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6,000 AIDS Patients Face Cutoff Of Drug That May Prolong Lives

By BRUCE LAMBERT

The expiration next month of a \$30 million Federal grant to buy a costly drug against AIDS will jeopardize the ability of 6,000 patients around the country to continue receiving the treatment, which may prolong their lives.

The Federal grant was provided on a one-time only basis to state governments to help AIDS patients who were unable to obtain azidothymidine, or AZT, by other means: those without private health insurance who cannot afford to pay themselves but who are not poor enough to qualify for Medicaid assistance.

The antiviral drug, which studies indicate, prolongs the lives of some patients, is the only AIDS treatment approved for marketing by the Federal Government. Manufactured by the Burroughs Wellcome Company of Research Triangle Park, N.C., the drug, marketed under the name Retrovir, can cost patients \$8,000 a year or more.

Debate Over Who Should Pay

The expiration of the grant Sept. 30 will not affect commercial purchases of AZT or access to the drug for Medicaid patients.

Congress has not renewed the funds, nor have most state and local governments acted to assume the cost and retain the program. At the same time, the number of AIDS patients is climbing steadily.

To win Congressional approval of the emergency AZT fund last year sponsors labeled it "a one-time only" appropriation and promised not to return seeking more money to extend it. Critics of the bill had expressed fears that without the one-year limitation the bill would open a Pandora's box that would lead to potentially enormous Federal expenditures. Supporters said the concession was the only way they could get any money approved.

The debate over the program underscores the rising controversy over who should pay for costly treatment as the number of patients with acquired immune deficiency syndrome climbs. More than 70,000 cases of the disease have been reported to date. More than half the patients have died, and no one has been cured.

Federal officials estimate that a total of 450,000 Americans will have been diagnosed with AIDS by the end of 1993. In addition, unless other drugs are proved effective, the demand for

AZT will soar still more if studies show that the drug, now mainly used by patients with serious immune damage, helps deter the AIDS virus in people who are infected but still well.

"There are a lot more people who are ill now who would be eligible," said Dr. Samuel C. Matheny, the associate administrator for AIDS for the Federal Health Resources and Services Administration, which issued the grant. "Obviously, the more people who have AIDS, the more difficult it's going to be." The impact of the grant expiration varies around the country as the states' dwindling allocations run out at different times, depending on how much they got when their programs began and how many patients enrolled.

In California, for example, health officials are cutting off new applications for AZT under the program after next month. They say their state's \$7.6 million share of the Federal money will be exhausted in April. So far, there is no substitute financing to continue AZT for the 700 residents now receiving it.

"We have received an awful lot of calls and letters — hundreds — from clients and legislators, especially as we get closer to the expiration time," said Thelma L. Frazier, chief of the Office of AIDS for the California Health Department.

New York received \$8.5 million, which officials say is serving 900 patients and will last until a year from now. "It's definitely posing a problem," said Barbara L. McTague, director of the state's AIDS Drug Assistance Program. "It's absurd to put \$30 million on the street and expect the problem will go away."

Health officials in Texas and Florida are already barring new applicants for AZT and do not project the money to last more than a few months.

Patients in the program who are unable to afford AZT when the program ends may be able to obtain it by impoverishing themselves and applying for Medicaid. This is a federally assisted program administered by states to provide medical care to the poor. In many cases, qualifying for Medicaid would require patients to give up their jobs and spend most of their remaining assets. Two states, Alabama and Colorado, still do not provide AZT under their Medicaid programs.

Nearly all the patients who have received assistance under the program in New York have had incomes below \$20,000 a year, according to state officials. To qualify for Medicaid in New York, a single person must have an income not exceeding \$5,200 a year and assets not exceeding \$3,100.

Nationwide, about 6,000 patients are now receiving AZT under the Federal grant. Patients have been in the program for varied periods of time, and many will receive the free AZT for only a few months before the funds run out.

Earlier Deaths Foreseen

"Some people will certainly die much sooner if they can't afford AZT," said Mervyn F. Silverman, president of the American Foundation for AIDS Research. "Are we really going to have people dying because they can't afford access? The important thing is for the Federal Government to refund this program, and short of that, the states must pick up the tab."

So far, the Federal Government and the states are each hoping the other will fill the void left by the expiring program.

Dr. Molly J. Coye, the Health Commissioner of New Jersey, which has about 200 patients using the drug under the Federal program, said, "We will be facing a problem on AZT, and we look to the Federal Government for that help, and we hope to keep the pressure on."

But many Federal officials are calling on the states to come to the rescue. Dr. Matheny said, "It certainly is a concern, and we hope the states are going to be picking this up."

Philosophical objections have been raised to government financing of AZT. Some officials, Federal and state alike, question the wisdom of singling out specific diseases and drugs for special consideration.

"Legislators say that while they're sympathetic, there are many other diseases which are also deserving," said Karen P. Hastings, manager of Florida's AZT program. For example, she said her state had 7,000 new cases of breast cancer each year, far more than AIDS, yet the state does not pay for mammography tests that could save lives.

At the request of Senator Lowell P. Weicker Jr., Republican of Connecticut, a Congressional report this month urged Congressional committees and the states "to act as quickly as possible" to keep the program going.

"It's a life and death issue," said Paul Stephan, a pharmacist who helps run the AZT program in Long Beach, Calif. He said he closed off applications three weeks ago and has told patients "we're running out and they better do something before they need a refill."

Citing the cost of hospitalization and other medical care and for ailing patients, Mr. Stephan said, "Without the medicine, it's going to cost taxpayers more money in the long run."

The sole exception to the trend of inaction, according to advocates for AIDS services, is the District of Columbia, which recently appropriated \$250,000 in local funds to supplement its \$536,000 Federal grant.

U.S. Is Using Random Blood Tests to Gauge Spread of AIDS

By PHILIP M. BOFFEY
Special to The New York Times

WASHINGTON, Aug. 29 — The Federal Government has begun a blood-testing surveys that, within the next several months, should help clear up uncertainty about how fast the AIDS virus is spreading.

About 1.6 million blood samples will be taken annually from newborns, hospital patients, and clients of health clinics in most states.

They will also test blood drawn each year from, among others, tens of thousands of college students, patients of family doctors, prisoners and emergency room patients.

Tests on Anonymous Basis

Most of the tests will be carried out on an anonymous basis on blood samples collected for other purposes. Participants will not know their blood has been tested and the health authorities will have no way of notifying those who are infected. Experts say this method, which does not rely on voluntary participation, is the best way to get a truly random sampling of a group.

These new surveys, costing some \$40 million a year, will supplement continuing tests on more than 7 million blood samples drawn each year from other groups, primarily blood donors and military personnel who have been screened routinely for the past couple of years.

The combined surveys are probably the largest effort ever started to track a single infection through the American population, according to Dr. Timothy J. Dondero Jr., chief of the sero-epidemiology branch of the AIDS program at the Federal Centers for Disease Control in Atlanta.

"We anticipate some initial results that we can make sense out of by the end of 1988," Dr. Dondero said. "It won't be definitive, but we should have enough data by the end of the year to at least see some patterns."

The new surveys were initiated last year at the request of the White House to resolve uncertainties and disputes over how far the virus has spread. The Centers for Disease Control has estimated that 1 million to 1.5 million Americans have the AIDS virus,

mostly contracted through homosexual intercourse or sharing contaminated drug needles. Other experts project higher or lower levels of infection, and some have speculated that the virus is already spreading rapidly into the heterosexual population, sending shivers of concern through the public.

The surveys, many of which are already under way, should yield a useful portrait of the epidemic even if the most contentious study proves impossible to conduct. That study would involve a national household survey in which investigators visit 50,000 or more randomly selected homes to ask people to give blood samples voluntarily.

Household Survey Delayed

The household survey seeks to measure the prevalence of infection with the AIDS virus on a national level. But many health experts believe that homosexual men, drug users, prostitutes and other high-risk groups would not participate in such a survey, resulting in a flawed estimate. A pilot study to determine if a national household survey is feasible has itself been delayed by community opposition.

"Quite frankly, I think the other surveys will provide a better picture even if the household survey is feasible," said Dr. Dondero. "You won't get much detail from a national sample of 50,000. For many purposes, the more focused collection of surveys will be more useful."

The chief surveys include:

¶**Screening of Newborns.** In one of the largest surveys, blood specimens routinely drawn from some 1.3 million newborn infants a year in about 30 states will be tested for antibodies to the AIDS virus. If the antibodies are found, it will be a clear indication that the mother was infected but the baby itself will have only a 30 percent to 50 percent chance of being a virus carrier. The findings will provide the best picture yet of how the AIDS virus is affecting the female half of the population.

¶**Women's Health Clinics.** Surveys in some 100 family planning, prenatal, abortion, and other clinics that serve women of childbearing age will reach about 100,000 women a year, including many who do not carry their babies to full term and would therefore be missed by the survey of newborns.

¶**Sentinel Hospitals.** In a project well under way, more than 40 hospitals in at least 32 cities will each test 300 blood samples a month that would otherwise be discarded by hospital laboratories, for a total of more than 144,000 tests a year.

¶**Sentinel Laboratory.** At least one diagnostic laboratory that tests blood specimens for primary health care doctors will test on an anonymous basis about 100,000 of the specimens a year for AIDS antibodies.

¶**Family Doctors.** A large network of family practitioners who draw blood from their patients for other purposes will send some of the blood anonymously to a central laboratory for AIDS testing, covering at least 10,000 patients a year and possibly more.

¶**Drug Treatment Centers.** In one of the most important studies, also well under way, clinics in about 30 metropolitan areas will test the blood of about 10,000 intravenous drug abusers a year. These studies should provide the first clear evidence on whether many of the nation's cities are unknowingly experiencing a "silent explosion" of infection among their drug addicts.

¶**Clinics for Sexually Transmitted Diseases.** In a rapidly expanding survey, some 50 clinics for sexually transmitted diseases in 30 cities will test about 100,000 blood samples a year from their clients, who include homosexually and heterosexually active people, both male and female, with venereal diseases.

¶**Tuberculosis Clinics.** Blood tests will assess the prevalence of AIDS infections among tuberculosis patients to manage their therapy better.

¶**Blood Donors.** Blood samples from 6 million donors a year are routinely being incorporated into Federal assessments of AIDS prevalence. But in a new wrinkle, systematic interviews will be conducted with a total of about

1,000 infected donors in 20 blood-collecting areas each year to determine how the donor became infected.

¶**College Students.** Some 20 college campuses will each conduct AIDS tests on about 1,000 blood specimens drawn for other diagnostic purposes at college clinics each year, covering a total of 20,000 students annually.

¶**Prisoners.** Ten state prison systems are each testing the blood of some 1,000 incoming prisoners each year, covering 10,000 prisoners in all, as a complement to other surveys and screening programs already being conducted in various prisons.

¶**Hospital Emergency Rooms.** Blood samples from an undetermined number of emergency patients will be tested to assess the risk posed to health workers and how best to manage such patients, who often shed copious amounts of blood.

¶**Job Corps.** About 60,000 new entrants to the Job Corps program are being tested each year. ¶**Military Service.** About 600,000 applicants for military service and a large number of active duty personnel are being screened each year.

¶**High Risk Groups.** Twelve cohorts of homosexual and bisexual men and two cohorts of intravenous drug abusers are being evaluated periodically to determine the rate of new infections in the groups and the behavior that caused the infections.

¶**National Health and Nutrition Examination Survey.** The Federal Government will conduct anonymous AIDS antibody tests on some 18,000 blood specimens collected in this six-year survey, with initial data available in 1991.

Experts call it the best way to get a true sample.

NYT 8/29/88

Federal Control Urged to Keep Costs Down on AIDS-Related Drugs

By PHILIP M. BOFFEY
Special to The New York Times

WASHINGTON, Aug. 23 — Two health organizations asked the Government today to require that AIDS-related drugs and vaccines developed with Federal assistance be made readily available to patients at the lowest possible prices.

Ralph Nader's Health Research Group, a consumer advocacy organization, and the American Public Health Association, the nation's largest professional society for public health professionals, made the request in a petition to the Department of Health and Human Services.

It would apply only to products developed by scientists at Government institutions or supported by Federal grants,

but would not affect those developed exclusively by private companies.

In a joint statement, the two groups charged that while federally supported scientists are developing treatments and vaccines for AIDS, government patent lawyers "are giving away some of these precious inventions to drug companies in licenses with grossly inadequate controls over their eventual pricing and availability."

Jim Brown, chief spokesman for the United States Public Health Service, said the petition would be reviewed by a committee that is analyzing the best ways to keep the pharmaceutical industry competitive with foreign companies while protecting the public interest in access to needed drugs.

The petition noted that AZT, or azidothymidine, the only drug thus far ap-

proved for treatment of AIDS, has been priced at \$8,000 to \$10,000 per patient per year by the Burroughs Wellcome Company, even though the the National Cancer Institute, a Federal agency, played a major role in establishing that the drug was useful against AIDS.

The company has said the high charges were necessary if it was to recoup its costs, but it has declined to release cost information.

The two health groups warned that loose language in government licensing agreements with other drug companies to make AIDS-related drugs could "virtually guarantee exaggerated costs" to patients, insurance companies, the Government and tax payers. Federal and state governments will spend an estimated \$2.4 bil-

lion buying AZT alone from 1987 to 1992, the petition said.

The petition said that the price of pentamidine, one of the two standard drugs for treating a severe pneumonia that kills many AIDS patients, had quadrupled since 1984, soaring to \$100 a vial from \$25. In marked contrast, the petition said, the price of the other standard drug, trimethoprim-sulfamethoxazole, which is made by multiple competing manufacturers, only rose to \$40 from \$28 a vial in the same period.

The petition expressed concern that proposals to grant exclusive licenses to the Bristol-Myers Company to market Peptide T, a drug that is aimed at blocking the AIDS virus, and to the Warner-Lambert Company to market trimetrexate would lack adequate controls on pricing or availability.

USA TODAY

8/28/84

11% abuse drugs in pregnancy

By Dan Sperling
USA TODAY

About 11 percent of U.S. babies are at risk for medical complications because their mothers abused drugs during pregnancy, a study suggests.

Dr. Ira J. Chasnoff, director of the perinatal center for chemical dependence at Northwestern University Medical School in Chicago, and colleagues surveyed 36 hospitals across the country.

Overall, 11 percent of the births involved mothers who had used drugs during pregnancy. But the rate varied widely — from 0.4 percent at some hospitals to up to 27 percent at others, Chasnoff says.

Infants whose mothers used drugs during pregnancy are at increased risk for premature birth, low birth weight, infection (including AIDS), developmental and learning problems, Chasnoff says.

But hospitals with the lowest rates had the worst procedures for identifying drug abuse in pregnant women. And hospitals with the best identification procedures had the highest rates — suggesting the overall rate may be much higher than 11 percent, says Chasnoff, who presented his findings Sunday at a conference of the National Association for Perinatal Addiction Research and Education in New York.

Cocaine was the drug used in 85 percent of the cases; marijuana was next most popular.

THE FIGHT AGAINST AIDS

Video aims to educate college students

By Kim Painter
USA TODAY

Joel Gray, 25, calls himself a farm boy. He grew up near a small Iowa town and got his nursing degree from the University of Iowa.

Gilbert Garcia, 22, a former medical technologist who wants to be a chef, has humble roots, too. He's the middle child in an Hispanic family of 13 from tiny Shamrock, Texas.

And Jim Walters, 32, originally from Dearborn, Mich., is a former drug addict who's turning his life around, working on degrees in history and urban planning at San Jose State University in California.

They are three young men with hopes for the future, three young men who could be role models for other farm boys, Hispanics or former drug addicts — and three young men whose futures are in doubt because they carry the AIDS virus.

Thousands of college students whose own futures could be darkened by AIDS are about to meet Gray, Garcia and Walters, via a government-produced videotape: *AIDS: Why Should I Care?*

The message, Walters says, is: "This (AIDS) is going on, but it doesn't have to happen to you. You have to know what the boundaries are. Unfortunately, some of us had to learn the hard way."

The video for college students — going to 3,340 campuses in time for freshman orientation programs — is the second such government production. The first targeted health-care workers.

Health officials know they must reach other groups, too — such as intravenous drug users and minorities, says Public Health Service spokesman Jim Brown.

But Dr. Robert Windom, assistant secretary for health, is making college students a high priority, not only because their sex and drug habits may put them at risk for AIDS, but also because campuses are an untapped source of volunteers for AIDS programs, Brown says.

Windom appears on the video along with such stars as Dionne Warwick, Nell Carter,

Firsthand accounts



Photos by Tom Stanford, USA TODAY

Joel Gray, 25, of Iowa City, Iowa, has a pre-AIDS condition, trains AIDS counselors: "The only people who can just say no are people who've never said yes... during college years you're... finding out who you are. There's some experimentation that goes along with that. So if you're going to experiment, at least know how to protect yourself."



Gilbert Garcia, 22, of Tucson, was diagnosed with AIDS two years ago: "Somebody asked me how I deal with this. I said, 'I brush my teeth.' I brush my teeth and I comb my hair. I don't think about it. I can't. I'm only 22 and I've got my life to live."



Jim Walters, 32, of San Jose, Calif., started college after being diagnosed with AIDS two years ago: "I saw my diagnosis as a chance to be alive. I had really been dead for so many years. The way I look at it, if I don't do the things I want to do now, I'll never do them."

Karen Akers, Stockard Channing and Griffin Dunne.

They talk about the facts — what AIDS is, how it spreads and how college students can help people with AIDS. Gray, Garcia and Walters talk about the facts, too. More importantly, they represent the young face of AIDS and the voice of caution.

On a muggy day, the three gathered in a chilly studio in a federal office building in Wash-

ington, D.C., to tape their segment of the program.

Gray and Garcia, who had just flown in from a gay and lesbian health conference in Boston, were tired, but in high spirits. Walters looked thin and worn, but said he felt fine.

One by one, each took a seat before the camera in a mock office and, guided by a Tele-Prompter, did his bit.

College students who see the video will hear the same

themes Surgeon General C. Everett Koop and other health officials have repeatedly expressed in public service announcements, brochures and interviews.

From Garcia, safe sex advice: "Be smart. Be safe. ... You know what condoms are. Use them. They aren't a 100 percent insurance policy, but safe sex is smart sex, and it's the way to intelligently protect yourself."

From Gray, a plea for compassion and understanding: "You won't get AIDS from shaking my hand, or talking to me face to face. I could sit next to you at lunch or share a chemistry lab with you or be your nurse and not expose you to the AIDS virus through casual, normal daily contact."

And from Walters, a call for volunteers: "People with AIDS are people too. Get to know them. ... Reach out a helping hand to people with AIDS."

Because this is a government production, carefully written not to offend, the three don't talk about some of the grittier facts of their lives.

None of the three mentions he's gay, and Walters doesn't talk about his long addiction to speed. He quit shooting up just a month before he was diagnosed with AIDS in October 1986.

Gray — who has what some doctors call AIDS-related complex — doesn't talk about how hard it's been for his parents to accept his sexuality, much less his disease.

And Garcia doesn't talk about losing his job as a medical technician because of a four-month hospital stay or losing a job as an assistant manager at a chicken restaurant "because they were afraid I might get something on the money."

But that's all complicated stuff.

And the three say the points they want to make to college students are simple: Protect yourself, protect your friends and extend your friendship to people with AIDS.

It's all about getting your priorities straight, Walters says: "Go get that BMW and the house, but balance it with friendship and caring for people, caring for yourself."

Going 'Beyond AIDS 101' on campuses

Campus AIDS education goes beyond fundamentals this fall.

"I call what we're doing this year 'Beyond AIDS 101,'" says Dr. Richard Keeling, director of student health services at the University of Virginia, Charlottesville, and president of the American College Health Association.

Keeling says most students know the basic facts about AIDS. But many lack the assertiveness and communication skills needed to protect themselves.

"One of the main reasons people get sexually transmitted diseases in college is that they don't know how to communicate with a sex partner."

Campus AIDS educators are designing programs that address those problems, as well as the links between AIDS and alcohol.

Keeling says: "We tell students, 'You know what happens when you try to drive a car drunk — well, just try to put on a condom drunk.' Drinking also clouds judgment."

With \$650,000 from the federal Centers for Disease Control, Keeling's group is gearing up to:

► Hold workshops to teach AIDS education techniques to students and faculty members from more than 200 campuses — who will in turn teach students attending voluntary workshops and required classes.

► Complete a study to find out how many college students already carry the AIDS virus.

Those tests — using blood collected for other purposes from unidentified students — started last April and will resume at about 25 campuses this fall. Results could be out by the end of the year.

Pharmacy Data May Aid U.S. In Drug War

By Kim I. Mills
Associated Press

Using Medicaid computer data to identify pharmacies selling unusual amounts of controlled substances could help investigators in the battle against illicit drugs, according to a congressional report.

"It's an astoundingly simple concept, despite the complexity of the computer system," said Rep. Charles B. Rangel (D-N.Y.), who released the General Accounting Office study yesterday.

"Locate the drugstores selling the highest percentage of controlled substances to Medicaid 'patients,' and you might also be finding the crooked drugstores and the doctors purposely making illegal prescriptions," he said.

Aside from such drugs as heroin, unlawful under any circumstances, controlled substances include many drugs that can be prescribed legally, but pose risks of physical or psychological harm through abuse.

Included are morphine, methadone, cocaine, aspirin with codeine, phenobarbital, Valium and Darvon.

Except in small states, Medicaid agencies are required to have a Medicaid Management Information System (MMIS) containing data on recipients, physicians and pharmacies, according to the report.

