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INTERNATIONAL ACTIVITIES OF THE UNITED STATES GOVERNMENT
AGAINST THE INTERNATIONAL HIV PANDEMIC: A THREE-YEAR ACTION PLAN

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EXECUTIVE SUMMARY

In his memorandum of August 5, 1988 to the Secretary of State, the President directed the development of a three-year plan for international efforts against human immunodeficiency virus (HIV) infection, with emphasis on less-developed countries. The attached action plan summarizes the current international efforts by federal departments and agencies against the HIV pandemic and presents the strategy and plan for their programs for the period FY 1989-1991.

The HIV pandemic continues to grow rapidly. At present, 142 countries report 124,114 cases of the acquired immunodeficiency syndrome (AIDS) worldwide. The AIDS case count, however, represents only a fraction of the extent of HIV infection and is also subject to substantial under-reporting, particularly in the infrastructure-poor developing world.

HIV infection is transmitted in only three ways: through sexual activity, by the exchange of blood or blood products, or perinatally from mother to child. Worldwide, the dominant mode of transmission is through sexual activity.

The extent of HIV infection in many parts of the world and the potential for further spread make control and treatment of infection and related disease a major public policy challenge in many developing countries. The potential implications for the economic and political stability of these countries, their internal security, and regional security, make the control of HIV infection an important foreign policy issue for the United States.

Given the extent of infection and modes of transmission, a worldwide effort will be required to control the further spread of infection. Because of the exceptional public and private sensitivity of human sexuality in all societies, programs to control the spread of infection will require extraordinary social, cultural, and political specificity. These factors require that policy leadership in the worldwide effort be given to an organization such as the World Health Organization (WHO), which has the capacity to interact effectively on international health issues and can provide the framework for effective multilateral and bilateral coordination.

The modes of HIV transmission and the current level of technology dictate that control of the spread of infection will largely depend on changes in sexual behavior. At present, there is no vaccine to protect against infection and no treatment for those who are infected to prevent them from infecting others. Furthermore, there is at present no cure for AIDS or other HIV-related disease, and the limited methods of treatment available are only partially effective and very costly.

The principal program tools for eliciting voluntary changes in the behavior of those at risk of transmitting the infection are information and education. These must be targeted to those at risk and specific to their social, cultural, and political environment. There are encouraging signs that behavior will change when those at risk understand the full extent of the risks and the methods for avoiding them. However, the process of changing behavior will, even under the best of conditions, be slow.

The urgent need for HIV prevention and control worldwide demands the development of better tools. Of highest priority for research are a better understanding of the process of behavior change, an affordable, heat-stable vaccine against HIV infection, and affordable treatment regimens that prevent HIV transmission and development of disease, and, ideally, eliminate infection. Successful development and testing of these tools will depend on international collaboration.

The U.S. has committed itself internationally to support the WHO Global Programme on AIDS (WHO/GPA) in its planning and coordination of programs to control the spread of HIV and to coordinate the research needed to eventually eliminate infection. The WHO/GPA has moved quickly and effectively to develop global and country-specific plans and expects to have put them into place in all cooperating countries within the next three years. Therefore, the WHO/GPA plan for the period from 1989 to 1991 is the framework for U.S. participation in the worldwide effort. The three-year action plan by federal Departments and Agencies outlines program implementation within that framework.

U.S. government actions against the HIV pandemic must be well-coordinated internally and internationally with those of the WHO/GPA and with those of other donor and recipient countries. Coordination mechanisms are in place and are expected to be strengthened in the next three years.

The three-year action plan presented here represents a continuation of programs this Administration has already put into place, is consistent with and supportive of the major international recommendations of the Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic chaired by Admiral Watkins. Current budget plans of the concerned Departments and Agencies will continue these programs. The action plan in FY 1989-91 anticipates expansion of technical assistance and other activities for AIDS prevention and control worldwide and increasing effectiveness of these activities.

The following achievements are illustrative of the progress anticipated during the period of this three-year action plan:

1. All countries with which the U.S. is working will have implemented AIDS and HIV public information campaigns.
2. All of these countries will also have implemented, and most will have evaluated, targeted educational programs aimed at the reduction of high-risk behavior.
3. All of these countries will have implemented blood transfusion screening programs for HIV. There will be a safe source in each country, however, only a few will have ensured complete freedom of the blood supply from HIV infection.
4. New rapid, simple HIV diagnostics appropriate for developing countries will have been field-tested and will be in common use.
5. Development of vaccine field trial sites will have taken place.
6. Models of the economic and demographic impact of the pandemic in the developing world will have been completed and validated and will be in use to further understanding and to more effectively target HIV control strategies.

INTRODUCTION

On August 5, 1988 the President directed the Secretary of State to develop a three-year action plan for international efforts by the U.S. government against HIV infection, with emphasis on less-developed countries. This action plan was coordinated through the Department of State's Interagency Working Group on International Aspects of AIDS, which focuses largely on the foreign policy aspects of the epidemic, and through the International Subcommittee of the Public Health Service Federal Coordinating Committee on the HIV Epidemic (FCCIS), which focuses on the prevention and control of the epidemic internationally, and on related research.

U.S. Departments and Agencies are involved in the international effort to control the spread of HIV infection in a variety of ways (Appendix 1). Those in a first category have an explicit mandate for the health and welfare of the United States citizenry and undertake programs of research, analysis, and service delivery for the U.S. public at large. International collaboration and cooperation can strengthen these programs and may be essential to their success. This action plan covers the international part of their programs, particularly in the developing world (1). A second category has responsibility for a discrete segment of U.S. citizens at risk. For example, the Department of State medical department has responsibility for the health of Foreign Service personnel, the Veterans Administration for U.S. veterans, and the Department of Defense for U.S. military personnel. For these agencies, the level of their involvement in HIV-related issues is dependent on the degree to which HIV infection becomes important to their mission. A third category includes the Department of State, which has overall foreign policy responsibility, the Department of Defense, which has national security responsibility, and the Agency for International Development (A.I.D.), which has the specific mandate to help other nations in their economic development.

- 1 The Department of Health and Human Services (DHHS) has primary responsibility in this area. This action plan covers only the quantifiable international portion of the DHHS program. The domestic DHHS program and the importance of its contribution, particularly in research, is enormous. Any effort to segment the international portion unavoidably understates the value of these programs to international scientific collaboration, research, and capacity-building and to the people of the developing world.

This action plan reflects contributions by all U.S. government Departments and Agencies known to be involved in international efforts to control the global HIV epidemic. As all agencies give priority internationally to prevention and control, health care issues are not considered except in the broad context of their economic and social burden.

The action plan summarizes existing activities and outlines their trends for FY 1989-1991. It is divided into seven sections: 1) a global review of the ever-changing status of the pandemic and its relationship to U.S. interests, 2) international collaboration to control the spread of infection, 3) international AIDS prevention and control activities of U.S. Departments and Agencies, 4) international AIDS-related research activities of U.S. Departments and Agencies, 5) coordination mechanisms, 6) budgetary implications of the plan, and, finally, 7) conclusions about the directions and goals of the U.S. government in its efforts to control HIV and AIDS.

THE PANDEMIC AND ITS RELATIONSHIP TO U.S. INTERESTS

The HIV pandemic was first recognized seven years ago. It is still in its early stages. Our knowledge about the magnitude of the pandemic, its modes of transmission, its impact, and its relationship to U.S. interests has progressed rapidly.

The Magnitude of the Pandemic

At present, 142 countries on every continent report 124,114 cases of AIDS. The AIDS case count, however, represents only a fraction of the extent of HIV infection and is also subject to substantial under-reporting. Because of the long latency period between initial infection with HIV and the onset of AIDS or other HIV-related disease, a given AIDS case reflects an HIV infection that may have begun eight or more years earlier. More recent infections often remain asymptomatic and undetected. Furthermore, AIDS manifests as a variety of opportunistic infections which may be recorded as tuberculosis or common diarrhea, or in many parts of the infrastructure-poor developing world, not recorded at all.

Current estimates are that over 250,000 cases of AIDS have already occurred worldwide and that five to ten million people are infected with HIV, the causative agent of AIDS. Within the next five years, about one million new cases of AIDS will occur.

The best AIDS case reporting is in the developed world, where the count continues to grow. The largest number of cases already reported is in the United States, which had recorded 76,670 AIDS cases by October 26, 1988. In western Europe, as in the United States, Canada and Australia, the incidence is moderate to high.

The continent which is hardest hit by HIV infection, however, is Africa, where under-reporting has resulted in marked underestimates of the number of cases to date. The actual total is estimated to be higher than the number reported for the United States. Studies of the prevalence of HIV infection have provided alarming results. In many urban centers of Southern and Central Africa, 5% to 20% of the sexually active population has been infected with HIV. Rates of infection of some urban prostitute groups range from 27% in Zaire to 88% in Rwanda. Over half of the patients on some medical wards of hospitals in these countries are infected with HIV, as are from 10% to 25% of the women of childbearing age.

Asia and Latin America have smaller but growing problems, while the magnitude of the problem in parts of the Caribbean rivals that in Africa. In Asia and the Pacific, the incidence

of AIDS is quite low, but there are disturbing reports that 16% of the drug users in Bangkok, Thailand and 13% of the paid professional blood donors in one city of India are infected with HIV. In Latin America, approximately 8,000 cases had been reported by June 1988 but, because of under-reporting, the actual incidence is estimated to be several times that number. In several urban areas of the Caribbean, HIV infection levels among heterosexual men and women and their children are similar to those in Central and East Africa.

Modes of Transmission

As knowledge increases, it remains clear that HIV can be spread in only three ways: sexually, through blood and blood products and perinatally from mother to child. Sexual transmission predominates worldwide and can occur during both heterosexual and homosexual intercourse. Although early cases of AIDS in the United States were largely confined to adult males, in many developing countries, men and women have been equally affected. The risk of sexual transmission increases proportionally with the number of sexual partners an individual or his or her partner has. Sexually transmitted diseases that produce genital sores, such as chancroid, herpes, and syphilis, also facilitate transmission.

Exposure to infected blood and blood products is the second most important mode of HIV transmission worldwide. While transmission via contaminated blood transfusion in the United States has been virtually eliminated by screening, the required equipment, reagents and training are only sporadically available in many other parts of the world. Intravenous drug users, who often share their needles, can also transmit HIV. Nevertheless, the use of needles and syringes for therapeutic injection appears to carry a low risk of infection, even when sterile procedures are not followed. Contrary to early fears, childhood immunization programs in the developing world have not been associated with HIV infection.

Finally, HIV can be transmitted from mother to child during pregnancy and childbirth. There is evidence that the virus can also be present in a mother's milk but no confirmed evidence that breastfeeding is a route of transmission.

The Impact of AIDS on the Developing World

The greatest impact of the pandemic will be on the individuals who suffer the ravages of the infection. Nevertheless, the impact and costs of the infection will spread far beyond the individual to family and society. Economic

consequences include increased direct health-care costs, lost wages and the costs of lost business (e.g. tourism). The effects on society could include changes in family, social, and political structures.

A very large number of people are infected with HIV or will become infected. This means that they will develop symptoms of one or more opportunistic infections, develop a type of cancer, suffer diminished mental capacity and/or require frequent hospitalizations during the last 12 to 24 months of their lives. During this time, they will no longer be able to support and care for those who are dependent on them, and they will become dependent themselves, draining the emotional and financial resources of those around them.

The spread of HIV among adults also threatens the survival of children. The HIV pandemic threatens children directly, through HIV transmission from mother to infant and through blood transfusions for children with diseases like malaria. It also threatens children indirectly. A child with an infected parent is likely to lose that parent, and in time, both parents. In Central Africa as many as 1 in 5 urban children face this situation. Thus the AIDS epidemic may well undermine the hard-won gains made in increasing the health status and survival of children in the developing world.

The economic consequences of the pandemic are easy to conceptualize. First, the medical needs and costs of medical care for afflicted individuals will far exceed the capacity of health systems in the developing world. Second, the premature deaths in the 20-to-49 age group will be felt economically in loss of manpower, wages and production. Financial responsibility for surviving family members will fall on grandparents, siblings and more distant relatives. The ratio of dependent children and elderly adults to productive young adults may change significantly. Third, AIDS may affect specific industries such as travel and tourism. The effect on tourism in Haiti was seen after that country was identified as an endemic area. Tourist travel plummeted with an immediate effect on the hotel, transportation and related industries.

Other consequences of AIDS for societies may include changes in population size and character. AIDS-related increases in death rates have led to speculation that sub-Saharan Africa would be depopulated. These dire predictions are probably incorrect, however. The substantially increased death rate will likely be offset by ongoing fertility-related population increases of 3 percent or more annually. The virus, however, preferentially strikes young urban adults, who are among the most productive members of society. The loss of these individuals will have a disproportionate effect on productivity, economic development and education.

