



6/4/93

~~Executive~~ ^{Special} Assistant
to the Secretary
Washington, D.C. 20201

Carol -

Here is some information on AIDS
as promised:

- 1) HIV/AIDS Surveillance Report
from CDC. This includes numbers
of cases by state, city, race, gender,
sexual orientation, age, etc.;
- 2) List of cumulative AIDS cases in
cities over 500,000, excluding
the top 20;
- 3) National Commission on AIDS
report on AIDS in rural America;
- 4) Information on AIDS among
veterans (just received today).

Let me know if there's anything
else you need.

Patsy Fleming
690-5400

P.S. I'm sure graduation was wonderful!

HIV/AIDS

SURVEILLANCE REPORT

First Quarter Edition

U.S. AIDS cases reported through March 1993

Issued May 1993, Vol. 5, No. 1

Contents

Notice to readers	2
Table 1. AIDS cases and annual rates per 100,000 population, by state	3
Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population	4
Table 3. AIDS cases by age group, exposure category, and sex	6
Table 4. Male adult/adolescent AIDS cases by exposure category and race/ethnicity	7
Table 5. Female adult/adolescent AIDS cases by exposure category and race/ethnicity	8
Table 6. Pediatric AIDS cases by exposure category and race/ethnicity	9
Table 7. AIDS cases in adolescents and adults under age 25, by sex and exposure category	10
Table 8. AIDS cases by sex, age at diagnosis, and race/ethnicity	11
Table 9. AIDS cases, case-fatality rates, and deaths, by half-year and age group	12
Table 10. AIDS cases by year of diagnosis and definition category	13
Table 11. Health-care workers with documented and possible occupationally acquired AIDS/HIV infection, by occupation	13
Table 12. Adult/adolescent AIDS cases by single and multiple exposure categories	14
Figure 1. Male adult/adolescent AIDS annual rates per 100,000 population	15
Figure 2. Female adult/adolescent AIDS annual rates per 100,000 population	15
Figure 3. Male adult/adolescent AIDS cases	16
Figure 4. Female adult/adolescent AIDS cases	16
Figure 5. Pediatric AIDS cases	17
Figure 6. Results of investigations of AIDS cases with risk not identified	17
Technical notes	18

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: This issue of the *Report* initiates the following: 1) three months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents are included in the report; 2) Table 2 uses revised Metropolitan Statistical Area definitions issued in December 1992; 3) several tables and figures have been expanded to provide separate tabulations for adult/adolescent males and females and to provide additional tabulations for the most recent 12-month period; and 4) volume and issue numbers have been added to the title page. See technical notes for additional information.

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

Suggested Citation: Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, 1993;5(no. 1):[inclusive page numbers].

Centers for Disease Control and Prevention William L. Roper, M.D., M.P.H.
Director

James W. Curran, M.D., M.P.H.
Associate Director (HIV/AIDS)

National Center for Infectious Diseases James M. Hughes, M.D.
Director

Division of HIV/AIDS Harold W. Jaffe, M.D.
Director

Surveillance Branch John W. Ward, M.D.
Chief

Reporting and Analysis Section Patricia L. Fleming, Ph.D.
Acting Chief

Russ P. Metler, R.N., M.S.P.H.
Surveillance Report Coordinator

Statistics and Data Management Branch W. Meade Morgan, Ph.D.
Chief

Xenophon M. Santas
Assistant Chief for Operations

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 1-800-456-5231. 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 April 1991 through March 1992, April 1992 through March 1993¹; and cumulative totals, by state and age group, through March 1993²

State of residence	Apr. 1991– Mar. 1992		Apr. 1992– Mar. 1993		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Alabama	404	9.9	667	16.1	2,013	43	2,056
Alaska	22	3.9	15	2.5	136	3	139
Arizona	312	8.3	1,080	28.2	2,704	13	2,717
Arkansas	199	8.4	415	17.3	1,093	18	1,111
California	8,501	28.0	12,916	41.7	53,516	335	53,851
Colorado	439	13.0	1,010	29.2	3,143	19	3,162
Connecticut	542	16.5	868	26.3	3,330	91	3,421
Delaware	88	12.9	266	38.3	681	7	688
District of Columbia	738	123.3	895	151.8	4,403	69	4,472
Florida	5,590	42.1	7,655	56.2	27,692	684	28,376
Georgia	1,470	22.2	2,277	33.6	8,261	80	8,341
Hawaii	191	16.8	105	9.0	967	7	974
Idaho	34	3.3	62	5.8	178	2	180
Illinois	1,681	14.6	2,392	20.5	8,970	122	9,092
Indiana	404	7.2	531	9.4	2,010	15	2,025
Iowa	96	3.4	204	7.3	539	5	544
Kansas	165	6.6	306	12.2	934	5	939
Kentucky	161	4.3	246	6.6	953	12	965
Louisiana	882	20.7	914	21.3	4,215	61	4,276
Maine	56	4.5	77	6.2	362	2	364
Maryland	997	20.5	1,521	30.8	5,757	132	5,889
Massachusetts	969	16.2	1,443	24.1	5,872	112	5,984
Michigan	816	8.7	1,212	12.8	4,121	61	4,182
Minnesota	197	4.4	520	11.6	1,574	12	1,586
Mississippi	212	8.2	341	13.1	1,261	20	1,281
Missouri	685	13.3	1,709	32.9	4,349	31	4,380
Montana	25	3.1	31	3.8	116	1	117
Nebraska	63	4.0	135	8.4	394	3	397
Nevada	247	19.2	442	32.4	1,366	13	1,379
New Hampshire	47	4.3	89	8.1	337	6	343
New Jersey	2,318	29.9	2,910	37.4	15,759	412	16,171
New Mexico	111	7.2	269	17.0	751	2	753
New York	7,731	42.8	11,032	60.9	53,962	1,192	55,154
North Carolina	616	9.1	713	10.4	3,034	72	3,106
North Dakota	1	0.2	4	0.6	29	—	29
Ohio	663	6.1	951	8.6	4,080	61	4,141
Oklahoma	256	8.1	593	18.5	1,573	15	1,588
Oregon	287	9.8	629	21.0	1,978	9	1,987
Pennsylvania	1,214	10.1	1,674	13.9	7,519	111	7,630
Rhode Island	101	10.1	164	16.3	649	9	658
South Carolina	374	10.5	862	23.7	2,342	32	2,374
South Dakota	7	1.0	23	3.2	53	2	55
Tennessee	393	7.9	681	13.5	2,229	22	2,251
Texas	3,210	18.5	5,482	31.0	20,462	200	20,662
Utah	146	8.2	264	14.5	752	16	768
Vermont	17	3.0	31	5.4	127	2	129
Virginia	627	10.0	1,201	18.8	4,009	75	4,084
Washington	591	11.8	563	10.9	3,538	18	3,556
West Virginia	69	3.8	47	2.6	301	4	305
Wisconsin	207	4.2	234	4.7	1,124	11	1,135
Wyoming	12	2.6	33	7.1	87	—	87
U.S. total	45,184	17.9	68,704	26.9	275,605	4,249	279,854
Guam	2	1.5	2	1.5	12	—	12
Pacific Islands, U.S.	—	—	1	0.9	3	—	3
Puerto Rico	1,414	39.8	2,447	68.2	9,081	226	9,307
Virgin Islands, U.S.	22	21.5	42	40.8	139	5	144
Total	46,622	18.2	71,196	27.4	284,840	4,480	289,320

¹Includes 3 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²During the first quarter of 1993, CDC received reports of 35,779 cases and 11,471 deaths among adults/adolescents and 219 cases and 103 deaths among children.

Table 2. AIDS cases and annual rates per 100,000, population, by metropolitan area with 500,000 or more population, reported April 1991 through March 1992, April 1992 through March 1993¹; and cumulative totals, by area and age group, through March 1993

Metropolitan area of residence ²	Apr. 1991– Mar. 1992		Apr. 1992– Mar. 1993		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Akron, Ohio	36	5.4	42	6.3	195	—	195
Albany-Schenectady, N.Y.	91	10.5	108	12.3	506	12	518
Albuquerque, N.M.	69	11.5	163	26.5	441	1	442
Allentown, Pa.	33	5.5	58	9.5	236	4	240
Ann Arbor, Mich.	38	7.6	37	7.3	157	4	161
Atlanta, Ga.	1,093	35.8	1,547	49.2	6,135	39	6,174
Austin, Tex.	225	25.7	462	51.2	1,452	13	1,465
Bakersfield, Calif.	61	10.8	71	12.0	249	3	252
Baltimore, Md.	561	23.2	971	39.7	3,499	104	3,603
Birmingham, Ala.	115	13.5	207	24.1	615	11	626
Boston, Mass.	854	15.1	1,238	22.0	5,252	97	5,349
Buffalo, N.Y.	98	8.2	72	6.0	493	5	498
Charleston, S.C.	78	14.9	176	32.6	501	3	504
Charlotte, N.C.	100	8.4	146	12.0	582	9	591
Chicago, Ill.	1,461	19.5	2,094	27.6	7,914	109	8,023
Cincinnati, Ohio	112	7.3	148	9.5	646	9	655
Cleveland, Ohio	206	9.3	291	13.1	1,152	23	1,175
Columbus, Ohio	123	9.0	197	14.1	862	6	868
Dallas, Tex.	818	29.9	1,574	56.2	5,258	24	5,282
Dayton, Ohio	65	6.8	84	8.7	403	8	411
Denver, Colo.	368	22.1	838	48.9	2,595	14	2,609
Detroit, Mich.	625	14.6	793	18.4	2,872	45	2,917
El Paso, Tex.	31	5.1	77	12.2	241	1	242
Fort Lauderdale, Fla.	938	72.9	906	68.7	4,469	103	4,572
Fort Worth, Tex.	192	13.8	237	16.6	1,094	12	1,106
Fresno, Calif.	79	10.1	112	13.9	407	4	411
Gary, Ind.	39	6.4	52	8.4	192	1	193
Grand Rapids, Mich.	50	5.2	101	10.4	290	2	292
Greensboro, N.C.	114	10.7	120	11.1	520	11	531
Greenville, S.C.	47	5.6	169	19.8	391	1	392
Harrisburg, Pa.	43	7.2	56	9.3	269	6	275
Hartford, Conn.	163	14.5	342	30.4	1,087	18	1,105
Honolulu, Hawaii	138	16.2	82	9.5	725	5	730
Houston, Tex.	1,183	34.4	2,019	56.8	8,181	80	8,261
Indianapolis, Ind.	196	13.9	224	15.7	949	4	953
Jacksonville, Fla.	270	28.9	863	89.8	1,910	50	1,960
Kansas City, Mo.	276	17.2	753	46.4	2,065	7	2,072
Knoxville, Tenn.	35	5.8	39	6.4	184	2	186
Las Vegas, Nev.	195	21.1	342	34.3	1,053	13	1,066
Little Rock, Ark.	70	13.5	172	32.8	437	8	445
Los Angeles, Calif.	3,130	34.9	4,344	47.8	18,760	140	18,900
Louisville, Ky.	81	8.5	112	11.6	406	7	413
Memphis, Tenn.	129	12.6	260	25.2	763	6	769
Miami, Fla.	1,976	100.0	1,707	84.6	8,061	234	8,295
Milwaukee, Wis.	107	7.4	130	8.9	614	7	621
Minneapolis-Saint Paul, Minn.	169	6.5	459	17.5	1,398	9	1,407
Nashville, Tenn.	120	12.0	212	20.8	717	9	726
New Haven, Conn.	338	20.7	463	28.3	1,981	70	2,051
New Orleans, La.	518	40.0	467	35.8	2,534	34	2,568
New York, N.Y. ³	8,947	52.7	12,669	74.5	63,021	1,495	64,516
<i>Bergen-Passaic, N.J.</i>	<i>268</i>	<i>20.9</i>	<i>346</i>	<i>27.0</i>	<i>1,982</i>	<i>50</i>	<i>2,032</i>
<i>Jersey City, N.J.</i>	<i>434</i>	<i>78.4</i>	<i>344</i>	<i>62.1</i>	<i>2,556</i>	<i>69</i>	<i>2,625</i>
<i>Middlesex, N.J.</i>	<i>199</i>	<i>19.4</i>	<i>285</i>	<i>27.6</i>	<i>1,337</i>	<i>30</i>	<i>1,367</i>
<i>Monmouth-Ocean, N.J.</i>	<i>141</i>	<i>14.2</i>	<i>278</i>	<i>27.6</i>	<i>1,108</i>	<i>33</i>	<i>1,141</i>
<i>Nassau-Suffolk, N.Y.</i>	<i>306</i>	<i>11.7</i>	<i>398</i>	<i>15.1</i>	<i>2,376</i>	<i>60</i>	<i>2,436</i>
<i>Newark, N.J.</i>	<i>956</i>	<i>52.5</i>	<i>1,084</i>	<i>59.6</i>	<i>6,429</i>	<i>179</i>	<i>6,608</i>
<i>New York, N.Y. (1983 MSA definition)</i>	<i>6,641</i>	<i>77.7</i>	<i>9,921</i>	<i>115.9</i>	<i>47,188</i>	<i>1,071</i>	<i>48,259</i>
Norfolk, Va.	133	9.1	248	16.7	865	22	887
Oakland, Calif.	481	22.8	1,027	48.0	3,691	25	3,716

Table 2. AIDS cases and annual rates per 100,000, population, by metropolitan area with 500,000 or more population, reported April 1991 through March 1992, April 1992 through March 1993¹; and cumulative totals, by area and age group, through March 1993 — Continued

Metropolitan area of residence ²	Apr. 1991– Mar. 1992		Apr. 1992– Mar. 1993		Cumulative totals		Total
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	
Oklahoma City, Okla.	103	10.6	278	28.3	745	1	746
Omaha, Neb.	46	7.1	104	15.8	287	1	288
Orange County, Calif.	645	26.4	429	17.3	2,438	16	2,454
Orlando, Fla.	391	30.8	838	63.8	2,060	37	2,097
Philadelphia, Pa.	934	18.9	1,293	26.1	5,760	77	5,837
Phoenix, Ariz.	237	10.4	843	36.1	2,045	9	2,054
Pittsburgh, Pa.	120	5.0	164	6.8	902	4	906
Portland, Oreg.	237	15.1	566	34.8	1,716	6	1,722
Providence, R.I.	94	10.3	154	16.8	610	8	618
Raleigh-Durham, N.C.	140	15.9	144	15.8	684	17	701
Richmond, Va.	136	15.4	281	31.3	832	12	844
Riverside-San Bernardino, Calif.	385	14.1	794	27.8	2,268	25	2,293
Rochester, N.Y.	92	8.6	95	8.8	557	8	565
Sacramento, Calif.	261	18.8	335	23.3	1,229	14	1,243
Saint Louis, Mo.	371	14.8	791	31.4	2,053	21	2,074
Salt Lake City, Utah	125	11.3	240	21.2	668	12	680
San Antonio, Tex.	217	16.1	308	22.5	1,350	14	1,364
San Diego, Calif.	573	22.5	1,167	44.9	4,232	30	4,262
San Francisco, Calif.	1,994	122.9	3,430	209.0	15,303	26	15,329
San Jose, Calif.	172	11.4	284	18.8	1,199	10	1,209
San Juan, P.R.	842	45.4	1,669	89.0	5,876	147	6,023
Sarasota, Fla.	124	24.7	117	22.8	485	10	495
Scranton, Pa.	23	3.6	48	7.5	167	3	170
Seattle, Wash.	429	20.6	433	20.4	2,673	10	2,683
Springfield, Mass.	98	16.3	177	29.5	501	15	516
Stockton, Calif.	49	9.9	46	9.1	231	8	239
Syracuse, N.Y.	57	7.6	66	8.7	352	6	358
Tacoma, Wash.	38	6.3	38	6.1	237	8	245
Tampa-Saint Petersburg, Fla.	517	24.6	995	46.6	3,104	50	3,154
Toledo, Ohio	29	4.7	72	11.7	230	3	233
Tucson, Ariz.	56	8.3	181	26.4	492	3	495
Tulsa, Okla.	89	12.3	185	25.1	476	5	481
Ventura, Calif.	62	9.2	101	14.7	323	1	324
Washington, D.C.	1,352	31.5	1,771	40.6	7,936	115	8,051
West Palm Beach, Fla.	408	46.0	733	80.6	2,568	98	2,666
Wichita, Kansas	60	12.2	86	17.2	252	2	254
Wilmington, Del.	64	12.3	193	36.3	500	6	506
Youngstown, Ohio	17	2.8	22	3.6	130	—	130
Metropolitan areas with 500,000 or more population	39,005	24.8	59,552	37.4	242,761	3,767	246,528
Metropolitan areas with 50,000 to 499,999 population	4,851	10.4	7,532	15.9	27,033	447	27,480
Non-metropolitan areas	2,558	4.9	3,915	7.4	14,079	246	14,325
Total⁴	46,622	18.2	71,196	27.4	284,840	4,480	289,320

¹ Includes 3 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

² Based on Metropolitan Statistical Areas (MSA) revised December 1992. See technical notes.

³ The current MSA definition for New York City includes several formerly independent MSAs (listed in italics). Because of the epidemiologic significance of these areas, case counts and rates will continue to be listed in this table. See technical notes.

