

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records
Subgroup/Office of Origin: Chief of Staff
Series/Staff Member: George Stephanopoulos
Subseries:

OA/ID Number: 8028
FolderID:

Folder Title:
Gays in the Military Questionnaire

Stack:	Row:	Section:	Shelf:	Position:
S	22	2	9	3

G:

OMB would

like you to review

this Gays in the
Military

Questionnaire.

☒ FINE
GRS

1996 MAR 26 PM 1:35

COMMITTEE ON NATIONAL SECURITY**U.S. House of Representatives****Washington, DC 20515-6035****ONE HUNDRED FOURTH CONGRESS****FLOYD D. SPENCE, SOUTH CAROLINA, CHAIRMAN****March 25, 1996**

STUMP, ARIZONA
 DUNCAN HUNTER, CALIFORNIA
 JOHN S. EASER, OHIO
 HERBERT A. BATTMAN, VIRGINIA
 JAMES V. HANSEN, UTAH
 CURT WILSON, PENNSYLVANIA
 ROBERT E. DORNAN, CALIFORNIA
 JOEL HURLEY, COLORADO
 JIM SANTON, NEW JERSEY
 RANDY "DUKE" CUMMINGS, CALIFORNIA
 STEVE BUYER, INDIANA
 PETER G. TOROLOSIN, MASSACHUSETTS
 TILLIE E. FOWLER, FLORIDA
 JOHN M. MCNEIL, NEW YORK
 MANDY TALLENT, MISSOURI
 PIERRE, ALABAMA
 G. BARTLETT, MARYLAND
 HOWARD "BUCK" MCGON, CALIFORNIA
 RON LEWIS, KENTUCKY
 J.C. WATTS, JR., OKLAHOMA
 MAC THOMAS, TEXAS
 JOHN H. ROBERTS, INDIANA
 SANDY CHAMBERS, GEORGIA
 VAN HALEART, TENNESSEE
 JOE SCARBOROUGH, FLORIDA
 WALTER B. JONES, JR., NORTH CAROLINA
 JAMES B. LONGLEY, JR., MAINE
 TODD TART, KANSAS
 RICHARD "DOC" HASTINGS, WASHINGTON

ROTHMAN, CALIFORNIA
 G.V. GEORGE, MONTGOMERY, ALABAMA
 PATRICK SCHWARTZ, COLORADO
 KE SELLER, MICHIGAN
 NORMAN ESBAY, WISCONSIN
 JOHN M. SPATY, JR., SOUTH CAROLINA
 SOLOMON P. DUFFY, TEXAS
 OWEN PICKETT, VIRGINIA
 JANE EVANS, ILLINOIS
 JOHN TAMMER, TENNESSEE
 GLEN BRONDER, ALABAMA
 DENISE TAYLOR, MISSISSIPPI
 NEIL ADKINS, HAWAII
 CHET EDWARDS, TEXAS
 FRANK ELLER, TEXAS
 MARTIN A. MCGEE, MISSISSIPPI
 ROBERT A. UNDERWOOD, CLARK
 JAMES HARRMAN, CALIFORNIA
 PAUL MARANT, PENNSYLVANIA
 PETE GARNER, TEXAS
 PETE PETERSON, FLORIDA
 WILLIAM J. JEFFERSON, KANSAS
 ROSA L. DEALING, CONNECTICUT
 MIRE WARD, KENTUCKY
 PATRICK J. KEENE, RHODE ISLAND

ANDREW K. ELLIS, STAFF DIRECTOR

Honorable William J. Perry
 Secretary of Defense
 The Pentagon
 Washington, D. C. 20301-1000

Dear Mr. Secretary:

I would appreciate answers to the following questions by each of the services as soon as possible, but not later than Thursday, March 28.

1. What is the total DoD annual spending on HIV/AIDS, including medical care and research, from 1986 until the present?
2. What is the total number of DoD personnel who tested positive each year as well as the total number who were on active duty at the end of each year from 1986 to the present?
3. By service, what is the total number of permanent non-deployables compared to the number of HIV-positive personnel from 1986 to the present?
4. Regarding venereal diseases, especially syphilis, how do these diseases affect deployability and retention?
5. How many service personnel deployed or stationed overseas have been returned to the United States as a result of becoming HIV positive (1992, 1993, 1994 and 1995)?
6. What specific information from the services regarding HIV is reported to the Center for Disease Control (CDC)?
7. Is the mode of HIV transmission maintained in personal medical files or any other files? If not, where is such information maintained? What is the current breakdown of modes of HIV transmission within the HIV positive population of the military?