Impact on U.S. Foreign Policy

U.S. foreign policy interests will continue to be affected by the pandemic. As outlined above, the pandemic may result in diminished political stability of the hardest-hit countries. HIV infection may have a profound effect on military forces and readiness in developing countries. The size of the population available for military forces will decrease because of the increased death rate in the 20-to-49 year old age group. The potential for strategic imbalance and regional conflict in areas of importance to the U.S. may increase. The pandemic has also, moreover, impaired the ability of the State Department to carry out its political mission. Areas of impact include travel restrictions (imposed by the U.S. on incoming travelers and on U.S. travelers by foreign countries), and the negative effects of disinformation campaigns conducted by other countries.

One need only look at HIV-related travel restrictions to see some of the global political implications of the pandemic. Testing for HIV has been instituted for employees and dependents of the Department of State who are scheduled for foreign assignments. Employees and dependents of 40 other agencies who are beneficiaries of the Department's health program are also tested. The policy was prompted by medical concerns that overseas health-care facilities are often inadequate and because of concern for the supply of HIV-free blood.

The rationale for testing military applicants and active duty personnel is that the condition existed prior to appointment or enlistment; DoD avoids potential medical costs and the possibility that the individual will not complete his or her service commitment; clinical evidence indicates that individuals with serologic evidence of HIV infection may suffer adverse and life-threatening reactions to some live-virus immunizations administered at basic training; an individual with serologic evidence of HIV infection is not able to participate in battlefield blood donor activities or other blood donation programs; and presently there is no way to differentiate between individuals with serologic evidence of HIV infection who will remain healthy and those who will develop AIDS.

The U.S. is also one of the growing number of nations that requires HIV testing for immigrants or travelers. HIV-related travel restrictions limit freedom of travel, restrict business transactions, and, in the case of student travel, curtail educational opportunities. The U.S. implemented a testing requirement on December 1, 1987 for those applying for immigrant or refugee status. HIV-infected individuals are automatically ineligible to immigrate to the U.S. The U.S. has not established testing requirements for tourists, students, businessmen or other

temporary visitors with the exception of the requirement by the Department of Defense that all foreign military trainees enrolled in Defense-sponsored programs in the U.S. be tested (in compliance with previously existing and long standing examination and testing requirements for other infectious disease).

Our foreign policy has also been affected by disinformation campaigns. In 1985, the Soviet Union launched a disinformation program alleging that the AIDS virus was a man-made organism which had escaped from a U.S. military facility devoted to germ warfare. The U.S. has vigorously refuted these charges by making available as much factual information on the campaign and on AIDS as possible. Soviet scientists have disavowed these baseless charges and, in fact, the Soviet Union is a signatory to a United Nations General Assembly Resolution wherein the virus is designated as a naturally-occurring agent of undetermined origin. However, the charge sporadically continues to surface around the world.

The HIV pandemic is clearly a worldwide problem of major importance to the United States. U.S. federal departments and agencies have been prompt in participating in the multilateral response to the pandemic as well as in their bilateral prevention and control and research efforts. The next three sections will describe these activities.

INTERNATIONAL COOPERATION: THE WORLD HEALTH ORGANIZATION GLOBAL PROGRAMME ON AIDS

Given the extent of HIV infection and modes of transmission, a worldwide effort is required to control the further spread of infection. With current technologies, control of the spread of infection will involve changes in sexual practices. Because human sexuality is a matter of exceptional public and private sensitivity in all societies, programs to control the spread of infection will require extraordinary social, cultural, and political specificity. These factors require that policy leadership in the worldwide effort be given to an organization such as the WHO Global Programme on AIDS (WHO/GPA), which has the capacity to interact effectively on international health issues and can, together with the United Nations Development Program (UNDP), the United Nations International Children's Emergency Fund (UNICEF), and the World Bank, provide the framework for effective multilateral and bilateral coordination. The U.S. was a leader in urging the establishment of the WHO/GPA and continues to be its largest political and financial supporter.

The WHO/GPA is an extrabudgetary program of WHO and is funded by a group of donors whose contributions are made in addition to any assessed dues to the United Nations or WHO. The U.S., through the A.I.D., was the first such donor, contributing \$2 million in 1986 directly for AIDS control. In 1987 the U.S. contribution to the WHO/GPA was \$5.5 million; in 1988 it was \$15 million; and in 1989 the amount is \$25.5 million, over 25% of WHO/GPA's annual budget.

The U.S. also makes important contributions to management and direction of the WHO/GPA. The current WHO/GPA Director is a U.S. civil servant detailed from the Public Health Service. A.I.D., as the largest donor to the program, is a key member of the WHO/GPA Management Committee, which makes recommendations to the Director-General of WHO on the direction and management of the program. U.S. government scientists are members of most or all of the WHO/GPA's scientific and technical advisory bodies.

The WHO/GPA provides two critical services. It provides leadership in the planning, coordination and evaluation of national AIDS plans in all countries seeking cooperation, and it provides a mechanism and support for international coordination in all scientific areas necessary to the control of HIV infection. Its effectiveness in both of these areas is enhanced by a relationship with UNDP that broadens the relationships with developing country governments to include ministries other than the Ministry of Health.

By 1991, the WHO/GPA projects the following programmatic results. In the area of support to National AIDS Programs, the WHO/GPA will have provide planning and coordination assistance to 131 countries, and it will have undertaken technical collaboration with 54 more. National AIDS Prevention Plans will have been implemented in all 131 countries, with review and reprogramming completed in 120 of them. In the area of research, one of the primary objectives of the WHO/GPA, functioning centers for drug and vaccine trials will have been established and will be operational; vaccine and treatment trials will be underway. The reagent bank will be expanded, and new diagnostic technologies will have been evaluated in the field. The results from communications research will have been applied in the field. Finally, demographic models for projecting the course and implications of the epidemic will be have been evaluated and improved and will be in use.

The WHO/GPA budget has risen rapidly since the program began. In 1987, the worldwide WHO/GPA program cost \$23 million. In 1988, the budget rose to \$66 million. The preliminary budget for 1989 is \$94 million. WHO/GPA anticipates that its annual costs will rise to \$100-110 million and stabilize at that level in real terms. Within this budget, approximately 50% is devoted to national AIDS programs and the balance to research and regional and multilateral coordination and collaboration. The U.S. provides approximately 25% of the WHO/GPA budget through A.I.D.

The WHO/GPA national plans are the best available approximation of the cost of AIDS prevention and control programs in the developing world. When all national plans are in place, current estimates are that their total annual cost, including the cost of WHO/GPA planning and coordination, could approach \$750 million, of which the external assistance cost to donors is approximately \$400 million. Field implementation of prevention and control programs on this scale by WHO/GPA would require a massive expansion of WHO/GPA staff and supporting bureaucracy and would duplicate the existing field program capacities of many donors. Consequently, the WHO/GPA is focusing its attention and resources on planning, coordination, and evaluation needs and is the financier of last resort to ensure that all national programs are adequately supported.

Originally, the WHO/GPA budgeted funds sufficient to cover 20% of the cost of any national plan, however, experience has shown that bilateral assistance accounts for a much larger proportion of the support for these plans. To date, there have been 14 country pledging sessions to fund these plans, all but one of them in Africa. All of the plans were oversubscribed by bilateral and other multilateral donors with the result that the WHO/GPA was only required to support 8.5% of the cost of the plans. These first 14 pledging sessions were held in the

hardest-hit African countries and had received worldwide attention. Consequently, they may not be a reliable indicator of the support likely in other countries where HIV infection is not considered as urgent a priority. The U.S. was the largest contributor to these first pledging sessions and will need to continue a bilateral as well as a multilateral leadership role if the WHO/GPA worldwide efforts to control the spread of HIV infection are likely to succeed.

The WHO/GPA has done an outstanding job of putting into place a global and country-specific AIDS planning process, for prevention and control, and for research. Implementation of this planning depends on the existence of a set of vigorous, flexible, and responsive bilateral assistance programs capable of undertaking activities in the priority areas of these plans. The aggregate of these plans therefore serves as the plan for U.S. international actions for the next three years. The specific actions of the U.S. implementing agencies are presented in the next two sections.

INTERNATIONAL PREVENTION AND CONTROL ACTIVITIES OF FEDERAL DEPARTMENTS AND AGENCIES

U.S. international prevention and control activities focus on the developing world. This section describes the U.S. strategy, current activities, and plans for the next three years.

Prevention and Control Strategies

Sexual transmission is the most common mode of transmission of HIV and is therefore the highest priority for prevention. Although prevention and treatment of sexually transmitted diseases may have some effect on transmission, the principal tool currently available is provision of information and education aimed at reducing high-risk behavior. Information and education programs can be divided into three categories: public education campaigns, education and counseling of infected individuals and education targeted specifically at those who practice high-risk behavior. Massive public education campaigns, such as the one undertaken by the Surgeon General in the U.S., are one way to teach people about HIV infection and ways to avoid it. They are underway around the world. Although these campaigns have resulted in rapid knowledge gains, there is little evidence that they alone will significantly change behavior.

A second way to prevent sexual transmission is to counsel individuals who are infected. It is unfortunately true, however, that a person can be infected and infectious long before the onset of any symptoms. In order for a person to know that he or she is infected, that person must know that he or she is engaging in a high-risk behavior and therefore seek confidential counseling, or must develop symptoms which require medical testing or treatment. Thus the disease is being spread by people who are unaware that they are doing so.

Because these factors make it difficult to reach all infected individuals, an important third strategy for reduction of sexual transmission is to target AIDS counseling and education for individuals who practice high-risk behaviors. This counseling and education focuses on faithful relationships and condom use. If it were possible to ensure that every sexual union occurred within a faithful relationship or involved a condom, sexual transmission of HIV would be dramatically slowed today. This is obviously an unreachable goal. Condom usage worldwide is extremely low, nevertheless even a doubling or quadrupling of condom usage by individuals at high risk of infection could have a significant impact on the spread of HIV. The condom is still one of the best tools presently available for limiting the spread of the infection.

The second priority for limiting the spread of HIV is to prevent transmission via transfusion of blood and blood products. Prevention techniques involve testing donated blood for the presence of HIV antibodies and discarding infected blood. In the U.S., the necessary training and equipment are generally available, and the blood supply is considered to be safe. This has not been the case in developing countries. Therefore, one major element in the strategy of HIV prevention and control has been to provide training for blood testing technicians, and reagents and equipment for the routine testing of blood samples.

Other modes of transmission appear to be less important and therefore of lower priority in the developing world. To date, intravenous drug use has not emerged as a major mode of transmission internationally, except in Thailand. Prevention efforts will rely on behavior-change methods similar to those used to reduce sexual transmission. Use of contaminated needles and syringes for therapeutic purposes such as immunization, while not a major mode of transmission, can and should be avoided by upgrading of supplies and training. Mother-to-child transmission is best approached at present through primary prevention by avoidance of sexual transmission to women of child-bearing age.

Agency for International Development (A.I.D.)

A.I.D. is the lead U.S. agency in international AIDS prevention and control efforts. A.I.D.'s field staff and its cooperating agencies responsible for implementation are experienced and active in over 70 countries. The Health, Child Survival, Population, and Education programs of A.I.D. have pioneered work in service delivery and communications as well as in technical assistance and training immediately relevant to the prevention of HIV transmission. The Agency's policy and programs are built on these strengths in areas in which the U.S. has a particular comparative advantage.

The Agency's AIDS policy, adopted formally in April 1987, can be summarized as follows:

1. Support for the WHO/GPA is the cornerstone of the Agency's program. All bilateral programs will operate within the framework of WHO/GPA's national plans.
2. Aggressive bilateral programs to implement the WHO/GPA national plans will be focused on prevention and control.
3. Research will be limited to program operations needs, adapting U.S. research products to developing country needs, and meeting the urgent developing country needs that may not be a high U.S. domestic research priority.

Since the adoption of this policy, the Agency has moved rapidly to develop a program of bilateral support for prevention and control of HIV transmission in developing countries. This support is provided in 6 major areas: 1) technical assistance and training, 2) provision of commodities, including condoms, 3) support of private voluntary organization (PVO)-led programs, 4) dissemination of technical information and materials, 5) intervention-oriented research, and 6) modelling to project the impact of the pandemic. The first four will be discussed here and the latter two in the next section on research.

The Agency provides short-term and long-term technical assistance and training in the areas of surveillance, behavior change and risk reduction, blood transfusion screening, sexually transmitted disease management and control, and planning for sustainable health-care financing. As of December 1988, the Agency has provided short-term technical assistance to 34 countries in Africa, Asia and the Near East, and Latin America and the Caribbean. In addition, long-term resident advisors have been stationed in the Dominican Republic and the Philippines, and long-term prevention projects, most often in the area of behavior change and risk reduction, have been organized in the majority of these countries.