⁴ Totals include 987 persons whose area of residence is unknown.

Table 3. AIDS cases by age group, exposure category, and sex, reported April 1991 through March 1992, April 1992 through March 1993¹; and cumulative totals, by age group and exposure category, through March 1993, United States

Adult/adolescent exposure category	Males				Females				Totals					
	Apr. 1991-Mar. 1992		Apr. 1992-Mar. 1993		Apr. 1991-Mar. 1992		Apr. 1992-Mar. 1993		Apr. 1991-Mar. 1992		Apr. 1992-Mar. 1993		Cumulative total ²	
	No.	(%)	No.	(%)										
Men who have sex with men	24,997	(62)	35,106	(58)	—	—	24,997	(54)	35,106	(50)	160,345	(56)		
Injecting drug use	8,393	(21)	12,879	(21)	2,797	(48)	4,359	(44)	11,190	(24)	17,238	(24)	65,778	(23)
Men who have sex with men and inject drugs	2,608	(7)	3,864	(6)	—	—	2,608	(6)	3,864	(5)	18,041	(6)		
Hemophilia/coagulation disorder	333	(1)	696	(1)	9	(0)	18	(0)	342	(1)	714	(1)	2,519	(1)
Heterosexual contact:	1,407	(4)	2,400	(4)	2,264	(39)	3,672	(37)	3,671	(8)	6,072	(9)	19,178	(7)
Sex with injecting drug user	611		911		1,335		1,793		1,946		2,704		9,676	
Sex with bisexual male	—		—		156		265		156		265		980	
Sex with person with hemophilia	5		4		19		39		24		43		154	
Born in Pattern-II ³ country	318		409		176		222		494		631		3,251	
Sex with person born in Pattern-II country	20		28		23		19		43		47		234	
Sex with transfusion recipient with HIV infection	29		35		54		68		83		103		370	
Sex with HIV-infected person, risk not specified	424		1,013		501		1,266		925		2,279		4,513	
Receipt of blood transfusion, blood components, or tissue ⁴	428	(1)	550	(1)	263	(5)	359	(4)	691	(2)	909	(1)	5,384	(2)
Other/risk not identified ⁵	1,898	(5)	5,071	(8)	488	(8)	1,450	(15)	2,386	(5)	6,521	(9)	13,595	(5)
Adult/adolescent subtotal	40,064	(100)	60,566	(100)	5,821	(100)	9,858	(100)	45,885	(100)	70,424	(100)	284,840	(100)
Pediatric (<13 years old) exposure category														
Hemophilia/coagulation disorder	26	(6)	16	(4)	—		2	(0)	26	(4)	18	(2)	194	(4)
Mother with/at risk for HIV infection:	352	(87)	322	(88)	307	(92)	385	(94)	659	(89)	707	(92)	3,887	(87)
Injecting drug use	144		107		133		134		277		241		1,768	
Sex with injecting drug user	60		52		56		61		116		113		761	
Sex with bisexual male	9		3		5		8		14		11		83	
Sex with person with hemophilia	5		1		—		3		5		4		20	
Born in Pattern-II country	22		21		15		15		37		36		293	
Sex with person born in Pattern-II country	1		3		1		3		2		6		20	
Sex with transfusion recipient with HIV infection	1		1		2		2		3		3		18	
Sex with HIV-infected person, risk not specified	34		25		17		52		51		77		234	
Receipt of blood transfusion, blood components, or tissue	11		16		6		10		17		26		90	
Has HIV infection, risk not specified	65		93		72		97		137		190		600	
Receipt of blood transfusion, blood components, or tissue	22	(5)	13	(4)	15	(4)	7	(2)	37	(5)	20	(3)	315	(7)
Risk not identified	3	(1)	13	(4)	12	(4)	14	(3)	15	(2)	27	(3)	84	(2)
Pediatric subtotal	403	(100)	364	(100)	334	(100)	408	(100)	737	(100)	772	(100)	4,480	(100)
Total	40,467		60,930		6,155		10,266		46,622		71,196		289,320	

¹ Includes 3 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 adults/adolescents and 2 children developed AIDS after receiving blood screened negative for HIV antibody. Five additional adults developed AIDS after receiving tissue or organs from HIV-infected donors. Two of the 5 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 April 1992 through March 1993¹, and cumulative totals, through March 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Apr. 1992- Mar. 1993		Cumulative total		Apr. 1992- Mar. 1993		Cumulative total		Apr. 1992- Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	23,211	(74)	110,868	(79)	7,084	(38)	29,108	(42)	4,341	(43)	18,438	(46)
Injecting drug use	2,855	(9)	10,319	(7)	6,319	(34)	24,231	(35)	3,638	(36)	15,200	(38)
Men who have sex with men and inject drugs	2,204	(7)	10,339	(7)	1,083	(6)	4,986	(7)	534	(5)	2,582	(6)
Hemophilia/coagulation disorder	560	(2)	2,018	(1)	79	(0)	207	(0)	45	(0)	190	(0)
Heterosexual contact:	411	(1)	1,326	(1)	1,529	(8)	5,125	(7)	447	(4)	1,056	(3)
<i>Sex with injecting drug user</i>	155		686		583		1,772		172		511	
<i>Sex with person with hemophilia</i>	1		8		1		3		1		3	
<i>Born in Pattern-II² country</i>	—		7		406		2,247		—		11	
<i>Sex with person born in Pattern-II country</i>	7		49		18		67		3		11	
<i>Sex with transfusion recipient with HIV infection</i>	11		58		14		35		8		29	
<i>Sex with HIV-infected person, risk not specified</i>	237		518		507		1,001		263		491	
Receipt of blood transfusion, blood components, or tissue	356	(1)	2,331	(2)	113	(1)	535	(1)	72	(1)	341	(1)
Risk not identified ³	1,750	(6)	3,881	(3)	2,212	(12)	4,314	(6)	1,011	(10)	2,329	(6)
Total	31,347	(100)	141,082	(100)	18,419	(100)	68,506	(100)	10,088	(100)	40,136	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ⁴			
	Apr. 1992- Mar. 1993		Cumulative total		Apr. 1992- Mar. 1993		Cumulative total		Apr. 1992- Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	264	(71)	1,292	(79)	113	(67)	310	(65)	35,106	(58)	160,345	(64)
Injecting drug use	15	(4)	58	(4)	14	(8)	51	(11)	12,879	(21)	49,962	(20)
Men who have sex with men and inject drugs	11	(3)	41	(3)	27	(16)	77	(16)	3,864	(6)	18,041	(7)
Hemophilia/coagulation disorder	9	(2)	28	(2)	3	(2)	11	(2)	696	(1)	2,460	(1)
Heterosexual contact:	9	(2)	20	(1)	1	(1)	5	(1)	2,400	(4)	7,540	(3)
<i>Sex with injecting drug user</i>	1		7		—		4		911		2,980	
<i>Sex with person with hemophilia</i>	—		—		—		—		4		15	
<i>Born in Pattern-II country</i>	1		3		—		—		409		2,274	
<i>Sex with person born in Pattern-II country</i>	—		1		—		—		28		128	
<i>Sex with transfusion recipient with HIV infection</i>	2		2		—		—		35		125	
<i>Sex with HIV-infected person, risk not specified</i>	5		7		1		1		1,013		2,018	
Receipt of blood transfusion, blood components, or tissue	8	(2)	64	(4)	1	(1)	3	(1)	550	(1)	3,280	(1)
Risk not identified	58	(16)	126	(8)	10	(6)	19	(4)	5,071	(8)	10,735	(4)
Total	374	(100)	1,629	(100)	169	(100)	476	(100)	60,566	(100)	252,363	(100)

¹ Includes 3 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 534 men whose race/ethnicity is unknown.

Table 5. Female adult/adolescent AIDS cases by exposure category and race/ethnicity, reported April 1992 through March 1993¹, and cumulative totals, through March 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Apr. 1992- Mar. 1993		Cumulative total		Apr. 1992- Mar. 1993		Cumulative total		Apr. 1992- Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	1,047	(43)	3,481	(42)	2,459	(46)	9,097	(53)	818	(41)	3,136	(47)
Hemophilia/coagulation disorder	9	(0)	39	(0)	6	(0)	14	(0)	2	(0)	5	(0)
Heterosexual contact:	859	(35)	2,748	(33)	1,959	(37)	6,147	(36)	813	(41)	2,634	(40)
<i>Sex with injecting drug user</i>	378		1,342		892		3,366		509		1,938	
<i>Sex with bisexual male</i>	121		495		94		337		39		121	
<i>Sex with person with hemophilia</i>	28		112		8		18		3		7	
<i>Born in Pattern-II² country</i>	—		2		218		965		3		8	
<i>Sex with person born in Pattern-II country</i>	1		12		18		91		—		3	
<i>Sex with transfusion recipient with HIV infection</i>	44		155		14		45		8		40	
<i>Sex with HIV-infected person, risk not specified</i>	287		630		715		1,325		251		517	
Receipt of blood transfusion, blood components, or tissue	177	(7)	1,282	(16)	104	(2)	465	(3)	65	(3)	297	(4)
Risk not identified ³	331	(14)	708	(9)	821	(15)	1,562	(9)	277	(14)	545	(8)
Total	2,423	(100)	8,258	(100)	5,349	(100)	17,285	(100)	1,975	(100)	6,617	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ⁴			
	Apr. 1992- Mar. 1993		Cumulative total		Apr. 1992- Mar. 1993		Cumulative total		Apr. 1992- Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	8	(13)	26	(15)	14	(50)	43	(55)	4,359	(44)	15,816	(49)
Hemophilia/coagulation disorder	1	(2)	1	(1)	—	—	—	—	18	(0)	59	(0)
Heterosexual contact:	31	(49)	68	(39)	8	(29)	20	(26)	3,672	(37)	11,638	(36)
<i>Sex with injecting drug user</i>	8		21		6		15		1,793		6,696	
<i>Sex with bisexual male</i>	9		21		1		3		265		980	
<i>Sex with person with hemophilia</i>	—		2		—		—		39		139	
<i>Born in Pattern-II country</i>	1		1		—		—		222		977	
<i>Sex with person born in Pattern-II country</i>	—		—		—		—		19		106	
<i>Sex with transfusion recipient with HIV infection</i>	2		4		—		—		68		245	
<i>Sex with HIV-infected person, risk not specified</i>	11		19		1		2		1,266		2,495	
Receipt of blood transfusion, blood components, or tissue	10	(16)	49	(28)	3	(11)	8	(10)	359	(4)	2,104	(6)
Risk not identified	13	(21)	31	(18)	3	(11)	7	(9)	1,450	(15)	2,860	(9)
Total	63	(100)	175	(100)	28	(100)	78	(100)	9,858	(100)	32,477	(100)

¹Includes 3 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²See technical notes.

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

⁴Includes 64 women whose race/ethnicity is unknown.

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

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Apr. 1992- Mar. 1993		Cumulative total		Apr. 1992- Mar. 1993		Cumulative total		Apr. 1992- Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	9	(7)	131	(14)	3	(1)	26	(1)	5	(3)	33	(3)
Mother with/at risk for HIV infection:	100	(83)	598	(66)	442	(95)	2,300	(94)	155	(90)	957	(88)
<i>Injecting drug use</i>	32		269		148		1,044		55		443	
<i>Sex with injecting drug user</i>	13		111		58		348		40		295	
<i>Sex with bisexual male</i>	10		37		1		28		—		17	
<i>Sex with person with hemophilia</i>	2		12		1		5		1		3	
<i>Born in Pattern-II¹ country</i>	—		3		36		288		—		2	
<i>Sex with person born in</i> <i> Pattern-II country</i>	—		—		6		18		—		1	
<i>Sex with transfusion recipient</i> <i> with HIV infection</i>	1		6		—		4		2		8	
<i>Sex with HIV-infected person,</i> <i> risk not specified</i>	9		41		50		127		18		62	
<i>Receipt of blood transfusion,</i> <i> blood components, or tissue</i>	5		26		11		40		10		24	
<i>Has HIV infection, risk not specified</i>	28		93		131		398		29		102	
Receipt of blood transfusion, blood components, or tissue	6	(5)	162	(18)	5	(1)	70	(3)	8	(5)	75	(7)
Risk not identified ²	6	(5)	16	(2)	17	(4)	51	(2)	4	(2)	17	(2)
Total	121	(100)	907	(100)	467	(100)	2,447	(100)	172	(100)	1,082	(100)

Exposure category	Asian/Pacific Islander		American Indian/Alaska Native		Cumulative totals ³							
	Apr. 1992- Mar. 1993		Cumulative total		Apr. 1992- Mar. 1993		Cumulative total		Apr. 1992- Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	—		3	(16)	1	(20)	1	(7)	18	(2)	194	(4)
Mother with/at risk for HIV infection:	1	(100)	9	(47)	4	(80)	14	(93)	707	(92)	3,887	(87)
<i>Injecting drug use</i>	1		3		1		5		241		1,768	
<i>Sex with injecting drug user</i>	—		2		2		3		113		761	
<i>Sex with bisexual male</i>	—		1		—		—		11		83	
<i>Sex with person with hemophilia</i>	—		—		—		—		4		20	
<i>Born in Pattern-II country</i>	—		—		—		—		36		293	
<i>Sex with person born in</i> <i> Pattern-II country</i>	—		—		—		—		6		20	
<i>Sex with transfusion recipient</i> <i> with HIV infection</i>	—		—		—		—		3		18	
<i>Sex with HIV-infected person,</i> <i> risk not specified</i>	—		1		—		2		77		234	
<i>Receipt of blood transfusion,</i> <i> blood components, or tissue</i>	—		—		—		—		26		90	
<i>Has HIV infection, risk not specified</i>	—		2		1		4		190		600	
Receipt of blood transfusion, blood components, or tissue	—		7	(37)	—		—		20	(3)	315	(7)
Risk not identified	—		—		—		—		27	(3)	84	(2)
Total	1	(100)	19	(100)	5	(100)	15	(100)	772	(100)	4,480	(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 10 children whose race/ethnicity is unknown.

Table 7. AIDS cases in adolescents and adults under age 25, by sex and exposure category, reported April 1991 through March 1992, April 1992 through March 1993¹, and cumulative totals through March 1993, United States

Male exposure category	13-19 years old						20-24 years old					
	Apr. 1991- Mar. 1992		Apr. 1992- Mar. 1993		Cumulative total		Apr. 1991- Mar. 1992		Apr. 1992- Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	30	(29)	67	(29)	273	(33)	687	(60)	1,092	(61)	5,745	(65)
Injecting drug use	5	(5)	11	(5)	55	(7)	171	(15)	191	(11)	1,077	(12)
Men who have sex with men and inject drugs	4	(4)	6	(3)	40	(5)	120	(10)	138	(8)	920	(10)
Hemophilia/coagulation disorder	48	(47)	112	(48)	359	(43)	43	(4)	103	(6)	321	(4)
Heterosexual contact:	2	(2)	12	(5)	25	(3)	51	(4)	83	(5)	304	(3)
<i>Sex with injecting drug user</i>	—		5		9		25		28		115	
<i>Sex with person with hemophilia</i>	—		1		1		—		—		1	
<i>Born in Pattern-II² country</i>	—		1		8		7		12		89	
<i>Sex with person born in Pattern-II country</i>	1		—		1		—		1		1	
<i>Sex with transfusion recipient with HIV infection</i>	—		—		—		2		1		6	
<i>Sex with HIV-infected person, risk not specified</i>	1		5		6		17		41		92	
Receipt of blood transfusion, blood components, or tissue	5	(5)	5	(2)	32	(4)	10	(1)	11	(1)	75	(1)
Risk not identified ³	8	(8)	19	(8)	44	(5)	61	(5)	168	(9)	382	(4)
Male subtotal	102	(100)	232	(100)	828	(100)	1,143	(100)	1,786	(100)	8,824	(100)
Female exposure category												
Injecting drug use	13	(27)	13	(11)	77	(23)	115	(33)	184	(29)	765	(36)
Hemophilia/coagulation disorder	1	(2)	—		4	(1)	—		4	(1)	8	(0)
Heterosexual contact:	24	(50)	68	(59)	170	(50)	186	(53)	310	(48)	1,037	(49)
<i>Sex with injecting drug user</i>	15		29		101		112		160		612	
<i>Sex with bisexual male</i>	1		4		8		15		15		86	
<i>Sex with person with hemophilia</i>	2		2		6		1		5		22	
<i>Born in Pattern-II country</i>	1		3		9		8		6		58	
<i>Sex with person born in Pattern-II country</i>	1		1		2		1		—		10	
<i>Sex with transfusion recipient with HIV infection</i>	—		—		1		—		—		5	
<i>Sex with HIV-infected person, risk not specified</i>	4		29		43		49		124		244	
Receipt of blood transfusion, blood components, or tissue	1	(2)	5	(4)	30	(9)	11	(3)	15	(2)	71	(3)
Risk not identified	9	(19)	30	(26)	58	(17)	38	(11)	129	(20)	244	(11)
Female subtotal	48	(100)	116	(100)	339	(100)	350	(100)	642	(100)	2,125	(100)
Total	150		348		1,167		1,493		2,428		10,949	

¹Includes 3 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²See technical notes.

