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PRESS RELEASE

FOR IMMEDIATE RELEASE
FEBRUARY 7, 1994

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JOHN PAUL GURROLA 202/632-1090
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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

HIV/AIDS BUDGET RELEASE
FEBRUARY 6, 1994
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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.

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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.

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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)

	<u>FY 1994 Enacted</u>	<u>FY 1995 Budget</u>	<u>Dollar Increase FY 94 to FY 95</u>	<u>Percent Increase FY 94 to FY 95</u>
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.

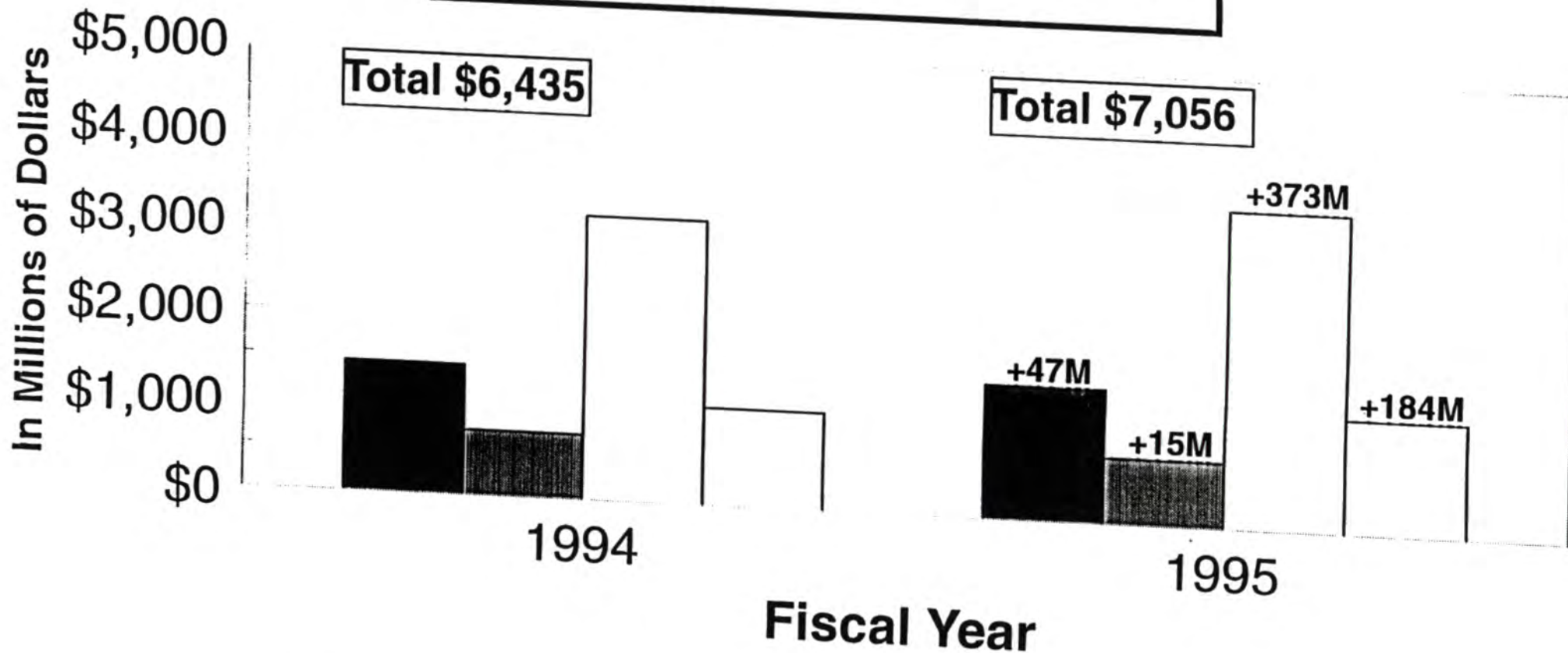
HHS HIV/AIDS Funding

(Dollars in thousands)

	1993 Enacted	1994 Approp.	Pres. Budget	1995	
				Chg. +/-	
				'94 Appro.	% Chg.
<u>PUBLIC HEALTH SERVICE:</u>					
FDA.....	\$72,628	\$72,399	\$72,399	\$0	0.0%
<u>HRSA:</u>					
<u>Ryan White:</u>					
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%
<u>ENTITLEMENTS:</u>					
<u>HCFA:</u>					
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%
<u>Social Security:</u>					
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%
<u>OTHER:</u>					
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