Through its Population program, the Agency has extensive experience and mechanisms for procurement, shipping, and distribution of commodities. In the last two years, these mechanisms have been used to deliver condoms and blood screening reagents and equipment to more than 45 countries worldwide.

Recognizing the rapid response capacity of PVOs and that PVOs work at the community level which national programs may fail to reach, the Agency is also seeking to stimulate and support PVO-led AIDS prevention and control activities. In 1987 and 1988, A.I.D. and its cooperating agencies have conducted and participated in a number of workshops and conferences on PVO programs for AIDS prevention. The Agency and its field missions are funding PVO AIDS prevention projects in 13 countries. In FY 1988, over \$2 million in bilateral assistance programs was provided to PVOs. A small grants program encourages new organizations and innovative activities.

In addition to providing direct technical assistance, the Agency supports AIDS prevention programs by worldwide dissemination of technical information and materials. These consist largely of journal articles and prevention program-related guidelines distributed on a bi-monthly basis to over 400 individuals and institutions in 70 countries.

The Agency's budget for this bilateral support has increased rapidly. In FY 1986, the Agency had no bilateral program. In FY 1987, the budget was \$11.4 million. In FY 1988, it increased to approximately \$15 million. In FY 1989, the Agency expects to provide \$14.5 million, a slight decrease due to Congressional reordering of the Administration request. In FY 1990, a further increase to \$20 million is planned. In addition to these amounts, related support from the Health and Population programs and the Development Fund for Africa totals approximately \$5 million a year.

Although the Agency funding for bilateral HIV-related activities has increased from nothing to \$20 million a year in a four-year period while the total available for foreign assistance has remained relatively constant, it is clear that the staff resources and program funds are not meeting the need. There is a backlog of unfunded requests approaching \$7 million, and requests are frequently delayed or reduced because of competing demands. Consequently, even this \$7 million figure may understate the real needs as delays in meeting existing requests discourage the formulation of needed new programs.

At present, funding for bilateral programs is relatively more constrained than that available for the WHO/GPA. This will affect the global effort and progress in controlling the spread of HIV infection. The WHO/GPA has performed outstandingly in the coordination and planning of a system of national AIDS control programs. However, WHO is encountering understandable bottlenecks in attempting to build a field implementation capacity. Delayed delivery of goods and services requested from the WHO/GPA by cooperating countries is increasing. Bilateral programs are organized to meet and can meet many of these needs. U.S. funding of bilateral activities is a limiting factor.

In the next three years, the A.I.D. program will continue in the general direction already established. The basic framework is in place. The policy approach focusing on prevention and control and the comparative advantage the Agency has in field delivery of health and communications services has proven to be sound and cost-effective. Working relationships and coordination with the WHO/GPA are excellent. The level of commitment of all governments involved in the global AIDS prevention effort is extraordinary. The issues that arise usually concern how to get something done, not what to do. Therefore, progress in implementing bilateral program will be limited primarily by the resources available and the inherent constraints to rapid change in developing countries. Geographically, Africa will continue to receive priority attention, but relatively more focus will probably be placed on Asia and the Near East and Central and South America as the pandemic becomes more evident there.

Public Health Service

Of the six Public Health Service (PHS) agencies, four are engaged in international AIDS-related activities. The Centers for Disease Control (CDC) in Atlanta works in the area of epidemiology. The Food and Drug Administration (FDA) is working to provide drugs for testing and treatment in the developing world. The National Institutes of Health (NIH) and the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) have the lead in promoting and carrying out research in AIDS. Of these, only the CDC focuses on AIDS prevention and control internationally. These activities are discussed here, while the research activities of CDC and the other agencies are discussed in the next section.

The CDC provides leadership and direction for a broad range of programs designed to safeguard and improve the health of the American people. It is involved in health risk reduction in the workplace, and general health promotion. It also provides support in the basic areas of epidemiology, disease surveillance, laboratory science, and training to local, state, national and international disease prevention efforts. The CDC supports a number of AIDS efforts under its international mission. CDC activities include: 1) providing staff to A.I.D. for short-term technical assistance for AIDS in developing countries. This occurs both in the host country and, for visiting foreign scientists, in the Atlanta facilities. 2) Staff from the CDC provide technical assistance to health programs in developing countries in support of the capacity-building mission of the WHO/GPA. 3) The CDC also collaborates in the development of a WHO Center on Health Education & Health Promotion for School- and College-Aged Youth; this WHO Center has a major new focus on AIDS. 4) Training in HIV antigen and antibody detection methods for laboratory personnel is being provided by the CDC for a PAHO/WHO project.

The CDC is committed to continued support for this bilateral and multilateral effort. The CDC will spend \$1.8 million from A.I.D. over the next two years and a projected total of \$6 million over a five year period for its technical assistance programs.

Peace Corps

The Peace Corps promotes world peace and friendship by sending volunteers abroad to help people of other nations to meet their need for trained manpower. Volunteers promote better understanding of Americans among the people with whom they live and work as well to promote a better understanding of other peoples on the part of the American people. Peace Corps programs

are designed to meet the basic needs of those living in the poorest areas of the countries in which the Peace Corps operates.

The Peace Corps has committed its resources to responding to the AIDS crisis. Working within the guidelines of the WHO/GPA, the Peace Corps is attempting to establish a series of pilot projects in AIDS education. These projects will be developed in close cooperation with the host countries within the frameworks of the hosts' national priorities. These programs will then be evaluated to determine what services the volunteers can deliver best and what kinds of capacities can be built in other countries by replicating these projects.

There are presently six thousand volunteers working in sixty-five countries. Their programs involve health, education, agriculture, rural development, small business enterprise, and conservation of natural resources. The health volunteers are placed to improve the health service delivery and capacity-building for the section of the country assigned; AIDS has been a very specific topic many health centers have been able to accommodate. In the general and specific capacity of the volunteers, the Peace Corps is able to contribute to the local community by using the knowledge and skills of the volunteers to prevent further AIDS spread.

The costs of these programs are difficult to predict because they will represent only a portion of a volunteer's efforts. Furthermore, health issues are only a secondary function for many of the non-health volunteers, and diseases other than AIDS are more frequently encountered by the health volunteers. Nevertheless, the Peace Corps is committed to maintain and enlarge its efforts as opportunities in host countries and volunteer availability may allow.

Veterans Administration

The Veterans Administration has many hospitals and facilities at which AIDS patients are treated. These represent a resource which could be used for training of developing country personnel in blood screening techniques, surveillance methods and other technical issues related to AIDS. The Veterans Administration plans to consider developing this possibility during the next three years.

RESEARCH ACTIVITIES

Current Research Priorities

Because of the difficulties in preventing the spread of AIDS, it is imperative that alternative tools for combatting it be developed. These will be the product of research, both basic and applied.

The first tool likely to be developed is a treatment to decrease the destruction of the immune system caused by HIV or to reduce transmission from those who are infected. When AIDS was first shown conclusively to be caused by HIV, in 1984, prospects for a therapeutic agent seemed grim. Antiviral agents are generally scarce and have little effectiveness against the viral diseases and retroviruses, of which HIV is an example, are particularly difficult to treat. That grim outlook has improved dramatically, however. One treatment, AZT, while far from being a cure, has shown some promise already. Study of the life cycle of the virus has enabled researchers to design potential treatments which capitalize on vulnerabilities of the virus.

A second research priority is development of a vaccine against HIV infection. Production of a vaccine against HIV has several inherent technical difficulties. First, the virus attacks the very cells which should attack it. Second, the virus can change its coat, thus disguising itself against attack by the body's immune system. Third, there is no good animal model of the disease in which to develop vaccine candidates. Fourth, the virus often wraps itself in fragments of the host's own cell membranes, cloaking itself against recognition as an invader. Nevertheless there are several potential vaccines which are being tested in humans at this time. Although few scientists are optimistic about their effectiveness, new and improved vaccine candidates are being developed constantly.

A third research priority is the natural history and epidemiology of the disease itself. For example, the role that other infections play in the progression of disease is still not fully understood. The role of other sexually transmitted diseases in facilitating transmission demands further study. The possibility that close relatives of the virus might have evolved in their relationships with their own hosts in such a way as to reduce the mortality or morbidity of the infection is also a candidate for scrutiny.

Finally, operations research to improve existing methods of prevention and control must be continued and expanded. While great strides have been made in changing the high-risk behaviors of some groups of people (e.g. the homosexual populations in the U.S. and elsewhere) there are other examples in which little has

been accomplished. Use of condoms, although increasing, is still at very low level. In Africa, where HIV is rampant, the rate of condom use is less than 1%. There are recent reports that this trend is being reversed, however. In Kinshasa and in Bangui, both cities where condom distribution is being handled by commercial enterprise, the demand exceeds the supply. Research into extending and replicating these changes is needed.

Public Health Service

The PHS agencies have taken the lead in international HIV-related research as well as development of international research collaboration and cooperation. The CDC has a major domestic and international role in research on the natural history of HIV-related disease as well as on epidemiological surveillance systems. The international research activities in these areas involve Cote d'Ivoire (Ivory Coast), Kenya, Sierra Leone, and Zaire; the Zaire project, sponsored in 1983, is also sponsored by the NIH (NIAID). These have major importance to the host country and to the U.S. investigators as opportunities for longitudinal studies are made available. A major contribution will be in the study of HIV-2 in the African continent. CDC researchers will also be able to investigate HIV infection in areas where diarrheal and respiratory diseases are very prevalent in the general population and may often confuse or delay the diagnosis of HIV infection. A total of about \$9 million will be spent by CDC on these programs during the next three years.

The FDA role is one of drug and vaccine development and regulation. It has provided a major contribution to building the capacity of host countries to carry out this role. One area for this leadership is as a major WHO Collaborating Center on AIDS; this allows the FDA, among other things, to collaborate on assay assessment, to provide technical assistance on safety of blood-derived products and serological testing systems, provide reference panels of sera, and provide training for laboratory and public health personnel. The FDA also reviews requests for, and authorizes, the export of drugs and biologicals which are not yet approved in the U.S. These substances will be used in clinical investigations in foreign countries within the bounds of FDA regulations for this purpose. This allows items under development to have wider clinical evaluations while ensuring host country approval of the trials. Additionally, under the provisions of the Drug Exports Amendments Act of 1986, the FDA authorizes U.S. pharmaceutical manufacturers to export human and animal drugs and human biologicals, not yet approved for use in this country, to any of 21 countries that listed in the Act and whose drug regulatory authorities have approved their use. Unapproved drugs and biologicals used for AIDS detection and treatment are exported under either of the two conditions described above. The FDA provides technical assistance to the

regulatory agencies of about 60 countries. Development of AIDS drugs and vaccines has increasingly been the focus of the consultation provided. There is also a monthly collection of information on FDA-related articles, speeches, and other non-journal based information which is furnished to PAHO and WHO.

The National Institutes of Health are the center of the Federal government's health research. Their mission is to uncover new knowledge that will lead to better understanding of the fundamental life processes that underlie human health and better means to prevent, detect, diagnose, and treat disease. NIH works toward these goals by conducting research in its own laboratories; supporting research of non-Federal scientists in universities, medical hospitals, and research institutions throughout the U.S. and abroad; supporting the training of promising new researchers; and fostering and supporting biomedical communication. The NIH has made a significant contribution to the definition of AIDS, understanding its progression, and investigating preventive/therapeutic options. The NIH plans to continue to make contributions through its research programs and training programs, on which it will spend about \$21 million in FY 1989 (see Appendix 2: \$12.2 million through NIAID, \$2.8 million from NCI, \$1.0 million from NICHD and \$ 4.7 million from FIC).

The NIH also contributes to capacity-building through the Fogarty International Center (FIC). The FIC will spend nearly \$4 million through the International Training Grants In Epidemiology Related To AIDS program in FY 1989. This program operates through eight universities which take responsibility for development work with selected countries; this year the program will impact at least 21 different countries. The FIC also has an International Postdoctoral Research and Training Grant program which operates through four universities. The program will expend \$700,000 in FY 89 and will recruit Fellows from at least nine countries.

The National Institute of Drug Abuse has two major projects which focus on the intravenous drug use transmission route. This effort involves some mathematical modeling and the building of a database of experiences in developing countries. About \$600,000 will be expended during the period FY 1989-1991.

It should be noted that the recent PHS authorization legislation pertaining to HIV infection underscores the importance of international collaboration, research and training related to this worldwide problem.

Department of Defense

The Assistant Secretary of Defense for Health Affairs is responsible for Department of Defense health matters, including preventive medicine, medical readiness, health-care delivery, drug and alcohol abuse prevention, and procurement, development, and retention of medical personnel. The Department has a worldwide scope of activities and, as such, has operating bilateral and multilateral defense agreements. These agreements allow the U.S. to maintain laboratories which can study region-specific disease impact on military forces and develop effective preventive and treatment techniques. These laboratories also allow the U.S. to provide consultation to host country or multilateral member medical personnel.