UO 4291 196

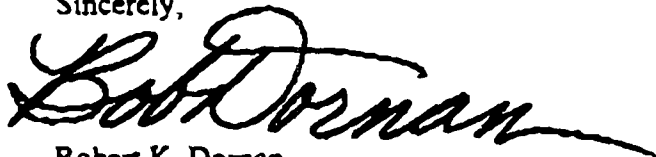
Honorable William J. Perry

March 25, 1996

Page two

8. Where, for each of the services, are the personal medical records kept of HIV-positive personnel?
9. How often are military personnel tested or checked for HIV?
10. How many family members of HIV-positive military personnel are also HIV positive?
11. Do all of the infected dependents live with their military spouses? If not, how many live apart?
12. Of the current HIV-positive military personnel, how many have HIV II? How many have HIV E?
13. How many cases of Hepatitis B are there currently in the military? What is the status of personnel with Hepatitis B in terms of deployability/retention?
14. How many current HIV-positive military personnel have their condition as a direct result of blood transfusions?

Sincerely,



Robert K. Dorman

Chairman

Military Personnel Subcommittee

INFORMATION PAPER

SUBJECT: Response to Representative Dorman Questions Dated 25 March 1996

DISCUSSION:

- **Question 1:** What was the total DoD annual spending on HIV/AIDS, including medical care and research, from 1986 until the present?

Answer 1: The exact cost of medical care for HIV/AIDS care can not be determined due to the inability to account directly for inpatient and outpatient care. However, some aspects of cost can be estimated. The cost of DoD's HIV/AIDS testing and monitoring program is approximately \$12-\$13 million per year. This figure includes:

- the HIV testing programs for all military applicants, active duty and reserve component members, and dependents
- databases and repository which support the testing programs
- the virological and immunological (CD4 cell) determinations of those infected
- maintenance of reference labs and overall quality assurance programs

Approximate *lifetime* cost estimates of treating a person with HIV in the civilian sector have been estimated to be \$100,000 to \$150,000 with a ten year life expectancy.

Over 3.5 million military applicants have been screened and over 3,860 infected applicants have been excluded from military service at a little under \$3.00 per test per person (at a cost of \$11,580 transferring into an estimated cost avoidance of \$482,500,000).

The annual DoD research costs from FY 86 to the present are:

FY	86	87	88	89	90	91	92	93	94	95
Research Cost (in Millions)	\$34	\$18	\$10	\$27	\$33	\$44	\$42	\$50	\$45	\$40

- **Question 2:** What is the total number of DoD personnel who tested positive each year, as well as the total number who were on active duty at the end of each year from 1986 to the present?

Answer 2:

CY	Newly Diagnosed HIV Positive			HIV Members at End of CY		
	Army	Navy/USMC	Air Force	Army	Navy/USMC	Air Force
86	1040	1271/155	218	864	1271*	282
87	407	626/58	375	887	1015*	537
88	189	453/64	131	598	1095*	520
89	172	249/43	104	548	948*	468
90	145	249/49	65	520	831*	401
91	135	186/37	57	511	822*	358
92	125	183/29	51	440	785*	313
93	91	161/41	39	408	751*	251
94	65	118/28	31	372	634/82	187
95	63	83/16	17	314	507/62	99

- USMC numbers are not available from 1986-1993.

- **Question 3:** By Service, what is the total number of permanent non-deployables compared to the number of HIV positive personnel from 1986 to the present?

Answer 3:

CY	PERMANENT NON-DEPLOYABLES**			HIV POSITIVE MEMBERS		
	Army	Navy/USMC	Air Force	Army	Navy/USMC	Air Force
86	Unk*	1657**	2737	864	1271**	282
87	Unk*	1292**	3400	887	1015**	537
88	Unk*	1459**	3600	598	1095**	520
89	Unk*	1283**	3340	548	948**	468
90	Unk*	1161**	3250	520	831**	401
91	Unk*	1196**	2850	511	822**	358
92	Unk*	1126**	2287	440	785**	313
93	Unk*	1034**	1779	408	751**	251
94	Unk*	864**	1888	372	634/82	187
95	3997	694/131	2134	314	507/62	99

* Unk = Unknown Data. The Army did not begin compiling data on non-deployable members Army wide until 1995.

** USMC numbers are not available.

- **Question 4:** Regarding venereal diseases, especially syphilis, how do these diseases affect deployability and retention?

Answer 4: Sexually transmitted diseases are treated as a temporary, curable medical condition and, as such, are not disqualifying from deployability or retention. If a member has symptomatic neurosyphilis or complications of the disease to a degree that the member is incapable of performing military duty, the member will be referred to the disability evaluation system (DES).

- **Question 5:** How many Service personnel deployed or stationed overseas have been returned to the United States as a result of becoming HIV positive (1992, 1993, 1994, and 1995)?