While separate statistics are not collected on controlled drug transactions, the GAO found that "data contained in the MMIS can be manipulated to produce reports that may be useful in the identification of providers who may be diverting controlled substances."

The GAO said MMIS information could be helpful in spotting prescription abuses within the Medicaid program through closer analysis of data and sharing the information with law-enforcement agencies.

For example, GAO auditors analyzed pharmacies in New York where 20 percent or more of Medicaid claims in 1986 involved controlled substances. They found 11 drugstores substantially above the statewide average for prescriptions involving controlled substances. Of those, seven were disqualified from Medicaid last year.

The GAO said, however, that a higher-than-average level of controlled-substance sales is not necessarily an abuse of the program.

WASHINGTON

POST

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Medicine & Health

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IG Plans Bar on Copayment Waiver

Hospitals couldn't waive Medicare's coinsurance or deductible under rules drafted by HHS Inspector General Richard Kusserow. Violators would risk suspension from Medicare and Medicaid, fines reaching \$25,000, and, in extreme cases, up to five years in jail. Competition among hospitals and ambulatory surgery centers has increased hospital waivers of cost-sharing as a lure for patients. Current Medicare rules are silent on the issue. To date, no hospital has been prosecuted for such waivers. In 1985, Kusserow asked the Justice Dept. to allow cost-sharing waivers; Justice declined, saying that's a job for Congress. But Kusserow says Congress "appears disinclined to weaken the requirement that beneficiaries share in the cost of their hospitalization," says a copy of the draft reg obtained by *Medicine & Health*. The IG's plan to bar cost-sharing waivers appears in a package of changes in Medicare's fraud and abuse rules. On other issues, Kusserow says the rules would set up "safe harbors" for certain business ventures. Providers could invest in large public corporations and in smaller entities if done on an equal basis with other investors. Companies couldn't offer doctors sweetheart investments in return for referrals. The

regs would let one provider lease real estate and equipment to another if the lease ran for at least a year and reflected "fair market value." The same limits would be placed on personal service and management contracts. The IG would let hospitals provide incentives to doctors to join their staffs if the purpose were to "induce a physician to move his residence and start a new practice in the hospital's service area or to assist established physicians or specialists." The rules would let retiring doctors sell their practices but would bar other sales.

Macdonald Delivers AIDS Plan

A war on illegal drug use and on AIDS-related bias are hallmarks of a new national AIDS policy urged by White House adviser Donald Ian Macdonald, MD. The same elements figured prominently in a report by the President's AIDS Commission (*M&H* 6/6/88); Reagan asked Macdonald to go over that plan and suggest a course of action (*M&H* 7/4/88). Macdonald presented his plan to Reagan July 28. He found 39.2 percent of the commission's proposals for federal action are already "planned, underway, or done" and another 30 percent will appear in Reagan's fiscal 1990 budget, Macdonald told *Medicine & Health* in an exclusive July 29 interview. He rejected only 7 percent of the commission's 597 proposals but says he rebuffed "not the goals but the means." Until Reagan gives his nod -- perhaps this week -- Macdonald says he can't discuss his plan's contents. Sources say the report urges an executive order barring AIDS-related bias on federal jobs, but seeks further study of the need for a federal law barring discrimination against people with AIDS and those infected with the AIDS virus. The commission urged such a law as the centerpiece in a national AIDS policy. Macdonald and his four-person "A-team" spent much of the past month meeting with public and private groups to get reactions to the commission's report. His ideas include some that "can be done right away"; others, before Reagan leaves office in January. Some must wait for the next President. Among issues to be left until 1989: HHS organization.

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Assignment Sweeps Northeast



Richard Sorian, Editor

THE AIDS/ HIV RECORD

**COMPLETE COVERAGE
OF
THE HUMAN
IMMUNODEFICIENCY
VIRUS EPIDEMIC**

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ROBERT WOOD JOHNSON FOUNDATION REPORTS STAGGERING NEED FOR COMMUNITY-BASED AIDS PROJECT FUNDING

For an analysis of the 1,026 grant proposals received by the Foundation in July in response to a request for proposals last March, see story pages 2-3.

U.S. OFFICE OF TECHNOLOGY ASSESSMENT FINDS ONLY 45% OF DOCTORS TEST SEMEN DONORS FOR HIV

Semen from donors subsequently found to have AIDS has been used for artificial insemination in at least two locations in the U.S. However, there are no confirmed reports of women infected with HIV in this country as a result of artificial insemination. See story page 4.

UNIVERSITY OF CALIFORNIA - SAN FRANCISCO SCIENTISTS FIND PNEUMOCYSTIS PNEUMONIA CAUSED BY FUNGUS

The fact that *pneumocystis carinii* pneumonia (PCP), the most common opportunistic infection in people with AIDS, is caused by a fungus, has implications for how the disease is transmitted. This finding will influence the future design of drugs to treat the deadly infection. See story page 5.

FROM THE WHITE HOUSE

IMPLEMENTATION OF THE RECOMMENDATIONS OF THE PRESIDENTIAL COMMISSION ON THE HIV EPIDEMIC

Dr. Donald Ian MacDonald says early press reports were somewhat misleading and that President Reagan was happy with the report for the most part. Anti-discrimination recommendations are under consideration - nothing has been ruled out yet, he insists. For verbatim White House documentation, see story pages 7-10.

TESTING OF CD4 IN HUMANS BEGINS IN THREE MEDICAL CENTERS IN U.S.

Studies in laboratory animals showed that CD4 prevented other cells from becoming infected with HIV. The clinical trials will determine if results from the animal studies can be replicated in humans, and at what dosage. See story page 5.

FRED KROGER ASSUMES HELM OF CDC'S NATIONAL AIDS INFORMATION AND EDUCATION PROGRAM

In this capacity, Mr. Kroger will head up key federal government programs including the National Clearinghouse, hotlines and media campaigns. See story page 6.

U.S. CENTERS FOR DISEASE CONTROL SUBMITS THIRD REPORT ON THE PREVALENCE AND RATE OF SPREAD OF HIV IN THE U.S. TO DOMESTIC POLICY COUNCIL

For highlights of the latest case reports, incidence and prevalence trends and future projections, see story page 13.

From the White House

OFFICIAL WHITE HOUSE DOCUMENTS - IMPLEMENTING RECOMMENDATIONS OF THE PRESIDENTIAL COMMISSION ON THE HIV EPIDEMIC August 1988

As noted previously in *The AIDS/HIV Record* (See Vol.2, No.13), President Reagan received the Commission Report on June 27. At that time he directed Dr. Donald Ian Macdonald, White House Drug Policy Advisor, to coordinate a plan of action based on the findings and recommendations contained in the report. Dr. Macdonald, along with agency staff, performed a preliminary analysis of recommendations of the Commission (See *AIDS/HIV Record* Vol.2, No.10) and determined that: 1.) Of the 597 recommendations, 364 of them pertained to the federal government and 233 were directed to non-federal entities (i.e. pertained to state/local governments and/or the private sector) 2.) Of the 364 federal recommendations: 126 have already been implemented or are ongoing activities; 32 are scheduled for implementation in FY 1989; 106 are planned for implementation in FY 1990; 62 were referred to cabinet/agency heads for further review; and 36 were disagreed with. 3.) Of the 233 non-federal recommendations: 210 were agreed to by the White House and plans are underway to facilitate their implementation; 11 were referred to agencies for further consideration; 3 were disagreed with; and there are 9 recommendations for which no position has been taken. (According to White House staff, although the federal government has influence, it does not have the absolute authority to impose these recommendations on local governments or the private sector.)

At press time, the White House had not made available documentation specifying which recommendations fall into the various categories noted in points 1, 2 and 3 above. However, at a White House press briefing on August 11, Dr. Macdonald said that this information eventually would be made available, at which time *The AIDS/HIV Record* will publish it. In the meantime, in light of conflicting reports about the President's response to the Commission Report and at the request of many readers, all documentation released by the White House in August appears on the following pages. In addition, Dr. Macdonald made the following statements at the August 11 briefing:

• "The President did not reject the recommendations related to antidiscrimination. . . It is very clear to me that the President has not rejected legislation." Dr. Macdonald also stated that these nondiscrimination recommendations are among the 62 recommendations that have been referred to the Attorney General for further consideration. He indicated that the relative merits of federal versus state initiatives are being evaluated.

• Dr. Macdonald expressed frustration over initial media reports about President Reagan's intentions, "I think that media reports focused in on one part of one issue . . . there are lots of other issues that we agree with completely and others that were addressed very seriously. . . . The media tended to give people the impression that the President rejected the Commission report - not true. . . . that he had no intention of following the recommendations - not true."

• Regarding funding of drug treatment programs, Dr. Macdonald stated that the President did not disagree with the \$1.7 billion dollar funding suggestion from the Commission, but rather cited \$500 million as what the government could realistically spend in the near future. Dr. Macdonald said that this amount should not be interpreted as a funding ceiling, but rather as first phase spending. He also stated that this figure is in concert with the budget being discussed in the ombudsman drug legislation currently under consideration by Congress (which Dr. Macdonald feels will be passed into law this year). For more information contact Dr. Macdonald at (202) 456-6554.

STATEMENT BY THE PRESIDENT - AUGUST 2, 1988

Acquired Immunodeficiency Syndrome (AIDS), caused by the Human Immunodeficiency Virus (HIV), has moved through our society with tragic human consequences. It is a public health threat that has touched the lives of Americans with alarming speed and frightening consequences. It demands knowledge and attention by the best experts in our society. I am today ordering a number of actions to focus the efforts of the Government and private sector on this horrible human problem. These directives will assure compassion toward those with the HIV infection, provide dignity and kindness in treatment and medical care, and require that we inform and educate our citizens to prevent further spread of the disease.

We are today adopting a 10-point action plan to advance the battle against AIDS and HIV consistent with the recommendations of the Presidential Commission on AIDS. It is a wide-ranging plan that calls on the action and cooperation

of all levels of our society. As a first step, I am today directing that every Federal agency adopt a policy based on Office of Personnel Management (OPM) guidelines on how to treat HIV infected persons in the workplace. I ask American businesses, unions and schools to examine and consider adopting education and personnel policies based on the OPM and Centers for Disease Control guidelines.

I am directing the Attorney General to provide me with an expeditious review of how the Federal government should provide direction and leadership in encouraging non-discrimination for HIV-infected individuals.

We will also proceed to improve laboratory safety, accelerate drug approvals, evaluate the health care financing system and pursue a multi-focused international initiative among other steps. I have asked Dr. Macdonald to monitor our response to the Commission's recommendations and report to me in September.

Continued on next page . . .

STATEMENT ISSUED BY THE OFFICE OF THE PRESS SECRETARY, AUGUST 2, 1988:

Fact Sheet

President Reagan today directed all Federal agencies to protect HIV-infected persons against discrimination in the Federal workplace. He instructed agencies to adopt a policy based on Office of Personnel Management (OPM) guidelines developed in March. They state: "... HIV-infected employees should be allowed to continue working as long as they are able to maintain acceptable performance and do not pose a safety or health threat to themselves or others in the workplace."

President Reagan's directive to Federal agencies is part of a 10-point plan he put in place August 2, 1988, that will advance the battle against Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infection. The plan calls for actions to assure compassion towards those with HIV infection, to allow for their care with dignity and kindness, and to inform and educate citizens to prevent further spread of the disease.

The plan is based on recommendations of the Presidential Commission on the Human Immunodeficiency Virus Epidemic. The President received the commission's report on June 27, 1988, from the chairman, Admiral James D. Watkins, and praised it as an impressive effort that significantly increases our understanding of AIDS.

After reviewing the report, the President asked Dr. Donald Ian Macdonald, his Special Assistant and Director of the Drug Abuse Policy Office, to evaluate the commission's 20 summary recommendations and 597 recommendations and develop a course of action that addresses the most pressing problems posed by HIV infection. The plan announced today results from Dr. Macdonald's evaluation and recommendations.

As part of his review, Dr. Macdonald agreed with the commission's recommendation that attention be focused on the threat from HIV infection rather than on AIDS, the most advanced stage of the infection. An estimated 1 million to 1.5 million Americans are infected with HIV. Since 1981, there have been 68,000 cases of AIDS.

Comprehensive Review

The President's plan was developed through a review process that involved consultation with executive branch agencies, the Office of Management and Budget, White House staff and a cross-section of private groups and individuals, including the National Academy of Sciences. That group recently released an AIDS report with conclusions similar to those of the commission.

The review determined that 40 percent of the commission's recommendations with a Federal component have already been completed, are underway or are planned. Another 30 percent are under consideration as part of the FY 1990 agency budget plans.

The 10-Point Plan

Under the action plan, the President:

1. *Directs the Department of Health and Human Services (HHS) to develop a series of consensus conferences with representatives from all levels of government and the private sector to intensify public health measures to reduce the spread of HIV infection. The President instructs HHS to increase the number of community based education programs directed to those at increased risk of HIV infection.*

2. *Requires the Food and Drug Administration (FDA) to improve laboratory quality and blood screening tests immediately and within 45 days begin notification of transfusion recipients. In addition, FDA should encourage self-donated blood before surgery.*

3. *Emphasizes his concern about drug abuse and its relation to HIV infection and continues his call for bipartisan efforts to enact his anti-drug proposals.*

4. *Begins action in and out of Government that will accelerate development, approval and distribution of vaccines and drugs.*

5. *Reaffirms his commitment to provide adequate resources (dollars, staff, office and laboratory space) to combat the HIV epidemic and directs the Office of Management and Budget to make certain there are no impediments to efficient use of these resources.*

6. *Asks Congress to accelerate enactment of his FY 1989 HIV appropriations request and adopt the FY 1990 budget request for HIV activities as early as possible after the budget is submitted. The President will seek a special HIV emergency fund for unanticipated problems and opportunities in the FY 1990 budget request.*

7. *Instructions the Secretary of HHS to evaluate the current system of health care financing; and directs HHS to conduct specific studies of ways to promote out-of-hospital care; encourage states to establish insurance risk pools for medically uninsurable persons; and increase the public health response to HIV infected infants, children, adolescents and low income disabled individuals.*

8. *Directs the Secretary of State to develop a multi-focused international initiative to combat HIV, particularly in less-developed countries; increases U.S. commitment to international technical assistance; and seek development of a three-year plan for international efforts against HIV infection.*

9. *Requires the Public Health Service to update the 1986 Public Health Service plan for combatting HIV infection. The President has asked Dr. Macdonald to provide him with status reports in September and December on progress to implement the commission's recommendations.*

10. *Calls on all sectors of society to respond equitably and compassionately to those with HIV infection and their families. In addition to directing all Federal agencies to adopt a policy based on OPM guidelines, the President requests that American labor unions and schools examine and consider adopting similar personnel policies based on the OPM and Guidelines for Control guidelines.*

In addition, the President referred to the Attorney General for an expeditious review and response to the commission's recommendations as to how the Federal Government should provide direction and leadership to encourage non-discrimination for HIV infected persons.

**PRESIDENTIAL MEMORANDA TO CONGRESS, DEPARTMENT AND AGENCY HEADS
RELEASED BY THE WHITE HOUSE PRESS OFFICE - AUGUST 5, 1988**

TO THE CONGRESS OF THE UNITED STATES:

I have approved a 10-point action plan to advance the national and international response to the public health threat caused by the Human Immunodeficiency Virus (HIV) infection and the AIDS epidemic. These strong measures require compassion, cooperation, and commitment from all levels of government and all segments of society.

It is imperative that action and progress continue in the Federal government and in the private sector, as well as throughout the Nation. Those infected with the HIV must be treated with dignity and compassion as our health systems accelerate their response to the infection. To this end, my initiatives direct that every Federal agency adopt policies and guidelines on compassionate treatment of HIV-infected persons in the workplace. I ask that unions, schools, businesses, and private citizens consider adopting similar guidelines. The 10-point action plan is consistent with the fine work and recommendations of the President's Commission, which has moved the Nation forward in its understanding of the HIV infection and AIDS.

I now ask the Congress to take another important step forward; I ask you to enact the FY 1989 appropriations for HIV activities as expeditiously as possible. I further call on the Congress to adopt the FY 1990 budget request regarding HIV measures as soon as possible after the budget is submitted.

It is imperative to the future of our Nation that we move with compassion and skill to ease the tremendous human, social, and economic costs caused by the HIV infection and AIDS. I know we can work together in this matter of tremendous concern and priority for all Americans.

MEMORANDUM, DEPARTMENT AND AGENCY HEADS

I have approved a 10-point action plan as part of my response to the Report of the Presidential Commission on the Human Immunodeficiency Virus (HIV) Epidemic.

The plan expresses my concern about fair and compassionate treatment of HIV-infected individuals and directs every Federal agency to adopt a policy based on the Office of Personnel Management's (OPM's) "Guidelines for AIDS Information and Education and for Personnel Management." I also have asked American businesses, unions, and schools to examine and consider adopting education and personnel management policies based on the OPM and the Centers for Disease Control (CDC) guidelines. Many agencies have already adopted policies based on the OPM guidelines. If your agency has not already done so, you should proceed to do so. The Office of Personnel Management is available to answer questions or provide any needed assistance. The Justice Department and the Department of Health and Human Services offer additional sources of information and assistance.

To further encourage businesses, unions, and schools as well as housing projects, correctional facilities, and others to adopt policies based on OPM and CDC guidelines and provide the education that is vital to effective implementation, I also ask each of you to communicate through your programs the value of this approach.

I am directing Donald Ian Macdonald, Deputy Assistant to the President for Drug Abuse Policy, to monitor progress on our response to the Commission's Report and provide me with status reports in September and December, 1988. Please provide Dr. Macdonald with appropriate information about your progress.

MEMORANDUM FOR THE DIRECTOR OF THE OFFICE OF PERSONNEL MANAGEMENT

I have approved a 10-point action plan as part of my response to the Report of the Presidential Commission on the Human Immunodeficiency Virus (HIV) Epidemic. The plan directs every Federal agency to adopt a policy based on your Office's "Guidelines for AIDS Information and Education and for Personnel Management."

To carry this out, you should offer Federal departments and agencies the assistance of your Office in helping develop any necessary agency modifications.

I am directing Donald Ian Macdonald, Deputy Assistant to the President for Drug Abuse Policy, to monitor progress on our response to the Commission's Report and provide me with status reports in September and December, 1988. Please provide Dr. Macdonald with appropriate information about your progress, including an update at regular intervals on agency actions on the guidelines.

MEMORANDUM FOR THE ATTORNEY GENERAL

I have approved a 10-point action plan as part of my response to the Report of the Presidential Commission on the Human Immunodeficiency Virus (HIV) Epidemic. The plan expresses my concern about fair and compassionate treatment of HIV-infected individuals.

To carry this out, please provide me with an expeditious review and response to the Commission's recommendations on how the Federal government should provide leadership in caring for and supporting the needs of HIV-infected individuals, including a review of the Federal laws in this area.

I am directing Donald Ian Macdonald, Deputy Assistant to the President for Drug Abuse Policy, to monitor progress on our response to the Commission's Report and provide me with status reports in September and December, 1988. Please provide Dr. Macdonald with appropriate information about your progress.

Continued on next page

MEMORANDUM FOR THE SECRETARY OF STATE

I have approved a 10-point action plan as part of my response to the Report of the Presidential Commission on the Human Immunodeficiency Virus (HIV) Epidemic. This plan includes developing a multi-focused international initiative involving: encouragement and assistance to international HIV efforts, with emphasis on less-developed countries; a heightened U.S. commitment to international technical assistance within established technology transfer laws; and the development of a 3-year plan for international efforts against HIV infection.

In carrying out your functions, I ask that you address HIV-related activities as follows:

1. Review your FY 1989 spending plans to incorporate relevant recommendations of my HIV Commission;
2. Include in your FY 1990 budget submissions appropriate funds for the United States regular and special contributions to international HIV efforts, especially those in less-developed countries;
3. Continue to emphasize our commitment to international technical assistance; and
4. Propose, within 120 days, a 3-year plan for international efforts against HIV infection.

MEMORANDUM FOR THE SECRETARY OF HEALTH AND HUMAN SERVICES.

I have approved a 10-point action plan as part of my response to the Report of the Presidential Commission on the Human Immunodeficiency Virus (HIV) Epidemic. This plan addresses many issues that fall within the purview of your Department. In carrying out your functions, I ask that you address HIV-related activities as follows:

1. Review your FY 1989 spending plans to incorporate relevant recommendations of my HIV Commission.

2. Convene a series of consensus conferences over a 12-month period involving State, local, and private groups to encourage them to adopt the specific public health measures discussed in the Commission Report, such as increased counseling and testing, reporting of HIV infection, partner notification, and health care worker safety. One conference should address restrictive measures and criminal statutes directed to HIV-infected persons who knowingly persist in maintaining behaviors that transmit their infection. Another possible topic is the serious problem of neighborhood resistance to facilities for the care of HIV patients, drug abusers, and group homes for HIV-infected infants and children.

3. Increase the number of community-based educational programs, especially programs directed to those women and members of minority groups who are at highest risk of HIV infection. These programs, and especially those directed to youth, should place greater emphasis on my *Principles for AIDS Education*, especially those encouraging individuals to take responsibility for their efforts to prevent the spread of HIV infection. Please collaborate with the Department of Education in developing youth-oriented programs.

4. Implement actions within the next 45 days that address the blood safety issues raised by the Commission. This plan should address: (a) the prompt notification of transfusion recipients who are at increased risk of HIV infection; (b) steps to improve HIV laboratory quality and HIV screening tests; and, (c) ways to encourage the use

of autologous transfusions in appropriate circumstances.

