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Folder Title:
Panel Discussion - "Health Care Reform: Impact on HIV Care and Services"

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Day:	Friday
Date:	October 22, 1993
Time:	3:45-5:15 PM
Location:	San Francisco Civic Auditorium
Subject:	Panel Discussion - "Health Care Reform: Impact on HIV Care and Services

Carlos brought you the pages from Dr. Judith Feders group on Q & A's regarding HCR.

[13] From: Ben Merrill 10/20/93 4:32PM (3541 bytes: 71 ln)
To: Kristine Gebbie, Carlos Velez, Arthur Lawrence
Subject: SFran Community
---------- Message Contents ----------

Here are some specific items that the SFran Community asked me to bring to your attention that they would like addressed. Perhaps you can see your way to do some of these:

1. Advocate appropriate funding for HIV prevention and outreach for immigrants and undocumented residents to the CDC

2. Advocate that the CDC establish an external review panel that addresses HIV prevention for gay men and gay men of color.

3. Advocate the inclusion of gay men and gay men of color as participants on all relevant CDC external review panels and advisory committees.

4. Facilitate a meeting of HIV policy advocates with Dr. Satcher, Director of CDC to discuss national prevention reform, prevention funding removal of content restrictions, needs of gay men and gay men of color and needle exchange issues.

5. Make a public statement of support for the HOPWA prgram, continue to advocate for this program and its expansion, send Tony Cuomo a letter of support, and keep the community involved.

6. Make a public statement of support for Ryan White CARE Act particularly in favor of a community based model for planning and appropriate funding for services.

7. Make a public statement regarding full funding of Ryan White.

These are the items that the community is looking for some public statements on. Take your pick.

The subject areas that I discussed with them were as follows:

Needle Exchange	Immigrant Exclusion
Ryan White Reauthorization	Housing
Prevention Reform	Services for Undocumented
Health Care Reform	Housing
Research	Outreach Workers
Prevention for gay men	TB
Immigration	Medical Marijuana

Art told me today that you made the comment that he and I wanted to keep you "wrapped in cotton" and away from the activists. Nothing could be further from the truth and let me disabuse you of that ideal; I think that you need to wade into it as much as you can, I just want you to know how

deep it is. I'm not going to these groups to insulate you from them but to find out what is on their minds.

With regard to John and the good job he did in New York, that's great and I'm glad he did. There is an old strategy to destroy people politically, it goes like this: make their appearance so uncomfortable that polititions won't appear on a stage with them, especially in an election year. After a while, the person is isolated. I don't know if this is the activists strategy or not. But I think that we should strategize about it sometime. Carlos has some good ideas and I think I have too. Let us know if you want to talk about it.

Good luck in San Francisco. You'll get the questions behind the requests above.

[16] From: Carlos Velez 10/21/93 12:14PM (3182 bytes: 52 ln)
To: Kristine Gebbie, Ben Merrill, John Gurrola, Arthur Lawrence
Subject: Wash. Times/CNN and me
---------- Message Contents ----------

Text item 1:

If you haven't seen it or heard it--the WAsh. Times is apparently playing up a somewhat distorted view of what I said yesterday about human sexuality and Victorian repressions. This is a try at a clarification statement--I need to make it final and get it over to the WHite House quickly, so no long turn-around. If Carlos isn't in the office and we know where to find him, his comments would be most useful, since he heard me make the speech in question yesterday.

In a presentation to the Association of Reproductive Health Professionals, Kristine Gebbie, National AIDS Policy Coordinator, re-stated a view she has shared with many audiences in recent weeks. This is the position that effective HIV prevention with adolescents must be developed in a larger context which includes two elements:

-a comprehensive health education curriculum which begins early and is age appropriate

-a view of human sexuality which is affirmative.

Abstinence is the surest prevention of HIV transmission, and must be communicated. But simply stating the negative messages about sexual behavior, without clarifying sexuality as an important and pleasurable part of the human experience is not sufficient to prevent sexual activity. The next generation of young people should be prepared to enter an adult sexual life with a better base of attitudes and informtion than we have provided so far. This can only happen if we move away from a Victorian repression in which "nice people don't talk about these things".

Text item 2: What really happened

The distortion is primarily centered on the section on "Victorian Society." They reversed the order of the statement and put the Victorian Society issue up front and totally reversed the approach. The Victorian Society issue is totally distorted.

The entire context of the comments is as follows (shorter version):

We are not working on a strategy, that is very simple "Stop AIDS."

In our society, the message of sexuality is generally couched in negative messages of what can happen to individuals if they do not behave appropriately. What needs to be done is talk about the natural aspects of sexuality, so that young people can get the whole picture of sexuality, which is a natural, beautiful process.

We also have to work on changing the attitudes of our society in order to achieve this. We have stop being a repressed "Victorian morality" if we are going to accomplish this.

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WID
WORLD INSTITUTE ON DISABILITY

ELISSA CHANDLER, R.N., M.P.H.
AIDS & Disability Project Manager

ACT UP/Golden GATE

SHELDON RAMSDELL
Founding Vice President
Vietnam Veterans Against The War

Hm 415 826-3844

415-550-9638

1350 Dolores
San Francisco, CA 94110

LEWIN-VHI, INC.
a Value Health company

RAYMOND J. BAXTER, Ph.D.
Senior Vice President

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Brochure: Moving Toward Equality

MOVING TOWARD EQUALITY

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REALIZING THE REHABILITATION POTENTIAL FOR INDIVIDUALS LIVING WITH AIDS

AIDS is following the pattern of several other diseases that were once quickly terminal and then became conditions that people had to learn to live with for extended periods of time. As people with AIDS became a part of the disabled population, there are changes which need to occur -- in the way in which people with AIDS perceive themselves, and the way in which they are perceived by the caring community, the rehabilitation system and the Independent Living Movement.

The World Institute on Disability (WID) is undertaking a demonstration project, partially funded by the U.S. Department of Education, to promote the vocational and independent living outcomes for people with disabilities resulting from HIV/AIDS. The goal of the project is to demonstrate how this population can be helped to develop a more accurate and complete comprehension of AIDS-related disabilities and the ways in which independent living and vocational rehabilitation can improve the quality of life of people with AIDS.

The AIDS and Disability Project has four interrelated objectives:
*Demonstrate the effectiveness of peer support programs to educate people with AIDS about independent living and vocational rehabilitation and understand their own potential for rehabilitation.
*Build a cooperative and more trusting atmosphere in the community by drawing organizations together to discuss commonalities, differences, problems and opportunities.
*Share information about AIDS-related disabilities and the rehabilitation needs and potential of this community with rehabilitation professionals.
*Develop needed consumer-oriented resources to help people with AIDS better understand their disability-related needs.

In developing the project, WID understands that AIDS is a controversial and frightening disease. There is great deal of fear and prejudice and discrimination, and the different populations most affected by the illness have responded very differently to its presence. Even without AIDS there are barriers to some of these populations working together. These factors will make the work of the project harder, but we are confident that we are proposing a tested methodology and that we have assembled a multi-ethnic and diverse Advisory Committee that will open doors that have previously been closed.

We believe that the project will show the efficacy of implementing, in communities around the country, a project like this one which focuses on building networks, sharing good information, and offering persons with AIDS the peer support services that have proven to be so effective in the Independent Living Movement.

continued...

BACKGROUND AND NEED

AIDS is a problem that will not soon go away. Along with the sheer numbers of those affected, other factors are now coming into play. AIDS is now not simply seen as a disease that quickly runs its course and results in early death. Due to early medical intervention, aggressive drug therapies and appropriate support services, people are living longer lives. AIDS has moved from an acute illness to a disabling chronic condition. Whereas only the medical community and its accompanying services were once needed to meet the rather short term need of people with AIDS, now other systems must come into play as the person with AIDS becomes a part of the larger population of people with disabilities.