AIDS is one of the health problems studied by this worldwide system of laboratories. The system is in place in Egypt, Japan, Peru, Philippines, Zaire, and Zambia. Expansion of the programs to include AIDS began as early as FY 1986. Most of the AIDS studies are epidemiological and the results have immediate application for host military and civilian organizations, especially in developing countries, and are focused on region-specific aspects of the natural history of the disease. Plans call for these laboratories to continue to support the U.S. defense mission and responsibilities through AIDS-related research.

Agency for International Development

AIDS-related research funded by A.I.D. is applied and intervention-oriented. Of highest priority is program-oriented operations research in behavior change, condom and viricide promotion, and blood transfusion screening. Epidemiological research is examining HIV transmission, in particular the influence of other sexually transmitted diseases. New prevention technologies important for developing countries are also being field-tested. These include new diagnostics and new condom formulations, such as the female condom, designed to empower women to protect themselves from HIV infection.

Examples of this research can be found in all regions of the developing world. In Ghana and Mexico, operations research is being conducted to determine the best means of extending short-term successes in reduction of high-risk behavior. In Zaire, a recent clinical trial examined the utility of five simple and rapid HIV antibody tests for blood transfusion screening in developing countries. A follow-on study will attempt to reproduce these results in isolated rural hospitals. In cooperation with WHO and UNICEF, A.I.D. is funding the development and testing of disposable, non-reusable syringes and needles to ensure that immunization programs do not transmit HIV.

Projecting the Impact of the Pandemic: Modeling

Our understanding of the extent of HIV infection and the consequences of international control strategies is rudimentary. The infrastructure in the developing world to collect reliable health data needs to be improved, but this will be a long and probably slow process. Nevertheless, all U.S. agencies involved in the international aspects need more reliable data on the extent of infection and possible impact. This was recognized by Admiral Watkins in his report which urged it be given a high priority.

The complexities of the HIV pandemic lend themselves to mathematical modeling. The modeling process simulates reality and forecasts possible trends and provides insights into the dynamics of the pandemic. The necessity of such an appraisal was recognized early and led to the establishment of an Interagency Working Group on AIDS Models and Methods. The Working Group is a subcommittee of the State Department's Interagency Working Group on International Aspects of AIDS, established in 1985. It is chaired by the Department of State and includes A.I.D., the Bureau of the Census, CDC, DOD, and members of the intelligence community. The subcommittee is a vehicle for sharing information and coordinating research. Its mission is to develop mathematical models and to make projections on the impacts of HIV infection and AIDS in affected countries. The subcommittee expects to have a fully tested and validated model which can forecast the epidemiologic scope and demographic impact HIV infection and AIDS by the end of FY 1989.

PROGRAM AND POLICY COORDINATION

AIDS is a U.S. domestic, foreign policy, and national security issue. It has a broad societal, political, and economic impact. It is a priority concern of several federal departments and agencies and an important interest of many others. An effective mechanism of cooperation and coordination is essential to ensure that international HIV-related activities by the U.S. government are cost-effective and focused on priorities. Three areas of coordination are important: multilateral coordination, coordination within the U.S. government, and coordination with the private for-profit and not-for-profit sector. Formal coordination mechanisms to meet these needs are described below, however, the value of informal coordination through close ongoing relationships cannot be overstated.

Coordination with multilateral agencies such as the WHO/GPA, other United Nations agencies, and other governments and bilateral donors occurs through the committees of the WHO/GPA. These include the Management Committee, which meets twice yearly to discuss prevention and control activities, and the scientific and technical committees, which monitor prevention strategies and research.

Two formal coordination mechanisms exist within the U.S. government. In order to carry out the Congressional mandate to coordinate international activities by U.S. federal agencies, A.I.D. has chaired the FCCIS since October 1988. Prevention and control activities and related research are reviewed in the FCCIS, convened by the Public Health Service. The FCCIS has compiled a database of all international AIDS activities by U.S. government agencies. It allows consideration of activities by agency, by country, by type of activity, etc. A print-out from that database is contained in Appendix 1. The impact of the pandemic on other countries and on U.S. foreign policy is reviewed by the Interagency Working Group on the International Aspects of AIDS, convened by the State Department.

The private sector has a critically important role to play in controlling the spread of HIV infection. Non-governmental agencies can be extraordinarily effective in delivering community-based AIDS education and health services in the developing world. Many are already doing so. Through the National Council for International Health, a process of regular consultation on AIDS issues has been instituted with PVOs. A.I.D. is exploring similar consultations with the private, for-profit sector, through the National Leadership Coalition on AIDS.

BUDGET IMPLICATIONS

The action plan for FY 1989-1991 is an extension of programs and activities now underway. The framework for international activities is set by the WHO/GPA planning process and is largely in place in the developing world. The WHO/GPA expects to have global and national AIDS plans in place by the end of 1989. The U.S. has committed itself to work within this WHO/GPA planning process. The basic elements of these plans are sound, and there is a broad consensus that they address the right issues in the right priority.

The estimate, based on WHO/GPA's analysis, of the annual cost of WHO/GPA national plans approaches \$750 million. This includes several activities, such as the promotion of condoms, which will have to be commercialized through the private sector. It also includes the contributions of the recipient countries. The need for external support to the national AIDS prevention and control programs is therefore on the order of \$400 million.

The U.S. support for international AIDS prevention and control and related research by all agencies reflected in this action plan was \$88 million through FY 1988 and is estimated to be \$65 million in FY 1989. The estimates, by agency, are summarized in Table 1 below. As stated, the budget data cover only those aspects that can be directly attributed to international AIDS activities. The estimates give no value to the substantial knowledge, experience, and research products which will come from U.S. domestic programs in the next three years. This knowledge and experience will undoubtedly be of significant benefit internationally.

The U.S. has been providing 20% to 25% of the WHO/GPA budget and a comparable share of the budgets of national AIDS control programs in those countries in which A.I.D has economic assistance programs. Maintaining this contribution to the global effort will require maintaining and even increasing the U.S. contribution in real terms.

Table 1

U.S. Government Obligations for International
AIDS Activities, by Agency and Fiscal Year,
in Thousands of Dollars

AGENCY	To Date	FY89
A.I.D.	48900	40000
D.o.D.	4986	1426
ADAMHA	613	0
CDC	3801	2939
NIH	30000	20701
TOTAL	88300	65066

Source: International Subcommittee of the Federal Coordinating
Committee on AIDS

CONCLUSIONS

HIV infection and AIDS are widespread in much of the developing world. The pandemic has major political, economic, social and security implications for developing countries, and is therefore a major public policy issue for them and a major foreign policy and national security issue for the U.S.

These implications were recognized by the international community, and the WHO was asked within the UN system to take international leadership and mobilize a worldwide response to the pandemic. WHO formed the WHO/GPA under the auspices of the donor community. The WHO/GPA has moved with extraordinary speed and outstanding effectiveness to establish cooperative relationships with all countries wishing help with their AIDS control and prevention programs. WHO/GPA actions have included the establishment of national AIDS committees, the initiation of short-term emergency activities, and the development and implementation of national AIDS control programs.

The U.S. has fully supported WHO/GPA in this effort by detailing senior personnel, providing contractor services, and financing the WHO/GPA. The U.S. and all other donor nations have committed to working within the policy and program framework of the individual WHO/GPA national AIDS control programs. The WHO/GPA plan for the period from 1989 to 1991 is the U.S. plan. The U.S. endorses its major elements, implements it with support for the WHO/GPA and extensive bilateral activities, and cooperates with all donors and affected countries to ensure that U.S. resources are coordinated and focused on the priority activities of these WHO/GPA plans.

During the three-year period from 1989 to 1991, the WHO/GPA expects to have put into place national plans in all cooperating countries and to have undertaken the evaluation and re-design of those eligible for renewal. The three-year cost of this WHO/GPA global prevention and control program is approximately \$1.5 billion, for an annual cost of \$500 million.

The WHO/GPA worldwide effort is closely coordinated with the ongoing bilateral activities of all donors. Its success depends upon a strong and continuing response from all donors through their bilateral programs. WHO/GPA estimates that approximately 90% of the external funding for this global AIDS prevention and control program will need to be provided by donors' bilateral programs. The contributions of bilateral donors to date have met the need, but increased levels of bilateral support will be required if the full global program is to be realized.

For these reasons, the U.S. action plan for the prevention and control of AIDS in the developing world includes both continued support for the WHO/GPA global effort and major bilateral activities by the various federal agencies concerned with the international aspects of AIDS prevention and control. The continuation of a significant bilateral assistance program which takes full advantage of the special skills and capacities the U.S. can bring to this problem is essential to the success of the global plan.

The strengths of the various U.S. agencies concerned with the international aspects of AIDS prevention and control have been summarized above. Their programs are expected to continue to be focused during the action plan period largely as they are now. The U.S. research effort is not discussed at any length in this action plan but is vital. The search for a better understanding of transmission, and for better tools to arrest transmission and cure those who are infected must continue.

The variety of U.S. programs reflects the complexity of the issues which must be addressed in dealing with the prevention and control of the spread of HIV infection. To ensure that these programs draw from areas of comparative strengths, are focused on the correct priorities, and take into account the resources and the skills available in the private sector and in the international community requires careful and close coordination. The coordination arrangements among federal departments, with the WHO/GPA and other donors, and with the U.S. private for-profit and not-for-profit sector are in place. Sound working relationships in these areas have been formed and will need to be broadened and strengthened during the action-plan period.

To date, the funds available from the donors have met all of the WHO/GPA's needs, and the funding requests for the national prevention and control plans have been oversubscribed. However, U.S. funding and that of other donors will need to increase further if the needs of the WHO/GPA and the national plans are to continue to be met.

The targeted design of the individual national AIDS programs makes it difficult to aggregate accomplishments. Nevertheless, the following achievements are illustrative of the progress anticipated during the period of this three-year action plan:

1. All countries with which the U.S. is working will have implemented AIDS and HIV public information campaigns.
2. All of these countries will also have implemented, and most will have evaluated, targeted educational programs aimed at the reduction of high-risk behavior.

3. All of these countries will have implemented blood transfusion screening programs for HIV. There will be a safe source in each country, however, only a few will have ensured complete freedom of the blood supply from HIV infection.
4. New rapid, simple HIV diagnostics appropriate for developing countries will have been field-tested and will be in common use.
5. Development of vaccine field trial sites will have taken place.
6. Models of the economic and demographic impact of the pandemic in the developing world will have been completed and validated and will be in use to further understanding and to more effectively target HIV control strategies.

APPENDIX

1

Current and Planned International AIDS Research and Related Activities

A. I. Research Programs

The need for international collaboration on a biomedical problem, AIDS, has never been more important. AIDS has clearly been shown to be a disease which knows no national boundaries, having now been reported from over 140 countries. International studies have already contributed critical information related to understanding the natural history of AIDS, major modes of HIV transmission and risk factors for HIV infection. Studies in other countries have provided vital information in such areas as characterization of existing and identification of new infectious agents, understanding heterosexual transmission and documenting the effects of AIDS upon women and children. Research conducted in other countries is of direct benefit to U.S. citizens and often provides unique opportunities to improve our knowledge and understanding of HIV infection and AIDS. Progress in the international efforts against HIV depends upon strong, long term support for biomedical research.

International AIDS Research at the National
Institutes of Health (NIH)

Historically, international collaboration has been an important part of the NIH response to the global AIDS epidemic. The National Institutes of Health and the Centers for Disease Control (CDC) have been collaborating with scientists from Belgium and Zaire in the support of pioneering studies of the epidemiology of AIDS in Africa since 1983. NIH supported research, in collaboration with investigators from the Pasteur Institute in France, resulted in the identification of HIV as the etiologic agent for AIDS. The NIH has been closely coordinating its efforts with those of the World Health Organization (WHO) Global Program on AIDS (GPA). The NIH has been designated as a WHO Collaborating Center on AIDS. NIH scientists and NIH-supported researchers worldwide have played prominent roles in the various international conferences on AIDS with NIH having been primarily responsible for organizing the III International Conference on AIDS held in Washington, DC in June 1987. The NIH, under existing agreements, has also shared clinical protocols for NIH-sponsored drug evaluation studies with German and French scientists in an effort to obtain data comparable to that obtained in U.S. trials. For

example, a multicenter study of the pulmonary complications of HIV infection was expanded to include participating institutions from both Germany and France.

