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FROM ALL WALKS OF LIFE

Nashville CARES and you can make a difference in the fight against HIV/AIDS. Your participation in the From All Walks of Life event is a commitment to helping and caring for those facing HIV/AIDS in Nashville.

From All Walks of Life is a pledge walk sponsored by Nashville CARES. A percentage of the proceeds raised will be given to other agencies providing HIV/AIDS services and education through the Community AIDS Partnership, an initiative of the United Way of Middle Tennessee. The leisurely walk of 5k (3.1 miles) or 3k (1.8 miles) is designed for people of all ages who care about those living with HIV/AIDS. Friends, families, companies, congregations, students and civic or professional groups are encouraged to walk together in a show of support.

Grab your sneakers, oxfords, deck shoes... whatever it takes to get your happy feet moving! Come join us in our celebration of caring and community support.

WHAT'S IT ALL ABOUT. ABOUT HIV/AIDS

One in 450 Tennesseans are infected with HIV and more become infected every day. Participation in FROM ALL WALKS OF LIFE is a loving and caring way to support community organizations which provide a range of direct services, counseling, medical services, housing, physical and emotional support to people with HIV/AIDS.

HOW TO DO IT. EASY AS ONE, TWO, THREE, FOUR

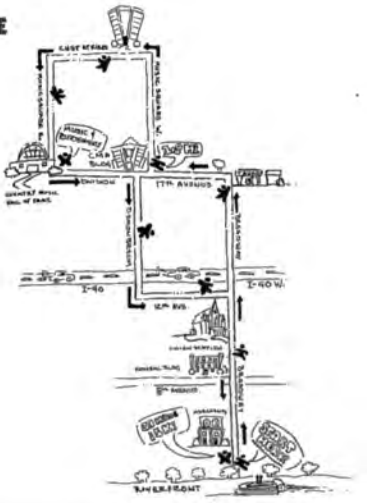
STEP ONE: Register today. Send in the enclosed registration card immediately let us know you plan to participate. Participation in this event is simple!

STEP TWO: Think Sponsors. Just take your sponsor envelope everywhere you go. Take it to the office, the store, the gym, your place of worship, to a neighbor's house, or wherever you may meet friends or family. As you're talking to people, explain that you're participating in From All Walks of Life. Ask everyone you can to sponsor you for at least $3.00 per kilometer (for a total of $15). Inform your supporters that their tax-deductible contribution will make a difference in the fight against HIV/AIDS.

STEP THREE: As a pre-paid event, all funds should be collected prior to the Walk. As you collect contributions, remind sponsors to make all checks payable to **FROM ALL WALKS OF LIFE,** and their cancelled check will serve as their receipt. Use your official sponsor sheet and collection envelope to record and keep all the contributions you receive. **On the day of the walk, turn in all your donations at the registration tables before you begin.** Remember, there's a great selection of prizes you can earn.

STEP FOUR: Join in the fun and walk, come rain or come shine, to make a difference in the fight against HIV / AIDS on Sunday, October 10, 1993. The opening ceremonies begin at 12:00 p.m. Walk the distance. Enjoy the sights and sounds of the city with entertainment, refreshments and restrooms along the way. Then enjoy the closing celebration and concert.

THE ROUTE



TO THANK YOU. THE PRIZES

Special incentive gifts will be awarded for those turning in the following amounts of collected funds on the day of the Walk:

$10 Official Walk Water Bottle
$100 Official Long Sleeve Walk T-Shirt

A little extra incentive. For those collecting the following funds, these prizes will be awarded after the Walk:

$300 Official Walk Baseball Cap
$500 Official Walk Long Sleeve Sweatshirt
$1000 Athletic Shoes from NIKE

All prizes are cumulative. Individual members of Walker Teams collecting pledges of $100 or more will receive a commemorative Walk Bandana.

Nashville CARES 2nd Annual

LOGO BY KARINNE MILLER

AN ANNUAL PLEDGE WALK TO BENEFIT AIDS CARE AND PREVENTION

Sunday, October 10, 1993

Honorary Event Chair:
Kathy Mattea

Registration
12:00 p.m.

Opening Ceremonies & Light Aerobics/Warm Up
1:30 p.m.

Walk Begins
2:00 p.m.

Walk Location
Riverfront Park

FOR MORE INFORMATION CALL
Nashville CARES
385-AIDS (2437)

nashville CARES

Please place stamp here

From All Walks of Life
Nashville CARES
700 Craighead Ave.
Suite 200
Nashville,TN 37204

Nashville CARES 2nd Annual

FROM ALL WALKS OF LIFE!

An Annual Pledge Walk to Benefit AIDS Care and Prevention
Sunday 2:00 p.m. ◆ October 10, 1993
For More Information Call Nashville CARES 385-AIDS (2437)

REGISTRATION CARD

Yes! I want to support "From All Walks of Life"
An Annual Pledge Walk to Benefit AIDS Care and Prevention

- ☐ Please count me in as a registered walker, and I will participate on Sunday, October 10, 1993.
- ☐ I'm interested in forming a team.
- ☐ Please call me to volunteer.

NAME _____

COMPANY OR ORGANIZATION (ONLY IF WALKING WITH A TEAM) _____

ADDRESS _____

CITY/STATE/ZIP _____

TELEPHONE (DAY) _____ TELEPHONE (EVENING) _____

- ☐ Sorry, I'm unable to join you in From All Walks of Life, but I want to support this project. Enclosed is my tax-deductible contribution of $_____ toward your goal. Good Luck!

☐ Check Enclosed ☐ VISA ☐ Mastercard

CARD NUMBER _____

EXPIRATION DATE _____

SIGNATURE _____

HIV IN THE WORKPLACE - ~~CHICAGO~~ Nashville 9/23

Chamber of Commerce-

Congratulations-for conference-~~TB/Cancer~~ who is here

Problems of Epidemic
- -huge human cost; huge economic cost
- -multinational corporations know already

"Not nice" disease TB/Cancer history
- -gay white men - hairdressers and entertainers (perception)
- -it's their fault - issues of attaching blame
- -examples provided to me "for reasons of confidentiality" (the name of the grocery chain/hairdresser not revealed)

What we need
- -real honesty on risks and exposures
- -good basic policies both in the workplace and nationwide
- -not just delegate but participate
- -nondiscrimination
- -exposure control

Leadership in the family and the community
- -mother's voices and father's voices

National psyche issues
- -pioneer vs. communitarianism
- -technology vs. human intervention

RESTAURANTS & LOUNGES

For reservations and information touch 6848.

OLD HICKORY RESTAURANT®: Elegant dining in the tradition of Andrew Jackson is the hallmark of the Old Hickory Restaurant. Reservations Requested. Magnolia Lobby.

THE CASCADES RESTAURANT: Offers dining in an unforgettable locale situated in our breathtaking water garden. Our award-winning chefs will vary the menu, making each visit a new dining experience. Cascades Lobby.

CASCADES TERRACE: Our revolving lounge with all the charm of an outdoor setting, providing patrons with an ever changing panorama of waterfalls, foliage, and Dancing Waters™. Cascades Lobby.

CASCADES LOBBY BAR: A pleasant place to relax, enjoy your favorite beverage, and watch people pass by. Cascades Lobby.

CONSERVATORY CAFE, ICE CREAM & CONFECTIONS: Freshly brewed gourmet coffees. Pastries, croissants, and muffins baked fresh daily. Offering gourmet ice creams and specialty gifts. Open daily. Located off the Magnolia Lobby at the Conservatory.

RHETT'S℠: Frankly, my dear, Rhett's offers traditional Southern dining excellence in an atmosphere of comfortable graciousness that will take you back to the days of mansions and magnolias. Conservatory.

RACHEL'S KITCHEN®: A delightful spot in which to enjoy any meal of the day. Magnolia Lobby.

THE VERANDA®: Our outdoor restaurant, located in a sunny, flower-decked courtyard near the swimming pools. (Seasonal)

THE STAGEDOOR LOUNGE®: A lively setting for viewing top contemporary entertainment. Relax and enjoy the intimate atmosphere while you dance the evening away. Magnolia Lobby.

JACK DANIEL'S SALOON®: The name says it all! A great place to get together for drinks, snacks, and conviviality. Conservatory.

PICKIN PARLOR®: A great place to meet friends, relax, sip a bit, and tune in to a sample of the pickin', grinnin', and singin' that make Nashville "Music City, USA"! Magnolia Lobby.

OPRYLAND HOTEL'S SUNDAY BRUNCH: Our Sunday Brunch has become a Nashville tradition, a legend in its time. Magnolia Lobby.

SHOPPES & BOUTIQUES

NASHVILLE GALLERY: An intriguing collection of figurines, stained glass lamps, decoys, jewelry boxes, unusual metal work, and many other gift items by individual artists. Touch 1348. Located in the Magnolia Lobby.

MISS SCARLETT'S JEWELRY AND GIFTS: Fine jewelry, imported giftware, lead crystal, and unique gifts. Touch 6820. Located in the Magnolia Lobby.

GIFTS AND SUNDRY SHOPS: Two locations. Replace your forgotten toiletries or pick up a last minute gift. Magnolia Lobby, touch 1350. Cascades Lobby touch 1377.

RAMONE'S: A full service beauty salon, specializing in the latest hair care and styling for men and women. Touch 1341. Located in the Magnolia Lobby.

ACCENTS: For that special occasion, choose from a selection of Lalique Crystal, porcelain figurines and giftware, pewter sculpture, collectibles and many other unique gift items. Located in the Cascades Courtyard. Touch 1356.

EMPEROR CLOCK COMPANY: Solid wood grandfather clocks from the world's largest clock manufacturer, built by some of America's finest craftsmen. Touch 1340. Located in the Magnolia Lobby.

DERRINGER'S-A MEN'S CLOTHIER: Choose from a large selection of designer sportswear, accessories and gifts. Located in the Galleria. Touch 1349.

SAVANNAH'S: Select from an exciting collection of dresses, sportswear, accessories, and jewelry. You will find many fabulous gift ideas. Located in the Cascades Courtyard. Touch 1378.

WINE AND SPIRITS SHOPPE: An extensive collection of your favorite spirits, including domestic and imported wines and brandies. Located in the Cascades Lobby. Touch 1342.

PETAL'S: Consider the special touch of floral arrangements. Brighten a private room, meeting site or banquet table with a beautiful fresh bouquet. Free consultation available for your floral and decorating needs . Located in the Magnolia Lobby. Touch 1343.

THE GREEN LEAF: A selection of Bonsai trees and an assortment of environmentally friendly gifts and supplies for the Gardener at Heart. Located off the Magnolia Lobby at the Conservatory. Touch 2866.

MEMENTO'S: "Something to Remember Us By." Featuring monogrammed items, apparel, and novelty gifts. Located in the Cascades Courtyard. Touch 1367.

MEMENTO'S II: Offering a special selection of favorite items featured in Memento's I. Located in the Magnolia Lobby. Touch 1339.

COUNTRY CHRISTMAS SHOPPE: Enjoy Christmas all year. Imported ornaments, Christmas collectibles, wreaths, china, and much more. Located in the Magnolia Lobby. Touch 1365.

PRISSY'S: Offering an unusual selection of fashion accessories for the contemporary woman. Located in the Cascades Lobby. Touch 1338.

AUNT PITTY PAT'S: Select from a collection of beautiful dolls & figurines hand crafted by local artists as well as nationally famous designers. Located off the Magnolia Lobby at the Conservatory. Touch 1345.

GENUINE JACK DANIEL'S GOODS: Signature Jack Daniel's merchandise ranging from T-shirts, sweatshirts, and caps to glassware and bar sets. Located in the Magnolia Lobby. Touch 1398.

SPRINGHOUSE GOLF SHOP: Offering a selection of golfing apparel and accessories. Located at the Conservatory Entrance. Touch 3856.

LASSO'S: Select from a wide assortment of current styles of Western Wear and accessories for men and women. You will find many unique "Nashville Style" selections. Located in the Magnolia Lobby. Touch 1398.

CHILDREN'S SHOP: Opryland logo items, Fun clothing and play wear for infants through teen sizes, accessories and gifts including books, tapes, and educational travel toys. Located in the Cascades Courtyard. Touch 1376.

AUTOMATED TELLER MACHINE

Access to all major networks including: PLUS, CIRRUS, MasterCard, VISA and AMERICAN EXPRESS. The machine is located at the Magnolia lobby across from Opryland International Travel.

VIDEO REVIEW/CHECKOUT

Turn TV on and touch "88" on your free TV keys. Follow instructions for the function of your choice.

Account Review
Account/Review Checkout

Use the TV to check out from the convenience of your room. A printed copy of your bill is available for pickup at special desks located in the lobby indicated on your TV screen; otherwise, it will be mailed to you.

EXPRESS SELF-CHECKOUT

Guest express automatic checkout machines are located in the Magnolia and Cascades Lobby.
Just insert the credit card you used to check in, into the card reader. Your itemized folio prints out and is available immediately. Charges will be billed to your credit card.

CHECKOUT TIME

11:00 a.m. Late checkouts are subject to charge. If your departure schedule does not coincide with our check-out time, please contact our Bell Captain to arrange baggage storage. Touch 3880.

OPRYLAND INTERNATIONAL TRAVEL

A full service travel agency. Located off the Magnolia Lobby at the Conservatory. Touch 5745.

SAFE DEPOSIT BOXES

We recommend all valuables be placed in these special boxes. They are available to you at no additional cost. Touch 3809.

SPRINGHOUSE GOLF CLUB

Our splendid Larry Nelson designed course features 18 spectacular holes sculptured from the banks of the winding Cumberland River. Our 7200 yard, par 72 course is complete with driving range, pro shop, and instructional center. Touch 7759.

ROOM SERVICE

Serving many specialties and Ala Carte items throughout the day. For your hospitality suggestions, please feel free to call the Room Service Manager. For any arrangements touch 101.

TICKETS

For your convenience, tickets or information for the following may be obtained at Guest Services in the Magnolia or Cascades Lobbies, or please touch extension 3809 or 3810.

Opryland Theme Park — Nashville Now
Grand Ole Opry — Opryland Transportation
General Jackson — Grand Ole Opry Tours

Reservations-615/883-2211
Facsimile-615/871-7741
2800 Opryland Drive, Nashville, TN 37214 615/889-1000

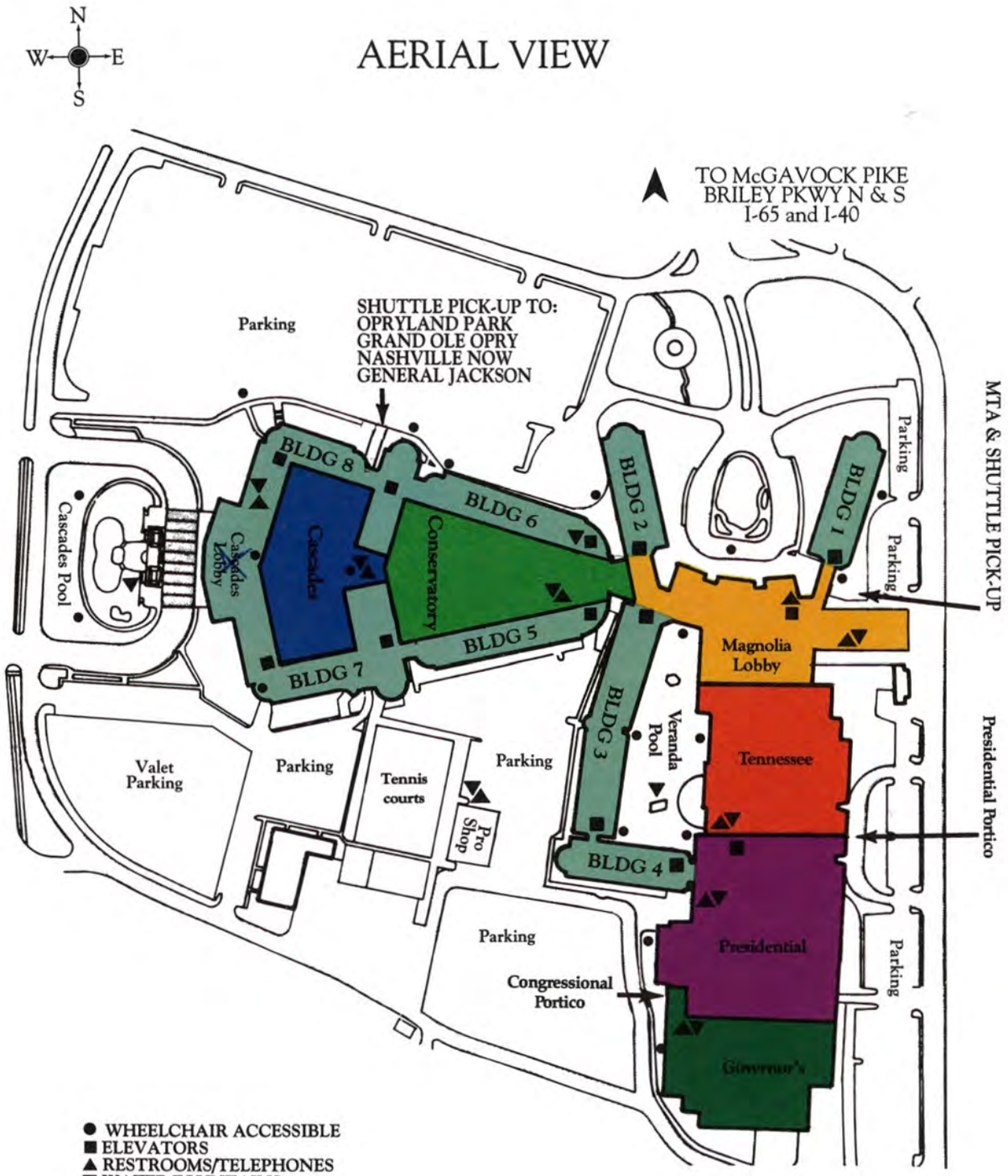
A Property of Gaylord Entertainment Company