Thus AIDS is following the pattern of several other diseases which were once seen as quickly terminal and then gradually became conditions that persons had to learn to live with. Persons with AIDS are joining the community of people with disabilities and as part of this new identity, need to understand the rehabilitation system and how to deal with the prejudices and fears aimed at a new disability population.

Important changes will have to be made by persons with AIDS themselves and the communities which have developed around them. As the life span of persons with AIDS increases, changes need to occur in the support systems which these communities have developed. The emphasis needs to be shifted from "caring-for" to that of encouraging independence and rehabilitation.

The problems involved in improving access to independent living and vocational rehabilitation services are made all the more difficult by the great disparities of services and supports needed due to gender, geography, populations affected, and distinct cultural differences of those affected by AIDS.

All these problems are difficult to change, but they are also problems that are familiar to many disabled people. One of the lessons learned in the Independent Living Movement is how effectively people with very different kinds of disabilities can be in helping one another through peer support, peer counseling and role modeling. This demonstration project will stimulate, encourage and nurture the linking of the AIDS population and the AIDS service network with the disabled population, the Independent Living Movement and the rehabilitation system.

COLLABORATION

In accord with WID's style of operation, this project was designed in collaboration with organizations involved with the AIDS issue; and it will be implemented in collaboration with other disability, rehabilitation and AIDS organizations.

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continued...

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The problems involved in improving access to independent living and vocational rehabilitation services are made all the more difficult by the great disparities of services and supports needed due to gender, geography, populations affected, and distinct cultural differences of those affected by AIDS.

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IMMEDIATE ACTION NEEDED

meeting this morning with the White House Health Reform Task ..., the Congressional Hispanic Caucus was told that the national ...th care reform legislation will eliminate OBRA Medicaid ...ents for emergency care for undocumented immigrants. 42 U.S.C. ...ion 1396b(v). Under OBRA, individuals otherwise eligible for ...caid and who have no other means of payment can receive ...caid reimbursement for emergency health care costs. These ...caid costs are shared between the federal and state ...rnments. Eliminating OBRA Medicaid will not result in cost ...gs: emergency health care costs will continue to be incurred ...will have to be paid solely by state and local governments. ...c health departments and public hospitals will lose millions ...dollars in Medicaid reimbursements if OBRA Medicaid is ...inated.

...e contact the following immediately to urge them to maintain ... Medicaid payments in the national health care reform ...slation.

...d Rasco, Domestic Policy Council
...e: 202/456-2216 fax: 202/456-2878

...n Rosenbaum Cannon Office Building
...leave message at George Washington University 202/296-6922

...ase pass this action alert on to others who can respond ...diately. Thank you.

by 9:00

1554.2622 Fax

SENT BY:AmFAR-DC ;10-22-93 ; 3:11PM ; → M.F. SILVERMAN;# 1/ 1

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STATEMENT OF MERVYN F. SILVERMAN, M.D., M.P.H.
PRESIDENT, AMERICAN FOUNDATION FOR AIDS RESEARCH
IN RESPONSE TO REMARKS ON HUMAN SEXUALITY BY
KRISTINE GEBBIE, NATIONAL AIDS POLICY COORDINATOR

October 22, 1993

In her recent remarks at a conference on teen-age pregnancy, National AIDS Policy Coordinator Kristine Gebbie was correct in stating that in order to slow the spread of HIV and other sexually transmitted diseases, and the rate of teen-age pregnancy, we must, as a society, openly and honestly discuss issues of human sexuality.

It has been the nation's unwillingness to do just that which has helped to fuel the continued alarming rate of HIV transmission.

The American Foundation for AIDS Research hopes that Ms. Gebbie's future actions as the National AIDS Policy Coordinator will help to create an atmosphere in which all Americans, especially our young people, will have access to honest information about human sexuality and disease prevention, so that they can make well-informed decisions that promote their health and well-being.

Peregrine Productions
330 Santa Rita Avenue
Palo Alto, California 94301
415/328-4843

Oct. 22, 1993

Ms. Kristine M. Gebbie RN MN
National AIDS Policy Coordinator
Washington D.C.

Dear Ms. Gebbie:

Please accept this film as a token of my appreciation for the valuable work you are doing.

Seven years ago, my brother-in-law died of AIDS. As a medical journalist this impelled me to make AIDS In Your School, a video for teens about the virus. The film was picked up by the World Health Organization and won a CINE. Thus inspired, I made "A" Is for AIDS one of the few videos for elementary school age youngsters.

Most recently I have completed AIDS and Women: the Greatest Gamble about five women who have the virus. The program features Aileen Getty, grand-daughter of billionaire John Paul Getty, as well as Millie Ortiz, a Puerto Rican from the New York barrio. There are interviews with Dr. Jonathan Mann of Harvard and teens from Harvard Square to the San Francisco Haight Ashbury. If you think it advisable, perhaps you could show the tape to Hilary Clinton and her daughter.

The program is distributed by the Altschul Group 1-800-323-9084 in Evanston, Ill.

Thanks for your interest.
Sincerely,

Charlotte K. Beyers

Producer

Background on 'AIDS and Women:The Greatest Gamble'

Directed by Jesse Block of San Francisco, "AIDS and Women: The Greatest Gamble" is a 26-minute color video. It is the third AIDS program produced by Charlotte K. Beyers, president of Peregrine Productions, Palo Alto.

Harvard Prof. Jonathan Mann, former AIDS director for the World Health Organization, tells viewers that women and children will become a majority of the 130 million expected to be infected with HIV world-wide by the turn of the century.

Filmed in San Francisco, Oakland, New York, Boston, and Los Angeles, "AIDS and Women" features:

* Aileen Getty, white granddaughter of billionaire John Paul Getty, a mother of two, living in Los Angeles;
* Monia Lisa Perry, of Oakland, a black dancer who works in the entertainment business;
* Millie Ortis, of New York, a Puerto Rican mother of five who considers herself "empowered" as an AIDS educator;
* Gloria Littlemoon, of San Francisco, a Latina/Native American AIDS educator; and
* Mary Corwin, a white San Franciscan, former financial analyst, and her 12-year-old daughter, Sinead.

Young people from the Haight-Ashbury in San Francisco and Harvard Square in Massachusetts voice their questions and concerns about the epidemic.

Facts about women and AIDS

Program hosts Shannon Johnston and Iza Pardinas of San Francisco describe several reasons why AIDS has become a "silent epidemic" among women:

* Women are much more easily infected by men;
* Women are infected through the risky behavior of their partners - people who have had sex with others already infected or shared needles when shooting drugs.
* One third of men lie to their partner about risky behavior.

(OVER)

As caregivers, women are more likely to ignore their own health. They are diagnosed later, have more difficulty obtaining treatment, and die quicker than men with HIV infection.

If a pregnant women becomes infected, there's a 15 to 30 percent chance her infant also will have HIV.

Many women with HIV are isolated and rejected by their families. Few have support groups.

How to avoid infection

How can women avoid HIV infection?

The only 100 percent safe way is never to have sex and never to inject drugs, except those prescribed by a doctor.

Women can reduce their risk by limiting the number of their sexual partners. The more partners, the more risk - not only from them but from all their previous partners.

Always use condoms.

Sometimes condoms break, so it's important for partners to communicate. Find out if your partner has been tested for HIV. Ask about the results. Take the test yourself if there's a chance you've become infected.

If you do inject drugs, never share needles. If you have a sex partner who injects drugs, you can get the virus.