5. Implement actions within the next 60 days to improve and accelerate further the process for development, evaluation, approval, and distribution of HIV-related vaccines, drugs, and devices. This plan should draw upon research of Federal and State governments, the private sector, academia, and national laboratories.

6. Provide me, within 120 days, with an assessment of private incentives for development and marketing of HIV products, including an evaluation of the need, if any, to have Federal authority with which to offer increased incentives in exchange for royalties, licenses, or pricing concessions. This assessment should take into consideration solutions proposed in the February 1986 report of the Tort Policy Working Group. In doing this assessment, please consult with the Departments of Justice and Defense.

7. Undertake an evaluation of our current system of health care financing to be completed within 1 year.

8. Conduct specific studies of ways to better promote out-of-hospital and case-managed care; to encourage States to establish insurance risk pools for medically uninsurable persons; and to increase the responsiveness of the public health and health services system to HIV-infected infants, children, adolescents, and to low-income disabled individuals.

9. Provide me an update by December 15, 1988, of the 1986 PHS plan for combatting HIV infection, reflecting, in part, both the Commission Report and the recent Public Health Service Charlottesville planning conference.

I am directing Donald Ian Macdonald, Deputy Assistant to the President for Drug Abuse Policy, to monitor progress on our response to the Commission's Report and provide me with status reports in September and December, 1988. Please provide Dr. Macdonald with appropriate information about your progress.

MEMORANDUM FOR THE DIRECTOR OF THE OFFICE OF MANAGEMENT AND BUDGET

I have approved a 10-point action plan as part of my response to the Report of the Presidential Commission on the Human Immunodeficiency Virus (HIV) Epidemic. As you know, I am committed to ensuring that the Federal government's HIV-related activities receive appropriate resources and support, and that no impediments to their efficient use exist, consistent with good management. In carrying out your functions, I ask that you address HIV-related activities as follows:

1. Consult with the General Services Administration, the Office of Personnel Management, and the Department of Health and Human Services to ensure that HIV activities included in the FY 1989 and FY 1990 budgets reflect appropriate funding, personnel levels, and office and laboratory space. The budget, as well as program management initiatives, should also address the removal of administrative and statutory impediments to efficient use of these resources including grant, contract, and hiring procedures. OMB should take a positive role in removing any unnecessary administrative and management impediments to the agencies' attack on HIV infection.

2. Ensure that my FY 1990 budget for HIV-related activities is submitted to the Congress in a timely manner, and that the Congress is encouraged to act on it quickly.

Talking Points on Anti-discrimination protections

- o The Civil Rights Restoration Act makes it clear that in the employment context HIV-infected individuals are covered by Section 504 of the Rehabilitation Act.
- o DOJ is currently examining existing statutes case proceedings and their applicability to the changing situation in relation to HIV-infection. An opinion is due soon.
- o In terms of reported AIDS cases, New York, California, and Florida rank first second and third. About half of the 69,000 cases have been reported from those three States.
- o Two court cases in New York have extended the disability protections under New York Human Rights Law to "persons perceived to be infected by HIV." The law covers employment, housing, public accommodations, and credit.
- o Florida recently passed an AIDS bill that provides AIDS specific discrimination protections (effective July 7, 1988) to "anyone perceived of having HIV infection" in the areas of housing, employment, public accommodations, and government services.
- o California prohibits discrimination against HIV-infection in its fair employment and housing law.

CRISIS MANAGEMENT

AIDS

National-American Wholesale Grocers' Association
201 Park Washington Court
Falls Church, VA 22046

NAWGA

"The way mankind responds to crisis is first disbelief, then denial, then the third stage is mobilization, and we're at the horizon of that now."

Steven C. Joseph, M.D.
New York City Health Commissioner

Nation's Business

"Many small companies are in a total vacuum on how to handle AIDS. They are unaware of the potential legal and benefits issues and are simply uninformed about the medical picture—much like most Americans."

Alan Emery, M.D.
AIDS Foundation

Business Insurance Magazine

... Nationwide study reports 20% of participating companies have one (or more) employees with AIDS virus...

"It's only a matter of time before business people have AIDS in their workplace."

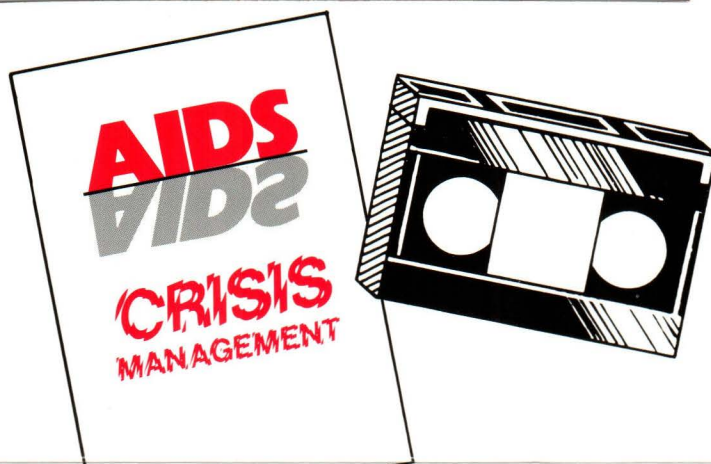
James Mason, M.D.
Director of Center for Disease Control

AIDS AIDS

CRISIS MANAGEMENT

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A comprehensive package (including videotape and accompanying manual) on one of today's most complex, costly and topical issues facing the business community.



AIDS AIDS

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YES,

please send me _____ complete packages of AIDS CRISIS MANAGEMENT includes videotape, manual and full instructions at \$150 per package, plus \$3.50 shipping and handling.

If payment is by check, please attach to card and mail it to address on overleaf. Please verify/correct address if appropriate.

Charge my ☐ VISA ☐ MC ☐ AMEX

Card Number _____

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Signature _____

FIGHTING DRUGS AND ALCOHOL IN THE WORKPLACE

Designed
for industries
with
warehousing,
transportation
centers,
and supervisory
personnel

The Supervisor's Guide to Limiting Workplace Substance Abuse

A complete training program
for managers to use in teaching
supervisors how to recognize and deal
with drug and alcohol abuse—and other
job performance problems in the workplace.
A looseleaf training manual and 24-minute
videotape for use in your own in-house program
to train your supervisors how to deal with substance
abuse and other performance problems.

nawga

The goal of any drug program must be to ensure

The supervisor is on the "front line" every day.

He's the person you rely on to ensure high job performance and a workplace that is safe and free of drug or alcohol abuse.

But many supervisors are not prepared to deal with the problem of substance abuse by their workers. They are not doctors, and even medical professionals can have difficulty in detecting addiction problems.

Supervisors are now expected to deal effectively with the difficult situation of substance abuse, as well as other problems affecting job performance, but their training rarely provides them with the necessary skills.

Also, supervisors are not lawyers, but in dealing with substance abuse problems they are stepping into an area that's loaded with legal pitfalls.

Are your supervisors really prepared to take on these essential tasks?

The Stakes for You and Your Company

THE SCENE: A lawyer representing a terminated worker is questioning the company supervisor during a pre-trial hearing.

"Am I correct in stating that neither you nor any other management representative personally observed my client using drugs?"

"Yes," is the supervisor's hesitant reply.

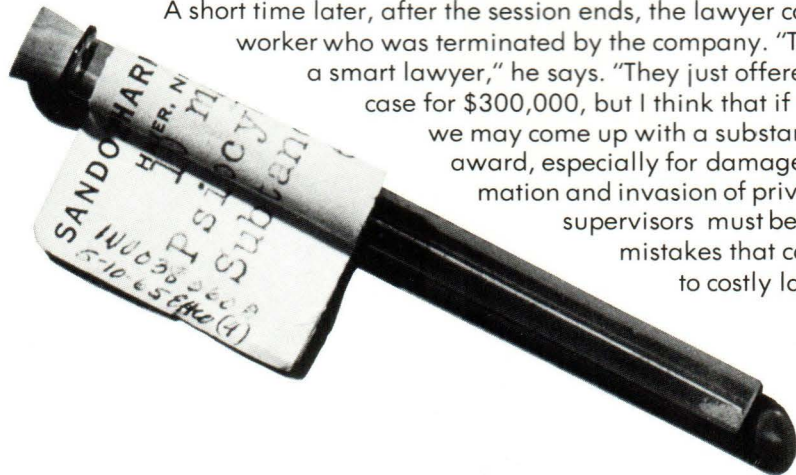
"And isn't it also true that you confronted my client in front of coworkers and customers, calling him a 'druggie' and a 'sleaze'?"

"Well, yes," is the response again.

"And didn't your 'investigation' consist of calling my client's friends and acquaintances to inquire into his behavior off the job?"

"Well... I did make some calls like that," the supervisor mumbles.

A short time later, after the session ends, the lawyer calls his client, the worker who was terminated by the company. "The company has a smart lawyer," he says. "They just offered to settle this case for \$300,000, but I think that if we take it to trial we may come up with a substantially higher award, especially for damages on our defamation and invasion of privacy counts." Your supervisors must be trained to avoid mistakes that can lead to costly lawsuits.



The Supervisor's Guide to and the videotape, Training Abuse, represent state-of-the-art humanistic approach. Together, they are preventive in nature, and they are a further step in the Program, the only such program and presented as a prototype Conference on Substance Abuse.

Drug and alcohol abuse cost companies annually in lost productivity.

Sometimes we convince our companies and not in our '.

- The U.S. consumes over
 - 65% of young Americans ages of 18-25 have used
 - 74% of those persons re
- Hotline say they use drugs

Dear Jack:

I am delighted to see Wholesale Grocers' Association spirit of our national by designing the Guide Substance Abuse Program

We must show our in by being tough can v out to the user and tough can we say to start.

Your model drug abuse toughness and company address the issues th a program designed to

Nancy joins me in th your efforts and your role. When we work we cannot fail. God

The Honorable John President National-American Wholesale Grocers' Association 201 Park Washington Falls Church, Virginia

The Supervisor's Guide to Limiting Workplace Substance Abuse and the videotape, Training Supervisors to Combat Substance Abuse, represent state-of-the-art educational material with a humanistic approach. Together they form a package designed to be preventive in nature, comprehensive in scope, and cost effective. They are a further step in NAWGA's Workplace Substance Abuse Program, the only such program endorsed by President Reagan and presented as a prototype to the United Nations' International Conference on Substance Abuse.

Drug and alcohol abuse costs American business \$100 billion annually in lost productivity

Sometimes we convince ourselves the problem is elsewhere in other companies and not in our "family." Not so!

- The U.S. consumes over 60% of the world's supply of drugs.
- 65% of young Americans entering the work force between the ages of 18-25 have used illegal drugs.
- 74% of those persons responding to a survey by the 800 Cocaine Hotline say they use drugs in the workplace.

THE WHITE HOUSE
WASHINGTON

December 2, 1986

Dear Jack:

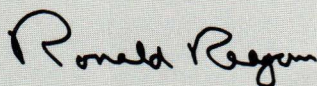
I am delighted to see that the National-American Wholesale Grocers' Association has entered into the spirit of our national crusade for a drug-free America by designing the Guide to Developing a Workplace Substance Abuse Program.

We must show our intolerance for illegal drugs. Only by being tough can we be compassionate, can we reach out to the user and say, quit using. Only by being tough can we say to the potential user, do not ever start.

Your model drug abuse program meets the criteria of toughness and compassion. It helps the food industry address the issues that arise when a company develops a program designed to meet particular needs.

Nancy joins me in thanking and commending you for your efforts and your hard work in taking a leadership role. When we work together, united and committed, we cannot fail. God bless you and your colleagues.

Sincerely,



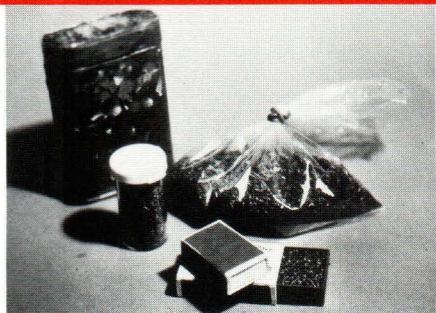
The Honorable John R. Block
President
National-American Wholesale
Grocers' Association
201 Park Washington Court
Falls Church, Virginia

FIGHTING DRUGS AND ALCOHOL IN THE WORKPLACE

Designed
for industries
with
warehousing,
transportation
centers,
and supervisory
personnel

NAWGA

e the health and welfare of employees... NOT to catch drug users!



Signs and Symptoms of Substance Abuse...

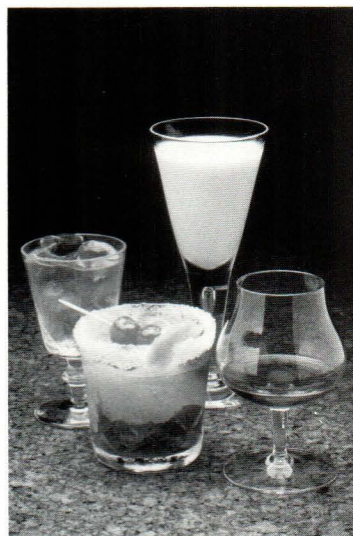
Regular and thorough observation by the supervisor is the first step in countering the substance abuse habits of employees. Supervisors must be knowledgeable about the warning signs of drug abuse and alert to any variations from the normal work pattern or behavior of employees. What are the physical symptoms of substance abuse? What do absenteeism, time off "emergencies," and periodic "disappearances" from the work area mean? What should your supervisors be on the alert for, and how should they handle it when it happens?

Abused Substances... Millions of Americans are problem drinkers or alcoholics, and millions more abuse drugs—both legal and illegal. A guide to the effects of different forms of substance abuse, and the warning signals they send to the alert, well-informed supervisor.



Dealing With Performance Problems... Absenteeism, tardiness, fatigue, unreliability, and inability to deal with fellow workers. How does the supervisor handle the situation with an employee that has these problems? What does the supervisor do when the employee denies any problems, puts the blame on others, or responds to the supervisor's mild suggestion that drinking might be involved by flatly denying any problem with alcohol? How does the supervisor get the employee to take advantage of assistance and get back on the high performance road?

Suspicion of Drug Use... What is "reasonable suspicion" of drug abuse? What does the supervisor do when he gets a tip that an employee has been selling drugs on the job? How does the supervisor handle the situation, when a mechanic reports finding unidentified pills and butts that look like marijuana joints in a driver's cab? What if the driver or suspected drug dealer wants a union steward present when the supervisor calls them in? What are the legal pitfalls awaiting the supervisor, and how does he—and the company—avoid falling into them?



A Videotape That Brings the Lessons to Life

Training Supervisors to Combat Substance Abuse—A 24-minute role-playing videotape that shows the supervisor dealing with his employees and the on-the-job problems that your supervisors are running into every day—on your workplace floor! This videotape will show your supervisors the right way to meet face-to-face with employees whose job performance is unsatisfactory, how to talk to them, and get them on the road to solving the problem—whether it's drug or alcohol abuse or some other personal trouble—that's preventing them from being safe, productive employees.

A "train the trainers" tool for management to use in preparing to train supervisors to effectively combat substance abuse in the workplace. The nucleus for an in-house seminar for your supervisors—an essential training experience for new supervisors, as well as those veteran foremen who lack the expertise and knowledge to effectively deal with substance abuse problems among their subordinates and at the same time avoid all those legal pitfalls. An invaluable "refresher" also, to keep supervisors AND managers on their toes about a problem that may be with you for a long time.

FIGHTING DRUGS AND ALCOHOL IN THE WORKPLACE

The Supervisor's Guide to Limiting Workplace Substance Abuse

A Complete Package for Management's Use in Training Your Supervisors

There is a lot of public information available on drugs and drug screening. But nowhere else is there one source that provides a complete program for training supervisors for their front-line role in the fight against drug and alcohol abuse in the workplace. Nowhere else is there one source that provides the information you need to train your supervisors to be alert to signs of substance abuse and deal effectively with personnel whose performance is slipping, while at the same time avoiding the pitfalls that can lead to costly lawsuits that can end in six or seven figure judgments against your company.

Training Manual—*The Supervisor's Guide to Limiting Workplace Substance Abuse*—a role-playing guide for supervisors in dealing with substance abuse and performance problems in the workplace.

24-Minute Educational Videotape—*Training Supervisors to Combat Substance Abuse*—brings the lessons to life and shows the supervisor the right way to help employees, who have substance abuse or other problems which interfere with satisfactory job performance, become safe, productive workers. A valuable tool for training seminars.

The National-American Wholesale Grocers' Association is a nonprofit trade association representing wholesale grocers and foodservice distributors in the U.S., Canada, and abroad. For more information, call 1-703-532-9400.

I prefer the following videotape format:

- ☐ VHS ☐ Beta
☐ (3/4 inch tape is \$25 extra)

☐ I have enclosed my check in the amount of \$ _____.

☐ Please charge my training package to the indicated credit card:

- ☐ VISA ☐ MasterCard
☐ American Express

Card Number _____

Expiration Date _____

Name as it appears on card _____

Address (if different from above) _____

YES, I want to explore the details and considerations which must be addressed when establishing a drug program within my company. Please send me _____ copies of The Supervisor's Guide To Limiting Workplace Substance Abuse package at \$150 each (10% discount for multiple orders).

Name Phone

Title

Company

Street City State/Province Zip/Postal Code

NAWGA

Mail completed form with check to:

National-American Wholesale Grocers' Association Drug Program
201 Park Washington Court, Falls Church, VA 22046



National-American Wholesale Grocers' Association
201 Park Washington Court
Falls Church, Virginia 22046

Surgeon
General's
Report
on

ACQUIRED
IMMUNE
DEFICIENCY
SYNDROME



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**U.S. Department of Health
and Human Services**

Foreword



October 22, 1986

This is a report from the Surgeon General of the U.S. Public Health Service to the people of the United States on AIDS. Acquired Immune Deficiency Syndrome is an epidemic that has already killed thousands of people, mostly young, productive Americans. In addition to illness, disability, and death, AIDS has brought fear to the hearts of most Americans—fear of disease and fear of the unknown. Initial reporting of AIDS occurred in the United States, but AIDS and the spread of the AIDS virus is an international problem. This report focuses on prevention that could be applied in all countries.

My report will inform you about AIDS, how it is transmitted, the relative risks of infection and how to prevent it. It will help you understand your fears. Fear can be useful when it helps people avoid behavior that puts them at risk for AIDS. On the other hand, unreasonable fear can be as crippling as the disease itself. If you are participating in activities that could expose you to the AIDS virus, this report could save your life.

In preparing this report, I consulted with the best medical and scientific experts this country can offer. I met with leaders of organizations concerned with health, education, and other aspects of our society to gain their views of the problems associated with AIDS. The information in this report is current and timely.

This report was written personally by me to provide the necessary understanding of AIDS.

The vast majority of Americans are against illicit drugs. As a health officer I am opposed to the use of illicit drugs. As a practicing physician for more than forty years, I have seen the devastation that follows the use of illicit drugs—addiction, poor health, family disruption, emotional disturbances and death. I applaud the President's initiative to rid this nation of the curse of illicit drug use and addiction. The success of his initiative is critical to the health of the American people and will also help reduce the number of persons exposed to the AIDS virus.

Some Americans have difficulties in dealing with the subjects of sex, sexual practices, and alternate lifestyles. Many Americans are opposed to homosexuality, promiscuity of any kind, and prostitution. This report must deal with all of these issues, but does so with the intent that information and education can change individual behavior, since this is the primary way to stop the epidemic of AIDS. This report deals with the positive and negative consequences of activities and behaviors from a health and medical point of view.

Adolescents and pre-adolescents are those whose behavior we wish to especially influence because of their vulnerability when they are exploring their own sexuality (heterosexual and homosexual) and perhaps experimenting with drugs. Teenagers often consider themselves immortal, and these young people may be putting themselves at great risk.

Education about AIDS should start in early elementary school and at home so that children can grow up knowing the behavior to avoid to protect themselves from exposure to the AIDS virus. The threat of AIDS can provide an opportunity for parents to instill in their children their own moral and ethical standards.

Those of us who are parents, educators and community leaders, indeed all adults, cannot disregard this responsibility to educate our young. The need is critical and the price of neglect is high. The lives of our young people depend on our fulfilling our responsibility.

AIDS is an infectious disease. It is contagious, but it cannot be spread in the same manner as a common cold or measles or chicken pox. It is contagious in the same way that sexually transmitted diseases, such as syphilis and gonorrhea, are contagious. AIDS can also be spread through the sharing of intravenous drug needles and syringes used for injecting illicit drugs.

AIDS is *not* spread by common everyday contact but by sexual contact (penis-vagina, penis-rectum, mouth-rectum, mouth-vagina, mouth-penis). Yet there is great misunderstanding resulting in unfounded fear that AIDS can be spread by casual, non-sexual contact. The first cases of AIDS were reported in this country in 1981. We would know by now if AIDS were passed by casual, non-sexual contact.

Today those practicing high risk behavior who become infected with the AIDS virus are found mainly among homosexual and bisexual men and male and female intravenous drug users. Heterosexual transmission is expected to account for an increasing proportion of those who become infected with the AIDS virus in the future.

At the beginning of the AIDS epidemic many Americans had little sympathy for people with AIDS. The feeling was that somehow people from certain groups "deserved" their illness. Let us put those feelings behind us. We are fighting a disease, not people. Those who are already afflicted are sick people and need our care as do all sick patients. The country must face this epidemic as a unified society. We must prevent the spread of AIDS while at the same time preserving our humanity and intimacy.

