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THE WHITE HOUSE

WASHINGTON

Communicating prevention to people:
Lessons from the HIV epidemic

by

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

presented to

PREVENTION 94
Atlanta, GA
March 20, 1994

(15 minutes)

I. The HIV prevention message.
- **Desired behavior change:**
  - **sexual**
  - **substance abuse.**
- **Social constraints:**
  - **"taboo topics"**
  - **ill-prepared professionals.**

II. Lessons learned from our experience.
- **Saying it is not enough.—**
- **Targeting an audience.**
- **Ownership by the target group.**
- **Role of Providers -- MMWR data.**

III. Ideas from the tobacco experience. — 30 years —
- **The facts: Surgeon General's report.**
- **The messages: ACS role/counter advertising.**
- **The professionals: role of physician.**
- **The community: use of regulation and social attitudes.**

(Applied to HIV.)

Surg. Gen'l's report to every home
Community based Orgs / CBO's
Professionals - prevention info
Community - many communities in both sexual & drug behaviors

[ask is real
can do something
need to know you are worth
the trouble of the change

SCIENCE, SKILLS AND STRATEGIES

PREVENTION 94

MARCH 19-22, 1994, ATLANTA, GA

AMERICAN COLLEGE OF PREVENTIVE MEDICINE
ASSOCIATION OF TEACHERS OF PREVENTIVE MEDICINE

1015 15TH STREET NW, SUITE 403
WASHINGTON, DC 20005
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FAX: (202) 842-1980

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The Carter Center
National Association of Community Health Centers
National Association of County Health Officials
National Council for Education of Health Professionals in Health Promotion
Partnership for Prevention
Society for Public Health Education, Inc.
Society of General Internal Medicine
Society of Prospective Medicine
Society of Teachers of Family Medicine
U.S. Conference of Local Health Officers

DEC 13 1993

December 6, 1993

Kristine Gebbie RN
National AIDS Policy Coordinator
750 17th Street NW, Suite 1060
Washington DC 20503

Dear Ms. Gebbie:

On behalf of the Program Planning Committee and the PREVENTION 94 sponsors, the American College of Preventive Medicine and the Association of Teachers of Preventive Medicine, I would like to thank you for agreeing to participate in the General Session scheduled for Sunday, March 20. The enclosed "Session Description Form" provides more details about the session and other presenters.

You will find enclosed a Speaker Release Form, Audiovisual Equipment Request Form and a Personal Information Profile. Please return these as soon as possible, but no later than **JANUARY 14, 1994**.

In addition, we would like you to prepare an abstract of your presentation. Use the enclosed abstract reproduction form for your submission. The abstract will appear, exactly as submitted, in the PREVENTION 94 Program Book.

A preliminary PREVENTION 94 meeting brochure is enclosed for your information and assistance in registering. An updated brochure will be mailed to you in early January.

Should you have any questions, please feel free to contact me.

Sincerely,

Emily Slough

Emily Slough
Meeting Manager

Enclosures:
Speaker Release Form
Audiovisual Equipment Request Form
Personal Information Profile
PREVENTION 94 Flyer
Abstract Reproduction Form

THE WHITE HOUSE

WASHINGTON

Health Care Reform and the HIV Epidemic
Top Ten Issues

For those infected with HIV, the assurance of comprehensive health insurance is an essential public health goal.

The Office of the National AIDS Policy Coordinator has provided advice on policy formulation during the development of the Health Security Act (HSA). These efforts were directed towards assuring adequate care and services for people with HIV/AIDS. As the Congress now debates the HSA, the Administration is making every effort to assure that modifications to the President's proposal maintain equity and sensitivity to the special needs of HIV-infected individuals.

Private insurance companies, like other businesses, seek to maximize profits by choosing only "acceptable" insurance risks. Under the HSA, universal coverage is guaranteed. Universal means everyone! What does Health Security mean to you?:

- **Universal coverage - HIV status or other health conditions do not prevent you from getting coverage.**
- **Community ratings prevent persons with HIV infection from being charged more for premiums.**
- **Prescription drugs will be covered.**
- **Ryan White CARE Act services will not be lost.**
- **Any form of discrimination is prohibited.**
- **Essential providers - specialists in treating HIV and AIDS will be available to all people who need them.**

Based on a series of focus groups with people with AIDS and HIV/AIDS service organizations, a list of "top ten" concerns for the HIV community were identified. Information regarding these concerns is attached for your review.

I hope this information will be helpful to you. If I can be of further assistance or provide any additional information, please contact me or Andrew E. Barrer, Ph.D. at (202) 632-1090. Thank you.

Kristine Gebbie

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

Top Ten Issues

1. **Premium Financing and Risk Adjustment**

2. **Availability of and Assured Access to "Essential Providers"**

3. **Long-term and Home Care Coverage**

4. **Availability of Mental Health and Substance Abuse Services**

5. **Impact of the HSA on the Ryan White CARE Act**

6. **Medicaid and Medicare Funding and Program Transition Issues, especially as related to the Medicare and Medicaid programs**

7. **Confidentiality**

8. **Grievance Procedures**

9. **Effects of "State Options" on the HSA package of benefits**

10. **Funding for Public Health System Core Functions (e.g. Behavioral Research, Prevention Services, etc.)**

1. Premium Financing and Risk Adjustment

Issue: Will the risk adjustment mechanism prevent "redlining" for persons with HIV/AIDS or other life threatening illnesses?

Summary: Yes. Redlining, or any attempts to limit access to people with HIV or AIDS is clearly prohibited. The HSA provides mechanisms which require states to spread the financial risks associated with special communities by adjustments which would take into account such factors known to affect utilization of services, such as age, sex, health status and services to disadvantaged populations. The health plans have to meet specific rules on enrollment, community rating, information, and grievance procedures.

2. Availability of HIV Specialist, "Essential Providers"

Issue: Will HIV positive persons be able to continue using their local HIV medical specialist?

Summary: The Health Security Act establishes a special category of health care provider which is referred to as an "essential provider". Any health care provider or organization can make application to be certified as an essential provider. Within the HSA, a Ryan White grantee or subgrantee can be automatically certified as an essential provider. Each health plan must enter into a written agreement with each essential provider located within its service area.

3. Long-term Care and Home Health Care

Issue: Persons with HIV/AIDS often need home health care and long-term care services. Will the Health Security Act provide those needed services?

Summary: Home health care is included in the nationally guaranteed comprehensive benefits package. A new long-term care initiative will expand coverage of home and community-based care. This will make it possible for more elderly and disabled persons, including persons living with HIV/AIDS to live in their homes and communities while receiving long-term care. The Act will improve

Medicaid coverage for persons in nursing homes.

The HSA will improve the quality and reliability of private long-term care insurance and provide tax incentives for persons to buy it; and tax incentives to help individuals with disabilities work.

4. Availability of Mental Health and Substance Abuse Services

Issue: Mental health needs in the HIV/AIDS community tend to be greater than the average. What will HSA do to provide these services? Injecting drug users, at high risk of HIV infection and transmission, currently have inadequate treatment and preventive services available to them. Will adequate services be available to treat these individuals in order to ameliorate their additive disease and halt the epidemic?

Summary: A base level of mental health services will be provided to all persons through the Health Security Act. We know that viable mental health services are part of a good program of health care and especially beneficial to HIV infected persons.

In order to make a significant difference in the rate of new infections in the injecting drug use population and their sexual partners, the HSA will provide substance abuse treatment to everyone.

5. Health Care Reform and the Ryan White CARE Act

Issue: Will the financial restructuring of the health care system assure the delivery of health care services appropriate to the needs of vulnerable populations whose access problems go beyond lack of insurance?

Summary: The comprehensive benefits package provided by the HSA may not provide all essential services for persons with HIV/AIDS. Conversely, a variety of services currently provided by the CARE Act would be covered under the HSA benefits package. These would include primary care services, medications, assistance for health insurance coverage, home-based services, case management,

transportation, and outreach. It may be necessary to utilize Ryan White CARE Act funds "freed up" by the provision of these services under HSA to subsidize the supplemental and client's share of insurance premiums, co-payments, deductibles, and expenditures that exceed spending caps.

The CARE Act is not a "band-aid" that can be discarded after health care reform. The Act will serve as a critical resource to sustain health care delivery systems and insure the continued delivery of essential and comprehensive health and support services to those infected with HIV.

6. Medicaid and Medicare Funding and Program Transition Issues

Issue: What impact will the HSA have on funding for the Medicaid and Medicare programs? What programs will be available during the transition from the old system to the one provided under the HSA?

Summary: Under the HSA adult Medicaid recipients who now receive cash supplements (currently 9 million beneficiaries) would be enrolled in the new system, but would not have to pay premiums. Further, they would be entitled to join a new state and federally-matched program providing wrap-around services similar to those now available under the Medicaid program. Children less than 18 years of age who are currently eligible or would be Medicaid recipients, with eligibility for wrap-around services (primarily based on poverty level), would be provided those services through a new federally funded (but state administered) program, ***regardless of their cash assistance status.***

The Medicare program will be preserved and strengthened under the HSA, which will add new coverage for prescription drugs and expanded coverage of home and community-based care.

7. Health Security Act (HSA) and Confidentiality Issues

Issue: What safeguards are envisioned for the handling of health information on HIV affected persons under the Health Security Act ?

Summary: The HSA addresses the issue of how information will be handled and what penalties will be imposed for misusing information. The HSA will provide guidance level information on creation of the oversight board, users and uses of information, privacy standards, enrollee rights, outright prohibitions, training of information handlers, and comprehensive health information privacy protection. The development of the Comprehensive Health Information Privacy Protection Act will be implemented within two years from the date of passage.

8. Grievance Procedures

Issue: How can individuals ensure that their health plan will provide the health benefits and services they require?

Summary: The HSA is intended to provide adequate health care coverage for all citizens and legal residents of the United States. The Act requires States to approve each health plan before it can engage in providing health care under the Act. The law prohibits exclusions because of pre-existing conditions or through "red-lining," the practice of excluding a particular group of individuals because of perceived high risk.

The Health Security Act includes a comprehensive grievance process for any person aggrieved by acts or practices which result in denial or delay of benefits or payments. Individuals must work within the individual plan's grievance process before going to adjudication through the Complaint Review Offices set up in each state. If there is a question as to an individual's eligibility for a plan, subsidies or cost sharing, the individual may go directly to court and all costs can be reimbursed if the court finds for the individual.

The complaint office must rule in under 30 days, although a 24 hour appeal is available in cases of emergency. Appeals must be processed within 60 days. There are means of appealing, with the national board being the ultimate administrative appeal.

9. "State Options"

Issue: What impact will "State Options" have on coverage under the HSA? What impact will it have on services, availability, and affordability?

Summary: Some states cover additional services under federally matched Medicaid programs. Under the HSA, a number of programs will become available at each state's option. To assure that there is not a loss of services to the person with AIDS, Ryan White will continue to act as the safety net to assure needed services reach all people in need. The expanded use of case management, will help follow individual needs and assure services are provided.

10. Public Health System Core Functions

Issue: What is the nature of the funding for research on behavior, health services and Core Functions of Public Health Programs?

Summary: The Health Security Act will provide funding for AIDS specific research and public health initiatives that will have to be provided under the authority of the Public Health System. Behavioral research into those behaviors that may cause or contribute to disease will be conducted by the National Institutes of Health. The Act will also provide funding for strengthening the public health core function of states, including those components related to diseases of public health significance. This support will allow communities to maintain strong programs to prevent the spread of HIV, tuberculosis, and other conditions of public health importance.

THE WHITE HOUSE

WASHINGTON

PRESS RELEASE

FOR IMMEDIATE RELEASE
FEBRUARY 7, 1994

FOR MORE INFORMATION:
JOHN PAUL GURROLA 202/632-1090
ANDREW BARRER 202/632-1090

FEDERAL AIDS BUDGET FOR 1995 INCREASES

WASHINGTON, D.C. -- Kristine M. Gebbie, President Clinton's National AIDS Policy Coordinator discussed the increases in the Federal budget on AIDS today. "In a time of over-all budget cuts and other budget-related program reductions, the President's continued commitment to HIV/AIDS is shown in a budget increase of nearly ten percent" Gebbie said. The Office of National AIDS Policy has three focus areas in its mission -- research, treatment/services and prevention. The budget requests for these three areas and the requests for the specific departments that are closely related to HIV/AIDS issues are described below.

The President's Budget proposes a 6% increase in NIH basic and preventive research for HIV and AIDS. This provides $1.379 billion for NIH AIDS research, a 29% increase since 1993. The President proposes an additional $231 million for AIDS research in other federal agencies, bringing the total federal investment to $1.61 billion.

This investment is combined with the Administration's commitment to improved management of AIDS research planning and budgeting at the NIH, and to enhancing government-wide and

private sector coordination.

HIV/AIDS treatment and care services are primarily funded through the Ryan White CARE Act. The Administration is recommending an increase in these treatment funds of 16.1% for a dollar increase of 93 million dollars. These funds will be split between the four titles of the Act as follows: Title I (cities) 39 million, Title II (states) 30 million, Title III (primary care systems) 19 million, Title IV (pediatric and maternity care centers) 5 million.

In FY 94 $1.1 billion was appropriated for block grants to states for substance abuse treatment, of which approximately $25 million were specifically earmarked for HIV related programs. The FY 95 budget shows an increase of $310 million for substance abuse treatment under the Substance Abuse and Mental Health Services Administration. This amount will go to the block grants given to states and will have direct impact on HIV prevention for persons with chronic substance abuse issues, including injecting drug users. This number will be adjusted based on the number of states that qualify in the coming weeks. Of the new amount, $15.5 million have been specifically earmarked for HIV prevention activities. Since drug abusers are at high risk for HIV transmission, we consider this budget line a significant part of our Federal AIDS prevention programs. HIV prevention activities under the Centers for Disease Control and Prevention will receive the same level of funding as in FY 94.