The NIH is planning to spend in excess of \$15 million on International AIDS research during FY 89. Including research-related training, the total international NIH efforts related to AIDS in FY 89 is expected to exceed \$20 million. A summary of these efforts is shown in the accompanying table. These research endeavors are focused mainly in 3 of the NIH Institutes, the National Institute of Allergy and Infectious Diseases, the National Cancer Institute and the National Institute of Child Health and Human Development. A number of other NIH components also have or are planning international AIDS research and related activities. In this regard, the Fogarty International Center (FIC) has taken a leadership role in the development of international research training related to AIDS at the NIH.

NIH international research efforts involve both intramural and extramural programs. The research includes studies which take advantage of unique research opportunities in foreign countries. These

endeavors also involve collaborative research which depends to a great extent upon participation by scientists in other countries. The following is a brief summary of these research activities.

Anticipated Expenditures for International AIDS Activities
at the NIH During FY 89

<u>Organizational Component</u>	<u>Anticipated Expenditures</u>
National Institute of Allergy and Infectious Diseases	\$12,188,871
National Cancer Institute	2,833,600
National Institute of Child Health and Human Development	1,000,000
Fogarty International Center	<u>4,679,000</u>
Total	\$20,701,471

THE WHITE HOUSE

WASHINGTON

December 23, 1988

100-10-113-10

MEMORANDUM FOR THE PRESIDENT

FROM: DONALD IAN MACDONALD, M.D. *[Signature]*

SUBJECT: Progress on 10-Point Action Plan on HIV/AIDS

Our knowledge of the Human Immunodeficiency Virus (HIV) and our response to the epidemic have come further faster than with any disease in history. However, the death toll continues to rise. The predicted consequences of this disease will place increasing demands on the Nation's health and science resources.

Status In June, you asked me to review the report of your Commission on the HIV Epidemic (The Watkins' Report). In this, my third and final report, I am pleased to state that most of the 354 Commission recommendations within Federal purview have been completed or will be implemented with FY 1989 funds. Additionally, Federal leadership will continue to stimulate action on most of the 243 recommendations that fall outside Federal jurisdiction.

Progress Progress since September on your 10-point plan is addressed at Tab A. Highlights include:

- o Legislation you signed in November includes the largest increase for drug abuse treatment to date.
- o Your 1990 budget contains a ^{24 per cent} double-digit funding increase for HIV/AIDS activities of the Public Health Service and additional funding for other programs (e.g., Medicaid).
- o The Food and Drug Administration has implemented a process which will speed approval of therapies to treat life-threatening illnesses such as AIDS.
- o The Public Health Service has set in place a plan to implement many of the specific recommendations of your Commission.
- o The Department of State has begun a three-year plan to enhance international prevention activities.

Unresolved Issues and Recommendation Your 10-point action plan directs immediate implementation or further study of most of the Commission recommendations. Some deferred issues have been resolved; a number will require attention from the next Administration. My recommendations for disposition of the major unresolved issues are:

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- 2 -

THAT THE NEXT ADMINISTRATION EXAMINE THE ROLE OF PUBLIC HEALTH OFFICIALS IN LEADING HIV EFFORTS.

o Management of HIV Issues Points 5 and 6 of your 10-point plan address the Commission's recommendations on improving adequacy and coordination of Federal management and resource allocation. I am proposing to increase the influence of public health officials (Tab B). I recommend that this issue be addressed by the upcoming Administration.]

AT THE SAME TIME, THERE IS A LEGITIMATE PUBLIC HEALTH "NEED TO KNOW" (CRIPPER)

o Confidentiality Many public health officials believe that lack of adequate and consistent privacy protection for HIV-infected individuals is inhibiting the medical efforts. An option considered for legislative action is discussed at Tab C and should be considered by the Bush Administration.

o Discrimination Discrimination remains an issue of legal, economic, and political concern. Since my last report to you, the Attorney General has ruled that asymptomatic carriers of HIV infection are protected under the Federal Rehabilitation Act if they are linked to agencies which receive Federal funds. In addition, states have been strengthening their protections; however significant gaps remain. The Department of Justice is reviewing options for additional Federal action.

o Nursing Shortage Planning is necessary for expansion of our health care system which, by 1992, will be caring for 172,000 people with AIDS. The shortage of nurses is already affecting our general medical system. The Secretary of HHS is considering recommendations from his Nursing Commission. I recommend that HHS continue to take the lead on this issue.

o Financing of Health Care Per your request, HHS has begun a one-year study of the health care financing system; the report is due in September 1989. I recommend that the next Administration continue to monitor this important study.

o National Commission on AIDS The Health Omnibus Programs Extension Act of 1988 (P.L. 100-607) establishes a two-year National Commission to make recommendations on AIDS policy and to monitor policy implementation. Congress plans to defer appointment of their commissioners until the next session. I recommend that the Presidential appointees to this Commission be named by the new Administration.

TRAGEDY

BUILD

CONCLUSION The HIV/AIDS [crisis] will continue during/through the next Administration. We are making every effort to [capitalize] on the foundation laid under your leadership in stopping the spread of HIV disease.

I plan to transmit a summary of the the HIV/AIDS effort, along with an explanation of the unresolved issues, to Vice President Bush and his advisors. The Nation must not lose momentum in dealing with [this health crisis]. - AIDS

THE PRESIDENT'S 10-POINT ACTION PLAN
AGAINST HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

Second Progress Report

December 23, 1988

TAB A

1. 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. Increase the number of community-based education programs directed to those at increased risk of HIV infection.

Point 1 responds to 129 recommendations of the HIV Commission.

- o Consensus Conferences Key state and local public health officials met November 28-29 at the HHS "Health Summit" to discuss the next steps to reduce the spread of HIV infection. Issues discussed included outreach programs to get IV drug users in treatment, management of public health agencies, testing issues such as counseling, reporting and partner notification, and health care worker safety and education. This was the first in a series of ten conferences which HHS will sponsor throughout 1989.
- o Issue Many State and local officials expressed reservations in implementing stronger public health measures in the absence of stronger privacy and anti-discrimination protections for HIV infected persons. The Health Summit recommended that the Federal government take the lead on this issue. The importance of confidentiality of health information and recommendations for its resolution are addressed at Tab C.

2. Implement actions within 45 days that address: (a) 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.

Point 2 responds to 19 recommendations of the Presidential HIV Commission.

- o U.S. blood supply is among the safest in the world, however its safety must continually be monitored and improved.
- o HHS has begun drafting regulations to mandate notification of transfusion recipients through "look back" programs.

OMB
CANNOT
VERIFY

- o Within the next few months, FDA will send to all blood establishments a document consolidating all of the HIV and blood specific recommendations.
- o The Social Security Administration is establishing a Blood Donor Locator Service to aid notification and identification of HIV infected donors.
- o FDA has begun its enhanced inspection program to improve the laboratory quality of HIV antibody testing.

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- o FDA WILL SOON PUBLISH RULES THAT REQUIRE FDA-REGULATED BLOOD BANKS TO MEET HIV PROFICIENCY TESTING REQUIREMENTS ESTABLISHED BY HCFA.

3. The President 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.

Point 3 responds to 50 recommendations of the HIV Commission.

- o Your goal of a drug-free America has been aided by passage of the Omnibus Drug Act of 1988² however, strong efforts must continue and be updated by the next Administration.
- o The "drug bill" contained the single largest expansion of funding for drug abuse treatment and authorized the following activities which are being implemented:
 - Prevention and Treatment of Intravenous (IV) Drug Abuse Funds will go to States for development, implementation and operation of IV drug abuse treatment programs, training of drug abuse counselors, and outreach activities to bring persons into treatment.
 - Expansion of Demonstration Programs 3-year demonstration projects will be funded to: (1) study efficacy of providing drug treatment and vocational training in exchange for public service; (2) conduct outreach activities to IV drug users to prevent the spread of HIV, and (3) provide drug treatment services to pregnant and postpartum women, and their infants.

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

Point 4 responds to 67 recommendations of the HIV Commission.

- o Accelerate Approval Process Since the September report, FDA has implemented procedures to speed up the development, evaluation, and marketing of products for AIDS.
- o Incentives for Drug Development HHS is exploring 2 ways to improve Federal incentives to the private sector for developing HIV-related products:
 - a legislative proposal to assure that the important research and development (R&D) incentives under the Orphan Drug Act (i.e. market exclusivity, R&D tax reductions) will be available after the number of AIDS patients exceeds the 200,000 ceiling ^{imposed} applied by the act; and CREDITS
 - negotiation of equitable pricing assurances in cooperative R&D agreements when exclusive licenses are granted to industrial partners for HIV-related products.
- o Liability Issues HHS has found no indication that promising research has been delayed or foregone in the public or private sector because of fears about liability. HHS has, however, identified a series of options for continued attention to possible liability problems.

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.

Point 5 responds to 41 recommendations of the HIV Commission.

- o Construction of NIH and CDC (the) office/laboratory facilities will begin in FY 1989. (OCA) THIS HAS BEEN PREPARED AND SENT TO OMB PROPOSED LEGISLATION THAT WOULD ADDRESS THIS PROBLEM
- o Unresolved Issue The recruitment and retention of science personnel remains a problem for HHS. Several sources, including the Commission on Executive, Legislative and Judicial Salaries, have recommended salary increases to make the Federal government more competitive. ON DECEMBER 1989 THE INSTITUTE OF MEDICINE RELEASED ITS REPORT ON RECRUITMENT AND RETENTION OF NIH INTRAMURAL SCIENTISTS, WHICH IS UNDER REVIEW WITHIN THE ADMINISTRATION.

CMB

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.

SEE OMB
IN SOUT A

- o FY 1990 funding for HIV will include a double digit increase for PHS and additional funding will be available from other sources (i.e. Medicaid, Social Security, the Veterans Administration, DOD, Medicare). In addition, FTE allocations have been made above HHS' requested level.

7. Instructs 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.

Point 7 responds to 68 recommendations of the HIV Commission.

- o An estimated 172,000 people with AIDS will be alive in 1992. (OCA) PRESIDENT (CMB) THE RESOURCES TO PAY FOR The HIV epidemic is also spreading rapidly in populations unable to pay for their medical care. Ensuring availability of an adequate number of health care workers and the financial burden of medical care (\$5 to \$13 billion in 1992) are issues which will need much consideration. TO BE ADDRESSED (CMB)
- o Risk Pools The Secretary of HHS is sending an advisory letter to State Governors and legislative leaders (January 1989) to encourage replication of risk pools for the medically uninsurable. The letter also suggests sources of technical information and assistance.
- o Infants, Children and Adolescents Within the next year, HHS will implement many of the recommended actions of the Secretary's Task Force on Pediatric HIV Infection Report to respond to the needs of infants, children and adolescents.
- o FINANCING HCFA HAS A STUDY UNDERWAY CONCERNING FINANCING AND HHS IS RUNNING DEMONSTRATION PROJECTS TO PROMOTE OUT-OF-HOSPITAL CARE. THE HCFA STUDY WILL BE AVAILABLE IN SEPTEMBER 1989. (OCA)

Insert A:

was **The Budget includes \$1,600 million for PHS HIV spending in FY90, representing \$313 million over the amount available in FY89 (a 24 percent increase) and \$644 million over the FY88 level of \$956 million. The proposed increase for FY90 is approximately equal to the FY89 increase of \$331 million. OMB recommended that HHS increase HIV FTE allocations substantially in FY89-90.**

Helen
(x5178)

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

Point 8 responds to 41 recommendations of the HIV Commission.

- o The following achievements are anticipated in the next 3 years from the State Department's international plan:

- The 70 countries with which the U.S. is working will have implemented HIV public information campaigns;
- All of these countries will have implemented, and most will have evaluated, educational programs aimed at the reduction of high risk behavior;
- All of these countries will have implemented blood transfusion screening programs for HIV;
- New HIV diagnostics appropriate for use in developing countries will have been field tested and will be in common use;
- Vaccine field trial sites will have been established;
- Better estimates of the number of HIV infected individuals in developing countries will have been completed.

9. Requires the PHS to update the 1986 Public Health Service plan for combatting HIV infection.

- o PHS has completed a strategy for the Nation's response to AIDS. The strategy includes goals and objectives for the major topics raised by your HIV commission. The goals will cross referenced with the recommendations of your Commission on the HIV Epidemic. PHS will track progress on the goals beginning in January 1989.

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

Point 10 responds to 89 recommendations of the HIV Commission.

- o Attention to anti-discrimination is needed to ensure that all sectors of society respond equitably and compassionately to those with HIV infection. A discussion of the related issue of privacy/confidentiality is included at Tab C. (THIS POINT ALSO REFLECTS THE CONCRETE ACHIEVEMENTS CITED IN THE OCTOBER 26TH STATUS REPORT.)

OCA
OSG
ROBERTSON
INSUR
B

3. INSERT 2
New bullets under section 10.:

- o The Department of Justice announced its decision that HIV infected persons are covered by the anti-discrimination provisions (Section 504) of the Vocational Education and Rehabilitation Act.
- o As required by recent legislation, HHS is conducting an evaluation of state and local handling of confidentiality of HIV related information.