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

Table 8 AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through March 1993¹, United States

Males	White, not Hispanic		Black, not Hispanic		Hispanic		Asian/Pacific Islander		American Indian/ Alaska Native		Total ²	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Age at diagnosis (years)												
Under 5	304	(0)	1,063	(2)	443	(1)	7	(0)	8	(2)	1,828	(1)
5-12	228	(0)	168	(0)	132	(0)	6	(0)	1	(0)	535	(0)
13-19	393	(0)	261	(0)	157	(0)	8	(0)	9	(2)	828	(0)
20-24	4,222	(3)	2,817	(4)	1,693	(4)	57	(3)	21	(4)	8,824	(3)
25-29	20,725	(15)	10,323	(15)	6,618	(16)	222	(14)	92	(19)	38,057	(15)
30-34	32,997	(23)	16,222	(23)	10,009	(25)	334	(20)	132	(27)	59,804	(23)
35-39	31,424	(22)	16,219	(23)	9,022	(22)	359	(22)	98	(20)	57,256	(22)
40-44	22,304	(16)	10,629	(15)	5,917	(15)	279	(17)	61	(13)	39,282	(15)
45-49	13,155	(9)	5,540	(8)	3,136	(8)	180	(11)	31	(6)	22,090	(9)
50-54	7,130	(5)	3,083	(4)	1,723	(4)	88	(5)	13	(3)	12,065	(5)
55-59	4,147	(3)	1,754	(3)	1,008	(2)	51	(3)	10	(2)	6,992	(3)
60-64	2,487	(2)	949	(1)	499	(1)	16	(1)	7	(1)	3,963	(2)
65 or older	2,098	(1)	709	(1)	354	(1)	35	(2)	2	(0)	3,202	(1)
Male subtotal	141,614	(100)	69,737	(100)	40,711	(100)	1,642	(100)	485	(100)	254,726	(100)
Females												
Age at diagnosis (years)												
Under 5	302	(3)	1,050	(6)	413	(6)	—		6	(7)	1,777	(5)
5-12	73	(1)	166	(1)	94	(1)	6	(3)	—		340	(1)
13-19	84	(1)	200	(1)	52	(1)	1	(1)	1	(1)	339	(1)
20-24	542	(6)	1,085	(6)	477	(7)	7	(4)	7	(8)	2,125	(6)
25-29	1,532	(18)	3,145	(17)	1,396	(20)	18	(10)	15	(18)	6,114	(18)
30-34	1,925	(22)	4,549	(25)	1,717	(24)	34	(19)	24	(29)	8,264	(24)
35-39	1,467	(17)	3,993	(22)	1,358	(19)	28	(15)	11	(13)	6,873	(20)
40-44	853	(10)	2,148	(12)	783	(11)	34	(19)	10	(12)	3,835	(11)
45-49	448	(5)	898	(5)	353	(5)	16	(9)	5	(6)	1,726	(5)
50-54	295	(3)	554	(3)	214	(3)	9	(5)	1	(1)	1,074	(3)
55-59	295	(3)	312	(2)	124	(2)	7	(4)	1	(1)	741	(2)
60-64	228	(3)	199	(1)	69	(1)	10	(6)	2	(2)	508	(1)
65 or older	589	(7)	202	(1)	74	(1)	11	(6)	1	(1)	878	(3)
Female subtotal	8,633	(100)	18,501	(100)	7,124	(100)	181	(100)	84	(100)	34,594	(100)
Total	150,247		88,238		47,835		1,823		569		289,320	

¹Includes 3 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²Includes 537 males and 71 females whose race/ethnicity is unknown.

Table 9. AIDS cases, case-fatality rates,¹ and deaths, by half-year and age group, through March 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	84	84.5	31	7	71.4	1
1981 Jan. - June	97	89.7	39	11	81.8	2
July - Dec.	206	90.3	88	5	100.0	7
1982 Jan. - June	406	92.1	154	13	84.6	8
July - Dec.	700	91.0	289	15	80.0	5
1983 Jan. - June	1,289	93.8	524	33	100.0	13
July - Dec.	1,654	93.2	938	42	90.5	16
1984 Jan. - June	2,576	92.7	1,407	52	84.6	26
July - Dec.	3,392	92.9	1,974	59	83.1	22
1985 Jan. - June	4,922	92.3	2,827	98	76.5	44
July - Dec.	6,343	91.4	3,891	129	82.2	70
1986 Jan. - June	8,359	90.2	5,102	135	83.0	64
July - Dec.	9,968	88.2	6,560	188	70.7	92
1987 Jan. - June	12,990	88.5	7,599	222	70.7	118
July - Dec.	14,397	85.3	7,985	257	66.1	168
1988 Jan. - June	16,604	82.8	9,370	256	64.1	134
July - Dec.	17,124	82.0	10,709	339	58.7	173
1989 Jan. - June	19,585	77.5	12,492	339	58.7	170
July - Dec.	19,707	75.0	14,383	335	53.1	185
1990 Jan. - June	21,392	68.2	14,072	349	47.9	192
July - Dec.	20,846	62.4	14,940	371	38.8	190
1991 Jan. - June	23,690	53.3	15,497	338	38.5	158
July - Dec.	24,610	42.5	16,818	287	27.2	185
1992 Jan. - June	26,228	28.9	16,345	342	27.2	160
July - Dec.	22,768	15.4	13,125	228	19.3	133
1993 Jan. - Mar.	4,903	6.2	2,509	30	10.0	18
Total³	284,840	63.2	179,917	4,480	52.6	2,358

¹Case-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 406 adults/adolescents. Through March 1993, 374 of these 406 were reported as dead. Therefore, the case fatality rate is 92.1 (374 divided by 406, multiplied by 100). The case-fatality rates shown here may be underestimates because reporting of deaths is incomplete. Reported deaths are not necessarily caused by HIV-related disease.

²Includes 3 months of data collected under the 1993 AIDS surveillance case definitions for adults and adolescents.

³Death totals include 249 adults/adolescents and 4 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 March 1993¹, United States

Definition category	Period of diagnosis											
	Before Mar. 1989		Apr. 1989-Mar. 1990		Apr. 1990-Mar. 1991		Apr. 1991-Mar. 1992		Apr. 1992-Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)								
Pre-1987 definition	91,625	(81)	27,899	(68)	27,561	(63)	27,953	(55)	17,188	(42)	192,226	(66)
1987 definition	20,524	(18)	12,521	(30)	14,334	(33)	16,552	(33)	11,581	(28)	75,512	(26)
1993 definition: ²	528	(0)	820	(2)	2,042	(5)	6,210	(12)	11,982	(29)	21,582	(7)
<i>Severe HIV-related immunosuppression³</i>	381		671		1,668		5,470		11,094		19,284	
<i>Pulmonary tuberculosis</i>	136		137		354		686		708		2,021	
<i>Recurrent pneumonia</i>	9		12		18		49		157		245	
<i>Invasive cervical cancer</i>	4		1		3		8		25		41	
Total	112,677	(100)	41,240	(100)	43,937	(100)	50,715	(100)	40,751	(100)	289,320	(100)

¹Includes 3 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.

²Persons who meet only the 1993 AIDS case definition and whose date of diagnosis is before January 1993 were diagnosed retrospectively. The sum of diagnoses listed for the four conditions under the 1993 definition do not equal the 1993 definition total because some persons have more than one diagnosis from the added conditions of pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

³Defined as CD4+ T-lymphocyte count of less than 200 cells/ μ L or a CD4+ percentage less than 14 in persons with laboratory confirmation of HIV infection.

Table 11. Health-care workers with documented and possible occupationally acquired AIDS/HIV infection, by occupation, reported through March 1993, United States¹

Occupation	Documented occupational transmission ²	Possible occupational transmission ³
	No.	No.
Dental worker, including dentist	—	6
Embalmer/morgue technician	—	3
Emergency medical technician/paramedic	—	7
Health aide/attendant	1	7
Housekeeper/maintenance worker	1	5
Laboratory technician, clinical	14	12
Laboratory technician, nonclinical	1	1
Nurse	12	17
Physician, nonsurgical	4	8
Physician, surgical	—	2
Respiratory therapist	1	1
Surgical technician	1	1
Technician/therapist, other than those listed above	1	3
Other health-care occupations	—	2
Total	36	75

¹Health-care workers are defined as those persons, including students and trainees, who have worked in a health-care, clinical, or HIV laboratory setting at any time since 1978. See *MMWR* 1992;41:823-5.

²Health-care workers who had documented HIV seroconversion after occupational exposure: 31 had percutaneous exposure, 4 had mucocutaneous exposure, 1 had both percutaneous and mucocutaneous exposures. Thirty-three 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.

³These health-care workers have been investigated and are without identifiable behavioral or transfusion risks; each reported percutaneous or mucocutaneous occupational exposures to blood or body fluids, or laboratory solutions containing HIV, but HIV seroconversion specifically resulting from an occupational exposure was not documented.

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

Exposure category	AIDS cases	
	No.	(%)
Single mode of exposure		
Men who have sex with men	154,623	(54)
Injecting drug use	55,818	(20)
Hemophilia/coagulation disorder	1,846	(1)
Heterosexual contact	18,500	(6)
Receipt of transfusion ¹	5,379	(2)
Receipt of transplant of tissues/organs ²	5	(0)
Other ³	12	(0)
Single mode of exposure subtotal	236,183	(83)
Multiple modes of exposure		
Men who have sex with men; injecting drug use	16,205	(6)
Men who have sex with men; hemophilia/coagulation disorder	69	(0)
Men who have sex with men; heterosexual contact	3,179	(1)
Men who have sex with men; receipt of transfusion/transplant	2,302	(1)
Injecting drug use; hemophilia/coagulation disorder	73	(0)
Injecting drug use; heterosexual contact	8,501	(3)
Injecting drug use; receipt of transfusion/transplant	1,003	(0)
Hemophilia/coagulation disorder; heterosexual contact	16	(0)
Hemophilia/coagulation disorder; receipt of transfusion/transplant	644	(0)
Heterosexual contact; receipt of transfusion/transplant	678	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder	16	(0)
Men who have sex with men; injecting drug use; heterosexual contact	1,404	(0)
Men who have sex with men; injecting drug use; receipt of transfusion/transplant	350	(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	24	(0)
Men who have sex with men; heterosexual contact; receipt of transfusion/transplant	144	(0)
Injecting drug use; hemophilia/coagulation disorder; heterosexual contact	16	(0)
Injecting drug use; hemophilia/coagulation disorder; receipt of transfusion/transplant	23	(0)
Injecting drug use; heterosexual contact; receipt of transfusion/transplant	338	(0)
Hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	13	(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	59	(0)
Men who have sex with men; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	1	(0)
Injecting drug use; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	6	(0)
Multiple modes of exposure subtotal	35,074	(12)
Risk not identified⁴	13,583	(5)
Total	284,840	(100)

¹ Includes twenty adults/adolescents and 2 children who developed AIDS after receiving blood screened negative for HIV antibody.

² Five adults developed AIDS after receiving tissue or organs from HIV-infected donors. Two of the 5 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 April 1992 through March 1993, United States (N=60,566)

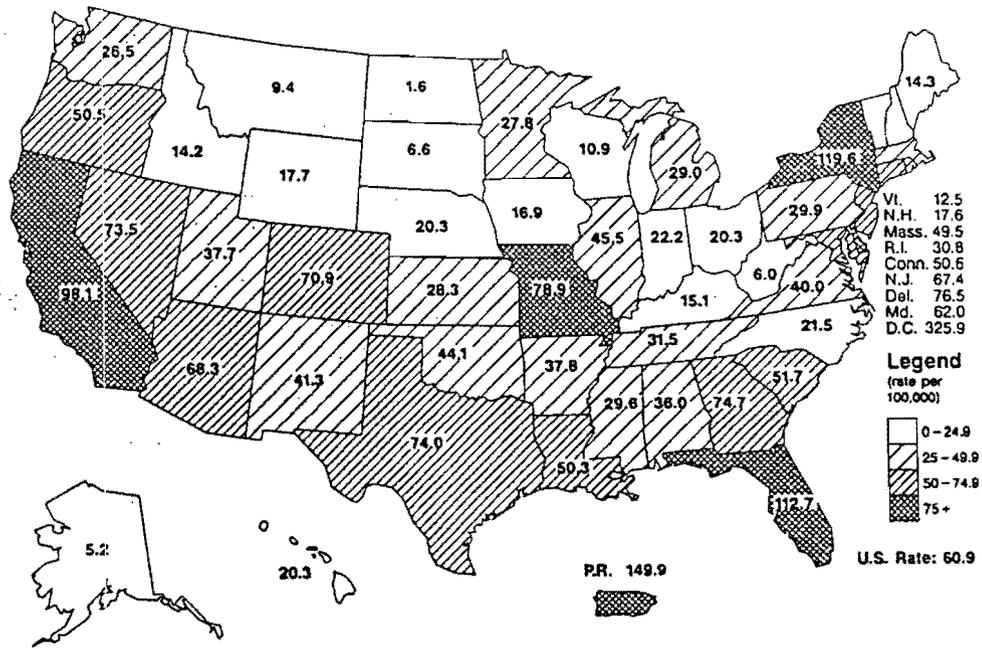


Figure 2. Female adult/adolescent AIDS annual rates per 100,000 population, for cases reported April 1992 through March 1993, United States (N=9,858)

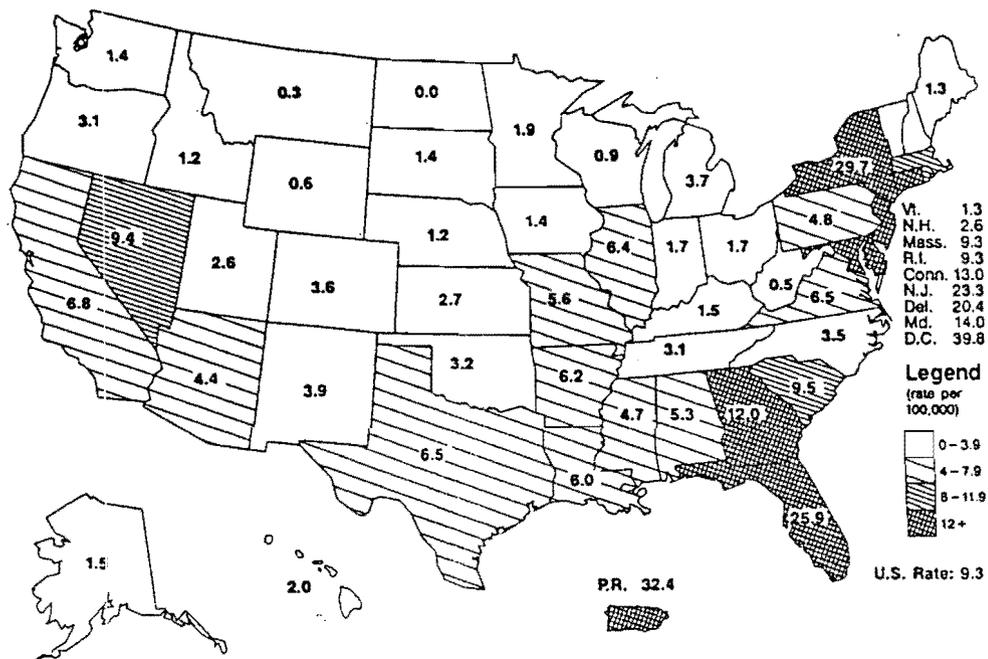


Figure 3. Male adult/adolescent AIDS cases reported April 1992 through March 1993, United States (N=60,566)

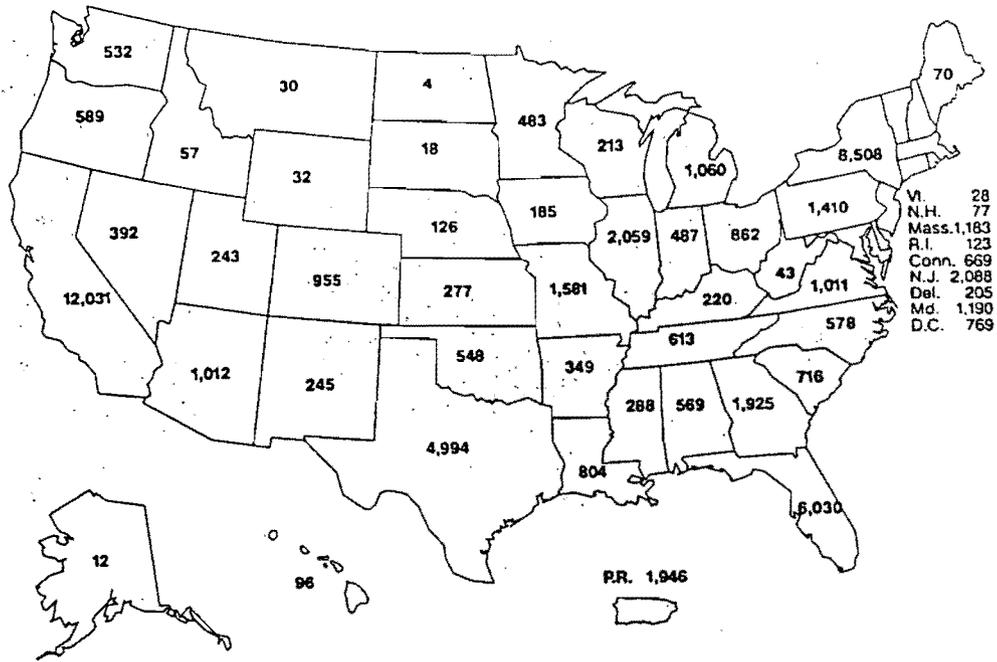


Figure 4. Female adult/adolescent AIDS cases reported April 1992 through March 1993, United States (N=9,858)