Women in the San Francisco Bay Area with questions about AIDS can call (800) 262-2430.

To order preview copies of the film call the Altschul Group, Evanston, IL (800) 323-9084 and ask for Eileen Cronin.

Charlotte K. Beyers, president
Peregrine Productions
330 Santa Rita, Palo Alto CA 94301
Phone (415) 328-4843 Fax 327-3258

Teenage Girls Are on the 'Leading Edge' of the AIDS Scourge

Worldwide, 3,000 women a day become infected, 500 women a day die of the virus

By Boyce Rensberger
Washington Post Staff Writer

HEALTH

Among sexually active people, those being infected with the AIDS virus at the fastest rate are women in their teens and early twenties, including many who have had relatively few sex partners.

As women grow older, they become less likely to contract the virus even though, on average, their number of sex partners increases. Men, by contrast, do not encounter their peak risk for AIDS infection until they are in their late twenties and early thirties.

Those findings, described in a recent report by the United Nations Development Programme (UNDP), can be traced to a variety of causes from social and behavioral factors to anatomy. According to the study, women between the ages of 15 and 25 make up about 70 percent of the 3,000 women a day who become infected with the AIDS virus and of the 500 women a day who die of AIDS.

In most of the Third World, where AIDS is overwhelmingly a heterosexually transmitted disease, the report said, there are as many female cases as male and sometimes more.

In the United States, women accounted for just 14 percent of AIDS cases last year, but the proportion is growing rapidly. The Centers for Disease Control and Prevention reports that American women of all ages are coming down with AIDS four times as fast as men. In 1992, CDC says, the number of women with AIDS climbed 9.8 percent while the number of men with AIDS grew 2.5 percent.

Also in 1992, heterosexual transmission of HIV, the AIDS virus, became the leading cause of the disease in women, overtaking the sharing of needles used for intravenous drugs. A recent study of youths serving in the Job Corps showed that 4.2 women per 100,000 were infected with HIV as compared with 2.4 per 100,000 for men.

"HIV is into the teenage population and it's spreading quickly and silently," says Karen Hein, a specialist in adolescent medicine at the Albert Einstein College of Medicine and director of the adolescent AIDS program at Montefiore Hospital in the Bronx. She says half of the teenage girls at her clinic who are HIV-positive have had fewer than five sex partners.

"Adolescents are the leading edge of the next wave of the epidemic," says Hein, a consultant to UNDP's effort to examine the impact of AIDS on economic development and a spokeswoman for the study.

The special vulnerability of women was first noted in Africa some years ago, but it was not considered relevant to industrialized countries. In 1986 in Zaire, for example, a study of the first 500 AIDS cases admitted to Kinshasa's Mama Yemo Hospital found as many women as men; but the women averaged 10 years younger.

Still, in those early days of the pandemic, many experts considered African AIDS a different phenomenon from American or European AIDS, which then was overwhelmingly a disease of gay men and intravenous-drug users. The conventional explanation was that Africans had high rates of other sexually transmitted diseases that predisposed them to HIV, especially by causing open sores on the genitals. Another presumed differentiating factor was large numbers of sex partners.

"Things like that led a lot of people to think of AIDS [in the United States] as mainly a gay disease," Hein says. "But things have changed. What people are talking about in Africa is really happening now in this country."

She says American girls are now having sex at younger ages than before, with the median age at first intercourse at 15 to 16. And young people have high rates of other sexually transmitted diseases.

In addition, the UNDP study found, there are factors that put young women at much greater risk than young men.

One is anatomy. The tissue that lines the vagina, and which can be injured during sexual intercourse, is very thin in preadolescent girls. It begins to thicken as puberty progresses and reaches its maximum about two years after the first menstrual period. This factor is most relevant to girls between the ages of 10 and 18. Also increasing during that time is the thickness of vaginal mucus, which exerts several kinds of protective effects.

Yet another factor, which affects women in their later teens and early twenties, involves a special type of cells that ring the opening of the cervix. It is these cells that the human papilloma virus infects to cause cervical cancer and that researchers suspect HIV infects to cause AIDS.

In young women this "transition zone" of cells lies outside the cervical opening, where it is exposed to microbes that enter the vagina. As women mature, the zone moves to a less exposed position inside the opening. Childbirth, however, can move the zone back into an exposed position. As a result, women who give birth at relatively young ages have a higher risk of becoming infected. A study in Rwanda, which lies in the heart of Africa's AIDS region, showed that more than 25 percent of women who became pregnant before age 18 are HIV positive.

By far the most important behavioral factor that makes young females more vulnerable than young males, Hein says, is the low rate of condom use. This is especially significant because girls often have sex with men who are older (and thus more likely to be infected). Boys, on the other hand, tend to have sex with girls their own age. Another factor is that young people have a higher rate of anal intercourse. Hein says that 26 percent of the females in a New York City study had practiced anal intercourse, many citing it as a way of preventing pregnancy and maintaining virginity. As in men, the anal tissues are highly susceptible to HIV infection.

In Third World countries, another prominent factor is that when rural people move to the cities, job opportunities for women are even scarcer than for men. As a result, many girls find the only way to support themselves is by selling sex.

"The silence surrounding the infection of young women must be broken," the UNDP report said. "Girls and young women must be able to speak out, to cease to feel silenced or powerless to change what happens to them. Others, too, must speak out."

To remedy the problem, the report urges the development of strategies to lengthen the time before young women are pressured to have sex, to delay the first pregnancy and to increase the ability of girls to control situations in which they have sex, either to avoid it or to insist on condom usage. ■

For further information call or write: The Director; HIV and Development Programme; United Nations Development Programme; 304 East 45th St., Room FF 1094; New York, N.Y. 10017 Telephone: (212) 906-6976 Fax: (212) 906-6336

HIV NATIONAL AIDS UPDATE CONFERENCE SAN FRANCISCO

Return

September 7, 1993

Kristine Gebbie, MN, RN, FAAN
AIDS Policy Coordinator
750 17th St. NW, Suite 1060
Washington, D.C. 20503

Dear Kristine:

I am delighted that you will be able to participate in the 6th National HIV/AIDS Update Conference in San Francisco, California, October 20-23, 1993. The Conference will be held in the San Francisco Civic Center Auditorium located in the Civic Center across the street from City Hall at 99 Grove Street. You are scheduled to speak on a panel presentation and then do the closing address for the Conference on Friday, October 22, 1993.

The panel discussion is titled **Health Care Reform: Impact on HIV Care and Services**. This session is scheduled for October 22, 1993 from 3:45-5:15 p.m. At this time the other panelist that are scheduled to participate include: Mary Pittman, DrPH (moderator), Ray Baxter, PhD, former Director of Public Health, San Francisco and Mervyn F. Silverman, MD, MPH, President, AmFAR.

Immediately following this panel is the closing plenary presentation which is scheduled from 5:15-5:45 p.m. We would like for you to speak for approximately 15-20 minutes outlining what you think are the most important policy issues for the epidemic and giving the participants an update on where your emphasis will be at that time. We will talk some before the conference and I will give you an update on where we are with the planning.

As you develop your presentation, please note that the theme of the overall conference is "Learning From the Past, Focusing on the Future" Therefore, your presentation should reflect the theme of the conference as much as possible.

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1. Speaker Information; including correct spelling of your name, intials after your name (if you use any), and your title exactly as they should appear

in the final program; *(if possible please fax name & title as you want it in the program to me as soon as possible so that we can get it in the final program. Fax # 415/206-0796)

2. Hand-out materials that you want distributed;
3. Registration Form (registration fee is waived for speakers, please indicate on the form that you are a speaker);
4. Cassette Recording Authorization.
5. Audio-Visual needs

I will enclose a copy of our preliminary brochure for the Conference and if you should need any information or assistance with hotel arrangements or travel, please let me know. I can be reached in San Francisco at 415/206-1644. My fax number is 415/206-0796.

