creates a visible gender imbalance that should be restored. As it currently stands, there remains four men and two women - which includes two HIV+ men and one HIV+ woman. It will, therefore, b e useful to make particular effort to recruit HIV+ and HIV- negative women, wherever possible.

The PCB normally holds its meeting once a year. The one for this year just finished in June 10-11, 1996. The next PCB meeting will be in early March 1997. In order to ensure that we are there in full force, the selection of the replacement of the committee members must be done as soon as possible. We are writing to you now to request for your nominations for this committee. Based on the names submitted, it was also agreed that the remaining NLC members, will facilitate the process of selection and propose these names to ECOSOC and UNAIDS for formal inclusion on the NLC.

We have adapted the terms of reference for the members that were drawn up by the former GMC-TASK Force composed of Maria de Bruyn, As Sy El-Hadj, and Don de Gagne.

For this selection process, however, the members for North America will be serving two years from 1997-1998. The Latin American alternate member and the Asia/Pacific main member will serve one year in 1997 since by next year, we will need to determine which among the regions of Africa, Asia/Pacific, Europe, and Latin America would be extended for one year to provide continuity.

While thinking of the person you wish to nominate, please strongly consider the following:

1. Anyone serving the UNAIDS NLC must be prepared and able to devote at least 3 working days/month to the work of the NLC. This includes: preparing for PCB meetings and attending them, systematically reporting back to the constituencies and consulting with them.
2. The work will often have to take place on short notice and be done quickly (NLC members must be prepared to deal with PCB/NLC issues at any time).
3. The NLC members must be able to dissociate themselves from their own organizational/network interests in order to also bring the perspective of other NGO/PHA besides their own direct constituency.

In submitting your nominations, we ask that you keep the following points in mind:

1. The geographical location of candidates is important; the NLC members will probably consist of people from industrialized and developing countries and will include development assistance agencies, gender balance and people living with HIV/AIDS.
2. Anyone nominated must have been consulted in advance to ensure that they are willing and able to serve on the committee if selected.
3. Each organization is requested to submit no more than five candidates.

Nominations should include the following information: name of the nominating organization; organization/network affiliation; name of the person and address (including telephone, fax and e-mail, if they have an e-mail); sex ; HIV status if this is important as a qualification; length of time working on HIV/AIDS issues; type of experience in the field (i.e., policy-making, advocacy work, intervention design and implementation, focus on prevention, research, care/support, human rights, etc.); and country(ies) region where they have been active.

NOMINATIONS MUST BE RECEIVED BY 30 NOVEMBER 1996 AT THE LATEST AND CAN BE SENT TO:

Martina Clark, UNAIDS (NLC/PCB)
NGO/PHA Liaison Officer
20, avenue Appia - M628
CH-1211 Geneva 27, Switzerland
or via e-mail on clarkm@who.ch

The selection will take place before the end of December 1996 and we will communicate this list to UNAIDS. Should you have other questions: please feel free to contact any of the NGO PCB member nearest you or send your comments through Martina Clark. Please indicate "NLC/PCB" on your correspondence.

We look forward to your response. In solidarity,

Bai Bagasao
Mazuwa Banda
Luis Gauthier
Arnaud Marty-Lavauzelle
- *Dorothy Odhiambo*
- *Bill O' Loughlin*
- *Erlinda Senturias*

NLC MEMBERS TO THE PCB OF UNAIDS

(AS OF 30 AUGUST 96)

Asia/Pacific
*Primary Seat Currently vacant
Alternate: Bill O' Loughlin
HIDNA, c/o ACFOA, Coordinator,
14, Napier Close, Deakin, ACT 2600,
Australia
Tel.: (61 6) 285 1816
Fax: (61 6) 285 1720
E-mail: acfoa@peg.apc.org

Africa
Dr M. Mazuwa Banda
Christian Medical Association of Zambia, (CMAZ)
Ben Bella Road, P.O. Box 34511
Lusaka, Zambia
Tel: (260 1) 229 702, or 223 297
Fax (260 1) 223 297
E-mail: cmaz@zamnet.zm