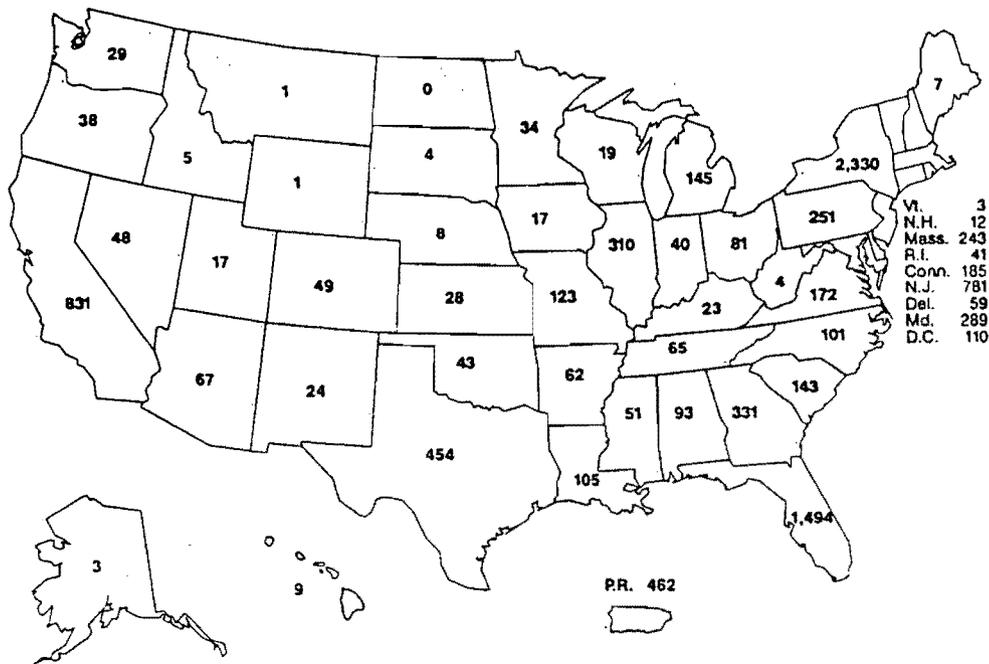


Figure 5. Pediatric AIDS cases reported April 1992 through March 1993, United States (N=772)

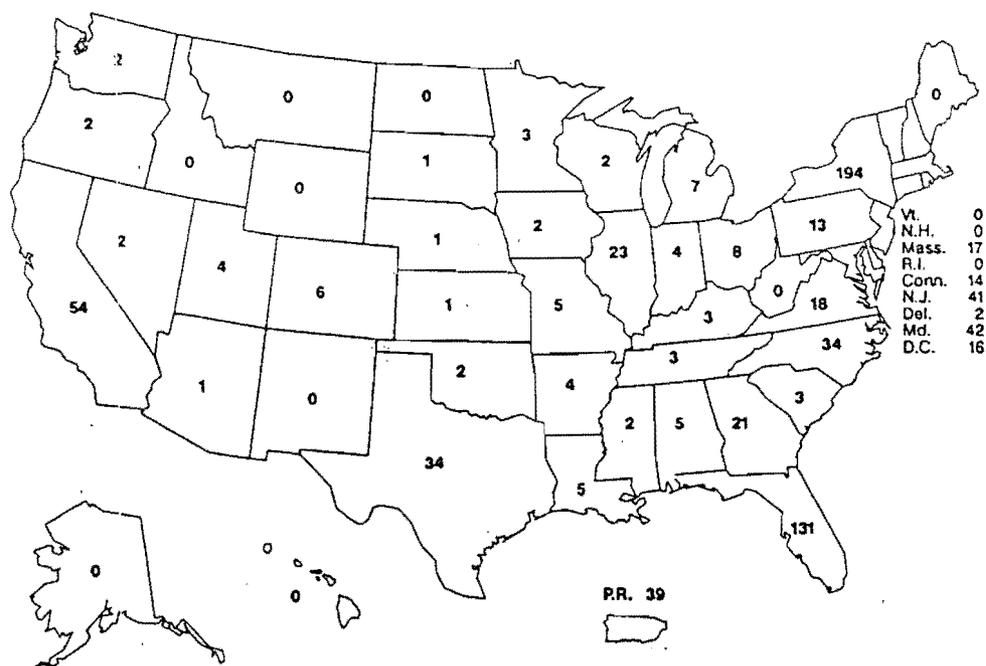
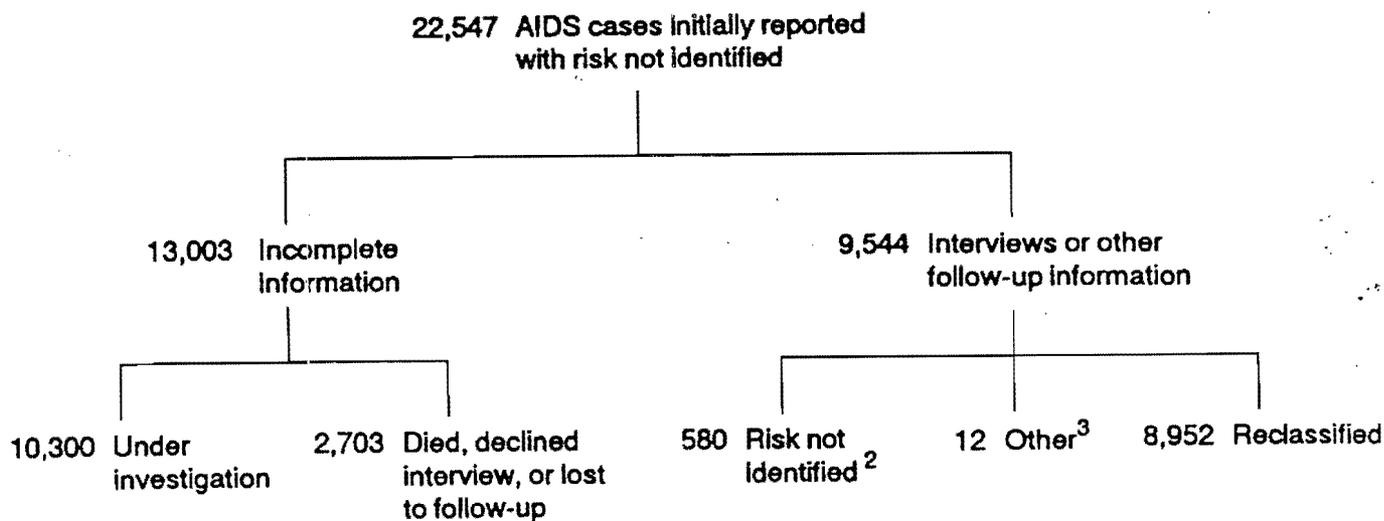


Figure 6. Results of investigations of adult/adolescent AIDS cases with risk not identified, reported through March 1993¹



¹ Excludes 84 children under 13 years of age whose risk is not identified: 74 children who are under investigation and 10 who have died, declined interview, or were lost to follow-up. An additional 175 children who were initially reported with a risk not identified have been reclassified after investigation.

² Heterosexual transmission. 510 of the 580 persons who had no risk identified after follow-up responded to a standardized questionnaire: 173 (37%) of 469 persons responding to questions related to sexually transmitted diseases gave a history of such diseases and 114 (36%) of 315 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.

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 States¹ 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/ μ L 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/ μ L 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 new definitions in many cases are substantially different than the MSA definitions they replaced. The cities and counties which compose each metropolitan area in Table 2 (except for the areas indented under New York City as explained below) are listed in the publication "Metropolitan Area Definitions as of December 31, 1992" (available from National Technical Information Service, accession no. PB93-111-292). The current MSA designation for New York City includes the formerly independent MSAs of Bergen-Passaic, N.J.; Jersey City, N.J.; Middlesex, N.J.; Monmouth-Ocean, N.J.; Nassau-Suffolk, N.Y.; and Newark, N.J.

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:

¹Included 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.

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 determined 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 homo-

sexual 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.

**DEPARTMENT OF
HEALTH AND HUMAN SERVICES**
Public Health Service
Centers for Disease Control
and Prevention
Atlanta, GA 30333

Official Business
Penalty for Private Use \$300

**FIRST CLASS MAIL
POSTAGE & FEES PAID
PHS/CDC
Permit No. G 284**

AIDS Case Counts for Selected Metropolitan Areas

Cities over 500,000 Population, EXCLUDING the Top 20 AIDS Cities
(Cumulative cases since 1981)

<u>Metropolitan Area</u>	<u>Total 12/31/91</u>	<u>Total 12/31/92</u>	<u>Pct Increase In One Year</u>
Akron	138	179	30%
Allentown	198	241	22%
Austin	924	1,178	27%
Bakersfield	168	217	29%
Birmingham	398	509	28%
Bridgeport	714	882	24%
Charleston, SC	298	383	29%
Charlotte, NC	413	534	29%
Cincinnati	453	579	27%
Cleveland	764	957	25%
Columbus	617	800	30%
Dayton	288	359	25%
Fresno	271	360	33%
Grand Rapids	144	176	22%
Greensboro, NC	362	465	28%
Greenville, SC	168	247	47%
Harrisburg	206	248	20%
Honolulu	618	718	17%
Indianapolis	625	790	26%
Jacksonville	1,015	1,381	36%
Kansas City	1,232	1,528	24%
Knoxville	147	175	19%
Las Vegas	672	858	28%
Little Rock	253	371	47%
Louisville	280	380	36%
Memphis	480	623	35%
Milwaukee	463	591	28%
Minneapolis-St. Paul	928	1,118	20%
New Haven	800	1,010	26%
Norfolk	802	769	28%
Oklahoma City	455	587	29%
Omaha	174	217	25%
Orlando	1,120	1,417	27%
Phoenix	1,150	1,404	22%
Portland, OR	999	1,231	23%
Raleigh-Durham	497	588	18%
Richmond	528	691	31%
Rochester	439	539	23%
Sacramento	871	1,145	31%
Salt Lake City	415	535	29%
San Antonio	1,014	1,241	22%
Scranton	168	207	25%
Springfield, MA	308	413	34%
Syracuse	199	270	36%
Toledo	185	188	22%
Tucson	295	394	34%
Tulsa	263	345	31%
Wilmington, DE	328	444	35%
Worcester, MA	235	305	30%

Source: HIV/AIDS Surveillance Report, CDC

Does not include:

- > cases diagnosed but not reported,
- > cases not diagnosed (e.g. not seen by a Doctor), or
- > those ill with HIV-caused symptoms but not CDC-defined AIDS.

Place of diagnosis may not be place of subsequent residence.

Prepared by: National Association of Community Health Centers

NATIONAL
COMMISSION
ON AIDS



Report Number Three:
Research, the
Workforce and the
HIV Epidemic in
Rural America

COMMISSIONERS

June E. Osborn, M.D., Chairman
David E. Rogers, M.D., Vice-Chairman
Diane Ahrens
Scott Allen
Harlon L. Dalton, Esq.
Eunice Diaz, M.S., M.P.H.
Donald S. Goldman, Esq.
Don C. Desjarlais, Ph.D.
Larry Kessler
Charles Konigsberg, M.D., M.P.H.
Belinda Mason
Honorable J. Roy Rowland, M.D.
Honorable Dick Cheney
Honorable Edward J. Derwinski
Honorable Louis W. Sullivan, M.D.

**NATIONAL COMMISSION ON
ACQUIRED IMMUNE DEFICIENCY SYNDROME**

1730 K Street, N.W., Suite 815
Washington, D.C. 20006
(202) 254-5125 [FAX] 254-3060

August 21, 1990

President George Bush
The White House
Washington, DC 20500

Dear Mr. President:

Since our last report to you, the National Commission on AIDS has traveled to rural Georgia to better understand the impact of the HIV epidemic in rural communities across the country. Two formal hearings have examined the current status of HIV research and drug development and looked at the mounting hardships which shortages in health care personnel are imposing on people with HIV infection and AIDS. A working group of the Commission also met with public health officials and others from the Southwest region of the country in Dallas and heard poignant testimony about the lack of many basic publicly supported services needed by people affected by the HIV epidemic. The enclosed report highlights the National Commission's most recent findings. Again it contains a short series of recommendations for swift action.

Sincerely,

June E. Osborn *David E. Rogers*
June E. Osborn, M.D. David E. Rogers, M.D.
Chairman Vice Chairman

cc: The Honorable Robert C. Byrd
President Pro Tempore of the Senate

The Honorable George J. Mitchell
Majority Leader of the Senate

The Honorable Bob Dole
Minority Leader of the Senate

The Honorable Thomas S. Foley
Speaker of the House of
Representatives

The Honorable Richard A. Gephardt
Majority Leader of the House of
Representatives

The Honorable Robert H. Michel
Minority Leader of the House of
Representatives

NATIONAL COMMISSION ON AIDS

Report Number Three

AIDS IN RURAL AMERICA

OVERVIEW

The number of new AIDS cases diagnosed in rural communities across the country is growing at an alarming rate. Although the epidemic continues to be most severe in urban areas, there has been a 37 percent increase in diagnosed AIDS cases in rural areas compared to a 5 percent increase in metropolitan areas with populations of over 500,000 in just a one year period. In Georgia the number of AIDS cases has tripled in the past two years. For the first time, the spread of disease in rural Georgia and small cities has equalled the growth of HIV infection in metropolitan Atlanta.

This is happening all across the country. The Commission was told of alarming rates of increase in HIV infection in Arkansas, Mississippi and rural communities in Texas. It is happening tragically and secretly without adequate health care services or human support in these rural areas.

FINDINGS

- In rural America, there is an epidemic of fear and bigotry, fanned by the absence of education and knowledge, surrounding HIV infection and AIDS. Like much of urban America, rural communities are just beginning to confront the realities of HIV infection and AIDS. The fear of being "found out," we were told, is almost as

great as the fear of the disease itself. As one Commission member, Belinda Mason, noted, "I have seen rural America at its warm, supportive best and at its close-minded, bigoted worst."

In one community we learned of a young man who sneaks out to his mother's car at night, covers himself with a blanket and waits for his mother to come out at dawn to drive him many miles to another county where he can receive treatment anonymously. When he returns home he remains in the car covered by the blanket until sundown when he creeps back into his mother's trailer home. All this, to prevent others from knowing that his mother is housing and caring for a son who has AIDS. Little will be known of his life — only that he died of AIDS.

One man told us of being "thrown out of my church and told not to come back." A local doctor told us, "We've had people lose their jobs and get kicked out of their apartments." Another told us, "President Bush talks about those thousand points of light, but whenever people hear that I have HIV, the lights go out and I am in the dark."

In Texas we were told that the isolation and stigmatization of people with AIDS in rural areas is similarly severe. "Even a family is apt to reject the patient because of fear that the neighborhood or community will respond hatefully."

- AIDS education is virtually non-existent and desperately needed in rural communities. This includes even the simplest of education about HIV infection for health care providers. Ignorance and misinformation are seriously hampering if not crippling efforts to treat those who are sick; clearly contributing to the rapid increase in rates of HIV infection in rural America; and contributing greatly to the discrimination against and ostracism of people living with HIV infection and AIDS.

Drug education, prevention, and treatment programs range from grossly inadequate to non-existent. If there is to be any hope of stemming the tide of what one health official described as "three epidemics - AIDS, drugs and STD (sexually transmitted diseases)" - services for all

of these disease problems and educational programs designed to contain them must be dramatically expanded.

One infectious disease specialist from Macon, Georgia expressed great concern about the spread of AIDS into families, noting that he was currently seeing five families in which both parents are infected with HIV. The growth in the number of heterosexual cases of AIDS, in rural communities, particularly among women, (many in their teens), is often attributed to the combination of crack cocaine, trading sex with multiple partners for drugs or money, and rising rates of syphilitic infections which seem to increase transmission of HIV infection. In the last five years, the number of new cases of syphilis has increased tenfold in Southeast Georgia.

- The singular lack of access to primary health care services in rural America was shocking and heartrending. The Commission's first-hand look at rural communities made graphic and personal reports of "a rural health care crisis evidenced by rising rural maternal and infant mortality rates, lower health status of rural Americans compared to those living in cities, [and] a greater proportion of rural Americans lacking any health insurance" (Senate Report 101-127). AIDS is dramatically accentuating the problem.

In Macon, Georgia, the Commission visited the Bibb County HIV Ambulatory Clinic where health care providers were virtually overwhelmed with the increasing number of people with HIV infection and AIDS needing treatment and support services. As the need for services increases, the dollars decrease. The Bibb County HIV Ambulatory Clinic, operated by the Bibb County Health Department, receives no direct financial assistance whatsoever from the federal government. Given the rising demand for services this can no longer continue. Federal assistance is essential for this clinic and other similar clinics serving the growing numbers of people living with HIV infection and AIDS.