I look forward to seeing you at that time.

Sincerely,

Cliff

Cliff Morrison, MS, MN, RN, FAAN
Program Director

cc: M. Pittman

SEP 27 1993

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SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS PROGRAM
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

Paul — I'd like to try & see you for a half hour or so while I'm in SF —

22 September 1993

Christina Gebbie, R.N.
National AIDS Policy Coordinator
750-17th Street, N.W., Suite 1060
Washington, DC 20503

Dear Ms. Gebbie:

Congratulations, first of all, on your appointment to the AIDS Policy Office. As I was asked to submit my own CV for the position, I gave enough thought to the job to follow your appointment quite closely. You seem to be off to an excellent start and I would assume that the appointment of Jocelyn Elders as Surgeon General should make it even more possible to accomplish something, finally in the field of HIV prevention. I assume that we will have an opportunity to cross paths at some point or another, perhaps at the Institute of Medicine, where I continue to be involved in the AIDS Drug and Vaccine Development Roundtable.

Again, belated congratulations on your appointment. I wish you all possible success in your position.

Sincerely,

Paul A. Volberding, M.D.
Professor of Medicine, UCSF
Director, AIDS Program, SFGH

PAV:CR

415/476-
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6th National HIV/AIDS Update Conference
October 19-23, 1993

Plenary & Workshop Schedules

Plenary Speakers

Wednesday, Oct. 20.1993, 9:15-10:30 a.m. (Opening Plenary)

"Scientific Update: Anti-retroviral Update."
Paul A. Volberding, MD
Professor of Medicine, UCSF
Director, AIDS Program, San Francisco General Hospital

"Learning from the Past, Moving Toward the Future."
Jeanne White
President and Founder, Ryan White Foundation
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"Worldwide HIV Vaccine: Reality or Illusion?"
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Community Family Planning Council
New York, NY

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Executive Vice-President
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"Evaluating Our Past Experiences to Plan for the Future."
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Former President & CEO, National League for Health Care
New York, NY

"The Future in HIV Research: Will We Learn from the Past?"
Sten Vermund, MD, PhD
Chief, Vaccine and Epidemiology, Division of AIDS
NIAID, National Institutes of Health
Bethesda, MD

"Issues for the Gay Community in Treatment and Research."
Derek Hodel
Director, Treatment and Research
AIDS Action Council
Washington, DC

Friday, Oct. 22, 1993, 5:15-5:45 (Closing Ceremony)

Keynote Address:
"HIV Policy: Learning from the Past, Focusing on the Future."
Kristine Gebbie, MN, RN, FAAN
National AIDS Policy Coordinator
Washington, DC

Hi-Vibrations, Musical Presentation

Mary Pittman, Dr. P.H., Closing Remarks
Conference Co-Chair
The Hospital Research & Educational Trust
The American Hospital Association
Chicago, IL

Conference Recording Service

CONSENT TO RECORD FORM

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I prefer my presentation NOT be audio taped.

Name _____ Date _____

Session Title _____ Date _____

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510/527-3600 • 800/647-1110 • FAX 510/527-8404

REGISTRATION FORM — NAUC 1993

Please complete this form and send to:

NAUC 93 Conference Registrar, c/o KREBS Convention Management Services
555 DeHaro Street, Suite 200, San Francisco, CA 94107-2348
Fax: 415/255-2244 (For registration by credit card only.)
If registering by fax, do not send additional copy of Form by mail.
Phone: 415/255-1297 (Assistance only; registrations not accepted by phone)

Full registration fee must accompany this form. For additional registrants, please make photocopies of this form.

First Name_____ Middle Initial_____ Last Name_____ Degree_____
(As you want your name to appear on badge)

Organization_____ Title_____
Address_____
City_____ State/Country_____ Zip_____
Business Phone_____ Fax_____ Home Phone_____

❑ Please check here if you have accommodation or dietary needs. Hearing Impaired: there will be signing for plenary sessions only if requested in advance. Specify requirements:_____

WORKSHOPS
List nine workshop numbers of choice (see page 4) ____ ____ ____ ____ ____ ____ ____ ____ ____

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Please check appropriate categories	Before September 10	After September 10	
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❑ Intensive Workshop Participant *Indicate Intensive Workshop #*_____	$ 50	$ 50	.....$_____
❑ Continuing Education Credit *Please check* ❑ Nurse ❑ Social Worker ❑ Physician	$ 25	$ 25	.....$_____
❑ Person with HIV/AIDS	$ 75	$100	.....$_____

TOTAL AMOUNT ENCLOSED ALL FEES .....$_____

Please Check ❑ Check Enclosed (Payable to: **1993 National AIDS Update Conference**)
❑ MasterCard ❑ VISA ❑ American Express

Cardholder's Name_____
Credit Card Number_____ Expiration Date_____
Signature_____

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HOUSING FORM — NATIONAL AIDS UPDATE CONFERENCE 1993

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First Name_____ Middle Initial_____ Last Name_____
Organization_____
Address_____
City_____ State/Country_____ Zip_____
Business Phone_____ Home Phone_____
Name of preferred hotel_____
Indicate type of room requested ____ Single ____ Double ____ Twin ____ 2-room suite (1 bedroom, 1 parlor)
Arrival date_____ Departure date_____
Please Select Payment Method For One Night Hotel Deposit. .....$_____
❑ Check Enclosed (Payable to selected hotel) *Please check:* ❑ Smoking ❑ Non-smoking
❑ Credit Card ❑ American Express ❑ MasterCard ❑ VISA ❑ Diners Club
Cardholder's Name_____
Credit Card Number_____ Expiration date_____
Signature_____

HIV NATIONAL AIDS UPDATE CONFERENCE SAN FRANCISCO

For Immediate Release
September 30, 1993

Contact: Wendy Ho Iwata
Phone: (415) 554-2556

SIXTH NATIONAL AIDS UPDATE CONFERENCE REFLECTS ON PAST, LOOKS TO FUTURE – OCTOBER 19 - 23, 1993, IN SAN FRANCISCO

Looking ahead to national healthcare reform with the hind-sight gained from twelve historic years of grappling with the AIDS epidemic, the nation's largest gathering of HIV/AIDS healthcare providers will meet for the sixth year in San Francisco for the *National AIDS Update Conference*. The theme of the *Sixth Annual National AIDS Update Conference* (*NAUC*) is "*Learning from the Past, Focusing on the Future,*" and will reflect the changing nature of HIV and AIDS-related care, as well as overall changes in healthcare as a result of the continuing epidemic. This year's Conference runs from October 19 through 23, at the San Francisco Civic Auditorium.

Confirmed speakers for the *AIDS Update Conference* include: **Kristine Gebbie** (the nation's AIDS Policy Coordinator), **Jeanne White** (President and Founder of the Ryan White Foundation), **Paul Volberding**, MD (UCSF Professor, Director AIDS Program at San Francisco General Hospital), **Donald Francis**, MD (HIV/AIDS Consultant), **Mark Smith**, MD (Member of the National Task Force for Healthcare Reform), **Don DesJarlais**, PhD (Research Director, Beth Israel Medical Center, Chemical Dependency Institute, New York), **Marilyn Chow**, DSc, RN (President and CEO, National League for Health Care), and **Mervyn F. Silverman** (President, American Foundation for AIDS Research).