The Department of Health and Human Services, budget requests an increase of 592 million dollars over the 1994 level of spending. This raises the 1995 AIDS spending for HHS to nearly 6.0 billion. The increases within the Public Health Service include 93 million for the Ryan White AIDS services, 78 million for NIH and one million at AHCPR.

At the Department of Defense the 1995 budget request is divided between research, prevention and services/treatment money. $14 million is earmarked for research; $22 million for prevention and $63 million for treatment services for military members and their families.

The Department of Housing and Urban Development's (HUD) FY 95 budget requests $257 million towards the housing needs of people with HIV and AIDS. HUD funds can be used for a wide range of housing related services to prevent homelessness. Services can include emergency housing, transitional housing, and permanent housing arrangements; and the acquisition, rehabilitation and leasing of existing housing. Appropriate supportive services must be provided as part of HUD's HIV-related housing and include such activities as health and mental health services, permanent housing placement, chemical dependency treatment and counseling, day care, nutritional services, intensive care when required, and assistance in gaining access to local, state and federal government benefits and services. Housing Opportunities for People with AIDS remains stable at $156 million.

The Department of Veterans affairs, through its large system of hospitals, provides AIDS prevention education, performs research and provides treatment services to Veterans. The total VA budget request for FY 95 is increased by $18 M overall. Of the $349 M requested for FY 95, $312 M is earmarked for treatment services; $6 M for research and $31 M for prevention education.

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THE WHITE HOUSE

WASHINGTON

OFFICE OF NATIONAL AIDS POLICY
PUBLIC HEALTH SERVICE FY 95 BUDGET INFORMATION

Summary

The FY 1995 budget includes $2.7 billion in budget authority for the PHS for research, prevention and other related activities in the battle against AIDS and HIV infection. This is an increase of $177 million, or 7 percent, over the FY 1994 appropriations. The funds requested for HIV/AIDS activities are included in the budget for each of the PHS components. The tables below summarize the entire PHS-wide HIV/AIDS effort, both by PHS agency and by function.

For FY 1995, the President's Budget proposes a $93 million, or 16 percent, increase for HRSA's Ryan White AIDS health care services, and a $78 million, or 6 percent increase for NIH basic and preventive research on AIDS. (More detailed discussions of these program increases for AIDS are included in the individual agency sections.)

HIV/AIDS FUNDING BY PHS COMPONENT
(Dollars in millions)

	1993 Actual	1994 Approp.	1995 Request	+/-
FDA.....	$73	$72	$72	–
HRSA.....	390	608	701	+$93
IHS.....	3	4	4	–
CDC.....	498	543	543	–
NIH.....	1071	1301	1379	+78
SAMHSA.....	26	28	33	+5
AHCPR.....	10	11	12	+1
OASH.....	5	5	5	–
TOTAL, HIV/AIDS Budget Authority.....	2077	2572	2749	+177

SUBSTANCE ABUSE DOLLARS

In FY 94 $1.1 Billion was appropriated for block grants to states for substance abuse treatment. Through the efforts of the Office of the National Drug Control Policy Coordinator an additional $310 Million will be added to FY 95. This money is to be used by states for the most severe substance abuse cases, such as injecting drug abusers, who are at great risk for HIV transmission. $15.5 Million of the new money will be specifically earmarked for HIV-related substance abuse programs. Of the original $1.1 Billion, approximately 25 Million is also specifically earmarked for HIV related programs. (This number will be adjusted based on number of states that qualify in the coming weeks.) Because such abusers are at high risk for HIV transmission, this budget line is a significant part of federal AIDS prevention programs.

Office of National AIDS Policy

Federal HIV Funding

(In Millions of Dollars)

	FY 1994 Enacted	FY 1995 Budget	Dollar Increase FY 94 to FY 95	Percent Increase FY 94 to FY 95
Public Health Service	2,572	2,749	+177	+7%
Office of Civil Rights	3	3	+0	+0%
Veterans	331	349	+18	+5%
Defense	129	99	-30	-23%
Housing	253	257	+4	+2%
OPM-FEHB	193	213	+20	+10%
*Other	129	131	+2	+2%
Total Appropriations	***3610***	***3,801***	***+191***	***+5%***
Medicaid (Federal Share)	1,490	1,640	+150	+10%
Medicare	500	600	+100	+20%
Social Security	835	1,015	+180	+22%
Total Entitlement	***2,825***	***3,255***	***+430***	***+15%***
Total Spending	6,435	7,056	+621	+10%

* Includes USDAID, Bureau of Prisons, State, and Labor.

Note: Provided as draft by Office of Management and Budget 2/7/94.

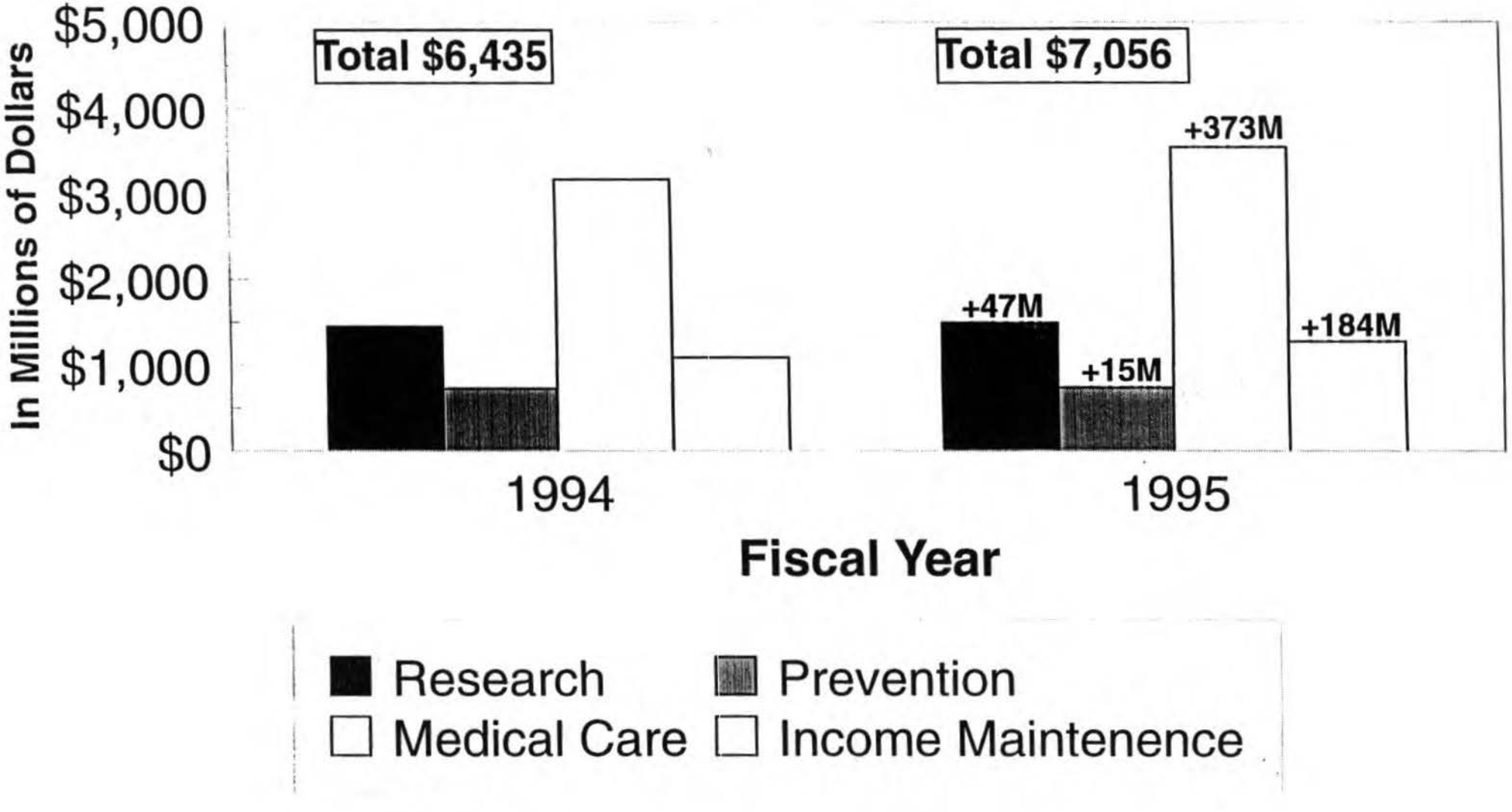
HHS HIV/AIDS Funding

(Dollars in thousands)

	1993	1994	1995		
			Pres.	Chg. +/-	
	Enacted	Approp.	Budget	'94 Approp.	% Chg.
PUBLIC HEALTH SERVICE:					
FDA	$72,628	$72,399	$72,399	$0	0.0%
HRSA:					
Ryan White:					
Title I	$184,757	$325,500	$364,500	$39,000	12.0%
Title II	115,288	183,897	213,897	30,000	16.3%
Title III	47,968	47,968	66,968	19,000	39.6%
Title IV	--	22,000	27,000	5,000	22.7%
Sub, Ryan White	$348,013	$579,365	$672,365	$93,000	16.1%
Other HRSA AIDS	42,328	28,431	28,431	0	0.0%
Sub, HRSA	$390,341	$607,796	$700,796	$93,000	15.3%
IHS	$3,303	$3,556	$3,556	$0	0.0%
CDC	$498,253	$543,253	$543,253	$0	0.0%
NIH	$1,071,457	$1,301,045	$1,379,052	$78,007	6.0%
SAMHSA	$25,655	$28,111	$32,986	$4,875	17.3%
AHCPR	$9,624	$10,624	$12,000	$1,376	13.0%
OASH	$5,330	$5,323	$5,323	$0	0.0%
Subtotal, PHS	$2,076,591	$2,572,107	$2,749,365	$177,258	6.9%
ENTITLEMENTS:					
HCFA:					
Medicaid (Fed Share)	$1,290,000	$1,490,000	$1,640,000	$150,000	10.1%
Medicare	385,000	500,000	600,000	100,000	20.0%
Sub, HCFA	1,675,000	1,990,000	2,240,000	$250,000	12.6%
Social Security:					
DI	505,000	635,000	775,000	$140,000	22.0%
SSI	165,000	200,000	240,000	40,000	20.0%
Sub, Social Security	670,000	835,000	1,015,000	$180,000	21.6%
Subtotal, Entitlements	$2,345,000	$2,825,000	$3,255,000	$430,000	15.2%
OTHER:					
OS/Office for Civil Rights	$2,600	$2,600	$2,600	$0	0.0%
TOTAL, HHS	$4,424,191	$5,399,707	$6,006,965	$607,258	11.2%

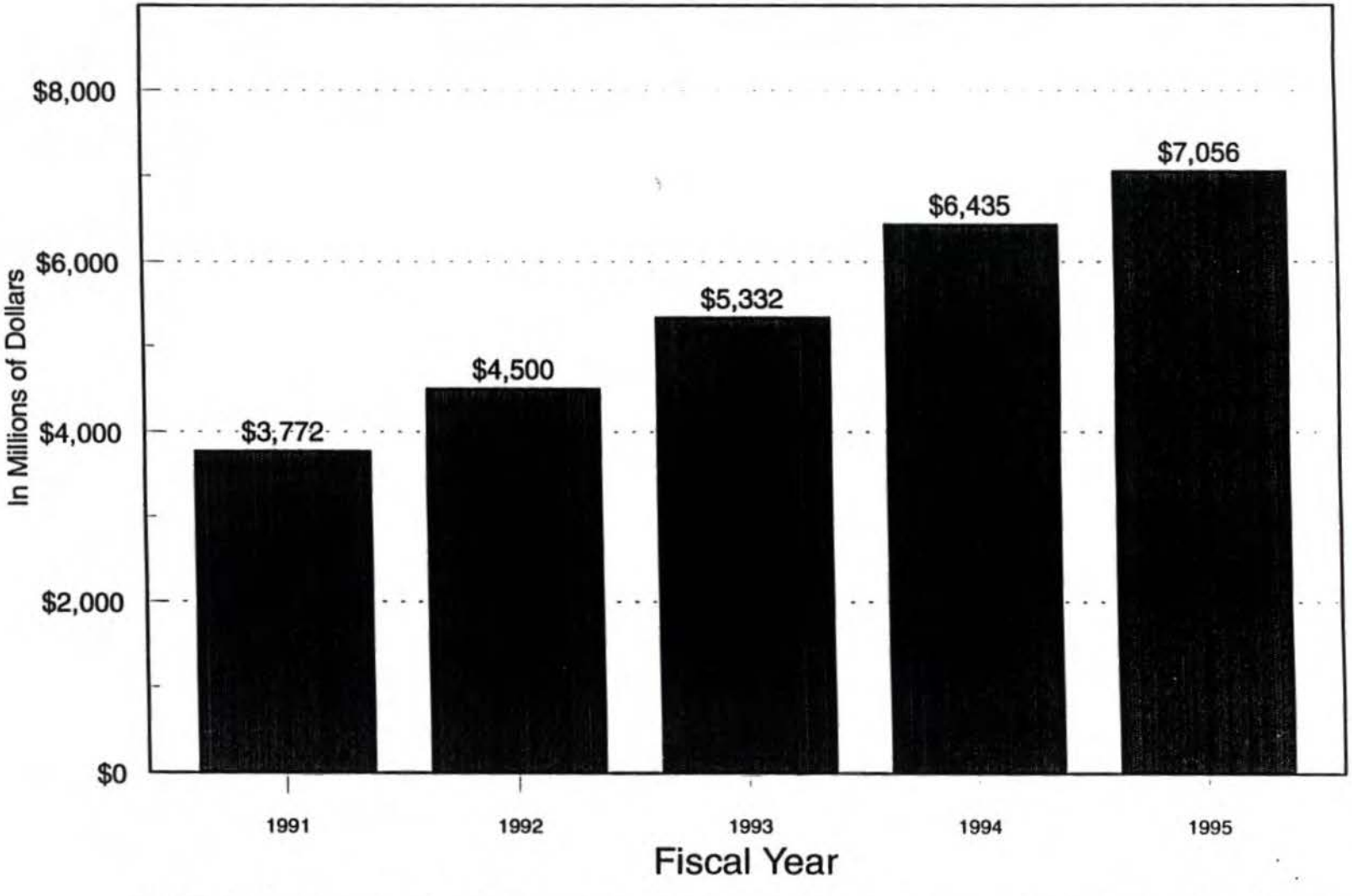
Office of National AIDS Policy

Federal HIV Funding



Office of National AIDS Policy

Total Federal Spending for HIV/AIDS
1991 THRU 1995



FY95 includes an estimated $15.5 million in HIV/AIDS prevention services in the Hard Core DrugTreatment Initiative, an increase of approximately $6 million above previous HIV/AIDS programming in SAMSHA