HIV RESEARCH AND DRUG DEVELOPMENT

■ OVERVIEW

On May 7 and 8, the Commission convened hearings to review the current status of HIV-related biomedical research efforts and the status of new clinical drug trials. Representatives from the National Institutes of Health (NIH), Institute of Medicine, ACT UP, the American Foundation for AIDS Research, Project Inform, American Association of Physicians for Human Rights, and others were invited to report to the Commission on their ongoing efforts to support and monitor private and public HIV-related research efforts. The Commission will continue to rely on these organizations, with expertise to carefully examine many complex scientific issues, to keep us apprised of research efforts and findings.

While the investment of public and private funds into HIV-related research is impressive, and the fundamental biomedical knowledge about HIV infection acquired over a very short time remarkable, the transfer of knowledge and treatment to those who are HIV infected falls far short of the mark. To put it bluntly, the number of people involved in clinical trials (12,000) versus the number of people eligible for clinical trials is pitifully small. The ground rules for trials seem often too rigid to permit many (such as drug users) from being included. People of color, women, and children are grossly under-represented in federally financed trials. This limits access to experimental therapies as well as basic health care services many receive only through participation in trials. Communication between researchers, people living with HIV infection and AIDS, and the public is not being done well, accentuating all the problems noted above. Much of the blame for many of these problems rests with academic health centers. These centers and the federal government must do better. A clear, crisp, well articulated clinical research strategy is simply not in evidence.

Also grossly apparent is that many people seeking access to experimental therapies are simply not getting basic health care services for HIV-infection and AIDS. Clinical trials cannot exist or be productive in a health care vacuum. They must be part of a comprehensive health care system which ensures adequate access and reimbursement for all kinds of care needed, including experimental therapies for HIV-infection and AIDS.

■ FINDINGS

- Opportunistic infections are usually the cause of death for people with AIDS, yet the NIH has been slow in expanding its AIDS-related research activities to include research on drugs to manage opportunistic infections. The Commission agrees with all those who have called for a greater priority to be given to research related to these infections without slackening research on drugs to treat HIV infection and AIDS. Clearly, both are vitally needed and the dollars to ensure both are essential.

- Severe criticism was repeatedly expressed about the lack of results from the sizable investment (to date, approximately \$428 million) in the AIDS Clinical Trials Group Program (ACTG). It was pointed out that the majority of FDA approved drugs for AIDS and AIDS-related opportunistic infections have all been developed outside the ACTG program.

Heated criticism about the limited number of participants in ACTG trials continues. Barriers contributing to the low level of participation in clinical trials, in addition to those already mentioned, include lack of adequate transportation, day care needs, exclusion of persons with hemophilia, and lack of access to basic medical services and clinical trial information. These barriers all demand aggressive attention and solutions, not more discussion.

- People of color are grossly under-represented in clinical trials. Approximately forty-three percent of all AIDS cases are seen in men and women of color. Yet only approximately 23

percent of the participants in clinical trials are men and women of color.

The Commission was told that this under-representation was of concern to the NIAID and that efforts were underway to increase minority participation in clinical trials. The Commission strongly supports these efforts and believes these efforts should be swift and carefully monitored to assure their success, with the results promptly reported to the public.

- Women, particularly women of color, have traditionally experienced difficulty qualifying for clinical trials. One witness told the Commission she has attempted to qualify for a research protocol for two years. "In this country," she said, "women have been secondary to men with AIDS, and most recently are secondary to babies."

According to the Chief of Perinatology at Harlem Hospital, "This historical precedent for excluding women of childbearing age from treatment trials can no longer be allowed. On the other hand, including women, especially pregnant women, only for the sake of improving the outcome of the child, is also intolerable. Women have a right to be included simply because they are infected and are dying. No other reason is needed." The Commission emphatically agrees.

- For a parent whose child is diagnosed with AIDS and whose only hope lies in the child's participation in an AIDS-related clinical trial, the exclusion of children from trials certainly highlights one of the gross inequities in our research programs. Since the early days of the epidemic, parents have been demanding that children be included in AIDS-related clinical trials and that parents and patient advocates be included in decisions about the care of their child.

Traditionally, children have been denied access to experimental drugs because of the unresolved ethical dilemma of whether or not to include children in trials. In fact, the Director of Pediatric AIDS Research at the National Cancer Institute told the Commission how efforts to increase participation of children in clinical trials were hampered by the lack of a national consensus on this major ethical question. Clearly,

science has moved forward to where the inclusion of children in experimental therapies is essential.

The location of clinical trial sites and the availability of affordable transportation to them are crucial factors in making clinical trials accessible to children. We heard from one mother who traveled from Florida, to North Carolina and finally to Maryland before she could get her daughter into a clinical trial. We were also told that unless transportation is available and affordable it can be impossible for many people to travel even 45 minutes away from home. These are problems we can address and must address quickly.

- The Commission believes the NIH Community Program for Clinical Research on AIDS (CPCRA) is an imaginative and positive step. Because of a different philosophy and an aggressive grassroots impetus, these trials should help include people of color, women, intravenous drug users, children and other under-represented communities in clinical trials. The Commission heard testimony from three physicians participating in the CPCRA program. All testified that the program would enable greater participation of people in trials at the places where they receive primary health care. "Clinical trials conducted in the primary care setting," according to one physician, "have access to large numbers of patients and are likely to fill quickly and finish as rapidly as possible." We also heard testimony from the National Hemophilia Foundation (NHF) about an ACTG-without-walls concept that demonstrates community programs do not sacrifice scientific value and integrity. The Commission strongly encourages continuation and expansion of the CPCRA program in parallel with the steps necessary to strengthen the ACTG's.

- Complaints were expressed about delays in the publication of clinical trial information. One witness urged all agencies sponsoring clinical trials in HIV/AIDS "to be more accountable to an anxious public, and that they actively and expeditiously release specific data concerning the results of their clinical trials."

- One impression needs swift settlement. We were also told that there currently exists a perception of conflict of interest for some investigators who play an advisory role with the NIH in setting national AIDS research priorities. One witness called on the Secretary of Health and Human Services "to mandate the full disclosure of all consulting relationships these investigators maintain with pharmaceutical companies." This deserves a prompt response from the Department of Health and Human Services.

SUMMARY

As is apparent, the Commission is worried about the status of clinical treatment trials. We are vividly aware of the enormous challenge confronting all scientists in developing new drugs and therapies for HIV and opportunistic infections. The obstacles are many and the successes, still sadly enough, are all too few. But the hope for thousands of people still rests with our clinical trial programs. Clearly these must be made more encompassing, more readily accessible to all, easy to find, well managed and well coordinated. There are many problems which need attention. We know they are being addressed but we can and must do better, swiftly and visibly.

PERSONNEL AND WORKFORCE

OVERVIEW

On July 18 and 19, the Commission convened a hearing to examine the personnel shortages which are hampering our response to the HIV epidemic. Physicians, nurses, dentists, social workers, allied health workers, volunteers, and representatives from the federal government and professional organizations presented the Commission with a picture of a national health care workforce confronted with increasing demands and decreasing support and re-enforcements. We were also reminded that unrealistically low health care reimbursement rates, especially rates for outpatient services, continue to serve as institutional disincentives for many health care providers to care for people with HIV infection and AIDS.

FINDINGS

Dentists

While there does not appear to be a national shortage of dentists, we heard repeatedly about a serious shortage of dentists willing to treat people with HIV infection and AIDS. We were told that since the early days of the epidemic many dentists did not treat people with AIDS because they were afraid and because they felt dentists had a traditional right to choose their own patients and refuse to see those who were suspected of or who openly admitted to being infected. "Happily," we were told by the American Dental Association, "not all dentists chose this avenue of escape, and the avenue has been closing as understanding of the disease has grown, as courts have declared this kind of behavior unacceptable, as dentists have become more comfortable with the disease and as their sense of moral and professional responsibility has replaced their initial fears."

While the Commission believes more dentists are willing to treat people with HIV infection and AIDS than in the early days of the epidemic, the number remains grossly inadequate and unacceptable. The difficulty, and in many cases complete inability, of obtaining dental services is still an all too common problem for people living with HIV infection and AIDS. One witness told us of only two dentists in his community who would accept Medicaid, neither of whom would see him due to his HIV infection. One dentist's excuse was that his office was carpeted and he would not be able to sterilize the room after the visit. The other dentist said she had plants and could not take the risk of him infecting her plants and her plants then infecting her other patients. That particular witness did find an oral surgeon who was willing to see him, but only if he would come after hours, come in the back door, and not tell anyone he had been there.

As one Commissioner put it, "Whether it is in rural communities or big cities, when it comes to dentists, I just keep hearing people with HIV infection and AIDS saying, 'I can't get help.'"

Nurses

The current nursing shortage continues to be of crisis proportions. The Commission heard testimony from experts who have studied the overall nursing shortage. It is clear to us the shortage promises to get worse in the future unless it is addressed now. We were told the Department of Health and Human Services and Department of Labor are predicting that the need for Registered Nurses will increase by 60 percent in the next 10 years. And, contrary to popular opinion, there is no untapped resource of trained nurses. One witness told us that only 4 percent of licensed Registered Nurses are working outside of nursing.

While efforts are underway to address the overall nursing shortage, special efforts are needed to better understand and address how the shortage is compounded by the HIV

epidemic. Misinformation and fear about caring for people with HIV infection and AIDS and the considerable emotional strain that often comes with caring for people with HIV infection and AIDS are issues which must be confronted if we are to prevent nurses from avoiding the field.

Physicians

A shocking number of physicians are reluctant to take care of people living with HIV infection and AIDS. The New York Times recently reported that "with an estimated 200,000 people infected with the virus, New York City has more AIDS cases than any other city in the world. Still, the city's Health Department records show that 78 percent of local physicians and dentists have never done a single AIDS test. Although the city has about 25,000 physicians, the Gay Men's Health Crisis, the largest volunteer AIDS agency, has a referral list of just 45 qualified private AIDS specialists in Manhattan who are willing to take patients. There are only one or two for each of the city's other four boroughs which have half of the city's cases." Nationally, the Physicians Association for AIDS Care has a referral list of only 2,000 physicians, a tiny fraction of the country's total of 600,000.

One witness told us of a recent study that estimated only "10 percent of internal medicine residents have a strong commitment to the care of HIV infected people and are likely to include them in their post-training practice. About 25 to 30 percent have a definite aversion to HIV work and are planning their professional lives to avoid contact with these patients. The remaining 65 percent are neutral or uncommitted in their stance towards the AIDS epidemic."

Unwillingness or reluctance to care for people with HIV infection and AIDS is often attributed to fear of occupational risk and lack of adequate training and expertise in treating HIV infection and AIDS. The Commission believes both of these concerns should be acknowledged and addressed. Support at every institutional level is needed for education about occupational risks, training in the use of universal

precautions, and the provision of adequate equipment. Support is also needed to develop a comprehensive HIV/AIDS educational strategy that effectively meets the needs of all physicians, particularly primary care physicians. After all, as one witness reminded us, if you consider that we have one million or more cases of persons infected with HIV across the country, it can no longer be acceptable for a physician or dentist to offer as an excuse, "I don't have expertise in relation to this particular disease." They simply must acquire the expertise.

Finally, we were told that "physicians who do not intend to work with HIV infected patients are characterized by negative attitudes toward people from predominant HIV risk groups, dislike working with an incurable disease which produces progressive loss of function and decreasing dependency, and a weak sense of professional responsibility." These findings certainly have important implications as we attempt to increase the willingness of physicians to work with people with HIV infection and AIDS, and to ensure access to care.

Social Workers

Many people living with HIV infection and AIDS have relied on social workers for much of their care. Social workers have developed many of the early models of AIDS services and community care and provided all levels of service for patients and families. The number of social workers across the country (500,000 in total) falls far short of the growing need. Social workers have long gone unsupported and unrewarded. It is time that changed.

Allied Health

Clearly, physicians, nurses, dentists, and social workers are not the only care providers in the HIV epidemic. Indeed, allied health workers do much of the hands-on care provided to people with HIV infection and AIDS. One witness pointed out there are 85 allied health professions, representing one-to two-thirds of the entire health workforce. These professionals

are the hundreds of thousands across the country who draw blood, process HIV antibody tests, provide respiratory therapy, physical therapy, nutritional therapy and countless other health care services so many of us take for granted. There is a shortage of allied health professionals and, we were told, the shortage will be greater than the current physician and nursing shortage.

Public Health

The Commission also recognizes that there is an increasing need for public health specialists such as epidemiologists and biostatisticians. Nurses, physicians, dentists and others trained specifically in public health and often serving in community settings need support and re-enforcement. Schools of public health must expand and enrich HIV/AIDS specific programs in their curricula and training opportunities.

Volunteers

Volunteers are now and always have been at the heart of our response to the HIV/AIDS epidemic. They provide many of the services traditionally provided by paid professionals. "It is the volunteers," we were told, "who do the job, and most important in some ways it is the volunteers who save all of us millions of dollars every single year in this epidemic."

But all too often volunteers are viewed as a free resource, when in fact volunteers require financial and management support for recruitment, training and coordination. The cost effective dollars to train and support one of our most valuable resources in the HIV/AIDS epidemic simply must be given priority in government grants and agency operating budgets. In addition, one witness told us, something as simple and inexpensive as the President inviting AIDS volunteers to the White House would not only honor AIDS volunteers but would also send the message that our country is still in the midst of an HIV/AIDS epidemic and volunteers are key to the country's response.

SUMMARY

Finally, the Commission heard from experts about the ethical dilemmas confronting health care workers in the HIV/AIDS epidemic. Concerns about occupational risk, duty to treat, the right to know a patient's HIV antibody status, emotional stress and strain, and assisting patients to make treatment decisions were all raised as difficult, sensitive issues that we must begin to confront and to assist health care workers to resolve. Caring for people with HIV infection and AIDS will challenge health care providers to overcome their fears, ignorance and prejudices. For many this will not be easy. But, as one witness reminded us, "We have taken on difficult tasks before." What we must do, he said, "is teach people a set of skills that we have largely ignored: how to relate to patients, how to understand their frame of reference.... We are defined by our patients and by the depth and breadth of care that we provide for them...we must encompass that when we become a professional."

It is clear to the Commission that effective AIDS education programs are needed for all health care workers. This includes those who are currently practicing, as well as those in training. We must support and re-enforce those who have chosen to provide the care and services needed over the last decade to people living with HIV infection and AIDS. We can no longer rely on what one witness called "people with a calling." By a personal demonstration of tolerant, less judgmental, more accepting, more compassionate, and more constructive attitudes toward all people living with HIV infection and AIDS, each of us could help this nation move more swiftly toward the changes that must come if we are to truly care for all people and control the HIV epidemic.

The Commission makes the following recommendations:

1. A comprehensive community-based primary health care system, supported by adequate funding and reimbursement rates, is essential for the care and treatment of all people, including people living with HIV infection and AIDS. The Commission highlighted this need in its first report and continues to believe that lack of access to primary care services provided by adequately trained primary care providers is undermining current efforts in HIV/AIDS research, prevention and treatment. The development of a comprehensive system with linkages to research protocols, existing community-based services, hospitals, drug treatment programs, local health departments, and longterm care facilities, based on a foundation of adequate support, is long overdue and should be a top priority for the federal government.

2. AIDS education and outreach services in rural communities should be expanded and designed to provide clear and direct messages about how HIV is and is not transmitted, and the kinds of behaviors that may place an individual at risk for HIV and other sexually transmitted diseases. Expansion of programs, resources and health care providers is also needed to respond to rural America's need for prevention and treatment programs that address the three epidemics of HIV infection, drug addiction and sexually transmitted diseases.

3. The NIH clinical trials program is in serious trouble. The limited number of enrollees in trials and the lack of demographic and geographic diversity of the participants threatens the success of the program and denies many people living with HIV infection and AIDS the opportunity to participate in experimental drug therapies. The academic health centers involved have not been as vigorous as one would hope in advancing these trials, nor has the NIH been

vigorous in monitoring their performance. Aggressive efforts must be made to overcome the obstacles to participation for many who are under-represented. Success in this area can only be measured by increased participation in trials.

4. There is a desperate need for more research on the management of opportunistic infections, usually the cause of death for people with AIDS. The NIH simply must expand the level of research in this area. This expansion must not come at the expense of other research efforts and should be an integral part of a comprehensive AIDS research plan. This plan should outline the AIDS research priorities and goals for the entire NIH, and the resources needed to achieve them. The plan should be widely disseminated and should incorporate the views of persons living with HIV infection and AIDS.

5. There is a shortage of crisis proportions of health care providers capable and willing to care for people living with HIV infection and AIDS. This crisis will only get worse as the HIV epidemic continues into the 1990's. Action must be taken now to increase and improve the effectiveness of all programs designed to educate and retain practicing health care professionals, and to create incentives for providers to care for people in underserved areas. Existing programs such as the National Health Service Corps should be expanded. New programs such as those outlined in the Disadvantaged Minority Health Improvement Act (H.R. 3240) should be created. And, specific HIV/AIDS fellowships and training programs should be established and supported to prevent a crisis of greater magnitude.