The *NAUC* will be chaired by **Raymond J. Baxter**, PhD, former Director of the San Francisco Department of Public Health, and **Mary Pittman**, DrPh, President and CEO for The Hospital Research and Education Trust, Affiliate of the American Hospital Association. There will be ten plenary presentations, over 100 workshop sessions and ten optional intensive workshop sessions covering a variety of HIV-related issues. The Conference program also features an AIDS in the arts festival, performing arts theater, film festival, over 100 exhibits, roundtable discussions on a variety of topics, poster sessions, and formal receptions and other social networking opportunities.

The Conference includes five educational tracks: Policy and Administration, Prevention and Education, Care and Services, Treatment, Health Services/Program Evaluation. The program was selected from a broad range of subject areas developed by a national planning committee, and features such topics as:

- Behavior and Relapse Education: Media Hype or Reality?;
- Treating Pediatric HIV;
- Gay Men: Issues for the Second Decade;
- The AIDS Health Services Program: Final Evaluation;
- Tuberculosis and HIV;
- Learning from AIDS: Cost Financing and Healthcare Reform.

The Conference is co-sponsored by a unique consortium of over 30 national and regional organizations including professional organizations, healthcare associations, private and public health service providers, community-based and government agencies, and others. Participating in the *Sixth Annual National AIDS Update Conference* will be a broad range of healthcare providers, elected and non-elected community leaders, state and local government representatives, individuals with HIV infection, policy-makers and others concerned with the prevention and management of HIV infection. For general information, registration and exhibits, contact **KREBS Convention Management Services**, 555 DeHaro Street, Suite 200, San Francisco, CA 94107-2348, phone: (415) 255-1297, Fax: (415) 255-8496. For media or public relations information, contact Wendy Ho Iwata, Conference Media Relations Director at the **San Francisco Department of Public Health**, phone (415) 554-2556.

HIV NATIONAL AIDS UPDATE CONFERENCE SAN FRANCISCO

June 29, 1993

The Honorable Kristine Gebbie, MN, RN, FAAN
HIV/AIDS Policy Coordinator
330 C Street, SW
Switzer Building, Room 2132
Washington, DC 20201

Dear Kristine:

On behalf of the planning committee for the 6th National HIV/AIDS Update Conference, I want to congratulate you on your appointment by President Clinton to the post of AIDS Policy Coordinator. We believe that the President has made a very wise choice and we are optimistic that you will be able to bring to the national level the kind of leadership that has been missing since the beginning of the epidemic. The National HIV/AIDS Update Conference has been a forum for the exchange of ideas in the HIV epidemic for almost a decade. In fact, you were a plenary speaker at the 4th National Conference in 1991. You may recall that the conference is very broad based. We anticipate that between 2,000 to 3,000 people representing all of the health care disciplines as well as volunteers and persons living with HIV disease will be in attendance this year. The theme for the conference this year is **Learning From the Past: Focusing on the Future**. The Co-Chairs for the conference this year are Raymond Baxter, PhD, Director of the Department of Public Health, San Francisco and Mary Pittman, DrPH, President and CEO, California Association of Public Hospitals, Berkeley, CA. There will be five tracks including Care and Services, Policy and Administration, Prevention and Education, Program Evaluation and Treatment. There will be over 80 worshop/panel presentations, 10 intensive workshops on specifics issues and approximately 10 plenary presentations. The conference is scheduled to be in San Francisco at the San Francisco Civic Center Auditorium October 20-23, 1993. As the Program Director for the conference, I would personally like to invite you to be a plenary speaker at this event. This is the only conference at the national level that involves such a broad based audience of participants. In addition to the represented disciplines, participants come from clinical,

administrative, educational and policy making roles in institutions, community based organizations and from local, state and federal agencies. The conference is a non-profit venture that is funded by a variety of organizations and philanthropies including federal agencies such as the CDC and the U.S. Public Health Service, HRSA AIDS Program. I believe that your participation at this conference would give you the kind of exposure to a wide cross section of providers that could greatly facilitate you in your new role. I hope that you are able to schedule this important event on your calender. If you are able to participate, we have the ability to be very flexible at this time. We will have plenary sessions on Wednesday, Thursday and Friday mornings (October 20, 21 and 22) from 9:00 to 10:30 a.m. In addition we also have a plenary time slot on Friday afternoon, October 22, from 4:30 to 5:30 p.m.

If you are available to participate in the conference please let me know. You can reach me in my San Francisco office at 415/206-1644 or at my University of California, Berkeley office Monday through Thursday at 510/231-5647. You can also write to me at 655 Corbett Avenue # 406, San Francisco, CA 94114.

Again, I want to congratulate you on your appointment and I hope to hear from you soon.

Sincerely,

Cliff Morrison, MS, MN, RN, FAAN
Program Director

cc: conference planning committee

HIV NATIONAL AIDS UPDATE CONFERENCE SAN FRANCISCO

Return

September 7, 1993

Kristine Gebbie, MN, RN, FAAN
AIDS Policy Coordinator
750 17th St. NW, Suite 1060
Washington, D.C. 20503

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Sincerely,

Cliff

Cliff Morrison, MS, MN, RN, FAAN
Program Director

cc: M. Pittman

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Name of preferred hotel_____
Indicate type of room requested ____ Single ____ Double ____ Twin ____ 2-room suite (1 bedroom, 1 parlor)
Arrival date_____ Departure date_____
Please Select Payment Method For One Night Hotel Deposit. .....$_____
❑ Check Enclosed (Payable to selected hotel) *Please check:* ❑ Smoking ❑ Non-smoking
❑ Credit Card ❑ American Express ❑ MasterCard ❑ VISA ❑ Diners Club
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Hi-Vibrations, Musical Presentation

Mary Pittman, Dr. P.H., Closing Remarks
Conference Co-Chair
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Chicago, IL

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HIV

6TH NATIONAL AIDS UPDATE CONFERENCE

OCTOBER 19-23, 1993

SAN FRANCISCO CIVIC CENTER

PRELIMINARY PROGRAM

"Learning from the Past, Focusing on the Future"

6th National HIV/AIDS Update Conference
October 19-23, 1993

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Mary Pittman, Dr. P.H., Closing Remarks
Conference Co-Chair
The Hospital Research & Educational Trust
The American Hospital Association
Chicago, IL

Keep with Health reform Speech materials

[15] From: Carlos Velez 10/18/93 10:00AM (5425 bytes: 109 ln)
To: Alice Litwinowicz, George Walter, Kristine Gebbie, Ben Merrill
Subject: Questions and Answers on Health Care Reform
---------- Message Contents ----------

The following is the summary of Questions and Answers that Phyllis Zucker requested re: Health Care Reform & AIDS.

1. Access

Q. The plan is not clear on the mechanics of how to join alliances, how the alliances would determine what benefits to offer, how much premiums would be and how much would be paid in out-of-pocket expenses. Individuals with very limited income will need special attention, especially those who may need the same range of services that they can obtain under the current system at little-or-no cost. The participants were concerned also about geographic (territories) and non-financial (discrimination) limitations imposed by the plan, and wanted to know what controls would be placed on the states to ensure equal access.

A. The plan will allow all individuals to join. All individuals will receive at minimum benefits package, which will provide for their health care needs. Other than the basic benefits plan, individuals may opt for a higher benefits package, which will increase their level of contributions. Unemployed individuals and persons with disabilities will be able to obtain the higher level of coverage without having to pay more, if the qualify for special coverage under the plan.

The plan will cover all American citizens and resident aliens. In U.S. territories, the plan will provide services through the existing health care structure.

The plan will also provide for redress in situations where individuals do not obtain adequate care or are unfairly excluded from benefit packages.