HIV/AIDS

SURVEILLANCE REPORT — Third Quarter Edition

U.S. AIDS cases reported through September 1993 — **Issued October 1993, Vol. 5, No. 3**

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

Table 1. AIDS cases and annual rates per 100,000 population, by state, reported October 19 through September 1992, October 1992 through September 1993;[1] and cumulative totals, by state and age group, through September 1993, United States[2]

State of residence	Oct. 1991-Sept. 1992		Oct. 1992-Sept. 1993		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children < 13 years old	Total
Alabama	465	11.4	705	17.0	2,275	43	2,318
Alaska	18	3.2	60	10.2	154	2	156
Arizona	408	10.9	1,202	31.3	3,059	14	3,073
Arkansas	237	10.0	420	17.5	1,239	21	1,260
California	8,641	28.4	17,474	56.4	62,201	356	62,557
Colorado	415	12.3	1,193	34.5	3,516	18	3,534
Connecticut	538	16.3	1,693	51.4	4,415	98	4,513
Delaware	126	18.5	346	49.9	830	7	837
District of Columbia	724	121.0	1,370	232.3	5,231	78	5,309
Florida	5,007	37.7	9,613	70.6	32,008	751	32,759
Georgia	1,348	20.4	2,597	38.4	9,255	87	9,342
Hawaii	175	15.4	324	27.9	1,250	10	1,260
Idaho	36	3.5	71	6.6	203	2	205
Illinois	1,842	16.0	3,005	25.8	10,522	140	10,662
Indiana	370	6.6	831	14.6	2,443	17	2,460
Iowa	86	3.1	196	7.0	577	6	583
Kansas	188	7.5	335	13.3	1,031	5	1,036
Kentucky	207	5.6	316	8.4	1,148	13	1,161
Louisiana	829	19.5	1,172	27.4	4,811	67	4,878
Maine	50	4.0	126	10.2	427	4	431
Maryland	1,096	22.6	2,353	47.6	7,187	152	7,339
Massachusetts	767	12.8	2,532	42.4	7,238	132	7,370
Michigan	784	8.4	1,752	18.6	4,904	62	4,966
Minnesota	237	5.3	624	13.9	1,829	13	1,842
Mississippi	231	8.9	468	17.9	1,483	20	1,503
Missouri	650	12.6	1,679	32.3	4,626	33	4,659
Montana	22	2.7	35	4.3	134	2	136
Nebraska	68	4.3	179	11.1	469	4	473
Nevada	235	18.3	601	44.0	1,641	15	1,656
New Hampshire	48	4.3	99	9.0	368	6	374
New Jersey	2,051	26.4	4,390	56.3	18,106	423	18,529
New Mexico	90	5.8	307	19.4	831	2	833
New York	8,232	45.6	16,031	88.4	63,660	1,321	64,981
North Carolina	648	9.6	1,059	15.5	3,735	75	3,810
North Dakota	4	0.6	4	0.6	32	—	32
Ohio	696	6.4	1,490	13.5	4,944	68	5,012
Oklahoma	228	7.2	716	22.3	1,795	15	1,810
Oregon	283	9.7	732	24.4	2,233	9	2,242
Pennsylvania	1,338	11.2	2,556	21.2	9,086	120	9,206
Rhode Island	102	10.2	305	30.3	842	9	851
South Carolina	347	9.7	1,395	38.4	3,022	38	3,060
South Dakota	8	1.1	23	3.2	57	2	59
Tennessee	442	8.9	967	19.2	2,734	26	2,760
Texas	2,944	17.0	7,164	40.4	23,572	213	23,785
Utah	145	8.2	270	14.9	818	20	838
Vermont	26	4.6	60	10.5	176	2	178
Virginia	606	9.6	1,590	24.9	4,710	82	4,792
Washington	573	11.4	1,459	28.2	4,765	18	4,783
West Virginia	61	3.4	78	4.3	359	5	364
Wisconsin	224	4.5	700	13.9	1,705	19	1,724
Wyoming	4	0.9	36	7.7	91	—	91
Subtotal	**44,900**	**17.8**	**94,703**	**37.0**	**323,747**	**4,645**	**328,392**
Guam	1	0.7	2	1.5	12	—	12
Pacific Islands, U.S.	—	—	—	—	2	—	2
Puerto Rico	1,796	50.5	2,621	73.1	10,436	256	10,692
Virgin Islands, U.S.	19	18.6	42	40.8	147	5	152
Total	**46,716**	**18.2**	**97,368**	**37.5**	**334,344**	**4,906**	**339,250**

[1]Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]During the third quarter of 1993, CDC received reports of 23,664 cases and 9,951 deaths among adults/adolescents and 196 cases and 105 dea among children.

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

Metropolitan area of residence[2]	Oct. 1991–Sept. 1992		Oct. 1992–Sept. 1993		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children < 13 years old	Total
Orlando, Fla.	331	26.1	870	66.3	2,249	42	2,291
Philadelphia, Pa.	1,005	20.3	2,110	42.5	7,082	87	7,169
Phoenix, Ariz.	292	12.8	863	36.9	2,236	9	2,245
Pittsburgh, Pa.	148	6.2	214	8.9	1,026	6	1,032
Portland, Oreg.	249	15.9	655	40.3	1,943	6	1,949
Providence, R.I.	96	10.5	285	31.1	791	8	799
Raleigh-Durham, N.C.	128	14.5	189	20.8	787	18	805
Richmond, Va.	140	15.9	385	42.9	1,006	13	1,019
Riverside-San Bernardino, Calif.	435	16.0	1,045	36.6	2,727	27	2,754
Rochester, N.Y.	76	7.1	243	22.4	742	8	750
Sacramento, Calif.	287	20.7	453	31.5	1,490	14	1,504
Saint Louis, Mo.	290	11.6	841	33.3	2,224	21	2,245
Salt Lake City, Utah	129	11.7	241	21.3	726	14	740
San Antonio, Tex.	217	16.1	426	31.1	1,591	14	1,605
San Diego, Calif.	631	24.8	1,474	56.7	4,877	32	4,909
San Francisco, Calif.	1,896	116.9	4,592	279.8	17,397	27	17,424
San Jose, Calif.	183	12.2	502	33.2	1,514	11	1,525
San Juan, P.R.	1,075	57.9	1,638	87.3	6,577	168	6,745
Sarasota, Fla.	90	18.0	148	28.9	570	12	582
Scranton, Pa.	26	4.1	54	8.4	188	3	191
Seattle, Wash.	424	20.4	1,043	49.1	3,536	10	3,546
Springfield, Mass.	92	15.3	210	35.0	574	15	589
Stockton, Calif.	34	6.9	109	21.6	307	8	315
Syracuse, N.Y.	71	9.5	168	22.2	497	6	503
Tacoma, Wash.	38	6.3	137	21.9	360	7	367
Tampa-Saint Petersburg, Fla.	535	25.5	1,421	66.6	3,781	53	3,834
Toledo, Ohio	33	5.4	90	14.6	271	4	275
Tucson, Ariz.	93	13.7	258	37.6	619	5	624
Tulsa, Okla.	70	9.7	236	32.1	549	5	554
Ventura, Calif.	73	10.8	130	19.0	378	1	379
Washington, D.C.	1,345	31.3	2,560	58.7	9,366	138	9,504
West Palm Beach, Fla.	529	59.7	787	86.5	2,916	107	3,023
Wichita, Kansas	62	12.6	96	19.2	276	2	278
Wilmington, Del.	93	17.8	261	49.1	617	6	623
Youngstown, Ohio	23	3.8	29	4.8	148	—	148
Metropolitan areas with 500,000 or more population	**39,112**	**24.8**	**81,352**	**50.9**	**284,441**	**4,131**	**288,572**
Metropolitan areas with 50,000 to 500,000 population	**4,821**	**10.5**	**10,306**	**22.0**	**31,977**	**485**	**32,462**
Non-metropolitan areas	**2,587**	**4.9**	**5,288**	**10.0**	**16,621**	**268**	**16,889**
Total[3]	**46,716**	**18.2**	**97,368**	**37.5**	**334,344**	**4,906**	**339,250**

[1]Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]Based on Metropolitan Statistical Areas (MSA) revised June 1993. See technical notes.
[3]Totals include 1,327 persons whose area of residence is unknown.

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

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	30,094	(73)	125,392	(78)	9,614	(37)	34,166	(42)	5,638	(42)	21,475	(45
Injecting drug use	4,285	(10)	12,670	(8)	9,667	(37)	29,762	(36)	5,094	(38)	18,143	(38
Men who have sex with men and inject drugs	3,001	(7)	11,959	(7)	1,568	(6)	5,974	(7)	712	(5)	3,021	(
Hemophilia/coagulation disorder	794	(2)	2,349	(1)	110	(0)	260	(0)	68	(1)	224	(
Heterosexual contact:	607	(1)	1,654	(1)	2,125	(8)	6,279	(8)	570	(4)	1,375	(
Sex with injecting drug user	*227*		*804*		*682*		*2,118*		*185*		*599*	
Sex with person with hemophilia	*6*		*13*		*1*		*4*		*2*		*4*	
Born in Pattern-II[2] country	*1*		*8*		*605*		*2,571*		—		*10*	
Sex with person born in Pattern-II country	*10*		*52*		*31*		*86*		*2*		*11*	
Sex with transfusion recipient with HIV infection	*25*		*72*		*26*		*51*		*6*		*28*	
Sex with HIV-infected person, risk not specified	*338*		*705*		*780*		*1,449*		*375*		*723*	
Receipt of blood transfusion, blood components, or tissue	431	(1)	2,519	(2)	157	(1)	606	(1)	91	(1)	385	(
Risk not identified[3]	2,032	(5)	4,380	(3)	2,807	(11)	5,127	(6)	1,234	(9)	2,728	(
Total	**41,244**	**(100)**	**160,923**	**(100)**	**26,048**	**(100)**	**82,174**	**(100)**	**13,407**	**(100)**	**47,351**	**(10**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[4]			
	Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%
Men who have sex with men	445	(74)	1,583	(79)	158	(63)	388	(63)	46,025	(56)	183,344	(6
Injecting drug use	28	(5)	79	(4)	23	(9)	62	(10)	19,142	(23)	60,835	(2
Men who have sex with men and inject drugs	22	(4)	57	(3)	42	(17)	107	(17)	5,353	(7)	21,142	(
Hemophilia/coagulation disorder	12	(2)	35	(2)	6	(2)	16	(3)	990	(1)	2,890	(
Heterosexual contact:	15	(2)	29	(1)	4	(2)	10	(2)	3,328	(4)	9,361	(
Sex with injecting drug user	*6*		*12*		*1*		*5*		*1,102*		*3,539*	
Sex with person with hemophilia	—		—		—		—		*10*		*22*	
Born in Pattern-II country	—		*3*		—		—		*607*		*2,597*	
Sex with person born in Pattern-II country	—		*1*		—		—		*43*		*150*	
Sex with transfusion recipient with HIV infection	*2*		*2*		—		—		*59*		*154*	
Sex with HIV-infected person, risk not specified	*7*		*11*		*3*		*5*		*1,507*		*2,899*	
Receipt of blood transfusion, blood components, or tissue	12	(2)	72	(4)	1	(0)	5	(1)	695	(1)	3,596	(
Risk not identified	69	(11)	152	(8)	15	(6)	26	(4)	6,174	(8)	12,474	(
Total	**603**	**(100)**	**2,007**	**(100)**	**249**	**(100)**	**614**	**(100)**	**81,707**	**(100)**	**293,642**	**(10**

[1]Includes 9 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 follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

[4]Includes 573 men whose race/ethnicity is unknown.