6. Volunteers should be publicly recognized not only for the invaluable contribution they have made to people living with HIV infection and AIDS, but also for the way in which they fight fear and bigotry by fostering compassion and caring. The cost effective dollars needed to

recruit, train, support and manage volunteers must be provided by the government and the private sector, and recognized as essential to our national response to the HIV epidemic.

VHA's AIDS Caseload Mirrors That Of Nation

In the following article Marvelu (Bobbie) Peterson, Ph.D., director of the AIDS service in the Veterans Health Administration, outlines the beginning of VHA's AIDS program and describes future plans.

The Veterans Health Administration has provided health care services to eligible veterans with HIV infection and AIDS since the beginning of the epidemic. One of the first cases of AIDS reported in the country was seen at the New York VA Medical Center (VAMC) in 1979.

By 1983, 211 cases of AIDS were reported by 46 medical centers. Since that time, the growth of the epidemic, its characteristics and the distribution of AIDS cases in VA has essentially mirrored that seen in the nation.

By October 31, 1992, 157 medical centers had reported 14,319 cases of AIDS, or approximately 6 per cent of the adult cases reported in the nation. During fiscal 1991, VA treated approximately 15,000 patients with HIV infection or AIDS.

Although AIDS cases have been reported by the majority of VA's 171 medical centers, the geographical distribution continues to be more concentrated in facilities located in large urban areas in coastal states. Approximately half of the AIDS cases treated in VA have been seen in 12 medical centers in New York, New Jersey, Florida, California, Washington D.C. Puerto Rico and Texas. Among those facilities, the most heavily impacted remain those with early, heavy caseloads, namely the West Los Angeles, San Francisco, Miami and New York VAMCs.

Specialized Units

Because of the early impact of the epidemic, the Veterans Health Administration responded quickly to the epidemic. Clinical care issues were spearheaded by the New York VAMC, where in late 1987 the facility developed an inpatient AIDS Clinical Unit. At that time, approximately 25 per cent of the patients seen in the medical service were AIDS patients.

This unit was quickly followed by the development of other inpatient AIDS clinical units at Miami and West Los Angeles and an outpatient care model at San Francisco VAMC.

These four units serve as models for comprehensive and coordinated inpatient and outpatient care through a multi-disciplinary approach. They also serve as a milieu for clinical research, an educational environment for training of residents, medical students and health care professionals.

Research

Biomedical and health services research has always served as cornerstone for the enhancement and improvement of the standard of care provided to VA patients. Through the Medical Research Service career development, merit review and cooperative studies programs, AIDS related projects on a diverse range of biomedical, basic science and clinical topics are conducted.

In fiscal 1991, more than 450 VA and non-VA funded AIDS research projects were in progress in a number of VA medical centers. Early in the epidemic, the Medical Research Service established six AIDS research centers to provide core funding for HIV and AIDS research.

These centers are located at the Baltimore, Durham, Houston, New York, San Diego, and San Francisco VA Medical Centers.

A variety of HIV/AIDS research projects in virology, molecular biology, immunology, pharmacotherapy and clinical care and treatment are in progress. VA researchers are at the forefront of biomedical and clinical research. For example, the recently published results of the VA cooperative study on early versus late treatment with zidovudine in patients with symptomatic HIV infection was the first to address the question of whether early rather than later use of AZT prolongs life. Numerous publications and presentations at national and international conferences can be credited to VHA staff involved in both research and clinical care activities.

anticipated implementation of the standard, the AIDS Service formed an interdisciplinary group of advisors to assist in the development of a national approach to this important area in June of 1990. Many of the suggestions made during a meeting of that group were incorporated in a national training program implemented through the Office of Academic Affairs in late fiscal 1991 and throughout fiscal 1992.

Since the standard offers a unique opportunity for interdisciplinary as well as inter-agency collaboration, the program focused on team training of core staff responsible for coordination and oversight of the OSHA standard in each medical center in the system. Other activities include the recent formation of another expert interdisciplinary advisory group to address specific questions related to the standard via a newsletter format.

The quality of care and ethical issues which arise in the care of AIDS patients are also being addressed. Guidelines for evaluation of ethical issues are being developed through VHA's national ethics center. Clinical indicators for national implementation are in the developmental stage. It is anticipated that the national HIV registry may also be a useful source of information in this process.

In general, issues surrounding HIV infection and AIDS of national interest are those which affect VA as well. VHA staff participate in national as well as local inter-agency issues and efforts. Representation on the National AIDS Commission is provided by the Office of the Secretary.

Future Planning

Care of HIV infected and AIDS patients is being incorporated into the National Health Care Plan for VHA. Future plans include the continuing development of model specialized programs where needed to meet the changing face of the epidemic.

As care of the HIV infected and AIDS patients becomes one of long term commit-

ment on an outpatient basis, discrete outpatient clinics in primary care settings are projected. Additional clinical units in those areas now becoming heavily impacted by the epidemic have been proposed.

A new model of care recently proposed is the development of AIDS long-term care programs. These programs would focus on the needs of special populations requiring sheltered environments such as the homeless, those without community support systems, the chronically mentally ill or patients with HIV related dementias.

Such programs would entail the cooperative planning efforts of acute, long-term and extended care facilities within the system.

Through our educational, research and clinical care foci and the dedication of our health care providers, researchers and educational staff, we believe VHA can be proud of its response to the AIDS epidemic. Through coordinated planning, we feel confident of our ability to continue to meet the needs of eligible veterans with HIV infection and AIDS and look forward to the challenges of the future.

Resource utilization needs for each of the four stages of HIV infection are tracked in the registry. The AIDS model has been incorporated into an overall Resource Planning and Management process for resource distribution system-wide. Although a preliminary costing study was completed early in the epidemic, the need for a formal research project related to costing and patient outcome has been recommended by the group. Such a multi-center study is in the proposal development stage.

Protection of health care workers against bloodborne pathogens has received increasing attention with the publication of the OSHA standard on occupational exposure to bloodborne pathogens. To meet the an-

-Education

VA has had a strong commitment to combating the AIDS epidemic through education. A national education plan with specific training initiatives was developed by the Office of Academic Affairs in fiscal 1988. The goals of the initiatives are to enhance the quality and humaneness of care and to promote behavior to prevent transmission and reduce the risk of infection.

A number of programs to educate both VA staff and veterans and their families about AIDS have been implemented. Initial efforts were directed toward training a cadre of staff at each of the medical centers to address local areas of educational need.

The training programs included a train-the-trainer program for staff charged with facility employee training on HIV prevention and transmission, including the use of universal precautions, and a patient health education program designed specifically to prepare caregivers to conduct pre- and post-HIV antibody test education and counseling for patients. Since completion of those efforts, training for new staff is conducted on an annual basis.

Several other national programs have been conducted to meet the changing educational needs associated with the epidemic. These programs include one designed to assist staff at VA health care facilities to integrate HIV disease prevention activities into substance abuse treatment in order to facilitate both addiction recovery and HIV disease prevention.

Other activities have included a facility based AIDS/HIV education demonstration project to fund new approaches to education at the local level and discipline-specific educational programs for physicians,

dentists, social workers and Vet Center personnel. Four teleconferences on a variety of HIV/AIDS clinical topics have been offered on an annual basis.

Health Care Services

A wide array of services to meet the medical and psychosocial needs of HIV infected and AIDS patients are available at VHA facilities. Depending upon the size and mission of the facility, these services range from HIV antibody testing and counseling and outpatient management to the provision of specialized treatments. Services may be provided in a variety of settings in primary, extended and long term facilities. In general, care of HIV infected and AIDS patients is provided at the facility closest to the patient's home.

Adherence to strict confidentiality and non-discrimination in admission and treatment are mandated by legislation. HIV antibody testing is performed only with the voluntary and written informed consent of the patient and all testing must be accompanied by pre- and post-test counseling. The medical records and information related to HIV antibody testing and diagnosis have additional confidentiality requirements.

Program Administration

The AIDS Service was formally established to advise the Chief Medical Director on policy issues related to the epidemic, coordinate the national program of education, research and clinical care on HIV/AIDS, serve as liaison for congressional and budgetary affairs and provide consultation to medical centers.

National policy has been developed on a wide range of HIV/AIDS related issues including AIDS case reporting, confidentiality and HIV antibody testing and counseling, implementation of universal precautions and post-exposure management of employees accidentally exposed to blood and body fluids. The service was also charged with the formation and maintenance of a national database on AIDS to determine the impact of the epidemic on the system and to plan for future needs. This database was established with reporting requirements to the VHA administrative offices beginning in 1983.

Sharing information is a key element of any national program. Networking among staff is encouraged through the national training programs. The AIDS Service publishes a quarterly newsletter, the AIDSGRAM, that is disseminated to AIDS coordinators and directors in each medical center.

The newsletter contains information about the demography and geographical distribution of the epidemic and articles pertinent to the VA policy, care, research and educational activities.

Articles from staff in VHA health care facilities are solicited.

Current Issues

The need for a local as well as national database to track patients through their stages of illness and to track resource needs for care was identified by staff in the large medical centers as early as 1987. In response to that need, an advisory group of HIV/AIDS field experts and San Francisco Information System Center staff began development of an HIV registry to be utilized on the decentralized hospital computer system at each facility.

This registry was distributed to all medical centers in late 1991. Patients in four stages of disease, HIV infection through AIDS, are entered into the database at each medical center. Each stage of disease is defined by CD4 count level and clinical criteria. Successive stages reflect increasing severity of disease.

Demographic, diagnostic and drug information as well as information on inpatient stays and outpatient visits are provided for each patient. Data entered and extracted at the local medical center is then automatically transmitted to a national database.

Both the local and national databases have been developed to strictly maintain patient confidentiality. This database will be used for continuing assessment of the impact and growth of the epidemic in VA as well as for planning future programmatic and resource needs. It is also expected to provide a means by which a large patient population may be followed through the various stages of HIV infection as well as a means of defining the natural history of AIDS in an era of expanding drug treatment.

Determination of the cost of care for HIV infected and AIDS patients continues to be an area requiring definition and study. In 1990, another advisory group of field experts was formulated to develop an AIDS model for cost estimation and resource distribution in cooperation with the Boston Development Center. This group worked in concert with the expert panel in the development of the HIV registry in anticipation of increasing resource requirements as a patient progresses through increasingly severe stages of illness.

AIDS Patient Registry – Demographic Update

Cumulative Totals to December 31, 1992

Cumulative total: 14,649

New patients reported in month noted:

October	239
November	150
December	180
Year to date	2,241

Ethnic:

White	7,383	50.40
Black	5,123	34.97
Hispanic	1,725	11.78
Unreported	356	2.43
Pacific/Asian	36	0.24
American Indian	26	0.18

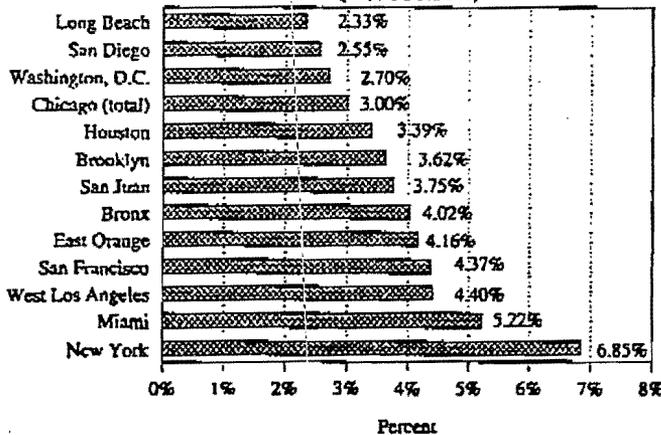
Risk Factor:

Risk Factor	Number	Percent
Homosexual or Bisexual	6,980	47.65
IV Drug User	3,957	27.01
Both Homosexual & IV Drug User	954	6.51
Heterosexual contact	458	3.13
Transfusion (TRF)	511	3.49
Unknown or unreported	1,789	12.21

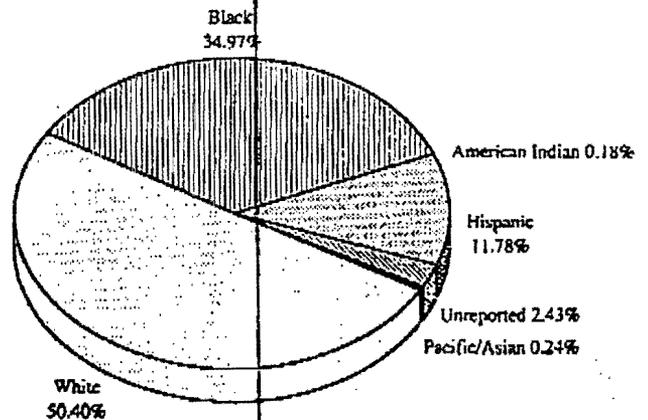
Sex:

Male	14,411	98.38
Unreported	168	1.14
Female	70	0.48

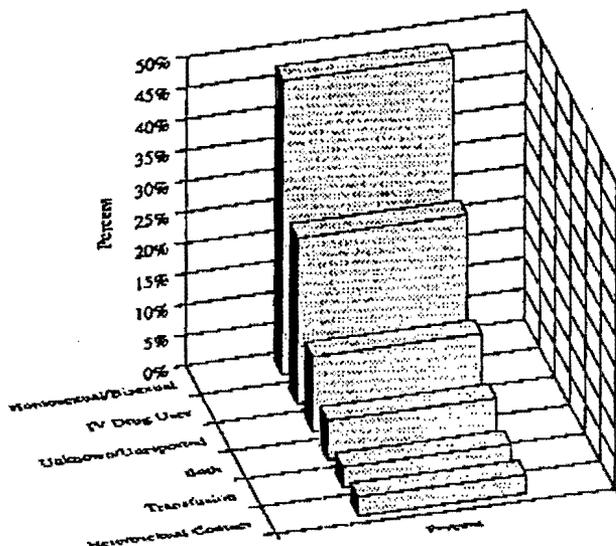
AIDS Patient Registry
(CUM 50.36%)



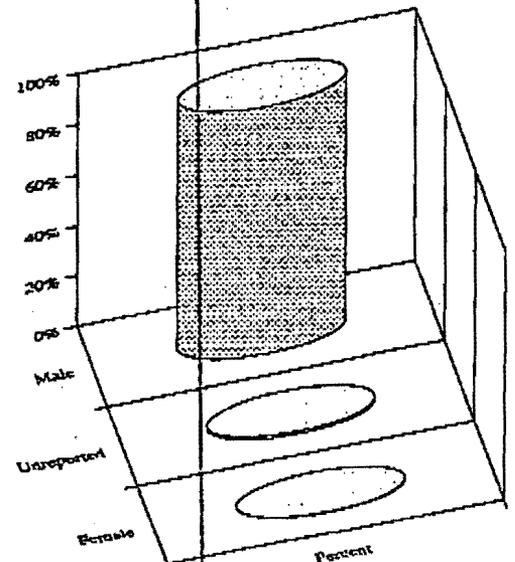
Race and Ethnic Groups



Risk Factor



Sex of Patients



FROM
THE WHITE HOUSE
WASHINGTON, D.C.

Stc 815 - 1730 K St. NW
Wash, DC 20006
(202) 254-5125

Letter to the National Commission on AIDS

From the President

During the past three-and-a-half years, the National Commission on AIDS has made an enormous contribution to the nation through its efforts to illuminate the problems and propose the solutions to the tragedy of AIDS. You have labored to inform the government, the public, and the Congress of the extent and the severity of this epidemic.

I write to thank you for your work and to let you know that it has fallen on fertile ground. For this Administration will strive as none before it to carry out your recommendations with concern, commitment and resolve.

I have reviewed the letter and recommendations you submitted to me in January. They are based, I am sure, on evidence gained through your investigations, hearings and reviews. The recommendations speak to the need for swift and heroic action to stop the sweep of AIDS throughout this nation and the world.

As I stated during the campaign, I am committed to implementing many of the Commission's recommendations. This

process has already begun. As you know, among the first budgetary actions taken by my Administration was a request for greatly increased funding for AIDS research and prevention, and full funding of the Ryan White Comprehensive AIDS Resources Emergency Act. My budget request for fiscal year 1994 includes a 78 percent increase for Ryan White, 18 percent for AIDS research and 27 percent for prevention.

Moreover, on June 10, I signed into law the National Institutes of Health Revitalization Act that establishes the Office on AIDS Research which will coordinate all AIDS research in the NIH. In addition, the Centers for Disease Control and Prevention has asked a distinguished group of experts from outside CDC to undertake a critical review of the entire AIDS prevention program. This review is now in progress.

You are undoubtedly aware that ^I we have ^{today} ~~undertaken a serious~~ ^{named} ~~effort to place a highly qualified person in the position of AIDS~~ ^{to} ~~Policy Coordinator, I will soon fill this critical position with~~ ^{Kristine Gebbie. (over) insert} ~~an expert who~~ ^{She} will have my full support in providing leadership and coordination among all relevant executive branch departments.

I understand that the Commission is about to issue a final report, and as you do so, I wish to offer my gratitude for your invaluable service to the nation. Your work will guide us through the coming months and years as we continue the fight against this tragic disease.