2. Benefits

Q. The plan is not clear on the range of services which will be available. Many are not covered by the plan or are limited. Critical among these: medications and treatments (especially off-label use); psychosocial support, substance abuse and mental health services for persons living with HIV; ob/gyn; and, non-primary care services (e.g., transportation, food banks,etc.). The participants suggested that many of these services, which are currently being provided by community based organizations (CBOs), may be provided by them under the new plan, and the plan must allow for reimbursement for services even when the providers are not certified.

A. The plan will provide for all necessary medications and treatment for persons living with HIV. All medications that are medically necessary and prescribed by a physician will be paid for, along with a contribution for the individual. The plan will allow for a limitation on the amount of

personal contributions, based on the ability to pay.

The plan will also allow for support services to continue to be provided by community based organizations. The transition to Health Care Reform will allow for a continuation of current programs, which will not be eliminated outright.

3. Confidentiality

Q. The plan will provide for integration of medical information. The participants wanted to stress that confidentiality should be paramount, even where there is intent to aggregate information for surveillance and epidemiological purposes.

A. The Health Insurance Card will contain only the information necessary to include all individuals in their respective plans and to ensure access. The plan will also provide for limited access to all health care files to service providers.

4. Transition

Q. The participants communicated their desire for an extensive transition plan that would allow for current categorical programs to continue to serve the needs of individuals and communities. Participants also indicated that many of these categorical programs may need to continue after HCR is instituted, but that the plan will have to coordinate current categorical programs with the services being provided by the alliances.

A. The plan will include extensive transition mechanisms that will allow for a continuation of existing services for persons living with HIV/AIDS.

5. Non-financial Barriers

Q. Participants indicated that HCR addresses the financial barriers to care, but that the plan makes no specific provision to eliminate discrimination based on race, ethnic background, sexual orientation, age or gender. The plan must allow for service providers to learn about cultural competency and for individuals to learn how to access the system better. The system must also indicate what redress individuals will have in situations where they do not obtain the necessary services.

A. The plan will provide coverage for all Americans, and will provide for access for communities that have been traditionally underserved. The plan will allow for all individuals to participate in alliances in their communities and to obtain the best health care possible.

NATIONAL HEALTH SECURITY ACT: CONSIDERATION FOR HIV/AIDS CARE

An estimated one million people are infected with HIV in the United States. While the epidemic has continued to affect the gay community, it is also increasing disproportionately among heterosexuals, persons of color, women, and adolescents. Providing comprehensive health and prevention services for populations at risk is essential, and will be accomplished under health care reform.

- First and foremost, the guarantee of comprehensive health coverage with no lifetime limits will provide Americans with serious, chronic disease the security of knowing that their medical needs will always be met. Some particular areas of importance for AIDS patients included in the benefit package are coverage for prescription drugs, home-care, long-term care, and reasonable limits on how much patients can be required to spend out-of-pocket each year.

- Persons with HIV or AIDS will always be able to buy this universal coverage at any time and at the same community rates paid by everyone else within a health alliance. There will be no pre-existing condition exclusions, and the amount of premiums paid by individuals will not be based on their health status.

In many ways, the way AIDS and other serious chronic diseases will be accommodated will demonstrate the National Health Security system's flexibility in treatment decisions, and in portability within the larger health care system.

The National Health Security program will build on the existing structure and spirit of Ryan White programs for high HIV prevalence cities and states, and community-based clinics. Outpatient care, prevention, and treatment of substance abusers, and specialty sites developed for the HIV-infected community will be expanded.

- The National Health Security Act does not pretend that health reform alone will provide all that AIDS patients require. The proposal includes expanded funding for research, education, and prevention efforts related to the spread of HIV and continued funding for the Ryan White Care Act.

- Providing quality care for AIDS patients requires a complex mix of primary care and specialized services, with the capacity to respond quickly and with flexibility to emerging medical developments.

- AIDS is infectious, and people living with the HIV virus or AIDS frequently develop other infectious diseases such as tuberculosis. The clinical treatment of AIDS encompasses several important public health objectives, chief among them the need to refer infected individuals into care programs as early as possible. The Public Health Initiatives component of the health care reform will devote new resources to these purposes.

- The National Health Security Act's public health initiatives will build new capacities and strengthen the core public health functions throughout the nation, enabling communities to reduce the spread of the HIV epidemic.

From the Office of the National AIDS Policy Coordinator

NOTE TO: Kristine M. Gebbie, RN, MN

FROM: Carlos Velez and Alice Litwinowicz

SUBJECT: Health Care Reform Meeting at NORA, October 18, 1993 SUMMARY

ATTENDANCE: Michael Lux, Special Assistant to the President, Liaison; Carlos Velez, Alice Litwinowicz, Office of the White House AIDS Policy Coordinator; Judy Feder, Principal Deputy Assistant Secretary for Planning and Evaluation, HHS; Clifford Gaus and Lisa Simpson, Office of the Assistant Secretary for Health, HHS. Representatives from all of the NORA organizations.

Overall, this meeting went very well for a couple of reasons. First, the Department representatives had received our two previous meeting summaries (with the outside groups and PWAs), the health care reform questions and answers and were prepared to discuss HIV/AIDS issues and health care reform. Second, it was important that both Mike Lux and Judy Feder were there. While Mike gave a broad overview, he pointed out the importance of not losing sight of the big picture to pass health care reform. Judy Feder provided creditability by taking the time to attend and expertly responded to the questions.

Mike Lux reported there will be a formal ceremony with the Hill next week to introduce health care reform. He asked that the groups represented work with the Administration as the bill goes to Congress. While he encouraged them to keep working on all of the details, he also advised that they aggressively continue to support the bill, which provide for have universal coverage, choice of physicians, as well as addressing quality of care.

Judy Feder seconded that theme by stating that the groups should "focus our eye on the ball and not shoot ourselves in the foot."

ACCESS

Q. Managed care as currently defined in the plan raises questions as to the available legal course of action if there are civil rights and quality concerns.

A. Judy Feder responded that the plans must have utilization control as well as a grievance mechanism internal to the plan. There will be an ombudsman, who will not necessarily be the final means of redress, but who will facilitate the process for the individual members. She also spoke of the need to stress the application of national standards to the services to be provided. Finally, she indicated that they are envisioning a process that will allow recourse to other means of appeals (courts and a State administrative system

and a Federal board). This is also being currently examined.

Q. **Specifically, how will civil rights issues be enforced?**

A. The Department is looking at the language to make sure it is very strong. It depends somewhat on the remedies and the assistance of the plan with minimal input from the Federal board.

Q. **We must ensure that managed care provides appropriate services. Currently, managed care cannot meet the service needs and barriers remain. Can you assure us that fee-for-service will be maintained? What about the waiver for fee-for-service?**

A. This has been clarified in the statutory language.

Judy Feder did warn that care must be taken calling this a "managed care" problem when it really appears to be a provider problem. If providers will not join managed care, there is probably a shortage under fee-for-service as well.

Q. **If a plan is filled, how will the random selection work? For example, where there is a need for an AIDS specialists? This is a problem where the expertise is limited situation.**

A. We will watch very closely to determine how plans declare themselves "full" and why this expertise is not available.

Q. **What about an undocumented worker? What is the connection between health care card and the immigration card? An example was presented of a couple in Wisconsin who went to be tested for HIV; they tested positive and the immigration officials were called by the hospital. Now they have gone underground. How will this work under health care reform?**

A. The health care is explicitly for access to health insurance and NOT to enforcement by immigration and naturalization. The health care card is only to indicate which individuals are in the system, but does not require specific identity information based on residency. We are also working on using identifiers other than standard information on the card.