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

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	13	(9)	141	(14)	1	(0)	24	(1)	4	(2)	33	(
Mother with/at risk for HIV infection:	118	(84)	663	(68)	489	(97)	2,556	(95)	197	(93)	1,074	(9
Injecting drug use	*38*		*290*		*153*		*1,133*		*69*		*483*	
Sex with injecting drug user	*22*		*132*		*70*		*390*		*40*		*318*	
Sex with bisexual male	*4*		*39*		*2*		*28*		*3*		*20*	
Sex with person with hemophilia	*2*		*13*		—		*5*		*1*		*3*	
Born in Pattern-II[1] country	—		*3*		*37*		*300*		—		*2*	
Sex with person born in Pattern-II country	—		—		*5*		*22*		—		*1*	
Sex with transfusion recipient with HIV infection	*1*		*6*		*1*		*5*		*1*		*8*	
Sex with HIV-infected person, risk not specified	*10*		*45*		*57*		*148*		*27*		*77*	
Receipt of blood transfusion, blood components, or tissue	*6*		*29*		*12*		*43*		*5*		*25*	
Has HIV infection, risk not specified	*35*		*106*		*152*		*482*		*51*		*137*	
Receipt of blood transfusion, blood components, or tissue	9	(6)	167	(17)	6	(1)	74	(3)	7	(3)	76	(
Risk not identified[2]	1	(1)	9	(1)	8	(2)	29	(1)	4	(2)	11	(
Total	**141**	**(100)**	**980**	**(100)**	**504**	**(100)**	**2,683**	**(100)**	**212**	**(100)**	**1,194**	**(10**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[3]			
	Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	—		3	(14)	—		1	(7)	18	(2)	202	(
Mother with/at risk for HIV infection:	2	(50)	10	(45)	2	(100)	13	(93)	814	(94)	4,328	(8
Injecting drug use	*1*		*3*		*1*		*6*		*264*		*1,920*	
Sex with injecting drug user	—		*2*		*1*		*2*		*133*		*846*	
Sex with bisexual male	—		*1*		—		—		*9*		*88*	
Sex with person with hemophilia	—		—		—		—		*3*		*21*	
Born in Pattern-II country	—		—		—		—		*37*		*305*	
Sex with person born in Pattern-II country	—		—		—		—		*5*		*23*	
Sex with transfusion recipient with HIV infection	—		—		—		—		*3*		*19*	
Sex with HIV-infected person, risk not specified	*1*		*1*		—		*2*		*96*		*275*	
Receipt of blood transfusion, blood components, or tissue	—		*1*		—		—		*23*		*98*	
Has HIV infection, risk not specified	—		*2*		—		*3*		*241*		*733*	
Receipt of blood transfusion, blood components, or tissue	2	(50)	9	(41)	—		—		24	(3)	327	(
Risk not identified	—		—		—		—		13	(1)	49	(
Total	**4**	**(100)**	**22**	**(100)**	**2**	**(100)**	**14**	**(100)**	**869**	**(100)**	**4,906**	**(10**

[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 follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

[3]Includes 13 children whose race/ethnicity is unknown.

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

Male	White, not Hispanic		Black, not Hispanic		Hispanic		Asian/Pacific Islander		American Indian/ Alaska Native		Total[2]	
Age at diagnosis (years)	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Under 5	329	(0)	1,167	(1)	478	(1)	8	(0)	8	(1)	1,992	(1)
5-12	248	(0)	183	(0)	155	(0)	7	(0)	1	(0)	594	(0)
13-19	473	(0)	299	(0)	186	(0)	11	(1)	11	(2)	980	(0)
20-24	4,735	(3)	3,282	(4)	1,938	(4)	75	(4)	23	(4)	10,071	(3)
25-29	23,298	(14)	12,067	(14)	7,742	(16)	267	(13)	123	(20)	43,576	(15)
30-34	37,653	(23)	19,017	(23)	11,723	(24)	420	(21)	173	(28)	69,100	(23)
35-39	35,879	(22)	19,483	(23)	10,671	(22)	443	(22)	126	(20)	66,742	(23)
40-44	25,717	(16)	13,213	(16)	7,088	(15)	346	(17)	85	(14)	46,548	(16)
45-49	15,223	(9)	6,869	(8)	3,793	(8)	218	(11)	34	(5)	26,191	(9)
50-54	8,173	(5)	3,800	(5)	2,012	(4)	108	(5)	17	(3)	14,140	(5)
55-59	4,671	(3)	2,121	(3)	1,174	(2)	62	(3)	9	(1)	8,066	(3)
60-64	2,775	(2)	1,155	(1)	587	(1)	20	(1)	10	(2)	4,551	(2)
65 or older	2,328	(1)	869	(1)	437	(1)	37	(2)	3	(0)	3,680	(1)
Male subtotal	161,502	(100)	83,525	(100)	47,984	(100)	2,022	(100)	623	(100)	296,231	(100)
Female												
Age at diagnosis (years)												
Under 5	320	(3)	1,143	(5)	455	(5)	1	(0)	5	(5)	1,933	(4)
5-12	81	(1)	189	(1)	106	(1)	6	(3)	—		384	(1)
13-19	102	(1)	262	(1)	68	(1)	1	(0)	1	(1)	435	(1)
20-24	672	(6)	1,347	(6)	594	(7)	12	(5)	10	(9)	2,641	(6)
25-29	1,875	(18)	3,801	(16)	1,699	(19)	23	(10)	23	(21)	7,430	(17)
30-34	2,455	(23)	5,618	(24)	2,126	(24)	48	(20)	34	(31)	10,300	(24)
35-39	1,918	(18)	5,094	(22)	1,707	(19)	38	(16)	14	(13)	8,792	(20)
40-44	1,093	(10)	2,826	(12)	988	(11)	37	(16)	9	(8)	4,961	(12)
45-49	594	(6)	1,187	(5)	472	(5)	21	(9)	5	(5)	2,286	(5)
50-54	359	(3)	706	(3)	273	(3)	14	(6)	2	(2)	1,356	(3)
55-59	344	(3)	381	(2)	168	(2)	8	(3)	1	(1)	903	(2)
60-64	249	(2)	248	(1)	87	(1)	12	(5)	3	(3)	599	(1)
65 or older	632	(6)	258	(1)	91	(1)	16	(7)	1	(1)	999	(2)
Female subtotal	10,694	(100)	23,060	(100)	8,834	(100)	237	(100)	108	(100)	43,019	(100)
Total	**172,196**		**106,585**		**56,818**		**2,259**		**731**		**339,250**	

[1]Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]Includes 575 males and 86 females whose race/ethnicity is unknown.

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

Definition category	Period of diagnosis: Before Sept. 1989 No.	(%)	Oct. 1989–Sept. 1990 No.	(%)	Oct. 1990–Sept. 1991 No.	(%)	Oct. 1991–Sept. 1992 No.	(%)	Oct. 1992–Sept. 1993 No.	(%)	Cumulative total No.	(%)
Pre-1987 definition	106,479	(79)	28,634	(64)	29,523	(58)	28,340	(47)	13,876	(29)	206,852	(61)
1987 definition	26,788	(20)	13,559	(30)	16,078	(31)	17,521	(29)	9,537	(20)	83,483	(25)
1993 definition[2]	1,610	(1)	2,402	(5)	5,467	(11)	15,032	(25)	24,404	(51)	48,915	(14)
Severe HIV-related immunosuppression[3]	*1,181*		*2,021*		*4,669*		*13,587*		*22,718*		*44,176*	
Pulmonary tuberculosis	*362*		*333*		*706*		*1,195*		*1,115*		*3,711*	
Recurrent pneumonia	*55*		*44*		*85*		*223*		*541*		*948*	
Invasive cervical cancer	*16*		*8*		*13*		*38*		*48*		*123*	
Total	**134,877**	**(100)**	**44,595**	**(100)**	**51,068**	**(100)**	**60,893**	**(100)**	**47,817**	**(100)**	**339,250**	**(100)**

[1]Includes 9 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.

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

Occupation	Documented occupational transmission[2] No.	Possible occupational transmission[3] No.
Dental worker, including dentist	—	6
Embalmer/morgue technician	—	3
Emergency medical technician/paramedic	—	8
Health aide/attendant	1	9
Housekeeper/maintenace worker	1	6
Laboratory technician, clinical	15	14
Laboratory technician, nonclinical	1	1
Nurse	13	15
Physician, nonsurgical	5	8
Physician, surgical	—	2
Respiratory therapist	1	2
Technician, dialysis	1	1
Technician, surgical	1	1
Technician/therapist, other than those listed above	—	3
Other health-care occupations	—	2
Total	**39**	**81**

[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: 34 had percutaneous exposure, 4 had mucocutaneous exposure, 1 had both percutaneous and mucocutaneous exposures. Thirty-six exposures were to blood from an HIV-infected person, 1 to visibly bloody fluid, 1 to an unspecified fluid, and 1 to a concentrated virus in a laboratory. Eleven 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.

Figure 1. Male adult/adolescent AIDS annual rates per 100,000 population, for cases reportec October 1992 through September 1993, United States

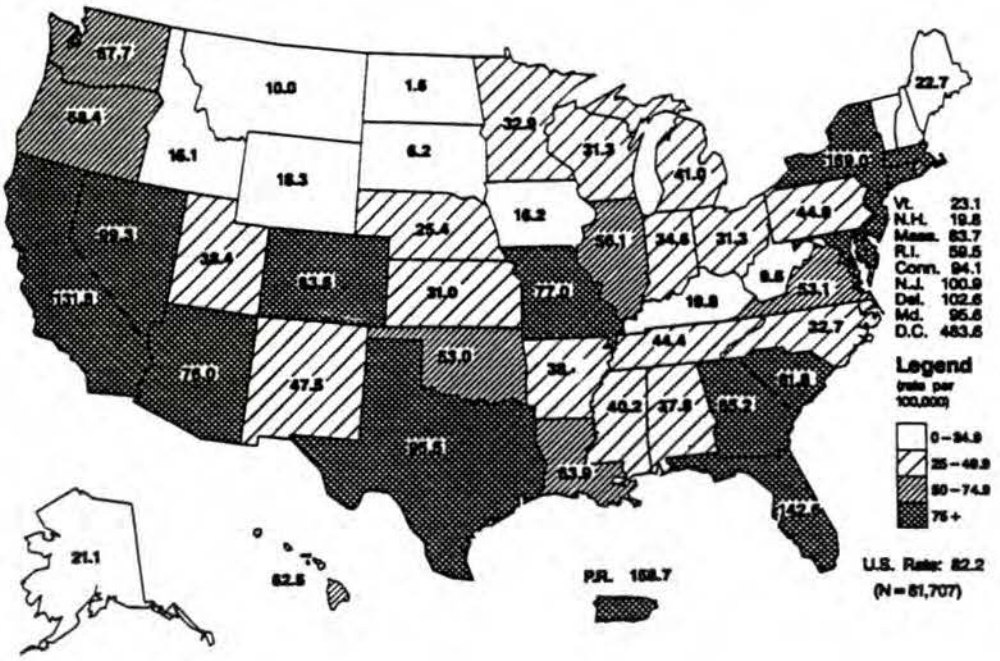


Figure 2. Female adult/adolescent AIDS annual rates per 100,000 population, for cases reported October 1992 through September 1993, United States

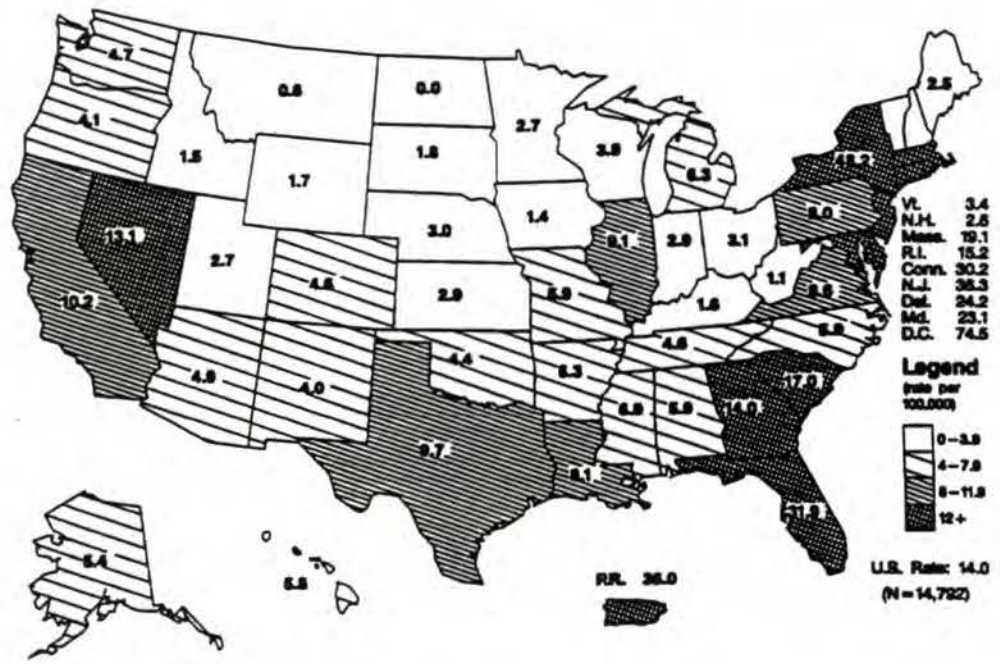


Figure 5. Pediatric AIDS cases reported October 1992 through September 1993, United States