1298 3840 Gamble

GUEST GUIDE

OPRYLAND HOTEL

AERIAL VIEW



CASCADES	LEVEL
Accents	Lower
Budget Rent A Car	Lobby
Cascades Guest Services	Lobby
Cascades Restaurant	Lobby
Cascades Sundry Shop	Lobby
Cascades Terrace	Lobby
The Childrens Shop	Lower
Fitness Center	Lower
Front Desk	Lobby
Memento's I	Lower
Prissy's	Lobby
Reservations	Lobby
Savannah's	Lower
Wine and Spirit Shoppe	Lobby

CONSERVATORY	LEVEL
Aunt Pitty Pat's	Lobby
Automated Teller Machine	Lobby
Conservatory Cafe	Lobby
Golf Shop	Lobby
Jack Daniel's Saloon	Lobby
Opryland International Travel	Lobby
Rhett's Restaurant	Lobby

MAGNOLIA	LEVEL
Appalachian	Mezzanine
Catering Department	Lobby
Cheekwood	Mezzanine
Cherokee	Mezzanine
Commodore	Mezzanine
Convention Services	Lobby
Country Christmas Shoppe	Lobby
Cumberland	Mezzanine
Davidson	Mezzanine
Derringers	Lobby
Emperor Clock	Lobby
Grand Ole Opry Tours	Lobby
The Green Leaf	Lobby
Hermitage Board Room	Mezzanine
Jack Daniels Shop	Lobby
Jackson	Mezzanine
Johnson	Mezzanine
Lasso's	Lobby
Magnolia Ballroom	Mezzanine
Magnolia Guest Services	Lobby
Magnolia Sundry Shop	Lobby
Memento's II	Lobby
Miss Scarlett's Jewelry and Gifts	Lobby
Nashville Gallery	Lobby
Natchez Trace	Mezzanine
Old Hickory Restaurant	Lobby
Opryland Executive Conference Center	Second
Petal's	Lobby
Pickin' Parlor	Lobby
Polk	Mezzanine
Rachels Kitchen	Lobby
Ramone's Hair Salon	Lobby
Sales and Marketing	Second
Shiloh	Mezzanine
Special Events	Lobby
Stagedoor Lounge	Lobby
Sumner	Mezzanine
Volunteer	Mezzanine
Williamson	Mezzanine

TENNESSEE	LEVEL
Business Center	Lobby
Chattanooga Ballroom	Lobby
Judges Parlor	Lower
Knoxville Ballroom	Lobby
Memphis Ballroom	Lobby
Nashville Lobby	Lobby
Ryman Exhibit Hall A	Lower
Tennessee Ballroom	Lobby
Veranda Restaurant	Lobby

PRESIDENTIAL	LEVEL
Adams Ballroom	Lobby
Belle Meade	Mezzanine
Belmont	Mezzanine
Caucus	Lobby
Centennial Room	Lobby
Chickasaw	Lower
Congressional Lobby	Lobby
Congressional Portico	Lobby
Donelson	Mezzanine
Iroquois	Lower
Jefferson Ballroom	Lobby
Nancy Ward	Mezzanine
Presidential Ballroom	Lobby
Presidential Lobby	Lobby
Presidential Portico	Mezzanine
Robertson	Mezzanine
Ryman Exhibit Hall B	Lower
Sam Davis	Mezzanine
Sam Houston	Mezzanine
Sevier	Mezzanine
Shoe Shine	Lobby
Two Rivers	Mezzanine
W. C. Handy	Mezzanine
Washington Ballroom	Lobby

GOVERNOR'S	LEVEL
Ashwood	Lobby
Browning Ballroom	Lobby
Capitol Hall	Lobby
Carrol Ballroom	Lobby
Cleveland	Lobby
Clifton	Lobby
Governor's Ballroom	Lobby
Governor's Lobby	Lobby
Mercer	Lobby
Ryman Exhibit Hall C	Lower
Sylvan	Lobby
Taylor Ballroom	Lobby

September 1993

KRISTINE G

NETWORK SCHEDULER 3

From 07:00a until 04:00p (Where: ALL Why: ALL)

25 Saturday

Retina - is still working on

THE WHITE HOUSE

WASHINGTON

September 22, 1993

MEMORANDUM FOR CAROL RASCO

FROM: Kristine M. Gebbie

SUBJECT: GP160 Vaccine

In the FY93 budget, the Department of Defense was given $20 million for trials of the AIDS vaccine, gp160, manufactured by Microgenesis. While questions were raised about the appropriateness of this particular expenditure, the best that could be gotten at the time was the opportunity for the NIH and FDA to comment within six months, with the money going to other DOD HIV-related research if this study was found to be flawed.

The time for NIH/FDA comment was early in this administration, and there was no strong voice forcing a clear statement regarding the scientific flaws in the study and allowing for DOD to invest the money elsewhere. (It is not worth space here reconstructing this period--suffice it to say that hindsight would suggest a very different process than that which was used.)

There has also been a debate with the manufacturer of gp160 regarding their insistence that the vaccine for the trial be purchased, something which has never happened in other vaccine trials. At the present, the manufacturer has offered one year of free vaccine (within a three year study), a step which leaves other manufacturers of vaccine concerned about level playing fields as their products come to trial.

The DOD believes that they are obligated to proceed with the Congressionally mandated trial of gp160, despite the fact that the scientific community has been clear in identifying the flaws in this study, and in identifying the more important questions which could be answered at this point. Initial steps have been taken on the study.

On behalf of the Administration, I have informed those who have asked, including staff to some members of Congress, that from an AIDS policy viewpoint the study as now envisioned is not a wise use of funds, and that the priority for $20 million in HIV vaccine-related research at either DOD or HHS would be at a more basic level that a trial of a specific agent.

There is interest on the part of the HIV community in general, and legislators concerned about health matters in approaching Senator Johnston and the DOD appropriations committee with a proposal which would allow for a better investment of these funds. I would like concurrence from you and appropriate others in the White House to send the attached letter to Senator Inouye, Senator Kennedy, Representative Waxman and Representative Dingle.

Given the timing of work on appropriations, the letter would need to be sent within the next day or so, which makes the review process tight. Please call me with any questions.

cc: Steve Richetti

DRAFT

Dear _____ (Inouye, Kennedy, Dingle, Waxman)

There have been a number of questions asked about the trial of GP160 vaccine about to be conducted by the Department of Defense. This is a study specifically mandated in the FY93 appropriations process, and funded at $20 million.

In the opinion of many in the scientific and AIDS-interested community, in which I concur, this single-vaccine trial is not a useful investment at the present time. While the study could be slightly improved by comparing this product to other vaccines, that would cost more and be only a slightly better investment. It would be far wiser to allow an appropriate review process to identify more basic research questions essential to the successful development of a vaccine, whether therapeutic or preventive.

If it would be possible to identify some amendment to the existing language which would allow a reconsideration of this study, and the possible reinvestment of these funds, I would be delighted to work with you or your staff.

Sincerely,

cc: Shalala
Aspin
Rasco

HIV/AIDS

SURVEILLANCE REPORT — Second Quarter Edition

U.S. AIDS cases reported through June 1993 — **Issued July 1993, Vol. 5, No. 2**

Contents

Acquired immunodeficiency syndrome (AIDS) is a specific group of diseases or conditions which are indicative of severe immunosuppression related to infection with the human immunodeficiency virus (HIV).

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
and Prevention
National Center for Infectious Diseases
Division of HIV/AIDS
Atlanta, Georgia 30333

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Notice to readers: Table 2 of this quarter's *Report* uses revised Metropolitan Statistical Area (MSA) definitions issued by the Office of Management and Budget in June 1993. These latest MSA definitions retain most of the revisions issued in December 1992. However, the New York City MSA is returned to its pre-December 1992 definition, and the six MSAs in New Jersey which were included as part of the New York City MSA are again defined as separate MSAs. See technical notes for additional information.

The *HIV/AIDS Surveillance Report* is published quarterly by the Division of HIV/AIDS, National Center for Infectious Diseases, Centers for Disease Control and Prevention (CDC), Atlanta, GA 30333. The year-end edition contains additional tables and graphs. All data contained in the *Report* are provisional.

Suggested Citation: Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, 1993;5(no. 2):[inclusive page numbers].

Single copies of the *HIV/AIDS Surveillance Report* are available free from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone 1–800–458–5231. Individuals or organizations can be added to the mailing list by writing to Centers for Disease Control and Prevention, OD/OPS/MASO, 1/B49, Mailstop A-22, Atlanta, GA 30333. Confidential information, referrals, and educational material on AIDS are available from the CDC National AIDS Hotline: 1–800–342–2437, 1–800–344–7432 (Spanish access), and 1–800–243–7889 (TTY, deaf access).

Table 1. AIDS cases and annual rates per 100,000 population, by state, reported July 1991 through June 1992, July 1992 through June 1993;[1] and cumulative totals, by state and age group, through June 1993[2]

State of residence	July 1991–June 1992		July 1992–June 1993		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Alabama	424	10.4	704	17.0	2,154	43	2,197
Alaska	16	2.8	29	4.9	150	3	153
Arizona	371	9.9	1,138	29.7	2,874	13	2,887
Arkansas	200	8.4	429	17.9	1,160	18	1,178
California	8,448	27.8	15,402	49.7	57,672	344	58,016
Colorado	429	12.7	1,100	31.8	3,337	19	3,356
Connecticut	480	14.6	1,444	43.8	3,980	91	4,071
Delaware	104	15.3	305	44.0	756	7	763
District of Columbia	806	134.7	1,083	183.6	4,812	78	4,890
Florida	5,246	39.5	8,765	64.4	30,073	713	30,786
Georgia	1,653	25.0	2,194	32.4	8,595	85	8,680
Hawaii	166	14.6	204	17.6	1,088	10	1,098
Idaho	39	3.8	69	6.4	194	2	196
Illinois	1,838	15.9	2,851	24.5	9,880	136	10,016
Indiana	379	6.8	768	13.5	2,312	16	2,328
Iowa	86	3.1	192	6.8	550	5	555
Kansas	168	6.7	300	11.9	957	5	962
Kentucky	178	4.8	296	7.9	1,058	13	1,071
Louisiana	864	20.3	1,130	26.4	4,586	62	4,648
Maine	57	4.6	77	6.2	371	2	373
Maryland	1,036	21.3	2,058	41.7	6,580	146	6,726
Massachusetts	858	14.3	1,933	32.3	6,535	122	6,657
Michigan	826	8.8	1,556	16.5	4,587	61	4,648
Minnesota	241	5.4	593	13.2	1,732	12	1,744
Mississippi	225	8.7	399	15.3	1,370	20	1,390
Missouri	706	13.7	1,660	31.9	4,456	31	4,487
Montana	21	2.6	28	3.4	123	1	124
Nebraska	61	3.8	152	9.5	425	4	429
Nevada	249	19.4	541	39.6	1,522	15	1,537
New Hampshire	53	4.8	92	8.4	353	6	359
New Jersey	2,213	28.5	3,482	44.7	16,836	419	17,255
New Mexico	109	7.0	277	17.5	785	2	787
New York	8,061	44.6	14,099	77.8	59,312	1,258	60,570
North Carolina	643	9.5	1,007	14.7	3,521	74	3,595
North Dakota	1	0.2	5	0.8	30	–	30
Ohio	771	7.0	1,156	10.5	4,445	66	4,511
Oklahoma	244	7.7	670	20.9	1,701	15	1,716
Oregon	290	9.9	663	22.1	2,077	9	2,086
Pennsylvania	1,370	11.5	2,122	17.6	8,331	118	8,449
Rhode Island	122	12.1	238	23.7	762	9	771
South Carolina	345	9.7	1,076	29.6	2,609	35	2,644
South Dakota	9	1.3	23	3.2	56	2	58
Tennessee	407	8.2	834	16.6	2,481	24	2,505
Texas	3,184	18.4	6,223	35.1	21,881	210	22,091
Utah	129	7.3	276	15.2	785	18	803
Vermont	22	3.9	29	5.1	133	2	135
Virginia	656	10.4	1,365	21.4	4,340	79	4,419
Washington	520	10.4	1,180	22.8	4,297	18	4,315
West Virginia	70	3.9	71	3.9	339	5	344
Wisconsin	224	4.5	625	12.5	1,562	16	1,578
Wyoming	11	2.4	33	7.1	90	—	90
U.S. total	**45,629**	**18.1**	**82,946**	**32.4**	**300,615**	**4,462**	**305,077**
Guam	2	1.5	2	1.5	13	–	13
Pacific Islands, U.S.	–	–	–	–	2	–	2
Puerto Rico	1,814	51.0	2,535	70.7	9,911	243	10,154
Virgin Islands, U.S.	20	19.5	42	40.8	139	5	144
Total	**47,465**	**18.5**	**85,525**	**32.9**	**310,680**	**4,710**	**315,390**

[1]Includes 6 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]During the second quarter of 1993, CDC received reports of 25,964 cases and 12,313 deaths among adults/adolescents and 230 cases and 159 deaths among children.

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported July 1991 through June 1992, July 1992 through June 1993;[1] and cumulative totals, by area and age group, through June 1993

Metropolitan area of residence[2]	July 1991–June 1992		July 1992–June 1993		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Akron, Ohio	42	6.3	38	5.7	199	–	199
Albany-Schenectady, N.Y.	97	11.2	194	22.1	615	14	629
Albuquerque, N.M.	67	11.1	169	27.4	461	1	462
Allentown, Pa.	39	6.5	73	12.0	261	4	265
Ann Arbor, Mich.	37	7.4	49	9.7	173	4	177
Atlanta, Ga.	1,186	38.9	1,490	47.4	6,371	41	6,412
Austin, Tex.	264	30.2	505	56.0	1,574	14	1,588
Bakersfield, Calif.	51	9.0	125	21.2	307	3	310
Baltimore, Md.	588	24.4	1,394	57.0	4,104	110	4,214
Baton Rouge, La.	97	18.0	123	22.5	437	4	441
Bergen-Passaic, N.J.	272	21.2	402	31.4	2,103	51	2,154
Birmingham, Ala.	106	12.5	250	29.1	674	11	685
Boston, Mass.	760	13.4	1,707	30.3	5,871	107	5,978
Buffalo, N.Y.	80	6.7	191	16.0	622	7	629
Charleston, S.C.	76	14.5	218	40.4	554	4	558
Charlotte, N.C.	124	10.4	232	19.0	709	9	718
Chicago, Ill.	1,607	21.4	2,500	33.0	8,700	121	8,821
Cincinnati, Ohio	118	7.6	180	11.5	702	10	712
Cleveland, Ohio	237	10.7	354	15.9	1,260	25	1,285
Columbus, Ohio	153	11.2	236	16.9	938	6	944
Dallas, Tex.	776	28.3	1,686	60.2	5,574	24	5,598
Dayton, Ohio	78	8.2	118	12.3	451	8	459
Denver, Colo.	354	21.2	926	54.0	2,767	14	2,781
Detroit, Mich.	631	14.7	1,092	25.4	3,256	45	3,301
El Paso, Tex.	41	6.7	110	17.4	286	1	287
Fort Lauderdale, Fla.	856	66.5	1,080	81.9	4,845	103	4,948
Fort Worth, Tex.	148	10.6	381	26.6	1,254	14	1,268
Fresno, Calif.	80	10.2	153	19.0	464	4	468
Gary, Ind.	40	6.5	77	12.5	228	1	229
Grand Rapids, Mich.	52	5.5	111	11.5	307	2	309
Greensboro, N.C.	133	12.5	147	13.6	598	11	609
Greenville, S.C.	47	5.6	208	24.3	437	2	439
Harrisburg, Pa.	48	8.1	64	10.6	289	6	295
Hartford, Conn.	144	12.8	428	38.0	1,200	18	1,218
Honolulu, Hawaii	119	14.0	166	19.2	826	7	833
Houston, Tex.	1,177	34.2	2,160	60.8	8,537	87	8,624
Indianapolis, Ind.	177	12.6	349	24.4	1,100	5	1,105
Jacksonville, Fla.	309	33.1	813	84.6	1,964	49	2,013
Jersey City, N.J.	365	66.0	421	76.0	2,685	69	2,754
Kansas City, Mo.	291	18.2	738	45.5	2,124	7	2,131
Knoxville, Tenn.	33	5.5	60	9.8	213	2	215
Las Vegas, Nev.	192	20.8	425	42.6	1,176	14	1,190
Little Rock, Ark.	67	12.9	173	33.0	455	8	463
Los Angeles, Calif.	3,072	34.2	5,196	57.1	20,192	142	20,334
Louisville, Ky.	87	9.1	150	15.5	466	8	474
Memphis, Tenn.	153	15.0	334	32.3	883	8	891
Miami, Fla.	1,691	85.5	2,063	102.3	8,777	249	9,026
Middlesex, N.J.	209	20.3	333	32.2	1,447	31	1,478
Milwaukee, Wis.	122	8.4	322	22.1	837	10	847
Minneapolis-Saint Paul, Minn.	207	8.0	530	20.2	1,541	9	1,550
Monmouth-Ocean City, N.J.	122	12.2	339	33.7	1,198	33	1,231
Nashville, Tenn.	125	12.5	228	22.3	765	9	774
Nassau-Suffolk, N.Y.	309	11.8	876	33.3	2,927	63	2,990
New Haven, Conn.	294	18.0	883	54.1	2,440	70	2,510
New Orleans, La.	498	38.5	579	44.4	2,732	35	2,767
New York, N.Y.	6,979	81.6	11,798	137.9	51,112	1,126	52,238
Newark, N.J.	922	50.6	1,283	70.6	6,853	185	7,038
Norfolk, Va.	120	8.2	274	18.4	917	22	939
Oakland, Calif.	571	27.0	1,106	51.6	3,908	26	3,934
Oklahoma City, Okla.	123	12.7	299	30.4	798	1	799