Answer 5:

CY	Army*	Navy/USMC**	Air Force
92	12	Unk	4
93	2	Unk	4
94	7	Unk	4
95	8	12	4

* This data reflects only the number of service members currently on active duty who were reassigned from overseas assignments upon being diagnosed HIV positive. Data is not available for members who have left the service and who may have been reassigned from overseas upon being diagnosed HIV positive.

** The Navy retains information only on HIV positive personnel currently on active duty. Of the 507 HIV positive on active duty at the end of CY95, 12 were re-assigned from overseas duty assignments at the time of diagnosis (an additional 251 were re-assigned from shipboard assignments that require overseas deployments).

- **Question 6:** What specific information from the Services regarding HIV is reported to the Center for Disease Control (CDC)?

Answer 6: The only data DoD reports directly to the CDC are periodic reports concerning the results of HIV screening of potential military recruits. The Services do not report any information directly to the CDC. It is DoD policy for military medical treatment facilities to report HIV/AIDS statistics to local and state health agencies in accordance with local and state laws and regulations. While all states are required to report AIDS statistics to the CDC, only 26 states routinely report HIV seroconversion statistics and associated demographic data. This data does not ordinarily contain information on suspected mode of transmission.

- **Question 7: Is the mode of HIV transmission maintained in personal medical files or any other files? If not, where is such information maintained? What is the current breakdown of modes of HIV transmission within the HIV positive population of the military?**

Answer 7: The "mode of transmission" can only be presumed, and not validated, from self-reported questionnaire data. Each Service has collected, stored and processed HIV risk factor data in the following manner.

Army

As HIV-positive soldiers are identified, the preventive medicine service is responsible for conducting a public health interview for purposes of contact tracing and reporting in accordance with local and state regulations. At this interview, risk factors for HIV transmission are discussed. All information from this interview is maintained in secure files separate from the medical record at each Army post. No attempt has ever been made to assemble or analyze this information.

Because of the highly sensitive nature of some of the behavioral risk factors for HIV infection, the validity and usefulness of risk factor data collected from military patients by military physicians has always been limited. From 1986 through January 1995, Army physicians interviewing newly identified HIV positive patients completed a clinical evaluation form (CEF) that included questions on risk factors. These forms were forwarded to the US Army HIV Data Systems (USAHDS) office, originally housed at the Walter Reed Army Institute of Research. This limited access data base is now part of the Army Medical Surveillance Activity of the Center for Health Promotion and Preventive Medicine. Because of the poor response rate and concern about the lack of validity of these data, a new clinical evaluation form with no risk factor questions has been used for submission of data to USAHDS since January 1995. There is now no routine centralized collection of risk factor data by the Army.

Separate from the above epidemiological interviews, most Army HIV risk research has been conducted in collaboration with the Henry M. Jackson Foundation for the Advancement of Military Medicine (HMJFAMM). HIV risk factor transmission data gathered for these research protocols were collected, stored and processed according to clinical investigation review board approved study protocols. In addition, the Walter Reed Army Institute of Research independently conducted two research studies. Complete results of both studies have been published in the medical literature.

- **Study 1: Risk factors for prevalent human immunodeficiency virus (HIV) infection in active duty Army men who initially report no identified risk: a case control study. Journal of Acquired Immune Deficiency Syndromes, Volume 3, pages 266-71, 1990. For this study 26 HIV-positive soldiers with no previously identified risk factors and 74 HIV-negative (control) soldiers volunteered to participate in anonymous and confidential interviews.**

- Study 2: HIV-1 seroconversion and risk behaviors among young men in the US Army. American Journal of Public Health, Volume 85, Number 11, pages 1500-06, November 1995. For this study, 128 HIV-positive men and 128 controls volunteered to participate in anonymous and confidential interviews to determine behavioral risk factors for infection with HIV.

These studies and those conducted in collaboration with HMJFAMM comprise all known Army sources of research data concerning behavioral risk of HIV infection.

Navy

Risk factor information is gathered from individuals during a confidential epidemiologic interview as part of the intake evaluation for those who have evidence of HIV seroconversion. Stored separate from the medical records, information is forwarded to the appropriate public health agency for contact tracing. The process to forward all but risk behavior data is through the Adult HIV/AIDS Confidential Case Report form. This form is used to report HIV seropositive cases to state health departments in accordance with state law. Risk factors are neither recorded on the Confidential Case Report nor reported because military restrictions against risk relevant behavior make this information unreliable.

Between 1988 and 1991, an approved active research protocol included questions about risk information. An unpublished document written in 1988, and discovered April 3, 1996, at the Naval Health Research Center San Diego, indicates that NHRC staff asked 2500 Navy and Marine Corps personnel to complete an anonymous personal history questionnaire during their initial HIV evaluations. Only 200 of the 2500 patients completed the questionnaire. Due to the poor response rate, the aggregated data was not considered representative of the population and was not published and the anonymous questionnaire project was discontinued. The Navy Medical Department has no plans to conduct further studies related to risk factors and does not maintain a central data base with risk factor information.