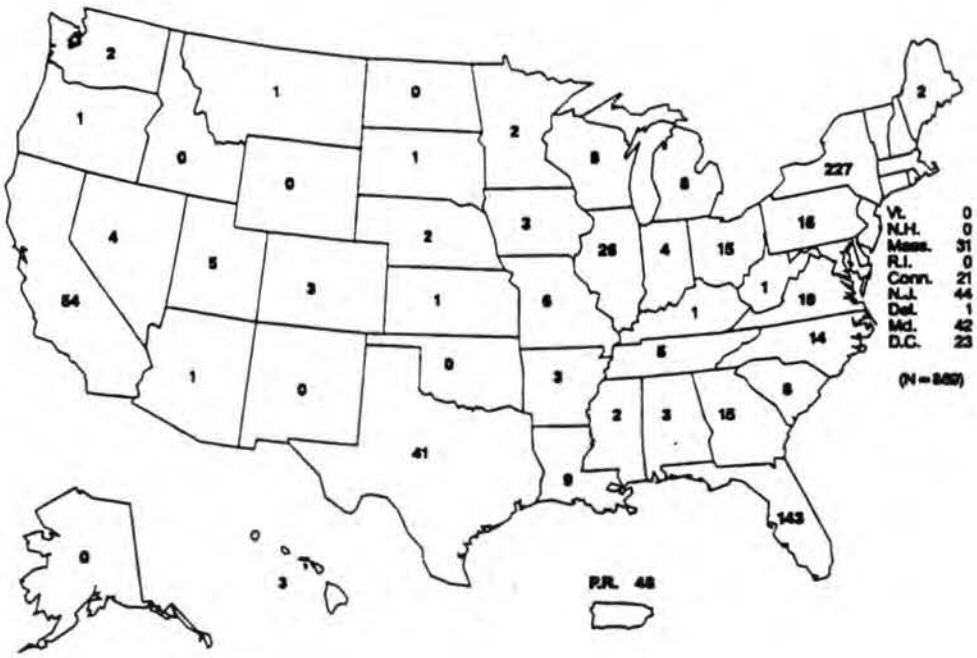
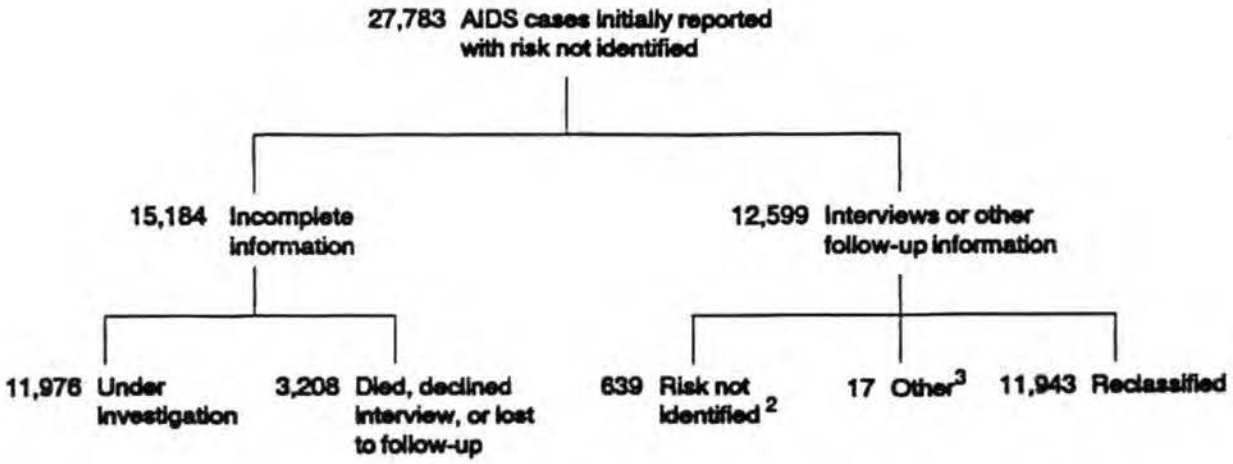


Figure 6. Results of investigations of adult/adolescent AIDS cases with risk not identified, reported through September 1993[1]



[1]Excludes 49 children under 13 years of age whose risk is not identified: 40 children who are under investigation and 9 who have died, declined interview, or were lost to follow-up. An additional 228 children who were initially reported with a risk not identified have been reclassified after investigation.

[2]Heterosexual transmission. 553 of the 639 persons who had no risk identified after follow-up responded to a standardized questionnaire: 185 (36% of 511 persons responding to questions related to sexually transmitted diseases gave a history of such diseases and 123 (36%) of 342 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]Eleven are health-care workers who developed AIDS after occupational exposure to HIV-infected blood, as documented by evidence of seroconversion; 4 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.

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 n reported history of exposure to HIV through any the routes listed in the hierarchy of exposure categ nes. Risk not identified cases include persons wh are currently under investigation by local heal department officials; persons whose exposure hi tory is incomplete because they died, declined to b interviewed, or were lost to follow-up; and persor who were interviewed or for whom other follow-u information was available and no exposure mod was identified. Persons who have an exposure mod identified at the time of follow-up are reclassified in the appropriate exposure category.

Rates

Rates are calculated on an annual basis p 100,000 population, based on U.S. Bureau of Ce sus data from the 1990 census, and on extrapol tions from the 1990 census and official Censu Bureau estimates for 1991. Each 12-month rate the number of cases for a 12-month period divide by the 1991 or 1992 population, multiplied b 100,000.

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

PM69B175691093

THE WHITE HOUSE

WASHINGTON

January 12, 1994

AID Atlanta

1438 West Peachtree St., NW
Suite 100
Atlanta, GA 30309-2955

Office: (404) 885-6801
(404) 872-3298
Fax: (404) 885-6799

Richard L. Sowell, PH.D. RN, FAAN
Director Division Research &
Client Services

Emily Slough
Meeting Manager
PREVENTION 94
1015 15th Street, N.W.
Suite 403
Washington, D.C. 20005

Dear Slough:

This letter confirms the participation of Kristine M. Gebbie, National AIDS Policy Coordinator, in the PREVENTION 94 conference, on March 20, 1994 in Atlanta. Ms. Gebbie plans to arrive at 3:00 p.m. to participate on the panel, "Communicating Prevention to People."

Please call me at (202) 632-1090 with any questions or for further clarification. As requested, I am enclosing the audio visual equipment release from, personal information profile, and speaker release for audio tape cassette.

Sincerely,

W. Steve Lee, Executive Assistant
and Scheduler to the
National AIDS Policy Coordinator

Enclosures

SCIENCE, SKILLS AND STRATEGIES

PREVENTION 94

MARCH 19-22, 1994, ATLANTA, GA

AMERICAN COLLEGE OF PREVENTIVE MEDICINE
ASSOCIATION OF TEACHERS OF PREVENTIVE MEDICINE

1015 15TH STREET NW, SUITE 403
WASHINGTON, DC 20005
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FAX: (202) 842-1980

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American Osteopathic College of Preventive Medicine
American Public Health Association
American Society of Addiction Medicine
American Society of Internal Medicine
Association of Academic Health Centers
Association of American Medical Colleges
Association of Preventive Medicine Residents
Association of Schools of Public Health
Association of State and Territorial Health Officials
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National Council for Education of Health Professionals in Health Promotion
Partnership for Prevention
Society for Public Health Education, Inc.
Society of General Internal Medicine
Society of Prospective Medicine
Society of Teachers of Family Medicine
U.S. Conference of Local Health Officers

AUDIOVISUAL EQUIPMENT REQUEST FORM

X No equipment is required for my presentation.

____ I will require audiovisual equipment as follows:

____ 35 mm slide projector (carousel), screen and pointer

____ Overhead projector

____ Video player, TV Monitor (VHS)

____ Flip Chart with markers

____ Other (Specify: _____)

Name: Krstine M. Gebbie

Telephone: 202 · 637. 1090

Session Title: Communicating Prevention to People

Session Date/Time: 3/20 @ 3pm

RETURN THIS FORM BY JANUARY 14, 1994

SCIENCE, SKILLS
AND STRATEGIES

PREVENTION 94

MARCH 19-22, 1994, ATLANTA, GA

PERSONAL INFORMATION PROFILE

The following information is needed for P94 program book. Please write or type legibly.

Kristene M. Gebbie, R.N., M.N.
NAME

National AIDS Policy Coordinator
POSITION/TITLE

The White House
INSTITUTION/ORGANIZATION

750 17th Street NW Suite 1060
BUSINESS ADDRESS

202.632.1090 202.632.1096
PHONE NUMBER FAX NUMBER

Summarize the following information related to your presentation topic in space provided. ***DO NOT SUBMIT FULL CV!***

DEGREES RECEIVED (academic area & university): [redacted] RN - St. Olaf College; MN - UCLA

CURRENT POSITION: National AIDS Policy Coordinator

PROFESSIONAL EXPERIENCE: Public health official in Oregon and Washington state; past coordinator of ambulatory care for St. Louis University Hospitals. Ms Gebbie also taught health courses at the University of Washington, Oregon Health Sciences University in Portland and St. Louis University

CITE RELATED PUBLICATION(S):

RETURN TO PREVENTION 94 BY JANUARY 14, 1994

SCIENCE, SKILLS
AND STRATEGIES

PREVENTION 94

MARCH 19-22, 1994, ATLANTA, GA

AMERICAN COLLEGE OF PREVENTIVE MEDICINE
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Substance Abuse and Mental Health Services Administration

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Ambulatory Pediatric Association
American Academy of Family Physicians
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American Association of Public Health Physicians
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National Council for Education of Health Professionals in Health Promotion
Partnership for Prevention
Society for Public Health Education, Inc.
Society of General Internal Medicine
Society of Prospective Medicine
Society of Teachers of Family Medicine
U.S. Conference of Local Health Officers

SPEAKER RELEASE FOR AUDIO TAPE CASSETTES

Your scheduled presentation(s) at PREVENTION 94 is to be recorded for immediate cassette distribution to the attendees and the membership of the American College of Preventive Medicine and the Association of Teachers of Preventive Medicine and co-sponsoring organizations. Your colleagues will be able to benefit from your remarks by listening to the cassettes.

The cassettes will be copyrighted and marketing of the tapes will be done exclusively by an Atlanta, Georgia vendor through the American College of Preventive Medicine and the Association of Teachers of Preventive Medicine under Title 17 of the U.S. Code or other law as may be enacted, and all claims for royalties in conjunction with cassette sales are waived.

This agreement does not preclude the publication by you of your paper at any time.

Please cooperate with the audiovisual company staff to obtain the best possible recordings by using the microphone at all times and by repeating all questions asked by persons not near a microphone.

X I hereby give permission to the American College of Preventive Medicine and the Association of Teachers of Preventive Medicine to record and distribute cassettes containing my presentation as outlined above.

___ I do not give my permission for recording and distributing my presentation.

Signature — **PLEASE SIGN & DATE**

Communicating Prevention to People
Session Title

Please sign above and return as soon as possible. If we do not hear to the contrary from you by January 14, 1994 we will presume your permission. Thank you.

SLIDE SHOWS MADE EASY

A SHORT COURSE IN PLANNING AND PRODUCING SLIDE SHOWS

Planning and Producing Slide Shows—An Overview

1. Define your objectives.
The first step is to establish your objective(s). What do you want to accomplish? What changes do you want to take place in the attitude or behavior of the members of your audience? Do you want them to perform a task? Recall some information? Or express a feeling or attitude? A well-defined objective is specific and includes a description of the behavior you expect as well as a statement about the quality of performance you will accept.

2. Analyze your audience.
How much does your audience know about your topic? What are their ages and educational backgrounds? Are they fifth graders? College students? Or skilled technicians in the field? The more you know about the audience, the easier it will be to plan the appropriate content of your program.

3. Make an outline.
Prepare an outline of the material you want to cover in your presentation. It is a good rule to keep your outline simple and limit it to a concise summary of those major points and supporting facts which will help your audience attain your objective(s). In organizing this outline, you will want to plan the logical "flow" as well as the content of your major points.

4. Review your progress.
It is much easier and more economical to review what you have done so far and make changes during early stages rather than later during production.

5. Identify an overall treatment plan.
Make a decision about the prevailing mood and overall treatment of the content. Do you want a humorous treatment using cartoons and a light, comic narration? Or maybe a more serious, informative treatment is appropriate? The way you treat your content will greatly influence the effectiveness of your presentation.

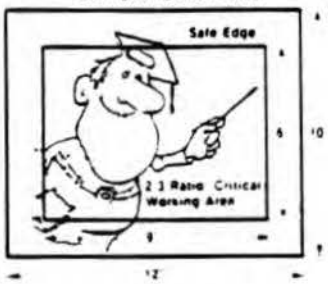
BIOMED ARTS ASSOCIATES, INC.
350 Parnassus Avenue, Suite 905
San Francisco CA 94117
(415) 564-1000

6. Write a script.
This step is optional. Some people prefer to deliver their presentation directly from their outline. Others like to prepare a full script that includes everything they want to say. If you decide to write a script, you can follow your outline as you do your writing. Remember to keep your script simple, well-organized, and not too long. Your audience's attention span is limited. Therefore, your goal is to keep their attention without boring them with unnecessary facts and details.

7. Plan your slides.
Now you are ready to develop your visual ideas. Your outline and script will be your guide for deciding how many and what kind of slides you will need. As you plan your slides, keep in mind the following rules-of-thumb:

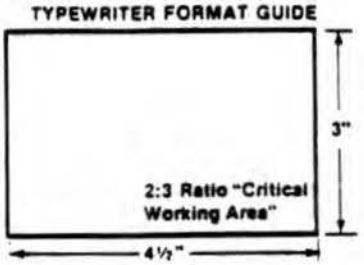
- **Use the horizontal format.** The standard 2:3 ratio in the horizontal format will always result in a larger effective viewing area for your slides. Vertical slides do not work well in filmstrips, video tape and certain screen situations.
- **Prepare artwork using a 6 × 9 inch "critical working area".** This maintains the 2:3 ratio for slides, and makes it easy to photograph the art. The 6 × 9 inch "critical working area" is the portion of the frame that will be projected. Extend your art to a 10 × 12 inch "safe edge". The 10 × 12 inch "safe edge" is used when the artwork is photographed.