TAB B



**Organizational Issues Raised by the
Presidential Commission on the HIV Epidemic**

Issue The HIV Commission focused heavily on resource and management issues, such as: overall budget levels; adequate personnel, space and equipment; grant and contracting policies; and communication between government agencies. Your 10-point plan responded to many of the direct and immediate needs, however, a number of larger organizational considerations were appropriately deferred for consideration by the next Administration.

The Department of Health and Human Services bears the primary responsibility for the Federal response to the HIV epidemic and receives most of the HIV budget. Understandably, many of the management and organizational questions are targeted at HHS and raise issues of micro-management and unresponsiveness to requests from science and health officials. Improvements in these areas should be possible without eliminating or by-passing the important oversight and management functions of the current system.

Recommendation I recommend that the next Administration examine ways to strengthen the lead agency position of HHS. Revision of the HHS structure could include bringing HCFA/PHS under a senior health official. Also, changes should be made at HHS to facilitate more direct input from public health officials to the Secretary, OMB and the White House.

Federal Privacy Legislation Regarding Health Records of HIV Infected Individuals

Issue The HIV Commission recommended Federal law to assure privacy and confidentiality of medical information obtained during testing, counseling and treatment encounters. Such assurances are particularly important to people with illnesses such as AIDS which are surrounded with stigma. With adequate assurances I believe that HIV-infected individuals will come forward for testing and early counseling and treatment. A balance must be reached, however, between privacy/confidentiality and a genuine public health "need to know."

Concerns exist about casual or inadvertent disclosure to a landlord, employer, or neighbor which could result in discrimination, loss of job, denial of services, ostracism, etc. and about legally-compelled disclosure in private litigation or in governmental proceedings, may result in undesired consequences for the individual.

THAT

Background The 100th Congress considered HIV confidentiality legislation similar to that recommended by the Commission. None was enacted, but Congress did direct the Secretary of HHS to study existing State laws governing confidentiality of HIV-related information (due May 1989).

In general, the key legal enactments on use and disclosure of medical information are State laws. An increasing number of States have strengthened their confidentiality protections, some specifically for HIV-related data. The strength and breadth of these protections vary widely, however.

Existing Federal confidentiality law for drug and alcohol abuse patient information sets a precedent for Federal action in stigmatized public health conditions. Federal action on confidentiality of HIV-related records would provide reassurance that should encourage more people to be tested. Further, such a law would provide uniformity across the United States and would protect the integrity of HIV records.

Recommendation If the HHS survey of State confidentiality laws does not show substantial progress by States in offering better protection for HIV-related records, Federal or model legislation should be promoted.

CONSIDER (OMB)

ANY SUCH EFFORTS, HOWEVER, WILL
NEED TO BE BALANCED BY THE
PUBLIC HEALTH "NEED TO KNOW" --
AS WE DO WITH OTHER COMMUNICABLE
DISEASES.

TAB C

CRIPPOW

THE WHITE HOUSE

WASHINGTON

December 28, 1988

1010 DEC 28 PM 4:17

MEMORANDUM FOR RHETT B. DAWSON
ASSISTANT TO THE PRESIDENT
FOR OPERATIONS

FROM: ROBERT M. KRUGER
ASSOCIATE COUNSEL TO THE PRESIDENT 
SUBJECT: Progress on 10-Point Action Plan on HIV/AIDS

At your request, Counsel's office has reviewed the above-referenced report and has the following comments.

In general, we find the report a bit imprecise in certain respects. For example, the "ten points" which head the "second progress report" on the President's action plan are not consistently expressed. The first and second point appear to recite actual directives from the President, the third point states the President's views in the third-person, the fourth point does not seem to refer to the President at all, but rather to actions undertaken in response to his plan. Similarly, the bulleted items under these headings are not fully and consistently responsive to the calls for action contained in the heading themselves. For example, point five concerns the provision of adequate resources to combat the HIV epidemic and the elimination of impediments to the efficient use of those resources. It is not clear how the reference to the "[c]onstruction of NIH and CDC the [sic] office/laboratory facilities" relates to this concern. (Is it the case that these facilities will be used to fight AIDS?) Even more obscure is how the salary recommendations of the Pay Commission directly relate to the provision of adequate resources to combat HIV. (Indeed, some might criticize any assertion that the President's support for a salary increase for top level federal employees demonstrates his commitment to fighting AIDS.) Most important, there is no mention under point five of how OMB is working to remove impediments to the use of governmental resources.

To note one other potentially troublesome example, we do not know what is meant by the reference in the bulleted paragraph following point six to funding for HIV purposes "available from" Social Security and other sources. Any reference to tapping Social Security funds is, of course, extremely sensitive from a political perspective.

With respect to the transmittal memorandum to the President, we assume that Dr. Macdonald's "recommendations for disposition of the major unresolved issues" (e.g., the recommendation that additional legislation on confidentiality be considered by the next Administration) have been reviewed by and coordinated with the Office of Policy Development and the interested departments and agencies. We note, however, that the description of the Justice Department's recent action in the bulleted paragraph on "discrimination" is somewhat misstated. First, the Attorney General did not "rule" on this matter, rather the Office of Legal Counsel issued an opinion. Second, it is somewhat misleading to say that OLC found asymptomatic carries of HIV infection to be protected under the Rehabilitation Act if they are linked to agencies which receive Federal funds. More precisely, OLC concluded that the protection of the Rehabilitation Act extends to so-called "asymptomatic" HIV-infected persons in the federal workplace and in federally-conducted or financed programs and activities. This statement, as well as the further statement that "[t]he Department of Justice is reviewing options for additional Federal action" should, of course, be cleared with the Department of Justice.

Finally, we have indicated a few stylistic or grammatical edits on the attached draft.

Attachment

HOBBS

**Organizational Issues Raised by the
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Issue The HIV Commission focused heavily on resource and management issues, such as: overall budget levels; adequate personnel, space and equipment; grant and contracting policies; and communication between government agencies. Your 10-point plan responded to many of the direct and immediate needs, however, a number of larger organizational considerations were appropriately deferred for consideration by the next Administration.

The Department of Health and Human Services bears the primary responsibility for the Federal response to the HIV epidemic and receives most of the HIV budget. Understandably, many of the management and organizational questions are targeted at HHS and raise issues of micro-management and unresponsiveness to requests from science and health officials. Improvements in these areas should be possible without eliminating or by-passing the important oversight and management functions of the current system.

improve the functioning of HHS.
Recommendation ~~I recommend that the next Administration examine ways to [strengthen the lead agency position] of HHS. [Revision of the HHS structure could include bringing HCFA/PHS under a senior health official. Also,]~~ changes should be made at HHS to facilitate more direct input from public health officials to the Secretary, OMB and the White House.

HCFA already reports to the Secretary. Note that the Secretary-designate, like the present Secretary, is a physician knowledgeable about public health issues, and that recent HCFA administrators have also had experience in the public health arena. This does not seem to be the appropriate place to determine organization for HCFA (which is responsible for over \$100 billion of federal spending) vis a vis the Department's assistant Sec for Health who has a large organizational and research responsibility which ~~could impact~~ does not in nature the budgetary considerations of HCFA. The new Administration's hands should not, by implication, be tied in this fashion.

TAB B

HOBBS

Federal Privacy Legislation Regarding Health Records of HIV Infected Individuals

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Recommendation If the HHS survey of State confidentiality laws does not show substantial progress by States in offering better protection for HIV-related records, ~~federal~~ or model legislation should be promoted.

Such legislation should protect the public health while providing for confidentiality

Previous draft asked Attorney-General to review this issue. Response stated in corporate justice concerns

TAB C

DRAFT

Human Immunodeficiency Virus
Government-wide Crosscut
(Obligations in \$ millions)

DRAFT

	FY82 Actual	FY83 Actual	FY84 Actual	FY85 Actual	FY86 Actual	FY87 Actual	FY88 Actual	FY89 Estimate	FY90 Estimate	FY82-90 Estimate
Public Health Service	6	29	61	109	234	502	956	1,287	1,600	4,783
(Research & Prevention)										
Medicaid (Federal share)	0	13	30	73	130	200	330	490	670	1,930
Medicare	3	3	3	5	5	10	20	30	40	110
Social Security										
DI	3	3	5	13	25	40	70	110	170	430
SSI	3	3	1	3	8	15	18	28	39	112
Human Development Services	3	3	3	3	0	0	1	3	3	8
Office of Civil Rights	1	0	0	0	0	0	0	3	3	5
VA	2	5	6	10	23	54	69	96	186	452
(Res, Prev, & Treatment)										
DOD	0	0	0	0	79	74	52	52	58	315
(Res, Prev, & Treatment)										
AID	0	0	0	0	0	0	10	40	42	112
(Prevention)										
DOJ -- Bureau of Prisons	0	0	0	0	1	1	1	2	3	7
(Prev & Treatment)										
State	0	0	0	0	0	1	2	1	2	6
(Prevention)										
Labor	0	0	0	0	0	1	1	1	1	4
(Prevention)										
Education	0	0	0	0	0	0	1	3	0	1
(Prevention)										
TOTAL	8	44	104	207	504	898	1,550	2,144	2,816	8,275

DRAFT

Embargoed until 1/9/89

IADDA FOCUS ON AIDS:

January, 1989

Suggestions for Risk-Reduction Counseling

[From *EAP Digest*, May/June, 1988]

A report in the *Journal of the American Medical Association* recommends that careful choice of sexual partners be emphasized when counseling heterosexuals. The article estimates the chances of contracting HIV through vaginal intercourse with an infected partner are 1 in 500.

A condom manufacturer, the Mentor Corporation, reports that in a survey of 600 women (ages 22-50) in the U.S., 95% were aware of the risk of AIDS and 79% recognized condoms offer effective protection; however only 6.4% reported using condoms.

Many of the symptoms of AIDS Dementia may create barriers to behavior changes and risk-reduction. *Psychology Today* reports 90% of people with AIDS suffer from dementia. In addition to directly influencing clients' ability to exercise judgment and impulse control, the following symptoms of dementia could also increase clients' sense of powerlessness and frustration:

- depression
- "organic-manic" illness
- hyperactivity
- psychosis
- agitation
- delusions
- forgetfulness
- difficulty concentrating
- mental slowness
- poor decision making
- mood changes
- apathy
- leg weakness

- hand tremor
- irritability
- impaired judgment
- difficulty in writing.

AZT or medication for underlying opportunistic infections may produce remission in the AIDS dementia.

According to a report in the *Journal of the American Medical Association*, the suicide rate among men with AIDS (ages 20-59) was 66 times higher than the rate for the general population. While single, white homosexual men with a recent diagnosis were the "typical" population taking their lives, the report suggests the depression and psychiatric syndromes related to HIV infection may increase the likelihood of suicide, and therefore a similarly high rate of suicide could emerge in all people with AIDS.

Tom Smith, MD in his article, "Counseling Gay Men About Substance Abuse and AIDS," stresses that despair, depression, worry and anxiety, "can be greatly magnified by substance use." Whether clients are infected or not, agitation, stress and negative thinking increase with alcohol or other drug use. Gay men who are in substance abuse treatment programs are experiencing the stress of seeing friends die. He reports suicides among Gay men who feared they had AIDS, but who, autopsies revealed, were not infected with HIV. Since suicide is correlated to substance abuse, counselors working with Gay men need to be sensitive to their suicide potential.

Gay men who have symptoms of HIV infection or AIDS present special issues in substance abuse treatment--"they are in the midst of catastrophe." Tom Smith recommends that counselors modify their

IADDA Chicago Office
Lynn West, MSW, ACSW, NIDA Project Coordinator
Aline Stevens, Secretary
Dan Bigg, Program Specialist
Bella Selan, MS, AIDS Project Director

IADDA Springfield Office
Gene Landrum, MD, Medical Consultant and Editor
Mary Ann Anderson, MA, Program Coordinator
James E. Long, Executive Director

The staff at either office is available as a resource for subscribers of FOCUS on AIDS.
312/472-0731 (Chicago) or 217/528-7335 (Springfield)

This publication was produced with funding from the Illinois Department of Alcoholism and Substance Abuse.

thinking in a few ways: 1) recognize Gay men with HIV infection/AIDS are "special" and recognizing their needs will not provide an excuse to drink or drug; 2) differentiate between "enabling" behavior and the extra help these clients may need as their energy and health declines; and 3) increase efforts to intervene in substance abuse or relapse, because life expectancy is short.

While some Gay men in substance abuse treatment may be part of the "Gay Community," others may not feel they have support from peers because they have not disclosed their sexual orientation. They have not developed a friendship and support network with men who share their feelings of loss in this epidemic. Isolation is a key component of addiction for many people and Gay clients may feel doubly stigmatized by their addiction and sexual orientation.