Air Force

The U.S. Air Force Public Health epidemiology nurse (civilian GS-09) asks each HIV-infected person on their initial evaluation to complete CDC Form 50.42A. This CDC form contains the name of the individual being interviewed and thus is not anonymous. Because the form is not anonymous, its accuracy is doubtful. This form is filed in the epidemiology nurse's office until the individual develops CDC-defined AIDS or dies. At this time, this form is sent to the appropriate state or local health agency who in turn forwards it to the CDC. A copy is retained by the epidemiology nurse in her file.

At the inception of the USAF HIV Program at Wilford Hall Medical Center (WHMC) in 1985, the direction and management of the program was placed under the Department of Infectious Diseases. At this time, a questionnaire was developed by the Department of Infectious Diseases which included questions regarding HIV risk factor data. From 1985 to 1988, this information was obtained from each HIV positive individual who was referred to

WHMC for evaluation. This form was not anonymous and the interview was conducted by the Infectious Diseases fellows who completed the form in the presence of the individual. Thus, the accuracy of these forms was questionable. These forms were initially retained with copies of the periodic HIV evaluations and filed in the department. In 1988, these forms were discontinued and they were all destroyed.

In October 1989, the Henry M. Jackson Foundation (HMJF) established a research unit at WHMC to assist with the Tri-Service HIV Research Program. Major George Brown (separated) and his colleagues in the Department of Psychiatry developed a psychiatric and neuropsychiatric protocol to evaluate the natural history of psychiatric illness in HIV infected persons for the Behavioral Science Program. This protocol was assigned a study number, RV-26. Participation in this study was voluntary and included active duty, retired and dependents. Part of the data collected included an anonymous questionnaire containing questions regarding sexual practices and other factors including intravenous drug use. This study was active from approximately 1990-1992. All of these study records are retained in storage in San Antonio by the HMJF.

In 1990, the HMJF Behavioral Science program developed a second anonymous, voluntary sexual questionnaire. This questionnaire was developed to identify HIV transmission risk factors. Since 1990, this anonymous form has been voluntarily completed by approximately 90% of individuals who have been referred to HMJF for their initial evaluation. (This form is completed on their initial evaluation only.) To date, 213 individuals (active duty, dependent, retired) have completed the form. In this group, 191 of the volunteers have been active duty males. Upon the completion of the form, the contents are entered into the HMJF database and the original form is destroyed.

The Public Health epidemiology nurse at WHMC requests that each HIV infected person, referred for an initial evaluation, complete an anonymous contact tracing form. The epidemiology nurse reviews the contact tracing form and notifies the appropriate public health officials. For contacts who are active duty Air Force, she notifies the Public Health officials at their local base. For contacts who are civilian, she notifies the County Health Department and for contacts who are active duty in other services, she notifies the HIV Coordinator for the US Army or the US Navy in Washington, DC. Following the completion of these notifications, these forms are destroyed.

Thus, the only form which makes any connection between the individual's name and their HIV risk factor data is the CDC Form 50.42A.

There have been only two published references by Air Force personnel regarding HIV risk factor data. The first was an abstract presented by Captain Robert Zajac (separated) at the 1986 Air Force Regional Meeting of the American College of Physicians in San Antonio, TX. The data source for the HIV risk factor data presented in this abstract was obtained from the questionnaire developed by the Department of Infectious Disease referred to above. Because this data was collected through a face-to-face interview, its accuracy is questionable. In this abstract, Captain Zajac states that 16 individuals admitted to homo/bisexual activity

and two individuals admitted to drug use. However, as noted above, these forms were all destroyed in 1988. The second publication was a manuscript published by LtCol Janice Rusnak in the Journal of Infectious Disease. In the last two paragraphs of the results sections, she described some HIV risk behavior data obtained from a HMJF research study. This data was obtained from the RV-26 behavioral science protocol that is referenced above. As stated, all of the data for this study is maintained in storage by the HMJF in San Antonio, TX. To our knowledge, these are the only published materials which refer to HIV risk factor data by Air Force personnel.

- **Question 8:** Where, for each of the services, are the personal medical records kept for HIV positive personnel?

Answer 8: Personal medical records for HIV positive members are maintained at the local hospital or clinic of the duty station to which they are assigned.

- **Question 9:** How often are military personnel tested or checked for HIV?

Answer 9:

DoD: HIV testing is conducted on prospective applicants prior to entrance into the Service, during periodic physical examinations or during Permanent Change of Station transfers. Those who test positive at accession points are not accepted for entry. Specific service requirements for HIV screening are as follows:

Army: All members will be tested at a minimum of biennially. All members are tested prior to overseas Permanent Change of Station Transfers.