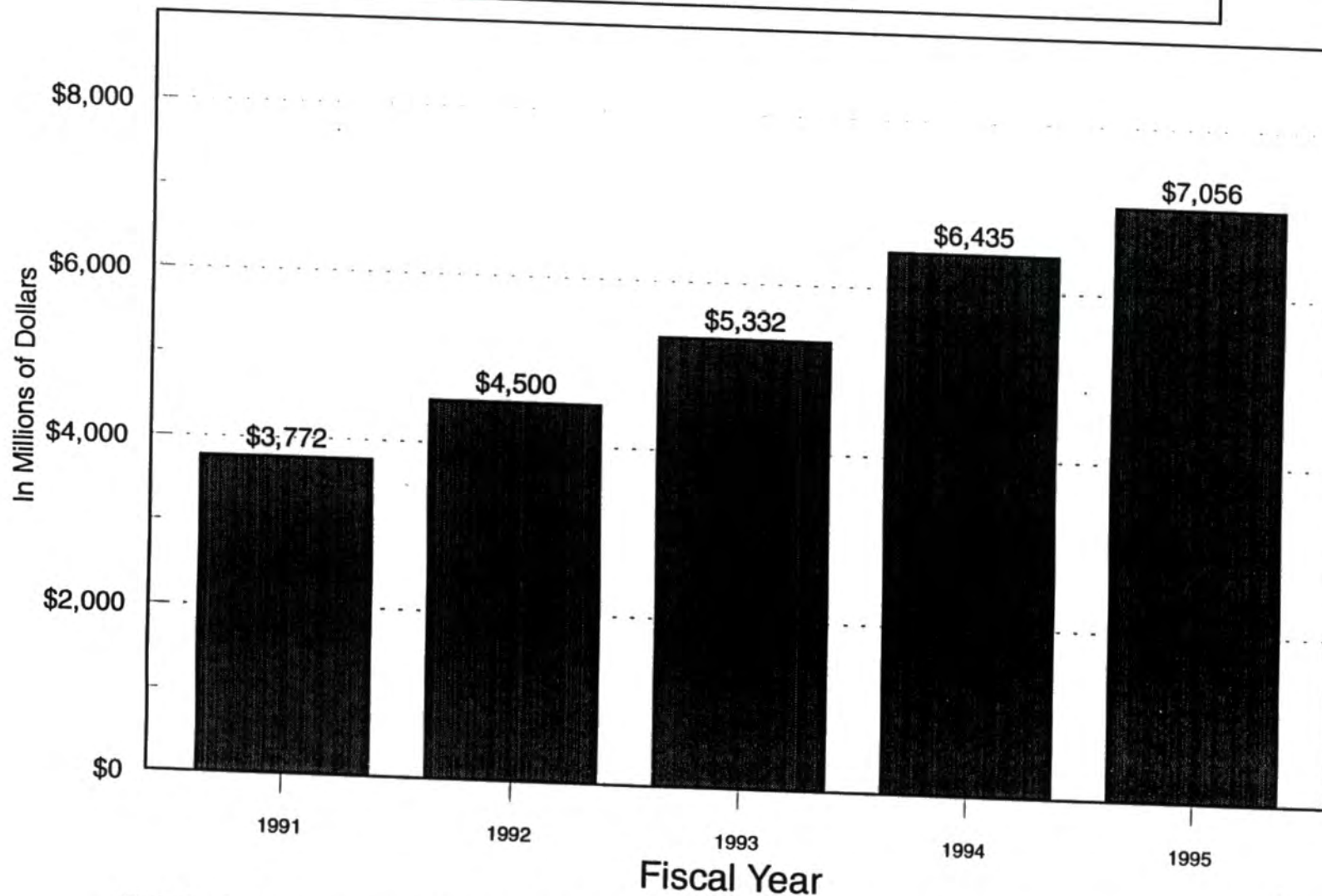
Federal HIV Funding



■ Research ▨ Prevention
□ Medical Care □ Income Maintenance

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 Drug Treatment Initiative, an increase of approximately \$6 million above previous HIV/AIDS programming in SAMSHA.

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.

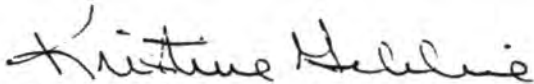
The Office of the National AIDS Policy Coordinator has provided advice on policy formulation during the development of the Health Security Act (HSA). These efforts were directed towards assuring adequate care and services for people with HIV/AIDS. As the Congress now debates the HSA, the Administration 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 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.

HIV/AIDS

SURVEILLANCE REPORT

Third Quarter Edition

U.S. AIDS cases reported through September 1993

Issued October 1993, Vol. 5, No. 3

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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



Table 1. AIDS cases and annual rates per 100,000 population, by state, reported October 1991 through September 1992, October 1992 through September 1993;¹ and cumulative totals, by state and age group, through September 1993, United States²

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

¹Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²During the third quarter of 1993, CDC received reports of 23,664 cases and 9,951 deaths among adults/adolescents and 196 cases and 105 deaths 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
Total³	46,716	18.2	97,368	37.5	334,344	4,906	339,250

¹Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²Based on Metropolitan Statistical Areas (MSA) revised June 1993. See technical notes.

³Totals 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	(6)
Hemophilia/coagulation disorder	794	(2)	2,349	(1)	110	(0)	260	(0)	68	(1)	224	(0)
Heterosexual contact:	607	(1)	1,654	(1)	2,125	(8)	6,279	(8)	570	(4)	1,375	(3)
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	(1)
Risk not identified ³	2,032	(5)	4,380	(3)	2,807	(11)	5,127	(6)	1,234	(9)	2,728	(6)
Total	41,244	(100)	160,923	(100)	26,048	(100)	82,174	(100)	13,407	(100)	47,351	(100)

Exposure category	Asian/Pacific Islander		American Indian/Alaska Native		Cumulative totals ⁴			
	Oct. 1992–Sept. 1993		Oct. 1992–Sept. 1993		Oct. 1992–Sept. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	445	(74)	1,583	(79)	158	(63)	388	(63)
Injecting drug use	28	(5)	79	(4)	23	(9)	62	(10)
Men who have sex with men and inject drugs	22	(4)	57	(3)	42	(17)	107	(17)
Hemophilia/coagulation disorder	12	(2)	35	(2)	6	(2)	16	(3)
Heterosexual contact:	15	(2)	29	(1)	4	(2)	10	(2)
Sex with injecting drug user	6		12		1		5	
Sex with person with hemophilia	—		—		—		—	
Born in Pattern-II country	—		3		—		—	
Sex with person born in Pattern-II country	—		1		—		—	
Sex with transfusion recipient with HIV infection	2		2		—		—	
Sex with HIV-infected person, risk not specified	7		11		3		5	
Receipt of blood transfusion, blood components, or tissue	12	(2)	72	(4)	1	(0)	5	(1)
Risk not identified	69	(11)	152	(8)	15	(6)	26	(4)
Total	603	(100)	2,007	(100)	249	(100)	614	(100)

¹Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²See technical notes.