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported July 1991 through June 1992, July 1992 through June 1993;[1] and cumulative totals, by area and age group, through June 1993 — Continued

Metropolitan area of residence[2]	July 1991–June 1992		July 1992–June 1993		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Omaha, Neb.	42	6.5	115	17.4	308	1	309
Orange County, Calif.	590	24.2	602	24.3	2,642	19	2,661
Orlando, Fla.	357	28.1	850	64.8	2,145	38	2,183
Philadelphia, Pa.	1,044	21.1	1,756	35.4	6,502	85	6,587
Phoenix, Ariz.	280	12.2	809	34.6	2,100	9	2,109
Pittsburgh, Pa.	147	6.1	164	6.8	936	4	940
Portland, Oreg.	235	15.0	615	37.8	1,820	6	1,826
Providence, R.I.	114	12.4	221	24.1	715	8	723
Raleigh-Durham, N.C.	119	13.5	189	20.8	754	18	772
Richmond, Va.	158	17.9	359	40.0	951	13	964
Riverside-San Bernardino, Calif.	399	14.7	901	31.6	2,455	26	2,481
Rochester, N.Y.	91	8.5	205	18.9	684	8	692
Sacramento, Calif.	252	18.2	408	28.4	1,348	14	1,362
Saint Louis, Mo.	376	15.0	783	31.0	2,111	21	2,132
Salt Lake City, Utah	115	10.4	247	21.8	697	13	710
San Antonio, Tex.	234	17.4	330	24.1	1,427	14	1,441
San Diego, Calif.	607	23.8	1,400	53.9	4,588	30	4,618
San Francisco, Calif.	1,986	122.4	3,862	235.3	16,228	26	16,254
San Jose, Calif.	172	11.4	402	26.6	1,365	11	1,376
San Juan, P.R.	1,092	58.8	1,645	87.7	6,316	159	6,475
Sarasota, Fla.	68	13.6	134	26.1	526	12	538
Scranton, Pa.	29	4.5	53	8.2	183	3	186
Seattle, Wash.	366	17.6	904	42.6	3,249	10	3,259
Springfield, Mass.	87	14.5	183	30.5	525	15	540
Stockton, Calif.	37	7.5	78	15.5	264	8	272
Syracuse, N.Y.	59	7.9	143	18.9	448	6	454
Tacoma, Wash.	37	6.1	97	15.5	305	8	313
Tampa-Saint Petersburg, Fla.	516	24.6	1,314	61.6	3,529	52	3,581
Toledo, Ohio	38	6.2	83	13.5	254	5	259
Tucson, Ariz.	68	10.0	256	37.3	585	3	588
Tulsa, Okla.	67	9.3	219	29.7	513	5	518
Ventura, Calif.	66	9.7	119	17.4	352	1	353
Washington, D.C.	1,465	34.1	2,087	47.8	8,627	133	8,760
West Palm Beach, Fla.	444	50.1	837	92.0	2,791	105	2,896
Wichita, Kansas	61	12.4	84	16.8	257	2	259
Wilmington, Del.	76	14.6	231	43.5	561	6	567
Youngstown, Ohio	21	3.5	27	4.5	140	–	140
Metropolitan areas with 500,000 or more population	**39,678**	**25.2**	**71,621**	**44.9**	**264,665**	**3,971**	**268,636**
Metropolitan areas with 50,000 to 500,000 population	**4,969**	**10.8**	**8,946**	**19.1**	**29,476**	**465**	**29,941**
Non-metropolitan areas	**2,616**	**5.0**	**4,629**	**8.7**	**15,343**	**253**	**15,596**
Total[3]	**47,465**	**18.5**	**85,525**	**32.9**	**310,680**	**4,710**	**315,390**

[1]Includes 6 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]Based on Metropolitan Statistical Area definitions revised June 1993. See notice to readers (page 2) and technical notes.
[3]Totals include 1,217 persons whose area of residence is unknown.

Table 3. AIDS cases by age group, exposure category, and sex, reported July 1991 through June 1992, July 1992 through June 1993;[1] and cumulative totals, by age group and exposure category, through June 1993, United States

Adult/ adolescent exposure category	Males				Females				Totals					
	July 1991-June 1992		July 1992-June 1993		July 1991-June 1992		July 1992-June 1993		July 1991-June 1992		July 1992-June 1993		Cumulative total[2]	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	25,051	(62)	41,029	(57)	–		–		25,051	(54)	41,029	(48)	172,085	(55)
Injecting drug use	8,742	(22)	16,267	(22)	2,859	(47)	5,685	(46)	11,601	(25)	21,952	(26)	73,610	(24)
Men who have sex with men and inject drugs	2,591	(6)	4,636	(6)	–		–		2,591	(6)	4,636	(5)	19,557	(6)
Hemophilia/coagulation disorder	333	(1)	866	(1)	6	(0)	24	(0)	339	(1)	890	(1)	2,762	(1)
Heterosexual contact:	1,520	(4)	2,991	(4)	2,521	(41)	4,556	(37)	4,041	(9)	7,547	(9)	21,873	(7)
Sex with injecting drug user	*670*		*1,052*		*1,450*		*2,152*		*2,120*		*3,204*		*10,800*	
Sex with bisexual male	*–*		*–*		*182*		*338*		*182*		*338*		*1,115*	
Sex with person with hemophilia	*4*		*8*		*16*		*50*		*20*		*58*		*172*	
Born in Pattern–II[3] country	*296*		*548*		*182*		*282*		*478*		*830*		*3,557*	
Sex with person born in Pattern-II country	*19*		*30*		*20*		*29*		*39*		*59*		*261*	
Sex with transfusion recipient with HIV infection	*25*		*49*		*49*		*92*		*74*		*141*		*420*	
Sex with HIV-infected person, risk not specified	*506*		*1,304*		*622*		*1,613*		*1,128*		*2,917*		*5,548*	
Receipt of blood transfusion, blood components, or tissue[4]	411	(1)	651	(1)	263	(4)	456	(4)	674	(1)	1,107	(1)	5,733	(2)
Other/risk not identified[5]	1,926	(5)	5,910	(8)	487	(8)	1,651	(13)	2,413	(5)	7,561	(9)	15,060	(5)
Adult/adolescent subtotal	40,574	(100)	72,350	(100)	6,136	(100)	12,372	(100)	46,710	(100)	84,722	(100)	310,680	(100)
Pediatric (<13 years old) exposure category														
Hemophilia/coagulation disorder	28	(7)	19	(5)	–		2	(1)	28	(4)	21	(3)	202	(4)
Mother with/at risk for HIV infection:	332	(87)	362	(89)	352	(94)	382	(96)	684	(91)	744	(93)	4,121	(87)
Injecting drug use	*122*		*123*		*145*		*129*		*267*		*252*		*1,844*	
Sex with injecting drug user	*53*		*54*		*66*		*58*		*119*		*112*		*802*	
Sex with bisexual male	*8*		*5*		*10*		*2*		*18*		*7*		*85*	
Sex with person with hemophilia	*5*		*1*		*1*		*3*		*6*		*4*		*21*	
Born in Pattern-II country	*19*		*21*		*17*		*13*		*36*		*34*		*301*	
Sex with person born in Pattern-II country	*3*		*3*		*2*		*2*		*5*		*5*		*23*	
Sex with transfusion recipient with HIV infection	*1*		*1*		*3*		*1*		*4*		*2*		*18*	
Sex with HIV-infected person, risk not specified	*34*		*38*		*20*		*52*		*54*		*90*		*260*	
Receipt of blood transfusion, blood components, or tissue	*10*		*16*		*7*		*9*		*17*		*25*		*93*	
Has HIV infection, risk not specified	*77*		*100*		*81*		*113*		*158*		*213*		*674*	
Receipt of blood transfusion, blood components, or tissue	17	(4)	15	(4)	12	(3)	7	(2)	29	(4)	22	(3)	321	(7)
Risk not identified	4	(1)	10	(2)	10	(3)	6	(2)	14	(2)	16	(2)	66	(1)
Pediatric subtotal	381	(100)	406	(100)	374	(100)	397	(100)	755	(100)	803	(100)	4,710	(100)
Total	**40,955**		**72,756**		**6,510**		**12,769**		**47,465**		**85,525**		**315,390**	

[1]Includes 6 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

[2]Includes 6 persons known to be infected with human immunodeficiency virus type 2 (HIV-2). See *JAMA* 1992;267:2775-9.

[3]See technical notes.

[4]Twenty-three adults/adolescents and 2 children developed AIDS after receiving blood screened negative for HIV antibody. Six additional adults developed AIDS after receiving tissue or organs from HIV-infected donors. Three of the 6 received tissues or organs from a donor who was negative for HIV antibody at the time of donation. See *N Engl J Med* 1992;326:726-32.

[5]"Other" refers to 8 health-care workers who developed AIDS after occupational exposure to HIV-infected blood, as documented by evidence of seroconversion; to 2 patients who developed AIDS after exposure to HIV within the health-care setting, as documented by laboratory studies; to 1 person who acquired HIV infection perinatally and was diagnosed with AIDS after age 13; and to 1 person with intentional self-inoculation of blood from an HIV-infected person. "Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

Table 4. Male adult/adolescent AIDS cases by exposure category and race/ethnicity, reported July 1992 through June 1993,[1] and cumulative totals, through June 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	July 1992–June 1993		Cumulative total		July 1992–June 1993		Cumulative total		July 1993–June 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	26,995	(73)	118,368	(78)	8,451	(37)	31,694	(42)	4,999	(42)	19,907	(45)
Injecting drug use	3,630	(10)	11,528	(8)	8,108	(36)	27,115	(36)	4,436	(37)	16,811	(38)
Men who have sex with men and inject drugs	2,631	(7)	11,140	(7)	1,314	(6)	5,448	(7)	637	(5)	2,808	(6)
Hemophilia/coagulation disorder	706	(2)	2,210	(1)	93	(0)	231	(0)	53	(0)	206	(0)
Heterosexual contact:	535	(1)	1,510	(1)	1,911	(8)	5,783	(8)	524	(4)	1,235	(3)
Sex with injecting drug user	*203*		*748*		*658*		*1,974*		*184*		*566*	
Sex with person with hemophilia	*5*		*12*		*1*		*3*		*1*		*3*	
Born in Pattern-II[2] country	*1*		*8*		*545*		*2,444*		*–*		*11*	
Sex with person born in Pattern-II country	*7*		*51*		*22*		*75*		*1*		*11*	
Sex with transfusion recipient with HIV infection	*20*		*67*		*21*		*45*		*6*		*29*	
Sex with HIV-infected person, risk not specified	*299*		*624*		*664*		*1,242*		*332*		*615*	
Receipt of blood transfusion, blood components, or tissue	414	(1)	2,450	(2)	131	(1)	568	(1)	93	(1)	370	(1)
Risk not identified[3]	1,996	(5)	4,240	(3)	2,614	(12)	4,837	(6)	1,187	(10)	2,597	(6)
Total	**36,907**	**(100)**	**151,446**	**(100)**	**22,622**	**(100)**	**75,676**	**(100)**	**11,929**	**(100)**	**43,934**	**(100)**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[4]			
	July 1992–June 1993		Cumulative total		July 1992–June 1993		Cumulative total		July 1992–June 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	356	(71)	1,422	(78)	136	(66)	349	(64)	41,029	(57)	172,085	(63)
Injecting drug use	25	(5)	70	(4)	19	(9)	58	(11)	16,267	(22)	55,698	(20)
Men who have sex with men and inject drugs	18	(4)	51	(3)	32	(16)	93	(17)	4,636	(6)	19,557	(7)
Hemophilia/coagulation disorder	12	(2)	32	(2)	2	(1)	12	(2)	866	(1)	2,697	(1)
Heterosexual contact:	14	(3)	26	(1)	3	(1)	8	(1)	2,991	(4)	8,572	(3)
Sex with injecting drug user	*5*		*11*		*1*		*5*		*1,052*		*3,305*	
Sex with person with hemophilia	*–*		*–*		*–*		*–*		*8*		*19*	
Born in Pattern-II country	*1*		*3*		*–*		*–*		*548*		*2,472*	
Sex with person born in Pattern-II country	*–*		*1*		*–*		*–*		*30*		*138*	
Sex with transfusion recipient with HIV infection	*2*		*2*		*–*		*–*		*49*		*144*	
Sex with HIV-infected person, risk not specified	*6*		*9*		*2*		*3*		*1,304*		*2,494*	
Receipt of blood transfusion, blood components, or tissue	12	(2)	69	(4)	1	(0)	4	(1)	651	(1)	3,466	(1)
Risk not identified	67	(13)	145	(8)	13	(6)	24	(4)	5,910	(8)	11,915	(4)
Total	**504**	**(100)**	**1,815**	**(100)**	**206**	**(100)**	**548**	**(100)**	**72,350**	**(100)**	**273,990**	**(100)**

[1]Includes 6 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]See technical notes.
[3]"Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.
[4]Includes 571 men whose race/ethnicity is unknown.

Table 5. Female adult/adolescent AIDS cases by exposure category and race/ethnicity, reported July 1992 through June 1993,[1] and cumulative totals, through June 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	July 1992–June 1993		Cumulative total		July 1992–June 1993		Cumulative total		July 1992–June 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	1,400	(44)	3,995	(43)	3,228	(48)	10,285	(53)	1,017	(43)	3,516	(47)
Hemophilia/coagulation disorder	13	(0)	43	(0)	6	(0)	14	(0)	4	(0)	7	(0)
Heterosexual contact:	1,144	(36)	3,168	(34)	2,370	(35)	6,976	(36)	978	(41)	3,022	(41)
Sex with injecting drug user	*494*		*1,522*		*1,032*		*3,732*		*607*		*2,185*	
Sex with bisexual male	*164*		*571*		*115*		*376*		*45*		*136*	
Sex with person with hemophilia	*39*		*125*		*7*		*18*		*3*		*7*	
Born in Pattern-II[2] country	*1*		*3*		*277*		*1,070*		*3*		*10*	
Sex with person born in Pattern-II country	*4*		*15*		*24*		*104*		*1*		*4*	
Sex with transfusion recipient with HIV infection	*55*		*166*		*17*		*53*		*11*		*45*	
Sex with HIV-infected person, risk not specified	*387*		*766*		*898*		*1,623*		*308*		*635*	
Receipt of blood transfusion, blood components, or tissue	215	(7)	1,347	(14)	142	(2)	528	(3)	82	(3)	326	(4)
Risk not identified[3]	379	(12)	777	(8)	956	(14)	1,741	(9)	295	(12)	580	(8)
Total	**3,151**	**(100)**	**9,330**	**(100)**	**6,702**	**(100)**	**19,544**	**(100)**	**2,376**	**(100)**	**7,451**	**(100)**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[4]			
	July 1992–June 1993		Cumulative total		July 1992–June 1993		Cumulative total		July 1992–June 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	11	(13)	29	(15)	16	(40)	49	(52)	5,685	(46)	17,912	(49)
Hemophilia/coagulation disorder	1	(1)	1	(1)	–		–		24	(0)	65	(0)
Heterosexual contact:	46	(55)	86	(43)	15	(38)	27	(29)	4,556	(37)	13,301	(36)
Sex with injecting drug user	*9*		*23*		*9*		*18*		*2,152*		*7,495*	
Sex with bisexual male	*11*		*25*		*2*		*4*		*338*		*1,115*	
Sex with person with hemophilia	*–*		*2*		*1*		*1*		*50*		*153*	
Born in Pattern-I country	*1*		*1*		*–*		*–*		*282*		*1,085*	
Sex with person born in Pattern-II country	*–*		*–*		*–*		*–*		*29*		*123*	
Sex with transfusion recipient with HIV infection	*9*		*11*		*–*		*–*		*92*		*276*	
Sex with HIV-infected person, risk not specified	*16*		*24*		*3*		*4*		*1,613*		*3,054*	
Receipt of blood transfusion, blood components, or tissue	14	(17)	55	(28)	3	(8)	8	(9)	456	(4)	2,267	(6)
Risk not identified	11	(13)	29	(15)	6	(15)	10	(11)	1,651	(13)	3,145	(9)
Total	**83**	**(100)**	**200**	**(100)**	**40**	**(100)**	**94**	**(100)**	**12,372**	**(100)**	**36,690**	**(100)**

[1]Includes 6 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]See technical notes.
[3]"Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.
[4]Includes 71 women whose race/ethnicity is unknown.