AIDS is a life-threatening disease and a major public health issue. Its impact on our society is and will continue to be devastating. By the end of 1991, an estimated 270,000 cases of AIDS will have occurred with 179,000 deaths within the decade since the disease was first recognized. In the year 1991, an estimated 145,000 patients with AIDS will need health and supportive services at a total cost of between \$8 and \$16 billion. However, AIDS is preventable. It can be controlled by changes in personal behavior. It is the responsibility of every citizen to be informed about AIDS and to exercise the appropriate preventive measures. This report will tell you how.

The spread of AIDS can and must be stopped.

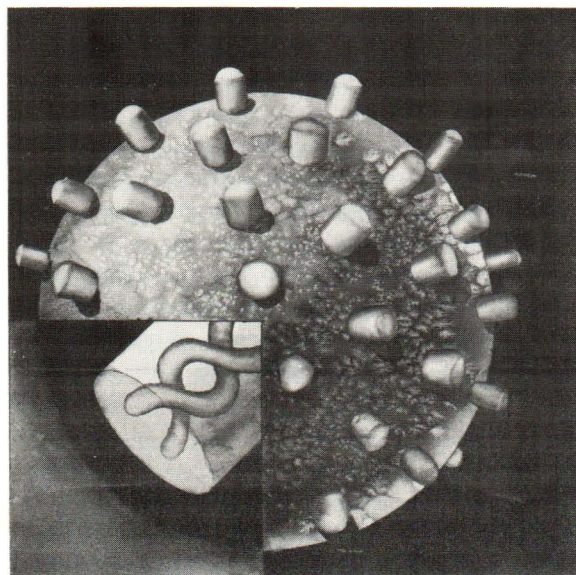


C. Everett Koop, M.D., Sc.D.
Surgeon General

AIDS

AIDS Caused by Virus

The letters A-I-D-S stand for Acquired Immune Deficiency Syndrome. When a person is sick with AIDS, he/she is in the final stages of a series of health problems caused by a virus (germ) that can be passed from one person to another chiefly during sexual contact or through the sharing of intravenous drug needles and syringes used for "shooting" drugs. Scientists have named the AIDS virus "HIV or HTLV-III or LAV"¹. These abbreviations stand for information denoting a virus that attacks white blood cells (T-Lymphocytes) in the human blood. Throughout this publication, we will call the virus the "AIDS virus." The



Artists drawing of AIDS virus with cut away view showing genetic (reproductive) material.

¹These are different names given to AIDS virus by the scientific community:

- HIV — Human Immunodeficiency Virus
- HTLV-III — Human T-Lymphotropic Virus Type III
- LAV — Lymphadenopathy Associated Virus

AIDS virus attacks a person's immune system and damages his/her ability to fight other disease. Without a functioning immune system to ward off other germs, he/she now becomes vulnerable to becoming infected by bacteria, protozoa, fungi, and other viruses and malignancies, which may cause life-threatening illness, such as pneumonia, meningitis, and cancer.

No Known Cure

There is presently no cure for AIDS. There is presently no vaccine to prevent AIDS.

Virus Invades Blood Stream

When the AIDS virus enters the blood stream, it begins to attack certain white blood cells (T-Lymphocytes). Substances called antibodies are produced by the body. These antibodies can be detected in the blood by a simple test, usually two weeks to three months after infection. Even before the antibody test is positive, the victim can pass the virus to others by methods that will be explained.

Once an individual is infected, there are several possibilities. Some people may remain well but even so they are able to infect others. Others may develop a disease that is less serious than AIDS referred to as AIDS Related Complex (ARC). In some people the protective immune system may be destroyed by the virus and then other germs (bacteria, protozoa, fungi and other viruses) and cancers that ordinarily would never get a foothold cause "opportunistic diseases" — using the *opportunity* of lowered resistance to infect and destroy. Some of the most common are *Pneumocystis carinii* pneumonia and tuberculosis. Individuals infected with the AIDS virus may also develop certain types of cancers such as Kaposi's sarcoma. These infected people have classic AIDS. Evidence shows that the AIDS virus may also attack the nervous system, causing damage to the brain.

Signs and Symptoms

No Signs

Some people remain apparently well after infection with the AIDS virus. They may have no physically apparent symptoms of illness. However, if proper precautions are not used with sexual contacts and/or intravenous drug use, these infected individuals can spread the virus to others. Anyone who thinks he or she is infected or involved in high risk behaviors should not donate his/her blood, organs, tissues, or sperm because they may now contain the AIDS virus.

ARC

AIDS-Related Complex (ARC) is a condition caused by the AIDS virus in which the patient tests positive for AIDS infection and has a specific set of clinical symptoms. However, ARC patients' symptoms are often less severe than those with the disease we call classic AIDS. Signs and symptoms of ARC may include loss of appetite, weight loss, fever, night sweats, skin rashes, diarrhea, tiredness, lack of resistance to infection, or swollen lymph nodes. These are also signs and symptoms of many other diseases and a physician should be consulted.

AIDS

Only a qualified health professional can diagnose AIDS, which is the result of a natural progress of infection by the AIDS virus. AIDS destroys the body's immune (defense) system and allows otherwise controllable infections to invade the body and cause additional diseases. These opportunistic diseases would not otherwise gain a foothold in the body. These opportunistic diseases may eventually cause death.

Some symptoms and signs of AIDS and the "opportunistic infections" may include a persistent cough and fever associated with shortness of breath or difficult breathing and

may be the symptoms of *Pneumocystis carinii* pneumonia. Multiple purplish blotches and bumps on the skin may be a sign of Kaposi's sarcoma. The AIDS virus in all infected people is essentially the same; the reactions of individuals may differ.

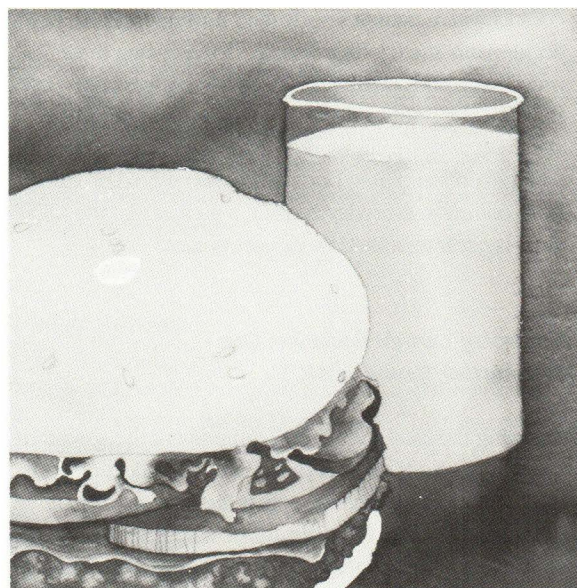
Long Term

The AIDS virus may also attack the nervous system and cause delayed damage to the brain. This damage may take years to develop and the symptoms may show up as memory loss, indifference, loss of coordination, partial paralysis, or mental disorder. These symptoms may occur alone, or with other symptoms mentioned earlier.

AIDS: the present situation

The number of people estimated to be infected with the AIDS virus in the United States is about 1.5 million. All of these individuals are assumed to be capable of spreading the virus sexually (heterosexually or homosexually) or by sharing needles and syringes or other implements for intravenous drug use. Of these, an estimated 100,000 to 200,000 will come down with AIDS Related Complex (ARC). It is difficult to predict the number who will develop ARC or AIDS because symptoms sometimes take as long as nine years to show up. With our present knowledge, scientists predict that 20 to 30 percent of those infected with the AIDS virus will develop an illness that fits an accepted definition of AIDS within five years. The number of persons known to have AIDS in the United States to date is over 25,000; of these, about half have died of the disease. Since there is no cure, the others are expected to also eventually die from their disease.

The majority of infected antibody positive individuals who carry the AIDS virus show no disease symptoms and may not come down with the disease for many years, if ever.



No Risk from Casual Contact

There is no known risk of non-sexual infection in most of the situations we encounter in our daily lives. We know that family members living with individuals who have the AIDS virus do not become infected except through sexual contact. There is no evidence of transmission (spread) of AIDS virus by everyday contact even though these family members shared food, towels, cups, razors, even toothbrushes, and kissed each other.

Health Workers

We know even more about health care workers exposed to AIDS patients. About 2,500 health workers who were caring for AIDS patients when they were sickest have been carefully studied and tested for infection with the AIDS virus. These doctors, nurses and other health care givers have been exposed to the AIDS patients' blood, stool and other body fluids. Approximately 750 of these health workers reported possible additional exposure by direct

contact with a patient's body fluid through spills or being accidentally stuck with a needle. Upon testing these 750, only 3 who had accidentally stuck themselves with a needle had a positive antibody test for exposure to the AIDS virus. Because health workers had much more contact with patients and their body fluids than would be expected from common everyday contact, it is clear that the AIDS virus is not transmitted by casual contact.

Control of Certain Behaviors Can Stop Further Spread of AIDS

Knowing the facts about AIDS can prevent the spread of the disease. Education of those who risk infecting themselves or infecting other people is the only way we can stop the spread of AIDS. People must be responsible about their sexual behavior and must avoid the use of illicit intravenous drugs and needle sharing. We will describe the types of behavior that lead to infection by the AIDS virus and the personal measures that must be taken for effective protection. If we are to stop the AIDS epidemic, we all must understand the disease—its cause, its nature, and its prevention. *Precautions must be taken.* The AIDS virus infects persons who expose themselves to known risk behavior, such as certain types of homosexual and heterosexual activities or sharing intravenous drug equipment.

Risks

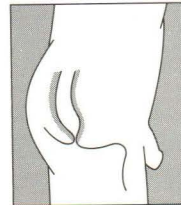
Although the initial discovery was in the homosexual community, AIDS is not a disease only of homosexuals. AIDS is found in heterosexual people as well. AIDS is not a black or white disease. AIDS is not just a male disease. AIDS is found in women; it is found in children. In the future AIDS will probably increase and spread among people who are not homosexual or intravenous drug abusers in the same manner as other sexually transmitted diseases like syphilis and gonorrhea.

Sex Between Men

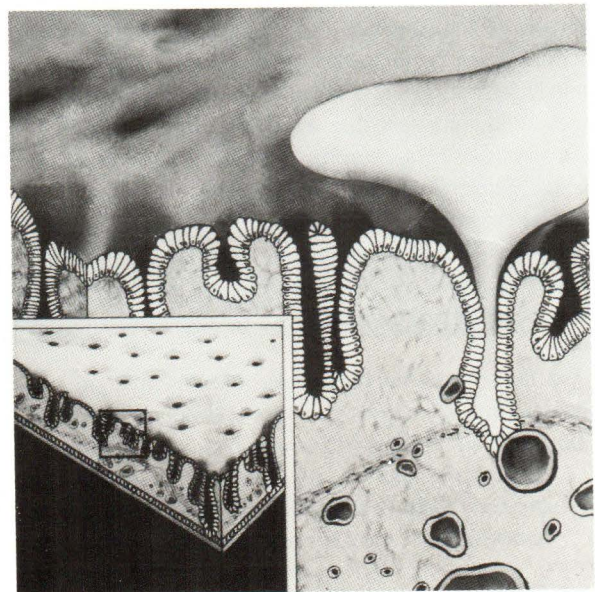
Men who have sexual relations with other men are especially at risk. About 70 percent of AIDS victims throughout the country are male homosexuals and bisexuals. This percentage probably will decline as heterosexual transmission increases. *Infection results from a sexual relationship with an infected person.*

Multiple Partners

The risk of infection increases according to the number of sexual partners one has, *male or female*. The more partners you have, the greater the risk of becoming infected with the AIDS virus.



Vulnerable rectum lining provides avenue for entry of AIDS virus into the blood stream.



How Exposed

Although the AIDS virus is found in several body fluids, a person acquires the virus during sexual contact with an infected person's blood or semen and possibly vaginal secretions. The virus then enters a person's blood stream through their rectum, vagina or penis.

Small (unseen by the naked eye) tears in the surface lining of the vagina or rectum may occur during insertion of the penis, fingers, or other objects, thus opening an avenue for entrance of the virus directly into the blood stream; therefore, the AIDS virus can be passed from penis to rectum and vagina and vice versa without a visible tear in the tissue or the presence of blood.

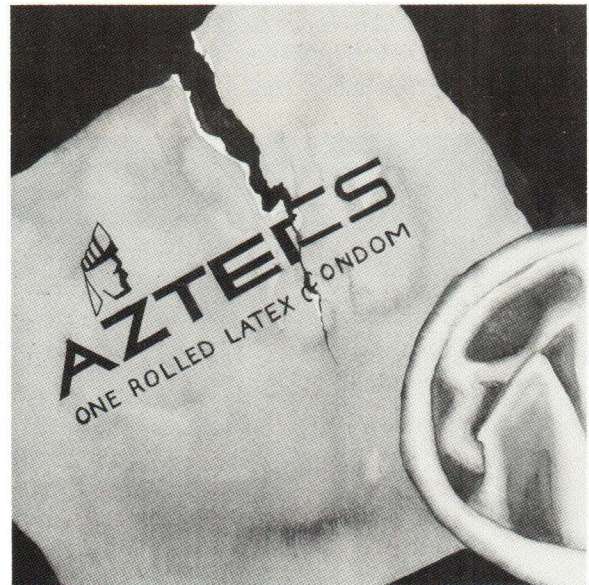
Prevention of Sexual Transmission – Know Your Partner

Couples who maintain mutually faithful monogamous relationships (only one continuing sexual partner) are protected from AIDS through sexual transmission. If you have been faithful for at least five years and your partner has been faithful too, neither of you is at risk. If you have not been faithful, then you and your partner are at risk. If your partner has not been faithful, then your partner is at risk which also puts you at risk. This is true for both heterosexual and homosexual couples. Unless it is possible to know with *absolute certainty* that neither you nor your sexual partner is carrying the virus of AIDS, you must use protective behavior. *Absolute certainty* means not only that you and your partner have maintained a mutually faithful monogamous sexual relationship, but it means that neither you nor your partner has used illegal intravenous drugs.

AIDS: you can protect yourself from infection

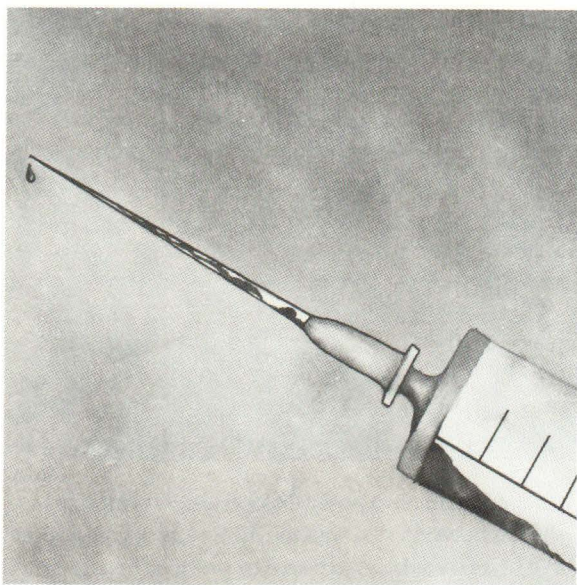
Some personal measures are adequate to safely protect yourself and others from infection by the AIDS virus and its complications. Among these are:

- If you have been involved in any of the high risk sexual activities described above or have injected illicit intravenous drugs into your body, you should have a blood test to see if you have been infected with the AIDS virus.
- If your test is positive or if you engage in high risk activities and choose not to have a test, you should tell your sexual partner. If you jointly decide to have sex, you must protect your partner by always using a rubber (condom) during (start to finish) sexual intercourse (vagina or rectum).



- If your partner has a positive blood test showing that he/she has been infected with the AIDS virus or you suspect that he/she has been exposed by previous heterosexual or homosexual behavior or use of intravenous drugs with shared needles and syringes, a rubber (condom) should always be used during (start to finish) sexual intercourse (vagina or rectum).

- If you or your partner is at high risk, avoid mouth contact with the penis, vagina, or rectum.
- Avoid all sexual activities which could cause cuts or tears in the linings of the rectum, vagina, or penis.
- Single teen-age girls have been warned that pregnancy and contracting sexually transmitted diseases can be the result of only one act of sexual intercourse. They have been taught to say *NO* to sex! They have been taught to say *NO* to drugs! By saying *NO* to sex and drugs, they can avoid AIDS which can *kill* them! The same is true for teenage boys who should also not have rectal intercourse with other males. It may result in AIDS.
- Do not have sex with prostitutes. Infected male and female prostitutes are frequently also intravenous drug abusers; therefore, they may infect clients by sexual intercourse and other intravenous drug abusers by sharing their intravenous drug equipment. Female prostitutes also can infect their unborn babies.



Dirty intravenous needle and syringe contaminated with blood that may contain the AIDS virus.

Intravenous Drug Users

Drug abusers who inject drugs into their veins are another population group at high risk and with high rates of infection by the AIDS virus. Users of intravenous drugs make up 25 percent of the cases of AIDS throughout the country. The AIDS virus is carried in contaminated blood left in the needle, syringe, or other drug related implements and the virus is injected into the new victim by reusing dirty syringes and needles. Even the smallest amount of infected blood left in a used needle or syringe can contain live AIDS virus to be passed on to the next user of those dirty implements.

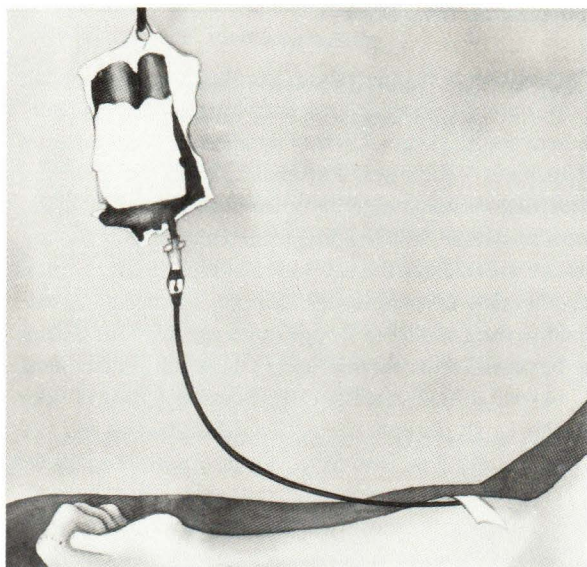
No one should shoot up drugs because addiction, poor health, family disruption, emotional disturbances and death could follow. However, many drug users are addicted to drugs and for one reason or another have not changed their behavior. For these people, the only way not to get AIDS is *to use a clean, previously unused* needle, syringe or any other implement necessary for the injection of the drug solution.

Hemophilia

Some persons with hemophilia (a blood clotting disorder that makes them subject to bleeding) have been infected with the AIDS virus either through blood transfusion or the use of blood products that help their blood clot. Now that we know how to prepare safe blood products to aid clotting, this is unlikely to happen. This group represents a very small percentage of the cases of AIDS throughout the country.

Blood Transfusion

Currently all blood donors are initially screened and blood is *not* accepted from high risk individuals. Blood that has been collected for use is tested for the presence of antibody to the AIDS virus. However, some people may have had a blood transfusion prior to March 1985 before we knew how to screen blood for safe transfusion and may have become



infected with the AIDS virus. Fortunately there are not now a large number of these cases. With routine testing of blood products, the blood supply for transfusion is now safer than it has ever been with regard to AIDS.

Persons who have engaged in homosexual activities or have shot street drugs within the last 10 years should *never* donate blood.

Mother Can Infect Newborn

If a woman is infected with the AIDS virus and becomes pregnant, she is more likely to develop ARC or classic AIDS, and she can pass the AIDS virus to her unborn child. Approximately one third of the babies born to AIDS-infected mothers will also be infected with the AIDS virus. Most of the infected babies will eventually develop the disease and die. Several of these babies have been born to wives of hemophiliac men infected with the AIDS virus by way of contaminated blood products. Some babies have also been born to women who became infected with the AIDS virus by bisexual partners who had the virus. Almost all babies with AIDS have been born to women who were intravenous

drug users or the sexual partners of intravenous drug users who were infected with the AIDS virus. More such babies can be expected.

Think carefully if you plan on becoming pregnant. If there is any chance that you may be in any high risk group or that you have had sex with someone in a high risk group, such as homosexual and bisexual males, drug abusers and their sexual partners, see your doctor.

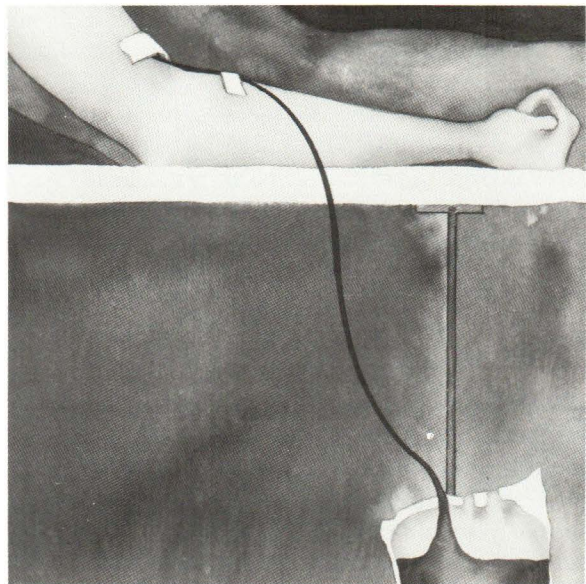
Summary

AIDS affects certain groups of the population. Homosexual and bisexual males who have had sexual contact with other homosexual or bisexual males as well as those who "shoot" street drugs are at greatest risk of exposure, infection and eventual death. Sexual partners of these high risk individuals are at risk, as well as any children born to women who carry the virus. Heterosexual persons are increasingly at risk.