ARTWORK FORMAT GUIDE



- **Keep all copy and symbols simple and legible.** Eliminate small type, thin lines and poor color contrasts. Adequate spaces should be left between words. Light colored type should be used against dark colored backgrounds. White and light colored backgrounds show dust and dirt as well as creating a harsh distractive glare.
- **Make all copy (word) slides short and concise.** A slide should never be cluttered with too much copy. If a slide is to contain only copy, try not to use more than 15 words. (An effective highway billboard uses only 5 words!)
- **Keep your slides simple and bold.** Limit each slide to one main idea. Use two or more simple slides rather than one complicated slide. There is nothing that "turns off" an audience faster than visuals that are complex and confusing.
- **Use charts and graphs rather than tables to display your facts and figures.** Visual comparisons can be made more quickly and easily with a graph. Tables tend to look complicated and confusing.
- **Use a 3 × 4½ inch template for typewritten copy slides.** The template will help you keep your copy within the "critical working area" for copy produced on a typewriter. The typewriter is a convenient tool for producing quick, inexpensive copy slides.

TYPEWRITER FORMAT GUIDE



- **Keep your photographs uncluttered and plan your scenes carefully.** Many times, a close-up showing details is more effective than an overall view. Effective lighting is also important. Your audience needs enough time to see and read the slide at a comfortable rate.
- **Never leave a slide on the screen for too short or too long a length of time.** The pacing of your slides is important. Your audience needs enough time to see and read the slide at a comfortable rate. Remember you are using slides to supplement and support your oral presentation.

8. Make sure all slides are legible.
Throughout production, you will want to check all slides for legibility. This means all elements of a slide be sufficiently large and sharp enough to be seen and read by everyone in your audience, including the people in the last row. Just because a graph or chart is legible in a book or magazine doesn't mean it will be legible in a slide.

Legibility is also affected by: the lighting conditions in the presentation room, the projected image size, the viewer's distance from the projected image, and, the amount of time the image will appear on the screen.

9. Edit your slide presentation.
When the production of your slides is completed, it is time for you to put your presentation together and edit your work. Your outline will be helpful during this process. You will want to check your slides and script for sequencing and to see how adequately you have covered each point. When editing, ask yourself the following questions:

- Have you covered all of the major points in your outline?
- Does the content of each slide fit the content of the narration?
- Are your slides legible?
- Are the colors in your slides bold and effective?
- Does each slide depict one clear idea?
- Is there good continuity from one slide to the next?
- Do all of the slides together add up to form a visually coherent and pleasing presentation?

10. Prepare for a smooth presentation.
After the final touches have been completed on your script and slides, you are ready to prepare for your presentation. The following are some suggestions to help your presentation go smoothly:

- **Never carry your slides in your baggage when you are traveling.** If you lose your bags, you will have nothing to show at your presentation.
- **Rehearse your presentation many times.** You can never rehearse too much. You should be completely familiar with your script and the sequence and timing of your slides. Make a mark at each place on your script where you want to advance to the next slide. Avoid reading your script - reading can be boring for you and your audience.
- **Visit the room in which you will present your slide show.** Make sure it is an appropriate size and adequate lighting is provided.
- **Make arrangements for the proper equipment to be available.** Request a projector with remote control so you can control your slide changes from the lectern. Always have a spare bulb on hand. Obtain a pointer and tape recorder if you need them.
- **Check your slides.** Make sure they are numbered and properly placed in the tray. To avoid spills, do not remove the ring from the top of the tray. Always store your tray in a box to keep your slides clean.
- **Project your slides.** Make sure they can be seen and read by everyone in your audience under the conditions provided in the presentation room.
- **On the day of your presentation - arrive early.** Allow yourself enough time to make sure your equipment is working properly.

The preceding points won't make you an expert on the first try, but they will help you put together a successful slide presentation. Just remember - organization, simplicity, clarity and legibility are the key elements for producing a good script and an effective slide show.

PREVENTION 94
SESSION DESCRIPTION FORM

SESSION TITLE: General Session II "Communicating Prevention to the People"
DAY/DATE/TIME: Sunday, March 20, 3:00pm - 4:30pm

TIME OF PRESENTATION

MODERATOR: **Gerald Durley** EdD MDiv
TITLE: Acting Director
INSTITUTION: Health Promotion Resources Center, Morehouse School of Medicine
ADDRESS: 720 Westview Drive SW
Atlanta GA 30310-1853
TELEPHONE:
FAX:

****

PRESENTER: **William DeJong** PhD
TITLE: Adjunct Lecturer
INSTITUTION: Department of Health and Social Behavior, Harvard University, School of Public Health
ADDRESS: 29 Rice Spring Lane
Wayland MA 01778
TELEPHONE: (508) 358-5327
FAX:

PRESENTER: **John Seffrin** PhD
TITLE: Executive Vice President and Chief Staff Officer
INSTITUTION: American Cancer Society
ADDRESS: 1599 Clifton Road
Atlanta GA 30329
TELEPHONE: (404) 320-3333
FAX:

PRESENTER: **Kristine Gebbie** RN, MN
TITLE: National AIDS Policy Coordinator
INSTITUTION: WHITE HOUSE
ADDRESS: 750 17th Street NW, Suite 1060
Washington DC 20503
TELEPHONE:
FAX:

SCIENCE, SKILLS
AND STRATEGIES

PREVENTION 94

MARCH 19-22, 1994, ATLANTA, GA

Scheduled for 3/20/94

AMERICAN COLLEGE OF PREVENTIVE MEDICINE
ASSOCIATION OF TEACHERS OF PREVENTIVE MEDICINE

1015 15TH STREET NW, SUITE 403
WASHINGTON, DC 20005
(202) 789-0006
FAX: (202) 842-1980

Sept. 3, 1993

Let her know is interested & set up = phone call

Kristine Gebbie, RN
National AIDS Policy Coordinator
750 17th St. NW
Suite 1060
Washington, DC 20503

Dear Ms. Gebbie,

I am writing as a member of the Prevention '94 annual meeting's planning committee. As you know from having spoken at the Prevention'92 luncheon, for the last several years the American College of Preventive Medicine and the Association of Teachers of Preventive Medicine have sponsored a national meeting that brings together professionals from governmental agencies, foundations, managed care and other clinical settings, insurance, industry, and academia. While the theme of the meeting changes each year, the focus is always on health promotion and disease prevention. The theme for Prevention '94 is Prevention: Science, Skills, and Strategies.

The planning task for which I share responsibility is a general session which focuses on education for the prevention sciences. The tack that we want to take, and the reason I am writing to you, is that we would like one of the speakers to address the issue of how to approach educating the so called hard-to-reach sectors of the public about health promotion/disease prevention. We thought that from your vantage point of coordinating national AIDS policy where so much of the work is focused on prevention and on reaching groups of people who are not the privileged of society, that you could tackle this portion of the program quite effectively. In addition, we know that you received rave reviews for the talk you gave a year and a half ago. (I am still trying to get a copy of a tape of your session so that I can have the chance to hear your talk.)

The conference is scheduled this year for March 19-22. The education general session would take place either Sunday, March 20 or Monday, March 21. I would appreciate having the opportunity to speak with you at your earliest convenience about your availability and interest in being a speaker at this general session.

Thank you.

Sincerely,

Suzanne B. Cashman

Suzanne B. Cashman, ScD
Associate Director
Center for Community Responsive Care

617-265-4400

SCIENCE, SKILLS
AND STRATEGIES

PREVENTION 94

MARCH 19-22, 1994, ATLANTA, GA

AMERICAN COLLEGE OF PREVENTIVE MEDICINE
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WASHINGTON, DC 20005
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American Association of Public Health Physicians
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American College of Physicians
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American Medical Association
American Medical Student Association
American Osteopathic College of Preventive Medicine
American Public Health Association
American Society of Addiction Medicine
American Society of Internal Medicine
Association of Academic Health Centers
Association of American Medical Colleges
Association of Preventive Medicine Residents
Association of Schools of Public Health
Association of State and Territorial Health Officials
Canadian Association of Teachers of Community Health
The Carter Center
National Association of Community Health Centers
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Partnership for Prevention
Society for Public Health Education, Inc.
Society of General Internal Medicine
Society of Prospective Medicine
Society of Teachers of Family Medicine
U.S. Conference of Local Health Officers

March 1, 1994

Kristine Gebbie RN MN
National AIDS Policy Coordinator
The White House
750 17th Street NW, Suite 1060
Washington DC 20503

Dear Ms. Gebbie:

This is the final piece of correspondence you will be receiving from the PREVENTION 94 staff regarding your participation in a session at PREVENTION 94 in Atlanta. The conference is just over three weeks away and the registrations are coming in at a tremendous pace. We anticipate that a very large, diverse audience (between 700-800) will be in attendance, attracted to the meeting's theme as well as Atlanta's key location. We hope you will help us provide them with a solid, interesting program.

Some final details:

(1) I have enclosed a form that details the location of your session, the time you will be presenting, and session description and objectives written by your session moderator. This information will appear, almost exactly as you see it, in the meeting program book.

(2) If you plan to use audiovisual aids and/or handouts during your presentation, and would like to make copies available to session attendees, please send us one original (paper) copy of your transparencies/slides **to arrive at PREVENTION 94 headquarters no later than March 9.** Even if you cannot meet this deadline, we will be accommodating our attendees' needs by providing speakers' addresses in the Program Book so that they may contact you after the conference for a copy of your materials. (On-site copying facilities cannot handle large jobs.)

One final note: if you have not registered for the meeting and wish to do so, it is advisable to send in your registration by mail and thus avoid the line for on-site registration at the conference. We will be taking mail registrations until March 16, at which time we'll depart for Atlanta.

Thank you in advance for your contribution to the PREVENTION 94 program. Please call if you have any questions.

Sincerely,

Carol O'Neill

Carol O'Neill
Program Manager

SCIENCE, SKILLS
AND STRATEGIES

PREVENTION 94

ABSTRACT FORM

MARCH 19-22, 1994, ATLANTA, GA 1015 15TH STREET NW SUITE 403 WASHINGTON, DC 20005 (202) 789-0006

Name: _____

Title: _____

Work Address: _____

_____

City _____ State _____ Zip _____

Daytime Telephone:(_____) _____

Internal Use Only
Date Recd _____ Abstract # _____
Comments:

GENERAL INSTRUCTIONS:

1. Complete an original Abstract Reproduction Form for each submission. **DO NOT FOLD THE FORM! DO NOT OUTLINE THE BLUE BOX!** If you must use a photocopied form, be sure to stay within the 6"x 4" dimensions of the box indicated by the corner marks.
2. **The original and one copy of each abstract must be received no later than October 1, 1993.**
3. Send a stamped, self-addressed postcard if you desire an acknowledgment of abstract receipt.
4. Abstracts will be reviewed by members of the Program Planning Committee. Selection will be based on adherence to criteria outlined in this Call for Abstracts. The Committee will make the final decision on presentation type. The corresponding author will be notified of results by December 15, 1993.
5. **All presenters are expected to attend PREVENTION 94 and are required to pay the meeting registration fee and all other expenses involved in attending the meeting.**

Check ☑ one if applicable:

☐ Student* ☐ Resident*

*A faculty advisor or residency program director must submit a letter approving the abstract for review.

STYLE INSTRUCTIONS:

Title: TYPE ABSTRACT TITLE IN UPPER CASE LETTERS, flush left (do NOT underline).

Author: Skip one line. Type author's name in upper and lower case letters and underline, follow with degree abbreviations (without punctuation) and institution. Separate authors from the same institution with a semicolon, followed by their institution. Use a colon to separate authors from different institutions.

Text: Skip one line and type abstract, flush left, single-spaced. The full width and length of the typed material MUST NOT extend beyond the lines of the box (6" x 4"). The entire abstract must be of camera-ready quality. Type must be at least 10 cpi in size. DO NOT USE DOT MATRIX PRINTER. Abstracts will appear in the program reduced in size, but otherwise exactly as submitted.

EXAMPLE:

AIDS SCHOOL HEALTH INITIATIVES

Robert E. Brown, MD DrPH; J.Jones, RN MPH, Centers for Disease Control and Prevention: Bill Williams, PhD, Emory University.

Responding to the Centers for Disease Control and Prevention...

Presentation Type Preferred (check ☑ one)

☐ Poster Session ☐ Oral Presentation ☐ Workshop

PREVENTION 94

WORKSHOP QUESTIONNAIRE

Proposed Workshop Title: _____

Names of Workshop Leader(s): _____

What are the one or two main objectives of this workshop, i.e., what particular knowledge and skill(s) do you want the participants to acquire?

(1) _____

_____

(2) _____

_____

Describe the format and methods you will use to accomplish the above-stated objectives (e.g., small groups, problem-solving, commentary, discussion, question-and-answer, etc.). **Please bear in mind that workshop rooms are normally set for 50 people, classroom style. Changes in this room set-up and/or extensive audiovisual needs (beyond a slide or overhead projector) should be noted.**

_____

_____

_____

_____

_____

_____

_____

If your abstract is not accepted for presentation as a workshop, it may be considered for a poster presentation or an oral presentation during a submitted papers session. Please indicate below if you do **not** want your abstract to be considered for other potential presentation styles.

_____ NO, I do not want to present in other formats if this abstract is not accepted as a workshop.

THIS FORM MUST ACCOMPANY ALL ABSTRACTS FOR PROPOSED WORKSHOPS.