Table 6. Pediatric AIDS cases by exposure category and race/ethnicity, reported July 1992 through June 1993, and cumulative totals, through June 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	July 1992–June 1993		Cumulative total		July 1992–June 1993		Cumulative total		July 1992–June 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	13	(10)	138	(15)	2	(0)	26	(1)	5	(3)	34	(3)
Mother with/at risk for HIV infection:	103	(81)	625	(66)	452	(96)	2,435	(95)	180	(93)	1,025	(89)
Injecting drug use	*34*		*277*		*150*		*1,092*		*64*		*461*	
Sex with injecting drug user	*18*		*123*		*59*		*368*		*34*		*305*	
Sex with bisexual male	*5*		*39*		*1*		*27*		*1*		*18*	
Sex with person with hemophilia	*2*		*13*		*1*		*5*		*1*		*3*	
Born in Pattern-II[1] country	–		*3*		*34*		*296*		–		*2*	
Sex with person born in Pattern-II country	–		–		*5*		*21*		–		*1*	
Sex with transfusion recipient with HIV infection	*1*		*6*		–		*4*		*1*		*8*	
Sex with HIV-infected person, risk not specified	*8*		*40*		*51*		*137*		*29*		*77*	
Receipt of blood transfusion, blood components, or tissue	*6*		*28*		*10*		*40*		*9*		*25*	
Has HIV infection, risk not specified	*29*		*96*		*141*		*445*		*41*		*125*	
Receipt of blood transfusion, blood components, or tissue	8	(6)	164	(17)	7	(1)	73	(3)	7	(4)	76	(7)
Risk not identified[2]	3	(2)	15	(2)	11	(2)	40	(2)	2	(1)	11	(1)
Total	**127**	**(100)**	**942**	**(100)**	**472**	**(100)**	**2,574**	**(100)**	**194**	**(100)**	**1,146**	**(100)**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[3]			
	July 1992–June 1993		Cumulative total		July 1992–June 1993		Cumulative total		July 1992–June 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	–		3	(14)	1	(33)	1	(7)	21	(3)	202	(4)
Mother with/at risk for HIV infection:	2	(100)	11	(52)	2	(67)	14	(93)	744	(93)	4,121	(87)
Injecting drug use	*1*		*4*		*1*		*6*		*252*		*1,844*	
Sex with injecting drug user	–		*2*		*1*		*2*		*112*		*802*	
Sex with bisexual male	–		*1*		–		–		*7*		*85*	
Sex with person with hemophilia	–		–		–		–		*4*		*21*	
Born in Pattern-II country	–		–		–		–		*34*		*301*	
Sex with person born in Pattern-II country	–		–		–		–		*5*		*23*	
Sex with transfusion recipient with HIV infection	–		–		–		–		*2*		*18*	
Sex with HIV-infected person, risk not specified	*1*		*2*		–		*2*		*90*		*260*	
Receipt of blood transfusion, blood components, or tissue	–		–		–		–		*25*		*93*	
Has HIV infection, risk not specified	–		*2*		–		*4*		*213*		*674*	
Receipt of blood transfusion, blood components, or tissue	–		7	(33)	–		–		22	(3)	321	(7)
Risk not identified	–		–		–		–		16	(2)	66	(1)
Total	**2**	**(100)**	**21**	**(100)**	**3**	**(100)**	**15**	**(100)**	**803**	**(100)**	**4,710**	**(100)**

[1]See technical notes.

[2]"Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

[3]Includes 12 children whose race/ethnicity is unknown.

Table 7. AIDS cases in adolescents and adults under age 25, by sex and exposure category, reported July 1991 through June 1992, July 1992 through June 1993,[1] and cumulative totals through June 1993, United States

	13-19 years old						20-24 years old					
	July 1991–June 1992		July 1992–June 1993		Cumulative total		July 1991–June 1992		July 1992–June 1993		Cumulative total	
Male exposure category	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	36	(32)	81	(29)	299	(33)	716	(62)	1,291	(60)	6,116	(65)
Injecting drug use	6	(5)	14	(5)	61	(7)	169	(15)	234	(11)	1,166	(12)
Men who have sex with men and inject drugs	5	(4)	5	(2)	42	(5)	110	(10)	185	(9)	995	(11)
Hemophilia/coagulation disorder	54	(47)	147	(52)	409	(45)	37	(3)	131	(6)	352	(4)
Heterosexual contact:	2	(2)	13	(5)	28	(3)	55	(5)	98	(5)	330	(3)
Sex with injecting drug user	–		*6*		*10*		*27*		*33*		*123*	
Sex with person with hemophilia	–		*1*		*1*		–		–		*1*	
Born in Pattern-II[2] country	–		*1*		*8*		*7*		*12*		*92*	
Sex with person born in Pattern-II country	–		–		*1*		–		*1*		*1*	
Sex with transfusion recipient with HIV infection	–		–		–		*2*		*2*		*7*	
Sex with HIV-infected person, risk not specified	*2*		*5*		*8*		*19*		*50*		*106*	
Receipt of blood transfusion, blood components, or tissue	6	(5)	7	(2)	36	(4)	11	(1)	13	(1)	78	(1)
Risk not identified[3]	5	(4)	17	(6)	38	(4)	54	(5)	191	(9)	409	(4)
Male subtotal	114	(100)	284	(100)	913	(100)	1,152	(100)	2,143	(100)	9,446	(100)
Female exposure category												
Injecting drug use	16	(28)	12	(8)	82	(21)	125	(32)	231	(29)	847	(35)
Hemophilia/coagulation disorder	1	(2)	–		4	(0)	–		4	(0)	8	(0)
Heterosexual contact:	29	(51)	93	(65)	208	(54)	206	(54)	401	(50)	1,193	(50)
Sex with injecting drug user	*19*		*34*		*115*		*124*		*196*		*689*	
Sex with bisexual male	*1*		*6*		*10*		*15*		*26*		*99*	
Sex with person with hemophilia	*2*		*1*		*6*		*1*		*7*		*24*	
Born in Pattern-II country	*1*		*5*		*11*		*6*		*8*		*60*	
Sex with person born in Pattern-II country	–		*1*		*2*		*2*		*1*		*12*	
Sex with transfusion recipient with HIV infection	–		*1*		*2*		–		*1*		*6*	
Sex with HIV-infected person, risk not specified	*6*		*45*		*62*		*58*		*162*		*303*	
Receipt of blood transfusion, blood components, or tissue	2	(4)	9	(6)	36	(9)	9	(2)	21	(3)	79	(3)
Risk not identified	9	(16)	30	(21)	58	(15)	45	(12)	145	(18)	267	(11)
Female subtotal	57	(100)	144	(100)	388	(100)	385	(100)	802	(100)	2,394	(100)
Total	**171**		**428**		**1,301**		**1,537**		**2,945**		**11,840**	

[1]Includes 6 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]See technical notes.
[3]"Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

Table 8. AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through June 1993,[1] United States

Males Age at diagnosis (years)	White, not Hispanic No.	(%)	Black, not Hispanic No.	(%)	Hispanic No.	(%)	Asian/Pacific Islander No.	(%)	American Indian/ Alaska Native No.	(%)	Total[2] No.	(%)
Under 5	313	(0)	1,117	(1)	466	(1)	8	(0)	8	(1)	1,916	(1)
5-12	242	(0)	178	(0)	143	(0)	6	(0)	1	(0)	570	(0)
13-19	434	(0)	284	(0)	174	(0)	11	(1)	10	(2)	913	(0)
20-24	4,466	(3)	3,051	(4)	1,829	(4)	65	(4)	21	(4)	9,446	(3)
25-29	22,109	(15)	11,251	(15)	7,196	(16)	245	(13)	109	(20)	40,991	(15)
30-34	35,468	(23)	17,682	(23)	10,899	(24)	373	(20)	157	(28)	64,693	(23)
35-39	33,713	(22)	17,928	(23)	9,903	(22)	398	(22)	112	(20)	62,200	(22)
40-44	24,075	(16)	11,980	(16)	6,544	(15)	312	(17)	72	(13)	43,082	(16)
45-49	14,268	(9)	6,232	(8)	3,472	(8)	199	(11)	32	(6)	24,255	(9)
50-54	7,661	(5)	3,466	(5)	1,878	(4)	100	(5)	14	(3)	13,149	(5)
55-59	4,407	(3)	1,942	(3)	1,096	(2)	57	(3)	9	(2)	7,536	(3)
60-64	2,628	(2)	1,066	(1)	546	(1)	19	(1)	9	(2)	4,272	(2)
65 or older	2,217	(1)	794	(1)	397	(1)	36	(2)	3	(1)	3,453	(1)
Male subtotal	152,001	(100)	76,971	(100)	44,543	(100)	1,829	(100)	557	(100)	276,476	(100)
Females **Age at diagnosis (years)**												
Under 5	309	(3)	1,100	(5)	436	(5)	1	(0)	6	(6)	1,859	(5)
5-12	78	(1)	179	(1)	101	(1)	6	(3)	–		365	(1)
13-19	96	(1)	231	(1)	58	(1)	1	(0)	1	(1)	388	(1)
20-24	610	(6)	1,218	(6)	541	(7)	10	(5)	9	(9)	2,394	(6)
25-29	1,712	(18)	3,463	(17)	1,559	(20)	20	(10)	23	(23)	6,786	(17)
30-34	2,196	(23)	5,094	(24)	1,933	(24)	39	(19)	28	(28)	9,308	(24)
35-39	1,707	(18)	4,560	(22)	1,526	(19)	32	(15)	12	(12)	7,855	(20)
40-44	987	(10)	2,514	(12)	879	(11)	37	(18)	9	(9)	4,433	(11)
45-49	526	(5)	1,033	(5)	400	(5)	16	(8)	5	(5)	1,987	(5)
50-54	329	(3)	628	(3)	246	(3)	11	(5)	2	(2)	1,218	(3)
55-59	314	(3)	352	(2)	144	(2)	8	(4)	1	(1)	821	(2)
60-64	239	(2)	218	(1)	81	(1)	11	(5)	3	(3)	552	(1)
65 or older	614	(6)	233	(1)	84	(1)	15	(7)	1	(1)	948	(2)
Female subtotal	9,717	(100)	20,823	(100)	7,988	(100)	207	(100)	100	(100)	38,914	(100)
Total	**161,718**		**97,794**		**52,531**		**2,036**		**657**		**315,390**	

[1]Includes 6 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]Includes 575 males and 79 females whose race/ethnicity is unknown.

Table 9. AIDS cases, case-fatality rates,[1] and deaths, by half-year and age group, through June 1993,[2] United States

Half-year	Adults/adolescents			Children <13 years old		
	Cases diagnosed during interval	Case-fatality rate	Deaths occurring during interval	Cases diagnosed during interval	Case-fatality rate	Deaths occurring during interval
Before 1981	93	79.6	30	7	71.4	1
1981 Jan.–June	98	89.8	37	11	81.8	2
July–Dec.	210	91.4	87	5	100.0	7
1982 Jan.–June	408	92.2	155	14	85.7	8
July–Dec.	707	91.2	289	15	80.0	5
1983 Jan.–June	1,304	93.3	525	33	100.0	13
July–Dec.	1,660	93.1	938	42	90.5	16
1984 Jan.–June	2,575	92.7	1,405	51	84.3	26
July–Dec.	3,410	92.7	1,978	61	86.9	22
1985 Jan.–June	4,955	92.2	2,829	98	76.5	45
July–Dec.	6,372	91.5	3,901	130	81.5	70
1986 Jan.–June	8,400	90.3	5,108	136	82.4	64
July–Dec.	10,030	88.2	6,574	189	70.9	92
1987 Jan.–June	13,069	88.6	7,613	220	71.8	118
July–Dec.	14,535	85.4	8,010	260	67.7	168
1988 Jan.–June	16,771	83.0	9,389	258	64.7	134
July–Dec.	17,342	82.6	10,745	339	59.9	174
1989 Jan.–June	19,925	78.2	12,363	347	59.7	172
July–Dec.	20,201	75.8	14,200	337	54.6	185
1990 Jan.–June	22,200	69.9	14,346	355	51.0	192
July–Dec.	21,705	64.5	15,211	375	41.3	190
1991 Jan.–June	25,008	56.3	15,757	351	40.2	161
July–Dec.	26,415	46.4	17,244	301	32.6	189
1992 Jan.–June	28,933	32.4	16,904	362	30.7	166
July–Dec.	28,090	19.6	16,495	287	24.7	180
1993 Jan.–June	16,111	9.0	9,419	126	16.7	107
Total[3]	**310,680**	**61.7**	**191,824**	**4,710**	**53.3**	**2,510**

[1]Case-fatality rates are calculated for each half-year by date of diagnosis. Each 6-month case-fatality rate is the number of deaths ever reported among cases diagnosed in that period (regardless of the year of death), divided by the number of total cases diagnosed in that period, multiplied by 100. For example, during the interval January through June 1982, AIDS was diagnosed in 408 adults/adolescents. Through June 1993, 376 of these 408 were reported as dead. Therefore, the case fatality rate is 92.2 (376 divided by 408, multiplied by 100). The case-fatality rates shown here may be underestimates because of incomplete reporting of deaths. Reported deaths are not necessarily caused by HIV-related disease.

[2]Includes 6 months of data collected under the 1993 AIDS surveillance case defintion for adults and adolescents.

[3]Case totals include 153 patients whose date of diagnosis is unknown. Death totals include 282 adults/adolescents and 3 children known to have died, but whose dates of death are unknown.

Table 10. AIDS cases by year of diagnosis and definition category, diagnosed through June 1993,[1] United States

Definition category	Period of diagnosis: Before June 1989 No.	(%)	July 1989–June 1990 No.	(%)	July 1990–June 1991 No.	(%)	July 1991–June 1992 No.	(%)	July 1992–June 1993 No.	(%)	Cumulative total[4] No.	(%)
Pre-1987 definition	99,383	(80)	28,311	(66)	28,538	(60)	28,074	(50)	14,883	(33)	199,189	(63)
1987 definition	23,648	(19)	13,158	(31)	15,202	(32)	17,087	(31)	10,504	(24)	79,600	(25)
1993 definition[2]	1,067	(1)	1,618	(4)	3,699	(8)	10,841	(19)	19,224	(43)	36,601	(12)
Severe HIV-related immunosuppression[3]	*766*		*1,353*		*3,118*		*9,740*		*17,812*		*32,846*	
Pulmonary tuberculosis	*263*		*239*		*534*		*955*		*1,013*		*3,099*	
Recurrent pneumonia	*29*		*26*		*43*		*129*		*366*		*593*	
Invasive cervical cancer	*11*		*4*		*8*		*26*		*40*		*89*	
Total	**124,098**	**(100)**	**43,087**	**(100)**	**47,439**	**(100)**	**56,002**	**(100)**	**44,611**	**(100)**	**315,390**	**(100)**

[1]Includes 6 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]Persons who meet only the 1993 AIDS case definition and whose date of diagnosis is before January 1993 were diagnosed retrospectively. The sum of diagnoses listed for the four conditions under the 1993 definition do not equal the 1993 definition total because some persons have more than one diagnosis from the added conditions of pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.
[3]Defined as CD4+ T-lymphocyte count of less than 200 cells/μL or a CD4+ percentage less than 14 in persons with laboratory confirmation of HIV infection.
[4]Totals include 153 patients whose date of diagnosis is unknown.

Table 11. Health-care workers with documented and possible occupationally acquired AIDS/HIV infection, by occupation, reported through June 1993, United States[1]

Occupation	Documented occupational transmission[2] No.	Possible occupational transmission[3] No.
Dental worker, including dentist	–	7
Embalmer/morgue technician	–	3
Emergency medical technician/paramedic	–	7
Health aide/attendant	1	8
Housekeeper/maintenace worker	1	6
Laboratory technician, clinical	14	13
Laboratory technician, nonclinical	1	1
Nurse	13	15
Physician, nonsurgical	4	8
Physician, surgical	–	2
Respiratory therapist	1	1
Technician, dialysis	1	1
Technician, surgical	1	1
Technician/therapist, other than those listed above	–	3
Other health-care occupations	–	2
Total	**37**	**78**

[1]Health-care workers are defined as those persons, including students and trainees, who have worked in a health-care, clinical, or HIV laboratory setting at any time since 1978. See *MMWR* 1992;41:823-5.
[2]Health-care workers who had documented HIV seroconversion after occupational exposure: 32 had percutaneous exposure, 4 had mucocutaneous exposure, 1 had both percutaneous and mucocutaneous exposures. Thirty-four exposures were to blood from an HIV-infected person, 1 to visibly bloody fluid, 1 to an unspecified fluid, and 1 to concentrated virus in a laboratory. Eight of these health-care workers have developed AIDS.
[3]These health-care workers have been investigated and are without identifiable behavioral or transfusion risks; each reported percutaneous or mucocutaneous occupational exposures to blood or body fluids, or laboratory solutions containing HIV, but HIV seroconversion specifically resulting from an occupational exposure was not documented.