³"Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

⁴Includes 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	(1)
Mother with/at risk for HIV infection:	118	(84)	663	(68)	489	(97)	2,556	(95)	197	(93)	1,074	(9)
<i>Injecting drug use</i>	38		290		153		1,133		69		483	
<i>Sex with injecting drug user</i>	22		132		70		390		40		318	
<i>Sex with bisexual male</i>	4		39		2		28		3		20	
<i>Sex with person with hemophilia</i>	2		13		—		5		1		3	
<i>Born in Pattern-II¹ country</i>	—		3		37		300		—		2	
<i>Sex with person born in Pattern-II country</i>	—		—		5		22		—		1	
<i>Sex with transfusion recipient with HIV infection</i>	1		6		1		5		1		8	
<i>Sex with HIV-infected person, risk not specified</i>	10		45		57		148		27		77	
<i>Receipt of blood transfusion, blood components, or tissue</i>	6		29		12		43		5		25	
<i>Has HIV infection, risk not specified</i>	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	(1)
Risk not identified ²	1	(1)	9	(1)	8	(2)	29	(1)	4	(2)	11	(1)
Total	141	(100)	980	(100)	504	(100)	2,683	(100)	212	(100)	1,194	(100)

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	(1)
Mother with/at risk for HIV infection:	2	(50)	10	(45)	2	(100)	13	(93)	814	(94)	4,328	(8)
<i>Injecting drug use</i>	1		3		1		6		264		1,920	
<i>Sex with injecting drug user</i>	—		2		1		2		133		846	
<i>Sex with bisexual male</i>	—		1		—		—		9		88	
<i>Sex with person with hemophilia</i>	—		—		—		—		3		21	
<i>Born in Pattern-II country</i>	—		—		—		—		37		305	
<i>Sex with person born in Pattern-II country</i>	—		—		—		—		5		23	
<i>Sex with transfusion recipient with HIV infection</i>	—		—		—		—		3		19	
<i>Sex with HIV-infected person, risk not specified</i>	1		1		—		2		96		275	
<i>Receipt of blood transfusion, blood components, or tissue</i>	—		1		—		—		23		98	
<i>Has HIV infection, risk not specified</i>	—		2		—		3		241		733	
Receipt of blood transfusion, blood components, or tissue	2	(50)	9	(41)	—		—		24	(3)	327	(7)
Risk not identified	—		—		—		—		13	(1)	49	(1)
Total	4	(100)	22	(100)	2	(100)	14	(100)	869	(100)	4,906	(100)

¹See 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.

³Includes 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 Age at diagnosis (years)	White, not Hispanic		Black, not Hispanic		Hispanic		Asian/Pacific Islander		American Indian/ Alaska Native		†Total ²	
	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	

¹Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²Includes 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		Oct. 1989–Sept. 1990		Oct. 1990–Sept. 1991		Oct. 1991–Sept. 1992		Oct. 1992–Sept. 1993	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Pre-1987 definition	106,479	(79)	28,634	(64)	29,523	(58)	28,340	(47)	13,876	(29)
1987 definition	26,788	(20)	13,559	(30)	16,078	(31)	17,521	(29)	9,537	(20)
1993 definition ²	1,610	(1)	2,402	(5)	5,467	(11)	15,032	(25)	24,404	(51)
Severe HIV-related immunosuppression ³	1,181		2,021		4,669		13,587		22,718	
Pulmonary tuberculosis	362		333		706		1,195		1,115	
Recurrent pneumonia	55		44		85		223		541	
Invasive cervical cancer	16		8		13		38		48	
Total	134,877	(100)	44,595	(100)	51,068	(100)	60,893	(100)	47,817	(100)

¹Includes 9 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²Persons 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.

³Defined as CD4+ T-lymphocyte count of less than 200 cells/ μ L 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 States¹

Occupation	Documented occupational transmission ²	Possible occupational transmission ³
	No.	No.
Dental worker, including dentist	—	6
Embalmer/morgue technician	—	3
Emergency medical technician/paramedic	—	8
Health aide/attendant	1	9
Housekeeper/maintenance 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

¹Health-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.

²Health-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.

³These 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 reported October 1992 through September 1993, United States