Alternate: Dorothy Odhiambo
WOFAK P.O. Box 58428 Nairobi, Kenya
Tel: (2542) 797 960
Fax: (2542)331 897

North America
** Primary and Alternate Seats both currently vacant

Latin America
Luis Gauthier
Alcade Carlos Aldunate 36B
Nunoa, Santiago, Chile
Tel: (562) 222 8356
Fax: (562) 632 2266
E-mail: chilaids@cchps.mic.cl

**Alternate Seat currently vacant

Europe
Arnaud Marty-Lavauzelle
AIDES Federation Nationale
23, rue de Chateau-Landon , 75010
Paris, France
Tel: (33 1) 53 26 26 81
Fax: (33 1) 53 26 27 85
E-mail:
joucla@world-net.worldnet.fr

Ms Erlinda Senturias
World Council of Churches
Unit 11, CMC - Churches' Action for Health 150 Route de Ferney
P.O. Box 2100 CH - 1211 Geneva, Switzerland
Tel: (41 22) 791 6111
Fax: (41 22) 791 0361
E-mail: ens@wcc.coe.org

RADICAL CHANGE FOR THE NAZ PROJECT

As of July 1st 1996 The Naz Project evolves into two new and independent agencies

The Naz Foundation an international HIV/AIDS and sexual health agency working with South Asian, Turkish, Arab and Irani communities providing training, technical assistance, resource development and consultancy
Tel: (44 181) 563 0191/0205
Fax: (44 181) 741 9841
E-mail:
100647.3422@compuserve.com

The Naz Project (London) providing HIV/AIDS and sexual health services for the South Asian, Turkish, Arab and Irani communities in Greater London.
Tel: (44 181) 741 1879

GNP+ LAUNCHES GLOBAL SPEAKERS BUREAU

The Global Network of People Living with HIV/AIDS, GNP+, is launching **'Positive Voices'** a Global Speakers Bureau. It's aim is to let the voices of People Living with HIV/AIDS be heard at the various global, regional and national platforms.

If you are an organisation or agency and you are looking for a speaker on a specific topic FROM THE POINT OF VIEW OF A PERSON WITH HIV/AIDS you can contact our Central Secretariat. The Central Secretariat will discuss with you what you want and will look in it's database for a speaker that meets your needs.
Arrangements then will be made between speaker & organisation. The Central Secretariat can be contacted at:
P O Box 11726
1001 GS Amsterdam, The Netherlands
Tel: (31 20) 6898218
Fax: (31 20) 6898059
E-mail gnp@gn.apc.org
If on the other hand you think you are a suitable speaker on some topics, we invite you to fill in an application form with your data. Application forms can be asked for at the above mentioned address or you can fill it in directly at our website http://www.xs4all.nl/~gnp (under 'projects") and e-mail it to us.
All information will be handled with the strictest confidentiality! No one else but the Central Secretariat of GNP+ will have access to these data!
Both organisation and speaker are requested to fill in an evaluation sheet after the event.

JOIN US! LET POSITIVE VOICES BE HEARD AT ALL LEVELS!

CONFERENCE CALENDAR

3rd International Conference on Home and Community Care for Persons Living with HIV/AIDS 21 - 24 May 1997 Amsterdam

The theme of the Amsterdam HIV97 conference is "***Meeting the needs of the infected and affected***". The quality of life of those who are infected with or affected by HIV/AIDS determines their need for care. Home and community care services should provide care according to this need. The core theme will be the guiding principle of the conference. It provides the viewpoint from which the organization, process, outcome and financial and political aspects of out-of-hospital care for PLWHIV/AIDS will be discussed. There will be five main tracks: medical care, psychosocial care, nursing and home care, self-care and community - based care, and prevention in the community care setting.