Because young men are becoming infected with HIV, counselors may expect to see Gay men with AIDS entering substance abuse treatment at a time when they are still in the "fun" phase of addiction. This means they may be less aware of the physical toll alcohol/other drug use takes on everyone, and especially on people with HIV infection. Similarly, young men in the early stages of addiction may underestimate the extent to which their judgment is impaired by alcohol and other drug use. Risk-reduction choices in sexual behaviors must begin with the choice not to use alcohol or other drugs.

In summary, risk-reduction counseling with Gay men in substance abuse treatment requires that counselors be sensitive to the special needs they share, while responding to the individual needs of each client.

A Suggestion for Staff Who Are Experiencing Grief

[From The AIDS Pastoral Care Network]

One way substance abuse treatment programs may help staff (and clients) through the process of grieving is to hold a brief memorial service for people who die. The service can acknowledge:

The importance of the person's life;
The significance of the care and support that was offered to the person;
The feelings of loss and sadness;
A Higher Power and the fact we are part of a power greater than ourselves.

The service can also be a time to share memories of the person. This type of service is one technique sometimes used by hospice staff to provide mutual support.

The AIDS Pastoral Care Network offers support groups for parents, family members, partners and friends; and is an opportunity to share loss, fear, frustration, anger, disappointment, doubt, sadness, faith, hope and love in an atmosphere of mutual respect and understanding. For more information,

call Rev. Ann Showalter, 312-975-5180.

Seropositive Women in UI Study

The University of Illinois at Chicago is seeking HIV seropositive women to participate in a study of their particular psychosocial issues and concerns. Strictly confidential, the study will reimburse time and transportation costs of subjects.

REACH (Research and Education in AIDS-related Concerns and Health) will identify, follow and assist HIV infected women, their families and health care providers over a 1-2 year period to obtain information about the natural history of the infection and the women's physical health, psychological well-being, and their support system.

Participants will receive: a psychological profile including assessments of coping and social support; advocacy to access medical care, social services and psychiatric consultation as needed; support to enhance compliance and follow-through with treatment; health education and counseling related to HIV; and reimbursement for participation.

Referral sources will receive access to information (with the woman's consent) and an opportunity to obtain ongoing education and consultation from Project Reach.

Call Marcia Harris, R.N., M.S. or Larry Goldman, MD 312-996-5266 for more information.

Three new publications are available from IADDA's Chicago Office:

859 West Wellington
Chicago, Illinois 60657
312/472-0731

- **The Chicago AIDS & Substance Abuse Resource Directory**, developed by IADDA, Interventions, CAP, TASC and the Cook County AIDS Prevention Unit for the University of Illinois-Chicago, Outreach Demonstration Project is available from for \$7.50 (plus \$3 shipping and handling charge).

- **HIVIES** cards with the 12 Steps of HIV Information, Exchange and Support self-help groups are available \$10 (100 cards).

- **Addicts Helping Addicts Prevent AIDS (AHAPA)** curriculum manuals provide a course outline for counselors to use in teaching clients to be peer educators. The set of manuals includes: Training of Trainers Manual, AHAPA Client Training Curriculum and the Advanced Training Manual (\$40).

Evidence of HIV Infection-Related Deaths Among IV Drug Users

[From "HIV Infection Among Persons Who Inject Illicit Drugs: Problems and Prospects" by Don C. Des Jarlais and Samuel R. Friedman, *Journal of Acquired Immune Deficiency Syndromes*, Vol. 1, No. 3, 1988]

There is continuing evidence that IV drug users are dying from "non-AIDS" conditions which result from their HIV infection. In New York City, epidemic-level increases in deaths among IV drug users are reported. A variety of infections are causing the deaths, including bacterial pneumonias, endocarditis and tuberculosis. In Milan, similar findings are being reported.

"The mechanisms through which HIV exposure in i.v. drug users leads to fatal infections that do not meet the surveillance definition for AIDS are not yet clear. Although the cellular component of the immune system has long been considered the primary target for HIV, and there is currently great interest in the infection of macrophages by HIV, the virus also affects the humoral component of the immune system, so that resistance to illnesses related to humoral immunity might also be impaired. Intravenous drug users may also be exposed to a variety of pathogens, e.g., for tuberculosis and endocarditis, at much high rates than persons in other risk categories. Additionally, i.v. drug users may engage in other behaviors, such as heavy alcohol use, that serve as cofactors for fatal episodes of these "non-AIDS" infection. Finally, HIV-seropositive i.v. drug users may not be receiving adequate health care in a number of areas in the United States and Europe. It is possible that early and aggressive medical treatment might prevent fatal outcomes of these other infections among i.v. drug users exposed to HIV."

"Based on the New York and Milan experiences, we can also use a working estimate that the actual number of fatal outcomes of HIV infection among i.v. drug users is twice the number of deaths from surveillance-definition AIDS."

TRAINING CALENDAR

AIDS: Training & Technical Assistance, sponsored by the Illinois Department of Alcoholism & Substance Abuse through a contract with the Illinois Alcoholism & Drug Dependence Association (IADDA). The registration fee is \$25.00 for each of the following:

AIDS & Substance Abuse: A Training Program in Education, Risk Assessment & Treatment Planning (NIDA Curriculum).

This comprehensive 2½ day training program was

developed by the National Institute on Drug Abuse and presented extensively in 1987 by IADDA. The training is continually updated with new information about the virus, its transmission, and current statistics.

Dates: February 1-3, 1989--Triangle Center, Springfield

AIDS Prevention for Substance Abuse Counselors (New NIDA Curriculum with Some Adaptations).

Preventing AIDS Among Substance Abusers is a course directed to the challenge and current opportunity of preventing infection with the Human Immunodeficiency Virus (HIV) and preventing symptoms of AIDS once a person is infected.

This comprehensive 2-day training program was developed and pilot-tested by the National Institute on Drug Abuse (NIDA). The trainers, Norbert Phillips and Dan Bigg, have adapted the new NIDA concepts to meet the needs of:

- 1) counselors and nurses who have attended the first NIDA training session and would like more in-depth training and practice in risk-reduction counseling;

- 2) counselors and nurses who work in adolescent programs and in adult programs which primarily serve alcohol-dependent clients or clients who have not used intravenous drugs.

Dates: January 5-6, 1989--BRASS, Chicago

Dates: January 18-19, 1989--Lake Co. Health Dept.

Addicts Helping Addicts Prevent AIDS (AHAPA)

This 1½ day training teaches substance abuse counselors to use the 6-hour AHAPA curriculum. Using AHAPA, counselors teach clients to be AIDS Ambassadors (peer educators). The curriculum was developed and pilot tested this year and includes a comprehensive manual. Programs may deliver the training to clients as a part of their overall AIDS education program and are encouraged to use the clients who graduate from the AHAPA to educate new clients who are entering the program. AHAPA does not encourage clients to go to shooting galleries or other high-risk environments, but urges clients to teach their peers in AA, NA, CA, the treatment program, their families or in other recovery-enhancing settings.

COUNSELORS ENROLLING IN THIS TRAINING MUST HAVE A THOROUGH UNDERSTANDING OF HIV AND ITS TRANSMISSION AND MUST HAVE COMPLETED "AIDS & SUBSTANCE ABUSE," "PREVENTING AIDS AMONG SUBSTANCE ABUSERS," OR AN EQUIVALENT TRAINING PROGRAM.

Date: Jan. 30-31, 1989--State of Illinois Building, Chicago

Gradually, though, the addict learns to accept responsibility without denying the worth of his self. In this learning, a separation is made between the actions one commits and one's soul.

David Mura

Whether we're addicts or not, most of us have done things that we wanted to keep secret. We've harmed other people and ourselves. Then, we hid our secrets in our heart and locked the door. We justified, and rationalized. We built thick walls around us and lived in fear of being found out. Finally, we lost ourselves in the deception.

Recovery means finding ourselves behind our guilt, shame, and rationalizations. It starts with honesty, telling our secrets, calling things by their right names, and owning up to the harm we've done.

The miracle is that when we unlock our heart and tell our secrets, we uncover our soul. When we let the secrets out, we let the light in. We experience the blessing of forgiveness and learn that who we are is not what we did.

From *The Color of Light* by Perry Tillerias

Three new publications are available from IADDA's Chicago Office:

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AIDS
Office of the Drug Abuse
Policy Advisor
The White House
Washington, DC 20500

IADDA FOCUS ON AIDS:

December, 1988

How can we educate addicted people about AIDS?

Bella Selan, M.S.
AIDS Project Director

On Monday October 17th, the television program "48 Hours" was devoted to substance abusers and AIDS. The audience was downcast by the message: Substance abusers, despite the valiant efforts of outreach workers, more or less pursue their risky behaviors, *even though they know AIDS causes them to die*. The program showed a number of HIV positive women with AIDS. A poll conducted by the network concluded that 76% of those surveyed said they are compassionate toward persons with AIDS, but only 26% of those surveyed said they felt compassionate toward *substance abusers* with AIDS.

With the exception of a methadone treatment program group session conducted by Dr. Beny J. Primm in Brooklyn, New York, (in which addicts were almost uniformly silent and passive) no other recovering addicts appeared in this show. What can we, in the substance abuse treatment community, say about educating addicts about AIDS? How can we counteract the powerful negative messages addicts are hearing in the media?

In "Communicating About AIDS," written by Mark Hochhauser, Ph.D. for FOCUS, October 1988 (a publication of the AIDS Health Project, University of California, San Francisco) cites a number of factors significantly limiting the effectiveness of safer sex educational materials:

- lack of rationale—why a certain behavior is considered risky;
- attention to AIDS only, to the exclusion of other sexually transmitted diseases;
- evocation of fear—without advice on how to

change behavior and deal with fear;

- recommendations to reduce the number of sexual partners—without giving specific numbers.

Basically, Hochhauser concludes we do not yet know WHAT information, presented in WHICH WAYS, works for WHOM, to CHANGE BEHAVIORS.

The gay population has made some changes in sexual practices and reportedly the rate of increase in HIV positivity has dropped. We do not really know why, or what messages were successful. Many people who have known one or more intimate friends to die of AIDS, have reported a change in attitudes toward risky sexual practices; and consequently have CHANGED THEIR BEHAVIOR.

Because the substance abusing population does not have the same close network of friends and families as gay men, substance abusers rarely see their friends progress through the end stages of HIV infection, AIDS and death. Addicts may not have watched a healthy 185 pound man waste away, becoming unrecognizable as a result of AIDS. Addicts certainly have seen people wasting away as a result of their drug use—yet they still shoot up. We, in the substance abuse field, must find out whether addicts can be inspired to change behavior as a consequence of "witnessing" the slow and painful death of someone they care about.

Dr. Hochhauser has identified two factors important in developing effective AIDS prevention materials. One factor is clarity—the information must be understood by the person who receives it. The

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second factor is appropriateness—focus groups are needed to determine what facts and attitudes influence behavior change.

In May-July, 1986 IADDA conducted focus groups with 108 drug addicts, and on separate occasions conducted focus groups with their counselors. Focus groups are usually comprised of about 12 persons who, with the help of a moderator, discuss a topic. The moderator must be knowledgeable about AIDS and the groups carefully planned (often a structured questionnaire is used). What do we need to know in preparing AIDS information for substance abusers? Can they understand the message? What do they know about AIDS? Does the brochure (or card or poster) provide the needed information? What do they (or don't they) understand? Would they change risky behaviors because of this brochure (card or poster)? If yes, why? If no, why not? What else do they think is necessary to motivate behavior change? These are some questions substance abuse counselors might ask to gather much needed information from clients or addicts on waiting lists to enter treatment.

Substance abuse counselors are on the front lines and in an excellent position to conduct focus groups. Clients participate eagerly (based on IADDA's experience), and focus groups generate a strong interest in AIDS training after the group. Beyond the immediate benefit you, as a counselor gain in improving the effectiveness of program AIDS prevention messages, you can help thousands of addicts, by giving the results of the focus group to IADDA. When new cards and pamphlets are developed IADDA staff can incorporate the information you gather.

Another AIDS prevention technique (hopefully effective) is to give your clients an opportunity to talk with a Person With AIDS or HIV infection. A PWA may come and visit with clients in your program, or you may suggest clients attend a HIVIES group or other support groups (obtain permission first). Visiting a hospital AIDS unit, while it might be effective, is not usually feasible or desirable. Visitors place patients at increased risk for infections and may appear to detract from patients' dignity.

In providing AIDS education, *listening is more important than talking.* We must listen:

- to what our clients know;
- to what our clients want to know;
- to our clients' fear;
- to our clients' denial.

Addressing CLIENT CONCERNS might be the best way to begin to help clients change their behavior.