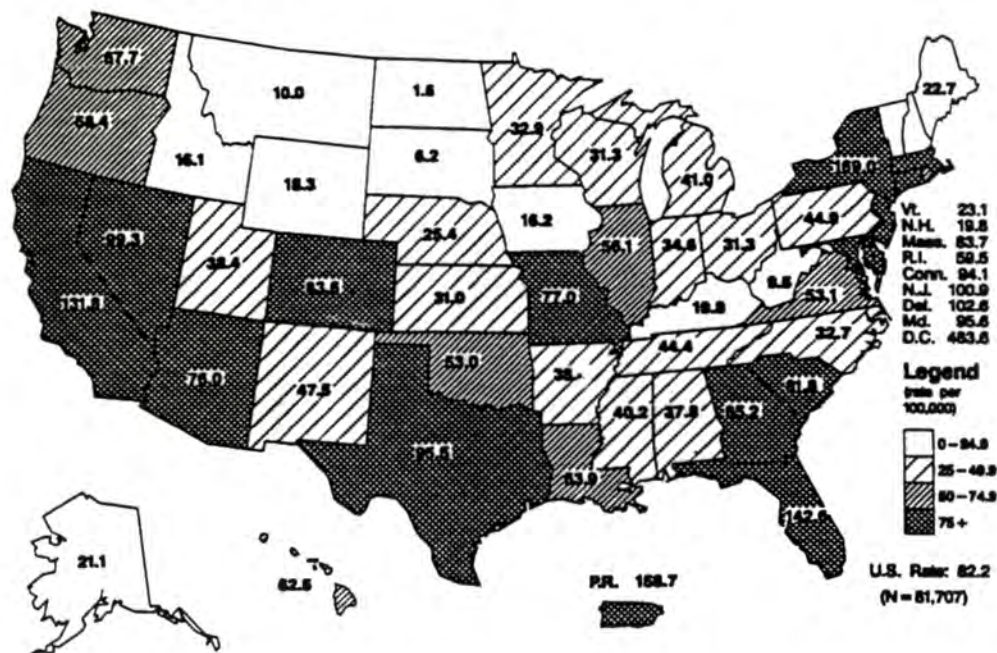
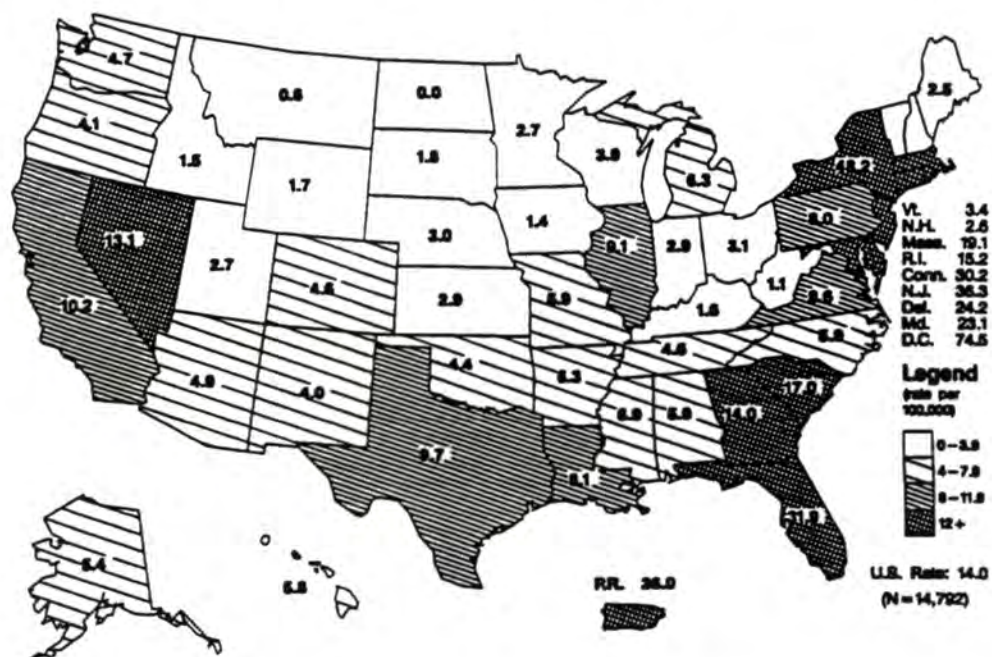


Figure 2. Female adult/adolescent AIDS annual rates per 100,000 population, for cases reported October 1992 through September 1993, United States



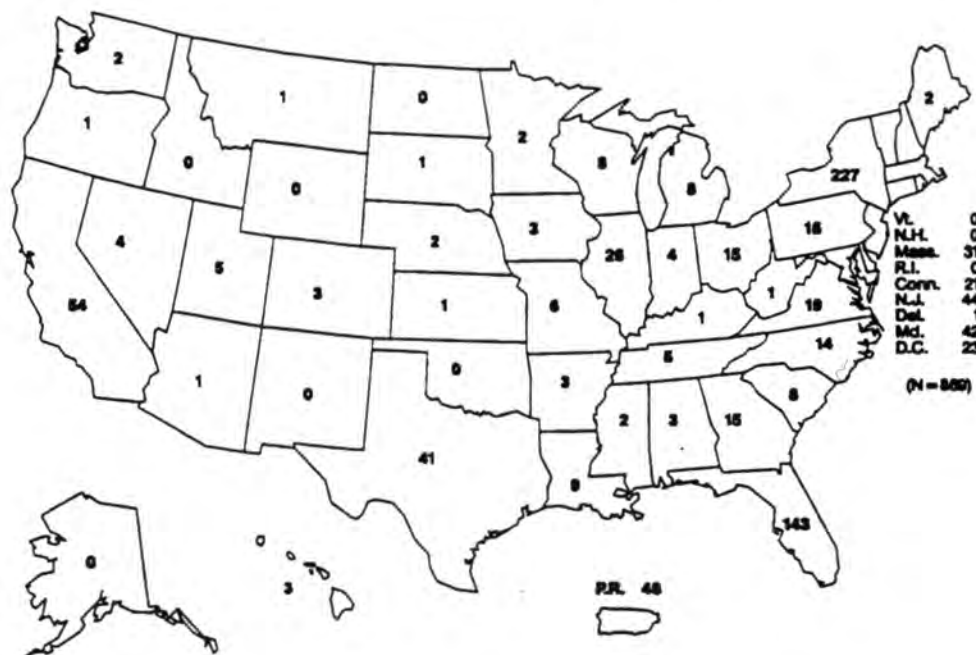
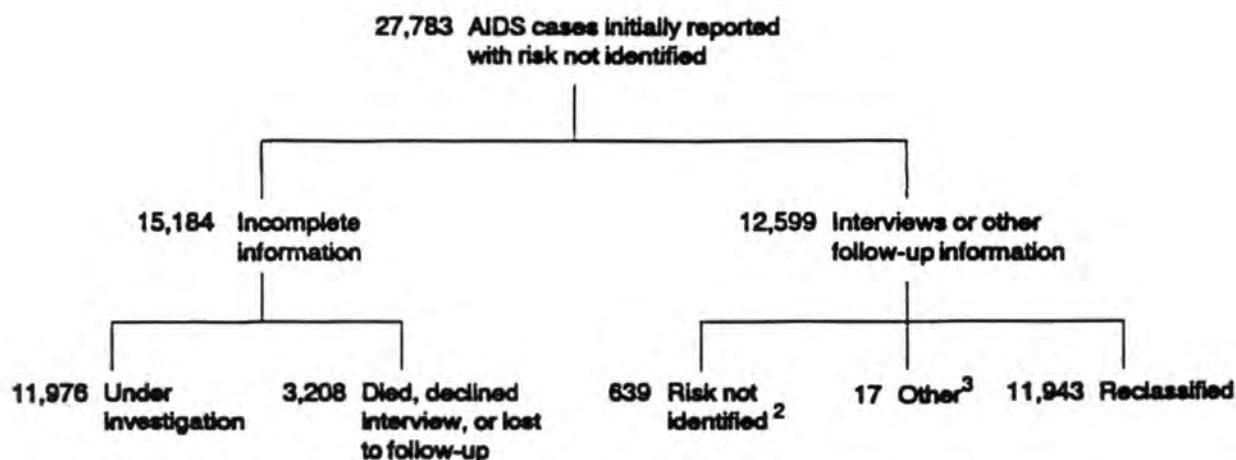