Kristine has served as ~~Secretary~~ Secretary of the Washington State Department of Health and Administrator of the Oregon Health Division. ~~As~~ An original member of the Presidential Commission of the Human Immunodeficiency Virus Epidemic, and a member of the AIDS Oversight Committee of Institute of Medicine, she has also been Chair of the Association of State and Territories Health Officials' ~~Committee~~ HIV Committee. She is Kristie is also a nurse and has ~~taught~~ ^{been on the faculty} at many ~~of~~ fine universities.

KRISTINE M. GEBBIE
RN, MN, FAAN

Department of Health
1112 S.E. Quince MS: ET-21
Olympia, WA 98504-7890
(206) 753-5871

P6/(b)(6)

PRESENT POSITION

Secretary
Washington State Department of Health

(202) 205-8660 office

DOB:

P6/(b)(6)

12:30 p.m. 6/16/93

4/28/93

Wanted to
(W)

PRIOR POSITIONS

- 1978-1989 Administrator, Oregon Health Division
Assistant Director for Health.
- 1976-1978 Assistant Director, St. Louis University Hospitals, St. Louis, Missouri
- 1974-1976 Coordinator - Ambulatory Care, St. Louis University Hospitals (responsible for all outpatient clinics)
- 1972-1977 Project Director, USPHS Training Grant (to prepare nurse practitioners for practice in distributive settings)

ACADEMIC CAREER

- 1991-1991 Affiliate Associate Profress, Department of Health Services, University of Washington, School of Public Health and Community Medicine, Seattle Washington
- 1990-Present Clinical Assistant Professor, Department of Community Health Care Systems, University of Washington School of Nursing, Seattle, Washington
- 1980-Present Adjunct Associate Professor, Department of Psychiatric/Mental Health Nursing, School of Nursing, Oregon Health Sciences University, Portland, Oregon
- 1977-1978 Associate Clinical Professor, St. Louis University
- 1972-1977 Assistant Professor of Nursing, St. Louis University
- 1968-1971 Instructor and Lecturer, Community Mental Health Nursing, School of Nursing, University of California at Los Angeles

EDUCATION

- 1965 Bachelor of Science Nursing Degree, St. Olaf College, Minnesota
- 1968 Master of Nursing Degree, University of California School of Nursing, Los Angeles, California
- Current Dr. P.H. Candidate, PEW Doctoral Program in Health Policy, University of Michigan School of Public Health, Ann Arbor, Michigan

PROFESSIONAL ACTIVITIES

- 1990-Present **American Public Health Association**
Executive Board
- Vice Chair, Executive Board
- 1983-1989 **Program Development Board**
- 1985-Present **Association of State and Territorial Health Officials**
Member - HIV Committee
- 1985-1988 **Chair - HIV Committee**
- 1984-1985 **President**
- 1984-1987 **Member - Executive Committee**
- 1989-Present **Chair, Centers for Disease Control Advisory Committee on the Prevention of HIV Infection**
- 1991 **Chair, Environment, Safety and Health Advisory Committee, US Department of Energy**
- 1992 **Member, Institute of Medicine**
- 1991 **Member, Secretary of Energy Advisory Board Task Force on Civilian Radioactive Waste Management, US Department of Energy**
- 1991 **Member, Comptroller General's Health Advisory Committee, US General Accounting Office**
- 1990-Present **Member, Advisory Committee for the Hanford Thyroid Disease Study, Centers for Disease Control**
- 1989-Present **Member, Editorial Board, Journal of Public Health Policy**
- 1989-1990 **Chair, US Department of Energy Secretarial Panel on the Evaluation of Epidemiologic Research Activities**
- 1987-1988 **Member, Presidential Commission on the Human Immunodeficiency Virus Epidemic**
- 1987-1990 **Member, AIDS Oversight Committee, Institute of Medicine**
- 1983-1989 **Board of Directors, Public Health Foundation**

HONORS

- 1979 **Distinguished Alumna, St. Olaf College, Minnesota**
- 1983 **Oregon Chapter of American Society for Public Administration Award II**
- 1987 **Civil Liberties Award, American Civil Liberties Union of Oregon**
- 1988 **Arthur T. McCormack Award for Public Health, Association of State and Territorial Health Officials**
- 1989 **Distinguished Scholar, American Nurses Foundation**
- 1990 **Fellow, American Academy of Nursing**
- 1991 **Sigma Theta Tau International, Mary Tolle Wright Award for Excellence in Leadership**

MEMBERSHIPS

- * American Public Health Association
- * American Nurses Association
- * Hastings Center
- * North American Nursing Diagnosis Association
- * Washington Public Health Association

CIVIC GROUPS

- * City Club of Seattle
- * Lutheran Family Services of Oregon and SW Washington, Board of Directors, 1979-1985
- * Oregon Psychoanalytic Foundation, Board of Directors, 1983-1987
- * Synod Council, Oregon Synod of Evangelical Lutheran Church in America 1987-1989

PUBLICATIONS

Daloughery, Grace W. and Gebbie, Kristine M., and Newman, Betty M. Consultation and Community Organization in Community Mental Health Nursing, The Williams and Wilkins Company, 1971.

Daloughery, Grace W., and Gebbie, Kristine M. Political Dynamics, Impact on Nurses and Nursing, St. Louis: C.V. Mosby Company, 1976.

Gebbie, Kristine M. "Impact of Cutbacks: Alternative Futures in Public Health Nursing," Journal of Public Health Policy, Volume 7, Number 1, Spring, 1986

Gebbie, Kristine. "How to Develop Health Policy", Alaska Medicine, January, February 1988

Gebbie, Kristina. "AIDS and Government: Regulation of Sexual Behavior", UMKC Law Review, Winter 1989.

Gebbie, Kristina. "Legal issues", Oregon State Bar Bulletin, February/March 1989.

Gebbie, Kristine. "The Presidential Commission: What did it Do?" American Journal of Public Health, July 1989.

Lang, Norma M., and Gebbie, Kristine. "Nursing Taxonomy: NANDA and ANA Joint Venture Toward ICD-10CM." Classification of Nursing Diagnosis, J.B. Lippincott Company, 1989.

Schwerc, Jean E. and Gebbie, Kristine M. Creative Teaching in Clinical Nursing, Third Edition. St. Louis: C.V. Mosby Company, 1976.

Many Articles in professional journals in the fields of nursing and public health (a list is available on request).



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

F A C S I M I L E C O V E R S H E E T

To: Rosalyn Kelly

Organization: _____

From: Patsy Fleming - 690-5400

Date: 6/25/95

Immediate Office of the Secretary
200 Independence Avenue, SW
Room 605-F
Washington, D.C. 20201

Phone: (202) 690-5400
Fax:

Recipients' Fax Number: 202-456-2878

Number of pages including this sheet: 2

Remarks:

NATIONAL COMMISSION ON AIDS

Chairman

June E. Osborn, M.D.
 The University of Michigan
 School of Public Health
 109 South Observatory Street
 Ann Arbor, MI 48109-2029
 Phone: (313) 763-5454
 Fax: (313) 763-5455

Eunice Diaz, M.S., M.P.H.
 770 Kristen Court
 Santa Barbara, CA 93111
 Phone: (805) 967-4105
 Fax: (805) 681-7332

Vice Chairman

David E. Rogers, M.D.
 Professor of Medicine
 Cornell University Medical College
 1300 York Avenue, Room A-127
 New York, New York 10021
 Phone: (212) 746-5431
 Fax: (212) 746-8670

Mary D. Fisher
 Family AIDS Network
 678 Front St., Suite 150
 Grand Rapids, MI 49504
 Phone: (616) 451-2361
 Fax: (616) 451-9180

Donald S. Goldman, Esq.
 1216 New Court Building
 50 West Market Street
 Newark, NJ 07102-2192
 Phone: (201) 621-5055
 Fax: (201) 621-4336

Diane Ahrens
 Board of Ramsey County Commissioners
 220 Court House
 St. Paul, MN 55102
 Phone: (612) 266-8350
 Fax: (612) 266-8370

K. Scott Allen
 University of Texas
 Southwestern Medical Center
 Department of Internal Medicine
 5323 Harry Hines Boulevard
 Dallas, Texas 75235-8889
 Phone: (214) 688-7626
 Fax: (214) 688-2087

Lawrence J. Kessler
 Executive Director
 AIDS Action Committee
 131 Clarendon Street
 Boston, MA 02116
 Phone: (617) 437-6200 (x239)
 Fax: (617) 437-6445

Don C. Des Jarlais, Ph.D.
 National Development
 and Research, Inc.
 11 Beach Street
 New York, New York 10013
 Phone: (212) 966-8700
 Fax: (212) 334-8417

Charles Konigberg, Jr., M.D., M.P.H.
 Director, Division of Public Health
 Delaware Health and Social Services
 Jesse Cooper Building, Room 121
 Water & Federal Streets
 Post Office Box 637
 Dover, DE 19903
 Phone: (302) 739-4700
 Fax: (302) 739-6659

Representative J. Roy Rowland
 2134 Rayburn House Office Building
 Washington, D.C. 20510
 Phone: (202) 225-6531
 Fax: (202) 225-7719

P6/(b)(6)

(M)

THE WHITE HOUSE

WASHINGTON

September 23, 1993

MEMORANDUM FOR LEON PANETTA
TONY LAKE
HOWARD PASTER

FROM: Carol H. Rasco, Assistant to the President for
Domestic Policy

SUBJECT: GP160 Vaccine

This is URGENT and time sensitive. Please advise immediately!

Thank you.

I DO NOT
THINK THIS
CAN GO
UNTIL SEVENTEENS
DOOD
LEIBERMAN
JOHNSON *
BRADY
CRAIG
NOTIFIED
H/A

Do you have a
problem w/
this letter

THE WHITE HOUSE
WASHINGTON

September 22, 1993

MEMORANDUM FOR CAROL RASCO

FROM: Kristine M. Gebbie
SUBJECT: GP160 Vaccine

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

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

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

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

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

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

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

cc: Steve Richetti

DRAFT

Dear _____ (Inouye, Kennedy, Dingle, Waxman)

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

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

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

Sincerely,

cc: Shalala
Aspin
Rasco

SP
Dingell

Office of the National AIDS Policy Coordinator



Executive Office of the President
750 17th Street, N.W. Suite 1060
Washington, D.C. 20500



Phone: (202) 632-1090

Fax: (202) 632-1096

Deliver To: Rosalyn

Sent From:

Kristine Gebbie, RN, MN, National AIDS Policy Coordinator

Retra Holmes

Number of Pages: 6 - cover Fax Number: 456-2878 Date: 11/16/93

Message:

Attached is a copy of the response letter to Dr. Remafedi. The original letter is being mailed today.

THE WHITE HOUSE

WASHINGTON

*for files -
let's discuss*

November 16, 1993

Gary Remafedi, M.D.
Assistant Professor
Department of Pediatrics
The University of Minnesota Hospital and Clinic
Loring Park Office Building
428 Oak Grove Street
Minneapolis, MN 55403

Dear Dr. Remafedi:

I am just starting my review of agency proposals for the FY95 budget. The funding for Ryan White programs, including Title IV, is of particular concern and I will be paying close attention to requests in this area. The pediatric programs you describe have been a critical part of our efforts to serve children with HIV. Thank you for writing.

Sincerely,



Kristine M. Gebbie
National AIDS Policy Coordinator

cc: Carol Rasco, Domestic Policy Council

NOV 12 1993

OFFICE OF DOMESTIC POLICY

THE WHITE HOUSE

FROM THE OFFICE OF: CAROL H. RASCO
ASSISTANT TO THE PRESIDENT
FOR DOMESTIC POLICY

TO: Mellicie

DRAFT RESPONSE FOR CHR BY: _____

PLEASE REPLY (COPY TO CHR):

PLEASE ADVISE BY: _____

LET'S DISCUSS: _____

FOR YOUR INFORMATION: _____

REPLY USING FORM CODE: _____

FILE: _____

RETURN ORIGINAL TO CHR: _____

SCHEDULE: _____

REMARKS:

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Youth and AIDS Project

*Division of General Pediatrics and
Adolescent Health
Variety Club Children's Hospital*

Annex

*Loring Park Office Building
428 Oak Grove Street
Minneapolis, MN 55403*

612-627-6820

Fax: 612-627-6819

November 3, 1993

Carol H. Rasco
Assistant to the President for Domestic Policy
Executive Office of the President
The White House
Washington, D.C. 20500

Dear Ms. Rasco:

The Youth and AIDS Projects has been a Pediatric/Family AIDS Demonstration Program since 1990; this funding allows us to provide case management and supportive services to our current case load of 29. I am writing to thank you for supporting the FY 1994 consolidation of funding for the Pediatric/Family AIDS Demonstration Program within Title IV of the Ryan White CARE Act, and to urge a significant increase for Title IV in the President's budget request for FY 1995.

As you know, Congress recently completed the Labor/HHS appropriations conference. Despite the President's request of \$21 million for the Pediatric/Family AIDS Demonstrations and \$6 million for Title IV in FY 1994, the final appropriation was only \$22 million. This represents a \$1 million increase out of a total increase of \$210 million for other Titles of the CARE Act. The Youth and AIDS Projects and other pediatric, adolescent and family AIDS demonstrations that are now a part of Title IV have been essentially level funded for the past three years.

I am now writing to strongly urge that Title IV of the Ryan White CARE Act be increased to \$42 million in FY 1995. While consolidation of funding within Title IV will enhance the delivery of services and access to clinical trials for our clients affected by HIV disease, it does not diminish the need for substantial new funding in FY 1995.

As you know, HIV infection rates among women, adolescents and children have rapidly increased. In FY 1991-92, the Youth and AIDS Projects had a case load of 10 young men and women who were HIV seropositive; in FY 1992-93, that number grew to 29. The Youth and AIDS Projects anticipates adding an additional 15 new HIV seropositive clients during the 1993-94 fiscal year. The 1992 report of the U.S. House of Representative's Select Committee on Children, Youth, and Families, titled A Decade of Denial: Teens and AIDS In America, reported that during the two years prior to the report, "the number of teens and young adults (ages 13-24) who were diagnosed with AIDS increased by 77%. More than half of U.S. AIDS cases among persons ages 13-24 have been reported during the past three years of the decade-old epidemic."

Ms. Rasco
11/3/93
page 2

Title IV of the CARE Act has now become an important focus of providing funds to deliver specialized pediatric and adolescent HIV comprehensive services throughout the United States. If you or your staff need further information related to programs funded under Title IV, please contact David Harvey, Coordinator for Public Policy at the National Pediatric HIV Resource Center (202-289-5970) in Washington, D.C. If you need further information related to services for adolescents, please contact me at (612) 627-6820.

Thank you for your consideration of this request.

Cordially,

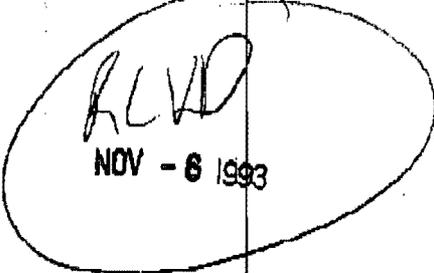
GR/bf

Gary Remafedi, M.D.
Assistant Professor
Department of Pediatrics
Director, Youth and AIDS Projects
Adolescent Health Program

UNIVERSITY OF MINNESOTA*The University of Minnesota Hospital and Clinic**Youth and AIDS Project
Division of General Pediatrics and
Adolescent Health
Variety Club Children's Hospital**Annex
Loring Park Office Building
428 Oak Grove Street
Minneapolis, MN 55403
612-627-6820
Fax: 612-627-5819*

November 3, 1993

Kristine Gebbie, R.N.
National AIDS Policy Coordinator
The White House
750 17th Street, NW
Washington, D.C. 20503



NOV - 6 1993

Dear Ms. Gebbie:

The Youth and AIDS Projects has been a Pediatric/Family AIDS Demonstration Program since 1990; this funding allows us to provide case management and supportive services to our current case load of 29. I am writing to thank you for supporting the FY 1994 consolidation of funding for the Pediatric/Family AIDS Demonstration Program within Title IV of the Ryan White CARE Act, and to urge a significant increase for Title IV in the President's budget request for FY 1995.

As you know, Congress recently completed the Labor/HHS appropriations conference. Despite the President's request of \$21 million for the Pediatric/Family AIDS Demonstrations and \$6 million for Title IV in FY 1994, the final appropriation was only \$22 million. This represents a \$1 million increase out of a total increase of \$210 million for other Titles of the CARE Act. The Youth and AIDS Projects and other pediatric, adolescent and family AIDS demonstrations that are now a part of Title IV have been essentially level funded for the past three years.

I am writing to strongly urge that as the Department of Health and Human Services finishes its FY 1995 budget request and submits it to the Office of Management and Budget, that the funding request for Title IV of the Ryan White CARE Act be increased to \$42 million. While consolidation of funding within Title IV will enhance the delivery of services and access to clinical trials for our clients affected by HIV disease, it does not diminish the need for substantial new funding in FY 1995.

As you know, HIV infection rates among women, adolescents and children have rapidly increased. In FY 1991-92, the Youth and AIDS Projects had a case load of 10 young men and women who were HIV seropositive; in FY 1992-93, that number grew to 29. The Youth and AIDS Projects anticipates adding an additional 15 new HIV seropositive clients during the 1993-94 fiscal year. The 1992 report of the U.S. House of Representative's Select Committee on Children, Youth, and Families, titled A Decade of Denial: Teens and AIDS In America, reported that during the two years prior to the

Ms. Gobbie
11/3/93
page 2

report, "the number of teens and young adults (ages 13-24) who were diagnosed with AIDS increased by 77%. More than half of U.S. AIDS cases among persons ages 13-24 have been reported during the past three years of the decade-old epidemic."