Table 12. Adult/adolescent AIDS cases by single and multiple exposure categories, reported through June 1993, United States

Exposure category	AIDS cases No.	AIDS cases (%)
Single mode of exposure		
Men who have sex with men	166,023	(53)
Injecting drug use	62,414	(20)
Hemophilia/coagulation disorder	2,057	(1)
Heterosexual contact	21,133	(7)
Receipt of transfusion[1]	5,727	(2)
Receipt of transplant of tissues/organs[2]	6	(0)
Other[3]	12	(0)
Single mode of exposure subtotal	**257,372**	**(83)**
Multiple modes of exposure		
Men who have sex with men; injecting drug use	17,547	(6)
Men who have sex with men; hemophilia/coagulation disorder	76	(0)
Men who have sex with men; heterosexual contact	3,410	(1)
Men who have sex with men; receipt of transfusion/transplant	2,397	(1)
Injecting drug use; hemophilia/coagulation disorder	79	(0)
Injecting drug use; heterosexual contact	9,619	(3)
Injecting drug use; receipt of transfusion/transplant	1,059	(0)
Hemophilia/coagulation disorder; heterosexual contact	20	(0)
Hemophilia/coagulation disorder; receipt of transfusion/transplant	670	(0)
Heterosexual contact; receipt of transfusion/transplant	740	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder	18	(0)
Men who have sex with men; injecting drug use; heterosexual contact	1,553	(0)
Men who have sex with men; injecting drug use; receipt of transfusion/transplant	365	(0)
Men who have sex with men; hemophilia/coagulation disorder; heterosexual contact	3	(0)
Men who have sex with men; hemophilia/coagulation disorder; receipt of transfusion/transplant	26	(0)
Men who have sex with men; heterosexual contact; receipt of transfusion/transplant	148	(0)
Injecting drug use; hemophilia/coagulation disorder; heterosexual contact	19	(0)
Injecting drug use; hemophilia/coagulation disorder; receipt of transfusion/transplant	25	(0)
Injecting drug use; heterosexual contact; receipt of transfusion/transplant	387	(0)
Hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	15	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder; heterosexual contact	2	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder; receipt of transfusion/transplant	5	(0)
Men who have sex with men; injecting drug use; heterosexual contact; receipt of transfusion/transplant	66	(0)
Men who have sex with men; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	2	(0)
Injecting drug use; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	8	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	1	(0)
Multiple modes of exposure subtotal	**38,260**	**(12)**
Risk not identified[4]	**15,048**	**(5)**
Total	**310,680**	**(100)**

[1]Includes 23 adult/adolescents who developed AIDS after receiving blood screened negative for HIV antibody.
[2]Six adults developed AIDS after receiving tissue from HIV-infected donors. Three of the 6 received tissue or organs from a donor who was negative for HIV antibody at the time of donation. See *N Engl J Med* 1992;326:726-32.
[3]"Other" refers to 8 health-care workers who developed AIDS after occupational exposure to HIV-infected blood, as documented by evidence of seroconversion; to 2 patients who developed AIDS after exposure to HIV within the health-care setting, as documented by laboratory studies; to 1 person who acquired HIV infection perinatally and was diagnosed with AIDS after age 13; and to 1 person with intentional self-inoculation of blood from an HIV-infected person.
[4]"Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

Figure 1. Male adult/adolescent AIDS annual rates per 100,000 population, for cases reported July 1992 through June 1993, United States

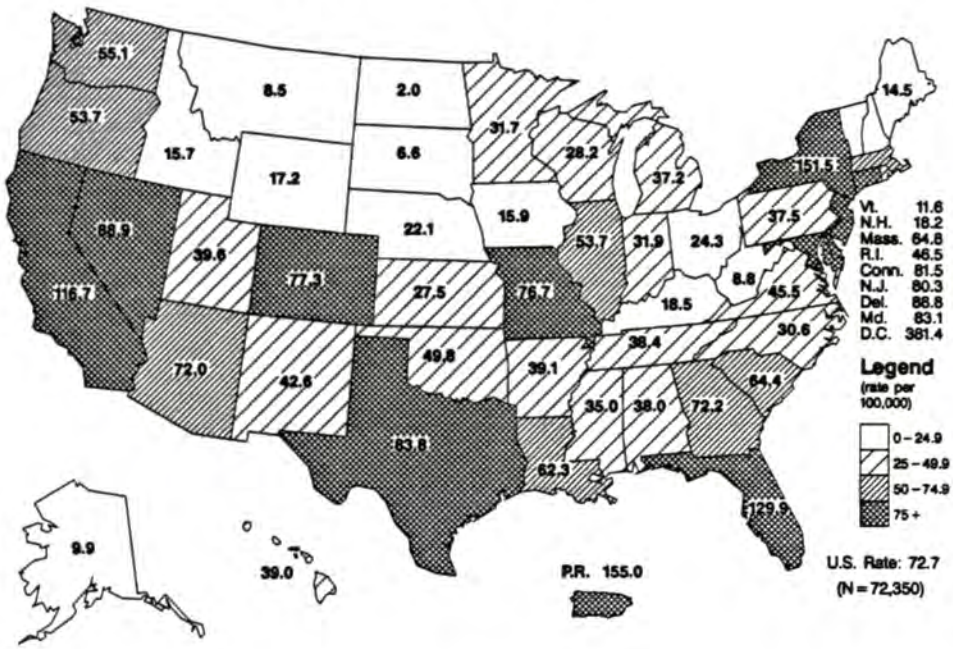


Figure 2. Female adult/adolescent AIDS annual rates per 100,000 population, for cases reported July 1992 through June 1993, United States

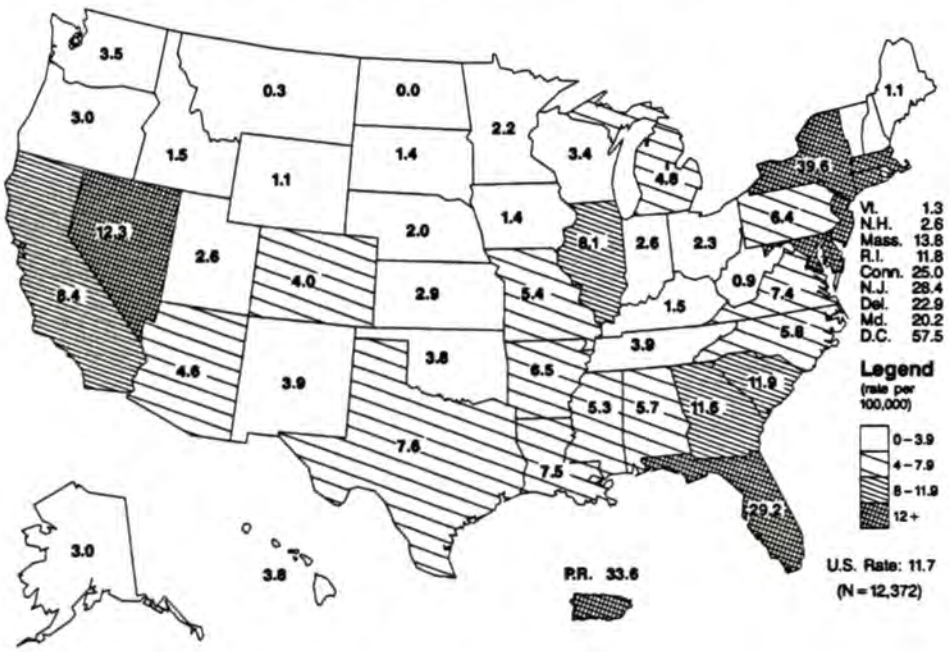
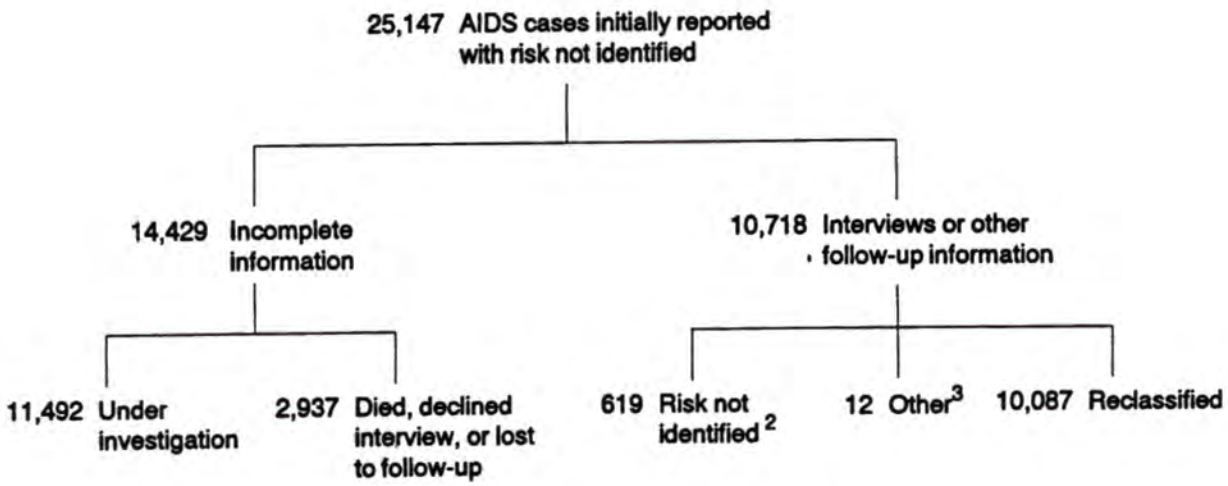


Figure 3. Male adult/adolescent AIDS cases reported July 1992 through June 1993, United States

Figure 4. Female adult/adolescent AIDS cases reported July 1992 through June 1993, United States

Figure 5. Pediatric AIDS cases reported July 1992 through June 1993, United States

Figure 6. Results of investigations of adult/adolescent AIDS cases with risk not identified, reported through June 1993[1]



[1]Excludes 66 children under 13 years of age whose risk is not identified: 56 children who are under investigation and 10 who have died, declined interview, or were lost to follow-up. An additional 201 children who were initially reported with a risk not identified have been reclassified after investigation.

[2]Heterosexual transmission. 533 of the 619 persons who had no risk identified after follow-up responded to a standardized questionnaire: 178 (36%) of 491 persons responding to questions related to sexually transmitted diseases gave a history of such diseases and 119 (36%) of 330 interviewed men reported sexual contact with a prostitute. Some of these persons may represent unreported or unrecognized heterosexual transmission of HIV. See *MMWR*;38:423-4, 429-34.

[3]Eight are health-care workers who developed AIDS after occupational exposure to HIV-infected blood, as documented by evidence of seroconversion; 2 are patients who developed AIDS after exposure to HIV within the health-care setting, as documented by laboratory studies; 1 is a person who acquired HIV infection perinatally and was diagnosed with AIDS after age 13; and 1 is a person with intentional self-inoculation of blood from an HIV-infected person.

Technical notes

Surveillance and reporting of AIDS

All 50 states, the District of Columbia, U.S. dependencies and possessions, and independent nations in free association with the United States[1] report AIDS cases to CDC using a uniform case definition and case report form. The original definition was modified in 1985 (*MMWR* 1985;34:373-5), in 1987 (*MMWR* 1987;36[suppl. no. 1S]:1S-15S), and again in 1993 (*MMWR* 1992;41[no. RR-17]:1-19). The revisions incorporated a broader range of AIDS-indicator diseases and conditions and used human immunodeficiency virus (HIV) diagnostic tests to improve the sensitivity and specificity of the definition.

For persons with laboratory-confirmed HIV infection, the 1987 revision incorporated HIV encephalopathy, wasting syndrome, and other indicator diseases that are diagnosed presumptively (i.e., without confirmatory laboratory evidence of the opportunistic disease). In addition to the 23 clinical conditions in the 1987 AIDS case definition, the 1993 expanded case definition for adults and adolescents includes HIV-infected persons with CD4+ T-lymphocyte counts of less than 200 cells/μL or a CD4+ percentage of less than 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia (more than 2 episodes in a 12-month period), and invasive cervical cancer. This expanded definition requires laboratory confirmation of HIV infection in a person with a CD4+ T-lymphocyte count of less than 200 cells/μL or with one of the added clinical conditions. Persons who meet the criteria for more than one definition category are classified hierarchically in the following order: pre-1987, 1987, and 1993. Persons in the 1993 definition category only meet the 1993 definition.

Each issue of this report includes information received and tabulated by CDC through the last day of the previous quarter. Data are tabulated by date of report to CDC unless otherwise noted. Data for U.S. dependencies and possessions and for associated independent nations are included in the totals.

Age group tabulations are based on the person's age at diagnosis of AIDS: adult/adolescent cases include persons 13 years of age and older; pediatric cases include children under 13 years of age.

Metropolitan areas with 500,000 or more population are included in this report. On December 31, 1992, the Office of Management and Budget announced new Metropolitan Statistical Area (MSA) definitions which reflect changes in the U.S. population determined by the 1990 census. These definitions were revised on June 30, 1993. The cities and counties which compose each metropolitan area in Table 2 are listed in the publication "Revised Statistical Definitions for Metropolitan Areas" (available from National Technical Information Service, accession no. PB93-505-824).

The metropolitan area definitions are the MSAs for all areas except the 6 New England states. For these states, the New England County Metropolitan Areas (NECMA) are used. Metropolitan areas are named for a central city in the MSA or NECMA, may include several cities and counties, and may cross state boundaries. For example, AIDS cases and annual rates presented for the District of Columbia in Table 1 include only persons residing within the geographic boundaries of the District. AIDS cases and annual rates for Washington, D.C., in Table 2 include persons residing within the metropolitan area, which includes counties in both Maryland and Virginia. State or metropolitan area data tabulations are based on the person's residence at diagnosis of the first AIDS-indicator disease(s).

Data in this report are provisional. Reporting delays (time between diagnosis and report to CDC) vary widely among exposure, geographic, racial/ethnic, and age categories, and have been as long as several years for some cases. About 55 percent of all cases are reported within 3 months of diagnosis, but about 20 percent are reported more than 1 year after diagnosis.

Although completeness of reporting of diagnosed cases varies by geographic region and population, studies conducted by state and local health departments indicate that reporting of AIDS cases in most areas of the United States is more than 85 percent complete (*J Acquir Immune Defic Syndr*, 1992;5:257-64; and *Am J Public Health* 1992;82:1495-9). In addition, multiple routes of exposure, opportunistic diseases diagnosed after the initial case report was submitted to CDC and vital status may not be deter-

[1] Included among the dependencies, possessions, and independent nations are Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Republic of Palau, the Republic of the Marshall Islands, the Commonwealth of the Northern Mariana Islands, and the Federated States of Micronesia. The latter 5 comprise the category "Pacific Islands, U.S." listed in Table 1.

mined or reported for all cases. Caution should be used in interpreting case-fatality rates because reporting of deaths is incomplete.

Exposure categories

For surveillance purposes, AIDS cases are counted only once in a hierarchy of exposure categories. Persons with more than one reported mode of exposure to HIV are classified in the category listed first in the hierarchy, except for men with both a history of sexual contact with other men and injecting drug use. They make up a separate category.

"Men who have sex with men" cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact). "Heterosexual contact" cases include persons who report either specific heterosexual contact with a person with (or at increased risk for) HIV infection (e.g., an injecting drug user), or persons presumed to have acquired HIV infection through heterosexual contact if they were born in countries with a distinctive pattern of transmission termed "Pattern II" by the World Health Organization (*MMWR* 1988;37:286-8, 293-5). Pattern II transmission is observed in areas of sub-Saharan Africa and in some Caribbean countries. In these countries, most of the reported cases occur in heterosexuals and the male-to-female ratio is approximately 1:1. Injecting drug use and homosexual transmission either do not occur or occur rarely.

"Risk not identified" cases are persons with no reported history of exposure to HIV through any of the routes listed in the hierarchy of exposure categories. Risk not identified cases include persons who are currently under investigation by local health department officials; persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow-up; and persons who were interviewed or for whom other follow-up information was available and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified into the appropriate exposure category.

Rates

Rates are calculated on an annual basis per 100,000 population, based on U.S. Bureau of Census data from the 1990 census, and on extrapolations from the 1990 census and official Census Bureau estimates for 1991. Each 12-month rate is the number of cases for a 12-month period divided by the 1991 or 1992 population, multiplied by 100,000.

Case-fatality rates are calculated for each half-year by date of diagnosis. Each 6-month case-fatality rate is the number of deaths ever reported among cases diagnosed in that period (regardless of the year of death), divided by the number of total cases diagnosed in the period, multiplied by 100. Reported deaths are not necessarily caused by HIV-related disease.

PM69B17566079325

NATIONAL LEADERSHIP COALITION ON AIDS

MEMORANDUM

Ceremony — bio

Return — put in my file for these speeches —

TO: Kristine Gebbie

THRU: Lance Alworth, Jr.

FROM: B.J. Stiles BJS

DATE: August 31, 1993

RE: Corporate leadership in AIDS

Here is a copy of AT&T's magazine, Focus, and a draft for a Clinton letter to the CEO, Robert E. Allen. Should some kind of communication occur between the White House and AT&T, please keep me informed.

Also, I'm pleased to share with you the text of a July speech by a Chubb executive. I think the speech is a model example of what corporate people are saying and doing in AIDS. You may wish to consider citing this as an example in your presentations in Chicago and Nashville, and adding Chubb to the list of corporations setting leadership examples.

Many thanks.

1730 M Street, NW
Suite 905
Washington, DC 20036
202/429-0930
FAX: 202/872-1977

CHUBB

CHUBB GROUP OF INSURANCE COMPANIES

[illegible] P O Box 1615, Warren, New Jersey 07061-1615

JAN TOMLINSON

AIDS IN THE WORKPLACE

NEW JERSEY SUMMIT ON AIDS

DOUGLAS COLLEGE CAMPUS OF RUTGERS 7/28/93

Good morning. I am pleased to be here this morning and to have the opportunity to share with you Chubb's approach to AIDS education and how we manage workplace issues. While it is a Chubb story, I believe you will be able to develop some thoughts and ideas of your own about AIDS awareness in the private sector

For those of you who may not recognize our name, Chubb is a diversified, financial services company primarily involved in underwriting property/liability insurance worldwide. We were founded in New York in 1882 as an ocean cargo insurer. Today, we have 78 offices in 24 countries and employ close to 10,000 people worldwide. About 3,000 are located in New Jersey, and we are headquartered in Warren, New Jersey.