CDC
CENTERS FOR DISEASE CONTROL

HIV/AIDS PREVENTION

Centers for Disease Control
Office of HIV/AIDS
1600 Clifton Road, N.E., MS D-21
Building 26, Executive Park
Atlanta, Georgia 30333

FACSIMILE TRANSMISSION

TO: Ms. Kristine Gebbie
National AIDS Policy Coordinator
Address: The White House

Telephone: (202)632-1090
Fax: (202)632-1096

From:
Wanda K. Jones, Dr.P.H.
Assistant Director for Science
Address: 26 Exec Pk, MS D-21
Telephone: (404) 639-0904
Fax No.: (404) 639-0910

Date: 1/5/94 No. of Pages 6
(excludes cover sheet)

Subject: MMWR Draft – HIV Prevention Practices ---

Notes/Comments: This is the latest draft of the upcoming MMWR article.
The draft is still subject to change before final printing tonight.

Vaccination Coverage — Continued

Despite ongoing and substantial efforts to improve the vaccine delivery system in the United States, vaccination levels for 2-year-olds remain below 90%. In addition, coverage levels vary by and are substantially lower in some population groups, especially those underserved by the health-care system. The prevention of vaccine-preventable diseases in the United States will require that uniformly high vaccination levels for preschool-aged children be achieved and sustained in all communities.

Differences in vaccination levels among racial/ethnic groups may be influenced by social and cultural phenomena and require special interventions. For example, in Los Angeles, 42% of Hispanic preschool-aged children were fully vaccinated by aged 24 months, compared with 25% of black children, even though Hispanic parents reported lower mean annual family incomes ($3218 vs $4596) and lower mean years of education (8.6 years vs 12.5 years) (CDC, unpublished data, 1993). Although this report documents undervaccination as a national problem affecting children in all demographic groups, vaccination coverage is disproportionately lower among racial/ethnic minorities and persons living below the poverty level. Despite limitations in the sample size of the 1992 NHIS that precluded estimation of vaccination coverage of Hispanic populations, the increased incidence of measles among Hispanics before and during the measles resurgence suggests that overall vaccination coverage is also substantially lower in Hispanics than in white non-Hispanics (*5–7*). Emphasis should be placed on improving coverage of children in racial/ethnic minority groups and of those living in poverty.

References

1. Massey JT, Moore TF, Parsons VL, Tadros W. Design and estimation for the National Health Interview Survey, 1985–94. National Center for Health Statistics. Vital Health Stat 1989;2(110).
2. CDC. Measles—United States, first 26 weeks, 1993. MMWR 1993; 42(42):813–6.
3. Goldstein KP, Kviz FJ, Daum RS. Accuracy of immunization histories provided by adults accompanying preschool children to a pediatric emergency department. JAMA 1993;270:2190–4.
4. CDC. Standards for Pediatric Immunization Practices [Standard 9], 1993:15.
5. Orenstein WA, Atkinson W, Mason D, Bernier RH. Barriers to vaccinating preschool children. J Health Care Poor Underserved 1990;1:315–30.
6. CDC. Measles vaccination levels among selected groups of preschool-aged children—United States. MMWR 1991;40(2):36–9.
7. Gindler JS, Atkinson WL, Markowitz LE, Hutchins SS. Epidemiology of measles in the United States in 1989 and 1990. Pediatr Infect Dis J 1992;11:841–6.

Effectiveness in Disease and Injury Prevention

HIV Prevention Practices of Primary-Care Physicians — United States, 1992

Encounters between patients and health-care providers are important opportunities for human immunodeficiency virus (HIV) prevention. In 1991, 15% of U.S. adults reported having been tested for HIV antibody; of these, 55% reported their most recent HIV test had been in a physician's office or a hospital (*1*). During 1992, CDC and the Health Resources and Services Administration (HRSA) commissioned a national survey to characterize the types of HIV prevention services provided by primary-care

HIV Prevention Practices — Continued

physicians and barriers to the provision of these services. This report summarizes the results of the survey.

In October 1992, a questionnaire was mailed to 4011* primary-care physicians who were randomly selected from the American Medical Association (AMA) Physician Masterfile, which comprises all physicians in the United States. The sample was stratified by location, race/ethnicity, and specialty. Two categories of location were defined on the basis of the prevalence of acquired immunodeficiency syndrome (AIDS) in metropolitan statistical areas (MSAs): 1) physicians practicing in the 20 MSAs with the highest prevalence and 2) those practicing in the remaining MSAs. Physicians were asked about their risk assessment of new patients; HIV counseling, testing, and treatment practices; and basic understanding and attitudes related to HIV infection and persons with HIV disease. The data were weighted to adjust for unequal probabilities of selection and for the variability of response rates among the strata.

Of the 3735 eligible† physicians, 2545 (68%) responded; of these, 802 were general/family practitioners; 360, pediatrician/adolescent medicine physicians; 683, obstetrician/gynecologists (OB/GYNs); and 700, general internal medicine physicians. Of the 2545 respondents, 76% were men. Two hundred eighty (15%) were aged <35 years; 1042 (41%), 35–44 years; and 1123 (44%), >44 years. A total of 1487 (60%) were based in private, single-specialty practices; 442 (18%), in private, multispecialty practices; 289 (12%), in hospitals, public clinics, and community health centers; and 287 (10%), from academia and other institutions. Twenty-four percent of the physicians were located in areas with high prevalences of AIDS.

Almost all (94%) respondents indicated they "usually" or "always" asked new adult (aged ≥19 years) patients about cigarette smoking; however, sexual history-taking was less frequently reported (Table 1): 49% asked about sexually transmitted diseases (STDs), 31% about condom use, 27% about sexual orientation, and 22% about number of sex partners. In comparison, 84% of all physicians asked new adolescent (aged 13–18 years) patients about cigarette smoking, 58% about STDs, 52% about condom use, 34% about number of sex partners, and 27% about sexual orientation. One fourth (25%) of all physicians believed their patients would be offended by questions about their sexual behaviors.

The percentage of physicians who indicated they would "likely" or "very likely" encourage HIV testing varied by patient risk category (Table 2) and ranged from homosexual men with multiple partners and injecting-drug users (95%) to sexually active adolescent patients (40%).

Most physicians (66%) indicated that if HIV testing were indicated for a patient, they would probably provide the test counseling themselves. Factors that either "moderately" or "strongly" influenced physicians to refer for counseling and testing rather than provide it themselves were that counseling was too time consuming (55%), information was insufficient to enable counseling (48%), and they preferred anonymous testing for their patients (42%). Most respondents indicated that their decision to refer was not influenced by inadequate reimbursement (88%) or discomfort with counseling (85%).

Ninety-two percent of physicians indicated that they would counsel an HIV-positive patient to reduce the risk for transmitting HIV. In addition, 76%–81% indicated they

*Represents 3% of the total primary-care physician population.
†Physicians who were not practicing in one of the primary-care specialties, were practicing out of the country, retired, or deceased were deemed ineligible.

HIV Prevention Practices — Continued

TABLE 1. Percentage* of primary-care physicians who would "usually" or "always" assess risks for new adult and adolescent patients, by risk behavior and physician specialty — United States, 1992

	General/Family practitioner				Pediatrician/Adolescent medicine physician				Obstetrician/Gynecologist				General internal medicine physician				Total			
	Adult (n=766)		Adolescent (n=723)		Adult (n=776)		Adolescent (n=627)		Adult (n=576)		Adolescent (n=553)		Adult (n=669)		Adolescent (n=662)		Adult (n=2169)		Adolescent (n=2159)	
Risk behavior	%	(95% CI†)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Cigarette smoking	93§	(±1.9)	81	(±2.9)	89	(±7.0)	75	(±4.1)	93	(±2.3)	92	(±2.6)	96§	(±1.3)	89	(±2.7)	94§	(±1.4)	84	(±1.6)
Alcohol use	79§	(±2.9)	68	(±3.4)	74	(±9.8)	67	(±4.4)	80	(±3.8)	89	(±3.9)	92	(±1.9)	84	(±3.1)	84§	(±1.6)	75	(±1.9)
Contraceptive use	53	(±3.6)	39	(±3.7)	65	(±10.8)	62	(±4.6)	57	(±1.7)	36	(±1.8)	48	(±3.6)	59	(±4.2)	61	(±2.1)	66	(±2.6)
STDs¶	34§	(±3.4)	43	(±3.6)	44	(±11.3)	49	(±4.7)	82	(±3.7)	85	(±3.4)	45§	(±3.5)	54	(±4.3)	49§	(±2.2)	58	(±2.1)
Other illicit drugs	36§	(±3.4)	43	(±3.6)	64	(±10.8)	53	(±4.7)	59	(±4.7)	85	(±4.6)	54§	(±3.5)	66	(±4.0)	49§	(±2.2)	55	(±2.1)
Risk IV drugs	37	(±3.5)	38	(±3.6)	57	(± 1.1)	46	(±4.7)	60	(±4.6)	85	(±4.6)	55§	(±3.5)	63	(±4.1)	53§	(±2.2)	51	(±2.1)
Condom use	21§	(±2.5)	41	(±3.6)	50§	(± 1.1)	56	(±4.7)	69§	(±4.6)	75	(±4.2)	23	(±3.0)	45	(±4.3)	31§	(±2.4)	52	(±2.1)
High-risk sex partner	22§	(±2.5)	29	(±3.3)	21§	(± 9.3)	32	(±4.4)	39§	(±4.8)	46	(±4.8)	28§	(±3.2)	49	(±4.2)	28§	(±2.1)	38	(±2.1)
No. sex partners	16§	(±2.6)	17	(±3.2)	24§	(± 9.5)	30	(±4.4)	37§	(±4.8)	52	(±4.8)	19§	(±2.7)	33	(±4.0)	22§	(±1.8)	34	(±2.4)
Sexual orientation	12	(±2.7)	16	(±2.6)	13	(± 7.6)	28	(±4.2)	36§	(±4.8)	36	(±4.6)	33	(±3.3)	32	(±4.0)	27	(±1.9)	27	(±1.9)

*Percentages are based on the number of physicians who indicated that they see adult or adolescent patients in their practice.
†Confidence interval.
§p<.001 (McNemar test comparing physicians' assessment of adults and adolescents).
¶Sexually transmitted diseases.

HIV Prevention Practices — Continued

TABLE 2. Percentage of primary-care physicians who would "likely" or "very likely" encourage HIV testing by patient's risk behavior, by physician specialty — United States, 1992

Risk behavior	General/Family practitioner			Pediatrician/Adolescent medicine physician			Obstetrician/Gynecologist			General internal medicine physician			Total		
	No.	(%)	(95% CI*)	No.	(%)	(95% CI)	No.	(%)	(95% CI)	No.	(%)	(95% CI)	No.	(%)	(95% CI)
Homosexual men/ multiple partners	768	(66)	(±1.5)	230	(94)	(±3.1)	74	(88)	(±7.4)	755	(95)	(±1.6)	1827	(86)	(±1.6)
Injecting-drug use	760	(65)	(±1.6)	263	(91)	(±3.3)	380	(96)	(±2.6)	750	(96)	(±1.5)	2174	(85)	(±1.9)
Homosexual man	771	(62)	(±1.9)	236	(85)	(±4.5)	73	(88)	(±7.4)	709	(92)	(±1.9)	1839	(81)	(±1.3)
Current/Past STD†	784	(76)	(±3.0)	373	(83)	(±4.9)	431	(71)	(±4.3)	784	(79)	(±2.9)	2352	(74)	(±1.8)
Heterosexual men/ multiple partners	767	(66)	(±3.3)	340	(53)	(±5.3)	426	(70)	(±4.3)	769	(72)	(±3.2)	2322	(67)	(±1.9)
Other drug/ alcohol users	783	(62)	(±3.5)	356	(50)	(±5.2)	416	(66)	(±4.5)	768	(67)	(±3.5)	2321	(67)	(±2.0)
Sexually active adolescents	755	(38)	(±3.5)	433	(32)	(±4.4)	427	(40)	(±4.6)	637	(46)	(±3.9)	2253	(40)	(±2.0)

* Confidence interval.
† Sexually transmitted disease.

TABLE 3. Percentage* of primary-care physicians who would provide obstetric/gynecologic services for all adult female patients and for all adult female patients with HIV infection, by percentage and physician specialty — United States, 1992

Service	General/Family practitioner (n=815)			Pediatrician/Adolescent medicine physician (n=74)			Obstetrician/Gynecologist (n=376)			General internal medicine physician (n=277)			Total (n=1541)		
	All	HIV	(95% CI)	All	HIV	(95% CI)	All	HIV	(95% CI)	All	HIV	(95% CI)	Total	HIV	(95% CI)
Contraceptive	91[1]	76	(±2.7)	66	50	(±1.2)	99[2]	96	(±1.1)	66[3]	51	(±6.1)	86[3]	73	(±2.5)
Post pregnancy	61[1]	50	(±4.0)	5	5	(±5.6)	92[2]	76	(±2.5)	16	12	(±4.0)	59[3]	49	(±2.8)
Emergency gynecology	22	(±3.6)	20	(±3.5)	4	(±4.9)	95[2]	85	(±2.0)	6	5	(±2.7)	42[3]	37	(±2.7)
Elective gynecology	20[1]	(±3.8)	18	(±3.5)	12	(±6.0)	95[2]	72	(±2.2)	7	5	(±2.6)	44[3]	33	(±2.8)
Prenatal	40[1]	(±4.3)	22	(±3.6)	5	(±5.2)	89[2]	58	(±3.0)	5	3	(±1.9)	47[3]	28	(±2.5)
Delivery	35[1]	(±4.2)	20	(±3.5)	9	(±5.6)	87[2]	59	(±4.7)	3	1	(±1.3)	44[3]	28	(±2.5)
Sterilization on request	12	(±2.8)	10	(±2.7)	0	–	93[2]	61	(±2.4)	1	0	(±1.0)	36[3]	31	(±2.6)
Pregnancy termination	3	(±1.4)	3	(±1.5)	<1	(±1.5)	27	25	(±4.3)	0	0	–	10	9	(±1.6)

* Percentages are based on the number of physicians who indicate that they provide obstetric/gynecologic services.
† Confidence interval.
§ $p<.001$ (McNemar test comparing services physicians would provide to all women and to women with HIV).