Figure 6. Results of investigations of adult/adolescent AIDS cases with risk not identified, reported through September 1993¹



¹Excludes 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.

²Heterosexual 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.

³Eleven 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 no reported history of exposure to HIV through any of the routes listed in the hierarchy of exposure categories. Risk not identified cases include persons who are currently under investigation by local health department officials; persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow-up; and persons who were interviewed or for whom other follow-up information was available and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified in the appropriate exposure category.

Rates

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

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

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FAX Transmittal Cover Sheet

San Francisco Department of Public Health

AIDS Office

Seroepidemiology and Surveillance Branch

FAX Number: (415) 431-0353

Date: 3/21/94 Number of pages to follow: 17To: Carlos Velez, J.D.
Director, HIV/AIDS PreventionFAX No.: 202 - 690 - 7560Call after transmission? Yes ☒ No ☐From: George Lemp, Dr. P.H.Phone: (415) 554-9050
(Call if any problems occur with this transmission.)Comments: Information on young gay
men as requested.

AIDS Office	San Francisco Department of Public Health	
Seroepi/Surveillance Branch	25 Van Ness Avenue, Suite 500	415) 554-9050
	San Francisco, CA 94102-6033	FAX 415) 431-0353

HIV-1 Seroprevalence and Risk Behaviors Among Young Men Who Have Sex With Men

San Francisco/Berkeley, California, 1992-1993

George Lemp, Anne Hirozawa, Daniel Givertz,
Giuliano Nieri, Jason Bishop, Vincent Fuqua,
Mario Hernandez, Luiz Goni, Welmin Militante,
Elliot Ramos, Sean Nguyen, Melissa Jones,
Laura Anderson, Robert Janssen,
Mary Lou Lindegren, and Mitchell Katz

San Francisco Dept. of Public Health, San Francisco, CA,
Berkeley Dept. of Health and Human Services, Berkeley, CA,
Division of HIV/AIDS, Centers for Disease Control, Atlanta, GA

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

LEMP 1

ABSTRACT

Objective.—To estimate the prevalence of HIV infection and risk behaviors among young gay and bisexual men sampled from public venues in San Francisco and Berkeley, CA.

Design.—A survey of 425 young gay and bisexual men sampled from 26 locations during 1992 and 1993. Participants were interviewed and blood specimens were drawn and tested for HIV, level of CD4+ T-lymphocytes, and markers of hepatitis B and syphilis.

Setting.—Public venues in San Francisco and Berkeley, CA, including street corners and sidewalks, dance clubs, bars, and parks.