AIDS: what is safe

Most Behavior is Safe

Everyday living does not present any risk of infection. You *cannot* get AIDS from casual social contact. Casual social contact should not be confused with casual *sexual* contact which is a major cause of the spread of the AIDS virus. Casual *social* contact such as shaking hands, hugging, social kissing, crying, coughing or sneezing, will not transmit the AIDS virus. Nor has AIDS been contracted from swimming in pools or bathing in hot tubs or from eating in restaurants (even if a restaurant worker has AIDS or carries the AIDS virus.) AIDS is not contracted from sharing bed linens, towels, cups, straws, dishes, or any other eating utensils. You cannot get AIDS from toilets, doorknobs, telephones, office machinery, or household furniture. You cannot get AIDS from body massages, masturbation or any non-sexual contact.



Donating Blood

Donating blood is *not* risky at all. *You cannot get AIDS by donating blood.*

Receiving Blood

In the U.S. every blood donor is screened to exclude high risk persons and every blood donation is now tested for the presence of antibodies to the AIDS virus. Blood that shows exposure to the AIDS virus by the presence of antibodies is not used either for transfusion or for the manufacture of blood products. Blood banks are as safe as current technology can make them. Because antibodies do not form immediately after exposure to the virus, a newly infected person may unknowingly donate blood after becoming infected but before his/her antibody test becomes positive. It is estimated that this might occur less than once in 100,000 donations.

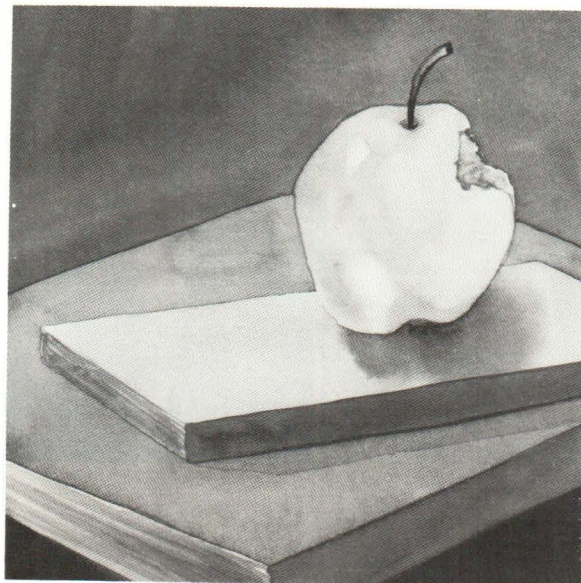
There is no danger of AIDS virus infection from visiting a doctor, dentist, hospital, hairdresser or beautician. AIDS

cannot be transmitted non-sexually from an infected person through a health or service provider to another person. Ordinary methods of disinfection for urine, stool and vomitus which are used for non-infected people are adequate for people who have AIDS or are carrying the AIDS virus. You may have wondered why your dentist wears gloves and perhaps a mask when treating you. This does not mean that he has AIDS or that he thinks you do. He is protecting you and himself from hepatitis, common colds or flu.

There is no danger in visiting a patient with AIDS or caring for him or her. Normal hygienic practices, like wiping of body fluid spills with a solution of water and household bleach (1 part household bleach to 10 parts water), will provide full protection.

Children in School

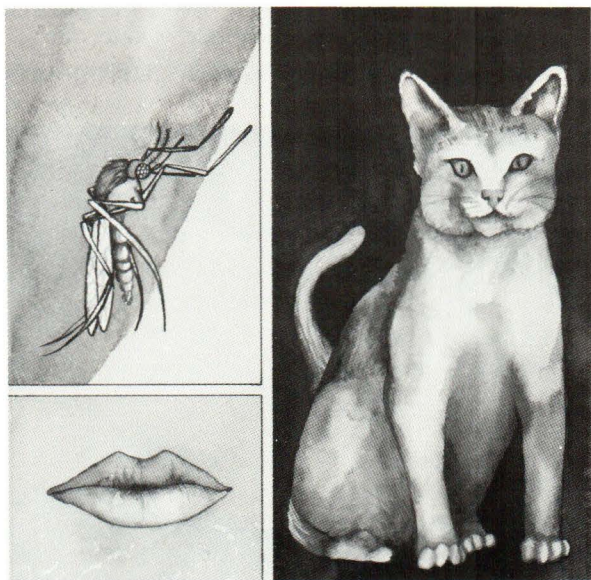
None of the identified cases of AIDS in the United States are known or are suspected to have been transmitted from one child to another in school, day care, or foster care settings. Transmission would necessitate exposure of open



cuts to the blood or other body fluids of the infected child, a highly unlikely occurrence. Even then routine safety procedures for handling blood or other body fluids (which should be standard for all children in the school or day care setting) would be effective in preventing transmission from children with AIDS to other children in school.

Children with AIDS are highly susceptible to infections, such as chicken pox, from other children. Each child with AIDS should be examined by a doctor before attending school or before returning to school, day care or foster care settings after an illness. No blanket rules can be made for all school boards to cover all possible cases of children with AIDS and each case should be considered separately and individualized to the child and the setting, as would be done with any child with a special problem, such as cerebral palsy or asthma. A good team to make such decisions with the school board would be the child's parents, physician and a public health official.

Casual social contact between children and persons infected with the AIDS virus is not dangerous.



Insects

There are no known cases of AIDS transmission by insects, such as mosquitoes.

Pets

Dogs, cats and domestic animals are not a source of infection from AIDS virus.

Tears and Saliva

Although the AIDS virus has been found in tears and saliva, no instance of transmission from these body fluids has been reported.

AIDS comes from sexual contacts with infected persons and from the sharing of syringes and needles. There is no danger of infection with AIDS virus by casual social contact.

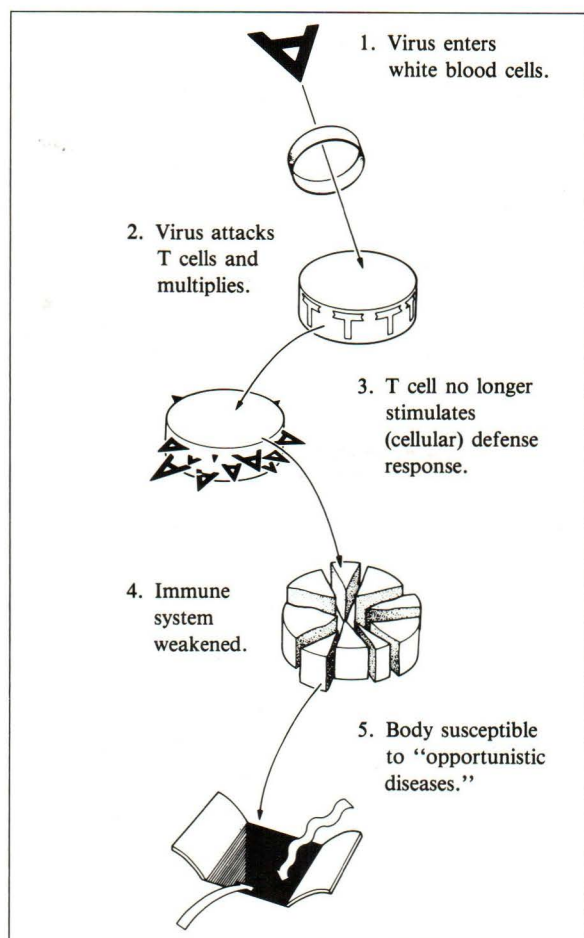
Testing of Military Personnel

You may wonder why the Department of Defense is currently testing its uniformed services personnel for presence of the AIDS virus antibody. The military feel this procedure is necessary because the uniformed services act as their own blood bank in a time of national emergency. They also need to protect new recruits (who unknowingly may be AIDS virus carriers) from receiving live virus vaccines. These vaccines could activate disease and be potentially life-threatening to the recruits.

AIDS: what is currently understood

Although AIDS is still a mysterious disease in many ways, our scientists have learned a great deal about it. In five years we know more about AIDS than many diseases that we have studied for even longer periods. While there is no vaccine or cure, the results from the health and behavioral research community can only add to our knowledge and increase our understanding of the disease and ways to prevent and treat it.

In spite of all that is known about transmission of the AIDS virus, scientists will learn more. One possibility is the



potential discovery of factors that may better explain the mechanism of AIDS infection.

Why are the antibodies produced by the body to fight the AIDS virus not able to destroy that virus?

The antibodies detected in the blood of carriers of the AIDS virus are ineffective, at least when classic AIDS is actually triggered. They cannot check the damage caused by the virus, which is by then present in large numbers in the body. Researchers cannot explain this important observation. We still do not know why the AIDS virus is not destroyed by man's immune system.

Summary

AIDS no longer is the concern of any one segment of society; it is the concern of us all. No American's life is in danger if he/she or their sexual partners do not engage in high risk sexual behavior or use shared needles or syringes to inject illicit drugs into the body.

People who engage in high risk sexual behavior or who shoot drugs are risking infection with the AIDS virus and are risking their lives and the lives of others, including their unborn children.

We cannot yet know the full impact of AIDS on our society. From a clinical point of view, there may be new manifestations of AIDS—for example, mental disturbances due to the infection of the brain by the AIDS virus in carriers of the virus. From a social point of view, it may bring to an end the free-wheeling sexual lifestyle which has been called the sexual revolution. Economically, the care of AIDS patients will put a tremendous strain on our already overburdened and costly health care delivery system.

The most certain way to avoid getting the AIDS virus and to control the AIDS epidemic in the United States is for individuals to avoid promiscuous sexual practices, to maintain mutually faithful monogamous sexual relationships and to avoid injecting illicit drugs.

Look to the Future

The Challenge of the Future

An enormous challenge to public health lies ahead of us and we would do well to take a look at the future. We must be prepared to manage those things we can predict, as well as those we cannot.

At the present time there is no vaccine to prevent AIDS. There is no cure. AIDS, which can be transmitted sexually and by sharing needles and syringes among illicit intravenous drug users, is bound to produce profound changes in our society, changes that will affect us all.

Information and Education Only Weapons Against AIDS

It is estimated that in 1991 54,000 people will die from AIDS. At this moment, many of them are not infected with the AIDS virus. With proper information and education, as many as 12,000 to 14,000 people could be saved in 1991 from death by AIDS.

AIDS will Impact All

The changes in our society will be economic and political and will affect our social institutions, our educational practices, and our health care. Although AIDS may never touch you personally, the societal impact certainly will.

Be Educated – Be Prepared

Be prepared. Learn as much about AIDS as you can. Learn to separate scientific information from rumor and myth. The Public Health Service, your local public health officials and your family physician will be able to help you.

Concern About Spread of AIDS

While the concentration of AIDS cases is in the larger urban areas today, it has been found in every state and with the mobility of our society, it is likely that cases of AIDS will appear far and wide.

Special Educational Concerns

There are a number of people, primarily adolescents, that do not yet know they will be homosexual or become drug abusers and will not heed this message; there are others who are illiterate and cannot heed this message. They must be reached and taught the risk behaviors that expose them to infection with the AIDS virus.

High Risk Get Blood Test

The greatest public health problem lies in the large number of individuals with a history of high risk behavior who have been infected with and may be spreading the AIDS virus. Those with high risk behavior must be encouraged to protect others by adopting safe sexual practices and by the use of clean equipment for intravenous drug use. If a blood test for antibodies to the AIDS virus is necessary to get these individuals to use safe sexual practices, they should get a blood test. Call your local health department for information on where to get the test.

Anger and Guilt

Some people afflicted with AIDS will feel a sense of anger and others a sense of guilt. In spite of these understandable reactions, everyone must join the effort to control the epidemic, to provide for the care of those with AIDS, and to do all we can to inform and educate others about AIDS, and how to prevent it.

Confidentiality

Because of the stigma that has been associated with AIDS, many afflicted with the disease or who are infected with the AIDS virus are reluctant to be identified with AIDS. Because there is no vaccine to prevent AIDS and no cure, many feel there is nothing to be gained by revealing sexual contacts that might also be infected with the AIDS virus. When a community or a state requires reporting of those infected with the AIDS virus to public health authorities in order to trace sexual and intravenous drug contacts—as is the practice with other sexually transmitted diseases—those infected with the AIDS virus go underground out of the mainstream of health care and education. For this reason current public health practice is to protect the privacy of the individual infected with the AIDS virus and to maintain the strictest confidentiality concerning his/her health records.

State and Local AIDS Task Forces

Many state and local jurisdictions where AIDS has been seen in the greatest numbers have AIDS task forces with heavy representation from the field of public health joined by others who can speak broadly to issues of access to care, provision of care and the availability of community and psychiatric support services. Such a task force is needed in every community with the power to develop plans and policies, to speak, and to act for the good of the public health at every level.

State and local task forces should plan ahead and work collaboratively with other jurisdictions to reduce transmission of AIDS by far-reaching informational and educational programs. As AIDS impacts more strongly on society, they should be charged with making recommendations to provide for the needs of those afflicted with AIDS. They also will be in the best position to answer the concerns and direct the activities of those who are not infected with the AIDS virus.

The responsibility of State and local task forces should be far reaching and might include the following areas:

- Insure enforcement of public health regulation of such practices as ear piercing and tattooing to prevent transmission of the AIDS virus.
- Conduct AIDS education programs for police, firemen, correctional institution workers and emergency medical personnel for dealing with AIDS victims and the public.
- Insure that institutions catering to children or adults who soil themselves or their surroundings with urine, stool, and vomitus have adequate equipment for cleanup and disposal, and have policies to insure the practice of good hygiene.

School

Schools will have special problems in the future. In addition to the guidelines already mentioned in this pamphlet, there are other things that should be considered such as sex education and education of the handicapped.

Sex Education

Education concerning AIDS must start at the lowest grade possible as part of any health and hygiene program. The appearance of AIDS could bring together diverse groups of parents and educators with opposing views on inclusion of sex education in the curricula. There is now no doubt that we need sex education in schools and that it must include information on heterosexual and homosexual relationships. The threat of AIDS should be sufficient to permit a sex education curriculum with a heavy emphasis on prevention of AIDS and other sexually transmitted diseases.

Handicapped and Special Education

Children with AIDS or ARC will be attending school along with others who carry the AIDS virus. Some children will develop brain disease which will produce changes in mental

behavior. Because of the right to special education of the handicapped and the mentally retarded, school boards and higher authorities will have to provide guidelines for the management of such children on a case-by-case basis.

Labor and Management

Labor and management can do much to prepare for AIDS so that misinformation is kept to a minimum. Unions should issue preventive health messages because many employees will listen more carefully to a union message than they will to one from public health authorities.

AIDS Education at the Work Site

Offices, factories, and other work sites should have a plan in operation for education of the work force and accommodation of AIDS or ARC patients *before* the first such case appears at the work site. Employees with AIDS or ARC should be dealt with as are any workers with a chronic illness. In-house video programs provide an excellent source of education and can be individualized to the needs of a specific work group.

Strain on the Health Care Delivery System

The health care system in many places will be overburdened as it is now in urban areas with large numbers of AIDS patients. It is predicted that during 1991 there will be 145,000 patients requiring hospitalization at least once and 54,000 patients who will die of AIDS. Mental disease (dementia) will occur in some patients who have the AIDS virus before they have any other manifestation such as ARC or classic AIDS.

State and local task forces will have to plan for these patients by utilizing conventional and time honored systems but will also have to investigate alternate methods of treatment and alternate sites for care including homecare.

The strain on the health system can be lessened by family, social, and psychological support mechanisms in the community. Programs are needed to train chaplains, clergy, social workers, and volunteers to deal with AIDS. Such support is particularly critical to the minority communities.

Mental Health

Our society will also face an additional burden as we better understand the mental health implications of infection by the AIDS virus. Upon being informed of infection with the AIDS virus, a young, active, vigorous person faces anxiety and depression brought on by fears associated with social isolation, illness, and dying. Dealing with these individual and family concerns will require the best efforts of mental health professionals.

Controversial Issues

A number of controversial AIDS issues have arisen and will continue to be debated largely because of lack of knowledge about AIDS, how it is spread, and how it can be prevented. Among these are the issues of compulsory blood testing, quarantine, and identification of AIDS carriers by some visible sign.

Compulsory Blood Testing

Compulsory blood testing of individuals is not necessary. The procedure could be unmanageable and cost prohibitive. It can be expected that many who *test* negatively might actually be positive due to *recent* exposure to the AIDS virus and give a false sense of security to the individual and his/her sexual partners concerning necessary protective behavior. The prevention behavior described in this report, if adopted, will protect the American public and contain the AIDS epidemic. Voluntary testing will be available to those who have been involved in high risk behavior.

Quarantine

Quarantine has no role in the management of AIDS because AIDS is not spread by casual contact. The only time that some form of quarantine might be indicated is in a situation where an individual carrying the AIDS virus knowingly and willingly continues to expose others through sexual contact or sharing drug equipment. Such circumstances should be managed on a case-by-case basis by local authorities.

Identification of AIDS Carriers by Some Visible Sign

Those who suggest the marking of carriers of the AIDS virus by some visible sign have not thought the matter through thoroughly. It would require testing of the entire population which is unnecessary, unmanageable and costly. It would miss those recently infected individuals who would test negatively, but be infected. The entire procedure would give a false sense of security. AIDS must and will be treated as a disease that can infect anyone. AIDS should not be used as an excuse to discriminate against any group or individual.

Updating Information

As the Surgeon General, I will continually monitor the most current and accurate health, medical, and scientific information and make it available to you, the American people. Armed with this information you can join in the discussion and resolution of AIDS-related issues that are critical to your health, your children's health, and the health of the nation.

Additional Information

Telephone Hotlines (Toll Free)

PHS AIDS Hotline
800-342-AIDS
800-342-2437

National Sexually Transmitted Diseases Hotline/
American Social Health Association
800-227-8922

National Gay Task Force
AIDS Information Hotline
800-221-7044
(212) 807-6016 (NY State)

Information Sources

*U.S. Public Health Service
Public Affairs Office*
Hubert H. Humphrey
Building, Room 725-H
200 Independence Avenue,
S.W.
Washington, D.C. 20201
Phone: (202) 245-6867

*Local Red Cross or
American Red Cross
AIDS Education Office*
1730 D Street, N.W.
Washington, D.C. 20006
Phone: (202) 737-8300

*American Association of
Physicians for
Human Rights*
P.O. Box 14366
San Francisco, CA 94114
Phone: (415) 558-9353

AIDS Action Council
729 Eighth Street, S.E.,
Suite 200
Washington, D.C. 20003
Phone: (202) 547-3101

Gay Men's Health Crisis
P.O. Box 274
132 West 24th Street
New York, NY 10011
Phone: (212) 807-6655

Hispanic AIDS Forum
c/o APRED
853 Broadway, Suite 2007
New York, NY 10003
Phone: (212) 870-1902 or
870-1864

Los Angeles AIDS Project
7362 Santa Monica
Boulevard
Los Angeles, California
90046
(213) 876-AIDS

Minority Task Force on AIDS
c/o New York City Council
of Churches
475 Riverside Drive,
Room 456
New York, NY 10115
Phone: (212) 749-1214

Mothers of AIDS Patients
(MAP)
c/o Barbara Peabody
3403 E Street
San Diego, CA 92102
(619) 234-3432

National AIDS Network
729 Eighth Street, S.E.,
Suite 300
Washington D.C. 20003
(202) 546-2424

*National Association of
People with AIDS*
P.O. Box 65472
Washington, D.C. 20035
(202) 483-7979

*National Coalition of Gay
Sexually Transmitted
Disease Services*
c/o Mark Behar
P.O. Box 239
Milwaukee, WI 53201
Phone: (414) 277-7671

*National Council of
Churches/ AIDS Task Force*
475 Riverside Drive,
Room 572
New York, NY 10115
Phone: (212) 870-2421

*San Francisco AIDS
Foundation*
333 Valencia Street,
4th Floor
San Francisco, CA 94103
Phone: (415) 863-2437

D.C. to Test Newborns, Clinic Patients for AIDS

Blood of 30,000 to Be Screened for Virus

By Lawrence Feinberg
Washington Post Staff Writer

The District of Columbia government plans to begin mass, anonymous testing for the AIDS virus next month of 20,000 newborn infants and 10,000 clinic patients as part of a nationwide, federally financed program to track the spread of the disease, D.C. and federal officials said yesterday.

The tests will be conducted on blood routinely taken from every child born in the city. Similar tests also are expected to be conducted next year in 30 states, including Maryland and Virginia, the federal Centers for Disease Control said.

In Washington and 29 other cities, including Baltimore and Richmond, blood samples will be tested for the AIDS virus among patients at clinics for drug use, sexually transmitted diseases and tuberculosis. In addition, blood will be tested for the virus from women using city-run prenatal care clinics and birth control clinics operated by Planned Parenthood in the District, Arlington and Silver Spring, according to Dr. Martin E. Levy, administrator for preventive health of the D.C. Public Health Commission.

"The idea is to find out what's really going on out there so we can target our prevention programs," Levy said. At present, he noted, the only unbiased information on the prevalence of AIDS comes from those who display symptoms of the fatal disease, which may take several years to appear.

Levy said all the AIDS tests will be performed on blood already taken for other lab testing. He said that since names will be removed from the samples before any AIDS test is performed, no consent from donors is required.

Information will be recorded on sex, race, age, jurisdiction of residence, and possibly ZIP Code of residence, Levy said, so that basic demographic characteristics on the incidence of the infection can be developed.

But since the samples are anonymous because of fears about confidentiality, no one who tests pos-

itive can be notified that they carry the disease, he said, though clinic patients can participate in separate, voluntary AIDS tests.