Navy/USMC: Active duty members in overseas and deployable units and all active duty health care providers are tested on an annual basis. All others will be tested during periodic physical examinations or at least every five years. All members will be tested prior to Permanent Change of Station Transfers.

Air Force: Medical personnel are tested annually. Individuals who are on flying status are tested during periodic physical examinations every three years. All others are tested during their periodic physical examination at least every five years. All members are tested prior to overseas Permanent Change of Station Transfers.

- **Question 10:** How many family members of HIV positive military personnel are also HIV positive?

Answer 10: This data is incomplete and very limited because an unknown percentage of spouses and other family members choose not to have HIV testing performed or do not report the results of the testing to DoD. Listed below are the numbers of known HIV positive family members of HIV positive members.

	Army	Navy/USMC	Air Force
HIV Positive Dependents	7	31	5

- **Question 11:** Do all of the infected dependents live with their military spouses? If not, how many live apart?

Answer 11: This data is incomplete and very limited. For those family members whose HIV status is known, not all of the HIV positive family members live with their military sponsors. In the Navy for example 6 HIV positive members are living apart from HIV positive family members. In the Air Force, all 5 known HIV positive family members live with the HIV positive sponsor. This information is not available from the Army.

- **Question 12:** Of the current HIV positive personnel, how many are HIV II? How many have HIV E?

Answer 12: There are no known HIV-II positive members in any of the services. HIV-E is a subtype of HIV-1 not normally differentiated from HIV-1 in serotyping done by the services. However, the Navy does report 3 members have been identified as HIV-1 clade E positive.

- **Question 13:** How many cases of Hepatitis B are there currently in the military? What is the status of personnel with Hepatitis B in terms of deployability/retention?

Answer 13: The best available numbers of Hepatitis B cases are listed below. There are no restrictions on deployability and retention of these personnel.

	Army	Navy/USMC	Air Force
Reported Hepatitis B Cases	43*	49**	83***

* - Data is from 1995 Hospital Admissions Data.

** - Data is from 1994 (last year available).

*** - Includes members diagnosed with acute hepatitis B and newly identified carriers of hepatitis B (1995 Annual USAF Sexually Transmitted Disease Report)

- **Question 14:** How many current HIV positive military personnel have their condition as a direct result of blood transfusions?

Answer 14: We are unable to ascertain with any degree of certainty exactly how any HIV positive member acquired the disease. The following details the number of cases of HIV positive members currently on active duty where blood transfusions were listed as one of the potential risk factors following diagnosis:

	Army	Navy/USMC	Air Force
Blood Transfusion As a Risk Factor	Unk	5	0

✓
Is the mode of HIV transmission maintained in personal medical files or any other files? If not, where is such information maintained? What is the current breakdown of modes of HIV transmission within the HIV positive population of the military?

QUESTION FROM MR. JOHN CHAPLA Prof. Staff Member House
National Security Committee, SUBCOMMITTEE ON MANPOWER
AND PERSONNEL



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

Honorable Robert K. Dornan
Chairman, Subcommittee on Military Personnel
National Security Committee
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

In response to your follow-up questions, I directed the three Surgeons General to conduct a thorough search back through each of their systems regarding any information that would bear upon the "risk assessment" HIV issue. Enclosed is the material that emerged from that review, divided into three categories:

1. Service-by-service description of the collection, storage, and use of risk assessment data.
2. Descriptions and lists of presentations, etc. from the Henry M. Jackson Foundation for the Advancement of Military Medicine's "Behavioral Prevention Program." This program is funded by the Army, but the data and research materials are under the purview of the Henry M. Jackson Foundation; further inquiries should be directed to them.
3. Publications that we are aware of that draw upon military risk assessment data.

I must re-emphasize what virtually all researchers who have dealt with this data have previously stated: The process of asking (anonymously or not) risk assessment questions in the military context yields results with a high probability of unreliability. Further, the samples of patients from whom such data has been collected are not adequately representative of the HIV-infected military population as a whole, nor do they reliably reflect trends over time.

I realize that this material does not offer the kind of clear-cut answers you are seeking, but that is the inherent limitation of the data.

Sincerely,

Stephen C. Joseph, M.D., M.P.H.

TAB 1

Is the mode of HIV transmission maintained in personal medical files or any other files? If not, where is such information maintained? What is the current breakdown of modes of HIV transmission within the HIV positive population of the military?

The "mode of transmission" can only be presumed, and not validated, from self-reported questionnaire data. Each Service has collected, stored and processed HIV risk factor data in the following manner.

Army

As HIV-positive soldiers are identified, the preventive medicine service is responsible for conducting a public health interview for purposes of contact tracing and reporting in accordance with local and state regulations. At this interview, risk factors for HIV transmission are discussed. All information from this interview is maintained in secure files separate from the medical record at each Army post. No attempt has ever been made to assemble or analyze this information.