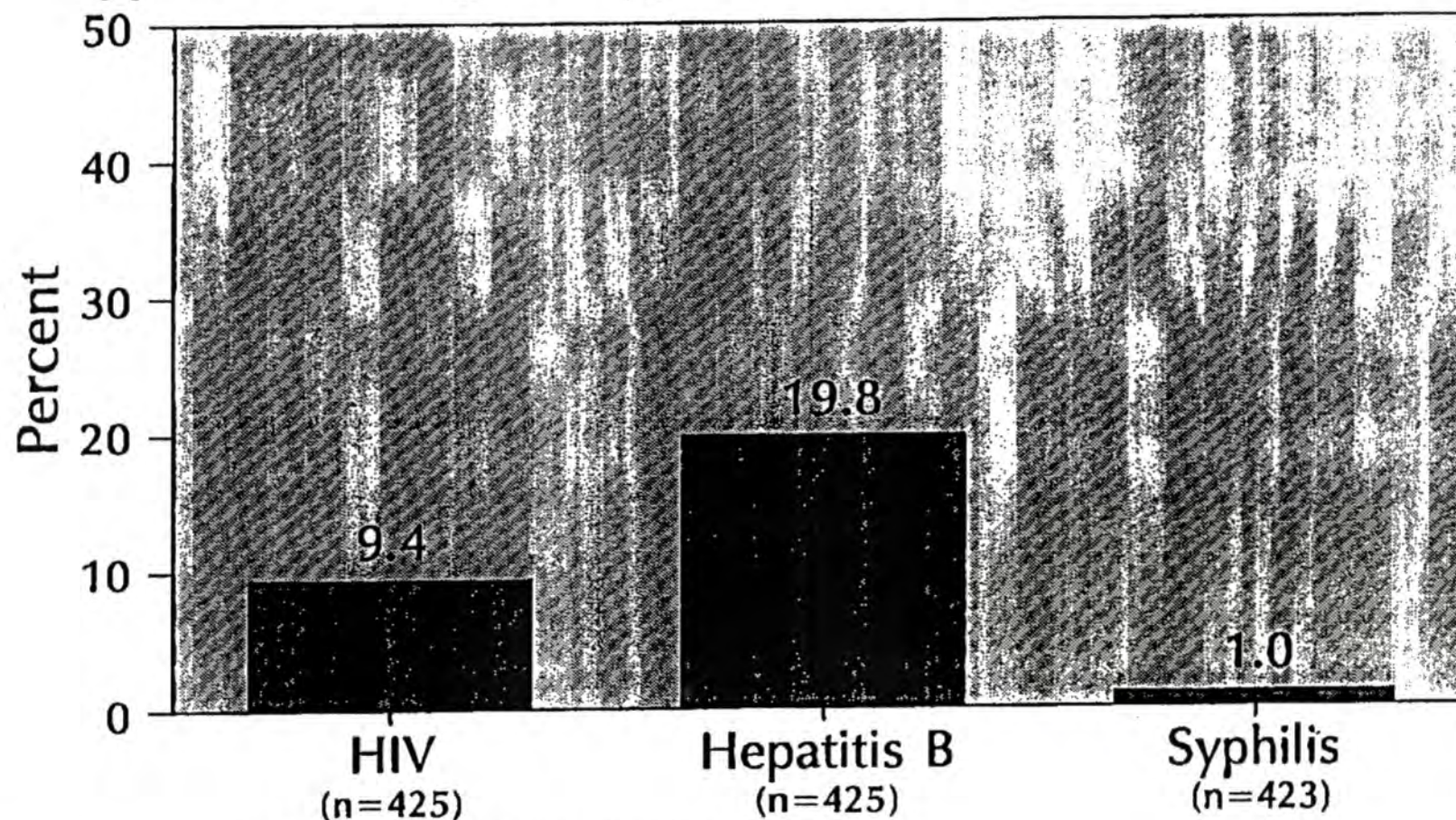
Population Studied.—Gay and bisexual men ages 17 to 22 years.

Main Outcome Measures.—Prevalence of HIV infection and risk behaviors.

Results.—HIV seroprevalence was 9.4% (95% CI= 6.8, 12.6%). The prevalence of markers for hepatitis B was 19.8% (95% CI= 16.1, 23.9%) and for syphilis was 1.0% (95% CI= 0.3, 2.4%). HIV seroprevalence was significantly higher among African Americans (21.2%) than among other race/ethnic groups ($p=.002$). Approximately one-third (32.7%) of the participants reported unprotected anal intercourse and 11.8% reported injection drug use in the previous six months. At the time of interview, 70.0% of the HIV-infected men did not know that they were HIV seropositive and only 22.5% were receiving medical care for HIV infection.

Conclusions.—The prevalence of HIV infection is high among this young population of gay and bisexual men, particularly among young African American men. The high rates of HIV-related risk behaviors suggest a considerable risk for HIV transmission in this population. Prevention programs and health services need to be tailored to address the needs of a new generation of gay and bisexual men.

Prevalence of HIV and Markers for Hepatitis B and Syphilis among Young Men who have Sex with Men



YMS: San Fransisco/Berkeley, 1992-93

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Seroprevalence of HIV by Age Young Gay and Bisexual Men, San Francisco/Berkeley, 1992-93

Age, (yrs)	No.	% HIV- Positive	95% CI	Adjusted OR	95% CI
17-19	122	4.1	1.3, 9.3	1.0	...
20-22	303	11.6	8.2, 15.7	2.7	1.0, 7.7
Total	425	9.4	6.8, 12.6		

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Seroprevalence of HIV by Race/Ethnicity Young Gay and Bisexual Men, San Francisco/Berkeley, 1992-93

Race/Ethnicity	No.	% HIV-Positive	95% CI	Adjusted OR	95% CI
White	210	8.1	4.8, 12.6	1.0	...
African American	52	21.2	11.1, 34.7	2.5	1.1, 6.1
Latino	95	9.5	4.4, 17.2	...	...
Asian/ Pacific Islander	48	4.2	0.5, 14.3	...	...
Other	20	5.0	0.1, 24.9	...	...

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Prevalence of Unprotected Anal Intercourse in the Previous Six Months by Age, Young Gay and Bisexual Men, San Francisco/Berkeley, 1992-93

Age, (yes)	No.	Percent Reporting Unprotected Anal Sex		Adjusted OR	95% CI
		Percent	95% CI		
17-19	122	28.7	20.9, 37.6	...	...
20-22	303	34.3	29.0, 40.0	...	...

Prevalence of Unprotected Anal Intercourse in the Previous Six months by Race/Ethnicity, Young Gay and Bisexual Men, San Francisco/Berkeley, 1992-93

Race/Ethnicity	No.	Percent Reporting Unprotected Anal Sex		Adjusted OR	95% CI
		Percent	95% CI		
White	210	28.1	22.1, 34.7	1.0	...
African American	52	38.5	25.3, 53.0	...	...
Latino	95	40.0	30.1, 50.6	1.6	0.9, 2.6
Asian/ Pacific Islander	48	27.1	15.3, 41.8	...	...
Other	20	45.0	23.1, 68.5	...	...