The District tests show whether blood contains antibodies to the HIV virus, indicating whether the donors or, in the case of newborns, their mothers were infected.

Dr. Timothy Dondero, of CDC in Atlanta, said the study here, financed by a first-year federal grant of \$400,000, is part of a nationwide research project, announced last fall. Blood from a large sample of patients at 40 hospitals around the country will also be used for anonymous AIDS testing, Dondero said. Levy said one hospital in the District is considering participation, but both he and Dondero declined to identify it.

Earlier this week CDC announced that it had canceled a house-to-house sample study of AIDS infection planned in the District because of local protests. That study, unlike the blood testing of specific groups such as male homosexuals and intravenous drug users, would have provided the first data needed to estimate the prevalence of AIDS in the general population.

Maryland Makes Plans To Preserve Skipjacks

Officials of the Maryland Historical Trust and captains of skipjacks have agreed that no more of their craft will be sold as pleasure boats.

They met in Tilghman Island, Md., Tuesday to discuss the state's efforts to try to preserve the skipjack fleet.

Capt. Paul Holland of the Clarence Crockett in Crisfield said the captains were pleased with the state's plans and were assured the state will do all it can to help them preserve the historic fleet of work boats. A spokeswoman said the state plans to help watermen meet the increasing costs of liability insurance and maintenance, which can run as high as \$10,000 a year.

No state funds will be available until next June.

SUPPLEMENT TO
THE QUARTERLY REPORT
TO THE DOMESTIC POLICY COUNCIL
ON THE PREVALENCE AND RATE OF SPREAD
OF HIV IN THE UNITED STATES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL

JULY 26, 1988

**SUPPLEMENT TO
THE QUARTERLY REPORT
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1. Overview

Since 1981, nearly 68,000 patients with AIDS have been reported in the United States with over 38,000 deaths due to AIDS recorded. During the past year, over 28,500 AIDS cases have been reported. The recent Public Health Service estimate that 1.0 to 1.5 million Americans are currently infected with the AIDS virus received the support of a group of leading scientific consultants. This indicates that the similar preliminary estimate made in 1986 was somewhat high at that time. This news is balanced by accumulating epidemiologic data regarding the ultimate likelihood an infected person will develop AIDS. These data indicate that over 80% of HIV-infected adults will develop signs or symptoms of illness within eight years of infection and that, ultimately the majority, if not most will develop AIDS unless effective long term therapy becomes available.

Data from existing surveillance systems for HIV infection continue to show highest rates of infection in young to middle-aged adults, with men having higher rates than women and blacks and Hispanics higher rates than whites, Asians, and Native Americans.

The implementation of the comprehensive family of HIV surveys has proceeded rapidly at the local as well as National level in the six months since the Domestic Policy directive. Nearly 500 surveys have begun or are near implementation to provide additional information to assist HIV prevention efforts. A contract has been awarded for a three-city pilot phase to begin in September 1988 for the National HIV household seroprevalence survey.

The Public Health Service projects that by the end of 1992, 365,000 cases of AIDS will have been diagnosed, mostly among those already infected with HIV. Medical care for patients needing treatment in 1992 alone is expected to cost between 5 and 13 billion dollars.

2. Estimate of HIV Infection

In the first report to the Domestic Policy Council, in November 1987, CDC revised the estimate of the number of persons in the United States currently infected with HIV to be between 945,000 and 1.4 million persons. In April 1988, CDC convened a meeting of many of the leading scientists working on mathematical modeling techniques for AIDS and HIV infection, including 20 consultants from universities, private research groups, and other Federal agencies. They considered two very different approaches to estimating the number of persons currently infected: 1) a calculation based on the prevalence of HIV infection in risk groups and on the size of these risk groups, and 2) a mathematical modeling technique based on the number of reported (and projected) cases and on the natural history of AIDS. The latter modeling technique uses estimates of the time from infection to the development of AIDS to "back-calculate" the number of persons infected from the number of cases.

Based on results of the two approaches, which use different types of data and assumptions, the consultants agreed that 1.0 million to 1.5 million is a reasonable estimate of the number of persons infected, although they felt that wider bounds of 700,000 to 1.7 million would more accurately reflect the uncertainty regarding the estimate. Although 1.0 to 1.5 million range is the same range as estimated by PHS in 1986, it does not mean that there have been no new infections. The 1986 estimate was based on preliminary data on the prevalence of HIV infection in risk groups. It seems likely that the number of persons infected in 1986 was fewer than 1 million.

Estimates on the national annual incidence (number of new HIV infections per year) are not yet possible and very difficult to obtain since the majority of newly infected persons are unaware they have become infected. Careful serial comparisons of HIV data collected in identical fashion in 1988 and 1989, and thereafter from the family of surveys should provide the most accurate estimates of HIV incidence.

3. Trends in HIV Prevalence

a. Selected Survey Results

(1) HIV Infection in Sentinel Hospital Patients

Thusfar, data are available from six urban and suburban hospitals predominantly in the midwest. The metropolitan areas served by these hospitals as a group are roughly average based on a comparison of the seroprevalence of military applicants from those areas and the country as a whole. Based upon 58 positives in the first 18,809 tests, the overall HIV seroprevalence, adjusted for age and sex, is 3.1 per 1,000 (0.31%), ranging from 1.1 to 8.8 per 1,000 (0.11% to 0.88%). By comparison, the military applicant data from the same group of cities, when similarly adjusted by age and sex, are 0.8 per 1,000 (0.08%). Infection in the six hospitals was concentrated in young to early middle-aged adults, was more frequent in males (3.6:1) than in females, and was more prevalent in blacks (2.7:1) and Hispanics (2.3:1) than in whites. In the four pilot hospitals, the prevalence level was stable over the 15 months of available data.

The sentinel hospital surveillance system was developed to provide data on levels and trends of HIV infection in the general population without the bias due to self-selection that affects most other general population surveys. The first four hospitals were enrolled in the pilot phase in September 1986; 35 are currently enrolled. Additional hospitals have been added since that time, with 35 currently enrolled or being enrolled throughout the country. A total of 42 will be included by December 1988. The survey is designed to represent a population whose HIV infection status is as close as possible

to that in the general population served by the hospitals. Therefore, specimens are selected only from patients with clinical conditions presumed to be coincidental to HIV infection, such as orthopedic conditions, childbirth, and accidents. The sample specifically does not include patients who come to the hospital for AIDS-related conditions because that would over-represent the HIV prevalence in the community.

(2) HIV Infection in Prisoners

As indicated in Table 1, the HIV seroprevalence obtained from these screening activities ranges from 0.0% to as high as 15.4%. The low end of the range includes the states of Washington and Idaho. The high prevalence was observed in female inmates in Maryland, 60% of whom were known to have been intravenous drug users (only 39 inmates had been screened). The median seroprevalence was 0.4%. Higher seroprevalence as been found, however, in special screening programs targeted at prisoners at increased risk for HIV. Seropositive inmates most frequently have histories of intravenous drug use. At least 9 State correctional systems plus the Federal Bureau of Prisons have conducted nonblinded HIV testing on all new inmates; the Federal Bureau of Prisons also tests prisoners on release. Five other jurisdictions have conducted blinded surveys on new inmates or inmates visiting the clinic.

(3) HIV Infection in College Students

By the end of 1988, a total of 20 colleges will be enrolled in HIV screening programs, and approximately 20,000 serum specimens will be collected. Thus far, 17 schools have agreed to participate in the blinded testing of students on their college campuses. Serum specimens from approximately 2,100 students from 3 colleges have been received. Results will be included in the next quarterly report when sufficient data for analysis will be available.

(4) HIV Infection in Job Corps Applicants

Between March 1, 1987 and March 31, 1988, 270 (4.1/1,000) of 65,960 specimens from incoming Job Corps members tested positive for antibody to HIV. Since October 1987, when comparison of subpopulations became possible, the seroprevalence in male applicants (4.8/1,000) has been only minimally higher than that in females (4.1/1,000); the seroprevalence in black applicants (6.9/1,000) has been higher than that in Hispanics (3.7/1,000) or whites (1.3/1,000); and the seroprevalence in applicants from urban counties that are part of standard metropolitan statistical areas (5.8/1,000) has been higher than in applicants from rural counties (2.4/1,000). Further data will be necessary to assess trends in seroprevalence over time.

Since March 1987, all new enrollees in Federal Job Corps residential training programs have been screened for antibody to HIV as a part of the intake medical evaluation. Since October 1987, results from this screening process have been maintained in a centralized database, permitting comparison of subgroups of applicants and trends in overall seroprevalence rates. This screening process provides information about a subpopulation of substantial interest about which seroprevalence data are otherwise difficult to obtain: economically disadvantaged youths aged 16-22 years, most of whom have dropped out of the formal education system.

b. Secular Trends in HIV Prevalence

None of the data show an increase in HIV infection levels over time, which would be expected if there were explosive spread in the general population. Three data sets are available that indicate the prevalence of HIV infection in specified groups over time: 33 months for first-time blood donors; 30 months for applicants to military services; and 15 months from the pilot phase of the sentinel hospital network. The first two groups, donors and military applicants, are self-selected; patterns of self-selection may vary over time. Sentinel hospital patients are not self-selected and are therefore not affected by this bias. Results obtained from these three data sets are shown in Figures 1-4.

The summary table provides additional HIV prevalence data, by population group, as of June 30.

4. Status of Implementation of Surveys

On November 30, 1987, the Domestic Policy Council directed the U.S. Public Health Service and its Centers for Disease Control to conduct a comprehensive family of HIV serosurveys to provide accurate information on HIV infection at the local, State, and national levels. These surveys will supplement AIDS surveillance data in providing accurate information on HIV, focus and evaluate prevention efforts, and determine the needs for health care and other services. The surveys have been enthusiastically received by State and local governments and implementation has proceeded rapidly.

a. Sentinel HIV Surveillance in 30 SMSAs

Initial funds totaling approximately \$6.1 million for the sentinel HIV surveillance being conducted in 30 SMSAs were awarded January 29, 1988, to 22 State health departments, the District of Columbia, and the Commonwealth of Puerto Rico. Additional funds totaling nearly \$16 million were awarded May 1, 1988.

Since the initiation of the HIV surveys in 30 SMSAs in late 1987, implementation has proceeded rapidly. The total number of clinics planning to participate now exceeds the original target number. Information about the status of enrollment of hospitals, clinics, and neonatal screening programs in the sentinel HIV surveillance in 30 SMSAs is provided in Table 2.

More than 420 different surveys will be conducted in the 30 SMSAs in sexually transmitted disease clinics, drug abuse treatment centers, tuberculosis clinics, women's health clinics, newborn infant screening programs, and sentinel hospitals. Major efforts are now underway to ensure that these surveys conform to the standardized scientific protocols and that data collection and reporting procedures will provide compatible national information. By July 1, more than 100 clinics participating in the blinded surveys will be collecting blood specimens.

In many areas, there is a lack of trained staff locally to adequately administer/manage these high-priority activities in a timely manner due to State and local personnel ceilings and hiring freezes that prevent the recruitment of the additional staff required to implement the surveys. Beginning May 1, 1988, CDC staff began in-depth site visits to all SMSAs participating in the HIV surveys to provide technical assistance and consultation. A major focus of these visits is to ensure that surveys meet human subject protection requirements. At the request of State and local health officials, 19 Federal public health advisors are being located by CDC at the State/local level to help implement the surveys, conduct AIDS case surveillance and carry out other prevention activities.

Additional information about the family of HIV surveys and studies, including those in the 30 SMSAs, is provided in the text and in Table 3.

Early data from HIV surveys have been instrumental in promoting changes in HIV prevention policies. In a written directive, the New York State Commissioner of Health has advised all physicians to counsel patients considering pregnancy to be counselled and tested for HIV antibody. In addition, HIV counselling and testing is now to be offered at all State-financed clinics in New York. State and local health departments receiving Federal funds for HIV prevention must now incorporate partner-notification strategies in their prevention programs.

Approximately 20 States are now or will soon utilize Statewide HIV reporting to assist the counselling and partner notification programs. CDC is encouraging States to implement and closely evaluate the effectiveness of these activities.

b. National Household Seroprevalence Survey

The nationwide HIV seroprevalence household survey to determine an estimate of the number of persons infected with HIV in the United States is proceeding on schedule.

The contract for the National Household Seroprevalence Survey (NHSS) was awarded to the Research Triangle Institute (RTI), Research Triangle Park, North Carolina. The NHSS is designed to determine the prevalence of HIV in the noninstitutionalized U.S. civilian population. The NHSS consists of a household interview to obtain information on demographic characteristics and HIV-risk behavior, and a blood test for HIV infection.

The NHSS is to be conducted in two phases. Due to uncertainties about the participation rate in the survey and the many methodological and technical issues involved in its implementation, the survey will include a pilot phase consisting of three pretests. The first will begin in September 1988 in Washington, D.C., and will include a sample of approximately 800 respondents. The second and third pretests for the NHSS are to be conducted between September 1988 and June 1989 in New York City and Los Angeles. Each of these pretests involves 1,500 respondents. The determination to proceed with the national survey (Phase II) will be based on the results from the pretests.

Phase II would involve national data collection, processing, and analysis. Phase II consists of a probability household sample of the entire United States and will be conducted from June 1989 through May 1990. Some 50,000 respondents between the ages of 18 and 54 will be asked to participate. Findings from the survey will show the prevalence of HIV infection for specific age, sex, race, and marital status subgroups and the overall prevalence of HIV infection for the four Census regions of the United States. The performance of Phase II is contingent on the demonstration of the feasibility of a methodology to obtain the blood samples and related demographic and behavioral risk data from a sufficiently large proportion of sampled respondents.

In the early planning for the survey as well as throughout its operation, the National Center for Health Statistics (NCHS) is working closely with public health and national and local organizations with specific interests in the design, operation, and results of the NHSS. Receiving special attention are outreach activities and materials to inform survey participants and interested groups and individuals about the survey and the implementation of the testing program.

c. National Health Interview Survey-AIDS Attitudes and Knowledge Survey

An AIDS questionnaire was developed for the National Health Interview Survey to provide estimates in 1987 of public knowledge and attitudes about HIV transmission and prevention of HIV infection and to measure changes in knowledge and attitudes over time.

The first phase of the National Health Interview Survey-AIDS Attitudes and Knowledge Survey began in August 1987 and was completed in early January 1988. Data from each month of the survey (August-December) have been published in the NCHS Advance Data series. The second phase of the survey began in early May. The revised questionnaire includes a number of questions designed to assist in the evaluation of the "Understanding AIDS" mailing.

The survey also includes more detailed questions on AIDS testing and counseling and on the assessment of personal risk. There are no questions on specific high-risk sex and drug behaviors, although there is an experimental item similar to the Red Cross blood donor exclusion question that asks respondents if they belong to any one of several high-risk categories but does not identify the specific category.

The baseline August-December 1987 surveys showed continuous improvement in knowledge of how HIV is transmitted. For example, the proportion of adults who know that HIV could be definitely transmitted through sexual intercourse grew from 75 to 82 percent from August to December 1987. Seventy-seven percent were aware of perinatal transmission and 93 percent of transmission from sharing needles used for intravenous drug abuse.

5. AIDS Projections and Case Definition

a. Five-Year Projection of AIDS Cases

In 1986, the Public Health Service (PHS) estimated that 270,000 cumulative AIDS cases would be diagnosed by the end of 1991. Of these, 15,800 were projected to be diagnosed in 1986 and 23,000 in 1987. The actual number of reported cases now expected in these years, after adjusting for reporting delays, is 17,100 and 25,200, respectively. The totals for 1986 and 1987 exceed the projections for those years in part because recent changes in the AIDS surveillance definition have allowed the reporting of cases not included originally.

Using a procedure similar to the extrapolation model used in 1986, PHS now projects that the cumulative number of diagnosed AIDS cases meeting the current definition will total nearly 365,000 by the end of 1992, with 263,000 cumulative deaths. In 1992 alone, 80,000 cases will be diagnosed, with 66,000 deaths. In 1992, a total of 172,000 AIDS patients will require medical care, at a cost expected to range from \$5 billion to \$13 billion. These figures do not represent the full impact of the AIDS epidemic because many

HIV-infected persons will have HIV-related symptoms before being considered to have AIDS according to the current AIDS surveillance definition. In addition, these figures do not estimate the potential cost impact of antiviral therapy.

The range for the cumulative number of cases diagnosed by the end of 1992 is from 205,000 to 440,000, and the range for the number of deaths is from 180,000 to 300,000 (Figure 5). The ranges for the projections are wide because we are projecting for a period of 5 1/2 years (July 1987 to December 1992) based on only 4 years of data (July 1983 to June 1987). Any such projection is likely to be uncertain by the end of the forecasting period. Changes made in the AIDS case definition in September 1987 and an estimation of the number of cases never reported to CDC have been factored into these projections. Cumulative reports of cases of AIDS continue to demonstrate substantial geographic variation in morbidity between States (Figure 6).

b. Case Definition

Increased use of HIV diagnostic tests has facilitated the revision of the AIDS case definition beyond the specific lifethreatening opportunistic infections and cancers to include severe neurologic disease (dementia) and the wasting syndrome. In addition, persons in lower socioeconomic groups, in particular, were believed to be more likely to have their opportunistic infections diagnosed presumptively rather than definitively.

In September 1987, the AIDS case definition was changed to more accurately reflect serious morbidity associated with HIV infection and recent changes in diagnostic practices. These recent changes in the AIDS case definition make it more difficult to extrapolate. Changes in the case definition have also had a significant effect on the distribution of reported cases. Of the cases meeting the pre-1987 case definition and diagnosed in the 12-month interval from July 1986 through June 1987, 67% were reported among homosexual and bisexual men. In contrast, of the cases diagnosed from September 1987 through March 1988 and meeting only the new surveillance definition, 43% were among homosexual and bisexual men. The corresponding percentages among intravenous drug users are 23% and 43%, respectively. It should be noted that there is some overlap between these groups. The proportion of cases associated with heterosexual transmission from others at risk has increased from 2.6% of cases diagnosed in the 12 months before September 1987, to 3.6% of cases diagnosed since then. The proportion of cases diagnosed among black men and women has increased from 24% to 36%, while the proportion among Hispanics has increased from 13% to 16%. It is somewhat difficult to interpret these early changes since in areas where a high proportion of cases meet only the new definition (e.g., New Jersey, U.S. territories), most reports have also been in blacks and Hispanics, and in heterosexual IV drug abusers. Data accruing from all States over the next several months should clarify this. The dramatic changes in these proportions demonstrate the effect improvements in the

revised case definition have made in detecting severe HIV-associated morbidity in certain populations. However, these changes make it difficult to project trends in cases by transmission category until it can be determined whether the changes are one-time adjustments for previous underreporting or represent significant trends.

6. Tables and Figures

- Table 1. HIV Infection in Prisoners
- Table 2. Target Number and Actual Number of Hospitals, Clinics, and Neonatal Screening Programs Enrolled in Sentinel HIV Surveillance (Blinded HIV Surveys in 30 SMSAs) as of June 30, 1988
- Table 3. Status of Family of Surveys and Studies as of June 30, 1988
- Figure 1. HIV Seroprevalence in First-Time Blood Donors, by Sex: October 1985-March 1986
- Figure 2. HIV Seroprevalence in Military Applicants, by Sex: October 1985-March 1988
- Figure 3. HIV Seroprevalence in Sentinel Hospital Patients, by Year, in 4 Pilot Sentinel Hospitals
- Figure 4. Prevalence of HIV antibody in military recruit applicants, 10/85-3/88, by State
- Figure 5. Observed and Projected Incidence of AIDS in the United States, by Quarter Year of Diagnosis
- Figure 6. Cumulative incidence of AIDS cases by State, through March 28, 1988

Table 1
HIV Infection in Prisoners

Jurisdiction	Inmate Category	Testing Dates *	Number of Individuals Tested	Number Positive	Percent Positive
Alabama	All new inmates	Until 10/87***	275	4	1.5
Colorado	All new inmates	Until 10/87***	5112	43	0.8
Idaho	All new inmates	Until 10/87***	163	0	0.0
Indiana	All new inmates**	5/87-7/87	602	1	0.2
Iowa	All new inmates	1/87-9/87	1925	7	0.4
Maryland	All new male inmates**	4/85-6/85	748	52	7.0
Maryland	All new female inmates**	4/85-6/85	39	6	15.4 ⁺
Michigan	All new inmates**	11/86	571	5	0.9
Missouri	All new inmates	7/87-10/87	1540	6	0.4
Nebraska	All new inmates	Until 10/87***	812	2	0.2
Nevada	All new inmates	9/85-12/87	6021	81	1.3
Nevada	Current inmates	8/85-9/85	3820	96	2.5
Oklahoma	All new inmates	Until 10/87***	2308	10	0.4
Oklahoma	Current inmates	6/87	9820	41	0.4
South Dakota	All new inmates	7/87-10/87	1025	1	0.1
South Dakota	Current inmates	7/87	982	2	0.2
Washington (Seattle)	All inmates visiting clinic**	3/87-6/87	199	0	0.0
W. Virginia	Current inmates	Until 10/87***	300	2	0.6
Wisconsin	All new inmates**	1986	997	3	0.3
Fed Bur Prisons	All new inmates	6/87-10/87	9640	240	2.5
Fed Bur Prisons	All releases	6/87-12/87	5100	133	2.6

* Unless otherwise noted, data are current as of October 1987.

** Blinded studies

*** Precise starting dates uncertain

+ Because of small sample size, estimate is relatively imprecise.