Q. **Define consumer involvement in the National Health Board, especially for vulnerable populations like gays and lesbians?**

A. The Board is based on expertise - essentially being a "board of excellence," rather than based on particular representation of community groups or professional organizations. The alliance holds health plan, employers and consumers, is emphasized in the language as more of "who

cannot be on the board." It is non-discriminatory language.

Q. **Followup to number 6, that the language is vague and HIV are a "criminalized" population and a lot of time the State does not recognize homosexuals, drug users, surrogates are not good enough.**

A. We will continue to look at the process.

Q. **How will access to services (this applies to undocumented aliens as well) work with HIV testing and surveillance? What types of anonymous services are there? How are they financed and reimbursed when the services are confidential or anonymous?**

A. Public health grants would continue to serve entire population regardless of resident status. There will be no linkage of counseling and testing.

However, the offset question remains. We need to track and are considering unique identifiers without names for those outside plan services. Those receiving services outside the plan need protections.

Q. **Affordability issues are of great concern. The cap is good; how will the subsidy work for persons under Medicaid getting SSI? There are no definitions for disability in the plan? It is used in different ways? Eligibles for current programs, Medicaid/SSI, will have a reduction in curren services.**

A. This is an area we looked at. While the whole policy is subject to re-evaluation- we are contemplating definitions that will provide the the widest possible range of coverage.

Q. **How will the subsidy for the premium work? It is an ongoing issue and continuing debate.**

A. We have a commitment for a quality package and carry the guarantee for fee-for-service.

Q. **Twenty percent for cost sharing is high cost-sharing is a lot of money for a person making minimum wage?**

A. Whether fee-for-service or network plans, the September 7 draft has a subsidy of 150% of the Federal poverty level for the 20%. There may be refinements of this.

Q. **Define "subsidy"? It does NOT mean "you will not have to pay" but rather you will have to pay your share.**

A. We contemplated a "sliding fee scale" but were not explicit on its nature.

BENEFITS

Q. Will providers be pre-certified? Yes, by the State to participate in the alliance.

A. Quality inside the plan will be measured by a number of performance indicators. A first cut at the "report cards" includes how acute and chronic conditions are handled, plus a consumer view. The disenrollment from plans will also be examined.

Q. What Department will actually enforce Department of Health and Human Services or Department of Labor?

A. The responsibilities will be allocated, Department of Labor will handle the employer mandates in the plan and Health and Human Services the audits. It will be a coordinated response.

Q. What about off-label use of drugs for persons 65 and under? How is routine care in clinical trials defined?

A. Off-label drugs will be covered. The Board will provide coverage guidance.

Q. Can you explain the transition of Ryan White CARE Act?

A. Ryan White remains in place, remaining true to President's commitment to full funding. We are requesting increases in the program. On the issue of offsets, we're still working down to the wire on the nature and amount replaced from other plans to Ryan White programs. Whether it will be federal funds commensurate with services, the policy is NOT settled. The question also involves whether we free up federal funds to be available to specific grantees or return the money to the federal budget to fund more projects.

Q. How about the 40 to 60 percent cuts we have heard about? The issue has been resolved.

A. There is a range of disagreements, however; everyone agrees there will be federal offsets commensurate with phase-in of health care reform.

Q. Many persons with disabilities are excited about the long term care benefits and prescription drug benefits in the plan. Will the Administration support these benefits when the plan is introduced on the Hill?

A. The advocates would like to see these improvements; but these benefits are "standing out there" beyond what is in many health plans. How large this benefit is what is really at risk. The Administration hopes the groups helps in assisting to keep the benefits in the plan.

Mike Lux pointed out that unless the commitment is apparent with the advocates endorsing; prescription drugs, long term care and disability benefits are all at risk. Especially troublesome is persons on the Hill against the plan keep pointing out that these benefits are "new entitlements or new benefits." We need help keeping the benefits in as well as not prioritizing one over another.

Q. **What about pap smears in the plan? Vaginal health has been under-researched at best and is especially important to women with HIV/AIDS. Why are there a minimum number?**

A. This addresses the periodicity of the screens in the plan, which is "no-cost" screening versus necessary or appropriate covered care, which the Board will determine. In other words, it is always covered, the question is really when is it free. In general, in designing the plan, we have looked at science and put together what is reasonable. However, it will be regularly reviewed. Again the principles of the plan are important; specifics are even more important.

Q. **Like the recent New York Times article regarding children, what will happen to the benefits that many persons with HIV/AIDS who receive disability?**

A. The issue really involves "wrap-around" benefits. The September 7 draft of the plan indicated that non-cash eligibles would not be covered. It is a matter of concern and we will press to improve. It is a potential gap to close when legislation is introduced.

Judy Feder continued: this issue is really one of the adequacy of protection and how we sustain current law. It is the cumbersome nature of eligibility. The States want administrative flexibility in this area; while others have argued that is "crazy" and this should not be block grants. While this is a continuing tension, we must make the protection administratively feasible manner.

Q. **Even with the $1500 limit, the plan provides fewer services than people want?**

A. Any time you have a commitment to comprehensive benefit there is always a risk. Even internally there are uncertainties about the benefits and costs, which hikes premiums. Plus whenever it reaches the Hill we are not pricing but the Congressional Budget Office is.

Q. **The benefit for mental health services appears to be more for mental health than for persons with substance abuse problems. For example, for chronically mentally ill, the benefit is good. For a substance abuser, it pays for methadone maintenance; which is not equivalent services. If you reduce Ryan White and block grants to "offset" these**

services provided in the long term low cost community health setting. What are you planning to do?

A. We need to protect the community substance abuse and improve the medical management of substance abuse. Again, this is what may be seen as a new entitlement, which relates to the need to keep costs under control. We will have to look at how to provide continued services through some of the existing structures to fill in this gap.

Q. We understand there is a way to game the system for mental health services, what is that about? Currently, under Medicare, beneficiaries cost share 20/80, with Medicare picking up the tab for the 80%. If a physician accepts the 80% as full payment the person will not have pay the 20%.

A. We need to carefully look at the language on this and are working with new language. There will be some disparity in the system, regardless of how we structure it. We are attempting to do is provide the widest possible coverage.

NON-FINANCIAL BARRIERS

Q. Health care reform and AIDS - do not allow the political right to use this either rhetorically or politically in this debate - confront them directly -- often and strong. This morning's Roll Call newspaper quoted a Hill member that would not hire homosexuals and used the excuse of "unit cohesion." Do not allow this. (More of a comment than a question.)

A. Thank you for that advice and important reminder.

HIV/AIDS

SURVEILLANCE REPORT — Second Quarter Edition

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

Contents

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[3]See technical notes.

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

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

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

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

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

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

[2]See technical notes.

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

[4]Includes 571 men whose race/ethnicity is unknown.

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

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

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

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

[2]See technical notes.

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

[4]Includes 71 women whose race/ethnicity is unknown.

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

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

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

[1]See technical notes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Definition category	Period of diagnosis: Before June 1989 No.	(%)	July 1989–June 1990 No.	(%)	July 1990–June 1991 No.	(%)	July 1991–June 1992 No.	(%)	July 1992–June 1993 No.	(%)	Cumulative total[4] No.	(%)
Pre-1987 definition	99,383	(80)	28,311	(66)	28,538	(60)	28,074	(50)	14,883	(33)	199,189	(63)
1987 definition	23,648	(19)	13,158	(31)	15,202	(32)	17,087	(31)	10,504	(24)	79,600	(25)
1993 definition[2]	1,067	(1)	1,518	(4)	3,699	(8)	10,841	(19)	19,224	(43)	36,601	(12)
Severe HIV-related immunosuppression[3]	*766*		*1,353*		*3,118*		*9,740*		*17,812*		*32,846*	
Pulmonary tuberculosis	*263*		*239*		*534*		*955*		*1,013*		*3,099*	
Recurrent pneumonia	*29*		*26*		*43*		*129*		*366*		*593*	
Invasive cervical cancer	*11*		*4*		*8*		*26*		*40*		*89*	
Total	**124,098**	**(100)**	**43,087**	**(100)**	**47,439**	**(100)**	**56,002**	**(100)**	**44,611**	**(100)**	**315,390**	**(100)**

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

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

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

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

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

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

[1]Includes 23 adult/adolescents who developed AIDS after receiving blood screened negative for HIV antibody.