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HIV Prevention Practices — Continued

would counsel the patient to notify sex partners, refer the patient to the local health department for assistance with the notification, or both.

Of physicians in OB/GYN practices, 85% indicated they would provide prenatal care and 47% would provide contraceptive services to all women, regardless of their HIV status (Table 3). In comparison, 73% would provide prenatal care and 29% would provide contraceptive services to women with HIV.

Physicians who reported they would refer patients with HIV for medical services indicated the primary reasons for referring were their lack of experience with HIV (83%) and the availability of other providers with more expertise in treating HIV infection (94%). Overall, 68% of physicians indicated they believed they had an obligation to take care of someone infected with HIV, and 87% indicated that professional training could help "increase their comfort in caring for AIDS patients."

Reported by: J Loft, PhD, W Marder, PhD, Abt Associates, Inc., Chicago. L Brasolin, PhD, R Rinaldi, PhD, American Medical Association. Div of Medicine, Bureau of Health Professions, Health Resources and Svcs Administration. National AIDS Information and Education Program, Office of HIV/AIDS; Women's Health and Fertility Br, Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion; Div of Sexually Transmitted Diseases and Human Immunodeficiency Virus Prevention, and Behavioral Studies Section, Behavioral and Prevention Research Br, Div of Sexually Transmitted Diseases and HIV Prevention, National Center for Prevention Svcs, CDC.

Editorial Note: Although primary-care physicians may contribute to the prevention of HIV transmission by counseling patients who are at risk, the findings in this report underscore the substantial number of physicians who are missing opportunities to counsel during encounters with patients. To more effectively use these encounters as a means of prevention, physicians first must be knowledgeable about HIV infection and its transmission (*3*). In addition, they should be sensitized to the importance of assessing patients' risk for HIV infection and prepared to counsel patients, based on their risk (*2*). Therefore, medical schools and professional organizations should continue to emphasize HIV/AIDS prevention and treatment as priorities in training new and practicing physicians.

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The findings in this report can assist in the development of HIV prevention policy and programs. For example, the reluctance of some physicians to assess the risky sex practices of patients underscores the importance for public health agencies to assist physicians in improving risk assessment and risk-reduction counseling efforts for their patients and patients' partners. These findings may be used by HRSA to improve training strategies and programs for health-care professionals and AMA and other professional organizations to develop training objectives for primary-care physicians.

Finally, the findings in this report can assist in efforts to achieve the national health objectives for the year 2000 regarding HIV prevention (*4*). These objectives include increasing to at least 80% the proportion of persons with HIV infection who have been tested (objective 18.8); increasing to at least 75% the proportion of primary-care and mental health-care providers who provide age-appropriate counseling on the prevention of HIV and other STDs (objective 18.9); and increasing to at least 50% the proportion of primary-care clinics who screen, diagnose, treat, counsel, and provide (or refer for) partner notification services for HIV infection and bacterial STDs (objective 18.13).

HIV Prevention Practices — Continued

References

1. Hardy AM. Advanced data—AIDS knowledge and attitudes for 1991: data from the National Health Interview Survey. Vital and Health Statistics; January 6, 1993: No. 225.
2. Valdiserri RO, Holtgrave DR, Brackbill RM. American adults' knowledge of HIV testing availability. Am J Public Health 1993;83:525–8.
3. Gerber AR, Valdiserri RO, Holtgrave DR, et al. Preventive services guidelines for primary care clinicians caring for adults and adolescents infected with the human immunodeficiency virus. Archives of Family Medicine 1993;2:969–79.
4. Public Health Service. Healthy people 2000: national health promotion and disease prevention objectives—full report, with commentary. Washington, DC: US Department of Health and Human Services, Public Health Service, 1991; DHHS publication no. (PHS)91-50212.

Epidemiologic Notes and Reports

Occupational Pesticide Poisoning in Apple Orchards — Washington, 1993

During July–December 1993, the Washington Department of Health (WDOH) received and conducted follow-up investigations of 26 reports of occupational illness related to exposure to mevinphos (Phosdrin®*), an organophosphate (OP) insecticide. The reports involved illnesses during June 13–August 18, 1993, in persons working in 19 different apple orchards; all involved use of mevinphos to control apple aphids. This report summarizes the results of these investigations by WDOH.

All the affected workers were men ranging in age from 19 to 72 years (median: 35 years). Eighteen (69%) were Hispanic; eight (31%) were non-Hispanic whites. Twenty-three (88%) of the workers were exposed during mixing and loading or application of mevinphos. The other three (12%) were exposed to mevinphos residues (two while working in close proximity to a recently treated orchard and one after reentering an orchard within 24 hours after it was sprayed).

Of the 23 workers exposed during mevinphos preparation or application, 22 had worked on ground applications and used an airblast† system; one worked on an aerial application. All 23 sought medical attention in emergency departments. Twenty-one workers had systemic manifestations characteristic of OP poisoning, including nausea (81%), vomiting (62%), dizziness (43%), visual disturbances (43%), weakness (38%), abdominal pain (29%), headache (24%), sweating (24%), and excessive salivation (5%). Two persons had conjunctivitis only, which was attributed to direct ocular exposure to mevinphos.

Of the seven workers who were hospitalized, four required intensive care. Plasma and/or red blood cell cholinesterase activity was depressed to at least 25% below the lower limit of normal in 14 (88%) of the 16 workers tested; in addition, for one worker the level of activity was depressed 97%, and for three, 75%–90%. Atropine was administered to all seven hospitalized workers and to four of the 14 workers with systemic illness who were treated in the emergency department and released. Eighteen (86%)

*Use of trade names is for identification only and does not imply endorsement by the Public Health Service or the U.S. Department of Health and Human Services.
†This application technique involves the use of a tractor-drawn sprayer with oscillating nozzles that are oriented in a flat plane and direct the spray mixture into the canopy of the trees for complete coverage.

3/8
10-10:45

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Feb. 9, 1994

FEB 22 1994

MEMO

TO: General Session Panelists, Prev '94
Willliam DeJong
Gerald Durley (moderator)
Kristine Gebbie
John Seffrin
FROM: Suzanne Cashman
RE: Conference Call

On behalf of the Prev '94 planning committee, thank you again for agreeing to participate as speakers/moderator of the general session entitled, "Communicating Prevention to the People." As I had mentioned in my conversations with you, we are hoping to schedule a conference call sometime during the first two weeks of March. Our aim is to have an oppportunity to talk about the content of your remarks so that we can develop a coherent, interactive session rather than one that consists of three distinctly independent speakers. I have enclosed abstracts and/or correspondence so that you all have current information about what the others are planning to cover in their remarks.
I know that as the moderator, Gerald Durley wants to set the stage for the session with several comments, and plans to promote an interactive dialogue at the conclusion of the prepared remarks.

Sharon Tippo from our office will be calling during the next few days to try to pull us all together for half an hour of conversation. Thank you for your cooperation.

cc: Kay Doggett, ATPM, Prev '94

encl.

SCIENCE, SKILLS AND STRATEGIES

PREVENTION 94

Revised

ABSTRACT FORM

MARCH 19-22, 1994, ATLANTA, GA

1015 15TH STREET NW SUITE 403 WASHINGTON, DC 20005 (202) 789-0006

Name: John R. Seffrin, PhD

Daytime Telephone: (404) 329-7601

Title: Executive Vice President & Chief Staff Officer

Work Address: American Cancer Society

1599 Clifton Road, NE

City Atlanta State GA Zip 30329

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Comments:

MISSION 2000: A Commitment to Change

John R. Seffrin, PhD, American Cancer Society, Inc.

MISSION 2000 is a revolutionary cancer prevention/control project which, if successful, will save an estimated 12 million lives (lifetime), serve 8 million new cancer patients (during the next 6 years), and generate $620 million in the Year 2000.

Based on the principle that "less is more" in terms of the targeting of priorities and application of interventions that will ensure maximal results for resources expended, this initiative is the catalyst for a major re-engineering process taking place throughout the ACS nationwide.

A primary focus of this effort is on sectors of the public that voluntary agencies haven't traditionally reached with health promotion/disease prevention messages. The MISSION 2000 challenge also represents a very palpable opportunity (and necessity) to demonstrate the building of bridges between the Society, other voluntary health organizations and the traditional public health/medical community in attacking the disease Americans fear most.

GENERAL INSTRUCTIONS:

1. Complete an original Abstract Reproduction Form for each submission. **DO NOT FOLD THE FORM! DO NOT OUTLINE THE BLUE BOX!** If you must use a photocopied form, be sure to stay within the 6"x 4" dimensions of the box indicated by the corner marks.
2. **The original and one copy of each abstract must be received no later than October 1, 1993.** ✓
3. Send a stamped, self-addressed postcard if you desire an acknowledgment of abstract receipt.
4. Abstracts will be reviewed by members of the Program Planning Committee. Selection will be based on adherence to criteria outlined in this Call for Abstracts. The Committee will make the final decision on presentation type. The corresponding author will be notified of results by December 15, 1993.
5. **All presenters are expected to attend PREVENTION 94 and are required to pay the meeting registration fee and all other expenses involved in attending the meeting.**

Check ☑ one if applicable:

☐ Student* ☐ Resident*

* A faculty advisor or residency program director must submit a letter approving the abstract for review

STYLE INSTRUCTIONS:

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Text: Skip one line and type abstract, flush left, single-spaced. The full width and length of the typed material MUST NOT extend beyond the lines of the box (6" x 4"). The entire abstract must be of camera-ready quality. Type must be at least 10 cpi in size. DO NOT USE DOT MATRIX PRINTER. Abstracts will appear in the program reduced in size, but otherwise exactly as submitted.

EXAMPLE:

AIDS SCHOOL HEALTH INITIATIVES

Robert E. Brown, MD DrPH; J. Jones, RN MPH, Centers for Disease Control and Prevention: Bill Williams, PhD, Emory University.

Responding to the Centers for Disease Control and Prevention...

Presentation Type Preferred (check ☑ one)

☐ Poster Session ☐ Oral Presentation ☐ Workshop

BEYOND PUBLIC SERVICE ANNOUNCEMENTS: NEW OPPORTUNITIES FOR USING THE MASS MEDIA IN HEALTH PROMOTION

William DeJong, PhD, Harvard School of Public Health

The public health community has remained fascinated by the possibility of using the mass media to teach people how to make healthy lifestyle choices, despite the fact that most evaluations have failed to demonstrate that public communication campaigns have a clear and unambiguous impact on people's behavior. A reason for this continuing optimism is the recognition that public health officials have had too few resources at their disposal to launch a first-rate campaign that could compete in quality and reach to the very best campaigns assembled by commercial advertisers. In essence, a reliance on public service advertising, which airs during unsold time donated by broadcasters, has caused pro-health messages to be marginalized. Voter referendums to increase excise taxes on tobacco, with the funds dedicated to the support of mass media campaigns that confront the tobacco industry, have launched an exciting new era in health communications.

SUNDAY, MARCH 20, 1994

GENERAL SESSION II
3:00pm - 4:30pm
Grand Ballroom III/IV

Communicating Prevention to the People

Gerald Durley EdD MDiv (moderator) 3:00-3:10pm
Director
Health Promotion Resources Center, Morehouse School of Medicine

Kristine Gebbie RN MN
National AIDS Policy Coordinator 3:10-3:25pm
The White House
"Communicating Prevention to the People: Lessons from the HIV Epidemic"

John Seffrin PhD MS 3:25-3:40pm
Executive Vice President and Chief Staff Officer
American Cancer Society
"Mission 2000: A Commitment to Change"

William DeJong PhD 3:40-3:55pm
Adjunct Lecturer
Department of Health and Social Behavior, Harvard School of Public Health
"Beyond the Public Service Announcements: New Opportunities for Using the Mass Media in Health Promotion"

DISCUSSION 3:55-4:30pm

This session will challenge participants to transmit the knowledge we have about promoting health and preventing disease to the public. Speakers will focus their remarks on approaches to reaching non main-stream segments of the population, linking voluntary health organizations to the traditional public health/medical community, and using the media to educate the public. The session will conclude with interactive dialogue between presenters and the audience.

At the conclusion of this session, participants will be able to: 1) articulate approaches to reaching people in the traditionally "harder to reach" populations about prevention services. 2) Understand the importance of and approaches to communicating the sciences of prevention to people in the community. 3) Introduce the media as a tool for educating people in the prevention sciences.

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SPEAKER'S NAME: Kristine H Gebbie
(please print)

NAME/DATE OF CME PROGRAM: PREVENTION 94, March 19-22, 1994, Atlanta, GA

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3/8/94
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[ ] I, the undersigned, declare that **I or an immediate member of my family has a significant financial interest, relationship** with one or more of the following corporate organizations offering financial support or educational grants for this continuing medical education activity, or with the manufacturer(s) of a commercial product/service that is discussed as part of my presentation.

AFFILIATION/FINANCIAL INTEREST	NAME OF ORGANIZATION
Grants/Research Support	
Consultant	
Shareholder (directly purchased)	
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Honorarium	
Other financial or material support	

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Date

Telephone

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