Source of data: T.M. Hammett, ABT Associates; National Institute of Justice

Table 2

**Target Number and Actual Number of Hospitals, Clinics, and Neonatal
Screening Programs Enrolled in Sentinel HIV Surveillance
(Blinded HIV Surveys in 30 SMSAs)
as of June 30, 1988**

HIV Surveillance Activity	Number Targeted	Actual Number Enrolled	Expected Annual Number of Specimens
Sentinel Hospitals*	40	35	144,000
Sexually Transmitted Disease Clinics	100	73	100,000
Drug Abuse Treatment Clinics	30	81	10,000
Women's Health Clinics**	100	106	20,000
Tuberculosis Clinics	30	62	10,000
Neonatal (PKU) Screening Programs (SMSAs)	(30)	(30)	1,300,000
Statewide***	24	26***	
TOTAL	324	373	1,584,000

* Currently, 12 hospitals have been enrolled and have already begun blinded HIV testing; 23 additional enrolled hospitals will be HIV testing by September 30, 1988; a total of 42 sentinel hospitals will be doing HIV testing by December 31, 1988.

** These include family planning clinics, prenatal clinics, abortion clinics, and various other clinics where women of childbearing age receive health care.

*** Neonatal blood specimen screening is being established in two additional states beyond those which contain the 30 SMSAs through an arrangement with one of the original states.

Table 3

Status of Family of HIV Surveys and Studies as of June 30, 1988

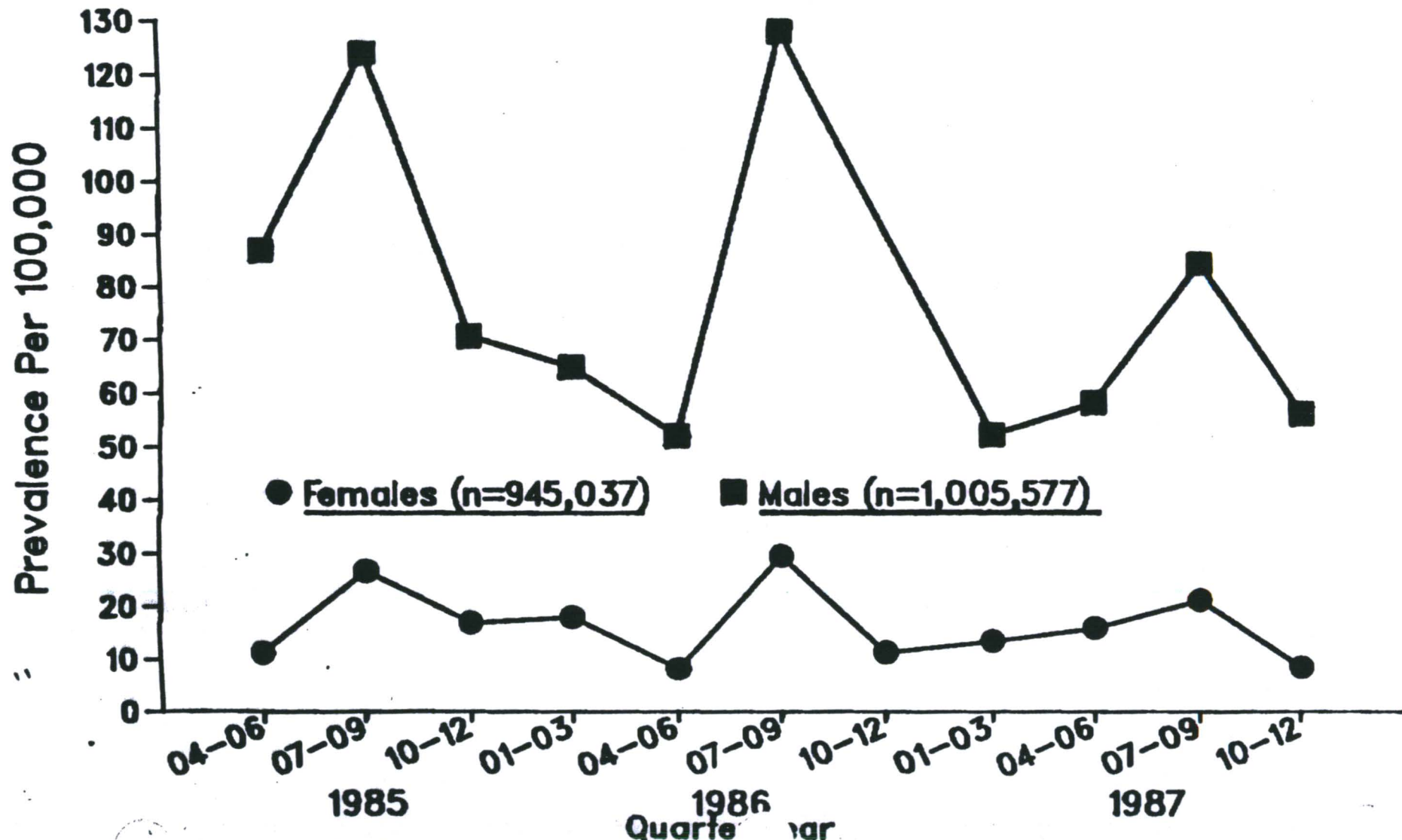
<u>Study/Survey</u>	<u>Funding</u>	<u>Operational Projection</u>
National HIV household survey (pilot phase)	ongoing	9/1/88
30 SMSA clinic-based surveys	ongoing	6/1/88
Sentinel hospitals	ongoing	ongoing
Clinical specimens		
Clinical laboratory	7/1/88	7/31/88
Family practice	7/1/88	7/31/88
Childbearing women/newborns	ongoing	7/1/88
Military applicants	ongoing	ongoing
Job Corps	ongoing	ongoing
Blood donors		
Prevalence/incidence	ongoing	ongoing
Risk assessment*	ongoing	6/13/88
Prisoners	ongoing	7/1/88
College students	ongoing	ongoing
Emergency rooms	9/30/88	11/30/88
Homosexual/bisexual cohorts	ongoing	ongoing
National Health and Nutrition Examination Survey	ongoing	pilot ongoing
National Health Interview Survey**	ongoing	ongoing

* Risk factor assessment in seropositive donors is conducted in geographically dispersed blood donation centers.

** This survey involves collection of interview information only. No blood specimens are collected.

FIGURE 1

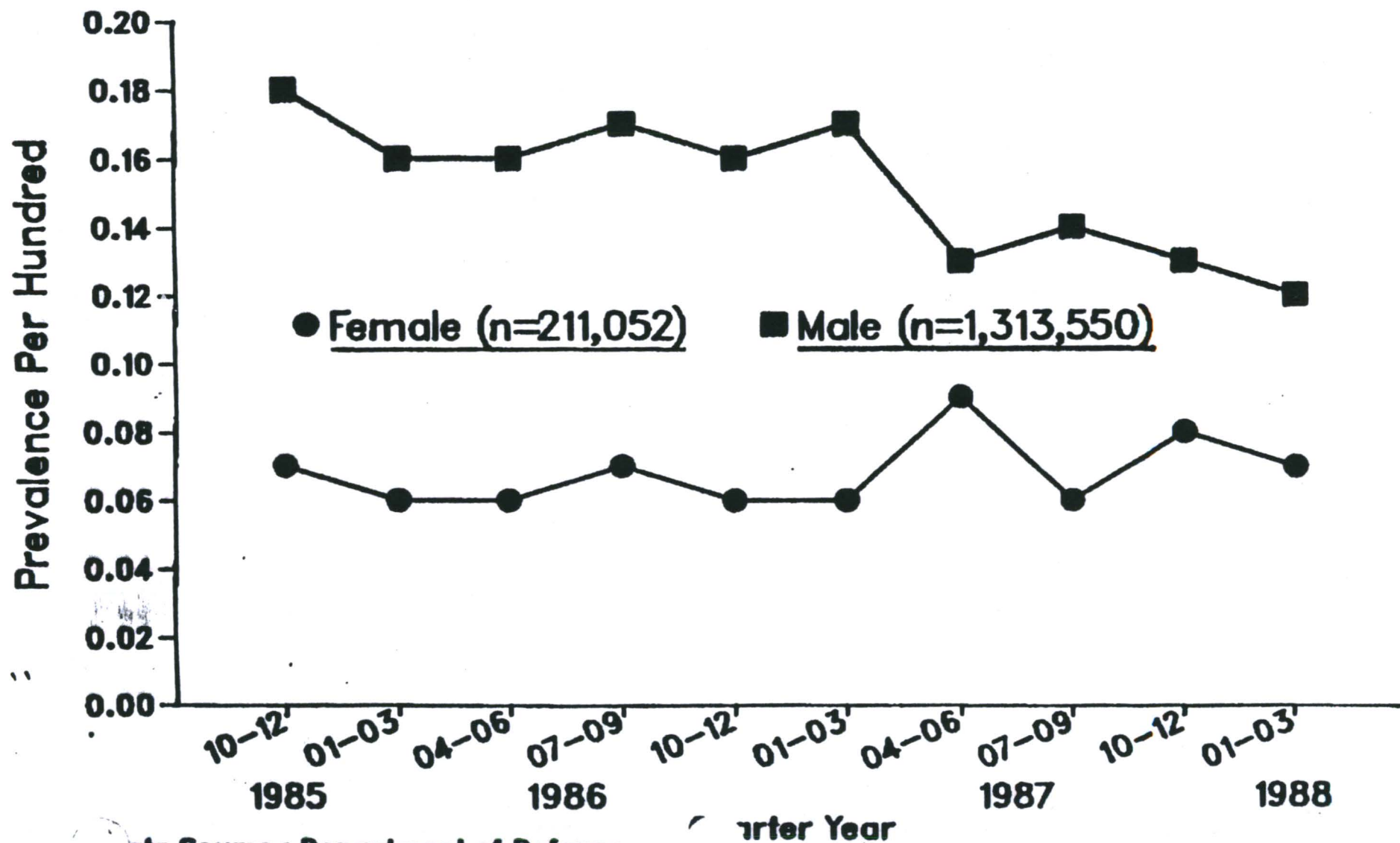
HIV Seroprevalence in First Time Blood Donors, by Sex, October 1985–March 1986



Source : 41 Regions American Red Cross

FIGURE 2

HIV Seroprevalence in Military Applicants, by Sex October 1985–March 1988



Data Source : Department of Defense

FIGURE 3

HIV Seroprevalence in Sentinel Hospital Patients, by Year, in 4 Pilot Sentinel Hospitals N=14,634

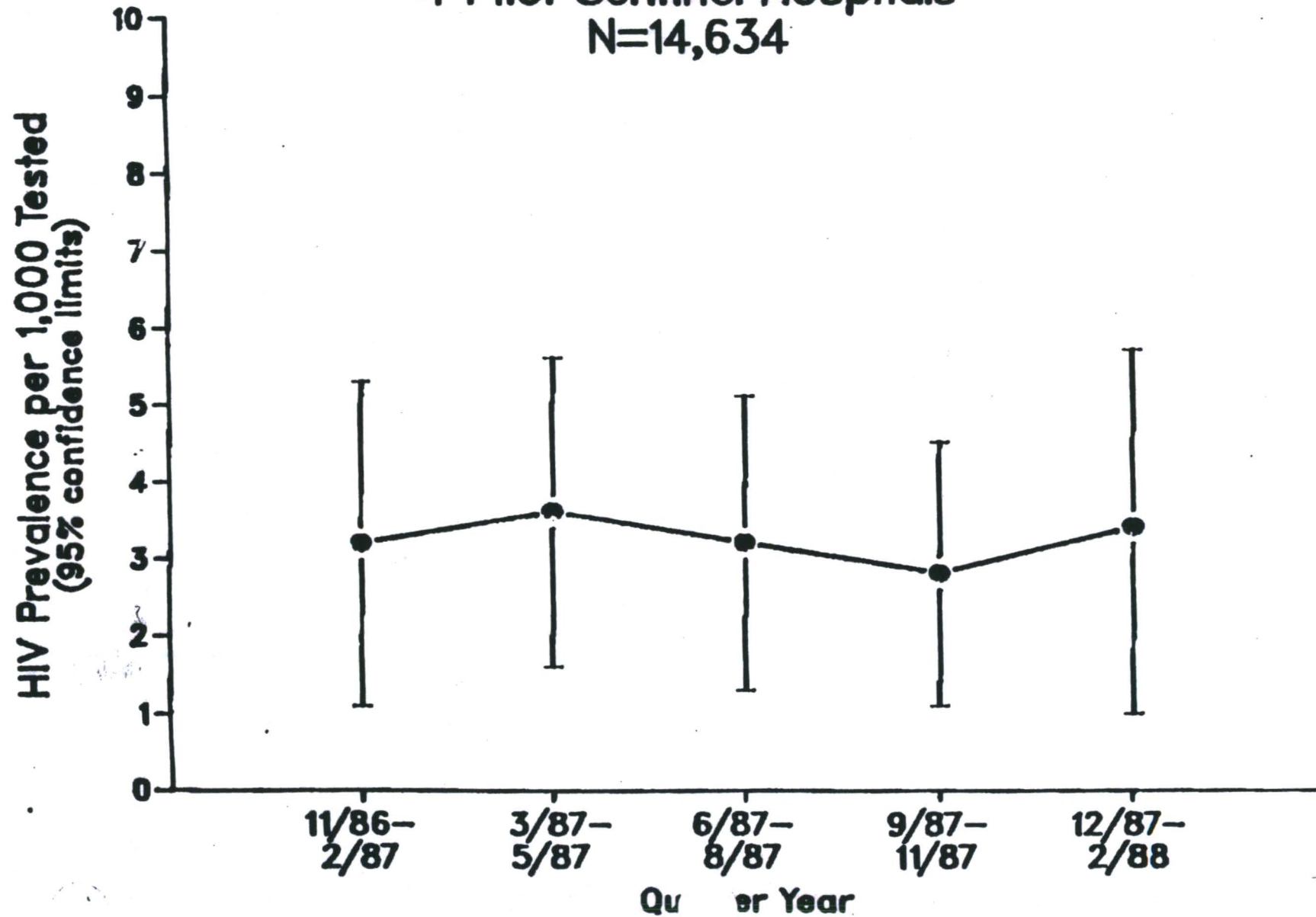


FIGURE 4

Prevalence of HIV Antibody in Military Recruit Applicants
Sex-Adjusted for Population of Age 17-59 Years, by State
(per 10,000), 10/85-3/88

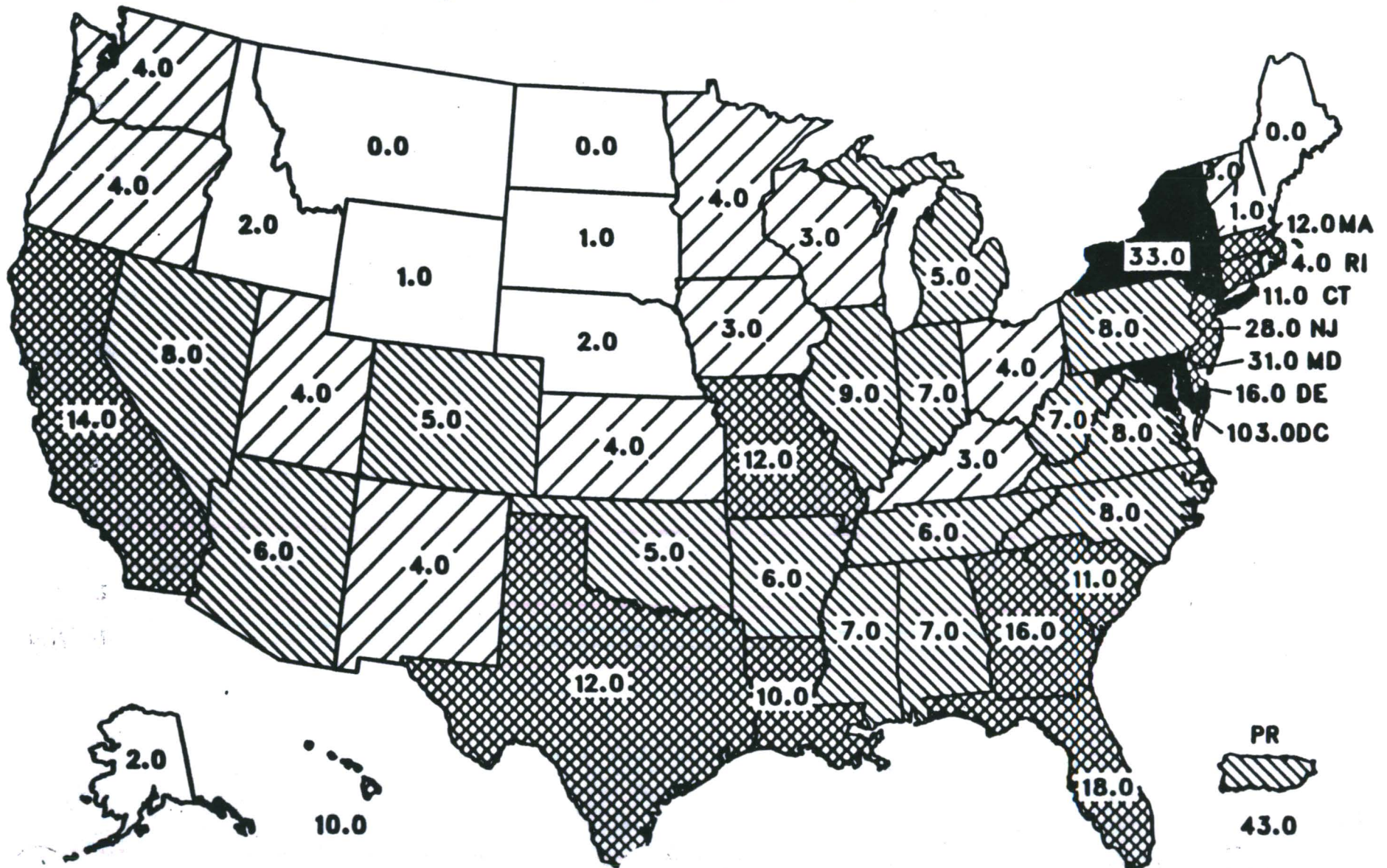
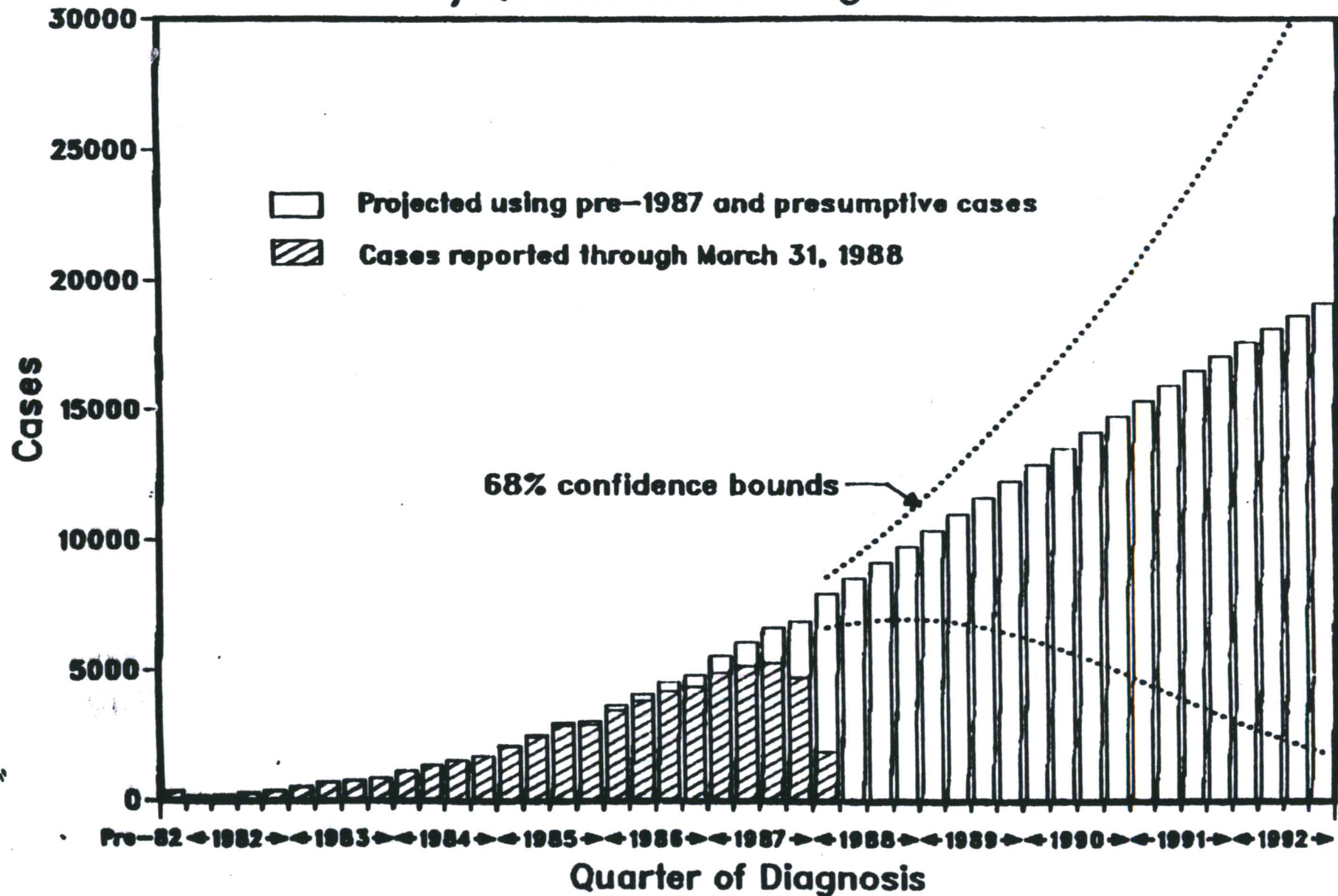