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Prevalence of Unprotected Anal Intercourse in the Previous Sex Months, Young Gay and Bisexual Men, San Francisco/Berkeley, 1992-93

High on Popper during Sex in last 6 months	No.	Percent Reporting Unprotected Anal Sex		Adjusted OR	95% CI
		Percent	95% CI		
No	371	31.8	27.1, 36.8	1.0	...
Yes	35	60.0	42.1, 76.1	3.0	1.4, 6.8
High on Alcohol during Sex in last 6 months					
No	180	27.8	21.4, 34.9	1.0	...
Yes	226	39.4	33.0, 46.1	1.7	1.1, 2.8

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Prevalence of Unprotected Anal Intercourse in the Previous Six Months by History of Forced Sex, Young Gay and Bisexual Men, San Francisco/Berkeley, 1992-93

Lifetime History of Forced Sex	No.	Percent Reporting Unprotected Anal Sex		Adjusted OR	95% CI
		Percent	95% CI		
No	251	26.7	21.3, 32.6	1.0	...
Yes	174	41.4	34.0, 49.0	1.9	1.2, 3.0

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Prevalence of Unprotected Anal Intercourse in the Previous Six Months, Young Gay and Bisexual Men, San Francisco/Berkeley, 1992-93

Knowledge of HIV Status	No.	Percent Reporting Unprotected Anal Sex		Adjusted OR	95% CI
		Percent	95% CI		
HIV+, know results	12	33.3	9.9, 65.1	...	...
HIV+, do not know	28	35.7	18.6, 55.9	...	...
HIV-, know results	106	30.2	21.6, 39.9	...	...
HIV-, do not know	279	33.3	27.8, 39.2	...	...

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Prevalence of Unprotected Anal Intercourse in the Previous Six Months, Young Gay and Bisexual Men, San Francisco/Berkeley, 1992-93

Peer Norms Regarding Safe Sex	No.	Percent Reporting Unprotected Anal Sex		Adjusted OR	95% CI
		Percent	95% CI		
Positive Peer Norms	233	23.2	17.9, 29.1	1.0	...
Negative Peer Norms	173	45.7	38.1, 53.4	3.0	1.9, 4.8
Know Someone with HIV/AIDS					
Yes	324	32.1	27.0, 37.5	...	...
No	96	35.4	25.9, 45.8	...	...

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Characteristics of HIV-Infected Young Gay and Bisexual Male Participants, San Francisco/Berkeley, 1992-93

HIV Antibody Testing History	No.	%
Ever Tested	36	90.0
Never Tested	4	10.0
Aware of HIV-infected Status at Time of Interview		
Aware	12	30.0
Unaware	28	70.0
Current in Primary HIV Care		
HIV Care	9	22.5
No HIV Care	31	77.5

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Characteristics of HIV-Infected Young Gay and Bisexual Male Participants, San Francisco/Berkeley, 1992-93

Year Initiation of High Risk Behavior (Anal Sex or Injection Drug Use)	No.	%
≤1984	5	12.5
1985 - 1988	18	45.0
1989 - 1991	17	42.5
CD4+ Lymphocyte Counts		
<200	4	10.8
200 - 499	16	43.2
≥500	17	46.0

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HIV INCIDENCE AND PREVALENCE IN SAN FRANCISCO IN 1992:
SUMMARY REPORT FROM AN HIV CONSENSUS MEETING

SURVEILLANCE BRANCH, AIDS OFFICE
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
FEBRUARY 12, 1992

I. EXECUTIVE SUMMARY

This report summarizes estimates of the incidence and prevalence of HIV infection in San Francisco for 1992. These estimates are based upon an HIV Consensus Meeting held on September 11, 1991, which was sponsored by the San Francisco Department of Public Health AIDS Office.

It is estimated that 28,000 men, women and children are currently living with HIV infection in San Francisco, representing almost 4% of the City's population. San Francisco has the highest number of HIV-infected persons per capita of any major city within the United States. Almost 3% of the estimated one million persons living with HIV infection in the U.S. reside in San Francisco.

It is also estimated that more than 1,000 men, women and children will become newly-infected with HIV during 1992 alone. This number is higher than previous predictions for 1992 and is driven primarily by data suggesting a "second wave" of HIV infection among gay and bisexual men.

Based on the large body of research conducted in San Francisco in the past decade, it is estimated that the vast majority of persons currently infected with HIV in San Francisco are either gay and bisexual men, injection drug users, or sexual partners of gay and bisexual men or injection drug users. In addition, the data suggest that the incidence of HIV infection among other risk populations is extremely small, and both parallels, and is driven by, the incidence among those populations at highest risk. The data suggest no evidence of significant HIV transmission within low-risk populations in San Francisco.

The current state of the HIV/AIDS epidemic in San Francisco provides a unique opportunity to re-emphasize prevention efforts within those populations at highest risk. This would prevent both transmission of HIV within the high-risk populations and would prevent further transmission to other populations where the prevalence of HIV infection is currently low.

The data suggest that focused prevention campaigns have been very successful in San Francisco when targeted to populations at high risk. The data indicate that comprehensive community-based prevention efforts among gay and bisexual men were primarily responsible for the dramatic reductions in the incidence of HIV infection among gay and bisexual men in the early to mid-1980s. These programs were designed and coordinated by persons within the gay/bisexual communities. The key aspects of these programs included a balance between grass-roots efforts, media campaigns, self-help groups, and a strategy of empowerment and support for persons at risk. Likewise, the data suggest that comprehensive street- and community-based programs designed for injection drug users have been successful in slowing the epidemic among injection drug users in San Francisco in recent years. The key to success in both instances was the use of comprehensive community-based prevention efforts and the commitment among those at risk to change their behavior.