You might wonder why a company like Chubb would take a pro-active role in AIDS Education. Chubb's interest in actively managing AIDS awareness in our workplace was a combination of practical concerns and traditional values. Over time, we've found that "doing what's best for the company" usually means doing "what's best for employees"... it's a cultural expectation that has guided our approach to this and many other issues that directly affect our people and their ability to perform.

In 1986, Chubb's Senior Management became increasingly aware of the issue of AIDS and the potentially devastating impact that it might have on employees' health and the health of their families. It was also a time when little was known about the disease.

Chubb firmly believed that corporations needed to play a role in communicating the facts about AIDS to ALL employees. Based in large part on this vision, in early 1987, we introduced an AIDS awareness program which all employees were required to attend. It included a video, a case study, and a question and answer session. We also provided all employees with a brochure describing how to prevent the spread of the disease.

Our main objectives were to:

1. prepare employees to deal with AIDS in the workplace in a manner consistent with company guidelines;

2. to decrease personal anxiety levels about AIDS so that individual responses could be based on fact rather than fear;

3. to promote individual responsibility for one's own health and personal safety;

4. and to provide information including outside sources of information and assistance.

As a result, affected employees felt comfortable about sharing their personal stories in the days that followed the AIDS training. It was at that point that we knew that this training had "legitimized" AIDS as being something that was okay to talk about in the workplace.

Simply stated, facts replaced fears.

1987 marked another milestone in our AIDS awareness. This was the year Chubb also became a member of the National Leadership Coalition on AIDS, an organization in Washington, DC, which is dedicated to working with private sector leaders to create a more thoughtful climate in which to address the AIDS epidemic. Since 1987, Chubb has been active in the Coalition by participating in their seminars and, most recently, providing case studies for an upcoming publication which will illustrate employer efforts to help employees with HIV or AIDS to keep working.

Many of you who represent small business may be wondering how you can afford the type of AIDS training I have been discussing. My response to you is, can you afford NOT to? Based on national cost estimates, we believe the cost of AIDS to Chubb to be approximately $150,000 per case from diagnosis to death. This figure addresses only the real costs, such as hospital, in-home health care, drugs, disability costs, and death benefits. The intangible costs such as employee suffering, absenteeism, and lost productivity are immeasurable.

Our involvement with the Coalition has proved to us that by working with other employers we can collectively respond to the crisis swiftly, intelligently, and effectively. The quality of the materials available through the Coalition and through other organizations such as the Bureaus of Health and the American Red Cross make it easy for ANY organization to provide quality, factual AIDS education to their employees at a nominal cost.

Our early commitment to AIDS education has proven to be forward thinking as the spread of the disease has escalated. In 1980, perhaps 100,000 people worldwide were HIV-infected; today, it's 12 million. By the year 2000, the conservative estimate is 40 million.

In Southeast Asia and Latin America, the spread of the epidemic is most evident. Because our operations extend to these areas, we have a COMMITMENT to accept the social and cultural issues of the countries in which we do business and where our employees live and travel. The diversity and sophistication of our worldwide employee population demands human resources policies that are fair, compassionate, and reflect current social and cultural concerns. Clearly AIDS is an issue we CANNOT, and WILL NOT, ignore.

In addition, the Americans with Disabilities Act has recently brought to the forefront the inclusion of AIDS as a disability that the private sector MUST manage. Our goal is to handle the disability process for employees who contract AIDS in a thoughtful, sensitive manner;

EXACTLY AS WE WOULD FOR ANY OTHER INDIVIDUAL WHO CONTRACTS A LIFE-THREATENING DISEASE.

We also recognize that our employees may be dealing with siblings, children, grandchildren or other family or friends with AIDS. Our response to AIDS in the workplace means creating an environment where our managers can be sensitive to the social stigma which still surrounds AIDS and provide a supportive atmosphere where employees can seek advice and discuss their concerns without fear.

I would like to share with you two cases that illustrate our philosophy. In 1991, a department manager began to notice progressive fatigue in one of his employees and counseled him to see his doctor and take rest periods at appropriate times throughout the work day. Shortly thereafter, the employee was diagnosed with AIDS Related Complex following hospitalization for pneumonia and fatigue.

While out on disability, the employee contacted our Health Department to discuss options for revealing his diagnosis to his manager. It was strongly suspected by his managers and co-workers that he had AIDS. The employee gave written permission to have his diagnosis disclosed but was frightened about the reaction of his co-workers, fearing rejection. He decided that only his manager should be made aware of his diagnosis and that our nurse would meet with him on his behalf.

His manager accepted the information and worked out accommodations upon his return to work. There have been at least two episodes of disability since his return to work. His co-workers, again assuming the diagnosis, have remained in touch with him, have invited him to lunch, sent cards, and kept him aware of office happenings.

It is now evident that this employee will not return to work. His co-workers have maintained their relationships with him, and the employee still feels connected to his work group. He has chosen not to discuss the issue any further with either his management or his co-workers. There does not seem to be a need for any further discussion. Chubb's employee assistance program has been offered to the employee and his family and all normal disability processes have occurred.

Here's another example: a male employee approached both his department and human resources managers advising them of his condition. He was far enough along in the disease process that he knew a work accommodation was necessary and that soon disability would be needed. He supervised a work unit which required physical energy that he no longer had. He felt he wanted to share information about his illness with his unit workers but was not sure how they would react.

In conjunction with his department and human resources managers, they decided it appropriate to have our nurse present the AIDS workshop as a refresher course to all branch employees. The employee sat in an adjoining room and listened to his co-workers' reactions, found them to be supportive, and later that day he disclosed his diagnosis to his unit workers. They offered

encouragement and understanding, and kept the information he shared with them private. The employee continued to work full-time, then went to a short week schedule, and eventually went out on complete disability. He has since died.

To my mind, these cases exemplify the way that business should respond to AIDS in the workplace. We should create an environment that allows our employees to continue to contribute as long as they are able.

Overall, we should maintain an environment that supports open, honest communication about the disease and our response to an employee who contracts it. From our perspective, this is not only the right thing to do, it also makes business sense. Because if employees are anxious and concerned, those fears come to the workplace with them and ultimately impact their ability to contribute.

We do not believe our role includes conducting AIDS testing, given the fact that the disease is not transmitted via the workplace. Testing would not change our course of action, anyway. We do recognize that in some parts of the world local regulations require testing. We emphasize with our employees that it is not a Chubb requirement.

We intend to maintain our commitment to fighting AIDS by following this course of action. First, we plan to integrate our education as part of our on-going wellness program by keeping current quality educational materials available for employees and providing on-going educational seminars as new developments unfold.

For example, in 1992 we updated our original video to include both recent statistics as well as a stronger message from an AIDS victim. The second video demonstrates our intent to share what some would consider extremely explicit information with respect to how AIDS is transmitted. And, earlier this year, we distributed to all employees copies of educational materials developed by the Coalition, which address concerns about secondary conditions which can arise as a result of AIDS, such as tuberculosis. We believe our employees are entitled to a safe workplace. By sharing accurate, timely information about the AIDS virus we will contribute to their ongoing knowledge of this epidemic.

Second, we will maintain our philosophy of making appropriate workplace accommodations based on each individual situation and his or her job. We have worked hard these past few years to help our managers feel comfortable discussing AIDS with their employees. It is gratifying to me to see the change in the questions I now receive. A few weeks ago, I received a phone call from one of our branch managers. This particular branch had experienced employees with AIDS before and the branch manager suspected that one of his employees had AIDS even though the employee had not confided his illness with anyone. However, it was obvious that he was ill and he was dangerously close to being terminated for abusing our attendance policy. Despite all the training we have done, he was still unwilling to acknowledge whatever his illness was.

The branch manager did not want to see this employee lose his job or his benefits, but he did not know how to go about getting the employee to admit that he was ill and could, therefore, qualify for disability attendance procedures. They decided to have a colleague close to the employee express concern over the employee's health. The employee revealed he did indeed have AIDS and was afraid of losing his job, his salary, and his benefits. The colleague counseled the employee to go to human resources.

The employee subsequently did visit his human resources manager who allayed his fears about his work situation and an appropriate workplace accommodation was made.

Thirdly, we want to maintain an environment that supports open, honest communication about the disease and our response to an employee who contracts it. Those who express concern need to be heard and counselled on the facts of the disease. We are committed to a management group and human resources staff educated about the illness, capable of counselling employees, and readily able to understand the necessity for and the ability to manage workplace accommodations.

Businesses can no longer say that AIDS is a legal issue -- let the lawyers handle it; or that it is a political issue -- let the politicians handle it; or even that it is a public health issue -- let the medical community handle it. The private sector **MUST** remain involved because AIDS is TOO large and TOO devastating an issue to handle individually.

In closing, I would like to remind those of you in the audience from the private sector that what occurs in society occurs in your employee group. **AIDS IS NO DIFFERENT.** It is up to all of us to collectively combat the disease. We all have something at stake.

Thank you.

AIDS.1TK/el

Single slide - (do need two slide of the new stamp)

who's organizing this trip? I'd like to have some time to Callum Conway Welch Dean Vanderbuilt ! Sch. of Nsg

BG Stiles was talking about a reception the evening before

should VP Gore's office on any key contacts we recommend

If the Nashville reception can be scheduled we could - the 23rd so I can accept this ?

STATE OF TENNESSEE
CORDELL HULL BUILDING
DEPARTMENT OF HEALTH
NASHVILLE, TENNESSEE 37247

To: Tennessee Business Responds To AIDS Conference Speakers

From: Matt Nelson, MSW
Conference Coordinator

Re: Conference Agenda and Plans

Date: September 3, 1993

Thank you for agreeing to participate in the Tennessee Busi Responds to AIDS Conference. Your willingness to share your time and experience is greatly appreciated and will make the conference more meaningful for all participants.

Enclosed you will find a finalized agenda. Please be sure to check the time listed for your portion of the program to determine if any changes have occurred since you were originally asked to participate. Some of the items may have been moved by fifteen minutes or so from what you were originally told.

Also enclosed is a brief description of the purpose/business thrust of each segment of the program involving a panelist. You will note that there is time allotted for questions at the end of each panel. These questions will be open to members of the audience or may come from your moderator. I also need to know as soon as possible if you need any audio-visual equipment. If you have questions after looking over your portion of this information, please give me a call at (615) 741-7500. Otherwise, I look forward to seeing you at the conference.

10:15 - 10:30 (15 min.) — Business Responds to AIDS: A Comprehensive Workplace Program

Fred Kroger, Director
National AIDS Information and Education Program
Centers for Disease Control and Prevention

This section will detail the BRTA Program as a primary tool for business leaders to use in developing policy and workplace education.

10:30 - 10;45 (15 min.) — Legal Issues and the ADA

Matt Lonergan, Esq.
Boult, Cummings, Conners and Berry

This presentation will stress the specific legal issues, including the American with Disabilities Act, that businesses must consider when addressing HIV in the workplace.

10:45 - 11:00 (15 min.) — Dealing with Sensitive Issues

Frances Cooper
Communication Technologies

Dr. Cooper, a consultant with the National Association of Broadcasters, will discuss innovative and creative ways of presenting sensitive information to various audiences.

11:00 - 11:10 (10 min.) — There will be 10 minutes for questions following these three speakers.

11:10 - 11:55 (35 min. + 10 min. of questions) — Partnerships and Resources

Stephen Raffanti, M.D. (10 min.)
Nashville Mayor's Task Force
Neil Diehl (10 min.)
Community AIDS Partnership of Middle Tenn.
Sam Coleman (5 min.)
Nashville CARES: representing Tennessee's network of Community-based Organizations
Elizabeth Owen (5 min.)
Nashville Red Cross
Wilma Templin-Branner (5 min.)
Knox County Health Department

This panel is designed to describe and promote the numerous partnerships and HIV-related resources, both in Nashville and across the state.

11:55 — Closing

Robert H. Gaskill, Vice President
Tennessee Association of Business

Business Responds To AIDS
September 23, 1993

8:00 A.M. (10 min.) — Welcome

Phil Bredeson, Nashville Mayor

8:10 - 8:35 (25 min.) — HIV: The National Challenge

Kristine Gebbie,
National AIDS Policy Coordinator
Executive Office of the President

Ms. Gebbie's presentation will serve to put HIV in focus regarding its national impact and the Federal response to the epidemic. It is anticipated that a number of Federal efforts, including BRTA, will be referenced.

8:35 - 8:45 (10 min.) — The Tennessee Challenge

Laurel Wood, Director
Tennessee AIDS Program

Details the HIV epidemic in Tennessee and emphasizes the important role of business in providing appropriate responses.

9:00 - 10:15 (1 hr. 15 min. 15 min./panelist + 15 min. for questions) — The Challenge To Business

Margaret Kraemer, Manager
Employee Assistance Program
Levi Strauss Co.; Knoxville
Fred C. Goad, President and CEO,
Envoy Corporation
Jerald Breitman, Director,
Professional Relations
Burroughs Wellcome Co.
Debbie Runions
Tennessee Business Roundtable

This panel is designed to present firsthand knowledge and experience in dealing with HIV in the workplace. Beginning with a company that has taken the lead nationally in promoting HIV related workplace activities, following with a CEO who had to balance an employee with AIDS and a workforce expressing concern, and ending with two professional business representatives living with HIV, the panel puts a very real face on HIV in the work environment.

Dick DeVos
President
Amway Corporation

Jay Van Andel
Chairman of the Board
Amway Corporation

Request the Pleasure of the Company of

Mr. Debbie and guest

for a Dinner Cruise

September 22, 1993

Aboard the Motor Yacht Enterprise

R.S.V.P.
(202) 547-5005

Business Attire
Cocktails at 6:30 P.M.
Departure at 7:00 P.M.

Ogilvy Adams & Rinehart

1901 L Street, N.W.
Suite 300
Washington, D.C. 20036
Tel: 202-466-7590
Fax: 202-466-7598

September 17, 1993

MEMORANDUM

To: John Gurrola

From: Beth Strode

Subject: Nashville Business Responds to AIDS Conference
PSA for St. Thomas Hospital - Nashville

Laurel Wood, Director of the AIDS Program for the State of Tennessee received a request from St. Thomas Hospital to videotape Kristine's speech at the Nashville Conference. The hospital indicated they wished to use soundbites from her speech and secure permission to use the footage for a PSA prior to the October 10 Nashville AIDSWALK.

Plans have changed and the hospital is taping the entire conference. St. Thomas would also like Kristine to do a 2-3 minute stand-up following her speech. During this footage, she would say something specific about the Walk such as the benefits to the community, etc. St. Thomas Hospital is a cosponsor of the Walk and this year's theme is "From All Walks of Life."

St. Thomas Hospital is part of a consortium of community-based organizations called Nashville Cares. They are also organizers for the AIDSWALK.

Beth

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GOVERNOR'S CONFERENCE

BUSINESS RESPONDS TO AIDS

THURSDAY • SEPTEMBER 23 • 1993

OPRYLAND HOTEL

NASHVILLE • TENNESSEE

CDC

CENTERS FOR DISEASE CONTROL AND PREVENTION

BUSINESS RESPONDS TO AIDS

Yes

STATE OF TENNESSEE
CORDELL HULL BUILDING
DEPARTMENT OF HEALTH
NASHVILLE, TENNESSEE 37247

August 9, 1993

Ms. Kristine Gebbie
National AIDS Policy Coordinator
750 17th Street N.W.
Suite 1060
Washington, D.C. 20503

Dear Ms. Gebbie:

On behalf of our planning committee, it is with great pleasure that I extend an invitation to you to address the Tennessee Conference on Business Responds to AIDS, September 23, 1993. As the second of five regional conferences coordinated with the assistance of the Centers for Disease Control and Prevention and the National Leadership Coalition on AIDS, this conference is anticipated to attract over 400 Tennessee business leaders and human resource managers. The support of the National Association of Broadcasters insures that members of the Tennessee Association of Broadcasters will also be heavily involved as participants.

The program, scheduled at the Opryland Hotel in Nashville, begins with a 7:30 a.m. breakfast, followed at 8:00 with introductions and opening comments from Nashville's mayor, Phil Bredeson. We are asking that you speak immediately following the mayor and focus on AIDS as a "Challenge to the Nation". We would like for you to include information on the Federal Goverment's response to the epidemic, emphasizing the significance of the formal "Business Responds To AIDS" national campaign.

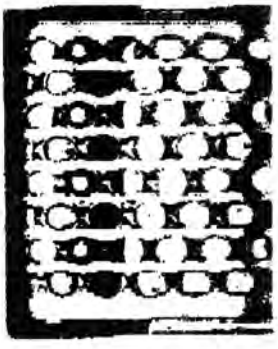
Staff with the state AIDS Program serve as contacts for the Planning Committee. As chairman, I will be responsible for all information you may need from this point on. I can be reached at (615) 741-7500. We sincerely appreciate your consideration to speak at our conference.