Because of the highly sensitive nature of some of the behavioral risk factors for HIV infection, the validity and usefulness of risk factor data collected from military patients by military physicians has always been limited. From 1986 through January 1995, Army physicians interviewing newly identified HIV positive patients completed a clinical evaluation form (CEF) that included questions on risk factors. These forms were forwarded to the US Army HIV Data Systems (USAHDS) office, originally housed at the Walter Reed Army Institute of Research. This limited access data base is now part of the Army Medical Surveillance Activity of the Center for Health Promotion and Preventive Medicine. Because of the poor response rate and concern about the lack of validity of these data, a new clinical evaluation form with no risk factor questions has been used for submission of data to USAHDS since January 1995. There is now no routine centralized collection of risk factor data by the Army.

Separate from the above epidemiological interviews, most Army HIV risk research has been conducted in collaboration with the Henry M. Jackson Foundation for the Advancement of Military Medicine (HMJFAMM). HIV risk factor transmission data gathered for these research protocols were collected, stored and processed according to clinical investigation review board approved study protocols. In addition, the Walter Reed Army Institute of Research independently conducted two research studies. Complete results of both studies have been published in the medical literature.

- Study 1: Risk factors for prevalent human immunodeficiency virus (HIV) infection in active duty Army men who initially report no identified risk: a case control study. Journal of Acquired Immune Deficiency Syndromes, Volume 3, pages 266-71, 1990. For this study 26 HIV-positive soldiers with no previously identified risk factors and 74 HIV-negative (control) soldiers volunteered to participate in anonymous and confidential interviews.

- Study 2: HIV-1 seroconversion and risk behaviors among young men in the US Army. American Journal of Public Health, Volume 85, Number 11, pages 1500-06, November 1995. For this study, 128 HIV-positive men and 128 controls volunteered to participate in anonymous and confidential interviews to determine behavioral risk factors for infection with HIV.

These studies and those conducted in collaboration with HMJFAMM comprise all known Army sources of research data concerning behavioral risk of HIV infection.

Navy

Risk factor information is gathered from individuals during a confidential epidemiologic interview as part of the intake evaluation for those who have evidence of HIV seroconversion. Stored separate from the medical records, information is forwarded to the appropriate public health agency for contact tracing. The process to forward all but risk behavior data is through the Adult HIV/AIDS Confidential Case Report form. This form is used to report HIV seropositive cases to state health departments in accordance with state law. Risk factors are neither recorded on the Confidential Case Report nor reported because military restrictions against risk relevant behavior make this information unreliable.

Between 1988 and 1991, an approved active research protocol included questions about risk information. An unpublished document written in 1988, and discovered April 3, 1996, at the Naval Health Research Center San Diego, indicates that NHRC staff asked 2500 Navy and Marine Corps personnel to complete an anonymous personal history questionnaire during their initial HIV evaluations. Only 200 of the 2500 patients completed the questionnaire. Due to the poor response rate, the aggregated data was not considered representative of the population and was not published and the anonymous questionnaire project was discontinued. The Navy Medical Department has no plans to conduct further studies related to risk factors and does not maintain a central data base with risk factor information.

Air Force

The Public Health epidemiology nurse (civilian GS-09) asks each HIV-infected person on their initial evaluation to complete CDC Form 50.42A. This CDC form contains the name of the individual being interviewed and thus is not anonymous. Because the form is not anonymous, its accuracy is doubtful. This form is filed in the Public Health epidemiology nurse's office until the individual develops CDC-defined AIDS or dies. At this time, this form is forwarded to CDC and a copy is retained by the epidemiology nurse in her file.

At the inception of the USAF HIV Program at Wilford Hall Medical Center (WHMC) in 1985, the direction and management of the program was placed under the

Department of Infectious Diseases. At this time, a questionnaire was developed by the Department of Infectious Diseases which included questions regarding HIV risk factor data. From 1985 to 1988, this information was obtained from each HIV positive individual who was referred to WHMC for evaluation. This form was not anonymous and the interview was conducted by the Infectious Diseases fellows who completed the form in the presence of the individual. Thus, the accuracy of these forms was questionable. These forms were initially retained with copies of the periodic HIV evaluations and filed in the department. In 1988, these forms were discontinued and they were all destroyed.

In October 1989, the Henry M. Jackson Foundation (HMJF) established a research unit at WHMC to assist with the Tri-Service HIV Research Program. Major George Brown (separated) and his colleagues in the Department of Psychiatry developed a psychiatric and neuropsychiatric protocol to evaluate the natural history of psychiatric illness in HIV infected persons for the Behavioral Science Program. This protocol was assigned a study number, RV-26. Participation in this study was voluntary and included active duty, retired and dependents. Part of the data collected included an anonymous questionnaire containing questions regarding sexual practices and other factors including intravenous drug use. This study was active from approximately 1990-1992. All of these study records are retained in storage in San Antonio by the HMJF.