In summary, we must convey our belief that addicts CAN CHANGE THEIR BEHAVIOR and that recovery is proof of addicts' ability to change.

Needle Sharing and AIDS

[From the New Jersey Department of Health; Alcohol, Narcotic, and Drug Abuse Unit; Office of Data Analysis and Epidemiology]

The sharing of nonsterile hypodermic equipment by IV drug users is a major mode of transmission of HIV. Needle sharing serves as both a function to bind group members together, and as a response to laws which restrain the purchase and possession of needles.

Any attempt to reduce the risk of transmission of the virus must consider the ramifications of these factors. In New Jersey (as well as ten other states and the District of Columbia), a prescription is required for the purchase of hypodermic equipment. Also, all states have statutes which prohibit the possession of paraphernalia used for the ingestion of illegal drugs.

As part of the New Jersey State Department of Health's efforts to examine possible risk reduction techniques, a questionnaire was administered to 193 former IV drug users in two major drug treatment programs in Northern New Jersey, where more than 50% of a sample of IV drug users in treatment programs were found to be seropositive for antibody to HIV. Although the results of the survey apply only to those who responded, it is reasonable to assume that they are fairly representative of users in the Northern New Jersey area.

Survey questions and answers are listed below:

Why do users share or rent sets?

	% Agreeing
New ones are hard to get	32
Sets cost money	53
It's a crime to carry sets around	58
It's a sociable thing to do	24

A respondent wrote "Doing the narcotics is the most important thing in their life at that particular moment."

What are the sources for needles and syringes?

Out of state	23
Mail order	4
Hospitals, MDs, ERs	60
Diabetics or their relatives	60
Forged prescriptions	18
Stores that sell w/o Rx	23
Make your own	32

What would cause users not to share sets?

If it were legal to carry a set	47
If new ones were easier to get	57
If new ones were very cheap or free	44
If you could buy them legally	62

Will users share sets no matter what?

Yes 52%

If users could safely trade in used sets for new ones, would they?

Yes 73

Some comments:

"Some users are just too ill or eager to get off and will use whatever is available."

"Anybody with normal brains knows it's taboo to use a used set."

"If users could get sets free somewhere, it would be a good possibility that they would cut down on sharing and using unclean sets."

"People will always use someone else's set because it's easier and quicker."

"When a person is sick or needs a set, they don't care. You say it won't happen to me. I just want to shoot my dope."

"Junkies will always share sets unless they were free, easy to get, and they could carry them."

"There will always be sharing of sets. I believe if sets were given out new each day, say early in the mornings, someone would always sleep late."

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Date: Jan. 30-31, 1989—State of Illinois Building, Chicago

Conference on "Special Families"

Sponsored by the Center for Children and Families and the Loyola School of Education, the conference will feature Hamilton McCubbin, PhD, President, National Council on Family Relations and Dean, Child and Family Studies, University of Wisconsin—Madison. Registration Fee: \$25 (\$15 for students). Contact Anne M. Juhasz, Conference Coordinator, Loyola University of Chicago, 820 N. Michigan Avenue, Chicago, Illinois 60611.

Date: April 13, 1989.

**Three new publications are available
from IADDA's Chicago Office:**

859 West Wellington
Chicago, Illinois 60657
312/472-0731

• **The Chicago AIDS & Substance Abuse Resource Directory**, developed by IADDA, Interventions, CAP, TASC and the Cook County AIDS Prevention Unit for the University of Illinois-Chicago, Outreach Demonstration Project is available from for \$7.50 (plus \$3 shipping and handling charge).

• **HIVIES** cards with the 12 Steps of HIV Information, Exchange and Support self-help groups are available \$10 (100 cards).

• **Addicts Helping Addicts Prevent AIDS (AHAPA)** curriculum manuals provide a course outline for counselors to use in teaching clients to be peer educators. The set of manuals includes: Training of Trainers Manual, AHAPA Client Training Curriculum and the Advanced Training Manual (\$40).

A yearly subscription to **IADDA's FOCUS on AIDS** is available from the Springfield office. Rates are \$20 for **IADDA** members and \$30 for non-**IADDA** members.

A few months ago someone asked me where I thought we would be with the AIDS epidemic ten years from now. My answer was that all I could see were spaces where people used to be. At that point, I realized my own profound sense of loss at the decimation of a generation. Death is real, immediate in a way never imagined before. In small towns with white frame houses and village greens, as well as in city hospitals, young people are dying.

I am concerned with the personal struggle to put aside the judgment of others in order to care for them effectively. I am also concerned with helping people live as long as they live. It seems to be the only death education I can do.

So, I have begun to learn all over again, but there are still all those empty spaces...

Carole A. Lambert
Foundation of Thanatology
Columbia - Presbyterian Medical Center
New York City

More students will present themselves to college health service clinics requesting HIV antibody testing. Many students do not practice safe sex.

Judith M. Shega, RN, MS
University Health Service
Case Western Reserve University
Cleveland, Ohio

A Publication of **IADDA**
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IADDA FOCUS ON AIDS:

November, 1988

IADDA Will Publish "FOCUS on AIDS" in New Format

IADDA will continue to furnish subscribers to **FOCUS on AIDS** with up-to-date information on AIDS, AIDS prevention, and AIDS policy. The *IADDA* contract from the Illinois Department of Alcoholism and Substance Abuse, however, does not provide funding adequate to distribute **FOCUS on AIDS** to individual counselors as we had hoped.

IADDA will mail **FOCUS on AIDS** to Directors of substance abuse treatment programs in Illinois as in the past. We must rely on individual agencies to disseminate this information throughout the agency to interested personnel.

STUDY REVEALS NEW DATA ON CHICAGO HIV INFECTION RATES

The first major study of Chicago's intravenous drug users shows 20.7% are infected. Wayne Wiebel Ph.D. and Edward Senay, M.D. are the researchers conducting education and testing through the University of Illinois-Chicago, School of Public Health. The Outreach Demonstration Project is providing AIDS information and collecting data from intravenous drug users and their sex partners. Most of the blood tested for HIV antibodies has been drawn from IV drug users, however a small part of the sample population (<10%) includes sex partners.

The study indicates Chicago may be at an earlier stage in the epidemic than Centers for Disease Control infection estimates (of 25%) would have indicated; and that it is not too late for AIDS prevention. At the same time, on Chicago's West Side, the number of Hispanic (especially Puerto Rican) IV drug users with HIV infection is very high. Specifics from the study include:

- On the South Side (near 47th and King Drive) 15.6% of those tested were infected.

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PLEASE CIRCULATE

• Among the 956 intravenous drug users tested, the highest level of infection was found in the Hispanic communities of Humboldt Park, West Town, and Logan Square where 29.5% were infected.

• On the North Side (around Montrose and Broadway) 19.1% of those tested were infected.

• Chicago's overall infection rate among IV users is higher than San Francisco's (16%) but much lower than Harlem which had a 53% infection rate as early as 1986.

• Chicago's IV drug users have a much lower rate of infection than Chicago's Gay men (more than 40% are believed to be infected with HIV already).

• Among the IV drug users surveyed, 87% report having shared needles; and 11% report 11 or more sex partners.

• Among the IV drug users surveyed, 88% report having injected cocaine.

Dr. Wiebel's findings provide a picture of Chicago's HIV epidemic among IV drug users, while the reported cases of AIDS are only "the tip of the iceberg":

• During 1988, 107 cases of AIDS have been reported in Chicago among heterosexual IV drug users (87 cases) and homosexual/bisexual IV drug users (20 cases). Among the most recently reported cases, 69% are Black, 15% are Hispanic, and 15% are White.

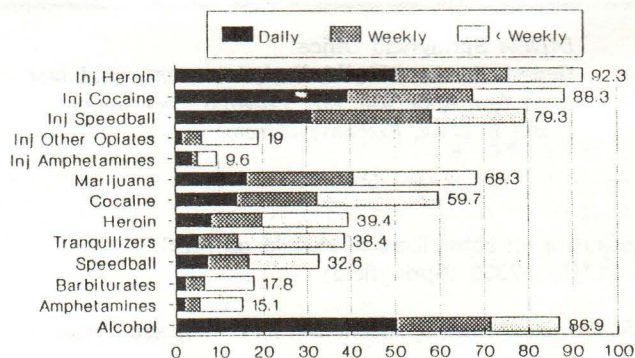
• IV Drug users now account for 15% of all AIDS cases reported in Chicago. A cumulative total of 240 cases of AIDS have been reported among Chicago heterosexual (161 cases) and homosexual/bisexual (79) IV drug users.

• At the end of October 1988, a cumulative total of 332 AIDS cases had been reported in Illinois among IV drug users.

The study is collecting information about the type and frequency of drugs used, and the findings are striking:

Frequency of Use By Type of Drug Used

n=619



University of Illinois at Chicago
AIDS Outreach Intervention Project
October 1988

The following describes the sample population included in the study:

Preliminary Sample Profile

n=699

- AGE - Mean (SD): 39.3 yrs (9.61), Range: 18-72 yrs. old.
- GENDER - 77% Male, 23% Female.
- ETHNICITY - 60% Black, 24% Hispanic, 13% White, 3% Other.
- 55% had not graduated from high school.
- 80% are unemployed.
- 25% consider themselves homeless.
- 45% report having had gonorrhea, 12% report having had syphilis, 26% report having had hepatitis.

University of Illinois at Chicago
AIDS Outreach Intervention Project
October 1988

Preliminary Sample Profile

n=699

- YEARS INJECTING - Mean (SD): 16.9 (10.47), Range: 0-49 yrs
- 87% report having ever shared needles.
- 24% report no needle sharing in the last six months. 38% report sharing needles with 1-3 people. 25% report sharing needles with 4 or more people.
- 48% report cleaning needles in the last six months. But only 14% report using bleach 100% of the time. Only 4% report using alcohol 100% of the time.
- 9% report no sex partners in the last six months. 38% report 1 sex partner; 40% report 2-10 sex partners; 11% report 11 or more sex partners.

University of Illinois at Chicago
AIDS Outreach Intervention Project
October 1988

Update on New York Needle Study

[From *The Drug Abuse Report*, Vol. 3, No.22, published by Manis Communications Group, Inc.]

A small number of intravenous drug users who are waiting to enroll in substance abuse treatment programs have received needles from the New York City Department of Health. To be eligible, subjects must be 18 years old, be current IV drug abusers, must be referred from a treatment program and must agree to an HIV antibody test.

The program has come under criticism that is amounts to "genocide," of Blacks and Hispanics, and "enables" drug users to continue injecting.

Supporters, including Stephen Joseph, MD, the city's health commissioner, see the project as a necessary, and limited, public health experiment. Up to 200 participants may receive free needles (and the study is designed to include 200 controls). If the project reaches this size, only one-tenth of one percent of the city's IV drug abusers will be participants. Counseling is part of the program for both needle recipients and controls.

Methadone, Needles & AIDS in the Netherlands

[From *Substance Abuse Report*, November 15, 1988]

The Netherlands policy is to provide substance abuse treatment to everyone, and this appears to be successful in preventing AIDS. 80% of all Dutch addicts are in treatment (largely methadone maintenance). The average daily methadone dose is 35-40 mg, however there is a tendency to increase the dosage to reduce client cravings and resultant heroin injection. Addicts who do not want treatment may obtain free needles. For more information write to Henk Jan van Vliet, Metropolink, Zeeburgerpad t.o. 38, NL 1018 AK Amsterdam, The Netherlands.

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Date: Jan. 30-31, 1989--State of Illinois Building, Chicago

"The Color of Light: Meditations for All of Us Living With AIDS"

This new day at a time book is available from Hazelden (\$6.95/Box 176, Center City, Minnesota 55012 ph:800-328-9000). The book is for people with AIDS and ARC, people who are HIV positive, lovers, spouses, family members, friends and caregivers; and everyone who is involved with AIDS. Hazelden Educational Materials is the world's largest publisher and distributor of books, pamphlets and audio-visual materials about chemical dependency and related topics.

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859 West Wellington
Chicago, Illinois 60657
312/472-0731

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*A lot of people with AIDS grab the
bottle and head for the grave.
Tom Kaufman, person with AIDS*

One of the hardest situations to deal with is someone else's addiction. It's painful to watch a relative or a friend hurt him- or herself day in and day out. An AIDS diagnosis doesn't make getting clean and sober any easier. For many of us, using alcohol or other drugs was a way to commit slow suicide. Having AIDS just makes it a faster way.

Many of us who are sober now are grateful for the miracle that happened when we turned toward the light and made a decision to live. We're not sure why it happened. It just did. So we fight against deciding what's best for other people. We try to extend love without judgment. We call in our scattered energies and concentrate on our growth, our sober living, our sanity and health. We trust that our friends are being protected by the same Spirit of the Universe that cares for and watches over us.

From The Color of Light, by Perry Tilleraas

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