Sincerely,

Matt Nelson, MSW
Director, Social Work Services
AIDS Program

Governor's Conference on Business Responds to AIDS DRAFT Agenda (8/11/93)

Time	Event	Speaker
7:30	Breakfast	
8:00	Welcome/Introductions	Mayor Phil Bredesen
8:10	The Challenges of HIV	
	Challenge to the Nation:	Kristine Gebbie (Nat'l AIDS Policy Coordinator)
	Challenge to the State:	Gov. Ned McWherter (or rep.) Dr. David Satcher
8:45	BREAK	
9:00	Challenge to Business:	Lee Smith (Levi Strauss) Bud Hale (Bridgestone) Fred Goad (Envoy) Jerald Breitman (Burroughs Wellcome) Debbie Runions (First Person & TN Business Roundtable)
10:15	Business Responds to AIDS: A Comprehensive Workplace Program	
	BRTA - An Overview	Angie Hammock (CDC)
	ADA/Legal Issues	Matt Lonergan (attorney)
	How to Communicate	Fran Cooper (Nat'l Assoc.of Broadcasters)
	Partnerships and Resources	
	Mayor's Task Force	TBA
	Community AIDS Partnership	Neil Diehl
	CBOs	Sam Coleman
	Red Cross	Elizabeth Owen
	Health Department	Wilma Templin
11:55	Closing	Bob Gaskill (TN Assoc. of Business)



Dick DeVos
President
Amway Corporation

Jay Van Andel
Chairman of the Board
Amway Corporation

Request the Pleasure of the Company of

Mr. Debbie and guest

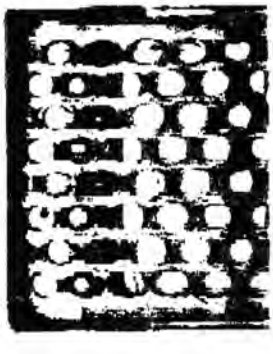
for a Dinner Cruise

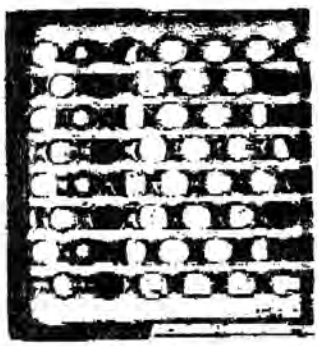
September 22, 1993

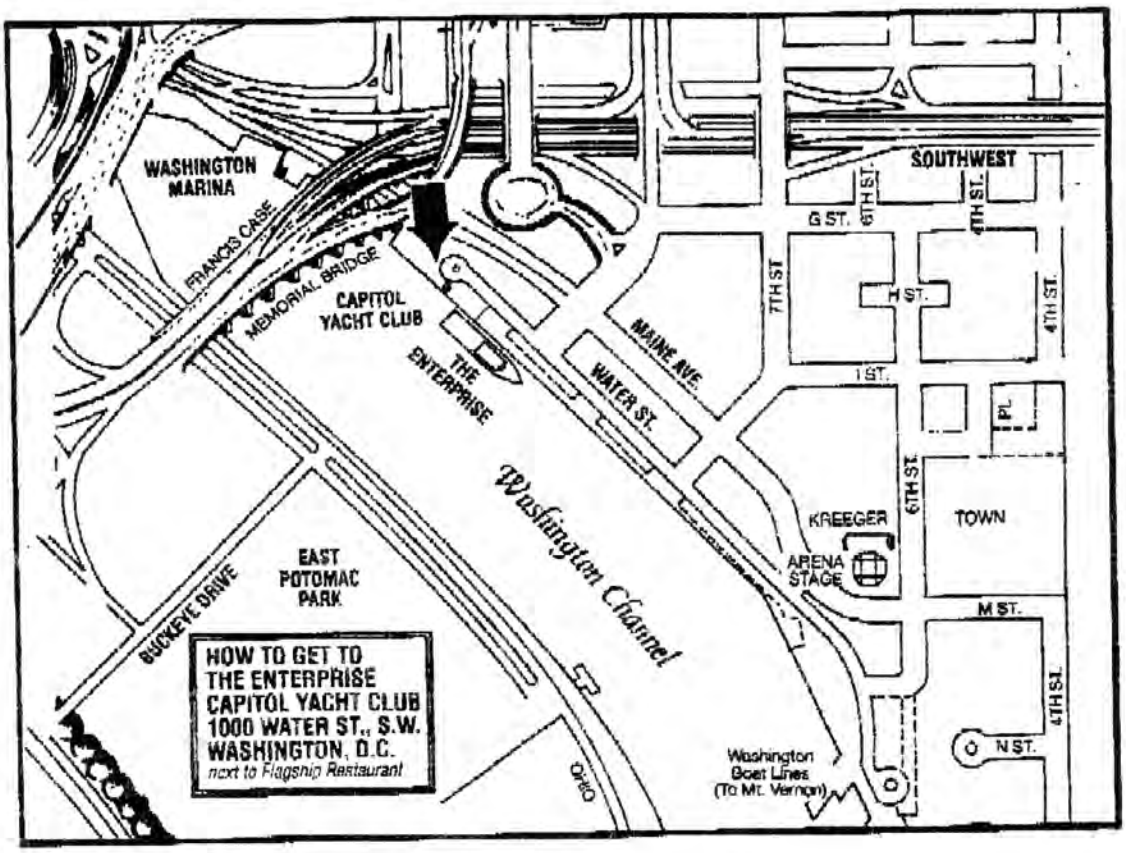
Aboard the Motor Yacht Enterprise

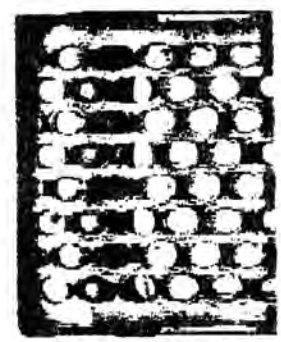
R.S.V.P.
(202) 547-5005

Business Attire
Cocktails at 6:30 P.M.
Departure at 7:00 P.M.









WASH.,D.C. GMF DCR#8 09/01/93 20:19

The Honorable Kristine Gebbie
Director
Office of AIDS Policy
The White House
Washington, DC 20500

Single slide - Do need the slide of the new stamp

Who's organizing this trip? I'd like to have some time to meet Colleen Conway Welch, Dean Vanderbilt Sch. of Nsg

BQ Stiles was talking about a reception the evening before

Should V= Gore's office on any key contacts Ned recommend

Buck - if the Nashville reception can't be scheduled get-could the Z3rd SOJ accept this?

STATE OF TENNESSEE
CORDELL HULL BUILDING
DEPARTMENT OF HEALTH
NASHVILLE, TENNESSEE 37247

M E M O R A N D U M

To: Tennessee Business Responds To AIDS Conferen
Speakers

From: Matt Nelson, MSW
Conference Coordinator

Re: Conference Agenda and Plans

Date: September 3, 1993

Thank you for agreeing to participate in the Tennessee Business Responds to AIDS Conference. Your willingness to share your time and experience is greatly appreciated and will make the conference more meaningful for all participants.

Enclosed you will find a finalized agenda. Please be sure to check the time listed for your portion of the program to determine if any changes have occurred since you were originally asked to participate. Some of the items may have been moved by fifteen minutes or so from what you were originally told.

Also enclosed is a brief description of the purpose/business thrust of each segment of the program involving a panelist. You will note that there is time allotted for questions at the end of each panel. These questions will be open to members of the audience or may come from your moderator. **I also need to know as soon as possible if you need any audio-visual equipment.** If you have questions after looking over your portion of this information, please give me a call at (615) 741-7500. Otherwise, I look forward to seeing you at the conference.

Business Responds To AIDS
September 23, 1993

8:00 A.M. (10 min.) — Welcome

Phil Bredeson, Nashville Mayor

8:10 - 8:35 (25 min.) — HIV: The National Challenge

Kristine Gebbie,
National AIDS Policy Coordinator
Executive Office of the President

Ms. Gebbie's presentation will serve to put HIV in focus regarding its national impact and the Federal response to the epidemic. It is anticipated that a number of Federal efforts, including BRTA, will be referenced.

8:35 - 8:45 (10 min.) — The Tennessee Challenge

Laurel Wood, Director
Tennessee AIDS Program

Details the HIV epidemic in Tennessee and emphasizes the important role of business in providing appropriate responses.

9:00 - 10:15 (1 hr. 15 min. 15 min./panelist + 15 min. for questions) — The Challenge To Business

Margaret Kraemer, Manager
Employee Assistance Program
Levi Strauss Co.: Knoxville
Fred C. Goad, President and CEO,
Envoy Corporation
Jerald Breitman, Director,
Professional Relations
Burroughs Wellcome Co.
Debbie Runions
Tennessee Business Roundtable

This panel is designed to present firsthand knowledge and experience in dealing with HIV in the workplace. Beginning with a company that has taken the lead nationally in promoting HIV related workplace activities, following with a CEO who had to balance an employee with AIDS and a workforce expressing concern, and ending with two professional business representatives living with HIV, the panel puts a very real face on HIV in the work environment.

10:15 - 10:30 (15 min.) **Business Responds to AIDS: A Comprehensive Workplace Program**

Fred Kroger, Director
National AIDS Information and Education Program
Centers for Disease Control and Prevention

This section will detail the BRTA Program as a primary tool for business leaders to use in developing policy and workplace education.

10:30 - 10:45 (15 min.) **Legal Issues and the ADA**

Matt Lonergan, Esq.
Boult, Cummings, Conners and Berry

This presentation will stress the specific legal issues, including the American with Disabilities Act, that businesses must consider when addressing HIV in the workplace.

10:45 - 11:00 (15 min.) **Dealing with Sensitive Issues**

Frances Cooper
Communication Technologies

Dr. Cooper, a consultant with the National Association of Broadcasters, will discuss innovative and creative ways of presenting sensitive information to various audiences.

11:00 - 11:10 (10 min.) There will be 10 minutes for questions following these three speakers.

11:10 - 11:55 (35 min. + 10 min. of questions) **Partnerships and Resources**

Stephen Raffanti, M.D. (10 min.)
Nashville Mayor's Task Force
Neil Diehl (10 min.)
Community AIDS Partnership of Middle Tenn.
Sam Coleman (5 min.)
Nashville CARES: representing Tennessee's network of Community-based Organizations
Elizabeth Owen (5 min.)
Nashville Red Cross
Wilma Templin-Branner (5 min.)
Knox County Health Department

This panel is designed to describe and promote the numerous partnerships and HIV-related resources, both in Nashville and across the state.

11:55 **Closing**

Robert H. Caskill, Vice President
Tennessee Association of Business

GOVERNOR'S CONFERENCE
TENNESSEE BUSINESS RESPONDS TO AIDS

THURSDAY, SEPTEMBER 23, 1993
OPRYLAND HOTEL

PRELIMINARY
– AGENDA –

7:00 AM **On-site Registration,** Presidential Ballroom, Adams Room

7:30 AM **Breakfast**

8:00 AM **Welcome**
The Honorable Phil Bredesen, Mayor

8:10 AM **HIV: The National Challenge**
Kristine Gebbie
National AIDS Policy Coordinator, Executive Office of the President

The Tennessee Challenge
Laurel Wood, Director, AIDS Program
Tennessee Department of Health

8:45 AM **Break**

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION
BUSINESS RESPONDS TO AIDS

CONFERENCE REGISTRATION:

Conference registration includes breakfast and the *Business Responds to AIDS* Manager's Kit. To register for the conference, complete the form and mail it to the address indicated with a $35.00 check payable to TPHA. Only checks made payable to TPHA will be accepted. If the registration and check are not received in the office by 10:00 am on September 22, it will be necessary to register and pay at the door.

9:00 AM **The Challenge to Business**
Fred C. Goad, President and CEO
Envoy Corporation
Jerald Breitman, Director, Professional Relations
Burroughs Wellcome Co.
Debbie Runions
Tennessee Business Roundtable

10:15 AM **Business Responds to AIDS:**

A Comprehensive Workplace Program
Angie Hammock, Director, BRTA
National AIDS Information and Education Program

Legal Issues & the ADA
Matt Lonergan, Esq.
Boult Cummings Conners and Berry

Dealing with Sensitive Issues
Frances Cooper
Communication Technologies

Partnerships and Resources
Stephen Raffanti, M.D. Director
Metro Nashville AIDS Services
Nashville Mayor's Task Force
Neil Diehl, Chairman Emeritus
Ingram Barge Co.
Community AIDS Partnership
Sam L. Coleman, VP, Human Resources
St .Thomas Hospital, Nashville CARES
Elizabeth Owen, Director, Consumer Affairs Division
Tennessee Department of Commerce and Insurance
Nashville Chapter of the American Red Cross
Wilma Templin-Branner, Public Health Educator
Knox County Health Department

11:55 AM **Closing**
Robert H. Gaskill, Vice President
Tennessee Association of Business

CONFERENCE SPONSORS:

Governor Ned McWherter
Mayor Phil Bredesen, Nashville
Tenn. Association of Business
Tenn. Business Roundtable
Tenn. Association of Broadcasters
Community AIDS Partnership,
United Way of Middle Tennessee
AIDS Program, Tenn. Dept. of Health
Nashville Area Chapter,
American Red Cross
Nashville CARES
National Association of Broadcasters
US Centers for Disease Control
& Prevention

CONFERENCE COORDINATOR:

Matt Nelson
AIDS Program
Tennessee Department of Health
615/741-7500

If you need special accomodations to attend this conference, please contact the conference coordinator.

"We must act now to develop a partnership with business to prevent the spread of the virus among the state's workforce and to protect our social and economic health."
—Governor Ned McWherter

"When a senior level staff member in our company developed AIDS, we were unprepared for the impact it had on our entire staff. Our first concern was to help him with whatever he needed, but the circumstances also challenged us to develop comprehensive policies regarding HIV. Although we were initially unprepared, the increased awareness has been positive; in fact, many of our employees have since volunteered with local AIDS agencies."
—Neil Diehl, Chairman Emeritus, Ingram Barge Co., Nashville

"We chose to implement mandatory AIDS training for all of our employees as a way to address this important issue. We wanted to deal with HIV/AIDS education and training before we had a crisis, and the training was quite effective."
—Ben Pugh, Training Specialist, Metropolitan Development and Housing Agency, Nashville

CDC

CENTERS FOR DISEASE CONTROL AND PREVENTION

BUSINESS RESPONDS TO AIDS

Across the nation, businesses large and small are recognizing the need to address the issue of HIV/AIDS in the workplace. The majority of individuals now infected with HIV — and those most likely to be infected in the future — are young adults age 25-44, an age group which comprises more than 50 percent of the nation's workforce. In Tennessee alone, an estimated 18,500 individuals will be infected with HIV by 1995.

The Governor's Conference provides the opportunity for business leaders and human resource managers to discuss the challenges confronting the business community and ways to better prepare for the problems created by HIV. *Business Responds to AIDS* is the title of a model program developed by the Centers for Disease Control and Prevention to assist businesses in developing comprehensive workplace programs. The program includes information for policy development, supervisory training and employee education.

Each participant will receive the *Business Responds to AIDS* Manager's Kit.

I will attend the Governor's Conference on *Business Responds to AIDS* on September 23, 1993. Enclosed is my check for $35.00 PAYABLE TO TPHA. This registration fee will guarantee my reservation and breakfast, and will not be returned. I understand if my check and registration form are not received in the office by 10:00 a.m. September 22, 1993, my check will be returned to me and I will pay registration on site. Attendance is limited to 400 participants.

Name

Company

Address

Title

Day Phone

Mail to: TDH AIDS Program, Attention: Matt Nelson
C2-221 Cordell Hull Building, Nashville, TN 37247-4947

This document was printed at no cost to the State of Tennessee

Please take a moment to answer these questions.

1 What is the size of your company? Number of employees:
15 or fewer ___ 16-49 ___ 50-99 ___ 100-249 ___
250-749 ___ 750-1249 ___ 1250 or more ___

2 Does your company have an HIV policy?
Yes ___ No ___ Don't Know ___

If yes:
A. Is it an HIV-specific policy?
Yes ___ No ___
B. Is it part of a comprehensive health-care policy?
Yes ___ No ___

If yes, who is responsible for HIV policy at your company?
Name:
Title:

3 Does your company offer managers HIV-specific training?
Yes ___ No ___

4 Does your company offer employees any form of HIV prevention education?
Yes ___ No ___

5 Does your company offer any form of HIV prevention education to employees' families?
Yes ___ No ___

6 Does your company offer any form of HIV community support (e.g., employee volunteerism or contributions to local AIDS organizations?)
Yes ___ No ___

September 21, 1993

NATIONAL HEALTH SECURITY ACT
TOWN HALL MEETING
CHICAGO

DATE/TIME:	Thursday, September 23, 1993 1:00 P.M. (Approx.)
DURATION:	60 to 90 minutes
LOCATION:	University of Illinois at Chicago Chicago Illini Union Auditorium 828 South Wolcott Avenue Chicago, IL
ADMINISTRATION REPRESENTATIVE:	Kristine Gebbie, RN, MN National AIDS Policy Coordinator
AUDIENCE:	300 - 500 individuals from: Congress Illinois State Public Health Office Illinois State Legislature City of Chicago Representatives Students from Northwestern University and the University of IL @ Chicago

MEETING FORMAT:

Welcome-	Mayor Daley (tentative) (10 min)
NHSA overview-	Ms. Kristine M. Gebbie (20 min)
Comments-	Congressperson ??????? (5 minutes)
Comments-	State Senator Gary La Paille (5 minutes)
Moderator-	Questions from the audience (20 - 30 minutes)

TRAVEL ITINERARY FOR KRISTINE GEBBIE'S TRIP TO NASHVILLE, TN AND CHICAGO, IL

WASHINGTON, D.C. TO NASHVILLE, TN

SEPTEMBER 22, 1993

LV: 6:40 p.m. on NW Air Flight #859 from National

AR: 7:57 p.m. in Memphis

LV: 8:30 p.m. from Memphis on NW Air Flight #1422, Seat 13B for Nashville, TN

AR: 9:20 p.m. in Nashville

HOTEL

Opryland Hotel
2800 Opryland Drive
(615) 889-1000

NASHVILLE, TN TO CHICAGO, IL

SEPTEMBER 23, 1993

LV: 10:11 a.m. on United Flight #511, Seat 14F from Nashville, TN for Chicago, IL

AR: 11:42 a.m. in Chicago

CHICAGO, IL TO WASHINGTON, DC.