In 1990, the HMJF Behavioral Science program developed a second anonymous, voluntary sexual questionnaire. This questionnaire was developed to identify HIV transmission risk factors. Since 1990, this anonymous form has been voluntarily completed by approximately 90% of individuals who have been referred to HMJF for their initial evaluation. (This form is completed on their initial evaluation only.) To date, 213 individuals (active duty, dependent, retired) have completed the form. In this group, 191 of the volunteers have been active duty males. Upon the completion of the form, the contents are entered into the HMJF database and the original form is destroyed.

The Public Health epidemiology nurse at WHMC requests that each HIV infected person, referred for an initial evaluation, complete an anonymous contact tracing form. The epidemiology nurse reviews the contact tracing form and notifies the appropriate public health officials. For contacts who are active duty Air Force, she notifies the Public Health officials at their local base. For contacts who are civilian, she notifies the County Health Department and for contacts who are active duty in other services, she notifies the HIV Coordinator for the US Army or the US Navy in Washington, DC. Following the completion of these notifications, these forms are destroyed.

Thus, the only form which makes any connection between the individual's name and their HIV risk factor data is the CDC Form 50.42A.

There have been only two published references by Air Force personnel regarding HIV risk factor data. The first was an abstract presented by Captain Robert Zajac (separated) at the 1986 Air Force Regional Meeting of the American College of Physicians in San Antonio, TX. The data source for the HIV risk factor data presented in this

abstract was obtained from the questionnaire developed by the Department of Infectious Disease referred to above. Because this data was collected through a face-to-face interview, its accuracy is questionable. In this abstract, Captain Zajac states that 16 individuals admitted to homo/bisexual activity and two individuals admitted to drug use. However, as noted above, these forms were all destroyed in 1988. The second publication was a manuscript published by LtCol Janice Rusnak in the Journal of Infectious Disease. In the last two paragraphs of the results sections, she described some HIV risk behavior data obtained from a HMJF research study. This data was obtained from the RV-26 behavioral science protocol that is referenced above. As stated, all of the data for this study is maintained in storage by the HMJF in San Antonio, TX. To our knowledge, these are the only published materials which refer to HIV risk factor data by Air Force personnel.

Jackson Ton

TAB 2

The Behavioral Prevention Program

Co-Directors:

Ellen D. Nannis, Ph.D.

Scientific Director
Henry M. Jackson Foundation

F.D. Daniell, CAPT, MC, USN

Chief, Behavioral Prevention
Department, WRAIR

Research Objectives:

In support of MMCARR's primary mission, the reduction of HIV incidence in military populations, the Behavioral Prevention Program:

1. Develops and evaluates behavioral interventions for the three services to reduce the exposure to HIV by individuals at higher risk for infection.
2. Provides support to the Preventive Medicine Departments of the three services by evaluating existing operational HIV education and prevention efforts.
3. Supports HIV vaccine and chemotherapy drug trials through research designed to understand behavioral factors.
4. Develops and evaluates behavioral interventions to reduce transmission by HIV infected military medical beneficiaries.

Introduction:

The primary focus of the BPP research program is to develop and evaluate behavioral interventions designed to reduce the transmission of HIV in military populations. The secondary focus of the program is to support preventive vaccine trials and other studies with behavioral data and assessments. This past year has been a period of transition from the collection of descriptive behavioral data, which formed the foundation for the initial behavioral interventions (through the Army Wide AIDS/HIV Survey – AWAS – and the Seropositive Behavioral Survey – SBS), to initiation of behavioral intervention protocols and development of a field site capability to assess the interventions.

Approach/Strategy:

The basic principle underlying this research program is that interventions must be developed based on extensive knowledge about the population for whom the

interventions are designed. For this reason, the AWAS and SBS data have been invaluable in assisting in designing the initial interventions.

In addition, sexual behavior is influenced by biological factors as well as by learned social and cultural patterns. Because of this, changes in sexual behavior are difficult to achieve and interventions will be differentially effective. Thus, behavioral, sociodemographic factors such as age, race, ethnicity, and gender, and neurobehavioral factors such as coping and cognitive style, will influence the impact of these preventive interventions. One of the goals of BPP interventions is to identify individuals or clusters of individuals, as defined by the above factors, who are most amenable to the different interventions being evaluated.