FIGURE 5

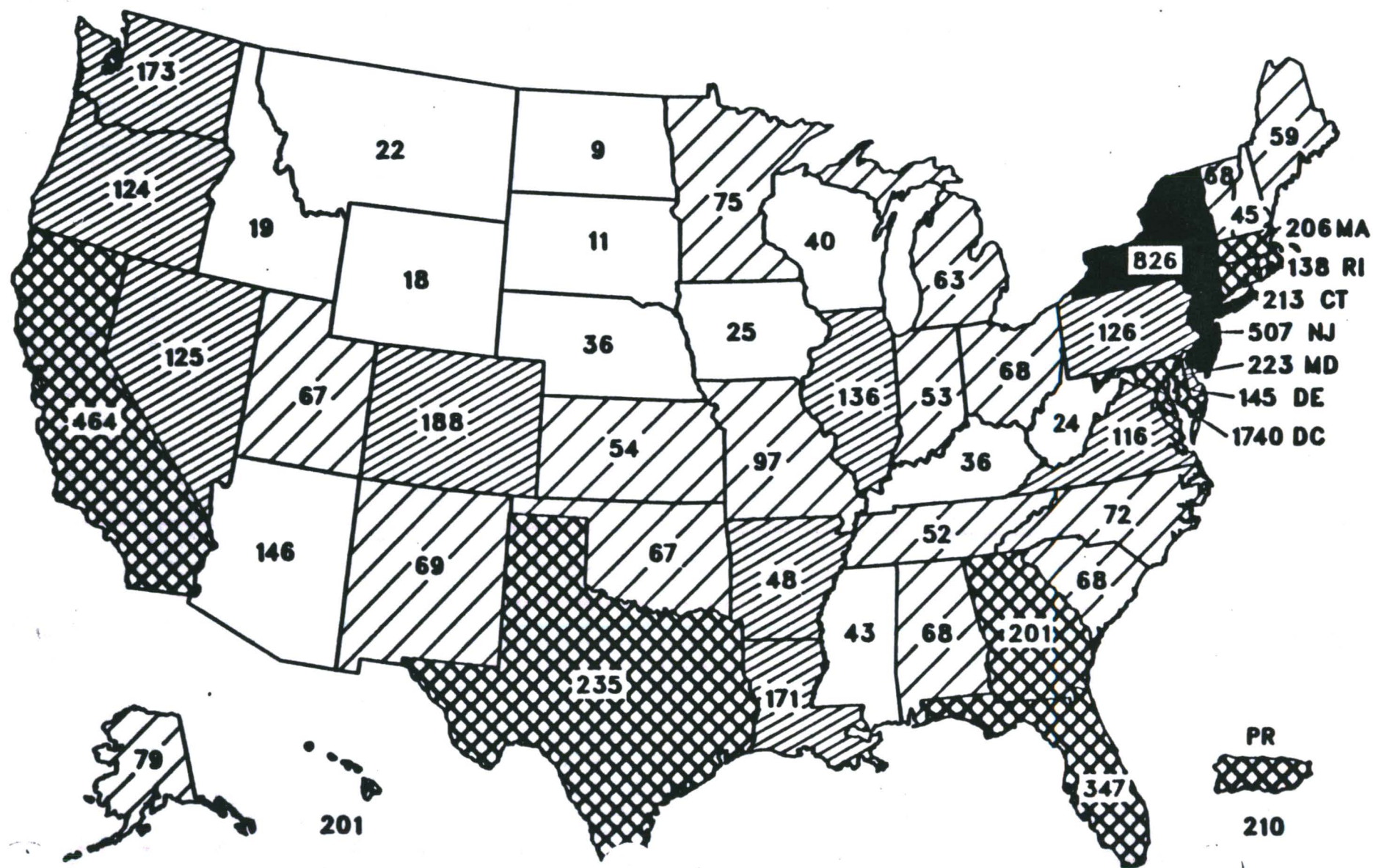
Observed and Projected Incidence of AIDS in the United States, by Quarter Year of Diagnosis*



* Projected from cases reported as of Mar 31, 1988 and diagnosed as of June 30, 1987. Projections do not include adjustment for cases not reported to CDC.

FIGURE 6

Incidence of AIDS Cases by State, Per Million Population, through March 28, 1988





DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

File
Needle
Shar

Memorandum

Date JUN 17 1988

From Director
National AIDS Program Office

Subject Attached Meeting Summary and Proposed Follow-Up

To MEETING PARTICIPANTS
Meetings on Needle Exchange and Bleach Distribution
Programs, May 11, 1988

(See attached list)

Attached is the summary of our recent meetings on needle exchange and other health interventions that address the IVDA/AIDS problem. As the summary amply indicates, I feel that the meeting surfaced key issues and provided real insight into the political and programmatic aspects of such programs.

I also agree with your suggestions to reconvene in the near future. Perhaps we can invite Portland, Oregon and Boston officials to join us to describe their programs. Also, perhaps we can hear from HRSA and ADAMHA officials who are visiting Region II health centers with Dr. Chang, Regional Health Administrator, in July to explore methods of providing primary care service to clients in methadone treatment programs and to assess the potential role of community health centers in providing drug treatment. In any event, Dr. Chang and I will be contacting you soon about another meeting. In the meantime, if you have any questions about the summary or suggestions for follow-up activities, please contact Winnie Mitchell of my staff at 202/472-4248.

Thanks to all of you for participating in the May 11 meeting. Each of your contributions enhanced my understanding, and I'm sure the understanding of others, of a very complex and volatile issue.

P. J. Fischinger
for Peter J. Fischinger, M.D., Ph.D.

Attachments

ATTENDANCE LIST
MEETING ON NEEDLE EXCHANGE AND BLEACH DISTRIBUTION
MAY 11, 1988

STATE AND LOCAL OFFICIALS

NEW JERSEY

Christine Grant, Deputy Health Commissioner,
New Jersey
Joyce Jackson, New Jersey State Health
Department

NEW YORK

Dr. Lloyd Novick, Assistant Commissioner for
Community Health Services, New York
Dr. Nicholas Rango, New York AIDS Institute
Mr. Dennis Whalen, Department of Substance
Abuse Services, New York
Dr. Don DesJarlais, Department of Substance
Abuse Services

NEW YORK CITY

Dr. Stephen Joseph, New York City Health
Commissioner
Dr. Stephen Schultz, Deputy Health
Commissioner, New York City
Dr. Beny Primm, Director, Addiction Research
and Treatment Corporation; Member,
President's Commission on HIV

PUBLIC HEALTH SERVICE

Dr. Robert E. Windom, Assistant Secretary for Health
Dr. C. Everett Koop, Surgeon General
Dr. Peter C. Fischinger, Director, National AIDS Program Office
Dr. Donald Ian Macdonald, Administrator, ADAMHA
Dr. James O. Mason, Director, CDC
Dr. David Sundwall, Administrator, HRSA
Dr. Everett R. Rhoades, Director, IHS
Dr. James B. Wyngaarden, Director, NIH
Dr. J. Michael Fitzmaurice, Director, NCHSR
Dr. Vivian Chang, Region II Health Administrator
Robert L. Trachtenberg, Deputy Administrator,
ADAMHA
Dr. Paul Parkman, FDA
Steven A. Grossman, DASH/OHPE
Richard Riseberg, General Counsel
Dr. Charles E. Schuster, Director, NIDA
Dr. Roy Pickens, NIDA
Dr. Stephen Jones, CDC
Gene Gerber, IHS
Rich Kotomori, IHS
Dr. Angela Mann, NCI
Joni Cunningham, ASPE
Lorraine Fishback, OASH
Iris Gelberg, NAPO
Dorothy Downes, OASH
Warren Hewitt, OMH
John Krzemien, PHS
Susan Lockhart, OSG

SUMMARY
MEETINGS ON NEEDLE EXCHANGE AND BLEACH DISTRIBUTION PROGRAMS
MAY 11, 1988
WASHINGTON, D.C.

On Wednesday, May 11th, the U.S. Public Health Service hosted two meetings with New York and New Jersey officials on the IVDA/AIDS health interventions planned or underway in those States. Dr. Peter Fischinger, Director, National AIDS Program Office, PHS, opened the first meeting by citing the need for a better data base on the efficacy of health interventions to reduce HIV transmission through intravenous drug abuse/needle sharing. Participants then discussed evaluation components in their current or planned programs so that, together, the group could assess the type of information such programs could yield.

Dr. Robert E. Windom, Assistant Secretary for Health, chaired the afternoon session which was devoted to a broader, more policy-oriented discussion of such interventions with policy officials from Federal and State government.

In both meetings, discussions centered on three central topics: current international needle exchange programs, New York City's planned needle exchange program, and other interventions (i.e., outreach, bleach distribution) going on in New Jersey and other States.

CURRENT INTERNATIONAL EFFORTS

Dr. Charles Schuster, Director of the U.S. National Institute on Drug Abuse (NIDA), reviewed current international needle exchange efforts. He informed the group that the World Health Organization (WHO) is developing an evaluation protocol for needle exchange programs that will be shared with NIDA in a WHO/NIDA meeting in Stockholm immediately following the June 12-16th International AIDS Conference.

He and Dr. Donald DesJarlais then summarized current information and data presented at a June, 1987 NIDA-sponsored conference on needle exchange programs:

- o In Amsterdam, Dr. Bruning et al. are interviewing and studying self-reported information on 175 drug addicts. Early findings have shown that needle sharing has declined - and that intravenous drug abuse in general is also declining. The overall orientation of Amsterdam's efforts is harm reduction.
- o The United Kingdom currently has 15 needle exchange programs operating at 26 sites, with rates of continued participation by IVDAs varying, but averaging 53%. Early results have been mixed, and community resistance has forced the closing of several sites. Entry of IVDAs into drug treatment does not appear to have dropped and may have increased.

- o Italy has a large population of intravenous drug abusers with a 50-70% seropositivity rate (accounting for 65% of all AIDS cases in Italy) -- even though needles are legally and easily available.
- o Dr. DesJarlais noted that in Australia, doctors have established a "guerilla" needle exchange program which began operating out of hospital hallways but is now officially sanctioned. Very preliminary studies of returned needles show a 3-4% rate of HIV infection.
- o Dr. DesJarlais also reported on Sweden, where one-fifth of addicts participating in a needle exchange program have never sought treatment before.

In ensuing discussion, participants noted that Amsterdam has a 30% seropositivity rate and a reported high rate of hepatitis B, even with this program. They also raised concerns that other drug paraphernalia (e.g., cookers, cotton swabs) could be infected as well.

In summary, Dr. Schuster said that, according to the June 1987 meeting participants, although evidence is limited, intravenous drug abusers do participate in such programs and the programs do not deter addicts from entering treatment (in fact, some participants noted that the programs may facilitate IVDAs entering treatment.) He noted, however, that the European programs may not be generalizable to the U.S. because of different cultural and demographic aspects. Specifically, none of these programs are opposed by the country's law enforcement officials.

NEW YORK CITY NEEDLE EXCHANGE FEASIBILITY STUDY

Noting that the "biggest issue is getting assurances from the criminal justice system that criminal penalties for possession of paraphernalia will be suspended" for those IVDAs participating in the New York City study, Dr. Lloyd Novick, Assistant Commissioner for Community Health Services for the State of New York, introduced Dr. Stephen Joseph, New York City Health Commissioner and his deputy, Dr. Steven Shultz, to describe New York City's planned "feasibility study" of needle exchange.

New York City Protocol

Introducing the planned protocol, which will be published as part of either emergency regulations or regular regulations requiring a 45 day comment period, Dr. Joseph noted that there are "many things in it that are not 'user friendly' or scientifically

sound." He then observed that, through the demonstration program, New York City officials expect to learn more about addicts, more about how many addicts will go into treatment, and "something about needle sharing" from the demonstration.

Dr. Stephen Schultz, Dr. Joseph's deputy, then reviewed the procedures New York City is currently planning to publish as part of the implementing regulations/protocol:

- o The New York State Commissioner of Health has the authority to issue regulations to implement such a program.
- o The source of IVDAs for the study will be from those on waiting lists for methadone maintenance clinics. Only documented IVDAs with evidence of chronicity will be considered, so as not to attract non-IVDAs.
- o The program will last about 9 months, with a preliminary evaluation to be conducted after 6 months.
- o It will be "fairly limited" -- with a overall group of 400 taken from waiting lists for methadone maintenance clinics and randomized from a central location. From the 400, one group would be enrolled in needle exchange and given counseling, and the second group would be given counseling only.
- o Rather than actual seroconversion (which is "very difficult to accomplish"), the end point may be based on process measures (i.e., drop-out rate, etc.).
- o There will be a mandatory intake medical assessment including blood testing (including blood type and STS).
- o There will probably be a blinded follow-up of HIV antibody status of the 400 as well as blood typing of the returned needles. New York plans to offer anonymous voluntary HIV testing to all 400 participants.
- o IVDAs entering the needle exchange group will be given specially marked syringes and a card identifying them as study participants. During subsequent visits, the study participants would exchange, one for one, the used, specially marked study needles for sterile replacements.
- o Following the example of the Australian needle exchange program, New York City intends to use micro, forensic methods to test for blood types (at this time only ABO groups) and HIV antibodies in the blood in returned syringes. Testing procedures to be used are not final.

Identification of more than one blood type or a blood type different than that of the IVDA who returned the syringe will be evidence that the syringe has been shared.

- o New York City expects a substantial drop-out (approximately 50%) of IVDA's initially enrolled in the study. Drop-outs will be replaced with new subjects.
- o New York City health officials plan to negotiate an agreement with criminal justice officials that study participants will be exempt from prosecution laws if they show the study identification card and the uniquely marked study syringes and needles.
- o The program would provide advocacy for participating IVDA's in the following ways: 1) it could act as an intermediary between the IVDA and the criminal justice system; and 2) it would identify available and geographically convenient treatment slots for participants; and 3) it could provide continuing support to all 400 participants through on-going counseling.

Dr. Novick noted several design problems with the planned study, including the lack of a clear objective (i.e., reduce HIV transmission or get addicts into treatment?), and the small number of IVDA's in the sample (with such a small group, the program can only demonstrate whether such a program can be done and whether addicts are receptive). Dr. Joseph responded that, while "methodologically impure," this is a first step which he felt must be taken.

Dr. Joseph concluded the program's description by noting that "the biggest problem we face is opposition by the law enforcement community." Dr. Primm added that community opposition is just as strong. He stated later, however, that if needle exchange were viewed as one step--an interim step-- in the progression to full IVDA treatment, such opposition could probably be defused. Dr. Joseph noted that the liability issues alone are thorny, including the potential issue of criminal liability in abetting a felony (drug addiction) by providing paraphernalia.

Comments on New York City Study

1. Objections to Program.

- o Dr. Macdonald, ADAMHA Administrator and Special Assistant to the President for Drug Abuse Policy, raised several objections to the study, including the potential for "harm" by encouraging drug abuse, and that this is not a valid

experiment because of the small number of subjects, the fact that the subjects are already motivated to come into treatment, and because conditions in New York City are different from the rest of the United States. He concluded that, if IVDA treatment is ultimately the answer, why not expand treatment?

- o Participants concluded that barriers to IVDA treatment need to be identified and overcome, including barriers to the establishment of neighborhood clinics, to the provision of methadone in regular hospital/clinic settings, and to the entire issue of utilizing the primary health care system for drug abuse treatment.

2. Treatment Availability.

- o The Surgeon General asked for information on the availability of IVDA treatment in NYC. Dr. Joseph responded that only one program (with numerous clinics in the three most affected boroughs), at Beth Israel Hospital, keeps a waiting list, and that the list has 1000+ persons on it at any time.
- o Dr. Primm noted that treatment availability must be advertised -- and treatment must be available on a full-time basis.

3. Outcome Evaluation.

- o Dr. Fischinger stressed the importance of outcome evaluation, including information on whether a needle has been shared (e.g., finding multiple blood types in a returned syringe), and assessment of the differences in the rate of HIV infection in the different groups.
- o Dr. Novick stated that, within the current intent, such a controlled study "can't be devised" because one would need 10 thousand IVDAs, and the blood testing technique would have to be proven.
- o Dr. Primm noted that, if addicts learn to clean their needles, blood typing of returned syringes may be impossible.

4. Educating the Public and the Criminal Justice System about Intravenous Drug Abuse and the Value of Treatment.

- o Participants in the morning session agreed that, while controversial and unproven, needle exchange does serve "to humanize the IVDA." They noted that there is an urgent need to educate the public about intravenous drug abuse and the nature of addiction -- and the fact that treatment can work.
- o In addition, the needle exchange process will allow repeated contacts with IVDAs to provide risk reduction counseling and encourage enrollment in drug treatment.

OTHER INTERVENTIONS

Chris Grant, Deputy Health Commissioner, New Jersey, and Joyce Jackson, New Jersey Health Department described New Jersey's efforts to reduce HIV transmission in IVDAs. Essentially, New Jersey's efforts are geared to "getting addicts into treatment." Ms. Grant added that there is anecdotal evidence that IVDAs do use treatment when available.

The New Jersey program consists of an extensive outreach effort to convince addicts to get treatment and to provide AIDS risk reduction information. The core of the outreach effort, however, is a highly successful coupon program that provides free and immediately available methadone maintenance to addicts with coupons. (The New Jersey program imposes a fee for methadone maintenance. New York City does as well, but waives the fee routinely.) Currently, the coupon redemption rate is 85%, and 40% of the IVDAs participating in the coupon program have never been in treatment before.

The outreach effort also provides bleach and information on how to sterilize equipment, without fanfare and as part of the overall effort to get addicts into treatment. Ms. Grant noted that bleach distribution is not as politically explosive as needle exchange. Mr. Whalen, New York City, mentioned ADAPT, a self-organized street outreach effort that distributes bleach.

New Jersey officials expressed concern that current HIV infection rates are so high in New Jersey and New York City that such interventions, even if successful, may be coming too late to show any immediate effect on HIV infection levels.

CONCLUSIONS

Over the course of the meeting, the group reached several conclusions:

1. At the suggestion of Dr. Mason, CDC, and Dr. Sundwall, HRSA, the group agreed that it should reconvene to discuss the kinds of barriers "within our power to remove" to providing IVDA treatment.
2. Interventions such as needle exchange and bleach distribution serve to "humanize" the IVDA. However, there is an urgent need to educate the public -- and the criminal justice system -- about the nature of addiction and the fact that treatment can be effective.
3. Treatment is the ultimate solution to the problem of the currently-addicted intravenous drug abuser and AIDS. All other interventions are "part of that whole."

7414 R
SEP 02 1988

THE
Crenshaw Clinic

Theresa L. Crenshaw, M.D.
Director

August 22, 1988

Donald Ian Macdonald, M.D.
Director, Drug Abuse Policy Office, and
Deputy Assistant to the President
The White House
Washington, DC

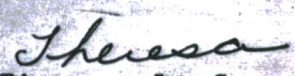
Dear Ian:

Thank you so much for your letter of August 4th. I read the ten-point action plan and the topic recommendations for HHS with considerable pleasure. You are to be congratulated for the fine work in a challenging area - again.

I look forward to talking with you again before the September follow up and that I understand will occur.

Thank you for the time you spent listening to my point of view and concerns. I really appreciate it.

Warm regards,


Theresa L. Crenshaw, M.D.

PLC/sd



Theresa L. Crenshaw, M.D.
3750 Riviera Drive, Suite 1
San Diego, California 92109

I

- scientists pay
- demonstration grants flexibility/waivers - Ross
- off-sets (ATO)

407H

FY '89 - severe constraints
FY '90 - running room

- FTEs, \$s, buildings

9/2

Actions to date [30 mil] → AZT (1-time)

ARRS - HHS

U.S. dues obligation { WHO supports Congress Klecker

FY '89

→ Jim Brown

→ Consensus conferences

scheduled - end of Nov

- reps. of states/health officials, CDC, Reg'l health admin

2-day "United States Summit"

"kick off - - -"

{ address non-fed'l 200+ recommendations }

- pass through of state monies

Use Fed'l government, ~~WHO~~ leadership, etc. to move 230 non-fed'l recs.

done - { 7th conference }

{ CDC \$ → for this purpose }

→ Community-based educational solicitation

award basis

of projects

funding cycle

→ look-back

- ipa's

{targetting ~ re-do
FDA ~ ~}

-

lab quality

- double inspections (3 mos ago)

labs in drs offices

- proficiency testing (human error v. testing error)

C. sterilization of red cells

- educate physicians (continuing ed. program)

(Pres. mention previously in public)?

(conferences - AMA, Red Cross,

specialty orgs)

{give BHS/Dr. Young a club w/ blood industry}

5 → Distribution ~ plan in place

Reg. {Bush request}

6 → Pharmaceutical Manufacturers
(help → royalties)

tech transfer / management contr.

{ Fair in Nov. ~ bring together NIH
agencies w/ pharm'l. industries }

- short policy working group
incentives - Little Rock, Ark. facility
{

7 → HICHA

8 → { Group of high-level consultants
{ Specific studies ~ grant (special) solicitation
w/ this type of research
{ ASPR State risk pools

8.5 Task force report

9 → PHS plan

~ Charlottesville report

→ Implementation of OIM guidelines - done (?) or soon
'86 Bowen letter

→ International implications + efforts
(CDC - AID - WHO)