SEPTEMBER 23, 1993

LV: 7:15 p.m. on United Flight #626 for Washington, D.C.

AR: 9:52 p.m. at National Airport

Office of the Vice President

Smith County Courthouse
Carthage, Tennessee 37030
615/735-0173

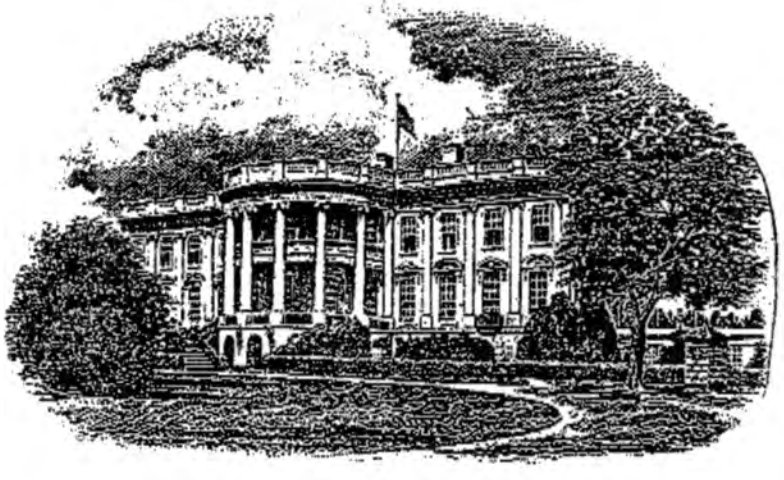
TO: John Durrola

FROM: Cynthia Draper

DATE: 9-21-93

number of pages including cover: 6

COMMENTS:



HEALTH NOTES
Promoting healthy habits
Page 3B

LOCAL NEWS

WEDNESDAY, AUGUST 25, 1993

Briefs
Deaths
Weather

AIDS clinic to open Jan. 1

VU doctors, nurses to staff

CYNTHIA FLOYD
Staff Writer

Nashville's AIDS patients will get the best of medical care in the heart of the city's medical community when a free-standing AIDS clinic opens Jan. 1, Mayor Phil Bredesen said yesterday.

The Comprehensive Care Center is a public-private partnership resulting from a task force Bredesen put together last year to develop a strategy for handling the growing number of Nashvillians with AIDS and HIV, the virus that causes AIDS.

"This is a business-like approach that requires no new public money," Bredesen said during a press conference outside the future clinic at 345 24th Ave., N.

"This also goes a long way toward ending the isolation that AIDS patients often feel."

The clinic will be in 10,000 square feet building, donated by Baptist Hospital, on the first floor of the building currently occupied by The Nashville Medical Group. That physicians' group is scheduled to relocate to an office at Baptist in November.

In that location, the clinic will be near Centennial Medical Center, Baptist, Meharry Medical College and a number of health-related offices.

The clinic, which will be staffed by physicians and nurses from Vanderbilt University Medical Center, is expected to ease the burden of AIDS care now carried by the Metro Health Department, Metro's General Hospital and a handful of private physicians, Dr. Stephen Raffanti said.

Raffanti, an assistant professor at Vanderbilt, will be medical director of the clinic. He is also director of the HIV clinic at the Health Department and AIDS services at General, the city's hospital for poor patients.

The Nashville Academy of Medicine, the city's medical society, has identified 20 of its member physicians who are willing to treat AIDS patients, which will help spread the burden of hospital care for people with AIDS throughout the city, Bredesen said.

Vanderbilt University Medical Center, General Hospital and Donelson Hospital have previously provided the bulk of AIDS hospital care because those facilities are where most of the few doctors who treated AIDS patients had admitting privileges, Bredesen's task force reported last year.

The new clinic will help the Health De-

Turn to PAGE 2B, Column 1

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Suspended ballplayers sue Metro

By KIRK LOGGINS
Staff Writer

Two players in the Metro parks' adult softball league got upset when Metro medical examiner Dr. Charles Harlan, umpiring a championship game Aug. 10, made what they considered a bad call.

The two men, Rock Hurst and Tony Pearson, got so upset that they "physically bumped" Harlan during an argument that followed his ejecting two of their fellow players from the game at Shelby Park, witnesses said.

Harlan's ruling forced Hurst and Pearson's team, sponsored by Two Rivers Baptist Church, to forfeit

City's AIDS clinic to open Jan. 1

FROM PAGE 1B

partment's HIV-Plus clinic return to its initial mission: testing, counseling and caring for HIV-infected individuals without symptoms to keep them healthy as long as possible, said Raffanti and Dr. Fredia Wadley, Metro's health director.

HIV attacks the immune system, leaving the person prey to a number of deadly opportunistic infections, but it can take 10 years or longer for an infected person to develop symptoms.

Last year, the clinic stopped taking new, HIV-infected patients who were still healthy because so many of the clinic's patients had become sick and required more intensive care.

"Of the 900 people enrolled at the health department, about 30% have symptoms, but they take about 60%-70% of the staff's time," Raffanti said.

The Comprehensive Care Center will treat HIV-infected people with medical coverage, either from private insurance or Medicaid, the government health program for the poor. HIV-infected people qualify for Medicaid when they develop AIDS.

The clinic is expected to care for about 2,000 patients, which would be about 75% of HIV-infected people in Nashville who are currently receiving medical care, Raffanti said. The potential effect from TennCare, Gov. Ned McWherter's proposal for replacing Medicaid with a managed care program, is still unknown, he said.■

PUBLIC NOTICE SUBAREA 8 PUBLIC MEETING

Notice is hereby given that the Subarea 8 Citizen Advisory Committee will hold a public meeting for the purpose of identifying land use problems in Subarea 8 and the public is urged to come and help identify these problems. Subarea 8 includes Metro Center, and the Tennessee State University, Fisk University, Meharry Medical College, Buena Vista, Batavia, and Germantown areas. It is bounded on the north by the Cumberland River and on the south by Charlotte and Clifton Avenues, and I-40 west of I-440 to the CSX Railroad. The meeting will be held on September 14, 1993 between 7:00 PM and 9:00 PM in the auditorium of the Z. Alexander Looby Center at 2301 Metro Center Boulevard. For Additional information, call Tom Swanson at 862-7158 or Gary Dixner at 862-7166.

Dickson

Action deferred on beer sale times

CHARLOTTE, Tenn. — Early risers will have to wait until next month to find out whether they can buy beer earlier on Sunday in Charlotte.

Charlotte City Council members last night deferred until a meeting scheduled Sept. 28 consideration of changing the hours for Sunday beer sales within the city limits to 6 a.m.-midnight.

Charlotte Mayor Bill Davis said council members wanted more time to think about the change.

Currently beer sales in Charlotte are permitted 1 p.m.-midnight on Sundays. Beer sales Monday through Saturday are the same as the proposed new Sunday hours.

The change was requested during a meeting of the council by David Duke, owner of Dukes Market.■

3. Carroll County

HUNTINGDON — A judge has sealed the statements of the three people accused in the brutal shooting and stabbing death of Dennis Brooks Jr., 19.

General Sessions Judge Larry Logan said yesterday he ordered the statements, which were presented as part of a preliminary hearing Monday, sealed to avoid pretrial publicity in the case. Three Huntingdon residents, Stacy Ramsey, 22, Teresa D. Harris, 22, and Walter S. Smothers, 23, each face first-degree murder charges in connection with the July 30 death of Brooks, a Jackson State Community College student. All have pleaded not guilty to the charges and are represented by court-appointed attorneys. The case goes to the grand jury in September. The three face, if convicted, a maximum penality of life imprisonment or the death penalty.

(N.J.). I see what happened to Detroit. I see what happened to a number of urban cities that allowed the suburban areas to leave them." Herenton set off a debate throughout the city and its Shelby County suburbs when he announced a plan Sunday to unite city and county governments.

MEMPHIS — Kotzebue loves the King. At least that's what demographers said in a new map of Elvis country that goes by the number — ZIP codes, that is — to pinpoint fans.

"Presley is still a favorite son of the South," the magazine *American Demographic* said in its August issue, "but he also has lots of fans in the Midwest and rural Northeast, as well as the Alaska hub of Elvis worship, Kotzebue." Kotzebue? "Beats the hell out of me," said Bob Lunn, a Texas researcher who spent two years collecting addresses of 7,000 members of Elvis fan clubs.

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TN 8-29-93

p.4D

Teamwork on AIDS

CONQUERING AIDS is going to take a cooperative effort on all fronts.

Nowhere is such cooperation more evident than right here in Nashville.

A freestanding AIDS clinic, known as the Comprehensive Care Center, will open January 1 and is the result of a public/private partnership that meets a growing need in the community.

The clinic is the result of work on several fronts:

- Mayor Phil Bredesen first launched the plan last year by putting together a task force to address the need for a clinic.
- Baptist Hospital has donated the 10,000 square feet of building space — on the first floor of the building that currently houses the Nashville Medical Group, near Centennial Medical Center, Baptist and Meharry Medical College.
- It will be staffed by physicians and nurses from Vanderbilt University Medical Center.
- An anonymous donor has contributed start-up costs.
- A financial analysis and staffing plan was provided by Hospital Corporation of America and Centennial Medical Center.
- Meharry Medical College has been awarded $700,000 from the federal government for an AIDS Clinical Trials Group, and Meharry will work with Vanderbilt staffers involving minorities in research projects.
- Dr. Stephen Raffanti, an assistant professor at Vandy, will be the medical director of the clinic.

The center will be established without local tax dollars.

Nashville is blessed with one of the finest centers of health care of any city in the country. It also has a mayor who recognizes the growing problem of AIDS. Metro currently has more than 1,900 patients with the HIV virus that causes AIDS, with 40-50 more added each month.

Forward-thinking communities that see the need to prepare for even more AIDS cases in the future will be the ones who are able to cope with the disease more successfully. The AIDS clinic should serve this community well. And there will be many people to thank for it. ■

Editorial policy

THE editorial board of *The Tennessean* includes Sandra Roberts, managing editor/opinion; Mike Morrow and Ellen Dahnke, editorial writers; Sandy Campbell, cartoonist; Terry Quillen, oped page editor; and Dwight Lewis, columnist.

AIDS shot nearing goal of test trials

TN'n 5-23-93 A1

VU researchers close in

By CYNTHIA FLOYD
Staff Writer

AIDS vaccine research is entering the "final drive" toward large-scale trials of a shot to prevent infection, a Vanderbilt University Medical Center researcher says.

New studies of three potential vaccines will begin next month at Vanderbilt. They are likely to produce a candidate for large-scale testing, which researchers hope can begin by the end of 1994, said Dr. Barney Graham.

Such trials would involve thousands of people, much as the polio vaccine trials did in the 1950s, and would be a major step toward getting a vaccine on the market.

"I view this as the most exciting time so far in AIDS vaccine research," Graham said.

"We've finished the first wave of testing our first-generation products. In that wave, we were really just testing the waters of how a vaccine might work. These new studies test a whole new group of products that apply what we've already learned."

Graham is eager to recruit 60 healthy adults for the studies over the next three months, but the goal is lofty. Over the past five years of AIDS vaccine research, an average of four volunteers have been recruited each month.

"It'll take a year to evaluate our results," Graham said. "The longer it takes to recruit, the longer it'll take to reach the next step. Now that it's in sight, the pressure is on to get there."

The new studies, like the 14 other AIDS vaccine trials that Vanderbilt has conducted, pose no danger of infection with HIV because the vaccines do not contain a whole, live virus that could multiply and cause acquired immune deficiency syndrome.

HIV, or human immunodeficiency virus, attacks

▲ Turn to PAGE 2A, Column 3

VU researchers to test AIDS vaccine

FROM PAGE 1A

and destroys the immune system, leaving the person prey to a variety of deadly infections. Though research continues slowly toward a cure, many researchers believe the best hope is for a vaccine.

The studies that Vanderbilt plans to launch next month will evaluate three different vaccine products.

One vaccine, called ALVAC gp 160, is made from a live "canary pox" virus that includes a portion of genetic material from HIV. The vaccine is expected to be virtually free from side effects because the canary pox virus does not grow in mammal tissue, Graham said. Its natural host is birds.

"If it replicates enough to work, it's a big step," he said.

The other trials will test two vaccines made by different companies. The vaccines include a purified protein called gp 120 found in the outer coat of the HIV. These trials also will be evaluating nine different adjuvants, substances designed to boost the immune system response.

"We're looking for the most effective combination," Graham said.

The goal is to trigger an immune system response in a vaccinated person so that his immune system will recognize and attack the HIV if the person is ever exposed to it.

HIV is spread through the exchange of infected body fluids such as blood or semen. Infection most commonly occurs during unprotected sex, the sharing of needles between injection drug users and from mother to baby, either during pregnancy or at birth.

Researchers are putting together study groups in cities such as San Francisco, New York and Miami that have large populations at high risk of getting HIV, Graham said. They are closely monitoring these groups for rates of HIV infection for comparison after large-scale trials begin.

Nashville will not be included in the large-scale trials because there are not enough people here at high risk of HIV infection, Graham said.

Even after large-scale trials begin, researchers will continue looking for new vaccines and vaccine combinations, he said.

"The likelihood is that our first product will not be the best product," Graham said. "The first product may not even work.

"But tests for efficacy are in sight. We can't do much in a practical sense until that's finished."■

Volunteering

Sixty healthy adults, ages 18-60, are needed for three new trials of potential AIDS vaccines about to begin at Vanderbilt University Medical Center.

Volunteers should not be infected with HIV, the virus that causes AIDS, and should be considered at low risk of becoming infected.

Participants will receive three or four shots over a six-month period and have several physical examinations and blood tests over a 12-month period.

To volunteer or to learn more, call the Vanderbilt AIDS Vaccine Unit at 343-AIDS. A person will be available to take messages around the clock, seven days a week. Messages will be kept confidential.

5/23/93 to Gore office

Circuit Court of Appeals refused to stop the extradition of Demjanjuk, a retired auto worker from Ohio, to Israel to stand trial.

Demjanjuk, who has consistently claimed to be a victim of mistaken identity, was subsequently extradited, convicted and sentenced to death. He remains in an Israeli prison, awaiting appeal.

Last year, Demjanjuk's plea of innocence was given fresh credence when the Soviet Union released post-war testimony from Nazi guards, who identified to vacate a ruling if it can prove it was defrauded in its judgment.

The appeals court later named U.S. District Judge Thomas Wiseman Jr. as special master to help determine the validity of the information given by the Justice Department to the 6th Circuit. His report is expected in a few weeks.

The Supreme Court's decision this week should be seen as a great endorsement of the 6th Circuit's search for justice in the Demjanjuk case. ■

Exciting AIDS progress

Vandy on cutting edge of AIDS research

THE current emphasis on the devastation of the AIDS virus has left the impression with some that absolutely nothing is being done about it.

But they're wrong.

The search for a cure for AIDS has been frustrating and slow. But progress is being made toward developing a vaccine for the disease. And researchers believe that a vaccine may offer the most realistic hopes for success in battling AIDS.

Dr. Barney Graham, a Vanderbilt University Medical Center researcher, says the push for an AIDS vaccine is in the "final drive" toward trials of a shot that would prevent the infection. Studies of three potential vaccines are to begin in June at Vanderbilt. The trials are expected to involve study groups in high-risk areas like San Francisco, New York and Miami.

The news is exciting on two fronts. It means that real steps toward the prevention of AIDS may be on the horizon. And it means that one aspect of the fight against AIDS is happening right in this community. Vanderbilt's medical research staff continues to provide leadership in the health care field.

Graham says, "I view this as the most exciting time so far in AIDS vaccine research." For such an uphill challenge, any developments called "exciting" by researchers should be encouraging indeed for the public.

A vaccine offers little comfort to those who now have AIDS. But a step toward a vaccine could well be a step toward a cure. The health-conscious public should support the ongoing efforts in research. The battle against AIDS is everyone's. And it's encouraging to know when inroads toward people conquering AIDS, instead of the other way around, are occurring. ■

(which happens regardless of law) even if the law specified nonsectarian prayer.

Moreover, as citizens of Tennessee, we are outraged that the legislature should pass a law already deemed likely to be unconstitutional by the state's own attorney general. State funds, so sorely needed for the real needs of education in this state, will be foolishly expended on legal defense of a doomed law.

We are aware of Governor McWherter's reluctance to veto the prayer bill, but urge him in the strongest possible terms to live up to the spirit of his oath of office, and veto this bill before it becomes law.

William P. Smith, Chair
Jewish Federation of Nashville and Middle Tennessee
801 Percy Warner Blvd. 37205

Parole board is not fair in decisions

To the Editor:

Having gone before two parole board members recently, I have first-hand knowledge of how the function. I was guilty of the crime for which I was sentenced. But 21 years later, with no write-ups or infractions of the rules within the system, I was treated as if the crime happened yesterday.

My file was read and reread by me. The board members dwelt

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Saturn Event
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