These data also suggest that current prevention programs must continue to be supported in order to maintain the recent changes in behavior and to reach new generations at risk. To sustain behavior change over long periods of time, prevention messages need to be repeated frequently and through a variety of channels. The inadequate Federal fiscal commitment to programs targeting gay and bisexual men in the late 1980's may have contributed to the development of a "second wave" of HIV infection among gay and bisexual men. It is critically important that existing resources not be diverted from programs for injection drug users or their sexual partners now that the data suggest a slowing of the epidemic within this

community in San Francisco. There needs to be continued advocacy for funding at the Federal level for a significant expansion of prevention activity.

Given scarce resources for the prevention of HIV infection, and the expense of waging strong grass-roots, community-based prevention campaigns in several risk populations, the most effective prevention strategy for addressing the HIV epidemic would be to focus the vast majority of new resources for prevention on those populations at highest risk: gay and bisexual men (especially young men and gay/bisexual men of color), injection drug users, and their sexual partners. The benefits from successful prevention efforts among those at highest risk would also spill over to other populations where the risk was much lower.

State and Federal agencies must realize that the robbing of prevention funds to pay for AIDS care programs will only perpetuate future waves of HIV infection. Instead of specifying target populations for localities, these agencies must permit local jurisdictions the flexibility to address needs based on local data.

The SFDPH AIDS Office will be seeking the cooperation of existing contractors to emphasize the highest-risk populations of young gay and bisexual men, gay and bisexual men of color, injection drug users, their sexual partners, and the issue of relapse in program development and planning. Contractors who currently target the general community will be assisted in focusing their programs to address the above.

The following points highlight the key findings from this report. These are followed by a table (Table 1) which summarizes the principal findings:

1. **An estimated 28,000 men, women and children are currently living with HIV infection in San Francisco, representing almost 4% of the City's population.**
2. **More than 1,000 men, women, and children will become newly-infected with HIV during 1992 alone. This number is higher than previous predictions for 1992 and is driven primarily by data suggesting a "second wave" of HIV infection among gay and bisexual men.**
3. **Approximately 25,000 gay and bisexual men (including gay and bisexual injection drug users) are currently living with HIV infection in San Francisco, with an additional 650 men expected to become infected in 1992. The men currently becoming infected are increasingly young men (25 years and under), and men of color, who may not have received the prevention messages of the first wave of the epidemic. These infections, together with new infections among some older gay and bisexual men who have relapsed to unsafe sexual behaviors, represent a "second wave" of HIV infection among gay and bisexual men.**
4. **An estimated 1,700 injection drug users (IDUs) other than gay/bisexual males are currently living with HIV infection in San Francisco and more than 200 are expected to become infected with HIV in 1992. The data suggest that the prevalence of HIV infection has stabilized since 1987 among both street-based and in-treatment IDUs in San Francisco. The current data, however, may underestimate the true prevalence and incidence of HIV infection.**
5. **More than 1,100 women are currently infected with HIV in San Francisco and it is estimated that 180 additional women will become infected with HIV in 1992. Most of these women were infected with HIV through injection drug use or through sexual contact with a male partner at risk for HIV. The**

prevalence of HIV infection has appeared to stabilize among women in recent years, a trend which parallels the stabilization of the HIV epidemic among injection drug users in San Francisco.

6. An estimated 250 non-injection drug-using heterosexual men are currently infected with HIV in San Francisco, and about 50 men will become infected with HIV in 1992. The prevalence of HIV infection has appeared to stabilize among both heterosexual men and women, a result of the slowing of the HIV epidemic among injection drug users in San Francisco. If the prevalence of HIV infection remains stable among injection drug users, relatively few new infections would be expected for women and heterosexual men in the future.
7. Approximately 8 to 20 infants will be born each year with antibodies to HIV, but only about 5 per year will eventually be determined to be infected with HIV. The incidence of HIV infection among infants has stabilized in recent years. Perinatal transmission will continue to be a relatively small problem in San Francisco.

TABLE 1

ESTIMATED HIV INCIDENCE AND PREVALENCE IN SAN FRANCISCO: 1992

<u>RISK GROUP</u>	<u>POPULATION SIZE</u>	<u>HIV PREVALENCE</u>		<u>ANNUAL HIV INCIDENCE</u>	
		<u>N*</u>	<u>PERCENT</u>	<u>N**</u>	<u>PERCENT</u>
<u>Gay/Bisexual Men:</u>					
Non-IDUs					
Young (17-25)	5,000	600	12%	200	4.0%
Older (26+)	50,000	22,500	45%	415	1.5%
IDUs	3,000	1,900	63%	35	3.5%
SUBTOTAL	58,000	25,000	43%	650	2.0%
<u>Injection Drug Users:</u>					
Heterosexual Men	8,500	1,200	14%	150	2.0%
Women	4,500	500	11%	80	2.0%
SUBTOTAL	13,000	1,700	13%	230	2.0%
<u>Other Adults/Adolescents:</u>					
Women	315,000	630	0.2%	100	0.03%
Heterosexual Men	253,000	250	0.1%	50	0.02%
SUBTOTAL	568,000	880	0.15%	150	0.025%
<u>Infants and Children:</u>	85,000	85	0.1%	5	0.03%
					(of births)
<u>TOTAL</u>	<u>724,000</u>	<u>27,665</u>	<u>4%</u>	<u>1,035</u>	<u>0.15%</u>

* Total number of persons living with HIV infection

** Number of new infections per year