Important Deadlines
Abstract Submission: *1 November 1996*
Notification of Abstract Acceptance: *15 January 1997*
Scholarship Application Submissions: *1 January 1997*
Payment of Early Registration Fee: *1 March 1997*
Deadline for Cancellation: *1 April 1997*
Deadline for Registration: *21 April 1997*

Conference Office
Bureau PAOG Amsterdam
Mariska Timmers/Clemens Walta
Tafelbergweg 25
1105 BC Amsterdam, The Netherlands
Tel: (31 20) 566 4801
Fax: (31 20) 696 3228
Email: F. Wolters@inter.nl.net

4th International Congress on AIDS in Asia & the Pacific 25 - 29 October 1997 Manila

The theme of the Congress is "***Partnerships across borders against HIV/AIDS***". It refers to alliances between individuals and/or groups belonging to diverse social, cultural, economic, religious, political and professional backgrounds, for the prevention, control and management of HIV/AIDS.

In response to the needs of the region, the scientific program committee has taken an innovative approach. Traditional tracks such as basic science, clinical science, epidemiology and public health, and social science have been replaced. Plenary sessions will open each day by posing questions that will set the daily subtheme. Discussions in the fora, symposia and workshops that ensue on each topic will cross tracks and will result in a comprehensive assessment of the subject.

Secretariat
2/F Physicians' Tower
533 United Nations Avenue
Manila, Philippines
Tel: (632) 521-4884/522-1081
Fax: (632) 521-2831

Xth International Conference on STD/AIDS in Africa 7 - 11 December 1997 Abidjan

For information please contact:
Xth International Conference on STD/AIDS in Africa
04 BP 2113
Abidjan 04, Côte d'Ivoire

12th World AIDS Conference 1998 Geneva

The 12th World AIDS Conference provides a forum for intersectoral and multidisciplinary exchange of information. The presentations and discussions are arranged according to four Tracks:
Track A - Basic Science
Track B - Clinical Science and Care
Track C - Epidemiology and Public Health
Track D - Social Science (incl. impacts and responses)

Important Dates
During the 3rd Quarter of 1997: Second Announcement and Call for Papers
1 February 1998: Deadline for submission of regular abstracts and for early registration
1 June 1998: Deadline for submission of late breakers abstracts

For more information please contact:
Congress Secretariat
12th World AIDS Conference
Congrex(Sweden)AB
Box 5619
S - 114 Stockholm, Sweden
Tel: (46 8) 612 6900
Fax: (46 8) 612 6292
Email: aids98@congrex.se
Internet: http://www.aids98.ch

ABOUT ICASO

ICASO unites groups throughout the world who have been affected by the HIV/AIDS epidemic. ICASO's recognition and respect for the human rights of all persons is central to an intelligent public health strategy to combat the AIDS epidemic. ICASO's mission is to promote and support the work of community-based organizations around the world in the prevention of AIDS and care and treatment for people living with HIV/AIDS, with particular emphasis on strengthening the response in communities with fewer resources and within affected communities.

ICASO is committed to:

- *The central role of community-based organizations within national programs and policy formation;*
- *The right of each community-based organization to determine its own priorities, methods of organization, and programs, and to have these choices respected by governments and international agencies;*
- *The maximum involvement of women and men living with HIV/AIDS in all aspects of prevention, care, support, treatment, and research;*
- *Recognition that there are diverse social and cultural perspectives on HIV/AIDS, but these should not override fundamental human rights to respect individual dignity and protection against political, social, and religious intolerance;*
- *Non-discrimination in all areas regarding HIV status, gender, religion, race, sexual orientation, sex-work, drug use, cultural, or social status;*
- *Recognition that coercion, fear, and scapegoating are ineffective in dealing with the challenge of the epidemic;*
- *The need for coordinated international programs to combat HIV/AIDS, involving a partnership in which those who are living with HIV/AIDS and community-based organizations are equal partners with governments and health professionals.*

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EDITORS: Yolanta Cwik & Richard Burzynski

If you have any comments or news from your region that you would like to see included in the next issue, please send material to the ICASO Central Secretariat.