Title IV of the CARE Act has now become an important focus of providing funds to deliver specialized pediatric and adolescent HIV comprehensive services throughout the United States. If you or your staff need further information related to programs funded under Title IV, please contact David Harvey, Coordinator for Public Policy at the National Pediatric HIV Resource Center (202-289-5970) in Washington, D.C. If you need further information related to services for adolescents, please contact me at (612) 627-6820.

Thank you for your consideration of this request.

Cordially,

GR/bf

Gary Remafedi, M.D.
Assistant Professor
Department of Pediatrics
Director, Youth and AIDS Projects
Adolescent Health Program

file - AIDS

OFFICE OF VACCINES RESEARCH AND REVIEW
CENTER FOR BIOLOGICS EVALUATION AND RESEARCH
U.S. FOOD AND DRUG ADMINISTRATION

FACSIMILE TRANSMISSION RECORD

4 NUMBER OF PAGES (INCLUDING COVER SHEET)

TO: *Dr. Phil Lee*
To Carol Rouse

FACSIMILE TELEPHONE NUMBER: 202-456-2878
VOICE TELEPHONE NUMBER: _____

FROM: *M. Carolyn Hardique*
CBER
FACSIMILE TELEPHONE NUMBER: (301) 480-4091
VOICE TELEPHONE NUMBER: (301) 402-1521

DATE: 6/28/93 TIME: 12:30

MESSAGE: *Sorry this is late. We have had computer problems today*
Dr. Kessler had not seen this. Dr. Henney asked that we send to
you directly.

NOTE: This transmission is from a XEROX 7033 telecopier. If you do not receive a legible document, or do not receive all of the pages, please telephone us immediately at the voice number above.

THIS DOCUMENT IS INTENDED ONLY FOR THE USE OF THE PARTY TO WHOM IT IS ADDRESSED, AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL, AND PROTECTED FROM DISCLOSURE UNDER APPLICABLE LAW. If you are not the addressee, or a person authorized to deliver the document to the addressee, you are hereby notified that any review, disclosure, dissemination, copying, or other action based on the content of this communication is not authorized. If you have received this document in error, please immediately notify us by telephone and return it to us at the above address by mail.
THANK YOU.

POLIO VACCINE AND AIDS

The origin of HIV-1 has long been controversial and elusive. Many lay and scientific theories have been proposed including, more recently, the contamination of polio vaccine with retroviruses.

- In an article in International Journal of Cancer Vol. 41, p. 601-608 (1988), it was reported that "sera from 160 Caribbean green monkeys showed no signs of SIV infection" as determined by antibody testing. This was in contrast to the positive sera obtained from African green monkeys from East Africa.
- Ohta et al. found no evidence for contamination of live oral poliomyelitis vaccines with SIV in 1989 (AIDS. 3:183).
- In November 1991, a Texas investigator, Robert Bohannon, reported finding a retrovirus, Type D, in an AIDS patient at the University of Texas, M.D. Anderson (J. Virology : 65).
- In March 1992 an article by Tom Curtis was published in Rolling Stone Magazine which speculated that the HIV may have been present in tissue from a monkey kidney used by Dr. Hilary Koprowski to grow polio vaccine. This article discussed a variety of issues related to viruses present in monkeys. The vaccine was stated to have been used in humans in Africa in the late 1950's. A press release of UPI quoted the Director of Wistar Institute as saying they were assembling a team to evaluate the theory.
- In March 1992, an attorney, Walter S. Kyle presented a "Viewpoint" which was published in Lancet (Vol. 339, March 7, 1992) which proposed that the "use of polio vaccine contaminated with small numbers of type-C retroviruses for the treatment of herpetic lesions, a sexually transmitted condition ----- in homosexual men" using high doses of vaccine "could have provided a point source for infection that spread to sexual contacts". Some of his speculation derived from information he had obtained from the Agency.
- On April 6, 1992 FDA prepared a talk paper stating several stories had appeared in media linking early polio vaccine trials to origin and

spread of AIDS. It stated that the PHS "has seen no convincing evidence to support this alleged connection or even indicates that it is remotely possible."

Further, it indicated that while monkeys are used to produce polio vaccine, there is no evidence that the animals used for production are infected with simian immunodeficiency virus (SIV); monkeys from SIV-free colonies are used. Breeders are tested for antibodies to SIV. The Talk Paper further stated that when individuals vaccinated with polio vaccine are tested, antibodies to SIV have not been found. Other experiments trying to recover SIV from monkey kidneys cells were cited which were negative.

- Science (March 20, 1992) reviewed the controversy surrounding the Rolling Stone article. This story was discussed in numerous other news forums including the lay press (i.e. Washington Post), New Scientist (April 4, 1992), the Journal of NIH Research (September 1992, vol. 4). Many of these reports discussed the issues including the need for samples from Wistar Institute to be tested using the new techniques of molecular biology, specifically polymerase chain reaction (PCR). One investigator indicated that "It's very tricky science."
- The Wistar Panel report issued October 22, 1992 [summarized by J. NIH Research (December 1992)] concluded that many "unlikely events" would have had to coincide in order for polio vaccine used in Africa by Koprowski to have resulted in AIDS. A press notice (AP) of this report, stated that testing of samples was recommended but "for technical reasons they doubted such testing would be conclusive." Only a limited sample of original vaccine was found. They did recommend that vaccine manufacture be modified to eliminate use of monkey tissues for human vaccines. Many newspapers including the New York Times have reviewed this report.
- CDC has also issued brief statements to the public indicating that the weight of the scientific evidence does not support the concept that HIV-1 originated using polio vaccine.
- FDA has long been involved in safety testing of vaccines. For example, the presence of retroviral infection in vaccines was

investigated by FDA scientists in 1975-76. No evidence of retroviruses was found in polio vaccine.

- Studies were initiated in Spring 1992 by CBER scientists to utilize several approaches to looking for SIV in polio vaccines (monovalent) and primary monkey kidney cells from Caribbean colony. These studies are currently incomplete and inconclusive. Therefore, no comment can be made regarding any results of these studies. That we are performing these studies is considered "Confidential" at this time. No information has been made available for any FOI request on this issue.
- Cases of HIV-I infection in children with no known risk factors have been reported (AP June 21, 1993). It has been suggested in the lay press that the etiology may include contaminated polio vaccine.

FDA continues to review information on this matter.

Prepared by: MCHardegree/AKhan/OVRR/CBER/FDA:06/28/93

BIOGRAPHY

11:00
4/22/93

Lee C. Smith

P6/(b)(6)

P6/(b)(6)

Lee C. Smith is currently on a community service leave with Levi Strauss & Co., and continues to hold the title of Corporate Vice President. Until April of 1992, and for the past eight years, he held the position of President of Levi Strauss International. In that position Mr. Smith was responsible for all of the company's businesses outside of the United States in some 70 countries around the world.

P6/(b)(6)

There are more than 9000 employees in Europe, Canada, Asia Pacific, and Latin America as well as a number of independent business partners who have the contractual right to make, market or distribute Levi Strauss & Co., products.

For the past eight years, Mr. Smith has led the team that has been responsible for the complete turnaround of Levi Strauss International from a virtual money losing operation to the point where, last year, it contributed one-third of the company's total revenues and one-half of the earnings.

Born in Plainfield, New Jersey, Mr. Smith received his Bachelor of Science degree from Pennsylvania State University in 1964, served a tour of duty in Thailand as an officer in the U.S. Army, and joined Levi Strauss & Co., in 1966 as a management trainee.

After 25 years with one company, 20 years in international business and the past 8 in his position, he decided to create some change in his life and seek some new challenges. His attraction to volunteer work for the Center for Southeast Asian Refugee Resettlement, membership on the Mayor of San Francisco's HIV Task Force, and various activities with the San Francisco AIDS Foundation have led him to join the National Leadership Coalition on AIDS, where he is a member of the Board, and to consider devoting more time to community service. Specifically at the present Mr. Smith hopes to be part of the team that will marshal the necessary resources to end the HIV pandemic.

Mr. Smith lives in Tiburon, California, and is married to Perry Smith, a graphic designer.

Call Kevin Shum
for a # -
need soon!

NATIONAL
LEADERSHIP
COALITION
ON AIDS

May 10, 1993

BOARD OF DIRECTORS

Officers

Lee C. Smith
Corporate Vice President
Levi Strauss & Co.
Chair

David N. Sundwall, M.D.
Vice President & Medical Director
AmHS Institute
Vice Chair

Michael Pollard, Esq.
Partner
Michaels & Wishner
Treasurer

B. J. Stiles
President

Members

Dushan (Dude) Angius, Ed.D.
Lawson-Hawks Insurance Associates
Rotary AIDS Project, Inc.

Gwynn C. Akin, Ph.D.
Syntex (U.S.A.) Inc.

Jordan Barab
The American Federation of State,
County & Municipal Employees

William H. Baumhauer
DAKA International, Inc.

Nora Kizer Bell, Ph.D.
University of South Carolina

Erline Belton
The Lyceum Group

Bill Borweggen, M.P.H.
Service Employees International Union

Jerald A. Breitman
Burroughs Wellcome Co.

Sharon Canner
National Association of Manufacturers

Debra W. Haffner, M.P.H.
Sex Information & Education
Council of the U.S.

Glenn E. Haughie, M.D.
International Business Machines Corp.

James Hawes, III
US West Communications, Inc.

Stanley G. Karson
Center for Corporate Public Involvement

Larry J. Kessler
AIDS ACTION Committee of Massachusetts

Bryan L. Knapp
Shearson Lehman Brothers

Michael Lauber
Tusco Display Company

Bryan Lawton, Ph.D.
Wells Fargo Bank

Jose I. Lozano
La Opinion

Jonathan Mann, M.D., M.P.H.
Harvard School of Public Health

L. Jay Marshall
Colgate/Palmolive

Brenda R. Moon
American Federation of Labor &
Congress of Industrial Organizations

Stephen T. Moskey
Actna Life & Casualty

Enoch J. Prow
NationsBank Corporation

Paul A. Ross, Ed.D.
Digital Equipment Corporation

Mervyn Silverman, M.D., M.P.H.
American Foundation for AIDS Research

John R. Taylor
The Principal Financial Group

The Rt. Rev. Douglas E. Theuner
Bishop, Diocese of New Hampshire
of the Episcopal Church

Carol Rasco
Assistant to the President
for Domestic Policy
The White House
West Wing, 2nd Floor
Washington, D.C. 20500

Dear Carol:

I am both honored and rewarded by the opportunities to meet with you, and your colleagues, and discuss the challenges we face in managing HIV/AIDS. These discussions have provided a reasonable basis for considering how best I, and the National Leadership Coalition on AIDS, can be fully supportive of President Clinton's determination to provide leadership and support in the fight against AIDS.

Having spent my career as an international business executive, I appreciate the complexity of the decisions you face, and the importance of moving forward on a number of pending appointments. Our discussions have given me a fairly good idea as to how you expect to organize the Federal Government's coordinated response to HIV disease. After a very thorough examination of your needs and expectations, and my skills, background, temperament, and contacts, I recognize that I am better suited to eliciting a constructive response to HIV from my vantage point in the business, labor, and private sector.

Thus, I have concluded that I am not the right person for the position you have described, and respectfully wish to withdraw my name from any further consideration for this position.

I care deeply about HIV disease, and what it has done to people I have known and loved. I am very troubled that, at a time when we can least afford it, HIV disease has sapped productivity in workplaces around this nation, due in large part to the discrimination surrounding the disease and to the lack of understanding as to how it is transmitted. And, I am very appreciative of the global

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

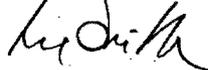
impact of HIV/AIDS and the challenges this poses as both an economic development factor and public health crisis.

The management team already in place around AIDS is very impressive, and I am confident of your ability to attract yet another critical player to assist in shaping and managing the Clinton Administration's response to AIDS. I greatly appreciate the commitment and perspectives I have witnessed in my several meetings with you and your colleagues, and offer you my full support in the work ahead. I am quite prepared, as a volunteer, to help convene others, to bring new players and additional resources to the table, and to offer the full resources of the National Leadership Coalition on AIDS to spearhead efforts to stimulate more effective responses from the private sector.

We are especially pleased with early responses from business and labor to the CDC's Business Responds to AIDS initiative, and see in this effort an important opportunity to assemble greater support from CEOs, mainstream business organizations, and organized labor. I am eager to offer guidance and assistance to you, the President, Secretary Shalala, Assistant Secretary Lee, and whomever you select to fill the post of federal AIDS coordinator, and look forward to hearing further from you.

Thank you again for the opportunity to meet, and to discuss how best to resolve these considerable challenges stemming from HIV/AIDS.

Cordially,



Lee C. Smith

LCS/dc

I understand
that you are
working on the
AIDS czar and
wanted to make
sure that you
were aware of
this woman.

Thanks.

Julie Jaffe

X7733



DEMOCRATIC CAUCUS
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C. 20515

STENY HAMILTON HOYER
CHAIR

December 21, 1992

Dear Susan:

I wanted to bring to your attention Ms. Sandra Thurman, who would make an outstanding addition to the new administration.

Sandy currently serves as Executive Director for AID Atlanta, the oldest and largest community-based A.I.D.S. service organization in the South. Since being named Executive Director in 1989, Sandy has tripled the budget of AID Atlanta and greatly improved that organization's troubled political standing in the community. Under her leadership, AID Atlanta has become a multi-million dollar organization with more than sixty people on staff and more than one thousand active volunteers. Sandy has dedicated her life to the service of others. Sandy took a thirty-day leave of absence to be the political director of the Clinton Campaign in the Georgia primary.

I think with Sandy's experience on the front line, she would be an asset to the Clinton administration as A.I.D.S. Czarina.

With kind regards, I am

Sincerely yours,



STENY H. HOYER

Ms. Susan Brophy
D.C. Director
Congressional Relations
Presidential Transition Office
1120 Vermont Avenue, N.W.
Washington, D.C. 20270

SANDRA L. THURMAN

**Executive Director
AID Atlanta**

As Executive Director of AID Atlanta, Sandra L. "Sandy" Thurman is responsible for planning and administering all programs and services for the Southeast's largest and oldest community-based AIDS service organization.

Her involvement with AID Atlanta began in 1988 when she joined the agency as its Director of Public Affairs, bringing to the post an extensive background in public service, politics, marketing and communications. She was named AID Atlanta's Executive Director in 1989. During her tenure, the organization has tripled in size to become a multi-million dollar agency with 60 staff and more than 1000 active volunteers.

A native of Atlanta with a family history of political and public service, Ms. Thurman's AIDS-related activities include membership on the State AIDS Task Force, the Fulton County HIV Planning Council and the Executive Committee of the Coalition of Title I Cities (CAEAR Coalition). In June 1992, she was selected by the Senate Labor and Human Resources Committee to testify with Ms. Elizabeth Taylor on federal AIDS programs and priorities during the Committee's oversight hearings on the success of the Ryan White CARE Act. The National Commission on AIDS requested Ms. Thurman, a nationally recognized AIDS leader, to present testimony in November

Sandra L. Thurman / Page Two

on care, financing and social support for persons with AIDS. Her testimony provided a blueprint for federal action in AIDS health care for the new administration.

Ms. Thurman currently serves on the Governor's Commission on Women and the Advisory Commission for the 1996 Atlanta Olympics. A graduate of Leadership Atlanta, she has been a board member of the National Kidney Foundation, the March of Dimes, Pets Are Loving Support, SisterLove and the Atlanta Ballet Associates.

Prior to joining AID Atlanta, she held positions as the Public Affairs Director for AmeriPlan Health Services, Georgia's largest health maintenance organization (HMO), and as a job placement specialist working with ex-offenders at the Georgia Department of Labor, Correctional Services Division.

Ms. Thurman earned her bachelor's degree in human resources administration and management from Mercer University in Georgia. Her educational background also includes extensive training in employment counseling and the rehabilitation of law offenders.

She remains an active consultant on fundraising and development and on managing organizational change, growth and diversity for non-profit organizations and public charities.

SANDRA L. THURMAN

Professional Experience

- 1989 - Present** **Executive Director, AID Atlanta, Inc.**
- 1988 - 1989** **Director of Public Affairs, AID Atlanta, Inc.**
- 1986 - 1988** **Account Services Coordinator, Partners Health Plan, Atlanta**
- 1985 - 1986** **Director of Public Affairs, AmeriPlan
Health Services, Limited, Atlanta**
- 1977 - 1985** **Job Placement / Statistical Analyst, Georgia Department of
Labor, Correctional Services Division, Atlanta**
- 1968 - 1977** **Freelance Special Events/Fundraising Consultant, self-
employed, Atlanta**

Att
JP Meyer

mike .

BOND, Alan
BOND, Jamie
BOND, Karen
BOND, Richard
BOND, William

BOND, Frederic
BOND, Jean
BOND, Langhorn
BOND, Shirley

BOND, Hannah
BOND, Julian
BOND, Laurance
BOND, Susan