In order to ensure maximum comparability across BPP studies, we have developed a core set of assessment measures for seropositive and seronegative samples. Hence questions about risk behavior are asked in identical ways with identical measurement units. Although sampling procedures for studies differ, thereby limiting exact comparisons, rough comparisons can be made concerning behavior and intervention efficacy across the three services. The core measures were developed based on the preliminary analysis of AWAS and SBS data. We narrowed the range of questions to the most specific behavioral and associated risk factors that had a sound psychometric basis. This allowed development of a more abbreviated assessment measure for further study populations.

The Behavioral Prevention Program has developed a field capability at four sites, for the purpose of evaluating a series of research protocols. These field sites are located at Ft. Bragg, NC (USA); San Antonio, TX (USAF); San Diego, CA (USN); and in the Washington area. Information gained from the first interventions at each site will be analyzed by the Fall of 1995, and a plan to transition potential interventions to the services' operational HIV Prevention Programs will be enacted.

Current Status/Accomplishments/Plans:

Over the past twenty-four months, the Behavioral Prevention Program has increased the momentum of its program, moving towards intervention development focusing on populations at highest risk within the military. In addition, the Program has developed a plan to support active field utilization of behavioral interventions.

1993

- Completed Tri-Service HIV Biopsychosocial Study including:
 1. Seropositive Behavior Survey
 2. Psychosocial Questionnaires
 3. Neuropsychological Assessment
- Completed Army-Wide AIDS/HIV Study.
- Assessed Psychological Factors related to Adherence to Vaccine and Drug Trials.

1994

- Initiated RV81 - Comparison of three behavioral interventions to reduce HIV exposure in a STD population.
- Initiated RV76 - Comparison of two formats to deliver HIV education in large group forum (Basic Trainees).
- Initiated RV89 - Impact of Uncertainty and Affective Reactions of Obstetrician Gynecologists in delivering HIV education.
- Completed development of three behavioral interventions to reduce HIV transmission in HIV+ population.
- Program Successfully Reorganized to a Field Site Structure.

Current Status:

- Data collection ongoing and will be completed for:
 1. RV81 - Comparison of three behavioral interventions to prevent HIV exposure in an STD sample. (30%)
 2. RV76 - Comparison of two formats to deliver HIV education in a large group forum. (10%)
 3. RV72 - Evaluation of an IAVD for seropositive individuals. (< 5%)
 4. RV82 - Alpha testing of two behavioral interventions to reduce HIV transmission in HIV+ individuals. (10%)
- Data collection ongoing and will be completed for Operational Evaluations of existing HIV education efforts in each of the three services. (30%)
- Completion of RV89 - "Obstetricians-Gynecologists' Affective Reactions to

Uncertainty and Discussing HIV / AIDS During Routine Gynecologic Care".

- Preparation of manuscripts from research data bases. (15%)
- Phase-out of BPP Program. (< 5%)

EXECUTIVE OFFICE OF THE PRESIDENT

COUNCIL OF ECONOMIC ADVISERS

WASHINGTON, D.C. 20500

96 APR 17 A8:59

April 17, 1996

MEMORANDUM FOR WHITE HOUSE SENIOR STAFF

FROM:

MARTIN N. BAILY

Martin N. Baily

SUBJECT:

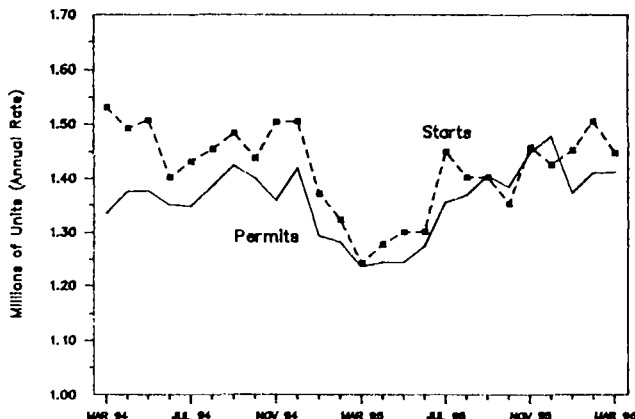
March Housing Starts, Commerce Department Release, Wednesday, 8:30 a.m.

Total housing starts fell 3.9 percent in March to an annual rate of 1.45 million units--in line with market expectations. The drop might be an early consequence of the March increase in mortgage rates (chart at lower right). Despite the decline, the level of starts in March was in the same range as during the second half of last year.

- Both single- and multi-family starts fell in March.
- The decline in March was concentrated in the Western part of the country--the same section that had seen the largest increases in January and February.
- Because starts precede residential spending by several months, the pattern of housing starts suggests that residential construction will make a solid contribution to real GDP growth in the first quarter.

Building permits--an alternate and somewhat more stable indicator of housing activity--was unchanged in March, about the same as market expectations.

HOUSING STARTS AND BUILDING PERMITS



MORTGAGE COMMITMENT RATE
30-Year Fixed