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

[3]"Other" refers to 8 health-care workers who developed AIDS after occupational exposure to HIV-infected blood, as documented by evidence of seroconversion; to 2 patients who developed AIDS after exposure to HIV within the health-care setting, as documented by laboratory studies; to 1 person who acquired HIV infection perinatally and was diagnosed with AIDS after age 13; and to 1 person with intentional self-inoculation of blood from an HIV-infected person.

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

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

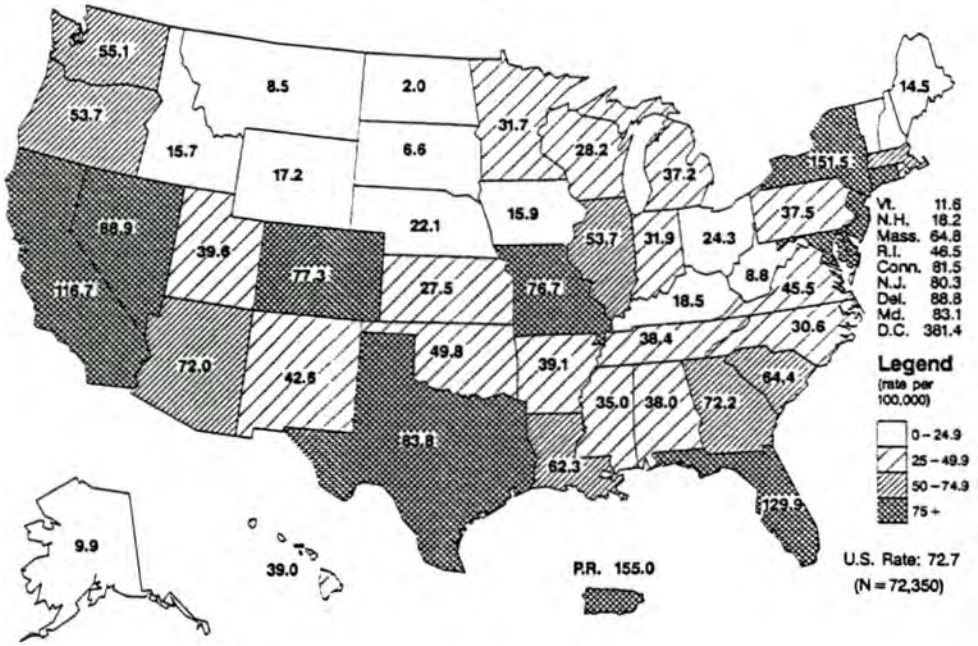


Figure 2. Female adult/adolescent AIDS annual rates per 100,000 population, for cases reported July 1992 through June 1993, United States

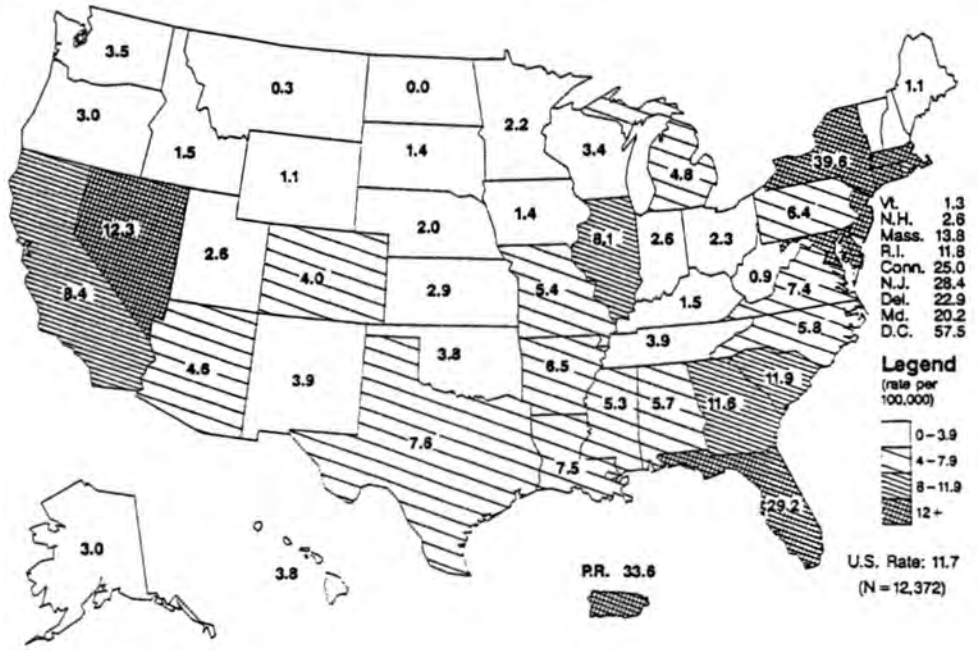
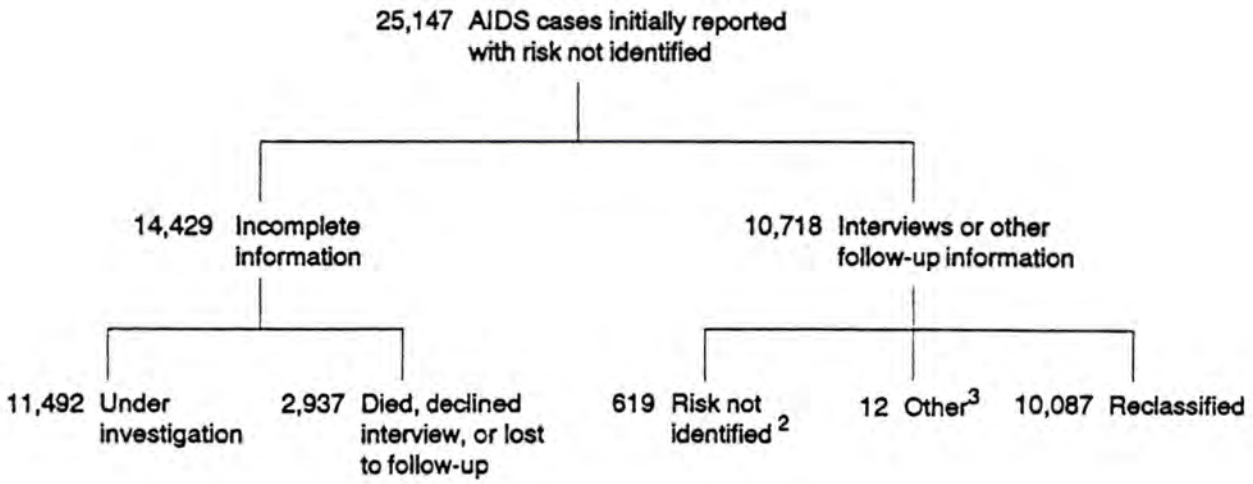


Figure 3. Male adult/adolescent AIDS cases reported July 1992 through June 1993, United States

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

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

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



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

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

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

Technical notes

Surveillance and reporting of AIDS

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

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

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

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

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

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

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

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

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

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

Exposure categories

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

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

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

Rates

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

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

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